Abstract P089 Figure 2 Final prototype liver model (1:1.3 scale) with embedded vasculature and tumour (above) and endoscopic view of right hepatic vein inside model (inset)

and was not adversely impacted by the COVID-19 pandemic. Patients do not need to travel to central hubs, and can remain under the care of their local hepatologist maintaining continuity of care and also promoting their involvement in decision making process. However, monitoring of 6- and 12-month response after starting OCA can be challenging as it is reliant on receiving follow-up data from the referring clinician. OCA dose must be adjusted based on the stage of liver disease and presence of pruritus.

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P090

ASSESSING DOCUMENTATION OF ASCITIC PARACENTESIS IN LANCASHIRE TEACHING HOSPITALS NHS TRUST

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Ascites is a common presentation of decompensated liver cirrhosis and is associated with 50% mortality over 2 years.¹ Although complication rates of paracentesis are low (1.6%) and usually mild, significant complications including bleeding and death can ensue.²

The aim of the study was to measure the Lancashire Teaching hospitals NHS Trust's compliance for paracentesis documentation using the British Society of Gastroenterology and British Association of study of liver disease's paracentesis safety toolkit.³ The study involved retrospectively collected data from patients between January and April of 2020. A total of 13 patients were identified in keeping the inclusion criteria (known liver cirrhosis patients admitted with large volume ascites).

We found poor documentation practices involving procedure in the person performing procedure (84%), consent (53%), pre-procedure weight (15%), the plan for the amount of human albumin solution to be given (61%) and total given (38%), platelet count documentation (84%), recorded time of insertion (85%), color of the fluid drained (53%), and plan on when to remove the drain (61%). The audit also noted poor documentation post procedure including recorded time of removal (38%), total ascites drained (46%), and patient's weight recorded after removal (0%).

An updated version of the BSG toolkit was designed (divided into 2 main forms; 1 for insertion and the other for removal of drain), which will be implemented on the wards as well as the local trust's online system to aid documentation on the acute medical wards and emergency department. Furthermore, teaching sessions will be implemented to the medical and nursing staff rotations. Moreover, there is a plan to liaise with the education team to add a learning module on the induction for medical and nursing rotations.

This audit found poor documentation practices on a commonly performed procedure on the wards especially in patients with decompensated liver cirrhosis. The purpose of this audit was to highlight this and to point out that a unified documentation including all parameters should be present. This aids the clinicians in making decisions regarding patient care, enhances patients' safety and prevents important information from being missed. In addition, this could potentially save time especially on ward rounds.

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P091

A COORDINATED NATIONAL RESPONSE MAINTAINED A SAFE AND EFFECTIVE UK LIVER TRANSPLANT PROGRAM DURING THE FIRST YEAR OF THE COVID-19 PANDEMIC

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Background UK healthcare provision has been severely affected by the COVID-19 pandemic, with specific challenges in liver transplantation (LT). Here, we describe the co-ordinated response to, and impact of, the first year of COVID, across all 7 adult and 3 paediatric UK LT centres.

Methods A series of national policy changes affecting the LT process were agreed. A 'high-urgent' (HU) category was established, prioritising for LT those with UKELD >60, HCC reaching transplant criteria, and others likely to die within 90 days. Donor age restrictions and changes to offering were phased throughout the year. These changes were flexed in response to the 'first wave' (implemented: March–July 2020) and 'second wave' (implemented: Jan–April 2021). During the second wave, organ and patient 'back-up' arrangements were introduced, selected centres were designated 'protected' by

Abstract P091 Figure 1 Number of livers from UK deceased donors offered, retrieved and transplanted, 4 February 2020 to 5 April 2021

NHSE and some patient care was transferred between centres, when overwhelmed critical care necessitated temporary unit closures.

Results During 2020/21, there was a significant fall in the total number of annual liver donors (21%; 870 from 1088) and transplants (22% 749 from 950) compared to 5-year mean, prior to the pandemic. This was exclusively amongst adult recipients (23%; 672, vs 868), both elective (22%; 609 vs 778) and SU (30%; 63 vs 90), whilst paediatric activity was maintained (77 vs 81). The reduction in adult LT varied widely geographically (-3 to -43%). LT registrations fell (11%; 1063 vs 1208), again with wide geographic variation (0 to -24%).

During the 'first wave', we successfully prioritised those with highest illness severity with no reduction in 90d patient ($p=0.89$) or graft survival ($p=0.98$). There was a small (5% cf 3%) but significant ($p=0.0015$) increase in deaths/removals from the UK LT waitlist, during this time. During the 'second wave', 5 adult units temporarily closed at various times, whilst 3 'protected' LT centres were maintained at any time. Consequently, 25 waitlist registrants were transferred to protected centres with 10 undergoing LT outwith their original centre.

Discussion A sophisticated national response has maintained a safe and effective UK LT program throughout the first year of COVID. We adapted our resources, implementing phased donor restrictions and a new category for recipient prioritisation. Patients benefitted from collaborative working, enabling those in most need to be transferred and transplanted in protected centres. Consequently, we mitigated against a significant fall in LT activity. Our collaborative response serves as an exemplar for other specialist healthcare services.

P092 SOCIOECONOMIC STATUS IS NOT A BARRIER TO LIVER TRANSPLANTATION FOR PATIENTS WITH ALCOHOL RELATED LIVER DISEASE

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Introduction Alcohol related liver disease (ArLD) carries significant morbidity and mortality; approximately 75% of deaths from liver disease in the UK result from excess alcohol consumption. Liver disease prevalence shows marked

geographical variation and people with liver disease living in the most deprived quintile die on average 9 years earlier than those living in the least deprived quintile. This study reviewed records for patients referred for transplant assessment with a history of ArLD to examine for obvious demographic, social or aetiology-based discrepancies in listing decisions.

Methods Electronic records of patients with a history of ArLD referred to our unit for liver transplant assessment between January 2019 and December 2021 were retrospectively

Abstract P092 Table 1 Baseline demographics, social factors, aetiology of liver disease, period of abstinence and assessment outcome of patients referred for liver transplant assessment with a history of ArLD

	Number assessed (%)	Number listed	% of category listed
Location at time of assessment			
Inpatient	50 (40)	33	66
Outpatient	75 (60)	54	72
Sex			
Male	97 (78)	69	71
Female	28 (22)	18	64
Age (years)			
20–29	2 (2)	1	50
30–39	6 (6)	4	67
40–49	22 (22)	15	68
50–59	49 (39)	37	76
60–69	43 (34)	29	67
70–79	3 (2)	1	33
IMD Quintile			
1 (most deprived)	21 (17)	13	62
2	29 (23)	23	79
3	33 (26)	23	70
4	23 (18)	16	70
5 (least deprived)	19 (15)	12	63
Residence			
Own house	54 (43)	37	69
HA/council house/HMO/rehab	22 (18)	12	55
Rented house	16 (13)	11	69
Lives with family	10 (8)	9	90
Caravan	2 (2)	2	100
Care home	1 (1)	1	100
Unknown	20 (16)	15	75
Employment			
Active	27 (22)	18	67
Retired	21 (17)	14	67
Unemployed	77 (62)	55	71
Aetiology of liver disease			
ArLD	63 (50)	46	73
ArLD + HCC	27 (22)	16	59
ArLD + 2nd aetiology	35 (28)	25	71
Period of abstinence			
0–3 months	15 (12)	9	60
4–6 months	26 (21)	18	69
7–12 months	37 (30)	25	68
13–24 months	25 (20)	18	72
25–36 months	9 (7)	7	78
>36 months	13 (10)	10	77