medical cause(6), drug-induced (3), no cause found (4). There were no cases of hospitalisation because of raised ALT and no cases of acute liver failure secondary to statins.

Conclusion Only 35% of cardiology patients started on statins had baseline LFTs measured and ¼ had a raised ALT. Most resolved during follow up. Only 2% had a transaminitis with an ALT > X10 ULN. None came to harm from this. Our results, even though not showing good compliance to NICE guidelines, confirm the safety of statins, in keeping with current evidence³. Monitoring of ALT after starting statin therapy only in symptomatic patients appears to be safe and would lead to savings in time and resources.

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PWE-28 'FURTHERING THE FIBROSCAN': PROMOTING THE USE OF TRANSIENT ELASTOGRAPHY IN PATIENTS WITH ALCOHOL DEPENDENCE

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Introduction Early identification of alcohol-related liver disease in patients with alcohol dependence is vital, both to enhance their clinical management and as a potential motivator for abstinence.¹ The current Commissioning for Quality and Innovation (CQUIN) performance target necessitates that at least 20-35% of alcohol-dependent patients are offered referral for transient elastography (Fibroscan) during a >1 night admission.² We aimed to assess and optimise our Fibroscan referral rate to ensure we were meeting this CQUIN target in our district general hospital.

Methods Quarterly data from 1st April 2020 – 31st March 2021 (Q1-4) was retrospectively analysed to determine the Fibroscan referral rate for alcohol-dependent inpatients. Those with known fibrosis, cirrhosis or prior Fibroscan within the last year were excluded. Interventions were then implemented via quality improvement methodology PDSA (Plan, Do, Study, Act) cycles. Existing alcohol liaison and Fibroscan referral pathways were simplified in PDSA #1 and #2, whilst PDSA #3 involved promotional educational programmes. Appointment of designated 'nurse champions' is currently underway for PDSA #4.

Results 128 patients met the inclusion criteria for Fibroscan referral. Between Q1 and Q4, the Fibroscan referral rate improved from 16.7% to 46.2% (Figure 1). The referral rate for patients admitted via the medical take increased from 19% (4/21) to 55% (11/20). However, for those with simply an overnight admission to the Emergency Department Observation ward before next day discharge, the referral rate increased less markedly from 0% (0/3) to 20% (1/5). Of the patients who underwent Fibroscan, 10.8% (4/37) had a significant finding of bridging fibrosis and were referred to hepatology services.

Conclusions This project has been a useful tool in highlighting gaps in our assessment of alcohol-related liver disease. We have demonstrated that our existing practice had failed to meet national performance targets, but that simple yet

Abstract PWE-28 Figure 1 Run chart data of Fibroscan referral rate in inpatients with alcohol dependence

effective interventions have markedly improved Fibroscan referral rates. These are easily reproducible in other trusts, and the implications for both patient care and CQUIN financial payment is clear. Indeed, if current performance is maintained, the trust will receive the maximum £100,000 annual CQUIN payment.² However, there remains scope to continue progressing referral rates, especially in the Emergency Department Observation ward setting, and efforts remain ongoing locally.

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PWE-29 ATTITUDES TO OFFERING INCENTIVES IN THE TESTING AND TREATMENT OF HEPATITIS C

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Introduction Hepatitis C virus (HCV) is now easy to test for and straightforward to treat, but encouraging those most at risk to engage with services can be more challenging. Incentivisation for testing and treating already takes place in some places for HCV as well as for other conditions. However, this is controversial for various ethical and practical reasons. We conducted a survey of people who work within two HCV Operational Delivery Networks (ODNs) to understand current attitudes to incentivisation.

Methods An anonymous online survey (Web Survey Creator[®]) was sent to participants of the Wessex and Southwest HCV ODNs in January 2020. Questions included personal experience of HCV incentivisation and its effect on engagement, opinion of incentivisation and the appropriate value, type and timing of an incentive.

Results There were 32 respondents, representing a range of ODN participants; specialist nurses(13), hepatologists(8), drug & alcohol workers(3), peer support(2), commissioner(1), other (5). 15/32 (46.9%) did not agree with offering financial incentives, 12/32 (37.5%) did agree and 5/32 (15.6%) were undecided.

14/32 (43.8%) had personal experience of financial incentives. 69% of those with experience felt incentives had increased engagement with HCV services and negative

consequences were encountered by 5/11 (45%) (3 did not answer). Consequences included increased drug dealing in the area and patients swapping vouchers for drugs.

Of those who agreed with incentives, 71% felt shopping or taxi vouchers would be preferable to cash. Appropriate value was split; 41% felt it should be $\leq$ £10, 27% $>$ £10 $\leq$ £40 and 32% $>$ £40 $\leq$ £50.

Timing of incentive could be at initial testing (preference for 8%), starting or completing treatment (preference for 21% & 25% respectively) or at all of these opportunities (46%).

There was no clear consensus on who would be best placed to give the incentive; 35% felt drug & alcohol services, 15% nurse specialist, 15% peer support worker, 5% pharmacist, 2.5% doctor and 27.5% felt any of these could provide it (respondents could select more than one option).

Respondents were asked how comfortable they felt patients with HCV would be with offering incentivisation (very uncomfortable=1, very comfortable=5). 68.9% of respondents felt patients with HCV would be comfortable or very comfortable with incentives.

Conclusions There was no clear consensus on incentivisation within these two HCV ODNs. Where offered, incentives have been felt to promote a rise in engagement, but alongside negative consequences. Vouchers were deemed preferable to cash. The survey was useful in gauging current attitudes as ODNs seek bold and innovative ways to test and treat HCV in working towards eradication. The impact of incentivisation where used should be carefully assessed to look for efficacy and any negative consequences.

PWE-30 USE OF A DISCHARGE BUNDLE CAN IMPROVE POST-ADMISSION CARE FOR PATIENTS WITH DECOMPENSATED CIRRHOSIS

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Introduction Decompensated Chronic Liver Disease (DCLD) is a medical emergency with high morbidity and mortality. Appropriate follow-up and monitoring can reduce readmissions and improve both outcomes and quality of life. It is vital that discharge planning and documentation is of a high standard to ensure key aspects of post-admission follow up are arranged and communicated to the patient and primary care team. The BSG Decompensated Cirrhosis Discharge Bundle (<https://www.bsg.org.uk/clinical-resource/decompensated-cirrhosis-discharge-bundle/>) was developed to support high-quality discharge planning, and we sought to evaluate the use of the bundle in our hospital.

Methods A retrospective audit of case notes and discharge summaries was conducted of all patients discharged from the gastroenterology ward with a diagnosis of DCLD over 3 months. This data was used to establish a baseline for completion/documentation of each item in the bundle checklist. The bundle was then implemented, and a further 40 DCLD discharges subsequently reviewed against the same criteria, followed by analysis of pre- vs post-bundle results.

Results The baseline cohort comprised 40 patients (21 male, 19 female; median age 60 [38-83]), with a further 40 patients included in the second cycle (25 male, 15 female; median age 45 [33-65]). Hepatic encephalopathy (63%, n=25) and ascites

(70%, n=28) were commonest reasons for admission. Introduction of the bundle led to improvements in several areas. 80% of appropriate patients had an out-patient paracentesis procedure booked prior to discharge after bundle introduction, compared to just 7.7%; $p<0.001$) beforehand. Likewise, variceal screening endoscopy was arranged for 50% post-bundle (27.5% pre-bundle; $p=0.21$), and more of those with recently identified varices were appropriately discharged on primary prophylaxis (50% vs 37.5%; $p=0.26$). Patients admitted with hepatic encephalopathy were more likely to be discharged with appropriate lactulose (93% vs 40%; $p<0.0001$) and Rifaximin (63% vs 22.5%; $p<0.0001$). Those with alcohol related liver disease had improved rates of planned community follow-up (83% vs 11%; $p<0.0001$) and documented need for abstinence (100% vs 30%; $p<0.0001$). Finally, communication was also improved, both for advice to primary care about renal function (documented in 70% vs 8.8%; $p<0.001$), and explanation of the need for specific medications (50% vs 12.5%; $p<0.0001$).

Conclusion Implementation of the discharge bundle led to improved discharge planning and documentation, justifying the continued use of the checklist for patients hospitalized with DCLD.

PWE-31 USE OF NON-SELECTIVE BETA-BLOCKERS (NSBB) IS NOT DETRIMENTAL IN CIRRHOTIC PATIENTS WITH SEVERE ASCITES

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Introduction The use of non-selective beta-blockers (NSBB) is the cornerstone in the treatment of portal hypertension. Despite convincing data, scepticism surrounding safety of NSBB, particularly in severe ascites remains. We aim to study the survival outcome in patients with liver cirrhosis and severe ascites on NSBB.

Methods This was a single-centre retrospective study of 131 patients with liver cirrhosis and ascites who presented consecutively from January 2014 to December 2019 by attending nurse-led large volume paracentesis (LVP) service at the Sunderland Royal Hospital. Data was obtained from patient notes using Meditech™ patient database. Survival was calculated from the date when first LVP was performed. Two time-varying covariates, Transjugular Intrahepatic Porto-Systemic Shunt (TIPSS) and liver transplant, which occurred during the follow-up period were included in the adjusted analysis. Cox regression was used to compare the survival times in the two groups, both before and after adjustments for potential cofounders.

Results Patient characteristics and other observed variables were comparable in the NSBB (n=47) and No-NSBB (n=84) group. Alcohol was the commonest aetiology of cirrhosis and comparable ($p=0.72$) across groups, 87% and 89% of NSBB and no-NSBB group respectively. 66% and 64% of patients continued to drink alcohol in the NSBB and no-NSBB group ($p=0.85$). Refractory ascites was present and comparable ($p=0.76$) in 68% and 65% of the NSBB and no-NSBB group respectively. The frequency of LVP was comparable between the groups ($p=0.13$). The median MELD was comparable ($p=0.65$) at 15.2 [11.8, 18.7] and 15.0 [10.3, 18.4] in the NSBB and no-NSBB groups. There was no statistically