**Introduction**

A significant number of patients with liver disease lead chaotic lifestyles, which often hinders their engagement with essential healthcare services. These individuals are at an increased risk of developing hepatocellular carcinoma (HCC) and may frequently miss critical outpatient follow-ups, placing them at heightened risk for complications. This lack of consistent medical care is a key challenge, particularly among those struggling with drug and alcohol dependency. To address this gap in care, "Better Lives," a North London-based drug and alcohol dependency unit, has established a nurse-led community outreach team. The purpose of this initiative is to re-engage patients who are missing regular check-ups and provide them with targeted support. By doing so, the team aims to ensure that these vulnerable patients receive the necessary care and monitoring for their liver disease, ultimately reducing their risk of developing HCC.

**Method**

We aimed to review clinic data from January 2023 to May 2024. Patients with a FibroScan reading of >9 kPa prior to Hepatitis C Virus (HCV) treatment or those with advanced fibrosis (F3/F4) were referred to this clinic. During the review, the nurse recorded patient attendance and checked whether a FibroScan (within the last three years) and an ultrasound (within the last six months) had been performed. We also reviewed hospital records to assess the Did Not Attend (DNA) rates for both clinic appointments and ultrasound scans.

**Result(s)**

Thirty-five patients attended the community outreach clinic, with 80% having liver disease related to HCV and 14% due to alcohol-related liver disease. Only 5% had attended their local hepatology follow-up. Of the attendees, 51% returned to the outreach clinic more than once, and 79% had a FibroScan within the last three years. 40% had an up-to-date ultrasound scan, and two cases of HCC were identified. Unfortunately, 37% of patients missed their scheduled ultrasound appointments.

**Conclusion(s)**

The results highlight the effectiveness of a nurse-led community outreach team. Prior to this service, 95% of patients did not engage with hospital appointments or HCC surveillance. Through our outreach efforts, we successfully re-engaged 46% of these complex, marginalized patients with advanced fibrosis. However, despite attending community outreach appointments, 13 patients missed their scheduled ultrasound scans. One way to address this issue is by implementing a one-stop clinic model, where all necessary services, including ultrasounds, are provided during a single visit.