implementing TDM with anti-TNF’s was collected. Logistic regression was used to predict factors influencing TDM use.

**Results** 243 respondents participated (51.6% male) of which 237 respondents met inclusion criteria; treating >5 IBD patients and at least 1 with an anti-TNF per month. Of the total respondents, 45% were Consultant Gastroenterologists (GI), 40% IBD Nurse Specialists (CNS) and 15% GI Specialist Registrars (SPR). Of these 237 respondents, TDM was used by 95.7% for secondary loss of response; 71.4% for primary non-response and 53.6% used TDM proactively. Barriers for TDM use were time lag in receiving results (27.1%), lack of awareness of guidelines (15.6%), and cost (11.9%). Clinicians working at a teaching hospital were more likely to use TDM compared to a district hospital (OR 2.6, 95% CI 0.71–9.8). IBD CNS and GI SPR used TDM more often, when compared to Consultant GI (OR 2.6, 95% CI 0.69–10 & OR 1.5, 95% CI 0.3–7.2 respectively). Clinicians practising for >20 years were more likely to check TDM than less experienced clinicians (OR 4.1, 95% CI 0.4–41.8). Clinicians with large volume IBD practice (>50% IBD patients per month) were more likely to check TDM than those seeing fewer IBD patients (OR 45.6, 95% CI 7.5–275). Proactive TDM was more likely to be used by clinicians working in a tertiary care setting (OR 2.25, 95% CI 0.84–6.05), IBD CNS (OR 1.2, 95% CI 0.6–2.1), clinicians managing large volume IBD practice (OR 10.8, 95% CI 1.2–90) and clinicians with 5–9 years of experience in practice (OR 2.6 & CI 1.04–6.42).

**Conclusions** Large volume IBD centres with more experience of treating IBD patients are more likely to employ treatment-optimising strategies with TDM. Significant barriers to TDM implementation in the UK are time lag from test to result, lack of awareness of current guidelines and evolving knowledge, cost and less experience. Validation of point of care tests was collected. Logistic regression was used to predict factors influencing TDM use.

**Results** Overall, n=97 UC patients (n=50 males, mean age 48 (range 18–82) participated. ICIQ-IBD data revealed that most patients experience FI (84/97 (87%) during ‘relapses’. Interestingly, 58/97 (60%) reported FI when in ‘remission’, and this group had higher median HADS depression (P=0.0002), poorer QoL scores (P<0.0001), and trend towards higher HADS anxiety (P=0.09) scores. Compared to those without FI, disease activity data (IBD-control and/or FCP) were available for all patients, and based on these 61/97 (63%) had quiescent UC. The prevalence of FI based on ICIQ-IBD did not differ between those with active (22/36, 61%) and quiescent UC (35/61, 59%), P=NS. In those with FI on ICIQ-IBD, median IBD-FI symptom scores, IBD-FI QoL scores and HADS anxiety; P=0.47, depression; P=0.18 did not differ between disease activity groups. However, within the quiescent group, patients that met the more stringent Rome IV criteria for FI (n=13) had higher median IBD-FI symptom scores (P=0.007) and HADS-depression scores (P=0.05), a trend to worse IBD-FI QoL (P=0.07), but similar HADS-anxiety (P=0.68).

**Conclusion** This study is one of the first to identify that regardless of disease activity, FI affects most patients with UC, detrimentally impacting patients’ psychological wellbeing, impairing their QoL, and should therefore routinely be screened for in clinics. There is an urgent need for further research in the often neglected area of FI and quiescent disease.