hospital-based ELISA testing were randomly selected. We compared these to 50 random patients who had a home-based FC testing. Patients who were supplied with home testing kits received training from IBD nurses as well as on-line training materials. Data was collated retrospectively. Compliance was recorded if result was documented within 6 weeks of request.

Result Prior to the introduction of home testing, only 52% of the patients' sampled complied with hospital-based testing. This compared to a 70% compliance rate, when home testing was requested. (Figure 1)

Conclusion The improvement in FC testing compliance with rapid home testing kit compared to laboratory based testing illustrates the benefit of adapting home testing as the standard in future. The considerable increase in compliance by home testing may be due less disruption to patient's personal life i. e., ability to undergo testing at home, symptoms such as faecal incontinence preventing patients delivering samples to hospital and COVID pandemic compelling patients to stay at home. Adopting rapid FC home testing as standard provides patients with increased locus of control regarding their care, providing health care professionals with rapid results, thus, will improve management of IBD. The ability for patients to perform home test has obvious advantages during the COVID pandemic.

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PTH-15 ECONOMIC ANALYSIS OF INTRAVENOUS IRON INFUSION IN IBD AND IDA: REAL WORLD DATA FROM UK

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Introduction Iron deficiency anemia (IDA) is a common symptom of inflammatory bowel disease (IBD), arising from the combined effects of gastrointestinal blood loss and reduced iron absorption. Intravenous (IV) iron is the preferred treatment option in patients with severe anaemia or in patients refractory to treatment with oral iron. Two high-dose, rapid-infusion IV iron formulations are currently available in the UK: ferric derisomaltose (FDI) and ferric carboxymaltose (FCM), differing in the nature of the carbohydrate with which the iron is complexed and the approved posology; FDI can be dosed up to 20 mg/kg bodyweight, while FCM can be dosed up to a maximum of 1,000 mg.

Aims and Methods The aim of the study was to evaluate the resource utilization and cost associated with treating IDA or hypoferritinemia with FDI versus FCM in patients with IBD in the United Kingdom (UK).

Data from 91 patients with IBD and either IDA or hypoferritinemia having received IV iron treatment at two UK gastroenterology services were pooled and analyzed using R. Of the included patients, 28 received FDI and 63 received FCM. Baseline age, bodyweight, hemoglobin, ferritin, and calculated iron need were compared between the FDI and FCM

treatment groups, and the total number of infusions administered to address the iron need was calculated. The average cost of treatment was then modeled using two approaches: healthcare resource group (HRG) tariffs from a national Department of Health (DoH) perspective and a microcosting analysis from the NHS Trust perspective. The HRG tariff approach utilized a weighted cost based on the 2019-20 tariff values for day cases and ordinary elective spells weighted by the combined day case and elective spell activity from 2018-19. The microcosting analysis captured observation and infusion time based on data from the summaries of product characteristics (SPCs) and the Personal Social Services Research Unit (PSSRU), costs of IV iron from the British National Formulary, and costs of giving sets, cannulas, and dressings from the NHS Business Services Authority and NHS Supply Chain.

Result None of the recorded baseline characteristics significantly differed between the FDI and FCM treatment groups ($p > 0.05$ for baseline hemoglobin, ferritin, and bodyweight). Patients treated with FDI received an average of 1.14 infusions to address the iron need (32 infusions in 28 patients), compared with 1.56 infusions with FCM (98 infusions in 63 patients). The economic analysis based on HRG tariffs showed that this would result in savings of GBP 121 per patient (GBP 334 with FDI versus GBP 455 with FCM), while the microcosted analysis showed cost savings of GBP 23 per patient (GBP 220 with FDI versus GBP 243 with FCM) from the NHS Trust perspective.

Conclusion An analysis of real-world data from two gastroenterology services in the UK showed that using FDI in place of FCM would result in 0.42 fewer infusions per patient to treat either IDA or hypoferritinemia in patients with IBD. In the UK, this reduction would be associated with cost savings of GBP 121 per patient from the national DoH perspective or savings of GBP 23 per patient from an NHS Trust perspective. The reduction in infusions associated with FDI also has the potential to free up infusion suite capacity for other patients, or other IV infusions in the same patient group.

PTH-16 LIFE IN LOCKDOWN: SUPPORTED SELF-MANAGEMENT OF IBD INCREASES DISEASE CONTROL THROUGH MY IBD CARE

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Introduction MyIBD Care is a mobile phone application delivering digital therapeutics and remote monitoring for patients with inflammatory bowel disease (IBD). The app provides a library of self-management content, direct messaging with clinical teams, and a range of clinically validated disease-measures.

During the first wave of the COVID pandemic many IBD patients were forced to shield due active disease or medication. In response to this we developed situationally relevant behavioral science-based courses to alleviate the increased risk of patients developing anxiety or depression due to isolation. Our two courses focussed on maintaining healthy relationships and exercise. The courses were created using the same behavior-change framework as existing courses in the app.

Methods Fifteen MyIBD users participated in a study designed to evaluate the effectiveness of the 'Life in Lockdown'

courses. We assessed changes in mental health (GAD-7) and disease control (IBD-Control) using patient-reported outcome measures delivered through the app.

Results Patients scored significantly higher on the IBD-control questionnaire following completion of either the 4 or 5-day courses, indicating that they feel more control over their disease following the intervention (median score 5 vs 8.5, $p < 0.002$). We observed non-significant improvement in self-reported anxiety and depression levels, a 17% improvement in self-reported wellbeing, along with an increased level of physical activity, and feelings of social connection.

Conclusions These measurable improvements following a short course highlight the need for supported self-care for people with IBD during uncertain times. Future work will investigate the effectiveness of non-lockdown-related courses on self-management of IBD in app users.

PTH-17 THE VIRTUAL REFERRAL TRIAGE CLINIC – A BENEFICIAL CHANGE IN PRACTICE?

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Introduction Due to the COVID 19 pandemic gastroenterology elective activities were suspended in March 2020. When elective services were reinstated, social distancing imposed within the Trust resulted in a significant loss in traditional F2F (face to face) clinic capacity. A Consultant led Virtual Referral Triage Clinic (VRTC) was introduced with the aim to ensure ongoing patient care within the confines of the pandemic. Our objectives were to review of all non-2WW clinic referrals to determine and maintain appropriate, safe patient management whilst reducing hospital attendances.

Method A Gastroenterologist reviewed all non-2WW referrals within 24 hours of receipt of referral. VRTC sessions (4 hours) were provided 5 days/week. The potential outcomes of triage were: redirect to a more appropriate speciality, direct to straight to test (STT), discharge with 'advice and guidance' to the patient and/or GP and arrange a F2F appointment or telephone appointment (prioritised as urgent or routine). Data was collected in Excel and analysed.

Results Above 1900 non-2WW referrals between 01/04/2020 – 31/10/2020 were received. Complete data was available in 1448 cases allowing detailed analysis. 88.9% of referrals were from primary care, the remainder from secondary care. Below are the VRTC outcomes.

9% were redirected to another speciality; 68% of those to colorectal or upper GI surgery. 38% were directed to a telephone clinic. 25.3% went STT, the majority for endoscopy, radiology and/or bloods tests e.g. parenchymal liver screen. 100 of the STT cases were reviewed; 79% were discharged or discharged as failed to attend their STT investigation. A total of 42.4% were redirected or discharged at triage or following STT investigations. Overall 86.3% of patients were managed without a 'new' patient F2F clinic appointment. This equates to approximately 155 F2F clinic sessions (8 patients/session). It required 105 VRTC sessions to complete work, therefore saved 50 clinic sessions.

Conclusions The challenges include the ability to access enough information to enhance decision making at triage and the need to formalise in consultant job plans so that the process can continue. There is little evidence that neither patients

Abstract PTH-17 Table 1

Triage Outcome	Number	%
STT	368	25.3
Discharged with A&G	196	14.0
F2F Routine	469	32.0
F2F Urgent	84	6.0
Telephone Routine	168	12.0
Telephone Urgent	34	2.0
Redirected	129	9.0

nor GPs are significantly dissatisfied with this change in practice, with low rates of re-referral or complaint. It also does not appear patients come to harm or are mismanaged by this approach but may need longer term follow-up. There are obvious benefits: redirection of patients to more appropriate care, earlier diagnosis in those directed STT and a large reduction in unnecessary patient attendances with a subsequent significant reduction in the need for F2F clinic capacity.

PTH-18 ELIGIBILITY FOR A STRAIGHT TO TEST COLONOSCOPY EXAMINATION IS BEST JUDGED BY SECONDARY CARE

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Background Straight to Test (STT) is the delivery of an appropriate diagnostic service without the requirement for the patient to first attend an out-patient clinic hospital appointment. A STT colonoscopy pathway was initiated for 2 week-wait (2ww) colonoscopy examinations at Sheffield Teaching Hospitals in March 2019. This pathway is associated with a reduced time to colonoscopy and therefore cancer diagnosis or exclusion. To select appropriate patients, General Practitioners were asked whether patients were suitable for a STT examination on the referral form. Patients judged inappropriate for a STT examination were seen for a face to face consultation prior to colonoscopy. This study assesses whether there was justification for excluding these patients from a STT examination.

Methods The clinical notes and investigations of patients that were referred to the Lower GI pathway between May and July 2019 and judged inappropriate for a STT examination were reviewed by two clinicians. Demographic information, clinical symptoms, FIT results and investigations were performed. Potential reasons for exclusion from a STT examination were assessed and categorised. The incidence of colorectal cancer was also assessed.

Results During the study period 104/985 (11%) patients were judged to be inappropriate for a STT examination of which 42/104 (40%) were male with a mean age of 69 (range 42-89) years. Reasons for referral included assessment of bleeding (23), change in bowel habit (61), anaemia (46), positive FIT test (10) and abdominal pain (23) with many having overlapping symptoms. There was justification for exclusion from a STT examination in 70/104 (67%) patients: 37 had significant comorbidities of whom 3 had dementia, 13 due to patient choice, 8 were frail, 5 did not speak English, 3 were for