Results Of the 10 surveys sent out all recipients responded. 2 trusts have access to TNE with only one trust having access to a specific TN service performing approximately 150–200 per year. The 2 trusts with access to TNE had both received training in TNE from industry and also in-house training. The trust with a TNE service had also received training from other endoscopists experienced in TNE and an ENT surgeon. When compared with standard endoscopy 30% thought views were worse, 60% the same and 10% unable to comment (due to lack of experience of TNE). 60% thought biopsy samples were adequate, 20% too small and 20% unable to comment.

Advantages of TNE: 2 felt unable to comment due to lack of familiarity with this method. Improved patient tolerance was the main advantage stated by 7 with improved comfort, less gagging and reduced sedation requirements, with 1 stating less nursing support and therefore potential for evening lists and improving capacity issues as the main advantage.

Disadvantages: 2 unable to comment, 2 no disadvantages, 2-stated cost of set up, 1- failure of nasal passage, 1-narrow channel limits therapy, 1-prolonged preparation time compared to throat spray and 1- poor views.7/8 without access to TNE felt a TNE service would be beneficial to their trust and 5 would be keen to set it up in their trust. Reported barriers to set up were cost 6/8 and time 1/8. 6 would be more likely to set up a TNE service if training were available.

Conclusion TNE is not widely used in our region with only 1 of 10 trusts performing regular TNE lists. It is perceived by the majority of endoscopists to have significant patient benefit and the majority are keen to set up a service. The main restriction to use appears to be the cost of set up despite the opinion that TNE is cost efficient overall. It is indicated that making TNE training available may increase its use. This was a regional survey and it would be interesting to see if these results are replicated nationally.

Disclosure of Interest C. Parker Grant/Research Support from: Submitting author's post is funded by Imotech Medical, S. Panter: None Declared

PTH-135 EXAMINING THE ATTITUDES, PERCEPTIONS AND BARRIERS OF BOWEL SCREENING WALES STAKEHOLDERS

doi:10.1136/gutjnl-2013-304907.622

[1,*]D Snelling, [1]H Heard. [1]*Screening Division, Public Health UK NHS Trust, Cardiff, UK*

Introduction Service evaluation is of paramount importance for the continued improvement and development of any health intervention and there is very little documented evidence that examines the attitudes and perceptions of Bowel Screeing Wales (BSW) stakeholders. Anecdotal evidence has suggested several factors that contribute towards the uptake of bowel screening in Wales, such as, lack of understanding around screening, the nature of the test, and the will to complete the test, but this evidence has not been evaluated or documented.

Methods A qualitative descriptive approach was undertaken and semi-structured interviews were conducted with stakeholders at the Royal Welsh Show, Builth Wells, Powys during July 2012 to gauge their attitudes, perceptions, and barriers towards bowel screening. Inclusion criteria was for all eligible men and women aged between 60–74 years who have been invited to be screened.

Results 42 participants agreed to take part in the interview (19 male and 23 female) of which 31 participants reported completing their bowel screening test with 12 participants reporting they had not.

The results indicate that participants are aware of cancer and have a very basic knowledge regarding bowel cancer but are not necessarily aware of the function of the bowel screening programme. A content analysis framework was developed (Newell & Burnard, 2006) which identified two major themes; health beliefs and health behaviour. This service evaluation suggests that participant's perceived susceptibility influences their decisions to take part. Participants who are not aware of BSW or the risks associated with bowel cancer will not complete the kit. Furthermore, this service evaluation suggests that participants who do not present with symptoms are also less-likely to complete their kit. Furthermore, only a very small number of participants sited fear or anxiety as a contributing factor for participating even though they were aware that the kit was to test for cancer. Majority of the participants who declined the invitation suggested that this was due to dealing with their faecal matter. It is interesting to note that their reasons for not completing their kit were lethargy and apathy.

Conclusion Service evaluations are essential in understanding the attitudes and perceptions of stakeholders. The findings from this service evaluation suggest that participants have a limited knowledge of the risks associated with bowel cancer and know very little about the programme but perceive screening to be important. However participants perceived severity and susceptibility are contributing factors in their participation to accept or decline the invitation to be screened.

Disclosure of Interest D. Snelling Employee of: Bowel Screening Wales, H. Heard: None Declared

REFERENCE

Newell, R; Burnard, P (2006) Research for evidence-based practise. Blackwell publishing. Oxford. UK.

PTH-136 FAECAL CALPROTECTIN - IS IT REQUESTED APPROPRIATELY AND IS IT COST EFFECTIVE?

doi:10.1136/gutjnl-2013-304907.623

[1,*]E Derbyshire, [2]C Wells, [2]J Hancock, [2]D Dwarakanath. [1]*Gastroenterology, North Cumbria University Hospitals NHS Trust, Carlisle;* [2]*Gastroenterology, North Tees & Hartlepool NHS Foundation Trust, Stockton-on-Tees, UK*

Introduction Faecal calprotectin is a neutrophil derived protein that can be detected by quantitative enzyme linked immunosorbant assay in stool samples. It reliably predicts the level of mucosal inflammation in the lower gastrointestinal tract (1). The high negative predictive value of faecal calprotectin should lead to invasive investigation being avoided with a subsequent reduction in cost and demand on already stretched endoscopy services (2). We reviewed the use of faecal calprotectin in the trust to establish if current practise confirms this.

Methods The hospital numbers of all patients who had a faecal calprotectin processed at North Tees & Hartlepool NHS Foundation Trust from 01/04/2011 to 31/12/2011 were collected from the biochemistry department's database. These patients' case notes were then analysed to record the indication for faecal calprotectin, its result, subsequent investigation and management.

Results Faecal calprotectin was requested in 2 groups of patients: 68 with lower gastrointestinal symptoms and 44 with Inflammatory Bowel Disease (IBD). Of the 68 patients with lower gastrointestinal symptoms, faecal calprotectin was normal in 48 patients: 13 (9 males, 4 females, median age 30 years, commonest symptom abdominal pain) at initial presentation had no further investigation, 23 (11 males, 12 females, median age 41, commonest symptom abdominal pain) went onto have further investigations (12 colonoscopies, 3 flexible sigmoidoscopies and 1 small bowel meal and follow through; all normal); in 12(3 males, 9 females, median age 45, commonest symptom chronic diarrhoea) the negative faecal calprotectin was as a second line following initial investigation including 8 normal colonoscopies and 1 normal flexible sigmoidoscopy. Of those patients with IBD, faecal calprotectin was normal in 9 patients. In 7 patients management decisions were taken on the basis of its result alone. These included commencement of Infliximab (n = 2), 6-mercaptopurine (n = 1), azathoprine (n = 1), pentasa (n = 2) and prednisolone (n = 1) without further investigation.