

were included. Exclusion criteria: outpatient and A&E attendances, telephone consultations.

Results Between 2004 and 2011 the mean inpatient readmission rate for medical detoxification was 26.7% (484 readmissions, 1813 total admissions). On average 22.4% of medical and surgical inpatients were readmitted over the 7-year period (293 readmitted/1512 total admissions). Both the yearly readmission rate and percentage of patients requiring readmission increased by 589% and 689% respectively between 2004 and 2011, peaking in 2008–2009 predominantly due to an increase in patients readmitted once (four patients in 2004–2005 compared to 67 patients in 2008–2009). On average patients were readmitted 2.5 times for detoxification. The average period between readmissions was 9.4 months. 10% of patients were re-admitted for detoxification more than 5 times in this period (mode 6 readmissions, range 6–23 readmissions).

Conclusion Admission rates for inpatient detoxification are high. However, <25% of patients require readmission and only a minority require more than five detoxifications, thereby reflecting the efficacy of the ASN and Alcohol Care Team in minimising revolving door patients and the economic cost incurred. We recommend that all general hospitals should offer this service to effectively manage alcohol misuse.

Abstract PTU-261 Table 1

Year	% Patients readmitted (absolute value/total patients)	% Readmissions (absolute value/total admissions)
April 2004–March 2005	3.9 (6/154)	4.6 (8/174)
2005–2006	19.5 (32/267)	15.4 (52/337)
2006–2007	14.2 (22/155)	20.3 (40/197)
2007–2008	19.0 (33/174)	22.7 (51/225)
2008–2009	40.6 (89/219)	43.1 (132/307)
2009–2010	17.8 (49/275)	39.5 (98/248)
2010–2011	23.1 (62/268)	31.7 (103/325)

Competing interests None declared.

REFERENCES

1. **BMA Board of Science.** *Alcohol Misuse.* 2008.
2. *Health Select Committee Report on Alcohol.* 2010.
3. **NHS Evidence.** *Alcohol Care Teams.* 2011.
4. **Moriarty K, et al.** *Alcohol Related Disease.* 2010.

PTU-262 ALCOHOL-MISUSE AND INPATIENT DETOXIFICATION: THE INCREASING WORKLOAD AND IMPACT OF AN ALCOHOL CARE TEAM AND ALCOHOL SPECIALIST NURSE (ASN) IN A DISTRICT GENERAL HOSPITAL

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Introduction The prevalence of alcohol misuse has risen dramatically over the past decade with younger individuals (aged 16–44 years) and women increasingly affected.¹ In 2007 24% adults were classified as hazardous drinkers (33% men, 16% women).² Over a 15-year period hospital admission rates for alcohol-related disorders have doubled,³ with significant social and economic consequences. Recently, The British Society of Gastroenterology and NICE recommended an Alcohol Care Team including an ASN in every District General Hospitals to ensure early and effective inpatient treatment of patients with alcohol misuse; maximising compliance and reducing relapse. Studies indicate that an ASN generates 400

fewer admissions per year with shorter durations of stay and lower mortality rates.⁴

Methods We retrospectively audited the impact of the ASN on rates of inpatient referrals and medical detoxification regimes undertaken between 2004 and 2011 at Bassetlaw District General Hospital. Rates of commenced and completed detoxifications in addition to self-discharge data were obtained. Medical and surgical inpatients were included. Exclusion criteria: outpatient and A&E attendances, telephone referrals.

Results Between 2004 and 2011 the number of inpatient referrals for medical detoxification increased BY 657% (49–371 referrals per year). On average, the majority of inpatients were male (66%) and 48 years of age (range 17–90 years). Over a 7-year period the number of inpatient detoxifications commenced increased by 600% (24–168 detoxifications per year). Similarly, completed detoxifications increased by 517% (23 and 142 completed detoxifications in 2004 and 2011 respectively). On average 90.8% (714/786) detoxifications were completed prior to discharge. 9.2% (72/786) patients self-discharged prior to completing the detoxification regime.

Conclusion The workload of the Alcohol Care Team and ASN has increased substantially over a 7-year period, reflecting the rising prevalence of alcohol misuse and alcohol-related disease. The ASN provides early recognition and implementation of medical detoxification regimes for inpatients, offering support and continuity of care to maximise compliance and efficacy of treatment. Greater recognition and investment in alcohol services is essential within all UK District General Hospitals to minimise the growing burden of alcohol misuse.

Competing interests None declared.

REFERENCES

1. **BMA Board of Science.** *Alcohol Misuse: Tackling the UK Epidemic.* 2008.
2. **NHS Information Centre.** *Statistics on Alcohol.* 2010.
3. **Institute of Alcohol Studies.** *The Impact of Alcohol on the NHS.* 2009.
4. **NHS Evidence.** *Alcohol Care Teams: To Reduce Acute Hospital Admissions and Improve Quality of Care.* 2011.

PTU-263 IS IT TIME FOR GASTROENTEROLOGY AND GENERAL MEDICINE TO GO THEIR SEPARATE WAYS?

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Introduction Currently most gastroenterologists within the UK are general physicians with a specialist interest in gastroenterology (85%) and most gastroenterology (GI) trainees train for dual accreditation in GI and general internal medicine (GIM). They therefore commit a major part of their time to the management of patients with GIM problems as part of their unselected acute medical take and ward work. With the development of “acute medicine” as a specialty in its own right and the formation of specialty-based wards to care for medical in-patients it has been questioned whether gastroenterologists should train to obtain dual accreditation in GI and GIM. The increasing demands for provision of GI services further support the conflict of whether training in GIM is required. With this in mind, we aimed to assess patients admitted with a primary GI complaint that should be triaged to a GI ward, the number of acute (active) non-GI diagnoses requiring acute treatment and whether these were managed by gastroenterology or whether referral to a specialist team was made.

Methods A single centre, prospective analysis of all patients admitted with a primary GI diagnosis during the unselected general medical take over a 6-week period (November 2011–January 2012)