Directory of acute adult services in the Norfolk and Norwich University Hospital.

This document aims to provide information for health professionals who wish to refer their adult patients into Acute Services at the Norfolk and Norwich University Hospital. The document can be navigated by using the embedded links.

It acts as a reference for health professionals who work within the NNUH. The document is closely associated with the NNUH's Internal Profession Standards (IPS) Policy. It focuses on areas where historically confusion can arise. It is not a "fixed" document but one which is expected to evolve as different services are setup and pathways change. Suggestions are welcome and can be made via email to: edward.markham@nnuh.nhs.uk

The principle used within this document is that the team who ***can*** provide definitive treatment for the primary presenting condition will admit the patient and co-ordinate their care. This holds even if the definitive treatment is not required. This also holds at any point along the patient's journey, accepting that initial diagnosis is often unclear.

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Same Day Emergency Care

The recent joint position statement from SAM and RCEM:

***"S**DEC should not be used for patients who present to the Emergency Department who would not have been considered for admission to an inpatient bed. This includes patients directly referred from primary and community care or Urgent Treatment Centres (UTC). With the advances in turnaround time and the development of new diagnostics, the clinical conditions and patient cohort who are suitable for management in SDEC will continue to evolve. We encourage organisations to be agile in their approach to appropriate use of SDEC services to ensure maximum benefit to all patients.
SDEC is not an alternative to an inpatient bed if that is what the patients needs even at times of system stress and is not "a place to wait" for that bed. Neither is it an alternative facility to be used to maintain performance against any time-based target".

Same Day Emergency Care Services are intended for the assessment and treatment of patients who would otherwise have been admitted to an acute bed. The services should not be used to "decompress" the emergency department or as a route for primary care to bypass routine outpatient clinics.
The nominated individual who receives referrals for each service will act as the guide for whether SDEC is a reasonable route or whether direct admission, deferred SDEC appointment or redirection to routine outpatient or two-week-wait services is more appropriate.
To ensure patients are directed to an appropriate service the referring clinician should be able to provide basic observations and (when relevant to the proposed diagnosis and in a setting in which it is possible) basic blood tests, urinalysis +/- ECG.

Ambulatory Services within the Medical Division

- Medical Same Day Emergency Care (mSDEC)
- Venous thrombo-embolism Clinic (VTE / DVT clinic)
- Acute Oncology and Haematology Service (AOS)
- Rheumatology Day Unit
- Pleural Clinic
- Older People's Assessment Service (OPAS)

Ambulatory Services in the Surgical Division

- Surgical SDEC
- Fracture clinic (Orthopaedics)
- Plastics dressings clinic (Plastic surgery)
- APU (Plastic surgery)
- ENT outpatients
- Eye casualty (Ophthalmology)

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Medical Same Day Emergency Care (mSDEC)

- Brief introduction to the mSDEC
  - mSDEC is an Emergency Clinic setting for patients who would otherwise need a short (<24hr) admission to the Acute Medical Units (AMU). The mSDEC takes referrals from Primary Care practitioners such as GPs, Nurse Practitioners and ACPs. We mandate that an in person clinical assessment has taken place prior to referral.
  - Patients need to be close to their usual level of mobility. The expectation is that patients will need to wait in our waiting room before and during their assessments.
  - Trolley space is a major limitation in the clinic, so acceptance is ultimately at the discretion of the AMU Consultant running the clinic. Referrals can be made by contacting the consultant on 01603 286286 ext 7767. If this number is not being answered or not working, then an alternative is 01603 289623.
  - The clinic is open to referrals from 8-20:00 during the weekdays and 10-18:30 at the weekend.

- The mSDEC is located on AMUk, level 1 East Block. Paramedics can bring patients directly to the AMU ambulance bay, rather than using the ED entrance.

- mSDEC clinical lead: Ed Markham

- Useful documents
  - Paramedic quick reference guide to mSDEC
  - Core conditions accepted by mSDEC
  - Exclusion criteria and conditions not routinely seen in mSDEC

Pathways relevant to the mSDEC at NNUH

These are available on NNUH Intranet or by email Edward.markham@nnuh.nhs.uk

- [Pulmonary Embolism Pathway]
- [Lower Limb Cellulitis pathway]
- [Atrial Fibrillation pathway]
- [Pneumothorax pathway]
- [Chest pain pathway]
- Future pathways planned.
  - [Jaundice Pathway]
  - [Syncope Pathway]
  - [Heart Failure Pathway]
  - [headache pathway]
  - [discitis pathway]

Exclusion criteria and conditions not routinely seen in mSDEC.

Exclusion criteria

- Diarrhoea and Vomiting
- Under the age of 16yrs
- High suspicion of requiring admission
- Severe cognitive impairment or lack of mental capacity, attending without a carer.
- Very limited mobility. For example wheelchair users requiring hoisting or bedbound patients
- Patients without access to their own transport

Conditions less suited to a review in mSDEC

Exacerbation of Asthma / COPD. Both these conditions require a period of observation and potentially nebulisers and oxygen. This makes them less appropriate for an ambulatory pathway. General Practice are able to refer such patients directly to the AMU but paramedic cases are seen in the Emergency Department.

Headache. The vast majority of patients suffering with headaches are managed in primary care. More serious causes of headache usually require investigation such as imaging and/or a lumbar puncture. General Practitioners are able to refer to the AMU but all other cases of headache are seen in the ED initially.

Trauma, syncope and falls. All patients who have fallen and need further review have an initial assessment of their injuries in the Emergency Department. During the day, older or frailer patients can then potentially access the OPED service.

Stroke / TIA. With the development of thrombolysis and thrombectomy. Stroke is now considered to be an emergency. Patients are taken to the Emergency Department for review on arrival by the stroke nurse.

Seizures. As patients need to wait in the waiting room, there are clearly concerns if patients go onto have further seizures. Patients who have had a seizure can be referred to the AMU by their GP, or where this is not possible can be seen directly in the ED.

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Venous thrombo-embolism (VTE) Clinic (DVT clinic)

- Scope of practice - The VTE clinic take referrals for patients with unilateral leg swelling.
- Referrals can be from General Practice, Emergency Department or Secondary Care (including the SDECs).
- There must be no history of trauma, chest pain or shortness of breath (Patients with possible co-existing Pulmonary Embolism are excluded from the VTE clinic). Patients with bilateral symptoms are not accepted, as it is rare that a DVT is responsible for this. Please consider other differentials if the patient has bilateral leg oedema.
- The clinic is open from 8am to 2pm Monday to Saturday.
- The VTE clinic team can be contacted on 01603 286286 ext 3659

Acute Oncology and Haematology Service

- Scope of practice - the AOS take referrals for patients who are known to the Oncology and Haematology teams, and whom have an issue arising as a result of their cancer, or treatment for cancer. This may include issues relating to palliative care for cancer.
- AOS take referrals from patients, GPs and paramedics on a case by case basis.
  - For Oncology patients AOS can be reached via the AOS nurse on 01603 641752.
  - For Haematology patients contact the haematology specialist nursing team 01603 646753
- The AOS is located in the East Block on Level 3, next to the Jack Prior Unit

Rheumatology Day Unit

- Scope of practice – The RDU is a small nurse led clinic. Patients under the care of the Rheumatology Team may receive infusions of immunosuppressive medication.
- Referrals are not accepted directly but arranged internally by the Rheumatology Team.

Pleural Clinic

- Scope of practice – The pleural clinic is an outpatient ambulatory service for patients with pleural disease. Examples might include unilateral pleural effusions and pneumothorax
- Referrals from Primary Care are usually made as written referrals via a 2WW pathway or as urgent letters. They can also be made after discussion with the Respiratory SPR or Consultant on call.
- Referrals from the ED, or elsewhere in secondary care, can also be discussed with the SPR or Consultant, or via the pleural clinic email address; pleuralservice@nnuh.nhs.uk
- Radiographers can refer directly, if a CXR requested in the community shows a significant effusion.
- Responsible clinician – Professor E. Mishra

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Older People's Assessment Service (OPAS)

- Scope of practice – The OPAS is a clinic run by the OPM team in outpatients East.

- Referrals are accepted for patients over 70 years old, who don't have suspected CVA or Parkinsons (there are separate clinics for these patients). OPAS see a wide range of conditions including patients with falls, mobility issues, anaemia, breathlessness, weight loss. Broadly speaking any issues that are not related to an obvious single pathology.

- The OPAS team are happy to assist with managing patients over 70years old who develop anaemia or iron deficiency, for which an iron infusion is needed.

- The clinic is made up of a Multi-Disciplinary Team so where needed patients can access a physiotherapy assessment.

- Referrals are made via a referral form [available here] or via email to OPAS@nnuh.nhs.uk

- Responsible clinician is Dr A Schweigart

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Notes about Medical referrals

- This is not intended as an exhaustive list of the scope of practice in the Medical Division or to cover work done in outpatients. It aims to cover work done by Acute Services and it hopes to provide information in areas where confusion can arise. It also aims to give some indication about which teams will assume responsibility for different diagnoses.

- New admissions to the Medical Division are routinely admitted through the Acute Medical Units. The broad aspiration is that patients referred from the community are seen on the AMUk. On AMUk we operate an "ambulatory until proven otherwise" model, so we aim to see all suitable patients in the mSDEC. Patients referred from the Emergency Department are seen on the Priority Assessment Unit (PAU or previously AMUh)
- GP referrals are taken by a dedicated nurse (historically known as the 0002 nurse) who is reached via switchboard. We ask, whenever safe and appropriate, for as many cases as possible to be deferred to the following day. There is a dedicated switchboard number for GPs 01603 286666.
- Patients who are suitable for the mSDEC can be discussed directly with the mSDEC consultant on 01603 286284 ext 7767
- The AMUs and mSDEC can only accept referrals from practitioners who have seen the patient in a face to face consultation. In exceptional circumstances, where patients have not been seen face to face, cases can be discussed with the consultant on call – 01603 286286 ext 4742
- Referrers are asked to provide a referral letter. This needs to arrive with the patient or be sent via email to [amugpcorrespondence@nnuh.nhs.uk]
- Patients over 80years old who are seen in the Emergency Department will be considered for review by the Older People's Emergency Department (OPED) team. An SOP is available for this service.

Notes about Surgical referrals

- General Surgical referrals from within the Emergency Department and General Practice can be made via the "0001 bleep holder". 0001 is no longer reached via the bleep system, but is now contacted via Dect 6609, Alertive, or if outside the trust via Switchboard.
  - 0001 will determine if General Surgical cases are appropriate for review in surgical SDEC.
  - Inpatient referrals to General Surgery occur via the Surgical SPR on call, via Alertive
- Referrals to surgical specialties are via the on call SPR for each Specialty.
  - Individual Registrars can be contacted via Alertive or Switchboard.
  - The SPRs for each surgical specialty will decide if patients are suitable for surgical SDEC.
  - Inpatient Alertive referrals to urology are via the "ward SPR" rather than the "on call SPR"

- Post Operative Surgical Site Complications

  Patients with such complications are admitted directly to the operating team, Dermatology patients are admitted under plastics.

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NNUH Virtual Ward

The NNUH Virtual Ward team are happy to review and assess patients who might be transferred to the virtual ward to continue their care and management. A wide range of clinical scenarios are suitable for care on the virtual ward including:

- early supported discharge of COPD patients requiring nebulised bronchodilators,
- patients needing inpatient priority imaging who could otherwise be at home,
- patients needing blood test monitoring,
- supporting complex antibiotic therapy that might otherwise necessitate admission,
- any other scenario that a clinician feels might be suited to this pathway.

It should be remembered that the referring team clinicians are expected to have ongoing involved with the patient's care while they are on the virtual ward. The virtual ward team can take referrals until 16.30 each day. To be admitted to the virtual ward patients must be referred on ICE as follows.

Referral Patients should be referred using the ICE services request portal "Virtual Ward"

Contacts To discuss whether a patient might be suitable for care on the virtual ward please use the following contacts:

Alertive	Virtual Ward Referrals 08.30 - 16.30
DECT	5898

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Directory of Services by Pathology / Specialty

Infectious disease

This secion aims to focus on those areas where it may be unclear which team is responsible for managing patients with a particular infection. It also aims to highlight potential pathways that can be accessed to streamline patient care.

Skin and Soft tissue infections

- Cellulitis
  - Cellulitis of the lower limb is accepted by Medicine. This extends to cover the upper thigh, buttocks and abdomen, but only when there is no evidence of underlying abscess.
    - If patients are not septic or suffering with delirium, they may be suitable for mSDEC
    - Patients with infected leg ulcers that do not need debridement can be accepted to medicine.
  - Cellulitis around the eye or orbit is managed by ophthalmology. When patients are systemically compromised joint care may be needed. This will be discussed on a case by case basis at consultant level.
  - Cellulitis on the face and arm is managed by plastics.
  - Bilateral leg cellulitis is exceptionally rare. All other possibilities should be explored before even considering this diagnosis. Many patients will have venous eczema and admission for this is rarely needed. Where diagnostic doubt remains, an assessment can be considered in the medical SDEC.
  - If there is no evidence of an abscess, cellulitis on the abdomen, groin and buttocks can be admitted to the medical division. Where there is the suspicion of an abscess this will be managed by the Surgical Team until an abscess is excluded, see below.

- Varicella zoster virus
  - Shingles in immune-compromised patients, widespread shingles or suspected encephalitis associated with a singles infectionis managed within the medical division.
  - Shingles around the eye is managed by Ophthalmology.

- Necrotizing fasciitis is treated as an emergency and admitted under the plastics team. Urgent discussions will usually be needed with the Critical Care Team and any other relevant teams.

- Abscesses are managed by the Surgical Division, usually via the Surgical SDEC
    - Over or including a joint, or leg – orthopaedics
    - Upper limb (not axilla) – Plastics
    - Torso and axilla – General Surgeons
    - Head and neck
        - Face and anterior triangle of the neck – ENT
        - Dental – Maxfax
        - Back of the head – General surgery
    - Groin abscesses in patients who inject drugs – Vascular team, in those who do not inject drugs this is managed by General Surgery.
    - Breast abscesses – Breast team – not via sSDEC, but directly to breast clinic
    - Genital abscesses in female patients – Gynaecology team

- Pressure Sores
    - Pressure sores often occur in patients with underlying health problems. These patients are best managed by the team responsible for the underlying pathology. In the case of older patients suffering with frailty issues they may well be best managed by the Older People's Medicine Team.
    - Where there is underlying bone infection the Orthopaedic team will manage the patient
    - Tissue Viability Nurse team will provide wound care support.
    - Where soft tissue debridement is required, or there is acute infection, the Plastics Team will admit the patient.

Bone and joint infection

Osteomyelitis

- Osteomyelitis is usually managed by the orthopaedic team, unless this is in relation to frailty / nursing care associated pressure sores, in which case the General Medicine or Older People's Medicine teams (according to age) will manage overall care, with input from orthopaedic or plastic surgical teams as requested.
- Osteomyelitis of the foot in diabetic patients
    - Many of these patients can be managed by the Endocrinology team in the Elsie Bertram Clinic with support from the community antibiotic team or Alysham Medical Day Unit. The mSDEC may be a suitable place to start investigations in ambulant patients.

Discitis

- The presentation of patients with back pain + raised inflammatory markers is non-specific and is not enough to make the diagnosis of discitis. Patients will need to have cross-sectional imaging to make the diagnosis, ideally with an MRI, but where this cannot be arranged, a CT can be used initially.
- Those patients who are suspected to have discitis, after other differentials have been excluded, will be admitted under the Acute Medicine team for initial work up. In most cases this is expected to be with an MRI spine. If there are any concerns about neurological deficit the Spinal Team will be happy to review.

Once the provisional diagnosis of discitis is made on cross-sectional imaging:

- Medicine will accept patients >80years old and those patients <80years old with significant co-morbidities (such co-morbidities will include diabetes and chronic renal failure). Care of patients <80years old with other significant medical co-morbidities will be discussed on a case by case basis at consultant level.
- The Spinal Team will accept patients <80years old and those with any evidence of an epidural abscess on imaging. The spinal team will also accept patients who have had recent spinal surgery within the previous 6 months.
- If any medical issues arise in patients accepted by the spinal team the medical team will support as needed. For urgent issues this will be via support from the Medical SPR. For all other issues, first contact for the spinal team will be the Acute Medicine Consultant on call.
- Where there are other sources of infection, these will often have been responsible for the haematological seeding of the discitis infection. Care will be managed by the team responsible for these primary infections.
- Many patients can be managed with daily IV antibiotics via outpatient pathways.
- The microbiology team will offer guidance about antibiotics choice and duration of antibiotics. In most cases this is expected to be for 6 weeks duration of IV antibiotics, followed by 6 weeks of oral antibiotics. Bloods are checked weekly to ensure inflammatory markers are falling appropriately.
- A revised pathway will be available in the near future, to guide the care of patients with Discitis. For additional advice the Spine MDT occurs on Tuesday lunchtimes, this can be accessed via ICE.

Hot joints

- Septic arthritis is managed by the orthopaedic team
- If the patient has a known crystal arthropathy and presentation is consistent with a flare of this, the Rheumatology Team will review during the day, out of hours the patient can be seen by the AMU team.
- More information is available here

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Urinary tract Infections

- Lower Urinary Tract infections are common, the majority of patients will be managed in Primary Care. When patients become septic or delirious, an admission under Medicine may be needed.

- Ascending infection, such as pyelonephritis, infection of ureteric stents/stones or renal collections are managed by the urology team

- Prostatitis is also managed by the urology team.

- See other conditions managed by the urology team

- Meningitis and Encephalitis are admitted to the AMU for review by the neurology team.
  - Other conditions managed by the neurology team

HIV

- Most issues relating to the diagnosis of HIV and its management are undertaken by our Genitourinary Medicine colleagues in the community. Much of this is accessed via the integrated Contraception and Sexual Health Clinic (iCaSH)
- Where patients develop compilations from HIV and need admission, this is managed by the most relevant Medical Department. If the most appropriate department is unclear, the Respiratory team have considerable experience and cases can be discussed with the Respiratory SPR or Consultant on call.

Pyrexia of unknown origin

- For patients that can be managed in an ambulatory setting, the mSDEC is the best place to begin investigations. This may include patients who remain systemically well but are suspected to have infective endocarditis and those returning after foreign travel.
- Patients that need admission are seen through the usual referral pathways to Medicine.

Bleeding conditions

- Epistaxis
  - The expectation is that most patients with epistaxis will be treated in the Emergency Department, with assistance from the ENT team when required. When bleeding has resolved the patient will be allowed home.
  - In all situations where there is ongoing bleeding the patient will be discussed and admitted under the ENT team.
  - In situations where a patient's epistaxis has resolved, but they are unable to leave the hospital because of social situations or frailty, then they will be admitted under medicine.
- PV Bleeding is managed in all cases by the Gynaecology team
  - Anaemia resulting from menorrhagia is also managed by the Gynaecology Team

- GI bleeding
  - Melaena and haematemesis, where upper GI bleeding is presumed to be the source of bleeding, is managed by the Gastroenterology team.
  - Fresh (bright red) PR bleeding is managed by Surgical team unless the patient is known to have Ulcerative Colitis or Crohn's disease. Inflammatory bowel disease is admitted to Medicine and reviewed by the Gastroenterology Team

- Anaemia and Iron Deficiency
  - Where anaemia is due to chronic blood loss, this is managed by the team usually responsible for that pathology. For example, chronic upper GI blood loss is managed by the Gastroenterology, menorrhagia is managed by the gynaecology team etc.The same is true for patients who become iron deficient due to chronic blood loss. In the rare situations when intravenous Iron is needed this is organised by the responsible team. The Alysham Medical Day Unit are happy to administer infusions of IV iron, they can be contacted on ext 3946 or 7420. Referrals are typically accompanied by an ICE form detailing the prescription of the drug that is needed to be given to the patient.
  - Where the cause of Iron deficiency is unclear, the vast majority of patients will be managed in the community with oral iron. The mSDEC can be considered if patients have become severely anaemic due to an unknown cause of Iron Deficiency.
  - When these issues arise in older or frailer patients, the OPAS will frequently be able to support. A referral can be made as detailed in the OPAS page of this document.

- Haemoptysis
  - Patients who have single episodes of haemoptysis should have a thorough clinical review. Many can be managed in the community with a watch and wait approach. Where further review is needed a number of different pathways are available depending upon the circumstances. If malignancy is the most likely pathology, a CXR and a 2WW referral to the respiratory team may be appropriate. Where pulmonary embolism is suspected then the mSDEC would be first line.

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Gastroenterology and abdominal pathology

- New abdominal pain will be assessed by the surgical team.
    - In the event that a patient presents to the ED with undifferentiated abdominal pain they will continue to be assessed in the ED. Once the diagnosis is clear they will be referred to the correct team. This may require further imaging.
    - If there is a high suspicion symptoms are due to an upper GI cause and admission is needed (Gastritis, Peptic Ulcer, GORD etc.) the Medical team will accept the patient

- Pancreatitis – Pancreatitis is managed within the surgical division. This includes acute and chronic pancreatitis.
    - Some patients with Chronic Pancreatitis may be well known to the Gastroenterology team due to previous admissions. These patients can be viewed as an exception to the above, and admitted under Medicine. All other cases of pancreatitis will be assessed by the surgical team, including those caused by alcohol and post ERCP.

- Cholecystitis, Biliary Colic, Gallstones – Managed by Upper GI Surgeons

- Jaundice
    - An outpatient pathway for the management of Jaundice is planned in the near future. Currently referrals to outpatients are via the usual 2ww / existing outpatient hepatology pathways, as per the presumed diagnosis.
    - Where admission is needed this will be under the gastroenterology team
    - Issues arising as a result of Gallstones will be managed by the Surgical team

- Decompensated liver disease
    - Ascites, without apparent cardiac failure or known malignancy, will be managed by the gastroenterology team

- Intrinsic liver disease is managed by Hepatology as part of the Gastroenterology team

- Alcohol related liver disease
    - It is no longer routine to admit patients for alcohol detoxification treatment. Most patients dependent upon alcohol can be safely supervised in the community by the CGL team.
    - When patients at risk of alcohol withdrawal are admitted, many will be automatically identified for review by the Substance Misuse Team. It is best not to assume this but to place a written referral onto ICE. Information about the CIWA protocol can be found on the Trust Intranet. The Substance Misuse Team will offer guidance about CIWA or fixed regimes to manage alcohol withdrawal.
    - Where there are high risks of complications, such as in patients with significant signs of withdrawal, patients will be admitted under the gastroenterology team. Those with co-existent liver disease will have onward review by the Hepatology team organised.

- Hepatitis is managed by Hepatology within the Gastroenterology Department

- Upper GI bleeding is managed by the Gastroenterology team

- Inflammatory bowel disease
    - Many patients with inflammatory bowel disease will be managed in the community with input from Specialty teams in Outpatients. The inflammatory

bowel nurse team are available for advice. When they cannot be contacted the gastroenterology on call team will assist.
    - When admission is needed this will be under the Gastroenterology Team.

- Diarrhoea
    - If a surgical cause is suspected – for example diverticulitis, this will be under the General Surgical team. Other patients with diarrhoea will be admitted under the Medical Division for assessment.
    - Patients with uncomplicated gastroenteritis will typically be managed in the community. When complications arise, admission will be under the medical division.

- Eating disorders
    - Most patients will receive their care in the community via the Norfolk Community Eating Disorder Service (NCEDS).
    - When complications arise and patients need admission this will be under the gastroenterology team.

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- Urological problems
    - Lower Urinary Tract infections are common, the majority of patients will be managed in Primary Care. When patients become septic or delirious, an admission under medicine may be needed.

    - Conditions managed by the Urology Team.
        - Ascending infection, such as pyelonephritis, infection of ureteric stents / stones or renal collections are managed by the urology team
        - Prostatitis is also managed by the urology team.
        - Pyelonephritis, urinary retention in men, renal Colic, male genitalia – Urology team
        - Urinary retention in isolation and Renal failure caused by urinary retention
        - Cancers of the urinary tract
        - Hydronephrosis
        - Testicular pathology
            - Most issues related to testicular pathology are managed by the urology team
            - The exception are patients recovering after hernia surgery, who will be assessed by the general surgical team
        - Fournier’s Gangrene is managed jointly by the Urology and Plastics Teams

Other abdominal pathology managed in the Surgical Division

- Peritonitis or perforation
- Abdominal obstruction
- Right upper quadrant pain, Right and Left iliac fossa pain
- Gastric band problems
- Diverticulitis
- Incarcerated / strangulated hernias
- Ischaemic colitis+ Mesenteric infarction

Pathology managed by the Women’s and Children’s Department

- Urinary tract infection and Pyelonephritis in Pregnancy - Obstetrics
- Post partum sepsis
- Ectopic pregnancy
- Abdominal pain in the first trimester of pregnancy
- Chronic pelvic pain
- Ovarian cyst accidents
- Menorrhagia
    - Anaemia arising as a consequence of menorrhagia

Trauma / Orthopaedics

- Patients who sustain trauma as a result of a medical cause for collapse (eg. seizure, cardiac syncope) and who have minimal injuries can be admitted under Medicine.
  - If patients have sustained polytrauma as a result of the collapse, see below

- Non-operative fractures
  - Non-operative fractures in patients less than 75yrs old will be admitted under orthopaedics. Where medical issues arise in these patients the Medical Division will support.
  - Non-operative fractures in patients over 75yrs will be admitted under Medicine.

- Isolated head Injury
  - Patients >80yrs old will be admitted to medicine.
  - Patients who are <80yrs will be initially managed within surgery, after 48hrs they will be taken over by the neurology team.
  - When patients have other injuries in addition to the head injury, they will be admitted under the team responsible for the other pathology. The General Surgical team will advise about the ongoing management of the head injury.

- Facial fractures are managed by the Maxillofacial team. If there a social issue that is preventing discharge home, then the medical team will admit the patient.

- Polytrauma - If injuries are in multiple different systems or are significant, then regardless of the underlying cause, the patient will be admitted under the Surgical Division and Medicine will support the patient in a surgical bed.
  - The expectation is that most patients presenting with polytrauma will be managed on the HDU.
  - The trust intends to setup a Major Trauma Service. In the interim, admission will be under the team responsible for the most potentially life-threatening injury. In the situation of chest trauma this will often be under the Thoracics team.

- Chest trauma – eg traumatic pneumothorax, lung contusion, haemothorax – Thoracic Surgical team.

- Fractured neck of femur – Admit under the Orthogeriatric team to Earsham Ward

- Hand Trauma

  Distal to carpus:
  - Closed fractures APU Hand Unit or Ortho fracture clinic
  - Open injuries - Plastics for APU Hand Unit or admission
  - Wrist and carpal injuries - ortho

Spinal Pathology

- Musculoskeletal back pain
    - When patients present with back pain alternative causes for the pain need excluding as a priority. Conditions such as pyelonephritis, aneurysms, pneumonia etc can sometimes present with back pain.
    - In patients with osteoporosis low impact fractures can occur with minimal history of trauma.
    - It is unusual for patients to need admission for musculoskeletal back pain. Where this is needed it will be under the Spinal Team.

- Spinal Cord pathology

    - Proven spinal cord compression will be managed by the Spine on call team (with the exception of those on the Metastatic Spinal Cord Compression pathway).

    - Patients on the Metastatic Spinal Cord Compression pathway are managed by the oncology team with referral to the Spine Team when appropriate.

    - Those with intrinsic cord lesions should be referred to the neurology team.

    - Patients with suspected Cauda equina syndrome seen in the Emergency Department should be referred urgently for an MRI directly by the ED team as per the new GIRFT guidelines and the NNUH pathway. Out of hospital referrals will be managed by the spine on call team.

- Discitis – see here

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Vascular pathology

- Upper limb Venous thromboembolism (VTE) – can often be managed in the mSDEC
  - If related to cancer, or treatment for cancer, contact Acute Oncology Service

- Lower limb Venous thromboembolism (VTE) – if unilateral and the patient is ambulant consider VTE clinic. If the patient is not mobile, they will be accepted onto the AMU. Bilateral DVT is very rare so please consider other causes of bilateral leg swelling first.

- Peripheral vascular disease and Ischaemia - patients with ischaemic digits or limbs are managed by the vascular team.

- Aortic Aneurysms
  - In patients suspected to have leaking aortic aneurysms these are seen in the Emergency Department as emergency cases
  - Suspected cases of aortic dissection are also seen in the Emergency Department.
  - Some cases of type b dissection may be appropriate for medical admission for blood pressure management.

- Groin abscesses in patient who inject drugs will be managed by the Vascular team.
  - For other abscess rules see here

- Deep venous leg ulcers that need debridement will be admitted under the vascular team
  - Frailer patients who develop bed / pressure sores will be managed within Medicine. The plastics team will advise if debridement is needed.

For vasculitis – see here

Neurology

Notes about neurology referrals: Where patients with chronic neurological conditions present with other general medical issues, for example issues relating to falls, chest or urinary tract infections, delirium etc. they will be admitted as General Medicine patients and then discussed at the Morning Report. They will not be directly admitted under neurology.

- Sudden severe headaches are admitted for investigation and management to the AMU to exclude Subarachnoid haemorrhage.
    - If subarachnoid haemorrhage is suspected, urgent CT imaging is indicated and if SAH is confirmed, transfer to Addenbrooke's Neurosurgery should be arranged. If CT is negative an LP should be undertaken no sooner than 12hours after the onset of the headache.
    - A pathway for the management of headache is under development and the expectation is that some of these cases will be managed by the AMU team via the mSDEC. At present it remains the default that patients who need admission due to severe headache are admitted under the care of the Neurology team.
    - This does not include haemorrhages caused by trauma / head injuries, which are managed within the surgical division.

- Extradural and Subdural Haemorrhages are also admitted under the neurology team unless there is a significant history of trauma. In which case they are managed as head injuries under the surgical division.

- Meningitis
    - Patients who are suspected of having meningitis (bacterial and viral) should be admitted under medicine and investigated urgently with an LP (unless there are clinical contraindications) and started on appropriate antibiotic therapy (according to Trust Guidelines which are based on National Guidelines). Delays in performing an LP should be avoided as this may result in difficulty interpreting CSF results and may lead to unnecessarily prolonged length of stay. Care should be taken to exclude other common differentials, but patients with suspected meningitis should be admitted under neurology.

- Encephalitis
    - Patients with encephalitis typically present with drowsiness and altered mental status associated with fever and headache. Patients may have additional focal neurological deficits and seizures. Other sources of infection, especially urinary tract and chest need to be excluded, particularly in the elderly.
    - Once other differentials are excluded patients with suspected encephalitis should be admitted under neurology.

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- Seizures
  - Many patients presenting with a single seizure who have recovered back to baseline may not require admission. Patients presenting with a first ever seizure who have recovered can be referred to the First Seizure Clinic. This can be done using the referral proforma on ICE. Further information or advice can be gained by contacting the Neurology Registrar on call via Alertive or Switchboard.
  - Patients should be admitted under neurology if:
    - The patient remains post-ictal.
    - The patient continues to have seizures.
    - The patient is in status epilepticus. These patients may require admission to ITU.
  - Seizures relating to alcohol withdrawal are not admitted under the care of the Neurology Team. These patients are at high risk of complications from alcohol withdrawal and so are admitted under the gastroenterology team.
  - Seizures from recreational drug use are also not admitted under the neurology team. These patients are admitted to the AMU for review by the Acute Medicine team.

- Myasthenia Gravis
  - Patients with suspected generalised or bulbar myasthenia gravis, or patients with established MG who are experiencing deterioration in their symptoms should be admitted under neurology.

- Multiple sclerosis exacerbation / relapse,
  - Patients with MS who are having a genuine MS relapse may require admission under neurology. In many patients with chronic MS, a deterioration may indicate an intercurrent infection, especially a urinary tract infection. These should be managed under AMU. If infection has been excluded, the patients may require admission under neurology.

- Parkinson's Disease
  - Patients with PD may present with confusion and clinical deterioration. These patients are often frail and have pre-existing cognitive impairment. The commonest cause of acute deterioration is intercurrent infection. Patients should be admitted under AMU and investigated and treated appropriately. Hospital based PD nurses and neurology input is available if required.

- Guillain Barre Syndrome
  - Patients with suspected Guillain Barre syndrome should be admitted under Neurology
  - CNS Tumours (not pituitary) are managed by the neurology team

- Intrinsic Spinal Cord lesions are managed by neurology. More information about Spinal Cord pathology can be found here

Stroke

- TIA / CVA
    - Patients with suspected TIA and Stroke are seen on arrival in the Emergency Department by the Stroke Alert Nurse. The Stroke Alert Nurse can be contacted via switchboard or Alertive.
        - If after the Stroke Alert Nurse completes their assessments, they feel that stroke is unlikely, the patient will be reassessed by the ED team.
    - Confirmed intraparenchymal haemorrhages are managed by the stroke team
        - Subdural, extradural and subarachnoid haemorrhages are managed by neurology.
    - The TIA clinic follows up patients with suspected TIA. Access to this is governed by the TIA pathway and advice can be gained via the Stroke Alert Nurse.
- Vertigo
    - Posterior circulation stroke is seen by the stroke team in the ED
    - Most peripheral causes of vertigo will be managed in the community. Where this is not possible, the ENT team will advise about further management.

Cardiology

- Chest pain
    - STEMIs - There is a direct pathway via the Cardiology SPR (ext 6627) for all STEMI cases. These patients are seen in the Emergency Department and considered for primary PCI
    - NSTEMIs are admitted to the AMU for review and onward triage to cardiology.
        - Please note that Troponin I rises can occur in the context of other acute illness. Common examples would include sepsis, arrhythmias and pulmonary embolism. Patients with such troponin I elevations should not be automatically classified as NSTEMI unless there are other features (such as cardiac chest pain or ECG changes) to support the diagnosis.
    - Angina
        - Suspected unstable angina - patients will need admission to AMU for review and onward triage to cardiology if the diagnosis remains the most likely differential. It should be noted that most patients with prolonged chest pain at rest, without troponin I elevation or ECG changes, will not have unstable angina. Care must be taken to consider other diagnoses.
        - Patients who present with chest pain suggestive of "stable angina" can be referred from Primary Care to the Rapid Access Chest Pain Clinic. A referral form is available here. Other referrers, not in Primary Care, can consider writing a referral letter to Cardiology Outpatients.

    - Where there is concern about a patient having had an Acute Coronary Syndrome, these patients will usually need an urgent assessment. If the patient's pain has resolved, then the mSDEC is a potential place for this assessment to occur.
        - Patients with an Acute Coronary Syndrome who are aged over 85yrs are managed by the Older People's Medicine department.

    - Most cases of pleuritic chest pain can also be assessed in the mSDEC. Inclusion and exclusion criteria for this are available here

- Arrhythmias
    - Atrial fibrillation
        - A pathway for the management of AF is available on the Trust Intranet.
        - Many patients with a new diagnosis of Atrial Fibrillation can be managed in the community. Where further assessments are needed this can often be done in the mSDEC. The mSDEC core criteria document gives suggested inclusion and exclusion criteria for this. Those patients who have co-existing signs of heart failure will often have to be admitted.
        - Patients with pre-excited AF should be admitted under cardiology for urgent review by the arrhythmia team
    - SVT
        - Episodes of SVT are generally managed with chemical cardioversion in the Emergency Department.
        - Most patients can typically go home after this, with a referral from the ED to the outpatient arrhythmia clinic accompanied by an ECG. If there are

ongoing concerns associated with the episode, for example persistent chest pain or ECG changes, then the mSDEC can be considered. Cases can be discussed with the on call cardiology SPR.
    - Patients with pre-excitation or syncope (or pre-excited AF) should be admitted under cardiology for urgent review by the arrhythmia team.
  - Palpitations
    - A palpitations pathway is close to being completed, in the meantime these patients can be referred to the arrhythmia clinic for further assessment.

- Cardiac Syncope
  - High risk syncope is admitted to the AMU. Low and medium risk syncope can usually be managed in an ambulatory or community setting. The Medium Risk Syncope Pathway is close to completion and when finished will give useful information about this. When completed the pathway will be available on the Trust Intranet. In the interim each case should be considered on its own merits and can be discussed with the mSDEC consultant on 7767.
  - Heart block – Complete heart block and Mobitz type 2 heart block need to be discussed and likely admitted under the Cardiology team, for consideration of a Pacemaker. Discuss if needed with cardiology SPR on 6627.

- Infective endocarditis
  - If patients are well, Initial investigations (the key to which are high quality blood cultures), can be organised in the mSDEC.
  - Confirmed, or highly likely, cases of endocarditis are admitted under the cardiology team.

- Heart Failure
  - Patients under the age of 80yrs old are managed by the cardiology team. Those over 80yrs are managed by Older People's Medicine.
  - Most patients with heart failure will be managed in the community. A NTpro-BNP can be used as a basic screening tool for heart failure. In cases where there is significant deterioration, a short admission to the AMU is usually needed. Where there are diagnostic doubts about the situation, the mSDEC can be considered for urgent investigations.
  - Patients with known heart failure who present with decompensation, NTpro-BNP >2000 or ECHO showing LVEF <50% can be admitted to AMU for triage to Cardiology.
  - A heart failure pathway is near to completion and will shortly guide management options. The heart failure nurses may be able to offer advice regarding patients that are known to their service.
  - Dr K Skinner is the trust's lead for heart failure and is supported by a small team of heart failure nurses. The mSDEC can be used as a resource for the heart failure team to review patients, in whom admission would otherwise be needed.

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Conditions managed by the Endocrinology Team

- New diagnosis of diabetes requiring admission
    - If systemically well an initial review can be organised in the mSDEC. It is usually best to seek the advice of the endocrinology SPR / consultant first, but in many cases the SPR will agree to see the patient in the mSDEC.

- Patients with poorly controlled diabetes
    - If not in DKA or HONK, many patients can be seen in the mSDEC. mSDEC will liaise with the diabetes nurses and Elsie Bertram Clinic when needed.

- Diabetic ketoacidosis.
    - Please refer closely to the Trust Guideline available on the intranet which gives extensive guidance about the management of DKA.
    - Many of these patients are profoundly unwell and will need to be seen in the resuscitation area of the Emergency Department. Those patients who could have DKA, yet remain systemically well can have their initial assessment in the AMU.
    - The endocrinology team will review cases of DKA on admission.

- Diabetic foot ulcers, Osteomyelitis of the foot in patients with diabetes

- Acute endocrinology problems - Hypo / hyperthyroidism, Addisonian crisis etc

- Pituitary disorders, including pituitary tumours or complications of pituitary surgery

- Hyper / hypocalcaemia

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Renal Medicine

- Suspected Secondary Hypertension
  - Patients with a new diagnosis of hypertension who are <50yrs old can be considered for the mSDEC. This is a good opportunity to screen for secondary causes before patients start on medication. Inclusion and exclusion criteria can be found here
- Essential hypertension with end organ damage.
  - Evidence suggests that patients with essential hypertension and no end organ damage can all be managed in primary care. Where difficulties arise with treatment, patients can be referred to Nephrology Outpatients. If urgent assessment is needed in the context of end organ damage, then the mSDEC provides a good environment for a clinical review.

Conditions managed by the Renal Team

- Intrinsic renal disease
  - Including nephrotic syndrome
  - Vasculitis affecting the kidney
- Infections of the lower urinary tract that need admission for IV antibiotics
- Chronic renal failure
- Dialysis
  - Acute indications for dialysis – uraemia, acidosis, hyperkalaemia, fluid overload.
  - Complications arising from dialysis.
- Hypo/hyperkalaemia
- Small vessel vasculitis
- Renal transplant
  - Patients with a renal transplant who have a primary renal presentation
- Pre-renal failure is managed by the team most appropriate to treat the underlying cause.

Conditions managed by the Urology Team

Rheumatology

- Acute hot joints.
  - Acute non-infectious inflammatory arthritis is managed by the Rheumatology team with support from the AMU team out of hours.
  - Crystal Arthropathy
    - Acute flares of Gout and Pseudogout can usually be managed in the community. Where this is not possible cases can be discussed with the on call Rheumatology team. Out of hours, when needed, these patients are admitted to the AMU.
    - If the patient has a known crystal arthropathy and presentation is consistent with a flare of this, the Rheumatology Team will review during the day and out of hours the patient can be seen by the AMU team.
  - Where Septic Arthritis is likely, this is managed by the orthopaedic team

- Connective tissue disease
  - Autoimmune connective tissue diseases are humorally mediated multi-system disorders and are managed by the rheumatology department, often in partnership with one or more departments depending upon the organs involved.

- Large vessel vasculitis
  - The trust has a Vasculitis Service comprised of two consultants (Dr Chetan Mukhtyar and Dr Sarah Fordham) and a specialist nurse (Georgina Ducker). They do not offer an emergency service but are available for opinions by direct contact.
  - Giant Cell Arteritis
    - Discuss cases in office hours with the on call Rheumatology team. If review is needed out of hours then cases can be discussed with the Medical SPR
    - If visual loss then patients are managed by the ophthalmology team
  - Takayasu arteritis is a rare diagnosis to be made in patients presenting in an acute setting. Where this diagnosis is made, the Rheumatology Team are able to advise about management.

- Autoimmune inflammatory arthritis
  - Discuss with rheumatology during the day and AMU out of hours.

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Respiratory Medicine and Thoracic Pathology

There is an "on the day" CXR service available to General Practitioners to assist in the diagnosis of thoracic pathology.

Conditions managed by the respiratory team.

- Airway disease
  - Exacerbations of COPD / Asthma
    - Patients unwell with COPD or Asthma are not particularly suited to ambulatory management. Most will need a short admission to the AMU for nebulisers, oxygen and review.
- Bronchiectasis
  - Patients with exacerbations of bronchiectasis requiring intravenous antibiotics who might be managed on an ambulatory pathway can be discussed with the bronchiectasis nursing team.
  - Contacts

Alertive	Respiratory Bronchiectasis SN
DECT	7906
Telephone	5634
Email	bronchiectasisnurses@nnuh.nhs.uk

[email should only be used for non-urgent communication e.g to arrange a clinic follow up]

- Infections in the lung
  - Tuberculosis
  - Pneumonia. Many cases of pneumonia will be managed in the community. In some circumstances there may be a role for the mSDEC to conduct an assessment of the patient and arrange appropriate investigations. In the circumstances when patients are compromised, they will need admission to the AMU.
  - Aspiration pneumonia – when admission is needed patients are not routinely admitted under the Respiratory team. Instead, they are admitted to the AMU so admission under a General Medical team can be arranged via the morning report.
- Cystic fibrosis
  - The Cystic Fibrosis Service welcomes early involvement with the AMU team to discuss the management of patients with cystic fibrosis admitted there.

Contacts	Alertive	Respiratory Cystic Fibrosis SN
	DECT	6049
	Telephone	5634

- Interstitial lung disease

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- Pleural disease
    - Pneumothorax
        - Pneumothoraces diagnosed in the ED can be managed according to the pneumothorax pathway (available on the intranet), with follow up in the pleural clinic or mSDEC
        - Primary and Secondary (due to underlying lung disease) pneumothoraces are managed by the Respiratory team
        - Patients having a 2nd pneumothorax, recurrent pneumothoraces or traumatic pneumothoraces are managed by the Thoracic Surgeons.
    - Unilateral pleural effusions
        - Where patients are suitable for an ambulatory pathway this can be arranged via the pleural clinic
    - Pleural malignancy
        - Management will depend on individual cases but most are expected to be have Respiratory involvement at an early stage.
    - Empyema
        - Admit via AMU for review by the respiratory team

- Pulmonary Embolism
    - A pathway for the management of Pulmonary Embolism is available on the trust intranet.
    - The majority of patients with suspected pulmonary embolism are managed in an ambulatory setting in the mSDEC. Inclusion and exclusion criteria for this are available here
    - Patients thought to have massive pulmonary embolism, saddle pulmonary embolism, and those with right heart strain (including those with syncope or associated troponin I rises) are managed as inpatients on the AMU.
    - Follow up
        - Where patients have provoked Pulmonary Embolism, many can be managed with a period of anticoagulation and cessation of the responsible risk factor.
        - If patients have unprovoked pulmonary embolism, large PE or bilateral PEs then review can be requested in the Pulmonary Embolism Clinic. Referrals are made via written referral letters to Dr Gray in Respiratory Outpatients. Patients will receive a standard letter highlighting what to do with their anticoagulation and approximate times of review. Most patients who have no clear cause identified for their PE will need lifelong anticoagulation, unless there are clear contraindications. This will be determined at the clinic review. Please can patients remain on anticoagulation until reviewed, usually in 3-6 months but this can be a little longer.

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- Lung Cancer and nodules
    - Pathways for Lung cancer referrals will depend on the individual circumstances.
    - Colleagues in primary care and those in secondary care (including the Emergency Department) are able to refer on a 2WW basis to respiratory outpatients.
    - Follow up of lung nodules can be arranged via the Nodule Clinic, with a written referral letter to respiratory outpatients.

- Acute or Chronic Type 2 Respiratory Failure is managed by the Respiratory team

Conditions managed by Haematology / Oncology / Palliative care

- Patients known to Haematology / Oncology who are on active treatment
    - The Acute Oncology Service (AOS) are contactable for referrals and for advice
    - For haematology advice a Consultant (ext 6477) and an SPR (ext 2919 or Alertive) and a specialist nurse are available during the day.

- Neutropenic sepsis

- Palliative cancer care

- Patients presenting with disseminated malignancy.

- Metastatic spinal cord compression pathway – see here

Haematology

- Sickle cell disease

- Haematological malignancy

- Primary non-haematological disorders – e.g. Haemophilia, Autoimmune haemolytic anaemia, Immune thrombocytopenia (ITP) are often suitable for outpatient management. Please discuss with a haematologist as above.

Acute Medicine and Mental Health problems

See also mSDEC

- Short Stay - Acute Medicine will manage patients who have been referred to the Medical Division, who can go home within 24hrs, and who will not benefit from a review by a specialty team.

- Patients with Mental health issues.
    - Patients who present with an acute deterioration in their mental health are seen by the Psychiatry Liaison Team in the Emergency Department. If an Inpatient Psychiatry bed is needed this is arranged by the Liaison team. In this situation the patient will wait in the ED for a bed to be available.

    - Patients who need admission to the AMUs
        - Patients who have taken an overdose – when treatment is needed, or complications arise as a result of taking an overdose, patients will be admitted to the AMU
        - Patients will also be admitted to the AMU if there are concerns psychosis may have been precipitated by an organic pathology.
        - Deliberate self harm – if patients are expected to need a surgical procedure they will be admitted to the Surgical Division. All other patients that need a mental health review will be seen by the psychiatry liaison team in the ED.
    - Foreign objects
        - Patients who have swallowed foreign objects that remain in the digestive tract will be managed by the gastroenterology team.
        - Patients who have foreign objects retained in the airways will be admitted under the thoracics team.
        - Foreign objects retained PV will be seen by gynaecology.
        - Foreign objects retained PR will be seen by general surgery.

- Homelessness
    - Patients who have become homeless remain the responsibility of the local authority.
    - The trust has a protocol to help guide the management of patients who have become homeless, this is available on the trust intranet.
    - The District Direct team are a source of information and assistance in helping patients that have become homeless. There is no expectation that homeless patients will need an admission to an acute bed at the NNUH.

Surgical Same Day Emergency Care (sSDEC)

- Brief introduction to the sSDEC
    - sSDEC is an Emergency Assessment area for patients who would otherwise be admitted to an acute bed in the surgical directorate.
    - All patients referred to GI surgery, Urology, Vascular, Trauma & Orthopaedic, Plastics, ENT, MaxilloFacial surgery, Thoracic surgery, Ophthalmology and Dermatology are evaluated initially by telephone conversation between the referring clinician and the nominated receiver – in a small number of cases it will be quite apparent that admission is required and the patient will be brought into a bed for the relevant specialty. The majority of cases will require in-person assessment before a decision to admit is made by the receiving team.
    - The unit is able to take non-ambulant patients in limited circumstances – i.e. When the trolley-based Ambulance Reception Suite has not been escalated into by the site-team.

- Conditions NOT suitable for consideration on Surgical SDEC
    - Patients in whom admission is already decided / mandated.
    - Patients in whom the suspected pathology is not one of the specialities with a presence on Surgical SDEC
        - Gynaecology
        - Obstetrics
        - Breast surgery
        - Neurosurgery
    - Non-ambulant patients when the Ambulance Reception Suite is in Escalation

- Surgical SDEC is not usually used as a place to routinely review patients after surgery.
    - Where unexpected complications arise the sSDEC can be considered.
    - Post Operative Surgical Site Complications are admitted directly to the operating team, Dermatology patients are admitted under plastics.

For more information about how to refer to Surgical SDEC please see here

Appendix 1 - Core criteria for mSDEC

Chest Pain	
Inclusion criteria	Chest pain, currently pain free. Ongoing pleuritic chest pain is acceptable if not severe.
Exclusion criteria	STEMIs or NSTEMIs - Dynamic ST change or new T wave changes Hypotension (systolic <100mmHg) or collapse Tachycardia HR >110bpm Ongoing non-pleuritic chest pain without a negative troponin Abnormal ECG – new LBBB, ischaemic change, anterior TWI Traumatic Chest pain
Shortness of breath due to suspected Pulmonary Embolism:	
Inclusion criteria	Acute shortness of breath, suspected to be due to Pulmonary Embolism,
Exclusion criteria	Hypoxia - saturations <94% or oxygen dependent Hypotension (BP <100mmHg), Tachycardia (heart rate >110bpm) or history of collapse. Troponin I rise.
Cellulitis of the leg:	
Inclusion criteria	Unilateral cellulitis of the lower leg (cellulitis in other places goes to other divisions)
	Signs of sepsis – (Temp > 39, BP <100mmHg, Heart rate >100bpm, Collapse, delirium) Patients who are unsuitable for an outpatient pathway – i.e. those who do not have their own transport Cellulitis associated with a suspected abscess. Suspected necrotising fasciitis – ie very rapidly spreading cellulitis Current Intra venous drug use
Arrhythmias:	
Inclusion criteria	Stable atrial fibrillation or atrial flutter, resolved SVT with ongoing concerns.
Exclusion criteria	AF secondary to other conditions, e.g. sepsis, thyrotoxicosis Sats< 94% BP <100mmHg, Ventricular rate >120bpm Evidence of pulmonary oedema in the history (orthopnoea, SOB) or on CXR Cardioversion likely to be required (either chemical or DC cardioversion) Associated chest pain Ongoing SVT – needs consideration of urgent cardioversion

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Diabetes:	
Inclusion criteria	New onset type 1 or type 2 diabetes Known diabetic patients whose presenting complaint is poorly controlled blood sugars
Exclusion criteria	Systemically unwell – hypotensive (systolic < 100mmHg) or tachycardic (HR >100bpm) Those in diabetic ketoacidosis (DKA) or Hyperosmolar states (HSS) Active vomiting Confusion or delirium Acute acid base or electrolyte disturbance requiring correction
Hypertension:	
Inclusion criteria	New diagnosis of Hypertension age <50years (>160mmHg systolic or >100mmHg diastolic pressure) or known essential hypertension with end organ damage
Exclusion criteria	Those with known essential hypertension without end organ damage – these patients can make an appointment with their GP. If hypertensive but presenting with another problem Any new neurological deficit, vertigo, vomiting or severe headache
Allergic Reactions	
Inclusion criteria	Patients presenting with allergic reactions that cannot see their GP
Exclusion criteria	Anaphylaxis Systolic Blood Pressure ≤ 90 mmHg, Heart Rate ≥110bpm, RR ≥ 21 Or SATS < 94% on air Patients who received IM Adrenaline or used their own Epipen

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Appendix 2

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Older Peoples Assessment Service (OPAS)

Referral form

Older Peoples Assessment Service
Outpatients East, Level 3
Norfolk & Norwich University Hospital
Colney Lane
Norwich, NR4 7UZ

Email to opas@nnuh.nhs.uk

1. Patient Information:	
Patient Name:	Date of Birth:
Address:	Hosp. No:
	NHS No:
Patient Tel:	Ethnic Origin:
Referring GP:	Date of Referral
Surgery Address:	GP Signature
	Surgery Tel No:
Accessible Information Standards	
Please specify below if the patient has additional needs related to:	
Vision	Speech
Hearing	Other communication difficulties
The patient, and or parent / carer, requires an:	
☐ Interpreter (*specify language)* ☐ Lip speaker ☐ BSL interpreter	

2. Referral Criteria:
The following criteria must be fulfilled otherwise referrals will not be accepted for OPAS ☐ Is the patient 70 or above ☐ Please confirm Parkinson's NOT suspected ☐ Please confirm TIA/Stroke NOT suspected
Clinical Frailty Score (Rockwood):
Reason for referral please state below

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3. Any other relevant information:
Past Medical History
Current Medications
Any known Allergies?

Useful Links:

Older People's Assessment Service OPAS - Service Information

Older People's Assessment Service Patient Leaflet

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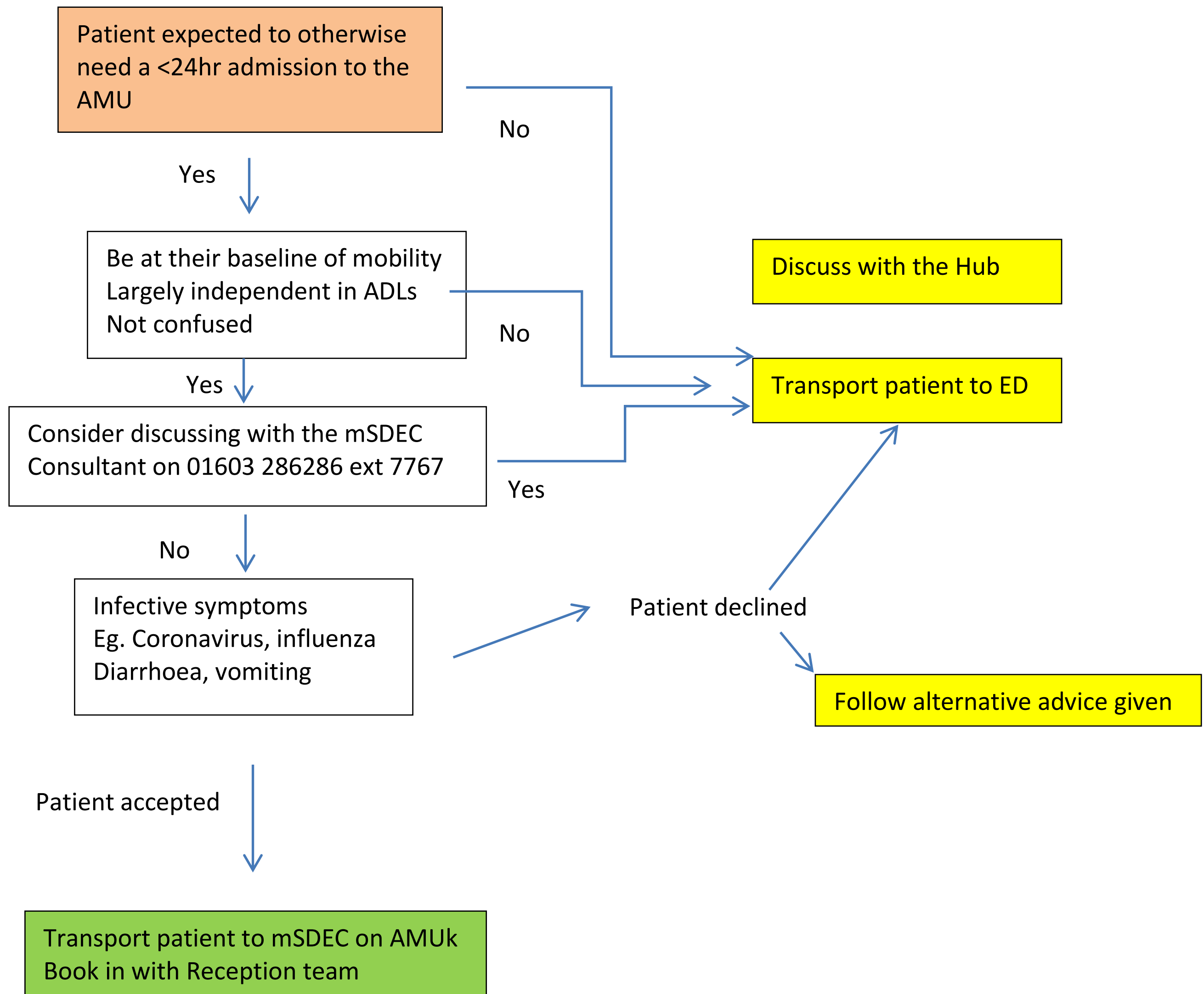
Appendix 3 - Medical Same Day Emergency Care (mSDEC) Paramedic Referral Pathway

mSDEC is an Emergency Clinic setting for patients who would otherwise need a short (<24hr) admission to the Acute Medical Units (AMU). This short pathway aims to give some reference to paramedics who wish to refer patients to the mSDEC. Trolley space is a major limitation in the Clinic so acceptance is ultimately at the discretion of the AMU Consultant running the clinic. Referrals can be made by contacting the consultant on 01603 286286 ext 7767. If this number is not being answered or not working, then an alternative is 01603 289623.

The clinic is open to referrals from 8-20:00 during the weekdays and 10-18:30 at the weekend.

As is shown in the flow chart below, we do need patients to be close to their usual level of mobility. The expectation is that patients will need to wait in our waiting room before and during their assessments.

We ask that paramedics consult the examples of our core conditions below and review the inclusion and exclusion criteria. Cases accepted will mostly be from this list. Included is a brief note about conditions that are seen in other ambulatory services in the NNUH.



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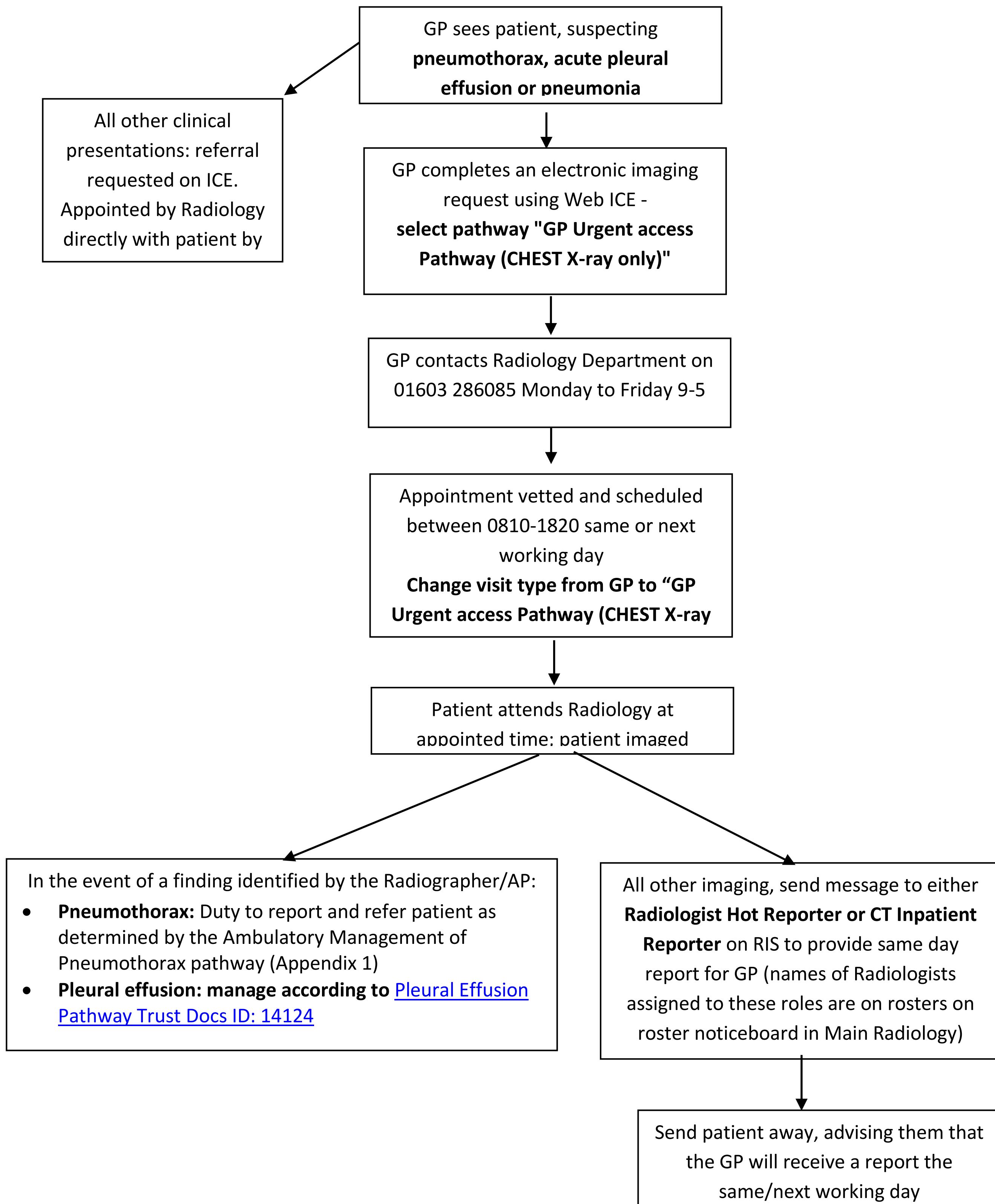
Appendix 4 - Procedure for Urgent Access Pathway for GP-referred Chest X-rays



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Aim: to avoid patient presentation to ED for GP referred patients with suspected pneumothorax, acute pleural effusion or pneumonia.

Summary of process:

- Pathway is for the following clinical presentations only:
    - Suspected pneumothorax;
    - Suspected pleural effusion;
    - Suspected pneumonia.
- GP refers patient in ICE selecting pathway **GP Urgent access Pathway (CHEST X-ray only)** on ICE; will appear in Collection Option line on RIS referral;
- GP calls Plain Film Leads on ext 2085 to book same/next working day appointment.
- Patient attends appointment and is imaged.
- Once CXR complete:

In the event of a finding identified by the Radiographer/AP: • **Pneumothorax:** Duty to report and refer patient as determined by the Ambulatory Management of Pneumothorax pathway (Appendix 1) • **Pleural effusion: manage according to** Pleural Effusion Pathway Trust Docs ID: 14124	All other imaging, send message on RIS to either **Radiologist Hot Reporter or CT Inpatient Reporter** on RIS to provide same day report for GP (names of Radiologists assigned to these roles are on rosters on roster noticeboard in Main Radiology)

The below will be completed by the Plain Film Leads at the Huddle each morning:

Date: ……………………………………………………………

Radiologist Hot Reporter: ……………………………………

CT Inpatient Reporter: …………………………………………

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Appendix 5 - RAPID ACCESS CHEST PAIN CLINIC

REFERRAL LETTER

Department of Cardiology
Outpatients East, Level 3
Norfolk & Norwich University
Hospital
Colney Lane
Norwich, NR4 7UZ
Direct dial: 01603 289828

Email to Cardiology racpc@nnuh.nhs.uk
Please note that faxed referrals cannot be accepted.
Our administration team will then check that the referral criteria below has been met and telephone the patient to make an appointment

Please consider carefully whether referral to RACPC is necessary.

The purpose of this clinic is to fast track the investigation and treatment of patients with recent onset angina.

1. Referral Criteria:	
All the following criteria must be fulfilled otherwise referrals will not be accepted for RACPC.	
☐	New or recent onset (<8 weeks) EXERTIONAL chest pain suggestive of STABLE ANGINA. **Date of symptom onset:**
☐	No known Ischaemic Heart Disease or prior investigation within 5yrs
☐	**ECG MUST BE ATTACHED WITH THIS REFERRAL**
☐	Recent blood tests available on ICE / requested (FBC, U+E, Glucose, Cholesterol, TFT)
☐	Patient is available to accept an appointment within the next two weeks (Please provide daytime/work contact details)
☐	Patient has been reviewed by a general practitioner: (insert name)
☐	Sections 2-5 overleaf have been fully completed

Patients with the following should **not** be referred:

Situation	**Recommendation**
Suspected Acute Coronary Syndromes (ischaemic rest pain ± abnormal ECG ± raised troponin)	Arrange urgent admission to hospital
Symptoms > 8 weeks duration	Refer to standard cardiology clinics
Undiagnosed murmur	Arrange echocardiogram / refer to standard cardiology clinic
Known ischaemic heart disease	Refer to standard cardiology clinics*
Non-specific pain and patient at low risk of ischaemic heart disease	Consider non-cardiac diagnoses
Normal coronary angiography within the past 5 years	Consider non-cardiac diagnoses

If in doubt about the appropriateness of a referral, please discuss with a cardiologist via switchboard, or refer to standard cardiology clinics. * Patients known to cardiology should be referred back to the same consultant

2. Patient Information:		
Name:	Date of Birth:	
Address:	Hosp. No:	
		Number
	NHS No:	
Daytime and/or work Tel Number:	Ethnic Origin:	
Referring Doctor: GP/Clinician GP Address:	Date of Referral:	

Patient Consent:

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☐	In line with GDPR, please tick to confirm that the patient has consented to this referral, and the sharing of their data, with this service

If the service user requires an interpreter, please specify language language not specified	
Accessible Information Standards	
Does the service user have additional needs related to:	Please specify below as applicable:
Vision	
Hearing	
Speech	
Other communication difficulties	

3. Referral Criteria: Please use your clinical history to calculate a symptom score: (please indicate scores)

		Score
Site on chest	Front of the chest/neck/shoulders/jaw/arms	1
	Right-side/sub-mammary/epigastric	0
Character of discomfort	Constricting/tight/pressure	1
	Stabbing/Sharp/Burning	0
Exacerbating factor	Always on exertion, relieved by rest	1
	Rest and exertion	0
	Nothing in particular/unpredictable	0
	Breathing	0
Time course	5-15 minutes	1
	Seconds/couple of minutes	0
	More than 15 minutes to hours	0

Total score for this patient: ☐

If score is 3-4	**TYPICAL ANGINA** - Start aspirin, beta-blocker, statin and GTN, unless contra-indicated.
If score is 2	**ATYPICAL ANGINA** - Consider starting medication.
If score is 0-1	**NON-ANGINAL CHEST PAIN** - unfortunately the referral will not be accepted. Please consider alternative causes for chest pain: treat risk factors using primary prevention risk calculator http://www.qrisk.org

4. The following additional information must be given:

Risk Factors (RFs) for Ischaemic Heart Disease (IHD):

Diabetes mellitus	☐ Yes	☐ No
Cholesterol > 6.47mmol/L	☐ Yes	☐ No
Current smoker or recent ex-smoker	☐ Yes	☐ No
First-degree relative (with no RFs themselves) with coronary disease <60yrs	☐ Yes	☐ No
Hypertension	☐ Yes	☐ No

5. Please provide a narrative about the chest pain and any relevant past medical history/co-morbidities:

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ECG:	

Blood Results (Last 2m):

FBC		Hb , WCC , Plts , MCV , Neut		
UE		Na , K , Urea , Creat , eGFR		
LFT		ALT , Alk Phos , Bili , Alb , GGT , Serum globulin , Total Protein		
CRP			**ESR**	
TFTs		TSH , Free T4	**INR**	
Bone		Ca , Ca cor , Ca adj , Phos		
Iron		Ferritin , Iron Saturation , TIBC		
Vitamins		B12 , Folate		
Lipids		Chol , LDL , HDL ,Chol:HDL ratio , Tri		
Random Glucose			**Fasting Chol.**	
Fasting Glucose			**HbA1c**	

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