

Directory of Acute Adult Services in the Norfolk and Norwich University Hospital

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Document Author:	Ed Markham, Consultant – Acute Medicine		
Document Owner:	Lindy-Lee Folscher – Clinical Director Unplanned Care		
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Consultation

The following were consulted during the development and/or review of this document:

Consultation with Service Directors
Clinical Directors of Planned and Unplanned Care

Relationship of this document to other procedural documents

This document is a directory of services applicable to Norfolk and Norwich University Hospitals NHS Foundation Trust please refer to local Trust's procedural documents for further guidance, as noted in Section 5.

Monitoring and Review of Procedural Document

The document owner is responsible for monitoring and reviewing the effectiveness of this Procedural Document. This review is continuous however as a minimum will be achieved at the point this procedural document requires a review e.g. changes in legislation, findings from incidents or document expiry.

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1. Introduction

1.1. Rationale

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 (NNUH). 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 historical confusion can arise. It is not a "fixed" document but one which is expected to evolve as different services are set up 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 definitive treatment is not required. This also holds at any point along the patient's journey, accepting that initial diagnosis is often unclear. Where patients have pathology that crosses specialty, the expectation is that involved specialties provide a documented assessment and management plan for the patient irrespective of the final admitting team.

1.2. Objective

This document aims to ensure that patients are assessed, triaged, and referred to the most appropriate specialty to ensure care is delivered in the most appropriate place by the most appropriate specialty.

1.3. Scope

This document applies to adult non-elective referral and attendances to the NNUH.

1.4. Glossary

The following terms and abbreviations have been used within this document:

Term	Definition
NNUH	Norfolk and Norwich University Hospitals NHS Foundation Trust
ACPs	Advanced Care Practitioner/s
AF	Atrial fibrillation
AMU	Acute Medical Unit
AOS	Acute Oncology Service
APU	Ambulatory Procedure Unit
BP	Blood pressure
CGL	Change, Grow, Live
CIWA	Clinical Institute Withdrawal Assessment for Alcohol
CNS	Clinical nurse specialist
COPD	Chronic obstructive pulmonary disease
CT	Computed tomography
CVA	Cerebral vascular accident

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CXR	Chest x-ray
DC	Direct current
DKA	Diabetic ketoacidosis
DVT	Deep vein thrombosis
ECG	Electrocardiogram
ECHO	Echocardiogram
ED	Emergency Department
EIA	Equality Impact Assessment
ENT	Ears, nose and throat
ERCP	Endoscopic retrograde cholangio pancreatography
GI	Gastrointestinal
GIRFT	Getting it right first time
GORD	Gastro-oesophageal reflux disease
GPs	General Practitioner/s
HDU	High Dependency Unit
HONK	Hyperosmolar nonketotic
HR	Heart rate
iCaSH	Integrated Contraception and Sexual Health services
ITP	Immune thrombocytopenic purpura
ITU	Intensive Care Unit
IV	Intravenous
LBBB	Left bundle branch block
LP	Lumbar puncture
LVEF	Left ventricular ejection fraction
MDT	Multidisciplinary team
MRI	Magnetic resonance imaging
MS	Multiple sclerosis
mSDEC	Medical Same Day Emergency Care
NCEDS	Norfolk Community Eating Disorder Service
NSTEMI	Non-ST segment elevation myocardial infarction
NTpro-BNP	N-terminal pro-B-type natriuretic peptide
OPAS	Older People's Assessment Service
OPED	Older People's Emergency Department
OPM	Older People's Medicine
PD	Parkinson's disease
PE	Pulmonary embolism
PV	Polycythemia vera
RCEM	Royal College of Emergency Medicine
RDU	Rheumatology Day Unit
RR	Respiratory rate
SAM	Society for Acute Medicine
SATS	Oxygen saturation
SDEC	Same Day Emergency Care
SOB	Shortness of Breath
SOP	Standard Operating Procedure
SPR	Specialist registrar
ssDEC	Surgical Same Day Emergency Care

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STEMI	ST segment elevation myocardial infarction
SVT	Supraventricular Tachycardia
TIA	Transient ischaemic attack
TWI	T-wave inversion
UTC	Urgent treatment centers
VTE	Venous thromboembolism

2. Directory of Services

2.1. Acute Ambulatory Services at NNUH

2.1.1. Same Day Emergency Care

The recent joint position statement from Society for Acute Medicine (SAM) and Royal College of Emergency Medicine (RCEM):

“Same Day Emergency Care (SDEC) should be used for patients who present to secondary care and would previously been considered for admission to an inpatient bed. This includes patients directly referred from primary and community care or Urgent Treatment Centers (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 organizations 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”.

SDEC 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.

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2.1.2. Ambulatory Services within the Medical Team

- [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 \(OPAS\)](#)

2.2. Ambulatory Services in the Surgical Team

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

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2.2.1. 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 after 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](#)

2.3. Information about conditions and referral pathways for patients

2.3.1. 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]

2.3.2. 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 in patients attending without a carer.
- Very limited mobility. For example, wheelchair users who 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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2.4. 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

2.5. Acute Oncology and Haematology Service (AOHS)

- Scope of practice - the AOHS 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.
- AOHS take referrals from patients, GPs and paramedics on a case by case basis.
 - For Oncology patients AOHS can be reached via the AOHS nurse on 01603 641752.
 - For Haematology patients contact the haematology specialist nursing team 01603 646753
- The AOHS is located in the East Block on Hoveton Ward, Level 1

2.6. 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.

2.7. 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

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- Radiographers can refer directly, if a CXR requested in the community shows a significant effusion.
- Responsible clinician – Professor E. Mishra

2.8. 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 70 years 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

2.9. Notes about Medical referrals

- This is not intended as an exhaustive list of the scope of practice in the Medical Team 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 Team 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 286286 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]

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- Patients over 80 years 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.

2.10. 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 other 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 post op patients are admitted under plastics.

2.11. 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"

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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

2.12. Directory of Services by Pathology / Specialty

2.13. Infectious disease

This section 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.

2.13.1. 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. Where there is the suspicion of an abscess this will be managed by the Surgical Team until an abscess is excluded, see below.
 - If patients are independently mobile, not septic and not 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.
- Varicella zoster virus
 - Shingles in immune-compromised patients, widespread shingles or suspected encephalitis associated with a single infection is 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

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- 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 patients who do not inject drugs - General Surgery.
- Breast abscesses – Breast team – not via sSDEC, but directly to breast clinic
- Genital abscesses in female patients – [Gynaecology team](#) – follow link for more information
- 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. For most patients, the most valuable interventions are high quality nursing care, good nutrition and support of any underlying health conditions. It is expected that most patients will therefore be managed within the Medical Division.
 - Patients needing surgical intervention will be managed by the Plastics Team in collaboration with tissue viability and the admitting specialty. Acute surgery is reserved for cases where the sore is clearly infected.
 - If underlying osteomyelitis is the principal problem, then the Orthopaedic team will manage the patient, unless the patient is over 80yrs old or has significant medical co-morbidities (diabetes or chronic renal failure \geq CKD3). It should be noted that radiological changes can often occur in pressure sores, and these do not necessarily mean there is underlying osteomyelitis.
 - The Tissue Viability Nurse team will provide wound care support when needed.

2.13.2. Bone and joint infection

Osteomyelitis

- Most patients with Osteomyelitis will be managed by the Orthopaedic Team. This will include all patients who need surgical intervention. It will also include those where there is a high suspicion of osteomyelitis on plain film or CT, but this is yet to be proven on MRI (unless exceptions are present as below).
- If patients do not need surgery AND are over 80yrs OR have significant medical co-morbidities (diabetes or chronic renal failure \geq CKD3). They will be admitted to Medicine. The Orthopaedic team will offer support as requested.
- Osteomyelitis of the foot in diabetic patients

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- 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 (AMDU). The mSDEC may be a suitable place to start investigations in ambulant patients.
- When osteomyelitis occurs as a result of pressure sore, the Medical team will accept the patient, as a surgical option is often not first line in such circumstances.

Infective Discitis

- The presentation of patients with back pain + raised inflammatory markers is non-specific and is not enough to make the diagnosis of infective 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 infective 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 infective 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 \geq CKD3). 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

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duration of IV antibiotics, followed by 6 weeks of oral antibiotics. Bloods are checked weekly to ensure inflammatory markers are falling appropriately. These patients can be managed on the virtual ward.

A [quick reference guide](#) is available to guide the care of those patients with Infective Discitis who are admitted to Medicine. 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](#)

2.13.3. 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](#)

2.13.4. 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 complications 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.

2.13.5. 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.

2.14. Bleeding conditions

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2.14.1. 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.

2.14.2. PV Bleeding

- Managed in all cases by the Gynaecology team
 - Anaemia resulting from menorrhagia is also managed by the Gynaecology Team

2.14.3. 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. Patients with inflammatory bowel disease are admitted to Medicine and reviewed by the Gastroenterology Team

2.14.4. 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.

2.14.5. 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

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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.

2.15. Gastroenterology and abdominal pathology

2.15.1. New abdominal pain

- 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

2.15.2. 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.

2.15.3. Cholecystitis, Biliary Colic, Gallstones

- Managed by Upper GI Surgeons

2.15.4. 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
 - Whilst issues relating to Gallstones will be managed by the Surgical team, it is appreciated that in a small number of patients jaundice can arise as a result of gallstones. A case-by-case approach will be needed until further specific agreements are reached. Discussions about such patients will occur between the Gastroenterology and General Surgical / Upper GI teams.

2.15.5. Liver disease

Decompensated liver disease

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

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Intrinsic liver disease

- 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 organized.

Hepatitis

- Managed by Hepatology within the Gastroenterology Department

Upper GI bleeding

- Managed by the Gastroenterology team

2.15.6. 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.

2.15.7. 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.

2.15.8. 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.

2.15.9. 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

2.15.10. Other abdominal pathology managed in the Surgical Team

- 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

2.16. Pathology managed by the Maternity and Paediatrics Department

Issues arising in Pregnancy.

- Early Pregnancy problems (must have positive urinary pregnancy test)
 - Abdominal pain in early pregnancy (<18/40) or other emergency problems.
 - Vaginal bleeding.
 - Nausea and vomiting in early pregnancy when other causes have been excluded.

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- Any pregnancy problem over 18/40 is managed by the obstetric team, usually via the Maternity Assessment Unit.

Abdominal / Pelvic pain in women.

- Ovarian cyst accident (suspected cyst rupture, haemorrhage or torsion) when other causes have been excluded (for example gastroenteritis, UTI, pyelonephritis, diverticulitis or renal colic)
 - Abdominal pain with evidence of an ovarian cyst on imaging
 - High clinical suspicion, for example left iliac fossa pain.
- Pelvic inflammatory disease requiring admission (severe pain / sepsis) with evidence of pelvic collection on imaging.
- Suspected new diagnosis (or recurrence) of gynaecological cancer (based on imaging findings)

Heavy menstrual bleeding

- Dysfunctional bleeding – irregular chaotic bleeding, very heavy or with low Haemoglobin requiring admission for assessment.
- Heavy menstrual bleeding – patients with heavy bleeding or low haemoglobins can often be managed with medications. Therefore, advice should be sought before admitting.

Vulval / vaginal problems

- Vulval abscess (on labia minora, labia majora, clitoral hood)
 - Not abscesses on mons pubis, groins or perianal – these are managed within the surgical Directorate – see guidance on [abscesses](#)
- Vaginal abscess (including Bartholin's cyst abscesses)
- Genital tract trauma (not arising from sexual assault)
 - If trauma is due to sexual assault this is managed in the Sexual Assault Referral Centre)

2.17. Trauma / Orthopaedics

2.17.1. Medical cause for trauma

- Patients who sustain trauma as a result of a serious medical cause for collapse (e.g. seizure, cardiac syncope) and who have minimal injuries can be admitted under Medicine. This does not include patients who have collapsed as a result of drug use or vagal collapses.
 - If patients have sustained polytrauma as a result of the collapse, see [below](#)

2.17.2. 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.

2.17.3. Head injury and facial fractures

- There are specific guidelines for the management of Traumatic Head Injury and/or Cervical Spine Injury in Adults. This covers questions about imaging, immobilization, management in the trust and onward referrals. It is available on Trust Docs.
- Isolated head Injury (no other site of injury)
 - Patients >80yrs old will be admitted to medicine regardless of CT findings. The exception being those with polytrauma – see below.
 - Medicine will then decide whether to admit to AIM, GIM (morning report) or to OPM as per clinical scenario and frailty score.
 - Patients <80yrs old with an abnormal CT head
 - Needing immediate neurosurgical intervention – transfer to CUH (Addenbrookes) ED via NCS
 - Needing non-time critical transfer pending bed – admit to EAUS under General Surgery.
 - Needing period of inpatient monitoring – admit to EAUS for first 48hrs from presentation under General Surgery with then step down after 48hrs to Neurology.
 - Patients who have a negative (normal) CT head but still need admission for issues related to frailty, mobility concerns etc. will be admitted under the Medical Team for review.
 - Patients with a negative CT who need admission for monitoring because of anticoagulation will also be admitted under the medical 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.
- Delayed presentation – All delayed presentations should be discussed with a senior decision maker. Admissions due to social concerns or SIADH should be admitted under Medicine. If >5 days post injury and no concerns above, consider if discharge with neurosurgical follow up is appropriate.
 - If admission is being considered AND patient <80, without social concerns or SIADH then the surgical SPR will review to determine if admission is appropriate.
- Facial fractures are managed by the Maxillofacial team. If there is a social issue that is preventing discharge home, then the medical team will admit the patient.

2.17.4. 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 Team and Medicine will support the patient in a surgical bed (this includes those with seizures / cardiac syncope).
 - The expectation is that most patients presenting with polytrauma will be managed on the HDU.
 - The trust intends to develop a Major Trauma Service in the future. 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.

2.17.5. Chest trauma

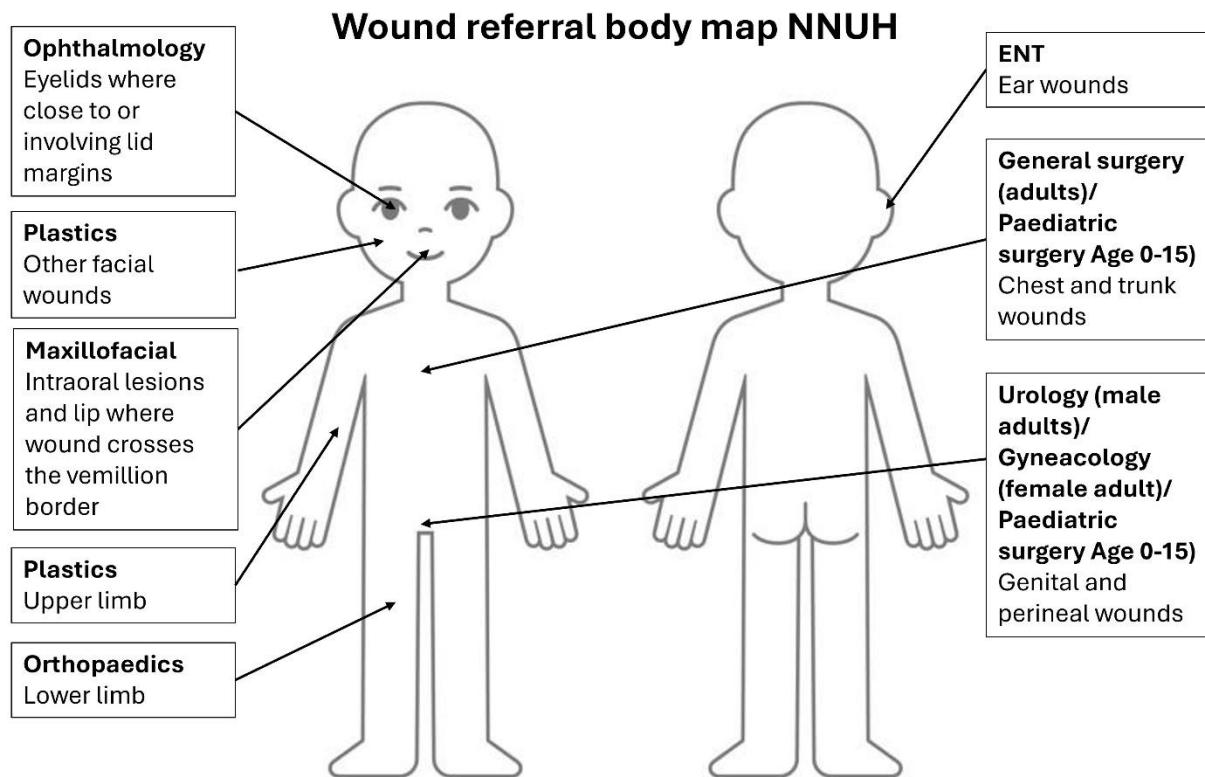
- E.g. traumatic pneumothorax, lung contusion, haemothorax – Thoracic Surgical team.
- A pathway for Rib fractures is under development.
 - The expectation is that those patients who need PCA or nerve blocks to relieve the pain associated with rib fractures will be admitted under the Thoracics team
 - Those patients who need intercostal drains or other surgical intervention will also be admitted under Thoracics.
 - Multiple rib fractures that create a “flail chest” will also be admitted under the Thoracics team.

2.17.6. Fractured neck of femur

- Admit under the Orthogeriatric team to Earsham Ward

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2.17.7. Wounds to the skin / Hand and Limb injuries / Vascular injury



- **Hand trauma** with injury 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
- **Vascular injury to a limb** (with or without the presence of a fracture)
 - Upper Limb – Axilla to cubital fossa – plastics and vascular
Distal to the cubital fossa - plastics
 - Lower Limb – Groin to popliteal fossa – vascular
Distal to the popliteal fossa – vascular and plastics

2.17.8. Spinal Pathology

Musculoskeletal back pain

- When patients present with back pain alternative causes for the pain needs 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 Spinal 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](#)

2.18. Vascular pathology

2.18.1. Upper limb Venous thromboembolism (VTE)

- Can often be managed in the [mSDEC](#)
 - If related to cancer, or treatment for cancer (especially those associated with percutaneous lines), contact [Acute Oncology Service](#)

2.18.2. 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.

2.18.3. Peripheral vascular disease and Ischaemia

- Patients with ischaemic digits or limbs are managed by the vascular team.

2.18.4. 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.

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- Some cases of type b dissection may be appropriate for medical admission for blood pressure management.

2.18.5. Groin abscesses in patient who inject drugs

- Managed by the Vascular team.
 - For other abscess rules see [here](#)

2.18.6. 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](#)

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2.19. 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.

2.19.1. Headaches

- 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.

2.19.2. Conditions managed by the Neurology team

- 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 Tumors (not pituitary) are managed by the neurology team

2.19.3. Spinal Cord pathology

- Intrinsic Spinal Cord lesions are managed by neurology. More information about Spinal Cord pathology can be found [here](#)

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2.20. Stroke

2.20.1. 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.

2.20.2. 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.

2.21. Cardiology

2.21.1. 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

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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](#)

2.21.2. 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.

2.21.3. 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.

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- Confirmed, or highly likely, cases of endocarditis are admitted under the cardiology team.

2.21.4. Heart Failure

- 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.
- When patients need admission for heart failure they are managed by several different departments within the Medical Team. The factors that determine most suitable team are the Clinical Frailty Score and the likely duration of admission.
- Patients with a CFS <6 can be triaged to Cardiology if they have known heart failure and present with decompensation, a NTpro-BNP >2000 or an ECHO showing LVEF <50%.
- 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.

2.22. 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

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- Pituitary disorders, including pituitary tumors or complications of pituitary surgery
- Hyper / hypocalcaemia

2.23. Renal Medicine

2.23.1. Hypertension

- 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.

2.23.2. 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.

2.24. 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

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- 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
- 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
 - A pathway for the management of GCA is available on the NNUH intranet. This includes a clerking proforma with the minimum assessments expected. It highlights the need for an urgent CRP to be sent before starting steroids. Steroid dosing is also covered in the guideline.
 - All patients with associated visual symptoms are managed by Ophthalmology, via on call SPR.
 - Patients without visual symptoms are managed by Medicine. Discuss cases in office hours with the on call Rheumatology SPR. If review is needed out of hours then cases can be discussed with the Medical SPR and the patient will be accepted to AMU. Depending on the circumstances of individual cases some of these patients may be suitable for mSDEC, but only after the initial assessments are completed.
 - After the initial review by AIM, Rheumatology or Ophthalmology the patient's details need to be emailed to nnu.tr.rheumatology@nnuh.nhs.uk
 - 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.
- Cutaneous vasculitis
 - Patients with cutaneous vasculitis are managed by the Dermatology team.
 - There must be no evidence of systemic involvement – no reduction in baseline renal function, bland urinalysis, no hypertension and they must not be systemically unwell.

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- For many patients this will be a self-limiting illness, and admission is unlikely to be needed. Advice can be gained via the Dermatology SPR on Alertive or via switchboard.
- Autoimmune inflammatory arthritis
 - Discuss with rheumatology during the day and AMU out of hours.
- 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.

2.25. 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 (<i>Email should only be used for non-urgent communication e.g. to arrange a clinic follow up</i>)

- 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.

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- 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
- 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.

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- 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.
- 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

2.26. Conditions managed by Haematology / Oncology / Palliative care

- Patients known to Haematology / Oncology who are on active treatment
 - The [Acute Oncology and Haematology Service](#) (AOHS) 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.

2.26.1. Malignancy associated Spinal Cord pathology

- Metastatic spinal cord compression pathway – see [here](#)

2.27. 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.

2.28. Acute Medicine and Mental Health problems

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2.28.1. Acute Medicine

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.

2.28.2. Mental Health

- 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.

2.28.3. Homelessness

- 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.

2.29. 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 specialties 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](#)

2.30. Dermatology

- Almost all patients with dermatology conditions will be managed in Primary Care.
 - The Dermatology Team are able to support Primary care via the Advice and Guidance service.
 - Where more urgent input is needed the Dermatology SPR can be contacted via switchboard (Alertive can be used within the NNUH) between 8am and 7pm.

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- If patients do need review, then this will usually be via Outpatient Referral Pathways.

Admissions

- It is rare for patients to need admission, but this might be considered for patients who are systemically unwell because of their dermatological diagnosis, or those who have erythroderma.
 - Dermatology inpatients must not be haemodynamically compromised, if this is the case, the patient will be admitted under Medicine. The Dermatology team will offer support for these admissions until they are well enough to either go home or be managed as Dermatology inpatients.
 - The first point of contact will typically be the SPR. The Consultant Dermatology team are able to offer advice about dermatological emergencies via switchboard.
- Post operative dermatology patients who develop acute complications are managed by the Dermatology SPR between 8am and 7pm.
 - After 7pm the Plastics Team will manage.
- Notes on specific skin conditions
 - Cutaneous vasculitis – see [here](#)
 - Chronic urticaria
 - First presentations with urticaria will typically be managed by the Acute Medicine team. For most patients this will be a self-limiting illness so it is expected that ongoing care will be provided in Primary Care.
 - When chronicity of the urticaria is established, if needed, patients can be referred to Dermatology Outpatients.
 - Those patients who have any angioedema associated with the urticaria should not be referred to Dermatology. These patients can be referred to the Immunology Team in Addenbrookes.
 - Cellulitis
 - cellulitis is not managed by Dermatology. The responsible team depends upon the site of the cellulitis and guidance can be found [here](#)
 - Information on other soft tissue infections such as abscesses and infected pressure sores can be found [here](#)

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3. Related Documents

See appendices

4. Monitoring Compliance / Audit of the process/policy principles/service to be delivered *

Compliance with the process will be monitored through the following:

Key elements (including sustainability)	Process for Monitoring	By Whom (Individual / group /committee)	Responsible Governance Committee /dept	Frequency of monitoring
Updates where new agreements and guidance arises	Contact Ed Markham or Lindy-Lee Folscher	Ed Markham / Lindy-Lee Folscher	Emergency and Unplanned Care	6 monthly

The audit results are to be discussed at relevant governance meetings ([where possible note which meetings](#)) to review the results and recommendations for further action. Then sent to ([insert relevant committee or Sub-Board](#)) who will ensure that the actions and recommendations are suitable and sufficient.

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5. Equality Impact Assessment (EIA) *

Complete the assessment inserted below

Type of function or policy	Existing
----------------------------	----------

Division	Unplanned Care	Department	
Name of person completing form	Ed Markham	Date	25/6/25

Equality Area	Potential Negative Impact	Impact Positive Impact	Which groups are affected	Full Impact Assessment Required YES/NO
Race	none	Improved access to services		no
Pregnancy & Maternity	As above	As above		As above
Disability	As above	As above		As above
Religion and beliefs	As above	As above		As above
Sex	As above	As above		As above
Gender reassignment	As above	As above		As above
Sexual Orientation	As above	As above		As above
Age	As above	As above		As above
Marriage & Civil Partnership	As above	As above		As above
EDS2 – How does this change impact the Equality and Diversity Strategic plan (contact HR or see EDS2 plan)?	This document ensures a fairer and more consistent access to services for patients. Its impact is only expected to be positive.			

- A full assessment will only be required if: The impact is potentially discriminatory under the general equality duty
- Any groups of patients/staff/visitors or communities could be potentially disadvantaged by the policy or function/service
- The policy or function/service is assessed to be of high significance

IF IN DOUBT A FULL IMPACT ASSESSMENT FORM IS REQUIRED

The review of the existing policy re-affirms the rights of all groups and clarifies the individual, managerial and organisational responsibilities in line with statutory and best practice guidance.

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6. Appendices

6.1. Appendix 1 - Core criteria for mSDEC

<u>Chest Pain</u>	
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
<u>Shortness of breath due to suspected Pulmonary Embolism:</u>	
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.
<u>Cellulitis of the leg:</u>	
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
<u>Arrhythmias:</u>	
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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<u>Diabetes:</u>	
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
<u>Hypertension:</u>	
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
<u>Allergic Reactions</u>	
Inclusion criteria	Patients presenting with allergic reactions that cannot see their GP
Exclusion criteria	Anaphylaxis Systolic Blood Pressure \leq 90 mmHg, Heart Rate \geq 110bpm, RR \geq 21 Or SATS <94% on air Patients who received IM Adrenaline or used their own Epipen

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6.2. Appendix 2: Older Peoples Assessment Service (OPAS) Referral Form

Older Peoples Assessment Service (OPAS) Referral form

Email to opas@nnuh.nhs.uk

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

1. Patient Information:

Patient Name:	Date of Birth:
Address:	Hosp. No:
Patient Tel:	NHS No:
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

3. Any other relevant information:

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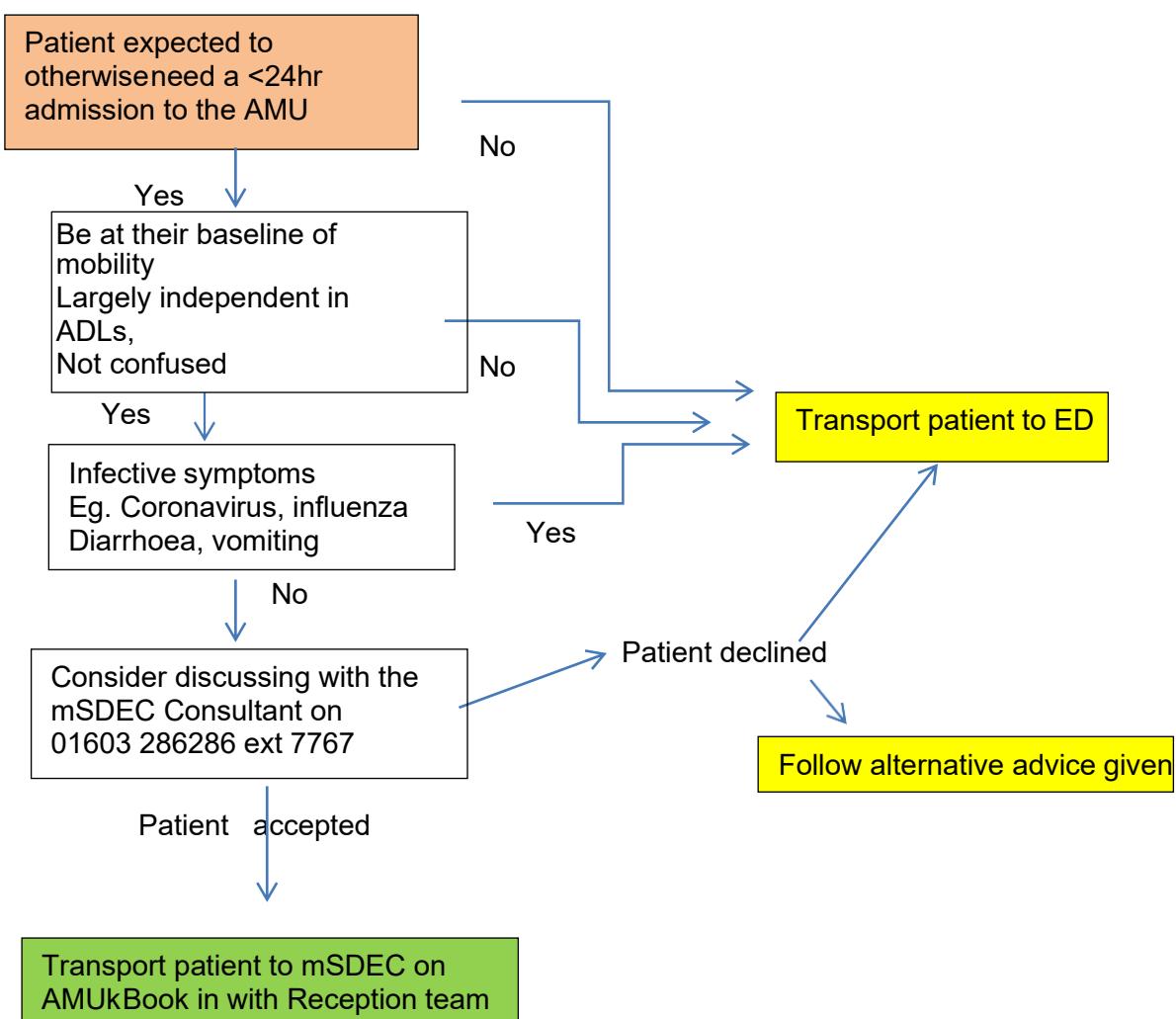
6.3. Appendix 3 - Medical Same Day Emergency Care (mSDEC) Paramedic Referral Pathway

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.

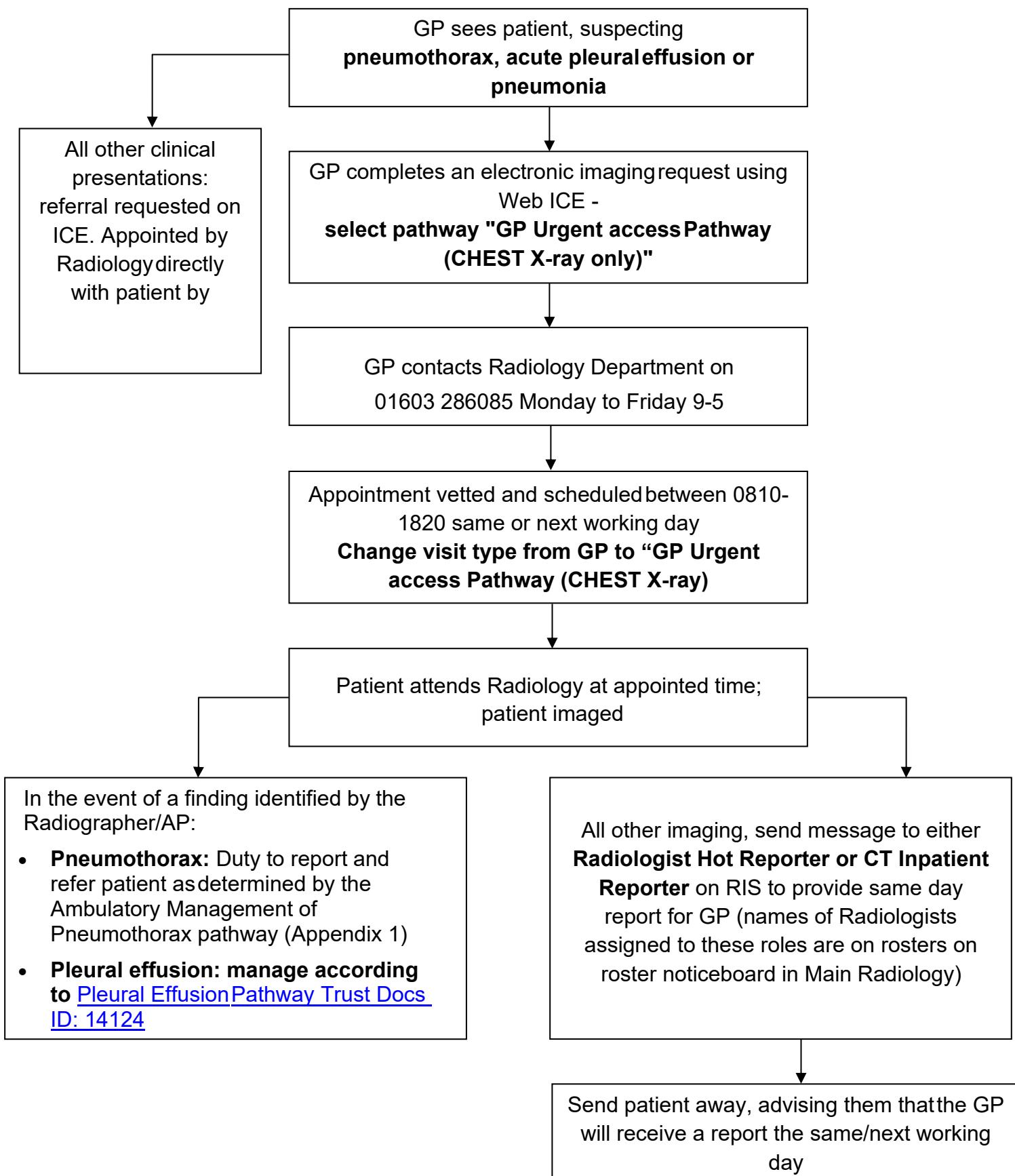
As is shown in the flow chart below, we do need patients to be close to their usual level of mobility. The expectation is that patients will need to wait in our waiting room before and during their assessments.

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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6.4. 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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6.5. Appendix 5 - RAPID ACCESS CHEST PAIN CLINIC

REFERRAL LETTER

Department of Cardiology
Outpatients East,
Level 3Norfolk & Norwich
University
Hospital
Colney
Lane
Norwich, NR4 7UZ

Email to Cardiology racpc@nnuh.nhs.uk

Please note that faxed referrals cannot be accepted.

Direct dial: 01603 289828

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

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

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4. The following additional information must be given:

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

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

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

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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6.6 Appendix 6 - Quick reference guide for how Infective Discitis is managed in Medicine

