University Hospitals of Leicester NHS
NHS Trust

UHL Policy for Transferring Patients from the Emergency Department with a 'Watershed Condition'

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REVIEW DATES AND DETAILS OF CHANGES MADE DURING THE REVIEW

August 2022 – existing policy moved into new template

Responsibilities section expanded

Updates to following sections to reflect changes in practice:

Cardiac surgery, specialist medicine, children, young people, professional standards

Addition of appendix 3

Expired links removed or updated.

KEY WORDS

Watershed, transfer, interprofessional standards, ED

1 INTRODUCTION AND OVERVIEW

1.1 This document sets out the University Hospitals of Leicester (UHL) NHS Trusts Policy and Procedures for patients with "watershed" conditions: some patients are at the "watershed" between different specialty teams. Debate about which is the responsible specialty for certain conditions can lead to delays in transferring patients out of the Emergency Department, with associated delays to appropriate patient care. Discussions have therefore been held with each of the relevant specialties and formal agreement made as to which specialty will be the lead for the various 'watershed' conditions, as detailed below.

1.2 Dr Andrew Furlong (Medical Director) and Richard Mitchell (Chief Executive Officer, - formerly Chief Operating Officer) have confirmed the following to all Lead Clinicians for UHL:

"There are still some occasions, often out of hours, where there is reluctance, despite the clear ED watershed policy, to accept patients from ED on grounds that this may not be the 'appropriate' specialty. **We are writing to reaffirm the policy that the decision of the consultant or senior doctor in the Emergency Department to admit is final.**

2 POLICY SCOPE – WHO THE POLICY APPLIES TO AND ANY SPECIFIC EXCLUSIONS

This policy applies to all patients that present in the Emergency Department with 'watershed conditions' as listed in Section 5 and is to be followed by all UHL staff.

3 DEFINITIONS AND ABBREVIATIONS

Watershed condition – a condition or injury where management of the patient could fall between referral to two different specialty teams.

CDU - Clinical Decisions Unit
CMG - Clinical Management Groups
ED - Emergency Department
LD - Learning Disability
LPT - Leicestershore Partnership Trust
SOP - Standard Operating Procedure

4 ROLES – WHO DOES WHAT

An overview of the individual, departmental and committee roles and responsibilities, including levels of responsibility and any education and training requirement.

4.1 Responsibilities within the Organisation

a) Board Director Lead- Andrew Furlong.
b) Responsible for supporting implementation – Deputy Medical Director for Urgent and Emergency Care
c) Reposonsible for implementation – CMG leads and Heads of Service.
d) Committee with responsibility for oversight – Urgent and emergency care board; and UHL transfer group.

4.2 CMG Leads

a) Responsible for ensuring services within their CMG are practising in line with this guidance
b) Responsible for ensuring that service reponses are timely in line with the trust ED Interprofessional standards SOP.

4.3 Heads of Services:

a) Responsible for ensuring that pathways in their specialty are adhering to this guidance
b) Responsible for ensuring that if that an inappropriate admission has been sent to their specialty you are encouraged to raise this at the first opportunity with either your lead ED consultant or directly with a member of the ED Clinical Leadership Team.

4.4 ED Consultants:

a) Responsible for ensuring that this policy is followed in the ED.
b) Responsible arbitrating any disagreement between specialties and making a final decision about referral of a patient.

4.5 Clinical Staff:

a) Responsible for ensuring that this policy is implemented
b) Responsible for referring patients to the correct specialty if the first referral out of ED to their specialty has been incorrect or inappropriate.
c) Responsible for ensuring timely (within 30 minutes) review of patients in the ED, or transfer to an admitting unit when they have been referred.
d) All clinical staff must accept that the decision by an ED consultant or senior doctor regarding referral to a specialty is final.

5. POLICY IMPLEMENTATION AND ASSOCIATED DOCUMENTS –WHAT TO DO AND HOW TO DO IT

5.1 SPECIALIST MEDICAL CONDITIONS

5.1.1 Oncology

See Oncology admission policy (Appendix 1)

5.1.2 Palliative Care

The Specialist Palliative Care team are a non-bed holding speciality within UHL and patients cannot therefore be admitted under their care. If a person requires admission to UHL because of their palliative care requirements or for care when they are dying, the person should be admitted under a relevant specialty.

The Specialist Palliative care team offer assessment and advice across all departments, including within the Emergency Department. There is planned face-face specialist palliative care presence on the emergency floor at LRI 9-5pm Monday to Friday. Face-face input outside of this time will be triaged for input alongside patients across all 3 UHL sites.

Referrals to Specialist Palliative Care should always be sent electronically (on ICE or NerveCentre e-referrals). For urgent matters, the specialist palliative care team can be contacted via mobile in addition to the electronic referral.

5.1.3 Anaemia Secondary to Epistaxis

If still bleeding – refer ENT (the ENT team are then responsible for onward referral if required). If not still bleeding but need transfusion – transfer to GPAU for transfusion or arrange day case transfusion on the medical day case unit.

5.1.4 Displaced Feeding Tube

In hours – contact UHL Nutrition Nurses on ext 16988 or 07960 867292. They will review the patient and advise if admission is required.

Out of hours – Attempt to place temporary tube from equipment located in Enteral feeding stack in ED. If patient unable to meet hydration needs, or a temporary tube cannot be placed, admit and refer on ICE to LIFFT for Enteral feeding tube review. If patient can maintain hydration, patient can be discharged and UHL Nutrition Nurses will follow up on next working day. Please ensure Nutrition Nurses are contacted via ext 16988 and a message is left and an ICE referral to LIFFT is completed.

Further information is located on the LIFT pages on Insite.

5.2 CARDIOTHORACIC CONDITIONS

5.2.1 Cardiac Contusions

Patients with significant chest / sternal injury in which cardiac contusion is suspected will be transferred to the CDU at Glenfield to be managed by the cardiologist/Cardiac Surgeons:

Referral Process

1. Place on bed bureau list for Glenfield CDU
2. Inform the Cardiac Surgical SpR, **but ensure they know the patient is going to CDU at Glenfield, NOT a cardiac surgical bed**.
3. Usually chest X-ray, transthoracic echo along with myocardial enzymes should be performed.

5.2.2 Thoracic Aneurysm or Dissection

Suspected thoracic aneurysm or dissections will be imaged at LRI. The ED guideline must be used: Acute aortic syndrome managment in the ED.

If positive, patient will be transferred directly to anaesthetic theatre/ITU (pending on emergent theatre availability) at Glenfield for cardiac surgery:

Referral Process

If **stable/unstable**: inform the Cardiac Surgical SpR, and ensure that patient is transferred **asap** to anaesthetic theatre/ITU (pending on emergent theatre availability) and imaging investigations are available.

5.2.3 Sternal Fractures Requiring Admission:

Patients with isolated sternal fractures caused by seat belts who have normal electrocardiography, chest radiography, and stable vital signs can be discharged. If admission needed, they will be transferred to the CDU at Glenfield under the care of the Thoracic Surgeons:

Referral Process:

1) Place on bed bureau list for Glenfield CDU.

2) Inform the Thoracic Surgical SpR, but ensure they know the patient is going to CDU at Glenfield, not a thoracic surgical bed.

5.2.4 Rib Fractures Requiring Admission

Few patients with rib fractures will need admission. If admission is needed consider transfer to the Major Trauma Centre. If UHL admission is more appropriate transfer to the CDU at Glenfield under the care of the Thoracic Surgeons:

Referral Process:

1) Place on bed bureau list for Glenfield CDU.
2) Inform the Thoracic Surgical SpR, but ensure they know the patient is going to CDU at Glenfield, not a thoracic surgical bed.

There is little geriatric input available at Glenfield Hospital, so for older patients with rib fractures who may need significant geriatric input a senior ED doctor will weigh up the balance of risks and make a decision on an individual patient basis.

5.2.5 Combined Chest Injury and Orthopaedic Injuries

If admission is needed consider transfer to the Major Trauma Centre. If UHL admission is more appropriate the ED Senior Doctor will decide the admission destination depending on best balance of risks for the individual patient, bearing in mind that Glenfield (CDU) has no orthopaedic injury management or rehabilitation service and LRI (MSK wards) have no chest injury service.

5.2.6 Combined Head and Chest Injury

Consider transfer to the Major Trauma Centre. If UHL admission is more appropriate the ED Doctor in Charge will decide the admission destination depending on best balance of risks for the individual patient, bearing in mind that Glenfield (CDU) has no head injury service and LRI (EDU) has no chest injury service.

5.3 MUSCULO-SKELETAL CONDITIONS

5.3.1 Pubic Ramus Fracture

Needing admission for pain control but no orthopaedic intervention: admit to EDU if it is anticipated home next day, otherwise admit to AMU.

NB: If no rehab goals can be set the patient will not be suitable for a community hospital so admit AMU.

5.3.2 Elderly Patients with Fractures not needing MSK Intervention

Fractures particularly in the elderly which do not need surgical intervention or not needing “medical” supervision but are unable to return home because of lack of support will be admitted to EDU if it is anticipated the patients will be home next day, otherwise admit to AMU.

NB: If the patient has no rehab goals they are not be suitable for a community hospital and so will be admitted to the AMU. By definition patients who cannot go to their own home with a POP in situ do not have rehab goals and so will be admitted to AMU awaiting a social care residential community placement.

5.3.3 Orthopaedic Patients with Medical Comorbidity

If a patient has an acute medical problem, in addition to their traumatic injury a discussion will need to be had involving both orthopaedic and AMU/specialty teams regrading best placement for the patient.

5.3.4 Limb Wound with Suspicion of Vascular Involvement
If soft tissue below elbow, refer as per Hand Injury SOP (see below section 5.4.9)

Otherwise refer to vascular surgery who will involve orthopaedics as required. Put patient on bedlist for surgical admission.

5.3.5. Limb Fracture with Suspicion of Vascular Involvement
Refer orthopaedics who will involve vascular and plastic surgery as required. Put patient on bedlist for orthopaedic admission.

5.3.6 Combination of Fracture Plus Severe Soft Tissue Injury
To be admitted under Orthopaedics, with Plastic Surgery input as required.

5.3.7 Severe Soft Tissue Injury
To be admitted under Plastic Surgery, with Orthopaedic input as required.

5.3.8 Severe Soft Tissue Injury in Elderly Patients
If the patient would not normally be admitted under Plastic Surgery, but is unable to cope at home; if it is anticipated home next day admit to EDU (Consultant Only Pathway), otherwise admit to AMU.

5.3.9 Diabetic Feet
Where complications of diabetic feet (sepsis or ischaemia) are the primary reason for the patient requiring admission then admit under vascular surgery.

5.3.10 Back Pain
If admission required for pain control only – if it is anticipated home next day admit to EDU (Consultant Only Pathway), otherwise admit to AMU for next day Ward 24 referral.

If suspicion of cauda equina – request MRI and make immediate orthopaedic referral (Note: ortho review not needed to make MRI request). Refer to this guideline Cauda Equina rule in-out guideline for ED department:

5.3.11 Combined Head and Limb Injury
The ED Consultant must decide destination (MSK ward or EDU) depending on best balance of risks for the individual patient, bearing in mind that MSK wards have limited head injury experience and EDU has limited orthopaedic trauma experience.

5.4 SURGICAL CONDITIONS

5.4.1 Testicular Torsion
Patients with testicular pain **up to the age of 18** will be seen by the Paediatric Surgeons at the Leicester Royal Infirmary.

Patients aged 18 and over must be referred to the Urology SpR and admitted to LGH.

5.4.2 Facial Lacerations
Admit to Maxillo-Facial Service. They will call in Ophthalmology, ENT or Plastic Surgery if required.

5.4.3 Abdominal Pain without Clear Surgical Signs
These will be seen initially in the ED by the Surgical SpR for a decision re ward destination, unless a clear decision has been made by an ED senior doctor.

5.4.4 Abdominal Pain in Children
- Young person (16 or 17) presenting with Abdominal pain not known to Paediatricsurgery

- Refer to Adult Surgery and to be placed in adult bed if admitted
- Young person presenting with Abdominal pain known to Paediatric surgery - Refer to Paediatric Surgery and to be placed in paediatric bed if admitted

5.4.5 Elderly ? Bowel Obstruction ? Constipation

These patients will be assessed in the ED by the Surgical Registrar under the 30 minute rule (see section 5.10). If small or large bowel obstruction is eliminated and there is no further surgical concerns then they will be admitted under Medicine. If the Surgical Registrar is unable to attend in the appropriate period of time the patient will be admission to the Surgical Admissions Unit for assessment and onward referral as required.

5.4.6 Large Wounds (>10cm), or Complex Wounds, in any Body Area

In the absence of any fracture, these will be admitted under Plastic Surgery.

5.4.7 Oesophageal FB in Adult

As there is no general agreed rule about where responsibility for these patients lies; the ENT, gastroenterology and acute medicine on-call teams will discuss and make a decision on an individual patient basis. It is suggested that a foreign body in the upper GI tract/pharynx should be referred to ENT; and lower GI tract foreign bodies to AMU. If there is no agreement about the best course of action the Senior Manager On Call (SMOC) will facilitate a teleconference call between the consultants in the relevant three specialties.

This following guidance must be followed for patients who have ingested button baterries or magents: Potential button or magnet ingestion in adults

5.4.8 Total Dysphagia

(Total dysphagia defined as inability to swallow either solids and fluids) High dysphagia – refer ENT

Lower dyspagia - admit to AMU for next day gastro referral. If known cancer undergoing treatment - admit Oncology.

5.4.9 Hand and Finger (tip) Injuries

For the purposes of this pathway, a ‘hand injury’ is defined as any soft tissue injury below the elbow.

Any patient with a bony injury distal to the carpal bones is defined as a finger injury.

Pathway for Referral:
Monday to Thursday All ED referrals to Orthopaedics
Friday to Sunday All ED referrals to Plastics

Specialist paediatric Fingertip injuries in children can be found here:

5.4.10 Abscesses

Trunk (including axilla, groin and buttock above infra-gluteal fold) – General Surgery
Limb (including buttock below infra-gluteal fold) – Orthopaedics
Face – Maxillofacial Surgery

5.4.11 Breast Abscess requiring Admission for Sepsis

Follow UHL Sepsis Pathway, including ICU referral as required.
In hours: Refer to Breast Surgery team (Ward 24 GGH Ext.2490).

Out of hours: Refer LRI surgical on call team.

Please see Appendix 2 for more detailed information on the referral pathway and for treatment guidance for both lactational and non-lactational abscesses.

5.4.12 Wound with Ear Cartilage Exposed
Refer to ENT who will involve plastics as required.

5.4.13 Wound to Ear with Tissue Loss
Refer to ENT who will involve plastics as required.

5.4.14 Necrotising Fasciitis
Refer to the surgical speciality responsible for that body area, who will be responsible until handed over to another speciality:

Trunk and perineum (including axilla, groin and buttock above infra-gluteal fold) – General Surgery

- Scrotum - Urology
- Lower Limb (including buttock below infra-gluteal fold) – Orthopaedics
- Upper Limb
- Mon to Thurs - Orthopaedics.
  Fri to Sun - Plastics (i.e. the same arrangement as for hand trauma)
- Head and Neck – ENT
- Vulva and Vagina - Gynaecology

Early critical care and microbiology involvement is essential. See Guideline B20/2015 Pathway for the Management of Patients with Necrotising Fasciitis for further details on management.

5.5 UROLOGICAL CONDITIONS

5.5.1 Pyelonephritis
Male patient - Urology
Female patient known to have an abnormal urinary tract - Urology Female patient with normal urinary tract – Acute Medicine
Pregnancy of > 16 weeks – Admit maternity (LGH/LRI - where they are booked)
Pregnancy <16/52 – Admit Gynae Admission Unit (GAU) at LRI

5.5.2 Urological Condition with Sepsis
If severe enough to be reviewed by critical care team the critical care team will discuss with a senior urologist to decide on the most appropriate admission (LRI or LGH).

5.5.3 Testicular Torsion
See section 5.4.1.

5.6 CHILDREN (FOR YOUNG PEOPLE PLEASE SEE NEXT SECTION)

5.6.1 Inhaled (lower airway) FB in a Child
These will be admitted under Paediatrics (who will involve ENT as required).

5.6.2 Oesophageal FB in Child
Upper 1/3 to ENT, middle and lower 1/3 to Paed surgery.
Please see guideline: Investigation of an oesphageal/ GI foreign body in children

5.6.3 Mental Health Referral for 16 / 17 Year Olds
To be discussed with ED senior doctor. Currently CAMHS responsible if under 18 and in full-time school education.

5.6.4 Upper GI Bleeding:
Upper GI bleed - Refer Adult Medicine GI bleed team with Paediatric bed as an option if required in view of Adult bed-state and dependent on appropriateness of paediatric bed for individual

5.6.5 Children at the HDU / ICU Interface
The Paediatric Registrar will determine if the child needs Children's Intensive Care input and will contact the CICU Reg directly. If no intensive care is required, the Paediatric Registrar will decide between HDU and CAU.
See SOP - Critical care guideline for children and young people.

5.7 YOUNG PEOPLE AGED 16 OR 17

Young people aged 16 or 17 will need a discussion between the ED team and the specialty regarding best placement to meet their needs. For some conditions this is already detailed in this policy. Where there is no specific mention of this then individual discussions need to occur. Please see flow chart in Appendix 3.

5.8 PREGNANCY WITH INTER-CURRENT CONDITIONS

For more detailed advice see Care of the pregnanat patient admitted outside of the maternity unit.

5.8.1 VTE
If > 16/52 – admit to Maternity for investigation
If <16/52 – follow same referrals as for non-pregnant women (ambulatory clinics if possible otherwise admit AMU).

See guidline VTE in pregnancy guideline for more detail.

5.8.2 Pylonephritis in Pregnancy
Admit Maternity Unit if > 16 weeks (either LRI or LGH depending on where they are booked)
If <16 weeks admit GAU (Gynae Admissions Unit).

5.8.4 Abdominal Pain in Pregnancy without a Clear Surgical Cause
>16 weeks – refer Obstetrics.
<16 weeks – refer Gynae.
(These teams will make onward surgical referral as required).

5.8.5 Admission of Breast Feeding Mother outside of Maternity Unit
There are no facilities to admit a baby with its mother if admission is required under any specialist team apart from obstetrics.

5.9 PSYCHIATRY

5.9.1 Forensic Referrals
In general, patients are sent back to prison / police custody for a mental health assessment. If the patient is too unwell to return to custody discuss with senior doctor and involve duty management team for discussion with LPT.

5.9.2 Learning Disability Referrals
There is no clear referral pathway – discuss with senior doctor and involve duty management team for discussion with LPT. Paediatrics can admit patients with LD up to the age of 35; AMU is an alternative. It is advised that the needs of patients are assessed and the patient placed accordingly.

5.10 PROFESSIONAL INTERACTIONS

***NB. Please see the document** ED Interprofessional standards SOP for a fuller explanation of the interprofessional standards.*

5.10.1 "30 Minute Rule"
If a specialist team is asked to review a patient in the ED and a destination plan has not been made within 30 minutes the patient will be admitted to await review on that team's ward.

5.10.2 Onward Referral
If a specialist team reviews a patient in the ED and feels that an alternative team needs to be involved it is their responsibility to make the onward referral.

If the original referral was clearly incorrect feedback should be sent to the ED Leadership Team for inclusion in the ongoing education / governance programs.

5.10.3 "Bouncebacks"
If a patient has been referred for admission, but the specialist team feels that an alternative specialty would be more appropriate it is their responsibility to make the onward referral. Patients will never be "bounced back" to the ED team.

If the original referral was clearly incorrect feedback should be sent to the ED Leadership Team for inclusion in the ongoing education / governance programs.

5.10.4 Actions in the event of Disagreements
In the event of a disagreement between specialists the registrars involved will talk to each other and discuss with their consultants. The ED junior doctor will not act as 'piggy in the middle' – a direct discussion between specialist is much more efficient. If there is no agreement about the best course of action, the Senior Manager On Call (SMOC) will facilitate a teleconference call between the consultants in the relevant specialties. Consultants must dial into this call if requested.

If there is still a disagreement between the specialties, the ED consultant will make the final decision about who is going to be responsible for the patient's care.

5.10.5 Escalation
In the event of ED crowding the following policy will be enacted:

Capacity and flow escalation policy and whole hospital response to emergency care demand policy.

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 An awareness of this policy is required by all clinicians working with the ED and it shall form part of the induction to the ED and for the specialties that receive patients from the ED.

6.2 Resources are available here for staff:

INsite - Working with the Emergency Department (xuhl-tr.nhs.uk)

7 PROCESS FOR MONITORING COMPLIANCE

7.1 These processes will be monitored through the Urgent and Emergency Care Board using the etrics that have been derived to ensure that the Interprofessional Standards are working.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9 SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

ED Interprofessional standards SOP
Acute aortic syndrome managment in the ED
Cauda Equina rule in-out guideline for ED department
Potential button or magnet ingestion in adults
Fingertip injuries in children
B20/2015 Pathway for the Management of Patients with Necrotising Fasciitis
Investigation of an oesphageal/ GI foreign body in children
Critical care guideline for children and young people.
Care of the pregnanat patient admitted outside of the maternity unit .
VTE in pregnancy guideline
Capacity and flow escalation policy and whole hospital response to emergency care demand policy.

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system.

POLICY MONITORING TABLE

The top row of the table provides information and descriptors and is to be removed in the final version of the document

What key element(s) need(s) monitoring as per local approved policy or guidance?	**Who will lead on this aspect of monitoring?** **Name the lead and what is the role of other professional groups**	**What tool will be used to monitor/check/** **observe/asses/** **inspect** **Authenticate that everything is working according to this key element from the approved policy?**	**How often is the need to monitor each element?** **How often is the need complete a report ?** **How often is the need to share the report?**	**How will each report be interrogated to identify the required actions and how thoroughly should this be documented in e.g. meeting minutes.**
Element to be monitored	**Lead**	**Tool**	**Frequency**	**Reporting arrangement Who or what committee will the completed report go to**
Response times from referral from ED to specialty review	Rachel Marsh	NerveCentre e-referrals data	Monthly	Urgent and Emergency Care Board review

Appendix 1:

ADMISSION CRITERIA TO THE ONCOLOGY ASSESSMENT UNIT

Patients admitted to the Osborne assessment unit should be known to and accepted by and oncologist (MDT referral is not sufficient). Not all patients with a diagnosis of cancer require admission to a specialist unit. Those that should be admitted to the unit include:

1. Patients receiving active treatment (chemotherapy/targeted treatments or radical radiotherapy) or those within 6 weeks of their last treatment date with:

   (i) Suspected complications related to the systemic treatment of cancer:
   - a. suspected neutropenic or non-neutropenic sepsis
   - b. uncontrolled nausea and vomiting
   - c. extravasation injury
   - d. acute hypersensitivity reactions including anaphylactic shock
   - e. complications associated with venous access devices
   - f. uncontrolled diarrhoea
   - g. uncontrolled mucositis
   - h. hypomagnesaemia
   - i. pancytopenia
   - j. patients with significant variation of haematological parameters

   (ii) Suspected complications related to radiotherapy:
   - a. acute skin reactions
   - b. uncontrolled nausea and vomiting
   - c. uncontrolled diarrhoea
   - d. uncontrolled mucositis
   - e. acute radiation pneumonitis
   - f. acute cerebral/other CNS oedema

2. Patients with the following complications and a known history of cancer caused directly by malignant disease and presenting as an urgent acute problem.
   - a. superior mediastinal obstruction syndrome, including superior vena caval (SVC) obstruction
   - b. metastatic spinal cord compression for which there is a proven diagnosis. No proven diagnosis goes to orthopaedics.

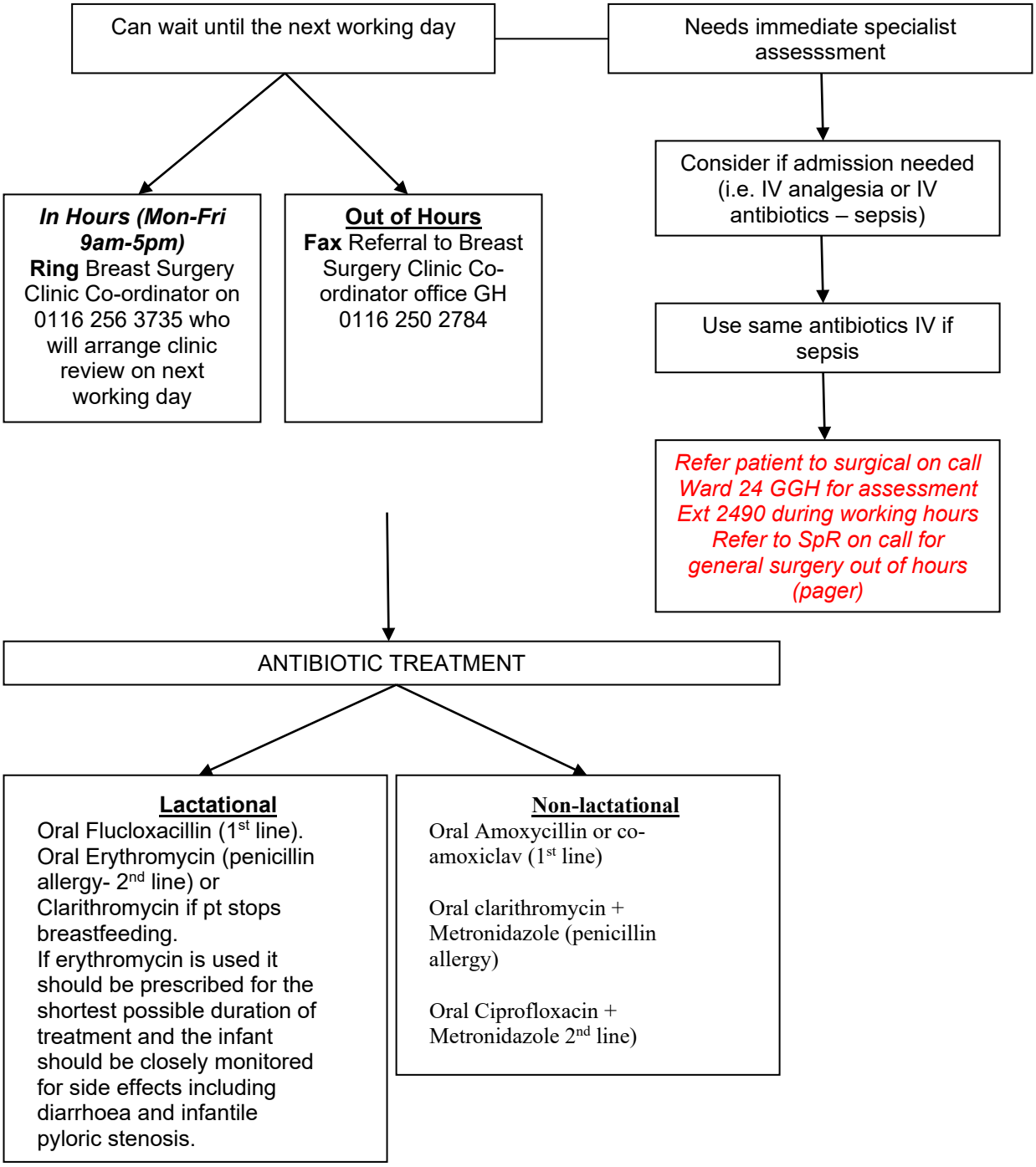
3. **Disease progression and end of life care does not necessitate transfer to the oncology unit** and should be discussed on a case by case basis with the responsible consultant team where possible. The following complications of cancer should not be admitted to the Oncology ward but should be assessed/admitted as indicated below:
   - a. pleural effusion → respiratory
   - b. pericardial effusion → cardiology

4. If in doubt speak to the on call oncology registrar or the on call consultant.

Appendix 2

BREAST ABSCESS / OTHER BREAST EMERGENCIES

(Excludes Breast Surgery Under Plastics at LRI)



Note: Patients with suspected breast cancer should be referred back to GP for urgent 2 week cancer referral.

Note: For all post operative breast emergency patients, contact relevant on-call surgical team (plastics team for plastic surgery breast patients and breast team for breast surgery patients)

Note: Infected sebaceous cysts of breast should be referred to the currently existing emergency general surgery pathway.

Appendix 3: Flow chart re: young people attending ED