KING EDWARDS HOSPITAL FUND FOR LONDON
KING'S FUND EMERGENCY BED SERVICE
STANDING ORDERS

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SO76/1

Secretary
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Note to be attached to each copy of Standing Orders dated March 1976

This latest edition of Standing Orders is intended, like previous versions, to serve as a guide to all concerned in seeing that we give of our best in our work here. Standing Orders are of course nothing new for the Emergency Bed Service, though for this latest edition there have had to be many amendments to match changes in our practice such as those reflecting the new structure of the Health Service. They are not intended to be treated as a 'rule book' in a restrictive way nor as something which tries to specify all eventualities, but rather to provide a sound framework for what we do. With this in mind, Miss Sharpe and the Senior Watchkeepers have taken great care in helping me to prepare this edition, and Miss Pike also helped by drawing up the index.

I propose to look at it all afresh after it has been in use for a few months, and meanwhile make only whatever amendments need to apply immediately such as in the arrangements now made with the London Ambulance Service for temporary headquarters in an emergency.

Irfon Roberts

27th April, 1976.

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Standing Orders

Revised March 1976

King Edward's Hospital Fund for London

King Edward's Hospital Fund, often called the King's Fund, is an independent charitable organisation. Its income is used for three main purposes: grants of money to hospitals situated within the Greater London area or serving it, both within the National Health Service and outside it: education and training, especially at the King's Fund College in Bayswater; and information and advisory services, for which the focal point is the King's Fund Centre, near Marble Arch. The head office of the Fund is at 14 Palace Court, Bayswater.

The King's Fund Emergency Bed Service, or the EBS for short, is also one of the main establishments of the Fund, but most of its running costs are met by the four Regional Health Authorities of London.

Scope and Purpose of the Emergency Bed Service

General practitioners usually have their own direct links with local hospitals for urgent admissions. The Emergency Bed Service handles cases, at the request of general practitioners in the Greater London area, in which the normal direct approach to hospitals has been unsuccessful. The service saves time for patients and trouble for GPs. It covers general emergencies but not psychiatric. It can ensure acceptance of responsibility for a patient by a local hospital through the medical referee procedure. This is an arrangement whereby the specified District hospital becomes responsible for seeing a patient with a view to admission when applications through normal EBS channels have failed. Regional Medical Admissions Officers, who are seconded from the Thames Regional Health Authorities as medical advisers, can refer patients to the medical referees designated within the Districts. Once the medical referee procedure is invoked, the hospital concerned must accept responsibility for the patient and the medical referee has full authority to say what is to be done about the admission of a patient referred in this way. This procedure is held in reserve as much as possible, and by far the greater number of applications are accepted without it. It becomes of special importance in times of stress, such as outbreaks of influenza.

The EBS performs other tasks such as arranging admission for terminally-ill patients to St. Joseph's Hospice, Hackney, and answering enquiries for the Medic-Alert Foundation. This organisation keeps records of special medical needs of its subscribers. Its master index is held by the EBS and, in an emergency, information from the records can be obtained by a doctor or other authorised person by a reverse-charge telephone call from anywhere in the world.

The EBS is uniquely placed to form an accurate picture of all aspects of admission of patients to hospitals. It is in close working contact with, and can give advice and information to, those concerned, though it is not an information bureau for the general public. The Fund's publication, "Admission of Patients to Hospital (1973)", reports a study which came from an idea put forward by the EBS, whence a sequel to take stock of the situation is also to be run.

1. Staff

a. Secretary

There is a Secretary in charge of all aspects of running the EBS. He is responsible to the Secretary of the King's Fund and to the Emergency Bed Service Committee, which reports to the Management Committee of the Fund.

It is the practice of the Fund to give other responsibilities to its senior officers apart from those of their main appointments, and under this arrangement the present Secretary of the EBS undertakes various other tasks, including ones with involvement abroad.

The Secretary has a deputy and a staff of about fifty, mostly employed in the operations room where they work in four teams called watches, each in the charge of a senior watchkeeper, to cover the work in shifts. The rest of the staff are engaged in general administration and secretarial duties.

b. The Deputy Secretary acts for the Secretary as he may direct. She has certain designated duties, being responsible to him for the day to day running of the EBS including the domestic, catering and accounting aspects and the initial two week training of new members of the staff. She is in full charge when standing in for the Secretary in his absence.

c. The Senior Watchkeepers are, in rotation, in charge of the operations room staff and the organisation of the work of the operations room to meet varying conditions. They are responsible to the Secretary, or to the Deputy Secretary when she is standing in for him or on matters delegated to her.

d. Senior and Junior Deputy Watchkeepers assist the Senior Watchkeeper on duty in running the operations room, taking charge where necessary. They are also particularly responsible for ensuring that the domestic "code of practice" in Section IV is adhered to. They are responsible to the Senior Watchkeeper for training new members of the staff and ensuring that they obtain all the necessary assistance to enable them to pass the three months' examination.

e. Duty Admissions Officer DADO. Each Senior Watchkeeper undertakes DADO duty for two days out of eight. The DADO is responsible for maintaining the internal routine organisation within the watches, such as keeping the leave files and sickness files and helping to interview candidates and receive visitors. She also helps as required in the day-to-day running of the operations room.

f. Admissions Officers. Each watch contains some seven or eight admissions officers. The working day and night are divided into three watches as follows:-

Watch A	9.00 a.m.	-	3.30 p.m.
Watch B	3.30 p.m.	-	10.00 p.m.
Watch C	10.00 p.m.	-	9.00 a.m.

The staff of the operations room, some 36 in all, are formed into four watches working in rotation for six consecutive days followed by two clear days off duty and for night duty of six nights in succession, which with a full complement of staff occurs every six weeks, followed by three days off duty.

g. Statistics and secretarial staff work normal office hours and are responsible to the Secretary and Deputy Secretary but undertake work for the operations room as and when required.

h. Switchboard operators work on alternate shifts from 09.00 to 15.00 hours and 15.00 to 21.00 hours Monday to Friday. On Saturday they work from 09.00 to 14.00 hours. When one operator is off duty the other works from 10.00 to 16.00 hours. They are responsible to the Deputy Secretary.

i. The resident caretaker is responsible to the Deputy Secretary for the security of the EBS premises and for carrying out certain duties in cleaning and repairs as allocated to him.

j. Cleaning staff. There are two morning cleaners who between them clean all the rooms. As they are not on duty all day it is left to operational and office staff to keep the place tidy, such as by emptying ash trays, and to replace toilet rolls and paper towels as required.

k. Catering staff are employed by Messrs. Gardner Merchant, a commercial organisation responsible for the catering service.

l. The Regional Medical Admissions Officers. The Thames Regional Health Authorities have attached to the EBS members of their own medical staff who are known as Regional Medical Admissions Officers. One of these RMAO's is available at any time of the day or night, either at the EBS or on call, to give advice on medical matters, including the question of whether to apply the medical referee procedure for a given patient.

2. a. Responsibility for night-duty. Either a Senior or Junior Deputy or another member of the watch will be made responsible for each night-duty. That person is in complete charge and will be held responsible not only for the operational work but also for domestic matters.

b. General. The Senior Operator in charge of the operations room is responsible to the Secretary and must feel free to refer any problem to him or the Deputy Secretary (not only during office hours): their private telephone numbers are always shown in the operations room.

c. Operations room staff work "Watches" as indicated in the Watch Book. This includes night-duty as required and standing-by for reserve. When standing-by, if not on the telephone at home, staff must telephone beforehand in time to join the watch if required.

d. Permanent night-duty. Permanent night-duty staff work three nights on and three off, working under whoever is nominated as in charge of night-duty. They work according to the conditions of service outlined to them. (See 1.7 note attached)

3. Terms and Conditions of Service

a. Appointments

All members of the staff are appointed for a probationary period of three months and during this time they will be paid weekly. If appointed to the permanent staff they will be paid monthly. All appointments are subject to satisfactory work, conduct and health record.

b. Salary

The letter of appointment shows the starting salary and increments.

c. Increments

Increments at dates will be as follows:-

For staff appointed between 1st January and 30th June - 1st January
For staff appointed between 1st July and 31st December - 1st July

Each annual increment on the scale of pay will in all cases be subject to the recommendation of the Secretary and may be withheld if the conduct, work or sickness record of the person concerned is unsatisfactory. The final decision on all increments will be the responsibility of the Secretary of the King's Fund after he has considered the recommendation of the EBS.

d. Examinations

Admissions Officers will be required to pass a preliminary examination on completion of their initial two weeks' training and a further examination at the end of three months after the date of appointment. During this time they are expected to study to reach the required standard. Other members of the staff will receive two weeks' initial training, but will not necessarily be required to undergo the examinations.

e. Notice of termination of employment

During their first three months, when staff are paid weekly, one week's notice will be required. After that, notice is one month on either side. For operations room staff the last day of duty must coincide with the last day of a Watch. Outstanding leave will be granted during the period of notice only if, in the opinion of the Senior Watchkeeper concerned, current conditions permit.

f. Leave of absence

The onus of responsibility for staffing the EBS, and hence for granting leave, rests with the Secretary. He delegates to the Senior Watchkeeper the task of arranging rotas of duty, days off, and holidays for the staff of the operations room, and to the Deputy Secretary for the remainder of the staff, leave of absence for the senior officers themselves being subject to the approval of the Secretary, after preliminary co-ordination by the Deputy Secretary.

i) Annual Leave

The leave year is from 1st January to 31st December and leave cannot be carried forward to the following year. Staff will be entitled to three weeks' paid holiday, in addition to public holidays, during their first two years of employment. In the year in which the appointment is made, the entitlement will be pro rata to the number of months served, and after 24 months completed service, this will be increased pro rata to four weeks holiday from the anniversary of the appointment to the end of the year. Thereafter the annual holiday will be four weeks. After ten years' completed service the annual holiday will be five weeks. Leave for permanent night duty staff for the first two years of service is twelve working days per annum, thereafter sixteen working days per annum.

For operations room staff a week is six working days, for switchboard operators, five and a half days, and for those working a five day week, five days.

Leave must always be approved by a senior officer. No new member of the staff can claim leave until she has completed two months' continuous service.

Leave must be taken, normally, as complete weeks. Where staff are eligible for three weeks' leave, it should be one or two periods e.g. three weeks together or two weeks plus one. Where four weeks' leave is due this may be taken in two or three parts. One week's leave must be taken before 31st May and no annual leave will be granted between 31st October and 16th March. Leave may not be taken in three or four separate weeks. Operations room staff are granted days off in respect of bank holidays and they may be taken singly or together at the discretion of the Senior Watchkeepers. With the exception of days off in lieu of Christmas, no leave may be carried forward to the following year but "Christmas days" are to be taken before the 30th June.

ii) Unpaid Leave

Leave entitlement makes no provision for unpaid leave.

Very occasionally there might be a special case when the possibility of granting unpaid leave might arise, but any exceptional application of that sort must be referred to the Secretary of the Fund.

iii) Maternity Leave

If a member of the staff has been employed for not less than twelve months it may be possible to grant her maternity leave. The conditions when this could be done would be similar to those applicable in the Health Service.

iv) Compassionate Leave

Compassionate leave with pay may be granted, normally not more than three days, in cases of urgent domestic distress, such as bereavement.

v) Special Leave

Operations room staff are allowed special leave of two months after five years' completed service and every fifth year thereafter. This leave may not be split.

vi) Absence through Sickness or Injury
(see also Contract of Employment - amended 1.11.1975)

If a member of the staff is unwell, she is to telephone, at the earliest possible time, to say so or to arrange for someone to do so on her behalf. Those in the operations room staff must speak to the senior person on duty, and other staff to the Deputy Secretary.

Extract from King's Fund Conditions of Service:-

"A medical certificate must be obtained and sent to the head of your department if you are off sick for more than three days and thereafter weekly, unless a certificate states incapacity for a longer period than one week. A certificate of fitness to resume work should be submitted on return to work. Your National Health Certificate must be sent to the Department of Health and Social Security and sickness benefit will be paid to you according to the Department of Health and Social Security leaflet NI 16.

In the case of a period of sickness extending beyond 12 days an earnings-related supplement will normally be payable in addition to the standard amount of sickness benefit. The total amount of such benefit receivable will be deducted from your monthly or weekly salary. Details of benefit received from the Department of Health and Social Security should be notified to the Salaries and Wages Section of the Accounts Department.

During a long period of sickness, payment of salary will be made according to the following table, less the benefits receivable from the Department of Health and Social Security.

During 1st year's service - one month's full pay and (after completion of four months' service) two months' half pay.

During 2nd year's service - two month's full pay and two months' half pay.

During 3rd year's service - four months' full pay and four months' half pay.

During 4th and 5th year's service - five months' full pay and five months' half pay.

After five years' service - six months' full pay and six months' half pay."

vii) Hours of Duty

Hours of duty are as specified in the Contract of Service.

Operations room staff may exchange duties (ie "early and "late" on the same day) at the discretion of the Senior Watchkeeper concerned but may not exchange duties until after passing the three month examination.

viii) Superannuation

The King's Fund has its own contributory superannuation scheme which members of the permanent staff will be required to join when eligible as soon as their probationary period is over and younger members must join at the end of two years' service. These are not optional, being part of the Fund's conditions of employment.

ix) Retirement

Retirement is at the age of 60 for women and 65 for men.

4. Change of Name or Address

Members of the operations room staff must inform a senior watchkeeper of any change in their name, address or telephone number, and this information will then be given to the Accountant of the Fund. Similarly, other members of the staff must inform the Deputy Secretary.

5. King's Fund Staff Social Club

Members of the permanent staff are eligible to join the social club. Details may be obtained from the senior watchkeepers.

6. Travelling Expenses

Fares incurred for travel on official business by bus, tube and second-class railway will be repaid but, except in extreme emergency, staff are not permitted to travel by taxi at the Fund's expense. Where previously authorised, a mileage allowance of $7\frac{1}{2}$p a mile is payable for those using their own cars on official business, but not in respect of journeys to and from home and the EBS for normal duties.

7. Publications of Articles etc.

In common with all members of the staff of the Fund, those of the EBS are at all times free to make contribution to the literature of their specialist subject in so far as it is written within that context and in their own name, i.e. as distinct from their official status in the Fund. No prior permission is required.

Where, however, the material contains reference to the practice or policies of the Fund, or where the author is writing as a member of the Fund's staff, it is necessary to obtain clearance with the Secretary of the EBS before the article goes to press.

The reason for this is not one of censorship but simply to check on accuracy which is necessary because once a communication of this kind makes its appearance in a journal or other publication it is the Fund itself and not the author who must accept responsibility.

PERMANENT NIGHT DUTY

This note sets out points governing the running of the permanent night duty, shown as P.N.D. for short.

Two operators are appointed to work permanently on night duty on a rota giving three nights on and three nights off. One member of the P.N.D. staff is thus on duty with each night shift. This gives a six day 'week' from 2200 hours to 0900 hours.

Two members of the staff of a watch will be on night duty and a named reserve for standby. If the reserve is not on the telephone she must telephone the DADO or senior watchkeeper on duty to see whether she is needed. The P.N.D. operator will be up all night and the staff of the watch up on alternate nights.

When one of the P.N.D. staff is on holiday or sick, a member of a watch will do night duty in her place, and the night watch will then work under the old procedure.

Terms and Conditions of Service

These are the same as for the remainder of the operations room staff unless stated otherwise.

a) Pay

At existing point on scale plus £100 p.a. in lieu of the £3 payable to members of the watch for each spell of night duty. A member of the P.N.D. staff if put in charge at any time will be paid an extra £1 a night.

b) Annual Leave

i. For the first two years of service, i.e. service within the EBS or elsewhere within the King's Fund, 12 working days per annum: thereafter 16 working days per annum.

ii. Bank holidays as for staff of the watches, i.e. a day's leave in lieu for each day of bank holiday.

iii. Requests for leave to be made to the senior watchkeeper on duty.

iv. P.N.D. staff may not both have leave at the same time.

Applicants for P.N.D.

All new members of the staff applying for P.N.D. must work at least two months in the operations room on shift duty before going onto the P.N.D. rota.

Pay of staff on watches

Any member of a watch who thinks that as a result of P.N.D. she will lose money by doing less night duty can inform her senior watchkeeper who will take this into account in making up the rota.

SECTION II — OPERATIONAL WORK

1. Answering the telephone (except for Medic-Alert)

Begin the conversation by saying 'EBS, can I help you?' and end with the words 'Thank you doctor, we will do our best and ring you back'.

2. Occasions when case sheets should be used

Case sheets should be used only for cases being offered for immediate admission to hospital, also for patients arriving from overseas who will require admission on arrival, and for patients being admitted to St Joseph's Hospice the next day.

All other enquiries, including cases referred to the 999 service, should be recorded in the Enquiry Book, with date, time, a complete note of the enquiry itself and any advice given by the EBS. This must then be shown immediately to the Senior Watchkeeper on duty who will check and sign it. If a number of particulars have already been recorded on a case sheet, the notes can be made on the case sheet which will be marked 'No Case' in the bottom right hand corner and put in the 'finished unchecked' basket to be checked in the usual way.

3. Types of case which may be accepted

In addition to cases from general practitioners, transfers from hospital casualty or outpatient departments may be accepted; however, these cases will not normally be referred to the RMAO if the EBS fails to find a bed; the decision when to refer the case back to the hospital concerned rests with the Senior Watchkeeper on duty.

For the transfer of a patient with an infectious disease of if the patient is in an unsuitable hospital, such as a patient with appendicitis in an ophthalmic hospital, the EBS has an obligation to transfer that patient whether from a casualty or outpatient department or from a ward, since the hospital may not have suitable equipment to deal with the case. These cases might have to be referred to the duty RMAO, but the Senior Watchkeeper must be consulted first. Care must be taken in such cases, since many hospitals which have not necessarily got separate wards for all specialities such as orthopaedic or genito urinary wards will in fact accept these patients and admit them into general wards.

When a Red or Yellow Warning is in force, the Secretary may suspend the transfer of hospital patients until the bed situation improves. This will be recorded in the Enquiry Book.

Any doubt as to the advisability of accepting a patient for transfer should be discussed by the senior operator on duty with the duty RMAO.

4. Callers from whom cases may be accepted

It is of great importance that a case should be taken from the doctor who has seen the patient. The following exceptions are permissible:-

(a) A case may be accepted from the general practitioner's partner, wife or secretary, as long as they have full details of the case.

(b) A maternity case may be taken from a midwife

(c) A hospital maternity transfer may be taken from a hospital midwife.

(d) Uncomplicated infectious diseases in a hospital transfer may be taken from a nursing officer but the name of the doctor who has diagnosed the patient and requested the transfer must be on the case sheet. Any other hospital transfer case should be taken from a doctor.

(e) Cases for St. Joseph's Hospice waiting list may be accepted from the social worker but the name of the general practitioner or hospital doctor requesting the admission must be on the case sheet.

The name and status of the caller must always be noted and where possible the name of the patient's general practitioner. With cases taken from relief services it is compulsory to get the name of the GP.

No cases can be taken from the patient's relatives or friends or from members of the public. If they are worried they must be advised to call in a doctor or, in the case of accident, to dial '999' and ask for an accident ambulance.

As a general rule, cases can only be accepted by the EBS when the patient has been seen by the doctor on the same day.

A GP may ask the EBS to take on a patient who has not been seen the same day, nor even within the last 12 hours. In these circumstances the Senior Watchkeeper must be consulted and if there are special problems with the case the rule may be waived at her discretion.

The most important factors to be determined when a patient has not been seen on the day for which admission is requested are that the patient is still alive and fit to be moved.

5. Reference of cases to the Regional Medical Admissions Officer (RMAO)

The advice and instructions of the RMAO on difficult cases are to be obtained by the senior operator on duty and not by the operator working the case.

The responsible District and, where applicable, the nearest suitable hospital should be marked on the case sheet before it is handed to the senior operator. As a general principle, a case is not referred to the RMAO until all suitable hospitals have been tried including special hospitals.

The RMAO will write his instructions on the case sheet in red. Instructions obtained from the RMAO by telephone are to be underlined in red.

(a) When the RMAO orders a case to be medically refereed, the EBS operator concerned will immediately contact the responsible hospital, having used the Medical Referee file to find the details for each District and the names or status of the Medical Referees. The referee must forthwith accept responsibility for seeing that the patient is taken into the care of a hospital within his jurisdiction.

(b) If the referee, or a doctor acting on his behalf, raises any objection, he should be referred to the written instructions issued by each Regional Health Authority and signed by the Regional Medical Officer; the gist of these instructions is also given in the supplement of the EBS information leaflet.

(c) The notation 'Med Ref' is to be printed on the bottom line of the right hand corner of the case sheet as soon as the operator starts to offer the patient under the medical referee procedure.

(d) The case cannot be referred to a medical referee without first being shown to the RMAO.

(e) If the RMAO orders a case to be referred back to the general practitioner it is important that the operator should repeat the exact words written on the case sheet. On occasions, for example, during a Red or Yellow Warning, the RMAO may advise a GP to ask for a consultant to make a domicilliary visit to the patient, or for a consultant geriatrician to contact the social services for a home help and meals on wheels. All instructions must be quoted exactly.

(f) A general practitioner or hospital medical officer who wishes to talk to the RMAO is entitled to do so. During office hours the call can be put through to him; out of office hours the caller can be connected through the small key and lamp unit on the Senior Watchkeeper's desk. At all times the RMAO should be told the name and status of the person wishing to speak to him, and for what reason. The RMAO will also like to have a reminder about the details shown on the case sheet if it is a medical referee asking to speak to him.

6. Medical Referee Procedure in General

When a medical referee instructs the EBS to send a patient to a hospital other than his own, the operator should make a point of asking whether the referee has informed the hospital concerned. The referee should inform the hospital himself, since he is responsible for the patient. The EBS cannot do this for him.

The Medical Referee instructions issued by the Regional Health Authorities state that after the RMAO has instructed the EBS to refer a patient to hospital under this procedure, then that patient becomes the responsibility of the medical referee as soon as the case is offered to him. He must accept responsibility for the patient either definitely for admission or to be seen with a view to admission, sometimes shown as CAIN i.e. see and admit if necessary.

Failure by the medical referee to accept the patient is a very serious matter and should be reported immediately to the Senior Watchkeeper who will inform the RMAO. After all channels have been explored the ultimate responsibility will rest with the RMAO to instruct the EBS to arrange for the patient to be sent by ambulance to the hospital in question.

7. Complaints by Doctors or Hospitals

In the event of a complaint being made by telephone to the EBS, the hospital or doctor concerned is to be asked to send a written complaint to the Secretary of the EBS. Such a complaint is to be noted on the case sheet if it concerns a particular case, or in the Enquiry Book in other instances.

8. Copies of case sheets

Any request for a copy of a case sheet must be made only to the Secretary.

9. Closures and Restrictions

Hospital authorities are expected to inform the EBS of any substantial restrictions in their service, such as the closure of wards or departments, by writing to the Secretary with the appropriate details, giving as much notice as possible. Information about unexpected or minor changes may be given by telephone direct to the operations room. When taking these messages, operators must obtain the following information:-

(a) On whose authority is the closure or restriction being made?

(b) For what reason?

(c) For what duration?

(d) What arrangements have been made for medical referee cover?

The above details are to be recorded in the closure file and the appropriate tickets put on the Bed Board.

This file must be checked every morning at 0900 hrs.

10. Making up cases

Operation staff are to ensure that the previous day's cases are made up in time order with a summary card attached, ready for the statistics department to start work at 0900 hours. The cases are to be divided into 'A' and 'B'. The 'A's from midnight to 1400 hours and the 'B's from 1400 hours to midnight. St Joseph's and overseas cases are to be filed at the front of the 'A' cases on the day that the patient is admitted. Where possible the second half of the day's case sheets should be checked and compiled after midnight by the person in charge of night-duty and before retiring.

11. Checking of cases

The previous day's cases will be checked by the DADO. This is in addition to the check done by the senior watchkeeper and her deputies the day before. Operational staff may be asked to explain things that have happened in the course of an admission or to amend notes, if they do not make sense.

12. Messages

Any messages or enquiries concerning cases being worked or already admitted must be recorded on the case sheet, with the name of the caller and the time.

13. Rubbing out

Rubbing out is forbidden. Anything that has been rubbed out on a case sheet renders that case invalid in a Coroners Court. Mistakes should be crossed out once - no scribbling out.

14. Reverse charges

The Service cannot accept reverse charged telephone calls from Relief Services. The doctor can have the call charged to the Relief Service account. See letter sent by IR to Deputising Services 1/9/75.

15. Pay Beds

EBS cannot help with a request for admission of a patient to a pay bed or private bed in any of the NHS hospitals. Private patients are always admitted through the consultant after consultation with the patient's GP, therefore it is correct procedure for the GP to make the contact himself. EBS may be able to advise the nearest hospital with private beds, but it is almost impossible for us to make the admission.

16. Faulty telephone lines

Faulty telephone and poor connections can happen in a GP's surgery as well as at the EBS. If an incoming call is of such poor quality that the operator cannot take details properly then it is important to try to get the GP's telephone number from which to ring him back immediately on another line and so complete the case sheet. The break in the conversation should reflect in the first times at the top of the case sheet. Faults on the operation room telephones should be reported to EBS switchboard operator who will contact the engineers dept. Telephone complaints are recorded in the book on the switchboard.

17. Warning bell

This bell will be operated by the senior operator in the Ops room. It will be put into action when the pressure of work builds up to the extent when extra help is needed in the Ops room. The bell will be heard throughout the top floor, and must be responded to IMMEDIATELY BY EVERYBODY.

SECTION III NOTES FOR THE GUIDANCE OF THE STAFF OF THE OPERATIONS ROOM

1. Addresses of patients

Particular care must be taken over the address of the patient, as an incorrect address causes a lost journey for the ambulance and delay in admission which may even result in the death of the patient.

The address must always be checked with the offering doctor by being read back to him, the street name being spelled out,(phonetically if necessary).

Before the case is worked, the address must be checked in the reference books provided. The initials of the operator must be placed in the left hand margin of the case sheet, beside the address of the patient, and the map reference number entered in the top left hand corner. This procedure is to be followed for all patients, those to be transferred from one hospital to another, when the address of the hospital holding the patient will be used, as well as for general practitioners' cases.

2. Diagnosis

The following points are to be observed to ensure that hospitals are aware of the essential details of cases offered to them:-

(i) Full diagnosis must be given when a case is offered to a hospital, including any relevant remarks in the notes, eg past hospital history, etc.

(ii) If a hospital representative chooses to accept a case without obtaining the full details, the name and status of the person accepting, eg admissions officer, porter, clerk etc. must be recorded on the case sheet and the fact that the full details were not required.

(iii) It must always be made clear in the offering of a case to a hospital whether the patient is to come from the casualty or outpatient department of another hospital, or from the general practitioner.

(iv) Any mention of TB in the diagnosis is to be underlined. This includes ?TB, old TB or no TB.

(v) An order for:-

(a) TRANSFUSION
or (b) OXYGEN
or (c) IMMEDIATE AMBULANCE

must be initiated by the doctor offering the case, without any suggestion by the EBS except where the patient is CYANOSED when the doctor should be asked if OXYGEN will be required in the ambulance.

In addition to the above, the following must always be entered on the case sheet in BLOCK CAPITALS.

(d) BLEEDING HEAVILY
(e) UNCONSCIOUS
(f) CYANOSED
(g) DEHYDRATED
(h) SHOCKED
(i) COLLAPSED
(j) FULMINATING
(k) ORTHOPNOEIC

(v) Full details of any treatment the patient has been receiving must be obtained from the doctor offering the case, and entered on the case sheet. The doctor must be asked whether he has included details of treatment in his note; if NOT, this must be indicated clearly on the case sheet and the information in question given to the admitting hospital. This applies particularly to STEROID treatment.

3. Deputising services

For a case received from a deputising service doctor, his name, that of the deputising service, and of the general practitioner for whom he is acting, must all be shown at the beginning of the case sheet.

4. GPs remaining available

All GPs have been informed by their Family Practitioner Committees that they are to remain available after referring a case to EBS until informed that a hospital has accepted the patient. On no account are GPs to consider that they are absolved from responsibility after giving a case to EBS. It is only after the patient arrives at the hospital, or the RMAO authorises a case to be medically refereed that the responsibility for the patient passes from the GP to the hospital.

5. GP's telephone numbers

When checking a GP's telephone number, it must also be ascertained whether the number is subject to transfer and if so from what time.

6. Top Priority cases

Agreement has been reached that in certain circumstances 'Top Priority' cases may be handled by the '999' procedure when the normal Medical Referee procedure fails to secure admission quickly enough.

Should serious delay be caused by the medical referee not being available, or for any other reason, the case may be treated as '999'. In this case the ambulance service is to be asked which hospital the patient will be taken to, and that hospital is to be telephoned by the EBS and warned of the impending arrival of the patient and the reasons for his/her being admitted in this way.

NB This procedure is only to be used on the authority of the senior member of the staff on duty, after consultation with the RMAO. If a GP rings back and is worried about his patient he can be advised to follow the '999' procedure making the patient a Top Priority case (see ambulance instructions page 3. 4)

7. Repeat cases

If a doctor telephones to re-offer a case for which no bed could be found on the previous day, full details of the doctor, patient and diagnosis are to be obtained, with information regarding any change in the condition of the patient.

The previous day's case sheet is to be looked up and its number and time of origin entered on the top right hand corner of the new case sheet. The number of hospitals tried on the previous day, and the RMAO's name and disposal instructions (if any), are to be recorded in the notes.

8. Cases pending

These are generally patients returning from abroad or those for admission to St Joseph's Hospice the next day. After admission has been arranged, the case is to be kept pending until the patient has arrived in hospital, or the case has been cancelled.

9. Cancelled cases

A cancelled case is one which the EBS has started working on, and then for some reason has been cancelled, eg if the patient refuses to go to hospital or if the GP telephones to say the patient is too ill to be moved. A line should be drawn across the case sheet diagonally from the bottom left to the top right hand corners and the word CANCELLED written in the bottom right hand corner.

10. No case

This is a case that the EBS has started to take but has not accepted for admission for some reason, eg a GP telephones giving a patient's name, address and age and then says the patient has taken an overdose; at this point the EBS would advise the use of the '999' service and the case would be a 'No Case'. A line is then drawn diagonally from left bottom to top right across the case sheet and 'No Case' written in the bottom right hand corner.

11. Ambulance Only

As a rule the only ambulances ordered by the EBS are for patients for whom it has arranged admission. If for some reason, such as suspended breathing, the ambulance has to go to a nearer hospital which accepts the patient, the case becomes one of Ambulance only, and the word AMB ONLY must be entered in the bottom right hand corner of the case sheet.

12. EBS refusals

If a doctor requests admission to a hospital which is known to be closed to that particular type of case, eg male medical, for the relevant time, he is to be informed of this and his choice of hospital recorded in line 1 of the section HOSPITAL on the case sheet, with the letter EBS instead of a time. This will ensure that when statistics are compiled, it will be known that a request for admission was made to the EBS and the reason why the hospital was not tried. This procedure is to be used as sparingly as possible and only in this context.

13. Hospitals tried

If a hospital is approached more than once concerning the same case, details of each occasion are to be entered under "hospitals tried" with the word "re-offer" written beside the name of the hospital.

14. Delays in dealing with cases

Any unavoidable delays in dealing with cases are to be recorded in the notes so that a consecutive time record is shown on the case sheet throughout the time during which the case is in hand. The number of the case sheet causing the delay is to be recorded, eg 1941-2002 on case sheet no 124931. It is important, however, that times should not be inserted before the call is actually made as this results in discrepancies between the times noted by the EBS and by the recipient of the call. All other delays must be recorded on case sheets, but in times of stress a cross reference will not always be possible owing to the large number of cases to be dealt with.

15. Ambulance instructions

a) General

All requests for journeys for admissions to general wards of hospitals in the Greater London area will be passed to the London Ambulance Service (LAS) on the appropriate electrowriter. Requests for journeys for admissions to fever hospitals and to St Joseph's Hospice the next day, must be made on the direct line from the red telephone on the taking desk, the names of the EBS and LAS operators being exchanged at the same time.

All requests for journeys outside the GLC area are to be passed by telephone and names exchanged. The telephone numbers of ambulance services will be found in the pockets at the sides of the desks.

Any query from any ambulance service must be timed and noted on the case sheet. On these occasions and when subsequent telephone calls are made, names must be exchanged and noted on the case sheet. This is very important since the staff at both the EBS and the ambulance headquarters change duties and delay can be caused if the names are not known.

b) Priority of journey

1.	IMMEDIATE	Top Priority, Very Urgent, Urgent
2.	ORDINARY	Liable to delay (maximum 60 mins) from time of receipt of case from the EBS to arrival of ambulance at patient's house.
3	DEFERRED (delayed)	Instructions to pick up at an exact time.

The senior operator on duty at the EBS has the authority to order an IMMEDIATE ambulance on her own initiative, if the situation warrants such a decision.

c) Coronary patients

All patients suffering from coronary thrombosis and myocardial infarction have an IMMEDIATE ambulance whether the GP has asked for this or not. This procedure was adopted at the request of the LAS itself.

d) Fever journeys

The ambulance is to be ordered on the direct telephone line, not on the electrowriter. The LAS requires the name and telephone number of the GP. Patients suffering from different fevers must not travel in the same ambulance without the agreement both of the GPs concerned and of the admitting hospital.

e) St Joseph's patients

When am ambulance journey is requested the following day, the words "Special Arrangement" are to be added to the order. This is meant to obviate the problem of journeys not executed on time by the LAS. When a patient has to be picked up at an exact time, the word 'PROMPT' is to be used.

f) Queries and enquiries

These will be made by the direct line on the red telephone.

g) Electrowriters

The electrowriter sheet must be attached to the case sheet as soon as the journey has been acknowledged by the LAS. Any faulty electrowriter sheet must also be attached to the case sheet even if this entails attaching several of them to the same case sheet. ONLY the LAS can eject the electrowriter sheet from their writer: this procedure ensures that the request for a journey has been seen and acknowledged.

The time inserted at the end of the electrowriter sheet by the EBS will be the time at which the EBS operator finishes writing the request. The LAS may take many minutes to acknowledge it and so the times written in the space marked TIME in the AMBULANCE section of the case sheet will be the time at which the written request was completed the time of acknowledgement by the LAS. The same items of information about the ambulance journey must be shown on the case sheet itself, whether the request has been made by electro-writer or not. The electrowriter sheets can easily become detached and torn when the case sheets are filed, and information passed to the ambulance service could then be lost. It could even be denied that a request for an ambulance had been made at all.

Any faults on an electrowriter should be reported to the LAS Control immediately. The morning watch should check with the LAS before 0900 hours that all the writers are plugged in and working properly.

h) Accident ambulance: 999 service

Full use is to be made of the Accident Ambulance Service, the 999 Service. Cases appropriate for admission by that service wi ll not be accepted by EBS. These cases come under the following headings:-

Accidents	Burns and scalds
Assaults	Epistaxis
Attempted suicide , including overdose	Illness in a public place, including
Top priority cases	place of work and a doctor's surgery

The term 'Accident' includes accidents in the general sense of the word, eg fractures, burns, scalds etc., whether in the home or elsewhere, and also cases of assault.

An accident ambulance is only appropriate if the request for hospital admission is made on the first occasion the patient has been seen by the doctor. If there has been some lapse of time since the occurance, the doctor is to be asked if he has seen the patient before. If this is the first time, he is to be advised to dial 999 and ask for the Accident Ambulance Service, but if he has requested hospital admission as the result of second thoughts, the case is to be accepted and worked in the normal way, even though the accident occurred less than 24 hours previously. Accidents which have happened more than 24 hours beforehand should only be referred to the 999 service if they have only just been discovered.

Illness in a public place such as the street, a public building, a doctor's surgery or place of work, is also dealt with by the Accident Ambulance Service and the doctor advised to dial 999. Cases of infectious disease and obstetrics in a GP's surgery are the exception and should be accepted and worked in the normal way as quickly as possible. If a GP is reluctant to dial 999 for a patient in his surgery who is too ill to go home it must be made clear that the EBS cannot give any idea how long it may take to find a bed and that somebody must stay with the patient until an ambulance arrives. Since the nearest hospital to the GP's surgery is likely also to be the one applicable for the medical referee procedure it would be quicker to dial 999 in the first place.

Cases of attempted suicide, including overdoses of aspirin or sleeping draught, are removed by the accident ambulance regardless of when the attempt was made. Those of overdose as the result of medical treatment, ie digitalis overdose, are accepted and worked in the normal way.

Cases of epistaxis will be dealt with by the Accident Ambulance Service.

Cases which are 'Top priority' in every sense of the word should also go by the Accident Ambulance Service. This advice should be given sparingly; it arises when the doctor requires admission within minutes. The EBS will normally work very urgent cases, trying several hospitals at once and referring the case to the RMAO at the same time.
NOTE This advice should not be confused with the instructions about difficulties in working urgent cases under the medical referee procedure. (See page 2. 2)

i) Escorts for children
Patients of 15 years and under require an escort for the journey to hospital. The doctor offering the case should be asked to obtain the services of a relative or neighbour if the child's parents are not available. The Ambulance Service cannot take responsibility for finding an escort. The local police station will often help if there is no escort at all.

Where the admission of a patient to hospital might leave any children in the household without care, the GP should be advised to contact the local Social Services Department immediately so that something can be arranged before the ambulance arrives at the house. The local police will also help if there is a risk to the patient through any delay on this score. Surgical patients under the age of 18 years need to be accompanied by a parent or guardian who can give the necessary consent for anaesthetic and operation

16. Obstetric Emergencies
a) In addition to the cases offered by hospitals or GPs the following will be accepted from midwives:-

i) Cases originally intended for delivery at home which have become emergencies and need admission either before, during or after labour.

ii) Patients needing a hospital confinement for social reasons and for whom it has been impossible to book a bed.

iii) Infants born at home who, either for medical or social reasons, cannot be adequately cared for. If 'premature' this word should be emphasised on the case sheet.

b) Emergency Obstetric Unit - EOU

Whilst it is normal practice for a request for an EOU to be made by the GP direct to the LAS as shown in the Night Duty File, nevertheless the LAS will accept a request for an EOU from the senior member of the operations room staff on duty.

c) Emergency Obstetric Unit and Premature Baby Unit: Procedure

Greater London Area:	GPs to be advised to telephone the LAS on 999 call for the whole area except Hammersmith	743 2030
	West Middx.	560 2121
Hertfordshire:	GP to telephone hospital direct: Herts County	433 2275
Surrey:	GP to telephone hospital direct: Epsom District	39 26100
	If any difficulty telephone Surrey Ambulance Service	255 3491

d) Abortions: terminology

The phrase 'threatened abortion, becoming inevitable' is a contradiction in terms; if it is going to be inevitable it already is so, and the word threatened is meaningless. It is not suggested that a diagnosis offered by a doctor should be challenged, but when a case of threatened abortion is referred to the EBS, the question of whether it is likely to become inevitable should not be raised.

e) Retained placenta

Any GP ringing with a case of retained placenta is to be told that the EBS may find it difficult to admit the patient unless an EOU has been summoned. If the GP agrees that an EOU is desirable, the procedure for obtaining this is to be followed. If the GP insists that the unit is not required, the case is to be worked in the normal way. If the hospital agrees to accept the patient only on condition that an EOU is used, the hospital is to be asked to discuss the matter direct with the GP and if the GP is not available then the hospital must order the EOU.

f) Post-partum haemorrhages

Cases of primary post-partum haemorrhages, ie within 24 hours of the delivery, are obstetric and should be dealt with by an EOU. Those of secondary post-partum haemorrhages, i e more than 24 hours after the birth, are usually admitted to gynaecological wards.

17. Medic Alert Foundation

This is an organisation which keeps records of the special medical needs of its subscribers. The master index is held in the operations room and, in an emergency, information from these records can be obtained by a doctor or other authorised person by means of a reverse charge telephone call from anywhere in the world.

The filing and clerical side of this service is maintained by the Medic Alert staff, the operational side by the EBS.

The cards filed in the operations room relate to subscribers from Great Britain only and have the prefix letters GB before the number. Enquiries made about subscribers with any other prefix letters are to be referred to the relevant telephone numbers as recorded in the list on the top of the Medic Alert cabinet.

All enquiries taken must be recorded in the Medic Alert book, also to be found on the top of the cabinet.

18. Court orders, as in Section 47, National Assistance Act 1948

If a District Community Physician telephones the EBS about a patient who is to be the subject of a magistrate's order, the case must be taken on. As these cases are usually social problems there is not much likelihood of acceptance by a hospital outside the District in which the patient lives, so only those hospitals in the Health District of the patient's address should be tried. If the patient is not accepted there, the case should be referred to the RMAO.

19. Infectious diseases

Cases of all types of infectious disease other than smallpox and typhus are accepted by the EBS. The question of whether a patient is to be offered for admission to a general or to a fever unit must be settled with the general practitioner at the time of taking the case.

If an in-patient at a general hospital contracts an infectious disease and is referred to the EBS every effort must be made to arrange a transfer to a suitable hospital. The same applies to a patient in the casualty department of a general hospital discovered to be suffering from an infectious disease.

a) Smallpox and typhus

The EBS does not deal with cases either of smallpox or typhus. A GP suspecting either disease in his patient must be referred immediately to the D.C.P. or other physician as shown in the District directory and a note made of the patient's name and address and of the GP's telephone number. The GP should be advised to telephone back to the EBS if he cannot locate the DCP: the EBS must then do its utmost to help the GP to locate a doctor or administrator in that District. ON NO ACCOUNT IS THE CASE TO BE ACCEPTED AND WORKED.

The District Community Physician will usually call in a consultant specialist in smallpox who will make arrangements for admission to a smallpox hospital if there is a positive diagnosis. At present Ipswich Smallpox Hospital is in use for the London area. Long Reach Hospital, formerly in use for smallpox, is closed.

b) Leprosy

Leprosy is not a highly contagious disease such as smallpox or typhus. The EBS will not normally be asked to arrange admission for a patient suffering from leprosy for treatment of the leprosy but a request could well be received for the admission of such a patient because of another condition, such as appendicitis or pneumonia. Any isolation hospital should be able to give the care required, and the Hospital for Tropical Diseases might also be tried. If difficulty is experienced the Consultant Leprologist of the Department of Health, Dr Stanley Brown, should be consulted telephone no. 407 5522.

c) Lassa Fever

Any cases of high suspicion of Lassa Fever should be referred to Coppetts Wood Hospital, Coppets Road, Muswell Hill, London N10 1JN, telephone no. 883 9792. The isolation unit there is in the care of Dr R T D Emond, Consultant in charge, to whom the suspected case is to be referred. Cases of low suspicion of Lassa Fever are to be referred to the Hospital for Tropical Diseases, 4 St Pancras Way, London NW1 OPE , telephone no. 387 4411, where the person to be consulted is Professor Woodruff.

d) Infective hepatitis

From 15th June 1968 infective hepatitis became notifiable under the Public Health Regulations, 1968 (S.1 1968 No. 861) All cases of infective hepatitis should be isolated.

e) Rabies

The first choice of hospitals at present would be:
The National Hospital, Queen Square, London WC1
telephone no. 837 3611
or The Hospital for Tropical Diseases, 4 St Pancras Way, London NW1
telephone no. 387 4411
(this is part of University College Hospital)

This choice is prompted by the fact that in 1975 the only two cases in this country for six years went one to each of these hospitals. Other suitable hospitals would be any of those with an intensive care unit. A patient in an advanced stage should be sent to a suitable hospital giving as short a journey as possible. The disease is not highly infectious, being only on very rare occasions transmitted from one human being to another. The likelihood is that it is suspected cases which will be offered to us.

20. Psychiatric and Psychiatric observation cases

The EBS does not deal with such cases, unless the patient has an acute surgical condition. A doctor applying for a patient to be admitted for a psychiatric condition should be referred to the psychiatric hospital responsible for the District in which the patient lives.

Acute surgical cases offered to the EBS for transfer from a psychiatric hospital are to be accepted, and the case referred to the RMAO for instruction if difficulty is experienced in finding a bed.

21. General paralysis of the insane

An acute tabetic crisis of GPI should be treated as an ordinary medical emergency, and an attempt made to arrange admission to a general ward, provided this is considered suitable by the GP. If there is doubt as to further action, reference is to be made to the RMAO.

22. Epileptics other than status

GPs should be advised to make application to the neurologist at the local District hospital.

23. Venereal Disease

Most cases are not urgent. If, however, the GP insists that the case is urgent, it should be accepted in the normal way. Difficulty is likely to be experienced with cases of ?VD.

24. Blood transfusion in the home

Except in the case of obstetric and gynaecological emergencies, no provision exists for the transfusion of blood in the patient's home. If the GP insists that the patient must be transfused before being moved, the GP should be referred to his local hospital.

25. Gastro-enteritis in adults

The GP is to be asked whether the patient needs to be isolated or not and the patient is then offered to fever or general hospitals accordingly. If the GP is uncertain whether the patient has infective gastro-enteritis or not, the case is to be regarded as one for a fever hospital. If it transpires that a case referred to a fever hospital under the medical referee procedure is not infectious, the EBS will arrange an immediate transfer to a general hospital, or vice versa. The RMAO is to be informed of any difficulty met in the course of the transfer.

26. Cardiac emergencies

Pace maker failure. Explanation. A pace maker is commonly used by patients in whom the conducting mechanism of the heart has been damaged, with the result that impulses from the auricles fail to reach the ventricles. This condition is called 'heart block' and occurs in ischaemic heart disease, or following a coronary thrombosis.

The apparatus consists of an electrode introduced into the right ventricular wall and connected via the external jugular vein to a battery implanted either in the breast or axilla. This then reproduces the normal impulses to stimulate the ventricles. It has been found that the normal life of these batteries is approximately 15 months.

Points to note in case taking

1. Pulse rate: approx 40-50 per minute. This is typical of heart block
2. Blood pressure: extensively lowered.
3. State of consciousness: Stokes Adams syncope.

Ambulance management. As for a coronary thrombosis. Oxygen should be available.

Destination. As these patients are already suffering from ischaemic heart disease, it may not always be possible for the GP to be sure that the patient is suffering from a failure of the pace maker or has suffered another thrombosis. Therefore, the patient should be sent to the nearest hospital initially for an ECG and resuscitation; the patient will then be transferred to the hospital where the pace maker was originally prescribed.

EVERY CASE MUST BE TREATED AS IMMEDIATE

27. Arterial diseases

Arterial diseases most suitable for surgery

a. Arterial aneurysms may occur in any artery, but most commonly in the Aorta and are then called dissecting aneurysms.

b. Arterial embolus is often associated with rheumatic heart disease. It causes obstruction of a large artery in a limb, usually femoral or popliteal which will produce loss of power and numbness; the limb is pulseless and eventually gangrene sets in.

c. Thrombo-angeitis obliterans or intermitten claudication affects the legs as in arterial embolus. It occurs in hypertension, syphilis, gout and diabetes. A case might be offered as an incipient diabetic gangrene.

d. Raynaud's disease is confined almost entirely to women. Due to poor blood supply, the hands are usually affected. Untreated it can produce digital thrombosis. The symptoms are due to arterial spasm, precipitated by exposure to cold.

28. Hypothermia

In winter, the EBS may expect to be offered cases of hypothermia in elderly patients. These brief notes will be of some help in dealing with them.

History. Progressive confusion, ataxia, slurring of speech, followed by drowsiness and finally unconsciousness. Apart from exposure to cold, drugs which depress mid-brain control of body temperature may cause or accelerate onset of the condition. The commonest of these is Largactil, often prescribed as a transquillizer for geriatric patients.

On examination. Skin icy cold to touch. No shivering, generalised muscular stiffness. Pulse rate, 40-60 per minutes, reflexes sluggish, blood pressure low, temperature 95 F or lower.
Mortality. This is very high. Cases offered should be worked as IMMEDIATE.

OXYGEN IN AMBULANCE IS OF PARAMOUNT IMPORTANCE.

29. Fulminating

Whenever the above word is used in a diagnosis it means that the case is deteriorating rapidly and is VERY URGENT; it should be treated as such.

30. London Chest Coronary Unit

This hospital provides a 24 hour Coronary Unit and is anxious to receive referrals from the EBS. Cases from the following London boroughs should be offered:-

Hackney	Tower Hamlets (E5, E9, N1, N16)
Waltham Forest	Newham
Leyton	Dagenham

The EBS operator will inform the switchboard at the London Chest Hospital that she has a coronary case for admission and she will be put straight through to the senior registrar on duty. Patients should not be above 65 years of age.

31. Disclaimed hospitals

When an admission is obtained at a disclaimed hospital, the EBS case sheet number must be given to that hospital.

32. South Middlesex Fever Area

Young babies with gastro-enteritis in the South Middlesex catchment area are all admitted to the West Middlesex Hospital.

33. Newham Health District

Haematemesis and melaena. To be offered (including cases for medical referee), to East Ham Memorial Hospital, Queen Mary's Hospital Stratford and St Andrew's Hospital Bow, only.

Orthopaedic cases. Can only be accepted at St Andrew's Bow, and East Ham Memorial Hospital.

Cases needing blood transfusion are not to be offered to Aldersbrook Hospital and Plaistow Hospital.

34. Manor House Hospital

The North West Thames Regional Health Authority has no contractual arrangements with this hospital, therefore admissions cannot be arranged through the EBS.

35. Lambeth Hospital

The EBS may offer fever cases with MEDICAL COMPLICATIONS to this hospital, but this only applies to children up to the age of 11 years.

36. London Airport

The DHSS has requested that the EBS accept calls from the doctors at London Airport instead of asking them to make use of the 999 service, which otherwise is generally applicable to illness taking place at work. Requests for admission from London Airport should be worked in the normal way.

37. Medway and Gravesham

The EBS cannot help with patients living in this Area. Hospitals in the Area do not recognise the Medical Referee procedure, so in the event of a failure to admit in the normal way the EBS could not ask the RMAO for his instructions.

38. Brompton Hospital

All patients suffering from diseases of the heart and lungs are suitable for this hospital and the facilities there are such that both ex-patients and new patients should be offered to the hospital as long as the patient is fit to travel. Appropriate cases would be:-

Asthma	Lung cancer
Cor pulmonale	Pleurisy
Chronic bronchitis	Pneumonia
Dyspnoea	Pneumothorax
Lung abscess	Respiratory failure

39 Bed bureaux

	Tel no.	Hours of service
Bromley	460 3492	24 hours
Charing X	741 1312	Office hours only
Chelmsford	0245 54851	0800 - 1800 Mondays to Fridays
Kings	274 6222	0800 - 2200 Every day
Kingston	546 1223	Office hours only
Lewisham	690 4311	Office hours only. Fevers direct to Hither Green Hospital
Metropolitan	254 6862	0900 - 1730
Redhill	91 63883	0900 - 2130 Mondays to Fridays 0900 - 1600 Sundays
Royal Free	794 0500 Ext. 3341/2	0900 - 1715
St Helier	644 4511	0830 - 2200 Mondays to Fridays 0900 - 1700 Saturdays & Sundays
St Thomas's	929 9292	Office hours only
West Middlesex	560 2121	24 hours
Whittington	272 3070 x 253	24 hours
Watford	922 2664	closed due to lack of staff
Windsor	95 63232	24 hour service on weekdays. Closed from 1400 Saturday to 0800 Monday. During this time GPs to ring 95b 0441

40. Relief Services

G P R - General Practitioners Relief	802 1234	or	800 8387
C R S - Central Relief Service	969 8322	or	969 6477/8
S R S - Southern Relief Service	659 3445	or	471 8136

(Base doctor is available until about 0100 hrs and messages for a doctor to ring a hospital or the RMAO should be channelled through him)

S L D S -South London Deputising Service	686 6295	or	681 2793
Danson Park	303 6255	or	303 2121

1. EBS List of accepted abbreviations

DHSS	Department of Health and Social Security
RHA	Regional Health Authority
AHA	Area Health Authority
HD	Health District
GLC	Greater London Council
LAS	London Ambulance Service
CRS	Central Relief Service
GPR	General Practitioner Relief Service
SRS	Southern Relief Service
SLDS	South London Deputising Service
DPRS	Danson Park Relief Service
RMO	Resident Medical Officer
RSO	Resident Surgical Officer
HP	House Physician
HS	House Surgeon
CO	Casualty Officer
RRO	Receiving Room Officer (London Hospital)
RAP	Resident Admitting Physician (St Thomas's Hospital)
RAS	Resident Admitting Surgeon (St Thomas's Hospital)
MSW	Medical social worker
GP	General Practitioner
RMAO	Regional Medical Admissions Officer
Med Ref	Medical Referee
Dom Con	Domiciliary consultant
DN	District nurse
HH	Home help
Pat	Patient
AMO	Area Medical Officer
AA	Area Administrator
DA	District Administrator
DCP	District Community Physician

OP	Out-patient
IP	In-patient
Cas	Casualty
CAIN	See and admit if necessary
RB	Refer back
R/B	Ring back
TFN	Till further notice
OOO	Out of order
ETA	Estimated time of arrival
TOO	Time of origin
NAD	No abnormalities diagnosed
NYD	Not yet diagnosed
AN	Antenatal
ABs	Antibiotics
ID	Infectious disease
O/E	On examination
TPR	Temperature, pulse, respiration
BP	Blood pressure
HBP	High blood pressure
RIF	Right iliac fossa
LIF	Left iliac fossa
D & C	Dilatation and curettage
LMP	Last menstrual period
PV	Per vagina
PR	Per rectum
APH	Antepartum haemorrhage
PPH	Post-partum haemorrhage
EDD	Expected date of delivery
Trans	Transfusion
CSM	Cerebrospinal meningitis
CSF	Cerebrospinal fluid
CNS	Central nervous system
PUO	Pyrexia of unknown origin
D & V	Diarrhoea and vomitting
O2	Oxygen
ECG	Electrocardiogram
EEG	Electroencephalogram
JVP	Jugular venous pressure

Ca	Carcinoma - Cancer
IUD	Intra uterine device
CCU	Coronary care unit
ICU	Intensive care unit

1. Security

a. Access

The Post Office, who are landlords of Fielden House provide a door-keeper at the front street entrance and members of the staff should be ready to show their passes every time they come into the building. The door-keeper must be notified of any visitor expected during the time when he is on duty. He is responsible for locking the main doors at about 17.30 daily Monday to Friday, and anyone coming or going after this time must use the small door. It is essential to ensure that this door is closed after coming or going. The house-keeper is responsible for the security of the building and for this reason he must be informed if anyone is coming or going at an unusual time. He must also be told if any visitors are due.

Night duty staff are not permitted to leave the building after they have taken up duty at 2200 hours, or have visitors in the building without permission of the operator in charge.

Visitors out of office hours must use the bell which is connected to an "Entryphone" in the house-keepers flat or alternatively, if he is out, to a telephone in the operations room.

There is a bell on the left hand side of the taking desk for emergency use: this rings in the house-keeper's flat. If it is necessary to call the police when neither the Secretary nor the Deputy Secretary is on duty, the Senior Watchkeeper or other person in charge in the operations room is the person to do so. The telephone number of the Borough Police Station is 407-8044. The house-keeper should be informed, as he will probably be required to open the door to them.

b. Master Key to Other Offices in the Building

Although the EBS has no responsibility for the lower floors, which are occupied by the Post Office, the house-keeper has a master key to enable him to get into these offices in case of emergency such as fire. There is a duplicate key in a box on the wall of the reception area of the ground floor by the first aid kit in the door-keeper's lobby for use if he is absent when such an emergency arises.

c. Cash and Valuables

The King's Fund cannot hold itself responsible for loss of money, valuables or other belongings of the staff: any loss should be reported to the Deputy Secretary immediately. Each member of the staff has a locker in the cloak-room and this should be kept locked and the key should be removed.

2. Fire

In case of fire please carry out fire drill: see paragraph Evacuation of Building.

3. Accidents

Any ac
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King Edward's Hospital Fund for London

King's Fund Emergency Bed Service

Standing Orders.

Revision of section IV. paragraphs 4 and 5 - Evacuation of building.

The following arrangements have now been made with the London Ambulance service and the EBS. standing orders are amended accordingly, especially at paragraph IV. a2, IV. b2, V. a1, V. a2 V. b1 and V. b3, all of which are now superseded by the arrangements shown below.

London Ambulance Service.

Provision of alternative operating facilities for Emergency Bed Service.

1. Evacuation Procedure. EBS. to advise LAS by telephone ("999" network - using public call box if necessary) that evacuation is essential. A suitable rendezvous point must be agreed.

2. Action by LAS on receipt of notification.

   i) Despatch vehicle to designated rendezvous point to collect EBS staff with current case records etc. and convey to operations room at Central Ambulance Control.

   ii) Alert 407 exchange to situation and advise that until further notice all calls to 407 7181 must be intercepted and referred to 735 9595/6.

   iii) Clear wing positions (4) on Inner Zone Control consoles. Monitor 735 9595/6 until EBS staff arrive. Should calls be received in the interim:-

      a) inform caller of situation.
      b) record name and telephone number.
      c) advise that he will be rung back shortly.
      d) if caller advises case is urgent accept as "999" call.

   iv) If operational, Inner Zone Control to inform crews by radio that 735 9595/6 not available for train queries and give alternative numbers.

   v) Central Ambulance Control staff to be prepared, during the initial stages, to receive queries or calls on "999" circuits.

3. Accommodation arrangements within control suite.

   i) Short term. Two telephone lines (735 9595/6) to be used exclusively for incoming calls can be made immediately available. These terminate on Inner Zone Control consoles where out going lines are also available. An administrative position can be made available with a telephone (extension 260) from the office PABX.

   ii) Long term. Reporting lines can be made available on the Eastern Sector consoles in the Central Ambulance Control to accommodate a small team receiving calls.

IR. 20th April 1976.
Secretary.

Arthur Ribbits

3. Accidents

Any accident on the premises involving a member of staff must be recorded in the accident book which is kept in the operations room. The house-keeper must be informed of any untoward incident, such as fire, flood etc.

4. Evacuation of Building

In the event of evacuation of the building for any reason: action to be taken:

a. During Office Hours:

1. Inform house-keeper/wife/children - switchboard operator to alert them.
2. Telephone exchange: switchboard to inform that 407 7181 is unmanned.
3. LAS: Senior Watchkeeper or deputy to inform that EBS evacuating.
4. Kitchen: Secretarial or Stats office to inform them to get out and turn off gas.
5. Dr. de Silva and dog: Secretary or Deputy Secretary to see to accompanying him out of building.
6. Firebag and day's case sheets to be collected by junior deputy with any cases being worked.
7. Patrol of all offices, kitchen etc. to be made by Senior Watchkeeper, as last outside, she will take the roll call with watch book.
8. In case of fire: all windows and internal doors to be shut.
9. Lift not to be used.

b. Outside Office Hours

1. House-keeper/wife: to be alerted.
2. Telephone exchange: senior operator to inform that 407 7181 is unmanned.
3. LAS: to be informed by a deputy or one of night duty staff.
4. Kitchen: Senior Watchkeeper or senior operator on duty to inform cook if on duty and turn off gas.
5. Firebags and case sheets: a deputy or PND girl to collect, with any cases being worked.
6. Patrol of all offices, kitchen etc. to be made by Senior Watchkeeper, as last outside, she will take the roll call with watch book.
7. In case of fire: all windows and internal doors to be shut.
8. Lift not to be used.

5. To be done after evacuation

a. During Office Hours

1. Establish a base to finish working cases in hand: Guy's Hospital or LAS or 999 through LAS.
2. If enforced evacuation lengthy, try to establish an emergency office to continue shift. Inform telephone exchange and LAS.

3. Inform Thames Regions and DHSS if lengthy evacuation.
4. Inform King's Fund head office.
5. Inform off-duty RMAO.
6. Inform local police: Telephone No. 407 8044, Borough Police Station.
7. Try to contact oncoming watch.

b. Outside Office Hours

1. Establish a base to finish working cases in hand: Guy's Hospital or LAS or 999 through LAS.
2. Inform Secretary and Deputy Secretary.
3. If enforced evacuation lengthy, try to establish an emergency office to continue shift. Inform telephone exchange and LAS.
4. Inform off-duty RMAO and on duty RMAO (who will be at home).
5. Inform local police: Telephone No. 407 8044 Borough Police Station.
6. If lengthy evacuation, try to inform oncoming watch in order to divert them.
7. Inform Deputising Services, if there is time.

Notes

a. If a case is about to be offered by the GP as the order to evacuate is given, the GP should be asked to deal with the case through the 999 procedure.

b. Those not required will be sent home at the discretion of the Senior Watch-keeper.

c. In the event of a serious fire, explosion etc. the house-keeper and family should be sent to some other temporary accommodation.

d. In the event of serious fire, explosion etc. and consequently a prolonged departure from the building, an interception on the EBS line would be made by the telephone exchange, and the radio services would be used to make known the temporary arrangements, telephone nos. etc.

1. Mr. Irfon Roberts at his home tel. no. 226 8911 or any other number given.
2. Miss R.V. Sharpe 713 6701
3. Mrs Betty Lucas - home number 580 3355

Note: At all times Mrs Lucas should only be contacted if neither Mr. Roberts nor Miss Sharpe is available.

On no account are these telephone numbers to be given in answer to an enquiry from the Press or similar source. It is an absolute rule that only the Secretary of the EBS, or, if he is unobtainable and the matter is one of immediacy, the Deputy Secretary, or the Assistant Secretary of the Fund, is authorised to deal with enquiries from the Press or other publicity media such as radio or television services. This rule is not made in any spirit of hostility to these media, which have their own part to play, but rather to try to ensure that they are all treated alike and told the same thing, and to safeguard the effectiveness of the EBS itself by protecting the operations room from involvement: experience has shown

that most of those concerned in seeking information from the EBS for the media do so in a proper way: one or two, however, evidently have no scruples in seeking favoured treatment. Whatever style of approach is encountered, including a threatening one, the matter is a simple one for all concerned ie. decline to become involved in any way, and refer the matter to the Secretary.

6. Occupational Therapy

Knitting, needlework, reading of books, newspapers etc. is allowed but must be set aside entirely by anybody engaged in any stage of dealing with a case. New entrants are not allowed to do any of these things for the first three months without permission from the senior operator on duty.

7. Domestic and Catering Arrangements

Domestic and catering staff are not on duty at week-end evenings or at night and it is necessary for the staff on night-duty and from 1400 hours on Saturdays and Sundays to cater for themselves. It is particularly important that the food left for the night watch in the cupboard under the service lift and in the small refrigerator is not removed by anyone else. The catering keys should be left with the Senior Watchkeeper when the catering staff are not on duty and she will decide when circumstances justify the opening of cupboards, deep freeze etc.

Night duty staff are supplied with fresh and tinned foods to eat on the premises; food not eaten is not to be taken home. Breakfast is to be eaten in the dining-room, not in the operations room, and breakfast washing-up is the only chore that can be left to the catering staff; everything else used during the night must be washed up and the kitchen left tidy and clean. THIS ALSO APPLIES TO SATURDAY AND SUNDAY AFTERNOONS.

If any crockery, glass etc. is broken, a note must be left to say so. If certain foods are in short supply, the rule is "fair shares for all".

At the end of night duty, sheets and pillow cases must be folded separately and left ready for the laundry; all personal belongings must be taken home or put away in lockers. The cloak-rooms and shower should be kept clean. It is essential that those in charge of night-duty, as well as being responsible for admitting patients to hospital, remember that they are responsible, as are the Senior Watchkeepers during the day watches, for seeing that the above duties are carried out.