OFFICER DELEGATION SCHEME
RECORD OF OPERATIONAL DECISION

TO BE UPLOADED TO THE INTERNET BY DEMOCRATIC SERVICES

Date: 24/03/20	**Ref No:** 2030

Type of Operational Decision:

Executive Decision	x	**Council Decision**	

Status:

Title/Subject matter: **RBMS Business Continuity Proposal**

Budget/Strategy/Policy/Compliance – Is the decision:

(i) within an Approved Budget	Yes (other than Laptops and phones)
(ii) in accordance with Council Policy	N/A

Equality Impact Assessment [Does this decision change policy, procedure or working practice or negatively impact on a group of people? **If yes** – complete EIA and summarise issues identified and recommendations – forward EIA to Corporate HR]	

Details of Operational Decision Taken *[with reasons]***:**

Background

The RBMS process most elective referrals to main providers including assessing/booking transport. Most of what they do in terms of patient contact relies on paper and telephone based activity (longer term we need to think about use of email

PTS - are cancelling all ambulance journeys as of Monday apart from Renal Dialysis, EOL and hospital discharge/transfer Journeys. The team have minimal to no contact regarding these remaining bookings. Therefore a telephone message has been added to the ambulance booking line

Planned – Important and Urgent next steps guidance issued on the 17th March stated that in order to free beds the system should 'assume that you will need to postpone all non-urgent elective operations from 15th April at the latest, for a period of at least three months. However, you also have full local discretion to wind down elective activity over the next 30 days as you see best, so as to free up staff for refresher training, beds for COVID patients, and theatres/recovery facilities for adaptation work. Emergency admissions, cancer treatment and other clinically urgent care should continue unaffected. In the interim, providers should continue to use all available capacity for elective operations including the independent sector, before COVID constraints curtail such work. This could free up 12,000-15,000 hospital beds across England'

Further guidance around Cancer referrals is also due out but at the time of writing this wasn't available

Risks within the Team

The team currently have no ability to work from home as they do not have laptops, smartcard readers or phones (received lap tops 24/03/20 but not yet loaded with ERS software and team aren't tech savvy, phones are on order). Even with the equipment they aren't able to offer a fully functioning service due to the above but also due to the archaic processes in place (printing/posting/scanning of letters).
A risk assessment has been done - at least 3 members of the 8 staff have underlying health conditions but would prefer to come into work rather than work from home.
One member of the team is currently self-isolating following displaying flu like symptoms

Recommendations/ considerations

- Gold are asked to approve the stopping of all non-urgent referrals as of 23rd March 20 and confirm preferred option from the 2 below
- The RBMS operate a skeleton service for the next month:
    - Cease all routine referral requests for the next 30days (following latest guidance). Two options:
        - Option 1 - Practices refer but they are held in the RBMS this ensures all referrals are held in chronological order to be dealt with at a time when hospital services resume. This might have an element of risk for clinics that are usually triaged and sometimes upgraded e.g. Dermatology.
        - Option 2 - Practices are asked not to refer until a later date. This relies on practices having systems in place to remember to refer at a later date and may impact on capacity of the practice given patients my need to be re seen
- The team would then focus on
    - 2ww
    - Rapid Access Chest Pain
    - Breast Referrals (All are seen within 2 weeks)
    - All other Urgent referral work by speciality
- SOPs are currently in development so that if the situation was to change (e.g. If more staff become sick or Townside has to close) then GP practices would be able to follow and book these referrals directly themselves
- PTS – we will need to ensure phone messages articulate where patients will need to contact (done)
- Processes still need to be considered by the service lead for:
    - Communications to Clinical Triagers - MSK/Dermatology/Paediatric/Diabetes/Cardiology
    - Upgraded Cardiology Referrals to RACP (mechanism to alert booking staff-generic e-mails).
    - Optoms regarding changes in booking processes
- Conference calls are being established with NCA in order to discuss Operational Issues /Sitrep within Booking and Scheduling.

Key decisions to be made

1. Which option is preferred for routine referrals?
2. Is Gold comfortable with high risk staff being present at work?

Decision taken by:	**Signature:**	**Date:**
Joint Chief Finance Officer (CCG & LA)		
Interim Executive Director - Communities & Wellbeing	J Goulden	31 March 2020
Head of Workforce – Communities & Wellbeing		

Members Consulted ***[see note 1 below]***		
Cabinet Member/Chair		
Lead Member		
Opposition Spokesperson		

Notes

1. It is not generally a requirement to consult with any Members on Operational Decisions but where a Chief Officer considers it necessary to consult with the appropriate Cabinet Member and/or Lead Member, they must sign the form so as to confirm that they have been consulted and that they agree with the proposed action. The signature of the Opposition Spokesperson should be obtained to confirm that he/she has been consulted.

2. **This form must not be used for urgent decisions.**