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NHS England

# System Control Centres

18 October 2022

# Contents

# 1. Background

1.1 The purpose of System Control Centres (SCCs) is to always ensure the safest and highest quality of care possible for the entire population across every area by balancing the clinical risk within and across all acute, community, mental health, primary care, and social care services. Led by senior clinicians and operational leaders harnessing the power of Integrated Care Systems (ICSs), SCCs will ensure a consistent and collective approach to managing system demand and capacity as well as mitigation of risks.

1.2 SCCs will operate at an Integrated Care Board (ICB) level to lead and facilitate collaboration through senior system-level operational leadership, although in some systems it may make sense to operate SCCs at a sub-ICS level dependent on local patient flows. SCCs will deliver:

- Visibility of operational pressures and risks across providers and system partners
- Concerted action across the ICS on key systemic and emergent issues impacting patient flow, ambulance handover delays and other performance, clinical and operational challenges
- Dynamic responses to emerging challenges and mutual aid
- Efficient flows of information

1.3 Significant steps towards this model were made during the pandemic, and last winter, with several regions and ICBs standing up operational control centres in support of maximising capacity for patients across the system and rapid escalation of emerging risks.

1.4 SCCs should be developed to deliver the following:

- **Improved situational awareness**: senior operational and clinical leaders, will have an aligned picture of the performance of the region, systems, and providers – and will drive action to improve performance as needed.

- **Holistic and real-time management of capacity and performance**: system-wide view of capacity across the acute providers, community, and mental health providers, leading to a collaborative effort, led at a system-level, to manage capacity, flow, and performance.
- **Coordinated action and mutual aid**: by placing shared data analytics as a central function of the SCCs, trends, and emergent issues across the region and ICBs will be visible and actionable. In turn, support will be diverted or offered from one place in the region or system to another.
- **Improved clinical outcomes**: resulting from optimised admissions, assessments, treatments, and discharge pathways – facilitated by the placement of patients in the right setting at the earliest opportunity.

1.5 It is recognised that many ICBs have existing teams performing some of the functions of SCCs. Where this is the case the ICB should complement and build on existing systems and process to meet the minimal viable product rather than duplicating.

## 2. Minimum Viable Product (MVP)

2.1 All ICBs should now take action to implement an SCC that means the MVP by 1 December 2022, where this can be delivered sooner implementation should not be delayed. The MVP requirements of an operational SCC are as follows:

| Ref | Description |
|---|---|
| 1 | SCCs should operate 7-days a week, 365 days a year, with 0800-2000 staffed provision. |
| 2 | The SCC should have 24/7 access to a senior clinician (senior medical or senior nurse decision maker) who can lead and take responsibility for the proactive management of clinical risk and make system-level decisions to balance risk across the urgent and emergency care (UEC) system. With a specific focus on mitigating clinical risks across the acute, community and mental health urgent and emergency pathway. |
| 3 | Between the hours of 2000-0800 ICBs should have director level on-call arrangements in place to maintain SCC continuity, with the ability to maintain and stand-up full SCC functionality as needed. The director level on-call must have the ability to access senior clinical support as per Ref 2, with agreed minimal triggers to do so. |
| 4 | A named ICB executive should be responsible for the development, implementation, and oversight of the operational delivery of the SCC. |
| 5 | The SCC must utilise national data sets to inform surveillance, decision making and risk management. Specifically, the SCC will have systems and process in place to monitor and respond to the nationally agreed target metrics including but not limited to:<br>• Type 1 ED performance<br>• >12-hour length stays in ED<br>• Category 1, 2 and 3 ambulance response times<br>• OPEL status<br>• Community Rehab Bed Occupancy<br>• Virtual ward bed state |

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| | To support decision making, ICBs should work with partners to develop systems and processes for the SCC to have sight of the demand and capacity for care home beds and broader social care across the system. |
| **6** | The SCC must utilise real-time data to ensure proactive management of ambulance handover delays and the proactive and reactive management of actions that will support ambulance response times. |
| **7** | The role of the SCC must be clearly defined in action cards as they relate to OPEL and REAP level 2, 3, and 4, and critical/major incidents. |
| **8** | Systems and processes must be in place to ensure that the SCC leads proactive planning as well as reactive management – specifically to include planning daily for 2000-0800, weekends, bank holidays and other events that are potentially destabilising to the system-level health economy e.g., large public gatherings/events. |
| **9** | SCCs will be appropriately staffed to respond to day-to-day management as well as surge or critical incident scenarios and will be aligned to existing EPPR arrangements. |
| **10** | SCCs will have systems and processes in place to ensure there is a robust cascade and action of national and regional communications. This should include a single point of contact mailbox that can be accessed in and out-of-hours by relevant SCC staff as needed, and appropriate systems and process to track and monitor returns as needed. |
| **11** | Systems and processes should be in place to coordinate and manage returns to regional and national teams, ensuring oversight that returns are accurate and provided in line with timelines – including SITREP returns, and completion of the capacity tracker including for community rehabilitation beds. |
| **12** | SCCs will proactively lead the system response as it relates to the repatriation of patients, and the management of delayed discharges from the acute, community and mental health bed base. |

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| **13** | SCCs will have systems and processes in place to identify, manage and escalate as needed risks and issues as they relate to patient safety and operational performance to system, regional and national teams in and out-of-hours as needed. |
| **14** | SCCs will have systems and processes in place to proactively ensure the effective management of flow and capacity across both bedded and non-bedded capacity. Ensuring the maximum clinically appropriate use of virtual ward capacity and non-acute bedded capacity. |
| **15** | SCCs will have agreed access points, 24/7, to partners in local authorities. SCCs will work in conjunction with, and escalate issues and risks to, local authorities as they relate to commissioned services and or matters for which statutory responsibility lies with local authorities. |
| **16** | SCCs will have the capacity to convene system-wide meetings on a daily or more regular basis, in and out-of-hours, to assess the operational rhythm. Such meetings will have appropriate leadership to ensure immediate actions to mitigate pressures are identified, operationalised, monitored and their impact assessed. |
| **17** | SCCs will operate in conjunction with, and cognisant of, the overall EPPR arrangements of the NHS, and associated statutory obligations of NHSE, ICBs, NHS providers, local authorities, and wider system partners. |
| **18** | SCCs will maintain appropriate contemporaneous records and decision logs for all actions in line with the standard principles of health command. |

## 3. Team composition

3.1 The below table outlines suggested roles and responsibilities needed within an SCC. This is provided for guidance purposes and does not represent a required resourcing model, however the final SCC model for each system will need to ensure these roles and responsibilities are fulfilled:

| Role | Responsibilities |
|---|---|
| **Deputy Director** | • Senior leadership of SCC<br>• Guidance on SCC delivery<br>• Leadership and comms to system partners and wider ICB<br>• Second point of escalation |
| **Clinical Leader** | • Senior clinical leadership of the function<br>• Risk assessment<br>• Co-ordination of clinical input to key issues |
| **Duty Manager** | • Rotation of pathway leaders such as emergency and elective care leads as duty manager<br>• Strategic lead and interface of SCC<br>• Provides oversight of SCC function and coherence with national standards<br>• Daily lead for ops<br>• Manage SCC delivery team<br>• First point of escalation for issues not resolved by SME (clinical and operational) |
| **Delivery Manager** | • Assigns tasks to specific functions<br>• Chases all actions assigned and escalates key issues to co-ordinator<br>• Triage and forward to relevant team for input |
| **Single Point of Contact (SPOC)** | • Manages SPOC inbox and all requests from national, regional, system and provider stakeholders |

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| **Analytical Support** | • Responsible for all data analysis and processing<br>• Provides daily and weekly reports<br>• Reviews live time data sets and alerts SCC leadership to trends and emergent issues |
| **Subject Matter Experts (SME)** | • Specialist in key workstream of SCC and responsible for SME input<br>• Strategic oversight and leadership of actions for that specialism |
| **Business support** | • Responsible for day-to-day staffing<br>• Drive improvement processes<br>• Manages strategic and operational business processes for SCC |

# 4. Data performance and activity information

4.1 To operate effectively SCCs will need to use data, performance, and activity information on a near real time basis – accessing, analysing, and making decisions based on multiple data sources and workflows, operational dashboards.

4.2 The potential for confusion and inefficiency relating to the interpretation of operational data is high, so appropriate resource, skills and systems alongside processes and a healthy culture of check and challenge will need to be in place to ensure that multiple data sets are reviewed and synthesised to support the identification of operational actions.

4.3 While national data sets, definitions, and dashboards will be available to the SCC, systems may should take steps to supplement these with relevant local data, analytical tools, and infrastructure.

4.4 The below outlines the metrics that SCCs should be using to support operational and clinical decision making. These are derived from national data collections and are available on a daily (or at most weekly) basis:

| Metric | Definitions |
|---|---|
| Type 1 ED Performance | Percentage of patients attending an ED department who were seen, treated, and admitted or discharged in under four hours. |
| Over 12 hours from arrival | Percentage of patients attending an ED department who were seen, treated, and admitted or discharged in under twelve hours. |
| Ambulance handovers >60 | Number of patients arriving by ambulance where the time between arrival and handover to the hospital team was more than 60 minutes. |
| C1, C2, C3 and C4 90th Percentile Response Times | 90th percentile of response time to category 1-4 calls, where response time is the time taken from call placed to the first presence at the scene of the incident. 90% of response times were faster than this. |
| 111 calls abandoned | Number of 111 calls abandoned. |
| OPEL | Operational Pressures Escalation Level. |
| Average weekend discharge balance | Average daily discharges for that weekend divided by the total average daily discharges for that week. |
| Beds occupied by patients who no longer meet the criteria to reside | Percentage of G&A beds occupied by pts who no longer meet the criteria to reside and have not been discharged. |
| GA Occupancy | Percentage of open general and acute beds used by patients. |
| All staff sickness | Number of overall staff who are sick. |
| COVID-19 staff sickness | Percentage of staff sickness that is due to COVID-19. |

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| Beds occupied – COVID-19 | Percentage of all hospital beds (ACC + G&A) occupied by patients with confirmed or suspected COVID-19. |
| Beds occupied by COVID-19 positive and suspected | Percentage of COVID-19 positive and suspected patients over all occupied beds. |
| Bed occupancy against baseline | Number of occupied beds against the baseline beds. |
| Level 3 equivalent bed occupancy | Number of occupied beds against number of funded beds or level 3 equivalent beds. |
| Open beds unreserved | Number of ACC open and unreserved beds. |
| Surge beds open | Number of surge beds open. |
| Nurse to patient ratio | Ratio between nurses and patients. |
| Open beds gap | Difference between actual available beds (occupied + open and unreserved) against funded beds and funded beds that should be available. |
| GP absence rate | Percentage of GP FTEs who are absent for a particular day. |
| Nurse absence rate | Percentage of Nurse FTEs who are absent for a particular day. |
| Admin absence rate | Percentage of Admin FTEs who are absent for a particular day. |
| DPC absence rate | Percentage of DPC FTEs who are absent for a particular day. |
| CYP on a paediatric ward awaiting a tier 4 bed | Number of children and young people on a paediatric ward awaiting a Tier 4 bed. |

4.5 In addition, the following datasets should be used to support the effective operational delivery of the SCC:

- Local Primary Care information returns
- National Ambulance Coordination Centre (NACC) data
- Faster Data Flows Acute
- National Bed Tracking Dashboard
- Admissions and Covid-19 Forecasting Model
- Real time bed state for Acute, MH, Community beds
- Real time Virtual Ward bed state
- Domiciliary care provider demand and capacity information
- ECDS/ED information include intermediate urgent care settings
- Primary care demand data

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