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# System Co-ordination Centre specification

## Version 2.0

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# Contents

1 Background and context ..... 2
2 Purpose ..... 2
3 Expected outcomes from SCC operations ..... 3
4 Governance ..... 3
5 Roles and responsibilities ..... 6
6 Operating protocol ..... 7
7 Data and digital ..... 8
8 Required Operational Standards (ROS) for SCC operations ..... 10

Glossary ..... 13
Further information and contact ..... 14

# 1 Background and context

1.1 This System Co-ordination Centre (SCC) specification builds on the minimum viable product for system control centres that NHS England released in October 2022 as part of the 2022/23 winter plan.

1.2 System Control Centres are now identified as System Co-ordination Centres (SCCs) in recognition of an evolved purpose, capability and core function.

1.3 System in this document refers to the Integrated Care System (ICS) whereby the SCC provides an operational platform within the ICS for the whole health economy, including local authority, primary care, and voluntary, community and social enterprise partners.

1.4 This SCC policy makes clear the purpose, key deliverables and minimum operating requirements, referred to as the Required Operational Standards (ROS), that all SCCs should meet. A breakdown of the ROS that the SCCs will need to achieve compliance with, in readiness for winter operations 2023/24 and beyond, is available in Section 8.

# 2 Purpose

2.1 The SCC exists to be a central co-ordination service to providers of care across the ICB footprint, with the aim to support patient access to the safest and best quality of care possible.

2.2 As part of their role, SCCs will be responsible for the co-ordination of an integrated system response using the Operating Pressure Escalation Level (OPEL) Framework alongside constituent ICS providers and ICB policies. The OPEL Framework contains specified and incremental core actions for the SCC at each stage of OPEL.

2.3 The SCC is responsible for supporting interventions across the ICS on key systemic issues that influence **patient flow**. This would include a concurrent focus on UEC and the system's wider capacity including, but not limited to, NHS111, Primary Care, Intermediate Care, Social Care, Urgent Community Response and Mental Health services.

2.4 SCCs should use their position within the ICB to support proactive co-ordination of a system response to operational pressures and risks. The SCC should also utilise available information and intelligence (see section 7) to assess and validate local assurance submissions with regards to planning for events that impact on UEC and wider system pathways that require specified operational planning.

## 3 Expected outcomes from SCC operations

### 3.1 Improved visibility of operational pressures

Senior operational and clinical leaders will have an aligned view of the operational pressures and risks across system providers which should support collective action to improve patient safety.

### 3.2 Real-time co-ordination of capacity and action

A system view of capacity across all providers and the wider health care system should lead to a collaborative effort to improve performance to patients' benefit. In line with local policies and the OPEL Framework 2023/24, data sharing, as a core role of the SCC, should identify predictable and emergent activity to support forward planning and data will be visible to all key decision-making and co-ordinating personnel.

### 3.3 Improved clinical outcomes

The SCC's unique position to oversee a suite of operational metrics in real time enables it to provide a timely response at a system level, assisting local providers to deliver the right care at the right time.

## 4 Governance

4.1 The SCC is a constituent part of the ICB and, as such, should facilitate collaboration within the system through its operational and clinical leadership.

4.2 It is important that the SCC is recognised as the ICB's 'real-time' forum for operational oversight. As such, an identified executive-level member will be accountable for the SCC at ICB Board level. This executive will ensure that there is co-ordination across the system using a shared framework of escalation policies including the OPEL Framework 2023/24. Where the executive member for the SCC is not the Accountable Emergency Officer (AEO), both executives will be expected

to work together to ensure joint working between Emergency Preparedness, Resilience and Response (EPRR) and SCC operations with the aim of ensuring seamless co-ordination of response to operational pressures. The executive member will be supported by a senior responsible officer (SRO) or equivalent who will lead the business planning and strategic oversight of the SCC.

4.3 Where the ICB chooses to **collaborate** with another ICB to share the function of the SCC, the requirements as described in this specification must be met for each ICB that is part of the collaboration.

4.4 The ICB will support the SCC in developing a reporting framework for the ICB Executive either as part of wider reporting arrangements or on its own. This would include a set of local metrics based on Sections 3 and 4.6 of this specification and would cover frequency of reporting. Where relevant, due consideration will be given to:

- All parameters outlined in the OPEL Framework 2023/24.
- Emergency Care 4-hour performance.
- Category 2 ambulance response time.

As part of its reporting, the SCC may also note unwarranted variation in system performance across the above metrics and whether system actions are harnessing the desired impact. This could cover:

- Time of Arrival to 12-hour delays.
- Length of Stay (7, 14 and 21+).
- No Criteria to Reside % or other appropriate discharge metric.

4.5 Where necessary and needed, the SCC will have constituent membership of relevant clinical governance and quality assurance forums within the ICS and ICB. This should enable a wider sharing and understanding of operational pressures. The ICB will also consider the role of the SCC:

- in the response to any formal patient safety incidents that are brought to the attention of the executive board.
- reducing health inequalities in line with local policies and programmes.

4.6 Complementing the role of the SCC as defined in the OPEL Framework 2023/24, the ICB will ensure that the SCC has a defined role within system policies, covering but not limited to:

4.6.1 **Local provider surge protocol (or similar)** that seeks to maintain the timely flow of patients through the emergency department (ED), mental health, community settings and other parts of the health system.

4.6.2 **Protocols covering ambulance conveyance and handover pressures (or similar)** that ensures an effective response to increased pre-hospital demand and/or an incident that requires specialised resources to manage it. This may also cover the role of SCC in ambulance diverts.

4.6.3 **Protocols covering access to mental health inpatient services (for all ages) or similar** that would specify system actions to mitigate risk of exceptional patient waits, heightened clinical risk and poor patient experience.

4.6.4 **System communication policies or similar** that would cover the interface between the SCC and the ICB Communication Team. Enabling patient choice or providing guidance to the public during critical events or dates should be a key aim of a joint communications plan.

4.6.5 **Inter-hospital transfers or similar** that would cover the role of SCC in monitoring, actioning and escalating cases of patients awaiting specialised care or return to local hospital in excess of provider or tertiary agreed local thresholds. The SCC would be expected to escalate delays to the region at 72 hours and request national support via the region at 96 hours.

4.6.6 **Incident management including EPRR**, ensures that the role of an SCC is outlined in the ICB Incident Response Plan and describes how it will provide real-time data and system intelligence to the Incident Co-ordination Centre (ICC).

4.6.7 **Protocols covering escalation of primary care pressures** that seek to ensure patients who can be treated in primary care remain in primary care.

The SCC would be expected to lead a regular review of the effectiveness of the actions as defined and covered in this section and seek amendments as required.

# 5 Roles and responsibilities

5.1 The ICB, through its support of the SCC, determines the impact of the SCC operation on patient care within the ICS. The ICB will ensure that the SCC has sufficient resources to meet the ROS (as laid out in Section 8). This section covers recommended roles and responsibilities, although ICBs will be expected to adapt these to their local context.

5.2 During operating hours, a senior member of staff will assume the role of SCC room lead (or equivalent). This role adopts day-to-day senior decision-making and will ensure the SCC is delivering the operating protocol to full effect as detailed in section 6. The SCC room lead is responsible for the oversight of system capacity, demand and escalation across the ICB. This includes briefing the SRO (or equivalent) on prospective and actual deployment of system protocol or exceptional intervention during this time.

Outside the SCC's core operating hours, the SCC room lead will provide a handover and action plan to the Director on-call (DOC) who will assume responsibility for the SCC function, as specified in section 5.5.

5.3 Depending on the size and complexity of the ICB, the number of personnel and skill-mix required to support the SCC room lead will be dictated by the SCC SRO (or equivalent) in consultation with the SCC room lead. This should be based on an assessment of the resources required to sufficiently deliver the ROS as laid out in Section 8. As part of this assessment, due consideration should be given to the roles and function of operational staff, analytics and business support to support the SCC room lead.

5.4 The ICB will ensure it has either SCC room leadership (SCC room lead) with active clinical registration (GMC, NMC or HCPC), or an operating structure that enables input from senior clinicians in the ICB[1]. This is to ensure that there is clinical insight to planning the SCC's local action and co-ordination of mitigation in response to pressure in the UEC and wider system pathways. The ICB will agree locally how it ensures access to clinical support, dependant on its chosen operating model.

*

[1] This should cover the OOH period for the SCC and provision of clinical support to the DOC. However, if theDOC has active clinical registration (GMC, NMC or HCPC), separate clinical support will not be required.

5.5 To support oversight outside the SCC's core operational hours, a DOC will be available to provide strategic leadership, support local decision-making and co-ordinate system actions as required. The ICB will be expected to ensure that the role of the SCC DOC is enshrined within local system protocols (section 4.6) with consideration given to relevant thresholds and criteria that would determine escalation of relevant issues and risks to the DOC. The DOC would be expected to escalate unmitigated risks to NHS England regional UEC on-call and prepare to work in tandem to formulate a plan that is endorsed by the NHS England regional officer.

5.6 The SRO (or equivalent), in consultation with the SCC room lead, will be responsible for determining the suitability of location for SCCs with local consideration for hybrid or virtual working as appropriate.

5.7 SCC staff will be trained to optimise the utilisation of local digital solutions, real time data* and other related reporting systems.

* Data refresh at 15 – 30 minutes intervals, or sooner

## 6 Operating protocol

6.1 The SCC will be required to develop and maintain a Standard Operating Protocol (SOP) that defines its function and key deliverables. This will be reviewed on an annual basis.

6.2 The SOP will include the following as a minimum:

6.2.1 Reference to ensuring OPEL score is collected in line with OPEL Framework 2023/24 and key actions for SCCs as defined in the OPEL Framework and local system policies (Section 4.6) are noted.

6.2.2 A consistent operational cadence that factors in meetings with ICS partners and regional NHS England teams in alignment with the OPEL Framework and local policies.

6.2.3 Systems and processes in place to co-ordinate and manage returns to regional and national teams – ensuring that returns (including SitRep returns) are accurate and provided in line with timelines and the Capacity Tracker is completed, including for community-based beds.

6.2.4 Recording and management of notes and the decision-making for all actions in line with the NHS England's Corporate records management policy.

6.2.5 Minimum staffing profile that allows the SCC to deliver its function and respond effectively to system pressures. Roster planning should ensure the availability of a staffing model to meet peaks in demand, both operational and emergent.

6.2.6 SCCs will provide 7-day cover in-line with the regional/national operational model between 0800 hrs and 1800 hrs. During OPEL 4, or as deemed necessary by the SRO (or equivalent), in consultation with the SCC room lead, the SCC should review and extend its cover to ensure a proportionate response to the level of operational challenge or clinical risk.

6.3 To support system co-ordination, SCCs should maintain an up-to-date directory of the in-hours and out-of-hours (OOH) system, contacts that cover the entire patient pathway. This would include primary care, admission avoidance, NHS111, social care and mental health. Relevant OOH details of such services, including Local Authority, should be available to the DOC.

6.4 The SCC must function during the core operational hours as a **single point of contact (SPOC)** for local system and NHS England regional stakeholders in line with the defined scope of the SCC. This will include the availability of a SPOC mailbox that can be accessed by SCC staff.

6.5 The SCC will share its OOH contact details with the Regional Operations Centre, for onward cascade to relevant teams. The SCC will also receive relevant details of the regional in-hours and on-call details.

## 7 Data and digital

7.1 SCCs will be expected to ensure that digital enablement meets the technical guidance issued for Smart System Control (SSC) by NHS England.

7.2 The SCC must have real time digital software and a process in place to monitor, as a minimum, the following key metrics across the ICS, NHS111 and Ambulance services:

7.2.1 Acute Hospital OPEL score.

7.2.2 Ambulance provider Resource Escalation Action Plan (REAP) and Clinical Safety Plan (CSP) level.

7.2.3 Category 1, 2 and 3 ambulance response times.

7.2.4 NHS111 performance and compliance with standards.

7.2.5 Ambulance-to-provider handover volume and handover intervals/mean.

7.2.6 Number of patients in the ED.

7.2.7 Number and % of patients spending >4 and >12 hours in ED from arrival.

7.2.8 The current, prospective and potential acute hospital G&A capacity.

7.2.9 Critical care capacity (to measure CRITCON status).

7.2.10 Virtual ward capacity and occupancy.

The SCC would utilise metrics 7.2.2, 7.2.3 and 7.2.4 for **situational awareness** and would be expected to escalate all concerns, issues and requests for actions relating to these to the relevant provider.

7.3 The digital software must have the following capabilities as a minimum:

7.3.1 Be able to evolve to include Primary Care, Mental Health, Community and Social Care real time metrics to meet local needs and future iterations of the SCC specification and OPEL framework.

7.3.2 Accessible through both 'desktop' and mobile devices.

7.3.3 Able to generate notifications to its users on locally determined thresholds for metrics noted in 7.2, to trigger rapid action and decision-making.

7.4 To ensure national, regional and ICS alignment on operational and performance data, SCCs will also have devolved access for their ICB-level data to the following dashboards as minimum:

7.4.1 National UEC SitRep and/or Emergency Care Data Set or similar.

7.4.2 National Ambulance Performance Dashboard.

7.4.3 National 111 data covering historical and real-time performance.

7.4.4 Virtual ward utilisation and occupancy.

7.4.5 Discharge and length of stay.

7.4.6 Capacity Tracker.

7.4.7 Primary Care Data and Insights Dashboard.

7.4.8 Mental health pathway:

- Mental health, Learning Disabilities and Autism SitRep.
- Urgent and Emergency Mental Health performance.
- Acute Mental Health and Adult Acute Mental Health benchmarking.

7.5 To support proactive planning and co-ordination of local pressures, ICBs will ensure that the SCC team have access to the following:

7.5.1 Data on the health of the population including health inequalities within the ICB area of operations.

7.5.2 Relevant demand and capacity planning data, including forecasting tools to support with pre-emptive operational planning.

7.5.3 System-agreed recovery trajectories for UEC standards as well as locally agreed improvement trajectories for operational performance and patient flow.

7.5.4 Benchmarking data through the NHS England Model Health System.

7.5.5 Local Healthwatch and other similar reports on patient experience of local services that fall within the domain of the SCC.

7.5.6 Where an SCC adopts hybrid working and has access to a physical location, consideration should be given to access and visibility of real-time data that covers the various ICS pathways as specified in section 8. Visibility of key data in real-time facilitates earlier response and better situational awareness and realises the potential effect of any subsequent intervention.

## 8 Required Operational Standards (ROS) for SCC operations

8.1 Based on the specification in this document, SCCs will be expected to compliant with the ROS as per the following tables. These are grouped into People and Processes. Each ROS has a corresponding section from this specification noted which provides additional detail.

8.2 The ROS will be subject to annual tri-partite audit as part of **winter preparedness and planning**. The tri-partite will consist of national, regional and ICS UEC teams reporting to the UEC Recovery Programme Board chaired by the National Clinical Director for UEC.

| People (PE) | | |
|---|---|---|
| **ID** | **Requirement** | **Section** |
| SCC – PE 1 | SCC has identified board-level executive member and is supported by a Senior Responsible Officer (or equivalent). | 4.2 |
| SCC – PE 2 | SCC has sufficient resource to deliver day-to-day function in line with national operating model between 0800 & 1800 hrs. | 5.2, 5.3 and 6.2.6 |
| SCC – PE 3 | The ICB will ensure that they either have SCC room leadership with active clinical registration (GMC, NMC or HCPC), or an operating structure that enables input from senior clinicians in the ICB | 5.4 |
| SCC – PE 4 | SCC Director on-call cover is in place between 1800 & 0800 hrs. | 5.5 |

| Process (PR) | | |
|---|---|---|
| **ID** | **Requirement** | **Section** |
| SCC – PR 1 | The SCC can demonstrate board-level presentation of SCC operations to the specification set out in the specification. | 4.4 |
| SCC – PR 2 | The SCC has membership of relevant clinical governance and quality assurance forums as required. | 4.5 |
| SCC – PR 3 | SCC's role and responsibility are clearly laid out in system escalation and governance frameworks, including but not limited to surge management, ambulance handover process and incident management. | 4.6 |
| SCC – PR 4 | SCC has an SOP in place that captures the daily operational cadence and reflects roles and responsibilities under the OPEL Framework. This will include the upload of the ICB OPEL onto the NHSE national database. | 6.1 and 6.2 |
| SCC – PR 5 | SCC will have SOPs to track, assure and validate submissions to NHS England national and regional teams as specified. | 6.2 |
| SCC – PR 6 | SCC will maintain appropriate records in line with the NHS England's Corporate record management policy. | 6.2.4 |
| SCC – PR 7 | SCCs will provide 7-day cover in-line with the regional/national operational model between 0800 and 1800 hrs, with a provision contained within a localised SOP to increase cover as required. | 6.2.6 |

| | | |
|---|---|---|
| SCC – PR 8 | SCC has real time digital software and a process to monitor in real time, the **minimum** key metric set detailed in section 7.2.1 to 7.2.10 to allow rapid identification of risks and required intervention. These will also be accessible to the DOC and relevant clinical support for the SCC. | 7.2 |
| SCC – PR 9 | SCC must have digital software that can add or evolve 'wider' system pathway metrics as part of real time process. | 7.3.1 |
| SCC – PR 10 | SCC digital software must be accessible through both 'desktop' and mobile devices. | 7.3.2 |
| SCC – PR11 | SCC digital software must have the capability to set notifications that alert / notify when pre-determined thresholds or parameters have been breached. | 7.3.3 |

## Glossary

| | |
|---|---|
| AEO | Accountable Emergency Officer |
| AHP | Allied Health Professional |
| BCP | Business Continuity Plan |
| CSP | Clinical Safety Plan |
| DOC | Director on-call |
| ED | Emergency Department |
| EPRR | Emergency Preparedness, Resilience and Response |
| FCP | Full Capacity Protocol |
| G&A | General and Acute |
| GMC | General Medical Council |
| HCPC | The Health and Care Professions Council |
| ICB | Integrated Care Board |
| ICC | Incident Co-ordination Centre |
| ICS | Integrated Care System |
| iUEC | Integrated Urgent and Emergency Care |
| MVP | Minimal Viable Product |
| NCC | National iUEC Co-ordination Centre |
| NACC | National Ambulance Co-ordination Centre |
| NMC | The Nursing and Midwifery Council |
| OPEL | Operational Pressure Escalation Levels |
| ROC | Regional Operations Centre |
| ROS | Required Operational Standards |
| SCC | System Co-ordination Centre |
| SOP | Standard Operating Protocol |
| SRO | Senior Responsible Officer |
| SPOC | Single Point of Contact |
| UEC | Urgent and Emergency Care |
| UCR | Urgent Community Response |

## Further information and contact

For queries about specification, please contact the National Integrated Urgent and Emergency Care Operations Team at NHS England: england.uec-operations@nhs.net