A shared system control total - a means to an end?

Healthcare

Going into the second half of the financial year, both providers and commissioners are gaining a clearer view as to whether their agreed financial control total (single organised control total 'SCT') is within reach or not. Could having a shared system control total (SSCT) on a higher level than the individual organisation be part of the solution?

A solution to what problem?

With the SCT, regulators try to ensure that everyone stays on track against their individual control totals. In theory – if everyone – would (and could) live up to it, the system would be in balance. So that makes sense doesn't it? Well, yes and no, we think. Yes, because SCTs help to strive for financial balance. But also no, because they may hamper system wide transformation by creating perverse financial incentives and a set of behaviours that create silos in the system.

For instance, say that two neighbouring acute trusts wish to reconfigure their services to resolve duplication of services. And say they want to concentrate orthopaedic planned care on one site instead of two locations through transferring accompanying resources and budgets. Whilst this could mean overall savings and quality improvements for the health systems, one of the two acutes is likely to be a winner or loser given positive or negative margins on the planned care. In a world of control totals at the individual provider level, such a reconfiguration may therefore not take place, hampering optimisation at the system level. Other examples may include programs that shift care left, out of hospital into the community, also potentially creating winners and losers, while the whole system would win.

So yes, in such cases a SSCT, for example, at a STP level can definitely help to give organisations the 'permission' and 'flexibility' to make transformational changes to improve quality, access and affordability. Also, it can help to unlock funding sitting in the local health economy if some parts of the system are in deficit, while others are in surplus.

An end or the end?

So although flexibility proposals regarding the SCT may not be the silver bullet for all problems, in specific situations it definitely can be a 'means to an end', provided there is 'an end'.

In certain situations where 1) care is being transferred from one provider to the other and 2) such care represents a profit or loss given positive or negative margins and 3) a potential win/lose situation is created, a SSCT at STP level can be an important enabler. In such cases it can strengthen inter-provider collaboration and help to achieve improved system performance.

Nonetheless, to let individual providers – and especially providers that are relatively financially sustainable - agree to a SSCT, there must be trust that the local system will deliver. Trust does not stem from a 'warm local feeling', but must be underpinned by medium to long term contracts, a solid plan describing the journey of system transformation, rigorous execution and credible analytics capabilities to allocate resources where they are needed most.

In the end, it all comes down to whether you have greater confidence to deliver as a 'system' or as an 'individual' organisation. Our view is that organisations cannot continue to act in isolation as the scale of the challenge is simply too great. We need to shift our thinking from 'what do I think is best for my organisation' to 'how can we work collaboratively across our system to improve our population health outcomes while also reducing cost'. By embracing SSCTs as an enabler for system change, organisations give themselves the opportunity and flexibility to do this. The challenge is to be brave and to start.

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