THE HEALTH DEVOLUTION COMMISSION

Response from The Royal College of Radiologists

1 What does good health devolution look like?

a) In what ways does health devolution enable the building of healthier communities and promote the prevention of ill-health?

Health devolution allows decision making to be more responsive to local needs, which can vary by cultures, languages, deprivation and geography (rural and urban areas). Health devolution should be properly employed to enable those in deprived communities, with the lowest life expectancy and poor access to health/ social care, to live longer. However, full devolution may prove challenging due to potential for inequality of access and performances against national standards.

b) In what ways does health devolution enable the marshalling of a wide range of services and partners across local authorities, the NHS, community and charity bodies, and the private sector to address the wider drivers of ill-health in local communities?

Health devolution should be a coming together of services; primary, secondary, third-sector and social care, to meet a central standard and better serve the needs of patients and carers in their locality through flexibility in how resources are used and finding local solutions.

c) Are there any barriers to the potential benefits of health devolution being realised; and if so how could these be addressed?

The barriers were highlighted as follows:

- Differing political agendas
- Lack of funding and reduced local authority budgets
- Interference to local decisions from the Centre.
- National approaches to disease do not always lend themselves to local solutions. Comparisons can be unhelpful and undermine attempts to promote local agendas.
- If healthcare providers continue to be funded separately, they will continue to behave so.
- Integrated Care Systems (ICS) should have legislative powers to organise care across providers.
- Improvements in population health generally take a long time, are often difficult to quantify, and tend to get overlooked because of day-to-day operational problems often focused on secondary and tertiary care. An example of this can be found in ambulances waiting outside A&E departments.
- Local managerial and political commitment levels.

- Good data-based planning, appropriate resource and an overarching strategy are needed but may be lacking.

- Greater involvement/ leadership of patients and carers in the locality would be beneficial in increasing uptake.

d) How does health devolution affect the outcomes and experience of care for people with specific conditions such as cancer or mental illness, or specific population groups such as older people with conditions such as dementia?

Devolution can help identify the key healthcare challenges in a local population and facilitate targeted investment. Some flexibility as to how to deliver these services at a local level will be welcomed.

However, critically, devolution must not result in a 'multi-tiered service' that is geographically dependent, especially for conditions such as cancer. Patients should feel assured that no matter where they live, they will receive excellent treatment and equal access to high tech imaging equipment and optimum cancer treatments. How national targets can still apply needs to be addressed.

Establishing long-term detailed UK-wide audit, already in place for a number of important conditions and treatment modalities, would help fully understand the situation on the ground.

e) To what extent does health devolution accelerate integration within the NHS and between health and social care services, and help make the NHS Long Term Plan a reality?

There may be local integration of services but national integration may still remain fragmented. Integration would only be achieved if it results in greater powers to the ICS as opposed to individuals, GP consortia and Foundation Trusts.

When 'system altruism' becomes the norm and there are incentives to work together (rather than drivers to keep organisations apart), people would emerge from silos to do the right thing for patients, which will contribute to fully integrated health and social care, and help the LTP to become a reality.

2 How can challenges of accountability, power and control be addressed in devolved and integrated health systems?

a) What is the relationship between central government, NHSE and devolved health areas? In what way is the Secretary of State for Health and Social Care and NHSE held accountable for improving a community's health as well as NHS performance in devolved health and social care systems?

Central Government and NHS bodies are responsible for funding allocation and determining the framework for delivery. The responsibility lies with the Secretary of State and his devolved agents. The Centre's role is to have a degree of oversight to ensure that patients receive core services no matter where they live and these are delivered to a high standard. Devolution must not be seen as the Centre 'washing its hands' of local issues and having easy scape-goats when things go wrong. There is a need for devolved health systems to remain an active part of UK health service development rather than passive recipients.

Regional and local agencies should be held accountable with incorporated measures to check that those holding the devolved budget use it wisely and report to local service users. However, there also needs to be an acceptance centrally that it will take years to see some programmes through.

b) How can local leaders in devolved health systems be held accountable locally and nationally at the same time for the performance of locally integrated services?

Central government could have a Health & Social Care Parliamentary committee that provides expert advice to the Secretary of State. Similar measures could be replicated at regional level.

Accountability at both local and national levels might be difficult to monitor when there is an uneven playing field in terms of access and resources leading to differing outcomes.

They should have to report not only to central government but also to those they serve. All those in charge of the purse strings should also have to divulge company directorships etc.

c) What is the nature of the relationships between local clinical leaders (health commissioners and providers) and civic (professional and elected) leaders? What decisions are each responsible for in a devolved and integrated system?

Both groups have the patient's best interests at heart but may come at things from different angles. A respectful, courteous but challenging relationship, encouraging diverse views and backgrounds should be fostered.

Elected leaders should not be able to exert undue pressure on commissioners and providers to make bad short-term decisions for the sake of re-election. They should however be able to lobby parliament on behalf of their constituents for resources etc.

They should also be able to scrutinise the working of the devolved healthcare system to ensure that it is rigorously held to account on behalf of people living in the locality.

If decision making is subject to individuals, national variation and fragmentation may increase.

d) How does health devolution affect policies to empower individuals to have more control over their health and social care services and outcomes?

Patients would benefit from care being more local and ancillary benefits such as not having to travel.

Awareness among patients will increase through partnership working between patients and providers.

It should also give people more power to help themselves, which could benefit from some incentives e.g. access to home tech for checking blood sugar/ blood pressure, if they comply with monitoring.

e) What impact does health devolution have on the charity sector, social enterprises and the independent sector as providers and partners in health and social care structures?

It gives them a stronger voice and opportunity for regular dialogue. This can also improve some local services although could also lead to more fragmentation.

If private providers and charities provide NHS services, they should be held to account as the NHS is. ‘Any qualified provider’ must be rigorously monitored and the same audit processes applied to them as to NHS organisations so that patients are assured that they are receiving the same quality service whoever delivers it.