

UNISON

Northern Ireland

Submission on

**PROGRAMME FOR GOVERNMENT
DRAFT DEPARTMENTAL BUDGETS
INFRASTRUCTURE STRATEGY**

December 2007

Core Issues

1. There are three fundamental flaws in the current process of consultation:

- a) The use of 'High Level Equality Impact Assessments' to suggest that an 'equality' process has informed the draft material. The 1998 Act, and statutory Equality Commission Guidance, recognise Screens and Assessments. In this case, Screening and Assessments can now only take place following final decisions and allocations by the Executive. There has been determined resistance by Departments to the publication of High Level Assessments.

All Programme and Departmental High Level Equality Impact Assessments must be published before the close of this consultation. The Executive must also hold itself in readiness to consider further analyses and responses on this issue during its deliberations in January.

- b) The continuing refusal of DFP to publish draft Departmental Efficiency plans, and of Departments to publish those required from Agencies and Public Bodies. This is crucial for full evaluation of the policy, public and equality impact of the Programme, Budgets and Infrastructure Strategy.

All Efficiency proposals should be published no later than 4th January, and the Executive should consider analyses and responses within a published time-frame before final decision and allocations.

- c) The decision of the Health and other Committees to consider and apportion Departmental Budgets in closed session. UNISON has formally complained to the Speaker and his team over this breach of the vision for accountability and transparency that was at the heart of the Good Friday and St Andrew's Agreements.

The minutes of closed Assembly Committee Budget meetings, and subsequent Reports, must be published before or at the close of this current consultation.

Only then, and in the light of material published under (a) and (b) above, will the development of policy and budgets in this process match best practice openness and accountability.

2. "This is a Budget for the economy rather than Health" – comment of Don Hill, DHSSPS, to Health Services Committee.

Prosperity does not in itself resolve poverty and inequality. Widening inequalities can have profoundly damaging impacts, e.g. the now powerful evidence base that greater relative deprivation reduces life expectancy and health status, even when absolute poverty and deprivation are reduced.

The focus of the Programme and Budgeting process should therefore have been a dynamic and interdependent process of economic and social advance. The promise of these proposals on economic progress is counterbalanced by the coat-trailing of Departmental 'social' proposals that on close examination prove to be unaffordable within the current CSR envelope.

In coming to final decisions, the Executive must determine to make a targeted and accountable difference on the known dimensions of poverty and inequality, and have the courage to vary allocations to do so.

3. The Programme document rightly lays to rest the off-repeated myth of the overlarge public sector. This still lives on in the land of myth on public sector/private sector pay differentials. 28% of low paid workers work for public employers, with many more in the undocumented world of private and voluntary public service providers. The clear majority of these low paid workers are women. Claims for efficiency must be examined on the facts of the case and impact assessment - not generalised stereotypes and prejudiced opinion.
4. The 2008-2011 proposals show a sharp transaction from UK public spending 'years of plenty' to CSR driven 'years of scarcity'. Our analysis in this document on Health demonstrates that Direct Rule Ministers further reduced the years of plenty growth path by marginalising and downgrading the Needs and Effectiveness Studies produced under the last Executive.

We have no expectations of concessions from the UK Treasury. The Executive must, however, be robust in indicating to the Chancellor that a budgetary outcome which, for example, demonstrates that the funding legacy for Social Care is 36% under-funding is not a legacy appropriate for the UK as Agreement Signatory, and must be addressed through such accountancy opportunities as are available over the 2008-2011 period and beyond.

Budget Issues: Department of Health

5. Our three briefings on the Budget process in Health are attached to this document; in reverse date order (See Appendices 1, 2 and 3).

The key issues are:

- The link between collective poor health and economic under-performance.

- Our detailed analysis of how Direct Rule short-changed the Health Budget in the 'years of plenty'.
 - The collapse of the Health Infrastructure programme following the Strategic Investment Board's false prospectus for PFI.
 - The need to avoid delusions such as 'cash releasing 10% productivity' or '£1.5bn Deloitte Cost of Division'.
 - The absence of any measurable progress on Health Inequalities.
 - The urgency of service improvement programmes based on the full involvement of all stakeholders including front-line workers.
6. Recognising the legacy constraints under which the Executive has to operate, we propose revised allocations to Health specifically to address the gap in Service Improvement (£84m 2008). While this does not remedy structural under-funding, it sustains the hope of improvement and better Health outcomes for all, including health workers currently operating under intense pressure.

Our model for revised allocation is set out in our attached Briefing (11th December 2007). In the light of the collapse of Infrastructure (ISNI II), when faced with the realities of PFI unaffordability, we would add cash-releasing the budget of SIB by its abolition. We would highlight the detailed scrutiny and overview measures of para. 16 of our Briefing as essential for any increased allocations by the Executive.

We would not presume to rank clinical priorities. We would, however, highlight the linked issues of Bamford implementation and suicide/self-harm reduction; cancer survival rates; case packages; hospital cleanliness; and young people in care. All proposals for expanding the Service Improvement Budget need rigorous assessment for impact on health inequalities.

Budget Issues: Department of Education/DECAL

7. The lower growth path for Libraries compared with Education is a matter of major concern. This will only worsen the problem of overhead absorption if a separate Library Authority is created, as per our recent evidence to the DECAL Committee.

8. The 'missing links' in the Programme and Departmental Budget are:
 - The need for marketing funding to develop further the Nutritional Meals programme as a key cross-departmental Health initiative.

 - A commitment to take forward re-modelling for teacher and classroom assistant workloads (essential for the forthcoming Classroom Assistant Review).

 - A workforce planning model for school support staff to address the impact of falling school rolls.

 - A policy commitment to reinvest Bain savings in areas of disadvantage and under-achievement.

9. The Programme for Government, however, translates Departmental statements into 'Direct Rule speak'; improvements at the margin in GCSE pass rates. In particular, there has been substantial confusion over the (low) target for GCSE success for Free School Meals pupils. The Programme should be redesigned to show baselines, and improvement on baselines, against key indicators such as literacy and numeracy for all.

Budget Issues: DSD

10. The laudable aspiration in the draft budget that “*DSD will continue to promote a strong vibrant and sustainable voluntary and community sector to enable better delivery of services and promoting strong, integrated, sustainable communities*” (page 98) is not supported with targets; creates no accountability; and when examined in the context of current and future expenditure plans (page 102) appears contemptuous of the clear need for targeted and accountable funding in this sector.

The UNISON submission “Communities in Crisis” (available on the UNISON NI website – unison.org.uk/northernireland) sets out the problem in stark detail including the critical need to develop a model for core funding. This analysis remains as relevant and serious now as it did under Direct Rule when funding was removed en masse across the sector and Government sectarianised programmes through a process which turned Targeting Social Need on its head.

The real fear of UNISON activists in the sector is that the current proposals will again fail to redress past mistakes; have the capacity to remove funding from many key programmes; and will continue to distort distribution on the basis of objective need.

Looking at the current and future expenditure plans in detail (page 102) we see proposed falls in Objective B funding from £228.9million in 2007-08 to £218.7million in 2010/11 [-2.9% in 2008-09; - 1.2% in 2009-10; and -0.4% in 1010-11]; and Objective C funding from £63.2million in 2007-08 to £56.5million in 2010-11 [-4.9% in 2008-09; - 4.9% in 2009-10; and -1.2% in 1010-11].

This is potentially devastating for the voluntary and community sector. We again recommend that a separate budget head with continued growth should be established for the community and voluntary sector to raise transparency and confidence.

As it stands this section of the document is a disgrace to Government and to any aspiration to performance management, accountability and the strengthening of the peace process. Fundamental and urgent review of this section of the Budget is a pre-requisite for credibility of the priorities/Budget as a whole.

The Investment strategy indicates that 10,000 new housing units are promised over ten years. It is unclear, however, how this will be funded. It appears that the money will be found, not from the DSD's budget but from the sale of assets and the £790 million that is to be raised through efficiencies in the next three years. As always it is likely that community organisations will feel the brunt of any cuts.

We require the urgent release of the high level equality impact statements used by DSD to inform its budget allocations.

Infrastructure Strategy

11. This convincingly demonstrates the bankruptcy of the SIB's PFI approach, with conventional procurements now being taken forward in Education, and the Health programme in a state of collapse. The added value and future role of the SIB – including its abolition – should become matters for Executive consideration.
12. The commitment to the use of apprentices on all major public sector schemes is a good example of how the Executive and Assembly have been able to go beyond the limitations in Direct Rule mindsets.
13. The equality and regeneration commitments for 'ISNI II' should have been there from the start of 'ISNI I'. It is not too late to incorporate them in projects such as the SW Hospitals.

14. For full effectiveness, developments in 2008-11, and the proposed 2012-2018 Strategy, must mainstream equality, regeneration impact and location policy (currently subject to consultation).

15. The Executive should now conclude that the PFI programme was a busted flush. The way forward is a partnership-based conventional procurement approach which will maximise opportunities for the local construction sector.

Conclusion

UNISON, while respecting the difficulties the Executive faces, has highlighted above a number of different approaches and perspectives which are central to final decision, and need to be adopted. A final Programme, Budget and Investment Strategy that are the 'same as before' will not meet needs or expectations. Strategic decision-making on boosting and reallocating resources is needed rather than lowest common denominator Executive consensus.

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UNISON BRIEFING NOTE: Assembly Health Services Committee

- 1) We understand your meeting this week includes issues arising from the Programme for Government and Departmental Budget 2008-2011

- 2) The issues of which bids were made, which were funded, and to what extent, is causing great concern in UNISON, health campaigning groups, and the community and voluntary sector. Reconciling the Departmental Statement with the Departmental Budget and the Programme for Government is not easy, and clarity will assist your Committee, the Assembly and the Executive in making effective decisions reflecting genuine and informed consultation in the weeks to come.

- 3) It is important to emphasise that the Departmental Budget Statement, and its varied commitments, is recognised within UNISON as a powerful and targeted approach to genuine and long-needed Health improvement. The width of its vision, and its accountable approach to targeting and improving performance and health outcomes, goes well beyond the approach in other Budget Statements. However, the Department, your Committee and our NHS will be damaged if final decisions lead to crushed hopes based on unrealistic expectations.

- 4) Taking the initiatives in the Departmental Statement (Draft Budget 2008 - 2011) in sequence as presented, we find the following:

Department Draft Budget Statement	Programme for Government	Comment	Notes
15% reduction present suicide rate	(No specific reference)	Is this funded 2008-2011? What specific measures are intended to achieve it?	
Reduce proportion of smokers in population	(No specific reference)	What are current measures? Is funding rolling over to 2008-2011? What % reduction?	
Reduce incidence of binge drinking	(No specific reference)	How is this to be measured? What current funding? Rolled over into 2008-2011 or improved?	
Reduce taking of illegal drugs	(No specific reference)	As above. What cross departmental measures may be required to achieve this? Are they cross-funded?	
Cut no. of children at risk of parental dependency on alcohol or drugs	(No specific reference)	Current no? proposed no? funding of measures required? How do we achieve this?	
Halt rise in obesity	(No specific reference)	Definition? Funded measures to be taken? Does this require cross departmental work with Education on expanding nutritional school meals? Is this funded?	
Increase average life expectancy	(No specific reference)	Current? Forecast? Differences between women and men? Differences between affluent and deprived areas? What will make the difference?	
Reduction in life expectancy disadvantage between overall NI	(Non-specific reference in Preamble only)	Chief Medical Officer recently stated at Health Committee that no improvement in inequalities during 5-year Investment for Health Programme. So are more	

average and most disadvantaged areas		resources being targeted here, or a different approach? What specific DHSSPS and cross departmental initiatives are being funded to address inequalities?	
Support for long-term conditions: unplanned hospital admissions reduced by 50% 2011	Specific reference in Programme for Government	Who is accountable for leading and achieving this? What funding is specifically allocated? Who will monitor outcomes? What consultation has there been with service users?	
Carers: 20% increase in care packages 2011	(No specific reference)	Funded? Basic or complex care packages? If both, what is mix?	
Cut maximum waiting time for specialised wheelchairs to 13 weeks (2011)	(No specific reference)	Funding identified? Current waiting time? (7 months?) Target for 2009? 2010?	
Bamford implementation: community resettlement 10% learning disabled patients, 5% long stay mental health patients	Programme for Government targets community treatment for all by 2013, with no unnecessary hospitalisation	How far do Dept. targets take us towards this goal? What further progress will be needed 2012-2013 to achieve Programme for Government objective? Who will be held accountable for achieving interim targets? What measures (funded?) will be required to achieve them?	
Bamford implementation: 10% reduction in admissions to mental health hospitals			
Bowel cancer mortality	Specific reference in	Where will accountability lie for achieving this? What	

reduction 10% (2011)	Programme for Government	measures are required?	
Cervical cancer 70% reductions – vaccination programme	Specific reference in Programme for Government	<ul style="list-style-type: none"> - what is timeline for improvement through vaccination? - Is current screening approach funded, meeting all needs for coverage, and to an appropriate frequency? 	
Stroke: 10% reduction in mortality and disability (stroke units)	Programme for Government sets <u>2013</u> target of 15% reduction of mortality only, plus 90 min target for thrombolytic assessment	How far are we away now from 90 min assessment standard, and for which areas? what funding streams exist to achieve Departmental and Programme for Government targets?	
Reduce maximum waiting times for arthritis drugs	(No specific reference)	What is current maximum and average? What level of reduction? How?	
Hospital cleanliness funding: 10% MRSA reduction, 20% C. Diff reduction	(No specific reference)	Crucial initiative. What level of increased funding in 2008-2011? Trusts previously tried to use such funding to reduce deficits – how will this be ring-fenced? What measures for non-acute and residential settings?	
Family support and foster care: 2011 10% reduction of children in care	(No specific reference)	Current and proposed levels? Measures funded to achieve target? Risks of non-achievement, and measures to control them?	
2011 5% reduction of	(No specific reference)	How? Which funding streams?	

care leavers living on own			
2011 50% growth in care leavers in education, training and employment	(No specific reference)	From? To? No by 2011 still not in education, training and employment? What resources in wider society can be mobilised to achieve this and more?	
To reduce by 10% children needing to be on child protection register	(No specific reference)	What funded measures will be in place? Are there interim targets for 2009, 2010? What alternatives exist to avoid placing on register?	
Efficiencies from more clinically appropriate management of long term conditions such as diabetes and asthma		How can clinical outcomes be maintained and improved while contributing to the Department's Savings targets? What specific savings anticipated?	
Savings generated as a result of rationalisation of health bodies		Have pre-Trust RPA targets been amended? Up or down? How will savings in non-Trust NHS be achieved given delay in identifying final structures?	
Savings from regional procurement of social care		Trusts currently do this on behalf of HSSB's; how can clinical autonomy for individual care decisions be protected? How will appropriate practice and labour standards be maintained? Will savings jeopardise in-house services or small providers?	

**UNISON (second) BRIEFING NOTE: Assembly
Health Services Committee**

21 November 2007

Draft Budget issues

1. In our previous briefing, we alerted Members to the difficulties of reconciling the Departmental Budget Statement with the Programme for Government. We also highlighted the public interest issues for effective consultation in ensuring there is understanding of which service development initiatives can be funded.

2. There are further – and acute – difficulties of reconciliation between the Departmental Bids presented to your last Committee meeting, and the aspirations of the Departmental Budget Statement. For example:

- a) 15% reduction in present suicide rate (Budget Statement). Is this wholly provided for in the Bid for Public Health Improvement, which also includes obesity, smoking, drugs, alcohol, and sexual health?
- b) Do the Bids individually or collectively contain a realistic strategy to meet the Departmental Statement objective of increasing average life expectancy, and reducing life expectancy disadvantages? How?
- c) Does the Long-Term Conditions Bid ensure that the Departmental and Programme for Government target of 50% reduction in unplanned hospital admissions by 2011 can be achieved?
- d) There needs to be reconciliation of the 2013 Bamford Target in the Programme for Government; and the two Bamford Bids. This is crucial to meeting the aspirations of the Mental Health community.
- e) The 'Quality and Safety' Bid was quoted by civil servants as key to issues such as MRSA. Does it contain the extra resources for cleaning indicated in the Departmental Statement?
- f) There is no reference in the Departmental Statement or the Programme for Government of the Bids for:
 - Cardiovascular Health and Well Being
 - Access to Acute Services
 - Free Personal Care
 - Enhanced Cancer Services; survival rates
 - Free Prescriptions for all
 - Elective Core Access: max 47 weeks to max 39 weeks
 - Universal Free Eye Examinations
 - Fire Service: personnel and training

- g) Crucially we do not have a Health inequalities strategy which demonstrates how targets and Bids can be integrated to make the difference and improvements needed.
- h) There needs to be detailed examination of whether the Service Development totals of:

2008-09	101,000m	(16m available)
2009-10	181,000m	(32m available)
2010-11	302,000m	(97m available)

fully reflect the costs of all commitments in the Programme for Government, the Departmental Statement, and the list of Bids.

3. Members will obviously be concerned at the gap between funds available for service development and the likely required totals. The gaps are such that 'prioritisation', as indicated by Civil Servants, will leave essential issues unfunded, with explicit and damaging consequences for our health.

4. Why do these gaps arise? Firstly, this is indeed 'a Budget for the Economy rather than Health'. This is a false dichotomy. Ill-health reduces economic performance, e.g. the evidence that mental illness reduces local economic output by 3-4%. So greater investment in Health is a strategic measure for improving economic performance. The language of priorities should require the Executive to address Health funding gaps from within the overall Departmental totals, not just the Health baseline.

5. Para.4 of the Departmental Note circulated at your meeting of 15/11/07 includes the crucial indication of a current funding gap of £300m, rising to £600m over 2008-11 as a result of the Comprehensive Spending Review. The origins of this gap lie in the actions of Direct Rule Ministers and the UK Treasury following the suspension of the last Executive.

6. The previous Executive commissioned a series of Needs and Effectiveness Reviews, including one for Health. Direct Rule Ministers chose not to publish these. The Review for Health identified a growth path of 13% to achieve UK and European parity in Health expenditure.

7. The Appleby report – to which frequent reference was made at your meeting – reduced this to a growth path for 7%. This was on the basis of a 'how do I feel about my health' mailshot with a low response, setting aside all other evidence. This has clearly damaged the necessary planned growth in Health expenditure between this Executive and its predecessor – and created the 'gap' in para. 5 above, and the consequent gap between service development need and funding.

8. That civil servants and DFP have now re-confirmed the growth path at 14/15% is of little consolation or use. It has not been reflected in recent budgets, and the Comprehensive Spending Review totals frustrate its use for 2008-11. Direct Rule wasted a key opportunity for Health improvement through bad intentions supported by statistical chicanery, with the collusion of

senior civil servants in DFP and DHSSPS. The only remedy is to reprioritise Health within the overall devolved Budget.

9. Frequent reference was made at your meeting to the Appleby Report claimed 10% productivity improvement equating to cash releasing of £400m to fund improvements. The Appleby report contains widespread inaccuracies, and our summary and analysis is attached to this Briefing.

10. What Appleby specifically alleged was that there is '10% lower employee productivity than in England'. He indicated that geography (rurality), deprivation, and poor Information Technology lay at the root of this. He did not quantify the impact of this, or how these factors could be changed to raise productivity.

11. Appleby was seeking to justify an increase in capacity. Cash releasing £400m would reduce capacity for current treatments and their growth to meet needs. If these spurious savings were used to fund service developments, current levels of treatment outside the Bids would not be able to grow to meet the already high level of unmet need.

Trust salaries and redundancies: 1700 jobs / £53m savings

Members sought information on 15/11/07 over the cost of releasing senior posts through the retirement of postholders. Some indication of this can be gained from published information in Trust Annual Reports. For example, the 2007 Report of the Belfast Trust indicates the following:

a) North and West Trust

Chief Executive: R G Black

Salary 2005-06 (incl PRP) £115-120k

Salary 2006-07 (incl PRP) £135-140k (15-20% increase)

Early Retirement / Voluntary Redundancy £250-255k

Pension value at age 60: £50-55k

Lump sum at age 60: £160-165k

b) Greenpark Trust

Chief Executive: H Boyd

Salary 2005-06: consent to disclosure withheld by postholder

Salary 2006-07: £90-95k

Early retirement / voluntary redundancy £170-175k

Pension value at age 60: £40-45k

Lump sum at age 60: £130-135k

APPLEBY REPORT

Extract: UNISON submission on “Health” section of Draft Priorities and Budget 2006 – 2008 - December 2005

- The inadequate 7% increase in the health service budget clearly arises from the Appleby Review (Appleby) which itself has not been a matter of public consultation. As there was no other opportunity for public consultation we set out some of our concerns here.
- We have fundamental concerns that the Appleby was designed to address Treasury and DFP concerns on the financial implications of the Needs and Effectiveness Evaluation (NEE) carried out under the Executive, though subsequently suppressed. The NEE recommended a 13% increase on current budget. The Appleby report is being used as a mechanism to substitute a lower growth path to the NEE evaluation. It has already moved the DHSSPS from a holistic vision of delivery (c.f. Hayes) to the English marketised model announced in the Review of Public Administration.
- The Appleby report is presented in a Wanless-type format, and whilst some of the findings are useful and confirm observations already made by UNISON and others (for example, the need for monitoring outcomes for disease/service groups and his conclusion that when ever the desirable growth path falls, a funding mechanism outside Barnett will be needed), it clearly had a restricted remit.
- There is no explicit equalities framework within the Wanless/Appleby model of analysis. Equality considerations lack a place within the review methodology, and therefore feature as an add-on.
- Generally, Appleby rejects international benchmarking because of the absence of a ‘strong local revenue base’. This is a fiscal argument, not a needs and delivery one. The main exception to this is the use of OECD models for delivery structures.
- The analysis does not use evidence of health care syndromes and need in post-conflict societies
- The NEE analysis is 13-16% additional resources. Appleby’s use of the EQ-5D self-reported health model claims a 4% uplift is required. Other needs models which include analysis of patterns of diversity and socio-economic/educational inequality, however show that a required uplift of 11-13% is required.
- The reasoning by which Appleby gets to 7% is highly obscure in the text, and needs clarification. It is a judgement, not a scientific conclusion. He

admits that this is provisional in the absence of a UK needs allocation model

- Appleby argues for lower pay for NI health workers. This argument is ill-founded and, if implemented, would further compound inequality. He incorrectly states that the NI Cost of Living is 5% lower than England. According to an Office of National Statistics report on relative prices (February 2005) the NI Cost of Living in Northern Ireland is 4.2% below the UK average, using national weights. In addition, there is a differential impact, which favours higher earners who may benefit from mortgage interest rate payments, depreciation, and Council Tax aggregation. For the lower paid (for example the majority of health service staff) the ONS analysis - excluding mortgage interest rate payments, depreciation, and Council Tax aggregation - shows Northern Ireland prices as 0.9% above the UK average.
- Despite Appleby indicating that (i) mortality rates for under 75's are 47% higher in 'deprived' wards, (ii) that such 'deprived' wards also have 41% higher hospital admission rates, and (iii) that the worst 20% of wards for mortality are 55% Catholic, Appleby formulates a personalised model around ill health that focuses on smoking, obesity, lifestyle as personal choices and not the product of institutional health settings. This makes no use of the accepted 'health inequalities' approach to health (e.g. the Richard Wilkinson) that makes causal links between existing patterns of socio-economic inequality and 'unhealthy' personal health practices such as these. Significant empirical evidence indicates that the more unequal societies are the lower the health standards and the higher the health inequalities.

The 2003 Government-funded report Bare Necessities (Hillyard et al) indicates that:

- Northern Ireland is one of the most unequal societies in the developed world.”
- “Inequality in Northern Ireland is increasing.”
- Those with disabilities “are nearly twice as likely to be in poverty as non-disabled.
- The youngest group of households are twice as likely to be in poverty compared with the oldest.
- Women are more likely to be poor than men.
- The level of poverty is 1.4 times higher in households where the respondent is Catholic compared to households where the respondent is Protestant.
- Many people however will think the most significant finding is that well over a third (37.4%) of our society's children are being brought up in poverty”.

Nowhere does Appleby consider the impact of his proposals on existing and future levels on health inequality.

- Appleby excludes renal dialysis from activity comparisons. But it is still substantial activity and uses people and funds for delivery.

- Appleby is unable to explain high usage of A & E – apart from claiming that attendances are 31% higher in Northern Ireland than in England, that this was “likely inappropriate use”. This is factually incorrect. The gap was 16% in 2003/4, and has closed again in 2004/5 according to data from the Northern Ireland Annual Abstract of Statistics 2004, and the English Chief Executive’s Report to the NHS (2005). The current gap most likely arises from comparative deprivation levels, and the geographical accessibility of small A & E Departments in Northern Ireland.
- In respect of the private sector it is clear that there is major under recovery of private medical treatment costs in NI. This is an issue UNISON has been highlighting for 20 years as a drain on the NHS. In addition, Appleby has clear reservations on VFM but stops short of concluding that there is not the ‘space’ for sustained private provision in addition to NHS provision.
- Appleby misses the opportunity to make recommendations on enhancing cross-border co-operation, despite the work done through CAWT and the North South Health Services Partnership, which could produce economies of scale and significant improvement in quality service delivery.
- With regard to new GP contracts the budget assumed 75% compliance with new targets. Payment is however on a 95% basis. Appleby strongly implies we are not getting 95% deliveries of targets in the new contract. This is substantial and may be an issue of DHSSPS mal-administration.
- The draft priorities and Budget proposes, in Chapter 5, major resource releasing targets on procurement with particular emphasis on drugs and other pharmaceutical products. In the Appleby report the conclusion on the Ministerial Taskforce misses the point that major savings are already assumed in budgets. In addition, transparency is crucial. Substitution by generics is, in the main, an acceptable proposal. However, restriction or deletion without a clear evidence base is not.
- In 1995, 50% care packages were in a domiciliary setting. In 2003 the figure is 38%. This contradicts best practice. There has been a small increases in number of domiciliary packages but major increases in residential packages. The reason is disturbingly simple. Benefits can be clawed back on residential care, but not on (free) domiciliary services. This is a scandal. Homefirst Trust is identified by Appleby as the major offender. The current budget proposals do nothing to address this increasingly important issue. Appleby runs an argument that better pay and conditions in the public sector rule out private providers. This is nonsense. He could have looked at market share which currently stands at 50%+ private domiciliary providers. His argument fails to stand up.
- In the crucial issue of Mental Health, Appleby accepts the 2004 Mental Health review conclusion that there is higher need in NI need due to deprivation and conflict. He also accepts that services are way behind in community settings, and suffer from lack of structure and leadership.

However, he fails to bring this into the 13% / 7% debate. The current priorities propose the lower allocation which will not meet need.

- Appleby, without any clear evidence base, doubts and debates the integration of Health & Social care in NI but fails to mention the trend to integration in England.
- On waiting times the report rather shockingly reverts to anecdotes and not analysis. Appleby has no clear prescription for sorting out waits other than structural reform. There is a range of operational research techniques that work and need to be reflected in the priorities. For example, 60% of plastic Surgery patients and 40% of Neuro Surgery patients are currently waiting over two years for their first appointment. This can be dealt with by targeted initiatives linked to funding. Structural reform is of marginal relevance here.
- On delayed discharge of patients (where currently 60%+ are more than a month, 20% are over three months and 6% are over six months) Appleby is correct in saying that the system has failed in handling waiting times, but he fails to take account of his own analysis that more funding is needed. Again, the strategies would work, and do not require structural reform.
- The Wanless report (p. 143) states that 'The U.K. as a whole has substantially fewer doctors and nurses than many other western industrialised countries'. Appleby then proceeds to show conclusions on 'fewer in England'. This misses the point and appears to downgrade the 'Hayes' projections for doctors and nurses.
- Appleby quotes Admin & Clerical staffing differences without identifying if acknowledged differences in definition NI/UK affect the analysis here. UNISON believes that the distinction was not made and that proposals to reduce numbers will create key front-line delivery problems.
- Appleby stated that there was '10% lower employee productivity than England'. He acknowledged geography, deprivation, and poor ICT as causes, but shows no conclusions. As a consequence we get front page headline figures and Ministerial comments that the NI health service is 'rubbish'. This is a myth which does a great disservice to the dedicated workers we represent. It must be put right and not used as a fallacy on which the budget is built.
- Appleby wants to formally join the pay bodies to implement lower pay. However, it is clear there will be no lower local pay outside London for the foreseeable future. In saying there is plenty of 'supply' he forgets the forthcoming USA recruitment drives as they expand recruitment.
- Appleby clearly fails to understand that Agenda for Change cannot be cherry picked. We therefore expect to see rejection by Government of his proposals for lower pay for NI. However we are extremely disturbed to see

that the draft priorities and budget document states that Ministers have accepted 'all' Appleby proposals.

- Appleby retains the purchaser/provider split and provider competition which in turn has resulted in a missed opportunity for the Review of Public Administration. The targets and regulation he proposes are correctly proposed but could have been delivered under the Hayes model.

**UNISON (final) briefing note: Assembly Health Services Committee,
Budget 2008-2011**

11 December 2007

- 1) We have previously described the lack of fit between proposals in the draft Programme for Government; the Departmental Budget Statement; and the Departmental Bids.
- 2) We have identified reasons for the Health 'deficit'. Recent 'politics' over this have not been helpful, and it is crucial that the Executive collectively move beyond this to a mature consideration of genuine health need and impact.
- 3) Committee members will by now be aware of UNISON's request to the Speaker to clarify procedures for closed discussion after last week's Committee closed session on the Health Budget.
- 4) We have taken careful note of a Departmental Briefing to Trade Unions, and response to UNISON questions.

UNISON core findings and updates

- 5) The sequence of (mis) calculations which has led to the current crisis can now be confirmed as follows:
 - (a) the Departmental NEEDS study during the last period of devolution demonstrated the need for a growth path of 17% for the 'Health' element of the Budget
 - (b) for reasons that remain unclear, Appleby misdescribed this as 13% in his report.
 - (c) Appleby's recommendation of 7% was used to deflate the growth in 'Health' expenditure in recent years (confirmed to UNISON by DHSSPS civil servants). These were the years of plenty: we now face the years of scarcity under the CSR.
 - (d) The Dept has now recalculated the Appleby figure of 7% as 10%. There is no visible reconciliation between this new figure and the original NEEDS 17% model. Publication of such a reconciliation, and of the long suppressed NEEDS report, should be an urgent priority. So should the accountability of DFP and DHSSPS Direct Rule ministers and civil servants for this outcome.
 - (e) Crucially, the Department has now stated that the deficit on provision for Social Care with funding in England is now a

terrifying 36% (sic). No such analysis has been published in recent years, though the facts must have been known.

On a weighted average basis, we therefore have the Departmental estimate of a 14-15% funding deficit, and the consequent initial £300m shortfall plus further £300m CSR shortfall.

- 6) The consequent gap on infrastructure is now clear. Acute schemes for Ulster B; Mater; Craigavon; Antrim Area; and Royal Women and Children's are now no longer in prospect until 2012 at the earliest. Other schemes such as Daisy Hill have receded into an indefinite future.
- 7) The Department is currently projecting £350m capital investment on 'community' health infrastructure (PCCI). The assumption is that this is 'off balance sheet' if delivered through PFI. The whole trend of international and UK accounting conventions is against this assumption. Finance and Personnel Committee were informed in the last period of Devolution that Acute Health infrastructure would be off balance sheet though PFI, only for all subsequent Outline Business Cases to confirm on balance sheet status. There are not, and never will be, PFI free lunches for public spending.
- 8) The real focus should be on why SIB sold a pup to politicians; our Health Service; and local and international companies on the prospects for PFI and Health Infrastructure. Only two years ago 10+ Acute schemes plus 40+ community facilities were being launched as the future through PFI. UNISON's warnings on the toxic unaffordability of PFI have now come home to roost, and the false nature of the SIB Prospectus is painfully clear.

Moving forward: key principles

- 9) The Committee in its recommendations to the Executive, and the Executive itself, have to lay aside current politics and division, and focus on service deficits and health need.
- 10) Those responding to the Budget need to support the Committee, Assembly and Executive in moving forward for improvement.
- 11) Within the confines of CSR, it is not realistic that the £600m deficit can be addressed with immediate effect from 2008. What matters is that the hope for improvement is maintained through concrete measures and funding. The DHSSPS budget has to be strengthened by redefining Executive priorities.
- 12) There is no distinction between the economy and Health. Health improvement is central to economic success and greater economic output and outcomes.
- 13) The hawked-about 'Appleby's 10% productivity means £400m can be found' is a false trail as demonstrated in our earlier briefings. The Executive would be justified in motivating and challenging the system to raise performance and outcomes through partnership working involving all

with a commitment to Health and Care, including employees at all levels. Those delivering need to work collectively for improvement instead of – understandably in the current situation – falling back into the politics of pessimism.

- 14) There has to be a plan and approach that makes a difference to Health Inequalities – which have not moved or changed in the last 5 years (comment of Chief Medical Officer to Health Services Committee). Any increased funding or new/enhanced activity in the DHSSPS budget should be tested against this.

UNISON proposals

- 15) The focus should be on the Service Development totals and gaps:

2008-09	£101m	(£16m available)
2009-10	£181m	(£32m available)
2010-11	£302m	(£97m available)

- 16) All additional funds allocated by the Executive to Service Development should be subject to rigorous ongoing scrutiny for impact and effectiveness by the Health Services Committee in dialogue with key stakeholders, including the BMA and UNISON, which has the majority of seats on Departmental and Trust Staff Sides.

- 17) This scrutiny must include planned and actual impact on inequalities.

- 18) Options for bridging this specific set of funding gaps in 2008-09 include:

- a) marginal allocation from planned reserves (maximum feasible £15m)
- b) setting additional income generation targets for all Departments and NDPB's, and allocating income over and above current levels as a 'Health Dividend' – realistically, £5m.
- c) while the gearing between Domestic Rates and Executive income is poor, consider varying the Executive decision on freezing Domestic Rates 2008-11 to yield a £10m input to Health in 2008-09. A further £5m should be factored in from marginal increases in Non-Domestic Rates given current high levels of economic activity and low unemployment.
- d) Reduce planned over-commitment 2008-09 from £100m to £90m (£10m health dividend gain)
- e) The following contributions from other Departmental revenue expenditure plans:

DARD	£2m	
DECAL	£1m	
DEL	£5m	
DETI	£5m	
DE	£4m	
OFM/DFM	<u>£2m</u>	
	£19m	(total to date £64m)

- f) The revenue consequences of phasing back capital expenditure in DARD and Regional Development. The Roads capital budget is projected to rise from £195m (2008) to £234m (2011) – with no measures to address carbon footprint, or evidence and cost Benefit models of economic or social gain. The Revenue consequences of phasing back investment in this area by £100m over 2008-11 should be identified, and redirected to Health.
- 19) This is a preliminary analysis of opportunities based on limited current information. It demonstrates the feasibility of addressing the Service Development deficit as an Executive process. Our recommendation is that the Committee focus on this priority in their analysis and report.

Equality

- 20) We have requested the release of the 'High Level Equality Impact Statements' referred to in the Departmental Budget Statement – so far without success. The Committee should require access for evaluation, and demand the publication of this material, which is an essential element of the current consultation process so far denied to the Committee and those party to the wider consultation.