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How The Finance Works

The Future

of Glasgow's

Hospital Services

Let's Plan It

Together!

GREATER GLASGOW
HEALTH BOARD

in partnership with
the NHS Trusts
in Glasgow

How The Finance Works

The NHS financial system is complicated! Not just because accountancy and its "rules" are complicated (which they are!) but because the local NHS provides so many hundreds of services, often involving GPs, hospitals, different departments and lots of different materials for individual patients. Tracking expenditure in the detail that matches each patient's experience would itself cost a lot of money.

This leaflet tries to explain the system in reasonably simple language and help you understand the financial impact of our proposals.

Firstly there is the money needed to run services on a day-to-day basis. The cost of staff salaries, medicines, dressings, most equipment, electricity, maintenance, food, cleaning and so on. This is usually known in the jargon as "revenue cost" (or, sometimes "running costs"). This money is provided by the Scottish Executive under a formula which, broadly, reflects the size and characteristics (age profile; amount of illness etc) of the population served by the Health Board.

The Health Board is required by law to spend no more than its "cash limit" (its allocation for the year). It decides how much money goes to the various NHS Trusts which provide different services for the population. Each NHS Trust has a number of financial duties which are defined in law. Basically a Trust must remain financially solvent and meet the financial targets set by the Scottish Executive.

Although the Health Board has a set cash limit for each year, it is also given an indication of what its future allocations are likely to be for the two years beyond the current year.

The UK government and the Scottish Executive have both said that they expect the amount of revenue available for the NHS to increase significantly over the next few years. Obviously a first charge on any increase is the cost of inflation (higher pay for staff and increased costs for medicines, materials and services) but the government and Executive aim to see that there would still be a lot of new money left to significantly improve services over and above the impact of inflation.

Greater Glasgow Health Board (GGHB) expects to get rather more "new money" than most other Health Boards over the next few years. This is because the old formula used for allocating money to Health Boards did not give enough recognition to the fact that Greater Glasgow's population has high levels of social and economic deprivation and this in turn leads to poor health. A new formula is being introduced. At the time of writing GGHB receives around £14 million less per year than it would if the new formula was fully in operation - but with the big increase in overall NHS funding over the next few years this figure will become much larger.

We say more later on the competing demands for "new money".

The second type of money is known as "capital" - used to build new hospitals, clinics and extensions, major new equipment (like x-ray machines) and major repairs and replacements (roofs, boilers and so on). Sometimes this money comes direct from the Scottish Executive - the NHS in Scotland has a capital programme of between £165 million and £200 million to spend each year. This has to be spread over all the NHS Trusts in Scotland and so the "queue" waiting for money for very large capital schemes can be quite long.

The Public Private Partnership (PPP) is a way that government has of trying to secure more capital investment in public services over and above what can be met from the main capital programme. It is a highly complicated process with large procedure manuals describing its principles, rules and accounting policies. In a nutshell it involves the private sector putting up the money to pay for a new building and its equipment and the NHS then pays the money back, with interest, over the next 25 to 30 years. The private partners may also provide some of the maintenance, cleaning and catering services in the new hospital. The principle is that the

private sector is likely to design and build the project and run its support services more efficiently than NHS managers would. In the last couple of years better safeguards have been agreed for any NHS staff transferring to a private sector employer as part of a PPP scheme.

Whether capital investment comes direct from the Scottish Executive or through a PPP arrangement, it has to be paid for - just like a mortgage on a private house. Hospitals that have been built with money from a government capital programme have an independent valuation placed on them and the Trust has to pay the Scottish Executive a "capital charge" each year (an interest payment on the capital cost). This capital charge becomes one part of the annual running cost of the hospital - along with staff, materials and services - and has to be funded by the Health Board.

If a new hospital is built through PPP the private sector partner levies a charge for capital repayment, interest and any support services they are providing. This has to be paid by the Trust - and therefore by the Health Board.

Old hospitals, because they are old and usually no longer very "fit for purpose", usually have a low valuation and therefore their capital charges are low. A new hospital will have a high valuation and so its capital charges (or PPP charge) will be much higher than an old hospital. This is why there is so much concern about the "affordability" of new hospitals. It's nice to have new buildings but the increased capital charge has to come out of the Health Board's revenue allocation. More money spent on bricks and mortar means less money available to spend on more doctors, nurses, other staff, medicines, and so on.

GGHB spends around £525 million revenue each year on hospital and community health services provided by NHS Trusts in Greater Glasgow. Most of that (around 70%) is spent on staff.

In modernising Glasgow's acute hospital services we need to recognise that several changes in cost will occur:

- modern buildings will have high capital charges or PPP charges.
- the modern buildings will directly replace some old buildings. Knocking them down or closing them will save their capital charges and the cost of running them.
- new patterns of care (more ambulatory care, for example) will probably mean fewer wards to staff.
- but the beds that we do have will probably have patients who are "iller"
- those whose illness or condition makes it impossible for them to be treated as an ambulatory care patient. So the fewer beds we have will need better staffing levels than we have per bed now.
- new buildings will allow services that need to work together to do so more efficiently. Fewer reception areas, less need for long journeys accompanied by porters, less need for the patient to make return visits.

These efficiencies will save some money.

The way these changes work out in detail will be worked out at future stages in planning. First in broad terms at what is called "Outline Business Case" stage and then in great detail when a "Final Business Case" is being prepared.

At this stage we can only describe the financial impacts in broad terms but we are confident that they are sufficiently well thought through to support this present consultation exercise.

How The Finance Works

So how does all this fit together?
First the profile for capital spending in the first half of the plan period:

In the North and East we estimate that early in the decade (by 2002/3) there will be two principal schemes:

- Ambulatory Care Centre at Stobhill £29.5 million
- An extra floor in the new ward block currently built at GRI, to accommodate orthopaedics £ 7.0 million

On the Southside we plan a single contract to deliver three distinct parts of the plan by 2006/7:

- Ambulatory Care Centre at the Victoria Infirmary)
- New surgical unit, medical receiving unit, theatres,) Intensive Care, High Dependency and pharmacy) facilities, some refurbishment of medical facilities -) £170 million all at the Southern General)
- New Children's Hospital, laboratories and) ancillary accommodation)

In West Glasgow the priority is to end split-site in-patient working for medicine and surgery and to make best use of the relatively modern facilities at the Western Infirmary. The key first elements for completion by 2005/6 are:

- Emergency receiving centre, intensive care unit,) minor injuries unit and improved ambulatory care) at Gartnavel)
- Improve facilities at Western Infirmary for Beatson) £31.2 million Oncology Centre and creation of single cardiothoracic) unit for Glasgow)

In the same period we would also see some smaller scale capital schemes that also contribute to the overall plan:

- concentration of in-patient gynaecology at GRI £ 3.5 million
- concentration of in-patient gynaecology at Southern General £ 2.5 million
- more efficient laboratory facilities : North Glasgow £ 2.7 million
- more efficient laboratory facilities : South Glasgow £ 2.5 million
- a new industrial centre (laundry/sterile supplies etc) £ 5.0 million serving all Glasgow hospitals

What would these mean for annual running costs? In our planning for the 5 year forward look for our Health Improvement Programme we are assuming that GGHB will need to spend more on acute hospital services. Work to refine this is still being done. There are two types of increase in cost to cater for:

- firstly the net increase in costs once the new services are fully in operation (mainly their increased capital charges less any savings arising from the greater efficiency of the new pattern of organising services).
- secondly short-run "transitional costs" - managing the costs of change, such as running current services while paying the start-up costs of the new.

We are making provision for these as follows:

	£ million					
	2001/2	2/3	3/4	4/5	5/6	
Net increase in cost						
• GRI maternity, plastic surgery & emergency receiving	1.7					
• Gartnavel: new linear accelerators	1.2					
• Stobhill Ambulatory Care Centre		1.1				
• GRI new in-patient orthopaedics unit			0.3			
• West Glasgow: revenue consequences of new buildings. Cost in year one (savings in year 2)				3.0	(5.0)	
• Victoria Ambulatory Care (incl. rehabilitation beds)				3.0		
• Southern General: net revenue consequences of new buildings				6.0*		
	2.9	1.1	0.3	6.0	1.0	11.3 **

* This figure assumes that the transfer of Yorkhill's services would be revenue cost neutral. However, we would expect that the "mortgage" charge of the new building would be only very slightly higher than the current Yorkhill capital charges and would be more than offset by efficiencies arising from the Yorkhill transferred services being able to share some of the support services/ infrastructure provided on the Southern General site. These will only be identified through careful detailed planning at Outline Business Case stage. It is possible that some savings could be identified which could be ploughed back into improved hospital services for children.

** This figure is the total increase in annual running costs that will have arisen by the end of this first half of the plan period.

	£ million				
	2001/2	2/3	3/4	4/5	5/6
Funding for non-recurrent transition costs also expected to be available each year	2.0	3.0	3.5	3.5	3.5

In the second half of the plan period the profile of capital spending would be:

In the North and East it would depend on the outcome of the current consultation on in-patient services involving the GRI and Stobhill. The issue would be how to modernise in-patient capacity to supplement the 600 modern beds in operation at the GRI from 2003/4 onwards. Capital spending of around £55 million spread from 2007/8 to 2010/11 has been estimated on the presumption that some 400 new beds will need to be built to replace GRI and Stobhill old beds.

On the Southside the final phase of redevelopment of the Southern General Hospital would commence in 2007/8 and be complete by 2010/11 at an estimated capital cost of around £75 million. It would provide new ambulatory care facilities plus around 320 medical beds and diagnostic imaging (mainly x-ray).

In West Glasgow, starting in 2006/7 (complete by 2010/11), the final phase of capital investment would involve moving the Beatson Oncology Centre and the cardiothoracic unit from the Western Infirmary into brand new accommodation. The estimated capital cost would be some £65 million.

How would this second half of the plan effect on running costs?

There has been less work done on this. However, the estimated capital spending in the second half of the programme would be some £195 million. The capital charges for that level of investment would be around £23 million but the new buildings would be replacing old buildings - principally the Western Infirmary (present capital charge is over £4 million), many old buildings at the Southern General and old buildings at either the GRI or Stobhill or both.

The other main influence over the running costs of a hospital is the number of beds. The precise number of beds to be built in the second half of the programme would be reviewed in the middle of the decade. And the replacement of old buildings and dispersed systems of working would also yield some efficiencies and savings that could help to offset the extra cost of the new buildings.

The South Glasgow Trust estimates that the net increased annual cost payable by GGHB following the final phase of the redevelopment of the Southern General would be some £4 million - equivalent to a net 5% "mortgage payment" per year related to spending £75 million on new buildings to replace obsolete old buildings currently with a very low capital charge.

In the case of North Glasgow the equivalent estimate is a £2 million extra cost per year after having spent £120 million in capital. This is a lower increased cost because the greatest scope for efficiencies offered by new buildings comes in the second half of the ten to twelve year programme period. It implies off-setting savings of around £12 million against the capital charge of the new buildings of £14.4 million. At least half of those off-setting savings would come from no longer having to pay capital charges at the Western Infirmary or for old buildings replaced at the GRI and Stobhill.

Clearly further detailed planning work will be undertaken before the capital investment proposals are put forward for formal Business Case approval. However, that detailed work cannot be undertaken until there is an approved broad service plan for Glasgow - which is what this consultation process is about.

How The Finance Works

So, are all these extra revenue costs affordable? We think so. The Health Board has many other demands for extra spending to deal with but during this time period we would expect that the Health Board would be able to find the money and still maintain a good pattern of improvement in services for the mentally ill, primary care, children, and other services aimed at tackling the inequalities in health associated with social and economic deprivation. The Health Board will review its revenue position for the next five year period at its meeting in April, 2000 when the results of the Chancellor's 2000 Budget are finally known. We will publish a revised projection of how money would be spent over the next 5 to 10 years in early May, 2000.

However, the increased recurrent revenue cost of £11.3 million for the first half of the plan up to 2005/6 amounts to approximately 25% of the total money available for NHS service development in Glasgow in the period 2001/2 to 2005/6 which was anticipated prior to the Chancellor's March, 2000 budget. The prospects are now even more favourable to affordability.

There is one final issue and that concerns land sales. The plan means that some existing sites become less fully used - or even unused - once new buildings are in place. There is a legal obligation on the NHS to sell surplus land for the best price it can achieve and the normal rule is that the proceeds of those sales are used to offset the capital cost of new buildings. The sites concerned will be:

- most of the existing Victoria Infirmary site
- the Mansionhouse Unit
- Cowglen hospital
- the Yorkhill site
- the Western Infirmary

The land sales would take effect when replacement accommodation was available and would therefore be mostly later in the mid to late part of the ten to twelve year planning period.

Comments on this issue or any other aspect of the proposals to modernise Glasgow's hospital services should be sent by June 30th, 2000 to

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Leaflet request form

Getting Informed

If you want to read up on any other issue please complete this leaflet request form. Tick the box ✓ next to the leaflets you want, provide your name and address in the space provided and send it to the Freepost address below (no stamp needed).

Acute Services Review
Greater Glasgow Health Board
FREEPOST (GW 707)
Glasgow G3 8BR

- ❑ 1. The Patient's Experience
- ❑ 2. Getting It Right For Patients: What It Means For Organising Services
- ❑ 3. Cancer Services: Specialisation In Action
- ❑ 4. Why Specialisation Matters - And What We Propose To Do To Make Its Benefits More Available
- ❑ 5. Creating More Responsive Accident And Emergency Services
- ❑ 6. Ambulatory Care: What Is It?
- ❑ 7. Minimally Invasive Technologies: Keyhole Surgery And The Like
- ❑ 8. The Overall Planning Challenge For Greater Glasgow - Acute Hospitals In A Wider Context
- ❑ 9. Some Recent Background History
- ❑ 10. Impact Of Regulations On Doctors' Working Hours
- ❑ 11. The Number Of Beds We Propose To Provide
- ❑ 12. Regional Services Provided By Glasgow Hospitals
- ❑ 13. Why Teaching And Research Matters
- ❑ 14. Staffing Matters
- ❑ 15. How The Finance Works
- ❑ 16. Detailed Analysis Of The Options For South Glasgow
- ❑ 17. Maternal And Child Health
- ❑ 18. Better Access For West Glasgow Residents
- ❑ 19. The GRI/Stobhill Partnership
- ❑ 20. Why Centralise Cardiothoracic Surgery?
- ❑ 21. Radiotherapy: Linear Accelerators - A Patient's Guide

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You can also send it by fax on 0141 201 4426.

Alternatively, you can call us on Freephone 0800 85 85 85.

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