000784

THE SCOTTISH OFFICE

National Health Service in Scotland
Management Executive

St. Andrew's House
Edinburgh EH1 3DG

NHS
MEL(1993)112

Dear Colleague

CAPITAL ALLOCATIONS 1994/95 AND PROVISIONAL ALLOCATIONS 1995/96 AND 1996/97

27 August 1993

Addressees:

For action:
General Managers, Health Boards

General Manager, State Hospital

Chief Executives, NHS Trusts

Project Managers of proposed Third Wave Trusts

For information:
General Manager, Common Services Agency

To be copied to Unit General Managers for action

Enquiries to:

Mrs M H Beattie
Strategic Planning and Performance Review Division
NHS Management Executive
Room 274
St Andrew's House
Edinburgh
EH1 3DE

Tel: 031 244 2396
Fax: 031 244 2051

Summary

1. This letter is to remind you that detailed capital plans for 1994/95 to 1996/97 should be submitted to the Management Executive by 30 September 1993 and to provide further information on what those plans should include.

Action

Building Projects, Existing Estate and Equipment

2. MEL(1993)17 described the full capital planning, monitoring and allocations system, and asked Boards and Trusts to submit capital plans twice a year. The first plans, which were due at the end of April, are being used to inform Ministers' decisions on levels of expenditure on hospital building etc in the next 3 years. The second set of plans will be used as a basis for capital allocations to Boards and the capital provision which will be included in Trust EFLs. These plans should reach the Management Executive no later than 30 September 1993.

3. Boards, Trusts and prospective Trusts should complete forms CAPAL A1 to A6, C1 and C2 (all attached to MEL(1993)17). They should include on A1 to A5 all projects (including equipment) but excluding existing estate projects (see paragraph 4 below) with a total cost of £100,000 or more. (Island Boards should include all projects.) A6 should give at b and c the total amounts needed for 1994/95 for, respectively, building projects and equipment, in each case costing less than £100,000. The other sections of the form should be ignored.

4. Information about projects to do with the **existing estate** should be provided on a revised form CAPAL A7 (copy attached). Details of all such projects costing £100,000 or more should be listed separately and **in order of priority**. In the case of projects costing less than £100,000, the total expenditure proposed at each hospital will suffice.

5. Since prospective third wave Trusts are required to submit their own plans, Boards should exclude these prospective Trusts' proposals from their plans. Where projects costing more than £1m were not included in the plans submitted in April, an explanation should be provided of why these projects could not have been foreseen then and the reasons why they are essential to the implementation of Boards' strategies. Trusts should give an explanation of any significant variations from their business plans; this should cover new projects and significant differences in the amount of capital needed.

6. Boards should note in particular the requirements in paragraph 12 of MEL(1993)17, namely that they should indicate whether or not they endorse Trusts' plans, indicate an order of priority amongst the projects for all Trusts for whom they are a major purchaser. Boards should also confirm, for each project which they endorse, that they are aware of the effects on the contract price and are prepared to meet these.

7. Boards, Trusts and prospective Trusts should take particular care to take account of the effects of slippage in the figures they provide for individual projects for 1994/95 to 1996/97. If, between the submission of capital plans and the issue of allocations, it becomes clear that slippage in the present year will increase the level of provision required in future years, the Management Executive should be informed immediately. Boards, Trusts and prospective Trusts are expected to deal from within their own resources with the consequences of any slippage which is not notified to the Management Executive before the end of November.

IS/IS EXPENDITURE PLANS

8. All Boards and Trusts are also asked to submit their 3 year IS/IT capital expenditure plans for the period 1994/95-1996/97 inclusive in the format of Annex C and in accordance with the guidance in Annex D. As in the past the first year's figures (ie those for 1994/95 relating to "priority systems") will be treated as being your bids for a capital allocation from the Computer Development Capital Fund (CDCF) for that year. However I should point out that CDCF funding is in any case only a contribution towards IS/IT costs and is not intended to cover all costs even in respect of "priority systems". While the figures for 1995/96 and 1996/97 will not be treated as bids they are nevertheless important as they will help provide the Management Executive with an indication of likely future demand for funds. This assists us in the preparation of our own bid to Ministers for appropriate funding. It is important that such expenditure plans are realistic and take full account of the capacity of sites to implement such systems and adapt their procedures or processes as necessary.

9. It will be for Boards/Trusts to meet all recurring costs associated with IS/IT although the Systems Implementation Fund (SIF) may provide support to help meet some of the non-recurring costs. Any appropriate IS/IT elements of capital plans for new builds etc should continue to be included in the CAPAL forms.

General

10. Annex A to this letter gives the present definitions of capital expenditure. Annex B gives a number of other useful definitions. In

this circular references to Boards should be taken to include the State Hospital.

11. We would hope that prompt submission of correctly completed plans by 30 September should enable capital allocations to be issued to Boards around the turn of the year. Trusts will be notified of the provision which will be included in their EFLs at the same time. Plans should be sent to the address at the head of this circular, addressed to the following people, who will also be happy to deal with any queries:-

Boards, Trusts and Prospective Trusts in the Following Areas	**ME Contact**
Argyll & Clyde Lanarkshire Ayrshire & Arran Dumfries & Galloway	Mrs F McLaren (031 244 2403)
Greater Glasgow State Hospital	Mr P Harley (031 244 2426)
Lothian Borders Forth Valley	Mrs F Neep (031 244 2395)
Fife Tayside	Ms M McAllan (031 244 2291)
Grampian Highland Orkney Shetland Western Isles	Mr R McClintock (031 244 2064)

12. Other enquiry points:-

General Enquiries	Mrs M Beattie (031 244 2396)
Disposals	Mr A Pinkerton (031 244 2363)
New Definition of Capital	Mr P Colville (031 244 2175)
IS/IT Expenditure	Mr D Cowie (031 244 2366)
Nationally Contracted Services	Ms M Grant (031 244 3580)
External Financing Limits	Mrs S Goldsmith (031 244 2383)
Existing Estate	Mr T Lodge (031 244 2276)
Copies of Forms CAPAL A1-A7 and C1-C2 or of MEL(1993)17	Mrs M Wood (031 244 2393)

Yours sincerely

WILLIAM MOYES
Assistant Secretary

ANNEX A

DEFINITION OF CAPITAL EXPENDITURE

Capital expenditure comprises expenditure, in excess of £5,000 on the following:

1. Acquisition of land and premises, lump sum payment for related rights (including capitalised rents), and payments made under the Land Compensation Act 1973 and associated fees.

2. Individual works schemes (ie buildings, external works, elements of buildings including engineering services and plant) for the initial provision, demolition, extension, improvement, adaptation (including upgrading), renewal or replacement.

3. Expenditure on improvements to the NHS Estate as specified in 2. above which is appropriate to the Special Allocation.

4. Pay and related expenses of directly or indirectly employed persons who are directly engaged on expenditure attributable to the acquisition of specific fixed assets or capital schemes eg Project Managers/Clerks of Works etc but not including staff employed to administer the capital expenditure programme of the Board. These latter costs should be charged to revenue.

5. Individual items of equipment as defined for the purposes of the capital charging system. The term equipment covers all categories, eg medical, dental, computer, printing or other equipment (technical or non-technical) not associated with works schemes referred to in 2. above).
This also includes all vehicles.

All expenditure as defined in points 1. - 5. above which results in improvement to original specifications and standards, should be capitalised and subject to capital charges irrespective of the source of funds.

For expenditure on buildings, the total expenditure should be compared to the de minimis limit rather than the expenditure on individual sub-elements of the building. Thus expenditure of £6,000 should be capitalised even if it is split evenly between internal walls (element 2G) and internal doors (element 2H).

NOTES

a. Where necessary, at the end of a large project it may be appropriate to request the District Valuer to estimate the proportion of cost to be capitalised and the consequent adjustment to remaining lives. (A large project might have a cost over say £0.5m or £1m).

b. Staff costs which fall within the definition at 4. above should be treated as part of the costs of the particular capital schemes involved (with apportionment where appropriate).

c. The following types of expenditure should be treated as revenue in nature:

i) Repairs and maintenance to capital assets in order to maintain effective working order

ii) Backlog maintenance insofar as the expenditure is incurred to reinstate assets as opposed to improving assets above their original specification

iii) Moving walls, doors, etc where there is no significant increase in the floor area or specifications

All expenditure in i) to iii) above should be treated as revenue irrespective of the source of funds.

d. Where an item of equipment has reached the end of its life it is disposed of and a replacement asset purchased.

It therefore follows that where a specific sub-element of a building reaches the end of its life and is replaced, the old asset should be treated in the accounts as being disposed of (probably for nil proceeds) with the recent expenditure being capitalised and given a full remaining life.

This is most likely to be appropriate for engineering plant items such as:

Electrical wiring and installations
Lifts and other mechanical items
Boilers and heat sources

This could also apply to equipment where the remaining life has been reduced or eliminated for Health and Safety reasons, eg, Legionella. Any loss on disposal of a building element would be charged to Capital Reserve and would therefore not affect contract prices.

CAPITALISATION OF INITIAL REVENUE EQUIPMENT COSTS

With the increase in the de minimis value of assets from £1,000 to £5,000, a new hospital would face an exceptional write off in its first year of trading as it would be unable to capitalise a large number of low value items of expenditure. Costs included in contracts and ECR tariffs would not reflect the true and recurring cost of delivering the service.

Previous guidance meant that items below the de minimis value were treated as stock rather than being capitalised. Given the increase in the de minimis value, and the need for NHS Trusts to earn a return on their net assets, including stock, it is appropriate to capitalise such expenditure as a "collective" asset. Health Boards and NHS Trusts therefore have the option to capitalise initial revenue equipment costs with a standard life of 10 years, or to write it off immediately.

ANNEX B

CAPITAL PLANS, ALLOCATIONS AND RELATED MONITORING

Definitions

1. 'Total cost' means works cost, professional fees, equipment and, where applicable, allowances for fluctuations and VAT. Estimates of capital expenditure should be in cash terms rather than on an income/ expenditure basis.

For projects not yet legally committed or not expected to be legally committed (see paragraph 2 below) no allowance should be made for inflation. Estimates should be of total cost but at the level of pricing prevailing when the plan is submitted.

2. 'Legally committed expenditure' means expenditure on projects for which a building contract has actually been let or expenditure on design fees where consultant firms have been formally instructed. In the latter case, where the building contract has not yet been let, the fee expenditure is legally committed, but the remainder is not.

3. 'Existing estate' comprises those assets of the NHS estate that physically exist and in which a Trust/Unit considers it appropriate to invest capital to secure compliance with statutory requirements, improvements in physical condition, improvements in energy efficiency; and the replacement of major elements of a building which have reached the end of their useful life (eg engineering plants).

HEALTH BOARD/TRUST

CAPITAL PLANS 1993 EXISTING ESTATE

PROJECTS OVER £0.1m LEGALLY COMMITTED AS AT 30.9.93

(£'000)

Project (In Order of Priority)	1994/95				1995/96				1996/97			
	SR	EE	PC	REV -/+	SR	EE	PC	REV -/+	SR	EE	PC	REV -/+
1.												
2.												
3.												
4.												
5.												

PROJECTS UNDER £0.1m LEGALLY COMMITTED AS AT 30.9.93 (GLOBAL FIGURES ONLY BY HOSPITAL)

1.
2.
3.

SR = Statutory Requirement
EE = Energy Efficiency
PC = Physical Condition
REV = Estimated Annual Revenue Saving (-)/Increase (+) - where applicable

K1301303.083

HEALTH BOARD/TRUST

CAPITAL PLANS 1993 EXISTING ESTATE

PROJECTS OVER £0.1m LIKELY TO BECOME LEGALLY COMMITTED BY 31.3.94(1)

Project (In Order of Priority)	1994/95				1995/96				1996/97				(£'000)
	SR	EE	PC	REV -/+	SR	EE	PC	REV -/+	SR	EE	PC	REV -/+	
1.													
2.													
3.													
4.													
5.													

PROJECTS UNDER £0.1M LIKELY TO BECOME LEGALLY COMMITTED BY 31.3.94(1) (GLOBAL FIGURES ONLY BY HOSPITAL)

1.
2.
3.

(1) = Exclude projects listed on Page 1
SR = Statutory Requirement
EE = Energy Efficiency
PC = Physical Condition
REV = Estimated Annual Revenue Saving (-)/Increase (+) - where applicable

HEALTH BOARD/TRUST

CAPITAL PLANS 1993 EXISTING ESTATE

OTHER PROJECTS OVER £0.1m

(£'000)

Project (In Order of Priority)	1994/95				1995/96				1996/97			
	SR	EE	PC	REV -/+	SR	EE	PC	REV -/+	SR	EE	PC	REV -/+
1.												
2.												
3.												
4.												
5.												

OTHER PROJECTS UNDER £0.1m (GLOBAL FIGURES ONLY BY HOSPITAL)

1.
2.
3.

SR = Statutory Requirement
EE = Energy Efficiency
PC = Physical Condition
REV = Estimated Annual Revenue Saving (-)/Increase (+) - where applicable

K1301303.083

ANNEX C

..... HEALTH BOARD/NHS TRUST

IS/IT EXPENDITURE PLANS

1994-95, 1995-96 and 1996-97

M1302023.073

.....HEALTH BOARD/NHS TRUST

IS/IT EXPENDITURE PLANS 1994-95

(a)	(b)	(c)	(d) Estimated Expenditure 1994-95 (£000's)		(e) Resource Availability		(f) Procurement Arrangements		(g)
System	Type (if known)	Site Served	Capital £	Revenue £	Staff	Revenue	Method	Support	Order of Priority
PART A PRIORITY SYSTEMS									
1. *Communications (including Networks, Structured Cabling, Electronic Mail and EDI)									
2. Patient Administration Systems									
3. Radiology Systems									
4. Laboratories									
5. Ward Nursing									
6. Theatre Management									
7. Community and Priority Services									
8. NHS Management Information System									
9. Clinical information and support systems (including coding and audit)									

*** excluding telecommunications (See Part B)**

.....HEALTH BOARD/NHS TRUST

IS/IT EXPENDITURE PLANS 1994-95

(a) System	(b) Type (if known)	(c) Site Served	(d) Estimated Expenditure 1994-95 (£000's) Capital £	Revenue £	(e) Resource Availability Staff	Revenue	(f) Procurement Arrangements Method	Support	(g) Order of Priority
PART B									
Telecommunication Investments									
Other Systems									
TOTALS									

.....HEALTH BOARD/NHS TRUST

IS/IT EXPENDITURE PLANS 1994-95

(a) System	(b) Type (if known)	(c) Site Served	(d) Estimated Expenditure 1994-95 (£000's) Capital £	Revenue £	(e) Resource Availability Staff	Revenue	(f) Procurement Arrangements Method	Support	(g) Order of Priority
PART C									
Computer Consortia									
TOTALS									

.....HEALTH BOARD/NHS TRUST

PROPOSED IS/IT EXPENDITURE PLANS 1995-96 AND 1996-97

System	Type (if known)	Site Served	Estimated Expenditure 1995-96 (£000's) Capital Only £	Estimated Expenditure 1996-97 (£000's) Capital Only £	Order of Priority
PART A **PRIORITY SYSTEMS**					
1. *Communications (including Networks, Structured Cabling, Electronic Mail and EDI)					
2. Patient Administration Systems					
3. Radiology Systems					
4. Laboratories					
5. Ward Nursing					
6. Theatre Management					
7. Community and Priority Services					
8. NHS Management Information System					
9. Clinical information and support systems (including coding and audit)					

* **excluding telecommunications (See Part B)**

.....HEALTH BOARD/NHS TRUST

PROPOSED IS/IT EXPENDITURE PLANS 1995-96 AND 1996-97

System	Type (if known)	Site Served	Estimated Expenditure 1995-96 (£000's) Capital Only £	Estimated Expenditure 1996-97 (£000's) Capital Only £	Order of Priority
PART A **PRIORITY SYSTEMS (Cont'd)**					
10. Pay, Personnel and Manpower Planning Systems					
11. Finance and Contract Management Systems					
12. Supplies and Pharmacy Systems (including Supplies EDI and Ward Cardex)					
13. Central Index and CHI Sub-Systems/CI Satellites					
14. Clinical and Resource Information Systems (CRIS)					
15. IT Security/Contingency Planning					
TOTALS					

.....HEALTH BOARD/NHS TRUST

PROPOSED IS/IT EXPENDITURE PLANS 1995-96 AND 1996-97

System	Type (if known)	Site Served	Estimated Expenditure 1995-96 (£000's) Capital Only £	Estimated Expenditure 1996-97 (£000's) Capital Only £	Order of Priority
PART B					
Telecommunications					
Other Systems					
TOTALS					

.....HEALTH BOARD/NHS TRUST

PROPOSED IS/IT EXPENDITURE PLANS 1995-96 AND 1996-97

System	Type (if known)	Site Served	Estimated Expenditure 1995-96 (£000's) Capital Only £	Estimated Expenditure 1996-97 (£000's) Capital Only £	Order of Priority
PART C					
Computer Consortia					
TOTAL					

ANNEX D

GUIDANCE NOTES ON THE PREPARATION OF IS/IT CAPITAL EXPENDITURE PLANS

1. Each 3 year IS/IT Expenditure Plan should follow logically from and tie in with each Board's or NHS Trust's local Information Strategy and reflect national and local priorities. The plan should take full account of the organisation's ability to manage and/or implement the various systems together and also the likely availability of resources. Plans must be submitted in line with the enclosed proforma (Annex C) and completed in accordance with this guidance.

2. Part A of the proforma relates to the introduction or replacement of the "priority" systems as detailed in paragraph 9 below. To help the Management Executive ensure consistency in the analysis of these plans the headings and list of systems should not be changed in any way.

3. In the case of major systems, their introduction will need to be phased and in some cases time will be required to complete procurements. The proposed expenditure figures should therefore indicate the actual year in which payment is likely to be made and not necessarily the year when the procurement or implementation commences.

4. Part B should include details of any plans for investing in telecommunications (eg, telephone networks etc) but must exclude any proposals for IT communications infrastructure as requested in Part A. While the Computer Development Capital Fund (CDCF) will not be providing financial assistance for such investments, it is important that Health Systems Division has a full picture of what is proposed in this area.

5. This section of the plan should also include any plans for "other" (ie, non-priority) systems which the Board/Trust propose to implement and for which CDCF support is not normally available.

6. Part C of the proforma should be completed by the "host" body of the various Computer Consortia. It should include details of any specific equipment required (eg, mainframe upgrades etc) and the reason for the proposed investment.

7. In the case of Parts A, B and C considerable detail will be required for 1994/95 as explained in the following notes. However, the information requested for the following 2 years is more limited.

8. The detail required for Year 1, by column number, is as shown below:-

(a) System

- For Part A the list of systems should be as shown and not changed.

- For Parts B and C the system description (eg, Estates Management) should be added as appropriate.

(b) Type

- Where the type or make of system or hardware is known, it should be shown (eg, COMPAS, HOMER etc).

(c) Site

- The hospital or unit etc to be served by the system.

(d) Estimated Expenditure

- The capital and revenue costs as shown below taking account of when actual payment will be made.

  Capital - The total capital cost including any VAT when it is not "recoverable".

  Revenue - Costs should include not only implementation and training but also ongoing running costs and capital charges etc.

(e) Resource Availability

- Before including proposals for a capital spend the Board/Trust should have considered both the availability of staff and revenue funding to ensure the viability of the plans and the proper implementation and running of any new or replacement systems.

  You should indicate that you have done so by entering either Y (Yes), N (No) NYK or (Not Yet Known) for each sub-heading.

(f) Procurement Arrangements

- The plan should take account of how any equipment or system will be procured and the availability of the necessary procurement support/advice to ensure that the activity is properly undertaken.

  Method - Please indicate whether the procurement will be through an existing Framework Agreement (FA), an EC/GATT competition (EC) or falls below the EC/GATT limit (EEC).

  Support - You should show whether the necessary procurement expertise/support will be provided In-House (IH), from elsewhere in the NHS (NHS), a Commercial Supplier (C) or Other (O).

(g) Order of Priority

- In each separate part of the proforma the priority which you place on the need for the installation of the systems or hardware etc should be shown. In each case the ranking should reflect your local Information Strategy priorities.

System Priorities

9. On the basis of the strategic objectives outlined in the Information Strategy for the NHS in Scotland and taking full account of the changing needs of the service the main priorities for systems implementation are as follows:-

- communications (including networks, structured cabling, electronic mail and EDI);
- patient administration systems (particularly the master patient index, in-patient, out-patient, waiting list and accident and emergency modules);
- radiology systems;
- laboratories;
- ward nursing;
- theatre management;
- community and priority services;
- NHS Management Information System;
- clinical information and support systems (including coding and audit);
- pay, personnel and manpower planning systems;
- finance and contract management systems;
- supplies and pharmacy systems (including Supplies EDI and Ward Cardex);
- Central Index CHI sub-systems and CI satellites; and
- Clinical and Resource Information Systems (CRIS).

10. In addition to these "priority" systems the Directorate also recognises that a number of Boards, Units and Trusts may have identified areas of weakness in their IT security or contingency planning arrangements. In the circumstances the CDCF may be used for such purposes as well as, or instead of, the listed "priority" areas.