

Dear Colleague

## Arrangements for the Management of NHSScotland Capital Resources after 2010-11

This letter sets out the recommendations made by the Capital Strategy Group on the future handling of capital resources across NHSScotland.

### Background

1. Chief Executives received a presentation on 9<sup>th</sup> December 2009 at which the key strategic issues regarding capital were described. Chief Executives supported the establishment of a Capital Strategy Group to consider the issues raised. The Group have met on four occasions and considered a wide range of issues. The proposed report has been considered and cleared by the Group. The membership and terms of reference of the Capital Strategy Group is contained at Annex A to this CEL.

2. The Capital Strategy Group considered the following key issues:

- Capital Allocation Formula
- Treatment of Capital Receipts
- Prioritisation and approval of capital projects
- Delegated Limits
- Central budgets
- Revenue Financing

### Impact of Recommendations

3. The recommendations from the Group are detailed in Annex B of this CEL. Measures to manage the transition to the new arrangements have been built into revised processes and, in addition to a summary of the recommendations below, an assessment of their impact if implemented is also provided.

4. In moving from an Arbutnott based formula calculation to an NRAC based formula there will be some small variations in outcome. However, the full effect is mitigated by the much diminished quantum of Formula capital going forward due to the level of existing project commitments which take priority and the

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### Addresses

#### For action

Chief Executives, Directors of Finance NHS Boards and Special Health Boards; Directors of Estates and Facilities

#### For information

Chairs of NHS Boards and Special Health Boards

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new process of bidding for project specific funding over each Board's delegated limits described below.

## Capital Formula

- a) In allocating Formula capital, safeguards will remain to ensure a continued equitable distribution of resources with adjustments for cross-boundary flows, an Island Board "uplift" to cover planned minor work programmes and a funding top slice earmarked for Boards performing specialist services.
- b) The revised approach will see a reduced amount of capital distributed via formula. The formula capital will support more routine capital expenditure and projects which fall within Board delegated spending limits of between £1.5m and £5m. This replaces the current position where high levels of capital are allocated via formula (£279m in 2010-11) and Boards fund locally determined projects via the formula regardless of capital value.
- c) In future all new projects with a capital value exceeding Health Board's delegated spending limit will be subject to a bid process for specific project funding. However, should Boards decide to re-prioritise formula capital away from the new purpose of routine and minor works and towards projects in excess of their delegated limit, this will be permitted.
- d) It should be noted, however, that Boards will still be required to submit a business case to the Capital Investment Group for approval to proceed if the capital value of the project is above the Board's delegated limit as set by SGHD.
- e) The Formula allocation will be calculated starting with the annual health capital budget and deducting central programme budgets and in-year project specific commitments of all Boards. To assist Boards' planning, the expected value of the formula allocation will be established for the Spending Review settlement period in order to allow forward planning, subject to Scottish Parliament approval of the annual budget.

## Capital Receipts

- f) For those capital receipts not already identified as supporting projects with approved Outline Business Cases the capital element of receipts will accrue to SGHD and be used to support the overall capital programme. Any element of an asset disposal that scores as revenue income (profit on disposal) will be left with the Health Board where the capital receipt arose. Although there may be gainers and losers amongst the Boards in one particular year, over a period of time the central pooling of capital receipts should benefit all Boards.

## Project Approvals

- g) The project approvals process will be phased in over the next two to three years. A transparent and consistent approach will be employed across the whole of NHS Scotland which utilises project assessment criteria and applies weightings incorporating factors such as 'invest to save' and taking into account national, regional and local level strategies, policies and objectives. Fairness and participation will be at the heart of the prioritisation exercise where there will be both a regional and central assessment of proposals for publicly funded capital projects going forward. The Capital Investment Group will have Service representation to consider this item. An additional safeguard will be to carry out an annual review of the project assessment methodology by Capital Investment Group, again with service representation.

## Delegated Limits

- h) Delegated limits will reflect each Board's size operating on a stepped basis as contained in Annex C.

## Central Budgets

- i) The number of central budgets for national priorities will be smaller and clearly defined. In the case of medical equipment the budget will be allocated from within the base capital formula. Other budgets such as the radiotherapy equipment budget will continue to be based on an agreed national replacement programme with clear parameters for planning, implementation and review and supported by the Technical Sub Group of the Scottish Radiotherapy Advisory Group.
- j) Central budgets, including support of the hub initiative, will generally be allocated by a mix of formula and a bidding process subject to a *de minimus* arrangement where equitable to do so.

## Revenue Financing

- k) For existing PFI schemes, reversionary interest will be taken into account in NHS Board capital allocations through top slice arrangements. For new revenue financed schemes, representations will be made within the Spending Review to address the differential affordability impact of capital charges (depreciation) when compared to publicly funded schemes.

## Governance

6. It is proposed that the Capital Strategy Group will remain in place to oversee and provide strategic direction to the implementation of the recommendations. Regular reports on implementation of the recommendations will be provided. The Group will also remain to consider the implications of Spending Review 2010.

## Conclusion

7. The projected fiscal environment and the impact on the health programme of a small number of large projects requires a refocusing of the arrangements in place for the distribution of capital resources across NHSScotland. In making its recommendations, the Capital Strategy Group, through its wide representation has sought to put in safeguards and apply principles of fairness to changes to the planning, distribution and management of capital resources.

## Action

8. NHSS Board Chief Executives and Directors of Finance are asked to share this letter with all staff involved in capital planning.

## Further Information

9. Further information on the content of this letter can be obtained from Ian Waugh on 0131-244-2101 or [ian.waugh@scotland.gsi.gov.uk](mailto:ian.waugh@scotland.gsi.gov.uk)

Yours sincerely



**John Matheson**  
**Director of Health Finance**

## CAPITAL STRATEGY GROUP – REMIT & MEMBERSHIP

### Remit

1. The remit of the Capital Planning Strategy Group (CSG) is to:
  - a) To consider approaches and make recommendations on the methodology for allocating and prioritising capital resources (including capital receipts) to NHSScotland having regard to:
    - the strategic objectives of NHSScotland;
    - the projected level of available resources;
    - the maintenance and improvement of the NHSScotland asset base in support of service delivery;
    - the delivery of strategic projects at national, regional and local level; and
    - linkages to broader SG objectives and funding streams.
  - b) To review current arrangements for central capital budgets in light of the above issues;
  - c) To review current delegation arrangements for NHSScotland bodies in light of the above issues;
2. To provide an overview and advice to a Capital Planning Systems Sub Group which will:
  - a) consider options for systems and processes to support the planning, utilisation and control of capital resources
  - b) consider the appropriate linkages to asset management policies; and
3. It is envisaged that CSG will meet monthly for a six month period (business permitting) with the focus on items 1a, b and c within the main group

## **Membership**

4. The initial membership of CSG is as follows:

Mr John Matheson, SGHD Director of Finance (Chair)

Mr Mike Baxter, Deputy Director Capital Planning and Asset Management

Ian Waugh, Head of Capital Planning (Secretariat)

Mr Douglas Griffin, Director of Finance, NHS Greater Glasgow and Clyde

Mrs Fiona Ramsay, Director of Finance, NHS Forth Valley

Mr Simon Belfer, Director of Finance, NHS National Services Scotland

Mr Craig Marriot, Director of Finance, NHS Dumfries and Galloway

Mr Ian Ross, Director of Strategic Projects, NHS Lanarkshire

Mr Iain Graham, Head of Capital Planning NHS Lothian

Mr Tom Steele, SFG Representative

**CAPITAL STRATEGY GROUP –**

**RECOMMENDATIONS ON KEY STRATEGIC ISSUES**

1. At its meeting of 9 December 2009, the Chief Executives' Group received a presentation covering a range of capital related issues resulting from future projections on public finances beyond 2010-11. It was agreed that a "Capital Strategy Group" would be established to consider these issues and make recommendations.
2. The Group commenced work at the end of January and, through ongoing discussion has agreed a series of recommendations covering the key issues associated with the distribution and management of capital resources across NHSScotland.
3. This report summarises the agreed position of the Group and sets out a series of detailed recommendations.

**Replacement of Arbuthnott formula based allocation**

4. Currently the capital allocation formula is based on the Arbuthnott formula adjusted for cross boundary flows and top sliced by 10% for specialist services flows relating to Medical and Clinical Oncology, Neurology and Cardiothoracic Surgery. For all Island Boards an uplift is applied equivalent to the difference between their formula allocation and their planned minor work programmes. This methodology has been in place since 2002.
5. The Group have recommended that the target NRAC formula should replace Arbuthnott as a basis of the capital formula and that this should be adjusted for cross boundary flows.
6. The CSG have also considered whether there is a need to retain a specialist service top slice and what the basis of any specialist services top slice should be. The quantum of 10% has not been revisited since 2002 with the allocation rising from £15m in 2002-03 to £29.7m in 2010-11.
7. The CSG consider that the principle of a specialist services top slice is accepted but that further work is required to determine the quantum to be top sliced. This will be achieved by surveying the equipment held by Boards in respect of specialist services to establish the ongoing replacement requirements for the same.
8. Subject to the outcome of the spending review (and the approval by the Scottish Parliament of the annual budget), it is proposed to fix formula allocations for the period of each spending review.

### **The nature of expenditure to be supported by a formula based allocation**

9. The CSG consider that the formula based allocation should provide funding to cover expenditure on routine medical equipment replacement, routine health and safety improvements and other improvements driven by statutory change, routine IM&T related improvements/upgrades, minor improvements/refurbishments/enhancements to buildings...i.e. all “locally driven” expenditure items below a Board’s delegated expenditure limit.
10. The formula allocation would be expected to cover projects with a total capital value that are within the Board’s delegated limit. Any new projects in excess of that delegated limit are outwith the scope of the formula and will be subject to bidding for specific project funding unless Boards decide to prioritise formula funding to support projects in excess of their delegated limit.
11. Boards will have discretion on the prioritisation of projects supported by the formula allocation but will be expected to demonstrate that they have undertaken appropriate risk assessments to decide on where and how their allocations are to be applied. This risk based approach will require to be demonstrated within a Board’s Property and Asset Management Strategy.
12. In order to ensure resources are managed in the most effective manner in respect of backlog maintenance, indicative allocations of future capital for investment should be set out over a Spending Review period. This would help Boards undertake their risk assessment in a more structured approach.
13. There is support for the need for better information regarding management of the backlog maintenance costs on a risk based approach. The establishment of the new Property and Asset Management system will support Boards in managing their estate but should provide appropriate information to be viewed centrally. However, it is essential that Boards still require to make appropriate decisions based on their own risk assessments using nationally developed guidance.

### **The basis of establishing an initial quantum for allocation of formula**

14. It is proposed that the formula allocation is initially based on the available budget less the sums identified for central budgets and contractual commitments of Boards to date. It is proposed that the expected quantum of the formula allocation will be set out for the spending review period in order to allow forward planning.

## **Treatment of receipts when considering the allocation of capital resources to Boards**

15. A common problem is the accurate forecasting and timing of capital receipts. Processes are required to track key stages in generation of receipts and highlight risks associated with realising receipts. National processes to be further developed regarding tracking of receipts and their impact on the overall capital programme.
16. It was generally agreed that there needs to be the right incentivisation to generate receipts. There are four options considered by CSG. These are:
- Boards should continue to receive full benefit as assets are disposed of (capital and revenue).
  - Create a central land bank to which all surplus assets would be notified and central responsibility is taken for the disposal of the land. This could then mean any income received from sales would be available to distribute on a national basis within the final agreed formula allocation.
  - The capital element of the receipt should accrue to SGHD and be used to support the overall capital programme while the revenue element should be left with the Health Board where the capital receipt arose.
  - As an extension of the third option it was suggested that any sum received above/below the net book value will require to be treated as revenue and be retained by the Board to improve the backlog maintenance position
17. In considering the above options it was recognised that where Boards retain the benefit of receipts there is often a timing problem where replacement facilities are required before surplus land can be sold. A brokerage mechanism would be required at national level to support such cases.
18. The CSG therefore propose that the third option be adopted where the capital element of the receipt should accrue to SGHD and be used to support the overall capital programme while the revenue element should be left with the Health Board where the capital receipt arose.
19. This would assist in spreading the risk associated with receipts across all Boards whilst retaining incentives locally and ensure that project funding was allocated on a priority basis rather than being skewed by the ability of individual Boards to generate receipts. The decision would rest with Boards regarding the application of revenue proceeds.
20. In such cases project specific funding could be allocated on the condition that all or a proportion is repaid within a particular time period from anticipated receipts. Clearly if such receipts are not realized then subsequent projects in other Board areas will be cancelled/ delayed.

## **Proposals for the basis of prioritising and allocating project specific funding (new approvals)**

21. The process for approving projects will need to operate on a transitional basis given the flow through of existing projects over the next two to three years. It is recognised that the scope for new projects will be limited in the short to medium term.
22. Project proposals should be based on assessment against key and consistent criteria. Criteria such as “Invest to Save” should feature prominently and strategies, policies and objectives will need to be ranked to create a consistent decision making framework based on relative priority. Within project proposals there needs to be clear links to clinical strategies at national regional and local level. This would link to such issues as improvements in HEAT targets, avoidance of backlog maintenance, Shifting the Balance and where other key government targets can be met with clear measurables identified.
23. In order to deliver this process it is proposed that the Initial Agreement is further developed to incorporate a consistent basis of assessment and could be expanded/developed with stronger evaluation on measures/outcomes of the planned project.
24. It is proposed that the prioritisation exercise be conducted on a six monthly or annual basis for public capital funded projects with a call for Initial Agreement proposals. It is further proposed that the process be overseen by the SGHD Capital Investment Group but that for this purpose only, the CIG membership be expanded to include Service representation.
25. In order to ensure that priority cases are developed the CSG recommend that Initial Agreement proposals require to be assessed at Regional level before submission to CIG. Additional clearance procedures require to be developed for Special Board proposals.
26. In order to ensure that the prioritisation methodology is consistent with Government objectives it is proposed that the methodology be reviewed by CIG (with service representation) on an annual basis and that the decision making criteria and weightings be made available

## **Delegated Limits**

27. Given the anticipated reduction in available capital and the reduced flexibility CSG propose that delegated limits be established on a stepped basis as for Special Boards. The proposed limits for Boards are attached as part of the tabulation at Annex c.
28. Approval and funding would therefore be allocated for projects whose value exceeds the delegated limit for the relevant Board except where Boards decide to prioritise projects in excess of their delegated limit from within their formula allocation.

## **Principles for the handling and allocation of central budgets**

29. The Group considers that there should be a small number of central budgets supporting very clear national priorities. In establishing such budgets more interaction is required in establishing and providing for the revenue consequences of such investment. For each programme there should be clear definition regarding whether national and local funding is complementary ( e.g. matched funding) or exclusive.
30. The allocation of ring fenced money for equipment has been welcomed by Boards. It has supported planned programme replacements. However there is no reason why Boards again should not be able to develop a clear investment strategy for equipment using a risk assessment process. Whilst the allocation should be on a NRAC basis the Boards should be able to demonstrate how expenditure has been allocated and how decisions were reached. In light of the limited available capital one option is that equipment could be part of the Board's general formula allocation and it would be up to individual Boards to decide whether the risk lies more with investment in equipment or property. This again pushes the management of risk to individual Boards but they must still be able to demonstrate why particular investment decisions were made.
31. On radiotherapy equipment there will be a nationally defined and agreed replacement programme with clear parameters for planning, implementation and review. It is proposed that such proposals are developed and implemented by the Technical Sub Group of SRAG. Such proposals would be founded on the basis of establishing and implementing a programme consistent with the Spending Review Period.
32. It is suggested that handling central budgets should be via a mix of formula and bidding. Where applied on a formula basis the target NRAC based capital formula will be applied subject to any deminimus arrangements made for small and/ or islands Boards business cases, using same approach as applied to the proportion of the capital funding earmarked for Health Boards.

## **Handling funding for investment through revenue finance**

33. The lack of available capital does mean that use of private finance must be an option for Boards to test. For new build stand alone projects in excess of £20m revenue finance will be tested. Hybrid financing involving public and revenue finance should also be tested. Revenue finance will be applied on a value for money basis.
34. For NHS Boards participating in the hub initiative, revenue finance will be tested for projects below £20m.
35. Representation will be made within SG on the differential affordability impact of private finance in relation to capital charges (depreciation).

36. There is a need to establish a maximum % of revenue budgets committed in Boards to Unitary payments to ensure a sustainable revenue position over the long term.
37. It is recognized that existing capital budgets contain long term commitments regarding the reversionary interest of existing PFI schemes. The capital cover for such commitments requires to be top sliced and ringfenced.

### **Conclusions**

38. On the key questions asked the following conclusions can be drawn:
39. The use of target NRAC is supported with further analysis required to validate the top slicing for specialized services.
40. Consensus that the formula should support capitalised maintenance/ rolling replacement programmes and projects contained within Board delegated limits. Clear and consistent views that Boards should be utilising risk based approaches to prioritisation of expenditure supported by the formula and that this prioritisation should be locally controlled.
41. The quantum for capital formulas should be established after taking into account existing committed projects and central priorities.
42. That there is a need for incentives around the generation of capital receipts and for brokerage to be available recognizing the timing expenditure on replacement facilities and subsequent receipts for surplus assets.
43. That clear and consistent approaches are required to support prioritization of project funding. Suggestion also that the role of CIG should be assessed to have service input.
44. Stepped approach to delegated limits required recognizing different size of Boards and formula allocations.
45. There should be a small number of central budgets which should have clear priorities and could be distributed on formula or business case basis.
46. Difficulty identified regarding affordability given differential revenue impact following removal of cost of capital charge.

## **Recommendations**

47. The Capital Strategy Group recommends that:

### **Capital Formula**

- a) Target NRAC should be used as the basis of the formula allocation adjusted for cross-boundary flows.
- b) For Island Boards an “uplift” should be applied equivalent to the difference between their formula allocation and their planned minor work programmes (adjusted pro rata for upwards/downwards revisions to the national settlement).
- c) A top slice adjustment for specialist services be retained but that further work, concentrated on the equipment held by Boards in respect of specialist services be surveyed and reported to CSG.
- d) Formula capital should be used primarily to support routine capital expenditure and projects within Board delegated limits unless Boards decide to prioritise formula capital for projects in excess of their delegated limit.
- e) New projects with a capital value exceeding Health Board’s delegated spending limit should be subject to a bid process for specific project funding, unless the Board propose to finance from within its formula capital. If the latter pertains, it should still require to submit a business case to CIG for approval to proceed, on the basis that the capital value of the project concerned is above the Board's approval limit as set by SGHD.
- f) Formula allocation should be calculated on the annual available budget less the central programme budgets and in-year project specific commitments of all Boards.
- g) Where practicable, the expected quantum of the formula allocation should be consistent with the Spending Review settlement period or the next three year period whichever is the longer in order to allow forward planning (subject to Scottish Parliament approval of the annual budget).

### **Capital Receipts**

- h) For those capital receipts not already identified as supporting projects beyond Outline Business Case approval the capital element of receipts should accrue to SGHD and be used to support the overall capital programme while the revenue element should be left with the Health Board where the capital receipt arose.

## **Project Approvals**

- i) A transitional process should be developed for the approval of projects over the next two to three years.
- j) Project assessment criteria and weightings should be developed which incorporate factors such as 'invest to save' and take account of national, regional and local level strategies, policies and objectives.
- k) The Initial Agreement should be developed to incorporate a consistent basis of assessment incorporating a stronger evaluation of the proposal's contribution to outcomes and measures thereof.
- l) The prioritisation exercise should be conducted on a six monthly basis for publicly funded capital projects with a call for Initial Agreement proposals.
- m) The prioritisation process should be overseen by the SGHD Capital Investment Group with membership expanded for this item to include Service representation.
- n) Proposals for Initial Agreements should be assessed at regional level before submission to CIG. Specific clearance arrangements should be put in place in respect of Special Boards.
- o) The project assessment methodology should be reviewed by CIG (with service representation) on an annual basis and the decision making criteria and weightings should be made available.

## **Delegated Limits**

- p) Delegated limits should be applied on a stepped basis as contained in Annex A

## **Central Budgets**

- q) The number of central budgets for national priorities should be small and well-defined. Such budgets, should they be accepted would clearly articulate the revenue consequences of the investment proposal.
- r) The medical equipment budget should be allocated from within the base capital formula
- s) The radiotherapy equipment budget should be based on an agreed national replacement programme with clear parameters for planning, implementation and review. The programme would be supported by the Technical Sub Group of the Scottish Radiotherapy Advisory Group.
- t) Central budgets should be allocated by a mix of formula and a bidding process. Where applied on a formula basis the Target NRAC based capital formula will be applied subject to any de minimus arrangements made for small and/ or islands Boards business cases. This would include capital funding in support of the hub initiative

## Revenue Financing

- u) Representation should be made within SG on the differential affordability impact of revenue finance in relation to capital charges (depreciation)
- v) Reversionary interest on existing PFI schemes to be taken into account in NHS Board capital allocations through top slice arrangements
- w) The Capital Strategy Group remain in place to provide strategic oversight and also direction to the work of the Capital Systems Sub Group as it takes forward the development of systems and processes to support the above recommendations. The Group will also remain to consider the implications of Spending Review 2010.

**ILLUSTRATIVE ALLOCATION OF £150m VIA FORMULA**

<b>NHS Board</b>	<b>90% Allocation on NRAC share (£m)</b>	<b>10% Allocation from Specialist Services</b>	<b>Total Allocation (£m)</b>	<b>Final NRAC Adjusted Shares</b>	<b>Delegated Limit (£m)</b>
Ayrshire & Arran	9.58		9.579	6.39%	1.5
Borders	2.58		2.581	1.72%	1.0
Dumfries & Galloway	3.94		3.942	2.63%	1.0
Fife	8.37		8.375	5.58%	1.5
Forth Valley	6.84		6.840	4.56%	1.5
Grampian	12.79	0.996	13.791	9.19%	3.0
Greater Glasgow	35.45	9.668	45.122	30.08%	5.0
Highland	8.21		8.214	5.48%	1.5
Lanarkshire	13.73		13.726	9.15%	3.0
Lothian	20.74	4.198	24.938	16.63%	5.0
Orkney	0.41		0.411	0.27%	1.0
Shetland	0.45		0.453	0.30%	1.0
Tayside	11.12	0.138	11.260	7.51%	3.0
Western Isles	0.77		0.769	0.51%	1.0
<b>Total</b>	<b>135</b>	<b>15</b>	<b>150</b>	<b>100%</b>	