Capital accounting manual nhs scotland

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Book Descriptions:

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We also use nonessential cookies to help us improve our websites. Any data collected is anonymised. By continuing to use this site, you agree to our use of cookies. FindBy contrast cash accounting records cash payments and receipts when they are made or received. They are included in DEL. Expenditure in AME is generally less predictable and controllable than expenditure in DEL. Sometimes referred to as the Scottish Block. Its purpose is to obtain management commitment and approval for investment in the project. The business case is owned by the Senior Responsible Owner. It includes the purchase of buildings, equipment and land. Often used to distinguish judge made caselaw and longstanding legal principles defined in legislation. It does not include expenditure on the purchase of assets above a certain threshold. Delegated authority for committing resources is separate from delegated purchasing authority DPA. It includes the Assigned and nonAssigned Budgets. Expenditure in DEL is generally more predictable and controllable than Annually Managed Expenditure AME. DEL is therefore planned and controlled across the period of each Spending Review i.e. set on a multiyear basis. Separate elements are identified for capital and current spending. The term amortisation is used in relation to intangible assets. Commissioners are appointed by member states. The body has three distinct functions initiating proposals for legislation; acting as guardian of the Treaties; and managing and executing EU policies and international trade relationships. Includes movements in deposits and borrowing by way of finance leases. This will include all direct and indirect costs of producing the output both cash and noncash costs, including a full proportional share of overhead costs and any selling and distribution costs, insurance, depreciation, and the cost of capital, including any appropriate adjustment for expected cost increases.http://fuerst-architects.com/uploads/dynamics-of-structures-solutions-manual-pdf.xml

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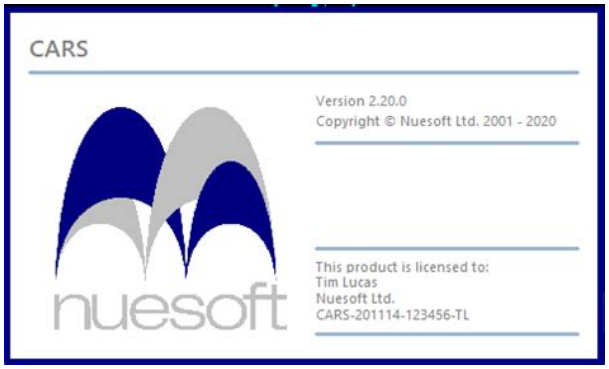
Economic data are often quoted as a percentage of GDP to give an indication of trends through to time and to make international comparisons easier. The IPD assists the Scottish Government in informing financial planning and procurement decisions as well as project governance and is

updated on a quarterly basis at source by project areas within the Scottish Government and other relevant bodies. Judicial review looks at the fairness of the decisionmaking process rather than the merits of the decision itself. Current Liabilities are liabilities incurred in the normal course of business, including creditors, accrued expenditure and receipts in advance. It represents local government expenditure financed from local resources such as council tax borrowing trading surpluses investment income and use of reserves. The maker of a misstatement can be sued for damages by those who have relied on the misstatement, but only if in the circumstances it was reasonable to rely on it. For example, expenditure on gas or electricity supply is incurred as the fuel is used, though the cash payment might be made in arrears on a quarterly basis. Other examples of nearcash expenditure are pay, rental. It represents the sum of net resources and net capital less noncash items and working capital. Resources comprise cash and noncash elements. NDPBs accordingly operate at arms length from government Ministers i.e. the body carries out its daytoday functions independently of Ministers, but Ministers remain ultimately accountable. The NPD model is defined by the broad principles of enhanced stakeholder involvement in the management of projects, no dividend bearing equity and capped private sector returns. The charge takes account of the fact that public bodies do not generally pay an insurance premium to a commercial insurer. Objectives contribute towards an organisations aim and are expressed in a way that enables determination of their
achievement.http://centrlita.ru/archive/image/dynamics-pytel-solution-manual.xml



They should correspond to ultimate objectives the impact of a policy intervention on the welfare of producers or consumers e.g. better educated school students. Outputs should facilitate the meeting of outcomes. An agreed overdraft would qualify as shortterm borrowing. Activities giving rise to expenditure are authorised by the Parliament in specific enabling legislation. Parliamentary authorisation of actual expenditure is provided in the annual Budget Act, including any Amendment Orders. For larger, complex or risky projects a PER may also be conducted at the end of a particular project phase. Other similar terms are Post Project Evaluation PPE. They start off as Bills on their introduction to the Parliament and become Acts on receiving Royal Assent. He or she may designate Accountable Officers for parts of the Scottish Administration and other bodies the accounts of which are subject to audit by or under the control of the Auditor General for Scotland. The procurement process begins when a need to buy something is identified and will generally end after the contract is awarded. It is classified to the public or private sector according to which has more control. Enables comparisons of spending across years without the distortion caused by price changes. It treats capital and current expenditure in a way which better reflects their economic significance and encourages greater emphasis on outputs and the achievement of aims and objectives. It typically operates where another person can be said to have been unjustly enriched by receiving such monies. Various measures of profit and of capital employed may be used in calculating the ratio. It is the balancing factor between an authoritys assessed spending need and its income raised locally through the council tax and nondomestic business rates.

Payments out of the SCF are subject to statutory authority while all receipts of the Scottish Administration but not other direct funded bodies must be paid into the SCF unless otherwise authorised by the Parliament. Normally used to set out technical and administrative provision in greater detail than primary legislation, they are subject to a less intense level of scrutiny in the Parliament. Where agreements are between central government bodies, they are not legally a contract but have a similar function. Normally held at 2 year intervals. NDPBs include Executive NDPBs, Public Corporations and NHS Bodies. Other organisations which do not meet the NDPB criteria may also be regarded as sponsored bodies where the activities of the organisation and the nature of the relationship between the Scottish Government and the organisation makes it appropriate to do so. It covers all current and capital spending carried out by the public sector i.e. not just by central government. WGA are produced on an accruals basis and use generally accepted accounting principles, adapted where necessary for government. Government is treated as if it were a single entity by eliminating all significant transactions between public sector entities. You can change your cookie settings at any time. It’s based on the 2020 to 2021 Treasury financial reporting manual. We’ll send you a link to a feedback form. It will take only 2 minutes to fill in. Don’t worry we won’t send you spam or share your email address with anyone. The product reflects all the accounting requirements laid down by the various NHS Capital Accounting Manuals and Manuals for Accounts, and is updated annually to reflect any changes new functionality this year included full support for IFRS 16 Leases, including the introduction of a Lease Register. CARS can be used by many types of NHS organisation including Just ask our existing users what they think of our support—ask us to provide a reference.

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All transactions can be imported from spreadsheet. We believe CARS is unrivalled when it comes to handling the nuances of NHS capital accounting. All your annual accounts reports are produced for you at the click of a button.These include both a Revaluation report and an Assets Under Construction report, detailing all transactions generated when you perform a Revaluation or add an Under Construction asset. If you make changes in any window, or run any calculations, the changes will be immediately reflected in your reports. It accounts for IFRS 16 Leases, Short Term Leases, Low Value Assets and Peppercorn rents. Future releases will introduce accounting for variable lease payments, rentfree periods, reassessment of lease liability and terminating leases. CARS can then be used to create matching Right of Use assets. It understands the differing requirements of NHS Trusts, Foundation Trusts and Welsh and Scottish organisations. Examples of this functionality include A key part of these sessions is for us to gain feedback from our users and to implement changes to meet their needs or requests wherever possible. These informal sessions are a great way to improve your knowledge of the system, to keep up to date with reporting requirements and to

meet other users. Nuesoft manage the group, but it is the users who participate in it. The purpose of the group is for them to make contact with each other, and to ask questions around Capital, to see how other organisations have dealt with particular scenarios, or to ask advice. Participation in the group is optional. Since the inception of Nuesoft, customer satisfaction has always been a priority. Our Helpdesk is available daily, via telephone or email, and we pride ourselves on the speed of our response and of resolution of any issues. Nuesofts ethos is to be there when you need us meaning we are even happy to assist with queries out of hours when necessary, such as at yearend.

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more frequently asked questions FAQs. Customers will need to register and login to CIPFA's website to access the publication. On this page you can access a range of articles, books and online resources providing quick links to practical guidance and background knowledge.It offers news updates, benchmarking surveys, technical helpsheets, as well as conferences and seminars. This includes sections on Health, including Public Health, Health VAT, and Adult Social Care and Health. The site includes regional statistics for medical practices, a search tool for locating AISMA members, information about the organisation and a news feed. NASDAL membership includes accountants and lawyers with an indepth knowledge of the dental profession. The Association works to promote and develop accountancy services to the dental profession and further knowledge of specialist dental accountancy matters. These journals are available to loggedin ICAEW members, ACA students and other entitled users subject to suppliers terms of use. You can obtain copies of articles or extracts of books and reports by post, fax or email through our document supply service. Please see the full copyright and disclaimer notice.

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Where structural change requires major investment, the private finance initiative is the only method of financing it. The relationship between new investment and service configuration raises questions about the planning process who is making decisions on future services, and on what basis 3 When faced with questions about the relative importance of clinical and financial factors in service planning, the government has tended to argue that the crucial decisions are all made by clinicians. Clinical directors are responsible for agreeing and medical directors for approving full business cases; however, healthcare planning has never been a core clinical competence, and making decisions is very different from agreeing to decisions taken by others. This issue was raised earlier this year in correspondence in the Glasgow Herald, in which the Scottish health minister responded to criticism of bed numbers at the controversial Royal Infirmary of Edinburgh private finance initiative scheme by stating, "It is the clinicians who decide on the number of beds. The assumptions on bed numbers were developed by clinicians." 4 But one of the clinicians involved in the planning

process illustrated the hidden ambiguity in the minister's statement "We were told the maximum costs and told how this translated into maximum bed numbers.As we shall see, business cases for other private finance initiative schemes lend support to this account of the planning process. In this paper we use the full business cases that are available to evaluate the adequacy and nature of the planning process as judged by the quality of the information and the nature of the evidence.

Summary points Hospitals funded through the private finance initiative are being planned on the basis of financial, not clinical, needs The data used in support of private finance initiative planning do not conform to the Department of Health's standards and definitions Full business cases under the private finance initiative are incomplete with respect to total and specialty bed numbers, the caseload to be treated, and the service needs of the population Private finance initiative hospitals entail major reductions in the clinical workforce, and service capacity—in direct contradiction of government policy In many areas private finance initiative hospitals will need to generate income from private patients; as a result some hospitals have increased the proportion of private beds The private finance initiative will result in a shrunken NHS, inadequate to meet the needs of the population Planning since the NHS Act 1990 drivers for change By 1998, a third of health authorities and trusts were in serious financial difficulties. 6 There are two main causes for this. Firstly, the introduction of capital charges in 1991 diverted hospitals' operating income to pay for buildings and equipment that were already owned outright. 7 Secondly, revenue pressures have increased through 3% annual efficiency savings, unfunded pay awards, and other costs. Capital charges and clinical spending are inversely related the higher the value of the asset base, the higher the capital charge and the lower the budget available for clinical care. Required by the 1990 NHS and Community Care Act to balance their budgets, trusts have reduced their capital charges through selling or mothballing assets and through mergers and rationalisations. 8 The 1990 act also made trusts responsible for capital and service investment strategies which by 1998, with capital funding no longer available, they were largely funding out of their own cash savings.

The original intention was to fund development under the private finance initiative through the sale of existing sites and the diversion to the private sector of the annual capital charge paid to the Treasury. This proved overoptimistic. 9 Because hospitals funded through the private finance initiative have turned out to be so expensive, 1, 10 the proportion of income spent on capital has increased, thereby reversing NHS trusts' attempts to reduce their capital costs. What impact do these increased costs have on the planning process. Planning in the devolved NHS Until 1990, planning priorities were set by regional health authorities and were based on service needs. Regional planning departments estimated bed capacity by using population based measures of utilisation and service provision adjusted to take account of sociodemographic projections, trends in utilisation, morbidity, and mortality, and estimates of changes in technology and clinical practice. The evidence from the available full business cases is that these methods have been abandoned. Now the planning process starts with "outline business cases," which trigger the process of application to the private finance initiative; "full business cases" then set out for approval the final scheme negotiated with the private sector. 11 The NHS Capital Investment Manual, which is the guidance on procurement, describes affordability as the critical constraint in planning. 12 Under this system trusts have to justify the affordability of their proposals and show value for money. 13 Regional assessments of need have been replaced by trusts' own assessments of the case for change. The case for change is not stringently tested in this procurement process. Despite the scale of investment in the private finance initiative, the 30 year contract, and the profound consequences for patient care, the financial exercise does not include an assessment of service needs.

The guidance does not require clinicians and public health doctors to be involved. Demand projections have replaced estimates of service needs. These are usually expressed as caseload or admissions and measured as finished consultant episodes. Performance, or the "efficiency" with which caseload is processed, is measured in several ways, most commonly as throughput, bed occupancy, day cases, and length of stay. In private finance initiative planning, these performance targets are used to reconcile projected caseload with projected bed numbers, as the Calderdale business case makes clear "A further bed modelling exercise was commissioned by the health authority and included more stringent targets for length of stay, occupancy, and day cases. This was then supplemented by a jointly commissioned exercise to impute performance targets from the agreed bed numbers and to verify the extent of change of practice required." 14 The full business cases released so far show serious departures from the Department of Health's definitions of admissions, bed numbers, and performance measures. The first box shows the way in which bed and caseload data have been altered, with the effect that comparisons with the Department of Health's data and some of the outline business cases can no longer be made, thereby concealing the extent of proposed changes in caseload and bed numbers. Case study 1 shows how Norfolk and Norwich's decision to use deaths and discharges rather than finished consultant episodes and to abandon trend analysis led the trust to seriously underestimate during the procurement process the caseload to be treated and the number of beds required. It is now preparing a new business case for a further 144 beds.

The third box gives the example of Calderdale the trust's departure from the Department of Health's definitions of beds and the inclusion of day case beds has led it to underestimate the scale of bed reductions that will take place under the private finance initiative. Data given in Hansard add to the confusion, as these state a total bed complement of 614 compared with 553 total beds in the full business case. 15 No explanation of how to reconcile the two sets of figures is given. In Scotland, Lothian Health Board's decision to use local classifications, which did not map to national classifications, disguised the scale of bed reductions; this was subsequently confirmed in a report from the information and statistics division of the Common Services Agency of the NHS in Scotland. 16, 17 How planning documents depart from national standards for data collection Baseline data for numbers of acute beds national data from the Department of Health are not comparable with projected bed data for private finance schemes because of various factors Inclusion of some GP general practitioner beds, day care beds, and continuing care and long term care beds these are currently counted separately and excluded from figures for availability of acute beds Bed data for private finance schemes may include private beds, even though these will no longer be available for NHS care Inclusion of 5 day beds and cots 5 day beds will not be available for emergency care; an increasing proportion of beds in the private finance initiative hospitals will be 5 day beds Bed data for private finance schemes always exclude beds lost across a district health authority as a result of hospital closures Business cases in the private finance initiative contain little or no planning material.

Many cases, for example those from the Norfolk and Norwich, Hereford, and Carlisle trusts, fail to define the numbers of total and specialty beds available for NHS use, and several do not specify the NHS caseload to be treated. The nature of the planning tasks These departures from normal planning methods suggest that the main function of the current planning process is to justify cost restructuring projected clinical activity has to be brought in line with the income and hospital capacity that will be available to cater for it. Four methods of restructuring costs are already common practice across the NHS as trusts struggle to resolve budget deficits. These are discussed below. Shifting the costs of care out of the NHS The NHS has a history of shifting out the costs of care in key areas such as NHS dentistry, optical services, and long term care. Constraints on capacity are now emerging in the acute sector. Under the private finance initiative, Norfolk and Norwich used deaths and discharges, rather than finished consultant episodes, to project a fall in

inpatient caseload of 8% from 19934 to 20034 with an increase of less than 1.5% a year in day cases. Their projection of numbers of discharges and deaths for the new hospital of 68 000 in 20034 was exceeded in 19967 when the number of discharges and deaths was 89 665. The trust revised its caseload estimates to 84 700 deaths and discharges a 6% decrease on 19967 and increased its bed numbers to 809, and the full business case was signed in 1998. In March 1999, the health authority increased its required capacity to 102 800 deaths and discharges. 18 On this basis the trust is now preparing a second business case for an additional 144 beds. The health authority plans to close 140 beds in community hospitals in the area. Furthermore, the private finance initiative business cases anticipate the diversion of caseload to care in the community without securing the resources to fund the alternative provision.

The strategy of the Norfolk and Norwich Trust and the health authority, which was to divert up to 8% of current caseload into the community, was followed by the health authority's decision to close five community hospitals and to reduce the availability of beds in community hospitals by a third. 25 In Hereford, where the 50% reduction in acute beds will require increased health authority funding and "accommodating caseload accounting for 14 000 bed days" in community settings, the extra nonacute resources are not identified in the business case. In Dartford, community spending has been reduced to fund the additional costs of the acute sector funding for the reprovision of services for mental health and learning difficulties and community nursing was withdrawn. 26 Despite a background rise in inpatient admissions these plans also assume a change in case mix through increased day case and private patient activity and reduced ordinary inpatient activity see below. Income generation and private patients According to the Norfolk and Norwich full business case, "East Anglia has a very high incidence of private medical insurance 21.3% in comparison with a national average of 13%. There are clearly opportunities for the trust to expand its income from private patients. But under current legislation, the NHS must give priority to NHS patients and can therefore convert private NHS beds back for NHS care; this option may no longer be available under the private finance initiative. Table 3 Private beds as proportion of all beds in a sample of private finance initiative PFI hospitals. Values are number of beds % of 19967 total NHS beds Trust Current private beds Private beds under PFI South Buckinghamshire 20 2.7 28 5.2 Carlisle 0 Under negotiation. Norfolk and Norwich 18 1.6 20 2.5 Calderdale 0 20 3.5 Open in a separate window Increasing clinical productivity A trust can try to reduce unit costs by increasing the productivity of the clinical workforce.

The full business cases show that the private finance initiative plans rely heavily on performance targets and efficiency measures such as throughput, length of stay, day case rates, and bed occupancy, which they openly acknowledge are "challenging." But instead of using national data these targets are derived from hypothetical norms. 27 In some cases planners take the application of these measures one stage further, deriving single composite measures based on all these efficiency measures and applying them across specialties and subspecialties. South Buckinghamshire, Greenwich, and Dartford trusts took the Tomlinson report for London, which suggested a hypothetical and unevaluated norm of 12.8 beds per 1000 acute finished consultant episodes, and adjusted it to increase productivity decrease in beds per 1000 finished consultant episodes by as much as 30% on current performance. Some trusts use targets taken from other private finance initiative hospitals, international comparisons, or the anonymised commercial CHKS Caspe Healthcare Knowledge Systems database, 28 which is used to provide data on the performance of "comparable peer groups." Comparability of the peer groups with the private finance initiative hospital in question in terms of population, case mix, and provision of health services is not established in any of the planning documents. The plans, by concealing the true extent of the assumptions, presuppose truly heroic levels of staff productivity. Many of these performance measures take no account of the different work tempos of specialties such as elderly care or rehabilitation medicine. Nor do they acknowledge the distinctive and different needs of individual

patients within specialties. The effect is to “dehumanise” the care process—assuming that a similar case mix and care process can be applied to all patients within a given specialty. In effect, the hospital becomes a factory for conveyor belt care.

Reducing the costs of the workforce The most common way of balancing the books is to cut the workforce. In both cases a greater proportion of nursing staff will be unskilled 37% compared with 25% in 19967 in North Durham and 30% compared with 21% in Edinburgh. Table 4 Staff numbers whole time equivalents and cash expenditure on staff at Edinburgh Royal Infirmary in 1996 and under private finance initiative plans Staff Whole time equivalent staffThe policy of cutting clinical labour to pay for the higher costs is fundamental to the private finance initiative. An incremental investment of 200 million requires 1000 job losses, which might be significantly greater than 25% of the work force and is probably only achievable by reducing the number of doctors and nurses, although often these job losses will not be realised within the hospital undertaking the development, but in the local healthcare market.” 30 Table 5 Structure of hospital costs and expenditure on clinical staff in 19667 and under the private finance initiative Edinburgh Royal InfirmaryPolicy contradictions The private finance initiative plans argue for a reduction in acute services and the dispersal and fragmentation of caseload into primary and community care services. But these services are labour intensive and overstretched, and they are already experiencing serious labour shortages. Indeed the parliamentary health select committee recently wrote “The evidence we have received leads us to conclude that on current trends the projected increases in the number of nurses and other clinical staff fall well short of what is required to deal with current shortages and future developments in the NHS. We hope that recent government initiatives will reverse these trends.” 31 The secretary of state for health has tried to stem rising waiting lists and bed shortages by promising to reopen 3000 beds—fewer than the number to be lost under the private finance initiative plans.