For decision

2014 Business Plan and Budget

Issue

1 To determine the 2014 Business Plan, budget and fee levels.

Options

2 In relation to doctors' annual retention fee level:

- **a** Option A: to freeze the annual retention fee at the current level.
- **b** Option B: to reduce the annual retention fee, effective from 1 April 2014.
- **c** Option C: to increase the annual retention fee, effective from 1 April 2014.

Recommendations

3 Council is asked to:

- **a** Approve the 2014 Business Plan.
- **b** Approve the 2014 revenue expenditure budget of £97 million and the capital programme of £8.1 million.
- **c** Determine the level of doctors' annual retention fees, by choosing between the three options set out above.
- **d** Agree to delegate authority to the Chair of Council to make the revised GMC Registration Fees Regulations, as necessary, effective from 1 April 2014.
- **e** Increase the threshold for eligibility for the income discount to £32,000, effective from 1 April 2014.

2014 Business Plan and Budget

Issue

Business Plan

4 The 2014 Business Plan has been developed in conjunction with the 2014 budget. Directors have ensured that key activities in the business plan have been fully costed and included in the 2014 budget.

5 The Business Plan reflects the development of the Corporate Strategy. The Corporate Strategy was discussed by Council in closed session on 13 November 2013. Following this a short, high level, external facing 2014 business plan has been drafted, which outlines the key activities that will be delivered in 2014 in fulfilment of our strategic aims.

6 Following practice in recent years we will support the publication of the Business Plan with a communications strategy based around a shorter and more accessible 'priorities leaflet' aimed at our key interest groups. The 2014 business plan is at Annex A, and the Corporate Strategy is set out as a separate item on this agenda.

7 The Business Plan will be used by the Performance and Resources Board as the basis for monitoring progress throughout 2014.

Context for the 2014 budget

8 Council has previously taken a medium term approach to financial planning, based on three financial priorities:

a Ensuring sufficient resources are available to deliver our strategic priorities and business plans.

b Continuing to deliver improvements in our economy, efficiency and effectiveness, enabling a freeze or reduction in doctors' fees.

c Maintaining free reserves at a level which is not excessive, but does not put our solvency at risk.

9 Our financial health is, to a large extent, measured by our reserves. We hold reserves for the following reasons:

a Risks – to provide funds to deal with any risks that materialise, resulting in an unexpected increase in expenditure and/or a reduction in income.

b Financial flexibility – to provide funds to respond to new initiatives, opportunities and challenges that may present themselves during the year.

c Timing – to manage the time lag in increasing/decreasing fee levels. Any change in fee levels in 2014 will not take full effect until 2016, due to the distribution of annual retention fee (ARF) payments through the year and the effect of the standard accounting treatment for deferred income.

10 Based on analysis of cashflows and the risks facing the organisation, our current policy is to maintain free reserves within the range of £25 million - £45 million.

11 As an organisation we are currently financially sound. We forecast that our free reserves will be around £51 million at the end of 2013.

12 Council has recognised that the actual level of reserves will fluctuate year on year, reflecting variations in actual levels of income and expenditure compared to budget. Our aim is therefore to bring actual reserves in line with the target range in the medium term.

13 The triennial valuation of the staff superannuation scheme is the subject of separate discussion by Council. The valuation shows a deficit of £4.7 million as at 31 December 2012, and Council will need to agree a schedule of contributions and a recovery plan to close the deficit. The increase in employer superannuation contributions has been included in the 2014 draft budget. The recovery plan will not be agreed until February 2014, but, for budgeting purposes we have assumed it will reduce our free reserves by around £6 million over the period 2014 to 2016.

2014 Revenue budget

14 We adopt a building block approach to budget-setting. The 2013 forecast outturn is used as the starting point for the 2014 budget, to reflect existing expenditure levels, and adjusted for the full year effect of 2013 Business Plan decisions, cashable efficiency gains, and known and unavoidable cost pressures in 2014. Bids for additional resources are scrutinised by the Performance and Resources Board, the Chief Operating Officer and Directors, before being incorporated in the budget.

15 The 2014 draft budget proposed is £97 million, set out at Annex B. This represents an increase of £7 million compared to the 2013 forecast, and the main reasons for the increase are set out at Annex C.

16 Our expenditure during the year is, to a large extent, influenced by activity levels over which we have little control. The key assumptions on which the 2014 budget is based are set out at Annex D.

Capital programme

17 Each year we incur a mix of revenue expenditure on day to day operational business, and capital expenditure on major IT and facilities projects and assets that will generate benefits over a number of years. The standard accounting treatment is to spread capital costs over the useful life of the asset, rather than accounting for the whole cost in the year of acquisition. This is achieved through an annual depreciation charge to the revenue account.

18 Annex E sets out the proposed capital programme of £8.1 million in 2014. A full business case will be prepared for all major capital projects before any costs are incurred.

Options

2014 Income

19 The introduction of revalidation creates a degree of volatility to our income projections. We know that 231,000 doctors currently hold full registration with a licence, with 20,000 doctors holding registration without a licence. However, we cannot predict with any degree of certainty what changes may occur in 2014 and beyond.

20 Typically the number of doctors joining the register each year has been higher than the number leaving each year due to normal turnover, and so we have seen a net increase in the number of registered doctors each year.

21 We know that 69,000 licensed doctors will revalidate during 2014 and it is likely that a proportion, for example those not in clinical practice, may choose to relinquish their licence. We also know that 14,000 doctors have declared that they have no prescribed connection, and around 23,000 doctors have yet to notify us if they have a prescribed connection, so a proportion of these may also choose to relinquish their licence. We have assumed that the impact of this on our income will be spread over the next three years.

22 In estimating the impact of different fee levels on our free reserves in the three options below, we have assumed that expenditure will increase by 3% in 2015 and 2016, and that the deficit on the Defined Benefit Pension Scheme will be closed by the end of 2016.

Annual Retention Fee level

Option A: to freeze the annual retention fee at the current level

23 We estimate that income in 2014 will be in the range of £92 million to £96 million. A prudent income budget for 2014 would be £95 million, if registration, retention and certification fees are maintained at their current levels.

24 The impact of a fee freeze would be to reduce our free reserves to around £35 million by the end of 2016.

Option B: to reduce the annual retention fee, effective from 1 April 2014

25 The annual retention fee is currently £390 for registration with a licence and £140 for registration without a licence. A £20 reduction in both fees with effect from 1 April 2014 would reduce our overall income by around £1.6 million in 2014. However, the full year impact of the fee reduction would be to reduce our income by around £4.8 million in 2015 and future years.

26 The impact of a fee reduction would be to reduce our free reserves to around £23 million by the end of 2016.

Option C: to increase the annual retention fee, effective from 1 April 2014

27 A £20 increase in the annual retention fee paid by all doctors for registration with or without a licence to practice, effective from 1 April 2014, would increase our income by around £1.6 million in 2014, and by around £4.8 million in 2015 and future years.

28 The impact of a fee increase would be to reduce our free reserves to around £47 million by the end of 2016.

Fees Regulations

29 Responsibility for making fees regulations rests with Council. Fee changes come into effect on 1 April each year, to allow sufficient time for changes to be made to our billing and collection systems.

30 The fee regulations cannot be drafted until Council has determined the fee levels, and so Council is asked to delegate authority to the Chair of Council to make the revised GMC Registration Fees Regulations, as necessary.

Income discount

31 Council introduced a discount in 2005, providing a 50% reduction in the annual retention fee for those with total annual income less than the starting salary for a doctor in Foundation Year 1.

32 In recent years Council has departed from this approach and agreed a higher income threshold in order to make the discount available to a greater number of doctors.

33 The threshold for eligibility for the income discount is currently £31,000, and we propose to apply a 3% increase to £32,000 effective from 1 April 2014.

34 The income discount scheme provides help to doctors whose income is below a certain threshold. It is available to doctors who are fully registered, with or without a licence to practise. There are no new equality and diversity issues arising as the eligibility criteria remains unchanged from previous years.

Supporting information

How this issue relates to the corporate strategy and business plan

35 This paper supports the development of the new Corporate Strategy.

If you have any questions about this paper please contact: Luke Bruce, Assistant Director – Strategy and Communication, lbruce@gmc-uk.org, 020 7189 5482; or Steve Downs, Assistant Director – Finance and Procurement, sdowns@gmc-uk.org, 0161 923, 6257.

General Medical Council

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Annex A

Draft Business Plan 2014

Our role

The General Medical Council is an independent organisation that helps to protect patients and improve medical practice across the four countries of the UK. We do this by defining the knowledge, experience and behaviour that are required of doctors. We decide which doctors are qualified to work in the UK and meet our high standards. And we oversee their training and education. We make sure that they continue to meet these standards throughout their careers, and that they're supported in doing so. We look into concerns about doctors and take firm but fair action where the safety of patients or confidence in the profession or public interest is at risk.

We believe that every patient should expect a high standard of care and that it's a vital part of our role to contribute to improving healthcare across the UK. We work closely with other organisations to do this and to build confidence and trust between patients and doctors.

Our plan for 2014

Our work in 2014 is designed to set us firmly on the road to achieving the strategic aims in our new Corporate Strategy (2014-2017) and ensure we continue to deliver a high quality service across our range of core regulatory functions. A more detailed Operational Plan underpins all of the activities in the Business Plan. The Operational Plan is overseen by our Performance and Resources Board, which will monitor our progress against the activities throughout the year.

Our continuing core work includes:

- Delivering high quality registration, certification, revalidation and licensing services to our published service targets.
- Dealing efficiently and appropriately with concerns raised about doctors' fitness to practise.
- Making sure that medical education and training meet our standards.
- Working with others to develop effective relationships that will enhance patient safety, both locally with employers, doctors and patients through our liaison services and with other organisations within the UK and internationally.

Our strategic aims

Our new Corporate Strategy for 2014-17 introduces five new strategic aims which set our direction for the next four years. These will allow us to enhance and expand on our core work.

Our strategic aims are to:

1 Make the best use of intelligence about doctors and the healthcare environment to identify risks to patients.

2 Help raise professional standards in medical practice.

3 Improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety.

4 Increase the impact of our work in relation to day-to-day practice.

5 Work better together to improve our overall effectiveness and the delivery of our regulatory functions.

The activities set out below are the main pieces of work we will undertake to help us achieve our aims during 2014.

Strategic aim 1: Make the best use of intelligence about doctors and the healthcare environment to identify risks to patients

We'll continue to develop smarter ways of using our data. In a rapidly changing healthcare environment with more information available than ever before, this will allow us to understand what's happening on the ground. We'll use this to both inform our own decision and policy making, and to share with employers, other regulators and patients so that risks can be acted on quickly.

Our work in 2014 will include:

- Continuing to develop our relationships and ways of working with other organisations, including the systems regulators across the UK and the NHS, so that we can share information effectively and help identify concerns.
- Delivering a new data strategy for the organisation so that we can make links between information quicker and easier.
- Publishing insights drawn from our data and intelligence on a range of themes affecting medical practice and patient safety. Continuing to develop *The state of medical education and practice in the UK* service and other reports will allow us and others to explore in depth issues affecting medical practice.
- Establishing a Patient Safety Intelligence Forum that will bring together information from a range of sources to help identify to help identify potential issues and risks to patient safety.

Strategic aim 2: Help raise professional standards in medical practice

We will work with doctors to make sure they have the tools they need to achieve high standards of professionalism and medical ethics and meet the challenges of a modern healthcare environment.

Our work in 2014 will include:

- Continuing to support the development of revalidation within the healthcare system. An important focus in 2014 will be supporting doctors to make their

prescribed connection to enable them to revalidate, or tell us where they don't have one. We will also finalise our approach for revalidation with doctors without a connection so that the system is accessible to all. We will process revalidation recommendations for nearly 70,000 doctors in 2014.

- Delivering an evaluation framework to determine the extent to which revalidation is delivering a real improvement in practice standards and patient safety.
- Taking forward the recommendations from the Shape of Training review (published November 2013), which will include looking at the timing of full registration and developing a regulatory framework for credentialing.
- Reviewing a number of areas of our work relating to professional standards including the Professional and Linguistic Assessments Board assessment; consulting on a revised set of standards for education and training.
- Begin developing new guidance on a range of topics including confidentiality and cosmetic practice.
- Making changes to our registration and licensing processes to make sure they are robust as possible. This will include using new legislation to ask EEA doctors for evidence that they have the 'necessary knowledge of English' and if necessary refusing to grant a licence to practice until such evidence is provided.

Strategic aim 3: Improve the level of engagement and efficiency in the handling of complaints and concerns about patient safety

We will work with doctors, employers, patients and other organisations to make sure that when a concern is raised, timely and appropriate action is taken.

Our work in 2014 will include:

- Using the new relationships developed with Responsible Officers to reform our complaint handling in a way that ensures that complaints are dealt with by those best placed to deal with them. We will develop processes to refer complaints to a doctor's RO where they do not warrant investigation by us and would be more efficiently dealt with locally.
- Improving how we deal with complaints, so that we are able to resolve issues which do not need further investigation, sooner. This will include making enhanced use of the Fitness to Practise rules during the initial stage of an investigation to determine which cases do not need further and can be closed earlier in the process than previously.
- Continuing to pilot meetings with doctors and patients involved during an investigation, with the aim of reducing stress associated with being involved in a fitness to practise case.
- Building on the success of our pilot 'Welcome to UK practice' programme, we will evaluate and develop our support for doctors new to practice in the UK.

Strategic aim 4: Increasing the relevance and impact of our work in relation to the day-to-day experience of doctors, medical students and patients

We will continue to fulfil our core functions to a high standard, but develop more tailored approaches to delivering our work that helps doctors and medical students meet the variety of challenges they face in their increasingly diverse roles. We will also take steps to support patients further in terms of being clear about what they can expect from their doctors and making their interaction with the GMC as stress-free as possible.

Our work in 2014 will include:

- Launching an annual tracking survey of doctors, doctors in training, patient representative bodies, patients and public that will provide intelligence on how the GMC and its services are perceived.
- Developing smartphone applications and other ways to communicate and share our guidance with doctors and patients.
- Piloting a Trainer Survey, which will tell us more about the experiences and perceptions of the senior doctors who support postgraduate trainees, to complement our annual National Training Survey.
- Using our liaison services to promote to patients and patient groups across the UK our new guide for patients on what to expect from their doctor

Strategic aim 5: Work better together to improve our overall effectiveness and the running of our regulatory functions

It is likely that we will see a major change in the legal framework that underpins our work in 2014/15, and we must prepare both internally and with others to ensure that the new arrangements enhance patient safety. We will set up a new team to plan our detailed work in preparation for the Bill, and to provide legislators and officials with the necessary information and to inform their deliberations.

As we expand and evolve, we need to make sure we work together so that everyone within the organisation is aware of how their work helps us fulfil our regulatory objectives and of the contribution which other teams make towards this. We will continue to challenge ourselves to find the best ways of being highly effective in using our resources to protect patients and improve medical practice.

Our work in 2014 will include:

- Undertake the next round of our staff survey, to gather views on how we work from across the whole organisation. We will also implement improvements to staff well-being which were developed in response to the previous survey.

- Continuing our corporate efficiency and effectiveness programme including reforms to our fitness to practise function, fostering a culture of excellence and continuous improvement.
- We will develop and overarching people strategy as part of continued investment in our people, their learning and development, their working environment and the information systems and infrastructure that support them.

Summary operating budget 2014 budget summary by expenditure type	**£000**	**%**
Direct Staffing Costs	47,902	49.4%
Indirect Staffing Costs	3,262	3.4%
Office Costs	6,620	6.8%
Accommodation Costs	6,470	6.7%
Legal Costs	5,806	6.0%
Professional Fees	4,604	4.7%
Council & Members Costs	388	0.4%
Panel & Assessment Costs	14,973	15.4%
Depreciation	6,696	6.9%
New Initiatives Fund	250	0.3%
Total	**96,971**	**100%**

2014 budget summary by directorate	**£000**	**%**
Chief Operating Officer's Office	1,123	1.1%
Fitness to Practice	29,989	30.9%
MPTS	10,471	10.8%
Strategy and Communication	10,822	11.1%
Education and Standards	5,499	5.7%
Registration & Revalidation	11,625	12.0%
Resources & Quality Assurance	14,026	14.5%
Accommodation	6,470	6.7%
Depreciation	6,696	6.9%
New Initiatives Fund	250	0.3%
Total	**96,971**	**100%**

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Annex B

2014 Draft Income and Revenue Expenditure Budget

1 Annex B(i) shows income and expenditure by cost type.

2 Annex B(ii) shows expenditure by directorate.

2014 Business Plan and Budget - income and expenditure by cost type - Annex B(i)

	Budget 2013 £000	Forecast 2013 £000	Budget 2014 £000	Movement Budget 2013 vs Budget 2014 £000	Movement Budget 2013 vs Budget 2014 %	Movement Forecast 2013 vs Budget 2014 £000	Movement Forecast 2013 vs Budget 2014 %
Annual Retention Fee (assuming a fee freeze)	86,600	85,773	85,200	-1,400	-2%	-573	-1%
Registration Income	4,100	4,040	4,000	-100	-2%	-40	-1%
PLAB Income	1,200	1,193	1,200	0	0%	7	1%
Certification Income	3,000	3,150	3,000	0	0%	-150	-5%
Investment Income	500	863	1,400	900	180%	537	62%
Other Income	200	375	200	0	0%	-175	-47%
Total Income	**95,600**	**95,394**	**95,000**	**-600**	**-1%**	**-394**	**0%**
Direct Staffing Costs	44,136	42,665	47,902	3,766	9%	5,237	12%
Indirect Staffing Costs	3,556	3,247	3,262	-294	-8%	15	0%
Office Costs	6,375	6,237	6,620	245	4%	383	6%
Accommodation Costs	6,623	6,324	6,470	-153	-2%	146	2%
Legal Costs	5,758	6,140	5,806	48	1%	-334	-5%
Professional Fees	6,386	4,435	4,356	-2,030	-32%	-79	-2%
Council & Members Costs	473	386	388	-85	-18%	2	1%
Panel & Assessment Costs	16,234	14,348	14,973	-1,261	-8%	625	4%
Bank Charges	250	257	248	-2	-1%	-9	-4%
Depreciation	6,162	5,746	6,696	534	9%	950	17%
New Initiatives Fund	500	250	250	-250	0%	0	0%
Total Expenditure	**96,453**	**90,035**	**96,971**	**518**	**1%**	**6,936**	**8%**

2014 Business Plan and Budget - expenditure by directorate - Annex B(ii)

	Chief Operating Officer's Office		Fitness to Practice		MPTS		Strategy and Communication		Education and Standards	
	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000
Direct Staffing Costs	808	893	15,422	17,100	2,548	2,725	5,388	6,818	3,796	4,396
Indirect Staffing Costs	68	50	731	691	71	100	525	540	216	172
Office Costs	20	16	1,033	916	335	397	1,597	1,496	133	120
Accommodation Costs	0	0	0	0		0	0	4	0	0
Legal Costs	1	10	6,061	5,703	17	24	0		0	0
Professional Fees	179	154	740	371	99	0	1,171	1,533	303	172
Council & Members Costs	0	0	0	0	0	0	386	388	0	0
Panel & Assessment Costs	0	0	5,032	5,208	7,076	7,225	30	43	359	639
Bank Charges										
Depreciation										
New Initiatives Fund										
Total	**1,076**	**1,123**	**29,019**	**29,989**	**10,146**	**10,471**	**9,097**	**10,822**	**4,807**	**5,499**

	Registration and Revalidation		Resources and Quality Assurance		Accommodation		Costs Controlled Centrally		Total	
	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000	Forecast 2013 £000	Budget 2014 £000
Direct Staffing Costs	7,825	8,404	6,878	7,566					42,665	47,902
Indirect Staffing Costs	368	294	1,268	1,415					3,247	3,262
Office Costs	935	1,023	2,184	2,652					6,237	6,620
Accommodation Costs	0	0	0	0	6,324	6,466			6,324	6,470
Legal Costs	4	16	57	53					6,140	5,806
Professional Fees	184	30	1,759	2,096					4,435	4,356
Council & Members Costs	0		0	0					386	388
Panel & Assessment Costs	1,851	1,858	0	0					14,348	14,973
Bank Charges			257	248					257	248
Depreciation							5,746	6,696	5,746	6,696
New Initiatives Fund							250	250	250	250
Total	**11,167**	**11,625**	**12,403**	**14,030**	**6,324**	**6,466**	**5,996**	**6,946**	**90,035**	**96,971**

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Annex C

2014 Budget Analysis

1 The 2014 draft budget proposed is £97 million, which represents an increase of £7 million compared to the 2013 forecast. The main reasons for the increase are set out below.

	£m	£m
2013 Budget		**96.5**
Less: Q3 forecast		-6.5
2013 Outturn		**90.0**
Less: cashable efficiencies and 2013 one-off projects		-4.3
Add: full year effect of 2013 business plan		3.6
Add: known and unavoidable cost pressures in 2014:		
Fitness to practise volumes	1.0	
Depreciation	1.0	
Potential increase in employers superannuation contributions	0.8	
Registration and revalidation activity levels	0.3	
Rent reviews	0.2	3.3
Add: bids for additional resources:		
Increased IS, HR and Facilities and QA support to directorates	1.2	
Data strategy	1.0	
Increased education visits and activity levels	0.7	
Work to support potential changes to our legal framework	0.4	
Investment fund management	0.3	
Increased research	0.2	
Strategic regulation	0.2	
Develop online resources	0.2	
Increased capacity in the Chief Operating Officer's office	0.1	
Governance review, effectiveness and appraisal	0.1	4.4
2014 Draft Budget		**97.0**

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Annex D

2014 Key Budget Assumptions

1 Our expenditure during the year is, to a large extent, influenced by activity levels over which we have little control. The key assumptions on which the 2014 budget is based are set out below.

Staffing

2 Our staff costs each year are affected by three factors:

a Staff turnover - we know from past experience that normal staff turnover is around 9% each year. For the 2014 budget, we have assumed that posts are vacant on average for three months.

b Internal promotions - a proportion of new and vacant posts are filled through internal promotions, which create further vacancies.

c Delays in filling new posts – typically directorates wish to recruit new staff as soon as possible in the year, and this has tended to create peak recruitment activity in January and April, which is difficult to manage. For the 2014 budget, we have deferred some start dates to smooth out the recruitment profile.

3 We have adjusted the 2014 staffing budget by £2 million, to reflect these factors.

Fitness to Practise volumes

4 We have developed a forecasting model that takes account of historical trends and key assumptions about future volumes. Our current estimate is that the increase in new enquiries will mirror the rolling average over the last 12 months.

a Based on this, we have budgeted for a 10% enquiry increase in 2014 which equates to 11,231 enquiries, 3,212 Stream 1 cases and 1,235 Stream 2 cases.

5 The 2014 budget includes provision to carry out 70 performance assessments, and 1,900 expert reports.

MPTS hearings

6 Based on the fitness to practise forecasting model, we estimate 1,965 hearing days and 529 Interim Order Panel days in 2014.

Education visits

7 Education quality assurance visits comprise three main elements: regional reviews, scheduled up to five years in advance, Response to Concerns Assessment Team (RCAT) visits in support of Postgraduate Deans to respond to concerns at specific sites, and check visits.

8 Regional reviews are a series of visits to a region of the country and include both undergraduate and postgraduate visits to medical schools, deaneries or Local Education and Training Boards and local education providers. Visits to the organisations involved take place across a period of two to three months. They are risk based, the risks being determined by our own evidence about education and training and also informed by evidence from other regulators. In 2014 we aim to carry out 19 visits.

9 We have budgeted for 25 days to cover RCAT visits.

10 We plan that our check visits in 2014 will include four medical schools and between six and eight local education providers.

Registration and revalidation

11 The 2014 budget is based on the following registration activity levels:

a 7,700 provisional registrations.

b 13,100 full registrations.

c 5,900 applications for a Certificate of Completion of Training.

d 400 applications for a CESR/CEGPR.

e 2,600 PLAB 1 tests and 1,900 PLAB 2 tests.

f 69,000 revalidations.

12 There are 14,000 doctors who have declared that they have no prescribed connection. We have assumed that those not in clinical practice, and those practising outside the UK, will relinquish their licence to practise over the next three years.

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Annex E

2014 Capital Programme

2014 Business Plan and Budget - Capital Programme - Annex E

	Capital Expenditure £	£	Depreciation charges 2014	2015	2016	2017	2018	2019
IS Projects								
Business Projects	1,150,000		95,833	383,333	383,333	287,500		
Infrastructure Projects	500,000		41,667	166,667	166,667	125,000		
SAP	2,955,748		246,312	985,249	985,249	738,937		
Back Up and Storage (Infra)	300,000		25,000	100,000	100,000	75,000		
New Website (Business)	150,000		12,500	50,000	50,000	37,500		
Livelink Capability (Business)	100,000		8,333	33,333	33,333	25,000		
FtP History	95,000		7,917	31,667	31,667	23,750		
CAC Electronic Marking	250,000	5,500,748	20,833	83,333	83,333	62,500		
Scheduled Homeworking Projects								
Facilities	583,000		29,150	116,600	116,600	116,600	116,600	87,450
IS	689,514	1,272,514	57,460	229,838	229,838	172,379		
Facilities Projects								
Facilities projects	1,324,000	1,324,000	66,200	264,800	264,800	264,800	264,800	198,600
Total charge for new projects in 2014		**8,097,262**	**611,205**	**2,444,820**	**2,444,820**	**1,928,966**	**381,400**	**286,050**
Prior years projects - Depreciation charges			6,084,947					
Total Depreciation charge for 2014			6,696,152					