

Salisbury NHS Foundation Trust

**Electronic application for 2022/23 CAPITAL funding**

**Medical Equipment Projects only**

**One bid per device or multiples of same device.** All sections to be completed.

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| **SECTION A: GENERAL** | | | | | | | | |
| Name of Medical Device | | | |  | | | | |
| Ward/department | | | |  | | | | |
| Directorate | | | |  | | | | |
| **Name of person submitting** | | | |  | | | | |
| **Approved and submitted by** Divisional Manager or Clinical Director | | | |  | | | | |
| **Date of application** | | | |  | | | | |
| **Financial approval by**  Directorate Finance Manager | | | |  | | | | |
| **SECTION B: PROJECT CATEGORY AND PRIORITY** | | | | | | | | |
| Department priority of bid | | | |  | | | | |
| Division priority of bid | | | |  | | | | |
| **SECTION C: PROPOSED SCHEME** | | | | | | | | | |
| Detailed description (including type and number of medical devices, this is essentially the case of need for the device. Please identify if there are financial or non financial benefits.  If no evidence is provided the bid will not proceed. | | | | | | | | | |
| Where is the location of the equipment? | | |  | | | | | | |
| Is this a replacement or development? | | | REPLACEMENT DEVELOPMENT | | | | | | |
| **SECTION D: RISK ASSESSMENT COMPLETED** | | | | | | | | | |
| A completed Risk Assessment (not a DATIX log) **must** accompany ALL bids for Capital funding. | | | | | | | | | |
| SECTION E: COSTS | | | | | | | |
| Medical equipment cost (**incl. VAT**, delivery and installation)  If multiple devices please give individual cost (each item must be over £250 and collectively more than £5000 **incl VAT**) | | | | | £  £ | | |
| Does this item have any associated revenue costs ie consumables, service or maintenance contract?  (These will be charged to your department budget) | | | | | Consumables ; Yes/No  Service/Maintenance; Yes/No  Comments: | | |
| SECTION F: MEDICAL EQUIPMENT | | | | | | | |
| Name(s) of manufacturers or suppliers  Please provide up to 3 separate suppliers and submit quotes if available. | | | Supplier | | | Contact details | |
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| **SECTION G: MEDICAL EQUIPMENT STATUS** | | | | | | | |
| FOR REPLACEMENT EQUIPMENT  Please identify name and asset number of the item of equipment being replaced. | | | Name:  Make:  Model: | | | Medical Electronics Asset ID:  Unit Serial Number: | |
| What is the age of the equipment being replaced? | | | | | | Years | |
| Why is it being replaced? |  | | | | | | |
| **SECTION H: MEDICAL EQUIPMENT USAGE** | | | | | | | |
| How many times is the equipment going to be used on average per month? | | | Please indicate  1 – 10 11 - 20 21 – 30 31 or more | | | | |
| How many patients per month? | | |  | | | | |
| **Please note: If funding is agreed and the purchase made, all replaced equipment must be returned to Medical Device Management Services .** | | | | | | | |

Capital Bids must be sent to

[sft.mdms@nhs.net](mailto:sft.mdms@nhs.net)

via Divisional Management teams only.

**To be submitted by Thursday 12th August 2021**