Guidelines for Capital Investment
Acknowledgements

These guidelines have been written following significant input from a wide range of people across the health sector. Those contributions are gratefully acknowledged. They have contributed to a document that is intended to be of practical assistance to DHBs, as well as to the Crown.

An update of these guidelines is anticipated. Feedback will be well received and will be acted upon.
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Introduction

The delivery of health services required to meet the New Zealand Health and Disability Strategies requires building and maintaining high-quality, well-located and safe public health facilities. There is a significant stewardship responsibility for all who are responsible for public health infrastructure.

To meet this responsibility requires tools to build community trust and deal with conflicting community expectations. It also requires clear requirements for business cases and a stable, trusted and transparent framework for capital decision-making that is appropriate for the DHB environment.

Much knowledge regarding the efficient allocation of capital expenditure resides in DHBs. What is required, therefore, are sound structures for inter-DHB decision-making and collaboration, and incentives for the sector to prioritise capital expenditure and to adhere to agreements. There is much potential for peer-led decisions and peer review to provide these incentives. This maximises local and regional contributions to the capital allocation process and avoids as much as possible decisions being removed from DHBs.

In order to best deliver defensible decisions on how to spend a limited budget, this Capital Investment Framework sets out a process to maximise the service and efficiency gains achievable from collaboration and the incentives from peer review.

Any peer process, however, must not undermine the individual accountability of DHBs. It should also not diminish the obligation of central agencies to take responsibility for final major capital allocation recommendations and discharge their duty to enable the health system to function as a coherent system.
1. The Health Capital Budget

The Health Capital Budget is a capped funding envelope for both new debt and equity from which the health sector’s capital requirements must be funded. The Ministry of Health is required to manage these pressures within this capped budget.

To manage the Health Capital Budget within the capital envelope, and to gain maximum value from health capital spending, both the Ministry and DHBs must ensure that demands for capital are carefully prioritised and consistent with national and regional service priorities.

Crown Financing Agency (CFA) debt and the role of the CFA

Funding for CFA debt as well as Crown equity is from the Health Capital Budget. Therefore, projects requiring debt must be prioritised in the same manner as those with an equity component.

Early contact should be made with the CFA when developing a business case. The CFA will act as a partner to the DHB in developing a bankable business case that is consistent with these guidelines. See also ‘CFA assessment of bankability’ on page 19.

Private sector debt

DHBs are reminded that accessing private sector debt to support cashflow (beyond the accepted overdraft for working capital) is not permitted. The Operational Policy Framework makes it clear that private debt is for working capital purposes only or where the Minister of Finance has approved a private facility.
Projects that require ministerial or other approval

The following approval for capital expenditure is required. Some DHBs may be subject to additional approval requirements as a consequence of their position on the Monitoring and Intervention Framework.

1. **Per Cabinet Minute (00) M 20/4**

**Thresholds for significant investments requiring Ministers’ support**

CAB (00) M 20/4 19 June 2000 recorded that Cabinet agreed that the agreement of the Ministers of Health and Finance be required for:

1. all capital investments in fixed assets that require Crown equity support
2. investment projects or programmes totalling $10 million or 20 percent of total assets whichever is the lesser (these figures being based on an assessment of materiality of DHB balance sheets)
3. investments potentially affecting in a strategic way the performance of DHBs, or investments that have been identified in DHB plans as being of high risk.

These criteria also apply to joint ventures and other such investment proposals.

2. **Per September 2003 ministerial directive regarding investment in information systems and communication technology**

Following concern regarding the quality of health IT investment, the Minister of Health has directed that a stepped approval be required for information systems and communication technology.

Information systems and communication technology is defined as computer systems such as applications, hardware and software and includes networking and communications. This definition excludes laboratory analysis equipment, telephone equipment and digital radiology systems. All information systems and communication technology investment must be consistent with the sector Information Systems Strategic Plan (ISSP), unless ministerial approval is given for a variation.

**Thresholds for information systems and communication technology investment requiring ministerial or other approval**

1. Approval by the Minister of Health is required if the investment is over $3 million, or is not consistent with the sector ISSP, or the Regional Capital Group does not support it.
2. Approval by the Director-General of Health is required if the investment is between $3 million and $500,000, and consistent with the sector ISSP and Crown debt or equity is not required.
3. Support by a Regional Capital Group is required if the investment is over $500,000.
2. Capital Investment Framework

Purpose

1. To manage the Health Capital Budget within the agreed funding envelope.
2. To be affordable in terms of Sections 3(2) and 41 of the NZPHD Act which require that DHBs operate in a financially responsible manner.
3. To promote the objectives of the New Zealand Health and Disability Strategies.

Principles

The Capital Investment Framework must:

- ensure capital expenditure is directed in a way that maximises health gain and is consistent with sector-wide health service objectives and planned service configurations
- incentivise provisioning by DHBs for future asset replacement
- incentivise DHB collaboration to achieve health and efficiency gains
- first sustain and then improve the quality of the current asset base
- maximise the efficiency and capacity of the current asset base by maximising the use of current land holdings and efficiently using current facilities (including equipment and information systems and communication technology)
- identify surplus assets and maximise revenue from disposal
- improve knowledge of condition, use and performance of assets.

Objectives

To be effective the Capital Investment Framework must deliver defensible sector-wide prioritisation of capital expenditure underpinned by incentives for the sector to reach binding decisions.

To achieve this the Framework must:

- provide a sector- and/or region-wide test of DHBs’ planned capital priorities and timing
- deliver clear results with no surprises
- have health sector commitment to the process
- ensure decisions are consistent with national and regional service priorities
- be transparent and robust over time
- provide collegial and other incentives to enable the sector to reach binding agreements
- facilitate collective DHB decision-making
- encourage a culture of valuing inter-DHB fairness
- preserve individual DHB accountabilities
- promote the Crown’s duty to enable the health system to function as a coherent system
- ensure that DHBs recognise that the Government must prioritise all capital spending decisions, and that the envelope is the result of that process, therefore spending must fit within it.

**Annual capital allocation round**

Prioritisation and indicative allocation of the capital envelope will be managed via an annual capital allocation round, the results of which will inform DHBs, DAP and DSP planning processes.

The allocation round will be managed via the National Capital Committee (see below). Final responsibility for funding decisions rests with Ministers.

**Capital allocation round timing**

The capital allocation round will take place during September and October each year. It will consider capital plans requiring Crown equity or debt and any project requiring ministerial approval.

DHBs must have proposals to the Ministry of Health by 31 August each year for consideration in the capital allocation round. When asset management planning is fully operational, proposals must be accompanied by a copy of the DHB’s asset management planning documentation (see page 10).

In considering projects as part of the annual allocation round, the National Capital Committee may establish next steps (as opposed to funding) that take account of the timeline reasonably required by the project. This is to avoid unnecessary rigidities arising as a result of an annual cycle. Ideally, however, the National Capital Committee will consider final business cases.
Capital funding signals and the DAP planning cycle

To inform DAP and DSP planning processes, capital allocation decisions will be announced to DHBs in November along with annual revenue signals.

Figure 1: Annual capital planning cycle

National Capital Committee

Purpose

The National Capital Committee (NCC) has been established to lead and facilitate an expert central capital advice capability. The Committee provides the mechanism to deliver a whole-of-sector view on capital and advice on capital investment to inform the Ministry’s advice to the Minister.

To ensure that its work is informed by national service priorities, the NCC will develop strong links to the service framework and the group charged with its development, the Chief Executive Officers/Deputy Director-Generals group.

Jurisdiction

The NCC will advise on all projects for which new Crown debt or equity is required and all projects that require ministerial approval. Detailed criteria for projects that require ministerial approval are described above.
**Conduct and conflicts of interest**

The NCC will adopt the standard DHB process for conduct and conflicts of interest per Sections 27 and 29 of the NZPHD Act.

The NCC will receive advice and act as a collective. Members will not undertake individual site visits or accept direct lobbying of individual members.

Members act in their individual capacity, not as representatives of the regions or DHBs from which they are drawn.

**Development of a business case prioritisation framework**

Consideration by the NCC of business cases requiring Crown equity or debt will be undertaken via a prioritisation framework for business cases. This framework is attached as Appendix 2.

**Terms of reference**

1. To provide strategic policy advice regarding capital investment and timely recommendations to the Ministry on capital projects that require ministerial approval.
2. To develop and keep current a Capital Investment Framework for managing the capital budget envelope.
3. To ‘champion’ the new agreed Capital Investment Framework and facilitate its introduction.
4. To consider wider matters and advise on the incentives, policies and structures that affect the Government’s capital ownership objectives.

**Membership**

1. A DHB Chair from each DHBNZ region nominated by the Minister.
2. The Chair of DHBNZ.
3. Ministry of Health – DDG, DHB Funding and Performance (Chair).
4. A CEO representative – Chair of National CEOs Group or nominee (if nominee, CEO must also be a member of the CEO-DDG Group).

In attendance:


A quorum shall consist of the Chair and three members.
Prioritisation and efficiency of capital spending by DHBs

To enable DHBs to demonstrate that every possible opportunity has been taken to maximise health gain from capital expenditure three other mechanisms – Regional Capital Groups, Health Development Initiatives and asset management planning – form part of the Capital Investment Framework.

These mechanisms are intended to maximise the opportunity for local and regional contribution to the prioritisation process, ensure affected DHBs are consulted on decisions and to avoid as much as possible decisions being removed from affected DHBs. They also reflect the interconnections of the DHB structure.

Regional Capital Groups

To ensure all opportunities are taken to gain maximum value from capital expenditure DHBs will be required to establish formal Regional Capital Groups (RCGs). The purpose of these groups is to:

- contribute to service planning
- enable standardisation
- avoid unnecessary duplication
- consider matters referred
- enable procurement co-ordination
- enable regional prioritisation of capital expenditure
- apply peer review to help improve the quality of DHB capital spending.

DHB Boards continue to be responsible for capital expenditure. Board consideration should be undertaken following the consideration by a Regional Capital Group of any proposals within its mandate.

The boundaries of RCGs should be the same as the regional shared service groups.

The Chair of the RCG should be appointed by the region. DHBs who form the RCG will jointly determine the value of the projects that will require consideration by the RCG. For the purposes of determining what should be considered by an RCG, donated equipment should be valued at market value and considered by the RCG if it is over the agreed threshold.

When requesting equity or debt, DHBs must provide evidence that a Regional Capital Group has considered the project.
Regional Capital Groups and information systems and communication technology investment

Health IT projects offer significant scope for collaboration. Regional Capital Groups will be expected to consider IT proposals (eg, via a sub-committee). For IT projects to proceed, evidence is required that all collaborative opportunities have been explored. Support from the RCG must be sought for all information systems and communication technology investment proposals greater than $500,000.

The intention is to use sector peer review to ensure that proposals minimise the level of risk associated with new IT implementations, maximise investment already made on existing systems and focus future IT investment on health care provision rather than on technology.

To meet the IT collaboration requirement, DHBs should seek written support from the other DHBs that proposals are consistent with the following objectives.

- Consistent with the integration of clinical information across the region’s health providers (primary and secondary).
- Empowers clinicians to provide efficient health care delivery through the use of shared information systems.
- Maximises return on information systems investment across DHBs.
- Maximises opportunity for savings from joint purchasing of IT.
- Minimises the risk associated with new implementations and big bang approaches.
- Identifies and develops centres of excellence within the health sector with resources and expertise prior to outsourcing.

Following this, prioritisation of the IT project within the region’s overall capital expenditure by the RCG can take place.

Health Development Initiatives

A Health Development Initiative is a process, prompted by a specific capital proposal, to prioritise and agree the allocation of health services and the capital implications for a region. It is discussed in detail on page 20.
Asset management plans
DHBs must undertake formal asset management planning to ensure that capital prioritisation decisions are well informed. The process will also inform the DSP and DAP.

Asset management planning must include the following components.
- Strategic Asset Financing Plan.
- Strategic Asset Management Plan.
- Facilities and Major Equipment Management Plan.
- Information Services Strategic Plan (ISSP).

Additional support and information on the requirements of asset management planning will be developed by the Ministry of Health in collaboration with DHBs.

Strategic Asset Financing Plan
A Strategic Asset Financing Plan must address the financial consequences of the conclusions of strategic asset planning and detail how proposed capital expenditure is to be funded. Importantly, it must specifically address allocation of a DHB’s own financial resources over time to cope with any lumpiness in forecast capital investment needs. This may be via accumulation of cash reserves from free cashflow or, more likely, by repayment of debt to enable balance sheet capacity to borrow to meet future needs. Repayment of debt in particular will also minimise interest costs between periods of major investment. This issue is particularly important as we move to population-based funding and the resulting reset of deficits to zero for almost all DHBs. A programme of debt amortisation will make it easier for DHBs to avoid overspending or pressure to use cash reserves, creating deficits again.

A Strategic Asset Financing Plan must also detail any planned asset sales and demonstrate how the appropriate disposal of assets, and reinvestment of the proceeds, will assist the DHB to maintain and fund its future facility requirements.

Strategic Asset Management Plan
A Strategic Asset Management Plan must detail current, medium (2–5 years) and long-term (5–15 years) asset requirements and facility-related drivers for change. It must be informed by operationally focused facilities management plans, an ISSP and site master plans. It should also consider equipment and facilities issues driven by forecast demand trends, new policy (eg, PHOs) and new technology.
National Capital Plan

Strategic asset planning will also be used to inform the development of a National Capital Plan of long-term health sector capital investment requirements. This national plan will involve long-term sector-wide capital planning that identifies and prioritises major capital projects (such as new hospitals, hospital extensions or major refurbishments) that are desired over the next 10 years and set indicative timeframes for their implementation in a manner that integrates capital and service funding at a national level.

Asset management planning cycle

Asset management plans must be updated annually and copies sent to the Ministry of Health at the same time as the DAP. (Note: facilities management plans should be updated in response to changes in the asset base, which it is acknowledged may not fit with an annual cycle.)

Figure 2: DHB asset management requirements

![Diagram of asset management planning cycle]

1. ISSP
2. Facility Management Plans
3. Strategic Asset Management Plan
4. Strategic Asset Financing Plan
5. DHB opex and capex budgets
6. Building blocks
7. Physical consequences
8. Financial consequences
Fit with District Annual Plan (DAP) and District Strategic Plan (DSP) process

Funding for the next financial year for major projects will be considered by the Crown in September and October each year. The DAP and DSP planning cycle will be informed by the outcome of the consideration of capital proposals by the Crown. (Note: projects will not be approved on account of support for a DAP unless specified in the DAP approval letter.)

All major capital projects, details of planned funding and any associated Health Development Initiative processes must be noted in DHB DAPs. Indicative timelines for each stage of the capital development pathway for major projects and reference to annual capital allocation round approvals given, or to be sought, must also be detailed in the Capital Investment part of DAPs.

The Operational Policy Framework sets specific requirements and must be consulted in the preparation of DAPs.

**Figure 3:** A national view of the Capital Investment Framework
**Figure 4:** DHB view of the Capital Investment Framework

- **Ministers of Health and Finance**
  - Health capital policy, business case guidance and annual capital allocation round

- **DHB**
  - Submission to annual capital allocation round

- **Regional Capital Group**
  - A standing committee to enable:
    - informed service planning
    - standardisation
    - procurement coordination
    - regional prioritisation of capital expenditure
    - avoidance of unnecessary duplication.

- **Strategic Asset Management Plan**
  - Addresses the consequences reached in the Strategic Asset Management Plan.

- **Facilities Management Plan**
  - Strategic Asset Financing Plan

- **Business Cases**
  - Developed via the development pathway for major projects.

- **Health Development Initiative (HDI)**
  - A (regional) process prompted by a specific capital proposal to identify best practice service delivery configuration and the consequences for facilities. Led by the initiating DHB (possibly facilitated by the RCG).

- **Equity and debt funding and signals for DAP and DSP capital planning**

- **Strategic Asset Financing Plan**
  - Addresses the consequences reached in the Strategic Asset Management Plan.

- **Seek support for any national IDF price adjustment.**
3. Business Cases

Business case development for a major capital project

A major project is a significant commitment of a DHB’s resources and will likely create a legacy for a generation. Tools to deal with conflicting expectations and clarity as to each project development step are essential if an outcome defensible well into the future is to result. To ensure that that is the case, and to enable the logical development of a business case, a three-stage process is to be undertaken.

1. Strategic stage.
2. Options analysis stage.
3. Completed business case stage.

This will also enable the Crown to work alongside the DHB. Approval of a business case is complex, potentially expensive and time-consuming. This staged process is intended to facilitate an informed, effective and timely consideration of the case by the Crown and mitigate against the risk of work being undertaken that will not secure Crown support.

The staged process will also enable DHBs to manage the development of business cases in a more consistent way while managing internal staff and external community expectations.

The business case should be a stand-alone document and not assume prior knowledge by the reader. A table of contents is attached as Appendix 3. This will assist in structuring the case and ensuring key areas are addressed.

Ministry of Health involvement

The Ministry of Health will be a partner to DHBs during each step. Ministry approval is required to proceed to each stage (however, ministerial approval may be required if major strategic decisions are being committed to as part of a step). The detail and type of approval required will be tailored to the size and risk of the project.

CFA involvement

Early contact should be made with the CFA when developing a business case. The CFA will act as a partner to the DHB in developing a bankable business case that is consistent with these guidelines.
DHB governance expectations

A business case is as much a tool for a DHB’s own needs as it is a document for the Crown. The DHB Board must demonstrate full ownership of the business case. DHB Boards are expected to take full responsibility for the assumptions and consequences of a DHB’s business case. Such full support by the Board of a business case prior to submission to the Crown is an essential requirement for ministerial support for capital funding.

It must also be clear that Boards have taken the prioritisation decisions necessary to ensure that capital expenditure proposals are affordable to the DHB overall.

Public consultation and public expectations

Public consultation requirements, including consultation with Māori, are detailed in the Operational Policy Framework (OPF) and should guide the consultation process. It is likely that public consultation, when required, will be best undertaken following completion of the option analysis stage (stage 2).

Public consultation is also likely to be required as part of any Health Development Initiative (discussed on page 20).

It is also a requirement that DHBs do not raise public expectations of capital investment greater than the ability of the DHB or the Crown to fund such investment. Sound management of public expectations by DHBs will be a requirement for proposals to receive favourable consideration for funding.

Ministerial approval of service change

Substantial reconfiguration of services requires ministerial approval. Guidance is available from the Ministry.

Public Private Partnerships (PPPs)

The OPF sets out the requirements for ministerial approval of arrangements such as public private partnerships. Policy developments, such as PHOs, create a number of opportunities for DHBs to practically explore such partnerships. Guidance is available from the Ministry of Health.
Key principle for development of PPPs and service change

A key high-level test that DHBs should apply when considering these situations is as follows.

‘Is the proposed structure likely to increase the quality (clinical and financial) of public health services and at least not diminish the level of community trust and confidence in the public health system, and remain consistent with the service coverage schedule?'

In essence, a DHB may explore realistic options that enhance health services provided the local community, the Ministry and the Minister accept the merits of the proposal and are supportive. Any proposal must also fit within the legislation and the scope of the Operational Policy Framework, and will likely require prior specific approvals by the Minister.

Option analysis and affordability criteria

An initial affordability analysis must be undertaken as part of the strategic stage (stage 1). The option analysis and evaluation of affordability must be undertaken as part of the second stage. Detailed financial planning must be completed as part of stage 3 of the development of the business case.

Determining the best option for the DHB

To answer the question ‘why is this the best project?’, the DHB should:

1. state the health objective(s) it is endeavouring to meet
2. detail the options considered (reference should be made to regional processes undertaken to explore potential options)
3. detail how each option will, or will not, meet the intended health objective (this must include the ‘do nothing’ option)
4. complete an NPV analysis to compare the practical options
5. demonstrate via a review of the case by the Regional Capital Group (RCG) that the proposed option has peer support (or prove the DHB’s case if there is a difference of opinion).

Site master plan

Development of a master plan for the whole hospital campus is essential to demonstrate that individual projects are not being developed ad hoc, so compromising future development and leading to poor flows of patients and staff. Proposals must therefore be shown in the context of the overall site.
Development of a fallback option
To assist with national prioritisation and management of the health capital budget, all business cases must develop a fallback position that details how the DHB will proceed if the funding requested is declined. This must demonstrate the most practical approach that could be taken by the DHB in the eventuality that national capital funding is not approved, or that only part of the funding requested is approved. This may involve detailing the potential for the project to be staged and specifying an urgent priority component.

Affordability
Affordability has two components.
1. Determining the DHB’s overall ability to afford the project.
2. National prioritisation and affordability within the health capital envelope.

‘Overall affordability’ requires that, taking into account all costs, including the costs of capital (interest depreciation, capital charge (IDCC)), debt amortisation and start-up or commissioning costs, that the DHB can afford the proposed investment and the operational costs of the services provided therein, such that it breaks even within its available PBF funding.

To demonstrate overall affordability the DHB should provide a year-on-year statement of financial performance, statement of position and statement of cashflows (the timeframe of the analysis should be consistent with the NPV timeframe).

Consequential impacts
Capital projects must not lead to unexpected requirements for additional capital funding or service costs.

Not only must the full costs of the proposal be included, but the consequential impacts must also be made explicit. It would assist, for example, if a diagram were provided that showed the links to any consequential projects, such as IT, and service initiatives.

The financial impact upon other DHBs (particularly for tertiary services) must also be detailed and confirmed with the DHBs concerned.

Provisioning
Investment in capital infrastructure is acknowledged to be ‘lumpy’, with some major assets lasting 20–30 years or more. Therefore, it is expected that a financially sustainable DHB will build up provisions to contribute to replacement of major assets. The expectation is greatest for DHBs with relatively new major assets, but all DHBs should demonstrate how they plan to use depreciation on major assets to provision for the eventual replacement of those assets. Completion of the attached DHB capital intentions spreadsheet (Appendix 1) will assist DHBs to demonstrate the degree of provisioning undertaken.
**Prioritisation of free cashflow expenditure on capital**

When requesting equity or debt, DHBs must demonstrate how free cashflow expenditure on capital has been prioritised.

There needs to be evidence that the DHB is accepting its responsibility to work within available funding and making the trade-offs required to do so. Business cases must clearly identify the considerations that the DHB has given to funding the investment through prioritising free cashflow from other potential projects.

A transparent DHB capital approval process and support from an RCG will enable DHBs to meet this requirement.

**Maximising funding from asset sales**

When proposing a major investment, DHBs must demonstrate how funding from such sources as potential asset and land sales will be maximised.

**Capital intentions spreadsheet**

To assist achievement of the above objectives, DHBs must complete a DHB capital intentions spreadsheet (see Appendix 1). This requires DHBs to detail their own contribution to capital costs from depreciation generated internal cashflows.

**Efficiency gains**

A DHB must satisfy the Crown that it has planned the ‘maximum practical efficiency gains’ achievable from the capital expenditure planned and that it has established mechanisms to achieve the planned gains. It must also demonstrate how it will manage ongoing costs and prioritise services to ensure the project is affordable, including meeting any increased costs of capital. That maximum service efficiencies have been sought by collaboration with other DHBs should also be demonstrated. Planned efficiency savings must, however, be demonstrable and sound if they are to be included in the financial analysis.

**DHBs and breakeven requirement**

When applying for equity or debt for a major project DHBs must provide evidence of a feasible and plausible strategy to deliver breakeven, or better. This must include evidence that the DHB has the systems in place and has taken all practical steps necessary to demonstrate a realistic prospect of successfully implementing the strategy. Steps to be considered include scope reductions on other major projects that may enable the savings to be applied to the proposed new project.
CFA assessment of bankability

The CFA is required to provide the National Capital Committee with an assessment of the impact of the project on the overall financial position of the DHB. This assessment will include an opinion on whether the DHB can meet the capital costs of the additional debt and/or equity required for the project, provide for debt amortisation and meet the CFA’s lending criteria.

The assessment will involve analysing and understanding:
- the assumptions (both revenue and cost) used in the financial forecasts
- the project cashflows
- their impact on the DHB’s financial performance and position
- the efficiency assumptions
- the ability of the DHB to amortise debt.

It is desirable that the CFA work alongside a DHB while the business case is being developed to facilitate access to Crown finance and enhance the CFA’s understanding of the overall project.

DHBs must recognise that CFA support for the project, as it develops, does not constitute a formal agreement to lend. Approval of any lending will remain subject to the normal loan application process.

Debt availability will also still be subject to securing funding from the health capital envelope, regardless of whether it is paid as equity or CFA debt.

National prices and DHB prices

Inter-District Flow (IDF) revenue must be planned at national prices. DHBs may currently pay prices or supplements that ensure that a project or facility breaks even following a capital investment (this may be net of efficiency gains). Accordingly, revenue from the DHB funder to the DHB provider may alter from national prices. If so, specific Board agreement to this must be demonstrated.

If the DHB contends that, having done the above, it cannot meet the increased operating costs, and where the new facility will provide services to other DHBs (eg, inter-district radiation treatment services provided by one DHB's linear accelerator), then it could seek higher national prices to the extent permissible under current policy.

It is acknowledged that discomfort exists in the sector regarding current arrangements and that the de facto status quo position above is subject to current joint policy work to examine potential new policy.

National prioritisation and affordability within the health capital envelope

National prioritisation and affordability will be determined via the application of a national prioritisation framework. A copy of the framework is attached as Appendix 2.
While ‘overall affordability’ is an essential requirement, the prioritisation framework will ensure annual capital allocation round decisions will be made based on a range of criteria and not guided solely on the basis of the highest financial return.

**Business case development process**

**Stage 1 – Strategic stage**

The objectives of the strategic stage are to:
- define what problem it is that requires a solution
- establish the resources available (both financial and clinical)
- determine the regional and national service implications (via an HDI)
- define specific outcomes that are expected from the investment in terms of both current and future services (via an HDI).

It may also inform the statutory DHB planning cycle.

In particular, if Crown debt or equity may be required DHBs will need to make initial contact with the Ministry of Health to establish the capacity of the Health Capital Budget to provide any funding.

**Health Development Initiatives**

A Health Development Initiative (HDI) is a process, prompted by a specific capital proposal, to prioritise and agree the allocation of health services and the capital implications for a region. It will be led by the initiating DHB who may be assisted by the RCG.

The strategic stage of business case development may require DHBs to collaborate with neighbouring DHBs in an HDI. This enables a DHB to demonstrate regional alignment when it is undertaking a major redevelopment, refurbishment or where the investment has broader service implications (e.g., cancer centre investment).

A major capital development provides the opportunity for a substantial re-examination of a region’s infrastructure and service delivery patterns. The potential for a region to reconfigure its health infrastructure to better meet future demand, clinical practice and health service priorities will be examined via an HDI. An HDI will be triggered automatically by a proposal by a DHB to undertake a major capital project or service change.

An HDI may be service specific, for example, triggered by a proposal to invest in a linear accelerator or cardiac catheterisation, or DHB-wide if triggered by a proposal such as a new hospital. It may be confined to only one DHB, but is more likely to be a regional process.

An HDI is a DHB-led process supported by the Ministry of Health. It will involve the most affected DHBs, typically the neighbouring one to five DHBs and focus on
maximising health gains from available operating and capital funding. In particular it will:

- determine the optimal facility configuration and service delivery patterns for a region
- undertake a condition stocktake of a region's facilities by collating existing asset management plans (and updating where necessary)
- apply any national service configuration strategy
- enable consistent approaches to service provision
- identify potential synergies and opportunities for rationalisation
- identify potential conflicts/duplication in proposed developments and approaches for addressing these conflicts
- ensure that an individual DHB is not compromised by the developments of another DHB(s)
- ensure inter-DHB co-operation over broader planning activities
- take into account non-DHB community assets (NGOs, trusts, private sector)
- co-ordinate DHB activities to ensure that there are no surprises about what is being planned by individual DHBs
- improve the ability of DHBs to make the trade-offs required to maximise value from capital expenditure and to prioritise and control expenditure (including investigation of non-capital options).

An HDI will require a broad mix of inputs from financial, workforce, clinical (including in particular primary care) and community perspectives.

The conclusions of an HDI may also inform later sector discussion regarding national IDF prices.
Figure 5:  The major capital project development pathway - Stage 1: strategic stage

Stage 2 – Options analysis stage

This is the point at which detailed service planning and evaluation of capital options for the DHB takes place. It must be guided by the conclusions of the HDI and applicable regional and national service strategies. It must also take account of links to primary care, service prioritisation strategies and workforce issues.

At this stage the DHB will:

- plan how services will be provided
- examine capital options that meet the service provision requirements
- identify the preferred option.

The options analysis stage must cover:

- the effects of the investment on the DHB’s clinical viability
- its synergy with the DHB’s existing operations
- the DHB’s comparative strengths and weakness in the service areas affected by the investment
- the implications for the DHB’s planned models of care
- the option analysis and affordability criteria detailed above.
Clinical requirements of business cases

Significant facility redevelopments must be soundly based on clinical requirements and supported by appropriate evidence. All health sector elements must be considered and discussed. Projections of facility demands and resulting facility requirements must be made taking all reasonably foreseeable developments into account. The clinical discussion contained in a facility development business case should include at minimum:

- evidence of a DHB- or locality-level population needs assessment based on current demand, future needs analysis and forecast population changes
- discussion of approaches to care (Care Models) and resulting impacts on both primary and secondary sector requirements. Discussion should reference the clinical evidence base
- choice, description of and justification of Care Model(s)
- definitions of primary, secondary and tertiary sector demand levels and requirements resulting from the selected Care Model(s)
- evidence of discussion (eg via an HDI) with affected neighbouring DHBs where primary or secondary service or facility development could impact on established IDF patterns or cross-boundary access to services. Discussion should explore potential for collaborative service or facility development and justify any decision to collaborate or not collaborate
- a workforce development plan covering all affected sectors and clinical areas, including indicative costings. All reasonably foreseeable workforce issues must be discussed in the plan, workforce-related risks identified and amelioration strategies outlined
- definition of facility requirement(s) taking into account changes resulting from Care Model(s).
  - The facility requirement should embrace ambulatory, outpatient, community and (where indicated by the Care Model) inpatient care requirements.
  - The requirement should look out about 10 years.
  - The requirement should take all aspects of demand modification from changes in Care Model(s) into account.
  - The logic connecting population needs, demand for services and the resulting facility requirements should be clearly demonstrated.
  - A staffing plan should be included as part of the facility requirement and the link to the workforce development plan must be demonstrated.
- development of an indicative plan for the most appropriate facility (or set of modifications to existing facilities) that will satisfy the defined facility requirement for about the next 10 years. Where it is likely or probable that facility expansion will be necessary beyond the 10-year timescale the plan should make provision for expansion options
- an indicative change management plan showing how the shift to new Care Model(s) will be managed, and the staging of the change process. The change management plan will need to be linked to the workforce development plan
- where appropriate, facility development staging options and staging prioritisation with indicative clinical impact analysis
- a statement of clinical quality. The business case must demonstrate how the DHB will ensure an acceptable level of clinical quality of the services to be provided as a consequence of the new investment.

Following identification and development of the preferred service delivery option, the various capital options should be developed and a preferred capital option identified.

**The preferred option**

The preferred service delivery and capital options must be able to demonstrate:

- ability to meet DHB strategic objectives as defined in its DSP and DAP
- value for money, ie, highest ratio of financial and non-financial benefits to costs
- improved quality of service
- flexibility and robustness to change
- financial viability
- community consultation (where required by the OPF)
- DHB Board support.

**Figure 6:** The major capital project development pathway – Stage 2: options analysis stage
Stage 3 – Completed business case stage

This stage involves completion of the business case with the conclusion of detailed planning. It also involves the detailed planning for implementation of the preferred option and detailed financial analysis.

A completed business case must convincingly demonstrate that the project is clinically sustainable, economically sound (through the option appraisal), is financially viable (affordable to the DHB) and will be well managed.

A final business case for any investment must also show that the proposal has support from the DHB Board. The success of any major investment may ultimately depend on the extent to which the DHB, from the funder arm perspective, supports the resulting cost and prioritisation consequences.

Value management

The preferred option should be tested and informed by value management workshops and analysis as part of completing the business case. Advice is available from the Ministry of Health if required.

Benchmarking

The completed business case should include some benchmarking of the performance of key departments against those of comparable providers.

Procurement

Where investments are similar to those planned by other DHBs, business cases must demonstrate that consideration has been given to joint procurement, staffing recruitment etc. Where this is not possible, justification must be provided.

Implementation and post project review

The completed business case must include information regarding the identification and management of risk, an outline project plan, implementation management, change management processes, related process redesign and any potential or consequent efficiency gains. Post project review must also be planned.
**Figure 7:** The major capital project development pathway – Stage 3: completed business case stage

- **Objective**
  - Final justification and detailed plan for new facilities and services

- **Strategic case (stage 1)**

- **Service and facility development options (stage 2)**
  - Service integration pathway plan

- **Completed business case (stage 3)**
  - Include conclusions of stages 1 and 2.
  - Detailed financial analysis.
  - Outline implementation plan and timetable.

  **Secure approval of Crown funding and determine approval conditions**

---

**Efficiency justified projects**

Efficiency justified projects are projects justified on the basis of their ability to generate cash surpluses that are available for reinvestment.

An ‘efficiency project’ must have the following criteria.

- The project has separate and identifiable revenue and expenditure.
- The business case demonstrates to the satisfaction of the Crown Financing Agency (CFA) that the savings planned are adequately verified and will be realised.
- The DHB has detailed how the savings will be applied.
- The project demonstrates a relatively short payback period.
- The business case has been reviewed by the CFA and the CFA is prepared to lend to the project (subject to ministerial approval).
- The business case meets all of the essential criteria in Appendix 2.

If these criteria are met, then the NCC will consider recommending funding for the project as a priority on a case-by-case basis. The qualitative criteria in Appendix 2 do not apply to these purely commercial efficiency projects. Funding is, of necessity, still subject to the judgement of the NCC as to the ability of the Health Capital Budget to accommodate the requested funding.
Appendix 1: Capital Intentions Spreadsheet

Do you plan a formal bid for the September/October capital budget round? Yes/No?

<table>
<thead>
<tr>
<th>Capex category / item / project</th>
<th>Year 1</th>
<th>Year 2</th>
<th>Year 3</th>
<th>Year 4</th>
<th>Year 5</th>
<th>Totals</th>
<th>Out years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline capex (sum of normal expected smaller capital purchases). Note 'provisioning' expectation below.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Radiation oncology (linacs, bunkers etc) cancer centres must complete this. List individual items.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Major equipment. Includes motor vehicles. (List individual items.)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Information systems and communication technology (see definition below).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Major refurbishment or new construction. Includes land, buildings, plant (individual projects should be listed separately).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td><strong>Total outlay (a)</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Internal funding of baseline capex (should match baseline capex) (b)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DHB contribution from depreciation provisions/free cashflows to future or current projects over and above baseline (c). Assume a nil deficit (ie, that cash is available up to the level of depreciation).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sum of rows (b) and (c) (Note: this row should equal the DHB’s free cashflow).</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Asset sales (d)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Approved private debt (e)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (ie, CFA refinancing, community trust, etc) please specify and add additional rows if required (f)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Funding required from Health Capital Budget (a–b–c–d–e–f)</strong></td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Planned CFA debt/equity split</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td>check total</td>
</tr>
<tr>
<td>Crown Financing Agency debt (new debt, not refinancing)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>0.00</td>
<td></td>
</tr>
</tbody>
</table>

Comments:
Provisioning: Investment in capital infrastructure is acknowledged to be ‘lumpy’, with some major assets lasting 20–30 years or more. Therefore, it is expected that a financially sustainable DHB will be reinvesting less than its depreciation provisions in most years. This is necessary to build up provisions for the replacement of major assets. The expectation is greatest for DHBs with relatively new major assets, but all DHBs should be demonstrating how they plan to use depreciation on major assets to provision for the eventual replacement of those assets.

Information systems and communication technology capital expenditure: This applies to computer systems such as applications, hardware and software and includes networking and communications. This definition excludes such things as laboratory analysis equipment and digital radiology systems.
Appendix 2: DHB Capital Priority Analysis

This is for analysis of proposals submitted to the National Capital Committee (NCC) and as a checklist and self-assessment tool for DHBs.

DHBs submitting proposals should include a completed ‘DHB Capital Priority Analysis’. Please provide a short statement, or reference the business case or other material, to justify the response to each question.

Please attach a copy of the Board and RCG recommendations regarding the project.

Electronic versions of the Capital Intentions Spreadsheet, DHB Priority Analysis and Business Table of Contents (Appendix 3) are available from the Ministry of Health.

Project details

Name of project: DHB:

Short description of project:

Additional DHB-wide capital planning and funding details should be provided by attaching a DHB capital investment intentions spreadsheet (DHB to complete).

Financial details

<table>
<thead>
<tr>
<th>Planned funding arrangements</th>
<th>($ million)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internally generated funds</td>
<td></td>
</tr>
<tr>
<td>Free cashflows</td>
<td></td>
</tr>
<tr>
<td>Asset sales</td>
<td></td>
</tr>
<tr>
<td>Approved private debt</td>
<td></td>
</tr>
<tr>
<td>Crown Financing Agency (CFA)</td>
<td></td>
</tr>
<tr>
<td>Existing credit facility (refinancing)</td>
<td></td>
</tr>
<tr>
<td>New CFA lending</td>
<td></td>
</tr>
<tr>
<td>From current capital envelope (to 2005/06)</td>
<td></td>
</tr>
<tr>
<td>Future debt</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Equity</td>
<td></td>
</tr>
<tr>
<td>From current capital envelope (to 2005/06)</td>
<td></td>
</tr>
<tr>
<td>Future equity</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td></td>
</tr>
</tbody>
</table>
Essential criteria

For a project to receive funding, the answer to all essential questions must be ‘yes’.

1. Governance
Has the DHB Board demonstrated a commitment to the assumptions of the business case and ownership of its implementation and consequences?  Yes / No

2. Option analysis
Has the DHB demonstrated that it has explored all practical options and demonstrated the comparative benefit of the preferred option?  Yes / No

3. Appropriate ‘fallback’ option
Has the DHB developed a ‘fallback’ option if planned funding is not available?  Yes / No

4. Regional DHB support
Does the proposed project have peer support from DHBs in the same region, or has the DHB suitably justified a different view?  Yes / No

5. Planned efficiencies
Has reasonable effort been made to identify efficiencies as a consequence of the investment? If any efficiencies are planned are they achievable and defensible?  Yes / No

6. Project budget
Project costing. Are the processes, assumptions and cost rates used when developing the budget appropriate and defensible?

Consequential projects: Does the financial analysis capture the financial impact of all projects and expenditure that needs to progress as a consequence of this investment?  Yes / No

7. Maximising the ability of the DHB to contribute to the capital cost of the project
Has the DHB maximised its ability to afford the project via management of free cashflow expenditure, asset sales and strengthening of its balance sheet by repayment of debt?  Yes / No
8. **Overall affordability**

Over the life of the project can the DHB break even given its forecast available PBF funding?  

Yes / No

9. **CFA analysis**

Has the business case been reviewed by the CFA and is the CFA prepared to endorse the project (subject to ministerial approval)?  

Yes / No

10. **Management of public expectations**

Has the DHB managed public expectations to a level consistent with the ability of the DHB and the Crown to afford the project?  

Yes / No

11. **Site master plan**

Has the DHB demonstrated that the project has been developed in the context of an overall assessment of the future use of the whole site and/or clinical space and will not unreasonably compromise future options?  

Yes / No

**Efficiency justified project criteria**

Efficiency justified projects are projects justified on the basis of their ability to generate cash surpluses that are available for reinvestment.

An ‘efficiency project’ must have the following criteria.

1. The project has separate and identifiable revenue and expenditure.
2. The business case demonstrates to the satisfaction of the Crown Financing Agency (CFA) that the savings planned are adequately verified and will be realised.
3. The DHB has detailed how the savings will be applied.
4. The project demonstrates a relatively short payback period.
5. The business case has been reviewed by the CFA and the CFA is prepared to lend to the project (subject to ministerial approval).
6. The business case meets all of the essential criteria above.

If these criteria are met, then the NCC will consider recommending funding for the project as a priority on a case-by-case basis. The qualitative criteria below do not apply to these purely commercial efficiency projects. Funding is, of necessity, still subject to the judgement of the NCC as to the ability of the Health Capital Budget to accommodate the requested funding.
Qualitative criteria

1. **DHB capital expenditure history**
   On the measure of capex to depreciation, over the last six years what has the DHB been?

<table>
<thead>
<tr>
<th>Low investment</th>
<th>Medium investment</th>
<th>High investment</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1</td>
</tr>
</tbody>
</table>

2. **Asset management planning**
   What is the quality of the DHB’s asset management planning?

<table>
<thead>
<tr>
<th>Sound</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Poor</th>
</tr>
</thead>
</table>

3. **Asset condition**
   What is the physical condition of the asset requiring investment / replacement?

<table>
<thead>
<tr>
<th>Poor</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Sound</th>
</tr>
</thead>
</table>

4. **Service quality A**
   What is the quality of the service currently provided by the asset requiring investment / replacement?

<table>
<thead>
<tr>
<th>Unacceptable</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Acceptable</th>
</tr>
</thead>
</table>

5. **Service quality B**
   What is the quality of the service provided by the proposed new asset likely to be?

<table>
<thead>
<tr>
<th>High</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Low</th>
</tr>
</thead>
</table>

6. **Service capacity**
   What is the ability of the asset requiring investment / replacement to meet forecast service need?

<table>
<thead>
<tr>
<th>Low</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>High</th>
</tr>
</thead>
</table>
7. **Service priority**

In the context of the Health and Disability Strategies, what is the priority for the planned services?

<table>
<thead>
<tr>
<th>High</th>
<th>10</th>
<th>9</th>
<th>8</th>
<th>7</th>
<th>6</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Low</th>
</tr>
</thead>
</table>

8. **Primary care integration and population health activities**

To what extent does this project maximise the potential of this particular project to integrate with primary care and population health activities?

<table>
<thead>
<tr>
<th>Maximum integration</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Minimum integration</th>
</tr>
</thead>
</table>

9. **Inter-DHB collaboration**

To what extent has the DHB maximised gains from collaboration with other DHBs (eg, via a Health Development Initiative (HDI))?  

<table>
<thead>
<tr>
<th>Maximum collaboration</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Minimum collaboration</th>
</tr>
</thead>
</table>

10. **Workforce planning**

What is the state of workforce planning for the project?

<table>
<thead>
<tr>
<th>Sound</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Poor</th>
</tr>
</thead>
</table>

11. **Implementation planning**

What is the state of implementation planning for the project?

<table>
<thead>
<tr>
<th>Sound</th>
<th>5</th>
<th>4</th>
<th>3</th>
<th>2</th>
<th>1</th>
<th>Poor</th>
</tr>
</thead>
</table>

Sum of qualitative criteria scores expressed as a percentage (this ensures that if criteria are not applicable then they can be deleted without disadvantaging a DHB): _______ %
Value for money judgement

Overall, in comparison with recent and other current requests, does this project represent value for money?

| Good | 10 | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | Poor |

Recommended next steps

What should the next steps be?

Is funding recommended?

What conditions should be attached to the funding?

Are there still requirements under the Operation Policy Framework (OPF) that remain to be addressed (eg, public consultation, service reconfiguration, public private partnerships)?
Appendix 3: Business Case Table of Contents

Note: Business cases must be developed for the purpose of the DHB to effectively deliver the best project for its population. A business case is as much the DHB’s own tool, for its own needs, as it is a document for the Crown. This fact must be a key driver of business case content and structure. The case should stand alone and the specific needs of the project should be the ultimate driver of the contents and structure. DHBs should consult with the Ministry of Health at each stage of the project.

Contents

Executive summary
1. Strategic analysis and background
2. Clinical or service analysis and requirements
3. Facility analysis and requirements
4. Financial analysis
5. Implementation and post project review

Appendices

Executive summary

1. Strategic analysis and background

<table>
<thead>
<tr>
<th>Strategic stage</th>
<th>Project objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>¶ Define what problem is to be solved and the imperative for change.</td>
</tr>
<tr>
<td></td>
<td>¶ Define the specific outcomes planned from the investment.</td>
</tr>
<tr>
<td></td>
<td>¶ Define at a broad level what resources (financial and clinical) are available to apply to the problem.</td>
</tr>
<tr>
<td></td>
<td>¶ Outline regional and national service implications.</td>
</tr>
<tr>
<td></td>
<td>DHB strategic context - proposal in the context of:</td>
</tr>
<tr>
<td></td>
<td>¶ DHB’s asset management plans</td>
</tr>
<tr>
<td></td>
<td>¶ fit with DAP and DSP</td>
</tr>
<tr>
<td></td>
<td>¶ fit with Government health policies and strategies</td>
</tr>
<tr>
<td></td>
<td>¶ potential of the project to build public trust and confidence in the public health system.</td>
</tr>
<tr>
<td></td>
<td>DHB Board resolutions</td>
</tr>
<tr>
<td></td>
<td>¶ Early Board resolutions should be included at the strategic stage.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Completed business case stage</th>
<th>DHB Board resolutions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>¶ Insert a copy of each of the relevant Board resolutions here.</td>
</tr>
<tr>
<td>Regional Capital Group peer review</td>
<td>¶ Detail results of the RCG consideration.</td>
</tr>
</tbody>
</table>
2. Clinical or service analysis and requirements

<table>
<thead>
<tr>
<th><strong>Strategic stage</strong></th>
<th>Population needs assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Demonstrate link between population needs and proposed development.</td>
</tr>
<tr>
<td></td>
<td>Health Development Initiative (HDI)</td>
</tr>
<tr>
<td></td>
<td>Detail the process and conclusions of the relevant HDI.</td>
</tr>
<tr>
<td></td>
<td>Include link with neighbouring DHBs.</td>
</tr>
<tr>
<td></td>
<td>Detail regional service co-operation.</td>
</tr>
<tr>
<td></td>
<td>Detail any relevant joint service development.</td>
</tr>
<tr>
<td></td>
<td>Project’s link with primary care and population health activities</td>
</tr>
<tr>
<td></td>
<td>Detail relevant primary health and health promotion strategies undertaken or planned by the DHB and the potential for these to impact on the proposed development.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Options analysis stage</strong></th>
<th>Service delivery background analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Benchmarking against other relevant services or departments.</td>
</tr>
<tr>
<td></td>
<td>Stakeholder consultation – composition, process.</td>
</tr>
<tr>
<td></td>
<td>Planned service delivery improvements.</td>
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<td></td>
<td>Service delivery options analysis</td>
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<td></td>
<td>Potential models of care / service delivery options.</td>
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<td></td>
<td>Evaluation of preferred option against other potential options.</td>
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<td></td>
<td>Sensitivity analysis.</td>
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<td>Prioritisation and trade-offs considered / made.</td>
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<td></td>
<td>Preferred option</td>
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<tr>
<td></td>
<td>Preferred service delivery option / Model of Care.</td>
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<tr>
<td></td>
<td>How preferred service delivery option / Model of Care meets strategic objectives (per DSP, DAP and HDI, Government strategies).</td>
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<td></td>
<td>Site master plan fit.</td>
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<td></td>
<td>Clinical co-locations.</td>
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<td></td>
<td>Consequential impacts on other services (including other DHBs and IDF flows).</td>
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<td></td>
<td>Quality of service (including current and foreseeable quality and legislative requirements).</td>
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<td>Access to service.</td>
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<td>Workforce implications.</td>
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<td>Flexibility and robustness to change.</td>
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<td>Ability to gain public confidence.</td>
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<td></td>
<td>Value for money ie, highest ratio of financial and non-financial benefits to costs.</td>
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<td>Community consultation (if required by the OPF).</td>
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</tbody>
</table>
### Completed business case stage

- Workforce development plan
  - Detail workforce requirements for proposed development – staff types, FTEs.
  - Benchmark workforce requirements against similar services.
  - Show fit with current and foreseeable workforce legislative requirements.
  - Show workforce cost estimates – current and proposed workforce.
  - Include professional association and union discussion.

- Indicative change management plan (refer to implementation section)

### 3. Facility analysis and requirements

From demand for services and service delivery models (Models of Care) to facility requirements.

#### Strategic stage

- Benchmarking of facility requirements
  - Review of existing facility.
  - Review of similar existing or proposed facilities.

- Stakeholder consultation
  - Composition.
  - Process.

- Initial briefing and design process
  - Size requirements.
  - Location requirements.
  - Master plan context.

#### Options analysis stage

- Options analysis
  - Potential facility and/or location options and evaluation.
  - Evaluation of preferred option against other potential options, eg,
    - fallback option (required)
    - ‘do nothing’ option
    - other options (including regional strategies)
    - ‘non-funding’ option
    - minimum compliance option.

- NPV analysis of potential options (including sensitivity analysis).

- Facility description.

- Initial capital cost estimate.

- Link with overall health objectives.

- Links with DHB’s existing operations and regional alignment opportunities.

- Prioritisation and trade-offs considered / made.

- Value for money, ie, highest ratio of financial and non-financial benefits to costs.
completed business case stage

Develop preferred facility option (should be informed by value management workshops / analysis)
- Fit with service and/or clinical requirements.
- Fit with all current and foreseeable quality and legislative requirements.
- Fit with site master plan.
- Consequential impacts on other departments / facilities / infrastructure / IT systems.
- Future expansion / flexibility.
- Ability to gain public confidence.
- Operational cost impact analysis.
- Facility design (consult the Ministry of Health for specific expectations).
- Detailed capital cost estimate.
- Preferred and alternative staging options, prioritisation and costs.
4. **Financial analysis**

<table>
<thead>
<tr>
<th><strong>Strategic stage</strong></th>
<th>Initial affordability analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>DHB’s willingness to fund.</td>
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<tr>
<td></td>
<td>DHB’s capacity to afford operating costs and costs of capital.</td>
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<tr>
<td></td>
<td>Health Capital Budget’s capacity to afford.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Options analysis stage</strong></th>
<th>Refined affordability analysis</th>
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<tbody>
<tr>
<td></td>
<td>Continued DHB willingness to fund.</td>
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<tr>
<td></td>
<td>Continued DHB capacity to afford operating costs and costs of capital.</td>
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<tr>
<td></td>
<td>Continued Health Capital Budget capacity to afford.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Completed business case stage</strong></th>
<th>DHB’s overall ability to afford the project</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Statement of financial performance.</td>
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<td></td>
<td>Statement of position.</td>
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<td>Statement of cashflows.</td>
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<td></td>
<td>Consequential financial impacts.</td>
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<td>Efficiency gains.</td>
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<tr>
<td></td>
<td>Demonstrate that breakeven requirement is met.</td>
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<tr>
<td></td>
<td>National prices and DHB prices.</td>
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</tbody>
</table>

Project in the context of the DHB’s overall capital plans

- Complete capital intentions spreadsheet.
- Detail fit with the DHB’s asset management plan.
- Show the project in the context of the DHB’s overall capital plan and detail the DHB’s financial contribution:
  - Provisioning (for asset replacement).
  - Prioritisation of free cashflow expenditure on capital.
  - Maximising funding from asset sales.

Project financing

- Statement on the financing and bankability of the DHB from the CFA.
- Debt requirements (including timing).
- Equity requirements (including timing).
- DHB financial contribution / provision for the project.

National prioritisation and affordability within health capital envelope

- National prioritisation analysis - append fully completed DHB capital priority analysis form.
5. Implementation and post project review

<table>
<thead>
<tr>
<th>Completed business case stage</th>
<th>Outline project plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Include indicative timetable.</td>
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<td></td>
<td>Include Procurement options.</td>
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</tbody>
</table>

- Implementation management
  - Maintaining ‘business as usual’.
  - Joint purchasing arrangements with other DHBs.
  - Maintaining public confidence and trust.

- Risk management

- Service delivery / models of care change management plan
  - Include clinical quality plan.

- Efficiency gains realisation process / programme
  - Benchmarking.
  - Indicative efficiency plan.

- Post project review
  - Indicate intentions post completion of the project.

Appendices

1. Board resolutions.
2. Regional Capital Group resolutions.
3. Completed capital intentions spreadsheet (Appendix 1, Capital Investment Guidelines. Electronic copies are available). DHB to complete.
5. Other.