Capital Assessment Guidelines

December 2011

Capital Investment Committee December 2011

Contents

Preface

We need to change the way we deliver health care if we are going to meet the predicted significant increases in demand, continue to improve health outcomes and reduce disparities of access -- all within an overall growth in health expenditure that is more in line with what the economy can sustain.

The changes in work practices and models of care required will need to be supported by a different configuration and mix of facilities, Information Systems, and workforce investments. We know that simply reinvesting in more of what we have will lock us into an unsustainable future that creates an unnecessary conflict between what the community expects of its health system and what the community can afford.

Investment requires us to make a judgment about what sort of capacity will be needed to support services that will be delivered over a twenty year timeframe. The long term health service planning needed to inform this process aims to provide high level guidance on the sort of changes that will be needed.

That planning has identified the larger trends that will shape our investment priorities. There will need to be relatively more emphasis on supported self care (including prevention) and on delivering care closer to home, with reduced emphasis on hospitalisation. The development of hospital facilities will need to give greater weight to supporting national and regional service delivery, with less local fragmentation and more recognition of private capacity. The system also needs to become truly patient-centric, ensuring a seamless patient journey between providers. All point to a much heavier emphasis on information sharing and teamwork with the supporting Information Systems and workforce infrastructure.

The National Health Board's (NHB) Capital Investment Committee (CIC) has developed a new centrally-led process for the national prioritisation and allocation of health capital funding. This process will take a long term view, will require a much greater emphasis on national and regional priorities and will apply transparent and, as far as possible, objective assessment criteria based on stronger economic and health impact analysis. Greater transparency is not just aimed at reducing wasted effort and better focusing capital proposals. CIC is deliberately exposing its process to sector scrutiny in order to engage health managers and clinicians in improving that process and refining its assessment criteria.

CIC will also place much more emphasis on the early and more strategic aspects of the assessment process. This will also help to better focus subsequent business case development as well as help streamline the consideration of proposals as they are developed. While each proposal will still need to meet project-level criteria, the overall pattern of investment across the country needs to make sense given regional and national priorities and system-level requirements for investment in areas like Information Systems infrastructure.

These Guidelines describe this new centrally-led process and the principles and criteria CIC will use to help Ministers approve, prioritise and sequence investments.

Murray Horn
Chairman
National Health Board

1. Introduction

The Capital Investment Committee (CIC) is responsible for a centrally-led process to prioritise and allocate health capital funding.

The establishment of the National Health Board and the IT Board has led to significant changes in the roles and responsibilities for Capital Investment. The recent alignment with the Treasury Better Business Case process has resulted in changes to the guidelines.

These guidelines set out the criteria, process and timelines that the CIC will use to form its advice to the Ministers of Health and Finance on capital investment proposals from District Health Boards (DHB) and the Ministry of Health.

2. Role and Scope of the Capital Investment Committee

The CIC ensures that the right capital investment proposals occur in the public health sector, either from DHBs or from the centre (e.g. sector-wide infrastructure investments in Information Systems and Communication Technology). The CIC is a sub committee of the National Health Board (NHB) and advises joint Ministers of Health and Finance, and the Director-General of Health, on capital investment. The advice CIC provides needs to be in line with Government's service planning direction.

To achieve this, the CIC will:

- develop a National Asset Management Plan (NAMP) for the health system based on agreed service plans
- establish relative priorities for capital investment
- approve individual proposals for capital expenditure
- provide information and advice to the Ministry of Health during the Crown Budget process relating to capital investment
- undertake any other matters that the Ministers (through the NHB) or the NHB may refer to it. CIC

meets at least eight times a year, including regional meetings with DHB Chairs and CEOs.
The scheduled CIC meetings dates are listed on the NHB website.

3. Capital Investment Delegations

The CIC process applies to capital investment proposals in the public health sector that meet any one of the following criteria:

i. all investment in fixed assets that require Crown equity

ii. investment in projects or programmes where one or more of the following applies:

   a) capital expenditure of $10M

   b) capital expenditure of $10M calculated as the capitalized value of future revenues if financed from those revenues (such as a finance lease)

   c) twenty percent of total assets on the DHB balance sheet.

iii. strategic investments by DHBs that may substantially affect DHB performance

iv. investments identified as high risk in DHB annual plans (using the State Services Gateway Risk Profile Assessment).

All proposals falling under criteria 1-4 require the agreement of the Ministers of Health and Finance [Cabinet Minute (00) M 20/4, refers].

3.1. Information Systems and Communication Technology (ICT)

Information systems and communication technology (ICT) is defined as any and all computer systems used in the electronic capture, processing, transmission or storage of information. This includes the hardware, software (including medical equipment components) and applications that make up the system as well as any necessary support systems such as access, security and backup. The CIC process is required for all ICT proposals that meet the criteria above. Prior to coming to CIC all ICT proposals must first go through the IT Board.

ICT proposals require the Minister of Health's approval at a lower threshold:

- all ICT investment over $3M calculated as the capitalized value of future revenues if financed from those revenues
- where not consistent with the National Health IT Plan
- where the Regional Capital Committee does not support the proposed investment.

Proposal that meet this threshold but not the CIC thresholds, will require IT Board approval and will be sent to CIC for noting purposes only.

3.2. Sources of Finance

The Health Capital Budget covers both new debt and equity. The health sector's capital requirements must be funded from the Health Capital Budget. DHBs are not permitted to access private sector debt to support cashflow (beyond the accepted overdraft for working capital). The Operational Policy Framework (OPF) makes it clear that private debt is for working capital purposes only or where the Minister of Finance has approved a private facility.

4. Capital Investment Process

This section details the capital investment process.

4.1. Strategic Alignment Across the Sector

DHBs will be expected, over time, to align local and regional service plans and align these with local and regional asset management plans. This will be outlined annually in the DHB planning guidelines. The CIC will use this information with a national overview to develop a NAMP. These are all iterative processes which will develop and improve with time.

4.2. Individual Business Case Process

DHBs will follow the Treasury Better Business Case process for all investments requiring CIC approval. A link to their website is provided at Appendix 1. Table one shows the three stages and the approval decisions at each stage.

In developing proposals DHBs should be careful to ensure that they comply with current operational policy guidelines on public consultation.

Table One: CIC approval stages

Stage	Deliverables	CIC and Government approval
Strategic Assessment	• Intervention Logic Map • Problem • Benefits • Strategic Response	CIC will make a yes/no decision on moving to an indicative business case. No funding will be allocated. Projects will not be prioritised.
Indicative Business Case	• Case for change • Long list of options • Alternative procurement considered • Short list of options • Range of costs estimates	***Self financed projects*** CIC will make a yes/no decision on moving to a detailed business case and Ministers of Health and Finance will be asked to approve this decision. ***Projects requiring Crown equity or loans*** CIC will make prioritisation decisions and recommend to Ministers of Health and Finance which projects should move to a detailed business case. Funding from the health capital envelope will be reserved for prioritised projects. Where insufficient funding is available for a project with high prioritisation Ministers will decide if they wish to take the project to Cabinet to seek approval to move to the detailed business case stage.
Detailed Business Case	• Revisit case for change • Detailed cost benefit analysis	***Self financed projects*** CIC will make a yes/no decision on final approval and Ministers of Health and Finance will be asked to approve this decision.

	• Preferred option	***Projects requiring Crown equity or loans*** CIC will confirm the prioritisation decision from the prior stage and recommend to Ministers of Health and Finance which projects to fund. Funding from the health capital envelope will be allocated. If funding is not available for a project with high prioritisation Ministers will decide if they wish to take the project to Cabinet to seek funding.

4.1.1. CIC Assessment and Prioritisation

CIC will use the assessment criteria at each stage of the business case process. The weight given to each criterion will differ at each stage. For example, policy congruence will strongly feature at the strategic assessment level, but cost effectiveness will feature more highly at the end of the indicative business case stage.

Proposals should be affordable and not counter to Government policy. The projects at the strategic assessment stage will not be prioritised nor will funding be allocated to them. These decisions occur at the indicative business case level.

CIC will provide feedback at each stage on expectations for the next stage. At the later stages CIC will use the full set of assessment criteria to prioritise projects. CIC will rank each project against the seven criteria. Final ranking of projects will be based on the judgement of CIC not a weighted average of the criteria weights.

4.1.2. CIC timelines for strategic assessment in 2012

DHBs need to present a Strategic Assessment to CIC by 30 June 2012 for all projects requiring Government funding from the 2012 or 2013 Budget.

Contact the NHB to discuss which meeting you would like to attend to present your proposal. The NHB will need to see proposals three weeks in advance of the CIC meeting to prepare advice for CIC. Strategic Assessments longer than ten pages need to include a comprehensive executive summary of ten pages or less that can be set to CIC members prior to the meeting.

No specific timelines exist for indicative and detailed business cases. However timelines will be agreed as part of the strategic assessment stage.

5. CIC Key Principles and Assessment Criteria and Process Steps

The following high level key principles and outcomes underpin the seven assessment criteria that will be used to assess, prioritise and sequence projects.

5.1. CIC Key Principles

Capital investment proposals should:

i. be driven by future population health needs, be informed by long-term demand projections and be based on realistic long-term revenue assumptions
ii. support changes to health care provision that ensures New Zealanders health and disability needs are met. This needs to be clinically and financially sustainable over the long term
iii. develop public capacity after considering where private capacity can meet future service needs
iv. balance investment in facilities with investment in IT and workforce to ensure the right capacity is used in the right place
v. align with CIC's view of National Asset Management Planning.

5.2. High Level Outcomes

Capital investment proposals need to support:

i. improved health outcomes for New Zealanders
ii. reduced disparities in health outcomes by addressing priority health needs first
iii. ensure the clinical and financial sustainability of the public health system.

5.3. Assessment Criteria

These principles and outcomes are reflected in the following assessment criteria for capital investments proposals, which are outlined in more detail at Appendix 2:

- Policy Congruence
- Health Gain
- Equity
- Affordability
- Sustainability
- Cost Effectiveness (Value for Money)
- Risk.

5.1. Further Possible Process Steps

5.1.1. Risk Profile Assessment

Agencies must complete an initial Risk Profile Assessment (RPA) for any project or programme that would expose the Government to significant fiscal or ownership risk if it were not delivered within the projected functionality, cost, and timelines [Cabinet Office Circular CO (10) 2,refers].

An RPA identifies at a high level the presence of risk indicators for a project. It is a DHB's initial self-assessment of a project's inherent risk. The RPA produces an indicative risk rating. Information on the RPA can be found at the State Services Commission website. A link is provided in Appendix 1.

5.1.2. The Gateway Process

Projects with a lifetime cost exceeding $25M must take part in the State Services Commission Gateway process. Compliance with this process should be noted with the submission of each stage. Information on the Gateway process can be found at the link provided in Appendix 1. (Note that there can be delays with the SSC process so DHBs are advised to contact SSC at the beginning of each stage to timetable the gateway process).

5.1.3. Fast Track Process

CIC will apply a “fast track” one-step process for capital proposals where the investment (or the capitalised revenue stream to finance the project) is below $10M (or the lifetime cost is below $25M) and the proposal is “low risk” as per the RPA.

This will be based on applying the normal assessment criteria to a single stage process that compresses each of the normal stages (i.e. has a compressed strategic rationale that is consistent with the regional strategy, options analysis and business case). CIC support will be expressed in terms of the project staying within clear benefit, costs, risks and timeliness parameters, with CIC interest then restricted to monitoring compliance with the parameters. If the parameters are breached, then a new proposal will be required.

5.1.4. Public Private Partnership (PPP)

For preferred investment proposals with a significant specific-purpose facility component, there are two choices:

i. Contract separately for the construction and for operating the facility. This is known as 'conventional procurement'. In this situation, the facility is owned by the DHB and the operating or service contracts can be re-tendered periodically or self managed.

ii. Contract for both construction and service delivery. This is known as a concession agreement, a form of public private partnership (PPP). The service can be either a full service or it can be just the maintenance of the facility, or something in between. The DHB may own the facility at the end of the contract period.

The more durable a service is the easier it is to contract for a PPP. Durability means it is less likely that the service requirement will change over time in unpredictable ways, requiring costly contract variations. To correctly account for all capital and debt any increase in debt on the Government balance sheet arising from a Public Private Partnership will be counted against the Health Capital Envelope.

Refer to the Treasury PPP guide for further detail. A link is provided in Appendix 1. It is important to engage early with the National Infrastructure Unit of The Treasury on all significant PPPs.

5.1.5. External Reviews

The NHB may require additional external reviews as part of the process (e.g. from NHB reference groups involving clinicians and consumers). The point at which these should occur will be agreed individually with projects. Note that external reviews (other than by NHB reference groups) are paid for by the DHB.

5.1.6. Level of Design Detail Expected

The Better Business Case process requires a more strategic approach to problem definition and solution than has been used in the past in the health sector. DHBs are not expected to develop facility designs at the Strategic Assessment stage other than the use of the DHBs existing master site plan to inform broad possibilities.

Prior to commencing the indicative or detailed business case DHBs should agree with the CIC the level of design detail required. As an example CIC might expect to see concept designs for the short list options at the indicative case and preliminary design of the preferred option at the detailed business case level.

Where CIC and Ministers have approved a business case on a preliminary design the NHB will approve the developed design as long as it is within budget and scope. Any material variations to budget or scope will need to be reapproved by CIC and Ministers.

6. Appendix One: Other Roles and Responsibilities

Following are the other roles and responsibilities within the health sector.

6.1. Crown Health Financing Agency (CHFA) Debt and the Role of the CHFA

Funding for CHFA 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.

CIC will seek CHFA views on the bankability of proposals, so early contact should be made with the CHFA when developing a business case. The CHFA will work with the NHB to assist the DHB in developing a bankable business case that is consistent with these guidelines.

6.2. Treasury

The Better Business Case guidelines are available from the website:
http://www.infrastructure.govt.nz/

They are also available, together with other resources on the public sector intranet:
https://psi.govt.nz/cam/Library/Forms/BetterBusinessCases.aspx If you are unable to access the PSI link please contact the NHB in the first instance.

The following Cabinet Circular provides the latest Cabinet expectations on capital asset management: CO (10) 02 (PDF) Capital Asset Management in Departments and Crown Entities: Expectations (01/08/2010).

A link to the Public Private Partnerships (PPP) guide can be found at:

http://www.infrastructure.govt.nz/publications/pppguidance/ppp-guid-oct09.pdf/view?searchterm=ppp

6.3. State Services Commission (SSC)

In late 2007 the New Zealand Government approved the use of the Gateway Review Process for quality assurance of large State sector projects. Full information about the Gateway Review Process, including how to apply to become a Gateway Reviewer, is provided on the State Services Commission website:

http://www.ssc.govt.nz/gateway

More information on the Risk Profile Assessment can be found at:

http://www.ssc.govt.nz/gateway-rpa-agency-responsibilities

6.4. Health Workforce New Zealand

Proposals with work force implications will require a review by Health Workforce New Zealand (HWNZ). Where work force implications are a major part of the proposal then early engagement prior to submission of the proposal will be recommended. The chair of HWNZ is a permanent member of CIC.

6.5. Health IT Board

Proposals with IT implications will require review by the Health IT Board. Where IT implications are a major part of the proposal then early engagement prior to submission of the proposal will be recommended. The Chair of the Health IT Board is a permanent member of CIC.

7. Appendix Two: Detailed Assessment Criteria

This appendix provides more detail on how the assessment criteria will be used (see 5 CIC key Principles).

7.1. Policy Congruence Criteria

Definition:

Consistency with CIC key principles 1, 2 and 5, the Government long term priorities and other regional and national priorities.

Measures:

The extent to which the proposals:

- Are necessary to better meet the Government's long term expectations.
- Support long-term local, regional and/or national service plans.
- Demonstrate goodness of fit with the priorities established by the Health IT Board (for proposals with a strong ICT element), Health Workforce New Zealand (for proposals with significant workforce implications) and NHB (for national guidelines for specific services or asset configurations and consistency with the evolving NAMP).
- Support the regional strategic and asset management plans and are consistent with emerging priorities for asset configuration at the regional level. The development of hospital facilities will, for example, need to give greater weight to supporting national and regional service delivery, with less local fragmentation. The support of the regional capital committee will typically be part of the assessment of this measure.
- Support changes in work practice or models of care that drive a more clinically and financially sustainable health system (e.g. improvements in system efficiency and effectiveness). This is likely to see relatively more emphasis on supported self care (including prevention) and on delivering care closer to home, with reduced emphasis on hospitalisation. The system also needs to become truly patient-centric, ensuring a seamless patient journey between providers.
- Support the CIC key principles 1, 2 and 5.

The regional DHB governance body (for regional policy congruence) and the NHB (for national policy congruence) will need to comment on the level of congruency with the relevant policy position.

7.2. Health Gain Criteria

Definition:

Helps ensure that we can meet increases in forecast demand and continue to improve health outcomes, especially those outcomes specified as Government's health targets and identified in the relevant long-term local, regional and/or national service plans.

Measure:

Provide sufficient evidence of the likely magnitude of the population health impact through maintenance of cover, extensions of cover or improvements in service and, preferably, by extension into a cost utility analysis.

The relevant governance body (DHB Board and/or regional DHB governance) will need to attest that, in their judgment, the investment will produce the expected health gain.

7.3. Equity Criteria

Definition:

Helps ensure that areas of highest health need, including currently unmet need, are met first.

Measure:

Provide sufficient evidence of the likely magnitude of the population health impact on high risk groups through maintenance of access and cover, extension of access and cover, or improvements in service.

The relevant governance body (DHB Board and/or regional DHB governance) will need to attest that, in their judgment, the investment will produce the expected improvement in equity.

7.4. Affordability Criteria

Definition:

The proposing DHB can afford the investment, without running a deficit or any deterioration in a previously agreed deficit track, given a realistic long term revenue assumption and the demands of the DHBs asset replacement and enhancement programme required to meet its long term service objectives.

The CIC has agreed to a sector wide long-term planning assumption of 4.5% nominal revenue growth per annum (based on economy-wide real growth of 2% and inflation of 2.5%). Revenue growth will be assumed to grow at the budget track for Vote:Health for the first three years and 4.5% per annum thereafter.

This is a sector-wide average and will be allocated to DHBs on the Population Based Funding Formula (PBFF) basis. This 4.5% should be seen as a mid-point of a 4-5% range. While CIC will review this assumption annually, stability in this long-term assumption is important and it will only be changed if there are strong reasons to do so.

Measure:

The DHB Board, attest that:

a) the financial assumptions supporting the affordability judgement are realistic and most likely under normal circumstances (including the basis on which this attestation is made); *and*

b) the proposed investment does not crowd other services or projects required to deliver the DHBs long term service objectives (including the basis on which this attestation is made). That "basis" should include a view that the DHBs Capital Asset Management Plan is sufficient to make a good judgement as to the degree of on-going investment required for the other asset replacements and enhancements needed to meet the DHBs long term service objectives.

7.5. Sustainability Criteria

Definition:

Promotes long term service sustainability in the sector by reducing existing service and workforce vulnerabilities.

Measure:

Where the proposed investment increases the demand for scarce workforce skills it must contain measures which ensure a supply of workforce skills necessary to fully utilize the capacity created by the investment, without diverting workforce from other parts of the sector (e.g. by improving workforce productivity). In order to achieve the required workforce productivity improvement, investment in ICT may need to be a key part of the solution.

Where the proposal is aimed at reducing service vulnerability, or increasing the supply or productivity of scarce workforce skills, sufficient evidence needs to be provided to demonstrate the likelihood of the expected result.

The relevant governance body (DHB Board and/or regional DHB governance) will need to attest that, in their judgment, the investment will not aggravate existing skill shortages and, where relevant, that it will produce the expected increased supply or productivity of scarce workforce skills and/or reduce existing service vulnerabilities.

7.6. Cost Effectiveness (Value for Money) Criteria

Definition:

That the proposal is the least cost way of generating the anticipated benefits and that the costs of the proposal are justified by the aggregate benefits it generates.

Measure:

Proposals will need to provide sufficient evidence that:

a) the proposed investment is the least cost way of generating the anticipated benefits; *and*

b) the costs of the proposal are justified by the aggregate benefits it generates. The benefit to cost ratio should be calculated using a format that allows comparison amongst different proposals. The NHB business unit will attest to the accuracy and comparability of the benefit to cost calculation.

In assessing (a) above, CIC will be looking for:

- an analysis of alternative models of care and asset configurations that would be expected to generate the desired benefits (largely the options analysis in the stage one business case);
- is well enough supported by complementary workforce and IT and/or facilities investments to ensure that it will be effective in making available the required capacity to produce the services needed to deliver the desired benefits and that this capacity will be able to be fully utilized;
- takes account of existing private capacity and likely changes in this capacity (CIC will seek private sector input in assessing this criteria);
- has considered a range of procurement options and settled on the most cost-effective approach.

The relevant governance body (DHB Board and/or regional DHB governance body) will need to attest that, in their judgment, the benefits and costs are accurately assessed.

7.7. Risk Criteria

Definition:

Risk are accurately assessed and effectively managed (including the risks to expected benefits, costs and timelines).

Measure:

Proposals provide sufficient evidence that risks are properly assessed and effective risk mitigation strategies are, or will be, put in place. This should include an assessment of the likely variability around the critical clinical and financial parameters of the proposal as well as the degree of financial (leverage) and execution (project) risk as well as the risks associated with the counterfactual (status quo).

CIC will take into account the recent performance of the proposing DHB when assessing the evidence provided.

The relevant governance body (DHB Board and/or regional DHB governance body) will need to attest that, in their judgment, the benefit, cost and timeliness risks are accurately assessed and that the proposed risk mitigation strategy will be effective.