

# **Service Planning and New Health Intervention Assessment**

Framework for collaborative  
decision-making

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## Acknowledgements

This framework document has been developed following significant input from a wide range of people across the health sector. Those contributions are gratefully acknowledged.

An update of the framework is anticipated. Feedback is welcome and will be acted upon.

## Links with Other Documents

This document should be used in conjunction with the following documents.

- District Health Boards New Zealand and Ministry of Health 2005. *The Best Use of Available Resources Prioritisation Framework*. Wellington: Ministry of Health.
- National Health Committee. 2005. *Decision-Making about New Health Interventions*. Wellington: National Health Committee.
- Ministry of Health. 2003. *Guidelines for Capital Investment*. Wellington: Ministry of Health.

These documents are available on the National Health Committee website [www.nhc.govt.nz](http://www.nhc.govt.nz) and Ministry of Health website [www.moh.govt.nz](http://www.moh.govt.nz)

## Relationship with Pharmac

This framework does not extend to pharmaceuticals. Pharmac continues to retain full responsibility for pharmaceuticals.

## Abbreviations

CEO	Chief Executive Officer
DDG-CEO	Deputy Director-General and Chief Executive Officer Group
DHB	District Health Board
DHBNZ	District Health Boards of New Zealand
IDF	Inter-District Flow
NSTR	National Service and Technology Review Subcommittee
NZGG	New Zealand Guidelines Group
NZHTA	New Zealand Health Technology Assessment
SPNIA	Service Planning and New Health Intervention Assessment



# 1 Introduction and Executive Summary

This Service Planning and New Health Intervention Assessment (SPNIA) framework aims to help District Health Boards (DHBs) and the Ministry of Health with health service changes that require a collective decision. The framework will also ensure that individual DHBs are not inappropriately compromised by the decisions of other DHBs.

The framework covers regional and national collaborative decision-making in two related areas:

- new health interventions (including a new method of delivering an existing treatment)
- service reconfiguration (including the introduction of a new service, cessation of a service, service expansion, quality change or change of providers).

The framework provides:

- horizon scanning for new interventions, service changes and potential disinvestments
- a clear format for writing a 'proposal for change' or a full business case
- a process for developing and consulting on a case for change
- assistance with the analytical support and access to evidence required to develop a credible case for change
- clear decision-making steps and responsibilities and assessment criteria
- an annual decision cycle linked to the district annual plan round that enables proposals to be prioritised and funding sources identified.

The framework draws on existing groups and structures and, where required, identifies new responsibilities, clearer steps, linkages and extra assistance. For example, the framework creates a clearer role for regional forums, provides assessment and analytical support to the Deputy Director-General and Chief Executive Officer (DDG-CEO) Group via the new National Service and Technology Review Subcommittee (NSTR), and improves analytical support and co-ordination of sector proposals via the SPNIA analytical and process support.

If two or more DHBs can reach a decision that does not have flow-on effects to other DHBs, then that is satisfactory. However, if a DHB is facing flow-on effects from a decision taken, or proposed, by another DHB, then the affected DHB(s) can seek redress via this framework. In addition, the Minister or the DDG-CEO Group can require a matter to be considered. Major capital projects with a regional or national service impact must also have those service aspects considered through the framework.

If the DDG-CEO Group agrees, then this framework can be applied to a specific health service or technology change proposed by the Ministry of Health. The framework can also be used to analyse the merit of continuing to fund an existing service or technology.

Funding for proposals is to be considered by the national CEOs in October each year. To help with this process, NSTR will provide a ranked list of proposals, which will enable

CEOs to consider funding for proposals on a priority basis up to the point that the sector can afford.

## 2 Jurisdiction of the Collaborative Decision-making Framework

### Jurisdiction principles

The principles in determining jurisdiction are that:

- decisions should be taken at the lowest level practical
- if two or more DHBs can reach a simple agreement directly that does not have flow-on effects to other DHBs, then such an approach should be taken
- jurisdiction of the various levels of the collaborative framework for services and new health interventions is determined by the flow-on or precedent-setting effect on a region, or nationally
- for service planning and new health interventions (other than ministerial or DDG-CEO Group mandatory referrals, detailed below), jurisdiction is triggered by either:
  - self-identification by a DHB, or the other parties listed below, who seek a framework to secure other DHBs' support and agreement, or
  - by an affected DHB, or the other parties listed below, who seek to respond to the actions or intentions of another DHB
- except for the mandatory referral detailed below, the decision as to whether or not to accept a referral lies with the NSTR or the regional forum concerned.

### Referrals to the framework

A matter may be referred to a regional forum or NSTR for a collaborative decision by:

- the DHB initiating the change (the most common situation)
- a DHB (potentially) affected by a service change or new health intervention
- a Regional Capital Committee
- the National Capital Committee
- the DDG-CEO Group
- the national CEO group
- the Ministry of Health
- the Minister of Health
- a regional forum or NSTR may choose to initiate consideration of a matter (including a retrospective review of the impacts of a previous service decision).

Referrals to NSTR from DHBs or a regional capital committee must first secure the support of the relevant regional forum.

A Primary Health Organisation, non-governmental organisation, professional agency or other recognised health organisation may bring issues that (potentially) affect more than one DHB to the attention of a DHB. The framework is all-inclusive and, if appropriate, the relevant DHB will refer the issues to the SPNIA framework. A sponsoring DHB is always required – other health organisations cannot access the framework directly.

## **Mandatory referral**

The DDG-CEO Group, or the Minister, may specifically request NSTR or a regional forum to consider, and *make a recommendation*, regarding a matter. This means that the DDG-CEO Group or the Minister have the authority to declare a matter as having regional or national impacts and require a regional or national process. This includes health service changes proposed by the Ministry of Health.

Jurisdiction of the collaborative framework is triggered and is *mandatory* if a capital investment business case:

- (i) has potential health service implications for other DHBs and requires consideration by the *National Capital Committee* (ie, new lending or equity is required, or it involves capital expenditure over \$10 million); such cases must go to the relevant regional forum, which should then report their view to NSTR each February
- (ii) does not require National Capital Committee consideration, but involves capital expenditure over \$1 million and has potential regional service implications; such cases must go to the relevant regional forum.

## **Disputes and appeals**

The dispute resolution process is as follows.

1. A local DHB process decision should be appealed using the DHB's own internal dispute resolution process.
2. A disputed decision by a regional forum should be appealed to the regional CEOs for resolution.
3. A disputed recommendation or decision by NSTR can be appealed to the DDG-CEO Group.
4. A disputed decision by the DDG-CEO Group can be appealed through existing DDG-CEO processes.
5. National CEO decisions can be appealed using existing national CEO processes.

### **3 Service Planning and New Health Intervention Decision-making Structures**

#### **National decision-making**

At a national decision-making level, there are two groups: the DDG-CEO Group and NSTR. Both these groups are linked with and supported by the Ministry of Health.

#### **DDG-CEO Group**

The DDG-CEO Group governs NSTR. The group has met bi-monthly since 2003 and comprises five DHB CEOs and five Ministry of Health DDGs. The recommendations of NSTR must be endorsed by the DDG-CEO Group.

The DDG-CEO Group is responsible for:

- resolving key national strategic operational matters
- making decisions on national service matters, new health interventions, cost effectiveness and related principles
- ensuring advice is available to the National Capital Committee on regional and national clinical service planning where appropriate.

#### **National Service and Technology Review Subcommittee (NSTR) terms of reference**

NSTR is governed by the DDG-CEO Group. It is responsible for horizon scanning, co-ordinating business case development, and analysing and evaluating proposals for change and business cases. It makes recommendations to the DDG-CEO Group on national service matters and new health interventions that have a national impact.

NSTR may propose to critically review the national impacts of an existing policy, service or technology. Its members act in their individual capacity as experts – not as representatives of the regions, organisations or professions from which they are drawn.

NSTR's role is to:

- provide technical and strategic policy advice to the DDG-CEO Group on health service configuration and health interventions that have a national impact
- horizon scan for new health interventions that could be considered for formal assessment because of their potential value
- horizon scan for services and health interventions that are obsolete, ineffective or inadequate, and therefore exit or cessation is likely to be appropriate
- maintain a register of health interventions and potential disinvestments that have been recommended for assessment, and their status
- develop, over time, a precedent-based threshold against which health interventions can be ranked on their appropriateness for introduction to the New Zealand public health system, or for their provision to cease

- provide timely recommendations to the National Capital Committee on the service aspects of capital projects that require National Capital Committee approval
- co-ordinate the development of business cases, including the evidence component
- analyse and evaluate proposals for change and business cases and recommend their adoption or rejection to the DDG-CEO Group.

### **NSTR membership**

DHBs will have majority representation on NSTR. A DHB representative will chair NSTR.

The members comprise:

- a representative from the DDG-CEO Group (chair)
- four senior DHB representatives (preferably one from each region), including at least two funder representatives, endorsed by the CEOs
- two DHB chief medical officers (to be agreed by the DDG-CEO Group)
- a Clinical Services Directorate nominee from the Ministry of Health
- a DHB Funding and Performance nominee from the Ministry of Health
- the Chief Medical/Clinical Advisor from the Ministry of Health
- a Māori representative nominated by Tumuwhakarai
- a consumer representative who is a member of the national or a regional ethics committee.

A quorum shall consist of seven members, one of whom must be the chair or their nominee. Voting shall be subject to the same rules as apply for the DDG-CEO Group.

### **Expert subgroup membership**

NSTR may invite people with expert knowledge on an issue to advise NSTR and take part in, but not vote on, NSTR discussions on that issue, subject to resolving conflicts of interest.

### **Secretariat and analytical support for NSTR and SPNIA**

The Ministry of Health will provide a convenor to support both NSTR and the DDG-CEO group, and to assist DHBs to establish the overall SPNIA framework. The convenor will:

- provide strategic policy advice to stakeholders such as regional DHB groups and clinical experts regarding service planning and new intervention assessment
- act as a key point of contact, champion the SPNIA framework and facilitate its introduction and proper use
- horizon scan and maintain a register of new health interventions and potential disinvestments
- maintain a register of previous NSTR recommendations and DDG-CEO decisions

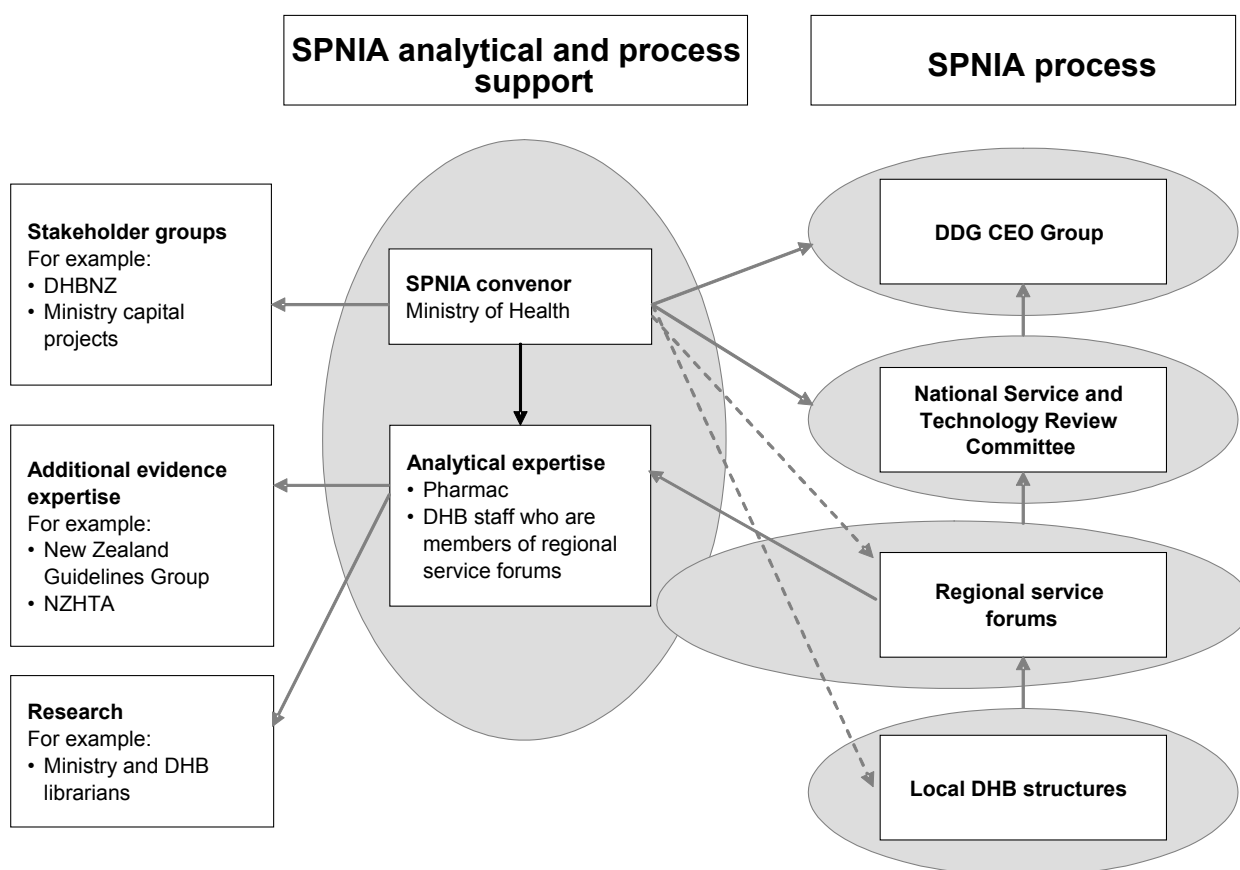
- co-ordinate sharing of regional service forum work plans
- collate proposals for change for NSTR
- collate business cases for consideration by NSTR
- facilitate and contribute to the analysis of and recommendations regarding proposals for change and business cases for NSTR
- advise on budget decisions regarding evidence analysis and evaluation of business cases.

DHBs, and Pharmac, depending on where the relevant expertise is housed, will provide analytical support for NSTR evaluation of proposals for change and business cases. In addition, while the SPNIA convenor will be responsible for co-ordinating the development of business cases, DHB expertise will be required to develop and take responsibility for writing business cases. Each regional forum must have analytical resources available to contribute to this task.

The convenor will help to identify a lead individual or group in the sector who will be responsible for writing a business case. This individual or group will be able to request assistance from each of the regional service forums, and NSTR will also work closely with regional forums to assist in this task. Those providing analytical support will also be responsible for identifying areas where additional expertise from evidence agencies such as the New Zealand Guidelines Group and New Zealand Health Technology Assessment is required, and will act as a point of contact for these other agencies.

The Ministry of Health will hold a budget for the purpose of funding expert input for the evaluation of business cases. This budget will be available until 31 December 2007. The need for and source of any funding and the location of the NSTR secretariat after 31 December 2007 will be reassessed before that date.

**Figure 1:** SPNIA analytical and process support



## Regional forums

Regional forums are responsible for ensuring optimal regional service configuration and considering new health interventions that have a regional or national impact. They are also responsible for assisting with the analytical support required to complete proposals for change and full business cases.

Regional forums should agree on which proposals from their region should be forwarded to NSTR and agree their annual work plan.

The role of regional forums is to:

- enable DHBs to deliver a sustainable, clinically viable and cost-effective regional configuration of health services and the introduction of new interventions
- horizon scan for new health interventions that should be subject to a formal assessment
- horizon scan for services and health interventions that are obsolete, ineffective or inadequate and therefore exit or cessation should be considered
- collaborate with Regional Capital Committees to ensure that the development of business cases is closely linked with regional and national service planning

- provide analytical support to assist in the preparation of proposals for change and business cases for the introduction of service changes and new interventions with regional or national impacts (this resource will be considered as a national resource and will therefore be made available to contribute to the development of proposals or business cases that are not being led by the regional forum's home region)
- be the regional-level gatekeeper for service change and new health interventions proposals.

All regions have existing committees and processes that are able to perform these functions. Regional forum membership and terms of reference need not be uniform. Rather, each region should determine what is appropriate for its needs.

The boundaries of regional forums should be the same as those for the regional shared service agencies. However, regional forums should seek to identify opportunities for collaboration across regions and co-operate closely with neighbouring forums.

Regional forums are accountable to the DHBs in their region, and make recommendations to those DHBs on regional matters. Individual DHB boards are responsible for making final decisions, drawing on the advice of the regional forums.

### **Expectations of regions**

All regions must demonstrate formal regional service planning for:

- major capital projects that have a potential regional service impact (according to the mandatory requirement above)
- new service configurations that have a regional impact
- new health interventions that have a regional impact.

### **Regional forum work plans**

All regions should provide NSTR with a high-level work plan in March each year. The work plan should be updated and then shared quarterly with both NSTR and the other regional forums. The purpose of regular sharing of work plans is to identify the key service or new health intervention issues requiring attention across the sector, and to avoid duplication of effort. The work plan must detail how the regional forum will provide the capacity required to address the issues included in the plan.

### **Secretariat and analytical support**

Regional forums must have access to sufficient analytical capacity and secretariat support, both for their own regional matters and to contribute to the development of national service and new health intervention proposals. Business cases for national proposals will be co-ordinated by NSTR. However, sector assistance and expertise will be required to complete business cases.

## **Local DHB decision-making**

DHBs should use or establish local DHB structures to undertake horizon scanning and act as the DHB's gatekeeper of proposals for change. These structures have an important role to play in advising on new health interventions and new services, and DHBs should make use of the expertise available from them and secure their advice. DHBs should ensure that the DHB funder is represented on these structures.

These local structures should:

- horizon scan for new health interventions that should be subject to a formal assessment
- horizon scan for services and health interventions that are obsolete, ineffective or inadequate and therefore exit or cessation should be considered
- refer results of horizon scans to the regional forum and NSTR if they relate to regional or national matters
- refer matters with flow-on or precedent-setting effects to the regional forum
- be the DHB-level gatekeeper on service change and new health interventions.

Each DHB should make its own decisions on new health interventions or new health services where the critical mass of patients required for the process or service to be viable will be resident within the DHB's boundaries.

### **Flow-on or precedent-setting effects of a local decision**

It is important that the potential impacts of an individual DHB's decision on other DHBs are addressed. If a DHB makes a decision that has a flow-on or precedent-setting effect that cannot be agreed directly with the DHBs affected, then the regional forum or NSTR will have jurisdiction (see section 2). Local structures must therefore take precedent-setting impacts into account when considering a matter, and may choose to refer a matter on to the regional forum, which will consider referral to NSTR if it has national impacts.

### **Proposals for change and business cases at a DHB level**

DHBs are responsible for determining the internal process required to secure support for a new health intervention or service change. It is recommended, however, that the rigour of a formal proposal for change or a full business case be applied at the internal DHB level (with the scope of the business case adjusted for the size of the matter being considered). Tables of contents for a formal proposal for change and for a business case are provided in Appendices 2 and 3, respectively.

## 4 Prioritisation and Funding

### Annual decision-making round and prioritisation

NSTR will operate on an annual decision cycle linked to the district annual plan (DAP) round. This is to enable proposals to be prioritised against one another and funding to be identified and agreed by DHBs.

NSTR will also develop, over time, a precedent-based threshold against which health interventions can be prioritised according to their appropriateness for introduction to the New Zealand public health system, or for their provision to cease.

### Annual decision-making round: steps and timing

The following steps and timing form the annual decision-making round:

1. *December to March* – horizon scanning is undertaken by DHBs, regional forums and NSTR.
2. *January to March* – DHBs develop proposals for change (including disinvestment proposals) as part of DAP planning and submit these to their regional forum – Ministry of Health service changes and new interventions that might be considered are identified by the Ministry and DHBs.
3. *March* – regional forums agree what proposals from their region should be forwarded to NSTR and agree their annual work plan – the DDG-CEO Group considers service changes and new interventions planned by the Ministry of Health that should be considered by NSTR.
4. *30 March* – DHB and Ministry proposals for change are due to NSTR – regional forum work plans are to be shared with NSTR.
5. *April* – NSTR considers proposals for change, determines what proposals to accept jurisdiction over and sets a work plan for the year (including both potential investments and disinvestments) – the DDG-CEO Group agrees the NSTR annual work plan, which is then shared with DHBs and regional forums.
6. *May to July* – full business cases are developed (where required) and co-ordinated by NSTR, including Service Framework Group and Service Improvement Group consultation.<sup>1</sup>
7. *August* – Service Framework Group and Service Improvement Group sign-off occurs, and national CEO consultation is undertaken.
8. *August to September* – analysis, review, ranking and recommendations on proposals are made by NSTR, including recommendations on the availability and amount of the funding pool from disinvestments.
9. *October* – national CEO sign-off occurs and funding agreement is achieved according to standard national CEO collective decision rules.

<sup>1</sup> See under 'Sector consultation' (below) for a description of the Service Framework Group and Service Improvement Group.

10. *October and November* – DDG-CEO Group decisions and any ministerial decisions – pricing and volume impacts are notified to the national Inter-District Flow group.<sup>2</sup>
11. *December* – funding signals sent to DHBs by the Ministry.
12. *February* – DAP planning is fully informed regarding service changes and new interventions – NSTR considers service configuration matters relating to major business cases for that year's annual capital allocation round (this then forms part of the advice to the March or May strategic meeting of the National Capital Committee).

### **Cases that can be considered outside the annual decision-making round**

Three types of proposals may be progressed outside the annual decision-making cycle. DDG-CEO Group agreement is required for a proposal to be considered as an exception.

#### **Cost-neutral national service configuration**

If a service configuration change has national implications and the cost impact is proved to be neutral, then the case can be considered at any time.

#### **Intervention substitution proposals**

If the source of funds for a proposal is proven to be a one-for-one substitution (ie, a new health intervention will be funded by swapping one thing for another), then the case can be considered at any time. Such a case is most likely to be for a substitution within a service, but if it can be linked to another service stopping something and agreeing to transfer the funding, that is also satisfactory. This is intended to provide an incentive for proposals that have proven and agreed funding streams.

#### **Outstanding health gain proposal**

If exceptionally good health gain can be proven and it would not be defensible to consider such a proposal in the normal cycle, then the case can be considered at any time.

#### **Sector consultation**

##### **Service Framework Group and Service Improvement Group**

Prior to NSTR recommendations proceeding to the DDG-CEO Group, its analysis, any recommendations and the relevant business cases will be referred to the Service Framework Group or the Service Improvements Group for consideration and recommendation to DHB CEOs. These referrals will be managed by DHBNZ on behalf of the DHB CEOs.

<sup>2</sup> See under 'Sector consultation' below for a description of Inter-District Flow groups.

## **National CEOs**

The national CEOs will be consulted on proposals in August. In October, CEO sign-off and funding agreement will be sought. Decisions will be made according to the standard national CEO collective decision rules.

## **Inter-District Flow consultation**

Regional Inter-District Flow (IDF) groups – and the national IDF group where national issues are involved – must be kept informed throughout the process of business case preparation for service change or the introduction of new health technology.

Regional IDF groups can assist those planning service change to ensure the IDF changes are considered and, when service changes have been implemented, that IDF changes are reflected in the IDF advice to the Ministry. Their advice should be incorporated into the business case.

## **Sources of funding**

There are five potential sources of funds. These are:

1. a disinvestment pool
2. funding from one-for-one substitution
3. funding from the annual Population Based Funding (PBF) future funding track
4. outside funding (eg, from a joint venture with a university)
5. new funding for a new government policy initiative that has been initiated by the centre.

## **Disinvestment proposals**

NSTR will encourage and consider proposals for disinvestment that can then provide a notional source of funds to be applied to other health services that are proven to deliver greater health gain. To be considered, a disinvestment must be a service or a health intervention that is obsolete, ineffective or inadequate, and therefore exit or cessation is likely to be appropriate.

Only savings generated from nationally agreed disinvestments would be available for the national disinvestments funding pool (refer to the sources of funding listed above).

## **Funding decisions**

Funding for annual decision-round proposals is to be considered by the national CEOs in October each year. To assist with this process, NSTR will provide a ranked list of proposals. This will enable CEOs to consider funding for proposals on a priority basis up to the point that the sector can afford.

**Figure 2:** Developing a business case for NSTR: significant steps and dates



## 5 Proposals for Change and Business Cases

Consideration of a matter by NSTR must be on the basis of either a proposal for change or a fully completed business case assembled with expert input. This should also be true of decisions by local DHB processes and regional forums.

### Assessment of proposals for change and business cases

NSTR (and, ideally, regional forums) will review proposals for change and business cases via a standard evaluation methodology. That methodology will assess the strength of the business case in the following areas:

1. expert clinical evidence and health technology assessment, including challenges to the evidence
2. population health gain
3. cost effectiveness
4. equity and opportunity cost
5. funding stream and affordability
6. community acceptability and ethical issues
7. service configuration and implementation planning
8. priority in relation to other proposals in the annual decision-making round and against past precedents.

### Critical review expectation

NSTR and regional forums are expected to challenge, rather than passively accept, evidence of health gain, particularly regarding new health interventions.

### Community expectations

DHBs and the Ministry should not raise public expectations of new health interventions or service reconfigurations beyond the ability of the DHB or the Crown to fund such new interventions. Sound management of public expectations is a requirement for proposals to receive favourable consideration.

### Proposal for change: expectations and format

A proposal for change must be prepared by a proposing DHB for consideration by a regional forum or for referral to NSTR. The purpose of a proposal for change is to enable an initial assessment by a regional forum or NSTR of a possible service change or new intervention without the need to undertake the requirements of a full business case.

A proposal for change is a brief document that should include (see Appendix 2 for a complete list):

- a statement of what is proposed and an options analysis
- the population affected, and whether regional or national
- the expected health or efficiency gain
- a summary of health technology assessment and other information known to be available
- a brief cost–benefit analysis
- a brief funding impact analysis, including IDF analysis
- an analysis of potential flow-on effects to other DHBs
- a small bibliography.

A regional forum or NSTR will evaluate the proposal for change, and get expert advice if necessary. The proposing DHB or region will be advised whether proceeding to a full business case is justified on the basis of the evaluation of the proposal for change.

### **Business cases: expectations and format**

A business case must be developed in order to credibly plan the delivery of a service change or new health intervention. A business case is as much a DHB or Ministry planning tool, for DHB or Ministry needs, as it is a document for the regional forum, NSTR or DDG-CEO Group. A business case should be a stand-alone document. (See Appendix 3 for a table of contents and format.)

### **Analytical support**

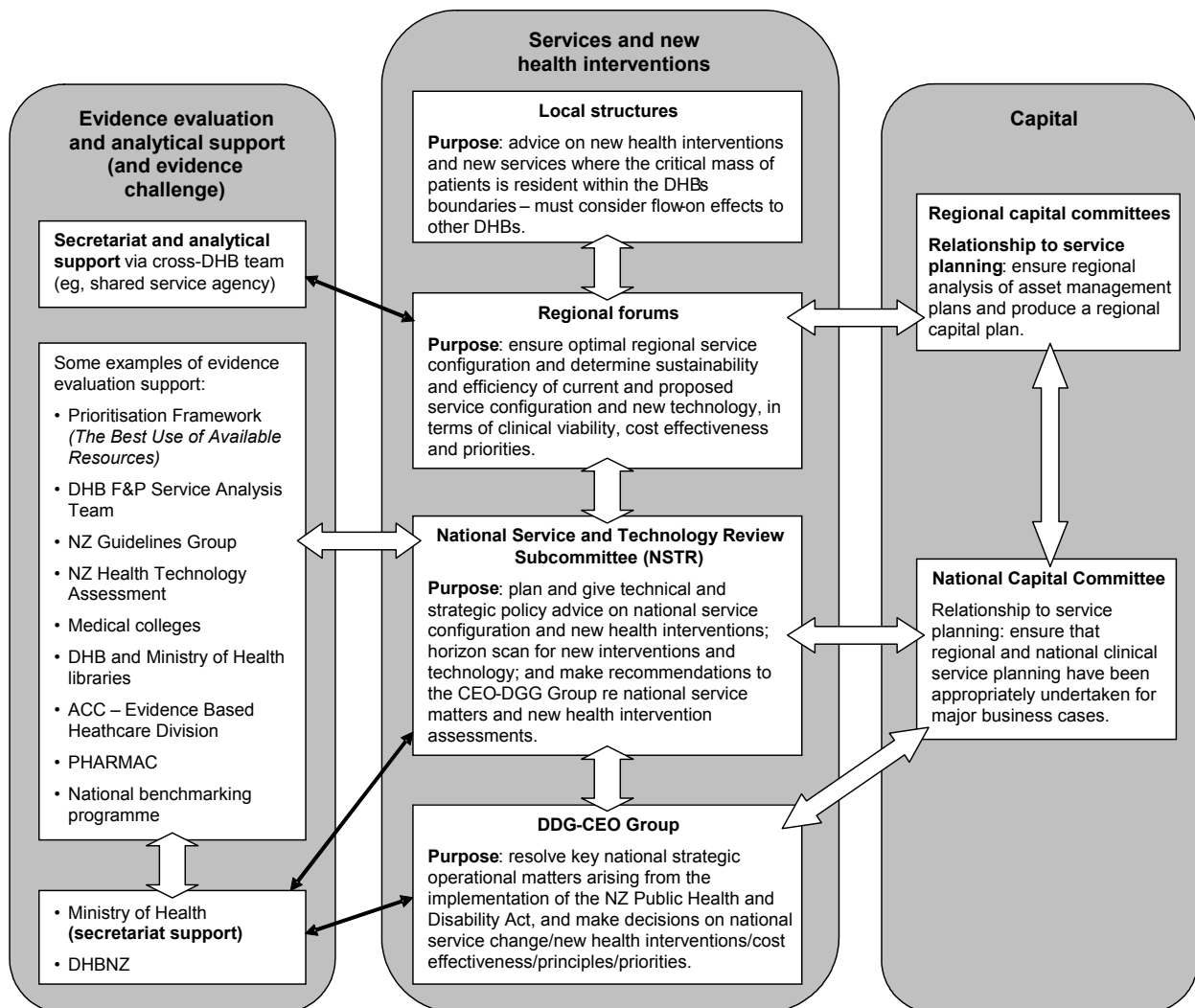
When proposing a change, DHBs and the Ministry should *not* be responsible for providing all the analytical support required to develop a business case for proposals that have regional or national implications. Co-ordination, advice regarding analytical support and funding for clinical evidence review will be available from the NSTR budget. Regional forums should also assist those responsible for preparing a business case.

### **Evidence evaluation**

A number of organisations provide analysis and research into health interventions and health service delivery. These organisations can often contribute to the clinical evidence base required for fully informed service planning for a major business case, new health intervention assessment or significant service change. Early consideration of what evidence and clinical expertise such organisations might provide is strongly recommended. NSTR and regional forums should ensure that these organisations are linked into health service, new health intervention and capital decision-making processes.

Appendix 4 contains a description of the work undertaken by key evidence analysis organisations and their contact details. Funding for purchasing expert advice is available from the NSTR budget.

# Appendix 1: The Service Planning and New Health Intervention Assessment Framework



# Appendix 2: Proposal for Change Format

## Definition

A proposal for change is a brief document (8 to 12 pages) that provides sufficient information for informed decision-making about whether or not a possible service change or new health intervention should proceed to a full business case.

A proposal for change does not replace the requirement for a business case to be developed if it is decided that the proposal should be referred to a regional forum or to NSTR for detailed consideration.

It is recommended that DHBs consult the Prioritisation Framework prior to commencing a proposal for change.

## Proposal for change format

It is essential that a proposal for change is well prepared and includes the body of knowledge currently known by the proposer about the relevant issues. Proposals for change must include the following sections.

### 1. Statement of what is proposed and an options analysis

This should be a reasonably detailed description of the proposed service change or new health intervention. It must also include discussion of the range of options available to achieve the desired outcome.

### 2. The population affected, and whether regional or national

Describe the population affected by the proposed change. Is it local only, regional only, or does it have national implications? (Note that it is unlikely that adoption of a new health intervention will *not* have national implications.) What are the characteristics of the population, age, gender or population group(s)?

### 3. The expected health or efficiency gain

What is the expected health gain for the affected population? What is the time-frame? What is the alternative, either currently provided or as an alternative new intervention? How does the proposal contribute to the delivery of modern models of care? Are there any potential efficiency gains?

### 4. Summary of health technology assessment and other information known to be available

What is the known health technology assessment literature? What reports are available? Do they support the proposed change? Are there other likely future uses/applications for the technology?

### 5. Brief cost–benefit analysis

Include estimated capital and annual operating costs. Are there any estimated savings that will accrue from the proposal, and when?

**6. Brief funding impact analysis, including IDF analysis**

How will the capital costs be funded? How will the annual operating costs be funded? Does the proposal rely on any new funding?

**7. A statement on the likely flow-on effects to other DHBs**

Are there inter-district flow implications, and if so how would they be managed? What is the likely effect on other DHBs of the proposal? Are there likely to be flow-on effects in other hospitals/DHBs?

**8. A small bibliography**

# Appendix 3: Business Case Format

## Definition

A business case is a comprehensive document that provides all the necessary detailed information and analysis required for informed decision-making about a service planning initiative or a new health intervention, and for planning the successful implementation of a project.

A business case does not replace the requirement for a business case for capital investment as set out in the Ministry of Health *Guidelines for Capital Investment* (2003). However, where service change or new intervention implementation requires a capital business case, the health service business case should be incorporated in the capital business case so that the two documents are compatible.

## Basic requirements of a business case

A business case must be developed in order to credibly plan the delivery of a service change or new health intervention. A business case is as much a DHB or Ministry planning tool, for DHB or Ministry needs, as it is a document for the regional forum, NSTR or DDG-CEO Group. A business case should be a stand-alone document.

To ensure that the funding and affordability section is accurate, please ensure that the clinical effectiveness assumptions are reflected in both the financial modelling and cost-effectiveness analysis.

The table of contents for a business case below along with the overall prioritisation framework are useful tools in the development of a successful business case.

## Business case standard table of contents

It is essential that a business case is thoroughly prepared and addresses all relevant issues. Business cases *must* include the following sections.

### 1. Framing the question and options analysis

What is the proposal? What are the alternatives with which this proposal is to be compared? (This is the counterfactual and options analysis.) Are these the right options to use? Consider possible alternatives. Can you frame a well-defined question to be answered? Write a description of the proposal and the counterfactual/other options.

## **2. Effectiveness and safety**

Have you found evidence for the effectiveness and clinical safety of the proposal, the effectiveness of the counterfactual and their relative effectiveness? Note your sources for this information. Are the units in which effectiveness has been measured appropriate? Can the effectiveness and safety of the proposal and the counterfactual be compared? How does the proposal contribute to the delivery of modern models of care?

## **3. Cost**

Have all the relevant costs of each alternative been identified? Have you defined the boundaries of what costs are included? Are you comparing the proposal and the counterfactual under the same boundaries? Are the physical units in which the costs have been counted comparable? Are all the consequential or downstream costs accounted for?

## **4. Cost-effectiveness/value for money**

What is the relative value for money of the proposal when compared with the counterfactual? Have you adjusted the costs and the benefits (effectiveness) for differential timing? That is, do the costs all come at once, and do the benefits come a long time into the future? Have you done an incremental analysis (eg, have you varied the number or severity of people treated to see what difference this makes to effectiveness and costs)? Have you done a sensitivity analysis (eg, have you found how far costs would have to fall/rise to make the proposal cost-effective/not cost-effective)?

## **5. Funding and affordability – including inter-district flows and opportunity cost**

What funding streams are planned or potentially available to fund the proposal? What consultation has taken place with funders? What impacts on inter-district flows would result? What are the implications / consequential impacts of a decision to fund? Would a decision to fund contribute to a break-even DHB environment? If not, what would need to take place to ensure that the proposal would contribute to a break-even DHB environment? What consideration has been given to the opportunity cost of funding this over other potential proposals?

## **6. Equity**

Will the proposal help to reduce current disparities in health and wellbeing compared with the alternative (ie, the counterfactual)? Can you quantify this in any way? What is the impact on equity, both between DHBs and between different groups in the community, in particular those with low health status?

## **7. Whanau ora**

How will the proposal contribute to whanau ora compared to the alternative? Is there evidence that the proposal will address a problem that is significant to Māori or affects Māori disproportionately? Is the proposal (in particular its delivery) likely to be effective for Māori and thus help to reduce disparities in health and wellbeing for Māori compared to the alternative? What evidence can you find for this? (You may need to discuss this with your DHB's Māori general manager or with local iwi.) Will this proposal reduce costs and other barriers to access for Māori, or could it impose costs? Can you identify these?

## **8. Information flows**

What consultation has taken place with groups (eg, the New Zealand Health Information Service or Information Liaison Group) on information requirements, or the consequential information flow impacts of the proposal? Can these information flow impacts be accommodated? If so, how and at what cost?

## **9. Constraints – including workforce**

In making a decision, the decision-maker will need to know how feasible the proposal is to implement. Does it reflect clinical realities and available resources? Can you identify any resource constraints that may impede implementation of the proposal (eg, workforce constraints, capital constraints, timing issues)? Will the proposal free up resources that can be used for other services?

## **10. Community acceptability – including ethical issues**

Is the proposal consistent with community values? How do you know? Are there significant ethical, social, political or legal issues, or other patient concerns surrounding the use of the technology? How do you propose that any such issues should be addressed?

## **11. Implementation planning, risk management and post-implementation review**

What training is required to ensure a workforce with the required skills to implement the proposal? What are the timeframes and steps/components required to implement the proposal and manage risks? Are there capital requirements or impacts? If so, how will these be addressed? For new health interventions, what service configuration changes are required? How do you propose to review the outcome and confirm that the benefits have been realised and the risks managed?

## **12. Completeness**

Have you covered all issues of concern for the decision-maker? Are there issues outstanding that you have not been able to cover?

### **13. Consultation**

What consultation has occurred – within the DHB sector, with other sector agencies, with the community? What were the outcomes of those consultations, and how have they been reflected in this document? What further consultation may be or will be necessary if this proposal is approved?

### **14. Summary and recommendations**

Given the information presented above, what advice can you give regarding the effectiveness and cost-effectiveness of the proposal? What will it cost? Are there any constraints to note that may impede its implementation? Will implementation help reduce current inequalities in health and wellbeing among the population? How will it contribute to the achievement of whanau ora? Are the conclusions defensible in the face of challenge? Does the business case align with the principles, process and inputs set out in recommendation 1 of the National Health Committee report, *Decision-Making about New Health Interventions*?<sup>3</sup>

<sup>3</sup> *Decision-Making about New Health Interventions*, National Health Committee, 2005, p.5.

## Appendix 4: Evidence Evaluation Support

A number of organisations provide analysis and research into new health interventions and health service delivery. These organisations can often make a significant contribution to improving the clinical evidence base required to ensure fully informed service planning for a major business case, new health intervention assessment or significant service change. Early consideration of what evidence and clinical expertise they might be able to provide is strongly recommended.

Examples of the organisations that can provide evidence for the effectiveness of new technologies, and in some cases service configuration, are:

- New Zealand Guidelines Group
- New Zealand Health Technology Assessment
- National Health Committee
- university medical schools and research departments, including the Effective Practice, Informatics and Quality Institute at the University of Auckland
- ACC
- Health Research Council
- Donald Beasley Institute
- Pharmac.

These New Zealand organisations can be approached to conduct new evidence reviews or to provide independent peer review of in-house evidence searches or to train/mentor DHB staff undertaking the evidence analysis. The following three organisations are likely to be of particular use in this area.

### **New Zealand Guidelines Group (NZGG)**

The NZGG is an independent not-for-profit organisation established to promote effective delivery of health and disability services, based on evidence. NZGG works with a broad-based network of clinical leaders, designing tools to promote an evidence-based culture. These tools include evidence-based guidelines, the circulation of the latest evidenced-based news from New Zealand and overseas, links to the international Cochrane Collaboration and training. Further information can be found at [www.nzgg.org.nz](http://www.nzgg.org.nz)

### **New Zealand Health Technology Assessment (NZHTA)**

The New Zealand Health Technology Assessment Clearing House for Health Outcomes and Health Technology Assessment is located within the Christchurch School of Medicine and Health Sciences, University of Otago. The clearing house carries out systematic reviews of the effectiveness of new health interventions. These reviews may be used to inform decision-making about capital purchases and services planning. Further information can be found at <http://nzhta.chmeds.ac.nz/>

## **National Health Committee**

The National Health Committee (an independent committee reporting directly to the Minister of Health) regularly produces evidence-based reports with recommendations for the Minister. These reports are normally made public after the committee has informed the Minister of its findings, and DHBs may find them useful in their planning processes. Recent reports have looked at a wide range of issues, including: prostate cancer, genetic testing, health impact assessment and child oral health. Copies of the committee's reports can be found on its website: [www.nhc.govt.nz](http://www.nhc.govt.nz)

Other international organisations and evidence sources include the Guidelines International Network, INAHTA, Cochrane Library, and the National Guidelines Clearing House. The New Zealand Guidelines Group website [www.nzgg.org.nz](http://www.nzgg.org.nz) has links to these sources.

Electronic databases such as MEDLINE, EMBASE, CINAHL, PschINFO and Cochrane are also useful sources of evidence, and these are available through DHB libraries.