Event Briefing

Community referred radiology investment announcement

To:	**Hon Dr Shane Reti, Minister of Health**	Reference:	**HNZ00050257**
From:	Abbe Anderson, Director Commissioning	**Due Date:**	31 May 2024
Copy to:		**Security level:**	In Confidence

Contact for telephone discussion (if required)			
Name	**Position**	**Telephone**	**1st contact**
Martin Hefford	Director, Living Well	S 9(2)(a)	**x**
Tim Wood	General Manager Planned and Unplanned Care		

Attachments
Appendix 1: Runsheet Appendix 2: Talking points Appendix 3: Draft media release Appendix 4: Biographical details of attendees.

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Event details	**Date:** Thursday 6 June 2024 **Time:** 9:30am – 10:15am **Venue address:** Waikanae Health Centre, 11 Marae Lane, Waikanae
Purpose of event	You, along with the Minister of Finance, are announcing a $30 million investment in community referred radiology services by Health NZ.
Expected Attendees	Please refer to Appendix 2, Runsheet, for more detail.
Health New Zealand representatives	Astuti Balram (Group Manager Primary Care, Commissioning) will attend the event.
Media	Media have been made aware of the event by your office. A press release has been prepared for your office to release publicly to coincide with the announcement. This is attached as Appendix 3.
Talking points	A comprehensive set of suggested talking points is attached to this briefing as **Appendix 2**. Note, that we suggest your office liaise with the Minister of Finance's office about specific parts of the talking points which each of you takes a lead on. The Minister of Finance is also likely to talk in broader terms about Budget 24 and the implications for the health sector.

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Background

1. This Event Briefing provides you with information on your announcement (along with the Minister of Finance) of a $30m annual investment by Health NZ in the community referred radiology. Talking points for the announcement are included in Appendix 2.

About community referred radiology

2. The Community Radiology Service provides diagnostic imaging services funded by Health NZ for individuals referred by community-based practitioners.

3. Diagnostic imaging provides images of bodily structures and functions to aid diagnosis and treatment. The range of diagnostics includes services such as X-rays, CT scans and non-maternity ultrasound.

About Health NZ's investment

4. In March 2024, the Health NZ Board approved an investment of $30m per annum to enable New Zealanders to have more consistent and local access to radiology across Aotearoa, New Zealand. The $30m per annum will be funded from Health NZ's allocated budget.

Anticipated benefits of the investment

5. The investment is expected to:

    - Provide faster, free access to radiology services across New Zealand and ensure New Zealanders get a diagnosis faster;
    - Enable more consistent access to diagnostic radiology services across New Zealand;
    - Enable GPs and other community-based practitioners to refer patients directly for imaging, removing the need for people to be referred to Hospital and Specialist Services (HSS) for access to imaging;
    - Include targeted support packages, such as travel assistance, which will reduce barriers for patients, making radiology services easier to access.

About Waikanae Health Centre

6. The event will take place at Waikanae Health Centre.

7. Waikanae Health Centre is a member of Tū Ora Compass Health (Tū Ora). Tū Ora is a Primary Health Organisation (PHO) that provides primary care services through 58 general practice teams and a number of other health care providers throughout the Wellington, Porirua, Kapiti and Wairarapa regions.

8. Waikanae Health Centre has 8,700 patients enrolled, of whom: 1,050 are high-needs patients, around 7,000 patients are quintile 1, 2 or 3, and around one-third are aged 65 or older. It is one of two general practices in Waikanae (the other is Mahara Health).

9. Tū Ora will be represented by Justine Thorpe (Chief Executive) and Debbie Chin (Board Chair).

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Risks and mitigations

10. You should be aware that Waikanae Health Centre is currently not enrolling new patients, with some exceptions (e.g. new-born babies of existing patients and youth who have aged out from Kāpiti Youth Support).

11. In choosing a venue, we specifically sought a location where the announcement would have minimal impact on patient consultations. Waikanae Health Centre has set aside a room specifically for the purposes of this announcement in order to minimise disruption to appointments in the Health Centre.

12. The funding being announced does not include funding for maternity ultrasounds. There has been some public commentary on the level of surcharges which these scans attract and the impact this has on uptake.

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Appendix 1 – Runsheet

Time	Details	Minister's Office notes
9:15am	Ministers to arrive at the venue at Waikanae Health Centre (11 Marae Lane, Waikanae) There are two drop-off points directly in front of the Health centre, and there is parking for Ministerial vehicles behind the Health Centre as well as on the other side of the road. Ministers will be met by Martin Hefford, Director Living Well S 9(2)(a) Justine Thorpe, Tū Ora Chief Executive and Tū Ora Chair Debbie Chin. The Tū Ora Pou Pikanga will lead the Karakia to welcome the Miisters. A space will be set aside in the Health Centre for Ministers to address the assembled members of the media and make the announcement. This will be in either the Health Centre's private garden or specialist waiting room, and will be confirmed shortly before the event starts.	
9:20am	Ministers will be introduced to the media by [Justine Thorpe]. Ministers to speak for 10-15 minutes, followed by 10 minutes of questions from the floor.	
10:10am onwards	Minister to depart any time after the announcement is complete and question time concludes.	

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Appendix 2 – Talking points for announcement

- In March 2024, the Health NZ Board approved an investment of $30m per annum to enable New Zealanders to have more consistent and local access to radiology across Aotearoa, New Zealand.
- The $30m per annum will be funded from Health NZ's allocated budget.
- New Zealanders will get faster, free access to radiology services across New Zealand and will get a diagnosis faster. This will lead to care considerations being made faster.
- Access to diagnostic radiology services is currently inconsistent across New Zealand.
- GPs and other community-based practitioners will have direct access to diagnostic imaging. They'll be able to refer patients directly for imaging, removing the need for people to be referred to Hospital and Specialist Services for access to imaging.
- This investment will include access to X-ray, CT scan and diagnostic ultrasound across New Zealand.
- This will be free to all patients, as co-payments, where they exist, will be removed.
- Timely access to diagnostic services is critical to:
    - Enabling timely diagnosis
    - Providing high-quality care
    - Improving outcomes for New Zealanders.
- Targeted support packages, such as travel assistance, will reduce barriers for patients, making radiology services easier to access.
- Implementation will take place in stages over the next two years (from 2024), with improved access being realised by 2025.
- This investment is part of a wider Radiology Transformation Programme being planned to make radiology services more responsive and accessible, no matter where people live in Aotearoa New Zealand.
- Our whole-of-system approach has a collective focus on the key priorities of improving equity of access and outcome for rural communities, Māori, Pacific and Tāngata Whaikaha. This includes:
    - Implementing unified data and digital solutions
    - Using AI
    - Developing new workforce models for specialist and scarce workforces.

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- Contemporary approaches to working with private providers and strengthening clinical and management partnerships are key enablers of this transformation.

Back pocket talking points

About Community Referred Radiology

- Consistent access criteria for community-referred radiology across New Zealand will be developed by the National Radiology Clinical Network and other clinical advisory groups.

Mixed model approach

- The model will use both public hospitals and private radiology providers to deliver these services in community and hospital settings.
- Preference will be given to hospital-based delivery, if available. Otherwise, a private provider will be used.
- This model will be informed by the National Radiology Timeliness Standards (in line with Planned Care Task Force recommendations).
- Discussions are yet to be held with private providers and ACC.

Better outcomes for Māori

- Improved access to diagnostic imaging is expected to create better outcomes for Māori.
    - It connects to the Te Pae Tata Interim New Zealand Health Plan goal for Māori health *Improved equity of health outcomes for Māori and deliver on improving pae ora for Māori*.
- Data from the Northern region* tells us that:
    - the likelihood of missing an appointment is 3.5 times greater than for non-Māori (excluding Pacific peoples).
    - 40% of Māori patients wait more than the 6-week clinical guideline, compared to 31% for non-Māori (excluding Pacific peoples).

** Northern Region Radiology Transformation Programme (2023).*

Timeframe

- Implementation will take place in stages over the next two years (from 2024), with improved access being realised by 2025.

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How the new model will work

Virtual regional referral hubs will be established where GP Liaisons will:

- Triage referrals to improve appropriate access and quality of referrals.
- Provide peer-to-peer feedback.
- Undertake referral reviews and education, where needed.

Coordinated procurement of private radiology services

- production planning for public radiology services and use of public capacity first
- organised procurement of private radiology services to get consistent pricing, data and reporting arrangements.

A regional repository for radiology reporting

- Covering both private and public provision to avoid duplication.

Patients will be:

- Seen faster post-triage through direct referrals to where capacity is available.
- Supported to book appointments online, at a location and time that suits them.
- Supported with targeted packages, e.g., travel where required, to ensure removal of barriers to timely access to radiology services.

Community-based practitioners can:

- Better manage patients closer to home
- Access timely diagnostic imaging to support timely treatment care plans.

Future initiatives

The following future initiatives are being considered as part of the Radiology Transformation Programme.

- **Common electronic referral system**:
    - Consideration will be given to a common electronic referral system: a shift that will require significant investment and change management.
    - Regions to replace paper-based systems with a common e-referral model.
- **Rural and remote services** – future service delivery for rural and remote areas may include investing in new ways of delivering services, e.g., mobile services.

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- **Expanding referral scope –** a wider range of community-based health professionals will be able to refer patients directly for imaging.

Reactive Q&As

How will the proposed new model be funded?

- The $30m per annum will be funded from Health NZ's allocated Commissioning budget.
- The $30m will be used for the provision of imaging, targeted support packages for access for patients, and to establish virtual referral hubs.
- In consolidating the functions of the previous DHBs, the Ministry of Health and shared service agencies, the Commissioning budget has achieved efficiencies that are being directed into frontline primary and community care, including $30m annually for the Community Radiology initiative.

When will this be fully implemented?

- Implementation will take place in stages over the next two years (from 2024), with improved access being realised by 2025.

What are the benefits for New Zealanders?

- New Zealanders will get faster, free access to radiology services across New Zealand, and will get a diagnosis faster.
- They will:
    - Be seen faster through direct referrals from their community-based primary healthcare provider;
    - Be supported to book appointments online, at a location and time that suits them;
    - Receive targeted support, e.g. travel packages, to ensure barriers to timely access to radiology services are minimised.

What are the benefits for community-based practitioners?

- Community-based practitioners will be able to:
    - Better manage patients closer to home
    - Access timely diagnostic imaging to support timely treatment care plans.

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How are we engaging with GPs and community-based practitioners?

- Health New Zealand is currently engaging with GP liaisons across Aotearoa, New Zealand.
- GP liaisons will be key contributors to implementation planning. We'll connect with GPNZ and the GP Leaders' Forum on the programme and implementation messaging.
- During regional implementation, GP liaisons will connect with local general practices.

Why does this investment only cover diagnostic radiology and not maternity ultrasound?

- We recognise there's variability in costs and access, for maternity ultrasound across New Zealand. We're looking at options to address this.

How does this fit within the broader Radiology Transformation Programme?

- This investment is part of a wider programme of work planned to improve and align radiology services across New Zealand.

About how much time do people have to wait to access radiology services now? And how much time are they likely to have to wait with the new community-based radiology?

- Current waiting times to access diagnostic radiology services vary considerably across New Zealand. For example, some x-rays and scans should be done the same day (sometimes within hours) while others can safely wait for 4-6 weeks.
- In some areas, community referred patients are accessing imaging in clinically appropriate timeframes, while others wait too long, especially for routine ultrasound scans.
- Variable wait times for the same clinical priority – e.g. a routine pelvic ultrasound – range from four weeks to nine months.

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How much will it increase our capacity to do scans? For example, with this new funding, how many more people would be seen per month?

- We know capacity will be increased. This work will shift referrals from hospital-based specialists to community-based practitioners.
- For example, in areas where there is restricted access currently, community practitioners will be able to refer directly for a broader range of scans rather than refer to specialists to assess patients and make those referrals.
- Creating a consistent referral criteria and triage mechanism will create a standard for community practitioners. Over time, this will minimise over-referring by upskilling referrers.
- In the future, the proposed National Report Repository will significantly reduce duplicate scans.

The "targeted support packages e.g. travel when required" – does that come out of the $30 million, or is it part of the NTA programme?

- Yes, targeted support packages will be funded as part of the $30m Community Referred Radiology budget.

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Appendix 3 – Draft media release

Community Referred Radiology

Media release

$30m investment creates better access to radiology services

A $30 million investment in community radiology services will see better access to services closer to home, resulting in faster diagnosis and improved health outcomes for New Zealanders.

Health Minister Dr Shane Reti welcomes the annual investment by Health Zealand | Te Whatu Ora (Health NZ), which will see community radiology services delivered free to New Zealanders and the removal of co-payments where they exist.

“Consistent access to radiology services is critical for timely diagnosis, high-quality care and improved health outcomes,” says Dr Reti.

“Around 50% of cancers are currently discovered during a visit to the ED. This investment will help New Zealanders get an earlier diagnosis through community-based practitioners.

“This $30 million investment will give all New Zealanders timely access to free radiology services and faster diagnosis.”

Thanks to the investment, GPs and community-based practitioners across New Zealand will be able to refer patients directly for imaging, removing the need for a hospital referral.

Radiology services covered by the investment include access to X-ray, CT scan and diagnostic ultrasound across New Zealand.

Services will be delivered across both public hospitals, where available, and private radiology providers.

The investment also includes targeted support packages to cover travel for communities who can’t access radiology services locally.

Implementation has started and will continue in stages over the next two years, with improved access being realised by 2025.

From June 2024, the Wellington, Kapiti, and Hutt districts will have consistent access to radiology services.

This investment is part of a wider programme being planned to make radiology services more responsive and accessible, no matter where people live in Aotearoa New Zealand.

ENDS

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Appendix 4 – Biographical details of attendees

Debbie Chin, Tū Ora Chair

Debbie has held executive and governance roles across the NZ health sector. She has had leading roles with the Department of Prime Minister and Cabinet, Ministry of Health, District Health Boards (particularly Waikato, Capital and Coast and Hutt) and NGOs. Debbie has a strong financial background and was a former partner with KPMG.

Justine Thorpe, Tū Ora CEO

Justine is an experienced health sector leader with 20 years' experience in primary health care senior management roles.

Justine brings to the CEO role a strong commitment to achieving Māori health equity and a genuine passion for making a difference to the community she serves. She has held various GM roles at Tū Ora Compass Health, with the most recent being GM Corporate Services alongside the role of Deputy CEO.

Justine's collaborative and inclusive leadership style enables effective stakeholder engagement which is essential as we navigate the transformation of the health and disability system over the next couple of years.

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Health New Zealand | Te Whatu Ora Board

Community Referred Radiology

Date:	14 March 2024	**Author:**	Tim Wood, Group Manager Planned and Unplanned Care, Dr Kate Aitken, Dr James Entwistle, Dr Sharyn MacDonald, Kim Arcus
For your:	Approval	**Approved by:**	Martin Hefford, Director Living Well Commissioning Rachel Haggerty, Director Strategy Planning and Purchasing, H&SS
Seeking funding:	Yes	**Funding implications:**	Yes
To:	Board		

Purpose

1. The purpose of this paper is to provide the direction for an optimal model for improved community-referred radiology and the investment required to implement. In the interests of time on this occasion, this paper is going to the board without pre-discussion by the Health Services Committee (HSC).

Recommendations

2. The Board is asked to:

   a) **note** that this paper has not been to Health Services Committee due to time constraints.

   b) **approve** plans for a Community Referred Radiology scheme to create a nationally consistent approach to provide for direct referral for imaging that meets published clinical criteria and health pathways **at no cost to the patient**.

   c) **approve** an investment of up to $30m ongoing to be taken from baseline savings set aside under the 2023/24 overall Te Whatu Ora budget.

   d) S 9(2)(f)(iv)

   e) **note** that implementation oversight is in place through the Transforming Radiology Programme S 9(2)(f)(iv) and will take 24 months to fully roll out.

   f) **note** that this paper will be shared with Te Aka Whai Ora ELT & Board.

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Contribution to strategic outcomes

3. Unwarranted variation in access across Aotearoa to both community referred radiology and maternity ultrasound is inhibiting timely access to care and contributing to variable outcomes for pregnant women and other patients.
4. The proposed investment in these services is aiming to address inequitable access and outcomes, and to improve system performance.
5. The proposed investment will contribute to Health NZ meeting the Health Targets.

Executive summary

6. Access to community referred radiology is inconsistent across the country with variable eligibility and access criteria resulting in some people paying part charges, and in some communities being unable to access a service and needing to purchase privately or access through ED/outpatients.
7. An optimal model for community referred radiology, along with an investment proposal, are described that will address the access issues.
8. The proposed model will ensure timeliness of access and consequently treatment and intervention needs, leading to improved health outcomes.

Community Radiology Background

9. Access to timely and effective diagnostic services, including radiology, is critical to providing high quality care, reducing waiting times for treatment and improving outcomes. Changes in access are a critical element in redesigning models of service delivery and eliminating wasted time and resources through unnecessary use of hospital and specialist services.
10. The distribution of radiology facilities, along with different access arrangements in different districts, means that some people face barriers to access and inequities, particularly those in provincial and remote areas. The future model will take more radiology services out into the community and reduce congestion in hospitals, through:
    a) A mix of public and private sector delivery in community and hospital settings
    b) Investing in new modes of service delivery for rural and remote areas e.g. mobile services (which is not included in the costings in this paper)
    c) Removing inconsistencies in what services are available at what cost in different areas
    d) Reducing the need for patients to travel for more commonly used services.
11. The process of community referred radiology service delivery starts with a GP or specialist referring for imaging as part of their diagnostic work-up. There are opportunities to improve this experience and achieve better diagnostic outcomes by:
    a) Providing consistent direct access for GP and other community-based clinicians to diagnostic imaging.

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b) Creating protocols to enable a wider range of health care workers, such as nurse practitioners, and allied health professionals, to refer for diagnostic imaging in accordance with their scopes of practice.

c) Creating nationally consistent health pathways and best practice guidance on referring for diagnostic imaging to achieve the most value.

d) Creating standardised timeframes for imaging occurrence. This needs to align with those for hospital referred radiology so that the system is fair to patients with similar clinical need.

e) Ensuring that past and recent images and reports are available to the referring clinician, reducing the need for repeat imaging.

12. Wait times for access to diagnostic imaging for similar clinical priorities vary across the country with routine waits varying between less than four weeks to over nine months.

13. Northern region data shows that if you are Māori:

a) The likelihood of missing an appointment is 3.5 times greater than for non-Māori (excluding Pacific).

b) The number of Māori patients waiting beyond the 6-week clinical waiting guideline is 40% compared to 31% for non-Māori (excluding Pacific).

14. Increasing primary and community care access to community-referred radiology will not in and of itself address Māori and Pacific attendance. Changes to other aspects of the way services are delivered is also required.

15. The development of this advice considers the Planned Care Task Force Reset and Restore Plan recommendations for radiology.

16. The development of this advice aligns with, and is informed by, the Transforming Radiology programme and the National Radiology Clinical Network.

17. The Transforming Radiology programme has highlighted that the approach, to date, with respect to outsourcing radiology has destabilised Health NZ radiology services. The proposal contained here is designed to mitigate further destabilisation.

Community Referred Radiology Optimal Model

18. A potential optimal model would have the following key elements:

a) A **regional referral hub** that will:

i) Triage referrals, S 9(2)(f)(iv) Triaging would be undertaken by GP Liaisons for all imaging. GP Liaisons would also provide peer to peer feedback and education which is shown to be effective in improving referral quality. S 9(2)(f)(iv)

ii) Direct referrals post triage to where the capacity sits to enable the patient to be seen in a timely manner. This will be a mix of Health NZ or private provision according to local capacity and availability. The mix may change over time.

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iii) Support patient choice through online booking (such as that used in the private system) – enabling people to book appointments at a location and time convenient to them.

iv) Undertake reviews to identify patterns of outlier referral behaviour.

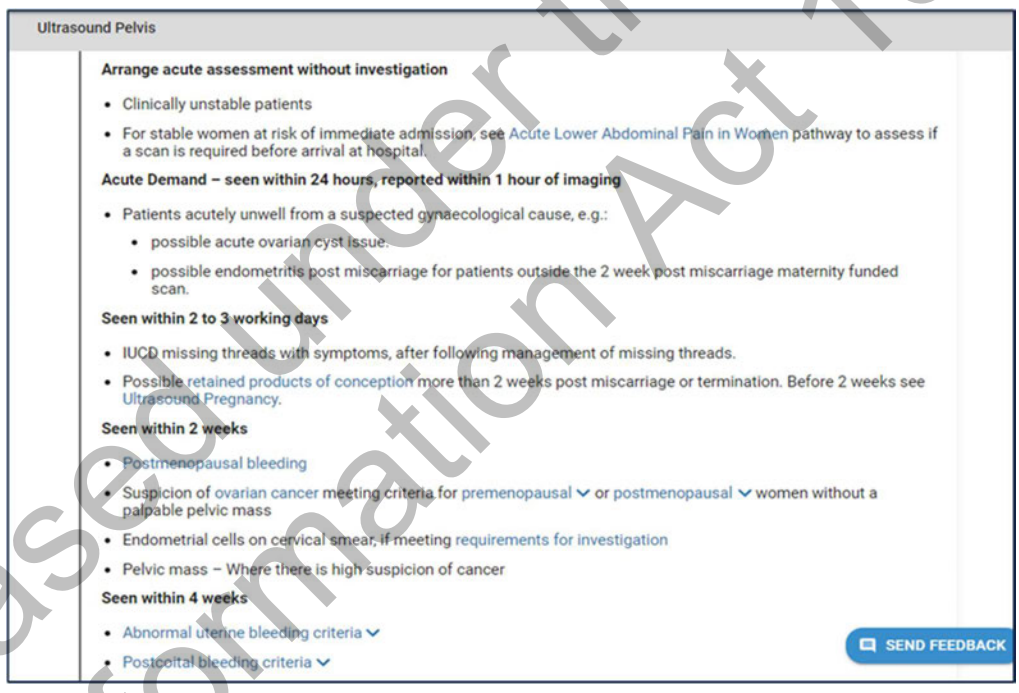
v) Provide education and utilisation feedback to referrers to support improved referral quality and appropriateness.

vi) Enable SMO advice to the referring clinician.

b) **Patient travel / support packages** to mitigate access barriers.

c) **Nationally consistent pathways and referral criteria**. These would be continuously developed and reviewed with input from the National Radiology Clinical Network along with other clinical advisory groups (e.g. the Maternity Ultrasound Advisory Group) and documented in the Health Pathways system.

d) **Common timeframes for access to imaging** - the following is an example of appropriate timeliness:



e) In line with Planned Care Task Force recommendations, it is proposed that national **radiology timeliness standards** are used to inform decisions as to whether public or private provision is used to deliver clinically appropriate imaging. That is, if the public system can provide the imaging within the clinically indicated timeframe, then the work should be sent to a Health NZ owned radiology service, if not private capacity should be used.

f) Using timeliness standards is a major shift from current arrangements where generally the provision is either public or private. A mixed delivery model may be appropriate in some areas – for instance in Canterbury where imaging capacity is available but reporting capacity is constrained, most referrals result in the imaging being performed in

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a Health NZ facility and then reported by a private radiologist. Using timeliness standards combined with a prioritisation framework will ensure additional equity of access issues do not eventuate between hospital referred and community- referred imaging.

g) **Integrated electronic referral systems and smart claiming technology.** In some districts paper-based systems remain in place necessitating heavy manual processing and carrying patient safety risks. Moving to a common electronic referral platform across a region is proposed. Later, consideration could be given to a common national system. This recognises that a move to a national system requires significant investment and change management, whereas scaling an already functioning local solution to cover districts with a paper-based system should be quicker with less initial upfront investment.

h) **A credentialling programme for high tech imaging.** Credentialled practitioner referrals would bypass triaging processes but would remain subject to clinical audit.

i) **Technological (AI) tools** to complement referral and triage processes can help improve referral quality, timeliness of triage and release triaging clinician time to focus on education, audit, and difficult cases.

j) A **national report repository** that enables patient and referrer access "from anywhere" to reports and, in time, images "done everywhere".

Community Radiology Other Considerations

Co-payments

19. In some parts of Aotearoa co-payments are applied. However, in most districts there are no co-payments for Health NZ funded imaging. Co-payments can apply to ACC funded imaging.

20. Allowing a co-payment when private provision is used adds inequity into the system as in parts of Aotearoa private provision will not be an option. Co-payments introduce an administrative burden and may drive increased non-attendance rates and delays in diagnosis and provision of appropriate intervention/care. A co-payment may encourage patients to attend hospital services to access a free service.

21. The proposal is this is a fully funded service.

Contract Arrangements

22. Contracts for community radiology currently can be directly with private radiology providers, through PHOs, or through other intermediary organisations (e.g. S 9(2)(j) in Auckland).

23. It is proposed that all contracts are repatriated back to Health NZ. The funding would then be applied through common contract mechanisms with combined Commissioning and Hospital and Specialist Services procurement from private providers, to achieve the following objectives:

    a) A nationwide strategic approach to the private radiology sector can be taken.

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b) Consistent service specifications and service standards.

c) Common pricing.

d) Consistent data collection.

24. Contracted capacity is supplementary to hospital and specialist capacity and is responsive to need in local communities.

25. Several districts are experiencing demand over and above contracted levels. Consistent peer review against agreed clinical criteria will moderate demand and will ensure clinical appropriateness.

26. In line with Planned Care Task Force recommendations, where demand exceeds available capacity, regions should use national radiology prioritisation guidance to help inform decisions relating to any delay or cessation of services. Decisions to cease services will require engagement with community, and hospital and specialist services stakeholders to identify and agree which indications/pathways will be impacted.

27. Private providers are increasingly seeking higher pricing and, in some cases, threatening to withdraw their services unless prices are increased. The proposed national procurement arrangements would set consistent prices for private provision nationally.

Private Specialist Eligibility

28. Private specialists can at times refer to publicly funded radiology services, especially where a patient cannot afford the cost of the imaging. There is an option to restrict private specialist access to publicly funded radiology, however this might simply result in patients being referred back to their GP or to outpatients for imaging.

29. It is proposed that the same rules for referral to community radiology would apply for private specialists.

Non-medical referrers

30. It is proposed that future arrangements would credential non-medical practitioners such as nurse practitioners, physiotherapists, paramedics, etc, to refer for public funded radiology, provided the referral is within the scope of the practitioner and meets clinical access criteria.

Implementation

31. Community-referred radiology implementation will be overseen by the ELT Transformation Committee through the Transforming Radiology programme.

32. The radiology clinical network will provide guidance on aligning pathways and timeframes across Aotearoa.

33. Implementation of the virtual regional referral hubs will be led out by the regional teams with support from the Transforming Radiology programme.

34. Implementation plans will be developed for each region cognisant of current state and steps needed to move to the nationally consistent model.

35. Timelines for each region will vary according to current state, capacity limitations, and health pathway implementation resources. The first phase in the April to June 2024 quarter would

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see rollout to the Wellington region and removal of the co-payment anomalies in that area. This would be followed by consolidation of the model in the south island and full rollout to the central region in year one.

36. S 9(2)(f)(iv)

Financial implications

Contributed by:	Note due to time constraints this paper has not yet been approved by the CFO or her delegate.

37. The indicative community-referred radiology service investment for a full year period is up to $30m including triage costs and patient support packages, but not including:
    a) maternity ultrasounds;
    b) licensing or implementation costs for a patient online booking system; or
    c) capex costs such as mobile radiology units).
38. S 9(2)(f)(iv)
39. The proposed community-referred radiology investment covers four key aspects:
    a) Moving to a consistent clinically appropriate access approach, as described in this paper, for community radiology across Aotearoa.
    b) Ensuring appropriate imaging use in context of recent demand growth of 7% per annum.
    c) Addressing pricing pressures and removing co-payments where they exist.
    d) Funding the GP liaison time to triage referrals against clinical criteria and provide ongoing education and feedback to primary care referrers.
    e) Funding patient support programmes (e.g. travel) to access community radiology.
40. Quantifying the required investment has been hindered by a lack of robust data on demand, available capacity across Health NZ and private provision, numbers of people not accessing community radiology in an appropriate timeframe, and absence of a robust pricing model.
41. Implementation of consistent pathways and timeliness rules may also impact on the ability to get the investment in place quickly.
42. A number of assumptions have been used to develop the anticipated level of investment:
    a) Access numbers for Wellington and Canterbury regions have been used to provide the basis to develop an indicative national figure.
    b) The level of access in Wellington and Canterbury regions is assumed as being broadly representative of the clinically appropriate access rates recognising that:
        i) In some areas referral review process will reduce imaging volumes

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ii) In other areas increased access will result in additional, clinically appropriate referrals.

c) The net volume effect of increased triage and increased access are assumed, over time, to increase clinically appropriate volumes nationally by:

i) 10% for Xray

ii) 15% for ultrasound

iii) 45% for CT

d) S 9(2)(j) [redacted]

e) A contingency for removal of copayments and provision of inconsistently available services such as DEXA scans has been provided for.

f) The cost of consolidating e-referral systems to support triaging is not yet clear but we expect it can be covered through phased introduction of improved access.

Te Aka Whai Ora Comments

Contributed by:	**Note due to time constraints this paper has not yet been shared with Te Aka Whai Ora. We intend to share the paper with their ELT and Board.**

43. Te Aka Whai Ora representatives have been involved in the Transforming Radiology work programme that has informed this paper, but not in the detail of this paper.

Document ownership

Approved for submission	**Abbe Anderson, National Director Commissioning**	

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