Concept design workshops summary

ACC and General Practice Connect

ACC has taken a co-design approach to create a new relationship framework with General Practice teams, and engaged the sector via a national roadshow in February and March 2019, as well as collecting feedback on Shape your ACC (http://www.shapeyouracc.co.nz).

Following the roadshow, ACC held concept design workshops to crystallise the key themes and form the strategic principles and conceptual framework for future working.

Three concept design workshops were held in Christchurch, Wellington, and Auckland, and were attended by a range of interested parties to gain diversity of perspectives from the sector.

Participants included General Practitioners, Nurse Practitioners, Practice Nurses, Practice Managers, Allied Health Professionals, and representatives of Primary Health Organisations and professional bodies. Table groups were pre-set to ensure each group had a mix of participants from different organisations and professions.

Part 1: Critical success factors

The first part of the workshops saw participants reflect on what a successful, future way of working would look like and prioritise the most significant elements of success for the new relationship and contractual model:

1. **Trust** — built on trust with mutual respect, understanding of the value created by all parties, clear expectations, and transparency of outcomes.
2. **Patient-centricity and reduced inequity** — outwardly focus, centred on genuine patient and whānau engagement, and allows for sufficient time and funding for this to happen.
3. **Systems and information sharing** — reduced administrative burden, with a robust electronic system to share clinical information, assist the referral process, and enable shared care planning as a key enabler for multi-disciplinary team (MDT) working. This connectivity should include all parties; the patient, providers, and ACC.
4. **Clinical pathways and quality** — clinical pathways that support the consistent delivery of services. This means providing a guide for 80% of treatment plans and allowing flexibility for complex cases that require more applied clinical judgement.
5. **Multi-disciplinary teams** — a flexible MDT relationship would allow emphasis on the right care, delivered by the right person, in the appropriate timeframe and setting, including proactive injury prevention.
6. **Reduced bureaucracy** — simplifying the system, improving alignment of outcomes, and transparency.
7. **Effective change management** — follows an iterative process with the sector, and accepts that a new contractual framework will evolve over time. The change process will need to be well executed and managed, with appropriate funding to support a new way of working and bringing stakeholders on the journey.

Part 2: Significant barriers to success

The second part of the workshops required participants to prioritise the most significant barriers that might occur over the next three years which could prevent success from being achieved:

1. **Insufficient capacity within General Practice** — insufficient time, energy, or resource within general practice to manage the changes required of a new contract.

2. **Lack of buy-in from providers** — a lack of buy-in to a new contractual and relationship framework if General Practice is not fully engaged throughout the design process. This could occur if the workforce is not interested and/or there is a sense that the change is being "done to" instead of with general practice.
3. **Increased cost of compliance** — the level of funding offered under a new contractual model may not adequately offset any additional work required within general practice.
4. **ACC is not ready for the level of change sought by General Practice** — the internal culture and way of doing business may not enable the change process to happen quickly enough or at all, and commitment to developing a new relationship is not followed through.
5. **External factors** — changes to the political landscape, a lack of appetite for political risk, new disruptive business models, and the power of health and social development ministries to slow the process or reduce its scope may disrupt and/or influence the change process.
6. **Insufficient investment in change** — primary care is financially constrained and there is little to no capacity within the current system to manage and absorb any large-scale change. The change plan could be too aspirational, and expectations about realistic change need to be well managed.
7. **Patient and clinical voices not heard or acted on** — the voice of the patient and the front-line practitioner is not heard throughout the development of a new contractual and relationship framework and post implementation.
8. **Outcomes not clearly defined or measured** — the return on investment or outcomes not being clearly articulated could lead to the project not being approved to proceed.

Part 3: Expansion of key themes

The third and final part of the workshops involved providing foundational concept guidance to the co-design team during the next stage of the design process:

1. **Building trust** will require consistent and frequent communication, establishing good processes such as agreed fora to work through and share ideas, allowing local issues to be heard and considered in the design process, and feedback on what works well and what needs to change.
2. **Flexibility and integration across multi-disciplinary teams** will require a scalable approach to care based on workforce groupings across localities. An integrated system across MDT providers that creates automatic notifications on dashboards would streamline workflow and timely treatment.
3. **Enabling equitable, consistent, quality outcomes** will require understanding what inequities currently occur within ACC services, and reaching agreement on expectations of quality and outcome. This baseline work should be transparent in collaboration with all interested parties. Work to define evidence-based care pathways across the MDT is also needed along with how these pathways should be supported.
4. **Tailoring for regional variation** will require working with interested parties to agree how a region is defined (access, concentration of providers, deprivation, cultural considerations, industries, urban/rural, access to highspeed internet, etc), and developing a contractual model that allows for phasing by practice, locality, and modularity.
5. **Responding to the patient voice** will require a partnership approach (as opposed to consultation) that seeks the patient voice across the various touch points of service delivery. It will also involve empowering patients to have their voice heard through the system, particularly for individuals who are less able to engage.
6. **Determining indicators and collecting data that will inform change and support ongoing improvements** will require drawing on meaningful existing data sets and use this to create a baseline view of what we know now. From this data, an iterative process will be necessary, allowing for indicators to be changed as required. IT will be a key enabler of this transition.
7. **Building and maintaining momentum** will require good and effective governance and an approach that enables incremental change. Evidence of success and improvements in outcomes will be required to support larger scale reform through legislation.