ACC’s proposed secondary care model

How we’re progressing

July 2026

He Kaupare. He Manaaki. He Whakaora.
Prevention. Care. Recovery.

What we’ve heard

Common ground

Where there appears to be common ground

Area of agreement	What this means for design
Clients need to get to the right care earlier	The service needs earlier decision-making
We need to make better use of specialist expertise and capacity	The service should help ensure clients who need specialist assessment can access it at the right time, supporting better recovery outcomes.
Complex and urgent cases need clear escalation	The service needs to ensure clear prioritisation and escalation rules, specialist input where needed and no avoidable delay for clinically urgent cases
Primary care needs support	Support is needed to assist primary care to identify the patients that should be sent to secondary care and advice on how to manage those that shouldn't. Referral quality needs to improve including information requirement that support clinical decisions.
Data and feedback loops need to improve	The service should create visibility of referral quality, pathway decisions, outcomes and variation

What we’re proposing

What ACC is proposing

We are proposing a clinically led MSK secondary care model that:

- ✓ improves the quality and consistency of referrals into secondary care
- ✓ creates an earlier clinical review point to determine the most appropriate next step
- ✓ strengthens clinical governance and specialist escalation
- ✓ improve visibility of how clients move through the pathway
- ✓ supports better use of specialist, imaging, surgical and rehabilitation capacity
- ✓ makes accountability, transition points and performance clearer across the pathway

Key improvements

Clinically-led care networks	Multidisciplinary provider groups work together across assessment, treatment planning and onward referral
Stronger clinical governance	Clear clinical leadership, decision criteria and quality assurance
Improved referral quality	Minimum information requirements support better decisions earlier in the pathway
Better visibility & transparency	ACC and providers can see referral patterns, pathway decisions, outcomes, variation and delays
Coordinated clinical decision-making	Clients are directed to the right next step based on clinical need, urgency and pathway fit

Areas we want to clarify

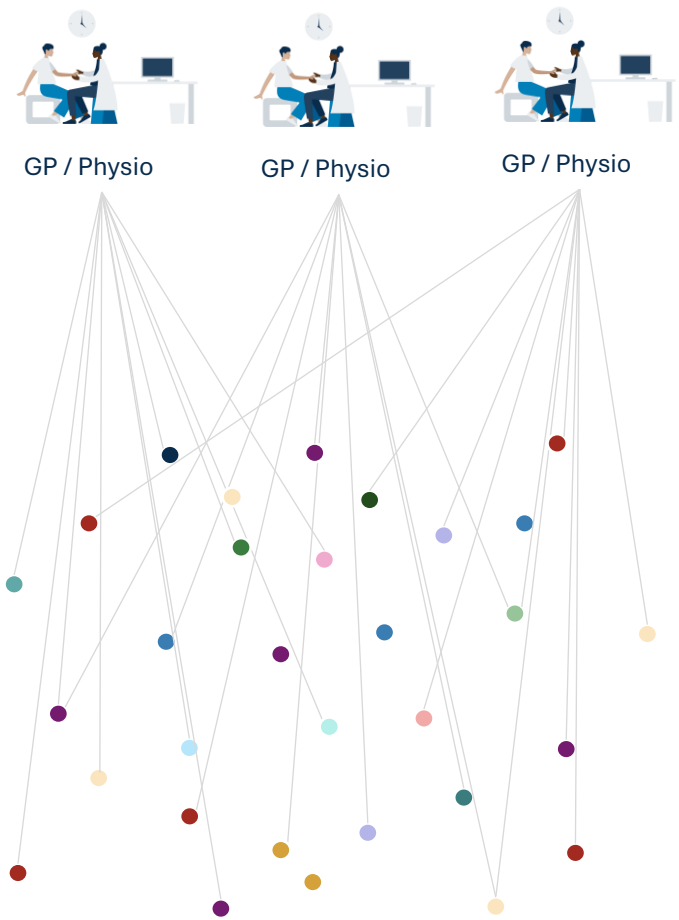
What we are **not** proposing

- a service that limits access to necessary specialist care
- a model where non-specialists override specialist decision-making
- a centralised or standalone triage gateway
- a national process that cannot recognise clinical complexity or regional context
- access to allied health treatment within the MSK service
- ACC employing clinicians to perform a triage function on claims

What this will look like

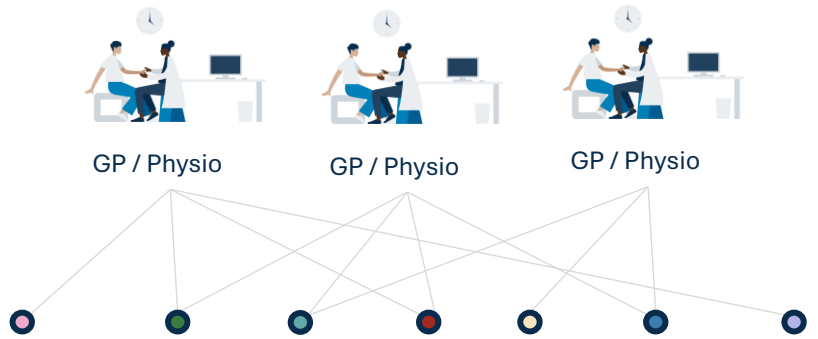
Key:
- MSK Supplier
- Clinical Services Supplier

Current State



A shift to a model delivered by multidisciplinary groups of clinicians working together to provide care in a coordinated way.

Future State



Clinically-led care networks with access to:

Suppliers will operate under clear clinical governance and shared accountability, led and supported by the:

Clinical Director

*Illustrative purposes only

What this means for you

- ✓ Less time chasing missing information and clearer basis for decisions
- ✓ Better matching of clients to specialist, non-surgical, imaging, surgery, rehabilitation or primary care pathways
- ✓ Specialist time focused where it adds most value
- ✓ More consistent decisions and clearer accountability
- ✓ Better feedback loops for suppliers, referrers and ACC
- ✓ Fewer gaps and less ambiguity for clients and providers

What does this mean for our contracts?

Current vs. future state

Now	Phase 1 - July 2027
High Tech Imaging	High Tech Imaging (with competitive pricing for MRI)
Elective Surgery Services	Elective Surgery Services
Now	**Phase 2 - December 2027**
Clinical Services	New service for musculoskeletal Injuries*
	Clinical Services (for non-musculoskeletal injuries)
ICPMSK	ICPMSK (without triage)

**Name of service has not been confirmed*

What has shifted following feedback

What we have clarified or strengthened through engagement

Feedback heard	What ACC is clarifying or strengthening
Triage sounds like gatekeeping which could delay care	The model is a clinically led pathway that supports adaptable decision-making.
Some patients will require input of a specialist during triage	Specialists will be able to input during triage where required.
HTI referrals require specialists	The design will ensure the right level of specialist oversight is maintained to ensure HTI is appropriately referred for, and reviewed
Primary care issues cannot be solved only in secondary care	ACC is also progressing work to improve primary care.
ACC needs better data	The model will include clearer reporting on referral quality, clinical decisions, pathways, outcomes, variation, and timeliness.
Conflict of interest need controls	Transparent reporting, audit and contract control frameworks for supplier referral patterns, onward referrals and use of related services.
Clinical governance and oversight not developed	Clinical governance framework in development. Inclusive of escalation pathways, decision criteria, audit trails and roles and responsibilities. The new service will set the conditions for adoption and accountability through a transparent data and performance framework.
Implementation risk is too high	ACC is taking more time for further sector input on operational design. We will ensure there are safeguards for transition planning, and iterative ongoing development required post-go-live.

Areas needing sector input

Where we need your input

Design area	What has been developed so far	Where sector input is needed
Clinical governance and accountability	Draft functions for key roles in the service e.g. Supplier, Clinical Director, Named Providers, and ACC	• What clinical governance, escalation and assurance arrangements would build confidence? • What clinical capability is needed to safely make pathway decisions? • Where should imaging sit in the pathway, and under what clinical oversight?
Clinically-led care networks	Draft provider types, supplier capability and digital / API requirements	• What requirements are essential, and what would create unnecessary barriers?
Service entry	Draft eligibility criteria, minimum referral requirements and role responsibilities	• What makes a referral clinically complete, without overloading primary care?
Coordinated clinical decision-making	Draft options for clinical eligibility, triage, assessment, referral pathways and return to primary care	• Which cohorts should be escalated, bypass triage, or require specialist review? • What information does ACC need, and at what point in the pathway?
Transparent, data-informed performance	Draft performance areas, measures, data definitions, and accountability transfers developed	• What measures would be useful, fair, clinically meaningful and hard to game? • Which measures and data would build sector confidence and support improvement?

Next steps

Key milestones

15 September 2026

High Tech Imaging Request for Quote (RFQ) for MRI services and Request for Application (RFA) for other modalities goes live

15 March 2027

Request for Proposals (RFP) for new musculoskeletal service contract goes live

15 September 2026

Elective Surgery Services RFA goes live

15 March 2027

RFA for Clinical Services (for non-musculoskeletal injuries) goes live

1 July 2027

New High Tech Imaging Services and Elective Surgery Services go live

1 December 2027

New service for musculoskeletal injuries, and Clinical Services (for non-musculoskeletal injuries) go live

How to share your feedback & stay informed

Website

www.acc.co.nz/health-sector-engagement

Provider Update e-newsletter

www.acc.co.nz/provider-news

Regular market engagement webinars

Email us your feedback at:

engage.secondarycare@acc.co.nz

Thank you