

Q and A Session Summary

ACC Pain Service Webinar One

(Confirmed Changes and Tender Information)

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IDT

Q: Is supervision for AHPs expected/permitted in the new service? Wondering how we support succession planning for clinicians wanting to upskill in pain services

A: The current requirement in the new contract is five years experience, that ensures practitioners coming into the service had a good underlying background and knowledge of rehabilitation in Pain. However if we identify service gaps following the tender we are open to reviewing this requirement at a later stage.

Q: Has ACC done any analysis on the number of providers that will be limited from delivering this contract with the high threshold of 5 years experience? if yes, what did that show?

A: No, our decision is based on the current suppliers who have providers who meet the criteria and is sufficient to cover the service. However we are open to reviewing this requirement if we identify a service gap at a later stage.

Q: You have stipulated "at least 3 years' experience in IDT pain management" very few providers of the current community programmes have ever worked in an IDT service - instead in an MDT service. How will you ensure the providers have IDT rather than MDT experience?

A: We will look to clarify the wording.

Q: What would count as experience for the medical specialist. Does this have to be pain specific ?

A: The requirements for the medical specialist would be in line with meeting their faculty requirements and there is a clinical expectation that their work is within scope. We would expect that medical practitioners working on the service would demonstrate competencies working on pain management specially but this isn't specifically noted in the purchasing contract.

Q: Can Nurses be part of the IDT for triage?

A: Not at this stage, however we can consider this if a requirement/need of this is identified.

Q: Could you clarify the comment on the slide for provider experience that noted "grandparenting existing providers" does this mean people currently delivering the service would be able to continue? Or was that something that was considered but not going ahead?

A: This was a question from the previous webinar. In the new contract we have put forward a requirement for minimum five year clinical experience, there is a concern that some current providers will no longer be able to work within this contract. We intend to keep this requirement however we will assess the impact that it will have on the market through the tender process and are open to review this if required.

Q: Are there any allied health professions excluded from this contract?

A: Refer to Appendix 1 in the new contract for full list of health professionals.

Q: Can you clarify what you mean by medical practitioners are expected to "work within their scope"? Will there be expectation that non SPMPs working in pain (i.e outside their registered scope) have an MCNZ collegial relationship with an SPMP?

A:

When we refer to medical practitioners being expected to "work within their scope", this means:

- Practitioners must provide services that are consistent with:
 - their **professional registration**,
 - their **recognised scope of practice**, and
 - their **training, competence, and experience**,
as defined by their relevant regulatory body.

SPMP and non-SPMP roles

- There is **no expectation** that non-SPMP medical practitioners working in pain services must hold an MCNZ collegial relationship with an SPMP **solely because they are not SPMPs**.

- However, where a practitioner is delivering services that:
 - extend beyond their usual scope, or
 - require specialist oversight, appropriate **clinical governance, supervision, or escalation pathways** are expected, consistent with professional and regulatory standards.

ACC's role

- ACC is **not redefining clinical scopes of practice**.
- Responsibility for determining appropriate scope, supervision, and collegial arrangements sits with:
 - the practitioner, and
 - the supplier's clinical governance framework, in line with MCNZ and other relevant professional guidance.

Q: Just a further question regarding MDT vs IDT. Can you explain why you would allow for an MDT model of community pain care when all research in persistent pain recovery indicates that an IDT model of care is needed?

A: ACC is looking to ensure that we have an IDT model of care to support our clients of pain, however there is a discrepancy in how suppliers deliver care where some are more in the MDT model. However we want to move towards an IDT model.

Q: Has the current allied health and/or psychology workforce been scoped re. how many work in a pain service? Given the years of experience required, is there concern it would pull workforce from other pain services to fill the need in ACC services?

A: We want to ensure we are procuring a service with requirements that have the most appropriate skill level to support the cohort of clients that utilise this service. However as mentioned if we identify service gaps as part of the tender activity we are open to reviewing the requirements.

Service Delivery

Q: Can you explain why the two options for community clinicians to receive oversight/assistance (PN412 SPMP desktop file review and PN375 tertiary support) have been removed? This removes the "liaison" bridge between community providers and expert SPMPs/tertiary services.

A: The new service is constructed where rather than adding or removing service components, we have allowance for SPMP support where it is identified outside of the service cap. However if the SPMP support is part of the service delivery of stage 1 or stage 2 it should occur within the service cap.

Q: Who will be undertaking the triage?

A: Can be taken by any member of the IDT or multiple member of the IDT. There's a requirement that within the service cap, an IDT meeting is held at the end where the care plan is agreed to.

Q: What is the makeup of the ACC team responsible for determining the necessity of a referral to the pain service? Which disciplines are involved in this decision-making process, and what is the minimum clinical experience required for team members to have worked in a pain service?

A: Referrals will be coming through from ACC recovery teams, who will review the referral request against the eligibility criteria in the contract. Registered Health Professionals and/or Rongoa Practitioners can request this service via ACC. ACC's Clinical Team will support ACC Recovery team decisions where required.

Q: The resources available under these contracts are very limited for patients who have conditions such as moderate to severe CRPS, who would typically need intensive input for at least several months. How does ACC propose to manage patients who need specialist pain service IDT input beyond a community service, and there are long waits for tertiary? Will ACC approve a second (or multiple) community service to provide continuity of care?

A: We will look at claims in a case by case basis. We have recently reviews claims where we have seen a movement from Pain Services into Training for Independence, we would like clients to remain in the service that is most appropriate to support their rehabilitation (i.e. if an extension in Pain services is more suitable than that is what we should accommodate)

Performance

Q: Can you clarify the comment about due diligence on past performance. Is this relating to past performance in delivering the current pain management contract.

A: Yes we will be considering past contract performance, we will look at this more broadly across all our contracted suppliers for the current pain contract and related services.

Q: Can you clarify if past performance is at individual provider level or contract holder level?

A: Supplier level, where a supplier has a performance activity for this contract or related contracts. We may place conditions on the contract awarded until those conditions are met.

Q: Please clarify if performance diligence will look at past performance at an individual or contract holder level, or both. Assume we would have been made aware if you had any past performance concerns

A: Yes we would expect the supplier to be aware of the performance issue, it may be in the form of a letter of expectation or performance improvement plan that we may review the outcomes of as part of due diligence.

Other

Q: There is no follow up code for SPMP. Will that be expected to be funded from CS1 2 or can it be approved by ACC under another code.

A: SPMP assessment sits outside the service caps of Community stage 1 and stage 2 however if the SPMP expertise is utilised to deliver the care that it will fall within the service cap.

Q: Could we obtain this recording today?

A: The recording will be made available week commencing 16th March.

Tender

Q: Is there a reason the tender closes on a Sunday afternoon, not during business hours?

A: We made allowance for 2 extra days in case there was any issues with meeting the end of Friday deadline..

Q: What day are you aiming for next week to release?

A: End of week commencing 16th march.