# Minutes
# interRAI Governance Board

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| **Date** | **Tuesday 5 April 2016** |
| **Location:** | **TAS Board Room 3A1, Level 3, 186 Willis Street, Te Aro, Wellington** |
| **Members** | **Paul McDonald** (Chair) Professor and Pro Vice Chancellor of Health, Massey University<br>**Chris Fleming** (Deputy Chair) CEO Nelson Marlborough DHB – Funder Representative<br>**Dana Ralph-Smith** General Manager- Adult Rehabilitation and Health of Older People, Counties Manukau DHB – Funder Representative<br>**Dr Nigel Millar** – Chief Medical Officer & Geriatrician Canterbury DHB – Clinician and interRAI Fellow Representative<br>**Judith Davey** – Senior Associate, Institute for Governance & Policy Studies, Victoria University & Voluntary Policy Advisor Age Concern – Consumer Representative<br>**Roy Reid** – Treasurer, Chair Age Care Committee, Grey Power – Consumer Representative<br>**Jan Adams** – Director Nursing, Quality & Risk, Bupa Care Services – Health Professional Representative<br>**Max Robins** – CEO CHT and Deputy Chair NZACA – ARC Provider Representative<br>**David Chrisp** – General Manager Access Home Health Ltd – Home Care Representative<br>**Matthew Parsons** – Professor Medical & Health Sciences University of Auckland, Chair Gerontology Nursing, Waikato DHB – Research Representative<br>**Dr Chris Hendry** – Director NZ Institute of Community Health Care & NZ IT Health Board – Health Informatics Representative |
| **In Attendance:** | **Chai Chuah** – Director-General, Ministry of Health<br>**Michele McCreadie** – General Manager interRAI Services, TAS<br>**Dr Brigette Meehan** – Manager interRAI National Services<br>**Karina Kwai** – Manager, Health of Older People, National Services Purchasing, Ministry of Health<br>**Deb Mulliss** – Secretariat, TAS |
| **Apologies:** | **Dana Ralph-Smith –** Board Member<br>**Dr Nigel Millar** – Board Member<br>**Graham Smith** – Chief Executive, TAS |

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| **1. Welcome – Agenda Overview** | **Item 1.1 Agenda Overview and Apologies**<br>The Chair opened the meeting at 9.15 am and welcomed members. He noted apologies from Dana Ralph-Smith, Nigel Millar, and Graham Smith. Jan Adams would join the meeting later due to a flight delay, Karina Kwai had also been delayed and David Chrisp would join the meeting at 1.00 pm.<br><br>**Item 1.2 Declaration of Interest Register**<br>The Chair called for advice on any Conflicts of Interest. Matthew Parsons noted that he had already declared his Conflict of Interest in developing an alternative 'Casemix System'. No other Conflicts were noted.<br><br>**Item 1.3 Minutes from meeting held 5 February 2016**<br>Chair moved to **confirm** the Minutes of 5 February 2016 this was **carried** by the Board. |

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| | **Item 1.4 Action Register**.<br><br>11/12-01 & & 02/16/01 Joint Aged Residential Care Steering Group. Letter of Acknowledgement. Open<br>Further detail agreed. Updated letter sent 9 February 2016. **Closed**<br><br>11/12-04 Paper on evaluation framework for Palliative Care project. Open. Paper due at meeting 5 April 2016. Now on interRAI work programme and the evaluation framework paper would be provided later in the year. **Closed.**<br><br>11/12-05 Briefing paper Resource Utilisation Groups. Matthew Parsons advised paper deferred to 5 April 2016 meeting. Paper on agenda at 1.5F. **Closed.**<br><br>02/16-02 Letter of Acknowledgement sent to David O'Toole. The Chair advised that David O'Toole had responded noting how much he had enjoyed his visit to New Zealand. **Closed.**<br><br>02/16-03 Updated interRAI Data Access Protocol. Data Access Protocol now available on interRAI website. **Closed.**<br><br>02/16-05 Update to Board on work undertaken by interRAI with Aged Residential Care (ARC)Facilities Managers around education and using data. Will be presented at the 1 June 2016 meeting. **Closed.**<br><br>**At 9.27 am Jan Adams joined the meeting.**<br><br>02/16-06 Standard suite of InterRAI Services National Data Analysis Reports. Agenda Item 1.6. Correspondence from Dana Ralph-Smith in her capacity as General Manager, Health of Older People Northern Region Heath Boards requesting consideration of a software enhancement also refers.<br><br>Michele McCreadie noted that the letter requests an update to the Momentum software to capture a referral date. The process for prioritising software updates was discussed noting this request could be submitted for consideration.<br><br>Discussion was held on the process noting that there was no streamline system for small enhancements and that all requests followed the same process. There was a yearly major upgrade process with minor enhance occurring as required.<br><br>Discussion was also held on why a sub-set of the National IT Board were making decisions and prioritising interRAI software enhancements as opposed to submitting recommendations to the interRAI Governance Board for approval and then the endorsement of the IT Board.<br><br>The Chair noted from the conversation that the interRAI Board felt it should have primary responsibility for prioritising, particularly with respect to the impact it might have on the Board's mission, and the IT Board should be limited to technical |

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| | aspects around feasibility etc and should advise the interRAI Board of those issues. The primary prioritisation should occur with the interRAI Board.<br><br>The Board agreed that the appropriate process to be followed should be:<br><br>• The IT sub-group should continue to collate user enhancement requests. Analysing the requests by cost, ease, complexity, and impact.<br><br>• Formalise a recommendation to the interRAI Board to agree priority.<br><br>• Final endorsement to be provided by the National IT Board.<br><br>Discussion was also held that where District Health Boards (DHBs) submitted requests for specific enhancements, particularly those that relate to reporting to the Ministry of Health (MoH), that the costs of the enhancement should be determined, and then discussion could occur with the MoH and the DHBs on the appropriate allocation of costs. Noting that the interRAI budget for software enhancements might not be the appropriate source of funding for these changes.<br><br>**Action:**<br>T*he request from the Northern Regional Health Board to be submitted to the IT sub group for advice on cost, complexity and impact.*<br><br>*Michele McCreadie to raise the process issue of accountability between the interRAI Board and the IT sub group with Andrew Downes Momentum Software Services Manager and to update the Board on progress.*<br><br>02/16-07 National interRAI Services Data Analysis Annual Report 2014/15. Michele McCreadie advised that the report was currently being printed and a hard copy would be distributed to the Board. An electronic version would be made available on the interRAI website. In line with the agreed communications strategy stakeholders would also be provided with a copy. **Closed.**<br><br>**Item 1.5 Matters Arising**<br><br>**Item 1.5E Draft Terms of Reference Post Project Review – Comprehensive Clinical Assessment (interRAI) in Aged Residential Care (2011 – 2015)**<br><br>Feedback from peer review, the Health of Older People (HOP) Steering Group and from the Joint Aged Residential Care and HOP Steering Groups had been incorporated in the draft Term of Reference (ToR).<br><br>It was noted that Brigette Meehan had an acknowledged conflict of interest in that she had been the Manager in the original project. The lead for this programme will be Michele McCreadie.<br><br>There was a discussion held on whether the TOR related to the delivery of the '*Project'* or if it was to include the '*Outcome Achieved'* by the project. It was noted that at the start of the project a business case was written, funding applied and a |

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| | project developed. In this scenario the question would be '*did that project meet its objective and intent*?' However, during the project the scope for the TOR was changed several times. In this scenario the question would be '*should the review report on the outcome as a result of those scope changes*'? It was noted that the review will focus on the delivery of the project and take particular note of the impact on the aged care sector. Benefits realisation was noted as 'out of scope' in the TOR.<br><br>The Review is set up to identify what is left to do, what is left still unknown and whether a benefits realisation process would be useful. The review is the first step in a process towards benefits realisation.<br><br>The review will identify 'lessons learnt'.<br><br>Discussion was held on who would be undertaking the review and Michele McCreadie noted that the person selected would be independent and selected through a limited competitive process.<br><br>Once the selection process had been completed the timeline for delivery will be reviewed.<br><br>Discussion was held on an appropriate evaluation framework to provide guidance for the review. The evaluation framework should include the Triple Aim outcomes. The work on identifying an appropriate evaluation framework and preparing a recommendation to the Board would be conducted in parallel to commencing work on the review. |
| **5. Update from interRAI International** | **Verbal update from Brigette Meehan**<br><br><u>The interRAI Caregiver Assessment</u><br>As advised at the December 2015 meeting a new Caregiver Assessment was being developed in collaboration with Ireland and was now ready for trialing internationally. A masters student at Auckland University had selected this as their masters study and would be participating in the international trial over this winter and expected to have the results at the end of this academic year. Fifty assessments of people's carers would be undertaken. This trial will be paper based.<br><br><u>World interRAI Conference</u><br>The conference will be held in Toronto, Canada, 10-14 April 2016 and presentations will be made by the interRAI team. |
| **3. Data Analysis and Reporting** | **At 10.00 am Dr Jackie Fawcett (Group Manager Health and Disability, Ministry of Health) and Simon Ross (Manager Analysis and Reporting, Ministry of Health) joined the meeting. Kevin Sharkey TAS joined the meeting.**<br><br>**3.1 Introduction of interRAI data to the Integrated Data Infrastructure at Statistics NZ**<br>After a general round of introductions Dr Fawcett noted that part of the work she had been undertaking with Simon Ross' team and other government agencies is to make health data more available to researchers through the Integrated Data Infrastructure (IDI) and it is in this role that today's presentation was being made. |

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| | Dr Fawcett noted her presentation provided a background on how the IDI came about and would outline the opportunities it offered for ensuring that the interRAI data set could add value and a mechanism for doing that.<br><br>Cabinet had a clear expectation that better use and re-use of data could deliver better value for citizens through better evidence, policy, products and services.<br><br>To this end, a range of initiatives have been undertaken:<br><br>• New Zealand Data Futures Partnership: a cross-sector group of influential people working together to drive high-trust and high-value data use for all New Zealanders.<br>• Open Government Data: to facilitate agencies' release of the non-personal government-held data and information that people, communities, and businesses want to use and re-use.<br>• Integrated Data Infrastructure: combines information from a range of organisations (such as health and education data) to provide the insights government needs to improve social and economic outcomes for New Zealanders.<br><br>The programme is managed by Statistics New Zealand who have a good reputation around privacy and security and the process for managing data.<br><br>IDI is designed to:<br>• promote greater use of public data for research;<br>• protect privacy of individuals and companies;<br>• facilitate ease of access to linked data for researchers; and<br>• provide data producing agencies with confidence about the stewardship of their data.<br><br>Statistics NZ operates within a 'five safes' framework to ensure that access to micro data is provided only after the following conditions are met:<br><br>• Safe people<br>• Safe projects<br>• Safe settings<br>• Safe data<br>• Safe outputs.<br><br>Simon Ross noted that his team had a culture of privacy and security and everything they have seen on how Statistics NZ operates is that they are probably more conservative under their legislation than people who would ordinarily be sharing information in the sector.<br><br>Noting that trust and confidence and one breach of confidentiality will undermine years of goodwill that an organisation had built up. Statistics NZ had commissioned research that looked at what it was that determined people's level of what was acceptable and the results can be located at the following website: http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/integrated-data-infrastructure/public-attitudes-data-integration-2015.aspx |

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| | Dr Fawcett then outlined the flow of data into IDI covering how the data is supplied by source agencies, how the data is processed, moved to a clean environment, how researchers are granted access to relevant data and finally how the output is checked.<br><br>Simon Ross noted that Statistics NZ were moving away of individual agency approval for research requests, due in the main to the somewhat onerous process involved and potential delays and MoH are looking to state principles that they want Statistics NZ to consider before they let projects through the gated process of approval.<br><br>There was a general discussion on the publication of research outputs and the requirement for information to be in the public domain, the Official Information Act, how this is balanced where research had been undertaken for the development of public policy.<br><br>Paul McDonald provided an overview of the 'Data Liberation' process undertaken in Canada noting that it had been highly successful and had led to a number of really important outcomes on how different organisations buy into it, and to the extent to which evidence informed decisions have informed policy.<br><br>Noting that we are at the beginning of a revolution in terms of the way in which we undertake evaluations, and policy analysis is fundamentally about to change. In the past, policy and practice analysis would be implemented for a trial period, sometimes at a significant cost, wait a number of years, because that was the length of time for the desirable outcomes to be apparent, and then find that it had no effect in many of the cases. This is a very cumbersome method.<br><br>Dr Fawcett presented an example of integrated health data on diabetes prevalence by ethnic groups and an example of the use of cross-sectorial data by Treasury on at-risk youth.<br><br>Dr Fawcett noted that the purpose of the presentation was to suggest that interRAI NZ might like to think about whether this was a way to increase the use and value of interRAI data.<br><br>Discussion was held on what would be required and the costs associated with making interRAI data available to the IDI and how this would sit amongst other priorities that interRAI were currently working on.<br><br>Michele McCreadie noted that this was an information session only and there was no requirement for a decision to be made at this time.<br><br>The Chair noted that the presentation be concluded with the caveat that a further explicit discussion be held with the Board and that if this was a direction that the Board wished to go how this will be achieved. Due diligence would need to be undertaken to look at what current agreements were in place with service providers and their expectations to ensure that interRAI does not violate any licence provisions or any other agreements that they are subject to. |

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| | The PowerPoint presentation would be provided and circulated to the Board.<br><br>The Chair thanked Dr Fawcett and Simon Ross for their informative presentation.<br><br>**Action:**<br>*Secretariat to liaise with Dr Fawcett to obtain a copy of the presentation and to circulate this to the Board.*<br><br>**At 11.06 am Dr Fawcett, Simon Ross and Kevin Starkey departed the meeting.** |
| **1. Matters Arising** | **At 11.16 am the meeting reconvened.**<br><br>**1.5F interRAI Casemix (Home Care profiles) in NZ.**<br>**Paper by Dr Matthew Parsons**<br>The Chair introduced the briefing paper on Casemix and recommended for the Board's consideration that Matthew Parsons be treated as a guest coming in to present rather than in his role as a member of the Board. That after a brief presentation of the paper and answering any questions raised that Matthew Parsons absent himself from the Board discussion. This approach was **agreed** by the Board.<br><br>Matthew Parsons commenced his presentation by providing a brief overview of what Casemix was, noting:<br>• It allowed for clients or patients to be grouped together by similar needs or diagnoses. For example if you have 50 people in a group from a clinical perspective you can provide the same type of services.<br><br>• Casemix was not new it had been around for a long time, it is used in hospitals around diagnoses. For example if you had 100 people who had broken their hip you are aware of the type of activities required to improve the final outcome for those individuals.<br><br>In relation to interRAI in 2008/2009 the Auckland DHB engaged Auckland University to review the interRAI International tool RUG III to assess if this could be implemented. Matthew Parsons noted that review concluded that the tool did not work in New Zealand, due to the way interRAI is used, with two tools, one for contact assessment and one for Home Care assessment.<br><br>This then brought about the development of a new Casemix system to replace the RUG III for complex clients having a Home Care assessment and then developed a Casemix system for non-complex assessments. This had now been in place for a number of years.<br><br>The reason for the report is that there is a need for only one tool to be used and the concern is, at the end of last year, the Bay of Plenty DHB released a Request for Proposal for a new Casemix tool which they have now developed internally.<br><br>Matthew Parsons noted that the paper provided an overview of the tools which are available and proposed a '*where to next'*, and that the interRAI Governance Board might wish to make a recommendation to the MoH around a single tool. |

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| | The Chair noted that the questions could be reframed '*What is the case that we should have a single tool?*' and if there is a consensus, that yes that makes sense, then '*what is the process that we should go about as a Board in terms of ultimately making a recommendation for what that tool might be?*'<br><br>Chris Fleming noted that this was where the Conflict of Interest for Matthew Parsons occurs as he was part of the Auckland University Team that developed the Casemix tool that he is recommending.<br><br>There was a discussion on the recommendation being made and what the Board's role was in making such a recommendation.<br><br>Max Robins noted it was a complex issue and if the RUG III differentiates effectively in other jurisdictions and is not differentiating effectively in New Zealand was this because our people who are covered by it are more homogeneous population than where it is applied in other places?<br><br>Brigette Meehan noted that there had been validation exercises undertaken in 8 countries where they tested to see if it worked in those populations, and it was confirmed that it did, however she was not aware if they had subsequently gone on to adopt the tool. If relevant this information could be sourced.<br><br>There was a discussion on whether RUG III could be made more applicable in New Zealand and the value of undertaking a formal validation to see why it was not working and what might be needed to make it work. It was recognised that all countries need to make some changes, for example the cost of services varies from country to country.<br><br>Matthew Parsons advised that the analysis undertaken by Auckland University had used a New Zealand adapted RUG III.<br><br>There was a discussion on the three casemix models in use and if these had undergone further adjustment meaning there was even greater diversity of tools in current use.<br><br>There was a discussion on the principle of one casemix approach for both Home Care and Residential Care.<br><br>Matthew Parsons advised that Appendix 1: HCSS CM analysis in the paper was the full report of the Auckland DHB analysis and this had been published.<br><br>**At 11.36 am Dr Parsons departed the meeting.**<br><br>The Board held a general discussion on the paper presented and the recommendation being made.<br><br>**At 11.38 am Karina Kwai joined the meeting**<br><br>From an interRAI perspective there was concern around different DHB approaches and different utilisation of the tool. Noting that the principle behind the adoption |

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| | of interRAI was to make cross comparisons, create consistency and efficiency.<br><br>It was noted that a casemix tool had yet to be extensively implemented in New Zealand, there is one already and the Board would be interested in knowing if there are alternative models and would like some evidence that these were going to enhance the Boards objectives in terms of outcomes.<br><br>Roy Reid noted that from a consumer perspective they would like to see a more standardised level of delivered on assessment need rather than different models of care being used across DHBs.<br><br>The Chair noted that at this point there is not enough information on one approach verses another to be in a position to recommend a specific tool and in the absence of this the best that can be done is to recommend that there is benefit in ultimately ending up with a tool that meets every ones needs but what will be required is a process to identify the tool.<br><br>Karina Kwai noted the concerns raised by the Board on their role in the development of a casemix tool noting that was also national work occurring in directly around casemix. Information would come from a trial. With the national context in mind, the role of the MoH is significant, along with the DHBs and sector input on how the casemix might be progressed.<br><br>Chris Fleming proposed that the Board support the development of both casemix in the home and community and residential care and strongly encouraged the MoH to ensure that interRAI is at the heart of those deliberations, noting that presently two and possibly three tools are being considered. The MoH could, if they so wished, consider if it was wise and acceptable to allow the divergence of one which is about to occur. From a provider and consumer perspective it would be important to point out the benefits of consolidation.<br><br>The proposal put forward was that the interRAI Board supports the ongoing development of a casemix tool in Home and Community and the exploration of it for Residential Care. The Board endorses and encourage interRAI as the founding tool underneath that, noting that there is a predominate casemix tool being utilised in DHBs with an alternative to be rolled out in another DHB and ask the MoH to have an opinion on the wisdom of this.<br><br>Michele McCreadie noted that on the interRAI work schedule and in the letter that came from the Joint ARC Steering Committee there was a request that interRAI would continue the work that had been started on RUG III and whether or not it could be adapted and made more appropriate for New Zealand and asked that this work should progress.<br><br>The Chair noted that a first step would be to complete a short summary of the available literature on its use in other jurisdictions.<br><br>The Board **agreed** the following actions: |

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| | **Actions:**<br>*That Chris Fleming as the lead CE for Health of Older People and Karina Kwai MoH to hold a discussion with DHBs and the MoH and to report back to the Board at the 1 June 2016 meeting.*<br><br>*Michele McCreadie to provide a brief literature summary of the use of RUGs III in other jurisdictions.*<br><br>**At 11.57 am Dr Parsons rejoined the meeting and Jim Nicolson, Ministry of Health joined the meeting.** |
| **3. Education and Support** | **Verbal report deferred to the next meeting.** |
| **2. Governance** | **2.1 Draft evaluation report Palliative Care pilot.**<br>Brigette Meehan noted that the paper was being presented on behalf of the DHBs that had been involved in the pilot; the paper had been prepared as a draft report for feedback.<br><br>The people involved in the pilot are already trained Home and Community Care Assessors, they are seeing people in the community and are using the interRAI assessment tool to identify home support that will help people stay in the community.<br><br>When using the Home Care Assessment tool they see that it directs the conversation more into a restorative focus. The palliative care version directs the conversation down the path of preparedness, the type of support that might be required. Any fears and concerns a person might have on managing their life in the community while they remain with this terminal diagnosis.<br><br>The assessors in the three DHBs tested two of the versions of the palliative care tool. The first is designed for the client group who will remain in the community and the second is much shorter and is really designed for people who are being assessed in their end of life stage.<br><br>At the completion of the pilot indications were that both assessments are useful but there is a level of clinical concern and if people are only newly coming to the system at the terminal stage, then the short one is too brief. The person's needs really do need to be identified. They want to maintain their original focus which was to use the Palliative Care Assessment in the community for those clients who are going to remain in the community.<br><br>The request to the Board is that because this assessment is already available on the software, the training is practically identical (a two hour difference), they would like to look at the referrals that come in from the Clinicians and understand the person's needs and select the most appropriate assessment, to use for example, either use the Contact Assessment or the Community Health Assessment, if more appropriate, and in more complex cases, the Home Care assessment. They would like to add the palliative care version as part of the choice for the assessors and their current clients.<br><br>In summary, the project notes that this had worked, was useful and if it suits the |

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| | DHBs model of care, the project would like interRAI Board to support this.<br><br>The Palliative Care tool also works in the Aged Residential Care environment but the project itself was testing it in the community because there was initial interest in the tool for that environment.<br><br>It was noted that the pilot did not include a very diverse ethic group, but also noting that Māori, Pacific Islands people and Asian people's palliative care was often linked to cultural tradition.<br><br>It was noted that the pilot was originally intended to continue through to October 2016.<br><br>It was noted that consideration needed to be taken on priorities for training and if it was appropriate at this point to divert training resource into this area.<br><br>Michele McCreadie noted that one option for the Board to consider was for the pilot to continue and this could then be evaluated against the Evaluation tool that is being developed. In six months time a formal evaluation could be conducted.<br><br>The Chair noted that the proposal was to thank the group for the work they had undertaken so far and encourage them to continue with the pilot to October 2016 with the aim of applying an evaluation framework with a full set of data to consider.<br><br>The motion was put forward by Max Robins and seconded by Roy Reid and the Board **agreed** to the proposal.<br><br>**Action:**<br>*Brigette Meehan to advise the interRAI Palliative Care Project Group of the Board's decision.* |
| **6. Update from the Ministry of Health** | **A verbal update – provided by Jim Nicolson**<br>Karina Kwai advised that Jim Nicolson had been invited to provide the Board with an update on the development of the Health of Older People Strategy.<br><br>Jim Nicolson provided an update on the actions undertaken since the last briefing:<br>• The early workshops had identified problems; these had been listed and had also identified other evidence-based issues.<br>• The information gathered was then taken, presented to a diverse group of people at 24 workshops around the country during February/March 2016.<br>• The sessions were very structured and there was a high level of participation.<br>• The draft Health Strategy Major Themes were considered alongside the development of the actions around the support for older people.<br>• The framework around keeping people healthy, enabling people to live well with health conditions, respecting the end of life, acute care and recovery were focused on people. The Health Strategy themes are more systems oriented and it was interesting to see how people addressed enabling people to stay healthy looking across a system orientation.<br>• The work to align the Health Strategy themes with the Older People |

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| | Strategy will be complex.<br>• The next action is to take the 500 actions that have been developed during the consultation phase and analyse them to assess their feasibility, appropriateness, timeliness and fit, to both the Health Strategy and the outcomes for older people and put them into an organised, coherent and meaningful document that is understood by both Ministers and older people.<br>• The team had a month to construct the draft strategy that will then go to the Minister of Health and then to Cabinet for approval to publicly consult.<br>• The MoH team is working with a wide group of people to construct the theme areas that will go into the draft strategy.<br>• The document will be similar to the Health Strategy documentation for ease and familiarity.<br>• Three or four hui and two fono will also be conducted.<br><br>There was a general discussion on the need for social connections, as lack of connection and social isolation is a major determinant for health issues for older people.<br><br>One issue that had been clearly identified was the need to construct a better framework for measuring the outcomes from the health and social sector as a whole.<br><br>The Chair thanked Jim Nicholson for his update.<br><br>Karina Kwai advised that the MoH had received District Annual Plan Reports (DAPs) from the 20 DHBs and their National Service Plans and interRAI have been a key initiative in both the documents. At the next meeting the MoH would like to table an update on these reports.<br><br>**Action:**<br>*Karina Kwai to present a report on the outcomes achieved by the 20 DHBs on the key interRAI initiatives reported in their DAPs and National Service Plans at the 1 June 2016 meeting.* |
| **7. General Business** | Chris Fleming noted he wished to introduce an item on interRAI training that he had received. It was from two organisations about whether a process of credentialing sector based training of interRAI competency could be undertaken. The example sighted was where CHT had recruited a former TAS interRAI Educator who currently cannot in their own right undertake interRAI training.<br><br>The request is for an exploration as to whether a credentialing process around competency, not to be confused by a funding discussion as that can be continued later, where a credentialed person could undertake training without the need to be a dedicated TAS interRAI Educator. The driver behind this was to increase capacity and reduce frustration in waiting times for initial interRAI training.<br><br>Chris Hendry noted that at a meeting with auditors recently, the issue of training had arisen and the problem associated with trained staff departing a facility and the need to train replacements. |

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| | Max Robins noted his conflict of interest in this area but noted the point Chris Hendry had made was an important one. As a provider it made economic sense to be able to provide training to a small group where it may not be economical for TAS.<br><br>**Action:**<br>*Michele McCreadie to explore the requirements needed to provide credentialising of external trainers to enable them to provide interRAI training.*<br><br><u>Item 1.5F Casemix (earlier discussion)</u><br>The Chair thanked Matthew Parsons for the paper that he had provided, noting that significant work that had gone into developing it.<br><br>The outcome of the Board's discussion was that the Board had commissioned Karina Kwai and Chris Fleming to work with DHBs and the MoH to have conversations to make all aware of the issues, and that the Board supports working towards a casemix model for these new areas. It encouraged the ultimate potential single system for use and would welcome the opportunity to showcase interRAI as a means of assisting the process.<br><br>interRAI will also provide a brief view on what the international literature shows on the use of casemix to this point.<br><br><u>ACC and interRAI</u><br>Matthew Parsons noted that joint work was being undertaken by MoH and ACC and three lead DHBs around a different way of funding casemix for inpatient and community based stay for people following an injury.<br><br>ACC are looking to explore opportunities to replace their current tool with an interRAI type of tool and other options. Matthew Parsons was proposing that key ACC people be invited to meet with the Board.<br><br>Michele McCreadie made the suggestion that she meet with ACC in the interim and if required extend an invitation to meet with the Board. This action was **agreed.**<br><br>**Action:**<br>*Michele McCreadie to meet with ACC to discuss the use of an interRAI tool and if appropriate to invite ACC to attend a interRAI Governance Board meeting to discuss this further.* |
| | **At 12.37 pm the meeting closed.** |
| **Next Meeting** | **Wednesday 1 June 2016, 9.30 am to 3.00 pm**<br>TAS Boardroom, Willis Street, Wellington |

# Governance Workshop

## A strategic vision for the future of interRAI in New Zealand

**At 1.00 pm the Strategic Workshop commenced.**

The Chair welcomed everyone to the Strategic Workshop noting that what the Board wanted was an overarching strategic vision that provided clarity around some of the significant issues to help to set the stage and ultimately develop a more detailed action plan for the next seven months and this would provide a foundation for the Memorandum of Understanding (MoU).

The Board would take the initiative on drafting the MoU for consideration and feedback from the Ministry of Health.

The Chair then introduced the Director-General of Health Chai Chuah to help set the stage for the strategic workshop.

The Director-General noted that there were a number of pertinent things created in the last 12 to 18 months, which provided the context for the direction the health system was travelling.

The context was around emerging mega trends that would come together:

- The rise of consumerism
- The pace, skill and convergence of multiple technologies.

This set the stage for the 21st century on how it would rapidly change the way we thought about looking after the health and wellbeing of citizens.

The rise of consumerism had a number of angles:

- Demographics – the unprecedented net migration.
- The composition of the net inflow.
- New Zealand like other developing countries was part of a consistent trend of an aging population and had either a shrinking, flat or growing population.
- Consumers were able to drive change because of the pace in the development of new technologies.

The Director-General noted that the Fourth Industrial Revolution by Klaus Schwab informed some of his thinking.

The changes could impact the way we work:

- Physical – the advance in robotics
- Digital – internet, on demand, SharePoint platforms
- Biological – genomics.

Consideration was needed on the convergence of these trends and this gave rise to how we thought about caring for people. Every sector could get disrupted by the rise of consumerism and the advance of technology and how these was shaped and harnessed.

The Director-General noted that the New Zealand Health Strategy would be formally released soon and the five big themes were meant to be interpreted in the broadest sense of the context which he had outlined.

- People powered
- Closer to home
- Value and performance
- One team
- Smart system.

The five themes needed to be considered on their convergence as well.

It was important to raise awareness of what was coming down the pipeline, how to create a different conversation on what this means, and then get an agreement about what we would do differently than what we do today. Disruption to the system would come from non traditional areas.

The Director-General provided a brief overview of the changes that were being made within his Executive Team and the need for his team to be able to clearly articulate in their own words the clarity of purpose, the vision and that would help shape the mission. This would help us be clear around the strategies that would be deployed and would be supported by an appropriate operating model that was underpinned by the values and cultures that reflect who we are as New Zealanders.

If there is not the clarity in changing the way we thought, we could have difficulty around adopting new innovations in investment and governance, leadership and prioritisation.

There was a general discussion on consumer demands, new technology and the balance required between technology and the need for a human interface.

The Director-General noted that in terms of interRAI a significant strength and contribution was in the data, and his challenge to the group was how this was done. Was it fit for purpose? Given how fast the environment was changing and to what extend did looking at historical data to inform future decision making become compromised.

If the interRAI data set had a predictive modelling tool how would that play a part if the context discussed? If we accepted the challenge in front of us was complex, we needed to be careful how we used predictive tools. Predictive tools were best used for uncomplicated problems. Within a complex environment there were always new variables being introduced.

**At 1.38 pm Chai Chuah and Karina Kwai departed the workshop.**
**It was noted that some workshop members would need to depart prior to the workshop conclusion:**
Karina Kwai re-joined the workshop for the period 1.50 pm to 2.15 pm.
Jan Adams departed at 2.25 pm.
Matthew Parsons departed at 3.57 pm.

**Facilitated workshop session**
The Chair introduced Jo Willis (facilitator) to the Board.
After introductions Jo Willis set out the workshop agenda noting that they would commence with a group SWOT (Strength's, Weaknesses, Opportunities and Treats) analysis and then work as two groups on Options for Creating Value and then coming together as a team to set some priorities.

The output from the workshop session would be collated and used as the basis for drawing up the Board's strategic work plan. This activity would be conducted as a separate exercise and a first draft aimed to be presented to the June Board meeting.

**The workshop concluded at 4.50 pm.**