Te Whatu Ora
Health New Zealand

New Dunedin Hospital
PIKI TE ORA

New Dunedin Hospital Project
Clinical Transformation Group Minutes
12 August 2022

1. Welcome, introductions and apologies
The Chair welcomed attendees, including new members, to the first meeting of the Clinical Transformation Group.
2. Confirm minutes of previous meeting; actions and matters arising
Minutes confirmed.
3. Correspondence
Response to Surgical SLT regarding the theatre leadership team's request for a review of doors in DPU. The letter outlines and confirms the review process and its outcome. The theatre leadership team had requested consideration of six locations where they felt sliding doors would be optimal. On review none of these met the threshold for a change request. However during the review process the logistics flow through the deboxing room were examined and it was identified that the door into the deboxing room would meet the threshold for recommended conversion to a sliding door. Some changes to the other doors in the area were also recommended to optimise flow and function. The project team accepted the recommendations and the changes have been instructed.
4. Final Report on Locker Analysis
Tabled for noting. There are still some outstanding areas to be completed and the PMO were asked to update CTG again in October.
5.
6. History of the NDH Project
The PMO presented a history and overview of the project for new members.
7. Fire Evacuation in ICU
NS updated. The ICU team felt that some of the assumptions in the Fire Evacuation plan should be tested. The Fire consultants have done some simulations but the ICU team were keen to do their own as well. NS to identify what – if any – would be the implications for design and update CTG when there is a plan in place.
8. Strategic Relationships
This was a general and broad discussion
9. Clinical Support for Digital Transformation Business Case
SB has been asked to provide clinical support for the Digital Transformation BC.
10. Orientation and plans for new CTG members
New members start on 1 August and we have invited them to come along to the PMO Office at any time for a visit. A Teams site has been set up for the new group including some material for orientation. At the first meeting on 8 August we will do a presentation on the history and background of project and cover off some key stakeholders and terminology.
11. Any other business and close

Te Whatu Ora
Health New Zealand

New Dunedin Hospital
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New Dunedin Hospital Project
Clinical Transformation Group Minutes
9 September 2022

1. Welcome, introductions and apologies

The Deputy Chair welcomed attendees and started the meeting. There were apologies for lateness from the Chair and Programme Director.

2. Confirm minutes of previous meeting; actions and matters arising

Minutes confirmed. Actions:

BD is meeting with James Goodwin next week to progress next steps for potential interim measures to monitor aspergillus, and possible purchase of an air sampler.

Aspergillus Patient education leaflet is being reviewed by Oncology and Haematology.

To close the loop with Haematology who raised concerns about aspergillus during construction, we should work up a paper outlining what we have done and the outcomes.

3. Correspondence

None tabled

4. CHC Rep Recruitment

Following the meeting held with candidates, PM and EG met with the Chair and facilitator of the Community Health Council. They were strongly in support of having a CHC rep based in Dunedin. There was also a discussion about how to build and strengthen the relationship between CTG and CHC, and the CHC Chair will considering proposing that the CTG reps be ex officio members of CHC.

The proposal is to appoint one rep from the regions and reissue the call for expressions for interest for the Dunedin area specifically.

5. CTG Roles

Discussion about how to assign workstreams and roles amongst CTG members.

It was generally agreed that it was a good idea to assign areas of responsibility to new members so they can focus on these. These should be based about members' strengths and areas of expertise and experience. One suggestions was to provide members with a list of possible topics and areas so they can rank their interest in these. This could focus on topics that will have the most 'bang for buck' in terms of impact on the success of the OB Opening.

ACTION: PMO and CTG Exec to prepare a list of topics for further discussion.

6. Hybrid Theatre Site Visit

KB introduced the item. There are two hybrid theatres planned for NDH, one on the theatre floor attached to the DSA, and one in CIS attached to the cardiac theatre. These were designed for the different areas with different teams, and the hybrid in CIS has been designed so it can function as a second cath lab while the one on the theatre floor can function as a DSA, although it is more in line with the other OTs.

It would be preferable for the two hybrids to be aligned with one another; both in view of our design principle of standardisation and flexibility, and to make it easier for staff to work across the two. Therefore a site visit to the Auckland City cath lab, DSA and hybrid was arranged for reps from both areas to help the two teams come up with some design principles which can be used to try to further standardise the designs while ensuring they will still work for both areas.

The Chair welcomed the presenters, Jane Beaton, CNM Radiology; Kevin O'Kane, Cardiac theatre Nurse; Trudy Shearer Charge MRT; Emma Guglietta, Cardiac Physiologist Team Leader; Bernie Bowen, Charge MIT of Fluoroscopy; Sarah Lesche, Vascular Surgeon; and everyone introduced themselves.

Bernie said that the visit was really useful for the team to see how they run their different areas and learn about what works well and what not so well. The group have since met and come up with a list of principles for the hybrid they all agree on:

Principles for hybrid theatres

Patient safety

- Workflow that allows staff to access to patient in an efficient manner in emergency and everyday workflow.
- Sterility of trolleys/ trolley set up bay- preservation of path movement for the sterile trolley.
- Patient visibility in both console rooms important for patient safety

Versatility of room

- One door for entry and exit
- Hybrid room must be interchangeable, a larger plate size must be considered for functionality purposes. Operators must be able to operate from either side of the table and the range of the C Arm should be 'head to toe' to cover for all procedures. A cardiology haemodynamic system should be considered for the DSA hybrid theatre.
- Design need to allow for maximum efficiency.

Digital comms to support internal comms and external online support

- Sound systems between operators and control room staff needs to be high spec to ensure safe clinical communication
- Digital theatre to enable viewing of images for live consultations during cases

Other principles /considerations

- Plant room position
- The two hybrids control room configuration may be different due to layout of controls rooms, procedures performed in DSA may have different requirement.
- Mobile storage which can interchanged between different hybrid/ Cath lab/ DSA theatres (no need to pack a trolley up.)
- Training or cross training of theatre/ radiology nurses.
- The 2 x Hybrids, Cath Labs and DSA must all have the same vendors equipment which makes it safe for staff to operate between the different lab.

The team also collected other learnings and insights:

- Hybrid theatre bed needs to have options for tilt/bend/positioning, as well as attaching arm boards, omnitract etc.(this would be ideal for both of them to ensure versatility)
- Theatre bed able to accommodate high BMI patients in terms of weight capacity. Table attachments that would widen table in order to operate safely for these patients. As well as table attachments that would be able to convert EVAR cases to open cases.

- Turning the bed to look from the feet up in the CIS level Hybrid would work well if patient entry into the room was considered and if anaesthetics are on a pendant. This arrangement would work well for the DSA Hybrid theatre.
- Pendants need to be moveable in rooms and screens or equipment on rails need extended reach.
- Two operating theatre lights. Ambient lighting system
- Anaes able to work from both sides and ends if possible to allow flexibility
- Anaesthetic/patient bays (pre/post?)
- Functionality of theatre that could respond to pandemic situation/ isolation cases.
- Storage room for equipment, consumables, sterile instrument crates both for radiology and vascular. Should be easily accessible to the hybrid theatre.
- Anaesthetic drug cupboard for hybrid theatre
- Licensing of practitioners in using hybrid theatre.
- Vendors need to be involved early

Discussion about bed entry and positioning – ideally to come in parallel and from the patient's right, avoiding the head. Cardiology are keen to have a good view of the patient's head from the control room. Shortest possible journey for the scrub team to travel. DSA team would prefer control rooms to be collocated. Different options for ceiling mounted pendants – need to consider how well they can be manoeuvred out of the way. Ideally pendants will align across the interventional spaces so we need to include the clinical teams in early vendor engagement. Procurement for pendants will be led by the Southern team. WE also need to work with procurement teams to ensure that the plant rooms are sufficiently sized for the equipment needs. Also need to ensure sufficient space in the theatres for parking mobile trolleys on the patient's right so operators can access easily.

ACTIONS: Kate to pull together a list of key principles for design. The users will then rank them for importance.

6. Aspergillus monitoring during construction

Niña gave a presentation on aspergillosis and the policies Dunedin Hospital has in place. Further suggested steps are to prepare a patient education leaflet and purchase an air sampler.

Currently no additional dust has been observed accumulating in the hospital. IPC are working on a dust checklist.

Matt presented what Building and Property are currently doing following an IPC risk assessment around NDH construction.

This assessment recommended maintaining Hepa filters (noting that hepa filters are only placed in high risk areas). Filters in other areas have been upgraded recently to F7 filters (this is industry standard for hospitals) and are effective to 95% for particulates of aspergillus size.

Matt noted that contractors on the NDH build site are monitoring for particles of this size and trigger points have been set based on ORC clean air standards. IPC are notified if these trigger points are crossed. There is further risk mitigation in the use of water sprays to reduce dust on the site. Based on the mitigations and analysis of wind direction B&P have rated the likelihood of increased aspergillus entering the ventilation system as rare.
Matt noted that there are other ways aspergillus could enter the hospital such as through doors and windows.

Matt said he has not looked into how aspergillus has breached other hospitals.

James confirmed this has been through IPC Governance Group and Clinical Council, Brendan Arnold has reviewed the information.

In discussion it was questioned whether the visual monitoring of dust accumulation is robust or evidence-based. It seems that there are good measures in place to control entry to the ventilation system.

James said they have not been able to find an external contractor to undertake dust analysis.

Matt suggested that an interim measure would be to monitor particulate size in the hospital. Monitors could be placed in high risk areas and have trigger points set. This would still raise the question of what happens when the trigger point is set – there could be some behavioural measures at this point.

ACTION: James to go back to IPC Governance Group and ask if there utility in instituting an interim measure like this pending possible purchase of air sampler.

ACTION: Niña to send through patient education leaflet when complete

ACTION: Close loop with Oncology and Haematology, show how we have responded to their concerns.

11. Any other business and close

Te Whatu Ora
Health New Zealand

New Dunedin Hospital
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New Dunedin Hospital Project
Clinical Transformation Group Minutes
14 October 2022

1. Welcome, introductions and apologies

The Deputy Chair welcomed attendees and started the meeting.

Carolyn Preston, Gary Hume and Vanessa Bent were in attendance for item 6.

2. Confirm minutes of previous meeting; actions and matters arising

Minutes confirmed. Actions:

BD is meeting with James Goodwin next week to progress next steps for potential interim measures to monitor aspergillus, and possible purchase of an air sampler.

Aspergillus Patient education leaflet is being reviewed by Oncology and Haematology.

To close the loop with Haematology who raised concerns about aspergillus during construction, we should work up a paper outlining what we have done and the outcomes.

3. Correspondence

None tabled

4. Update on CTG membership

Following the meeting held with candidates, PM and EG met with the Chair and facilitator of the Community Health Council. They were strongly in support of having a CHC rep based in Dunedin. There was also a discussion about how to build and strengthen the relationship between CTG and CHC, and the CHC Chair will considering proposing that the CTG reps be ex officio members of CHC.

The proposal is to appoint one rep from the regions and reissue the call for expressions for interest for the Dunedin area specifically.

5. CTG Roles

Discussion about how to assign workstreams and roles amongst CTG members.

It was generally agreed that it was a good idea to assign areas of responsibility to new members so they can focus on these. These should be based about members' strengths and areas of expertise and experience. One suggestions was to provide members with a list of possible topics and areas so they can rank their interest in these. This could focus on topics that will have the most 'bang for buck' in terms of impact on the success of the OB Opening.

ACTION: PMO and CTG Exec to prepare a list of topics for further discussion.

6. Outpatient Administration Site Visit

AT introduced the item, and shared a presentation recording the learnings from the visit. The team visited Burwood OP, Christchurch OP, Waitemata OP and Manukau Health Park.

Key points included:

- Need to understand allocated space for each specialty
- Patient Care Assistants provide some patient care and some admin – this is a value-add role to assist nurses to work at top of scope and streamline patient experience – we are starting to trial in 4th Floor Outpatients
- Use of VC interpreters – this worked well
- We need to do an admin review urgently, and restructure and get a consistent model in place prior to the move, likely move to a structure where admin report to admin
- Recommend OB specific meetings with Service Managers working collaboratively

- Put in place overall vision, principles and business rules ASAP
- Pilot electronic systems such as room scheduling, patient-focussed booking ASAP and work towards becoming paper-lite
- Service planning, understand churn and scheduling
- Work out who is moving in on Day 1
- Work out who will use/run procedure rooms
- Nursing development – get nurses working at top of scope, plan for future roles
- 'Dump the Junk' early and regularly – get this in place ASAP – needs to be a global approach
- The team have met with senior leadership to ensure they are in the loop, are thinking about the organisational structure for the OB and planning to develop this
- Many of the changes need to be overseen and led by senior organisational leaders who have oversight of all areas and can make clear expectations for the whole organisation
- Early stakeholder engagement across and between services is needed
- Need an urgent decision about resources to support the transition. Key leadership should be in post ~2 years prior to opening, suggested roles: Facility Manager, Nursing Leadership, Admin Manager

Confirmed that a Transition Manager is shortly to be appointed to the PMO for 1 year to develop a transition programme, which will be brought to ELT for endorsement – hopefully by the end of the year. This should help provide the roadmap and facilitate identification of key milestones and resource requirements. We anticipate the establishment of a Programme Board, with delegations from ELT, to make decisions and provide leadership. There will be a need to establish visibility of what is happening in different areas and how this aligns with Southern's priorities and strategic goals.

Carolyn and Gary are having regular meetings with their OP Planning group and the Digital Team are involved in this. They also stressed the need for wider collaborative meetings with staff and managers from different areas who will be working in the building. We can't underestimate the scale of culture change that needs to be stepped through and supported. We also need to look at bedding in the efficiencies on which the plans for the new hospital are premised.

The Comms strategy for staff will be critical and Christchurch have been able to offer a lot of learning around tips and strategies.

In terms of overall management structure for the building, Carolyn said she thought there should be a facility/ops manager plus nursing and administration management with an overarching responsibility. There needs to be oversight of the running of the building, including BoH and Logistics, especially as it will be standalone for some years.

The Chair asked Carolyn how CTG can support her and her team with their work in planning for the transition to the OB.

Carolyn said that they will continue to work on planning within their own areas but there needs to be a structure to ensure there is visibility over the planning for the whole facility, and this needs to be led by senior managers with oversight of the services. Amberley is leading this workstream for the PMO and has had discussions with HR about the Admin redesign process. The development within 4th floor Outpatients is essentially a pilot of the model planned for the OB with shared rooms and resources which are scheduled as needed. Many other outpatient areas are more siloed and not yet working in this way.

Carolyn and Gary are working with the Digital team to get more forms onto Health Connect South and move towards being paper-lite. Ophthalmology have also made a lot of progress in this area. Lance Elder is coming to their OP Admin planning meetings and has been reassuring that the tech will be able to meet their needs. Carolyn suggested that it could be helpful to have a liaison with CTG and the Digital team, to ensure that all

the OP services are working in the same direction. Gary said it would help if they had a 'go-to' person in the Digital team to assist. Charlotte has been doing some work in her area to get pre-admission forms online and allow patients to complete some of this themselves at home. Many of the digital initiatives are interdependent and we need to wait for systems to be implemented and integrated – SI PICS is a key system which is expected to come online mid 2023.

The Digital team have recently employed project managers to help plan the digital transformation, they will be creating the blueprint and talking to different areas and departments about what they are currently doing. In the near term there is a move to reduce paper, get more processes online or streamlined, and looking forward to understand how to integrate the systems departments rely on into the broader digital hospital framework.
ACTION: Invite Patrick Ng and Lance Elder to CTG to talk about how we link in with the digital transformation and how they are working more broadly with the clinical teams.

There was also discussion around the need to embed this in broader cultural change and to educate staff about 'what's in it for them' – in particular the need to ensure there is accurate information in iPM, and the benefits of having this available.

9. Assigning Workstreams

The Chair presented the current workstreams and suggestions from PMO and CTG Exec about how these could be assigned to CTG members.

DPU - Charlotte has attend a couple of the DPU planning meetings. They are looking at how they will operate, equipment needed etc., and will also need to link with other services about models of care – e.g. Womens for changes to TOP services. There is also a workstream about how the Procedure Rooms will operate. Charlotte is happy to continue with this workstream.

ADCs – it would be great to trial one in the current hospital or Filleul Street – there is the option to lease one for this. Charlotte and Joel for this worksteam.

23 hour ward – this is not yet starting but will fit well for Charlotte.

Charlotte is also interested in a clinical advisor role with the Digital team, she is currently involved in moving patient resources and forms online as part of her substantive ERAS role.

OP Admin and Service Planning Liaison – Sarah will pick these up with Hazel to support on Service Planning.

Combining Children's OP with Children's Day Unit and CDS (Vera Hayward) in the OB – Hazel will take this and has already had some contact with the Children's Team.

Transit Care MoC – Hazel will also pick this up – can see what other units (mostly in Australia) are doing. Charlotte can also support this workstream.

Eye Service Planning – Ophthalmology will be one of the first service to go through the Service Planning process given their new unit opening on Filleul street. There are weekly meetings for the Filleul Street development, link in with Melissa Law on these. Hazel to pick this up under the SP umbrella.

Med Phys Labs – bringing two departments together to work in one space – Kate has already started conversations and the teams are thinking about the model. Hazel to support this workstream.

Emergency response in OB – Kate said there should not be too much to do here, Bronwyn McGuire is working on this and hope to trial in the Fraser Building. Unlikely to need CTG support but can come back to CTG if we do.

Generalism / MDU / MedHDU – Joel to pick up aspects where medical input is needed.

7. Clinical Risk Register

Simon presented the paper which outlines the risk management framework. There is a process in place for the whole project. Te Whatu Ora Southern can raise risks and track risks that we need to monitor, manage or mitigate including clinical risks. These are reviewed by PCG. CTG can consider how they want to engage with and monitor risk going forward and we will plan a session to look at the risks in some more detail. In the future Southern may do our own risk report to ESG.

5. Update on VM process

PMO met with key users a couple of weeks ago and shared the Clinical and Operational Impact Statement with them. Following the VM discussion at ESG, a paper went to the Infrastructure and Capital Investment Board. We are expect them to make a recommendation to the HNZ Board who meet on 28 October, and then to joint Ministers, who will issue a decision in November. There is currently a stream of pre-start work underway which PMO is supporting.

8. Medical Gas Outlets

Brent introduced the paper.

There are two issues – the medical gas outlets themselves and the standards for the whole medical gas system. Equipment needs to be compatible with the outlets to be plugged in so it's important we decide what to adopt.

In the current hospital the outlets are nearly all Puritan Bennett – these are uncommon in NZ and expensive. Most areas in the South Island use the Australian standard outlets and this is what B&P are recommending for the new hospital. However, this will mean a cost to convert existing equipment to new fittings.

The exception is Anaesthetic Gas Scavenging which run at a different pressure. Currently these use Gem 10 terminal units. These are not recommended to change to Australian standard for this reason.

Given there are costs and risks around this, CTG agreed to support the recommendation to move to Australian Standard medical gas outlets on pendants and medical service panels but would like PMO to highlight this risk to clinical and operational leaders, request their feedback / plan to manage, and report back on this process at the next meeting.

Amendment 28/10/22: CTG asked for further consultation with clinical and engineering support and for this to be reported back to CTG before a decision on whether to support this proposal.

11. Any other business and close

Te Whatu Ora
Health New Zealand

New Dunedin Hospital
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New Dunedin Hospital Project
Clinical Transformation Group Minutes
28 October 2022

1. Welcome, introductions and apologies

The Chair welcomed attendees and noted Bridget is joining by phone and may not have good reception.

2. Confirm minutes of previous meeting; actions and matters arising

Minutes of the meeting of 14/10/22 were amended on the matter of gas outlets. CTG did not support the proposal as more feedback is needed from clinical and operational staff on the change. PMO were asked to consult further and then return the issue to CTG.

Aspergillis

Patient education leaflet is with Haematology for review.

James Goodwin advised they are not proceeding with purchase of air sampler – he has been asked to provide a paper to CTG to summarise their response and plans.

Amberley reported on meeting with the Digital Team where they presented on their learnings from the Outpatients site visit. Covered patient-focused bookings; room scheduling; getting paper-lite and what is covered in the BC. They expect to get a decision before Christmas on the release of the first tranche of funding. Digital Team have struggled to release staff to focus on paper-lite so they may start working with priority services. Some of the work will wait until SI PICS is online. APAC is working on getting some pre-admission paperwork online and 4th floor OP are keen to get going on this. Charlotte has been involved with this and is keen to assist with the digital liaison with CTG.

Appointment of Transition Programme Manager

Sara Kidd will join the PMO next week on a year-long secondment, to help plan the OP transition programme. She will construct a plan on a page outlining what needs to happen for a successful opening, with milestones and resource requirements. We would hope to get this endorsed by ELT so we have a mandate to deliver the plan. The Service Planning team are also going to ELT next week to get endorsement of their current planning. This will help clarify whether service planning should be focussed on BAU or more on the new strategic directions.

Hazel gave an update on Service Planning. There was a workshop last week with the SP team, reviewed the draft SP template, which is much easier to follow, with a supporting document to follow. This will include a section on NDH. We are working with the SP team on a priority matrix for services. This should help us and the services to understand the gap between current state and end state, where the biggest gaps are (these will be priority services) and how to bridge these. Furthermore while the change for some services is quite specific to them, there are generic changes which will apply more broadly. There will be a package of information about those generic changes such as clinic booking, shared administration, collaborative workspace etc. and we could work to have these ready for the next SP year.

There is a piece of work to figure out the co-dependencies and what we need to prioritise to maximise the efficiency of the building. There will have to be a scheduling exercise to work out where different services will be placed. The OP scheduling exercise will be redone with 22/23 data, which should give us better data. We can apply growth assumptions to this, and in parallel the Digital BC has some funding for OP scheduling.

3. Correspondence

None tabled

4. Update on Gas Outlets

Brent and Alice gave an update on the consultation on the change to Australian standard gas outlets proposed.

The proposal is to switch from current push-in gas outlets to Australian standard gas outlets which are screw-in style. Alice requested a literature search through the library but there was no significant evidence comparing the different types. She will also consult with the heli-paramedics, St Johns and Waipapa to ask if they have had any concerns. Alice is going to see whether there is any data on incidents involving gas outlets that might help determine if there are health and safety concerns with any particular types. It would also be useful to contact Southland hospital.

Concern expressed from ICU medical staff about the possibility of mis-threading the screw-on outlet; gas leaking and reduced flow pressure; and the external O-rings. Clinical Engineering advised that the national engineers organisation have a stated preference but this seems to reflect the situation in the North Island.

Will update CTG again if more information is available.

5. ICU Fire Evacuation Simulation and next steps

Nikki presented this item.

International standards confirmed by fire engineers are that evacuation of each pod should take no more than ten minutes. ICU felt this was ambitious.

On 23/09/2022 ICU carried out a fire evacuation simulation of two patients who were moved into PACU as per current plan. This exercise resulted in some good learnings for BAU and NDH.

- Need to take ventialtors with the patient – machines supplied by techs were not familiar to ICU staff and PACU staff not able to help
- Need oxygen close at hand – currently stored too far away and this caused delay
- Service is arranging to have oxygen bottles with ventilators and respirators available

In terms of the new facility, there is a tension between changes to the design to enhance evacuation capability and the BAU needs. The fire engineers will present to the ICU team on the current fire suppression mechanisms and evacutation routes and the team will have a chance to talk through the options and pros and cons. There will be a paper to CTG summarising this and asking for endorsement of the process undertaken. Learnings can then be applied to NICU which also has open bays.

6. Plan for ADCs

Item held over until the team have had a meeting.

8. Timing of CTG meetings

Sheila proposed moving the CTG meetings to the first and third Wednesday of each month. Mid-morning onwards indicated as the most suitable time.

DECISION: Meetings to be scheduled first and third Wednesday of each month, 11:00 – 13:00.

10. ELT paper on balustrades in OB

Liam presented this paper which is going to be tabled at ELT to confirm their level of comfort with the approach taken to balustrade height in the OB. The paper captures the process and outcome and seeks endorsement of the result, acknowledging the lack of national guidelines.

Clinical areas have handrails in line with AHFG. In public areas there has been more of a case-by-case approach considering different aspects of design and usability. The front of house area contains voids around the stairwells that present risks of accidental or intentional falls.

Long corridors like this example had handrails included to support accessibility.

During PD there was a process to look at aligning height of balustrades to level of perceived risk. This took place in the context where there was no clear guidance except NZ Building Code – at the time MoH did not

have any guidance. The Design Team provided examples from other facilities where post-occupancy changes were needed. Changes were made during the design process to respond to this. The approach was to increase the height of balustrades further up the building, with anything above L01 having a full-height balustrade.

Further informal consultation was undertaken internally and externally, and design has been refined in some areas.

The Front of house space at L01 over the stairs is an area of particular interest given the large numbers of people using this space including children. This void remains the only void in OB that has not attracted a full-height balustrade which supports the architectural design intent.

- The timber balustrade (East edge of the void) is 1.3m in height with a handrail at approx. 900mm in height; in line with the principle adopted during design that long corridors should have handrails to support accessibility, though is no an accessibility requirement.
- The glass balustrade (North edge of the void) is 1.3m in height without a handrail, however, has a steel structure at 1.1m in height to support the glass.

The main concern is that the handrail and structural support elements in this area could pose a risk to children who may see them as something to climb and play on. Children climbing these elements is a known concern at the local Dental School.

There was general agreement that the full height balustrades at higher levels is supported. CTG felt the potential risk around the FoH, particularly the handrails, should be highlighted to ELT with a recommendation that mitigations be considered, including removing the handrail or alternative design solutions.

Any further feedback can be provided direct to the chair.

11. Any other business and close

Meeting closed 2.30pm.

Te Whatu Ora
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New Dunedin Hospital
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New Dunedin Hospital Project
Clinical Transformation Group Minutes
11 November 2022

1. Welcome, introductions and apologies

The Chair welcomed attendees and noted apologies from Simon and Charlotte for lateness.

2. Confirm minutes of previous meeting; actions and matters arising

Minutes of the meeting of 28/10/22 were accepted.

Paper on Balustrade height has been to ELT. Liam will update CTG again after discussion with the Design Team.

Patrick raised the question of how to manage issues that may arise with FiT groups or teams that are not able to be resolved or decided at that level. Previously these came to CLG to determine, and given that there may be a further round of engagement with FiT groups there could be other issues to address, or occasions where CTG would need to sign off on a design phase or plan. The Terms of Reference for CTG do cover these functions and responsibilities, noting that CTG is not a decision-making group.

In discussion about the appropriate process it was agreed that issues that arise at the FiT group level should initially be escalated to the relevant Directorate Leadership team. If there are change requests these will come to CTG for a peer review/sense check, and to provide a whole-of-facility view.

Collaborative Workspace may be an outlier in the design process as the model/ design has changed and there is no longer a FiT group in place – given that workspace and staff amenities overarch all areas this will likely be reviewed and signed off by CTG with potentially some input from users.

This process may need to be reviewed once user engagement starts.

3. Correspondence

None tabled

5 Risk Register

Simon outlined that with the changes in the project, including changes in governance structure and current focus on value management, there will be a need to refresh the risk register and likely review the structure next year.

6. Digital Team Update

The Chair welcomed Lance Elder and Patrick Ng from the Digital Team, and also Talis Liepins and Heather Wilson from the Service Planning Team, who attended to hear the update:

- DBC has been approved and now working through the process to get Stage 1 funding released
- Original proposal was quite ambitious and involved upgrading systems across the Southern region, during the approval process feedback indicated some descoping was needed
- Current approved BC to implement infrastrstucture planned for the OB and upgrade current systems to work well with this
- There are some national initiatives (e.g. patient-focussed booking) which we can leverage
- There will be a second stage implementation BC for the IB next year, this will have more of a national perspective
- Currently going through procurement partner to find a digital infrastructure delivery partner and facility solutions, hope to have them in place around March 2023. This contract will have to be approved by the Te Whatu Ora Board.
- First step is to refine digital design to align with OB constructions schedule

- Currently wokring on enhancing HCS; looking to support paper-lite (especially when SI PICS comes online); designing document flows; scanning paper files; working on OP scheduling tool (may be able to align with work in other districts)
- User engagement – have used FiT groups so far, intend to establish a network of governnce and engagement groups when funding is available, anticipated to be Feb/March 2023
- No funding in this BC for Telehealth solutions, we expect this to be something that comes from national digital planning
- Digital Transformation is now part of a national programme, and it is likely that it will come under a national governance framework. Currently unclear what that means for local governance.

Charlotte and Hazel both indicated an interest in engaging with the Digital solutions for CTG. The Chair said CTG is happy to link in with the Digital Team as needed and thanked Patrick and Lance.

7. Service Planning – report on ELT paper and next steps

Talis and Heather attended to report on the presentation of their paper to ELT and next steps:

- The SP team have been in post for around four months, engaging with services, working on redesigning templates, aligning processes to national strategies and priorities and responding to local and district-wide service needs
- Paper went to ELT outlining the current state and plans to launch the new approach. This included a section on supporting services to prepare for the transition, focusing initially on OB
- ELT indicate we need a way to align service planning to funding to ensure we are investing efficiently – still to be worked through how this will be achieved
- SP team is working with PMO to identify priority services for the move to OB, and would like to talk about how PMO/COG can support the SP processes – e.g. attending meetings, review draft plans

In discussion – agreement that the lack of alignment with funding is problematic, it makes it hard for services to implement changes, and it's important teams understand this and how to navigate the funding cycle. Without this there has been a cycle of plans that have not been implemented due to lack of access to resourcing at the right time. Service Planning should enable services to understand how to apply for and access funding and align this to their planning.

In terms of NDH the intention is to take a tailored approach with different services, depending on the scope of change, and without wanting to overload services at this point. Initial focus will be on achievable preparation such as moving towards paper-lite. General agreement that we need to make sure services are not overwhelmed, and are set up to succeed.

The SP team are meeting regularly with PMO reps to align Service Planning with NDH priorities and transition planning. Sarah and Hazel will join these meetings going forward to link in from a CTG perspective.

Bridget spoke about her vision of CTG being the champions for service and transition planning with the services, as well as bringing a pragmatic view to what will work for the services.

Patrick suggested that the SP team bring the list of priority services to CTG for review, and as services develop their service plans, that the NDH related parts should come to CTG for review and to provide visibility over the direction of planning.

Sara spoke about her work in the ePMO and the structure proposed for a governance structure around investment to streamline and monitor larger investments. This has not been able to be progressed at this point but Sara is happy to share with CTG and the SP team. Canterbury have a structure that monitors investments and benefits, and they have seen gains from using this model.

We are expecting the Te Whatu Ora operating model to be released before Christmas at this may give us more clarity. In addition we expect that the governance scope of ESG will be restructured to have responsibility for the digital and transition programmes. At this stage there is no BC for the implementation phase.

10. Managing Aspergillus Risk in hospital

James Goodwin attended to answer any queries.

The paper outlines the BAU protections that are in place for patients at risk of aspergillosis. Investigation of an air sampler did not find this would offer any additional benefits. There are no guidelines on identifying or responding to elevated risk. Particle monitoring is ongoing at the NDH construction site and IPC are notified if the levels go above that recommended by ORC but this does not trigger any change in protocol for patients. The IPC Team are working on a plan around key construction stages for IPC monitoring.

The Patient Education leaflet is with the Haematology and Oncology team for review. When this is signed off it will be on MIDAS. IPC will promulgate this to all areas where immunosuppressed patients are at increased risk of aspergillosis – e.g. transplant patients, CF patients.

James confirmed he has been in liaison with the Haem/Onc team about the outcomes of the paper. The Chair thanked James and the team for their work. CTG agreed by consensus to accept the paper and Patrick will communicate this back to Lucy Pemberton.

11. Any other business and close

Bridget updated on the visit this week from Rob Campbell (Te Whatu Ora Board Chair). He confirmed that organisational decisions will become more aligned to national strategic priorities, or mandated business cases, such as SI PICs, paper-lite and enhancements of HCS, therefore these should be the initial foci. Te Pae Tata Interim New Zealand Health Plan 2022 – Te Whatu Ora - Health New Zealand gives an initial overview of the strategic priorities.

Meeting closed 3pm.

Te Whatu Ora
Health New Zealand

New Dunedin Hospital
PIKI TE ORA

New Dunedin Hospital Project
Clinical Transformation Group Minutes
9 December 2022

1. Welcome, introductions and apologies

The Chair welcomed attendees to the last meeting of 2022.

2. Confirm minutes of previous meeting; actions and matters arising

Minutes of the meeting of 11/11/22 were accepted.

Actions:

SK and HS have joined the group meeting regularly with the Service Planning team. SK has also been involved in Cardiology Service Planning Day and will ask to be kept up to date with Rheumatology Service Planning.
ACTION: SK and HS to liaise with GMs to communicate with services about their role in service planning.

ACTION: HS and EG to identify a location for shared documents (discuss Teams site with SP team).

PM has written to Lucy Pemberton to advice outcome of process on Aspergillus monitoring (see correspondence). Positive responses received.

3. Correspondence

Letter to Lucy Pemberton to advice outcome of process on Aspergillus monitoring noted.

Letter to FiT groups on outcome of CLG recommendations noted and was positively received.

ACTION: SB to write a list of changes in VM 4.5 for user reference.

4. ELT Papers

Staged implementation of ADC – ELT endorsed the concept to progress to Business Case stage, questioned whether the MAU is the best place for the medical pilot, so the Business Case will canvass where we would expect maximum benefits in terms of enhanced patient safety.

Land Title for Dairy Building – options presented to have the Dairy Building as a separate title or as part of the larger site – ELT preferred to keep it as separate title as it is a heritage building and this allows for the possibility of a separate sale at a later stage.

6. Gas Outlets

Recommendation has gone to Design Team that Southern wishes to adopt British standard gas outlets.

9. NDH Risk Register

We are still awaiting a direction on value management and pending that no other particular risks to be noted. The register will be reviewed following the decision.

10. November Update to ELT

Noted. Restructuring within Te Whatu Ora continues. The Southern ELT continues to operate in the interim.

11. Any other business and close

Emergency Response in Outpatients Building

This has been delayed due to staff secondment so will come to CTG next year, JP has agreed to review.

Simulation and Transition Planning

SB raised the need to build simulation training into the transition planning. Agreed to have a dedicated session on this with CTG and the Sim team next year and invite 9(2)(a) from Christchurch to share his experience, SKi can then plug into the transition programme. This could include the emergency response.

ACTION: Session with Sim teams to be arranged in 2023.

New Dunedin Hospital Project
Clinical Transformation Group Minutes
9 December 2022

ICU Lift Simulation Exercise – Sheila to write up. We should consider how best to share resources we have gathered and created – Health Infrastructure Unit, Health Design Council.

Transition Plan – SKi has drafted this and will be circulated for feedback to come to CTG early next year. Following this will go to ELT for endorsement. A comms plan will be developed to share the plan with staff. When the comms advisor is on board we can develop a broader comms strategy around the work CTG is doing. We will also consider the overarching strategy to the comms around the transition and change, and how best to develop this. Likely to need some additional resource – externally, internally or from Te Whatu Ora.

Planning for the ILC has restarted with funds released for initial design and a business case. Hamish Brown is the sponsor for Southern. At the appropriate time CTG reps will be included – PM has been involved and JP also happy to join.

FiT group for Collaborative Workspace – CTG can act as the FiT group with other users to be consulted as needed.

CHC reps on CTG – CHC has responded to our paper and advised that the support structure for the reps will consist of buddying with the CHC Chair and another member, and attending meetings regularly to update CHC. We can now proceed to contract our regional appointee and look to issue an EoI for a Dunedin rep in the new year.

Meeting schedule for 2023 confirmed.

New Dunedin Hospital
Clinical Transformation Group

Te Whatu Ora
Health New Zealand

Minutes

18 January Wednesday 2023 11:00 – 12:50

Attendees		Present
Sheila Barnett	CTG Chair	✓
Patrick Manning	CTG Deputy Chair	
Charlotte Paddon	Nursing representative	✓
Hazel Simmons	Allied Health representative	✓
Joel Papak	Medical representative	✓
Sarah Kalmakoff	Service Management representative	✓
Marie Wales	Community Health Council representative	
Bridget Dickson	Programme Director	✓
Simon Crack	Deputy Programme Director	✓
Alice Barach	Clinical Project Manager	✓
Amberley Thomson	Clinical Project Manager	✓
Kate Burton	Clinical Project Manager	
Liam Hutton	Clinical Project Manager	
Nikki Scott	Clinical Project Manager	✓
Brent Gardyne	FF&E Project Manager	✓
Janina Louie	Business Analyst	✓
Sara Kidd	Transition Programme Manager	✓
Emily Gill	Project Coordinator	✓

New Dunedin Hospital
Clinical Transformation Group

Te Whatu Ora
Health New Zealand

No.	Item
1	Welcome, introduction and apologies Noted that an EoI for a Dunedin CHC rep will be going out shortly.
2	• Confirmed minutes of last meeting • Actions and matters arising o A new Teams site has been established for CTG o The CTG Teams site includes a tab for Actions o A Teams site has also been set up for Outpatients Transition Planning
3	Correspondence None tabled
4	**User engagement post-VM decision** Decision was confirmed by Ministers at the end of 2022. This entails a delay for completion of the IB of around 12 months. This may be able to be mitigated to some extent by construction or reorganisation of the programme. A meeting for FiT groups has been held to update them on the new Block and Stack prior to the FiT meetings scheduled to begin at the end of January. CTG will cover Workspace and Staff Amenities with users being engaged later. There has not been a lot of public communication. Southern team have met with Mayors from the region who confirmed they would like more detail around the plans.
5	**Preadmission workstream** Emerging need for a workstream to agree the model for preadmission in the new hospital. Understand current state, how each speciality manages their preadmissions, processes used Understand requirements, constraints for different procedures / specialities, alternative models used elsewhere Plan to streamline and standardise ahead of need to align with Electronic Medical Records coming online in a couple of years
6	**Gas outlets** A DI has been issued to change from Australian standard (currently specified in OB) to British Standard (in both OB and IB), in alignment with the clinical preference. The procurement team has been informed of the changed specification, and examples requested for the Clinical Engineering Team. There is a cost to change fittings on existing equipment. A paper for noting will be provided.
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13	Any other business SKi offered to run a session on Business Case preparation and writing. Session scheduled 10 February. Business Case Writing Passcode: 9(2)(g)(ii)

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

15 February Wednesday 2023 11:00 – 12:50

Attendees		Present
Sheila Barnett	CTG Chair	✓
Patrick Manning	CTG Deputy Chair	✓
Charlotte Paddon	Nursing representative	✓
Hazel Simmons	Allied Health representative	✓
Joel Papak	Medical representative	✓
Sarah Kalmakoff	Service Management representative	✓
Marie Wales	Community Health Council representative	✓
Bridget Dickson	Programme Director	✓
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	✓
Amberley Thomson	Clinical Project Manager	✓
Kate Burton	Clinical Project Manager	✓
Liam Hutton	Clinical Project Manager	✓
Nikki Scott	Clinical Project Manager	✓
Brent Gardyne	FF&E Project Manager	✓
Janina Louie	Business Analyst	✓
Sara Kidd	Transition Programme Manager	✓
Emily Gill	Project Coordinator	✓

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No.	Item
1	Welcome, introduction and apologies Particular introduction to our Community Health Council representative Marie Wales who joined the meeting for her first time.
2	• Confirmed minutes of last meeting • Actions and matters arising o Actions updated on Teams
3	Correspondence None tabled
4	**Clinical Risk Register** Risks outstanding from the Value Management Process may need to be added.
5	**Update on Stage 1 Funded Digital Solutions** 1. Clinical Scanning Project 2. 0 2 EMR Project 3. Clinical Booking Solution Project 4. Consumer Engagement Solutions Project 5. Patient Queue Management Project 6. Message Integration Project 7. Wayfinding Project 8. Building Maintenance System Project 9. RTLS Realtime Location Services Project 10. Patient Journey Boards Project 11. Digital Signage Project Working with the Digital Team we have made good progress to outline the scope and benefits for most of these projects and will continue to complete this work. This can then be woven into planning for the Outpatients Transition Programme.
6	
7	**Report on site visit to Wellington Children's Hospital (Te Wao Nui)** Shirley Bell and Sarah Heggie attended for the Paeds Team and were welcomed to the meeting. A small team visited Te Wao Nui in December 2022. This is a wing of Wellington hospital incorporating inpatient and outpatient services, and is partially open at this stage. Aspects the team liked included: ➢ Attractive environment including floor and wall coverings, child friendly aesthetic ➢ Single rooms, well laid out

- Wayfinding strategy well thought through, bilingual signage and themed floors
- Interactive play area / digital screens
- Concealed Medical Services Planning
- Anti ligature bedrooms
- Auto doors on main bed routes
- Automated drug dispensing
- Good use of mobile trolleys rather than overstocking areas

Lessons and insights to think about for our new hospital:

- A lot of open waiting and play spaces but that did seem to mean space was not always used well. Time was wasted looking for patients and whānau who had checked in when their apointment came up.
- Staff were not visible, receptions and staff stations were often empty with staff in enclosed workrooms. We need to ensure good lines of visibility for staff and patients and whanau.
- Large communal areas appeared underutilised
- Unnecessary storage in consult rooms storage needs to be well thought through.
- Large dedicated areas for Allied Health also appeared underutilised equipment stored to claim spaces
- Specialist equipment kept in rooms makes shared use challenging
- Start model of care discussions early
- Think about what equipment you will need, what you can take and what needs to be purchased
- Service discussions are needed to agree and implement changes to practice
- Donations / fundraising can be done for the 'nice to haves'
- Design needs strong leadership and a balanced understanding of clinical need, operations, budget, build process and contractual constraints
- Design should balance the preferences of individual clinicians with best practice, guidelines and budget
- Health planning should be informed by evidence based design
- Value Management should not impact on future opex
- Establish changes in practice prior to relocation
- Leaders need to have time freed up to dedicate to transition preparation
- There were challenges in integrating services and sharing spaces
- Use leaders to front staff comms rather than project people

8	**Outpatients Transition Programme**

	Programme will cover the changes needed to ensure a successful opening for the Outpatients Building. This involve defining a high level brief and the benefits to be achieved. Changes have been identified as functions the new facility should achieve; these will each be defined in more detail through a series of workshops (one for each function) to outline the current and future states, the challenge and opportunities, and what is needed to achieve the future state. Each workshop will result in a one pager which will be presented to CTG for endorsement. Together these functions form the Target Operating Model for the Outpatients Building, and this will underpin the Business Case being prepared to secure funding. The schedule of workshops is being confirmed and invitations will be going out soon.
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13	Any other business

New Dunedin Hospital
Clinical Transformation Group Minutes
Wednesday 1 March 2023 13:00 – 14:00

Te Whatu Ora
Health New Zealand

Attendees		Present
Sheila Barnett	CTG Chair	
Patrick Manning	CTG Deputy Chair	✓
Charlotte Paddon	Nursing representative	
Hazel Simmons	Allied Health representative	
Joel Papak	Medical representative	✓
Sarah Kalmakoff	Service Management representative	
Marie Wales	Community Health Council representative	
Bridget Dickson	Programme Director	✓
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	✓
Amberley Thomson	Clinical Project Manager	✓
Kate Burton	Clinical Project Manager	✓
Liam Hutton	Clinical Project Manager	
Nikki Scott	Clinical Project Manager	✓
Brent Gardyne	FF&E Project Manager	✓
Janina Louie	Business Analyst	✓
Sara Kidd	Transition Programme Manager	✓
Emily Gill	Project Coordinator	✓

No.	Item
1	Deputy Chair led the meeting. Welcome, introduction and apologies.

2	• Confirmed **minutes** of last meeting
	• **Actions** updated on Teams
	• **Matters arising**
	  ○ Outstanding concerns with VM 4.5a:
	  ▪ Provision of pathology services
	  ▪ Mental Health Services for Older People
	  ▪ Collaborative Workspace
	  ▪ PET Scanning
	
	Pathology need reassurance that space provided in IB is sufficient to support robust acute service. Session booked with SCL for them to present their work to date, including data on frequency of specific tests. Contract holder would need to consider external lab space to support, noting there are opportunities identified within the Site Masterplan.
	MHSOP paper going to Leadership Team for endorsement on strategy for service provision. Following endorsement the recommendation with go to the regional integration team to include in their workplan and assign resource.
	Workspace continue to work through design process with a commitment to meet briefed requirements for workspaces.
	PET work through options in design process.
	ACTION CTG Exec to update the Clinical Impact Statement to outline clinical opinion on these issues.

3	**Correspondence** None tabled
4	**High Level Transition Programme Plan** Currently in development for noting.
5	**Update on Digital Planning** Digital team will use the same methodology as us for transition planning. Some joint workshops to be set up to integrate our work.
6	**Pathology in IB** SCL are collating data on the number and frequency of urgent tests and will present this to a small group of PMO and CTG Exec. This will help support the rationale for space required within the acute hospital.

	In parallel RCP have been asked to initiate a peer review of the design including comment on accreditation requirements.
7	**N-class Room Function in NDH** An engineering solution has been identified whereby doors can be left open when negative pressure is not required. An alarm will go off indicating a problem with negative pressure when doors are open but this can be disabled if the doors are wanted open. The alarm will come back on automatically after a certain period of time. When the doors are closed the room reverts immediately to negative pressure. CTG **noted** the paper.
8	Any other business • CTG Exec are meeting next week to discuss the workplan for the coming year, and will update at the next meeting.

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

Wednesday 15 March 2023 11:00 – 13:00

Attendees		Present
Sheila Barnett	CTG Chair	✓
Patrick Manning	CTG Deputy Chair	✓
Charlotte Paddon	Nursing representative	✓
Hazel Simmons	Allied Health representative	✓
Joel Papak	Medical representative	✓
Sarah Kalmakoff	Service Management representative	✓
Marie Wales	Community Health Council representative	
Bridget Dickson	Programme Director	✓
Simon Crack	Deputy Programme Director	✓
Alice Barach	Clinical Project Manager	
Amberley Thomson	Clinical Project Manager	✓
Kate Burton	Clinical Project Manager	✓
Liam Hutton	Clinical Project Manager	✓
Nikki Scott	Clinical Project Manager	✓
Brent Gardyne	FF&E Project Manager	✓
Janina Louie	Business Analyst	✓
Sara Kidd	Transition Programme Manager	
Emma Westwood	Senior Communications Advisor	✓
Nigel Barr	IPC and Patient Safety Liaison Advisor	✓
Emily Gill	Project Coordinator	✓
In Attendance	**Role**	**For item**
Hamish Cameron	Travel Coordinator	9
9(2)(a)		
Matt Jenks	Sustainability Champion	9 & 10
Heather Fleming	Service Manager: Non-Clinical Services	10

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No	Item
1	Deputy Chair led the meeting. Welcome, introduction and apologies.
2	• Confirmed **minutes** of last meeting • **Actions** updated on Teams ○ Chair presented memo being drafted from CTG Exec to the Project in response to VM Option 4.5a, outlining outstanding concerns • **Matters arising**
3	**Correspondence** None tabled
4	**OB Transition Programme** Not discussed
5	**CTG Risk Register** Digital team will use the same methodology as us for transition planning. Some joint workshops to be set up to integrate our work.
6	**Update from Joel** Update after nine months in the CTG role, it has taken some time to get up to speed with the current state of the project but now involved in several project workstreams: • Medical Day Unit Had some productive meetings with current users, surveyed current usage and potential future usage. Currently mostly independent patients, may expand to patients requiring more assistance, also considered pandemic usage. Discussion around digital transformation and how these tools could be leveraged. Relationship with the Medical School was raised with regard to clinical trials and wider. ACTION: PM and JP are to meet with the Dean to get an understanding of current issues and JP will also contact SMOs involved in clinical research to understand concerns / needs. • Medical HDU Working group set up historically to look at a pilot but this stalled. JP has had some initial meetings and identified staff who are keen to be involved and a potential location. However CICM requirements for a Medical HDU are demanding and unable to be met in DPH, and as a result there are not many in NZ, in larger hospitals. Likely approach would be to establish a progressive care unit in the current hospital which would provide a service not currently offered in DPH, and while not a true MedHDU under ICU it would allow staff upskilling. The establishment of a Medical HDU in NDH is an aspirational goal that would require meeting CICM requirements. CP is involved in work to establish a Surgical HDU in DPH and will discuss with JP. • Automated Dispensing Machines Awaiting outcome of Business Case – will resume when we know if we have funding.

	• Other areas Joel is involved in: Pathology/Southern Community Laboratories (SCL) Interprofessional Learning Centre (ILC) Collaborative Workplace Emergency Response Team – Outpatient Building Medical Outpatients
9	**Results and Update on Travel Survey** Hamish Cameron attended to present this item. 2023-03-15_CTG Travel survey presentation.pptx The travel survey has been completed for employees of Te Whatu Ora Southern, University of Otago and DCC. The data is to help understand how to support the Workplace Travel Plan and promote active sustainable travel options for employees.
10	**Results of Study on Organic Waste in Dunedin Hospital** 9(2)(a) undertook this study as a summer scholarship and attended CTG to present the results. The study included a two-week audit of waste returned to the kitchen. 2023-03-15_FINAL Presentation Dunedin Public Hospitals.pdf 2023-03-15_FINAL Report- DPH Food Waste.pdf Compass is the current contract holder for the kitchen and are keen to improve waste and sustainability. The contract comes up for renewal before NDH comes online but we will look to support initiatives to improve waste and sustainability. Change should focus on reducing waste and then redirecting organic waste into streams that create less wasted carbon dioxide. The recommendation from the study to have the most impact on reducing waste would be to move to a room service model, where patients order the food they want when they want to eat. Ideally the audit should be repeated every six months to measure any change.
11	Any other business

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

Wednesday 5 April 2023 11:00 – 13:00

Attendees	Role	Apology
Sheila Barnett	CTG Chair	
Patrick Manning	CTG Deputy Chair	
Charlotte Paddon	Nursing representative	
Hazel Simmons	Allied Health representative	
Joel Papak	Medical representative	
Sarah Kalmakoff	Service Management representative	
Marie Wales	Community Health Council representative	
Bridget Dickson	Programme Director	
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	✓
Amberley Thomson	Clinical Project Manager	
Kate Burton	Clinical Project Manager	
Liam Hutton	Clinical Project Manager	
Nikki Scott	Clinical Project Manager	
Brent Gardyne	FF&E Project Manager	
Janina Louie	Business Analyst	
Sara Kidd	Transition Programme Manager	
Emma Westwood	Senior Communications Advisor	✓
Emily Gill	Project Coordinator	
In Attendance	**Role**	**For item**
Lance Elder	Director Digital Transformation	7

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No	Item
1	Welcome, introduction and apologies.
2	• Confirmed **minutes** of last meeting • **Actions** updated on Teams • **Matters arising** ○ Workshops to complete the one-pagers for OB functions are underway. CTG members will be invited to those relevant for their areas. Please keep work diaries up to date to assist with scheduling and prioritise attendance at these where possible.
3	**Correspondence** Chair's letter to ODT re VM changes
4	**OB Transition Programme** Transition Programme over 6 years presented. This is a living document that is updated as information becomes available. Includes key milestones, workshops and work projects that need to be undertaken to ensure successful commission, opening and functioning of OB. A Commissioning Manager will be recruited to oversee some of this. The dates and milestones will be sense checked with relevant teams. The leadership team and structure for OB needs to be worked through. We are initiating a redesign of Administration Services with the PSA. A Communications Strategy and Plan for staff is needed. Currently in the latter stages of contracting consultants to assist with writing a Business Case for the additional resources needed to implement the Transition Programme, which will need to be completed around the middle of the year for consideration in the 2024 budget. Programme provides an excellent overview and provides visibility for CTG on items they should be tracking. Further standing updates will be provided to CTG on a quarterly basis. **Any further feedback on the programme to SKi please.** **Planning for IB Transition** Planning for the transition to IB expected to start next year. A longer programme is required for a larger and more complex building. SKi considering whether there are aspects of transition planning that can be combined for efficiency, including in the Business Case. **Risks for Workforce Requirement** Noted that the current restructuring and recruitment freeze within Te Whatu Ora poses serious challenges to achieving the uplift in workforce. There is a need to clearly delineate roles and responsibilities and identify what is within scope for the project and what needs to be managed by other parts of the organisation. The risks should be spelled out in the Business Case. **ACTION: SC to consider how else the risk should be articulated, managed or mitigated.**

Update from Digital Team

Lance Elder provided an update on the Digital Transformation Programme:

- Funding for Stage 1 was confirmed this week
- Currently in contract negotiations with a firm who will provide the Digital Infrastructure – initially for the OB but potentially for IB as well. The contract is expected to be signed by June 2023. This includes provision of wifi, desktops, AV, and facility systems such as check in kiosks, messaging engine (paging, telephones etc.). The Digital Team can present this spec in more detail to CTG at their next update.

7

- Currently in process of standing up the Enhancing HCS Project which has to be integrated with the national interim digital work
- Digital are attending OB function workshops where possible and engaging with other stakeholders
- Lance appointed to the Whānau, Consumer and Digital Council. This is a national clinician-led group and Lance is there to assist with the strategy. The Council is in the process of establishing sub groups to look at all the systems used by clinicians and consumers. The first focus is signing off projects that were already in train. One workstream is on the EMR which will likely comprise two workstreams – one looking at using what we currently have locally to best effect and one looking at further developments of this technology nationally.

Human Centric Lighting in NDH

Starting in December 2021, PMO looked at the evidence for providing human centric (Circadian) lighting for hospital patients. Extended stays in hospital in low natural light or sustained artificial light can disrupt the sleep rhythm which has measurable poor health outcomes. Areas within NDH where human centric lighting may be beneficial were prioritised on the basis of average LOS, access to external light, and a specified location. Consultation with FiT group members was undertaken. As a result two areas – the void side of MHSOP on L06 and the general ward on L07 – were identified as likely to benefit most. Two options were considered – provision of circadian lighting on opening, or provision of infrastructure to allow this to be fitted in the future – and costings obtained as follows:

8

Full fitout of 6 bedrooms in MHSOP with anti-ligature fittings: $45,000
Full fitout of 6 single and 2 double bedrooms in IPU on L07: $61,000
Infrastructure to allow retrofitting later: $22,000

CTG is asked to consider the evidence and costings and advise whether they would support any of these options going forward as a change request to the project.

In discussion the following points were made:

- Support for providing new and progressive therapies in the new hospital
- There is a lack of good quality or comparable evidence to demonstrate whether human centric lighting is beneficial

- Potential benefit seen to be in helping to prevent delirium developing in patients at risk (rather than as a treatment for delirium) so highest benefit may be in the general IPU rather than MHSOP
- Surgical wards also have some patients with very long
- There are some predictors that are used to identify patients at risk of dementia. However the ability to move patients into different rooms based on this could be challenging.
- Note that some patients report that they dislike the light which has to be at a very high intensity to entrain circadian rhythm, however there is little or no risk to patients from light.
- Other behavioural supports can also help to prevent dementia although these are often more labour intensive and thus harder to implement in a hospital. Circadian lighting appears to be a simple and cost-effective systemic intervention.
- Delirium is a significant problem in patients in general medicine – currently seen in 25% and likely to increase with more complex elderly patients.
- Could explore other potential sources of funding for the fitout such as charitable donations or funded research
- MHSOP has been affected by recent VM changes and this could help to support management of older patients within resources available

The group supported progressing this request with a priority on provision for the general ward. A paper presenting options for levels of funding will be prepared, including canvassing alternative sources of funds for fitout.
ACTION: SB, NS and JP to develop paper for progression.

9

OB Function One-pagers
These are presented to CTG following the workshop with stakeholders including PMO and CTG members and after the workshop group has reviewed. CTG needs some visibility on who has been involved in this process. When each is finalised CTG will be asked to formally endorse it so they can be incorporated into the business case for relevant resources. It was agreed that each should be presented to CTG by the member involved.

ACTION: SKi will develop a tracker showing progress and highlighting which one-pagers need further information and / or further support from CTG to develop an aspirational

10 **vision in line with Te Pae Tata strategic objectives.**

Currently in final draft and ready for final interrogation and endorsement:
CETES
Telehealth
Facilities and Property
Collaborative Workspace

Children's Services will need a further workshop with support from CTG to assist in identifying opportunities and developing a future state Vision. **SB and HS to support this group.**

	Back of House is still in draft as further information is required and depends on operating models for other areas being developed. Patrick presented Telehealth: • There is a Telehealth Steering Group and a Telehealth Coordinator established in Southern to support delivery of remote healthcare • Currently delivered in Southern at reasonably high levels compared to other areas. • Facility is designed to facilitate telehealth delivery in clinic rooms or quiet booths, using a hybrid model or dedicated telehealth clinic model • Staff need to be well-trained and competent in delivering remote healthcare • Referrals and Digital systems should identify patients who are willing and / or suitable to receive care remotely • Liaison with Primary Care needed to ensure that patients are informed of options and to support telehealth (e.g. hardware, space, supported telehealth) • Some cohorts need additional support to be comfortable and confident with telehealth – e,g. elderly, Māori, rural and people with English as a second language. Volunteers can help in this space. **ACTION: PM to liaise with Telehealth Coordinator about plans for NDH OB.**
11	Any other business Nothing raised.

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

Wednesday 3 May 2023 11:00 – 13:00

Attendees	Role	Apology
Sheila Barnett	CTG Chair	
Patrick Manning	CTG Deputy Chair	late
Charlotte Paddon	Nursing representative	✓
Hazel Simmons	Allied Health representative	
Joel Papak	Medical representative	
Sarah Kalmakoff	Service Management representative	✓
Marie Wales	Community Health Council representative	
Jack Ruddenklau	Community Health Council representative	
Bridget Dickson	Programme Director	late
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	
Amberley Thomson	Clinical Project Manager	
Kate Burton	Clinical Project Manager	
Liam Hutton	Clinical Project Manager	late
Nikki Scott	Clinical Project Manager	
Brent Gardyne	FF&E Project Manager	late
Janina Louie	Business Analyst	late
Sara Kidd	Transition Programme Manager	
Emma Westwood	Senior Communications Advisor	
Emily Gill	Project Coordinator	
In Attendance	Role	For item

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No	Item
1	Welcome, introduction and apologies. A particular welcome to Jack Ruddenklau who joins CTG as the Community Health Council representative for Dunedin.
2	• Confirmed **minutes** of last meeting • **Actions** updated on Teams • **Matters arising** ○ HS meeting with Child Development next week to progress development of one-pager.
3	**Correspondence** Noted.
4	**Update on OB Transition Programme** Update on OB Transition Business Case process. This BC is to secure the funds to commission, operationalise and move into the OB, and needs to be submitted by October in time for Budget 2024. This would include training and supporting staff to adopt new ways of working, uplift in workforce and ongoing running of the building. Tregaskis Brown have been contracted to assist with preparing the Business Case and there was a full-day workshop this week followed by some targeted meetings. A schedule of engagement has been mapped out.
7	**Risk Register** • Day Surgery Timing – risk can be closed. Construction is proceeding as fast as possible and the opening of Filleul Street has mitigated the risk. • Value Management – given progress since the original Ministers' decision, some of the risks have been addressed. Close this risk and open new records focussed on specific concerns around areas still being to be resolved.
8	**Human Centric Lighting in NDH** Starting in December 2021, PMO looked at the evidence for providing human centric (Circadian) lighting for hospital patients. Extended stays in hospital in low natural light or sustained artificial light can disrupt the sleep rhythm which has measurable poor health outcomes. Areas within NDH where human centric lighting may be beneficial were prioritised on the basis of average LOS, access to external light, and a specified location. Consultation with FiT group members was undertaken. As a result two areas – the void side of MHSOP on L06 and the general ward on L07 – were identified as likely to benefit most. Two options were considered – provision of circadian lighting on opening, or provision of infrastructure to allow this to be fitted in the future – and costings obtained as follows:

Full fitout of 6 bedrooms in MHSOP with anti-ligature fittings: $45,000
Full fitout of 6 single and 2 double bedrooms in IPU on L07: $61,000
Infrastructure to allow retrofitting later: $22,000

CTG is asked to consider the evidence and costings and advise whether they would support any of these options going forward as a change request to the project.

In discussion the following points were made:

- Support for providing new and progressive therapies in the new hospital
- There is a lack of good quality or comparable evidence to demonstrate whether human centric lighting is beneficial
- Potential benefit seen to be in helping to prevent delirium developing in patients at risk (rather than as a treatment for delirium) so highest benefit may be in the general IPU rather than MHSOP
- Surgical wards also have some patients with very long
- There are some predictors that are used to identify patients at risk of dementia. However the ability to move patients into different rooms based on this could be challenging.
- Note that some patients report that they dislike the light which has to be at a very high intensity to entrain circadian rhythm, however there is little or no risk to patients from light.
- Other behavioural supports can also help to prevent dementia although these are often more labour intensive and thus harder to implement in a hospital. Circadian lighting appears to be a simple and cost-effective systemic intervention.
- Delirium is a significant problem in patients in general medicine – currently seen in 25% and likely to increase with more complex elderly patients.
- Could explore other potential sources of funding for the fitout such as charitable donations or funded research
- MHSOP has been affected by recent VM changes and this could help to support management of older patients within resources available

The group supported progressing this request with a priority on provision for the general ward. A paper presenting options for levels of funding will be prepared, including canvassing alternative sources of funds for fitout.
ACTION: SB, NS and JP to develop paper for progression.

9 **Submission on Digital Restructure and risks to NDH Project**

Concern has been raised about how the restructure of digital services currently underway may impact on the project. Damon Thompson has written to CTG outlining some issues, in particular:

- Roles specifically focussed on supporting the digital transformation for NDH may be disestablished so there are no personnel specifically focussed on the needs of the project.

- The vision of NDH as the first truly digital hospital in Aotearoa implies the design of an integrated national digital system and it is unclear where this would happen within the new system proposed.

Damon indicates his intention to make a submission on the restructuring proposal and suggests that CTG/PMO consider making a submission. It would also be useful to raise this with PSG and test their view.

ACTION: Chair to liaise with Patrick Ng, Lance Elder and PMO leaders to form up a CTG response.

OB Function One-pagers

These documents summarise each of the functions we need the OB to provide and the future state we are planning for. Together they form the basis of the Business Case.

Presented today:

Collaborative Workspace

The aim is to use resources effectively and facilitate communication and collaboration to support better patient care. Challenges include behaviour and noise in workspace, need for privacy and quiet space, and different physical and/or sensory abilities and needs of staff. The workspace should support staff to work well and workforce is not homogenous.

As well as the building facility we also need to understand the digital hardware that will be provided to support activity-based working. All workstations have a compact desktop and option to dock your own device with tap-on tap-off login.

Retail

10 NDH Retail Services' FDB_v0.2.docx
2021 05 - Development of a Retail Strategy for the NDH_v1.0.pdf

There will be various third-party retail opportunities across the site. In OB we expect this would be targeted at drinks and heat-and-eat type food, and the facility will provide warm-shell with services to support this. Note that food and drinks supplied onsite needs to comply with Te Whatu Ora healthy eating policies (national working group is currently underway). Also space for a small shop. B&P will manage the leasing arrangements and will go to procurement next year.

Do we need to consider the particular customers (patients and whanau) who will be using these facilities? Note also that when this building is standalone there will be no staff café available on site. Do we need to develop a Customer Experience Strategy to overarch the OB?

ACTION: SB, EG, MW and JR to connect with Matt Somerville who is managing the procurement to ensure that customer needs are understood and included in the brief.

Leadership Model for OB

This work is in its early stages but we will need to develop a new model of leadership for the OB. We will move from a model where inpatient and outpatient services are offered from one site, with staff moving between the two, to a model where ambulatory services are separated

	and provided in a dedicated facility. The OB will need to operate as a collaborative unit with its own clinical and operational leadership. Establishing the leadership team will be a crucial part of the transition, as they will have a key role in ensuring we are ready to operate effectively on opening. Te Whatu Ora will have to liaise with mana whenua over the governance model and how the Māori model of care fits with the operating model. This workstream will progress when the leadership structure for Te Whatu Ora Hospital and Specialist Services is confirmed. **Facilities and Property** With the opening of the OB there will be new facilities and equipment to maintain so we need to ensure there is adequate space and resource to do this. B&P have reviewed this and are comfortable, CTG are also happy to endorse this.
11	Any other business Discussion around how we communicate with staff and the CHC around the timeline and steps in the project. The timing of comms needs to be appropriately managed with guidance from the Programme Director. **ACTION: BD, SC, SKi and EW to develop a plan on a Comms Plan including information can be released and when. EW will interview SKi for the newsletter to introduce the transition programme to staff, and look at developing key messages and a high-level project timeline and infographic to represent this for staff comms channels.**

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

Wednesday 7 June 2023 09:00 – 11:00

Attendees	Role	Apology
Sheila Barnett	CTG Chair	
Patrick Manning	CTG Deputy Chair	✓
Charlotte Paddon	Nursing representative	
Hazel Simmons	Allied Health representative	
Joel Papak	Medical representative	✓
Sarah Kalmakoff	Service Management representative	✓
Marie Wales	Community Health Council representative	
Jack Ruddenklau	Community Health Council representative	
Bridget Dickson	Programme Director	
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	
Amberley Thomson	Clinical Project Manager	
Kate Burton	Clinical Project Manager	
Liam Hutton	Clinical Project Manager	
Nikki Scott	Clinical Project Manager	
Brent Gardyne	FF&E Project Manager	
Janina Louie	Business Analyst	
Sara Kidd	Transition Programme Manager	
Emma Westwood	Senior Communications Advisor	✓
Emily Gill	Project Coordinator	
In Attendance	**Role**	**For item**
Patrick Ng	Chief Digital Officer	4
Lance Elder	Director, Digital Transformation	4
Richard Jocelyn	IT Project Manager	4

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No	Item
1	Welcome, introduction and apologies.
2	• Confirmed **minutes** of last meeting • **Actions** updated on Teams • **Matters arising**
3	**Correspondence** Noted.
4	**Update Digital Programme** 2023-06-07_Digital_CTG-update.pdf • Contract negotiations for DIDP are nearly completed with preferred provider for OB. Contract provides option to continue to IB. Approval process still being confirmed. • Planning underway with DIDP for workshops • Governance structure in place • Clinical Digital Operational Group will be re-established as an advisory group • Draft team structure shared. Various clinical roles included. • Recent Gateway review resulted in amber rating for the Digital programme, good feedback on contracting process for DIDP, noted lack of clarity around governance of the 3 workstreams in NDH project and that these need to be closely connected. • Funding for Stage 1 now approved. Process for drawdown is being confirmed. • Planning for BC for IB is about to start, to follow a similar structure to that for OB. • Work on Foundational Solutions programme to commence in the next month. Discussion • How can we work together and support each other? E.g. getting electronic forms signed off, identifying candidates for clinical roles – CTG member attending DICG? • Given that initially there will be an integration of existing systems there will still be some siloing within the system
7	**Risk Register** Temperature check on most significant risks: • Getting the workforce needed for operationalisation • Digital readiness • Operational readiness • Adequate services in Primary and Community • Cost escalations • Chante resistance • Fragmented patient journeys

	The way that risk is being reported and escalated is changing with the institution of the new Project Steering Group. The three workstreams of design and construction; digital transformation and models of care are being split out under different responsible owners. We are still in discussion about how we will report through to PSG. Te Whatu Ora is establishing an ePMO to assist with the way risk is managed. Note significant risks • Interprofessional Learning Centre cost blowout • Commissioning and operationalisation of the OB. Business Case for funding is being prepared, but if we are not successful in securing additional funding we would need to revise planning. Implications of this could be strengthened to emphasise the risk of transitioning within BAU budget as likely we would not be able to deliver expected benefits. • A related risk is whether Te Whatu Ora can build the ability to deliver more care closer to home, in Primary and Community settings, to support appropriate delivery of hospital level care in NDH. • Comms is an ongoing risk – still working through who leads which streams and how comms are signed off. • Digital dependencies – 9(2)(a) has met with Digital Team to discuss how to report shared risks • Value Management – can be updated with recent progress • Visibility of Change Management Programme
8	**CSSD PD Sign off** Value management meant there was a need for significant redesign of CSSD. There was good engagement with users but users still have some outstanding concerns about potential for contamination of clean areas with carbon from lift shaft. The engineers are comfortable with the current plans, ventilation and pressure gradients. However users are not prepared to sign off the plans without further investigation of this issue. Users' concern has been noted on the pack and the PMO will sign off the pack to allow the project to progress, but have requested the project undertake a peer review from a specialist to provide assurance that the risk level is acceptable. Users are aware of this approach. There will also be testing regime as part of the commissioning to confirm the system is operating as expected, and there would be ongoing auditing. CTG notes the process and supports this course of action. Chair confirmed CTG would be prepared to sign off once the peer review process is complete. Future process – CPM will submit a summary to CTG in advance.
11	Any other business **Update on Iwi representative** Proposal to create a broad role with a scope as a navigator across infrastructure and capital projects. The person would sit in the PMO office with close ties to the PMO. Iwi Chairs have the proposal for consideration.

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

Wednesday 19 July 2023 11:00 – 12:50

Attendees	Role	Apology
Sheila Barnett	CTG Chair	
Patrick Manning	CTG Deputy Chair	
Charlotte Paddon	Nursing representative	
Hazel Simmons	Allied Health representative	
Joel Papak	Medical representative	
Sarah Kalmakoff	Service Management representative	
Marie Wales	Community representative	✓
Jack Ruddenklau	Community representative	
Bridget Dickson	Programme Director	
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	✓
Amberley Thomson	Clinical Project Manager	
Kate Burton	Clinical Project Manager	
Liam Hutton	Clinical Project Manager	
Nikki Scott	Clinical Project Manager	
Brent Gardyne	FF&E Project Manager	
Janina Louie	Business Analyst	
Sara Kidd	Transition Programme Manager	
Emma Westwood	Senior Communications Advisor	✓
Emily Gill	Project Coordinator	

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No	Item
1	Welcome, introduction and apologies.
2	• Confirmed **minutes** of last meeting • **Actions** updated on Teams • **Matters arising**
3	**Correspondence** Correspondence with the Theatre Leadership Team tabled and noted.
4	**Project Updates** • Pathology Feasibility report from Health Planners confirms current space allocation for Stat lab is not workable. The option preferred by the current suppliers is a separate alongside building connected to the hospital by pneumatic tube. The report will now be reviewed by independent clinical peer reviewers and following this papers will be submitted to project governance to direct the way forward. • ILC Kate and Hazel have met with PDU staff to reassure them that there we will work on options for delivering a PDU within the precinct, likely starting after the OB Transition budget bid is completed. There was concern expressed about ensuring adequate simulation spaces which were assumed to be provided within the ILC. • Update to Clinical Directors Bridget and Patrick updated the Clinical Directors meeting on current planning regarding the value management changes. • CTG memo to PSG Sheila and Patrick prepare regular memos to PSG to provide a clinical view on the project and the value management changes.
7	**General discussion around the purpose and audience of the one pagers** • Developed as part of the conversation around the change needed to achieve the planned benefits from the Outpatient Building • Can be used as a basis to further understand operating models for the building, scope of change programme and budget required to achieve this • One pagers can also be used as a standardised format for services to build on FDB as a guide for service planning • Overarching principles that articulate the aspirational vision for the OB will apply to every area and may be detailed in separate documents • Highlight barriers and opportunities specific to the service to help with gap analysis and service planning – e.g. split site, workforce uplift • Note the importance of ensuring equity, principles of te Tiriti o Waitangi, and improved patient experience and outcomes are embedded in each one

Day Procedures Unit One Pager

- Outline how individual patient experiences and outcomes will be improved and how equity will be improved – e.g. how will whānau involvement be promoted
- Note option for telehealth support for rural access
- Note improved patient privacy and wait space in future state
- Note application of tikaka principles
- Note streamlined admission process
- Some areas will need specific application of emergency planning, assumed to be part of the remit of the OB manager
- Explain how waiting lists will be reduced and the impact of doing more complex procedures - principle of right place right time

Med Phys Labs One Pager

- Patient experience can be highlighted
- Would be helpful to see what facilities we currently have and what will be available in OB
- We may need to consider diagnostic cardiology in OB the interim state – e.g. ECGs, halter monitors – activity which may not be captured in the current data set

Both these documents can be updated and do not need to be recirculated.

ACTION: Develop whole of building one pagers:
Patient Experience Strategy (MW, JR, PM, AT, EG)
Operating Model of OB inc. Emergency Responses (SB, SKa, AT, KB)

ACTION: SB will write a summary of how one pagers should be critiqued; JR to send comments directly to SB.

8	
11	Any other business

New Dunedin Hospital
Clinical Transformation Group Minutes
Wednesday 2 August 2023 11:00 – 12:50

Te Whatu Ora
Health New Zealand

Attendees	Role	Apology
Sheila Barnett	CTG Chair	
Patrick Manning	CTG Deputy Chair	
Charlotte Paddon	Nursing representative	
Hazel Simmons	Allied Health representative	✓
Joel Papak	Medical representative	
Sarah Kalmakoff	Service Management representative	
Marie Wales	Community representative	Lateness
Jack Ruddenklau	Community representative	
Bridget Dickson	Programme Director	
Simon Crack	Deputy Programme Director	
Alice Barach	Clinical Project Manager	
Amberley Thomson	Clinical Project Manager	✓
Kate Burton	Clinical Project Manager	
Liam Hutton	Clinical Project Manager	
Nikki Scott	Clinical Project Manager	
Brent Gardyne	FF&E Project Manager	
Janina Louie	Business Analyst	✓
Sara Kidd	Transition Programme Manager	
Emily Gill	Project Coordinator	
In Attendance	**Role**	**For item**
9(2)(a)		

New Dunedin Hospital
Clinical Transformation Group Minutes

Te Whatu Ora
Health New Zealand

No	Item
1	Welcome, introduction and apologies. • CTG acknowledged the work of Emma Westwood who has recently resigned, and thanked her for contribution. • CTG welcomed 9(2)(a) who is with the project for 10 weeks as a Communications Design Intern from Te Pukenga Otago Polytechnic.

2	• Confirmed **minutes** of last meeting
	• **Actions** updated:
	  ○ Development of Patient Experience one pager and OB Operating Model one pager still to be started.
	  ○ SB working on guide to critiquing one pagers for next meeting.
	• **Matters arising**
	  ○ CTG Exec and PMO held planning meeting on how to progress work with Sim Team for the Transition Programme. Briefing and workshop to be arranged.

3	**Correspondence** Correspondence with Ohad Dar on behalf of the Sim Team tabled and noted.
4	**Pathology Update** Feasibility report from Health Planners Destravis confirms current space allocation for Stat lab is not workable. The report has now be reviewed by two independent clinical peer reviewers who agreed with the conclusion. The alternative option is a separate alongside building housing all pathology functions and connected to the hospital by pneumatic tube. CTG will include this in their memo to Project leaders and highlight that Te Whatu Ora needs to develop a plan to ensure the delivery of pathology services to NDH. A comms strategy to announce the outcome is being developed.

5	**Update after meeting with mana whenua chairs** There was a meeting this morning with the chairs of local runaka to continue the conversation about how to facilitate support for the project. PMO will support the process for them to request expressions of interest and we will work from there to develop roles that allow representatives to effectively provide the feedback, oversight and connections needed on a more granular level as the project moves forward.
6	**Administration Services Codesign** First workshop held last week with a number of administrators nominated through the PSA and a range of other staff and stakeholders. This was a very positive session following an introductory webinar which outlined the strategic drivers for change and the known parameters of the Outpatient Building. Participants in the workshop had high aspirations to improve clinical administration services, to deliver patient-centred services with better patient outcomes, more equitable access to healthcare and more integrated healthcare journeys. Feedback from participants was very positive, and they noted that for the process to be successful staff need to be empowered to participate and enact change. Themes and outcomes from the workshop will be written up, reconfirmed with attendees and validated by wider consultation with administrative staff. Design sprints with other stakeholders will be arranged over the coming months.
7	**Community Update** • Jack and Marie met with the CHC chair and will attend CHC meetings to report on their work with CTG and support the communication and relationship between CTG and CHC. • Discussion around community feedback relating to barriers for patients – specific concerns should be directed to Patient Affairs. Feedback around the current patient experience can be captured in the one pager. Feedback about BAU can also be given to the CHC. • Jack and Marie can bring questions about the new hospital to CTG during the standing update. • Questions and concerns from the community can be collated to inform communication strategies and planning. This can also feed into materials for the public website. • Plan to schedule a facilitated workshop with some CHC advisors to progress the one pager.

8	**Risk Report** • Management of risk continues to evolve, as the remit of PSG expands to cover NDH dependencies including the Digital Programme and Model of Care and Workforce development. Discussions about how risks will be reported and monitored are ongoing. • Te Whatu Ora has adopted a new risk management framework which is currently being rolled out. • Currently there are separate risk registers for Outpatients, Inpatients and Digital. • New emerging risks include the provision of pathology services for NDH and the provision of a PDU for NDH given that the ILC is not progressing. Other key risks relate to the impact of value management, and the OB transition programme. • Failure to implement the Site Masterplan commissioned by SDHB is a risk and the need to refresh this plan has been known for some time. We expect this to start early 2024. • The OB Transition Programme will bring its own set of risks – to the Programme and to BAU – which will need to be managed.
9	**Medical Day Unit one pager** • This is an area where there is significant opportunity for change and offering a more patient-centred service, both in the MoC and the range of procedures offered. It will have a prime place in the budget bid. • Draw out the planned impact on improving patient outcomes, including avoiding unnecessary admissions and readmissions. Opportunities to provide semi-urgent treatments to keep people well and not requiring inpatient admission. • Opportunities to expand support for treatments delivered in primary, community and at home to provide more service delivery closer to home for patients. Part of this is connecting people to community support and services. • Need to identify evidence-backed solutions to promote equity of access for underserved communities. • Emphasise the role of MDU in supporting people with long-term chronic illness to live well, facilitated by delivering service in an ambulatory setting.

	• The current unit works to schedule appointments to value patients' time (multiple appointments coordinated) and at times convenient to the patient. This can be added to the description of the current state, and will be further developed as the service grows. • Note that there is a long lead-in to train specialist nurses and NPs to staff nurse-led units. • Needs review by IPC/Patient Safety, Community and mana whenua. Can be reviewed when the patient experience strategy has been further developed. • Note the work done consulting with other sites.
10	**Collaborative Workspace one pager** • Staff engagement and buy in to the new model is crucial, but likely to be challenging. • Transition planning includes some budget for Change Management specialists to support the change process. This could be added to the one pager. • Add some more detail about what the workspace in the new facility will comprise. • Split site in the interim stage will pose some specific challenges. • Digital systems are important enablers for the future state. • Clear definition and use of new terms needed as we introduce this model to staff. • Is it possible to start developing or trialling more of the elements of the future state in the current setup, before the move? Some elements piloted in the Fraser Building redevelopment but the physical environment here does not match what will be in the OB. Some elements of activity based working are not dependent on physical environment however. • We have a number of nominees from unions who are keen to be involved in workstreams – this group could be employed to assist us in developing some principles, etiquette for collaborative workspaces, and engagement strategies for staff.
11	Any other business