CCDM programme standards

Standard 1.0 – CCDM governance

Standard 1.0

The CCDM governance councils (organisation and ward/unit) ensure that care capacity demand management is planned, coordinated and appropriate for staff and patients.

Criteria	Guidance
1.1 The purpose, values, scope and direction of the organisations CCDM council and ward/unit local data councils is clearly identified and regularly reviewed	• *There is a combined DHB and health union partnership approach to CCDM Programme implementation.* • *There are documented and agreed terms of reference that are reviewed annually.* • *The CCDM Programme forms part of the organisations documented quality improvement strategy.* • *The councils' activities are focused on both programme implementation and ongoing monitoring of care capacity demand management.* • *Membership includes all agreed and required stakeholders.*
1.2 Permanent governance for CCDM is established for the organisation and for each ward/unit	• *There is a CCDM council for the organisation and local data councils for each ward/unit.* • *The councils are led by suitably qualified and/or experienced persons with authority, accountability and responsibility for service provision. This may include a DHB and health union co-lead.* • *The councils' meet according to their documented terms of reference.* • *All stakeholders demonstrate knowledge and understanding of the CCDM Programme.* • *There is evidence of regular meetings with documented actions and timelines.* • *There are formalised agreed CCDM workplans which are reviewed at each meeting.*
1.3 Permanent governance for CCDM is effective and operational for a. CCDM council and b. Local data councils	• *The councils' meet according to frequency stated in their documented terms of reference.* • *Minutes show 80% attendance of all listed parties.* • *Both DHB and health union partners actively lead programme implementation.* • *Councils' at all levels of the organisation report from the floor to the board against agreed CCDM workplans.* • *The organisation CCDM council regularly communicates with all stakeholders and levels of the organisation.*

Criteria	Guidance
	• *Meeting minutes include evidence of regular DHB and health union partnership review.* • *CCDM Programme implementation is progressing according to agreed timelines.*
1.4 The CCDM council and ward/unit local data councils establish, monitor and act on CCDM data for continuous quality improvement.	• *The core data set is used to evaluate the effectiveness of care capacity demand management over time.* • *The core data set is reviewed at each council meeting at all levels of the organisation.* • *The core data set results are used to inform the annual CCDM workplans.* • *There are regular reviews of variance response management including reported staffing shortfall events.* • *There is evidence of a bipartite approach to issue resolution.* • *The CCDM council takes action on issues and escalates to the Board where appropriate.*

Standard 2.0 – Validated patient acuity tool

Standard 2.0

The validated patient acuity tool underpins care capacity demand management for service delivery.

Criteria	Guidance
2.1 There is a validated patient acuity committee that is effective and operational.	• *The committee meets according to its documented terms of reference.* • *The committee has accountability, authority and responsibility for ensuring the vendor 'gold standards' are met.* • *Meeting minutes include evidence of regular review of data integrity and accuracy.* • *Minutes show 80% attendance of listed parties.* • *There is a formalised and agreed annual workplan reviewed at each meeting.* • *Escalation of issues from the committee to the CCDM council occurs when needed.*
2.2 There is dedicated coordinator FTE for managing the validated patient acuity system.	• *The coordinator is suitably qualified and knowledgeable about the validated patient acuity system use and functionality.* • *The dedicated coordinator FTE is relative to the organisation's size and sufficient to be effective in the role.* • *Regular quality audits are undertaken and reported to the committee.* • *Staff training and education is scheduled, delivered and evaluated.* • *System maintenance occurs as required to meet the business needs.* • *System upgrades are planned and coordinated effectively.*
2.3 The patient acuity system is supported and prioritised as a critical 'service delivery' IT system.	• *System upgrades are scheduled and resourced.* • *System upgrades are installed within 3 months of release from the vendor.* • *The system effectively interfaces with other DHB IT systems e.g. roster, patient management system.* • *Electronic display of patient acuity data is supported by IT expertise.*
2.4 There are processes in place to ensure the validated patient acuity system is used accurately and consistently.	• *Assessment against the vendor standards occurs annually by the committee and results are reported to the CCDM council.* • *There is 100% attainment of the vendor standards for the components of the validated acuity system in use.* • *All staff receive training at induction and updates as required.* • *Inter-rater reliability is tested at least annually for all staff using the system.* • *The HPPD by patient type/category is checked 6-12 monthly against benchmarks.*

Criteria	Guidance
	• *The worked roster is accurately recorded in the system.* • *Line managers monitor data accuracy; daily, weekly and monthly.* • *Line managers' report on patient acuity data monthly.* • *Results of audits are reported at each committee meeting.*
2.5 Business rules are clearly defined and in use to ensure consistent use of the system.	• *There are documented and agreed business rules that are reviewed annually.* • *There is evidence that the business rules are applied in practice.*
2.6 Validated patient acuity data is utilised in daily operational and annual planning activities.	• *Acuity measures are included in the core data set and reported from the floor to the Board.* • *Validated patient acuity forms the basis of the daily operations meeting and variance response management.* • *Validated patient acuity data is used for forecasting and the staffing methodology.*

Standard 3 – Core data set

Standard 3.0

The organisation uses a balanced set of CCDM measures (core data set) to evaluate the effectiveness of care capacity and demand management overtime and to make improvements.

Criteria	Guidance
3.1 The CCDM council has the authority, accountability and responsibility for setting, implementing and monitoring the core data set.	• *The DHB has an agreed core data set.* • *Policies and procedures define the measures, tolerances and describe the process for reporting.* • *The core data set is centrally collected, collated and reviewed at each council meeting.* • *The core data set is aligned to the DHB strategic goals.* • *Line managers from the floor to the Board have accountability for the measures in the core data set.* • *The core data set informs decision-making and actions taken at all levels of the organisation.*

3.2 The core data set is used to evaluate the effectiveness of care capacity demand management in the DHB and make improvements.	• The *core data set* includes *measures from all three sides of the CCDM Programme triangle:*
	  • *Quality patient care*
	  • *Quality work environment*
	  • *Best use of health resources*
	• *The core data set includes all of the CCDM Programme measures.*
	• *Measures are trended over time and show improvement.*
	• *Control charts are used to identify special cause variation.*
	• *There are appropriate resources to support the collation, analysis and presentation of the core data set.*
	• *Clinicians and managers work together to identify actions for improvement.*

3.3 The core data set is monitored, reported and actioned at ward/unit, directorate and hospital wide level.	• *Staff at all levels of the organisation can identify CCDM measures and how they are performing.* • *Measures are reported monthly from the floor to the Board.* • *CCDM measures are on the ward/unit staff meeting agenda.* • *Budget holders discuss the core data set as part of regular monthly meetings.* • *The core data set is discussed at every council meeting.* • *Minutes reflect actions and timelines.*
3.4 The organisation annually reviews the relevance, frequency and effectiveness of the core data set. Reporting on progress with quality improvement.	• *Each measure in the core data set is revised annually for currency and relevance.* • *Reviews are documented and communicated from the floor to the Board.* • *Recommendations for improvements to the core data set are actioned.*

Standard 4 - Staffing methodology

Standard 4.0

A systematic process is used to establish and budget for staffing FTE, staff mix and skill mix, to ensure the provision of timely, appropriate and safe services.

Criteria	Guidance
4.1 The organisation has staffing budget setting procedures in place that are reviewed annually by the CCDM council.	• *The FTE calculation methodology is being used as the basis of annual staff budgeting.* • *The DHB has a formal process in place to validate FTE calculations.* • *The staffing budget is set using the results of the FTE calculation based on data from the past 12 months.*
4.2 The organisation uses the CCDM staffing methodology to establish staffing numbers, staff and skill mix for each ward/unit that uses a validated patient acuity system.	• *The DHB meets the validated acuity system standards recommended by the vendor.* • *Patient acuity data is validated as accurate before proceeding with the FTE calculation.* • *The DHB uses the staffing methodology software provided by the SSHW Unit.* • *All inpatient wards/units (that use a validated patient acuity) have completed at least one work analysis (and repeated this where indicated).* • *The FTE calculation is completed annually for all inpatient wards/units that use a validated patient acuity system.* • *Recommendations from the FTE calculation and work analysis are transferred into the annual CCDM workplan.* • *Recommendations are implemented and evaluated.* • *Both DHB and health union partners are actively involved in the staffing methodology process.*
4.3 Budget holders are involved annually in setting the roster model, FTE and budget.	• *Ward/unit managers and service managers meet with management accountants to discuss and agree the staffing budget.* • *Changes to the budget are notified in advance of the budget being set.* • *Plans to mitigate staffing budget shortfalls are discussed and agreed by the CCDM council.*
4.4 The roster model provides the best match of staffing to patient demand.	• *Each ward/unit has a documented roster model, staff and skill mix requirements.* • *The roster model in use reflects results from the FTE calculation and work analysis.* • *There is minimal variance between the posted roster and roster model.* • *Care hours variance is within accepted tolerances as evidence by outcomes in the core data set.* • *The budget and roster pattern accommodates seasonal or predictable variation in patient demand.*

Criteria	Guidance
	• *FTE calculations are run for summer and winter, where appropriate.*
4.5 The organisation regularly evaluates the adequacy of staffing levels/mix and acts on the findings.	• *The line manager reviews the roster model (daily, weekly and monthly) using validated patient acuity data.* • *The impact of the roster model is monitored using the core data set, at each CCDM council meeting, at all levels of the organisation.* • *Issues raised by staff about inadequate staffing levels or mix are reviewed and actioned through a bipartite process in accordance with the MECA and Health and Safety Act (2016).* • *There is evidence of partnership meetings, workplans with agreed time lines.* • *Issues of persistent concern are escalated to the CCDM council and Board where needed.*

Standard 5 – Variance response management

Standard 5.0

The DHB uses a variance response management system to provide the right staff numbers, mix and skills at all times for effective patient care delivery.

Criteria	Guidance
5.1 There is an integrated operations centre where hospital-wide care capacity and patient demand is visible in real time 24/7.	• *The organisation has electronic display of care capacity (staff and beds) and patient demand (numbers and acuity) in real time.* • *Patient flow, bed capacity and staff resource demand is visible for both acute and elective services.* • *There is hourly, daily, weekly and monthly monitoring and review of care capacity variance and responses.*
5.2 There is a suitably qualified and/or experienced person with authority, accountability and responsibility for managing staffing and patient flow 24/7.	• *This person has management responsibility for the operations centre.* • *This person receives orientation and training to the role, including the validated patient acuity system.* • *Performance indicators for the role include accountability and reporting of care capacity demand management across the hospital.* • *This person is replaced when absent with suitably qualified and/or experienced person/s.*
5.3 The organisation consistently matches staffing resource with patient demand on a shift by shift basis.	• *A Churchill exercise has been held or determined not to be needed.* • *There are effective communication systems and working relationships to deliver coordinated management of care capacity and demand.* • *There is a functional multidisciplinary (MDT) operations meeting held at least daily.* • *The daily operations meeting follows a relevant and standardised format.* • *The daily operations meeting is attended by ward/unit managers (or delegate), duty nurse manager/s and operations managers and other members of the MDT.* • *There are appropriate and timely actions to variance in care hours in real time.* • *Validated acuity data is used to forecast current and future shifts up to 24hrs in advance.* • *A documented process is used to request and allocate staff for unplanned staffing shortfalls.* • *Line managers periodically review the required staff mix and skill mix levels are being met.*