CCDM standards assessment form

CCDM council: Canterbury District Health Board

CCDM start date: August 2019

Purpose

The Safe Staffing Healthy Workplaces team of four Programme Consultants visited Canterbury DHB to learn about the DHB's current state with CCDM Programme initiation, the set up of the CCDM workforce teams to lead the work and then to highlight early programme enablers and potential risks to implementation success. Recommendations throughout the report aim to provide timely advice relevant to your current activity.

Key CCDM implementation enablers we gleaned from the two-day visit were:

1) Your intended CCDM implementation approach reflects both craft (the ability to adapt resources in order to achieve the work within your DHB context and structure) and compliance so the intended changes are achieved and in keeping with CCDM methodology. This provides a useful platform for developing effective partnerships with health unions

2) Effective engagement with colleague DHBs to ensure CCDM learnings are incorporated into CCDM implementation, and

3) Responsive education and communication strategies.

In terms of anticipated risks, we think it is important to highlight that CCDM aims to provide visibility of whole hospital staffing requirements every shift, in shift and every day, but will not guarantee the provision of staff to meet the need. The workforce may interpret the ability /inability to provide the right staff at the right time as a measure of CCDM and TrendCare success or failure. Therefore, effective communication should consider the views of new users and new implementers of TrendCare and CCDM to ensure local and meaningful updates to the workforce.

The CCDM standards assessment is an annual process and should be completed again in one year. The overall assessment of *partially met* in your standards results is a reflection of your early engagement with the CCDM programme.

Signed by Date: / / 20____

CEO	DON/M
Health union partner (1)	Health union partner (2)
Health union partner (3)	SSHW Unit Programme Consultant

Assessment contributors

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Assessment attainment levels

Attainment level	**Definition**
CI = Continuous improvement	The DHB can in addition to demonstrating full attainment show a process of continuous improvement through evaluation and review of implementation. Actions taken are evaluated and there is evidence of improvement at a ward, service and hospital level.
FA = Fully attained	The DHB can demonstrate implementation. This includes practice evidence, reporting and visual evidence of CCDM processes and systems that meet the criterion
PA = Partially attained	The DHB can demonstrate: **1.** Evidence of process implementation (systems / procedure / guideline) without supporting structures. OR **2.** Documented processes / systems or structure is evident but unable to demonstrate this at all levels of the organisation ward – directorate – DHB where required

UN = unattained	DHB unable to demonstrate appropriate processes, systems, structures to meet the criterion

Commendations

- The availability of draft CCDM plans to provide early visibility of CCDM resource commitments to 2021.
- Early engagement from NZNO to understand resource commitments for unions.
- Prioritisation of mental health and maternity workforces for TrendCare and CCDM implementation. Note There are limited implementation learnings for these workforce groups from other DHBs.,
- Organisational resilience acquired through experience with collective community trauma (forced change and adaptation) and multiple change projects
- Change management footprint - in particular the *Releasing Time To Care* programme for clinical workforces and settings.
- An existing culture of managing on data. This indicates the core data set project is a continuous improvement project at Canterbury DHB designed to provide effective visibility of CCDM performance to all levels of the organisation.
- State of the art visual tools for effective information management of multiple metrics

Recommendations

Governance

1. Ensure permanent governance structures (the Local Data Councils) meet their intended purpose and goals and are reviewed regularly for sustainability and effective oversight of CCDM implementation then business as usual
2. Consider the Safe Staffing Committee and union delegate groups as key reference groups for managing communication content and delivery to the workforce.
3. Confirm the value-add and capacity to participate in the proposed 2020 CCDM Learning Collaboratives hosted by the SSHW Unit.
4. Work with SSHW Unit to confirm an appropriate consultancy model. Detailed workplans provide the ability to secure scheduled consultancy support in advance. Quarterly resource planning is a useful timeframe for planning with the SSHW Unit.
5. Establish regular monthly meetings between DHB, union and Safe Staffing Healthy Workplaces leads to ensure well connected engagement.
6. Resource and plan for a CCDM Partnership workshop. Ensure unions who are minority representatives in decision-making forums are part of the endorsed workshop agenda.

TrendCare

7. Implement a system and process to ensure roster changes are added to *microster* in 'real-time' prior to the implementation of TrendCare
8. Plan a meet and greet with the SSHW Patient Acuity Consultant and your CCDM team to identify roles and responsibilities and scopes of work. Agree a plan for regular four to 6 weekly on-site visits to support TrendCare coordination activity in the first year of TrendCare implementation.
9. Consider how communication about acuity-based staffing is managed as part of TrendCare roll out. What, Why, How and When is consistent with CCDM information flyers format.
10. Ensure the CCDM team are linked to the national TrendCare Coordinator group managed by the Patient Acuity Consultant (SSHW)
11. Implement TrendCare operational business rules for staff and utilise the TrendCare *Operational Guideline* (SSHW Unit) documents as soon as able following vendor run TrendCare workshops.
12. Establish out of hours TrendCare user rules – refer to *TrendCare Operational Guideline* (SSHW)
13. Identify TrendCare key performance indicators for clinical managers and their ascendant line management structure. Sector learnings confirm that effective return on investment for TrendCare starts with leadership at all layers of management.
14. Develop transition plans to acuity-based staffing into daily capacity cluster meetings, after hours shift coordination practices and integrated operations centre practices. The SSHW Programme Consultant can provide support to identify readiness criteria and transition milestones.
15. There is an opportunity for the DHB to gather pre and post CCDM data about end of shift staff satisfaction. The survey can be accessed in the TrendCare system and "turned on" for an agreed timeframe. Following CCDM being fully implemented and as part of core data set reporting the End of Shift survey could provide important pre and post CCDM implementation data to the DHB.

Core Data Set

16. Consider attendance and relevant people for the proposed Core Data Set Learning Collaborative in the first quarter of 2020. The learning collaborative is designed to include DHBs who are showing implementation success and are close to meeting the CDS standard.
17. Consult with the SSHW Unit to identify best practise DHBs for the CDS and or technical alignments such as visual tool software where project insights can be lifted for Canterbury CDS project use.

Staffing methodology

18. Establish a plan for first generation FTE implementation. There are implementation process options identified in document 4.68 via the CCDM website
19. The SSHW Unit develop a proposed education requirement specific for the finance team to ensure early knowledge of FTE Calculation metrics
20. The CCDM FTE calculations for each service cluster be reviewed to align with the availability of 12 months of TrendCare data.
21. The FTE working group develop a business-as-usual plan for annual CCDM FTE calculations consistent with effective project management methodology.

Variance Response Management

22. Undertake VRM stocktakes for each hospital to inform the variance response requirements and overall plan. This will promote standard access to systems and processes to manage safe staffing where able
23. Consider resourcing a selection of people/person to attend the CCDM Learning Collaborative for VRM proposed in the first quarter of 2020 to identify best practice VRM tools and processes.
24. Consider the long-term locality of CCDM/TrendCare staff who are a critical cog in the IOC team and the desired culture of one staff, one workforce, one organisation

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	**Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level
1.1 The purpose, values, scope and direction of the organisation's CCDM council and ward/unit local data councils is clearly identified and regularly reviewed	The CCDM Council was activated in August 2019. An agreed term of reference consistent with CCDM governance goals was confirmed in September. A CCDM director of nursing role is appointed to provide operational leadership of CCDM and TrendCare implementation.

Criteria	**Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level
	The plan for the recruitment of dedicated CCDM FTE as per the 2018 NZNO Multi Employer Contract Agreement (MECA) is underway. The dedicated team will be tasked with supporting the implementation of TrendCare and CCDM. Dedicated data analyst resource will also support implementation goals. Allied health are in the early stages of CCDM programme implementation and are working on a CCDM plan. The CCDM partnership between the DHB and unions was reported and observed to be effective with functional relationships. To ensure a well-defined way of working between unions and the DHB, it is recommended that a partnership workshop agenda be co-designed between DHB and unions. An overall draft CCDM plan is scheduled to be submitted to the CCDM Council for endorsement in October 2019. Implementation plans for each of the CCDM programme components is mapped out to ensure a whole of organisation plan including the Burwood, Ashburton and Hillmorton sites. This is a significant planning achievement for this stage of programme implementation and provides excellent visibility of the people, time and capability resources required and when. There is an opportunity to confirm consultancy support from the SSHW Unit to secure resource at the right time by the right consultants. Local data councils (LDCs) are planned for the wards following their TrendCare set up starting with the medical cluster. A key success factor of Local Data Councils is a sustainable structure that can meet the terms of reference/goals. CCDM governance representatives emphasised the need to own their own processes for CCDM implementation consistent with adaptive change principles. This means Local Data Councils could look different to what the CCDM resources describe. It should be noted that LDCs have been difficult to set up and maintain in CCDM DHBs. Their advice and feedback would be useful prior to final structural agreements. Conversations and documented feedback from clinical workforce representatives across all sites reported a desire for change. There was awareness that the right staffing at the right time is a multi-

Criteria	Evidence (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level
	factorial issue with notable concern about persistent and acute staffing shortages in identified areas. A desire for more standardised access to effective systems and processes for managing their staffing was noted from some of the smaller hospital sites, while others reported a desire for change that will enable them to do their job in fair and reasonable workplace conditions most of the time. Regular CCDM communication updates and education strategies are planned change management strategies integrated into the CCDM programme of work. One stakeholder emphasised the need to communicate that TrendCare is not the CCDM programme. On this note the assessment team advise that the Safe Staffing Council and union delegate groups be key reference audiences for CCDM communication flow.
1.2 Permanent governance for CCDM is established for the organisation and for each ward/unit	There is a plan for the establishment of local data councils (LDC) which are timed to coincide shortly after TrendCare roll out for each cluster. The DHB is encouraged to assess the purpose of this permanent structure and monthly outputs so final LDC structure and membership decisions can be made in partnership with unions.
1.3 Permanent governance for CCDM is effective and operational for a. CCDM council and b. local data councils	Planned education workshops for LDCs and the CCDM Council are scheduled to ensure governance capability. CCDM quarterly reporting will begin in October so there is effective monitoring of CCDM implementation according to the CCDM overall plan. Governance actions are clearly defined and are consistent with the governance road map.
1.4 The CCDM council and ward/unit local data councils establish, monitor and act on CCDM data for continuous quality improvement.	

Standard overall attainment

CCDM Programme **CCDM governance**

☐ NA – Not attained	☒ PA – Partially attained	☐ FA – Fully attained	☐ CI – Continuous improvement

Areas of commendation:

- The availability of draft CCDM plans to provide early visibility of resource commitments required to 2021.
- Availability of draft CCDM plans to provide early visibility of CCDM resource commitments to 2021.
- Early engagement from NZNO to understand resource commitments for unions.
- Prioritisation of mental health and maternity workforces for TrendCare and CCDM implementation.
- Engagement with implementing DHBs to ensure programme learnings are identified and reflected in implementation activity
- Organisational resilience acquired through experience with collective community trauma (forced change and adaptation) and multiple change projects
- Change management footprint - in particular the *Releasing Time To Care* programme for clinical workforces and settings.
- An existing culture of managing on data. This indicates the core data set project is a continuous improvement project at Canterbury DHB designed to provide effective visibility of CCDM performance to all levels of the organisation.
- State of the art visual tools for effective information management of multiple metrics

Governance

1. Ensure permanent governance structures meet the purpose and goals of the group and are reviewed regularly for sustainability and effective oversight of CCDM implementation and business as usual thereafter
2. Consider the Safe Staffing Committee and union delegate groups as key reference groups for managing communication content and delivery to the workforce and from the workforce.
3. Confirm the value-add and capacity to participate in the proposed 2020 CCDM Learning Collaboratives hosted by the SSHW Unit.
4. Work with SSHW Unit to confirm an appropriate consultancy model. Detailed workplans provide the ability to secure scheduled consultancy support in advance.
5. Establish regular monthly meetings between DHB, union and Safe Staffing Healthy Workplaces leads to ensure well connected engagement.
6. Resource and plan for a CCDM Partnership workshop. Ensure unions who are minority representatives in decision-making forums are part of the endorsed workshop agenda.

Standard 2.0 – Validated patient acuity tool

Standard 2.0 The validated patient acuity tool underpins care capacity demand management for service delivery.

Criteria	**Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level
2.1 There is a Validated Patient Acuity Committee that is effective and operational.	The TrendCare Steering Group is in place proposed term of reference consistent with the vendor gold standards. TrendCare Working Groups will be established in each hospital who will report to the TrendCare steering group to ensure well connected engagement between operational and governance activity. There are standard agenda items for regular meetings to ensure data monitoring, progress to plans, education deliverables, communications and reportable risks/challenges are purposefully managed.
2.2 There is dedicated coordinator FTE for managing the validated patient acuity system.	There is business ownership of the TrendCare system and a recruitment plan in progress to achieve the 1:600 FTE requirement as per the NZNO MECA. The recruitment of 6.0 FTE is planned to be in position by end of January 2020.
2.3 The patient acuity system is supported and prioritised as a critical 'service delivery' IT system.	A project team is in place to manage the TrendCare software installation and ongoing technical system maintenance. TerndCare installation requirements are in progress and managed between the vendor and DHB project team. The TrendCare Steering Group are charged with ensuring there is well planned and functional TrendCare maintenance and troubleshooting service within the IT department resource.
2.4 There are processes in place to ensure the validated patient acuity system is used accurately and consistently.	The TrendCare steering group and hospital based TrendCare working groups are tasked with regularly monitoring TrendCare user compliance and data accuracy. After hours shifts and weekends can (not always) be vulnerable to more user compliance and data accuracy challenges when TrendCare Coordinators are not on site. The *TrendCare Operational Guidelines* (SSHW) are formatted to be user centric and provide guidance on roles and responsibilities for TrendCare user for each shift and out of business hours.

Criteria	**Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level
2.5 Business Rules are clearly defined and in use to ensure consistent use of the system.	There are national TrendCare Operational Guidelines as well as Maternity and Mental Health guidelines produced by the SSHW Unit (under review). The guidelines support the DHB to meet the TrendCare requirements for CCDM and vendor gold standards. The assessment team advise that the TrendCare Operational User Guidelines be implemented as soon as able following TrendCare vendor training. Early implementation of agreed user rules for each ward, reduces the risk of corrective actions further downstream. Corrective actions can delay readiness to undertake CCDM FTE Calculations.
2.6 Validated patient acuity data is utilised in daily operational and annual planning activities.	Following the availability TrendCare data from the "live" system, the transition to acuity-based staffing requires readiness criteria and an agreed transition process. Transition activity planning for the cluster groups should be agreed by the TrendCare governance and working groups. For daily ward level management of TrendCare for staffing decisions -the document *Key performance indicators (KPIs) for TrendCare* outlines a process for acuity-based staffing for daily cluster meetings and can be accessed as document 4.15 on the CCDM website. The KPIs are designed for weekly clinical manager review but can also be adapted for daily cluster meetings when the time to transition is confirmed. For daily IOC management of TrendCare data – there is a dependency on the availability of 'live' TrendCare data on Capacity at A Glance (CaaG) screens for each ward. The end display data reports real time variance hours between hours required versus hours available. TrendCare on 'live' screens is an important indicator of hospital wide adoption of acuity-based staffing. TrendCare data display on the the CaaG is scheduled to be implemented between July 2020 and February 2021. This will become a core care capacity demand management feature of the IOC tools and staff way of working.

Standard overall attainment			
☐ NA – Not attained	☒ PA – Partially attained	☐ FA – Fully attained	☐ CI – Continuous improvement

Commendation:

Recommendations

7. Implement a system and process to ensure roster changes are added to *microster* in 'real-time' prior to the implementation of TrendCare
8. Plan a meet and greet with the SSHW Patient Acuity Consultant and your CCDM team to identify roles and responsibilities and scopes of work. Agree a plan for regular four to 6 weekly on-site visits to support TrendCare Coordinator activity in the first year of TrendCare implementation.
9. Consider how communication about acuity-based staffing is managed as part of TrendCare roll out. What, Why, How and When is consistent with CCDM information flyers.
10. Ensure the CCDM team are linked to the national TrendCare Coordinator group managed by the Patient Acuity Consultant (SSHW)
11. Implement TrendCare operational business rules for staff and utilise the TrendCare *Operational Guideline* (SSHW Unit) documents as soon as able following vendor run TrendCare workshops.
12. Establish out of hours TrendCare user rules – refer to *TrendCare Operational Guideline* (SSHW)
13. Identify business as usual TrendCare key performance indicators for clinical managers and their ascendant line management structure. Sector learnings confirm that effective return on investment for TrendCare starts with leadership at all layers of management.
14. Develop transition plans to acuity-based staffing into daily capacity cluster meetings, after hours shift coordination practices and integrated operations centre practices. The SSHW Programme Consultant and Patient Acuity Consultant can provide support to identify readiness criteria and transition milestones.
15. There is an opportunity for the DHB to gather pre and post CCDM data about end of shift staff satisfaction. The survey can be accessed in the TrendCare system and "turned on" for an agreed timeframe. Following CCDM being fully implemented and as part of core data set reporting the End of Shift survey could provide important pre and post CCDM implementation data to the DHB.

Core Data Set

16. Consider attendance and relevant people for the proposed Core Data Set Learning Collaborative in the first quarter of 2020. The learning collaborative is designed to include DHBs who are showing implementation success and are close to meeting the CDS standard.
17. Consult with the SSHW Unit to identify best practise DHBs for the CDS and or technical alignments such as visual tool software where project insights can be lifted for Canterbury CDS project use.

Staffing methodology

18. Establish a plan for first generation FTE calculations. Examples of implementation process options can be accessed in document 4.68 via the CCDM website
19. The CCDM FTE calculations for each service cluster be reviewed to align with the availability of 12 months of TrendCare data.
20. The FTE working group develop a business-as-usual plan for annual CCDM FTE calculations consistent with effective change acceptance processes and systems.

Standard 3.0 – 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 over time and to make improvements.

Criteria	**Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level
3.1 The council has the authority, accountability and responsibility for setting, implementing and monitoring the Core Data Set.	The Core Data Set (CDS) work is scheduled for activation in February 2020 and follows the CDS milestones. Initial discussions with relevant staff indicate there is capacity and excellent capability to complete the work. A key enabler is effective technical infrastructure in place to deliver the intended benefits

	Resourcing the technical requirements for visualisation of the 23 metrics in one tool was reported to be the key focus of work. Decisions on the visual tool of choice will enable the DHB to access project advice from other DHBs to avoid duplicate project effort.
3.2 The Core Data Set is used to evaluate the effectiveness of care capacity demand management in the DHB and make improvements.	A combined view of all 23 CDS metrics in one tool is planned for roll out in all hospital sites. The detailed process steps for CDS usage provides limited definition in the CDS road map. End user requirements for the CDS including display, interpretation of the data and effective reporting are in early development phase in two other DHBs. Formal Learning collaboratives hosted by the SSHW Unit are planned for delivery in the first quarter of 2020. The assessment team recommend these formal collaborations be attended for timely access to project insights and best practice examples.
3.3 The Core Data Set is monitored, reported and actioned at ward/unit, directorate and hospital wide level.	The completion of the CDS is within the 2021 timeframe. The ability for the CDS to be monitored and reported is an important CCDM governance requirement. There are opportunities to collaborate with other DHBs to support the working group progress the scheduled milestones. Common CDS queries include - Priority metrics for early reporting capability to governance councils - CDS definitions - Data grouping display - Interpretation
3.4 The organisation annually reviews the relevance, frequency and effectiveness of the Core Data Set. Reporting on progress with quality improvement.	The CDS work plan includes a schedule for this review.

Standard overall attainment			
☐ NA – Not attained	☒ PA – Partially attained	☐ FA – Fully attained	☐ CI – Continuous improvement

Areas of commendation:

- An existing culture of culture of data literacy among current users
- Exemplary visual display of multiple metrics to tell a story

Recommendations

21. Consider attendance and relevant people for the proposed CDS Learning Collaborative in the first quarter of 2020. The learning collaborative is designed to include DHBs who are showing implementation success and are close to meeting the CDS standard.
22. Consult with the SSHW Unit to identify best practise DHBs for the CDS and or technical alignments such as visual tool software where project requirements have already been developed.
23. Identify priority data reporting to the CCDM Council as part of CCDM reporting

Standard 4.0 - Staffing methodology

Standard 4.0
A systematic process is used to establish and budget for staffing FTE, staff mix and skill mix for to ensure the provision of timely, appropriate and safe services.

Note: This standard excludes Allied Health and community

Criteria	Evidence (use standards guidance) expectation is to see evidence at Executive / directorate and ward level
4.1 The organisation has staffing budget setting procedures in place that are reviewed annually by the CCDM council.	FTE budgets are based on historical resourcing with an annual review with nurse leadership (CNM, Don, Management Accountants) to identify any changes required. Typically, this considers changes to model of care, seasonal variations, planned and unplanned leave. The finance, union and HR stakeholders identified the importance of attaining a shared understanding of the FTE creation process, based on engagement at the right time with the right people. The Hours Per Patient Day (HPPD) metric was discussed and identified as an area where focussed education and support will be required. It will be important for all users of patient demand data to understand how TrendCare derived patient demand data is generated, validated and calculated. When the Hours Per Patient Day (HPPD) generation journey is known – the process of roster reengineering for annual FTE establishment and daily staffing decisions becomes well understood and effectively utilised by staff.
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 CCDM FTE working group is planned to begin in November 2020. This provides sufficient lead in time to deliver education to the key stakeholders involved in the CCDM FTE Calculation processes and the change impacts for the various roles. Conversations with finance leads suggests that early education and sense-making of the CCDM FTE process can smooth the potential for downstream issues and provides an opportunity for the finance teams to assess the calculation requirements and required change impacts for the team before engagement with other key stakeholders.

Criteria	Evidence (use standards guidance) expectation is to see evidence at Executive / directorate and ward level
4.3 Budget holders are involved annually in setting the roster model, FTE and budget.	Budget holders are involved in current annual FTE establishment and roster setting and will continue to be in the CCDM FTE creation process.
4.4 The roster model provides the best match of staffing to patient demand.	The DHB operate utilise Hours Per Patient Day to inform their rosters and minimum staffing requirements. It is important to note that the move to TrendCare acuity-based staffing methods takes time. Just-in-time education and iterative opportunities to learn are critical to success in acuity staffing. Staff need to know what happens to their data so they are aware of it's use in daily staffing decision making and annual FTE establishment - not just how to use the system.
4.5 The organisation regularly evaluates the adequacy of staffing levels/mix and acts on the findings.	

Standard overall attainment			
☐ NA – Not attained	☒ PA – Partially attained	☐ FA – Fully attained	☐ CI – Continuous improvement

Areas of commendation:

Recommendations

24. Establish a plan for first generation FTE implementation. There are implementation process options identified in document 4.68 via the CCDM website
25. The SSHW Unit develop a proposed education requirement specific for the finance team to ensure early knowledge of FTE Calculation metrics
26. The CCDM FTE calculations for each service cluster be reviewed to align with the availability of 12 months of TrendCare data.
27. The FTE working group develop a business-as-usual plan for annual CCDM FTE calculations consistent with effective project management methodology.

Standard 5.0 – 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	Evidence (use standards guidance) expectation is to see evidence at Executive / directorate/service and ward level
5.1 There is an integrated operations centre where hospital-wide care capacity and patient demand is visible in real time 24/7.	There is an integrated operations centre (IOC) at the central Christchurch site which is utilised for daily 0830 stand-up bed management meetings. Meetings are run by the director of nursing for the IOC and attended by heads of department, RMO, allied health, and support services representatives. The meetings are efficient, run to script and completed by 845 hours. There are separate service/cluster and hospital site run daily meetings which operate later in the day for more local management of staffing decisions across the 24-hour period. The tools and processes available to hospital sites for matching staff to patient demand varies across hospital sites. As TrendCare becomes business as usual for services, the timing of bed management meetings will need to ensure that all TrendCare predictions (total clinical hours for patient care) for a 24-hour period are completed by 10am. Hospital at a glance screens in the IOC display projected hospital activity including admissions, discharges by time of day, predicted occupancy via CapPlan and theatre schedules to inform decision making. As part of CCDM Variance Response Management (VRM) implementation, it is recommended that VRM stock takes for each hospital are completed to inform hospital specific plans to meet the VRM standard.
5.2 There is a suitably qualified and/or experienced person with authority, accountability and responsibility for managing staffing and patient flow 24/7.	The IOC director of nursing is a suitably qualitied role (clinical background) for managing staffing and patient flow activities. The duty nurse management team, RMO unit and bureau coordination teams are located in the IOC.
5.3 The organisation consistently matches staffing resource with patient demand on a shift by shift basis.	The IOC is set up (people, processes, tools) to effectively match staffing resource with patient demand on a shift by shift basis. Ongoing adaptations to the IOC and daily cluster meetings can be identified by the completion of the VRM stocktakes.

Criteria	Evidence (use standards guidance) expectation is to see evidence at Executive / directorate/service and ward level
	All members of the IOC who are responsible for matching staffing to patient care will require education about VRM and TrendCare to be able to implement changes to current practice. Permanent TrendCare and or CCDM staff should be assessed for the most suitable location to work from as and when the VRM work begins. Factors to consider include the accessibility of CCDM staff at the hospital sites, change requirements for IOC and current resource space available. The overall end plan promotes TrendCare/CCDM staff as a core part of the IOC team. *NOTE: Utilising re-allocation practices as a result of acting on TrendCare nursing hours variance needs to be well communicated to staff and management before implementing. Effective and timely communication reduces the risk of staff being subject to changes before adequate familiarisation and knowledge of new way of working.*

Standard overall attainment			
☐ NA – Not attained	☒ PA – Partially attained	☐ FA – Fully attained	☐ CI – Continuous improvement

Areas of commendation:

- Efficient daily bed management meetings with multi-disciplinary attendance
- State of the art visual tools to monitor bed capacity and patient flow in the IOC

Recommendations

28. Undertake hospital specific stocktakes for informing the variance response requirements and overall plan. This will promote standard access to systems and processes to manage safe staffing where able

29. Consider resourcing a selection of people/person to attend the CCDM Learning Collaborative for VRM proposed in the first quarter of 2020 to identify best practice VRM tools and processes.

30. Consider the long-term locality of TrendCare Coordinators who are a critical cog in the IOC team and the desired culture of one staff, one workforce, one organisation.