CCDM standards assessment form

CCDM council:Capital and Coast DHB CCDM start date:October 2016

# Purpose

This document provides a tool for a partnership assessment against the CCDM Programme standards. Completing the assessment will provide evidence of the degree to which the standards have been attained from; not attained (NA), partially attained (PA), and fully attained (FA) to business as usual (BAU). The degree of attainment can in turn be used to develop the CCDM work plan.

The assessment can be completed prior to engaging with the CCDM Programme, during the programme or as an assessment for completion of the programme (or anytime in between to assess progress with implementation). Completed assessments will be reviewed by the CCDM council, Safe Staffing Healthy Workplaces Unit and the SSHW Governance Group.

# Instructions

* Use the assessment tool in conjunction with the CCDM Programme standards. Complete the assessment as an individual, team or group e.g. CCDM council.
* Start at the beginning and work your way through each standard and each of the criterion.

Note: CCDM Programme terminology is used throughout the document. CCDM councils may not use the same terminology but should have an equivalent e.g. local data council may be called another name.

* For each criterion, describe how the DHB meets the criteria (and the overall standard).
* Provide examples of evidence from each level of the organisation – executive, directorate (or services) and ward/unit. Examples of evidence should include what people have said, what is written in documents (e.g. meeting minutes, TOR, action plans, policies & procedures, standard operating procedures) and what is observed in practice (i.e. processes followed).
* Collate all respondents’ evidence into one document. Respondents must include DHB and health union partners. The SSHW Unit Programme Consultant can support evidence collection and/or collation of information.
* Submit the completed document for discussion at the CCDM council.
* Note the staffing methodology standard is for in-patient only areas.

Signed by **Please see additional document for signed pages** Date: 09 /06 /2020

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| CEO | CNO |
| 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

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| **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.

OR1. Documented processes / systems or structure is evident but unable to demonstrate this at all levels of the organisation ward – directorate – DHB where required
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| UN = unattained | DHB unable to demonstrate appropriate processes, systems, structures to meet the criterion |

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| DHB areas of commendation: CCDHB is building a sustainable CCDM programme which is underpinned by a sophisticated core data set which drives data driven decision making.All aspects of the programme are being implemented to maintain integrity of the programme.Partnership in action is practised and supported throughout all aspects of the programme.During the recent Covid-19 response aspects of CCDM were integrally involved i.e. variance response management. |
| DHB areas for improvement opportunities:CCDHB ensures CCDM milestone reporting accurately reflects progress made during each quarter. National inconsistencies with reporting appear to be evident in the infographics distributed to all DHBs. This affects how the CCDM programme at CCDHB is viewed by key stakeholders. |

## Standard 1.0 – CCDM governance

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| **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. |
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| **Criteria** | **Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level  |
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| 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 strong working partnership between the DHB and the Unions continues and is evident through all decision making.
* Terms of reference are in place and are reviewed annually.
* An executive level structure change is currently in progress which will impact and potentially change CCDM Council members – CCDM and partnership education is provided to all new CCDM Council members.
* CCDM for allied health is now included in the scope of the CCDM Council. Allied health CCDM resource to enable development of a work plan is gaining momentum. Initial focus will be on the establishment of a core data set and ensuring accuracy of data collection through the Allied Health Acuity Capture (AHAC).
 |
| 1. Permanent governance for CCDM is established for the organisation and for each ward/unit
 | * CCDM governance is well established.
* Minutes and agendas with best endeavours are distributed a week before and a week after the meeting. This has been delayed at times due to workload.
* Each of the 3 components of the CCDM programme have well established operational working groups that link directly to the CCDM council. These have their own terms of reference, are well attended and are assisting the CCDM programme to progress with momentum.
* Local data councils are in place in all acuity rating areas in the general and maternity areas. Local data councils have been implemented for MHAIDS and are progressing well.
* Operational and governance functions are clear to all CCDM council and working group members.
* Governance includes maternity, allied health, MHAIDS, surgical and medicine directorates as standard ensuring a whole of organisation approach.
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| 1. Permanent governance for CCDM is effective and operational for
	1. CCDM council and
	2. local data councils
 | * Governance to date at all council meetings and working groups has been effective with good reporting and sign off of key milestones been achieved.
* Governance and partnership is being tested in relation to the staffing methodology aspect of the CCDM programme. Some delays have been experienced as further understanding of the methodology has been required along with a change in reporting requirements and further data analysis for some areas.
* CCDM council meetings always achieve quorum with consistent attendance at meetings.
* Cancellations of CCDM Council meetings were required for March and April due to the Covid response required from DHB. Council meetings have been resumed as of June 2020. CCDM work has continued throughout March and April with the CCDM programme manager. The CCDM team was redeployed to necessary Covid planning. The team has returned to CCDM work as of mid-May.
* The CCDM programme manager continued to provide monthly reports to the CCDM Council members during this time ensuring the programme in partnership continued.
* Board updates are in place for the CCDM programme. A recent update to the Board, to facilitate further understanding, in person by the CNO has been provided as the DHB progresses FTE calculations for the 2020-21 financial year.
* A communications strategy is in place for CCDM across the organisation.
* CCDM has a page in the DHB magazine with relevant updates, the bi-monthly staffing report and enables regular information giving.
* Further communication from the CCDM Council to the wards and delegates is being explored and will progress from June 2020.
 |
| 1. The CCDM council and ward/unit local data councils establish, monitor and act on CCDM data for continuous quality improvement.
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| * The core data set, established in Qlik, is enabling data driven decision making with clear visibility and transparency. It is supporting the FTE calculations and variance response management. This is shared with the unions monthly prior to the CCDM Council meetings and within the core data set meetings. The union organisers and PNA are also encouraged to review the data as required with the CCDM programme manager.
* There is an expectation that all line managers will use the Data within Qlik to report on KPI ‘s.
* Each unit has access to their departmental data to drive continuous quality improvement over time.
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| **Standard overall attainment**  |
| [ ]  NA – Not attained | [ ]  PA – Partially attained  | [x]  FA – Fully attained | [ ]  CI – Continuous improvement  |

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| Areas of commendation:Representation of whole of organisation is enabled through CCDM governance from the CCDM Council through to work streams. Allied health, maternity, MHAIDS, surgical and medical have representation throughout the CCDM programme at CCDHB.Council attendance is consistent with a good balance of representation for all.The partnership charter and framework established throughout the programme is maintained enabling a high level of respect, inclusion and decision making during all meetings.The partnership established at CCDHB is exemplary practising partnership in action throughout the programme. This again is supported by the partnership charter and framework.  |
| Areas for improvement opportunities:The CCDM Council is progressing with CCDM in allied health. A dedicated CCDM coordinator FTE is required to facilitate this. Current FTE is for nursing and midwifery.Continue with education to facilitate CCDM literacy throughout the organisation. |

## Standard 2.0 – Validated patient acuity tool

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| **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 |
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| 1. There is a Validated Patient Acuity Committee that is effective and operational.
 | * The TrendCare operational group (with a terms of reference) meets monthly. Meetings have an Agenda, are minuted and are well attended with quorum met. Actions are followed through.
 |
| 1. There is dedicated coordinator FTE for managing the validated patient acuity system.
 | * There is currently 2 FTE in position for TrendCare implementation, monitoring, education and maintenance. This consists of 1 FTE for general wards (30 wards) and 1 FTE for MHAIDS (11 units).
* The TrendCare work required has been distributed through the CCDM team to enable some equity. Further resource requirement has been raised through the CCDM Council with necessary expansion plans to implement in further areas halted at present due to resource issues.
* The CCDM support coordinator role for FTE calculation support has become a 0.5 CCDM and 0.5 TrendCare coordinator role.
* An extension of a parental leave cover contract for 6 weeks to the end of June 2020 is in place.
 |
| 1. The patient acuity system is supported and prioritised as a critical ‘service delivery’ IT system.
 | * The system has a dedicated resource within ICT which increases as upgrades are scheduled into the work programme. This resource has other systems within the DHB to support also.
* TrendCare has recently been upgraded to Category 1 requirement, meaning if there is an issue it has to be rectified within 4 hours. With the inclusion of TrendCare acuity in the new Capacity at a Glance (CaaG0 screen this was required and ensures increased support for TrendCare from ICT.
 |
| 1. There are processes in place to ensure the validated patient acuity system is used accurately and consistently.
 | * TrendCare accuracy and quality checks are undertaken monthly in line with the CCDM FTE calculation quality checks. Opportunities for improvement are followed up with the charge nurse and midwife managers and team leaders at fortnightly meetings with the TrendCare coordinators.
* Focused improvement plans are implemented for areas as required.
* Weekly TrendCare statistics are shared with all wards and at the “Week that Was” meetings which have been implemented (see VRM standard).
* IRR testing is undertaken annually and within two weeks of new staff using TrendCare to ensure that IRR testing is as close to 100% consistently.
* Monthly reports and accuracy/quality checks for each ward are shared with the charge nurse/midwife managers/team leaders, operations managers and nursing/midwifery leaders to show areas of success and improvement requirements.
 |
| 1. Business Rules are clearly defined and in use to ensure consistent use of the system.
 | * There are clearly defined TrendCare business rules in place that are reviewed annually by the TrendCare operational group. These rules are monitored for compliance. All staff have access to the TrendCare Business Rules through CapDocs. These are referred to constantly to ensure consistent use of the programme.
* Significant improvement in Trendcare use over the last year is evident. CCDHB was able to proceed with 5 FTE calculations at the end of 2018, this has now increased to 18 wards as of May 2020.
* TrendCare is able to be used to assess redeployment opportunities along with the context of the ward due to increasing accuracy.
* Gains have been made in Maternity in particular.
* MHAIDS implementation has been seamless with excellent uptake and consistent use.
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| * 1. Validated patient acuity data is utilised in daily operational and annual planning activities.
 | * TrendCare is used in daily operation meetings throughout the 24 hour period. Automated reports come through to the IOC and the Duty Nurse Managers (DNMs) containing – TrendCare acuity/variance for the current and next 3 shifts, expected discharges and admissions, utilisation and occupancy, shift notes and bureau requests, all by ward. This is currently for all general wards but will progress to MHAIDS shortly.
* TrendCare acuity will also be present in the CaaG screen and will show
	+ - Green - 0hrs to positive variance
		- Orange – minus 1 to the equivalent hours of minus 8.49%
		- Red – equivalent hours of minus 8.5% and more (shift below target)
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| **Standard overall attainment**  |
| [ ]  NA – Not attained | [ ]  PA – Partially attained  | [x]  FA – Fully attained | [ ]  CI – Continuous improvement  |

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| Areas of commendation:Ownership and accountability of TrendCare at a ward level is now appropriately placed with the charge nurse and midwife managers and team leaders.TrendCare is used in collaboration CapPlan, WebPas and the bureau allocation tool in an automated report to the IOC and duty nurse managers eight times a day displaying utilisation, variance, expected admissions and discharges and bureau requests for the current and subsequent three shifts to enable safe and appropriate redeployment.Improvements in TrendCare compliance and accuracy are evidenced by the ability to undertake six FTE calculations in early 2019 and 16 in May 2020, including MHAIDS and maternity services.TrendCare has been successfully implemented into all MHAIDS units, including ID and forensic services.Formalised education and resources for all TrendCare using staff. |
| Areas for improvement opportunities:Current TrendCare resource meets the 1 per 600 FTE requirement as recommended by the Ministry of Health. However, this does not consider head count (part time staff). At present CCDHB is unable to expand TrendCare into other areas due to inadequate resource to facilitate.TrendCare education and improvements are continuous to ensure compliance and accuracy is maintained.Rapid ward changes during the Covid response posed some issues for ensuring TrendCare accuracy due to communication issues and a rapidly progressing situation. Opportunity to improve understanding and communication of the criticality of TrendCare throughout the organisation. |

## 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. |
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| **Criteria** | **Evidence** (*use standards guidance*) expectation is to see evidence at Executive / directorate/service and ward level |
| 1. The council has the authority, accountability and responsibility for setting, implementing and monitoring the Core Data Set.
 | * The core data set, developed and implemented using Qlik, is now being used to inform data driven decisions, support FTE calculations and to drive quality improvement through the local data councils.

This is with the exception of patient experience (HQSC redeveloping patient survey), staff experience (TrendCare end of shift survey under review by national lead DONs and unions, care rationing, professional development and variance indicator scoring (as VIS has not been implemented as yet).* The core data set work stream is now beginning to review the data to support FTE calculations. This will continue monthly with the implementation of the FTE required to monitor the impact which will be reported to the CCDM Council.
* The core data set is included in the CCDM Council papers ensuring that the union partners have access to this information. The information is ‘heat mapped’ to show areas of concern. The heat mapping has been developed in partnership within the core data set work stream and enables a ‘flag’ to areas of concern requiring further investigation. Union are encouraged to review the core data set with the CCDM programme manager as required to enable transparency and partnership.
 |
| 1. The Core Data Set is used to evaluate the effectiveness of care capacity demand management in the DHB and make improvements.
 | * The data literacy programme has been implemented with positive feedback. This is open to all charge and associate charge nurse and midwife managers and team leaders.
* The impact of the CCDM programme is being assessed using the core data set and is clearly visible through the metrics.
* The core data set has enabled a high level of visibility and transparency for whole of organisation and union partners.
 |
| 1. The Core Data Set is monitored, reported and actioned at ward/unit, directorate and hospital wide level.
 | * The CCDM Council receive the core data set monthly and moving forward will receive a summary from the core data set work stream as this group reviews and monitors the data and the impact of FTE implementation.
* Local data councils use the core data set within their monthly meetings and this activity is reported to the CCDM Council through the monthly CCDM programme managers report.
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| 1. The organisation annually reviews the relevance, frequency and effectiveness of the Core Data Set. Reporting on progress with quality improvement.
 | * As per the above points.
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| **Standard overall attainment**  |
| [ ]  NA – Not attained | [ ]  PA – Partially attained  | [x]  FA – Fully attainedWithin the constraints of metrics available to implement nationally | [ ]  CI – Continuous improvement  |

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| Areas of commendation:The overall implementation of the core data and its use within the organisation underpins and enhances the implementation of the entirety of the CCDM programme. The visualisation of the core data set through Qlik enables transparency and visibility throughout the organisation.Heat mapping of the core data set to easily identify flags requiring further investigation.The core data set is used from the local data councils to the CCDM Council and beyond to enable quality improvement and evidence based decision making.The core data work stream is using the core data set to identify and understand issue within the wards and organisationally to support FTE calculations.The core data set is being used to evidence the ‘Week that Was’ meetings to measure the success of the early stages of variance response management.The CCDHB core data set and the way in which it is used is attracting much national attention within the sector and has been showcased at the Qlik conference in Sydney (August 2019), the Learning Collaborative for the CCDM programme and across NZ at various DHBs. |
| Areas for improvement opportunities:Implementation of outstanding metrics as and when nationally available. |

## Standard 4.0 - Staffing methodology

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| **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 |
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| 1. The organisation has staffing budget setting procedures in place that are reviewed annually by the CCDM council.
 | * The FTE calculation process has a clear and measured timeline with a standard operating procedure.
* The DHB has an annual budget setting cycle that currently sits outside of the CCDM staffing methodology.
 |
| 1. 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.
 | * TrendCare data is checked monthly for data accuracy against the CCDM quality checks.
* FTE calculations for 5 of the first 6 wards were repeated due to a delay in progressing the requirement. This delay was due to further understanding of the methodology and further data analysis of some areas being required.
* A margin of error document was completed for all TrendCare using wards as of January 2020 to assess the risk of all areas of undertaking FTE calculations. FTE calculations are progressing for 16 wards.
* Business cases to support FTE calculations are no longer required. FTE calculations are progressing with a multi ward report and a recruitment business case.
* Areas with a high margin of error for TrendCare accuracy are further investigated and improvement plans put in place to address areas of concern.
* No FTE calculation to date has been fully implemented. 8 wards have had approval from CCDM Council to proceed. 16 FTE calculations are planned to be completed by the end of June 2020.
* Further ‘check points’ have been implemented to ensure a smoother process for FTE calculations which has been successful.
* Roster models have been completed for all FTE calculations.
* The required Covid response has had an impact on the timeline for this work. However, time has been made up and FTE calculations for all agreed areas will be completed by the end of June 2020.
 |
| 1. Budget holders are involved annually in setting the roster model, FTE and budget.
 | * Ward managers, union organisers/PNA’s, delegates, general managers and DON/Ms are all involved in the staffing methodology process to develop the roster model for each area.
* Executive directors and the chief nursing officer have been provided with further education around FTE calculations and staffing methodology software. This will also be provided to mental health leaders as we progress with FTE calculations in this directorate later in the programme.
 |
| 1. The roster model provides the best match of staffing to patient demand.
 | * In the completed calculations the roster model has been adapted to maintain the best match for demand versus capacity. No roster model has yet been implemented as noted above.
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| 1. The organisation regularly evaluates the adequacy of staffing levels/mix and acts on the findings.
 | * Acuity based staffing is yet to be formally implemented in the organisation.
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| Standard overall attainment  |
| [ ]  NA – Not attained | [x]  PA – Partially attained  | [ ]  FA – Fully attained | [ ]  CI – Continuous improvement  |

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| Areas of commendation:The core data set is driving decision making and implementation priorities.Using the core data set within roster testing and reporting of FTE requirements to evidence the need for increase or decrease and to validate recommendations.16 wards/units in progress (including two MHAIDS units and 2 maternity units) with FTE calculations to be included in the budget for financial year 2020/21.FTE calculation process is undertaken in partnership and includes the budget holders and professional nursing and midwifery leads.A standard operating procedure underpins the FTE calculation process and is followed for each calculation.The process has been refined to enable a more efficient and effective process.The required Covid response and redeployment of the CCDM and TrendCare coordinators had an inevitable effect and delayed progress with FTE calculations. However, this has been addressed by the CCDM team and the impact mitigated. FTE calculations are on schedule as planned. |
| Areas for improvement opportunities:Continue to ensure that FTE calculations progress as per annual work plan. |

## 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. |
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| **Criteria** | Evidence (use standards guidance) expectation is to see evidence at Executive / directorate/service and ward level |
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| 1. There is an integrated operations centre where hospital-wide care capacity and patient demand is visible in real time 24/7.
 | * The DHB as an integrated operations centre (IOC) with real time CaaG screens visible 24/7 and are available on staff desktops once logged into the Citrix accounts. These require changing in line with the CCDM specifications to ensure care capacity and patient demand is visible.
* Development of the new CaaG screens is complete and testing has commenced. The new CaaG incorporates all standard 5 specification requirements including –
	+ - * Variance indicator scoring using a mobile phone app. Updates CaaG screen within 10 seconds
			* Overarching hospital indicator
			* Real time TrendCare acuity based on percentages aligning with shifts below target
			* Occupied, open and resourced, beds
			* Planned admissions and discharges for the next 48 hours
			* All wards including full MHAIDS representation for CCDHB
			* Embedded standard operating procedures for escalation
			* Current CaaG functionality has been retained
* Morning and evening meetings are held within the IOC, which are well attended by charge nurse and midwife mangers and shift coordinators, to address patient flow and staffing issues.
* The Variance Response Management Guidance (VRMG) report has been established providing automated reports 7 times a day to the IOC and DNMs. This report offers a clear view of the current state of the hospital and the prediction for the next 3 shifts – TrendCare acuity/variance for the current and next 3 shifts, expected discharges and admissions, utilisation and occupancy, shift notes and bureau requests, all by ward. This is currently for all general wards but will progress to MHAIDS shortly.
* Variance response staff task lists have been developed and implemented for all inpatient areas. This has included education, gradual roll-out and is supported by a feedback survey for redeployed and receiving staff. This has revitalised redeployment and has received positive feedback. Redeployment options are now considered for task as well as full shifts. A ‘flattening out’ of the TrendCare variances has been evident over recent months. This is challenging as utilisation increases post Covid but is being managed well through the IOC with guidance and support from the CCDM team.
* A separate ‘TrendCare at a glance’ screen is visible 24/7 giving a picture of acuity and variance.
* CapPlan is utilised daily, weekly and monthly. This has been challenging with Covid due to significant differences in occupancy forecasted being inaccurate for this time.
* A “Week that Was” (whole of organisation) meeting has been implemented enabling weekly reviews of
	+ - * TrendCare statistics – accuracy and compliance
			* Care hours variance
			* Shifts below target
			* Utilisation
			* Bureau requests – filled and unfilled
			* Safe staffing reportable events
			* Predictions and forecasts for the week ahead
			* Upcoming leave for wards

This has again been met positively and is having an impact on the way we work as a DHB. |
| 1. There is a suitably qualified and/or experienced person with authority, accountability and responsibility for managing staffing and patient flow 24/7.
 | * The DHB is staffed by a duty nurse manager (DNM) 24/7 increasing to 2 DNMs from 1330 to 2130 and an additional DNM at the Kenepuru site on a PM and night shift.
* MHAIDS has DNM cover for 20 hours per day from 0730 – 2330 with an overlap early afternoon.
* During office hours the IOC is supported by the IOC general manager, the IOC nurse manager and associate charge nurse manager.
* During office hours the MHAIDS IOC is supported by the MHAIDS IOC manager.
 |
| 1. The organisation consistently matches staffing resource with patient demand on a shift by shift basis.
 | * Morning and evening meetings address staffing resource, patient demand and acuity using the VRMG report. The organisation is considering utilisation and acuity over occupancy now.
* Acuity and staffing is further considered at an 11am staffing meeting.
* The variance response staff implementation has been very successful to assist redeployment and staff are feeling supported and safe to assist in other areas – this has resulted in increased redeployment throughout the organisation particularly during the lower utilisation during the Covid response. Options for redeployment are less as the utilisation increases again displaying the staffing deficit in some areas.
* Unit specific escalation plans have been developed and implemented for Maternity and ED and are in progress for NICU. This has enabled visibility of Maternity and ED to whole of organisation and an organisational response when capacity exceeds demand. Maternity, in particular, have found this has had a significant impact on the unit with a recognition of the move into escalation earlier which enables a targeted response to prevent further escalation.
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| **Standard overall attainment**  |
| [ ]  NA – Not attained | [x]  PA – Partially attained  | [ ]  FA – Fully attained | [ ]  CI – Continuous improvement  |

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| Areas of commendation:The ‘Week that Was’ meeting is providing clear visibility to budget holders, decision makers, professional leads and ward/unit managers of shifts below target, care hours variance, safe staffing reportable events, TrendCare accuracy and compliance, bureau requests (filled and unfilled) and projections/forecasts for the week ahead. This has led to improved decision making for daily redeployment, leave and planning for the week ahead as well as clear visibility of the impacts on the wards/units.The VRMG report is sent to DNMs and IOC decision makers 8 times in 24 hours enabling safe and effective real time decision making to support wards and units and patient safety.The implementation of the variance response staff task lists has been well received and is enabling safe and effective redeployment throughout the impatient areas with the ability for staff to feed back their experiences through an online survey.The CaaG screen development has involved utilising the existing Occupancy at a Glance platform and functionality and has grown its capacity and sophistication to include variance response management tools – variance indicator score for wards and the overall hospital, acuity and overarching hospital variance, expected admissions and discharges and open, occupied and resourced beds. This also includes embedded standard operating procedures and reporting capability to enable CCDHB to meet Ministry of Health reporting requirements. |
| Areas for improvement opportunities:Implementation of the CaaG screen to enable 24/7 visibility in all inpatient areas including variance indicator scoring and acuity.Implementation of variance indicator scoring for allied health. |