

CCDM *discovery*

Discovery Report

Capital and Coast District Health Board

Document Information

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Acknowledgements	The Safe Staffing Healthy Workplaces Unit would like to thank the staff of Capital and Coast District Health Board who made us so welcome and to everyone who gave us their time and provided the information to make this report possible. In particular Emma Williams - CCDM site Co-ordinator who's coordination efforts were appreciated by all.
Limitations of the report	The information contained in this report does not imply a 'pass' or 'fail', but rather is a snapshot of a point in time. The information represents the perspectives of staff during the discovery interview process and associated key findings from analysis of the Staff Survey results. The report is focused on the key elements of the CCDM programme i.e. but does not describe all functions of the organisation. The report does not represent an entire or fully informed picture but is intended to give an overview of the organisation as articulated by participating staff.

Document History

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Distribution Control

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Signoff

Name	Role	Date	Signature
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Executive Summary

The aim of the Discovery Report for Capital and Coast DHB is to assess readiness to undertake the Care Capacity Demand Management (CCDM) Programme. The process undertaken for the Discovery phase was using a combination of interviews as a cross section of those in the organisation and an on-line survey for all staff, run through survey monkey. A total of 76 personnel were interviewed and 1,308 responded to the on-line survey. The interviews were thematically reviewed and make up the body of the report. The survey results are available to Capital and Coast DHB in PDF (appendix i) and analysis incorporated to support interview findings.

The CCDM programme is a partnership between the DHB and health unions facilitated by the Safe Staffing Healthy Workplaces (SSHW) Unit. The parties are working towards formalising their commitment to the CCDM Programme in the form of a signed Letter of Agreement (LOA) where the Chief Executive agrees to become programme sponsor, senior leadership and union representatives become signatories to their intention to make the CCDM Programme a priority initiative. Following this agreement the SSHW Unit will support CCDHB and their union partners in a phased approach to implement the CCDM Programme along with its associated tools and processes.

A shortened approach to the Discovery Phase was agreed by the CCDM Council due to the size of the DHB. The Discovery was therefore at a high level to gain an understanding the organisations readiness to implement CCDM rather than at a detailed level. This was agreed to ensure the whole of organisation aspects were identified, but to avoid raising expectations of the programme delivering rapid results to areas which are likely to be scheduled later in the overall programme plan.

Overall the SSHW Unit considers the findings from Discovery phase for Capital and Coast DHB in many areas are similar with other DHBs who have previously undertaken the Discovery process as part of the CCDM Programme implementation.

It is the assessment of the SSHW Unit, from the foundational information presented in this report, that Capital and Coast DHB is ready to implement the activity of the CCDM Programme. The programme will provide an opportunity for the parties to grow and sustain their partnerships and relationships, while attending also to the design and implementation of effective change processes and systems. With a common purpose and commitment to Best use of Health Resources, Quality Patient Care and Quality Work Environment.

Summary findings

Positives

- There is recognition from all levels of the organisation that CCDHB has dedicated staff who are committed to providing high quality care to patients.
- CCDHB is well placed to commence the implementation of the CCDM Programme.
- The SSHW Unit is confident that the DHB has the leadership, relationships and base systems in place from which to progress this agenda.
- The DHB and Health Union partnership is recognised as being the foundation for the successful implementation of the CCDM programme and that ongoing open engagement and collaboration is required to make the partnership success real.

Challenges

- CCDHB does have a challenging set of demands, capacity, cost and funding pressures.
- To maintain a high level of service the majority of staff surveyed are putting in a high work effort and at times this is viewed as being under recognised by the organisation.

- Evidence of silos existing within the DHB and there would definitely be benefits to coordinating and joining the different pieces. Consistent communication messages are seen as key.

Report Recommendations

Governance

1. Set up clear communication strategy for the CCDM programme with key messaging for each activity undertaken including:
 - a. Show case success
 - b. Incorporate CCDM into current meeting agendas
2. Review the list of current projects alongside the CCDM programme components and devise a strategy to minimise duplication
 - a. Undertake mapping process with the projects and components at council level
3. Partnership workshop
 - a. Understand the role of both the DHB and unions in the CCDM programme
 - b. External facilitation for all CCDM Council members
4. Have union representation and participation on all CCDM project groups

Validated Patient Acuity

1. Set the practice and use of TrendCare to meet CCDM Programme Standard 2.0
2. Review the current data and develop an improvement plan
3. SSHW Unit recommend a TrendCare Discovery in the later quarter of the year

Core Data Set

1. Review the current involvement with the DHBs reporting system and processes at a direct care level and utilise the CCDM CDS structures and processes, to increase front line staff knowledge and capability
2. Review reporting to match the minimum requirements of CCDM Core Data Set
3. Set up Local Data Councils within clinical areas or services as part of the programme roll out. This may be able to be set up within current quality meetings in clinical area or service level

Staffing Methodology

1. Enable and support TrendCare data to be at the required quality level in order to participate in the Work Analysis and FTE calculation process with the programme

Variance Response Management

1. Consider undertaking a Churchill exercise to add value to what is not visible
2. Set up bed capacity meeting to include reviewing what happened yesterday and planning for the next 3 shifts (24 hours) in advance
3. Review the current system to ensure forecasting monitoring reviewing and reporting is included e.g. patient flow, bed capacity, staffing resource demand, variance on a weekly and monthly bases
4. Have the OaaG boards highly visible on screens in each ward
5. Review current display boards to include elective services (theatre)
6. Set up the process of reallocation of staff, including Smart 5's

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Background

The Care Capacity Demand Management (CCDM) Programme, has been developed by the Safe Staffing Healthy Workplaces (SSHW) Unit in partnership with District Health Boards (DHBs), the New Zealand Nurses Organisation (NZNO) and Public Service Association (PSA). The SSHW Unit was established in 2007 and tasked to develop a programme to implement the recommendations of the Safe Staffing Healthy Workplaces Committee of Inquiry (COI) Report, 2006.

The CCDM programme has three main components, and the DHB is required to have established three foundations for the components to be effective.

Foundations

- **CCDM Governance:** The governance councils (organisation and ward/unit) ensure that CCDM is planned, coordinated and appropriate for staff and patients. This is not just for the programme implementation, but on going management of care capacity demand management. The CCDM council may develop into another governance group following the completion of the required programme of activity.
- **Validated patient acuity tool:** for CCDHB the validated acuity system is TrendCare.
- **Partnership:** a healthy active working partnership between the DHB, NZNO and other health unions is key to the successful implementation of the CCDM programme.

Programme Components

- **Core Data Set (CDS):** The organisation uses a balanced set of measures to evaluate the effectiveness of care capacity demand management, over time and to make improvements. The data is meaningful from the floor to the board, and ensures real time feedback and monitoring.
- **Staffing Methodology (SM):** a systematic evidenced based 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. This component utilises the validated patient acuity data as the basis of the methodology.
- **Variance Response Management (VRM):** 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. This includes strategies to manage short and midterm variance. With the ability to monitor and review the effectiveness of the above included in the Core Data Set.

CCDM Programme Standards

The CCDM Programme Standards were developed in August 2016. The development of the standards allows the DHBs to meet the required components in flexible ways. The programme standards are:

- **Standard 1** - The CCDM governance councils (organisation and ward/unit) ensure that care capacity demand management is planned, coordinated and appropriate for staff and patients.
- **Standard 2** - The validated patient acuity tool underpins care capacity demand management for service delivery.

- **Standard 3** - 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.
- **Standard 4** – 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.
- **Standard 5** – The DHB uses a Variance Response Management system to provide the right numbers, mix and skills at all times for effective patient care delivery.

Each of the standards have a number of criteria to support the DHB achieve and sustain CCDM. The standards also assist the DHB to maintain the focus within the planned activity of work for the year.

Introduction

Capital and Coast District Health Board (CCDHB) together with the New Zealand Nurses Organisation (NZNO), the Public Service Association (PSA) and Midwifery Employee Representation and Advisory Service (MERAS) have entered into a collaborative initiative to introduce a systematic approach to matching patient/client demand with the appropriate resources. This initiative, the Care Capacity Demand Management (CCDM) Programme, has been developed by the Safe Staffing Healthy Workplaces (SSHW) Unit in collaboration with District Health Boards (DHBs) and participating health unions. CCDHB is the 14th DHB to commence the implementation of CCDM.

The parties are working towards formalising their commitment to the CCDM Programme in the form of a signed Letter of Agreement (LOA) where the Chief Executive agrees to become programme sponsor and senior leadership and union representatives become signatories to their intention to make the CCDM Programme a priority initiative.

Following this agreement the SSHW Unit will support CCDHB and their union partners in a phased approach to implement the CCDM Programme along with its associated tools and processes.

The purpose of the Discovery phase is to:

1. Assess the DHBs readiness to implement CCDM by interviewing a selection of staff from all levels of the organisation. The interview questions focused on the CCDM Standards criteria:
 - Governance & Health union partnership
 - Patient acuity system – TrendCare
 - Data collection and management (Core Data Set)
 - Staffing methodology
 - Variance response management
2. Enable the CCDHB CCDM Council to identify its current baseline on its existing strengths, challenges and opportunities in managing care capacity against demand. This information will assist the DHB to prioritize activity for the CCDM Programme implementation.
3. Provide opportunity for SSHW Unit staff to meet DHB staff and Health Union representatives and gain further knowledge and understanding of the organisations systems and processes.
4. Identify how CCDM will fit with existing organisational projects.

A shortened approach to the Discovery Phase was agreed by the CCDM Council due to the size of the DHB. The Discovery was therefore at a high level to gain an understanding the organisations readiness to implement CCDM rather than at a detailed level. This was agreed to ensure the whole of organisation aspects were identified, but to avoid raising expectations of the programme delivering rapid results to areas which are likely to be scheduled later in the overall programme plan.

The Discovery Phase took place during April and May 2017.

Capital and Coast context

Capital and Coast is the tertiary hospital for the central region and sixth largest of 20 district health boards. The DHB provides regional services for, blood and cancer, renal medicine and transplants, neonatal, neurosurgery, bariatric, cardiothoracic surgery, cardiology, vascular surgery, intensive care/trauma, genetics, obstetrics, endocrinology, urology and mental health and addictions – adolescent and forensic service.

The DHB services a population of approximately 500,000 people, has three campus sites:

- Wellington regional hospital
- Kenepuru – provides a limited number of secondary services for north of Wellington, including Porirua and Kapiti. These services include Elective Surgery for both adults and children, Outpatient services, Dental, Allied Health, Medical day ward, and four inpatient wards (Health of Older People, Rehabilitation and General Surgery). Renal dialysis, Maternity services and forensic and adolescent Mental Health are also provided on site.
- Kapiti health centre

Capital and Coast employ approximately 5,796 staff and is the largest employer in the region. The three district health services are; Mental health, addictions and intellectual disability, Radiology and Information Technology. The services are integrated with Wairarapa, Hutt Valley and Capital and Coast DHBs.

In 2016 Capital and Coast DHB engaged the services of Price Waterhouse Cooper to complete an independent external review of opportunities to improve performance, to allow the delivery of the 2016/17 Annual Plan. As part of this it was recognised that CCDHB faces a challenging set of demands, cost and funding pressures. In the Final report on independent service review – discovery phase it was noted that CCDHB have been in deficit for a number of years however despite this they have also been a solid performer in terms of its financial performance, as measured by the improvements to its deficit performance over recent years. However, it was also stated that, financial sustainability is once again an issue for the DHB and that CCDHB management has developed a sustainability plan to address the underlying issues behind the worsening position. (Capital and Coast, 2016)

Within this context the positive finding of the report included:

- Second overall performer of DHBs
- One of the lowest length of stays in Australasia (As reported by Health Round Table)
- One of the lowest readmission rates in New Zealand
- Effective and efficient non-mental health provider of hospital services

The DHB has also engaged the services of Francis Health. The consultancy firm is working with the DHB to improve acute flow across the organisation with a focus on ED, General medicine, discharge in the first instance and then extending into health of older people and surgery.

Discovery Process Method

Data collection

The Discovery process was undertaken in three parts

1. Interviews of staff in executive and management positions across the spectrum of the DHB, and staff who have responsibility to deliver direct patient care. Union representation from NZNO and PSA were interviewed either as direct care staff or as organisation representation. MERAS was not available to be interviewed and declined phone interview.
2. SSHW Workforce On-line survey, through survey monkey, available to all staff.
3. A summary of other existing organisational projects.

Interviews were conducted in the DHB over a 5 day period, by consultants from the SSHW Unit. 76 staff in total were interviewed either as individuals or in a group. The participants were selected by the positions they held in the organisation, and representative of others.

Participation interview break down:

- 15 Executive staff - those that hold the executive positions and title as either Executive Director or General Manager.
- 20 Management staff - those with direct reports and lines of responsibility to the executive team and managers who support the direct care staff.
- 34 Direct care- clinical staff who care for patients of whom 16 were NZNO and PSA delegates.
- 7 Other which included 4 union organisers and one Professional Nursing Advisor for NZNO.

The interview questions were formulated on the CCDM Programme Standards, to find strengths and identify gaps that will assist the DHB with the CCDM programme implementation. Identification of the gaps will help the CCDM council develop the first year plan of programme implementation activity. The answers to the questions were thematically analysed for recurrent themes across all those interviewed.

The CCDM Council supported running the SSHW Unit Workforce 'high level' on-line survey with the questions focusing on:

- You and your background,
- Your perceptions of your work conditions and environment
- How you feel about your job

The online survey ran for 19 days, was accessed through the DHB intranet and was for all staff. The exception to this was hospitality staff who were unable to gain access. The survey commenced on April 24 and concluded on May 12.

The final return rate was 1,308 which is approximately 22.5% of staff. Of the responses 48% were from clinical staff. A full break down of the survey can be seen in Appendix (i). This is a great response and the SSHW Unit would like to acknowledge Emma Williams, CCDM Coordinator who did all she could to support the staff to participate.

Note: The DHB had run a full Staff Engagement Survey, two weeks prior and so there was a risk of a low response rate. However 22.5% is a good result compared to other DHBs.

The summary of other existing organisational projects are documented in Appendix (ii).

Findings

1. CCDM Governance

Organisational governance provides the framework for the leadership, the culture systems and processes. This includes corporate strategy, related strategic goals, job roles, business processes, core values, and communications practices. It is widely accepted that organisational culture does affect organisational performance. For real sustained organisational change to occur, change has to happen at the cultural level and will therefore require sustained attention to relationships, communication and working effectively in partnership with the participating health unions.

The purpose of the CCDM Governance is to ensure that care capacity demand management is planned, coordinated and appropriate for staff and patients. At its foundation CCDM governance is an active partnership between the DHB and health unions. This is about working cooperatively and jointly to address areas of mutual interest. The Governance is established through the CCDM Council and Local (or ward-based) Data Councils. The governance structure is important as it enables staff participation at all levels of the organisation, promotes joint accountability and responsibility for making implementing and evaluating decisions.

Executive

The executive staff interviewed for this report were all closely aligned in regards to the DHBs current key priorities: 1. Value for money, 2. Shorter safer health journey, 3. Growing our people. Within the three key strategic priorities there is specific focus on managing acute flow, meeting elective targets and the on going demand cost and funding pressures.

When asked what the DHB does well the overarching reply was that we have dedicated staff committed to providing high quality patient care in a challenging financial climate.

What do we do well?

Dedicated Staff committed to providing high quality patient care

They saw the success of the CCDM programme as supporting the DHB to meet its priorities, and in particular to support matching the capacity to demand more effectively. This is seen as one of the key ways of supporting recruitment and retention of staff and effective organisation performance.

It was seen as important by both the executive staff and Health Union staff that the partnership is real and adds value for all stakeholders and not just a token gesture. The relationship with NZNO was seen to have strengthened considerably in the last 18 months, and the need to continue being open and transparent with all union parties was recognised. However the union partnership is better with some health unions than others and could be tenuous at times. It was recognised that on-going engagement was important.

When asked about the accountability culture in the organisation, it was described as an area for improvement. At times accountability is weakened with the different lines of reporting (professional & operational) and knowing the 'named' person who is accountable for outcomes. "The DHB operates like a puzzle – each person working on parts and it needs coordination to make the pieces into a picture"

The majority of Executive team were able to identify the Integrated Operation Centre (IOC) as the place for meeting at 9.15am for the bed balancing meeting and listed another seven meetings which focused on bed management and/or patient through put.

Change culture was identified as a constant within the DHB and an area of improvement, along with the communication processes within the DHB. Communication was brought up as something that can always be improved and it was acknowledge that it is challenging to get right throughout the organisation. A suggestion for communication was at every meeting there should be a key take back message.

Management

The priorities identified by this group were more detailed, ten were identified, and top four were:

1. Acute flow, 2. Patient pathways, 3. Safe staffing and 4. Shorter safer stays. Within this group accountability lines was not always easy to identify and this was seen to be due to the structure of having - professional and operational reporting lines. It takes time to make decisions however the ownership was at the directorate level. That being said there was also a strong sense that the directorates strong ownership of everything that happened in their service, has contributed to silo thinking across the organisation.

The management staff saw that the success of the programme would be: appropriate staff rostering to meet the patient care demands, understanding more the required staff and skill mix, less acuity variance by shift and clear governance structure for care capacity demand management.

The union partnership with NZNO was considered to be good, with an open door policy, and increasing collaboration and support. Project groups tend not to have union representation, and more delegates from the clinical floor participation is seen as being beneficial. This way of working would also align with the new High Performance High Engagement sector initiative.

Change management was seen as requiring improved communication processes as projects were constant. There seems to be little time to embed and evaluate the effectiveness. The current different modes of communication are not completely effective; and face to face discussion was considered the best approach. Messaging also needs to be clear and standardised.

Direct Care Staff

The DHB priorities were generalised for this group with some specifics identified as: 1. Financial saving, 2. Shorter safer health journey, 3. ED target, 4. Ministry of health targets, 5. Quality Improvement Projects, 6. Managing acute flow and 7. Elective targets. Accountability was described as a 'no blame culture', charge nurses were held to account though there was a need to improve the reporting processes.

Success of the CCDM programme will be when; Patient demand is meet by the right staff who have the skills required to give quality patient care and staff are satisfied with the patient care they are able to deliver. Provision of accurate

TrendCare data from the areas.

Health Union involvement in wards is thinly stretched, NZNO have a monthly meeting but often the delegate cannot attend as no cover available due to being short staffed. NZNO provide good communication to the clinical areas. Bi-annual meeting is usually well attended by delegates.

Bed flow meetings were identified as the bed balancing meeting, ED breech and winter planning are attended by charge managers or those in acting charge roles, delegates do not currently attend. Bed balancing meeting however was seen as offering limited solutions on the day, to manage identified shortages.

What do we do well?

Good care. Good clinicians. Clinical staff care as this is their own backyard.

Direct care staff saw change management as a top down approach - “told to change and there is constant change and nothing appears to be finished or seen through before the next change occurs. “Everything seems to take too long”. Innovative ideas are supported, but the volume of change is not resourced appropriately to ensure it works and is embedded. Executive/Management is not seen at clinical level meetings and the charge nurse delivers messages about change. The Delegates are not involved in change unless they are active in the area, and not all areas have health union delegates.

Communication is difficult to manage: posters, emails and daily dose told interviewers “don’t work well for direct care staff”. Need face to face discussion at the ward level, with the same message, not mixed messaging.

In the Online Survey staff generally described good working relationships within teams, with 77% of survey respondents reporting this happens always or often. Bullying is identified as a persistent problem in healthcare organisation (Carter et al, 2013) however over half of the survey respondents indicated it seldom or never happened within the team. A further third of respondents indicating they were aware of it happening in the team sometimes.

Governance Summary

The key priorities for the DHB were seen as similar within the current layers of organisational structure. Value for money /financial savings and shorter safer health journeys/patient flow being key considerations. The CCDM programme will support both these priorities as the objectives are to support and balance; Quality patient care, Quality work environment for staff and Best use of health resources. Effective patient flow is also supported as the key to this and considered to be staff optimisation.

The DHB and Health Union partnership continues to improve, however on going engagement, collaboration and transparency need to be actively worked on particularly in regards to involving the direct care staff.

The CCDM Council structure will support this as it is established under a partnership model and each ward/service will establish its own Local Data Council (LDC). The LDCs will assess their ability to match demand and capacity at their ward/service level both ‘in the moment’ and over time.

Communication came though as a point of challenge at CCDHB and will be key to success of the CCDM programme. Face to face was described as the best way to communicate, however this can be time consuming with limited time slots available. Identifying leaders within groups to be the key message people can support this and thinking how CCDM can be added to current meeting agendas.

Internal communication mechanisms are critical to staff feeling valued in their work. In the online survey, 50% of respondents indicated the message they hear from the DHB is that patient safety and quality care must be balanced with achieving volumes, targets and budgets. With 30% indicating achieving volumes, targets and budgets is more important than patient safety and quality care.

When asked “Which statement BEST describes the message I believe I hear from this organisation about staff?” 55% of respondents indicated achieving volumes, targets and budgets is more important than staff wellbeing and the quality of the work environment. Further 34% saying staff wellbeing and the quality of the work environment must be balanced with achieving volumes, targets and budgets.

Communication plays a key role in the success of any workplace programme and helps to achieve the desired outcomes for the staff and the organisation alike. Bottom-up communication (from staff to management) provides feedback regarding the information needs of staff, values, perceptions and opinions. This helps the selection and tailoring of programme communications to meet the specific needs of staff and programme stakeholders. Top-down communication (from management to staff) can increase utilisation of workplace programmes by clearly explaining why the programme is being implemented and how it will support them in their endeavors. How and when they can access the Programme activity and tools, and demonstrate that management supports and values the programme.

Ensuring lines of accountability are clear with direct care staff and executive leaders of the programme with key reporting stop points along the way is important. Processes are set up within the component methodology to support this which will support the puzzle to become a full picture.

Change/projects are seen as constant in the organisation and this was evidenced by the list of approximately 37 projects currently underway (see Appendix ii). At least 10 of these projects have a direct correlation to the CCDM programme components. It is recommended that the projects list is reviewed for intersection of the work with CCDM to avoid duplication or misalignment.

2. Validated Patient Acuity Tool – TrendCare (TC)

The validated patient acuity tool underpins care capacity demand management for service delivery. New Zealand has adopted validated patient acuity data, as the basis for determining safe staffing and accurate patient acuity data underpins all of the components of the CCDM programme.

Executive

TrendCare (TC) version 3.5.1 upgrade was released in the second week of April. There is a small TC group that meet, however there are no visible decisions that are communicated to the executive team. There is an appointed 1.0 FTE TC Coordinator role however the person is currently seconded until July 2017. The purpose of this role is to improve the data and revitalise the use of the system. The data accuracy is felt to be improving however there are currently no TC business rules in place that the executive are aware of. TC data is being used daily at the 9.15am bed balancing meeting and used to reallocate staff to other areas.

Management

TrendCare (TC) is part of the IOC steering group of which, Associate Director Nursing (medical) holds the chair position. The group meet fortnightly and are a group of seven.

The TC Coordinator position is currently a secondment until July 2017. The role of the person is to focus on improving the data, support the upgrade of v3.5.1, support Inter-Rater Reliability (IRR) testing and reinvigorate the system within the DHB. The accuracy of the data is seen to be not there yet and categorisation and actualisation is being monitored, with increasing compliance being noted.

Within the group interviewed, one person knew that there were national maternity user guidelines for TrendCare, and was attempting to comply with the guide. There was limited knowledge regarding business rules and the application to practice was not widely known and not in current use across the organisation.

Doctors and Allied Health know about TrendCare but do not use the system themselves.

Operationally TrendCare data is being used at the 9.15am bed balancing meeting. Medical staff in Medicine looked at the discharge reasons for a discharge project but felt it was not accurately completed.

Direct Care Staff

Charge managers understand that TrendCare is an Associate Director of Nursing project. Not aware of union membership on the TrendCare group.

Information is shared in the IOC bed balancing meeting of categorisation and actualisation completion. The TrendCare Coordinator is not visible in all clinical areas. Staff hear the need to improve the categorisation and actualisation data and patients need to be predicted before 9.15am. Data not accurate all the time and the sense is that “nothing changes because of it”. There is no TrendCare reporting from wards and it is not discussed in manager meetings.

TrendCare

The data is not accurate- Used to move staff. Not used when we need staff

This group had not heard of, or aware of business rules for the clinical areas including the availability of national TrendCare user guides.

Data is used to deploy staff; however it is felt that nothing is done when it shows that additional staffing is required. It was also felt that completing TrendCare seems to be more important at times than anything else during the shift. Staff said that they do not see or hear about any TrendCare information on the wards.

The bed balancing meeting looks at the current shift and the next shift, but does not review what happened yesterday or plan ahead for tomorrow.

Validated Patient Acuity Tool Summary

The current activity of TrendCare is not meeting the DHB needs either within management positions or direct care staff. There appears to be not enough trust in the data, yet the data is being used to reallocate staff at bed capacity meetings. Work is underway to improve this, and the upgrade to 3.5.1 will support those clinical areas that are a current focus in the DHB.

Meeting the CCDM programme Validated Patient Acuity Standard will ensure the DHB deliver the expected benefits from the system, for the organisation:

- Set up a TrendCare committee that is effective and operational
- Appoint a dedicated TrendCare coordinator
- Ensure that IT know it is a critical service delivery system and support upgrades quickly and efficiently
- Processes are put in place to ensure the system is used accurately and consistently across the organisation
- Business rules are clearly defined to ensure consistent use of the system
- TrendCare data is utilised in daily operations and annual planning activity

3. Core Data Set

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.

Executive

In the recent Health and Disability Sector Standards Certification audit the DHB received a CI – Continuous Improvement for Criterion 1.2.3.6

Quality improvement data are collected, analyzed, and evaluated and the results communicated to service providers and, where appropriate, consumers. Quality improvement data collection, analysis and utilization, including the end to end clinical audit processes, reflects excellence. This is evidenced in a number of systems including the clinical audit schedule and the increasing use of the Health Round Table and Global Trigger Tools information. The examples demonstrate a commitment at all levels of the organization to using the findings from a wide range of data and audit activity to inform planning and decision making that guide continuous quality improvement. This is beyond the fully attained requirements of the standard.

The DHB collects over 400 different metric and report various key indicators to the DHB Board, Ministry of Health and Health Quality Safety Commission. All executive members have an active role



in reviewing how the DHB is performing. The meetings that look at care capacity demand collectively is the Bed balancing meeting, ED breach, ICU daily meeting and winter planning meeting. The DHB has an excellent Quality team along with a new Strategy, Innovation and Performance team to look at hospital measurements. Reporting is able to be looked at in detail in three levels:

Data is easy to get but difficult to interpret, ‘data rich information poor’. Information can be found on the DHB intranet through the by Decision Support Unit (DSU) portal and is well supported by DSU.

There is a balanced scorecard for the DHB Board, which is a broad overview of the DHB performance. Associate Directors of Nursing look at the wards in a more micro detail, in particular the human resource measures.

Management

Getting data is ‘clunky’, although there is a suite of reports available from DSU, and these can be found on the DSU portal. Each area has different measures: human resource information, sick and overtime etc., a number of quality indicators’ information – audits etc. Staff information and police vetting, “it is a long list”.

Each area has support in DSU; however there is not a standard format for delivering information consistently. The interfaces between IT systems are not seen to be that good however the DHB is looking at a data visualisation tool to help with this. The data that is available is used to help make informed decisions, in order to make improvements.

Both the Quality Unit and Strategy, Innovation and Performance teams use data to make improvements.

DHB is data rich information poor.

Data in the DHB: as gone from a “House with a fire to a home with electricity”

Direct Care Staff

Charge nurses noted there are a number of human resource and quality indicators that are reported upon monthly – over 24 were identified to the interviewers.

This group were not aware of any functioning group that looks at care capacity demand management (patient flow, beds or staffing) apart from the bed balancing. Direct care staff noted that they were not part of any group that looked at the wards data and were not aware of seeing how other wards were doing on the day.

The hospital as above noted reports on a number of measures (24 – 400). Data from DSU is given to charge nurses and some identified that they did not receive adequate training in the interpretation of the data. Data is mainly presented in graph form. DSU is able to provide information for their own clinical area easily. Monthly reporting against prescribed measures is normal activity for the charge nurses.

Staff reported that often ward meetings were cancelled at short notice. Information was not freely shared at this level, and delegates felt that there was often no feedback to the clinical staff in regards to reported event outcomes. Data was not seen as a driver for change in wards unless it was being used from TrendCare, for staff deployment. This group thought that seeing reports on some ward information would be beneficial. Others in the area would be receptive if they understood what the data meant.

Core Data Set Summary

The DHB collects a variety of measures for a number of reasons and regulatory bodies. There was discussion that a number of different tools are being looked at to help the DHB display data more easily and have more visual impact.

Reporting was similar but not standardised across the directorates and the term ‘Balanced Scorecard’ was used but not yet implemented.

The CCDM programme has a set of balanced measures that takes the guess work out of determining how to measure a quality work environment, quality patient care and better use of health resources:

- Quality patient care – 9 measures
- Best use of health resources – 6 measures
- Quality work environment – 8 measures

These above measures are the same or similar to what is currently being reported on from a ward level. The core data set can be shown at service and directorate and finally the CCDM council level, to evaluate the effectiveness of the care capacity and demand management overtime and to make improvements.

Direct care staff noted that information is not easy to access nor shared with this group and that this could strengthen the understanding of the key priorities of the organisation.

Implementation of Local Data Councils connects DHB strategy with activity on the floor and engages staff in reviewing their own performance. LDCs also increase data capability through the development of technical and social processes and connect people up, down and across the Hospital to focus on improving performance.

4. Staffing Methodology

CCDM provides an evidenced based method for setting the staffing model based on patient acuity.

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.

Executive

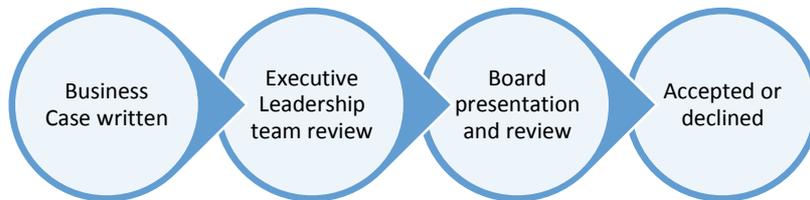
The staffing methodology that has historically been used was a ‘flat Nursing Hours per Patient Day’. However it has been agreed that now the DHB has TrendCare this system will be stopped.

Each directorate has their own budget and is responsible for the staffing spend. Budgets are set annually by finance, hospital manager and executive directors of operations. There is a winter and summer planning process which includes a review of staffing levels.

“We want to get this right for staff”

Planning was identified for winter and summer; winter tight for beds and summer planning was releasing staff for leave and close beds.

Request for additional staffing that is within budget can be signed off by the GM Hospital and Healthcare Services and /or be found within the directorate. If further additional (new) FTE was identified / required then the following process is completed:



Management

Described the process the same as the executive staff. All interviewed agreed that the roster model was based on a ‘flat NHpPD. However this has been agreed to be 100% employed roster to budget, and bureau/casual staff use was on top of the base FTE. This did make it difficult to manage turnover of staff and sick leave. This group work closely with the charge nurses and accountants with budget setting.

Note: Allied identified at time of interviews that Annual and sick leave entitlements were not included in the base rostering and this made it very difficult to get coverage.

Recruitment takes a period of time from the placement of the advert to the person starting in the position. Then there is a time of orientation to the area, it can be 3 – 4 months before staff are fully functioning within the clinical environment.

Currently the IOC is increasing the numbers of positions on the bureau team and an open advert for casual staff. This is to meet the demand from the clinical areas especially during the winter months.

Direct Care Staff

To support budget setting the charge nurse works with the Operations Director and the accountant, this occurs monthly and yearly budget setting is based on historical requirements. The budget is a ‘flat – NHpPD’. Unable to articulate the contextual setting well for the staffing mix e.g. RN/M, EN and HCA. Graduate staff are outside of the budgeted FTE for the New Entrance to Practice programme or equivalent

Skill mix not quite right
Not the right staff on the right shifts
Study day release too hard and often cancelled

programme. Seasonal planning is to release staff for leave over the summer months and closure of beds for 4 – 6 week period.

Roster gaps are posted and use bureau staff to fill the gaps either as a 'on the day' approach or offer short term contracts which then depletes the hospital resources.

Professional development release is challenging and at times staff are asked not to attend a study day due to short staffing, and this may be a short notice cancellation.

Replacement of staff can take 12 weeks or longer if there are not suitable applicants. The 12 weeks is from the release of the advert to placement in the ward, then orientation is required in the environment. Orientation time can be variable depending on the applicants' experience, two to four weeks. Direct care staff are not seeing the support that they feel they need at this time. Some areas are viewed as being particularly short staffed for a considerable period of time.

New or additional staff requirement outside of the budget can come out of the existing FTE from the directorate or a business case has to be written and submitted to the DHB board for approval or not.

The online survey asked if in the past six months staff had worked outside their contracted hours or through their breaks to get their work completed. 20 % indicated they had done this on at least two days of the week, with 40% responding they did this on 3 or more days in the week. Of these staff, 53% indicated they did not claim overtime or time in lieu. These responses indicate staff contribute a level of discretionary effort to maintain current service levels with much of this invisible to the organisation. These findings are similar with the discovery findings of other DHB's.

Staffing Methodology Summary

Overall it is thought that in some areas there is enough staff, but not in others. That overall work can be done to ensure that there are the right staff at the right time in every ward. Especially noted by a number of interviewees were the Mental Health and Maternity Services, both of which have had issues, recently highlighted in the media.

This was supported by responses to the survey that showed 36% of respondents indicated there is always or often enough staff to get the work done; with a further 38% of respondents identifying there is sometimes enough staff to get the work done. Staff indicating seldom or never enough staff accounted for 25% of responses.

Staff who participated in the survey also indicated that 42% of respondents considered the level of service provided by CCDHB were excellent or very good, with a further 33% rating the current level of service as good. However the Survey responses to determine the level of effort to maintain current levels of service indicated that 75% of staff considered this was high or very high with 24% considering it to be about right. This is similar with some other DHB's embarking on the programme.

This links back to the view for staff interviewed that the DHB has dedicated staff who are committed to providing high quality care and getting the capacity demand match more closely aligned would also support "getting it right for staff".

Historically the DHB has used NHpPD to calculate the required budgeted FTE. The staff interviewed appeared to have a reasonable understanding of the budget setting process. They all reported that the Operations Directors, Charge Nurses/Midwives and management accountants are involved in setting the budgeted FTE.

The CCDM Staffing methodology relies on accurate data from TrendCare for a minimum period of one year. The CCDM FTE calculation does differ from the current CCDHB approach as it is based on:

- Patient demand (acuity + 12.5% unexpected workload and tea breaks + other productive HPPD)
- Roster testing (to achieve the best match of supply for demand AM, PM, N for each day of the week)
- Staff supply (2086 hours/annum for 1 FTE – allowance for leave and other unavailable time, by staff type and new/experienced)

The aim of the CCDM staffing methodology is to ensure the right staff and skill mix are at the right time, by day of week. Right staffing means quality workplaces for staff, quality patient care and best use of health resources. Implementation of the CCDM Staffing Methodology processes - Work Analysis and FTE calculation will support developing a roster model that matches patient demand and sets an accurate budget.

5. Variance Response Management (VRM)

The DHB has a Variance Response Management system to provide the right staff numbers, mix and skills at all times for effective patient care delivery.

Executive

The introduction of the IOC and the electronic Occupancy at a Glance (OaaG) screen has certainly increased the daily organisational situation visibility over the past 18 months. The DHB would also like to purchase a capacity planner system to balance the short term view with long term information.

The IOC boards show the bed capacity for Wellington and Kenepuru, Emergency department with 6 hour wait time and the TrendCare variance data. Currently the DHB is unable to see elective services (theatre), Allied Health or other services such as Mental Health at the Kenepuru campus.

All identified with the IOC for the bed balancing meeting and seven other meetings all of which were looking at forecasting but could not identify meetings that looked retrospectively at capacity demand – ‘how well did we do, what can we change’.

There is one Duty Nurse Manager on daily covering both Wellington and Kenepuru sites and one manager at each site on the evening and night shifts.

The daily bed capacity meeting is attended by some members of the executive team, along with the charge nurse/midwife from all clinical areas and allied health, but no doctors at present. One doctor that was interviewed noted that it would be beneficial to have medical input into the IOC planning and on going operational management.

TrendCare data is used to reallocate staff if showing that there is additional resources, to try and support areas where resource is needed. The accuracy of data from TrendCare is not fully trusted as yet.

Management

All described the information the same as the executive team members. Organisational capacity and demand information is not currently visible on the clinical floor. Staff can log into computers to see the OaaG screen. Theatre is not visible in terms of who is in theatre, time in theatre or time in PACU. This is a required piece of work that has been identified.

Allied health complete a spread sheet to show the number of staff available. If short staffed this is not able to be addressed on a daily basis. Mental health staffing is covered by own casual pool and not included with general hospital side.

Staff often do not feel comfortable about being reallocated from their own ward to other wards. Increasing the bureau and casual staff resource to help meet demand is a priority for the manager.

Direct Care Staff

The IOC is running better and being more supportive to clinical areas. On a day to day view staff on the floor are unable to see the capacity and demand on the hospital. TrendCare and theatre are not visible in the hospital. So unable to see if other areas can help or need help, only in the IOC meeting room.

Duty Nurse Managers run the day shift from Wellington and supported by the Operations Directors and Associate Directors of Nursing/Midwifery. During the day there are administration staff that look to replace absent calls until 7-8pm at night. On the afternoon and night duty there is a Duty Nurse Manager at each site, Wellington and Kenepuru, they help where they can on the floor. Kenepuru Duty Nurse Manager, manages the replacement of staff as they call in sick for the organisation, exception is the community.

The bed capacity meeting is held at 9.15am daily except weekends. If the charge nurse/midwife is unable to attend the morning meeting an acting person goes. Prior to the meeting an excel sheet is completed. The excel spreadsheet informs the number of patient discharges, transfers, 'waiting for what' and absent staff. There are drill down reviews of overstaffing but not understaffing. Duty Nurse Managers often feel the only thing they can do is say "sorry" for not being able to replace staff.

Variance Response Management Summary

The journey in the DHB has begun for variance response management with the introduction and set up of the Integrated Operations Centre. Display boards in the IOC of an OaaG screen and ED visibility of patient with 6 hour target. Within the IOC vicinity are Duty Nurse Managers, IOC manager, CCDM Coordinator, TrendCare Coordinator and bureau administration staff.

The IOC 9.15am bed capacity meeting has made improvements over the last six months. Work continues to ensure at all areas of the organisation, such as child health and mental health can contribute and feel valued.

MDT are present in the way of Allied Health but medical staff are not visible or at meetings. Including medical staff in the IOC and operational development would support and strengthen the CCDM programme, VRM component.

The only current way for staff on the floor to signal, in the moment, that care capacity is not meeting patient care demand is via TrendCare.

There is an opportunity to strengthen the VRM process with wider visibility in the organisation of the care capacity boards in clinical areas. This enables front line clinical staff to gain a hospital wide understanding of capacity and demand. Operations meetings that are reviewing monitoring, and evaluating variance yesterday, today and tomorrow.

VRM will support the DHB to provide the right staff numbers, mix and skill at all times by:

- providing real time whole of system visibility of demand and capacity
- support the DHB to manage patient flow and meet ministry targets

- Staff alert demand-capacity variance using visual indicator scores
- Smart 5s for staff re-assignment makes sure staff are well supported
- Standard operating procedures ensure that staff know the plan when the unexpected occurs
- Essential care guidelines describe what patient care is essential to deliver when demand for care is greater than capacity

Conclusion

CCDHB does have a challenging set of demands, capacity, cost and funding pressures however despite this they are seen as a solid performer in terms of financial performance, as measured by the improvements to its deficit over recent years. The DHB has also been commended in a recent Health and Disability Sector Standards Certification audit in regards to utilising data findings from a wide range of data and audit activity to inform planning and decision making that guide continuous quality improvement.

There is recognition from all levels of the organisation that CCDHB has dedicated staff who are committed to providing high quality care to patients. To maintain a high level of service the majority of staff are putting in a high work effort and at times this is viewed as being under recognised by the organisation.

The DHB and Health Union partnership is recognised as being the foundation for the successful implementation of the CCDM programme and that ongoing open engagement and collaboration is required to make the partnership success real.

Overall the SSHW Unit considers the findings from Discovery phase for Capital and Coast DHB in many areas are similar with other DHBs who have previously undertaken the Discovery process as part of the CCDM Programme implementation.

It is the assessment of the SSHW Unit, from the foundational information presented in this report, that Capital and Coast DHB is well placed to commence the implementation of the CCDM Programme. The SSHW Unit is confident that the DHB has the leadership, relationships and base systems in place from which to progress this agenda. The CCDM programme will provide an opportunity for the parties to grow and sustain their partnerships and relationships. While attending to the improvement of the design and implementation of effective processes and systems, in order to support the improvement of care capacity and demand management.

Recommendations

Governance

1. Set up clear communication strategy for the CCDM programme with key messaging for each activity undertaken including:
 - a. Show case success
 - b. Incorporate CCDM into current meeting agendas
2. Review the list of current projects alongside the CCDM programme components and devise a strategy to minimise duplication
 - a. Undertake mapping process with the projects and components at council level
3. Partnership workshop
 - a. Understand the role of both the DHB and unions in the CCDM programme
 - b. External facilitation for all CCDM Council members
4. Have union representation and participation on all CCDM project groups

Validated Patient Acuity

1. Set the practice and use of TrendCare to meet CCDM Programme Standard 2.0
2. Review the current data and develop an improvement plan
3. SSHW Unit recommend a TrendCare Discovery in the later quarter of the year

Core Data Set

1. Review the current involvement with the DHBs reporting system and processes at a direct care level and utilise the CCDM CDS structures and processes, to increase front line staff knowledge and capability
2. Review reporting to match the minimum requirements of CCDM Core Data Set
3. Set up Local Data Councils within clinical areas or services as part of the programme roll out. This may be able to be set up within current quality meetings in clinical area or service level

Staffing Methodology

1. Enable and support TrendCare data to be at the required quality level in order to participate in the Work Analysis and FTE calculation process with the programme

Variance Response Management

1. Consider undertaking a Churchill exercise to add value to what is not visible
2. Set up bed capacity meeting to include reviewing what happened yesterday and planning for the next 3 shifts (24 hours) in advance
3. Review the current system to ensure forecasting monitoring reviewing and reporting is included e.g. patient flow, bed capacity, staffing resource demand, variance on a weekly and monthly bases
4. Have the OaaG boards highly visible on screens in each ward
5. Review current display boards to include elective services (theatre)
6. Set up the process of reallocation of staff, including Smart 5's

References

Capital and Coast (2016)., Final report on independent service review – discovery phase. Retrieved from: <https://www.ccdhb.org.nz/about-us/our-board/public-november-2016.pdf>

Carter M, Thompson N, Crampton P, et al. Workplace bullying in the UK NHS: a questionnaire and interview study on prevalence, impact and barriers to reporting. *BMJOpen* 2013;3:e002628.doi:10.1136/bmjopen-2013-002628

Appendix

(i) On-line Survey Graphs

(ii) List of Organisational Projects

CCDM Standards

Discovery Interview Questions