SAFE Staffing HEALTHY Workplaces
CCDM
Care Capacity Demand Management
NZ District Health Boards & Health Unions working together

CCDM
councils

CCDM overview

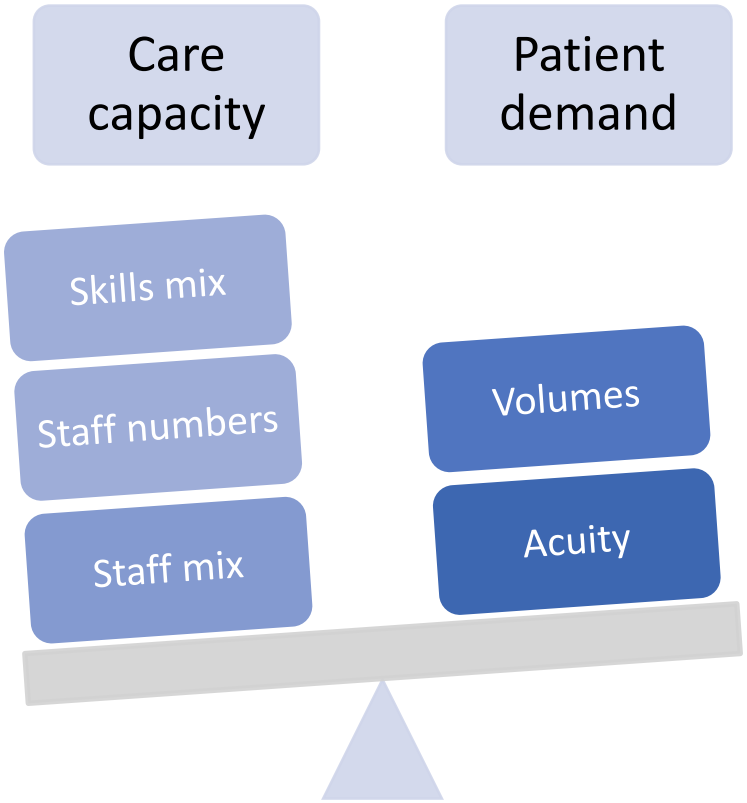
Safe Staffing & Healthy Workplaces Unit
June 2018

Session outline

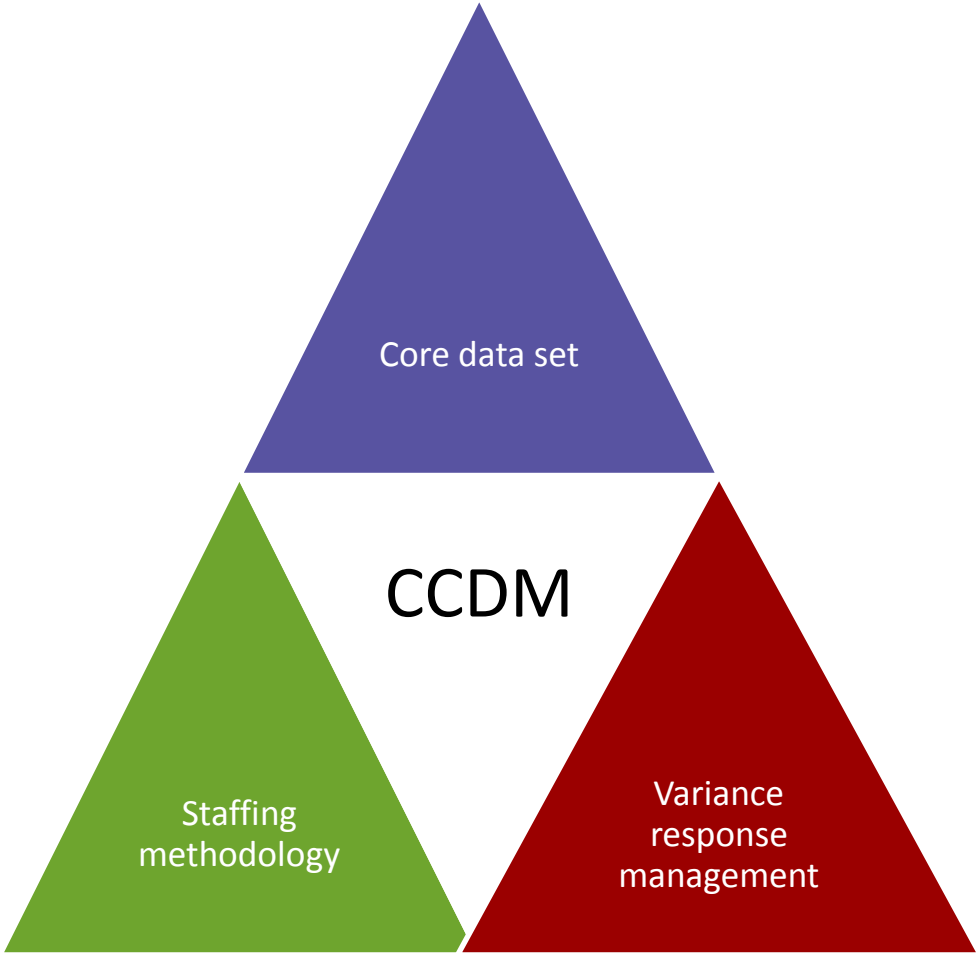
- What is the Care Capacity Demand Management (CCDM) programme?
- Why implement CCDM?
- How does CCDM work?
  - Core data set
  - Staffing methodology
  - Variance response management
- Constraints and enablers

What is CCDM?

- CCDM stands for Care Capacity Demand Management
- The CCDM programme helps DHBs to better match the capacity to care with patient demand



What is CCDM?



Governance + patient acuity + partnership

Why implement CCDM?

- Matching care capacity to patient demand is DHB core business
- Increasing demand and cost pressures
- Right staff, right place, right time is productive and efficient
- Expectations of ‘safe staffing’ through
  - Consumer Rights
  - Health & Disability Service Standards
  - Health & Safety Act
  - NZ Health Strategy
  - Triple Aim
  - DHB/NZNO multi-employer collective agreement

Programme logic

Situation

- Poor visibility of patient demand for care
- Mismatch between care capacity and patient demand
- Concerns about patient & staff safety
- Growing concerns about affordability

Outputs

- CCDM governance
- Staffing methodology
- Variance response management
- Core data set

Outcomes

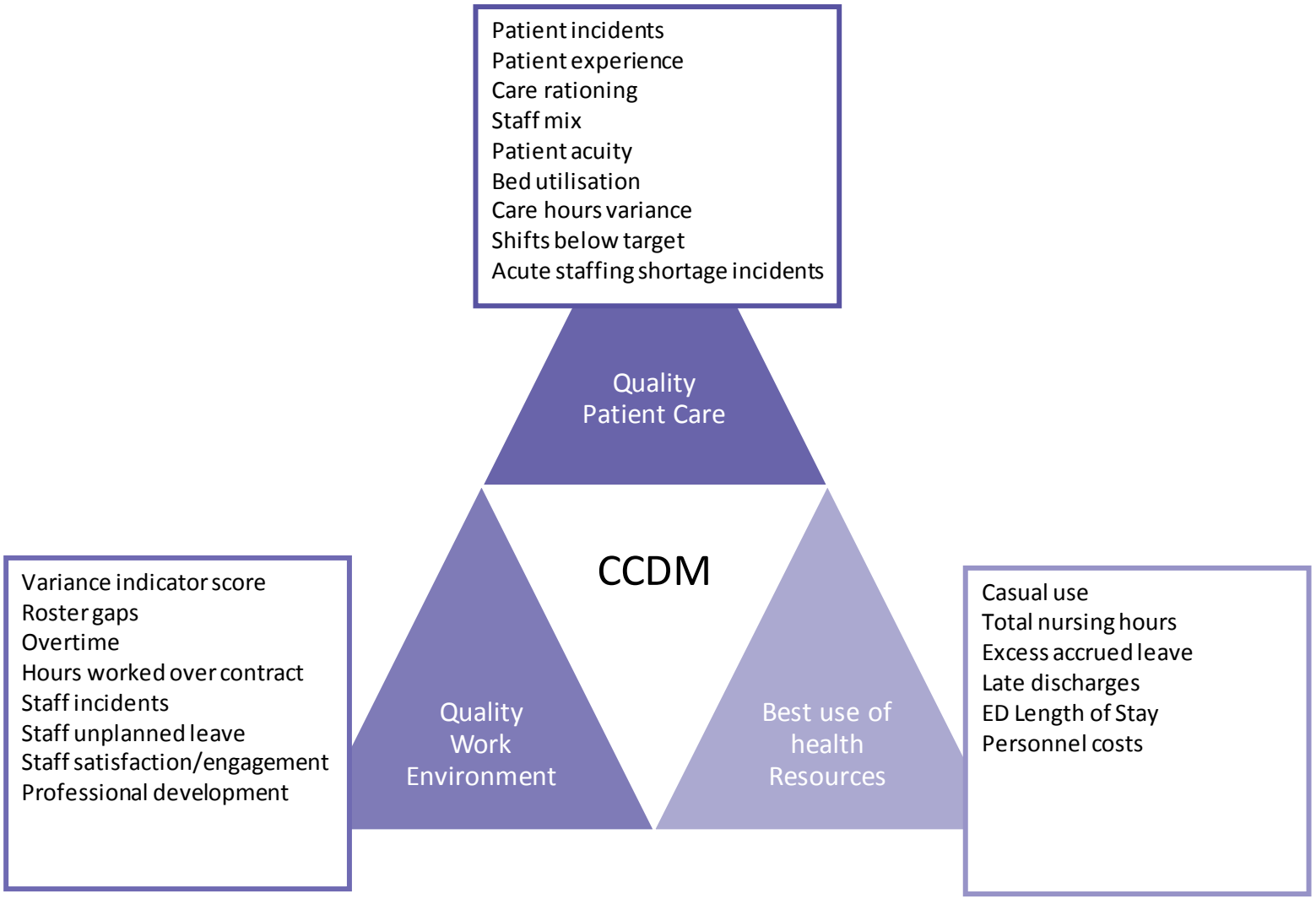
- Partnership
- Staff engagement
- Shared goals
- Increased transparency
- Increased visibility & accountability
- Right staffing every shift, every day
- Right budget

Impact

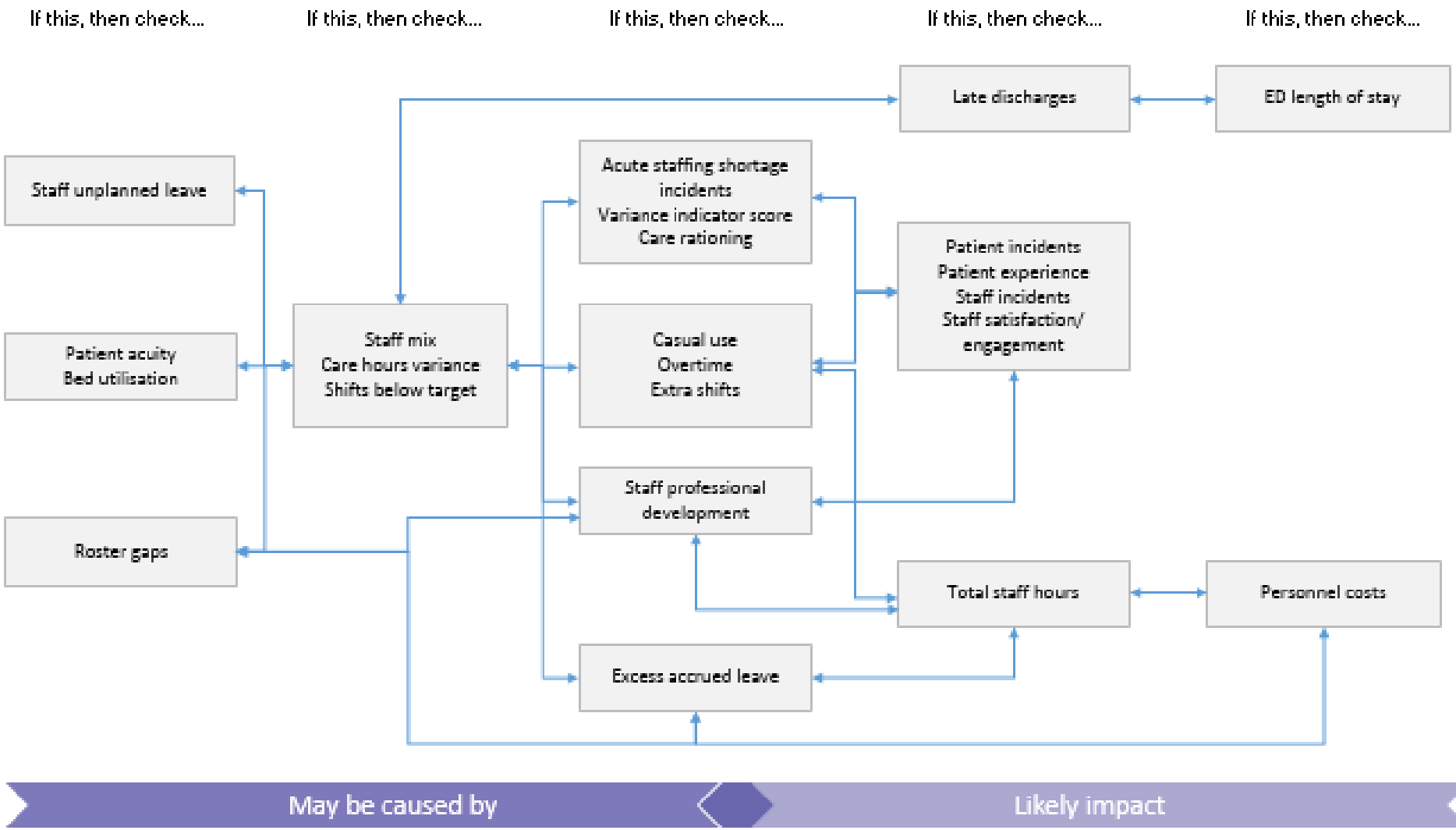
- Quality patient care
- Quality work environment
- Best use of health resources

core *data set*

What is the core data set?



Relationship between measures



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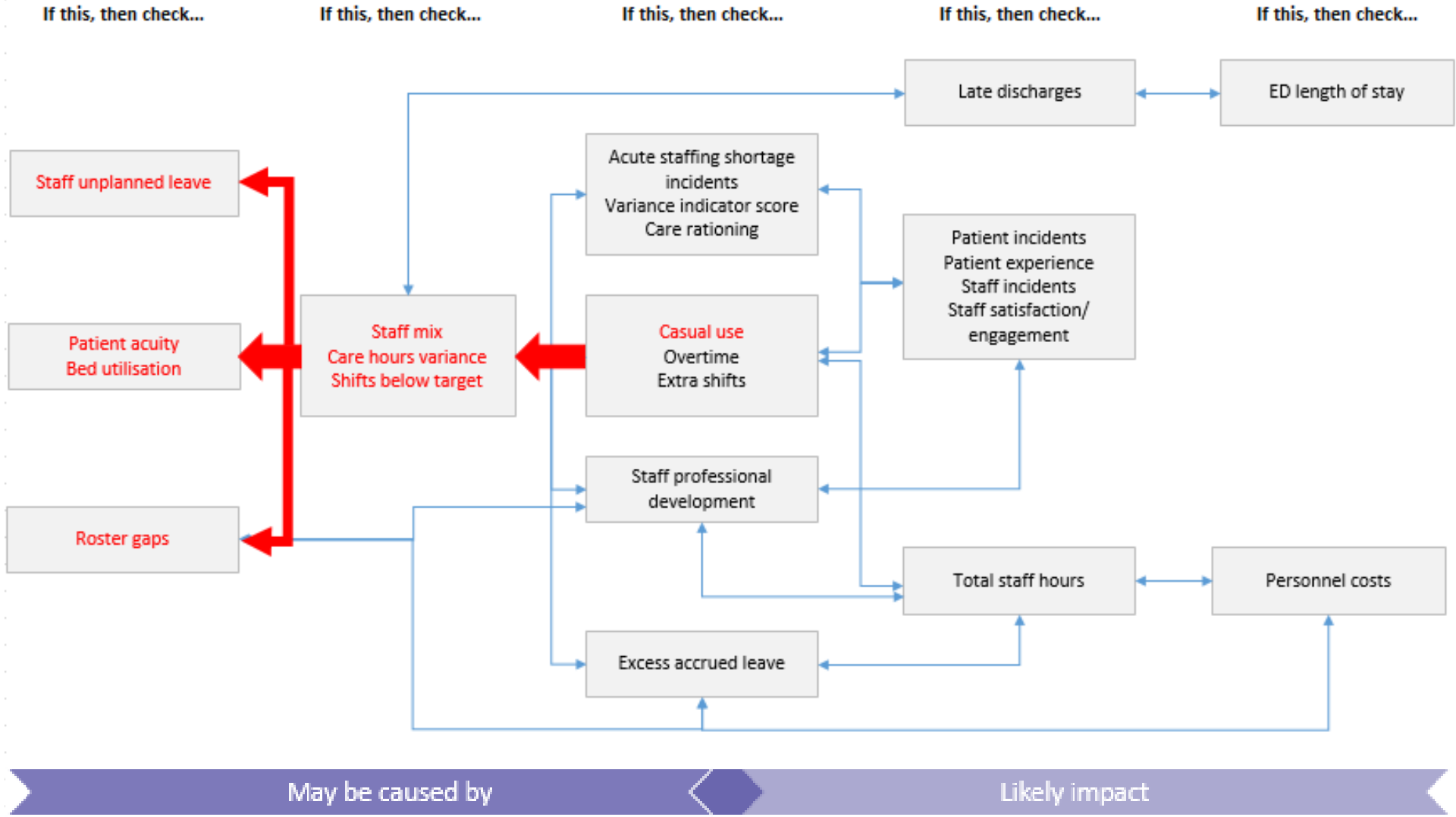

How is the core data set used?

Ward staff	• Reviews measures at Local Data Council/ Ward staff meetings • Measures displayed on ward's quality board • Contribute to problem solving and improvements
Ward/unit manager	• Reviews measures for the ward • Makes opportunities to discuss with staff • Links staff activities with DHB goals & priorities • Maintains ward's quality board • Develops improvement plans • Reviews measures with line manager
Service/nursing leaders	• Monitors measures for the directorate/service • Discusses measures with direct reports • Links ward performance to DHB goals & priorities • Oversight of service's improvement plans • Discusses measures with line manager
Executive team	• Monitors measures for the hospital • Reviews measures at CCDM council • Aligns activities with DHB goals and priorities • Provides direction and guidance on improvement plans

Local data council

Working groups

CCDM council

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staffing *methodology*

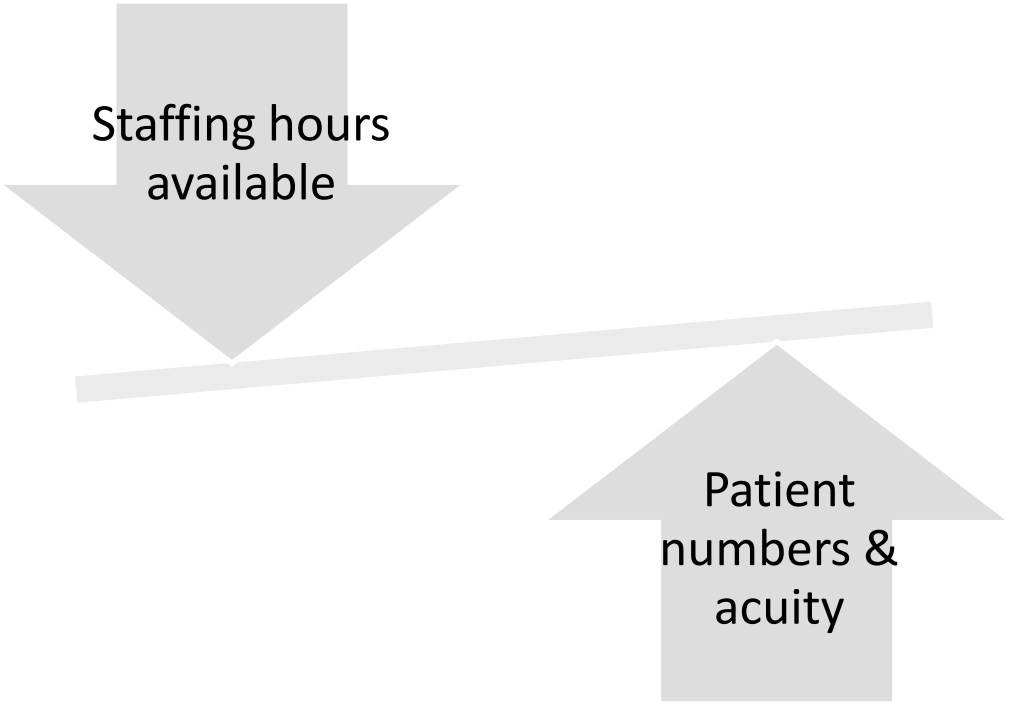
Work analysis and FTE calculation

What is a work analysis?

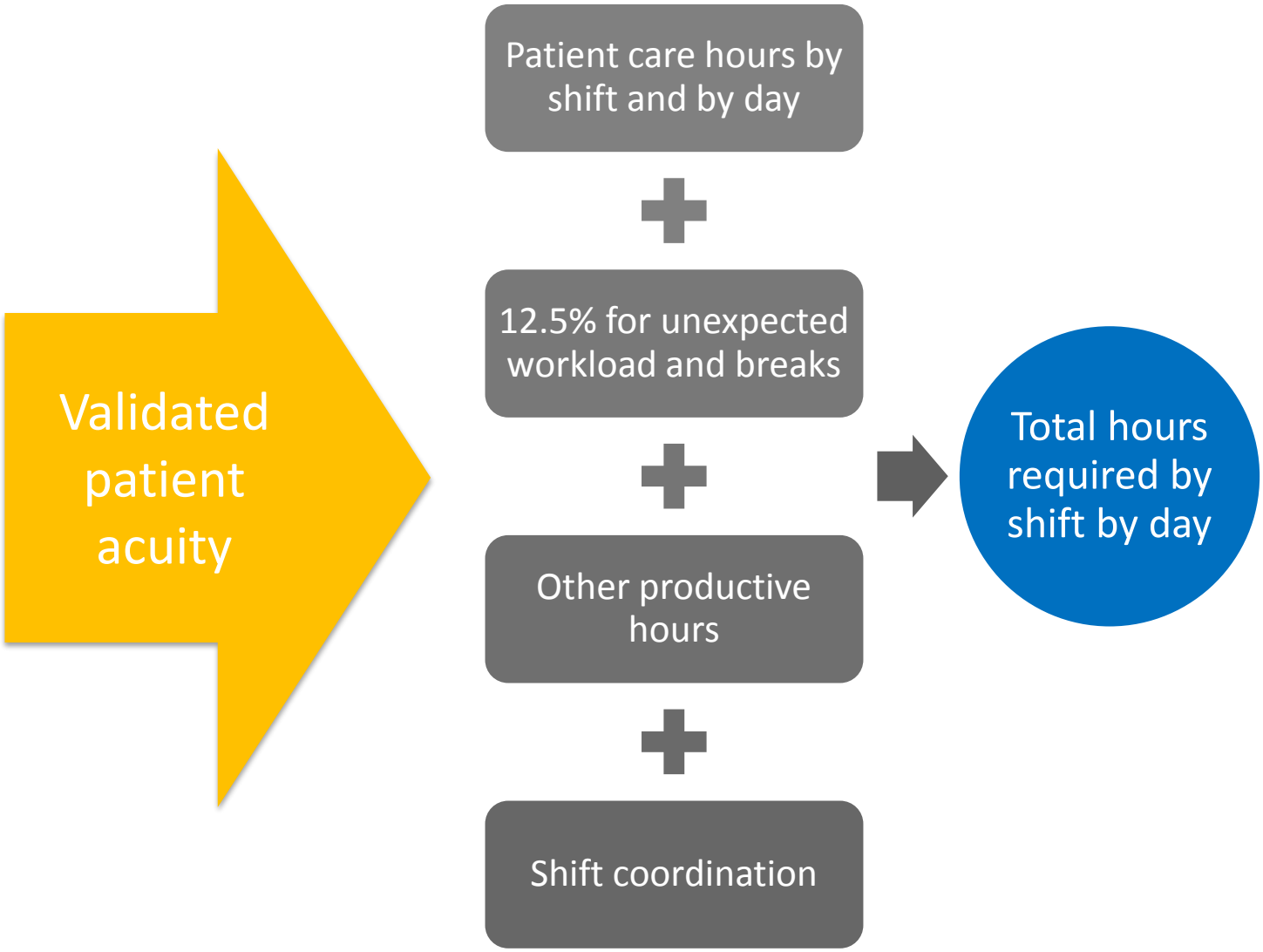
- A work analysis is an intense period of data collection over a minimum two week period.
- Data is collected by staff (nurses, HCAs, midwives) on the
  - Frequency of activities performed
  - Occurrence of care rationing
  - Satisfaction with work
  - Missed breaks, overtime worked
- Ward context data

What is the FTE calculation?

- A systematic process for establishing the FTE needed to deliver the care hours required by patients.



Components of patient demand



Roster testing

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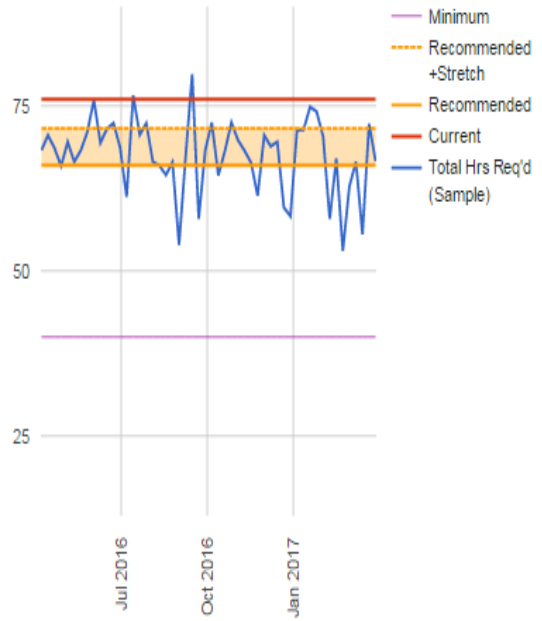
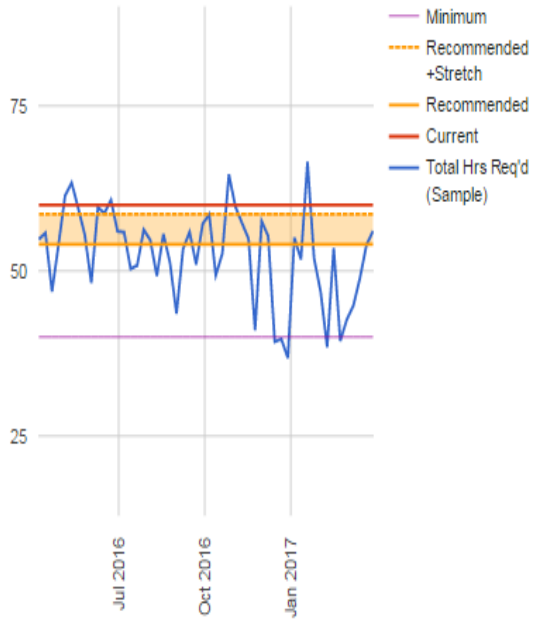
Thursday AM



Current	76	OK	Surplus	Deficit
Occurrence		2	50	0
Percentage		4%	96%	0%

Recommended	66	OK	Surplus	Deficit
Occurrence		28	14	10
Percentage		54%	27%	19%

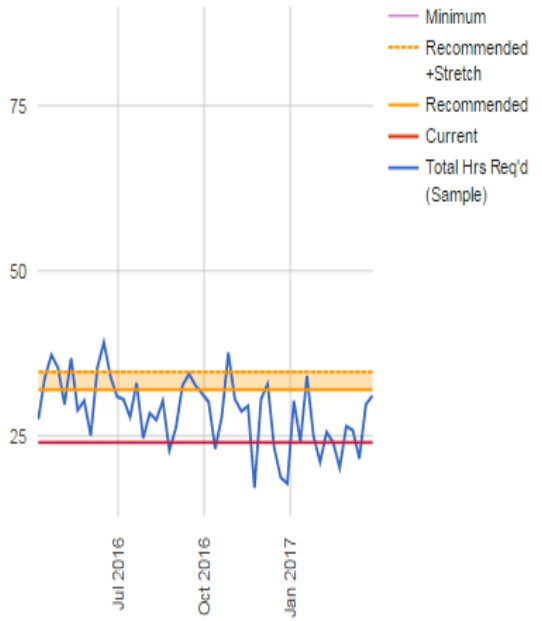
Thursday PM



Current	60	OK	Surplus	Deficit
Occurrence		4	47	1
Percentage		8%	90%	2%

Recommended	54	OK	Surplus	Deficit
Occurrence		18	25	9
Percentage		35%	48%	17%

Thursday Night



Current	24	OK	Surplus	Deficit
Occurrence		7	9	36
Percentage		13%	17%	69%

Recommended	32	OK	Surplus	Deficit
Occurrence		8	38	6
Percentage		15%	73%	12%

Staffing hours available

- Available hours once all leave has been subtracted from total hours (2086) for 1 FTE
- Available hours vary depending on:
  - Entitlements by role and experience level e.g. annual & study leave
  - Allocation for sick and parental leave

Role / experience	Hours paid (1 FTE)	Hours available	% hrs available
Existing nurse	2086	1666	80%
New experienced nurse	2086	1542	74%
Existing HCA	2086	1698	81%
New experienced HCA	2086	1654	79%
New graduate nurse	2086	1490	71%
Bureau nurse	2086	1666	80%
Clinical Nurse Manager	2086	1698	81%

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Care Capacity Demand Management

Quality patient care

Quality work environment

Best use of the health resource

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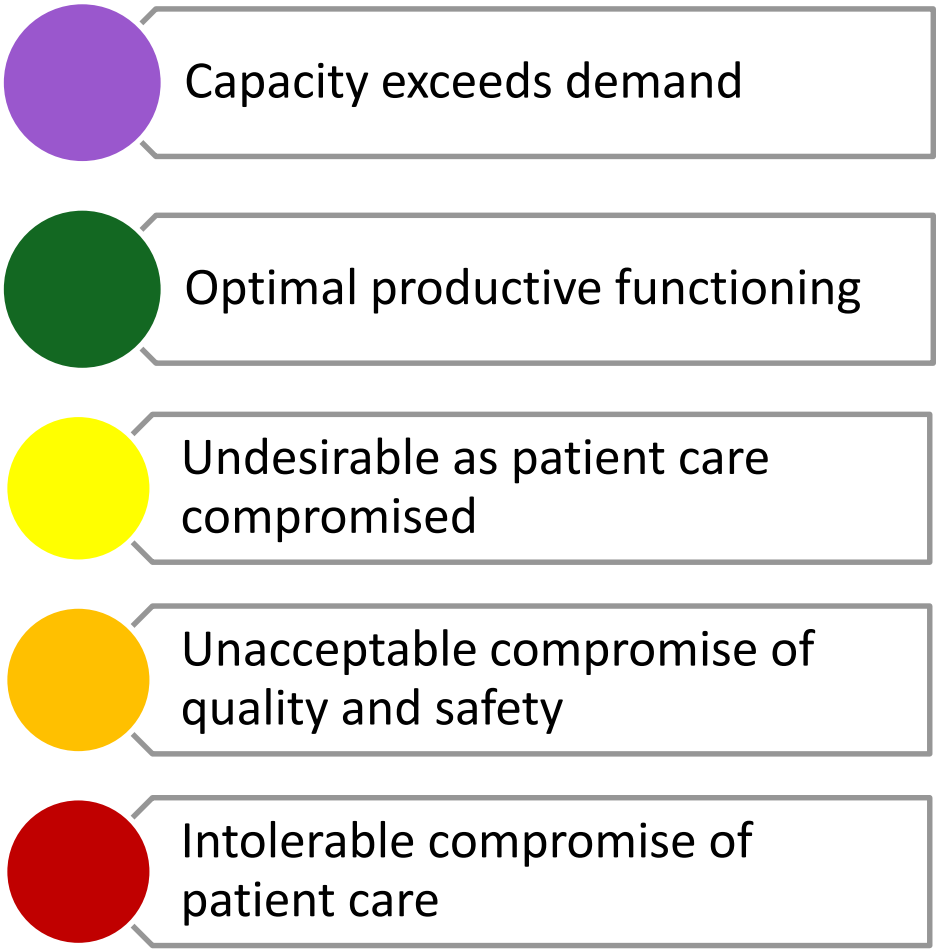
variance response *management*

Integrated operations centre

- The integrated operations centre is a physical space with dedicated staff
- The team manages care capacity demand management, in the moment & over time

Identify

- In any given moment we can identify what our situation is through using standardised colours and definitions.



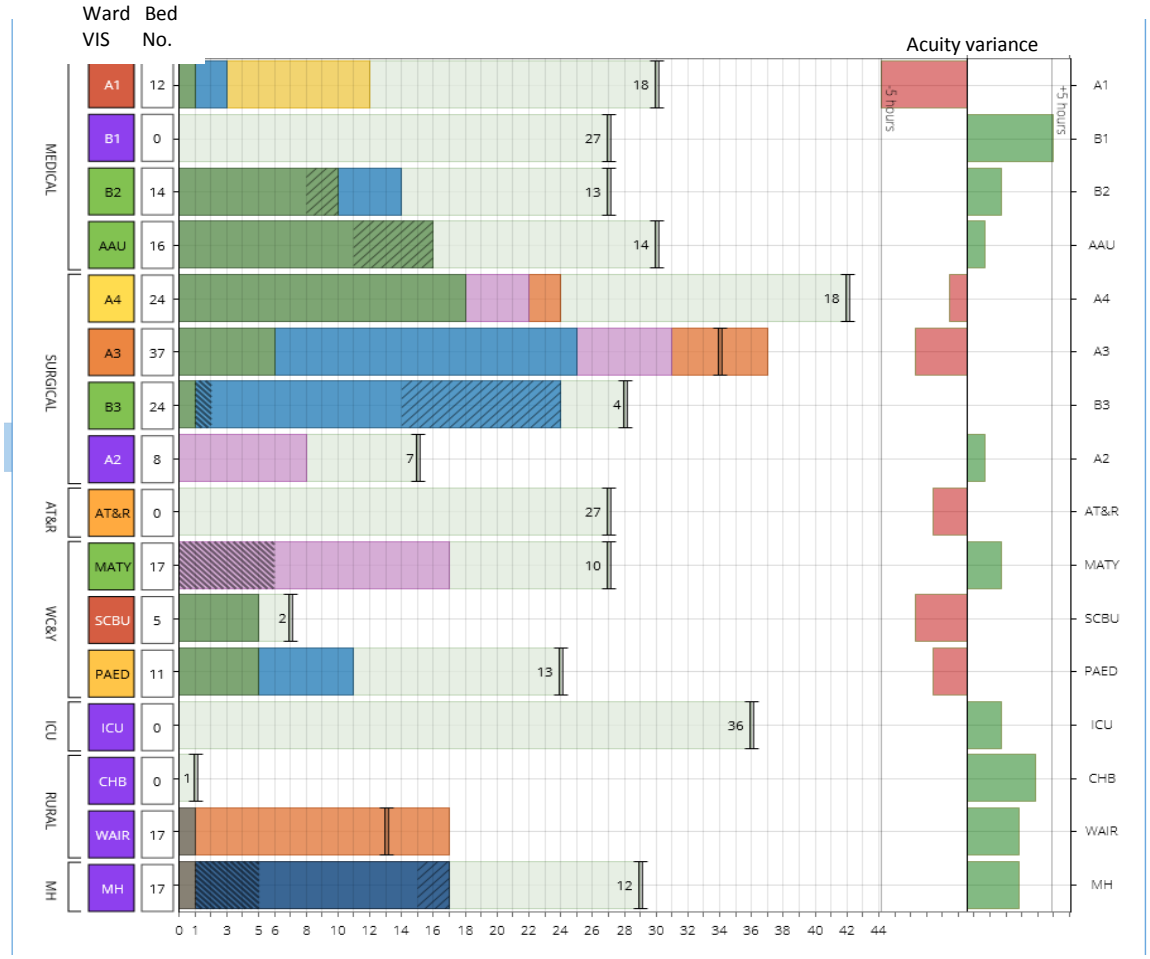
Quantify

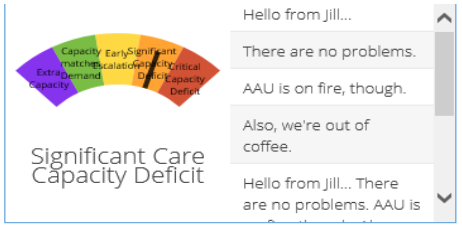
- In any given moment we can describe to others what our situation is through using variance indicator scoring.

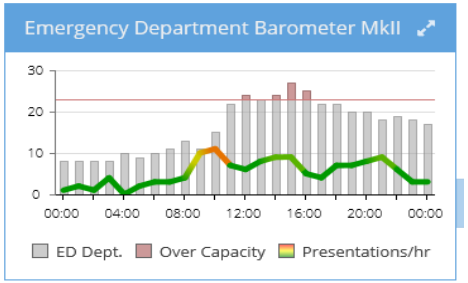
Indicator	Yes	No
Missed breaks	❍	❍
Poor skill mix	❍	❍
Poor staff mix	❍	❍
Negative hours variance	❍	❍
Positive hours variance	❍	❍
Care rationing	❍	❍
Professional judgement deems it unsafe	❍	❍

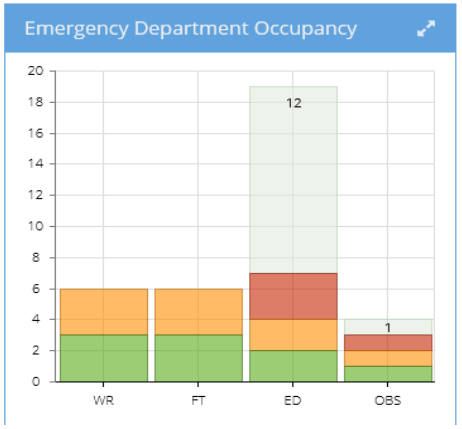
Alert

- At any given time we can alert the organisation to what our situation is.









Respond

- Whole of hospital are able to respond in a standardised and timely manner

	Definition	Ward	Operations centre	Executive
	Excess care capacity	Re-assign duties	Re-assign staff	
	Staffing meets demand	Status quo, monitor, report	Status quo, monitor, forecast	
	Early variance	Team huddle, assess workload, report	Assess, re-assign staff, forecast	
	Significant care capacity deficit	Team huddle, re-assign workload, essential cares, report	Assess, re-assign staff, invoke essential cares, report & plan	Review plan, monitor
	Critical care capacity deficit	Team huddle, emergency response, report	Assess, emergency response, update status & plan	Take charge, respond

CCDM challenges

- CCDM is not seen as a DHB strategic priority
- Relationship between the partners
- Poor quality validated patient acuity data
- Under resourcing of programme implementation
- Poor accountability processes
- Incomplete implementation and loss of programme integrity
- Emphasis on short term financial solutions
- Miss-match between expectations and priorities

CCDM enablers

CE and executive team support for:

- Prioritising CCDM
- Aligning CCDM with the organisational strategy
- Progress reporting against the plan
- Partnership model
- Resourcing programme implementation
- Dedicated CCDM site coordination time/resource
- IT systems
- Implementation of all parts of the programme to all areas
- Transition to business as usual

Questions?

Start by doing what is necessary, then do what's possible; suddenly you are doing the impossible
– Francis of Assisi

Quality patient care.
Quality work environment.
Best use of health resources.
– CCDM