CCDM standards assessment form

CCDM council:< Insert name > CCDM start date:< Insert date >

# 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 workplan.

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 Date: / / 20\_\_\_\_

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

## Assessment contributors

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| Name | Role | Name | Role |
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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.   OR   1. Documented processes / systems or structure is evident but unable to demonstrate this at all levels of the organisation ward – directorate – DHB where required |
| UN = unattained | DHB unable to demonstrate appropriate processes, systems, structures to meet the criterion |

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| DHB areas of commendation: summarise the indicators of success |
| DHB areas for improvement opportunities: **summarise the improvement opportunities** |

## 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 |  |
| 1. Permanent governance for CCDM is established for the organisation and for each ward/unit |  |
| 1. Permanent governance for CCDM is effective and operational for    1. CCDM council and    2. local data councils |  |
| 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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| **Standard overall attainment** | | | |
| NA – Not attained | PA – Partially attained | FA – Fully attained | CI – Continuous improvement |

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| Areas of commendation: **summarise the indicators of success** |
| Areas for improvement opportunities: **summarise the improvement opportunities** |

## 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. |  |
| 1. There is dedicated coordinator FTE for managing the validated patient acuity system. |  |
| 1. The patient acuity system is supported and prioritised as a critical ‘service delivery’ IT system. |  |
| 1. There are processes in place to ensure the validated patient acuity system is used accurately and consistently. |  |
| 1. Business Rules are clearly defined and in use to ensure consistent use of the system. |  |
| * 1. Validated patient acuity data is utilised in daily operational and annual planning activities. |  |

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| **Standard overall attainment** | | | |
| NA – Not attained | PA – Partially attained | FA – Fully attained | CI – Continuous improvement |

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| Areas of commendation: **summarise the indicators of success** |
| Areas for improvement opportunities: **summarise the improvement opportunities** |

## 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. |  |
| 1. The Core Data Set is used to evaluate the effectiveness of care capacity demand management in the DHB and make improvements. |  |
| 1. The Core Data Set is monitored, reported and actioned at ward/unit, directorate and hospital wide level. |  |
| 1. The organisation annually reviews the relevance, frequency and effectiveness of the Core Data Set. Reporting on progress with quality improvement. |  |

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| **Standard overall attainment** | | | |
| NA – Not attained | PA – Partially attained | FA – Fully attained | CI – Continuous improvement |

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| Areas of commendation: **summarise the indicators of success** |
| Areas for improvement opportunities: **summarise the improvement opportunities** |

## 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. |  |
| 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. |  |
| 1. Budget holders are involved annually in setting the roster model, FTE and budget. |  |
| 1. The roster model provides the best match of staffing to patient demand. |  |
| 1. The organisation regularly evaluates the adequacy of staffing levels/mix and acts on the findings. |  |

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| **Standard overall attainment** | | | |
| NA – Not attained | PA – Partially attained | FA – Fully attained | CI – Continuous improvement |

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| Areas of commendation: **summarise the indicators of success** |
| Areas for improvement opportunities: **summarise the improvement opportunities** |

## 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. |  |
| 1. There is a suitably qualified and/or experienced person with authority, accountability and responsibility for managing staffing and patient flow 24/7. |  |
| 1. The organisation consistently matches staffing resource with patient demand on a shift by shift basis. |  |

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| **Standard overall attainment** | | | |
| NA – Not attained | PA – Partially attained | FA – Fully attained | CI – Continuous improvement |

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| Areas of commendation: **summarise the indicators of success** |
| Areas for improvement opportunities: **summarise the improvement opportunities** |