Local data council terms of reference

# Purpose

The local data council is a solutions focused quality improvement team. It is a permanent structure that monitors and improves care capacity and demand management at a ward/service level. This is achieved through:

1. Timely implementation of the CCDM programme activities.
2. Monitoring how well the ward is matching demand with capacity on an ongoing basis.
3. Focusing on creating a positive workplace, delivering quality patient care and best use of health resources.

# Reporting structure

<Insert organisational diagram of CCDM governance>. Example:

# Key tasks/role

* Identify opportunities for improving the workplace, patient care and best use of health resources.
* Develop a ward/service work plan that is consistent with DHB goals and priorities.
* Follow processes and practices that promote health union partnership.
* Ensure local data council activities unfold in a logical, organised and efficient way.
* Assign roles, responsibilities and timelines for completing the work plan.
* Promote accurate and timely data collection with peers e.g. patient acuity data, event reporting, staff surveys, and work analysis.
* Review core data set monthly and identify good practice and opportunities for improvement.
* Acknowledge and celebrate good performance. Make a plan for areas for improvement.
* Action recommendations from work analysis, or other sources e.g. Health and Disability Sector Standards, Health Quality Safety markers, as required.
* Monitor and evaluate progress against the work plan.
* Make timely local decisions and hold peers to account for undertaking actions within the agreed timeframes.
* Escalate decisions to <directorate/service group> when needed.
* Report monthly to the <directorate/service group> on progress against work plan.
* Communicate with all staff on progress against work plan.
* Display within the ward/service the core data set over time and quality improvement projects.
* Seek input from all staff and provide timely feedback.
* Support peers to develop expertise in care capacity demand management tools and processes.

# Membership

## Permanent members

| Name/title | Role in council |
| --- | --- |
| Designated senior clinical Manageri.e. Nurse, Midwife | Co-chair the meeting. Promote CCDM in the ward, with peers and within the organisation. Share data/information. Engage and seek staff feedback. Apply the PDSA cycle consistently to all activities. Provide leadership. |
| Health union delegate/Organiseri.e. NZNO, PSA, MERAS | Co-chair the meeting. Promote CCDM. Represent members, work in partnership and advise on MECA entitlements. |
| Registered nurses, registered midwives, enrolled nurses | Team member, promote CCDM with peers, identify quality improvement opportunities and solutions, take an active role in assigned activities, undertake meeting responsibilities e.g. chair, minute taking with coaching, as required. |
| Health care assistants | Team member, promote CCDM, and identify quality improvement opportunities and solutions, complete assigned activities. |
| Medical representative | Provide medical perspective and professional advice in line with ward/service goals. |
| Allied health representative | Provide allied health perspective and professional advice in line with ward/service goals. |
| Quality adviser | Provide quality advice to ward/or directorate/service group. Provide expertise on quality improvement processes. Link to broader DHB quality improvement plans. Promote CCDM within the organisation as a quality improvement framework. |

Other members may be co-opted to the working groupas and when required to provide expert advice. Membership will be reviewed annually.

## Co-opted members

|  |  |
| --- | --- |
| Name/title | Role in council |
| Manager HR | Advise on employment relations, link to workforce strategy, assign resources |
| Service and/or operations manager  | Provide service/directorate perspective. Link to DHB goals and priorities. |
| Nursing/Midwifery Leadership i.e. ADON/Nursing Director | Provide professional advice in line with workforce strategy/service goals. Link to DHB goals and priorities.  |
| TrendCare Coordinator  | Support ward with patient acuity data collection. Check data accuracy and integrity, help ward explain plausible reasons for variance. |
| CCDM Site Coordinator  | Coordinate CCDM programme implementation. Provide CCDM education and support use of programme tools. |
| SSHW Unit Programme Consultant | Provide expertise on CCDM components and process, provide training as needed. |
| Manager Communications | Develop communications, work with Site Coordinator/CNM to tailor key messages |
| Business Support Manager | Support ward to source, analyze and display data. |

# Responsibilities

* Group members are expected to be familiar with the CCDM programme enablers, components and tools applicable to the ward/service.
* Group members are expected to attend and participate in all meetings.
* Abide by the decisions of the local data council and CCDM council.
* Ensure confidentiality of information provided to the local data council and CCDM council.
* Disseminate, discuss and collaborate across wards and/or disciplines as required to undertake the work plan.
* Read and provide feedback on all documents received within the agreed timeframes.
* Ensure meeting actions are followed through and reported on within the agreed timeframes.

# Meeting process

Meetings will be held on the <*insert frequency date and day*> for a maximum of *<one hour>*. Meeting time will be from <*insert start and finish time of the meeting* >.

* Agenda items will be called for by the Chair 3-5 working days prior to the scheduled meeting.
* Additional agenda items may be taken by the Chair at the meeting or prior to commencing.
* An agenda and relevant papers will be circulated by the Chair before the meeting.
* Members are to inform the Chair if not attending a meeting at least 48 hours prior.
* Where members are unable to attend a meeting proxy will not be accepted.
* One topic will be discussed at a time.
* All members will participate in discussion and decision making.
* One person will have the floor at a time.
* Members’ remarks will be relevant to the matters under discussion.
* The chair will summarise the main points
* Actions will be followed up on.
* New assignments will be specific and clear.
* Good timing will be maintained (start, finish and duration of discussions).
* Meeting minutes will be circulated 3-5 working days after the meeting (refer Appendix).
* Meeting minutes will be confirmed as ‘final’ at the next meeting. Copies will be retained as part of the local data council programme documents.
* Meeting process will be periodically evaluated using both verbal and written feedback methods. Quarterly, ask the following two questions or distribute the meeting evaluation form.
	+ What went well at this meeting?
	+ What needs to be changed?
* Meeting evaluation results will be fed back to the group at the next meeting.

# Decision making

* A quorum for a meeting is represented by a 50 percent attendance of the group plus the chair.
* The quorum must include union representation.
* Should the quorum not be present, items passed will be held for ratification until the next meeting.
* Where possible, decisions will be made by consensus.
* If group consensus cannot be reached a summary of views will be documented, distributed and held within the group document file.
* Where decisions are contentious and/or complex, a decision making framework will be used and separate detailed documentation made on the decision making record.

# Functional relationships

Examples include (but are not limited to): CCDM council, CCDM working groups, Quality unit, information technology, human resources, project management office and business support.