

# CCDM

Care Capacity Demand Management

# connect



## overview

Welcome to the quarterly Care Capacity Demand Management (CCDM) newsletter for 2018. In this issue Hawke's Bay DHB shines a light on CCDM FTE Calculations and the establishment of their Variance Response Management system. We also hear from Lisa Skeet before she departs her role as Director of the SSHW Unit.



## In this Issue

- Up close and professional about FTE for wards with CFO Tim Evans of Hawke's Bay DHB
- Farewell from Lisa Skeet (Director)
- Chief Nurse & Midwifery Officer – Chris McKenna speaks about the FTE Calculations
- Unit Resource Manager Lil Dineen shares VRM lessons and implementation tips
- NZNO Organiser – Sue Wolland shares insights CCDM FTE lessons and reflections

ISSUE APRIL 18

## Up close and professional with CFO Tim Evans – CCDM FTE Calculations at Hawke's Bay DHB

*What do you think are the main benefits of completing the CCDM methodology for FTE Calculations?*

They provide an objective evidence based assessment of safe nursing numbers. This replaces accumulated history, and local practice and experience. It is important to have some objective assurance that nursing numbers are right, and rosters are being effectively planned. This answers one of the key risks identified in the Mid Staffordshire Hospital NHS Trust's failings.

*What has been the most challenging aspect of completing the FTE Calculations and how were they overcome?*

Trying to ensure that you are not presenting a huge financial challenge you can't address with no warning from a mysterious black box you can't validate (see advice below).

*What advice would you give others who are about to undertake this process?*

Ensure that you own, understand, and can test the figures produced. To achieve this make sure your management accountants are part of the detailed production team/FTE working group, working alongside CCDM and nursing staff, challenging and learning in the process.

Make sure you get the whole picture (apart maybe from a pilot area) before implementing, some wards and directorates may be over, some under, the scale of the overall gap affects your options. You need to see the aggregate picture before planning a strategic response.

Manage expectations in the steering group and Executive Team from the get go. If the gap to be funded is very big, staging over time, or by area may be necessary.

Be in the steering group, as a CFO our biggest spend is on staff, and this is your biggest staff group, it is important to be at the centre of things so you can put in healthy challenge, agree assumptions (e.g. sickness levels in the model), and own and understand the outcome.





“...two types of staff. Those who deliver front line care and those who support the staff who deliver front line care. The CCDM programme supports both types of staff to connect with each other’s day to day worlds.”

## FTE Calculation answers from Chief Nurse & Midwifery Officer – Chris McKenna

*What do you think are the main benefits of completing the CCDM methodology for FTE Calculations?*

The CCDM approach is all about managing on metrics and now we have a validated science behind our FTE establishment. When you get your base staffing right there is less waste and greater use of our talented but sometimes scarce workforce. CCDM’s annual FTE establishment is far more evidence-based, transparent and cooperative between finance, operational leadership and clinical decision-makers. The roster selection process using the CCDM software is a great way of visualising well-matched rosters by shift and day of the week to meet the demand. The ability to test various roster scenarios is a strength of the CCDM software.

*What has been the most challenging aspect of completing the FTE Calculations and how were they overcome?*

My colleague Tim Evans has captured some of the strategic challenges. Putting our trust in the FTE methodology with limited validation from another DHB was difficult. When the status quo could be better you invest in CCDM.

Learning the FTE methodology wasn’t always black and white and this made agreement on the FTE inputs tricky when doing for the first time. Getting the right people in the room and transferring the required information and knowledge so people can make informed contributions was a coordination challenge. Planning effectively was how we overcame this.

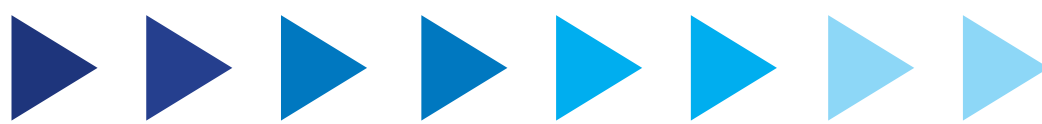
The impact of the MECA entitlements as part of a final FTE was considerable and so we needed to look at how we manage planned leave as an organisation. This requires clinical leaders to roster planned leave in a way that promotes a healthy work life balance for staff, great patient care and effective resource management.

Our daily challenge and opportunity is getting our TrendCare data to the gold standard required for the FTE Calculations. This requires staff to get their data right on every shift, every day.

*What advice would you give others who are about to undertake this process?*

Have high level decision makers on your CCDM governance group and the operational working groups. This supports the momentum of the FTE calculation and process because we can address barriers to implementation as they arise. Invest in people who are passionate and or capable and keep things simple.

“... Invest in people who are passionate and or capable and keep things simple.”





# NZNO Organiser Sue Wolland shares lesson and reflections about FTE Calculations at Hawke’s Bay DHB

## *What do you think are the main benefits of completing the CCDM methodology for FTE Calculations?*

My key focus in the CCDM programme at Hawke’s Bay DHB is safe staffing and a healthy workplace for staff. Healthy workplaces are also good for patient outcomes. The CCDM FTE calculation and its process enables a view of what it look like if we staff and budget to what our rosters need (with evidence of that need) while at the same time factoring in Muliti Employer Contract Agreement (MECA) entitlements as part of the final calculated FTE for each ward.

The FTE calculation is affirming in many ways because some wards are staffed adequately and it highlights where there are cases for change. The advantage of having the big picture view (multiple wards) allows insight into options for responding to the FTE recommendations within and across directorates. This can lead to greater sharing of resources and supports prioritisation of need.

## *What has been the most challenging aspect of completing the FTE Calculations and how were they overcome?*

Listening to other peoples viewpoints and respecting that contribution as a necessary requirement for getting to the best decisions. We all bring different priorities when making decisions about FTE. The partnership structure as part

of the CCDM programme allows us to operate in ways that equalise the voice of all representatives. This means we follow a robust merit based decision process which leads to final consensus.

People who contribute to FTE calculations have their own roles and generally do not have more than an hour to offer their support and knowledge in a time-poor work environment. If you manage meetings efficiently there is good productivity and stakeholders feel their contributions are not only valued but also needed. When people know they are needed they attend meetings regularly.

## *What advice would you give others who are about to undertake this process?*

Communication from the Steering Group about FTE calculation progress back to staff in wards is really key. At times there are decisions to be made and this can take some time.

Having an executive level nurse leader as Project Owner and union delegates on working groups sets the scene for CCDM across the hospital as a well-supported and coordinated initiative. A “no surprises” way of working from the CCDM Site Coordinator and Project Owner helps us operate in a way that challenges us to minimise blind spots - “have we got all the FTE assumptions and facts right? Can we teach the FTE calculation to someone else?”

“...A “no surprises” way of working helps us operate in a way that challenges us to minimise blind spots.”



# Lil Dineen – Resource Unit Manager talks about VRM at Hawke’s Bay DHB

## What do you think are the main benefits of CCDM Variance Response Management system

The CCDM variance response management tools have optimised our VRM system, Hospital at a Glance screen and improved our daily bed management meetings.

Ward level variance indicators feeding the HaaG provides a real time visual picture of staffing gaps and where other wards can assist. TrendCare variance between hours required by patient acuity and clinical hours available supports the overall variance picture.

HaaGs in wards helps staff see the hospital variance picture at a glance and the importance of their data and it’s reliability.

VRM has helped change our silo culture of supporting each other. Staff are seeing on our HaaG when a service or ward is orange or red and those with capacity are turning up and saying “I’m here to help”.

When building a VRM system there needs to be time for people to interrogate and challenge the system. We need to be mindful that the people who use the system haven’t had prior knowledge and familiarity, so often need repetitive coaching and training to really embrace the change.

Already we have made improvements to our HaaG so we now archive our VRM status information by day and shift and hour. Initially HaaG tool would refresh and we had no retrospection for examining themes or hunches about trends and so on. This new reporting capability will help us with resource decisions and forecasting.

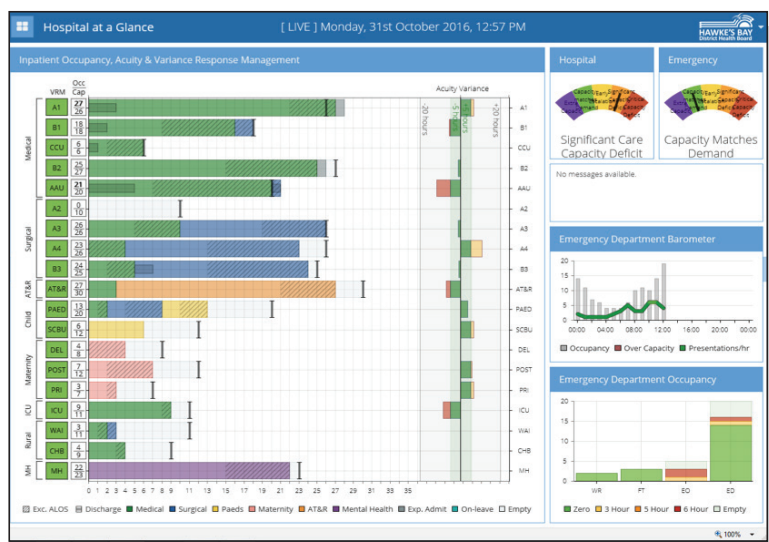
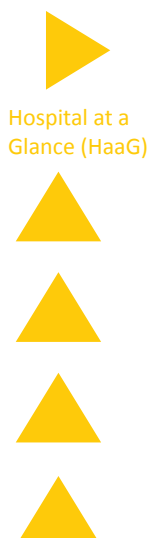
## What has been the most challenging aspect of establishing your VRM system in the DHB and how was this overcome?

Getting started and engaging staff when there is already a lot to do can be a challenge. We developed our own detailed education resources (adapted from CCDM resources) as this helped us own the system we were trying to establish and the vision of VRM success.

We looked at the tools from other DHBs and customised these making them as simple and user friendly as we could to suit our needs. Our variance indicators are easy to follow, which is essential so staff will use when needed. Standard Operating responses and Essential Care guidelines are embedded within the HaaG so people don’t have to go looking. This was piloted in two areas as well as discussed in CNM and NZNO meetings. All the feedback was considered to ensure maximum buy in from the staff.

## What advice would you give others who are about to undertake this process.

- Get a clear view of what you have already and build from this. The CCDM VRM Standard should help a DHB assess themselves
- Liaise with other DHBs as there are many learnings and you get the best examples from implementing DHBs.
- VRM set up and establishment involves different skills sets and people. Know the requirements of your entire VRM project and the various milestones and appoint the right people at different stages.
- Communicate VRM regularly and ensure staff adjust their VIS when their staffing situation changes or when back to safe operating
- Keep your Operations Centre the hub of VRM with the TrendCare Coordinator, Duty Nurse Management team, Care Capacity Manager and roster team located in the same place. This helps connect the VRM system to people and culture.



“... thankyou to the SSHW Team”

## Lisa Skeet – Director of the SSHW Unit shares her farewell thoughts with us



The Director of the Safe Staffing Healthy Workplaces (SSHW) Unit has been one of the most rewarding, but equally challenging roles of my nursing career.

It has been a privilege to contribute both to an incredible health sector team and the continuous improvement of the Care Capacity Demand Management (CCDM) programme.

There have been many instances, in conjunction with DHB and health union staff, where the programme, the SSHW team and I personally, have made a positive difference in our hospitals. However, this has not been at the speed or at the depth of change required (as yet) to make a sustained difference in ensuring safe staffing every day, on every shift.

CCDM provides a transparent reality of hospital service configuration and performance. From what is happening on the clinical floor, how the budgets are set, to what the organisation needs to ensure the best outcomes for staff, patients and the finances. It connects the organisations strategy with direct patient care activity.

I heard a wise colleague say once that the health sector employs two types of staff. Those who deliver front line care and those who support the staff

who deliver front line care. The CCDM programme supports both types of staff to connect with each other's day to day worlds. This enables the full realisation that we are all here to ensure sustainable quality patient care and that we all have an important part to play.

The programme provides an exciting opportunity to improve how we do things around here. However, it can also be seen as an unwanted challenge to what is “normally” known or done. Increased transparency of information and the decisions that are made brings increased accountability, both for the past and going forward. It forces problem recognition, which can be extremely challenging when people feel they have no way of managing those problems.

Many countries are struggling with providing safe staffing & quality patient outcomes within ever-increasing fiscal constraints. However, I do believe that there is a high level of maturity in New Zealand when it comes to the safe staffing agenda. The CCDM programme has recently seen a recommitment from both the District Health Boards and their Health Union partners, and after 10 years in the sector the SSHW Unit is now funded permanently. The

future has never been more positive. I believe I am leaving the SSHW Unit and CCDM programme in a very strong place to make a sustained difference in ensuring safe staffing every day, on every shift.

Thank you to the SSHW Governance Group for your commitment to CCDM being the safe staffing framework for the New Zealand health sector. Your leadership and contribution is needed and appreciated.

Thank you to the CCDM Site Coordinators who champion the work every single day.

Thank you to the DHB and health union staff who support and contribute to the work and believe it will make a positive difference.

Last but by no means least -Thank You to the SSHW Team! I am proud to have been part of such a knowledgeable passionate and resilient group of health professionals.

The Right Staff in the Right Place at the Right time, providing the Right care is the Right answer!

What will I miss – the most important thing of course - it is people, it is people, it is people.

*He tangata He tangata He tangata*



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