Standard operating procedure for FTE calculations

Purpose

- Table 1 outlines the standard operating procedure for conducting annual FTE calculations.
- The procedure should be discussed and agreed by the CCDM council or delegated to the working party.
- Review and agree the process annually.

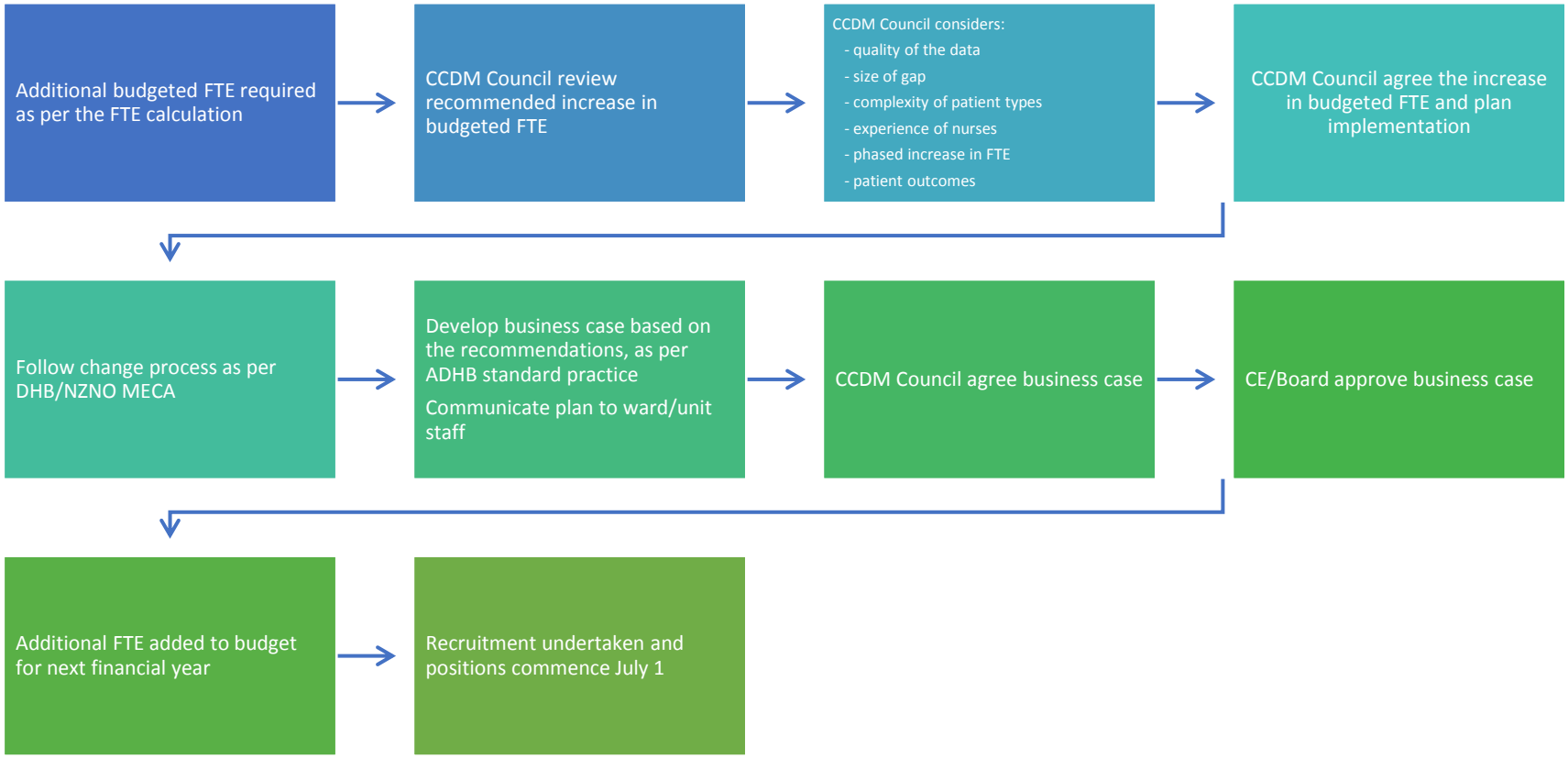
Table 1 - Standard operating procedures for annual FTE calculations

Item	Procedure
Budget setting	The FTE result informs budget setting for the upcoming financial year. The FTE to employ and the FTE to budget is identified in each calculation. The FTE to employ is allocated against each role type under personnel costs. The FTE for unplanned leave and patient 1:1 care (of 8 hours or more) is allocated to 'bureau' (or equivalent) under personnel costs.
CCDM programme standards	FTE calculations are completed annually in accordance with the CCDM programme standards and software standard operating procedures.
Communication	A no surprises approach is used. Regular catch-ups are scheduled with the co-chairs and held on an ad hoc basis as needed. Process for regular communication with staff is scheduled and implemented. The process for change to rosters or FTE (if any) is clearly outlined.
FTE Report	Where multiple studies are run concurrently the multiward report template is used, supplemented by printouts from the software.
Monitoring measures	Indicators from the core data set are selected and agreed to monitor outcomes from changes (if any) to the FTE or roster.
One on one care	Excluded from the base roster except where one on one care is core business e.g. ICU. The need for including one on one care in the base roster is considered for services where one on one care hours are high e.g. X% of total FTE. In this instance two studies are run in the software to compare one on one care excluded and included in the base roster. One on one care FTE is included in the budget whether it is in the base roster or not. The budget for one on care is held by the budget holder paying for the staff.
Other productive hours	As collected in TrendCare. Any other productive HPPD considered to be high by the working party (e.g. > 30% of total productive hours) is alerted to the CCDM Council.
Process for changes to FTE	The process for sign off of the final FTE results and authorisation of any changes to FTE is agreed and documented. See appendix 1 and 2.

Item	Procedure
Responsibilities	The CCDM council is responsible for ensuring that FTE calculations are completed annually. The FTE working group agrees the methods for calculating the data inputs. The CCDM Site Coordinator collates the pre-requisite data and assesses the quality of the data in collaboration with the TrendCare Coordinator. Clinical managers and their management accountant supply ward specific data (roster, ward context & budgeted FTE). Roster testing is carried out with clinical managers and their line manager. The CCDM Site Coordinator completes the FTE calculation checklists with the budget holder/s and drafts the FTE calculation reports. Results are checked and recommendations (for CCDM council) are agreed by the working group.
Roster model	The roster model is implemented with the start of the financial year. Any variance of the posted roster against the model is monitored and actioned.
Roster selection	Selection of the recommended roster aims to achieve AM 70% resourced, PM 80% resourced, N 90% resourced. Resourced means shifts that are 'ok' and 'surplus' as identified in the 'What if' charts in the software. This guide applies to general medical, surgical and rehabilitation areas only. The decision making is adjusted to context e.g. ICU may be 90% resourced for all three shifts. There may also be other reasons to select a different resourcing level e.g. practical/best practice/MECA rostering requirements, patient outcome measures. Any changes to the resourced roster level needs to be documented.
Seasonal workload variation	Summer and winter roster patterns are established by loading and comparing six-month summer and winter studies (of two or more time periods) in the software. The method of calculating the total FTE is documented and agreed e.g. run the 12 month study in the software using summer roster and add additional FTE for winter months.
Shift coordination	As per DHB/TrendCare business rules, or for specialty areas in accordance with national/international standards e.g. ICU.
Staff available/ productive hours	Staff available hours are calculated for each ward/unit. Values are not applied across multiple wards or units. Values are calculated for each role and level of experience (except where it is not possible/practical to do so e.g. sick leave by level of experience).
TrendCare quality checks	Quality checks are used to inform the decision to proceed with the FTE calculation. The risk of not proceeding is also assessed. Quality checks outside of target are alerted to the CCDM Council for arbitration.

Appendix 1 – Process for sign off of an increase in budgeted FTE

The following diagram provides a generic draft process for FTE sign-off in the case of increasing the budgeted FTE. This should be customized as agreed by the CCDM Council.



Appendix 2 – Process for sign off of a decrease in budgeted FTE

The following diagram provides a generic draft process for FTE sign-off in the case of decreasing the budgeted FTE. This should be customized as agreed by the CCDM Council.