

FTE calculation implementation options

Introduction

This document discusses three different options for implementing the full time equivalent (FTE) calculation in a DHB. Each of the options has advantages and disadvantages as listed in Table 1. Implementation decisions for the FTE calculation may also impact on work analysis implementation. In addition to this there are likely to be DHB contextual factors that need to be taken into consideration.

This document is intended to facilitate Care Capacity Demand Management (CCDM) council discussion and decision-making on the best approach for FTE calculation implementation.

Background

The work analysis and FTE calculation are the two components of the CCDM programme staffing methodology. The FTE calculation and the work analysis work in tandem to provide the required FTE and best rostering practices to meet patient demand.

The expectation from the SSHW Unit is that:

- The work analysis is usually completed once and then re-run if there is a significant change in the ward/unit's model of care and/or service delivery.
- The FTE calculation is an annual budgeting practice.

Ideally the work analysis and FTE calculation in a ward/unit should be run together the first time. The FTE calculation provides the FTE required for patient demand by shift (AM, PM and night) and by day. The work analysis provides an 'in the shift' view of the workload peaks and troughs for each staff role. This enables decision making about the best time of day to roster staff e.g. the use of swing shifts. If you are implementing an FTE in the absence of the work analysis the best start and finish times may not be known. The work analysis also identifies opportunities for improvement for indirect patient care and other ward/unit related work.

It is important to acknowledge that the FTE calculation component of the CCDM programme can create challenges for DHBs and health unions. Once known, the results cannot be unknown and there may be high staff expectations that action will be taken. It is also well understood that DHBs have significant financial constraints. So in order to make a decision about the best implementation approach it is important to understand the different options and the implications for each.

Validated patient acuity – data quality requirement

Work analysis and FTE calculations require 12 months of quality patient acuity data, as defined by the quality checks in the CCDM staffing methodology software. This is to ensure the full benefits are obtained from both processes.

- For the FTE calculation, 12 months of data is required in order for the annual FTE calculation to be completed in the CCDM software. If the data does not meet the quality checks the FTE calculation may be inaccurate.
- For the work analysis, if there is less than 12 months of quality data, the two week TrendCare data findings will be unable to be compared to the same time period the year before or the year trend. This will limit the generalisability of the work analysis findings.

Options analysis

There are three options to consider when deciding the best approach for the initial implementation of the FTE calculation. FTE calculation implementation decisions will also impact on the timing of the work analysis.

1. Ward by ward – eligible inpatient wards/units FTE calculations are run one at a time, coinciding as closely as possible with the work analysis for the ward/unit when run the first time.
2. By directorate/service – all eligible inpatient wards/units belonging to a directorate/service, FTE calculations are run individually, at the same time, and are then reviewed together. These may not all coincide closely with the work analysis.
3. Hospital-wide – all eligible inpatient wards/units FTE calculations are run individually, at the same time with the majority not coinciding closely with the work analysis.

Table 1 below outlines the advantages and disadvantages of the three approaches when considering undertaking the FTE calculation.

Table 1 – Advantages and disadvantages of implementation options

Ward/directorate/ hospital	Advantages	Disadvantages
Ward by ward, picture of surplus/deficits	<ul style="list-style-type: none"> • Focus on one ward/unit at a time • TrendCare data integrity and accuracy required for one ward at a time. 	<ul style="list-style-type: none"> • Takes longer to complete as sequential instead of concurrent. • No directorate or hospital view for some time. • Risk that ward/unit with right staffing supplies areas with staffing deficits. • May not meet staff expectations of timely action when FTE calculation results known but waiting for work analysis results or vice versa.
Directorate/service picture of surplus/deficits	<ul style="list-style-type: none"> • Balancing of surpluses/deficits across wards within directorate/service. • Identification of areas of greatest risk. • Targeted activity to greatest areas of need. • Prioritisation of work analysis • Resource planning across the directorate/service. • More efficient use of programme consultant, health union and site coordinator resource (economies of scale). 	<ul style="list-style-type: none"> • TrendCare data integrity and accuracy is required on all the directorate/service/wards. • Variance to budgeted FTE may be significant. • Any changes may impact staff in several wards/units. • Change management and risk mitigation processes requiring some resources to coordinate. • May not meet staff expectations of timely action when FTE calculation results known but waiting for work analysis results or vice versa. • Requires expert programme management & skills.
Hospital wide picture of surplus/deficits	<ul style="list-style-type: none"> • Balancing of surpluses/deficits across hospital. • Identification of areas of greatest risk. • Targeted activity to greatest areas of need. • Prioritisation of work analysis. • Resource planning across the DHB. • More efficient use of programme consultant, health union and site coordinator resource (economies of scale). 	<ul style="list-style-type: none"> • TrendCare data integrity and accuracy is required on all wards. • Variance to budgeted FTE may be significant. • Any changes may impact all wards/units. • Larger change management and risk mitigation processes requiring more resources to coordinate. • Work analysis may not be completed close to the FTE calculation. • May not meet the staff expectations of timely actions on results as hospital wide. • Requires expert programme management & skills.