

FTE calculation report

Ward name, service/directorate

DHB

Document Information

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# Executive summary

* It is easier (and more effective) to write the executive summary last once all the detail has been documented in the body of the report and synthesis of information completed
* Summarise the main points of the report in bullet point style.
* Highlight the main points from ward/unit Profile, method, findings and recommendations.
* The executive summary should be a synthesis of the report not just a repeat of each section.
* Use bullet points (but no more than 10-15 bullet points).
* The majority of the cost in running most wards or services is staff salaries. For example the annual cost of supplying the nursing roster for an average ward is between 1.2 and 2 million dollars.
* The consequences of failing to accurately match staff to actual patient requirements can be seen in budget overruns, lost productivity and negative staff and patient outcomes. Even a small degree of mismatch can lead to avoidable economic waste overtime.
* In <July 2016> the FTE calculation was run for <ward/unit X> using the CCDM methodology. ward/unit X is a xx bed ward/unit that provides care for patient with xx. Bed utilisation is xx and nursing hours variance xx. <Any other pertinent drivers for conducting the FTE calculation in this ward or was the calculation undertaken as part of annual budget setting>.
* This report outlines the process that was used to establish a recommended roster and budgeted FTE for Ward X. The methodology and assumptions are presented including the data that was used to inform the processes and the calculations that were applied.

## Findings

* E.g the TrendCare quality checks provided assurance that the FTE calculation is reliable at the time of publication
* E.g any missing data or other limitations to the results, variance to FTE methodology
* E.g. observed mismatch/match between supply and demand in the current roster versus recommended roster
* E.g. any particular contextual factors that needed to be taken into consideration in selecting the recommended roster. This may include relevant findings from the work analysis, if completed recently.
* E.g. the required total FTE compared to current total budgeted FTE, FTE to employ

Based on the findings the following recommendations can be made.

## Recommendations

* List the main recommendations. Copy from the last section of the report.
* E.g. change to roster model, monitoring roster gaps as per the core data set
* E.g. any arrangements that need to be put in place to support implementation of the roster model – sharing staff across a floor
* E.g. no change, increase or decrease to total required FTE by XX
* E.g. implement changes to budget
* E.g. areas to be addressed, opportunities for improvement or changes
* E.g improve TrendCare data quality and integrity
* E.g. improve variance response management systems in the ward/hospital
* E.g. monitor any variance to FTE calculation methodology

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# Introduction

* State objectives of the report
* Contains relevant definition of topic
* State background to topic
* State key findings and recommendations
* Describe report’s scope and limitations
* State report outline or structure

This report outlines the methods and outcomes of conducting an FTE calculation for <ward/unit xx> using the CCDM methodology. The CCDM methodology for calculating FTE was developed from the findings of the Safe Staffing Health Workplaces Committee of Inquiry (2006). The Inquiry stated:

*“It is critically important …… that, once the staffing requirements have been matched to the forecasted workload, this is the basis on which budgeting decisions are made. Budgets must fit staffing requirements, instead of staffing being made to fit budget requirements” (Committee of Inquiry, 2006, p 70).[[1]](#footnote-1)*

More recently the FTE calculation methodology has been independently validated by Martin Jenkins (2015).[[2]](#footnote-2) The methodology uses actual patient acuity data and the ward/unit staffing profile to compare staffing supply with patient demand, by day and by shift.

The FTE calculation results in:

* An FTE on which to base the staffing annual budget
* A recommended roster model, by day and by shift to achieve the best match of staff with patient need

Results from the FTE calculation are used in combination with findings from the work analysis. The work analysis complements the FTE calculation by showing patterns of work within a shift. This provides guidance about shift start and finish times and staff mix.

The FTE calculation is done within the CCDM Software and combines data with sound clinical judgment. It requires the participation and agreement of DHB and health union partners throughout the process. Several steps were needed to complete the FTE calculation including:

1. Collecting and agreeing on the data inputs
2. Entering the data into the software
3. Reviewing and selecting the recommended roster
4. Assessing the variance between total required FTE and the current budgeted FTE

The time frame used to for calculating the FTE was <1 July 2015 – 30 June 2016>.

The FTE calculation results show that the budgeted FTE of XX is <sufficient/insufficient/ in excess> of what is needed. The assessment is made on the basis that <include limitations where applicable>:

* E.g. The TrendCare data is reliable
* E.g. The FTE calculation reflects the current and predicted workload for this ward e.g. there are no expected increases in patient volumes or change to service delivery.
* E.g the context of the ward and hospital were considered in selecting the recommended roster. <Describe specific considerations e.g. ward skills mix is poor, after hours support from DNM is high etc, relevant findings from the work analysis (if completed more recently).

It is therefore recommended that the budgeted FTE for <ward/unit> be <increased/decreased> by XX FTE or remain the same. It is also recommended that the roster profile <change/remain the same> to reflect the recommended roster in this report. A 30, 60, 90 day action plan should now be developed to implement the recommendations of this report.

# Ward/unit profile

## Clinical profile

<Provide a summary of the ward/units current service provision>.

<2-3 paragraphs, for example include a description of:

* Patient demand - bed numbers, patient types, bed utilisation, churn, patient outcomes, any recent changes in service delivery
* Staffing supply - nursing leadership, nursing model of care/patient allocation, staff mix, skills mix, turnover, nursing hours variance, variance response management
* Ward context – environment layout and general condition, access to supplies and equipment, support systems, medical and allied health>

## Current roster

The current rostered FTE (or hours) are displayed in Table 1.

Table - Current roster

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Role** | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** |
| RN/RM/EN/HCA |  |  |  |  |  |  |  |
| Shift coordination |  |  |  |  |  |  |  |
| DSN/DSM |  |  |  |  |  |  |  |
| CNM/CMM |  |  |  |  |  |  |  |
| **TOTAL** |  |  |  |  |  |  |  |
| **KEY:**  RN – Registered Nurse; RM – registered midwife; EN – Enrolled Nurse; HCA – Healthcare Assistant; DSN – Designated Senior Nurse/Midwife e.g. Educator, Nurse/Midwife Specialist, Associate Clinical Nurse/Midwife Manager, CNM/CMM – charge or clinical nurse of midwife manager |

## Current budgeted FTE

The current budgeted FTE is displayed in Table 2.

Table - Current budgeted FTE by role

|  |  |  |
| --- | --- | --- |
| **Base/additional** | **Role** | **Current budgeted FTE** |
| Base | EN  |  |
|  | HCA |  |
|  | RN/RM |  |
|  | Shift coordination |  |
| Additional | Allied |  |
|  | Bureau |  |
|  | Clerical |  |
|  | Clinic |  |
|  | CNM/CMM |  |
|  | DSN/DSM |  |
|  | **TOTAL** |  |
| **KEY:**  RN – Registered Nurse; RM – registered midwife; EN – Enrolled Nurse; HCA – Healthcare Assistant; DSN – Designated Senior Nurse/Midwife e.g. Educator, Nurse/Midwife Specialist, Associate Clinical Nurse/Midwife Manager, CNM/CMM – charge or clinical nurse of midwife manager |

# Method

The FTE calculation was performed as per the CCDM methodology and includes:

1. Establishing patient demand (from TrendCare)
2. Roster testing (to achieve the best balance of staff supply with patient demand)
3. Establishing staffing supply (by calculating staff productive hours)
4. Establishing the additional FTE for supernumerary roles
5. Calculating the total FTE

Figure 1 below, summarises the main steps in the FTE calculation.

Figure - Main steps in the FTE calculation

## Patient demand

Patient demand for care is derived primarily from patient acuity data captured in TrendCare. Several reports (<enter start and end date used for the reports e.g. 1 July 2015 – 31 June 2016>) were downloaded from TrendCare and exported into the software, including the:

* Ward Period Shift Variance Report – used to calculate patient demand
* Ward Roster Re-engineering Report – used by the system to generate a recommended FTE for roster testing
* Ward Patient One on One Care Report – used to calculate one to one care requirements (either included in the patient demand or added separately as additional FTE).

Because the FTE calculation is reliant on accurate TrendCare data a number of quality checks were undertaken to determine compliance with the vendors ‘gold standard’. Results of the quality checks are shown in Figure 2.

Figure - Results of TrendCare quality checks

|  |
| --- |
| <Copy and paste ‘picture’ of Quality Checks from Software. This can be done from an export of the pdf or a screen shot. Crop picture to suit needs.> |

The results of the quality checks show:

* <Describe where performing well and therefore can demonstrate confidence in the results>
* <Describe where performing poorly and impact on FTE calculation, if any>

In addition to the TrendCare data there are a number of DHB user-defined data inputs that were entered into the software for the FTE calculation. These included:

|  |  |
| --- | --- |
| Data Input |  |
| Study date period | <Enter start and finish dates used for the FTE calculation> |
| One on One Care Hours(=/> 8 hours per shift) (included/excluded) | One on One care hours were <included/excluded> in this study.<Describe why specials where included or excluded for this ward/unit>. <If included> This means that the hours required for patient one to one care are included in the base roster FTE. The FTE needed for one to one care is not calculated separately. <OR If excluded> This means that the hours required for patient one to one care are excluded from the base roster FTE. The FTE needed for one to one care is calculated separately under Additional FTE.  |
| Other productive HPPD | <HPPD value used>. The other productive HPPD was derived from the TrendCare Ward productive and Non-productive Hours Report as per the CCDM methodology. <OR The default SSHW Unit value for other productive HPPD was used, as the ward/unit data was considered too unreliable for the purposes of an FTE calculation.> |
| Shift coordination hours | Refer to Table 1 – Current Roster for the allocation of shift coordination hours by day. <These are <consistent/inconsistent> TrendCare Benchmarks and/or as documented and agreed in the DHB TrendCare Business Rules>. |

Together, the clinical hours from TrendCare, (one on one care), other productive HPPD and shift coordination hours are summed in the software to generate the actual total hours required (or patient demand) by day and by shift. The patient demand is then graphed on the ‘What if Scenario’ charts in the software, ready for ‘roster testing’.

## Roster testing

Roster testing involves reviewing the What if Scenario charts in the software. Testing is done by moving the recommended FTE up or down (or leaving it as is) to achieve the best match between staff supply and patient demand. The recommended roster that was selected for this ward/unit and the rationale is discussed under Findings.

## Staffing supply

Staffing supply refers the productive hours that are remaining after deducting unavailable hours from the total hours available for 1 FTE.

Documents used to calculate the productive hours were as follows:

* District Health Board/NZNO Nursing and Midwifery Multi-employer Collective Agreement (MECA)
* District Health Board /MERAS MECA
* Information supplied by the DHB for ward/unit specific data

Appendix 2 shows the assumptions used to calculate the productive hours for each role and each level of experience.

Table 3 shows a summary of the productive hours used in the software for each staff type.

Table – Productive hours per staff type

|  |  |
| --- | --- |
| Staff type | Productive hours/ annum |
| Existing nurse |  |
| New nurse |  |
| Bureau nurse |  |
| Existing HCA |  |
| New HCA |  |
| New graduate nurse |  |
| Clinical Nurse/Midwife Manager |  |
| Other Designated Senior Nurse |  |
| Clerical |  |
| Clinic |  |
| Allied health |  |

The total productive hours are then compared in the software with the total required hours established from the recommended roster. The variance to budget is then calculated, leaving a positive or negative or zero variance.

## Additional FTE

Additional FTE refers to staff that are sometimes referred to as ‘supernumerary’ and may not work every shift 7 days per week. However, they are required for effective service delivery and included in the ward/unit budget. For this ward/unit this includes the following roles <delete those that do not apply>:

* Allied health
* Associate Clinical Nurse/Midwife Manager
* Clerical staff
* Clinic
* Clinical Nurse/Midwife Manager
* Clinical Nurse/Midwife Specialist
* Nurse/Midwife educator

The current rostered hours for these staff were entered into the software and the system calculates the required FTE using the productive hours for that role as calculated above (in Table 3).

## Calculating the total required FTE

The total required FTE is then calculated in the software using all the data inputs from above. This includes calculating the total FTE required to supply the recommended roster (factoring in expected turnover and new graduates) and the additional FTE needed for effective service delivery.

# Findings

The following section outlines the findings of the FTE calculation under the headings:

1. What If Scenario Charts
2. Current vs. Recommended Roster
3. Variance to Budgeted FTE

## What if Scenario charts

Appendix 1 displays the What if Scenario charts for the selected recommended roster for each day and each shift. The rationale for selecting the recommended FTE by day and by shift is outlined next.

## Current vs. recommended base roster

Table 4 displays the current rostered base FTE, the system calculated and the recommended FTE by day and by shift. The table also describes the rationale for the selected FTE. <Where relevant, include in the table below findings from the work analysis that support your rationale for selecting the recommended FTE>. <Alternatively insert a picture of the Roster Profile Tab from the software>.

Table - Current vs recommended (selected) roster

| **Day/shift** | **Rostered FTE** | **Calculated FTE** | **Recommended FTE** | **Rationale for recommended****roster** |
| --- | --- | --- | --- | --- |
| **Monday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |
| **Tuesday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |
| **Wednesday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |
| **Thursday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |
| **Friday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |
| **Saturday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |
| **Sunday** |
| AM |  |  |  |  |
| PM |  |  |  |  |
| N |  |  |  |  |

## New roster model

The following table shows what the new roster model would look like in practice. The roster model should be implemented and monitored for roster gaps as recommended in the CCDM core data set directory. <Complete the table below with the number of FTE rostered per shift. Delete roles that do not apply>.

Table : New roster model

|  |  | **Mon** | **Tue** | **Wed** | **Thu** | **Fri** | **Sat** | **Sun** |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| AM | EN |  |  |  |  |  |  |  |
|  | HCA |  |  |  |  |  |  |  |
|  | RN/RM |  |  |  |  |  |  |  |
|  | DSN/DSM |  |  |  |  |  |  |  |
| PM | EN |  |  |  |  |  |  |  |
|  | HCA |  |  |  |  |  |  |  |
|  | RN/RM |  |  |  |  |  |  |  |
|  | DSN/DSM |  |  |  |  |  |  |  |
| Night | EN |  |  |  |  |  |  |  |
|  | HCA |  |  |  |  |  |  |  |
|  | RN/RM |  |  |  |  |  |  |  |
| Additional | Allied |  |  |  |  |  |  |  |
|  | Clerical |  |  |  |  |  |  |  |
|  | Clinic |  |  |  |  |  |  |  |
|  | CNM/CMM |  |  |  |  |  |  |  |
|  | DSN/DSM |  |  |  |  |  |  |  |
| Planned leave | EN |  |  |  |  |  |  |  |
|  | RN/RM |  |  |  |  |  |  |  |
|  | HCA |  |  |  |  |  |  |  |

## Variance to budgeted FTE

Table 5 displays the current budgeted FTE for the ward/unit compared with the required budget as established from the FTE calculation. The total budgeted FTE is <less/more than or adequate> for requirements as calculated in the software. The FTE to employ is XX. The FTE to employ is <less/more than> the current budgeted FTE. The FTE for bureau and unplanned leave is XX. The total FTE to budget is XX. <Populate the table below or alternatively insert a picture of the Final FTE Tab>.

Table - Current vs. required FTE

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Base/ additional** | **Role** | **Current budgeted FTE** | **Required FTE** | **Variance to budget** |
| Base | EN |  |  |  |
|  | HCA |  |  |  |
|  | RN/RM |  |  |  |
|  | DSN/DSM |  |  |  |
| Additional | Allied |  |  |  |
|  | Bureau |  |  |  |
|  | Clerical |  |  |  |
|  | Clinic |  |  |  |
|  | CNM/CMM |  |  |  |
|  | DSN/DSM |  |  |  |
| **TOTAL** |  |  |  |  |

## Total FTE

The following table provides a summary of the FTE calculation results.

|  |  |
| --- | --- |
|  | FTE |
| Current budgeted total FTE |  |
| Recommended total FTE to employ |  |
| Recommended total FTE to budget |  |
| Variance to current budgeted FTE |  |

The following screen shot from the CCDM software provides a breakdown of the final results by role type.

<Insert a screen shot of the Total FTE tab, as required>

# Discussion

## Ward context

A key consideration in determining the recommended roster was the context in which the roster needs to work. Table 6 below shows an assessment of all the variables that contribute to successful variance response management; green is ‘good’, amber ‘average’ and orange ‘poor’. <Overall the table shows that AM shifts are better able to respond to variance than PMs or nights>. This means that AM shifts can accommodate more variance responses than PM or nights>.

The five variables in amber/orange for all three shifts warrant further mention. <Discuss why the assessment is amber/orange and the impact this has on decision making regarding the roster> e.g. Cover for one to one care is difficult to obtain because this is unpredictable workload and requires specialist skills. The ward has significant variation in HPPD and bed utilisation. This is particularly evident during the winter months due to increased presentations and acuity of patients. The ward has had a number of staff off on long term sick leave. This pattern is likely to continue for the next 12 months. Roster decisions therefore need to take the current ward context into account>.

Table – Ward context assessment

<Complete table with appropriate colour dots for this ward/unit>

|  |  |  |  |
| --- | --- | --- | --- |
| Variables | AM | PM | N |
| Access to designated nursing leadership | ⚫ | ⚫ | ⚫ |
| Staff mix  | ⚫ | ⚫ | ⚫ |
| Skills mix | ⚫ | ⚫ | ⚫ |
| Cover for 1:1 care | ⚫ | ⚫ | ⚫ |
| Mature organisational VRM system | ⚫ | ⚫ | ⚫ |
| Casual nurse availability | ⚫ | ⚫ | ⚫ |
| Stable HPPD  | ⚫ | ⚫ | ⚫ |
| Stable bed utilisation | ⚫ | ⚫ | ⚫ |
| Access to expertise/support | ⚫ | ⚫ | ⚫ |
| Ward equipment/supplies | ⚫ | ⚫ | ⚫ |
| Ward layout | ⚫ | ⚫ | ⚫ |
| Long term sick/vacancy | ⚫ | ⚫ | ⚫ |
| Key: ⚫ = good; ⚫ = average; ⚫ = poor |  |  |  |

## Further analysis of recommended roster

<This section can be included if you need to complete further analysis of the What If Scenario charts. This can be undertaken in table format in Excel (see Table 7). Figures from the software are transposed into the table and then colour coded. The advantage of this approach is being able to see all shifts and all the days in one single view. This means an even distribution between days of the week can be obtained. The report should explain where there are undesirable deficits or surpluses and what roster adjustments are proposed to correct this>.

Table - What If Scenario analysis of the recommended roster



<Roster decisions have also taken into consideration e.g.:

* Work analysis findings e.g. a ‘lull’ in the frequency of activities between 0200-0400 hours, increasing activity occurring from 0600
* The MECA which for example states that duties must commence between 0600 – 2315 and be no less than 4 hours.
* Surpluses and how the hours might be usefully deployed e.g. cover for sick leave or one to one care. This should be supported by data on one to one care hours and what shift these are more often required.
* RN or HCA resource which can be extrapolated from a manual calculation of the other productive hours using the TrendCare productive and Non-productive hours report.
* DHB’s nursing workforce strategy which might for example, be aiming to stratify the nursing workforce>

## One on One care

There are some areas with significant regular one on one care hours e.g. 8,000 hours per annum or routinely needed on certain days of the week. While the areas core business may not be one on one care, patient age, comorbidities and treatment may mean that this is routinely needed. In these circumstances further analysis of one on one care can help determine if it would be more efficient and effective to employ permanent FTE. Analysis would include:

* How much one on one care, on what shifts and what days of the week?
* What is the reasons one on one care being provided? RN/RM or HCA?
* What is the duration of the one on one care? Part shifts or full and in what proportion?
* Is the demand sufficient for the employment of permanent FTE? Part or all of the FTE required for one on one care? Rostered on some shifts or some days, or all?

The results of such an analysis should be provided here, along with any implications for the FTE to employ.

# Limitations

FTE calculations are not an exact science. For example, small changes to other productive HPPD or staff productive hours can have cumulative effects on the final FTE result. Every possible care has been taken to ensure that the data used to inform the FTE calculation is correct. There are other factors that must also be taken into consideration:

* The FTE calculation only provides a certain level of staffing (on average xx% of AMs, xx% of PMs and xx% of nights). There will be occasions where additional staff are required to meet increased patient demand. There will also be occasions where surplus staff can be re-assigned, offered short notice leave or undertake quality improvement activities. An organisational variance response management system will be essential in reaching the expected outcomes of an accurate FTE calculation.
* The FTE calculation assumes that the patient care hours required by acuity will remain similar to those of the last financial year 20xx/xx. Average patient acuity <increased/decreased> by xx hours per patient, per day between 20xx/xx and 20xx/xx. If the patient acuity <increases/decreases> by xx% in the next financial year then the current FTE calculation results will not match patient demand. The FTE calculation also cannot account for vacancy, long term sick leave or unexpected increases in patient volumes.
* Assuming the recommendations of this report are endorsed, the budgeted nursing FTE will not come into effect until the 20xx/xx budget. This means that the data on which the FTE calculation is based will be xx months out of date.
* The FTE calcultion maths does not always translate into a roster that can be implemented. Both MECA requirements and patient need (that occur through out a shift) result in compromises that must be made to satisfy what is reasonable and pragmatic. This may sometimes be at the expense of perceived efficiencies.
* A formal check of the TrendCare data was not carried out by the SSHW Unit. The data quality checks, as reported by the DHB, gave confidence that a formal check of TrendCare data quality and integrity was not required. The FTE calculation was undertaken on the basis that the data quality checks are accurate.

# Recommendations

* See Executive summary for examples. The recommendation/s listed here should be identical to the recommendation/s listed in the Executive summary.
* Bullet point the recommendations (no longer than approximately 10 bullet points).
* Aimed at solving problems outlined in the Findings and Discussion
* Action oriented – must be viable options
* Short and focused
* Numbered in order of importance
* No new information should be listed. If you need to add a recommendation that has not yet been discussed elsewhere go back to the findings to see if you have missed something or bring the recommendations back within the scope of this report.
* It is easier (and more effective) to write the recommendations last, once all the detail has been documented in the body of the report and the findings have been listed.

# Appendix 1 – What If Scenario charts

<Paste ‘pictures’ of the What If Scenario charts here. This can be done from a pdf export or from a screen shot. Crop the picture to suit your needs>

<Table 4 – Current vs Recommended Roster is a critical piece of information and summarises the What If Scenario charts and the decision making. This may mean that the What If Scenario charts are not required. However, the charts will appeal to those who like graphs better than tables of numbers. The charts are also a powerful way of demonstrating surpluses/deficits and making the case for change from staff to the Board. Deciding which charts to include depends on the audience for the report and the outcomes to be achieved. Some options are:

* Exclude the What if Scenario charts and emphasise the information in Table 4.
* Include all of the What If Scenario charts. This promotes openness and transparency, but will make the report a lot longer.
* Include a selection of charts to illustrate and support a recommendation/s
	+ e.g. a recommendation to increase FTE for all night duties would be supported by charts showing a shortfall in all night duties across the 7 days of the week,
	+ e.g. a recommendation to reduce staffing Dec-Jan would be evidenced by charts that show seasonal variation over Christmas/New Year
	+ e.g. a recommendation to move staff from PM to AM on a swing shift would be evidenced by AM and PM charts for the relevant days of the week>

# Appendix 2 – Assumptions used to calculate productive hours

<Complete the following table – copy and paste from the data request schedule>

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Non-Productive hours | Existing nurse | New experienced nurse | Existing HCA | New experienced HCA | New graduate | Bureau | Clinical Nurse Manager | Assumptions/ calculation |
| Available hrs (1 FTE) | 2086 | 2086 | 2086 | 2086 | 2086 | 2086 | 2086 |  |
| Annual |  |  |  |  |  |  |  |  |
| Long service |  |  |  |  |  |  |  |  |
| Maternity/ parental |  |  |  |  |  |  |  |  |
| Sick/ breavement |  |  |  |  |  |  |  |  |
| Shift Leave |  |  |  |  |  |  |  |  |
| Public Holidays |  |  |  |  |  |  |  |  |
| Orientation |  |  |  |  |  |  |  |  |
| Supernumerary |  |  |  |  |  |  |  |  |
| Mandatory |  |  |  |  |  |  |  |  |
| Specialty |  |  |  |  |  |  |  |  |
| Professional development |  |  |  |  |  |  |  |  |
| Certif/ re-certification |  |  |  |  |  |  |  |  |
| Additional |  |  |  |  |  |  |  |  |
| Subtotal Non-productive hours | **0** | **0** | **0** | **0** | **0** | **0** | **0** |  |
| Remaining hrs available | 2086 | 2086 | 2086 | 2086 | 2086 | 2086 | 2086 |   |

1. Safe Staffing/Healthy Workplaces Committee of Inquiry (2006). *Report of the Safe Staffing/healthy Workplaces Committee of Inquiry*. [↑](#footnote-ref-1)
2. Martin Jenkins (2015). *Review of the FTE Calculation Methodology in the Care Capacity Demand Management Programme*. [↑](#footnote-ref-2)