



ASMS RESEARCH BRIEF



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Survey of clinical leaders on Senior Medical Officer staffing needs: MidCentral District Health Board

The Association of Salaried Medical Specialists (ASMS) is examining Senior Medical Officer (SMO) staffing levels at selected District Health Boards (DHBs) via a survey of clinical leaders covering all hospital departments. The aim is to assess, in the view of clinical leaders, how many SMO Full Time Equivalents (FTEs) are needed to provide a safe and quality service for patients, including patients in need of treatment but unable to access it. This Research Brief presents the findings of the survey at MidCentral DHB.

Overview

Data produced by the Organisation of Economic Cooperation and Development (OECD) show New Zealand has one of the lowest numbers of specialists per head of population out of 33 countries.¹

The extent of medical specialist shortages in New Zealand has been well documented by the ASMS.² But while workforce shortages affect access to health care, as well as the quality, safety and efficiency of public hospital services, they go largely unnoticed by the general public in part because the shortages are so entrenched. Coping with shortages has become the norm for many public hospital departments.

An indication of the true state of the medical workforce is well illustrated in two major ASMS studies. The first, published in November 2015, found many DHB-employed SMOs routinely go to work when they are ill.³ The main reasons for doing so include SMOs not wanting to let their patients down and not wanting to over-burden colleagues. The second study, assessing the extent of fatigue and burnout in the SMO workforce, published in August 2016, found 50% of respondents reporting symptoms of burnout – revealing further evidence of the immense pressure that senior doctors are under to hold the public health system together at the expense of their own health.⁴

The incursion of heavy clinical workloads into SMOs' non-clinical time is a further 'buffer' that has saved many services from becoming dysfunctional. The SMO Commission's inquiry into issues facing the workforce in 2008/09 found as clinical work takes precedence for most SMOs, high workloads have a major impact on non-clinical activities such as supervision and mentoring, education and training, and their own ongoing professional development and continuing medical education."⁵

All the indications are that this situation has not improved; if anything it is now worse. Non-clinical time may not involve direct contact with patients but it is a vital part of SMOs' work which ultimately has a significant effect on patient care and safety, as well as cost-efficiency.



None of this is good for delivering high quality patient centred care which, according to a growing body of evidence, not only leads to better health outcomes for people but also helps to reduce health care costs by improving safety and by decreasing the use of diagnostic testing, prescriptions, hospitalisations and referrals. Genuine patient centred care will remain only an aspiration in New Zealand until specialists are able to spend more quality time with patients and their families to develop the partnerships that lie at the heart of this approach.^{6 7}

SMO shortages have also contributed to a growing unmet health need, and even those who qualify for treatment often face delays before they receive it. A Commonwealth Fund study of the performance of health systems in 11 comparable countries places New Zealand 10th for 'long waits for treatment after diagnosis' and 9th for 'long waits to see a specialist'.⁸

In view of these ongoing issues, the ASMS is conducting a series of studies using a questionnaire to clinical leaders in selected DHBs to ascertain how many specialists are required, in their assessment, to provide safe, good quality and timely health care for those who need it. This is the second in the series, following the study of Hawke's Bay DHB, published in July 2016.⁹

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Introduction

In May 2016, the ASMS distributed an online questionnaire to Clinical Directors and 'Medical Heads' of services at MidCentral DHB, seeking their assessment on the adequacy of SMO staffing levels in their respective departments. For the purposes of this report they are referred to as 'Heads of Department' (HoDs). The analysis of their responses included a process to avoid any double counting. Responses were received from all but four departments. The questions sought the HoDs' estimates of staffing requirements to provide effective 'patient centred care', which involves, among other things, SMOs spending more time with their patients so they are better informed about their condition, their treatment, any treatment options, and benefits and risks. Patient centred care has been shown to not only improve the quality of care and health outcomes for patients but also improve health service efficiency and cost-effectiveness.

Questions also sought estimated staffing requirements to enable SMOs to access non-clinical time and leave, both of which are crucial for providing safe and effective care. For example, the ASMS has previously reported on the high levels of 'presenteeism', where SMOs are turning up to work sick, in part because of insufficient short term sick leave cover.

The aim of this study - and similar studies either currently underway or planned for other DHBs - is to highlight the effects that entrenched shortages of SMOs are likely to have on patient care. The data gathered will enable an objective assessment of the state of the SMO workforce and any resultant deficits which we hope will instil a greater sense of urgency in our health workforce planners to act on addressing workforce deficits.

Summary of findings

- Of the 32 HoDs contacted for participation in this research, 28 responded to the survey (87.5% response rate).
- Just one of the hospital departments (Rheumatology) assessed indicated there was adequate FTE SMOs for their service at the time of the survey.
- Overall an estimated additional 41.1 FTEs – or 27.3% of the current SMO staffing level surveyed - were required to provide safe, quality and timely health care at the time of the survey.
- The estimated additional FTEs required above current staffing levels ranged from 5% (1 FTE) to 200% (2 FTEs).
- Despite the estimated 41.1 FTE staffing shortfall, there were only 7.6FTE vacancies at the time of the survey.
- An estimated 57% of SMOs are 'never' or 'rarely' able to access the recommended level of non-clinical time (30% of hours worked) to undertake duties such as quality assurance activities, supervision and mentoring, and education and training, as well as their own ongoing professional development and continuing medical education.
- More than half of the HoD respondents believed there was inadequate internal SMO cover for training and mentoring, short-term sick leave, annual leave and continuing medical education leave.
- Nearly two-thirds of the HoD respondents believed there was inadequate access to locums or additional staff to cover for long-term leave.
- Nearly half of the HoD respondents believed their staff had inadequate time to spend with patients and their families to provide good quality patient centred care.

Findings

FTE analysis of departments

The results from the FTE assessments conducted by the HoDs, as detailed in Table 1, show only the Rheumatology department out of 28 departments surveyed felt they had adequate FTE for their service at the time of the survey. However, the department's HoD assessment indicates the recommended non-clinical time was accessed only 'sometimes', and current SMO staffing levels did not provide sufficient time for training and education duties. Estimates for two departments – ICU and Breast Imaging – were not available.

The Emergency Department (ED) had the largest estimated staffing shortfall at the time of the survey, with the current SMO staffing (9.5 FTEs) requiring a further 3 FTEs just "to stand still" and "18-24 to implement the service improvements we would like". The HoD commented: "Most of us have significant arrears of leave built up."

The estimated shortfall of 41.1 FTEs (27.3% of current SMO FTEs) is greater than the estimated staffing shortfall in Hawke's Bay DHB (22%), survey earlier in the year, published in July 2016.

Vacancies

Six departments of the 28 surveyed reported vacancies for SMOs. The FTE for current vacancies in each department was, with the exception of Obstetrics and Gynaecology (O&G), far less than the estimated additional FTE required. This reflects the fact that DHB budget constraints affect the number of official vacancies as only funded positions are recorded. As such 'vacancies' are not an indicator of staff shortages from a clinical perspective.

Table 1 Summary of FTEs by Department

Department	Current FTE Allocation	Estimated Additional FTE Required	% of current FTE required	Current FTE Vacancies where applicable
Anaesthesia & ICU	19	5	26%	2
Breast Imaging	1.6	Not available	-	
Cardiology	4.3	1	23%	
Paediatrics / Child Health	8	1.5	19%	
ED	9.5	10.5	111%	2
Endocrinology and Diabetes	1	2	200%	
ENT	3.3	0.8	24%	
Gastroenterology	1.5	1.1	73%	
General Surgery	6	1	17%	
Geriatrics	4	2	50%	
Haematology, Regional Cancer	19.8	1	5%	
Hospital Dental unit	2.8	0.2	7%	
ICU	3.3	Not available	-	
Infectious Disease and Infection Control	0.6	0.4	67%	
Medical administration	1.7	0.8	47%	
Medical Oncology	5.6	1.4	20%	
Medical Services*	13.1	2.2	17%	
Mental Health & Addictions	15	2	13%	2
Nephrology	2.3	0.5	22%	
Neurology	2.2	0.6	27%	
O&G	6.1	1.4	23%	1.4
Ophthalmology	2.7	0.4	15%	
Public Health	1.7	0.7	41%	
Radiation Oncology	7.1	1.4	20%	0.2
Respiratory	1.8	0.5	28%	
Rheumatology	1.5	0	0	
Sexual Health	0.9	0.7	78%	
Urology	4	1	25%	
Totals	150.4	41.1	27.3%	7.6

*Comprises General Medicine, Rehabilitation, and Elder Health. Other Medical Services are listed separately.

Accessing non-clinical time

The rest of the survey assessed the views of HoDs concerning the ability of their senior staff to access non-clinical time, perform training and education duties and take leave of various types. The following section is broken down according to the questions asked in the survey.

How readily do you think SMOs are able to access the recommended 30% non-clinical time?

As detailed in Figure 1, 57% felt that SMOs were either 'rarely' or 'never' able to access their recommended 30% non-clinical time, and 14% believed this time was accessed 'sometimes'. Less than a third (29%) of HoDs believed their SMO staff could access non-clinical time either 'often' or 'always'. One HoD commented that only one SMO in their department had access to the recommended non-clinical time. Other comments included: "Despite the so-called non-clinical time, a consultant has to be always available for telephone consults". Another respondent estimated SMOs in their department probably accessed around a third of the recommended non-clinical time "broken here and there".

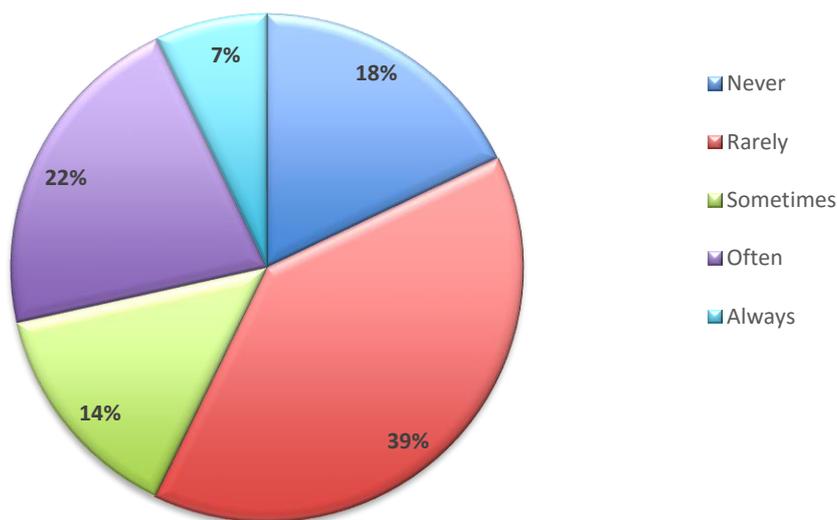


Figure 1: Access of SMOs to the recommended 30% non-clinical time

FTE assessment to provide time for training and education duties

The next question ascertained views on whether specialists had enough time to participate in the training and education of Resident Medical Officers (RMOs) as recommended by the 2009 SMO and RMO commission. As detailed in Figure 2, nearly two-thirds of respondents either 'disagreed' or 'strongly disagreed' there was adequate time for this in their departments. Just 28% 'agreed' or 'strongly agreed' there was sufficient time for training and education duties. Open feedback in this section included a comment that while training occurs during clinical time, as part of the apprenticeship model, "Our dedicated SMO's teach theory in there off time. One respondent commented consistently fail College training audit requirement in this area".

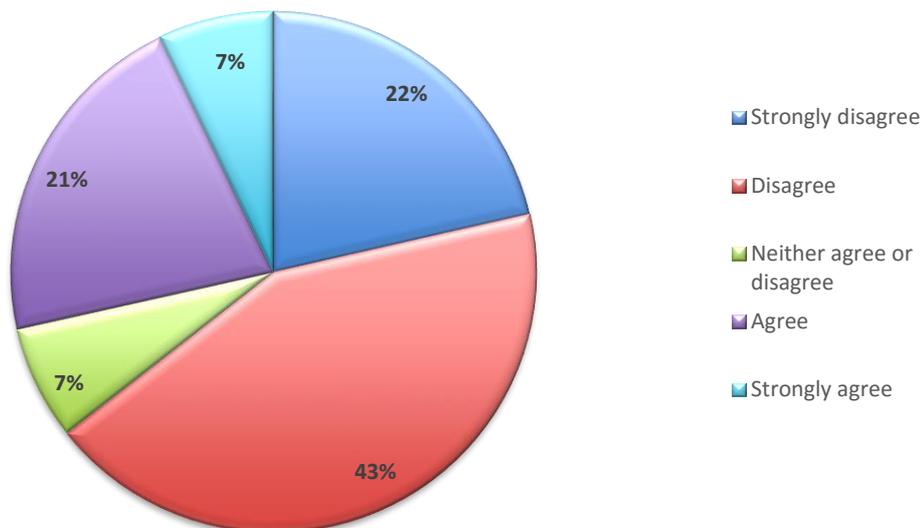


Figure 2: Sufficient time for training and education duties

SMO staffing levels and internal SMO cover to provide for leave

As detailed in Figures 2 and 3, the responses suggest that on the whole staffing levels are inadequate to allow for any of the listed factors – training and mentoring of staff, short-term sick leave, continuing medical education (CME), or annual leave. More than half of respondents either disagreed or strongly disagreed that there was sufficient internal cover to provide for all categories.

Just over a third of respondents agreed or strongly agreed there was sufficient cover to provide for training and mentoring. Less than a third of respondents could say the same for the other three categories.

Comments in this section noted particular challenges covering for annual leave and short-term sick leave. One respondent commented “staffing which is barely adequate when we are all present becomes desperate when someone is away. We all have large leave balances that we cannot take”.

In another department staff cover for leave was considered “generally adequate as long as clinicians make arrangements well in advance...” but “short term sick leave is the most difficult and if acute work cover is required usually someone drops something else in order to pick up the acute work”.

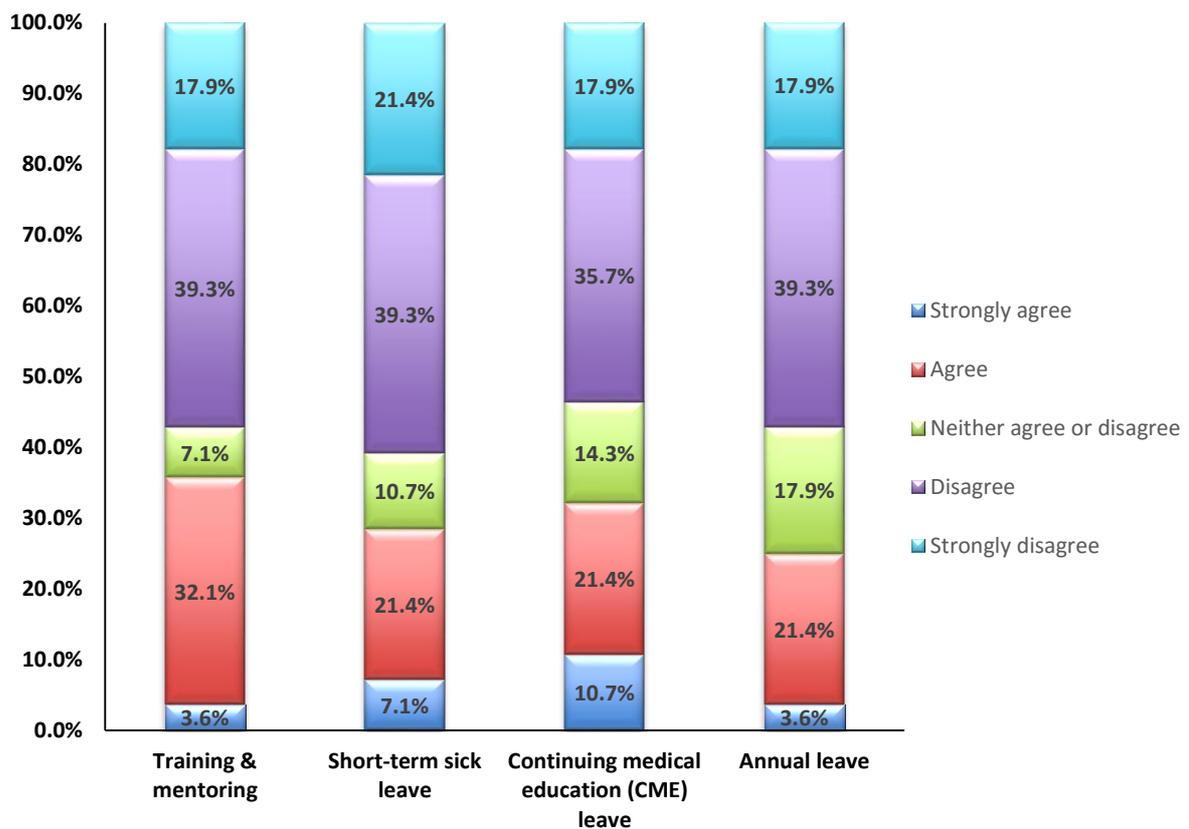


Figure 3: Assessment of internal SMO cover to provide for training and mentoring, short-term sick, CME and annual leave

The next section of the survey sought to ascertain whether HoDs believed their access to locums or other staff was sufficient to assist with other types of leave in their departments, including parental, sabbatical and secondment leave. As detailed in Figure 4, access to locums or extra staff was also viewed as poor by the majority, with nearly two-thirds either disagreeing or strongly disagreeing that access was adequate to enable access to various types of leave. None strongly agreed; 11% agreed access was adequate, while a quarter of respondents felt neutral on the matter. Comments from respondents noted there were often difficulties in finding locums, especially if it is at short notice. As one respondent commented “locum cover is not just related to DHB funding but also availability of a locum”.

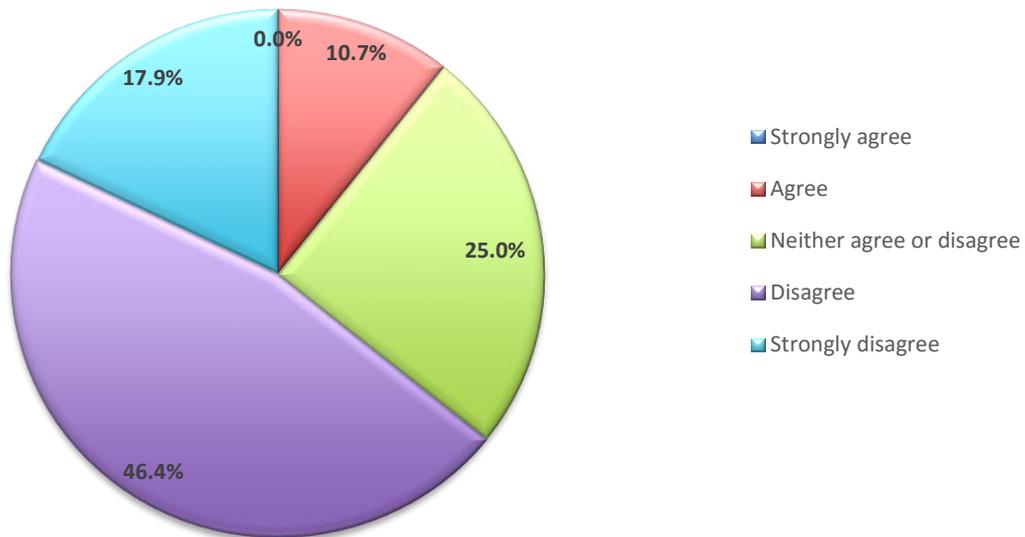


Figure 4: Degree of access to locums or extra staff to enable full use of longer-term leave

The final question in this section sought an overall assessment of whether the current staffing allocation was sufficient for full use of appropriate leave taking as well as non-clinical time and training responsibilities. Of the 28 HoDs who responded, 23 (85.7%) said 'no'. A number commented that leave was difficult to take and many staff had accumulated substantial unused leave (Figure 5).

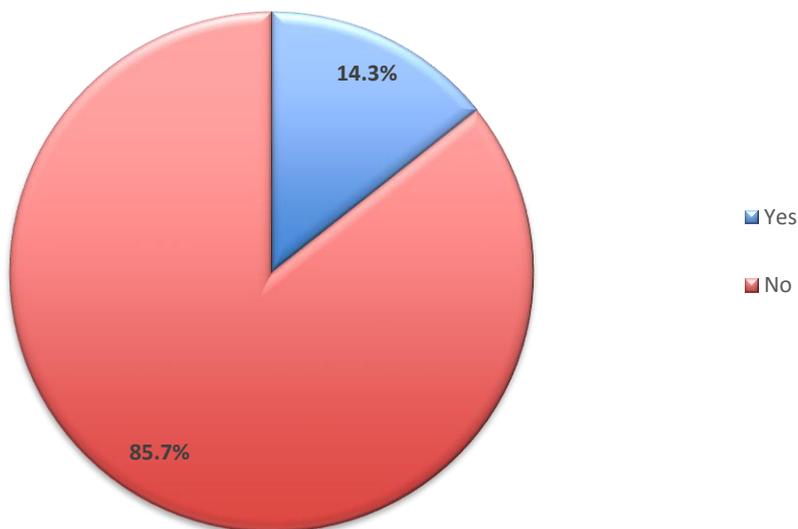


Figure 5: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

General Practitioner (GP) referrals and unmet need

The next area of enquiry focused on whether the specialties involved were actively referring patients back to GPs and whether they were aware of GPs holding back referrals. As detailed in Table 2 and Table 3, this question was not applicable to four departments (anaesthesia, intensive care, public health, and medical administration) and three of these departments (excluding anaesthesia) were not involved in specialist referrals.

Half of the respondents indicated their departments referred patients back to their GPs because they did not meet the DHB's treatment/financial threshold. Comments from HoDs were generally around the theme of having to restrict services according to funding constraints; "We are currently instructed not to accept anything other than urgent or emergency referrals into the service". One respondent pointed out that any 'over-delivery' in one area will mean siphoning off funding from other areas. Some had concerns about whether primary care services were adequately resourced to deal with returning patients.

To the question on whether HoDs believed GPs were withholding referrals to specialists in their departments, respondents were fairly evenly divided with 36% answering 'yes' and 39% giving 'no', with the remainder either not known or not applicable. Comments referred to the resulting hidden unmet health need in the community. Noting "adding SMO resource and finding alternative management pathways are the ways to redress a capacity-demand mismatch".

Table 2 Referrals back to GPs

Does your area of responsibility refer patients back to their GP because they do not meet your DHB's treatment/financial thresholds, or would exceed waiting time limits, even though they would benefit from immediate treatment?		
Answer Options	%	n
Yes	50%	14
No	36%	10
Not Applicable	15%	4

Table 3 GPs withholding referrals

From your contact with GPs do you think they are delaying or withholding referrals for first specialist assessments in your area of responsibility?		
Answer Options	%	n
Yes	36%	10
No	39%	11
Unknown	14%	4
Not Applicable	11%	3

Time for patient centred care

The final section of the survey sought HODs' views on whether their staff had adequate time to spend with patients and, where appropriate, their families to provide patient centred care. As detailed in Figure 6, the responses were divided slightly in favour of the affirmative. Comments referred to the tension between the need to spend quality time with patients against the need to attend to the next patient and an emphasis on patient 'throughput'. Comments also suggested time for patient centred care was achieved at the expense of other non-clinical work.

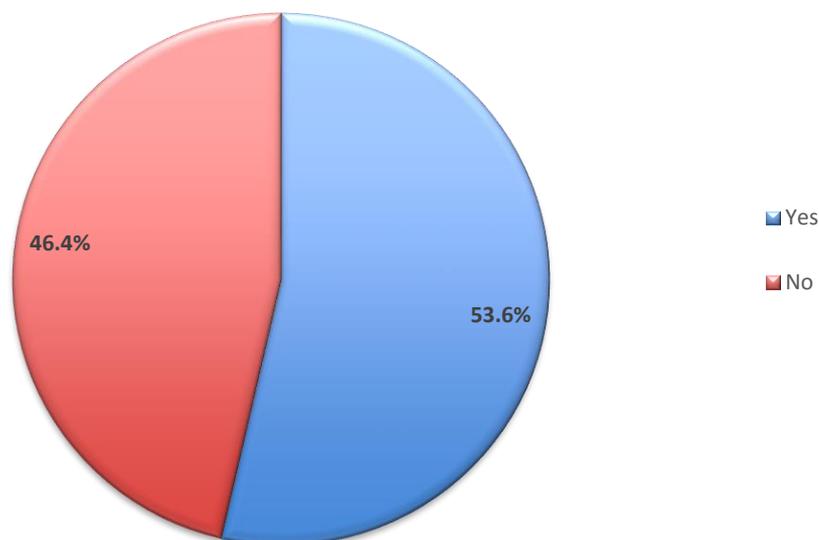


Figure 6: Do staff have adequate time for patients and their families?

References

¹ OECD Health Statistics, 2016.

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⁴ C Chambers, C Frampton. 'Tired. Worn-out and uncertain': Burnout in the New Zealand public hospital senior medical workforce, Health Dialogue, Issue 12, August 2016. Available: http://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf

⁵ SMO Commission. *Senior Doctors in New Zealand: Securing the Future*. Report of the SMO Commission, June 2009.

⁶ L Keene. *Why is patient Centred care so important?* Path to Patient Centred Care, Issue 2, ASMS, 18 July 2016. Available: http://www.asms.org.nz/wp-content/uploads/2016/07/Why-is-patient-centred-care-so-important-issue-2_165838.4.pdf

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