ASMS RESEARCH BRIEF

ASMS TOI MATA HAUORA

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Survey of clinical leaders on Senior Medical Officer staffing needs: Northland 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 ninth survey, at Northland DHB.

Background

Data produced by the Organisation of Economic Cooperation and Development (OECD) show New Zealand has one of the lowest number of specialists per head of population out of 32 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.

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. Commonwealth Fund studies of the performance of health systems in 11 comparable countries place New Zealand 7th for emergency department waiting times, 9th for waits for treatment after diagnosis, 9th for waits for elective surgery, and 10th-equal for access to diagnostic tests (eg, CT, MRI scans etc). On a measure of mortality amenable to health care, that is, deaths that could have been prevented with timely care, New Zealand was placed 10th.[3]

An indication of the true state of the medical workforce is illustrated in a major ASMS study which found many DHB-employed SMOs routinely go to work when they are ill.[4] The main reasons for doing so include not wanting to let their patients down and not wanting to burden colleagues. A study of fatigue and burnout in the SMO workforce reveals 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 and wellbeing.[5]

In many cases SMOs are also sacrificing non-clinical work to deal with heavy clinical workloads. 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."[6]

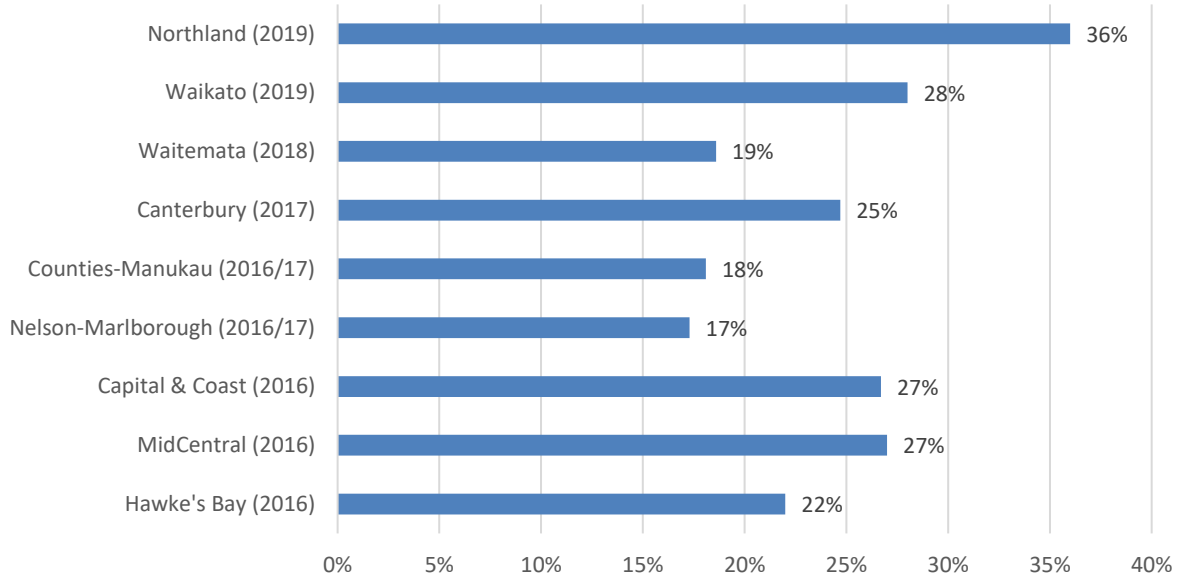
All the indications are that this situation has not improved; if anything, it is now worse. Non-clinical time may not involve direct contact with patients but it is a vital part of SMOs' work which ultimately has a significant effect on patient care and safety, as well as cost-efficiency.

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 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.

Nor are specialist shortages good for distributed clinical leadership, which is critical for implementing patient-centred care. Making the best use of the experience and insights of specialist staff is vital for fostering an environment supporting high-quality patient-clinician interaction, for there is broad consensus that this is where ultimately patient-centred care is determined. Involving senior doctors in the design and implementation of patient-centred processes is an important way of ensuring the whole clinical team is engaged in these efforts.

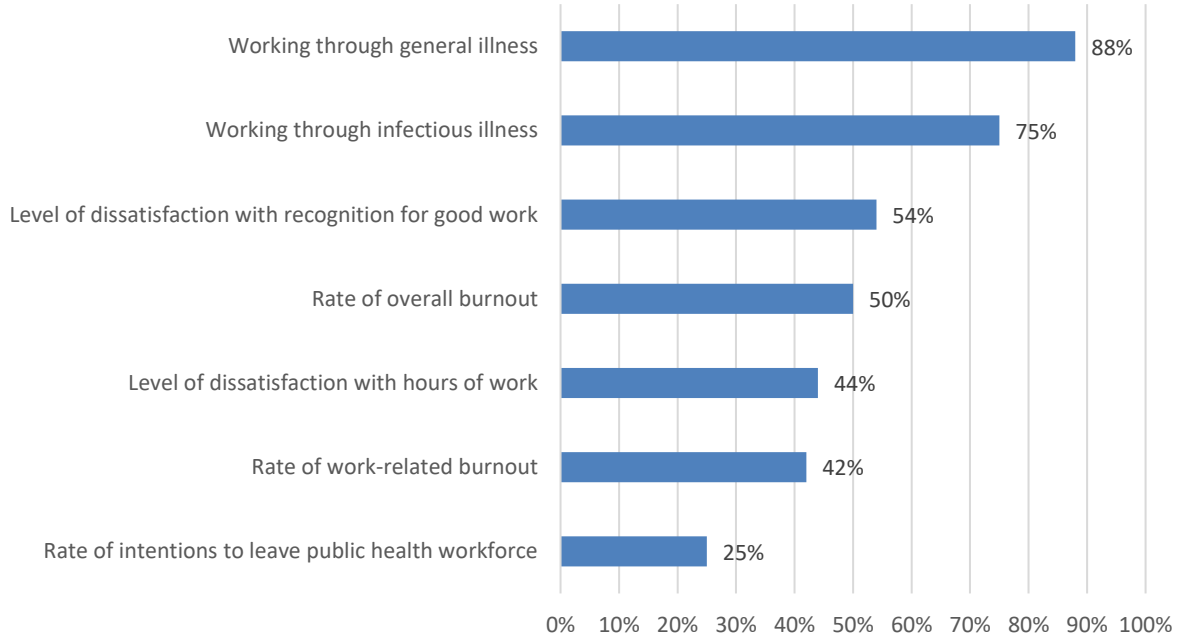
There is now strong consensus internationally that distributed clinical leadership is the best model to meet the challenges facing health care systems around the world.

In view of these ongoing issues the ASMS is conducting a series of studies using a survey of clinical leaders in selected DHBs to ascertain how many specialists are required, in their assessment, to provide safe, good quality and timely health care. This report is the ninth in the series, which started with Hawke's Bay DHB in February 2016, followed by MidCentral (2016), Capital & Coast (2016), Nelson-Marlborough (2016/17), Counties Manukau (2016/17), Canterbury (2017), Waitemata DHB (2018) and Waikato DHB (2019). The estimated SMO staffing shortfall to provide safe, quality and timely health care is shown in Figure 1. The results of ASMS research on the effects of these shortfalls on the health and wellbeing of SMOs is summarised in Figure 2. The full results of the staffing surveys and research are available at the links below.



Source: ASMS surveys of clinical leaders. Full reports available: https://www.asms.org.nz/publications/researchbrief/

Figure 1: Estimated SMO staffing shortfall as a percentage of current staffing allocations



Source: ASMS research, published in *Health Dialogues*, available: https://www.asms.org.nz/publications/health-dialogue/

Figure 2: Indicators of the health and wellbeing of the senior medical workforce

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Introduction

From July-September 2019 the ASMS distributed an online questionnaire to clinical leaders with immediate responsibility for specialty services at Northland DHB, seeking their assessment on the adequacy of SMO staffing levels in their respective departments. For the purpose of this report they are referred to as 'Heads of Department' (HoDs). The analysis of their responses included a process to avoid double counting. Responses were received from 21 of the DHB's 24 HoDs who were sent the survey. 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, 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.[7]

Questions also sought estimated staffing requirements to allow SMOs adequate access to 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.[i]

The aim of this study - and similar studies either 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 address workforce deficits.

Note: As with other DHB reports we have aggregated responses rather than report on individual departments.

[i] C Chambers. *Superheroes don't take sick leave*. Health Dialogue No 11, ASMS, November 2015.

Summary of findings

Of the 24 HoDs contacted for participation in this research, 21 responded (88%), representing about 84% (165.8 FTEs) of the SMO FTE workforce at NDHB (overall total FTE 198.2).[ii]

A total of 18 HoDs (86% of respondents) indicated they had inadequate FTE SMOs for their services at the time of the survey.

Overall, the HoDs estimated they needed 59.6 more FTEs – or 36% of the current SMO staffing allocations in their departments – to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 59.6 FTE staffing shortfall, there were only 26.7 FTE vacancies at the time of the survey.

From the 21 HoD responses, 43% indicated their SMO staff 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. Meanwhile, 24% said non-clinical time was accessible 'sometimes' and 19% said 'often'.

Over half (52%) felt their SMO staff had insufficient time to undertake their training and education duties. Only 15% agreed or strongly agreed.

On average, 61% believed there was inadequate internal SMO backup cover for short-term sick leave, annual leave, continuing medical education (CME) leave or for covering training and mentoring duties while staff were away.

Of respondents, 71% considered there was inadequate access to locums or additional staff to cover for long-term leave.

In an overall assessment of whether the current staffing level was sufficient for full use of appropriate leave taking as well as non-clinical time and training responsibilities, 86% of HoDs responded 'no'.

Meanwhile, less than half (43%) of respondents felt their staff had adequate time to spend with patients and their families to provide good quality patient centred care.

[ii] Based on a senior medical FTE data in District Health Board Employed Workforce Quarterly Report, June 2019. Available: http://centraltas.co.nz/strategic-workforce-services/health-workforce-information-programme-hwip/

Findings

Adequacy of staffing levels

Of the 21 HoD respondents, 18 (86%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall an estimated 59.6 more FTEs – or 36% of the current SMO staffing allocation in the 21 departments – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 59.6 FTE staffing shortfall, there were only 26.7 FTE vacancies at the time of the survey.

Respondents' comments frequently referred to difficulties in recruit required staff and growing need for services with inadequate staff to cope.

Accessing non-clinical time

The remainder 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 3, 43% of respondents assessed that SMOs were 'rarely' or 'never' able to access their recommended 30% non-clinical time, while 24% estimated their staff are 'sometimes' able to access it, and 19% felt their staff 'often' accessed it. Of those who felt they were able to access non-clinical time, some comments signalled the amount of time they were allocated was significantly less than the recommended 30%. For example, one respondent who responded 'always' stated that their non-clinical time was only 17% and another who responded 'always' noted their allocated non-clinical time was only 22%. As with earlier surveys, some respondents commented on the difficulties accessing any non-clinical time with some commenting that there was no additional FTE set aside for clinical leadership roles.

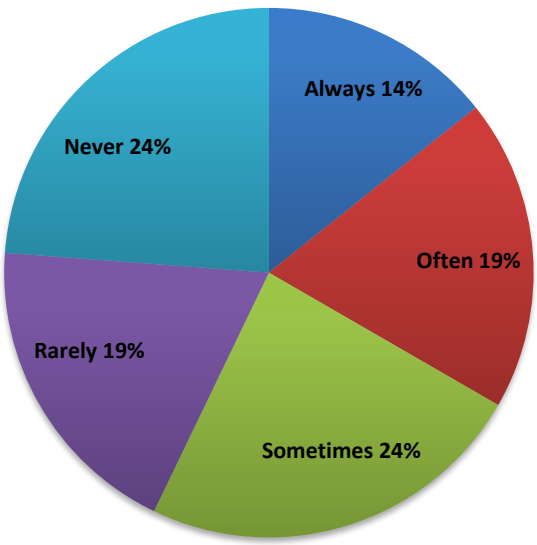

Figure 3: Access of SMOs to the recommended 30% non-clinical time

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 commissions. As detailed in Figure 4, 52% 'disagreed' or 'strongly disagreed' there was time for this, while only 15% 'agreed' or 'strongly agreed'. One respondent noted that even as a college supervisor "it is almost impossible to teach and supervise to the level I want to". Another respondent commented "There is no recognised SMO time for teaching or supervision of the trainee which there has been where I have worked previously".

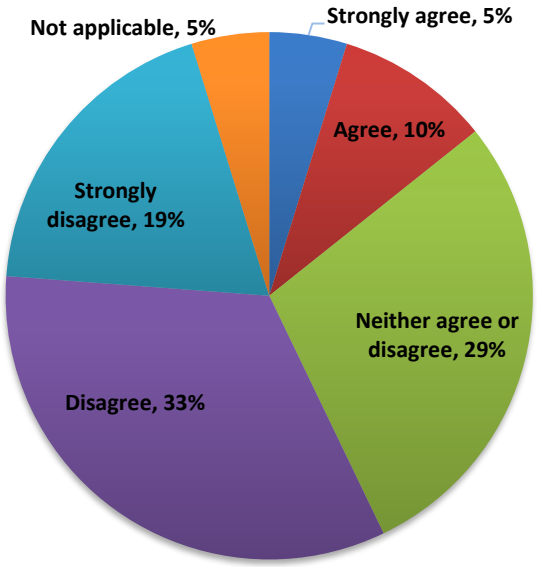

Figure 4: Sufficient time for training and education duties?

SMO staffing levels and internal SMO cover to provide for short-term leave

On average, 61% indicated staffing levels were inadequate to allow for short-term sick leave, annual leave, CME leave or for covering training and mentoring duties while staff were away (Figure 5). The highest proportion 'disagreeing' or 'strongly disagreeing' was regarding internal cover to provide for annual leave (67%). Respondent comments included the following:

"We have a vast and growing leave balance, due to inability to take leave when we want it."

"We rely on locums which are really hard to find and often create many problems due to lack of experience in a rural setting"

Another respondent noted that by December, they will be the only SMO "present Tuesday-Friday with no internal leave cover. This is an extreme situation"

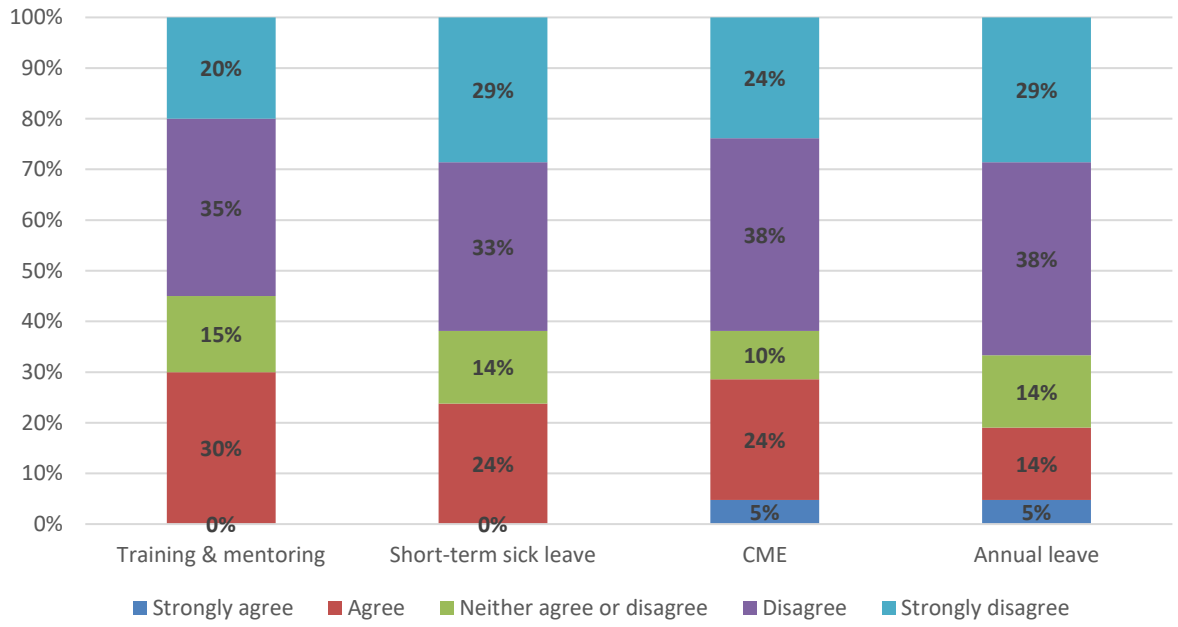

Figure 5: Sufficient internal SMO cover to provide for training and mentoring, short-term sick, CME and annual leave

Similarly, the next section sought to ascertain whether HoDs felt that their access to locums or other staff was sufficient to assist with other types of longer-term leave, including parental, sabbatical and secondment leave. As detailed in Figure 6, 71% of respondents 'disagreed' or 'strongly disagreed' access to locums or extra staff was sufficient, while only 10% 'agreed' there was adequate access. Some respondents commented that locum cover was very challenging. For example, "Not enough suitable locums available even when funding is approved", and "very difficult to get locums, advertised last year for >3 months with no suitable applicants".

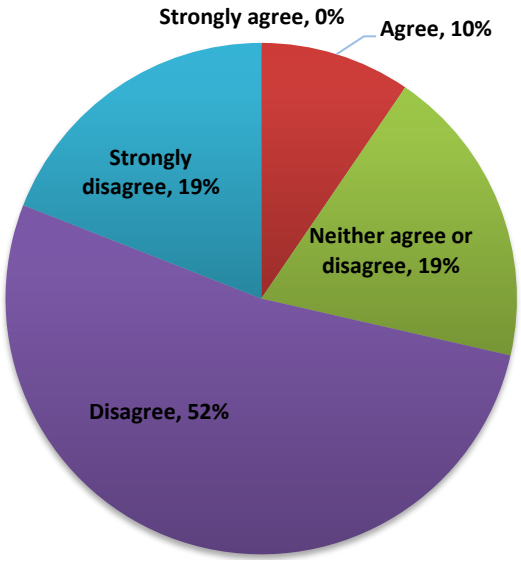

Figure 6: Sufficient access to locums or extra staff to enable full use of longer-term leave?

The final question in this section sought an overall assessment of whether the current staffing level was sufficient for full use of appropriate leave-taking as well as non-clinical time and training responsibilities. In response, 86% answered 'no' (Figure 7).

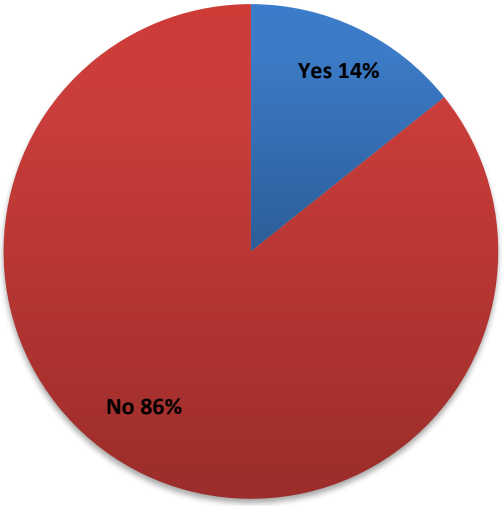

Figure 7: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

General Practitioner (GP) referrals and unmet need

The next area of inquiry focused on whether the specialties involved were actively referring patients back to GPs because they did not meet the DHB's treatment/financial thresholds, and if, to their knowledge, GPs were holding back referrals in the first instance. As detailed in Tables 1 and 2, in respect of referrals back to GPs, 10% of respondents indicated their department did not refer patients back to their GPs; 57% said theirs did. Of respondents, 19% believed GPs were not withholding referrals for first specialist assessments (FSAs); 24% believed they were. Of the 6 respondents who signalled they were aware of the withholding of referrals, 3 suggested this happened 'often' and 3 'sometimes'. Comments in this section included the following: "unless patients seen in ED require urgent assessment for anything (ie need to be seen within 2 weeks) our DHB mandates that we refer back to GP". Another respondent noted that "We have been asked to do this even more particularly on the basis that patients will exceed waiting time limits. This is fundamentally wrong as it denies equity of access across the whole country". There were also reflections on the pressures faced by GPs: "I know GPs are struggling to manage patients in the community setting".

Table 1: 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	57	12
No	10	2
Unknown	0	0
Not Applicable	33	7

Table 2: 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	29	6
No	19	4
Unknown	29	6
Not Applicable	29	6

Time for Patient-Centred Care

The final section of the survey asked whether HoDs believed their staff had adequate time to spend with patients and, where appropriate, their families to provide patient-centred care. As illustrated in Figure 8, 43% reported they believed their staff had time for quality patient-centred care; just under half (48%) believed they did not. One respondent noted that "We always try to make time, even if its at our own expense!" and another noted that for their service, "Appointments are 15 minutes. That is not sufficient time to give treatment options [to] patients".

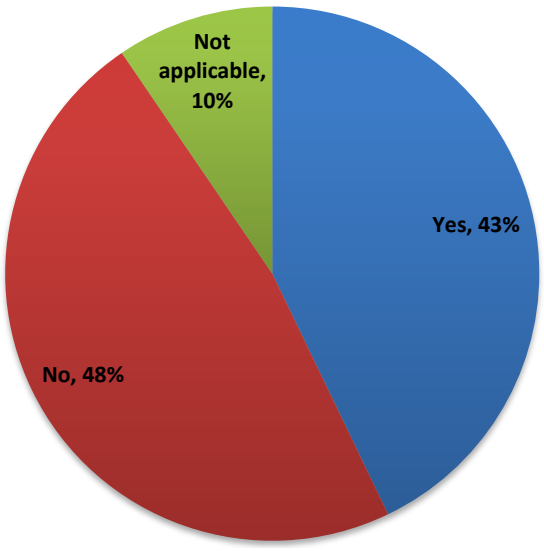

Figure 8: Time for patients and their families?

References

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