ASMS RESEARCH BRIEF

ASMS TOI MATA HAUORA

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Survey of clinical leaders on Senior Medical Officer staffing needs: Auckland 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 twelfth survey, at Auckland 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]

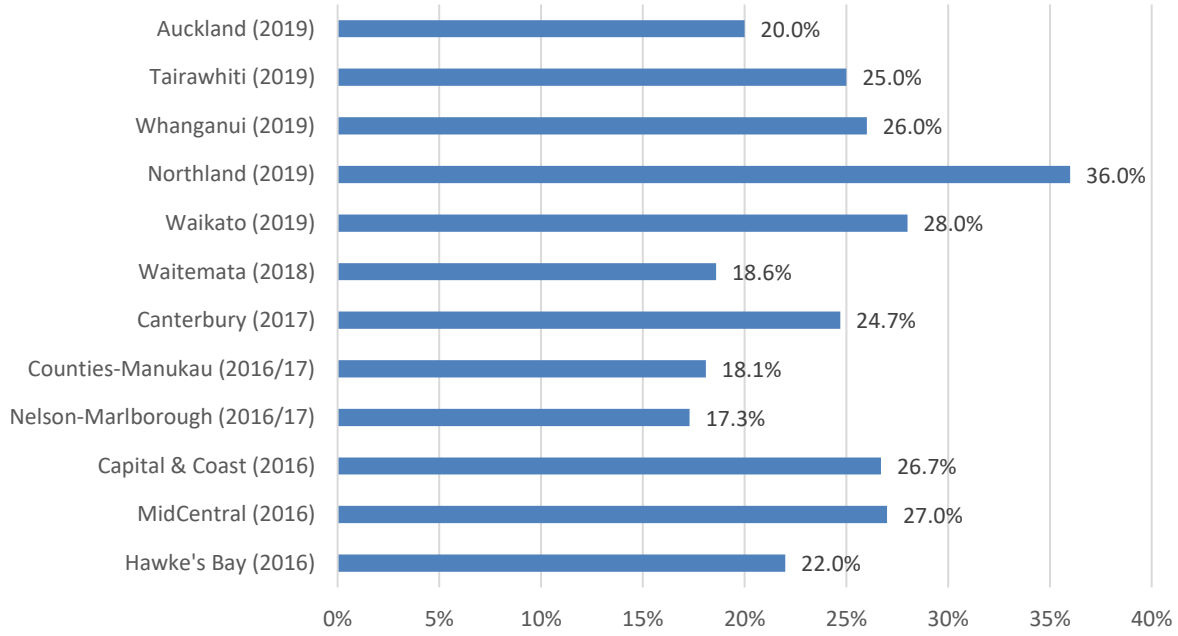
All the indications are that this situation has not improved; if anything, it is now worse. Non-clinical time may not involve direct contact with patients but it is a vital part of SMOs' work which ultimately has a significant effect on patient care and safety, as well as cost-efficiency.

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.

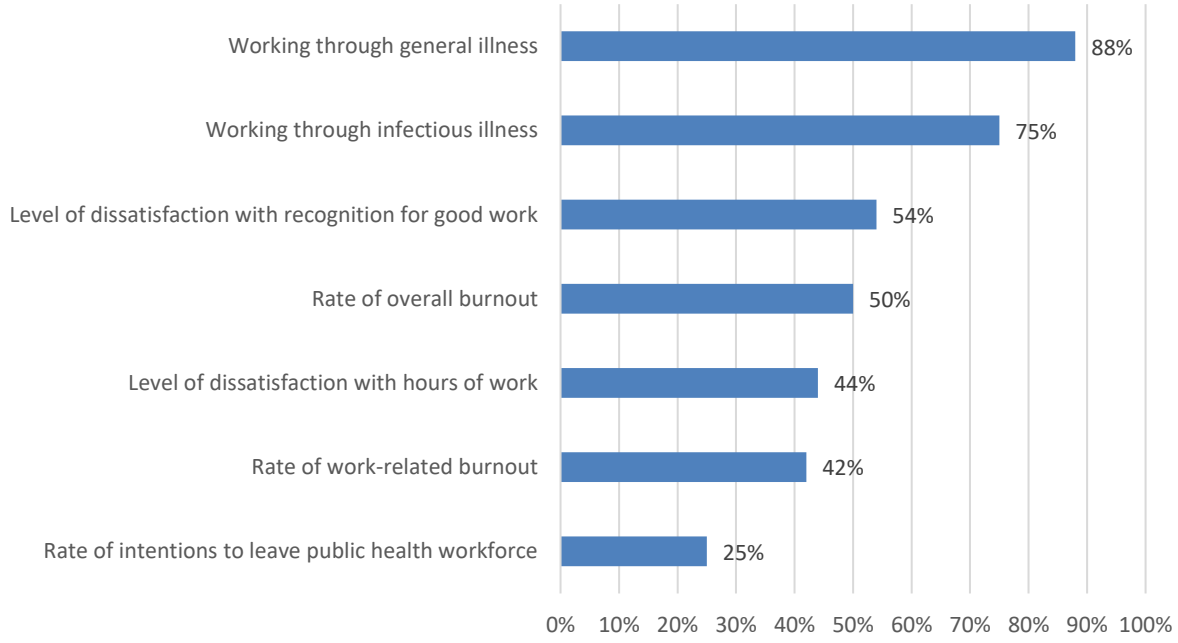
There is now strong consensus internationally that distributed clinical leadership is the best model to meet the challenges facing health care systems around the world.

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 twelfth in the series, which started with Hawke's Bay DHB in February 2016. 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 Auckland 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). Responses were received from 44 of the DHB's 71 HoDs who were sent the survey. The analysis of their responses included a process to avoid double counting but analysis was based on the most complete available data. 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 71 HoDs contacted for participation in this research, 44 responded (62%), representing about 58% (509.7 FTEs) of the SMO FTE workforce at ADHB (overall total FTE 883.3).[ii] Analysis was based on all best available data (not all respondents answered all questions).

A total of 29 HoDs (69% of respondents) indicated they had inadequate FTE SMOs for their services at the time of the survey.

Overall, the HoDs estimated they needed 101.05 more FTEs – or 20% 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 101.05 FTE staffing shortfall, there were only 26.02 FTE vacancies at the time of the survey representing a mere 26% of the estimated shortfall.

From the 42 HoDs who answered the question, 36% 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, 43% said non-clinical time was accessible 'always' and 'often'.

Over half (52%) felt their SMO staff had sufficient time to undertake their training and education duties. Twenty nine percent 'disagreed' and 'strongly disagreed'.

On average, 34% 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. More positively, 51% agreed that cover was sufficient.

Of respondents, 67% 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, 69% of HoDs responded 'no'.

Meanwhile, more than half (65%) 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 42 HoD respondents who answered the question, 29 (69%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall an estimated 101.05 more FTEs – or 20% of the current SMO staffing allocation in the 44 services – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 101.05 FTE staffing shortfall, there were only 27.02 FTE vacancies at the time of the survey.

Respondents' comments noted budgetary constraints and as with other surveys, difficulties recruiting. One service by contrast noted they were full up with more wanting to join. One respondent commented that "Some vacancies being filled with fixed term SMOs due to uncertainties re future funding".

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, 36% of respondents assessed that SMOs were 'rarely' or 'never' able to access their recommended 30% non-clinical time, while 21% estimated their staff are 'sometimes' able to access it, and 43% felt their staff 'often' or 'always' 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 20% and another commented that "Only 2 of 22 SMOs have this amount of non-clinical time in their job sizes."

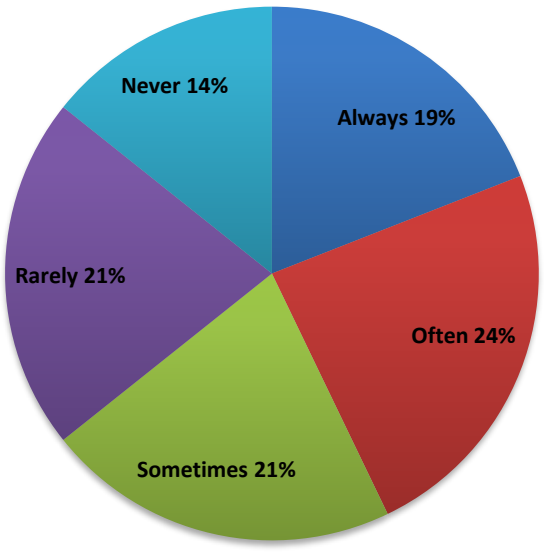

Figure 3: Access of SMOs to the recommended 30% non-clinical time

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, 29% 'disagreed' or 'strongly disagreed' there was time for this, while a positive 55% 'agreed' or 'strongly agreed'. One respondent noted that due to staff shortages "it's very hard to comply with best practice re: training and education duties". Another respondent commented "teaching is built into our weekly schedule, and clinical supervision levels are high".

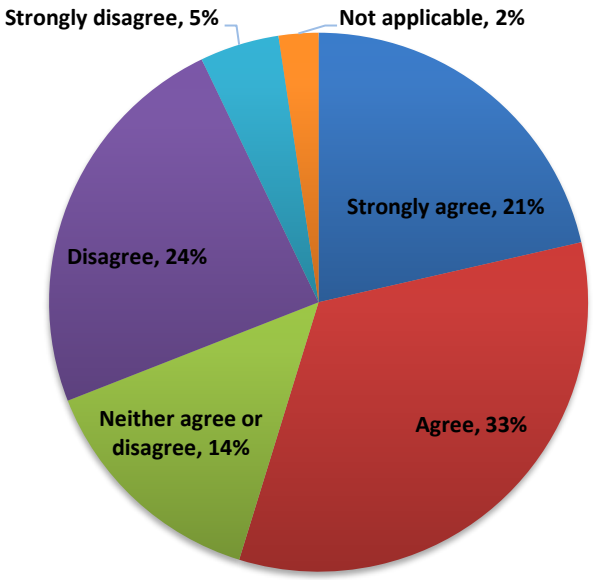

Figure 4: Sufficient time for training and education duties?

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

On average, 34% 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 'strongly disagreeing' was regarding internal cover to provide for short term sick leave (19%). Respondent comments included the following:

"It's very hard to apply for leave without affecting waitlist due to shortage"

"The leave is covered but with additional stress on the team."

"We plan our departmental leave well ahead of time but have minimal flexibility for short notice sick leave"

"Leave is often not taken because of the pressure of follow-up waitlists and the individual SMOs feeling of responsibility for these patients. Short-term sick leave is universally uncovered."

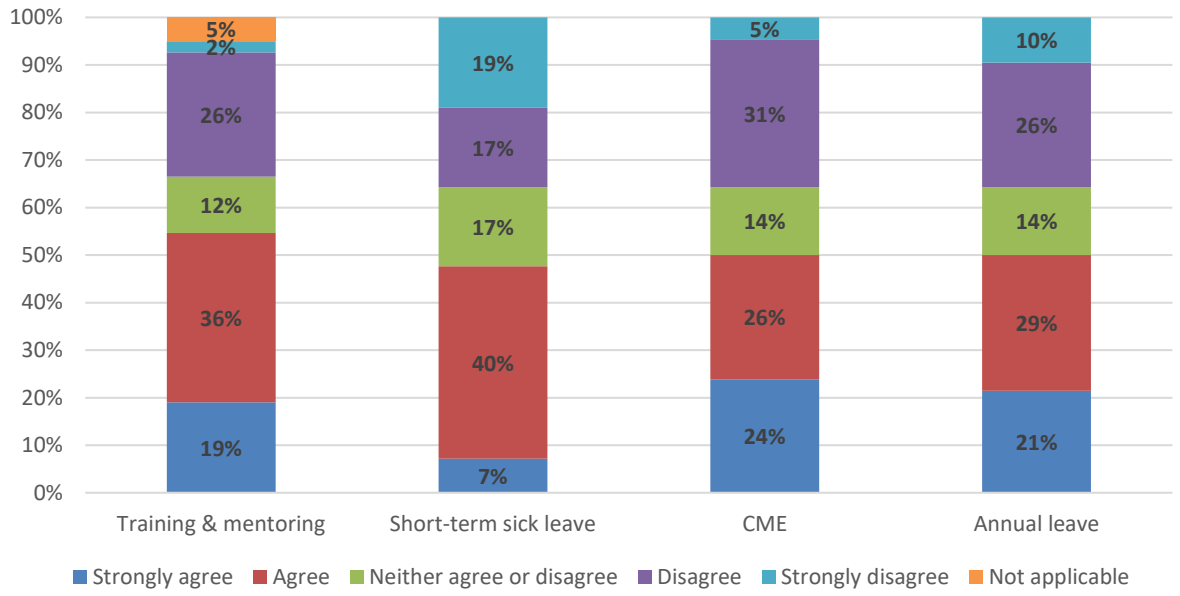

Figure 5: Sufficient internal SMO cover to provide for training and mentoring, short-term sick, CME and annual leave

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, 67% of respondents 'disagreed' or 'strongly disagreed' access to locums or extra staff was sufficient, while only 15% 'agreed' there was adequate access. Some respondents commented that locum cover could be hard to find. One respondent noted the difficulty of finding locums in a wider Australasian job market "Locums are hard to recruit due to lower salary than Australia and hard to find due to shortage". Others referred to insufficient funding to cover locums and some noted that if they requested additional funding to find locums there was the fear that sabbatical applications may be declined as a consequence.

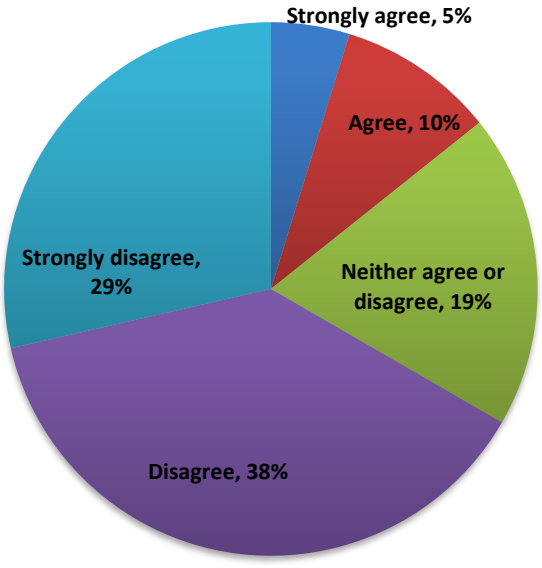

Figure 6: Sufficient access to locums or extra staff to enable full use of longer-term leave?

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, 69% (29 services) answered 'no' (Figure 7).

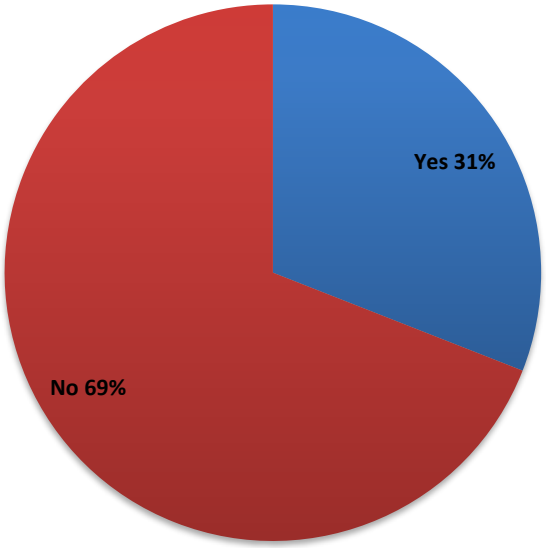

Figure 7: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

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, 52% of respondents indicated their department did not refer patients back to their GPs; 14% said theirs did. Of respondents, 45% believed GPs were not withholding referrals for first specialist assessments (FSAs); only 5% believed they were.

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	14	6
No	52	22
Unknown	5	2
Not Applicable	29	12

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	5	2
No	45	19
Unknown	17	7
Not Applicable	33	14

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, 65% reported they believed their staff had time for quality patient-centred care; just under a third (30%) believed they did not. One respondent noted that while they felt they always made time “there are many patients that do not receive "direct" SMO input. At times especially during winter or when there are critically unwell patients there can be a delay in SMOs being involved with all patients that they should / need to be involved in.”. Another respondent noted that the time made available was not sufficient: “we are given 15minute appointments to counsel patients and families when a new diagnosis of cancer is made”.

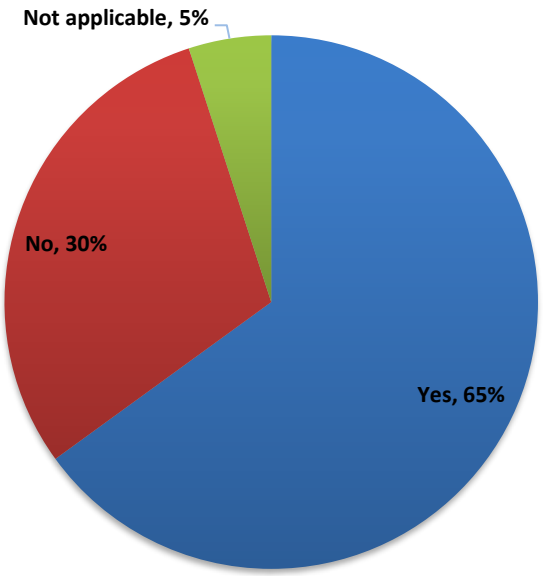

Figure 8: Time for patients and their families?

References

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