ASMS RESEARCH BRIEF

ASMS TOI MATA HAUORA

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Survey of clinical leaders on Senior Medical Officer staffing needs: Capital & Coast 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 third survey, at Capital & Coast 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 Association of Salaried Medical Specialists (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. 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'.[3]

An indication of the true state of the medical workforce is well 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 over-burden colleagues. A study on 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]

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."[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 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.

In view of these ongoing issues the ASMS is conducting a series of studies using a survey 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 report is the third in the series, which began with surveys at Hawke's Bay and MidCentral DHBs, results of which are available as '*Research Briefs*' in the 'Publications' pages of the ASMS website: www asms.org.nz.

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Introduction

Between June 2016 and January 2017, the ASMS distributed an online questionnaire to clinical leaders with immediate responsibility for specialty services at Capital & Coast 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 26 of the DHB's 41 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, 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.[7]

Questions also sought estimated staffing requirements to enable SMOs adequate access to non-clinical time and leave, both of which are crucial for providing safe and effective care. For example, 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.[8]

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.

Note: Due to requests for anonymity from some respondents to these surveys, we have aggregated responses rather than report on individual departments.

Summary of findings

- Of the 41 HoDs contacted for participation in this research, 26 responded (63%), except for questions pertaining to the adequacy of full-time equivalent (FTE) SMO staffing in their departments.
- 24 HoDs (59%) responded to questions pertaining to the adequacy FTE SMO staffing in their departments, representing approximately 58% (173.6 FTEs) of the SMO FTE workforce at CCDHB.[9]
- 17 HoDs (71% of 24 respondents) assessed they had inadequate FTE SMOs for their services.
- Overall the HoDs estimated they needed 46.3 more FTEs – or 27% of the current SMO staffing allocation in the 24 departments – to provide safe, quality and timely health care at the time of the survey.
- Despite the estimated 46.3 FTE staffing shortfall, there were only 13.1 FTE vacancies at the time of the survey.
- From the 26 HoD responses, 31% 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.
- 32% of HoDs felt their SMO staff had insufficient time to undertake their training and education duties.
- On average, 27% of the HoD respondents felt there was inadequate internal SMO backup cover for short-term sick leave, annual leave, continuing medical education leave or for covering training and mentoring duties while staff were away.
- 54% of the HoDs responded that there was adequate 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, 62% of HoDs responded 'no'.
- Most respondents (77%) felt their staff had adequate time to spend with patients and their families to provide good quality patient centred care. Comments from respondents suggested making time for patients was given priority, often at the expense of other non-clinical work or their staff's own personal time.

Findings

Adequacy of staffing levels

Two HoDs did not respond to the questions regarding overall adequacy of FTE staffing levels. Seventeen of the remaining 24 HoD respondents (71%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall an estimated 46.3 more FTEs – or 27% of the current SMO staffing allocation in the 24 departments – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 46.3 FTE staffing shortfall, there were only 13.1 FTE vacancies at the time of the survey.

Comments from respondents included acute workloads 'rapidly increasing', and a lack of coordinated time for SMOs to work alongside each other. One respondent referred to their last job-sizing as a 'sham'.

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 1, 50% felt that SMOs were able to access their recommended 30% non-clinical time 'always' or 'often'. 19% estimated their staff are 'sometimes' able to access this non-clinical time, while 31% felt their staff either 'rarely' or 'never' access the recommended level of non-clinical time. One respondent commented they officially had 10 hours a week for 'clinical leader's time' and 10 hours a week as 'clinical support time'; "however, all 20 hours plus several hours at home are spent on clinical leader's issues; no time for my own CPD [continuing professional development] other than my own time".

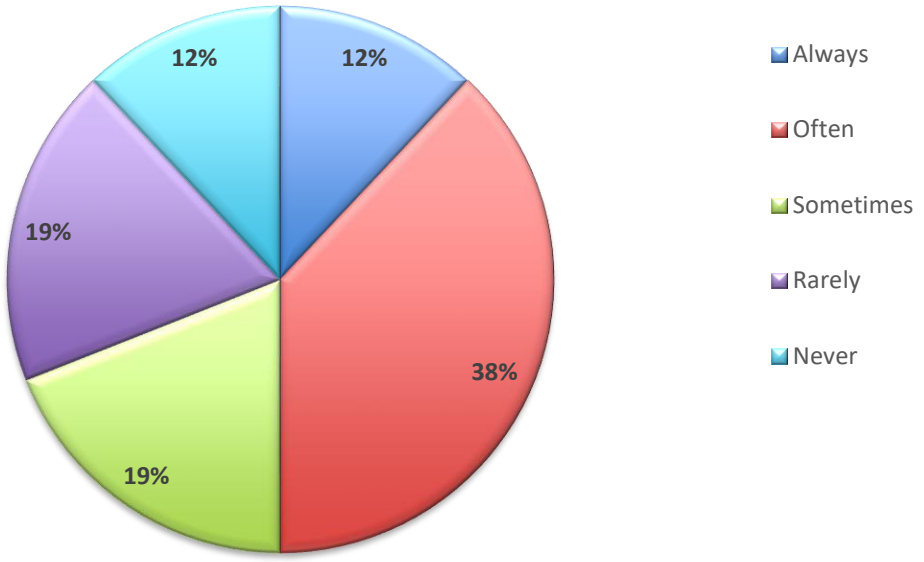

Figure 1: Access of SMOs to the recommended 30% non-clinical time

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 registered medical officers (RMOs) as recommended by the 2009 SMO and RMO commissions. As detailed in Figure 2, 60% agreed there was time for this but 32% disagreed that this was possible and 8% were unsure. Several respondents commented on clinical and administrative work often squeezed out quality time for apprenticeship-style training and clinical oversight.

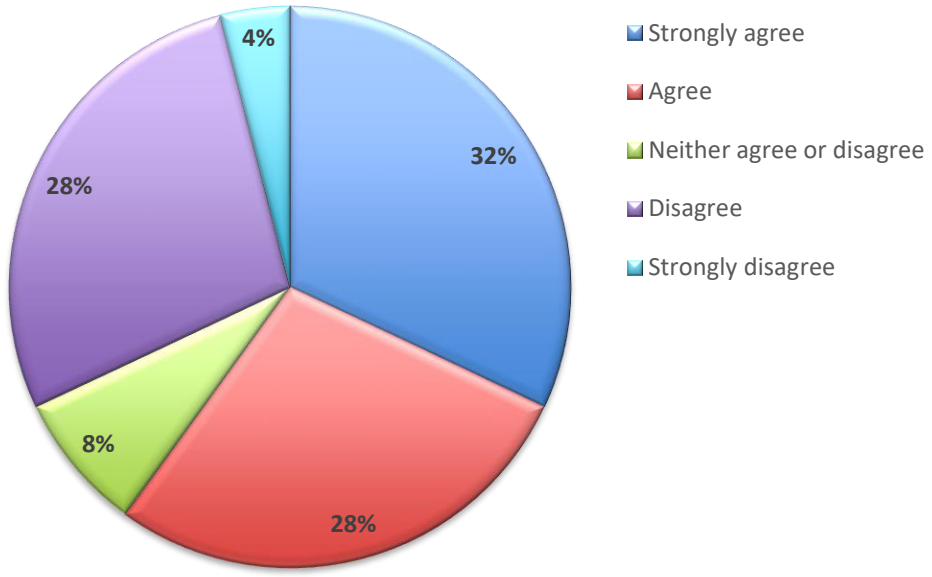

Figure 2: Sufficient time for training and education duties?

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

As detailed in Figure 3 the responses suggest that on the whole staffing levels are not adequate to allow for short-term leave. On average, 27% of the HoD respondents either disagreed or strongly disagreed there was adequate internal SMO backup cover for short-term sick leave, annual leave, continuing medical education leave or for covering training and mentoring duties while staff were away. One respondent noted: "We manage most of these activities, in practice by working more than our paid hours." Two other respondents commented that the lack of internal SMO cover and high clinical workloads had led to accumulated untaken annual leave.

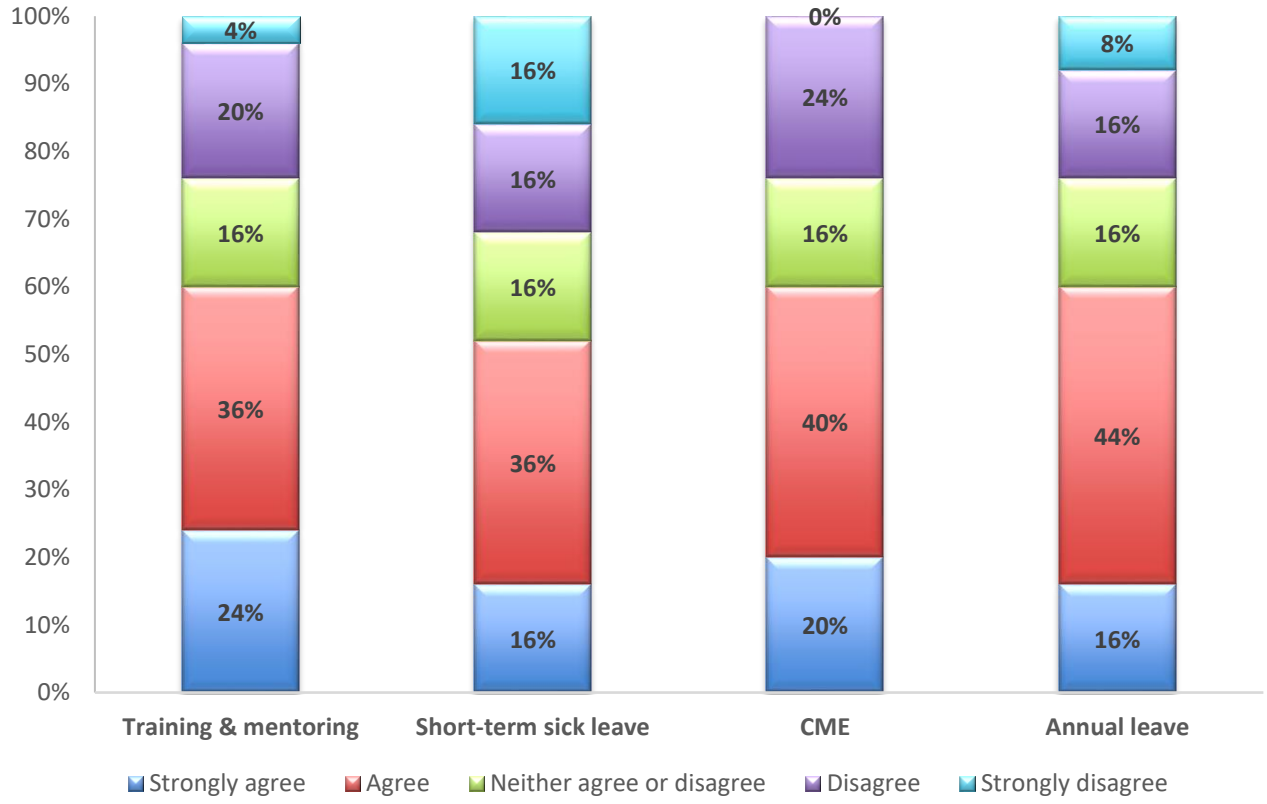

Figure 3: Sufficient internal SMO cover to provide for training & mentoring, short-term sick, CME and annual leave?

In a similar vein, 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 **Error! Reference source not found.**, access to l ocums or extra staff was also viewed negatively by the majority, with 54% estimating that access was not adequate to enable access to various types of leave (disagree and strongly disagree combined). Comments generally concerned the difficulties in recruiting suitable locums; a reluctance to employ locums because of cost were also raised by several respondents.

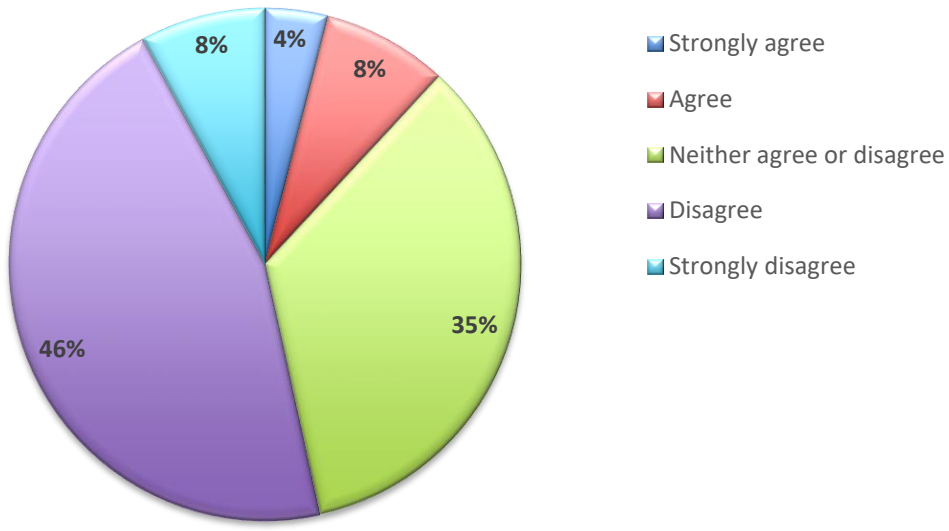

Figure 4: Sufficient access to locums or extra staff to enable full use of longer-term leave?

The final question in this section sought an overall assessment of whether the current staffing allocation was sufficient for full use of appropriate leave taking as well as non-clinical time and training responsibilities. Most HoDs (62%) responded negatively to this assessment (Figure **5**5). One respondent said three clinicians had more than 350 hours owed.

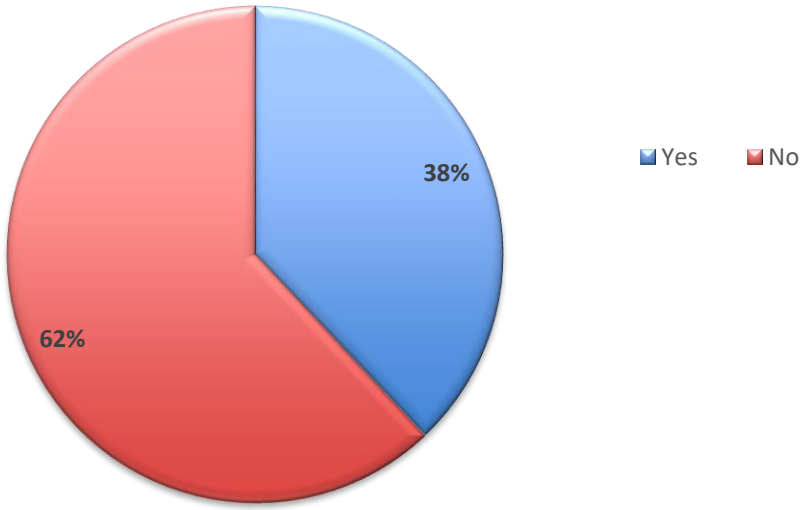

Figure 5: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

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 or not they were aware of GPs holding back referrals. As detailed in Table 1 and

Table 2, these questions were not applicable to three departments (ED, ICU and Obstetric Anaesthesia). With respect to referrals back to GPs, most respondents (65%) said this was not happening in their departments. Similarly, 54%of respondents believed GPs were not withholding referrals for first specialist assessments. 15% of respondents said their departments did refer patients back to their GPs because they did not meet the DHB's treatment/financial thresholds, and 15% believed GPs were delaying or withholding specialist referrals.

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	15%	4
No	65%	17
Unknown	8%	2
Not applicable	12%	3

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	15%	4
No	54%	14
Unknown	19%	5
Not applicable	12%	3

Time for patient centred care

The final section of the survey queried whether HoDs felt their staff had adequate time to spend with patients and, where appropriate, their families to provide patient centred care. As detailed in **Error! R eference source not found.**, the most (77%) reported they felt their staff did have time for quality patient centred care. However, several respondents explained that making time for patients was given priority but it was often at the expense of other non-clinical work or their own personal time. For example: 'this is prioritised above other things'; and time is found 'mainly due to SMOs culture and determination'. One respondent commented: "This need is driving the further recruitment of SMO's to increase the time available for SMO consultations."

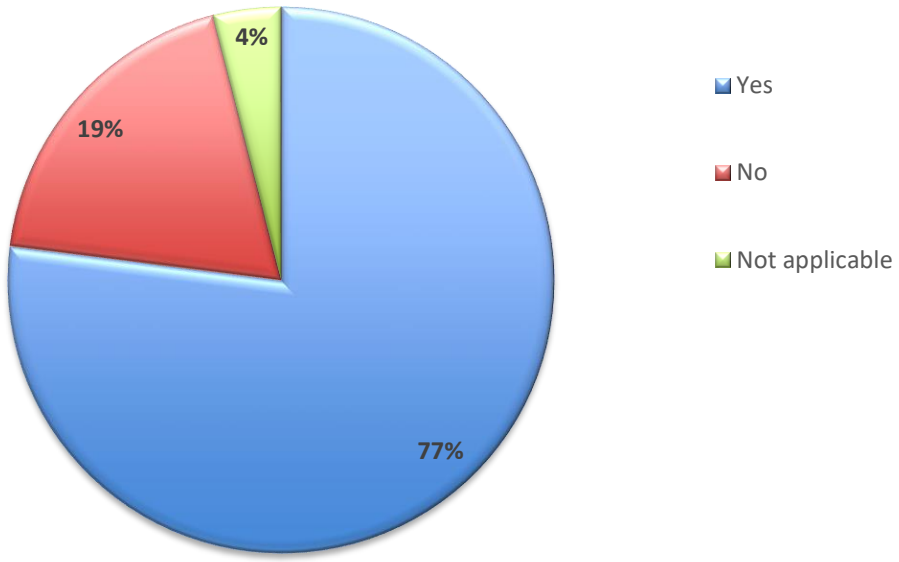

Figure 6: Do staff have adequate time for patients and their families?

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