



Survey of clinical leaders on Senior Medical Officer staffing needs: Counties Manukau 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 fifth survey, at Counties-Manukau 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 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 for those who need it. This report is the fifth in the series, which began with surveys at Hawke's Bay, MidCentral, Capital & Coast, and Nelson Marlborough DHBs, results of which are available as *Research Briefs* in the 'Publications' pages of the ASMS website: www.asms.nz.

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Introduction

Between October 2016 and April 2017, the ASMS distributed an online questionnaire to clinical leaders with immediate responsibility for specialty services at Counties Manukau 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 17 of the DHB's 30 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, 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.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 30 HoDs contacted for participation in this research, 17 responded (57%), representing approximately 58% (247.2 FTEs) of the SMO FTE workforce at CMDHB.⁹
- 16 HoDs (94%) assessed they had inadequate FTE SMOs for their services at the time of the survey. The remaining respondent was uncertain.
- Overall the HoDs estimated they needed 44.7 more FTEs – or 18% of the current SMO staffing allocation – to provide safe, quality and timely health care at the time of the survey.
- Despite the estimated 44.7 FTE staffing shortfall, there were only 16.8 FTE vacancies at the time of the survey.
- From the 17 HoD responses, 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. 41% said non-clinical time was accessible ‘sometimes’ and 24% said ‘often’; none said ‘always’.
- 71% of HoDs felt their SMO staff had insufficient time to undertake their training and education duties.
- On average, 59% 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.
- 59% responded that 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, 76% of HoDs responded ‘no’.
- 59% of respondents felt their staff had inadequate time to spend with patients and their families to provide good quality patient centred care.

Findings

Adequacy of staffing levels

Sixteen of the 17 HoD respondents (94%) assessed they had inadequate FTE SMOs for their services at the time of the survey. The remaining respondent was unsure.

Overall an estimated 44.7 more FTEs – or 18% of the current SMO staffing allocation in the 17 departments – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 44.7 FTE staffing shortfall, there were only 16.8 FTE vacancies at the time of the survey.

Respondents' comments frequently referenced clinical workload pressures. As one HoD remarked: "We manage, but it is extremely hard to staff the roster A constant battle dependent hugely on obliging SMOs but the camel's back is near breaking."

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, 36% of respondents assessed that SMOs were 'rarely' or 'never' able to access their recommended 30% non-clinical time, while 41% estimated their staff are 'sometimes' able to access it. 24% felt their staff 'often' had access but none felt non-clinical time was 'always' accessible. Clinical demands encroaching on non-clinical time was a common theme in respondents' comments. One commented they managed to allocate only 5%-8% non-clinical time each week 'and then on a case by case basis'. Another said it was "particularly difficult for part-timers". Several respondents said non-clinical time was capped at 25%, with one commenting that "apparently the two weeks of CME leave makes it up to 30%".

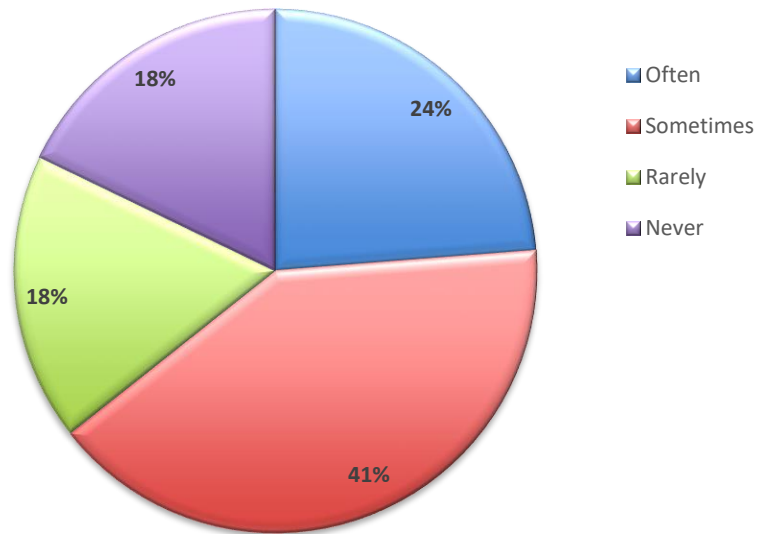


Figure 1: Access of SMOs to the recommended 30% non-clinical time

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, 71% 'disagreed' or 'or strongly disagreed' there was time for this, while 24% 'agreed' or 'strongly agreed'. Comments tended to refer to clinical workload pressures. Said one respondent: "There is no time for this and increasing requirements from colleges and medical council to document frequency of meetings and outcomes."

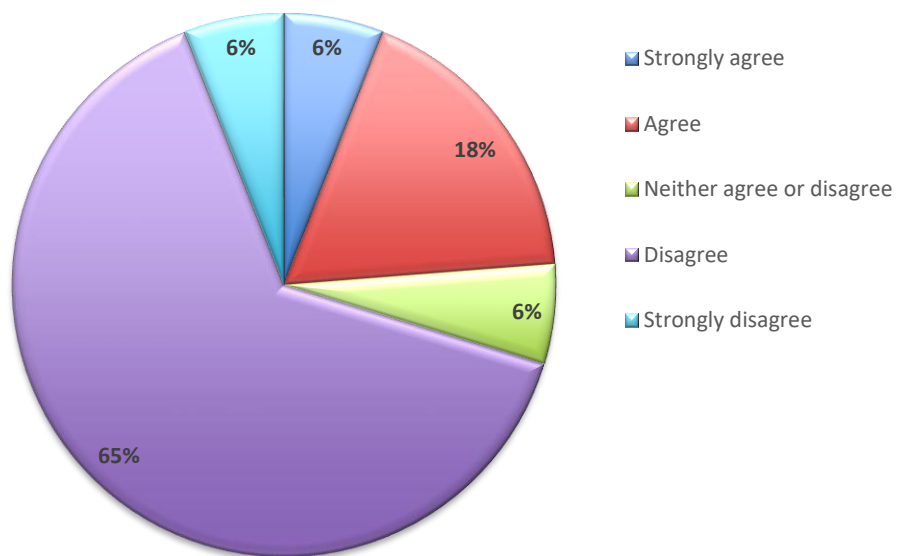


Figure 2: Sufficient time for training and education duties?

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

On average, 59% indicated staffing levels were inadequate to allow for short-term sick leave, annual leave, continuing medical education leave or for covering training and mentoring duties while staff were away (Figure 3). On average, around a third (32%) 'agreed' staffing levels were adequate, but none 'strongly agreed'. Respondents' main comments concerned pressures with coping with clinical workloads when SMOs took leave. As one respondent said: "We manage, but it is extremely hard to staff the roster, especially for CME and [annual leave]. I at times decline applications, especially for A/L. With school holidays and short-term sick leave this adds enormous pressure to cover modalities. A constant battle dependent hugely on obliging SMOs but the camel's back is near breaking." Another respondent commented: "Internal cover is voluntary and not reimbursed." Another noted supervision of students, nurse practitioners and registrars was ever increasing "with no FTE recognition".

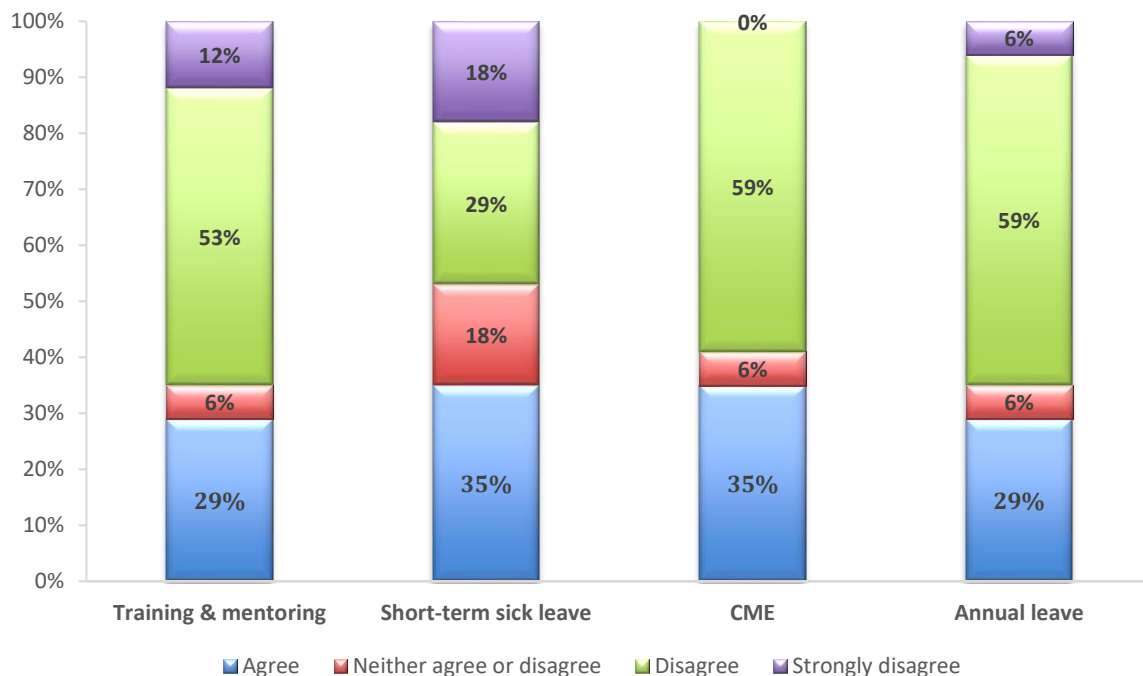


Figure 3: Sufficient internal SMO cover to provide for training & mentoring, short-term sick, CME and annual leave

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 4, 48% of respondents 'disagreed' or 'strongly disagreed' access to locums or extra staff was sufficient. 18% 'agreed' there was adequate access, while none 'strongly agreed'. One respondent commented: "This is a major issue for us. There are no short-term locums available in our specialty and the only way to cover is to provide this internally - but we are not resources to do this and there is a very real crisis in terms of finding adequate longer term SMO workforce. We have been in the situation over the past year of having to cover long term sick leave

internally in an already stretched department, and some in the department have regularly been doing 11 to 12 hour days.” Several respondents referred to a lack of suitable applicants. One respondent said their SMO staff was dependent on a continual supply of locums “as we cannot recruit and this makes it difficult to build a department”.

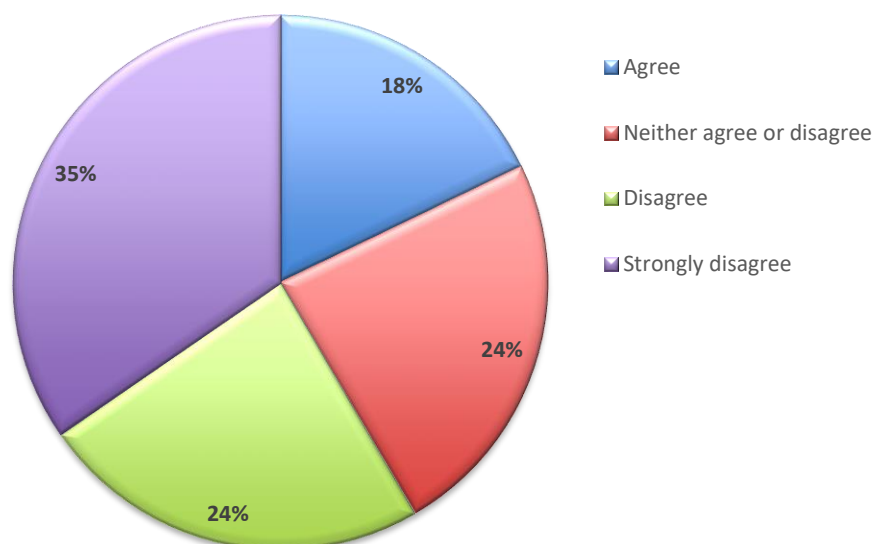


Figure 4: Sufficient access to locums or extra staff to enable full use of longer-term leave?

The final question in this section sought an overall assessment of whether the current staffing level was sufficient for full use of appropriate leave taking as well as non-clinical time and training responsibilities. 74% of respondents answered ‘no’ (Figure 5).

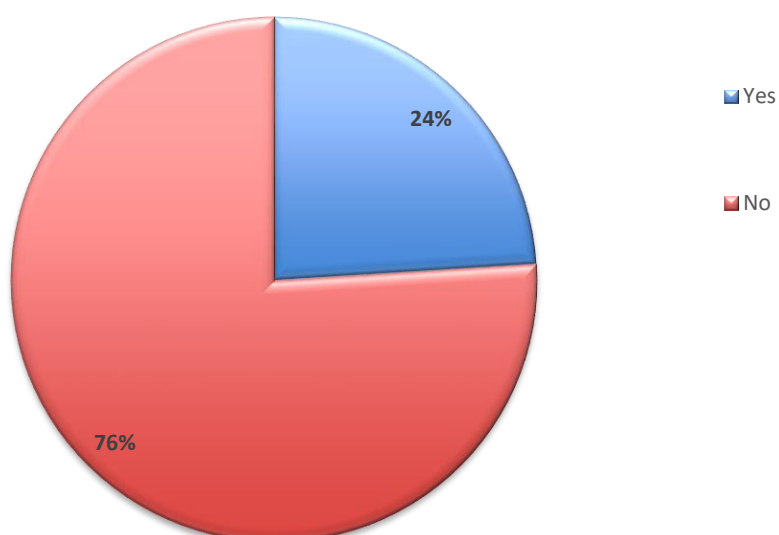


Figure 3: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

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 because they did not meet the DHB's treatment/financial thresholds, and whether or not they were aware of GPs holding back referrals in the first instance. As detailed in Table 2 and Table 3, with respect to referrals back to GPs, just over half of respondents (53%) indicated their department did not refer patients back to their GPs; 29% said theirs did. Most HoDs (59%) believed GPs were not withholding referrals for first specialist assessments (FSAs), while 35% were unsure. Comments included: "Our front door is wide open but we have a system of choice [appointments] followed by sending less complicated patients to NGO services." "We have worked closely with GPs to ensure those referred are the ones that need treatment by the DHB." "Our thresholds now result in a number of conditions not being seen at all."

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	29%	5	
No	53%	9	
Unknown	6%	1	
Not Applicable	12%	2	

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	0%	0	
No	59%	10	
Unknown	35%	6	
Not Applicable	6%	1	

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 illustrated in Figure 6, most (59%) reported they felt their staff did not have time for quality patient centred care; just over a third (35%) felt they did.

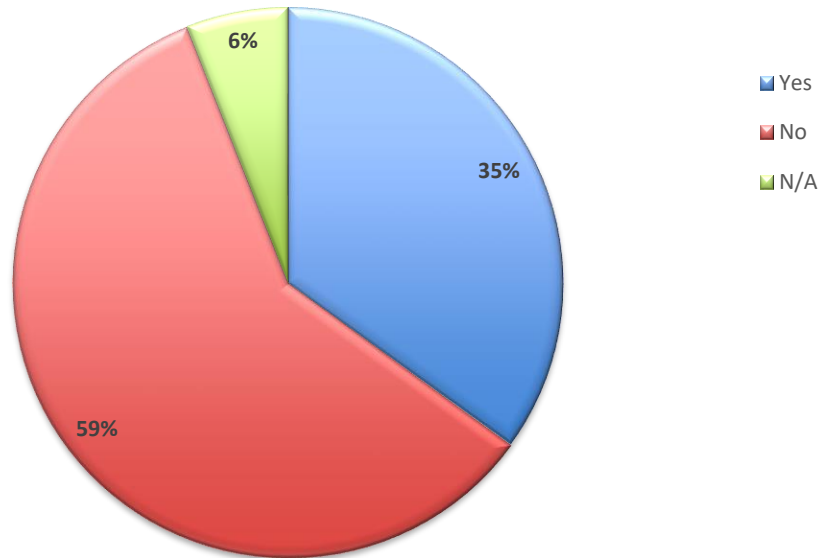


Figure 6: Do staff have adequate time for patients and their families?

References

¹ OECD Health Statistics, 2016 (data from 2014).

² ASMS. *Taking the Temperature of the Public Hospital Specialist Workforce*, August 2014. Available: <https://www.asms.org.nz/wp-content/uploads/2014/09/Taking-the-temperature-of-the-public-hospital-specialist-workforce-August-2014-FINAL.pdf>

³ K Davis, S Stremikis, et al. *Mirror, Mirror on the Wall: How the performance of the US health care system compares internationally*, Commonwealth Fund, June 2014.

⁴ C Chambers. *Superheroes don't take sick leave*; Health Dialogue, Issue No 11, ASMS, November 2015. Available: https://www.asms.org.nz/wp-content/uploads/2015/11/Presenteeism_A5-Final-for-Print_164753.pdf

⁵ C Chambers, C Frampton. *'Tired, worn-out and uncertain'*; Health Dialogue, Issue No 12, ASMS, August 2016. Available: https://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf

⁶ SMO Commission. *Senior Doctors in New Zealand: Securing the Future*. Report of the SMO Commission, June 2009.

⁷ L Keene. *Why is patient centred care so important?* Health Dialogue, Issue 2, ASMS, 18 July 2016. Available: https://www.asms.org.nz/wp-content/uploads/2016/07/Why-is-patient-centred-care-so-important-issue-2_165838.4.pdf

⁸ C Chambers. *Superheroes don't take sick leave*. Health Dialogue No 11, ASMS, November 2015.

⁹ Based on a senior medical FTE data in District Health Board Employed Workforce Quarterly Report, 1 October to 31 December 2016. Available: <http://centraltas.co.nz/strategic-workforce-services/health-workforce-information-programme-hwip/>