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Survey of clinical leaders on Senior Medical Officer staffing needs: Hutt Valley 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 thirteenth survey, at Hutt Valley 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]

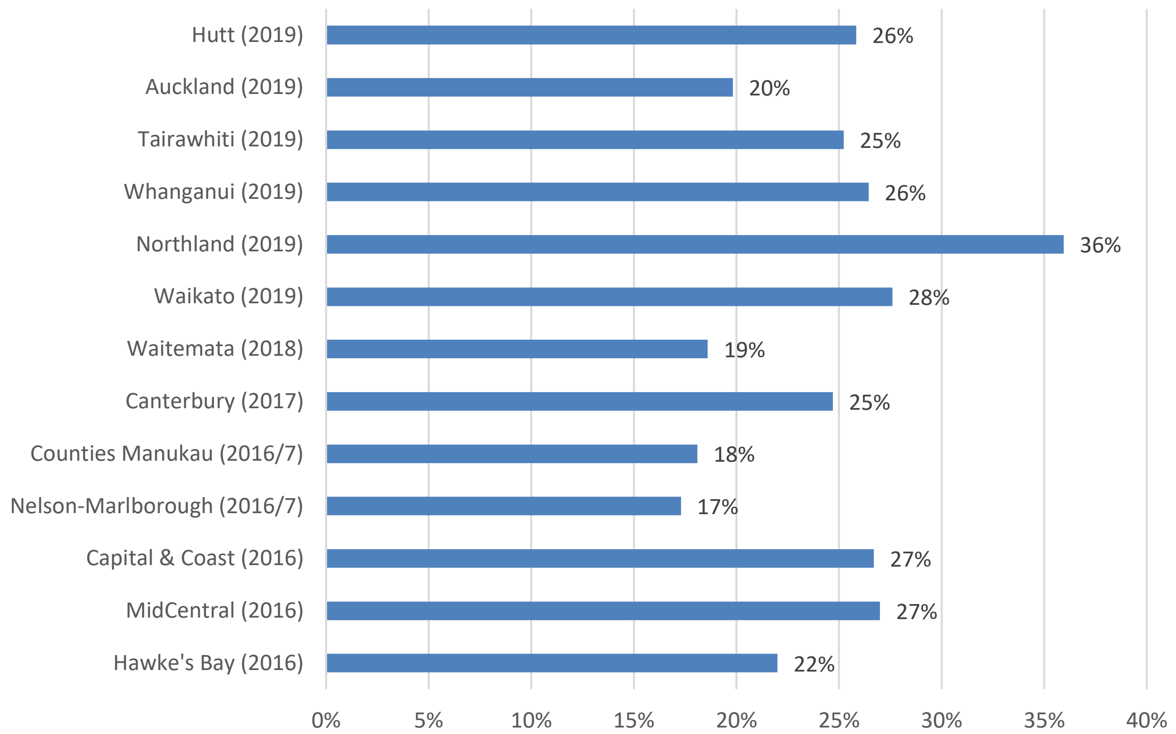
All the indications are that this situation has not improved; if anything, it is now worse. Non-clinical time may not involve direct contact with patients but it is a vital part of SMOs' work which ultimately has a significant effect on patient care and safety, as well as cost-efficiency.

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.

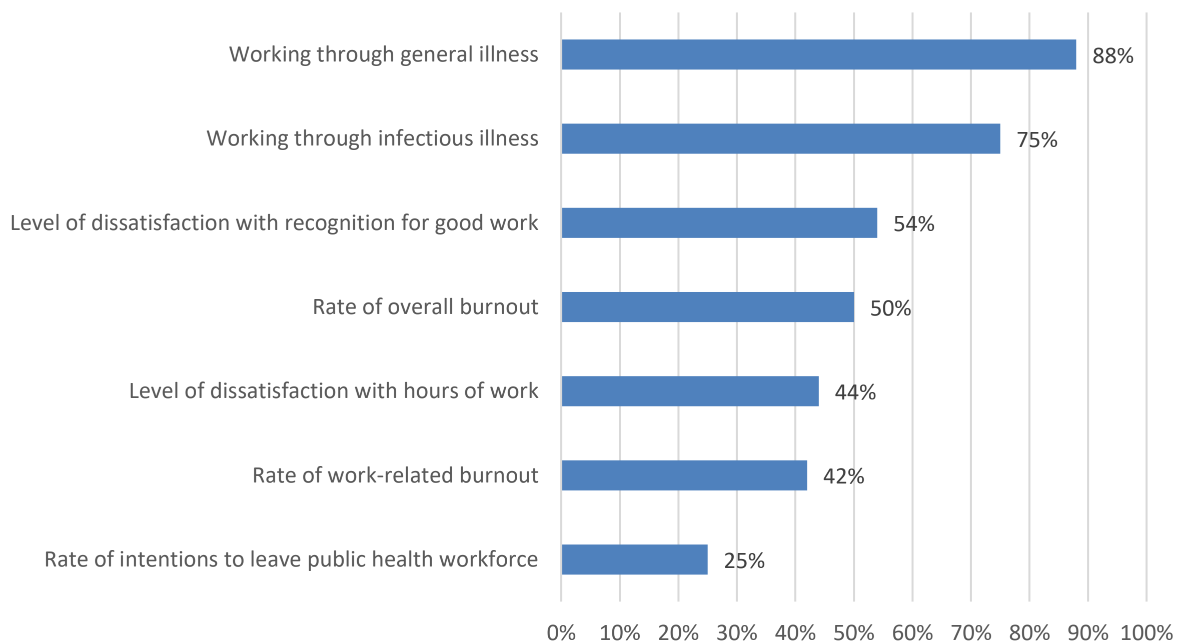
There is now strong consensus internationally that distributed clinical leadership is the best model to meet the challenges facing health care systems around the world.

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 thirteenth 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 August-October 2019 the ASMS distributed an online questionnaire to clinical leaders with immediate responsibility for specialty services at Hutt Valley 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 15 of the DHB's 19 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 underway 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 19 HoDs contacted for participation in this research, 15 responded (79%), representing about 74% (88.65 FTEs) of the SMO FTE workforce at HVDHB (overall total FTE 119.7).[ii]

Of the 15 HoD respondents, 11 (73%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall, the HoDs estimated they needed 22.9 more FTEs – or 26% 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 22.9 FTE staffing shortfall, there were only 9.2 FTE vacancies at the time of the survey.

From the 15 HoD responses, 47% 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, 33% said non-clinical time was accessible 'sometimes' and 20% said 'often' and 'always'.

Over half (60%) felt their SMO staff had sufficient time to undertake their training and education duties but 40% 'disagreed' or 'strongly disagreed'.

On average, 52% 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, 73% 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, 73% of HoDs responded 'no'.

Meanwhile, less than half (47%) 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 15 HoD respondents, 11 (73%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall an estimated 22.9 more FTEs – or 26% of the current SMO staffing allocation in the 15 departments – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 22.9 FTE staffing shortfall, there were only 9.2 FTE vacancies at the time of the survey.

Respondents' comments included reference to growing clinical demand and difficulties keeping up with patient needs.

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, 47% of respondents assessed that SMOs were 'rarely' or 'never' able to access their recommended 30% non-clinical time, while 33% estimated their staff are 'sometimes' able to access it, and 13% felt their staff 'often' accessed it. As with earlier surveys, some respondents commented on the challenges associated with protecting non-clinical time including the following: "Only because we fought tooth and nail for it and in effect reduced service to obtain protected time". Another noted that 20% was what was given in their department.

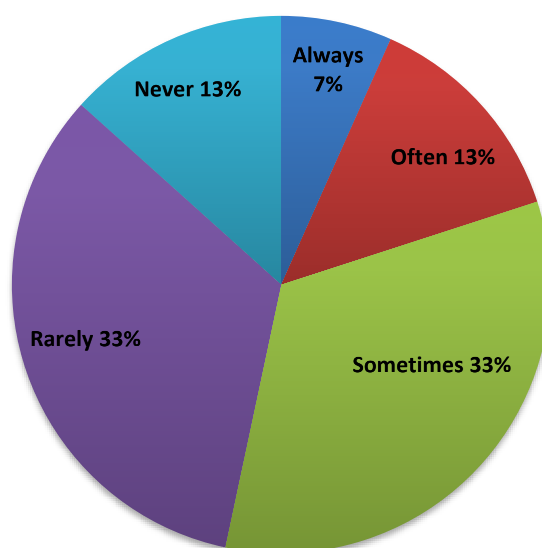

Figure 3: Access of SMOs to the recommended 30% non-clinical time

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, the majority 'agreed' or 'strongly agreed' there was time for this, while 40% 'disagreed' or 'strongly agreed'. One respondent noted that training happens but only because clinicians use their non-clinical time to do so.

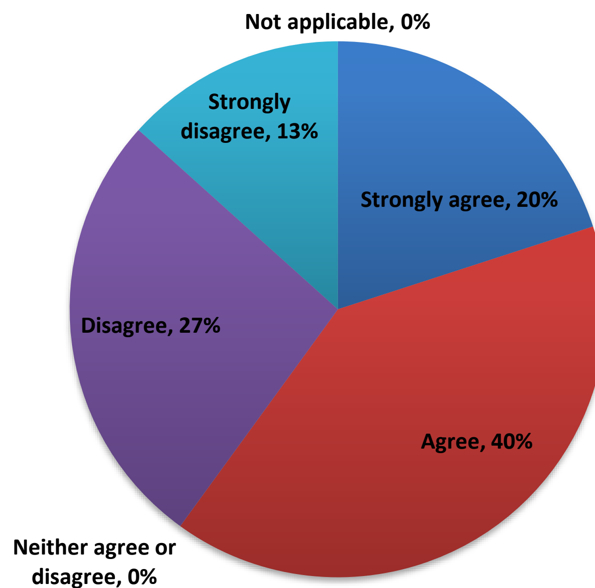

Figure 4: Sufficient time for training and education duties?

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

On average, 52% 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 'agreeing' or 'strongly agreeing' was regarding internal cover to provide for training and mentor duties (60%). Respondent comments included the following:

"We have simultaneously been told to take Annual Leave but also to keep all services going."

"There is no backfill for absence. We are largely ambulatory care so clinics are just cancelled. This means our patients miss out as they just wait longer for appointments"

Another respondent noted "sometimes we might do 4 on-call nights in 8 days (either side of a weekend) if a colleague is on leave / sick. Always a scramble to cover sick leave. Not enough staff to cover AL if everyone took their allotted time"

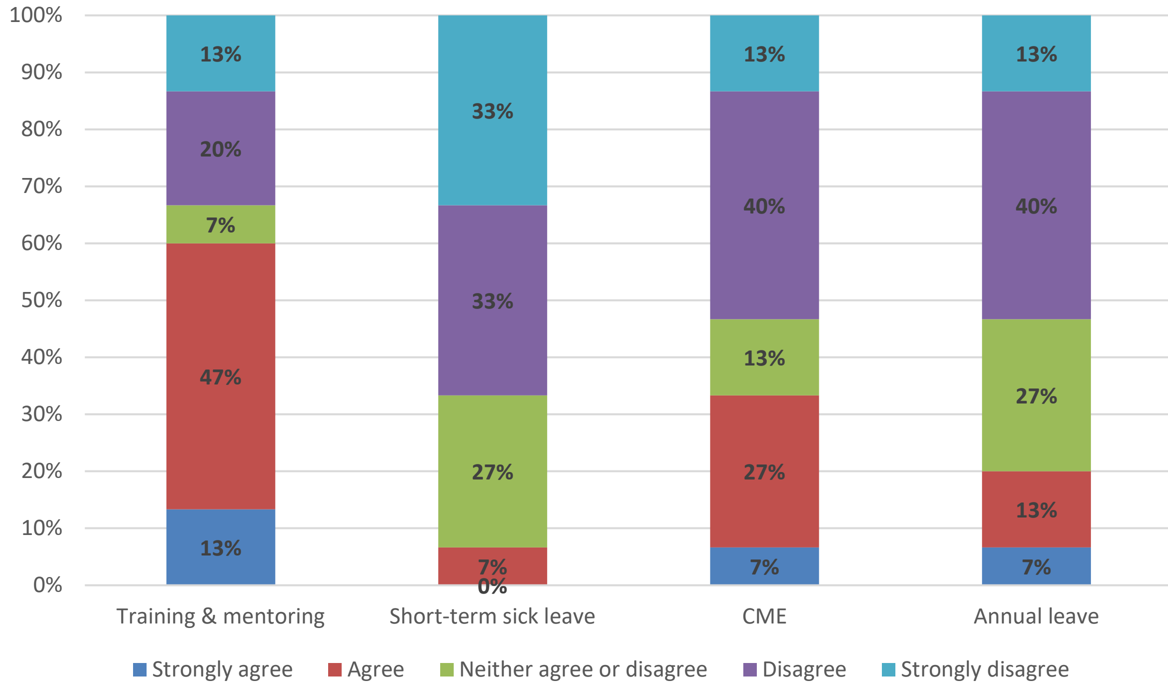

Figure 5: Sufficient internal SMO cover to provide for training and mentoring, short-term sick, CME and annual leave

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, 87% of respondents 'disagreed' or 'strongly disagreed' access to locums or extra staff was sufficient, while no one 'agreed' there was adequate access. One respondent noted that availability was an issue and others suggested that locum cover was "a real bone of contention".

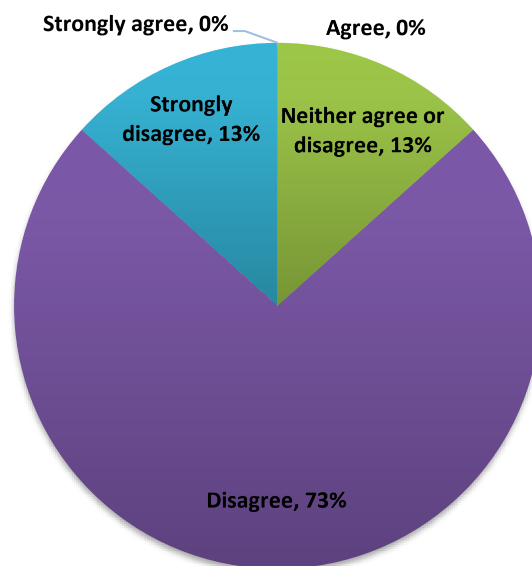

Figure 6: Sufficient access to locums or extra staff to enable full use of longer-term leave?

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, 73% answered ‘no’ (Figure 7). Comments in this section included “most clinicians do patient work in their non-clinical time” and another who answered “yes” but qualified the answer by stating “But we do not have sufficient FTE to meet clinical need”.

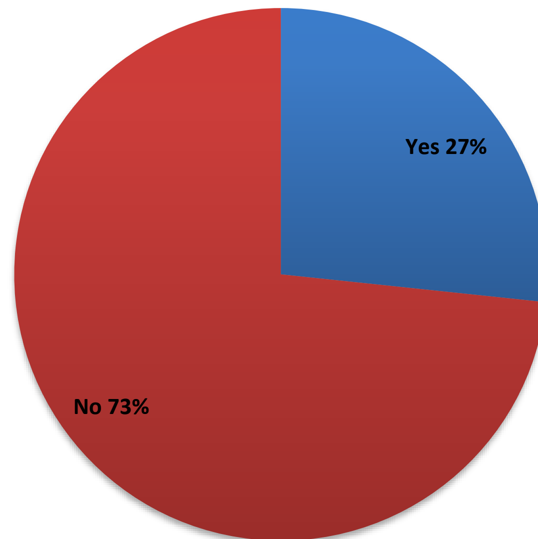

Figure 7: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

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	33	5
No	40	6
Unknown	0	0
Not Applicable	27	4

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	20	3
No	33	5
Unknown	20	3
Not Applicable	27	4

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, 47% reported they believed their staff had time for quality patient-centred care and 47% believed they did not. One respondent noted that "generally yes but this is very challenging due to the increased complexity of our caseload" and another commented that "Often long or complex consultations are held outside of normal clinic time. This often eats into non-clinical time. It is the only way good practice can be accommodated".

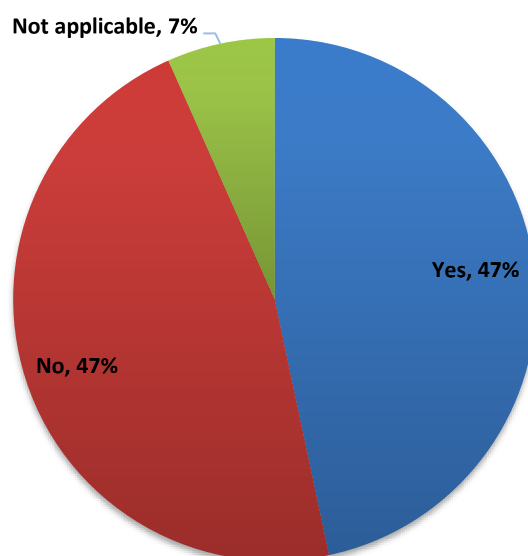

Figure 8: Time for patients and their families?

References

[1] OECD Health Statistics, 2018 (data from 2016).

[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] Schneider E, Sarnak D, Squires D, et al. *Mirror, Mirror: International Comparison Reflects Flaws and Opportunities for Better US Health Care*, Commonwealth Fund, New York, July 2017. https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2017_jul_schneider_mirror_mirror_2017.pdf

[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?* Research Brief: Path to Patient Centred Care, 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