



## Survey of clinical leaders on Senior Medical Officer staffing needs: Nelson Marlborough District Health Board

The 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 fourth survey, at Nelson Marlborough 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.<sup>1</sup>

The extent of medical specialist shortages in New Zealand has been well documented by the Association of Salaried Medical Specialists (ASMS).<sup>2</sup> 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'.<sup>3</sup>

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.<sup>4</sup> 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.<sup>5</sup>

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."<sup>6</sup>



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, 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 fourth in the series, which began with surveys at Hawke's Bay, MidCentral and Capital & Coast DHBs, results of which are available as *'Research Briefs'* in the 'Publications' pages of the ASMS website: [www.asms.org.nz](http://www.asms.org.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 Nelson Marlborough 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 14 of the DHB's 21 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.<sup>7</sup>

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.<sup>8</sup>

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 21 HoDs contacted for participation in this research, 14 responded (67%), representing approximately 61% (71.8 FTEs) of the SMO FTE workforce at NMDHB.<sup>9</sup>
- 8 HoDs (57%) assessed they had inadequate FTE SMOs for their services.
- Overall the HoDs estimated they needed 12.4 more FTEs – or 17% of the current SMO staffing allocation – to provide safe, quality and timely health care at the time of the survey.
- Despite the estimated 12.4 FTE staffing shortfall, there were only 5.1 FTE vacancies at the time of the survey.
- From the 14 HoD responses, 14% 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.
- 29% of HoDs felt their SMO staff had insufficient time to undertake their training and education duties.
- On average, 20% 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.
- 21% 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, 50% of HoDs responded ‘no’.
- Most respondents (71%) felt their staff had adequate time to spend with patients and their families to provide good quality patient centred care.

## Findings

### Adequacy of staffing levels

Eight of the 14 HoD respondents (57%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall an estimated 12.4 more FTEs – or 17% of the current SMO staffing allocation in the 14 departments – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 12.4 FTE staffing shortfall, there were only 5.1 FTE vacancies at the time of the survey.

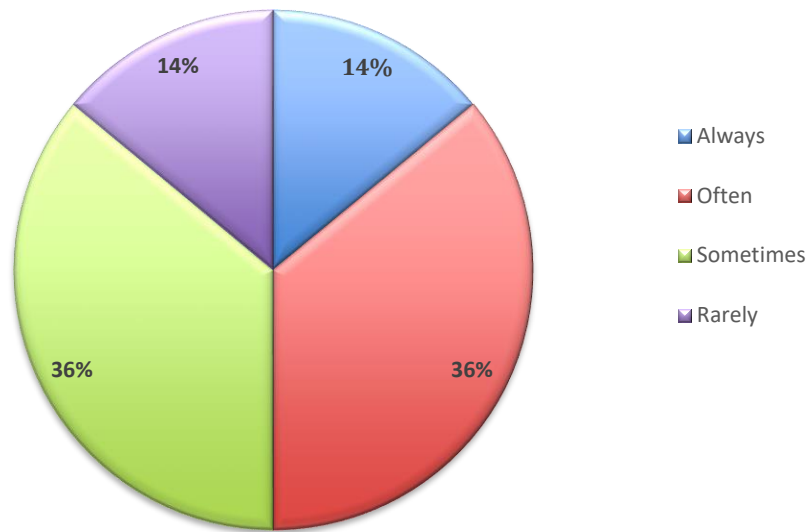
One respondent commented: “...We are currently working more than 1:3 weekends. More SMO staff to help cover weekends means not enough shifts during week days. We struggle to recruit to part time SMOs to small town New Zealand.” An another, remarking on back-up cover, commented, “.... I did 13 days out of 17 in the past weeks, but clinic waiting lists grow.”

### 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?

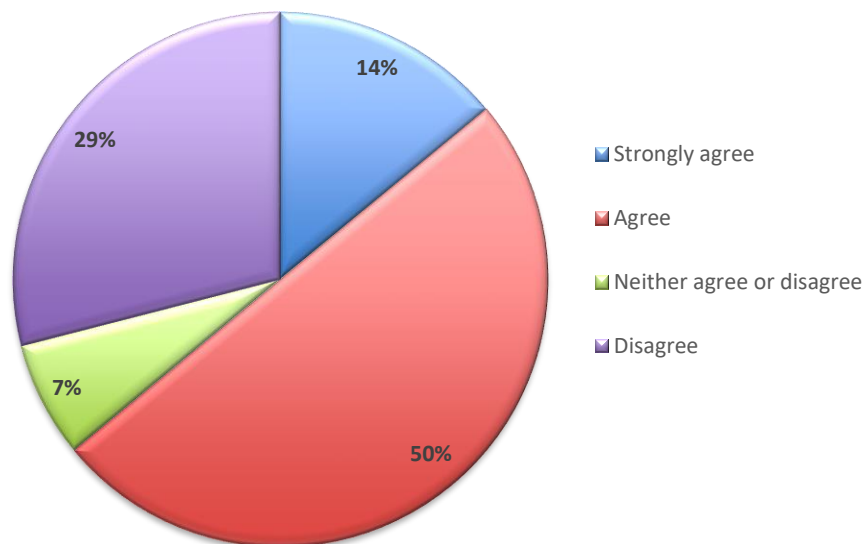
As detailed in Figure 1, 50% felt that SMOs were able to access their recommended 30% non-clinical time ‘always’ or ‘often’. 36% estimated their staff are ‘sometimes’ able to access this non-clinical time, while 14% believed their staff ‘rarely’ access the recommended level of non-clinical time. None of the respondents believed their staff ‘never’ accessed non-clinical time. Comments from respondents concerned prioritisation of clinical work; one respondent highlighted difficulties in scheduling with most SMOs ‘very part-time’.



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

**FTE assessment to provide time for training and education duties**

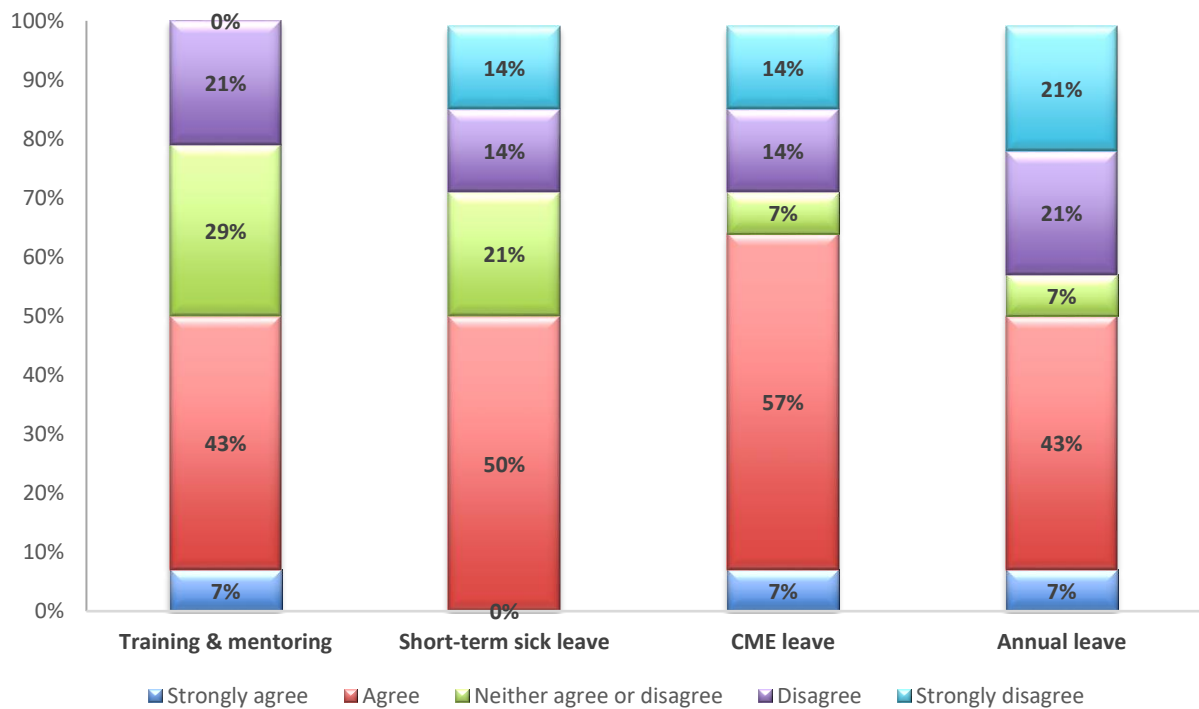
The next question ascertained views on whether specialists had enough time to participate in the training and education of registered medical officers (RMOs) as recommended by the 2009 SMO and RMO commissions. As detailed in Figure 2, 64% 'agreed' or 'strongly agreed' there was time for this, 7% were unsure, and but 29% 'disagreed' that this was possible; none 'strongly disagreed'.



**Figure 2: Sufficient time for training and education duties?**

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

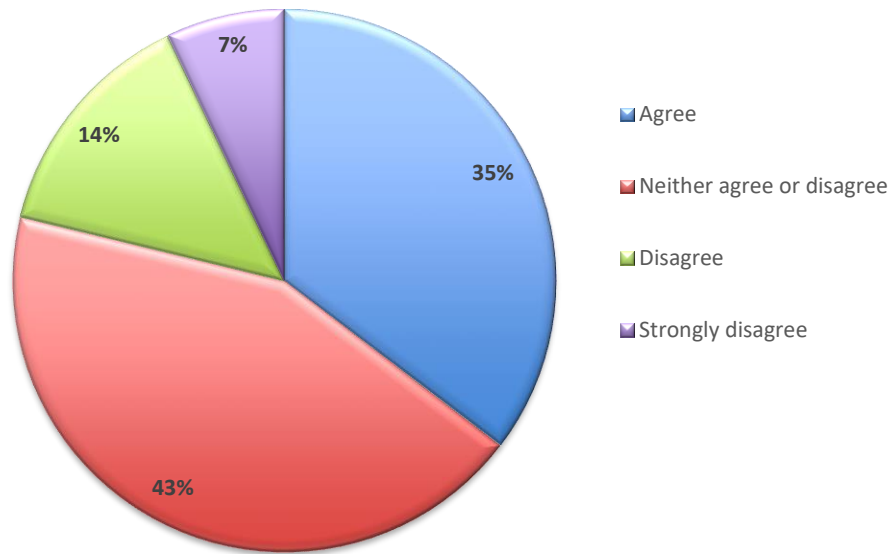
As detailed in Figure 3, around half of respondents indicated staffing levels were generally adequate to allow for short-term sick leave, annual leave, continuing medical education leave or for covering training and mentoring duties while staff were away. Having access to adequate cover for leave was problematic for a significant minority, however, especially for taking annual leave, where 42% of respondents either disagreed or strongly disagreed there was adequate internal SMO backup cover. Respondents' main comments concerned pressures with coping with clinical workloads when SMOs took leave. One respondent noted: "We have been short of SMOs for the last two years or more and have been struggling to provide cover for annual and CME leave."



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

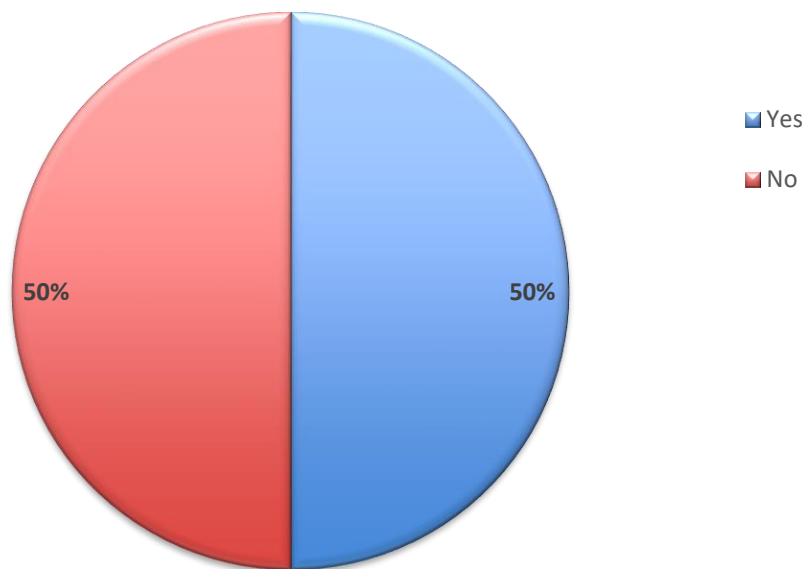
Similarly, the next section sought to ascertain whether HoDs felt that their access to locums or other staff was sufficient to assist with other types of longer-term leave, including parental, sabbatical and secondment leave. As detailed in Figure 4, access to locums or extra staff was viewed neutrally by 43% of respondents. Just 35% agreed there was adequate access, while none 'strongly agreed'.





**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. The responses were split down the middle (50/50). Respondents' comments generally concerned clinical workloads as challenging. One respondent reported having six months' annual leave owing.



**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 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 1 and

Table 2, with respect to referrals back to GPs, respondents were split three ways, with 29% answering 'yes', 29% 'no' and 36% 'unknown'. 36% of respondents believed GPs were withholding referrals for first specialist assessments (FSAs), while 43% thought not. One respondent commented that "GPs know that we ration FSAs."

**Table 1: Referrals back to GPs**

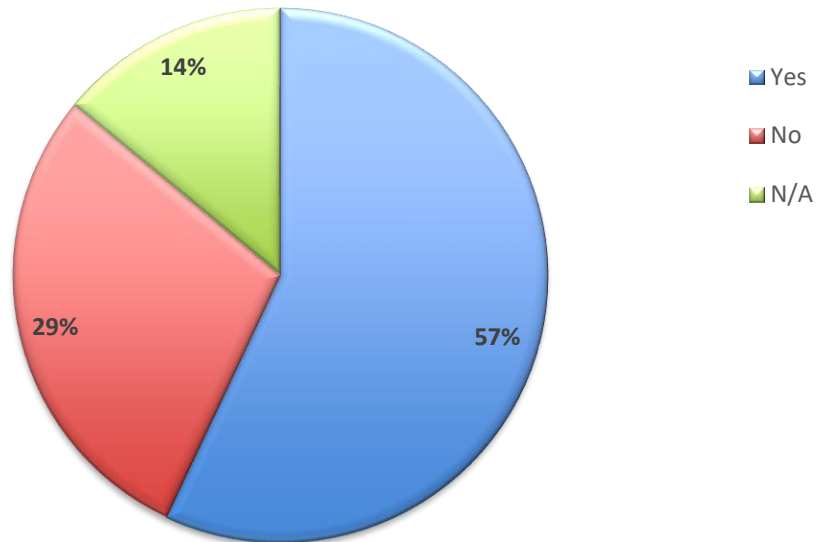
<b>Does your area of responsibility refer patients back to their GP because they do not meet your DHB's treatment/financial thresholds, or would exceed waiting time limits, even though they would benefit from immediate treatment?</b>		
<b>Answer Options</b>	<b>%</b>	<b>n</b>
<b>Yes</b>	29%	4
<b>No</b>	29%	4
<b>Unknown</b>	36%	5
<b>Not Applicable</b>	7%	1

**Table 2: GPs withholding referrals**

<b>From your contact with GPs do you think they are delaying or withholding referrals for first specialist assessments in your area of responsibility?</b>		
<b>Answer Options</b>	<b>%</b>	<b>n</b>
<b>Yes</b>	36%	5
<b>No</b>	43%	6
<b>Unknown</b>	21%	3
<b>Not Applicable</b>	0%	0

### 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 Fig, the most (57%) reported they felt their staff did have time for quality patient centred care. Two respondents (Public Health and Radiology) answered 'not applicable'.



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

## References

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<sup>1</sup> OECD Health Statistics, 2016 (data from 2014).

<sup>2</sup> 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>

<sup>3</sup> 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.

<sup>4</sup> 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](https://www.asms.org.nz/wp-content/uploads/2015/11/Presenteeism_A5-Final-for-Print_164753.pdf)

<sup>5</sup> 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](https://www.asms.org.nz/wp-content/uploads/2016/08/Tired-worn-out-and-uncertain-burnout-report_166328.pdf)

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

<sup>7</sup> 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](https://www.asms.org.nz/wp-content/uploads/2016/07/Why-is-patient-centred-care-so-important-issue-2_165838.4.pdf)

<sup>8</sup> C Chambers. *Superheroes don't take sick leave*. Health Dialogue No 11, ASMS, November 2015. Available: [https://www.asms.org.nz/wp-content/uploads/2015/11/Presenteeism\\_A5-Final-for-Print\\_164753.pdf](https://www.asms.org.nz/wp-content/uploads/2015/11/Presenteeism_A5-Final-for-Print_164753.pdf)

<sup>9</sup> 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/>