ASMS RESEARCH BRIEF

ASMS TOI MATA HAUORA

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Survey of Heads of Department on Senior Medical Officer staffing needs: Hawke's Bay District Health Board

The ASMS is examining Senior Medical Officer (SMO) staffing levels at selected District Health Boards (DHBs) via a survey of Heads of Department (HoD) covering all hospital departments. The aim is to assess, in the view of HoDs, 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 first survey at Hawke's Bay DHB.

Overview

Data produced by the Organisation of Economic Cooperation and Development (OECD) show New Zealand has one of the lowest numbers of specialists per head of population out of 33 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 impact on 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.

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.[3] The main reasons for doing so include not wanting to let their patients down and not wanting to over-burden colleagues. A soon-to-be-published 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.

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."[4]

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.

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'.

In view of these ongoing issues the ASMS is conducting a series of studies using a questionnaire to clinical leaders in selected DHBs, beginning with Hawke's Bay DHB, to ascertain how many specialists are required, in their assessment, to provide safe, good quality and timely health care for those who need it.

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Introduction

In February 2016, the ASMS distributed an online questionnaire to all 12 Heads of Department (HoDs) at Hawke's Bay DHB seeking their assessment on the adequacy of SMO staffing levels in their respective departments. All but one HoD responded to 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.

Questions also sought estimated staffing requirements to enable SMOs to 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 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.

Summary of findings

- Of the 12 Heads of Department (HoD) contacted for participation in this research, 11 responded to the survey (91.7% response rate).
- Eight out of 11 hospital departments assessed asserted they had inadequate FTE SMOs for their service at the time of the survey.
- Overall an estimated additional 20.6 FTEs – or 22% of the current SMO staffing level surveyed - were required to provide safe, quality and timely health care at the time of the survey.
- The estimated additional FTEs required above current staffing levels ranged from 12% (2 FTEs) to 88% (3.8 FTEs).
- Despite the estimated 20.6 FTE staffing shortfall, there were only 4.4FTE vacancies at the time of the survey.
- An estimated 27% of SMOs 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.
- 54% of the HoD respondents believed there was inadequate internal SMO cover for short-term sick leave, annual leave or continuing medical education leave.
- 64% of the HoD respondents believed there was inadequate access to locums or additional staff to cover for long-term leave.
- 73% of the HoD respondents believed their staff had inadequate time to spend with patients and their families to provide good quality patient centred care.

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

Findings

FTE analysis of departments

The results from the FTE assessments conducted by the HoDs were revealing. As detailed in Table 1, only three out of 11 departments surveyed felt they had adequate FTE for their service at the time of the survey. Although Paediatrics did not provide an estimate of additional FTE, the HoD noted that estimating additional FTE was 'difficult' but suggested that "we would get involved with new initiatives and enhance service provision if we had more SMO FTEs". This suggests that for this service the current FTE is also insufficient. Similarly, for the dental service, the HoD noted that the FTE was adequate but 'Maxillofacial concerning'.

The estimated additional FTE required ranged from 12% to 88%. One HoD noted in the comments section that the current FTE was "considerably less than 3-4 years ago, and certainly less than what we require". The respondent further noted that they had "2 Full time surgeons who dropped to 0.75 FTE. This funding has not been replaced". Another HoD noted that they had just received funding to increase the service to 5.7 FTE.

Overall, as a percentage of the existing FTE, the survey findings suggest the DHB has a 22% deficit for its specialist FTEs.

Vacancies

Three departments of the 11 surveyed reported vacancies for SMOs, with the HoD for one service reporting they had recently appointed two new staff who will be due to start in early 2017. The FTE for current vacancies was, with the exception of Mental Health, Older Persons Services, far less than the estimated additional FTE required. The HoD for the Emergency Department service noted that it is "difficult to recruit NZ trained specialists to regional EDs".

Table 1 Summary of FTE by Department

Department	Public Health	Emergency Department	Anaesthesia	Ophthalmology	Mental Health, Older Persons Services	Dental	Radiology	Paediatrics	Intensive Care	Medicine	Orthopaedics	Totals
Current FTE Allocation	2.55	8	17	2.7	5.0 Elderly 13 Mental health	2.4	7	7.5	4.2	19.6	4.25	**93.2 FTE**
Estimated Additional FTE Required	0.5	4	2	0	1 elderly	0	2.5	0	2.3	4.5	3.75	**20.55 FTE**
% of current FTE required	20%	50%	12%		20% elderly		36%		55%	23%	88%	
Total additional FTE required as % of total FTE												**22%**
FTE for Current Vacancies where applicable	n/a	2		n/a	1	n/a	n/a	n/a	n/a	1.4	n/a	

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, 46% felt that SMOs were able to access their recommended 30% non-clinical time although none of the HoDs thought SMOs in their department were 'always' able to do so. 27% estimated their staff as being either 'rarely' or 'never' being able to access their non-clinical time. One HoD noted staff were 'often' able to do so as "25% non-clinical time [is] rostered. Can be used for recovery post on-call previous evening". Another HoD noted that access to the non-clinical time was frequently dependent on the 'demand of services'.

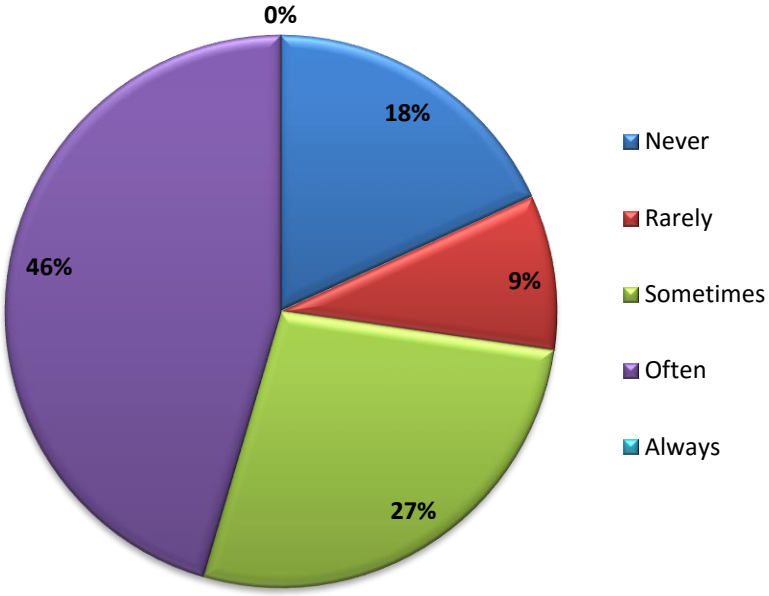

Figure 1 Access of SMOs to the recommended 30% non-clinical time

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 Resident Medical Officers (RMOs) as recommended by the 2009 SMO and RMO commission. As detailed in Figure 2, 40% agreed there was time for this but 30% disagreed that this was possible and 30% were unsure. Comments in this section noted that "we barely manage to provide an appropriate level of clinical care" and another that "teaching falls down during periods of SMO leave". Others noted that they either had no RMOs in their service or that they currently had no RMO training duties in the service. One HoD noted that much training "takes place in theatre", suggesting that training and educational duties were easier to accommodate in their particular service setting.

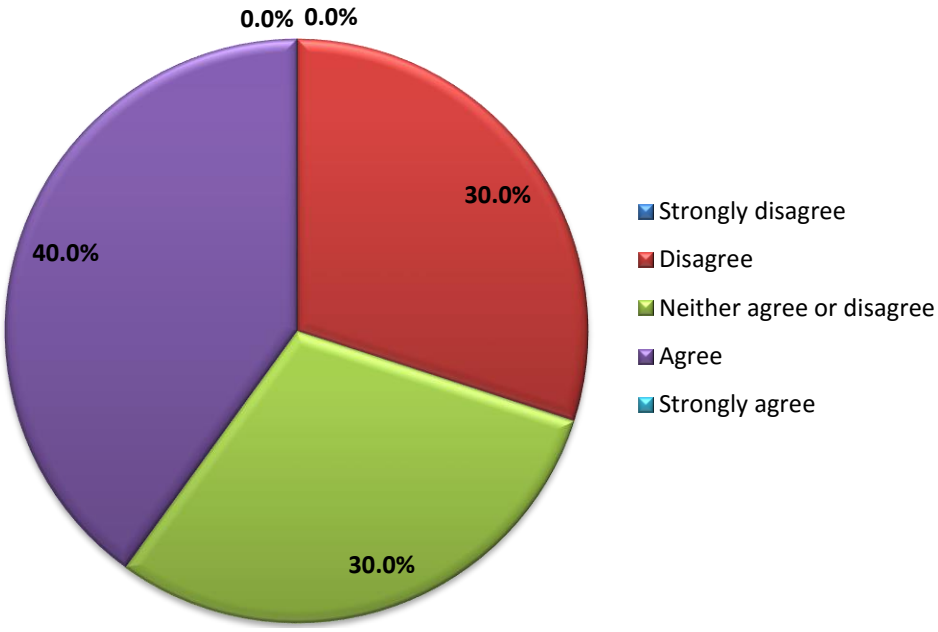

Figure 2 Sufficient time for training and education duties

SMO staffing levels and internal SMO cover to provide for leave

As detailed in Figure 3, the responses suggest that on the whole staffing levels are barely adequate to allow for leave, with the possible exception of annual leave.

For short-term sick leave, 54% either disagreed (18%) or strongly disagreed (36%) that there was sufficient internal cover and only 36% agreed with this statement. Similarly, 58% felt staffing levels were too low to allow for CME leave and only 36% agreed with this statement. Again, 54% felt staffing levels were inadequate for annual leave but a higher percentage agreed that staffing levels were adequate (45%).

Comments in this section noted the regular use of locums to cover sessions, the prioritisation of SME and annual leave but also the concurrent burden that internal leave coverage presents to those "who are left to cover the department".

The difficulties accessing short-term sick leave are particularly concerning given the recent emphasis on the high rates of presenteeism amongst senior doctors and suggest that presenteeism will continue to be an established behavioural norm unless more accommodating levels of FTE are forthcoming.

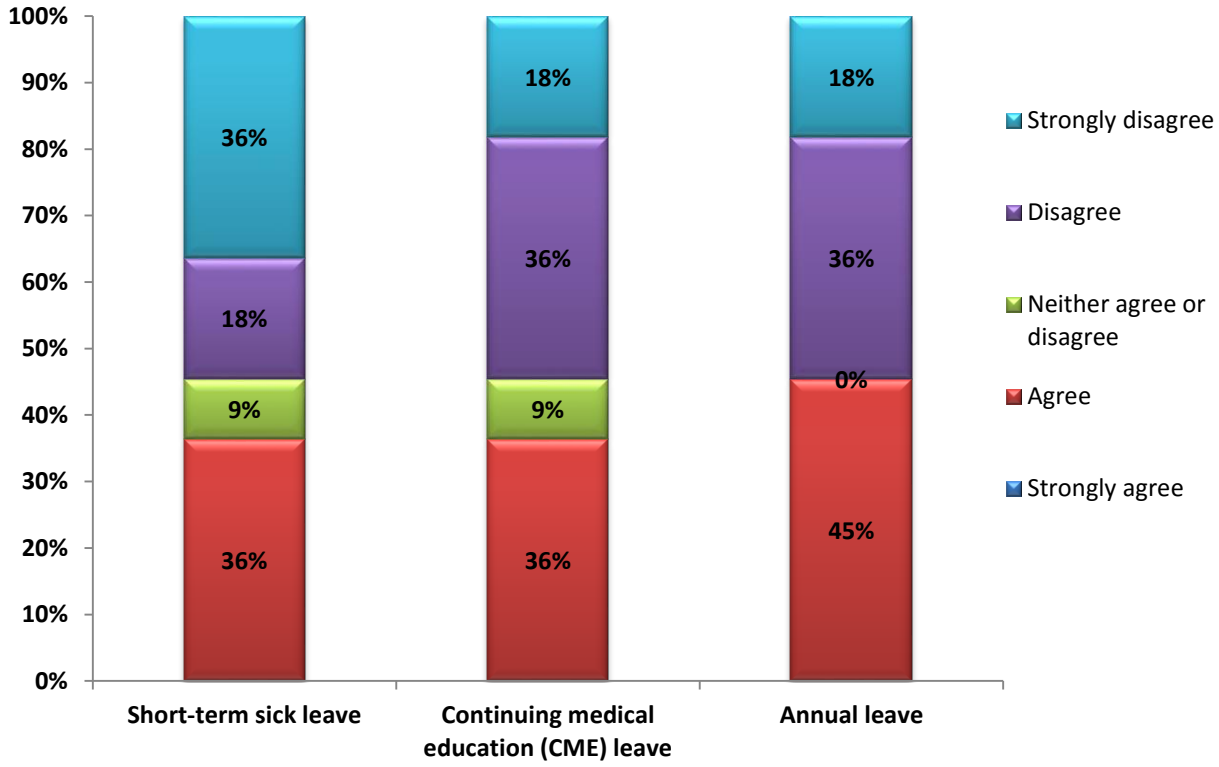

Figure 3 Assessment of internal SMO cover to provide for short –term sick, CME and annual leave

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 leave, including parental, sabbatical and secondment leave. As detailed in Figure 4, access to locums or extra staff was also viewed negatively by the majority, with 64% estimating that access was not adequate to enable access to various types of leave (disagree and strongly disagree combined). 9%, however, strongly agreed that access was sufficient and 18% agreed with this statement. Comments from respondents noted that it can be 'very hard to get locums' and that it could be "very difficult to organise coverage for sabbatical".

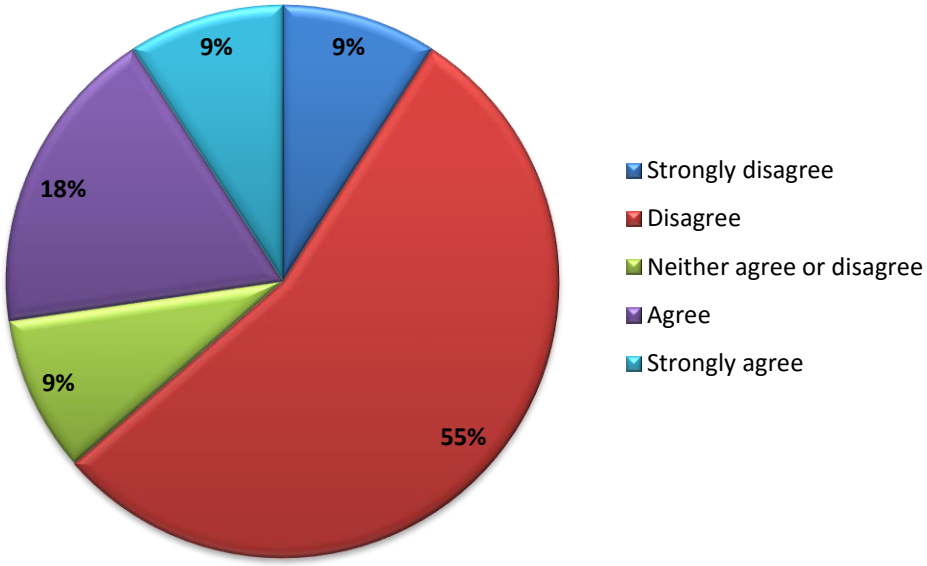

Figure 4 Degree of access to locums or extra staff to enable full use of longer-term leave

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. Three HoDs responded 'yes' but one noted that "pressure comes if we take sabbatical or long-term leave". All other HoDs responded negatively to this assessment (Figure 5).

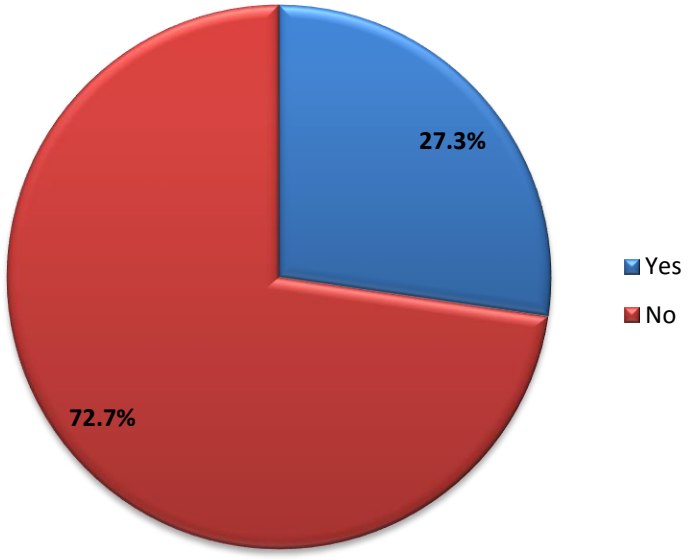

Figure 5 Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

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 2 and Table 3, this question was not applicable to three departments (anaesthesia, radiology and intensive care) and the same three departments were not involved in specialist referrals. With respect to referrals back to GPs, two were unsure and two asserted that referrals back to GPs did happen regularly. Only the HoD for Ophthalmology asserted that GPs are delaying or withholding referrals for specialist assessments, further asserting that this was 'always' happening.

Table 2 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	18%	2
No	36%	4
Unknown	18%	2
Not Applicable	27%	3

Table 3 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	9%	1
No	36%	4
Unknown	27%	3
Not Applicable	**27%**	**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 Figure 6, the vast majority reported they felt their staff did not have time for quality patient centred care. Only Mental Health, Dental and despite reported under-staffing, Orthopaedics, felt that they had sufficient time. Comments in this section were revealing with one noting that "significant increases in ED patient presentations means sufficient time is unable to be spent with patients and families. Throughput is prioritised over quality" (Emergency Department), and a different department noting "good pre-op assessment process for electives, but very difficult to get appropriate MDT pre-assessment for acutes".

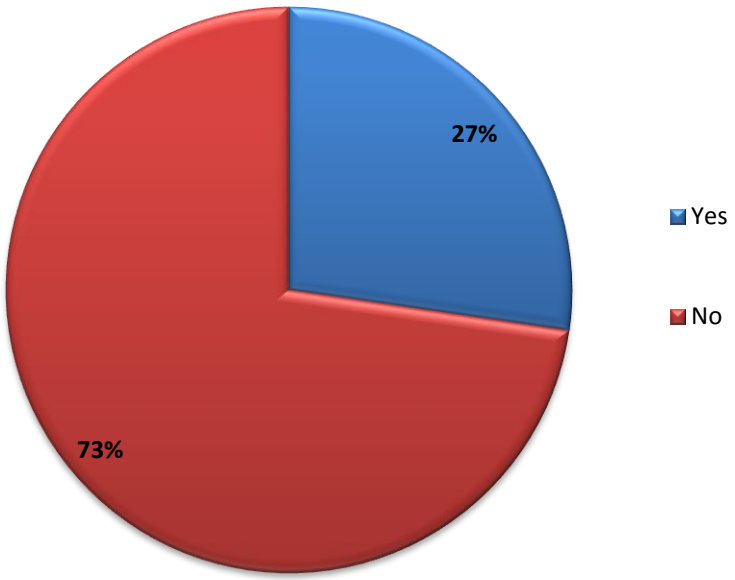

Figure 6 Do staff have adequate time for patients and their families?

References

[1] OECD Health Statistics, 2015.
[2] ASMS. *Taking the Temperature of the Public Hospital Specialist Workforce*, August 2014.
[3] C Chambers. *Superheroes don't take sick leave*; Health Dialogue, Issue No 11, ASMS, November 2015.
[4] SMO Commission. *Senior Doctors in New Zealand: Securing the Future*. Report of the SMO Commission, June 2009.