ASMS RESEARCH BRIEF

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Survey of clinical leaders on Senior Medical Officer staffing needs: Canterbury 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 sixth survey, at Canterbury 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 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.

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 10th for 'long waits for treatment after diagnosis', 9th for 'long waits to see a specialist', and 9th for elective surgery waiting time.[3] [4]

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.[5] 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.[6]

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."[7]

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.

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 to ensuring the whole clinical team is engaged in these endeavours.

There is now strong consensus internationally that distributed clinical leadership is the required 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 for those who need it. This report is the sixth in the series, which began with surveys at Hawke's Bay, MidCentral, Capital & Coast, Nelson-Marlborough and Counties Manukau DHBs. 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.

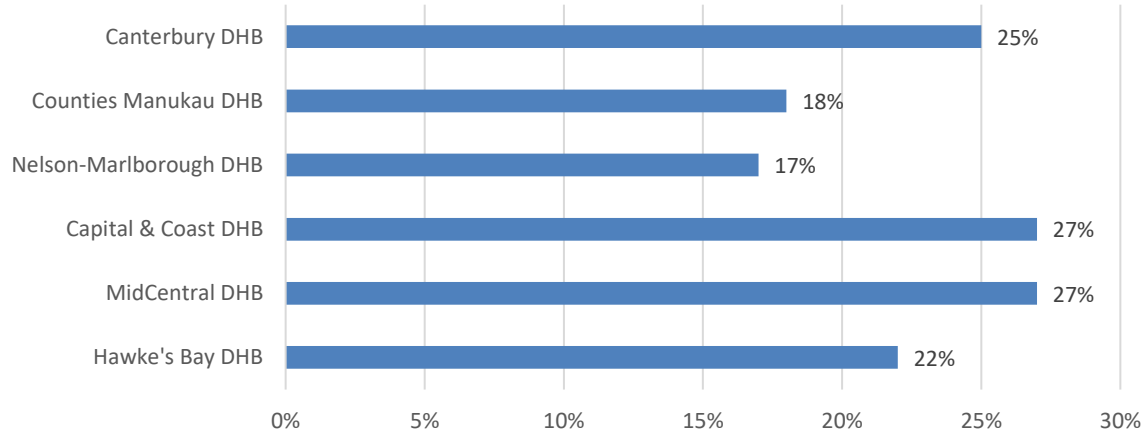

Figure 1: Estimated SMO staffing shortfall as a percentage of current staffing allocations

Source: ASMS surveys of clinical leaders. Full reports available: https://www.asms.org.nz/publications/researchbrief/

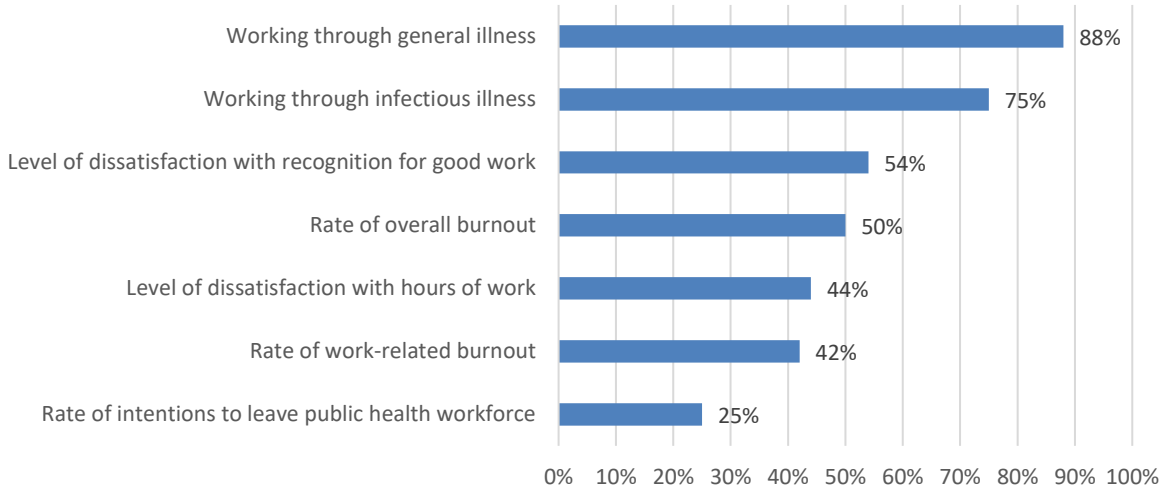

Figure 2: Indicators of the health and wellbeing of the senior medical workforce

Source: ASMS research, published in *Health Dialogues*, available: https://www.asms.org.nz/publications/health-dialogue/

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Introduction

Through November and December 2017, the ASMS distributed an online questionnaire to clinical leaders with immediate responsibility for specialty services at Canterbury 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 28 of the DHB's 55 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.8

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.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.

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

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

Summary of findings

Of the 55 HoDs contacted for participation in this research, 28 responded (51%), representing approximately 32% (152.5 FTEs) of the SMO FTE workforce at CDHB.ii

19 HoDs (68% of respondents) indicated they had inadequate FTE SMOs for their services at the time of the survey.

Overall the HoDs estimated they needed 37.6 more FTEs – or 24.7% 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 37.6 FTE staffing shortfall, there were only 8 FTE vacancies at the time of the survey.

From the 28 HoD responses, 39% 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. 35% said non-clinical time was accessible 'sometimes' and 27% said 'often' or 'always'.

Half of HoDs (50%) felt their SMO staff had insufficient time to undertake their training and education duties.

On average, 41% believed 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. 47% of respondents believed internal backup cover was adequate.

62% 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, 77% of HoDs responded 'no'.

62% of respondents felt their staff had adequate time to spend with patients and their families to provide good quality patient centred care. Nearly a third (31%) believed their SMO staff did not have adequate time.

[ii] Based on a senior medical FTE data in District Health Board Employed Workforce Quarterly Report, 1 July to 30 September 2017. Available: http://centraltas.co.nz/strategic-workforce-services/health-workforce-information-programme-hwip/

Findings

Adequacy of staffing levels

Nineteen of the 28 HoD respondents (68%) assessed they had inadequate FTE SMOs for their services at the time of the survey.

Overall, an estimated 37.6 more FTEs – or 24.7% of the current SMO staffing allocation in the 28 departments – were required to provide safe, quality and timely health care at the time of the survey.

Despite the estimated 37.6 FTE staffing shortfall, there were only 8.0 FTE vacancies at the time of the survey.

Respondents' comments frequently referred to clinical workload pressures.

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, 39% of respondents assessed that SMOs were 'rarely' or 'never' able to access their recommended 30% non-clinical time, while 35% estimated their staff are 'sometimes' able to access it, and 29% felt their staff 'often' or 'always'. Clinical demands encroaching on non-clinical time was a common theme in respondents' comments. One commented, "Most of our non-clinical time is spent checking lab results, dealing with referrals, triaging etc. These are all clinical duties." Another said access to non-clinical time was mostly restricted to 10% to 20% of duties.

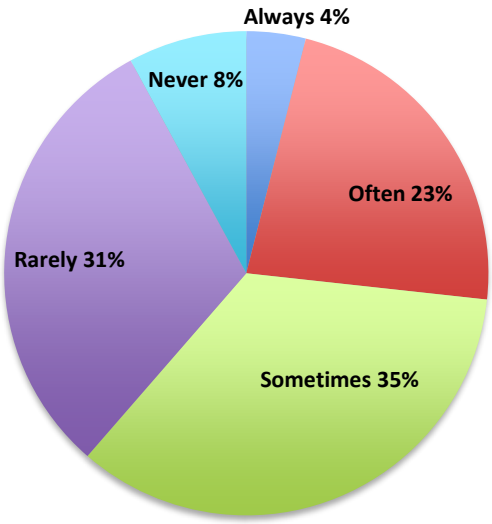

Figure 3: Access of SMOs to the recommended 30% non-clinical time

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 registered medical officers (RMOs) as recommended by the 2009 SMO and RMO commissions. As detailed in Figure 4, 50% 'disagreed' or 'or strongly disagreed' there was time for this, while 30% 'agreed' or 'strongly agreed'. One respondent commented: "Time available has not kept up with increasing requirements from MCNZ and Colleges."

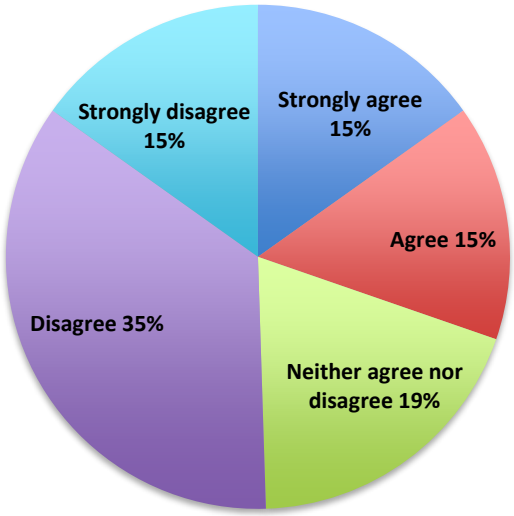

Figure 4: Sufficient time for training and education duties?

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

On average, 41% 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 5). On average, around a third (47%) 'agreed' or 'strongly agreed' staffing levels were adequate. Respondents' main comments concerned pressures with coping with clinical workloads when SMOs took leave. As one respondent said: "We cross-cover and that results in increased doctor stress...it is provided for, but at cost to the covering doctors." Another respondent said the lack of cover meant taking leave could only occur if clinics were cancelled. Some respondents spoke of the added difficulties with annual leave needs during school holidays, and others cited problems with accessing sabbatical leave. One respondent said they were still waiting to take sabbatical leave due in 2013.

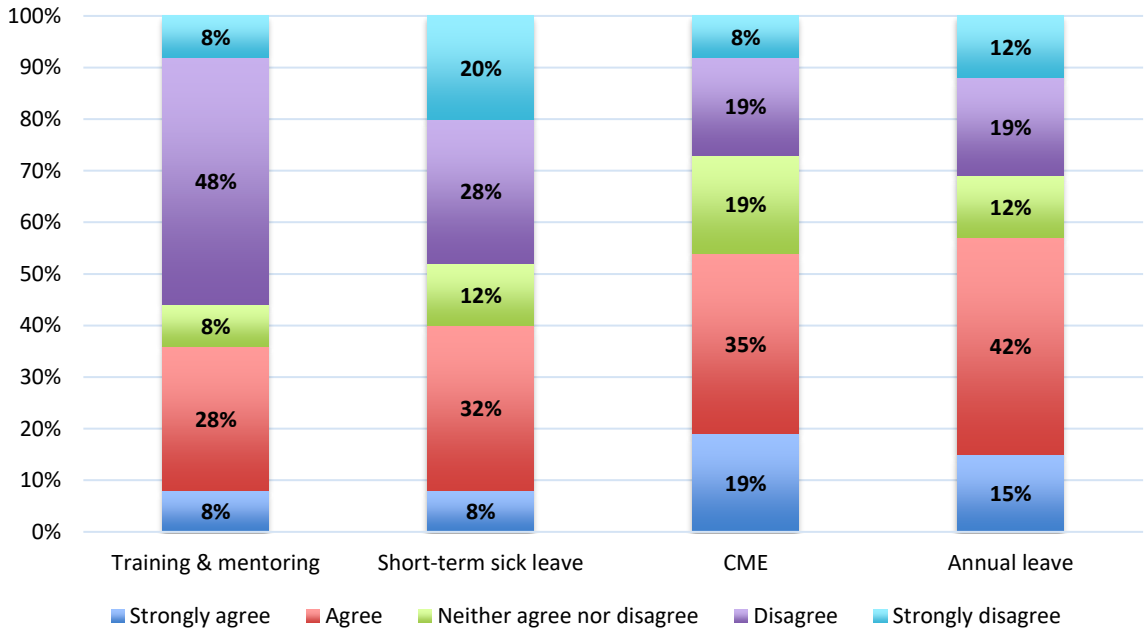

Figure 5: Sufficient internal SMO cover to provide for training & mentoring, short-term sick, CME and annual leave

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 6, 62% of respondents 'disagreed' or 'strongly disagreed' access to locums or extra staff was sufficient. 8% 'agreed' there was adequate access, while none 'strongly agreed'. Several respondents commented that locum cover was difficult to find; when locums were available, there was often no budget to pay for them. As one respondent commented: "[We are] reliant on semi-retired staff, which is not a long-term solution and not within the budget." Several respondents mentioned there was no locum cover for sabbaticals.

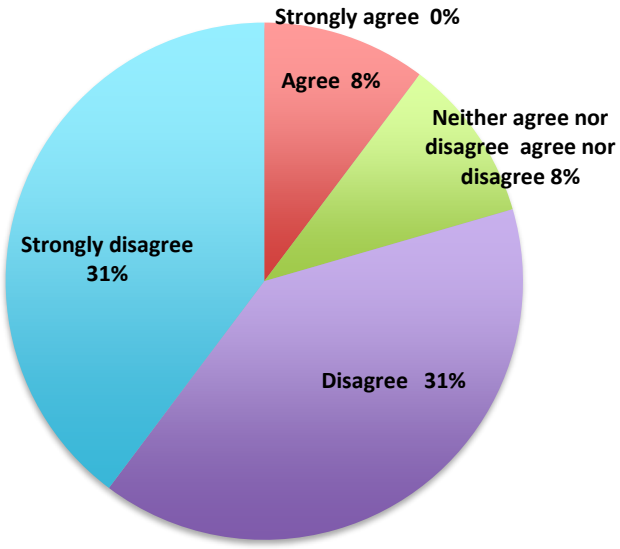

Figure 6: Sufficient access to locums or extra staff to enable full use of longer-term leave?

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. 77% of respondents answered 'no' (Figure 7). One respondent commented: "All areas are under some pressure, [there is] tension between protecting these conditions of employment versus constraints on service delivery and development." Some respondents singled out particular difficulties in finding adequate time for teaching and supervision duties.

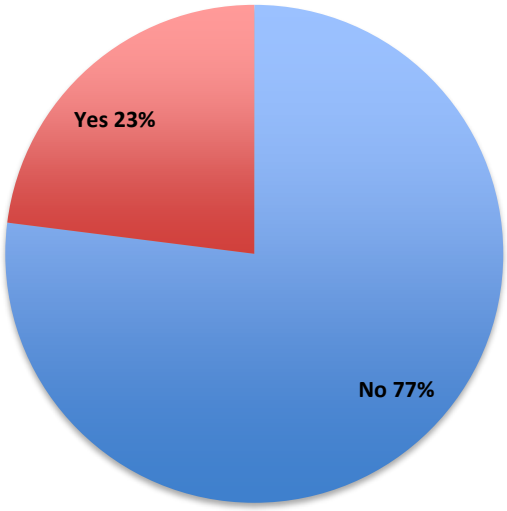

Figure 7: Sufficient SMO FTEs to enable full use of appropriate leave-taking, non-clinical time, including training responsibilities?

General Practitioner (GP) Referrals and Unmet Need

The next area of 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 Tables 1 and 2, with respect to referrals back to GPs, half of respondents (50%) indicated their department did not refer patients back to their GPs; 21% said theirs did. 43% of HoDs believed GPs were not withholding referrals for first specialist assessments (FSAs), 7% believed they were, while 32% were unsure. Comments ranged from: "The vast majority of referrals is rejected," to "about 5%" of patients are referred back to their GP. One respondent commented: "There has been basically no or a very minimalistic service for many years/decades which puts GPs off as there is no point in referring anyway."

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	21	6
No	50	14
Unknown	7	2
Not Applicable	21	6

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	7	2
No	43	12
Unknown	32	9
Not Applicable	18	5

Time for Patient Centred Care

The final section of the survey queried 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, most (62%) reported they believed their staff had time for quality patient-centred care; almost a third (31%) believed they did not. Some respondents commented on the time pressures due to heavy clinical workloads. For example: “Clinic appointment times are too short, and clinics often over-booked.” A common theme among those who commented was that SMOs tended to ensure they had time for quality patient centred care at the expense of other duties. For example: “We make time often at the cost of nonclinical time.” And: “I think docs tend to prioritise this over their other duties.”

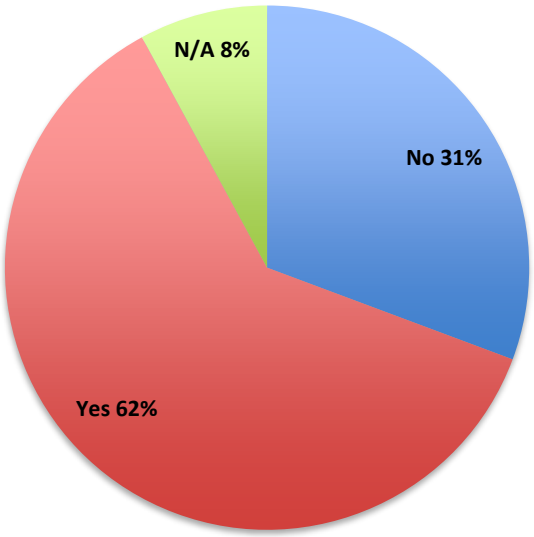

Figure 8: Time for patients and their families?

Reference

[1] OECD Health Statistics, 2017 (data from 2015).

[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] E Mossialos, A Djordjevic et al (eds). *International Profiles of Health Care Systems*. Commonwealth Fund, May 2017.

[5] 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

[6] 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

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

[8] 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