Report to Health Workforce New Zealand on the Rural Hospital Doctors Workforce Survey 2015

Authors.
Ross Lawrenson  Professor of Primary Care, Waikato Clinical Campus, University of Auckland
James Reid  Southern District Health Board and Chair of the Division of Rural Hospital Medicine
Garry Nixon  Senior Lecturer Rural Health, University of Otago
Andrew Laurenson  Division of Rural Hospital Medicine Registrar

Background
In 2009 we identified 28 rural hospitals offering 24 hour care (and requiring regular coverage by a medical officer) within New Zealand. This survey showed that there was a shortage of suitable applicants for positions in the hospitals with over 10% of posts being unfilled and 24% filled by locums. (Lawrenson 2011). Only half the doctors were vocationally registered and most were registered as general practitioners. Since that survey there has been the development of the Rural Hospital Medicine Training program which is managed under the auspices of the Royal New Zealand College of General Practitioners. (Nixon 2007) There are now over 90 vocationally registered rural hospital doctors on the Medical Council of New Zealand (MCNZ) register practising under this scope of practice. Many of these doctors are also vocationally registered in general practice. There is also an active cadre of Rural Hospital Medicine trainees who are registered by the Division of Rural Hospital Medicine (DRHM) of the Royal New Zealand College of General Practitioners (RNZCGP) and are currently training.
We were also interested in the governance processes in rural hospitals. Historically rural hospitals were run by Hospital Boards but with the structural changes in the 1990s many were handed over to community organisations to manage. Rural hospitals had used a high proportion of non-vocationally registered doctors, had relied on locums to provide cover and many had a high turnover of staff. In addition with the introduction of general management by District Health Boards (DHBs) in the 1990s the role of the Medical Superintendent of Hospitals was disestablished and clinical governance of doctors in the hospitals became dependent on variable management arrangements. With the introduction of the Health and Disability Commissioner (1994) and the emergence of the principles of clinical governance as part of the national health strategy in 2009 (Gauld R) the importance of the quality of medical care has come to more prominence. However little thought has been given to how this can be managed in rural hospitals many of which are not managed directly by DHBs.
Aims and objectives.
The aims of the study were
1) to assess medical workforce needs of New Zealand rural hospitals and
2) assess the quality and effectiveness of the DRHM program

The key questions that we tried to answer were:
What are the changes to the workforce needs in the 28 rural hospitals? We were particularly keen to find whether there had been a change in the number of available positions, any change to the number of unfilled and locum positions and changes to the age and vocational scope of the doctors filling these positions. What are the characteristics of the vocationally registered doctors in rural hospital medicine and what roles are these doctors currently fulfilling? We were also keen to understand the future intentions of these doctors, including the likelihood of them remaining in the community in which they currently work, their career intentions and the issues that are most likely to help retain them
We also wanted to survey the trainees in rural hospital medicine to understand their background and characteristics, their current training experience and their future intentions. We wanted to look at the barriers and enablers for these trainees with regards their training and work experience. We are also keen to find out whether the trainees are also training in another scope or taking on specials skills so they can work in an extended scope of practice. Finally we wanted to try and find out something about the non-vocationally registered doctors who are working in rural hospitals, why they are working in a non-vocationally recognised role and what their future intentions might be.

Methodology

We undertook five separate studies

1) We surveyed all 28 rural hospitals from our previous study.
2) We reviewed the details of all the doctors listed by the Medical Council of New Zealand (MCNZ) as being vocationally registered in rural hospital medicine.
3) We surveyed all DRHM current Fellows – this was undertaken by the RNZCGP at their expense
4) We surveyed all DRHM current Registrars– this was undertaken by the RNZCGP at their expense
5) We surveyed all current doctors who were working in rural hospitals but were not either vocationally registered in rural hospital medicine or in training.
1) We undertook a cross sectional study of all the rural hospitals. This was carried out by the New Zealand Institute for Rural Health (NZIRH). To ensure that we could compare our findings with the 2009 survey we used the same questionnaire. The only slight modification to 2009 survey was that we specified the vocational scope of doctors working in rural hospitals to include those working as vocationally registered Rural Hospital Medicine specialists. This questionnaire is Appendix 1. We would note that while we intended to post this questionnaire to the hospital managers in the end it was easier to ring the relevant manager and obtain the information from a teleconference call. As well as having questions about the medical workforce it also included questions relevant to the governance arrangements, including clinical governance in the hospitals. It was invaluable partnering with the NZIRH for this part of the survey due to their established relationships with all the rural hospitals.

2) We obtained the list of the doctors currently registered with the MCNZ as being vocationally registered in Rural Hospital Medicine. We identified in this group their country of qualification, the University they qualified from, the year of qualification and their gender.

3) We surveyed all DRHM current Fellows. This involved the development of a questionnaire by the RNZCGP Division of Rural Hospital Medicine (thanks to Pam Watson) – with input from Ross Lawrenson, James Reid and Garry Nixon. This questionnaire was put on College website using Survey Monkey and all Fellows registered with the Division of Rural Hospital Medicine were invited to complete the questionnaire. Invites were also made on e-pulse the RNZCGP e-newsletter and personal contacts from key members of the DRHM.

4) We surveyed all DRHM current Registrars. This involved the development of another questionnaire by the RNZCGP Division of Rural Hospital Medicine – again thanks to Pam Watson, with input from Ross Lawrenson, James Reid, Garry Nixon and Andrew Laurenson the representative of the registrars in training. Again this questionnaire was put on College website using Survey Monkey and all Fellows registered with the DRHM were invited to complete the questionnaire. Invites were also made on e-pulse personal contacts from key DRHM members and registrars.

5) Finally we developed a shorter questionnaire based on key questions for the DRHM Fellows but aimed at doctors working in rural hospitals but who were not Fellows of the DRHM. This questionnaire was hosted by the NZIRH website and again used Survey Monkey. Doctors were invited by word of
mouth via the hospital managers and DRHM Fellows to complete the questionnaire.

Results

Hospital Managers’ survey results

Ownership Structure

<table>
<thead>
<tr>
<th>Ownership Structure</th>
<th>2009</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>District Health Board (DHB)</td>
<td>19 (68%)</td>
<td>16 (61%)</td>
</tr>
<tr>
<td>Community Trust</td>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>LATE</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Private</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Iwi Authority</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>28</strong></td>
<td><strong>26</strong></td>
</tr>
</tbody>
</table>

12 of the 26 hospitals are approved for DRHM training
23/26 said they provide 24/7 medical cover
Mean number of beds was 16 (3-48) excluding maternity beds and residential care beds.
12 had vocationally registered staff. This increased from 4 in 2009 because in 2009 we recorded vocationally registered specialists in FACEM, surgery and Paediatrics but not DRHM.

18/26 (69%) hospitals directly employed medical staff. This is the same for both DHB managed hospitals (11/16 - 69%) and Trusts/other (7/10 - 70%)
The managers stated that for these 18 hospitals they had 96.8 budgeted FTEs. At the time of the survey there were 5.5 FTE filled by Locums. 39 FTE were filled by DRHM Fellows, 18 FTE were filled by non-vocationally registered doctors not in training while there were 8 FTE filled by DRHM registrars. The remainder are filled by general practitioners and a few specialists in other vocational fields. In comparison in 2009 we found 18 hospitals had 85.1 FTE and employed 19.5 FTE Locums.

Availability of Medical Staff.
Percent responding to question about availability of suitably qualified medical staff for rural hospitals 2009 and 2015

![Chart showing availability of medical staff](chart.png)

Percent responding to question about availability of suitably qualified locum medical staff for rural hospitals

**Clinical Governance arrangements.**

**Credentialing**
14/26 (54%) hospital managers say they credential their doctors. 14/18 (77%) hospitals that directly employ doctors said they had a credentialing process

Is there a designated medical leader e.g. clinical director?
This has improved to 19/26 (73%) hospitals identifying a clinical leader compared to 18/28 (64%) in 2009

Is there an active process of clinical governance?
21/26 (81%) said “Yes” in 2015 compared to 18/28 (64%) in 2009

**Key findings**
There has been a 7% reduction in the number of hospitals and a reduction in proportion of rural hospitals managed by DHBs. However there has been an increase of 14% in medical FTE
There has been an improvement in perceived availability of rural hospital doctors and locums – although there are still shortages
DRHM program means most hospitals now employ vocationally registered doctors – only 18 FTE are filled by non-vocationally registered doctors. We identified 8 DRHM registrar positions. We believe there is evidence of an improvement in clinical governance with presence of a clinical leader in most hospitals, an active process of clinical governance and wider use of credentialing

**Survey of MCNZ records of doctors who are vocationally registered in rural hospital medicine.**

92 doctors are vocationally registered in rural hospital medicine by MCNZ
- 28% were female
- 36/92 (39%) received their primary degree in NZ
- 12/36 (33%) of New Zealand medical graduates graduated from the University of Auckland and 67% from Otago.
- 53/92 (58%) were also vocationally registered in another scope - 37 (40%) were vocationally registered in general practice, 13 (14%) in Urgent Care, 3 in Emergency medicine and one each in internal medicine and paediatrics. (n.b. some were vocationally registered in more than one additional scope).
- The median year of qualification was 1988 (mean 1990)

**Survey of DRHM current Fellows**
The DRHM identified 110 Fellows on their membership list
- There are 3 doctors who are on MCNZ database but no longer reporting their CPD in RHM scope and 21 Fellows who have not registered their qualification with the MCNZ. 5 of these doctors are not registered with the MCNZ – possibly they are working overseas or are taking a break from working. However there are 16 Fellows who are active but not vocationally registered according to the MCNZ.
- 68/110 DRHM Fellows (62%) provided a valid response
- 25/68 (37%) were female (compared to 28% of MCNZ list)
- 47% received their primary degree in NZ (compared to 39% of MCNZ sample)
- Of the New Zealand graduates 30% graduated from the University of Auckland graduates compared to 33% in the MCNZ sample.
- These comparisons suggest that the sample is slightly biased to New Zealand qualified doctors, Otago graduates and females.

(Note a Full report on the responses from the Fellows and Registrars surveys is available from the DRHM of the NZCGP. We have concentrated in this report on the findings relevant to workforce planning and clinical governance. We believe that the issues regarding the training program are principally of relevance to the College and so we have not included all their findings in this report)
Median age group of Fellows was 45-54 years. Data regarding the number of survey respondents who come from a rural background (defined for the purpose of this survey as living rurally and attending school in a community with a population of less than 30,000 at the time of entry to medical school) shows that the proportion of current DRHM Fellows who come from a rural background is 31.3% (21 out of 67 respondents). For registrars, the proportion is higher, with almost one in two registrars (45.2%, 19 out of 42 respondents) coming from a rural background. 88% of Fellows received their Fellowship through “grandfathering”

**Additional scopes**
65% of respondents hold a vocational registration in another scope
Commonest scope is general practice (37%), followed by Urgent Care and Emergency medicine
18% are practising outside their vocational scope under a general scope – either in emergency medicine, general practice or internal medicine
51% have recently been registered to work in another country

**Employment**
88% of Fellows work in rural hospitals
44% work in a level 3 rural hospital, 35% in level 2 and 9% in level 1.
Only 28% work at a single worksite rural hospital
Some have 3 or more worksites
Northland DHB employs greatest number of Fellows, followed by Canterbury, Southern, Waikato and West Coast DHBs

**Clinical responsibilities**
Majority of Fellows (73.0%) have daily responsibility for adult acute medicine
Fewer than half have daily responsibility for paediatric acute medicine (47.6%), convalescent care (41.3%), long-stay inpatient care (31.7%) or palliative care (44.4%) (but all of these areas are covered occasionally or out-of-hours).
52.3% of Fellows indicate that they never have lead maternity carer responsibilities.
However, 66.2% are involved as support for midwifery colleagues in an emergency.

**Access to facilities**
94% have access to X-rays
89% have access to laboratory services
78% have access to ultrasound
46% have access to CT

**Clinical Governance**
80% say that there is active clinical governance in their worksite
73% identified there was clinical leadership – although this may be provided from a base hospital
**Teaching**
78% of Fellows are involved in teaching
44% in teaching medical students
39% as DRHM facilitator
Others teaching roles include GP training and acting as MCNZ supervisor

**Future**
60% say it is very easy or moderately easy to find employment in rural hospital medicine
52% are planning to leave rural practice in the next 10 years (2/3 due to retirement)
77% are interested in advanced training
9/68 (13%) are considering obtaining Fellowship in GP
A total of 33 Fellows (51.6% of the responses to this question) have indicated that they are intending to leave rural practice in the next 10 years. 5 of these respondents (7.8%) are intending to leave in the next 2 years, an additional 10 in the next 5 years (15.6%) and a further 18 in the next 10 years (28.1%).
Of those planning to leave, retirement is given as the reason in 21 cases (32.8% or respondents, or 63.6% of those planning to leave rural practice).

**Key findings**
Only 89/110 Fellows are working within scope
While 88% of Fellows work in a rural hospital the majority work in more than one role.
Approximately 60% hold vocational registration in another scope
50% are planning to leave rural practice in next 10 years

**DRHM registrars survey results**
Response rate for the Registrar survey was 42 out of a College list of 46 active registrars i.e. 91% response. Median age group of Registrars was 25-34 years (81%)
Majority graduated in 2005-2009 period. Data regarding the number of survey respondents who come from a rural background showed almost one in two registrars (45.2%, 19 out of 42 respondents) came from a rural background.
46% were female
71% had primary degree in NZ and remainder mainly UK
63% graduated from the University of Otago

**Additional scopes**
63% are on a dual training pathway with general practice and 12% already hold vocational registration in GP

**Employment**
11/42 (26%) said they were currently working in a rural hospital - mainly level 3 hospitals. (N.b. Grey Hospital is considered a level 3 hospital for DRHM training but was not considered in the rural hospital survey)
Data regarding current registrar employment shows that there are a limited set of runs that registrars are currently engaged in. These are anaesthetics, emergency medicine, general medicine, paediatrics, rural general practice, rural hospital and urban general practice. Registrars reported some difficulty in finding runs in paediatrics and anaesthetics. No registrars reported having taken a run in O&G or palliative care.

**Current registrar placements**

- anaesthetics
- emergency medicine
- general medicine
- paediatrics
- rural general practice
- rural hospital
- urban general practice

Canterbury is the largest employer (12 registrars) followed by Northland (7) and Southern (7)

**Access to facilities for registrars**
- 95% have access to X-rays
- 96% have access to laboratory services
- 82% have access to ultrasound
- 75% have access to CT

All these are slightly in excess of the figures reported by Fellows due no doubt to more registrars being based in a secondary or tertiary hospital

**Registrars future intentions**
- 33% intend to work in rural hospital practice only
- 61.5% say they are intending to work in a combination of rural hospital medicine and general practice
- 5% are intending to work in rural general practice only
- 34% intend to work overseas at the end of their training

**Key Findings**
There are 46 current registrars in training, almost 50/50 male/female and mostly NZ graduates.
Registrars undertake training in a variety of settings with a report of some difficulty in finding runs in paediatrics and anaesthesics. Most registrars intend to work in a combination of rural hospital medicine and general practice. One third of trainees intend to work overseas at the end of their training.

Non-vocationally registered doctors survey results

Findings
There were 11 eligible responses from non-vocationally registered doctors who were currently working in a rural hospital. The median age distribution of non-vocationally registered doctors was 35-44 – intermediate between the age of registrars and Fellows.

5 were Females (45%)
1 was a New Zealand graduate, 3 from UK, 6 from Europe
10/11 were practising more than 8/10ths
7/11 said they were considering further training

Reasons for working rurally
We asked these doctors why they had chosen to work in a rural hospital/location.
6/11 mentioned lifestyle/quality of life
4/11 mentioned diversity of work
1 did not answer

Discussion
This workforce survey has taken a dual approach – the first from the perspective of the rural hospitals management and the second that of the doctors working within the sector. One of the difficulties is the changing perception of what is a rural hospital and their role and function. There is increasing emphasis on encouraging generalist practice and decentralisation of services closer to patients. When considering this study we tried to be consistent with the survey we conducted in 2009. We acknowledged then that there were differences in our interpretation of a rural hospital to that of Janes et al in 1999 (Janes) He defined a rural hospital as “a facility with no resident medical specialists, where acutely ill patients are admitted and cared for solely by generalist doctors, either general practitioners (GPs) or medical officers of special scale (MOSS)” and included 44 hospitals under this definition. Murdoch in 2007 used the term “facilities with no resident specialists where acutely ill patients are admitted and cared for solely by generalist doctors,” and estimated there were 36 rural hospitals under this definition. In 2009 we looked for hospitals that provided 24 hour hospital care, had generalist medical cover and did not have more than 2 vocational registered specialists present. This identified 28 hospitals. In this survey we have further reduced to only being able to find 26 hospitals meeting this definition. Akaroa and Taihape that were both included in 2009 are no longer providing acute hospital care for their communities.
Our survey of rural hospitals has suggested that there is a much improved situation compared to 2009. The use of locums has reduced substantially. There are more medical positions although the number of hospitals has reduced. Most doctors working in a rural hospital are now vocationally registered or are in training. Many of the hospital managers have indicated that there is an adequate supply of rural hospital doctors – although some still characterise the situation as being a serious or critical shortage. No manager said there was an oversupply. We have ascribed the improved position to the RHM training program and the encouragement of doctors to undertake vocational training which gives them a career path. Only 2 Fellows were less than 35 years of age so it is unlikely the introduction of the Rural Origin Medical Preferential Entry (ROMPE) scheme in 2002 has had an impact. However the proportion of registrars who were from a rural background was greater than the proportion of Fellows and most had qualified between 2005 and 2009 so ROMPE may well have had an impact.

The findings from the hospital managers reporting and from the reporting by Fellows was consistent and suggested that 80% of hospitals have an active clinical governance process, and more than 70% can identify a clinical leader for the hospital. This has improved since 2009 and anecdotally it seems that achieving a vocational specialist registration has allowed more doctors to take up these roles as independent specialists who are able to lead the services. It is also good to see that there is generally some credentialing of new doctors before they start work – again a simple but useful way on ensuring the quality of medical care being provided. It has been suggested that rural communities can expect a second class level of practitioner (Simpson) – but a credentialing process ensures that only suitable qualified and experienced doctors are recruited to any vacant position. This should be especially important for locums but also a rigorous process is required for substantive positions.

Although there has been a small increase in the number of medical positions available in rural hospitals, the actual number of available doctors is similar to the 107 we identified in 2009. The characteristics of the doctors is different with most having gained extra qualifications since then. However most Fellows are still in the 45-54 year age bracket, are male and were trained overseas. It is pleasing to see the cadre of young rural hospital medicine doctors coming through, most of whom are New Zealand graduates and with an increasing proportion of women. This shows that there will continue to be new developments in the sector over the next ten years as many of the older doctors decide to retire from practice. It is important that the positions remain attractive with reasonable rostering, a female friendly work environment that allows opportunities for part time work or for breaks from practice for family reasons. We also noted in our previous survey that most rural doctors are not able to access non-clinical time - unlike their colleagues in base hospitals. This again is something to be considered for the future. Increasingly there will be opportunities for teaching, clinical leadership duties and even research – as well as the need for protected time.
for personal development. It is necessary that rural hospital doctors are treated equitably whether they work for a DHB or a community trust.

The scope of rural hospital medicine is defined by its context and in particular the MCNZ definition of a rural hospital. It is clear from the survey that a number of fellows are filling positions in larger hospitals – in particular small provincial hospitals such as Grey Base and Wairau. These doctors are “working out of scope” and currently need a collegial relationship. It is likely they are making a valuable contribution to the staffing of these small provincial hospitals which have struggled to find a sustainable medical staffing model. Because the role of RHM fellows in this context is still unclear it is difficult to determine the future size of the workforce. Resolving the MCNZ registration issues for these doctors would be a helpful first step.

Overall we believe this study provides useful information for rural hospital managers, clinical leaders and others involved in workforce planning. While there has been a reduction of the workforce shortages of a few years ago we still need to be vigilant and ensure that more doctors enter the RHM pathway -. It would seem that the shortage of rural general practitioners is also being helped by the dual pathway that many registrars have taken up. The College has to be commended for the way it has supported the work of the DRHM and at the same time seen the benefits of having a rural GP workforce who are better equipped to provide expert acute medical care. Two issues that we have highlighted are the ongoing schism between generalist medical practitioners and midwives – who currently appear to only relate to obstetric specialists. This needs to be reviewed to see if some accommodation can be reached so rural midwives can work with their local medical colleagues. A second issue is palliative care. It is uncertain why no registrars have undertaken a palliative care run as 44%of Fellows reported they provide cover for palliative care patients. It is predicted that the need for palliative care services will only increase as the workforce ages and it would be good for the specialist services to discuss with the DRHM how they can better facilitate the training of registrars so they can become competent in this important field of practice. Having said this overall it appears that the DRHM have a training program that is proving attractive to trainees and will help ensure rural comities will have a fantastically well trained workforce for the future.
**Recommendations**

HWFNZ should work with DHBs to ensure an adequate number of training posts are available in paediatrics and anaesthetics.

The Division should review the elective runs and where appropriate encourage more registrars to undertake training in areas such as palliative care and obstetrics.

The MCNZ and Division of Rural Hospital Medicine review the registration status of RHM fellows working in small provincials hospitals.

The MCNZ and National Health Board determine the role of RHM fellows in small provincial hospitals.

The RNZCGP and its Division of RHM along with HWFNZ continue to work together to make dual training in GP and RHM as seamless as possible.

**Dissemination**

The findings from this study have been presented at the Rural Health Conference in Rotorua in March 2015. A paper is being prepared for publishing in a peer reviewed journal. This report will be made available with permission of HWNZ.

**Acknowledgements.**

We would like to thank:
Health Workforce New Zealand (HWNZ) for their funding of this survey
Pam Watson from RNZCGP for the organisation of the Fellows and Registrar surveys
Robin Steed and Brent Nielsen from NZIRH for conducting the survey of rural hospitals
All the doctors and hospital managers who have participated
References.


Simpson C, McDonald F. 'Any body is better than nobody?' Ethical questions around recruiting and/or retaining health professionals in rural areas. Rural Remote Health. 2011;11(4):1867.
Appendices.

Appendix 1.

Abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCNZ</td>
<td>Medical Council of New Zealand</td>
</tr>
<tr>
<td>DRHM</td>
<td>Division of Rural Hospital Medicine</td>
</tr>
<tr>
<td>RNZCGP</td>
<td>Royal New Zealand College of General Practitioners</td>
</tr>
<tr>
<td>NZIRH-</td>
<td>New Zealand Institute for Rural Health</td>
</tr>
<tr>
<td>DHB</td>
<td>District Health Board</td>
</tr>
<tr>
<td>LATE</td>
<td>Local Authority Trading Enterprise</td>
</tr>
<tr>
<td>HWNZ</td>
<td>Health Workforce New Zealand</td>
</tr>
<tr>
<td>ROMPE</td>
<td>Rural Origin Medical Preferential Entry</td>
</tr>
</tbody>
</table>
Appendix 2.

Rural Hospitals included in the Study (Number - 26)

2 hospitals from the 2009 survey were not included - Akaroa which was closed after the Canterbury earthquake and has not re-opened and Taihape which the Mid Central DHB transferred to a Community Trust who then found the hospital unsustainable

Ashburton Hospital
Bay of Islands Hospital
Buller Hospital
Chatham Islands Hospital
Clutha Health First
Dannevirke Community Hospital
Dargaville Hospital
Dunstan Hospital
Golden Bay
Gore Hospital
Hawera Hospital
Hokianga Hospital
Kaikoura Hospital
Kaitaia Hospital
Lakes District Hospital
Maniototo Hospital
Murchison Hospital and Health Centre
Oamaru Hospital
Opotiki Hospital
Taumarunui Hospital
Taupo Hospital
Te Kuiti Hospital
Te Puia Hospital
Thames Hospital
Tokoroa Hospital
Wairoa Hospital and Health Centre
Appendix 3

Rural Hospital Managers Questionnaire
December 2014

1. General Information

Name of hospital

Ownership Structure e.g. District Health Board, Community Trust, Local Authority Trading Enterprise etc

Do you provide a walk-in emergency/out of hours service to patients

Yes/No (please circle)

Is this open 24/7?

Yes/No

If no can you say what hours the Emergency Department is open?

2. Services Provided

<table>
<thead>
<tr>
<th>Inpatient Bed Numbers</th>
<th>Number in each category of Bed e.g. Medical Surgical Geriatric Maternity Children</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Medical</th>
<th>Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geriatrics</td>
<td>Maternity</td>
</tr>
<tr>
<td>Child</td>
<td></td>
</tr>
</tbody>
</table>
3. Medical Workforce Information

a) Medical Staffing

Do you?

I. Employ individual Medical Officers
II. Contract a General Practice
III. Contract a Medical Company

(Please strike out not applicable)

b) Medical Staff

If you employ staff please could you get them to complete the NZIRH Survey online http://www.nzirh.org.nz/ (hard copies will be provided if Doctors prefer)

<table>
<thead>
<tr>
<th>Budgeted Specialists</th>
<th>Actual employed Specialists</th>
<th>Actual Locum Specialists</th>
<th>FTE</th>
<th>Head Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Hospital Medicine</td>
<td>Rural Hospital Medicine</td>
<td>Rural Hospital Medicine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Specialist Physician</td>
<td>• Specialist Physician</td>
<td>• Specialist Physician</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Surgeon</td>
<td>• Surgeon</td>
<td>• Surgeon</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• FACEM</td>
<td>• FACEM</td>
<td>• FACEM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
<td>Other</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Budgeted non-vocational doctors</th>
<th>Actual employed non vocational doctors</th>
<th>Locum Non-vocational doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• MOSS</td>
<td>• MOSS</td>
<td>• MOSS</td>
</tr>
<tr>
<td>• RHM</td>
<td>• RHM</td>
<td>• RHM</td>
</tr>
<tr>
<td>• Registrar</td>
<td>• Registrar</td>
<td>• Registrar</td>
</tr>
<tr>
<td>• Junior doctor in training GP</td>
<td>• Junior doctor in training GP</td>
<td>• Junior doctor in training GP</td>
</tr>
<tr>
<td>• General Practitioner</td>
<td>• General Practitioner</td>
<td>• General Practitioner</td>
</tr>
</tbody>
</table>
Do you credential your medical staff?

Yes/No (please circle)

If yes, briefly describe this process

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

d) Can you please indicate the number of salaried medical staff who have left Hospital in last two years? FTEs and vocational status

e) Can you please indicate the number of salaried medical staff (include vocational status) who have been recruited to the Hospital in the last two years?

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

f) What is your main method of recruiting medical staff? (Please tick preferred option)

☐ Recruitment Agency
☐ New Zealand Locums
☐ Organisation Advertising
☐ Other – please state

________________________________________________________________________

g) Please rate the availability of suitably qualified staff for New Zealand rural hospitals. (Please tick preferred option)

☐ Oversupply
☐ Adequate Supply
☐ Shortage
☐ Serious Shortage
☐ Critical Shortage

If you ticked critical shortage has or is that likely to impact on the hospital’s ability to provide service.

Yes/No (please circle)
h) **Please rate the availability of locum medical staff for New Zealand rural hospitals.** (Please tick preferred option)

- [ ] Oversupply
- [ ] Adequate Supply
- [ ] Shortage
- [ ] Serious Shortage
- [ ] Critical Shortage

If you ticked critical shortage has or is that likely to impact on the hospital’s ability to provide service.

Yes/No (please circle)

i) **Is there a designated medical leader e.g. Clinical Director?**

Yes/No (please circle)

What is their vocational status?

Are they a resident specialist acting in the role? i.e. they live in the town/district

Yes/No (please circle)

j) **Is there an active process of clinical governance?**

Yes/No (please circle)

If yes, please describe function of that clinical governance

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Thank you, please return to: Robin Steed
New Zealand Institute of Rural Health
9 Anzac Street
Cambridge