NEW ZEALAND RURAL GENERAL PRACTICE NETWORK

Scoping a nationally coordinated

Rural Hospital Locum Doctor Recruitment Service

December 2020

Contents of this Report

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Background to this Scoping Project

The Rural Hospital Summit Report, September 2019, identified the recruitment and retention of medical staff as one of the biggest challenges all hospitals that were at the Summit work with. They also agreed:

- Reliance on locum medical staff to fill rostering gaps results in a disproportionately large investment of their operational time and budget as they work independently to fill these gaps
- The lack of a coordinated approach to recruitment of rural hospital locums results in higher costs of locum travel and accommodation
- A coordinated, collaborative national approach is likely to reduce the costs of recruitment and make more effective use of locum medical staff time and availability.

The Rural Hospital Summit 2019 report was the catalyst for a meeting between the Rural Hospital Network Executive Committee, the Director-General of Health and some of the Ministry of Health's (the Ministry) senior management team in November 2019. One of the proposals discussed at this meeting was the need to scope a Ministry funded, rural hospital locum medical staff recruitment service. This could be premised upon the New Zealand Rural General Practice Network's (the Network) Rural General Practice Locum Support Services that is provided under contract with the Ministry of Health.

In July 2020, the Ministry commissioned the Network to undertake this scoping exercise. This report is the key deliverable of that agreement.

24 Rural Hospitals:

- Ashburton
- Bay of Islands
- Buller
- Chatham Islands
- Clutha First
- Dannevirke Community
- Dargaville
- Dunstan
- Golden Bay
- Gore
- Hawera
- Hokianga Health
- Kaikoura
- Kaitaia
- Lakes District
- Oamaru
- Taumarunui
- Taupo
- Te Kuiti
- Te Nikau Hospital & Health Centre
- Te Puia
- Thames
- Tokoroa
- Wairoa

Purpose

This report will enable key stakeholders to improve their understanding of the medical workforce pressures that rural hospitals deal with on a daily basis and the variable approaches they take to manage this.

This report provides:

1. A definition of rural hospitals that will inform eligibility to access a national rural hospital doctor locum recruitment service
2. A stocktake of rural hospital medical staff
3. Information about how rural hospitals currently recruit locum medical staff and the associated costs
4. An assessment of the ability of a hospital focussed service to leverage off NZLocums current infrastructure and expertise in rural workforce recruitment.

Out of Scope

This report is not a business case for the development and delivery of a rural hospital locum medical recruitment service.

The Process Applied to Preparing This Report

The Network has undertaken a widely consultative process to the preparation of this report:

- University of Waikato Rural Hospital Workforce Survey Report (Appendix 1)
    - 18/24 rural hospitals responded to the survey (respondents)
- Workshop with Rural Hospital Summit participants from 21 rural hospitals
- Consultation and advice from the Rural Hospital Network Executive Committee
- Consultation and advice from NZLocums team.

Summary of Key Points Made in Each Section of this Report

1. Defining Rural Hospitals

- The DRHM definition of rural hospitals could be the basis for eligibility for a rural hospital locum recruitment service
- Rural Hospital ownership and operational models vary greatly across the country. This has an impact on options available to them in meeting their locum doctor requirements.

2. Stocktake of Rural Hospital Medicine Staff

- Rural Hospitals provide clinical leadership for their medical staff. This will assist in supervision of internationally trained and recruited locum doctors
- Credentialling of doctors is an operational function of most rural hospitals that may contribute to developing a recruitment agency's screening processes
- Recruitment of IMG locums is likely to require clinical oversight to ensure candidates are appropriately qualified and have the experience required to work in the NZ rural hospital setting.

3. Recruiting Rural Hospital Locum doctors

- A national pool of locum doctors, rostered over a 12 month period, across participating hospitals is likely to provide financial and logistical benefits to the hospitals and the locum workforce
- An urgent locum service that is well resourced, would reduce the drain on rural hospital operational resources and contain the escalating costs of locum services
- The direct costs of recruiting rural hospital locums is not identifiable as in many organisations these costs have been incorporated in administrative and managerial accounting codes
- The direct cost of rural hospital locum doctors is not nationally identifiable as many accounting practices do not identify this as a separate item of expenditure from permanent staff.

4. Leveraging a Rural Hospital Locums Service Against NZLocums Existing Services

- Critical success factors of a nationally provided rural hospital locum recruitment service include:
  - Effective relationships with rural hospitals and the communities in which they work
  - Excellent relationships with MCNZ and Immigration NZ
  - Comprehensive knowledge and experience in working with MCNZ and Immigration policy requirements
  - A rural hospital 3 day Orientation Programme for IMGs arriving in NZ
  - A cost effective international recruitment campaign
  - A whanau approach to recruitment to meet short term needs but aiming for long term outcomes
  - Realistic goals for placing international candidates that reflect recruitment lead-in times.

5. The Development of a National Rural Hospital Locum Recruitment Service

- There are 4 levels of locum service required of a national rural hospital locum recruitment service:
  - Urgent 1-7 days
  - Planned 7 days – 6 months
  - Long term 6 – 12 months
  - Permanent Over 12 months
- NZLocums would require 3 years to establish a reliable and sustainable service that optimises technology, has a pool of NZ based and international locum doctors, has given rural hospitals time to adapt their current processes to move to a national recruitment service, and can credibly contract for future services on a volumes basis.
- The advantages of a national service considerably outweigh the disadvantages identified in this report.
- The University of Waikato Medical Research Centre recommendations contributed significantly to the Networks conclusions and recommendations made in this report.

Conclusions

The Network draws the following conclusions from the information in this report:

- Rural hospitals are reliant on locum doctors to maintain rosters, and sustainable levels of service for their communities
- Rural hospitals have a range of approaches to meeting all levels of locum doctor needs. Many of these are inefficient in the use of staff time, place pressure on permanent staff, and escalate the costs of locum services
- There is a need for a national rural hospital locum doctor service
- It will take 2-3 years to establish the service to the equivalent level of performance and sustainability of NZLocums rural general practice locum service.

Recommendations

The Rural General Practice Network recommends that the Ministry of Health Workforce Directorate:

- Receives this report and notes the endorsement of it by the NZ Rural Hospital Network Executive Committee
- Discuss the potential to enter into a three year contract for the development and delivery of a rural hospital locum doctor service based on:
    1. Two full time recruitment staff members
    2. A funded programme of service development outlined in table 2
    3. Regular review and monitoring of the service development.

1. Defining Rural Hospitals

Division of Rural Hospital Medicine, 2010:

A rural hospital is a non-metropolitan hospital staffed by suitably trained and experienced generalists, who take full responsibility for a wide range of clinical presentations. While resident specialists may also work in these hospitals, cover is limited in scope to less than full time. There are 3 levels that the 33 rural hospitals are grouped in:

1. Visiting medical cover once a day, with on call medical cover at other times.
2. Onsite medical cover during normal working hours – on call medical cover at other times.
3. Onsite 24 hour medical cover.[i]

The Ministry recognises this definition in its funding of DRHM places and so it has been applied to this report.

As a general rule, a rural hospital offers urgent, acute and maternity care without continued input of specialist medical practitioners. Some of the larger rurally facing hospitals that provide secondary care services are leaning toward the rural generalist model. Te Nikau Hospital and Health Centre (previously known as Grey Base Hospital) and Ashburton Hospital are examples of this.

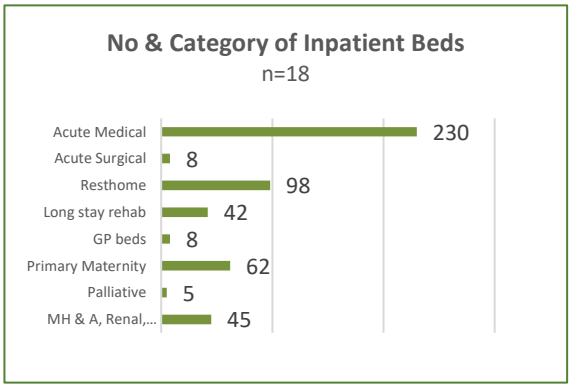


Figure 1: Category of Inpatient Beds

The Waikato University Study (the Study), identified 24 hospitals that fall across all 3 levels of the DRHM definition that are relevant to the Study.

Of the 24 rural hospitals, 18 provided full responses for the Study. Others contributed to the workshop discussion facilitated by the Waikato University researchers, at the Rural Hospital Network Summit in September 2020. Many rural hospitals also provided ad hoc information for this report.

Rural Hospital Ownership and Operational Models

There are considerable differences in the ownership and operational details of rural hospitals. The majority of them are owned and operated by a DHB but there are a range of community or iwi based NGOs that provide hospital services under contract with their DHB, PHO and other government agencies. This has an influence on their approach to the recruitment of medical staff and options available to them for recruiting locum doctors, particularly in urgent situations.

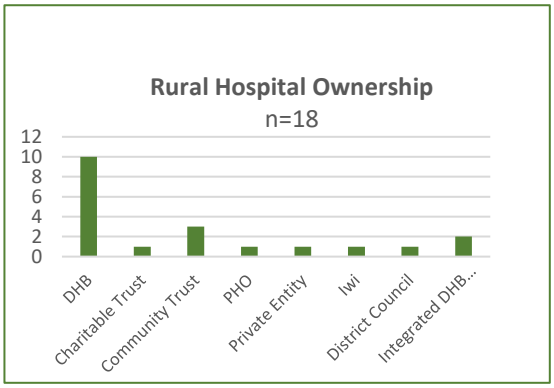


Figure 2: Ownership of Rural Hospitals

Across the 24 rural hospitals there are models of integration between Primary Care and Hospital services that can enhance their options for meeting urgent locum needs. This can include short term service changes, having GPs assume the locum hospital role, increasing nursing staff and if necessary, reducing service provision.

Key points:

- The DRHM definition of rural hospitals could be the basis for eligibility for a rural hospital locum recruitment service
- Rural Hospital ownership and operational models vary greatly across the country. This has an impact on options available to them in meeting their locum doctor requirements.

2. Stocktake of Rural Hospital Medical Staff

There are about 150 doctors employed across both DHB and non-DHB rural hospitals with roughly half employed in each (49% non-DHB and 51% DHB employed). More detailed analysis is required to account for the number of doctors who work in both a DHB's main hospital and it's rural hospitals.

The rural hospital workforce is heavily impacted by the rural health workforce crisis. 73% of respondents said they experience a serious shortage of medical staff. The Study noted that the percentage of rural hospitals that experience severe or critical workforce shortages is similar to that found in the 2014 Rural Hospital Doctors Workforce Survey.[ii]

Many respondents said that while they may not be fully staffed, they do have a fairly settled workforce for most of the time. However, they have difficulty covering CME, study, annual and sick leave with their permanent staff and so many are reliant on locum doctors to fill these gaps.

Most hospitals said they had enough allocated shifts, but the lack of a full complement of medical staff means that many of these are not used. The cost of locum shifts is higher than the equivalent of permanent staff, and so medical salary budgets are fully utilised while allocated shifts remain unfilled. This places pressure on all hospital staff to work at a more intense pace, reduces the time they can spend with each patient, and significantly contributes to the stresses they experience.

Clinical Leadership and Supervision

Respondent doctors indicated they have good levels of clinical support and that they work closely with a clinical director.

- 65% have designated in-house Rural Hospital Medicine Clinical Leadership. Others have agreements with DHB clinical governance, or another hospital.
- 77% of Survey respondents credential their medical staff. DHB hospitals defer this to their Chief Medical Officer.

This consistent approach to clinical leadership will support a national rural hospital locum doctor service, particularly for IMGs who are on their first rotation of working in a rural hospital in NZ and may require closer supervision.

Employment Arrangements of Current Medical Staff

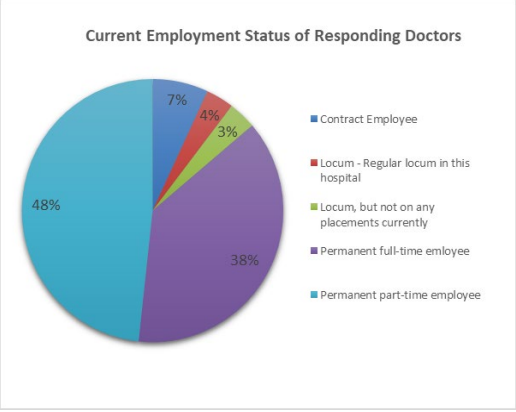


Figure 3: Employment Status of Responding Doctors

Most survey respondents said their rural hospital doctors are employed as permanent staff but 48% of them are part time. They were not asked to provide reasons for their decision to work part time but anecdotally we are told that the flexibility to work as a locum in another hospital, often at a higher rate of pay is a factor. For their employing hospital, this can provide capacity to fill locum shifts.

Most respondents live within 50Km of the hospital where they work but a quarter live more than 50Km from their place of work. This suggests that doctors who contribute to a rural hospital's pool of regular locums, do so within reasonably close proximity to where they live.

> *"Rural hospital medicine is responsive rather than anticipatory and doesn't continue for the same patient over time. It combines the generalism of general practice largely in a hospital setting with expanded practice scopes in obstetrics and anaesthesia. It is well suited for geographically isolated smaller hospitals serving small populations (West Coast's population is around 30,000).*
>
> *Unlike rural general practice, rural hospital medicine is practised in secondary care settings (hospitals), including outpatient and inpatient services."* ***Ian Powell, Dec 2020***

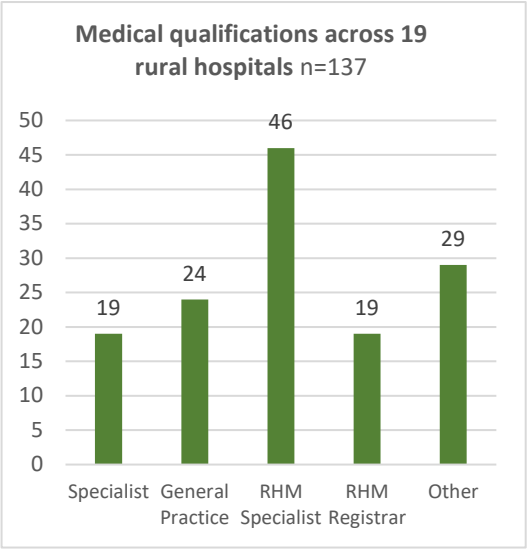


Figure 4 Rural Hospital Medical Qualifications

The qualifications of 19 respondent's medical staff shows the positive contribution the DRHM specialty has made to the capability of this critical workforce. (Fig.4)

The increased integration of rural general practice and rural hospital services, the need for flexible models across acute, ambulatory, and urgent care needs has a direct impact on the medical skills and experience needed to deliver this.

Urgent care has become a core business of rural hospitals particularly in areas where the rural general practice struggles to maintain an after-hours roster.

Not all respondents were able to provide data about the ED presentations but the information provided may be indicative of the situation in most rural hospitals. (Fig 5)

The role of rural hospitals in providing ED and urgent care services has an impact on the skills and experience of doctors, and on the volume of presentations they manage.

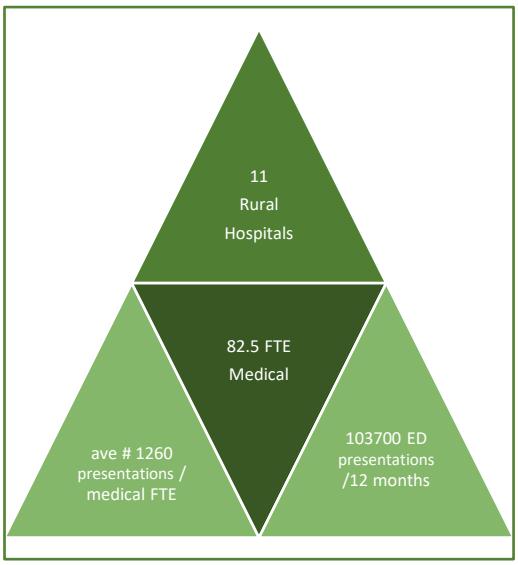


Fig 5: No of Rural Hospital ED Presentations over 12 months

Respondent hospitals endorsed this in their identification of the skills and qualities they look for in a locum doctor:

- Preferably RHMS, FACEM
- RMOs with recent experience in ED and rural hospitals
- Able to work independently across the scope and high volume of emergency presentations
- Comfortable managing patients on the inpatient unit.
- Prepared for maternal and neonatal resuscitation.
- Must be flexible in scope of practice.
- Have skills/awareness relating to resource management.
- Able to cover family medicine
- Whanau friendly
- A team player.

Due to the raft of international qualifications associated with international medical recruitment, a rural hospital locum recruitment service is likely to require clinical oversight of candidate selection to ensure the qualifications and experience of candidates aligns with the MCNZ registration requirements, and the needs of the employing hospital.

Key points:

- Hospitals provide clinical leadership for their medical staff. This will assist in the supervision of internationally trained and recruited locum doctors
- Credentialling of doctors is an operational function of most rural hospitals that may contribute to developing a recruitment agency's screening processes
- Recruitment of IMG locums is likely to require clinical oversight to ensure candidates are appropriately qualified and have the experience required to work in the NZ rural hospital setting.

3. Recruiting Rural Hospital Locum Doctors

About 70% of respondents said they have a network of locum doctors they roster on a regular basis. Given the relatively small pool of locum rural hospital doctors across NZ, it is likely that there are significant overlaps between these networks.

Coordination of a national pool of rural hospital locums could be an integral component of a rural hospital locum service. It would be reasonable to expect this approach to result in financial and logistical benefits to both the rural hospitals and the locum doctors.

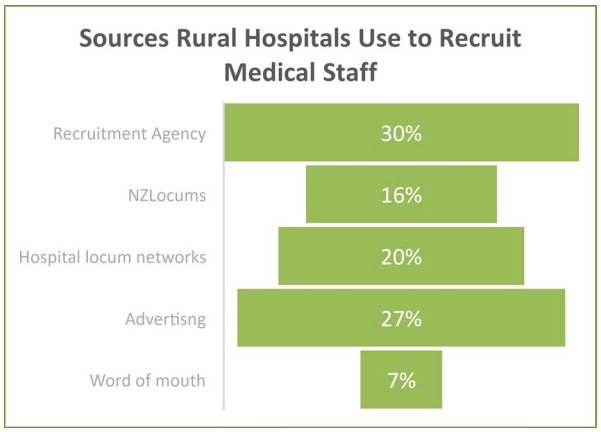


Figure 6 Rural Hospitals Recruitment of Medical Staff

The part-time employment arrangements of nearly half of the doctors who responded to the survey builds capacity within each hospital to roster planned and often, urgent locum services. With agreed parameters and appropriate resources, this could also be managed on a national basis.

Resources and Costs Associated with Recruiting Locum Doctors

Only 9 Study respondents were able to provide information about the cost of recruitment, locum fees, and associated expenses such as travel and accommodation. Other respondents told us that their locum fees are embedded in the organisations salary expenses and are not readily identifiable.

Respondents said that the actual cost of recruitment is only identified when an external agency is contracted to do this. There is very little international recruitment of locum doctors as the costs of doing so are outweighed by the short term nature of locum services.

Costs of hospital staff time involved in filling locum shifts, both planned and urgent, are not reported. Rural Hospital Summit attendees described the frequent loss of Friday afternoons as they rush to ensure locum cover for weekends. They described the time consuming and frustrating lengths they go to including phoning all of their locum contacts, emailing DHB colleagues and related networks, and negotiating with their own staff to juggle rosters and individual commitments at short notice.

Failure to fill the rostered shifts result in either a reduction in services or prioritising one service over another by allocating general practice doctors into hospital services.

There is consensus that these last minute arrangements can result in 'less than ideal' medical staff working in the hospital.

The lack of data limited the ability to calculate national average cost of locum shifts. This is further complicated by the escalated fees paid to locums when pressures of time, and competition with other hospitals to fill locum shifts, drives an escalation of locum fees.

A national recruitment service has the potential to mitigate these issues and stabilise the cost of locum sessions through more coordinated and longer term planning.

Key points:

- A national pool of locum doctors, rostered over a 12 month period, across participating hospitals is likely to provide financial and logistical benefits to the hospitals and the locum workforce
- An urgent locum service, that is well resourced, would reduce the drain on rural hospital operational resources and contain the escalating costs of locum services
- The direct costs of recruiting rural hospital locums is not identifiable, as in many organisations they are incorporated in administrative and managerial accounting codes
- The direct cost of rural hospital locum doctors is not nationally identifiable as many accounting practices do not identify this as a separate item of expenditure from permanent staff.

4. Leveraging a Rural Hospital Locums Service Against NZLocums Existing Services

The NZ Rural General Practice Network has been providing medical recruitment services for nearly 20 years under its internationally recognised NZLocums brand. Through the contract with the Ministry of Health, NZLocums ensures rural general practitioners and their families get an annual two week break, or have access to locum doctors to fill gaps in their service caused by workforce shortages and the everyday realities of providing services rurally.

The expertise and reputation of NZLocums is recognised across both the health and recruitment sectors. Evidence of this was seen in 2019 when the team were awarded the SEEK annual recruitment award for medium sized agencies. In 2020 they were asked by the Ministry to respond quickly to the pressures Covid-19 placed on the rural general practice workforce through a one-off pandemic emergency roving locum contract known as PERL.

Each year over 130 placements are made from both a NZ based pool of rural general practice locums, and a continuous international recruitment programme. A comprehensive marketing campaign that includes exhibiting at NZ and international health conferences and recruitment fairs, direct marketing to key stakeholders, and international forums and interviews with potential candidates, maintains a continuous pool of locum doctors available for placement across rural general practices.

The infrastructure, relationships and marketing approaches that NZLocums has developed, and its commitment to maintaining high levels of expertise in its staff, provides a platform from which service capacity can be developed. The PERL contract demonstrates how this enabled the service to be developed and provided in a very short timeframe and by utilising existing systems and increased economies of scale, achieved a lower per-placement recruitment fee.

The short term response toward a long term goal

The Network works on the premise that while locum recruitment is the focus of its contract with the Ministry, permanent placement of doctors is the ultimate goal. This is particularly relevant to assessing the return on investment into international recruitment as the Waikato Study respondents said this was one of the main barriers to them recruiting internationally for medical staff.

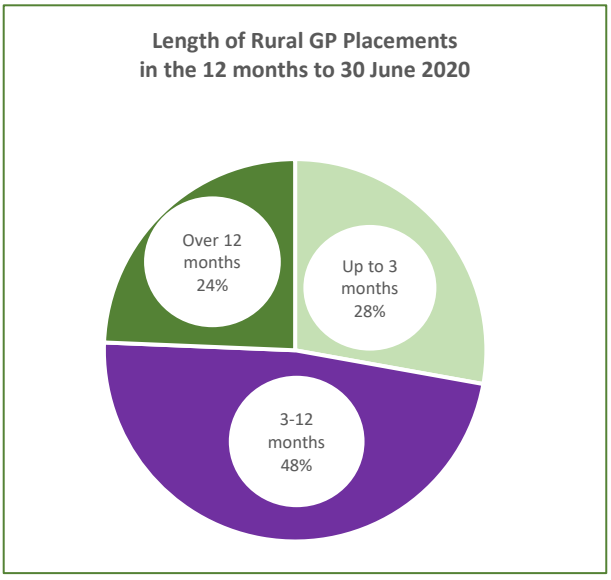


Figure 7 Length of placements in rural general practice in the 12 months to 30 June 2020

This goal underpins NZLocums approach to screening and selecting international candidates as it is not only the needs of the candidate, but those of their family who will be coming to NZ with them, that are taken into consideration when matching them with a position in a rural general practice.

In the long term, the Network's advocacy position to Government is to increase the NZ trained rural health workforce by adopting a 'by rural, for rural, in rural' approach to training and educating our future rural health workforce. Rural hospitals are fundamental to this nationally dispersed approach to building our future rural health workforce but in the short and medium term, increasing the pool of doctors available for positions in both rural general practice and rural hospitals is critical to mitigating the impact of the rural health workforce crisis.

Understanding Rural Communities and the Rural Health Workforce

Recruitment of rural health professionals relies on the understanding that this is a uniquely different proposition to recruitment into urban services.

The implementation of the Review will see more rural hospitals included in fewer DHBs which by very nature of their size and centralisation, are likely to have less connection to the realities of rural service provision. There has long been a concern that urban centric planning and funding of health services results in urban centric models of care, and consequently, the allocation of resources. This may reduce the focus on rural hospital issues, and in particular, workforce challenges.

The NZ Health system could mitigate the risks of this occurring by building on the Network's reputation for being the central repository of rural health expertise, and its effective relationships across rural NZ to alleviate the rural hospital medical workforce issues. The Network maintains its relationships with rural NZ through:

- Its Governance Board membership that mirrors the rural health sector – 25% of its members work in rural hospitals.
- The annual National Rural Health Conference that is well attended by rural hospital personnel
- Partnering with the RNZCGP to facilitate an annual Rural Research Day
- Providing full resourcing for the Rural Hospital Network including facilitating the annual Rural Hospital Summit and preparing the resulting Summit paper
- Providing full resourcing for the Rural Health Alliance Aotearoa NZ which connects Network staff to rural and agribusiness organisations. The Network also facilitates the RHAANZ annual RuralFest event and prepares the resulting Rural Health Road Map
- Provides secretariat support for Rural Nurses NZ
- Runs a year round Rural Health Careers Promotion Programme that sees Network staff and partners regularly working with the tertiary Students of Rural Health Aotearoa (SORHA) in rural secondary schools to encourage pupils to consider a career in rural health
- NZLocums Recruitment Relationship Managers visit rural general practices on a regular basis – this is critical to understanding their needs as our clients
- Network staff regularly visit rural general practices and hospitals in the course of a year's activities.

Through this vast array of interactions and activities, the Network maintains a high level of understanding of the challenges of living and working in a rural community. We are certain that this is critical to successfully recruiting medical staff . The specialist knowledge and relationships held within the Network and the NZLocums team has the potential to mitigate the possible impact of reduced numbers of DHBs on our rural health workforce and ultimately, the health outcomes of rural NZ.

Medical Council NZ registration

The logistical challenges of an IMG moving to NZ, with their family, to work in rural NZ can be daunting at best. Over the last 20 years NZLocums has built relationships with key stakeholders to streamline these processes so that we are able to optimise the rate of IMGs expressing an interest in working in NZ to this becoming their reality.

A critical component of this is an effective working relationship with the Medical Council NZ (MCNZ). It informs the international recruitment campaigns that are targeted at countries where there is compatibility with registration requirements.

NZLocums and MCNZ meet regularly to discuss practical arrangements including the orientation of IMGs to the NZ Health system, their supervision once working in the rural general practice, and collaboratively resolving issues as they arise.

The relationship between NZLocums and the MCNZ will increase the ability to develop an international recruitment campaign for rural hospital doctors. This would benefit both the candidates and the employing rural hospital through orientation and supervision arrangements aligned to the hospital's existing clinical governance arrangements.

Immigration Processes and Applications

NZLocums expertise in immigration processes is an excellent resource for international candidates as they work through their own immigration application. This assists to streamline the process so that candidates are able to move through it smoothly and are not 'put off' by the complex nature of this aspect of their move to NZ to work.

The Network also works closely with the Ministry of Immigration to address policy issues or complexities that have arisen through the Covid-19 border restrictions.

Current Immigration NZ policy does not include rural hospital medicine roles in the Essential Skills Work Visa list. However, changes to Immigration work visas that will come into effect mid-way through 2021, will replace this policy and have a positive impact on the processes for securing visas for internationally recruited rural hospital doctors. In a Rural Hospital Locum doctor service, NZLocums would need to work with the Rural Hospitals, to:

- Have them accredited with Immigration NZ
- Demonstrate that a medical vacancy has been genuinely advertised in NZ and that there are no NZ doctors available to do the job.

Orientation to the NZ Health System

Respondents to the Waikato Study said that rurally placed IMGs must be oriented to the NZ Health System, arrive on site with registration and compliance processes complete, and be familiar with DHB systems.

The Network concurs with this view and since the early days of the NZLocums recruitment services has provided a 3-day Orientation Programme for the IMGs once they have arrived in NZ.

The Orientation Programme is funded through the Ministry contract and is endorsed by the RNZCGP's CME programme to ensure it meets the needs of the medical profession and maintains quality standards. It includes sessions that ensure the international candidate moving to NZ is logistically ready to start work in a rural general practice, has a high level understanding of the NZ Health system and understands our commitment to the Treaty of Waitangi and Maori health outcomes. The programme for the 3 days is found in Appendix 3.

A rural hospital focussed orientation programme will be important to the successful recruitment of rural hospital IMGs. About half of the content of the existing orientation programme is relevant to rural hospital candidates, and some new content would need to be developed to ensure candidates are introduced to the DHB systems and the unique nature of working in a rural hospital environment.

Targeted international advertising and recruitment campaigns

Many of the NZLocums rural general practice clients acknowledge a preference that locum doctors are NZ trained, however the rural medical workforce shortage means that about 50% of our placements are recruited internationally. The same preferences and limitations are likely to apply to rural hospital locums.

NZLocums has established a multi-pronged international advertising and recruitment campaign that targets countries that are likely to result in a high level of locum applications. Through internet based advertising, exhibiting at international medical conferences and recruitment fairs, and face to face meetings with doctors in their own country, NZLocums are able to maintain a constant stream of IMGs into NZ for varying lengths of time.

This programme is easily extendable to multi-faceted marketing opportunities for rural hospital vacancies. It would leverage off the NZLocums current investment in its engagement with international conferences and recruitment activities.

NZLocums advises that on average, it takes 9 – 12 months from the first contact with an IMG interested in working in NZ, to their arrival here. This means, a national rural hospital recruitment service will require at least 2 years of operating until recruitment placement volumes can be identified.

Key points

- Critical success factors of a nationally provided rural hospital locum recruitment service include:
  - Effective relationships with rural hospitals and the communities in which they work
  - Excellent relationships with MCNZ and Immigration NZ
  - Comprehensive knowledge and experience in working with MCNZ and Immigration policy requirements
  - A rural hospital 3 day Orientation Programme for IMGs arriving in NZ
  - A cost effective international recruitment campaign
  - A whanau approach to recruitment to meet short term needs but that aims for long term outcomes
  - Realistic goals for placing international candidates that reflect recruitment lead-in times.

5. The Development of a National Rural Hospital Locum Recruitment Service

Close consultation with rural hospitals to design a recruitment model that is effective, may require them to adapt the way they plan for locum cover on an annual cycle of leave, CME requirements and respond to long term gaps in their medical workforce.

Rural hospitals have developed ways of filling their locum service gaps through:

- Individual hospital pools of locum doctors
- Regularly negotiating with their own staff to fill locum gaps
- Adjusting service levels and models of care to manage medical staffing gaps
- Canvassing DHB-wide medical staff to urgently respond to roster gaps
- Paying exorbitant rates for urgent locums when planned options fall over.

A national rural hospital locum service has the opportunity to disrupt this and, over a 2 – 3 year period, create a nationwide, well-resourced and cost effective platform from which rural hospitals can meet urgent and planned medical locum requirements.

Levels of Locum Service Responses

The Network proposes that there are four levels of locum service that will require systems and service development over a period of 2-3 years:

Locum Response	Duration of Locum	Reason for Locum Shifts	Components of Service Delivery
Urgent	1-7 days	Arising from unplanned absence of rostered staff	* Initial then ongoing relationship with rural hospitals as NZLocum clients * Online interactive platform that connects rural hospitals, the pool of NZ based locum doctors and NZLocums * Expansion of NZLocum Recruitment Software to include Rural Hospitals, and medical candidates * Establishment of a NZ based pool of rural hospital medical locums * International rural hospital medicine marketing campaign * Streamlining MCNZ and INZ policies to meet registration, credentialling and visa requirements * Development of a Rural Hospital Orientation Programme
Planned	7 days – 6 months	Annual, study, CME or family leave	
Long term	6 months and over	Maternity leave, sabbatical, unfilled staff vacancy	
Permanent	Over 1 year		

Table 1 Levels of Locum Service

Three Year Programme to Establish the Service

Year	Deliverable
Year 1	* IT systems developed, and current systems expanded * Work with MCNZ to adapt internal recruitment policies and procedures so they meet requirements for registration, credentialling and ongoing supervision * Upskill NZLocums staff in Immigration requirements for rural hospital medical professionals * International recruitment marketing campaign * Establish relationships with rural hospitals as clients * Establish a pool of NZ based rural hospital locum doctors as candidates * Begin placement of NZ based locum doctors * Review progress
Year 2	* Begin placing internationally recruited doctors into rural hospital locum role * Intensify the international marketing opportunities to rapidly increase the pool of candidates willing to work in NZ rural hospitals * Review progress and report on impact of the service to date
Year 3	* Service is fully operational, reporting on numbers of locum doctors placed in rural hospitals * Review efficacy of the service, and recommend future service deliverables

Table 2 High level programme of service development

Advantages and Disadvantages of a National Rural Hospital Locum Doctor Recruitment Service

Stakeholder	Anticipated Advantages	Possible Disadvantages
Rural Communities	* Service continuity * Reliable access to rural hospital services * Rural hospital sustainability	Regular rostering of locum doctors disrupts patient-doctor relationships
Hospital Staff Doctors	* Greater ability to plan for leave and time away * Less pressure to change shifts to fill urgent and planned gaps in rosters * Confidence that IMGs have been appropriately screened, registration compliant, and oriented to NZ health system	Regular rostering of locum doctors disrupts workplace relationships
Locum Doctors	* Greater ability to plan locum shifts * Greater choice of hospitals	Reduced ability to set shift rates based on urgency of locum need
Rural Hospital	* Greater ability to source locum doctors both NZ based and internationally recruited. * Confidence that internationally recruited doctors have been screened and meet MCNZ registration requirements * Reduced cost of locum doctor * Reduced cost of recruitment * Reduced staff time required to fill particularly urgent locum shifts	Greater need to plan for locum services on a nationally coordinated calendar
DHBs	* Confidence that rural hospitals are staffed with appropriated qualified and experienced locum staff * Reduced costs of recruitment agency services * Reduced staff time required to recruit and urgent locum shifts	Greater awareness of the locum needs of rural hospitals in their DHB
Ministry of Health	* Greater efficiencies across the NZ Health budget of staffing rural hospitals * Greater confidence in the clinical expertise of the rural hospital locum workforce	Contracted recruitment services front-foots the costs that are currently absorbed by DHBs or NGO contracted hospital

Table 3 Advantages and Disadvantages of a national rural hospital recruitment service

University of Waikato Medical Research Centre Recommendations

The Network recognised the importance of an independent opinion on the need for a national rural hospital locum recruitment service. It needed confidence in the validity of data that would inform this report, and consistency in the collection and analysis of that data against previous rural hospital workforce studies.

To achieve this, the Network subcontracted the University of Waikato to undertake a survey of the rural hospital workforce, and assess the need for such a service.

The University of Waikato Medical Research Centre recommendations are:

- There is sufficient demonstrated need for a rural hospital doctor locum agency
- The agency concentrates on bringing in overseas trained doctors that are experienced and qualified to work in NZ rural hospital practice while also employing locally trained and registered locum doctors
- The agency hires a part-time vocationally registered rural hospital doctor to assess the clinical suitability of any candidates
- The agency work with the Division of Rural Medicine of RNZCGP to develop a preferred profile for a rural hospital medicine locum (profile/competency checklist, specifications)

The full report is supplied in Appendix 1.

Key points

- There are 4 levels of locum service response that would be required to deliver a national rural hospital locum doctor recruitment service:
  - Urgent 1-7 days
  - Planned 7 days – 6 months
  - Long term 6 – 12 months
  - Permanent Over 12 months
- NZLocums would require 3 years to establish a reliable and sustainable service that optimises technology, has a pool of NZ based and international locum doctors, has given rural hospitals time to adapt their current processes to move to a national recruitment service, and can credibly contract for future services on a volume basis.
- The advantages of a national service considerably outweigh the disadvantages identified in this report.
- The University of Waikato Medical Research Centre recommendations contributed significantly to the Network's conclusions and recommendations made in this report.

APPENDIX 1: The University of Waikato 2020 Rural Hospital Workforce Survey Report

University of Waikato Medical Research Centre; Prof Ross Lawrenson, Bernadette Doube

The 2020 Rural Hospital Workforce Survey Report

Ross Lawrenson
Bernadette Doube

Background

Many rural communities in New Zealand are served by a Rural Hospital. The establishment of many of these hospitals goes back to the 19th century when communities required access to hospital care and through community actions built their own facilities and employed staff. There were many different models in which these hospitals operated, mostly providing emergency cover, surgical services and inpatient care.

In 1938, the first Labour Government nationalised many of the hospitals and took over the ownership of the assets and the responsibility for staffing. Thus in 1938, the Ministry were responsible for 134 public hospitals and over 300 private/community hospitals. The number of institutions coming under the heading of public hospitals for the year ended 31st March 1948, was 172, comprising 78 general hospitals - many of these would be considered rural hospitals today. Over the years a number of these rural hospitals lost their surgical capacity and some have closed. During the 1990 health reforms, a number of hospitals were restored to community ownership. (Barnett) Of those that remained in public ownership, a number provide a limited range of services such as hospital care for the elderly or maternity services. There remains a core number of hospitals that have retained their role as providers of emergency cover, acute medical care and inpatient beds. In 1999 Janes identified 36 such rural hospitals. He identified a shortage of medical staffing of these hospitals at that time. (Janes R) Most in this period were relying on non-vocationally registered doctors paid as medical officers, special scale (MOSS) or services were provided by local GPs who had the required skills and experience. Following Janes's paper, there was increasing recognition that the NZ GP training programme did not prepare doctors adequately to provide rural services (Hill) and a number of rural hospital doctors proposed the development of a new vocational speciality, rural hospital medicine. (Nixon) After the development of the training programme was approved by the Medical Council, the Division of Rural Hospital Medicine was established within the NZ College of General Practice, funding for training was obtained by the Division from Health Workforce NZ and the first trainees were recruited. A grandfathering process was also made available for existing rural hospital doctors who could satisfy the Division of their skills and experience. A workforce study in 2009 before the proposed programme was established, noted that there were 28 rural hospitals providing emergency cover and that in many of these, managers noted a severe shortage of medical practitioners. (Lawrenson 2011) Five years after the establishment of the Division an update in 2014 noted that by then, there were only 48 general hospitals in New Zealand of which 26 could be considered rural. Staffing these rural hospitals were over 100 vocationally registered rural hospital doctors but there was still considered to be a severe shortage and the need for locums was substantial. (Lawrenson 2016) Recently a number of rural hospital managers noted that they were still experiencing staffing shortages and were still reliant on locum agencies to provide cover for them at different periods of time and in some cases semi- permanently.

The Medical Council have defined for training purposes that a rural hospital is: “A hospital staffed by suitably trained and experienced generalists, who take full clinical responsibility for a wide range of clinical presentations. While resident specialists may also work in these hospitals, cover is limited in scope or less than full time.’

The Division of Rural Hospital Medicine recognises three broad levels of rural hospital:

Level 3: On-site 24-hour medical cover. 24-hour access to radiology and laboratory services. There may be limited specialist cover. Acute inpatient beds.

Level 2 - On-site medical cover during normal working hours and on-call medical cover at other times. 24-hour access to on-call radiographer and access to acute inpatient beds.

Level 1 – Generally has visiting medical cover but has acute inpatient beds.

Hospitals included in our study included those that met the MCNZ definition of a rural hospital but also provided 24 hour emergency cover and general acute beds.

See Appendix 3 for a breakdown of the rural hospitals by level.

The purpose of this survey was to understand whether there was a need for a locum service for rural hospital doctors and if that were the case, what were the competencies required for any locums expected to work in a NZ Rural Hospital. We undertook a two-part survey. One was to identify and survey all of the rural hospitals in NZ that were still providing out of hours and emergency care and had some hospital beds. We also surveyed a sample of rural hospital doctors working in rural hospitals to get a better understanding of the current clinical governance arrangements for these doctors and to better understand the competencies required, and the expectation or skills needed for a rural hospital doctor in a NZ hospital setting.

Methods.

A range of stakeholders was involved in discussions regarding the purpose and focus of the project including representatives from the Ministry of Health, the Rural Hospital Network and the Division of Rural Hospital Medicine (NZRCGP). Following these consultations, an iterative process was used to develop a questionnaire for rural hospital managers and another on-line questionnaire for the rural hospital doctors. These are provided in Appendix 2 and Appendix 3. Contributors were invited to enter data electronically and if there were difficulties then one of the researchers would ring the relevant people and enter the data for them.

It was agreed that rural hospital managers and rural hospital doctors would be surveyed separately and that some ad hoc visits would be undertaken. Two surveys were designed in the initial stage The design of each survey was reviewed by a group of stakeholders including Associate Professor Garry Nixon (Dunstan Hospital), Dr Jennifer Keys (Lakes, Queenstown), Dr Katharina Blattner (Hokianga Health) and Dr Jeremy Webber (Taupo Hospital. Rural Hospital Managers including Mr Ray Anton (Clutha Health and Chair of the Rural Hospital Network) and stakeholders from the Ministry of Health and the Rural Health Network also participated. The Comms Manager from the RNZCGP reviewed the doctor survey to ensure that it was suitable to send out to members.

The format of the two surveys differed due to the information requirements from the two groups. An e-survey was designed for the doctor’s form as it did not require complex tables and calculations. A fillable PDF format was required for the Manager Survey to collect the financial and numeric data required by the MOH and RHN.

The timeline agreed for collection and initial analysis of the data was set to meet the Rural Hospital Summit meeting date of September 22nd 2020 and distribution of the questionnaires occurred on August 18th with a return date by August 28th. 26 questionnaires were emailed to named managers on August 18th with several reminders in the form of phone calls, individual emails and email mail outs were sent from the 23rd August. The survey to doctors was distributed via the Rural Hospital Summit and RMDNZCGP databases.
A reminder was sent by email on 23rd August to doctors and managers. Follow up phone calls to individual managers occurred in the period August 26th – 28th and two further extensions were offered to several managers. Two managers were on leave at the time the survey was sent out and they were requested to complete the form on their return (week of September 7th). Qualitative and quantitative analysis of the results occurred.
A further survey to Managers was conducted in October building on the initial results received. Managers were asked specific follow up questions related to planning for and requirements of locum cover.

Findings
Of the 26 surveys distributed, 24 related to specific hospitals. The italicised names represent the 17 returned surveys, italicised and bold represent the ten hospitals that included both emergency numbers and doctor FTE. The ownership structures of the seventeen entities include 10 DHBs, 1, Charitable Trust, 3 Community Trusts and 3 "other".

Table 1 Participating hospitals

Ashburton Hospital Bay of Islands Hospital Buller Hospital Chatham Islands Hospital Clutha First Hospital Dannevirke Community Hospital Dargaville Hospital Dunstan Hospital Golden Bay Hospital Gore Hospital Hawera Hospital Hokianga Hospital	Kaikoura Hospital Kaitaia Hospital Lakes District Hospital Oamaru Hospital Taumarunui Hospital Taupo Hospital Te Kuiti Hospital Te Nikau, Grey Hospital & Health Centre Te Puia Hospital Thames Hospital Tokoroa Hospital Wairoa Hospital

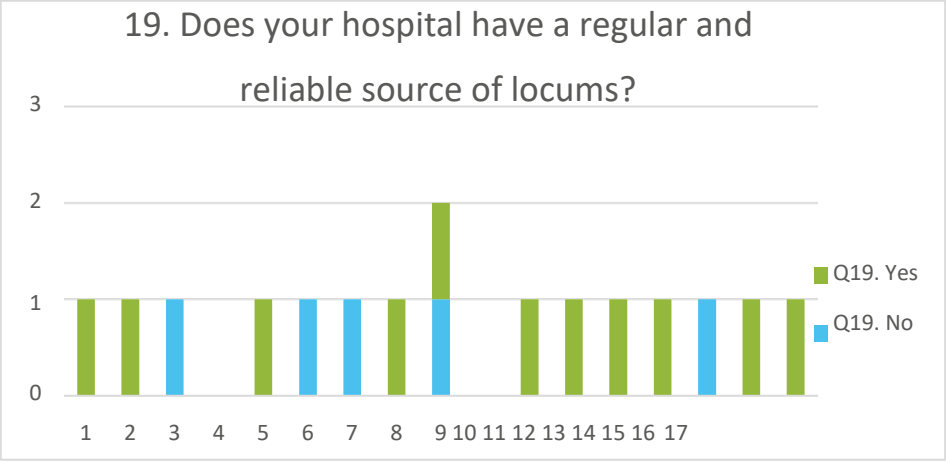
Populations served
Number of emergency patients seen each year
Of the seventeen hospital responses, ten supplied data related to 98,463 emergency patients seen each year. The range is from 2,000 – 20,000 with a median of 7,500 and an average of 9,300.

Number of doctors FTE /per Emergency
The total number of FTE doctors in the ten hospitals as above was 78, with a range of 3 – 18 fte per hospital with a median of 7.1 fte and an average of 7.82 fte.
Based on the comparable data across 10 hospitals the average number of doctors per emergency = 1,259 pa per doctor.

The number of doctors in the total group of seventeen responses is 121 FTE Locums/costs
The narrative comments from the survey and interviews suggested that most locums were for short term cover (mainly weekends, a few days or a week). The cover included sonographers, midwives and GPs as well as locum RHMS, FACEMS and RMOs.
Nine of the 17 hospitals returned information on the total locum costs with a range of $35,000 - $1,89m with a mean of $683,435. Table 2 Locum costs per hospital

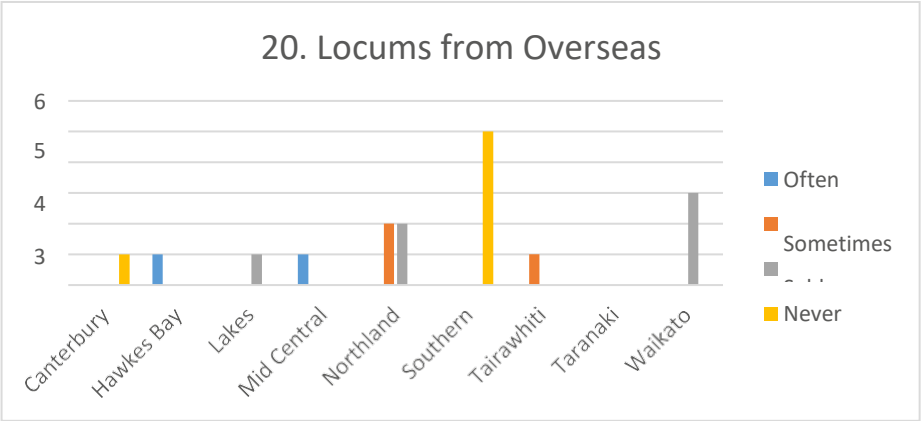
Hospital	Amount Spent
1	$0.00
2	$0.00
3	$0.00
4	$0.00
5	$722,614.00
6	$900,000.00
7	$0.00
8	$500,000.00
9	$0.00
10	$166,389.00
11	$1,800,915.00
12	$0.00
13	$1,200,000.00
14	$746,000.00
15	$80,000.00
16	$35,000.00
17	$0.00
Grand Total	$6,150,918.00

Table 3 Locum availability



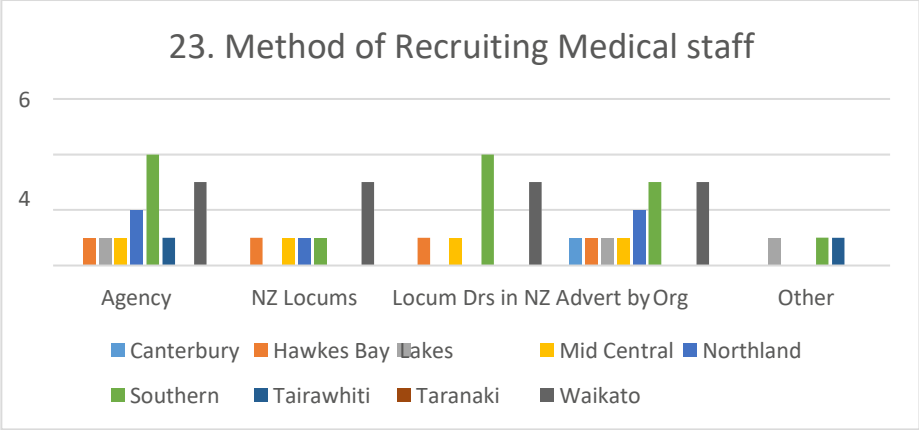
The majority of hospitals indicated that they currently have a reliable source of locum doctors, with six South Island hospitals stating that they never access overseas locums and five North Island hospitals saying often or sometimes. Two hospitals did not respond to this question

Table 4 Sourcing locums from overseas



From the data returned it was not possible to analyse the frequency and duration of locum cover in the financial year 2019-20.

Table 5 Method of recruiting medical staff and locums



It is clear that a variety of sources are used to recruit locums.

Table 6 Availability of medical staff in general

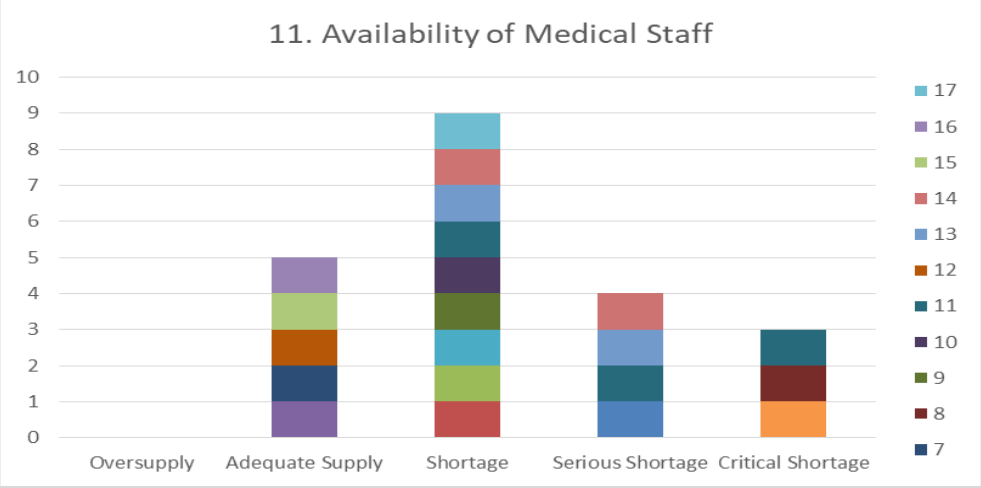


Table 7 Availability of locums

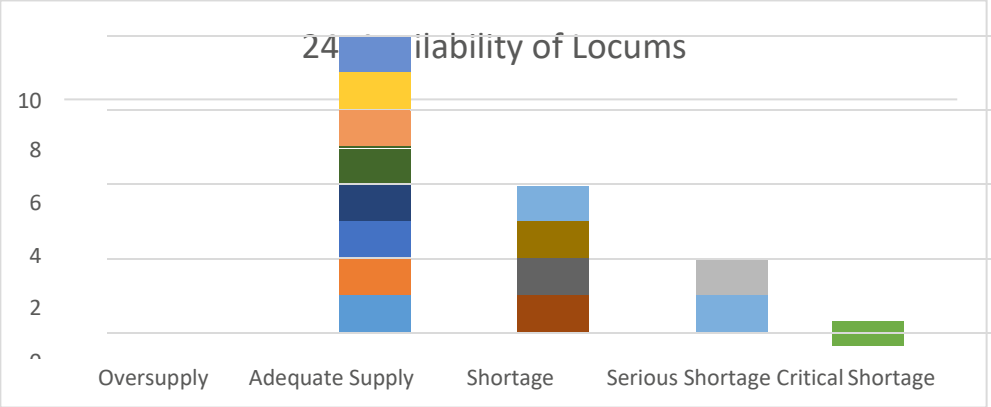
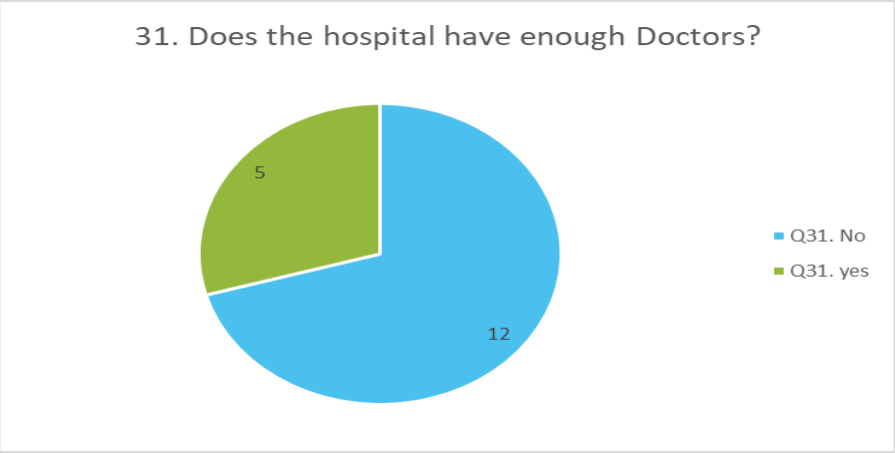


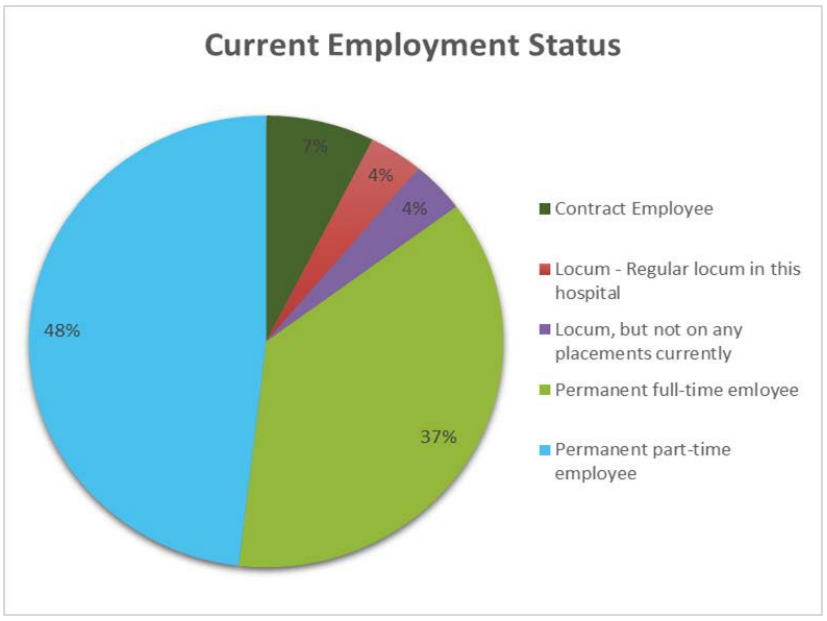
Table 7 shows the comparison of perceived availability of locum medical staff in general.
The response to the questions relating to having enough doctors and being able to cover the shifts required, shows that twelve of the seventeen hospitals believe they can cover their shifts but do not have enough doctors.

Table 8. Having enough doctors

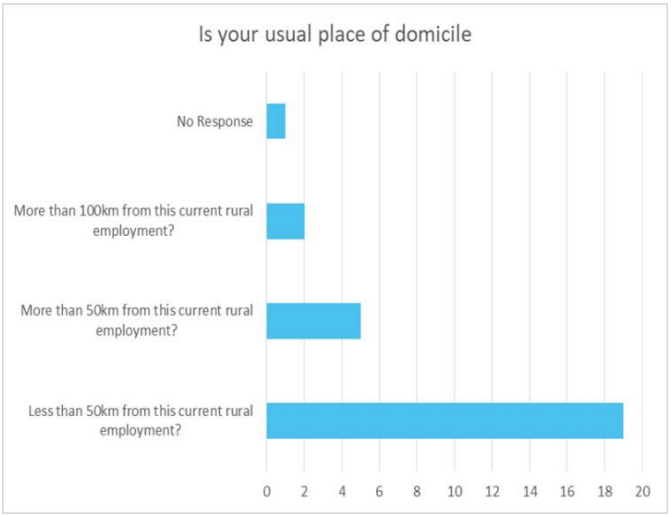


Returns from doctors
A total of 27 doctors completed surveys with 80% of returns occurring within 7 days of sending out the questionnaire and a further 20% being returned over the following 8 days.

A range of questions in 3 categories revealed interesting information about the vocational training and qualifications held by the doctors, their current employment and the support received or desired from Clinical Directors.



Only 37% of responders were permanent full-time employees with 48% having a part-time contract.



Most lived within 50Km of the hospital where they worked but a quarter lived more than 50Km from their place of work.

The responders indicated they had good clinical support with 90% reporting the hospital had a clinical director most of whom worked in the hospital with them and most met at last weekly with the CD.

The qualifications and competencies of rural doctors were not clear in all cases. Most responders were Fellows of the Division of RHM and many had additional qualifications. Over and above the initial medical qualification, 18 separate vocational qualifications are held by this group, with several doctors achieving 2 or more qualification. A total of 58 postgraduate medical qualifications were reported across the group of 27 doctors, the most common of which are FDRHMNZ (15 individuals), FRNZCGP (10), PGDipRH (8) DipRANZCOG (5). Most mentioned that they needed procedural competencies – but also needed to be a good team player.

Discussion/Conclusions

This review showed that rural hospitals in New Zealand are seeing a substantial number of patients in their emergency departments as well as providing generalist hospital beds. The hospitals are still a mix of public hospitals run by DHBs and Community Trusts. There is also a mix of staffing with some hospitals relying on rural GPs, while most of our responders have a mix of Rural Hospital Medicine specialists, complemented by GPs. In some of the larger rural hospitals, there were a number of doctors employed who were primarily emergency medicine doctors and some hospitals also have a specialist physician or surgeon in attendance. The managers surveyed indicated there was still a shortage of doctors who are qualified and experienced who want to work in our rural hospitals. These hospitals are open 24/7 and see on average around 9000 emergency patients a year. Many hospitals reported they had now got a fairly settled workforce but that they had difficult covering study leave, annual leave and sick leave and often had to resort to employing locums. Indeed the managers indicated that there was a similar proportion of hospitals with a severe or critical shortage as was the case in 2014. Our enquiries noted that there a cohort of rural hospital doctors who spent most of their time doing locums, or that hospitals used locum agencies to fill vacancies. There appeared to be a variation in the funding of locum positions with hourly rates varying depending on the locality/popularity both hospital. Managers noted that they often had to resort to using a range of locum agencies before getting a suitable doctor to provide cover. A number of these agencies are based overseas and charges are variable. It does seem there would be sufficient need for a locum agency that is based in New Zealand and could provide both locum short term cover and in some cases, recruitment to longer-term positions.

The hospital doctor survey revealed that the majority of rural hospital doctors who responded to the survey work part-time. As the survey was mainly distributed through the rural division the majority of responders were vocationally trained in rural hospital medicine. Most lived within 50Km of their workplace but a number were working in hospitals that were some distance from their homes. It does appear that some part-time doctors working in one hospital also provide locum cover for other rural hospitals. Part of the attraction of this may be the pay that locum doctors can attract especially for night, weekend work and holiday cover. It does appear that while there is a recommended hourly rate for Senior Medical Cover, some hospitals are paying in excess of this. It was also evident that having New Zealand training in rural hospital medicine does equip doctors for the range of cover that they may need to provide. Indeed some managers noted that when employing locums they often restricted them to cover the ED while the employed Rural Hospital Medicine specialists covered the ward wok and acute medical cases. In general, the doctors who responded to the survey indicated that doctors working in rural needed to be generalists who were comfortable looking after acute cases presenting to ED. Most had good support from a local clinical director who they met with on a one or two weekly basis. This is important when thinking of the risk encountered by locums working in rural hospital practice who are often on their own.

In summary, we noted that our rural hospitals are for the most part, busy providing urgent care to high needs populations. There appears to be a continuing shortage of doctors to serve these hospitals. We felt that the current system seemed to be coping, although a number of managers highlighted that there are times when the shortages could be critical and hard to solve. We do believe that to relieve the pressure at these times of shortage there should be a national locum agency for rural hospital doctors. One advantage would be that the agency could help provide some regulation over the costs of locums which are currently different in different hospitals. The hospitals provide cover to their communities at high risk to themselves and the doctors they employ. Much

of the risk is related to the often limited access to diagnostics and specialist advice available which means doctors have to rely on clinical skills. Therefore there is a reliance on “clinical acumen” which is brought about by experience and excellent training. In addition, there is a need for good judgement – e.g. when transferring critically ill or injured patients. In these cases, doctors have to take into account a range of factors including the weather, the distance to travel etc. Much of this is only learnt through experiencing rural practice. We believe it is therefore useful when recruiting to these locum positions that doctors are experienced in working in a rural environment.

Recommendations.

We believe that:

- there is sufficient demonstrated need for a rural hospital doctor locum agency
- the agency concentrates on bringing in overseas trained doctors that are experienced and qualified to work in NZ rural hospital practice while also employing locally trained and registered locum doctors
- the agency hires a part-time vocationally registered rural hospital doctor to assess the clinical suitability of any candidates
- the agency work with the Division of Rural Medicine of RNZCGP to develop a preferred profile for a rural hospital medicine locum (profile/competency checklist, specifications)

References

Janes R. Rural hospitals in New Zealand N Z Med J. 1999 Aug 13;112(1093):297-9.

Barnett R, Barnett P. "If you want to sit on your butts you'll get nothing!" Community activism in response to threats of rural hospital closure in southern New Zealand. Health Place. 2003 Jun;9(2):59-71. doi: 10.1016/s1353-8292(02)00019-9

Hill D, Martin I, Farry P. What would attract general practice trainees into rural practice in New Zealand? N Z Med J. 2002 Sep 13;115(1161):U161.

Nixon G, Blattner K; NZ Rural Hospital Doctors Working Party. Rural hospital medicine in New Zealand: vocational registration and the recognition of a new scope of practice. N Z Med J. 2007 Aug 10;120(1259):U2654.

Lawrenson RA, Nixon G, Steed RH. The rural hospital doctors workforce in New Zealand. Rural Remote Health. 2011;11(2):1588. Epub 2011 Apr 19.

Lawrenson R, Reid J, Nixon G, Laurenson A. The New Zealand Rural Hospital Doctors Workforce Survey 2015. N Z Med J. 2016 May 6;129(1434):9-16.

Acronyms and Abbreviations used in this report

Acronym/ Abbreviation	Detail
DRHM	Division of Rural Hospital Medicine
RHMS	Rural Hospital Medicine Specialist
RHMR	Rural Hospital Medicine Registrar
GP	General Practitioner
FACEM	Fellow Australasian College of Emergency Medicine
Network	NZ Rural General Practice Network
RHN	NZ Rural Hospital Network
ED	Emergency Department
IMG	International Medical Graduate
MCNZ	Medical Council of NZ
RNZCGP	Royal NZ College of GPs

End Notes:

[i]

Division of Rural Hospital Medicine All 33 rural hospitals – by level	
Level 3:	Ashburton Hospital Bay of Islands Hospital Dunstan Hospital Grey Hospital & Health Centre Hawera Hospital Kaitaia Hospital Lakes District Hospital Oamaru Hospital Taumarunui Hospital Thames Hospital Tokoroa Hospital Taupo Hospital
Level 2: Not included in our survey but listed by the DRHM as Level 2 Rural Hospitals: Reefton and Matamata as they do not provide an emergency facility or acute beds	Buller Hospital Clutha First Hospital Dannevirke Community Hospital Dargaville Hospital Golden Bay Hospital Gore Hospital Hokianga Hospital Te Kuiti Hospital Wairoa Hospital
Level 1 Not included in our survey but listed by the DRHM as Level 1 Rural Hospitals: Kaeo Hospital Morrinsville Maniototo Opotiki Te Aroha Stratford Taihape	Chatham Islands Hospital Kaikoura Hospital Te Puia Hospital

[ii] **The NZ Rural Hospital Doctors Workforce Survey 2015**, Ross Lawrenson, James Reid, Garry Nixon, Andrew Laurenson.