NZRDA

New Zealand Resident Doctors' Association

Community Based Assessment (CBA) 2017 Report

December 2017

Introduction

In 2015, the Medical Council of New Zealand announced that it was introducing the requirement to have all resident doctors complete a CBA in their first two years of practice (by the year 2020).

This staged program was introduced in 2016. NZRDA has been following the successes and other feedback reported by RMOs who have undertaken a CBA during 2017.

Overall, the feedback received from RMOs was positive. Of those who undertook a CBA run in 2017, 68% reported that they were more likely to consider a career in community based medicine as a result of their CBA experience. One RMO reported that their experience was an *"Invaluable run regardless of intention to work in the community. I gained more autonomy and also understanding of the primary care system and how it interacts/links with hospital based care".*

NZRDA has been monitoring the progress of and satisfaction with the CBA introduction among resident doctors since the inception of the scheme. We are now in a position to make two recommendations based on successful experiences to date and in support of the ongoing delivery of CBA runs to resident doctors.

Feedback Summary

Placements

General practice is still the most common CBA run that RMOs are undertaking, followed by Hospice and Accident and Medical (A&M) clinic placements.

There was a decrease in the number of CBAs available during the winter quarters, due to DHBs requiring more staff to be based on hospital runs to cover the inevitable increase in patient numbers and staff sickness. This practice reflected the situation in the 2016 training year.

Costs

81% of RMOs reported that the cost associated with the time spent on a CBA run (decreased run category, increased travel time) was balanced against the lower hours and the enjoyment they gained from the run.

After-hours component

Although 60% of RMOs were required to perform after-hours duties as part of their CBA run, most reported that this was not relevant to their CBA. Several RMOs said after-hours duties in the hospital negatively impacted their CBA experience, for a variety of reasons:

- they were required to finish their placement earlier
- the hours were physically and psychologically tiring
- they struggled with being unable to provide continuity of care
- they struggled with the isolation from not being part of a regular hospital-based team

It is interesting to note that RMOs reported being more likely to receive additional duties rates if they were asked to perform after-hours work in the hospital in quarter 1 compared to quarter 4.

RMOs who had the opportunity to undertake after-hours within their own clinical CBA environment were more likely to report that it enhanced their experience, as it was a good learning experience.

Accommodation and travel

The vast majority of RMOs commuted daily to their CBA. Of those RMOs who relocated in order to perform the CBA, the majority were provided with adequate accommodation free of charge. The only concern regarding accommodation was in quarter 4, when there was a report of sub-standard accommodation being provided. This deterioration in conditions has occurred since quarter 1. The NZRDA has raised this with the appropriate DHB and are investigating.

Infrastructure

There were only two reports of RMOs who did not feel welcomed into the team they were placed with. All RMOs were provided with adequate facilities appropriate for consultations with patients.

Access to internal emails and updates was reported to be difficult, as RMOs were not given access to their DHB emails whilst on a CBA. Several RMOs contacted their local units to try to resolve this. However, it appears to be an ongoing issue.

Clinical exposure

On the whole, RMOs reported that they were exposed to an adequate range of medical conditions whilst on placement. This meant that they developed the ability to work more autonomously and became more confident in their clinical skills and knowledge. RMOs who were placed in an A&M clinic reported that they struggled to receive exposure to patients who needed chronic condition management.

It is encouraging to see that CBAs are having a positive flow-on effect into the clinical exposure that RMOs are seeking when making run selections for the upcoming training year. One RMO said *"It was so good to have firsthand experience of working as a GP registrar/HO. It made me realise that I need to upskill and spend time on hospital based attachments such as adult medicine, orthopaedics etc."*

Supervision and support

Quarter 4 brought some difficulties with the provision of adequate supervision and teaching. There were no reports of issues prior to this. One RMO liaised with the RMO unit and this was resolved within a timely manner. Unfortunately, the other two incidents were reported at the cessation of the run, and have been raised with the DHB as a matter that needs addressing.

RMOs who were placed in clinics that had high-need patients were more likely to suffer from inadequate supervision or support.

2018 training year

For the 2018 training year, Auckland DHB has altered the clinical exposure that RMOs will receive whilst undertaking a CBA. The Auckland regional DHBs have not increased the number of CBAs for the past 2 years and will now struggle to meet the 2020 target.

Previously, ADHB offered RMOs the opportunity to spend time in general practice, with placements in the One Health Remuera and the ADHB Coast to Coast Wellsford runs. Both of these runs have been disestablished, and replaced by two runs within the community mental health area:

- Community Mental Health Centre run (CMHC)
- Mental Health Services for Older People (MHSOP) – Community Team run

NZRDA raised the disestablishment of CBA positions with the DHB, and asked for the justification behind the transfer of CBA focus to another area of community medicine. ADHB felt that community mental health was a higher priority, and therefore they needed to focus more resources here than in general practice.

A recent evaluation by the Auckland regional DHBs found that RMOs were receiving limited exposure to patients with mental illness in the community setting. Feedback from those RMOs who undertook the Waitemata DHB Community Mental Health position and Psychiatry positions reported these to be valuable experiences.

NZRDA has concerns that disestablishing certain CBA runs in order to expose RMOs to other CBA experiences will have a detrimental effect on the ability to achieve the NZMC requirements by 2020. NZRDA has challenged the DHB on this; however, they remain resistant to expanding the CBA opportunities.

It is encouraging to see that Northland DHB has increased the number of CBAs.

Summary

Overall, RMOs felt the CBA was an extremely valuable experience that had positive flow-on effects to the individual, the community and to the medical profession.

RMOs who undertook an CBA this year reported that the CBA experience was improved compared to RMOs who undertook a CBA in the 2016 training year. It is hoped that these improvements will continue in the 2018 training year, as the MCNZ 100% participation in CBA by 2020 draws ever closer.

NZRDA will continue to engage with members working in CBAs, and the continuous feedback loop we have established will continue to be part of the 2018 NZRDA work plan.

Recommendations

NZRDA has two recommendations:

1. After-hours non-CBA work should be performed on a voluntary only basis (through the additional duties mechanism).

2. Auckland regional DHBs should be required to establish sufficient CBAs to enable all house officers to undertake one CBA by 2020.