Special Commission of Inquiry into Healthcare Funding

Statement of David Quirk

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Occupation:	General Manager, Rural and Regional Health Services, Hunter New England Local Health District

1. This statement made by me accurately sets out the evidence that I would be prepared, if necessary to give to the Special Commission of Inquiry into Healthcare Funding ("**the Inquiry**") as a witness. The statement is true to the best of my knowledge and belief.

2. It is provided in response to topics identified by the Inquiry in a letter to the Crown Solicitor's Office dated 14 August 2024 (**MOH.0010.0542.0001**), to the extent that such topics are relevant to my role, and to the Inquiry's letter to the Crown Solicitor's Office dated 22 August 2024 (**MOH.0010.0541.0001**).

A. INTRODUCTION

3. I am the General Manager of Rural and Regional Health Services, Hunter New England Local Health District (**HNELHD**, **the LHD**). A copy of my curriculum vitae is exhibited (**MOH.0010.0595.0001**).

4. I report to the Executive Director, Operations, HNELHD. I am responsible for all HNELHD district and community hospitals, as well as multipurpose services (**MPS**), providing oversight at a senior level and strengthening collaboration between facilities to ensure community service availability continues to be met, whether that be at the patient's local facility or a nearby facility.

5. My responsibilities as General Manager, Rural and Regional Health Services, includes oversight of 28 regional and rural facilities in the HNELHD. These facilities are:

    a. 7 District Hospitals: Cessnock, Gunnedah, Inverell, Moree, Muswellbrook, Narrabri, and Singleton.

    b. 9 Community Hospitals: Dungog, Glen Innes, Gloucester, Quirindi, Murrurundi, Scone, Tomaree, Wee Waa and Tenterfield.

    c. 12 MPS sites: Barraba, Bingara, Boggabri, Denman, Guyra, Manilla, Merriwa, Tingha, Vegetable Creek-Emmaville, Walcha, Warialda, and Werris Creek.

6. Each facility has a Health Service Manager reporting to either the Service Manager, New England North West, or Service Manager, Hunter Lower Mid North Coast. These two Service Managers then report to me.

7. I have no managerial responsibility for Armidale, Belmont, John Hunter (Newcastle), Maitland, Manning (Taree), and Tamworth hospitals. Each of these hospitals has a General Manager reporting to the Executive Director, Operations, HNELHD.

8. The Rural and Regional Health Service executive team meets monthly, and there is a monthly accountability meeting between me and the Service Managers.

9. Following a recent restructure of HNELHD's clinical operations, implemented 1 July 2024, services were reorganised into the three streams of acute hospitals; rural and regional health services; and integrated care services, networks and partnerships. The objectives of the restructure are to create a whole-of-district focus, and to:

   a. Improve patient experience through consistency and greater integration across services.

   b. Enhance Emergency Department (**ED**) and surgical performance.

   c. Incorporate community health services more effectively in how we deliver care.

   d. Expand our virtual services to bring care to patients closer to home.

   e. Use our resources more efficiently to tackle workforce challenges.

B. WORKFORCE – MEDICAL OFFICERS, NURSING, AND ALLIED HEALTH

10. Workforce recruitment and retention is a significant challenge in Rural and Regional Health Services of the HNELHD.

(i) Medical officers

11. Historically, rural hospitals relied on General Practitioners (**GP**s) who lived in the local community providing primary health care in their private general practice, and also working as a Visiting Medical Officer (**VMO**) in the local hospital with a Fee-for-Service contract in accordance with the Rural Doctors Settlement Package (**RDSP**).

12. More recently, there has been considerable change to this model. Changes to the medical workforce in my view, is multifactorial. Primarily there is a generational impact,

with many rural GPs who provided VMO services to the LHD now retiring. There has not been replenishment of that retiring workforce by a younger generation of GP doctors. There is a preference for doctors to live on the east coast or in larger regional centres and metropolitan areas, for employment opportunities and lifestyle reasons.

13. In rural hospitals, HNELHD is managing the medical officer workforce challenges through several strategies. These include:

    a. An increased reliance on locum doctors.

    b. Increased use of sessional VMO contracts, which is more attractive to local doctors because it provides more certainty of income for hospital work.

    c. Virtual Medical Services, presently the LHD has a contract with “My Emergency Doctor” (**MED**) for the provision of a virtual telemedicine service that is staffed 24/7 by a Fellow of the Australasian College for Emergency Medicine (FACEM). MED is available at all rural and regional HNELHD facilities.

14. Regarding the increased reliance on locum doctors, these doctors are based outside the local community, do not provide primary health care in general practice, and are based at the hospital largely in the ED. This has increased the medical costs in rural hospitals as these locum doctors generally “fly in, fly out.” Therefore accommodation, travel and agency associated costs are borne by the rural hospital. Locum doctors are often paid at a higher rate than their colleagues providing the same service but being paid under the RDSP.

15. The increased reliance on locum doctors also impacts the clinical governance structures of the rural hospital and influences the provision of integrated primary health care. Usually, locum doctors are not as involved and invested in clinical governance processes in the local hospital as the locally based GP. Locum doctors increasingly are unwilling to provide after-hours services to the same extent as RDSP GP VMOs would typically do. Further, as locum doctors are only placed at the hospital for shorter periods of time, it can be difficult for them and the team they are working with to build relationships with each other.

16. There is considerable effort to create a stable medical workforce. The LHD is:

    a. encouraging rural students who have completed their university degree to return to practice as a Junior Medical Officer (**JMO**) or Resident Medical Officer (**RMO**)

in their regional community. Examples include the John Flynn Medical Program and the University of New England Joint Medical Program (JMP) which currently has Year 5 medical students undertaking the Longitudinal Integrated Clerkship programme.

b. facilitating placement of Royal Australian College of General Practitioner (RACGP) and Australian College of Rural and Remote Medicine (ACRRM) Registrars in rural hospitals.

c. clinical placement of rural GPs in the larger training hospitals for additional training and upskilling.

d. working with the Rural Doctors Network (**RDN**) to advertise, market and promote rural and regional medical vacancies and opportunities for employment.

e. promoting the NSW Rural Generalist Single Employer Pathway (**RGSEP**), which is an employment pathway for junior doctors seeking a career as a rural generalist. Trainees on the pathway are employed for up to four years by a regional LHD while completing training in primary care and hospital settings. The RGSEP offers rural generalist trainees a contract with a NSW Health LHD for the length of their training. This allows the trainee to keep their NSW Health Award entitlements (sick leave, annual leave, and parental leave), as other specialist trainees employed by NSW Health do.

17. HNELHD has 5 Rural Generalist Trainees engaged in the RGSEP as follows:

a. currently working with Singleton Heights Practice and will complete their 12-month advanced skills training at Maitland Hospital in Palliative Care in 2025;

b. currently working with Peppertree General Practice in Medowie and will complete another 12-month term in 2025 with the same practice.

c. currently working in a GP Practice in Tamworth will work in General Practice in Gunnedah in 2025.

d. currently completing their advanced skills training in the ED at Tamworth Hospital and will work in General Practice in 2025 in Manilla.

e. currently completing their advanced skills training in the ED at Maitland Hospital and will undertake further training in 2025 in Dungog.

(ii) Nursing

18. Challenges are also faced in maintaining the nursing workforce in HNELHD rural hospitals. Generational change has seen many nurses who live in rural and regional communities retiring and not being replenished by a younger generation of nurses.

19. To maintain an appropriately skilled and qualified nursing workforce in rural facilities there is increasing reliance on a "fly in-fly out" nursing workforce. The transient nursing workforce is sourced via two main streams:

    a. engaging locum agencies to provide locum nurses; and

    b. HNELHD Rural Relievers Program.

20. The transient nursing workforce brings additional cost to rural hospitals in the form of locum agency cost, travel and accommodation costs. The locum nurses are not routinely as engaged in the local hospital non-clinical duties as the locally based nursing staff.

21. There is significant demand for Registered Nurses (**RN**), who have experience and qualifications in specialist nursing fields. This would include ED, Operating Theatre, Renal Dialysis, and Oncology.

22. Rural hospitals providing maternity services have significant demand for Registered Midwives.

23. There is considerable effort to create a stable nursing workforce. The LHD is:

    a. providing school-based training programs in rural hospitals. This involves a year 11 or 12 school student completing an 'assistant in nursing' course and concurrently working at the hospital. A small rural site can accommodate school-based trainees easily. This process often encourages the student to pursue studying nursing at university and to return to the HNELHD for employment as a novice practitioner due to the relationship between the student and the rural hospital;

    b. utilising the Rural Health Workforce Incentive Scheme (**RHWIS**), which aims to recruit and retain staff in eligible positions at health services across regional and rural NSW. An incentives package of up to $20,000 is available. Financial and non-financial support includes professional development, accommodation assistance

and help with relocation costs, additional personal leave, family travel assistance, and/or a rural or regional allowance or bonus if relevant to the role;

c. recruiting international graduates – via recruitment agencies and a HNELHD recruitment drive in the United Kingdom. This has been successful in a number of rural hospitals, for example one at Inverell and one at Barraba;

d. promoting career progression opportunities within nursing such as clinical nurse specialists, clinical nurse consultants, and clinical nurse practitioners. There are nurse practitioners employed at numerous rural hospitals. For example, Bingara, Moree, Narrabri, and Warialda.

(iii) Allied Health

24. Similar issues are faced in attracting a permanent allied health workforce to regional and rural hospitals, for the reasons I have outlined above and additionally, because of competition created by other opportunities, in private practice, such as the National Disability Insurance Scheme (NDIS).

25. Generally, rural hospitals do not utilise agency staff to fill allied health vacancies which can result in there being gaps in allied health services.

26. To create a stable allied health workforce, the LHD is aiming to increase undergraduate students completing their placements at the LHD. This is by:

   a. partnerships with universities with supported clinical placement. The LHD offers some attraction, because students on rotation can rotate to both larger and smaller sites, so they can observe the benefits of working rurally and regionally;

   b. Novice Practitioners' Program with rotational placement in tertiary and rural facilities, for example Moree Physiotherapy; and

   c. Allied Health Rural Generalist Program which supports allied health practitioners in early career development and qualifications in partnership with James Cook University.

C. CAPITAL WORKS AND SERVICES

27. The need for capital works and investment in facility infrastructure is identified through a combination of:

a. local hospital prioritisation of repairs and maintenance and purchase of new equipment;

b. minor capital works programs coordinated through HNELHD Infrastructure, Planning and Sustainability;

c. recommendations of Work Health Safety and Australian Council of Healthcare Standards accreditation, reviews and audits;

d. major capital works programs coordinated through HNELHD Infrastructure, Planning and Sustainability;

e. recommendations of clinical streams and networks of HNELHD.

(i) capital works

28. Of the 28 Rural and Regional Health Service facilities in my portfolio, there are capital works being conducted or planned as follows:

a. **Cessnock Hospital redevelopment** has received $26.5 million in addition to the $111.48 million announced in 2021. This project is currently in the design phase, with concept designs released in mid-2024.

b. **Glen Innes Hospital redevelopment** is a $50 million investment that is in the design phase.

c. **Gunnedah Hospital redevelopment** is a $53 million investment with main works underway.

d. **Moree Hospital redevelopment** has received additional funding of $25 million, taking the total investment to $105 million. The majority of the design phase is complete, with the final scope to be finalised once a contractor is secured.

e. **Muswellbrook Hospital redevelopment** is a $45 million investment, with the tender for main works contractor due to be announced.

(ii) chemotherapy services in Moree and Narrabri

29. Chemotherapy services provided in the Moree and Narrabri Hospitals have evolved to meet the needs of the local community. Initially, Moree Hospital identified the need for

low-risk chemotherapy services to be provided locally. A service was established with one RN being trained to deliver chemotherapy services.

30. The Moree Hospital chemotherapy service was then expanded with additional funds, supporting the employment of chemotherapy nurses and a visiting Oncologist from Tamworth Hospital.

31. The chemotherapy service at Moree was further expanded in 2021 with additional funds to support the administration of a unit at Narrabri Hospital.

32. The present chemotherapy service (Moree and Narrabri Hospitals) provides chemotherapy services up to 3 days per week by specialist chemotherapy nurses, supported by oncologists of the North West Cancer Centre based in Tamworth.

(iii) Maternity services - Moree

33. A local GP and I developed a plan focused on improved antenatal care at Moree Hospital. This was supported by NSW Health for the employment of midwives and led to the establishment of antenatal clinics at the hospital. The Director of Obstetrics at John Hunter Hospital (**JHH**) also became involved and assisted in the establishment of a regular high-risk maternal fetal medicine clinic being held monthly at Moree Hospital.

34. In October 2023 the Initial Maternal Network Plan (**IMAP**) antenatal service commenced operation out of Moree Hospital to provide specialist led antenatal care. The IMAP service provides one clinic face-to-face in Moree and one virtual antenatal clinic each month.

(iv) Outreach clinic services

35. There are numerous specialist outreach clinics provided to rural hospitals. The medical specialists are based in tertiary and rural referral hospitals throughout HNELHD. The funding to support these outreach clinics is often provided by HNELHD, and sometimes in coordination with partner organisations such as Rural Doctors Network. Examples of outreach clinics include renal dialysis (Tamworth), paediatrics (Armidale), ophthalmology (Tamworth) and diabetes (JHH).

(v) Pathology services in Moree and Narrabri

36. Pathology services are transitioning from St Vincent’s Hospital Pathology (**SydPath**) to NSW Health Pathology (**NSWHP**) in Moree and Narrabri Hospitals.

37. HNELHD's contract with SydPath at those facilities ceases on 19 November 2024 and NSWHP has exercised its option to take over the service. NSWHP will begin operating in Moree on 10 September 2024, and then in Narrabri at a date to be determined, but no later than 19 November 2024.

38. The scope of the services to be provided in Moree and Narrabri was reviewed in the process. This included consideration of the extent of duplication between available Point of Care testing and formal laboratory testing at Narrabri, noting formal laboratory testing options are also available in Moree and Tamworth. Ultimately, the plan is 'like for like' services replacement of SydPath by NSWHP. That is, there will be formal laboratory pathology testing in both Moree and Narrabri (in addition to collection centres and point of care testing).

David J Quirk

David Quirk

04/09/2024

Date

Witness: Rebecca Smith

04/09/2024

Date