

**Special Commission of Inquiry
into Healthcare Funding**

**Before: The Commissioner,
Mr Richard Beasley SC**

**At Level 2, 121 Macquarie Street,
Sydney, New South Wales**

Monday, 29 April 2024 at 10.01am

(Day 024)

Mr Ed Muston SC	(Senior Counsel Assisting)
Mr Ross Glover	(Counsel Assisting)
Dr Tamsin Waterhouse	(Counsel Assisting)
Mr Ian Fraser	(Counsel Assisting)
Mr Dan Fuller	(Counsel Assisting)

Also present:

Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning.

2

3 MR MUSTON: Good morning, Commissioner. I think the first
4 cab off the rank today is Matthew Daly.

5

6 <MATTHEW THOMAS DALY, sworn: [10.03am]

7

8 <EXAMINATION BY MR MUSTON:

9

10 MR MUSTON: Q. Could you state your full name for the
11 record, please?

12 A. Matthew Thomas Daly.

13

14 Q. You are the deputy secretary or a deputy secretary of
15 NSW Health?

16 A. Yes.

17

18 Q. With a responsibility for the system sustainability
19 and performance division?

20 A. That's correct.

21

22 Q. A role you have held I think since July of 2022?

23 A. Yes, that's right.

24

25 Q. You have prepared a statement to assist the
26 Commissioner dated 9 April 2024?

27 A. Yes.

28

29 Q. Have you had an opportunity to review that statement
30 before giving your evidence?

31 A. Yes, I did refresh my memory on it before today.

32

33 Q. Are you satisfied that the contents of it are true and
34 correct to the best of your knowledge?

35 A. Yes, indeed.

36

37 MR MUSTON: That, in due course, Commissioner, will form
38 part of the bulk tender.

39

40 THE COMMISSIONER: Sure.

41

42 MR MUSTON: Q. Perhaps we could bring the statement up
43 on the screen. I don't have the document number
44 immediately at hand. [MOH.9999.0976.0001], if you have
45 a look at paragraph 2 of that statement, do you see you
46 refer there, towards the middle of the paragraph, to
47 internal alignment of functions that brought various

1 programs aimed at hospital avoidance and virtual care
2 together under a single portfolio, as being the
3 justification for a slight change in the name of your
4 division?

5 A. I'm sorry, is it possible to turn your volume up a
6 little bit?

7
8 Q. Let me lean forward a little bit. Is that a bit
9 better?

10 A. Yes.

11
12 Q. Do you see you refer in paragraph 2 to hospital
13 avoidance there?

14 A. Mmm-hmm.

15
16 Q. I'm just wondering, could you tell us, in that
17 context, what you mean by "hospital avoidance"?

18 A. I might step back and maybe just give you the
19 rationale for those changes. It was a series of
20 conversations between myself, the secretary, and Deb
21 Willcox, the deputy secretary, and we felt that Deb's
22 branches are far more policy oriented and the skill sets to
23 develop policy are very, very different to the skill sets
24 really around execution, and a lot of the branches that are
25 within my team are very executionally oriented, they
26 predominantly bring really strong operational experience,
27 which is just as well, because, you know, we are frequently
28 engaged with LHDs in an operational sense on a daily basis
29 right across the system.

30
31 And so given that patient experience, we thought,
32 could benefit from a stronger policy setting around it,
33 which would then go to execution, we thought the patient
34 experience was better in that policy regime of Deb's, and
35 similarly bringing things like integrated care into my part
36 of the ministry, that is really very much driven around
37 hospital avoidance, and that's now getting specifically to
38 your question.

39
40 So the hospital avoidance activities, they can take
41 many, many names and many guises, such as virtual care,
42 integrated care, collaborative commissioning, you know,
43 even philosophies like "Leading Better Value Care" is
44 a philosophy rather than a program of work, and it is about
45 ensuring that care is, one, only provided when it is
46 clinically indicated and evidence based, and I'm sure
47 Jean-Fred would have spoken to that, or he is more than

1 capable of speaking to it because a lot of work comes out
2 of ACI in that regard. So given the growth in ED
3 presentations, in part due to failure of primary care, to
4 be honest, we had a choice of just responding to the
5 volumes, particularly amongst category 4 and 5 patients,
6 and to a degree category 3, but predominantly cat 4s and
7 5s, that bringing all those avoidance teams and activities
8 together and into the operational milieu and the execution
9 space was deemed a far more effective way, particularly at
10 a time when we were implementing urgent care services
11 across the state, with good government support, I might
12 add, and it was expanding the suite of services that could
13 be provided by people coming through the digital front
14 door - we may talk about that again later - and getting
15 them to the right care setting, which increasingly is not
16 to an emergency department.

17
18 Q. So at the heart of hospital avoidance, we're dealing
19 with keeping people out of an emergency department who
20 don't really need to be there; is that right?

21 A. Or can be equally if not better cared for in a
22 different care setting that doesn't mean fronting up to an
23 emergency department, yes.

24
25 Q. Would it be right to say that hospital avoidance in
26 the context that you have used it is not aimed at referring
27 to a longer-term plan to keep people well and not needing
28 hospital care in general?

29 A. No, any contact through the single digital front door
30 are people requiring some degree of care.

31
32 Q. We're dealing with people who have reached a point
33 where they require some degree of care, and the hospital
34 avoidance strategies are aimed at keeping them to the
35 greatest extent possible out of the hospital and receiving
36 that care elsewhere, be it in the community or through some
37 other source?

38 A. Yes, that's correct.

39
40 Q. Could I ask you to go forward to paragraph 7 of your
41 statement. You tell us there that the Ministry of Health
42 is the system manager of the public health system. Could
43 I just ask you to expand a little bit on what you mean
44 there when you refer to the ministry as the "system
45 manager", in a practical sense?

46 A. Yes, sure. Well, the term "system manager" - one
47 could question its accuracy given, you know, the devolved

1 nature of the New South Wales health system. I think the
2 term "system manager" is enshrined in the legislation in
3 terms of the role, so that's why it's picked up, and
4 I assume that's why the team put the inverted commas around
5 that. But in terms of how that's operationalised, I would
6 say, in a simple form, that it is the role of the ministry
7 is not to tell people - or to tell LHDs how they are to
8 deliver services, but on behalf of government purchasing
9 services, to guide and prescribe what it is they will
10 deliver. That's the differentiation between the two.

11
12 Q. So when you refer to purchasing services to guide and
13 prescribe what will be delivered, what is the level of
14 control that the ministry has over those operational
15 decisions which manifest themselves at an LHD level?

16 A. Well, I guess control - I guess oversight would be
17 a better word than control, and I think there are so many
18 KPIs and measurements of - in safety and quality, the
19 measurements of inputs and outputs in the system, that
20 a significant variance from that, compared to the rest of
21 the system, flags a red flag and we'd engage with the LHD
22 as to why such a variance.

23
24 Q. So we will come back to the KPIs in a little bit more
25 detail soon, but to the extent that the ministry is
26 exercising oversight, to use your word, over the operations
27 of the LHD, is it primarily through a monitoring of LHD's
28 performance as against these KPIs?

29 A. Yes, fundamentally.

30
31 Q. And the KPIs are those which are contained in the
32 various service level agreements entered into between the
33 ministry and each LHD?

34 A. Yes, and those KPIs come from a variety of sources,
35 you know, they could be evidence based, that ACI might
36 identify; they could be National Health Reform Agreements
37 that prescribe those; they could be standards that the
38 national commission on safety and quality prescribe for the
39 system; or it could be premier's priorities each year from
40 government.

41
42 Q. So you go on to tell us in paragraph 8 that your
43 portfolio is divided up essentially into several different
44 branches that deal with different aspects of system
45 management, if we keep using that term?

46 A. Mmm.

47

1 Q. The first is the system purchasing branch. You see
2 you refer to that at paragraph 8(a), at least at a high
3 level?

4 A. Mmm-hmm.

5

6 Q. Can I ask, where it refers to "leading the development
7 and negotiation of the annual service agreements with
8 LHDs", to what extent is the service level agreement
9 discussions with LHDs truly a process of negotiation, do
10 you think?

11 A. To the extent that we're restricted obviously by the
12 size of the envelope, in terms of, you know, resources
13 government make available, so that's always a rate-limiting
14 step, the bulk of activity tends to be historically driven
15 and it's been a conscious decision of the system that in
16 order to address areas of inequity, that because we've got
17 to keep the rest of the system safe and operating, to be
18 eroding the base would be a courageous action for
19 a ministry or a secretary to take, in my opinion. So,
20 rather, we address equity in terms of incremental growth
21 and skewing of growth funding in order to address equity -
22 it could be on population, on ageing, sociodemographics; it
23 could be things around utilisation of GPs, utilisation of
24 the private hospital sector, all of which we take into
25 consideration.

26

27 Q. Again, we might come back to it in a little bit more
28 detail, but you mentioned a moment ago that a lot of that
29 negotiation is historically based.

30 A. Mmm-hmm.

31

32 Q. Are we to understand that as meaning there is an
33 amount of money which has been delivered to an LHD
34 historically as part of the divvying up of the pool, and
35 each year that pot of money might be incrementally adjusted
36 in some way for growth, but it's not a situation where one
37 starts with a clean sheet of paper and asks, what is it
38 actually going to cost us to deliver on the health needs of
39 the community within our LHD?

40 A. No, because sometimes we like to fool ourselves in
41 health that we don't know what's coming through the door.
42 The reality is we know exactly what's going to be coming
43 through the door, whether it be in a planned sense for, you
44 know, planned surgery, or whether it be for emergency care,
45 including ED performance. You know, we operate the system
46 on an algorithm and we can tell certainly within one
47 standard deviation of the number of patients, even kind of

1 the mix, in terms of triage. So it's - because we've got
2 this tremendous data that is historically developed and
3 built from and it varies very little. I mean, the disease
4 prevalence in the community, yes, it changes, but it
5 doesn't change dramatically from one year to another.
6

7 Q. So that data tells us about the likely experience that
8 the system will have of patients presenting at hospital for
9 acute care?

10 A. Yes.

11
12 Q. Or sub-acute care through an emergency department to
13 the extent that that's - doesn't quite get to the acute
14 level?

15 A. Yes.

16
17 Q. But does that data tell us much about wider population
18 health?

19 A. Sorry, why the?

20
21 Q. Does that data tell us much about wider population
22 health in terms of providing a clear and detailed
23 understanding of the health needs of the population within
24 an LHD?

25 A. Yes, I think that's a developing aspect of our data
26 systems. Certainly, you know, we've known for some time
27 things like what I mentioned before about ethnicity, age
28 ranges within districts, and they are fairly standard.
29 I guess the greatest insights will be coming by way of the
30 Lumos program that I think Sharon Smith may have talked to
31 you about, but that is kind of a nation-leading, if not
32 internationally-leading, data collection where, for the
33 first time at least in my 35 years in health, I've seen
34 true erosion of the barriers between Commonwealth and state
35 delivery arms for health in this country, because we're
36 getting line of sight of where our population are going
37 before they, say, hit an emergency department or before
38 they need to reach out for specialist either acute or
39 sub-acute care, because we've now got the history, at least
40 for about 60 per cent of GP activity, on why people are
41 presenting to a GP, how often they're presenting to a GP,
42 and that information's relatively new.
43

44 We've put it to practice in one substantive way, that
45 if not for Lumos, I don't think we would have made the
46 right decisions about the geographical locations and mix of
47 services in establishing the 25 urgent care services. The

1 Lumos data, because it was plotting the journey of
2 a patient in both primary and secondary care, gave us far
3 greater insight, and with the partnership of the PHNs and
4 general practices, I think we came to the best possible
5 decisions about that, but if it wasn't for Lumos, it would
6 be anecdote and assertion rather than empirical data.

7
8 Q. We'll come back to the urgent care services. Just
9 finishing a consideration of 8(a), do you see at the end of
10 (i) there, you tell us that the system purchasing branch
11 sets out the service delivery, performance and
12 expectations. Do we take it that that's a reference to the
13 KPIs that are contained in the service level agreements?

14 A. Yes, and the empirical measures of activity. You see,
15 where the districts have the best advice, if you think of
16 activity-based funding as being a series of product lines
17 where you would have acute episodes, sub-acute episodes,
18 ED, planned surgery, et cetera, they are best placed to
19 advise us on the mix of those product lines - that's just
20 a term I use, it is not an official one - because I think
21 it just - it simplifies what is ABM. And so LHDs can
22 actually guide us on any changes between those, because
23 they are closer to their population than we are.

24
25 Q. And you would see that as one of the strengths of the
26 devolved model of governance that we have at the moment?

27 A. Yes. As one who both worked as a chief in the
28 less-devolved system and then worked for the ministry to
29 devolved, I think the single greatest failure of the larger
30 area health services was their difficulty - almost said
31 "inability" but that might be a true word as well, but
32 certainly their difficulty - in engaging locally with
33 communities, given the size of the organisations that were
34 running. So they were certainly more arm's length to the
35 community than what LHDs are today.

36
37 Q. Moving down to the system management branch, you tell
38 us it is responsible for the NSW Health performance
39 framework and monitoring performance against annual service
40 agreements, et cetera. Again, is that a monitoring of the
41 extent to which the KPIs contained in the service level
42 agreements are being met by LHDs, SHNs or NSW Ambulance?

43 A. Yes, fundamentally.

44
45 Q. Is there an up-to-the-minute dashboard that is
46 available that enables that branch to consider just how
47 each LHD is performing as against each of its KPIs?

1 A. Not covering the full suite of KPIs. For a number of
2 the KPIs where real-time monitoring is really important,
3 particularly around ED performance, we do have live
4 monitoring of ED performances, of ambulance offloads, of
5 bed availability, you know, by ward, by specialty group.
6 So it does give us tremendous insight into individual
7 hospitals to actually have those conversations on why there
8 might be delays in offloading an ambulance when we can see
9 the number of bays that are actually empty in an ED; we can
10 see the number of vacant beds at the back of house, and
11 have those conversations that are quite pointed.

12
13 Q. Those things have the advantage of being easily
14 measurable within the system - that is, for example, wait
15 times in emergency departments; bed availability; ambulance
16 delays?

17 A. Yes.

18
19 Q. You referred to those things as the important things.
20 What is it about those considerations - for example, let's
21 use wait time in an emergency department as an example -
22 what is it about that that makes it more important than
23 some of the other KPIs contained in the service level
24 agreements?

25 A. Oh, if I either used the word "important", or implied
26 that it was more important than the other KPIs, that wasn't
27 my intention. Yes, it is an important set of KPIs, you
28 know, roughly 30 per cent of our admissions come through
29 emergency departments, so it's a fair volume, and hence
30 it's an important indicator to watch.

31
32 You know, there are other very important indicators
33 around, in an access sense, planned surgery, but nothing is
34 probably more important than the quality and safety
35 indicators, of which there are probably more quality and
36 safety indicators - not "probably", I would suggest there
37 are more quality and safety indicators - than there are
38 access indicators.

39
40 Q. What about access to other health services within the
41 LHD that are not being met through sources external to the
42 LHD - for example, public specialist clinics where people
43 within the community might not be able to get access to
44 specialist care through the private market?

45 A. Yes, we don't have good line of sight on that for
46 a number of reasons. One - and we have a team actually
47 working on a system for us to be able to have line of sight

1 on outpatient, if you like, waiting lists, the way we do
2 for planned surgery waiting lists. But there are a number
3 of other complicators in that, inasmuch as many
4 specialists, rightly or wrongly - and I won't proffer an
5 opinion - view the waiting lists as being their waiting
6 lists, and many waiting lists for outpatient appointments
7 are in fact held in VMOs' private rooms, so we don't - the
8 hospital itself doesn't even necessarily have access to
9 lists of patients awaiting --

10
11 Q. What about Lumos data, is there anything in the Lumos
12 data that assists with that, to the extent that GPs are
13 referring patients to specialist care and recording or
14 observing, in some way, that their patients are having to
15 wait for sometimes extraordinary periods to see
16 specialists?

17 A. Certainly Lumos gives us line of sight to GP
18 engagement. I would have to get advice as to whether it
19 would specifically flag or indicate that that GP
20 appointment was for purposes of getting a referral to an
21 appointment with a general surgeon, for instance. I'm not
22 sure of that.

23
24 Q. Can I just go down to subparagraph (ii) there, where
25 you tell us about the system management branch as one of
26 its other functions being supporting and monitoring
27 system-wide patient flow performance in real-time patient
28 safety and quality and supporting the state health
29 service's functional area coordinator. I gather that the
30 real-time monitoring that you are referring to there is
31 this process of monitoring, what, waiting times in
32 emergency departments, ambulance times, available beds in
33 hospitals, et cetera?

34 A. Yes, through two systems. One is the ambulance board,
35 and that's integrated closely to the patient portal. So
36 with those two systems, we get that line of sight you just
37 spoke to.

38
39 Q. What about the support that is being provided to the
40 state health services functional area coordinator, what is
41 the role of that person or body?

42 A. Well, HSFAC is the key lead for NSW Health in the
43 event of a disaster, natural or otherwise - disaster
44 management, but only where the event or impact transcends
45 beyond a single LHD. So, you know, like some years ago
46 a massive tree near the front door of the Ambulance at RPA
47 fell, and the HSFAC dropped in. Now, that was an

1 inappropriate engagement of the HSFAC. It was peculiar to
2 RPA. It may have had some flow-on benefits having to
3 redirect ambulances to other hospitals within Sydney LHD,
4 but it really plays the role like in the Lismore floods,
5 facilitating health response right across that district and
6 others that were impacted by it.

7
8 Q. When you say "facilitating" it, it uses the real-time
9 data available to distribute those in need of health care
10 in a way that best utilises the health care which is
11 available within the wider geographic area, or a geographic
12 area wider than the LHD?

13 A. Yes, the HSFAC and his or her team - his team as it is
14 at the moment - has access to that data. But we have
15 a patient flow centre who monitors it seven days a week,
16 and so he would probably defer to advice around where
17 capacity is and where capacity isn't, but yes, it's
18 available to him.

19
20 Q. Coming to the LHDs, you I'm sure are familiar with the
21 statutory function of the LHDs set out in section 9 of the
22 Health Services Act, the dual functions?

23 A. Yes.

24
25 Q. First, to provide relief to sick and injured people
26 through the provision of care and treatment, and the
27 second, to promote, protect and maintain the health of the
28 community. Can I ask, in relation to what you have told us
29 about the system purchasing branch, I know you have
30 indicated that it is largely historical, but to what extent
31 do decisions around purchasing or the allocation of
32 a budget for an LHD take into account those two purposes of
33 the LHD, the statutory purposes?

34 A. I guess the purchasing outcome and the framework for
35 those purchasing conversations is brought to the ministry
36 executive, you know, in advance, and that's where other
37 policy owners, whether it be around prevention, people like
38 Kerry Chant, who has responsibility for that, has input;
39 similarly around aged care initiatives or maternity and
40 neonatal care, Deb Willcox has policy responsibility. So
41 the framework and the intentions of the framework come to
42 the ministry executive. So that gets all those deputy
43 secretaries' input and guidance for then engagement back
44 with the LHD chief.

45
46 Q. Just pause for one moment. I've been informed,
47 Commissioner, that the live stream has ceased working. I'm

1 quite happy to keep going, but - and it no doubt will be
2 fixed in due course, but if it is not, I don't think we
3 should be waiting for it, but I'm equally very much in your
4 hands.

5
6 THE COMMISSIONER: It's ceased working because?

7
8 THE OPERATOR: There is no audio going out.

9
10 THE COMMISSIONER: Is there any unfairness if we continue
11 to anyone?

12
13 MR MUSTON: I don't think so.

14
15 THE COMMISSIONER: No, people are here, health
16 representatives. Let's keep going.

17
18 MR MUSTON: If anyone wants to read the transcript in due
19 course, they can.

20
21 THE COMMISSIONER: Of course.

22
23 MR MUSTON: Q. From the point of view of the LHDs, there
24 are two important features of the service level agreement
25 negotiations, just to make sure we've got it right. First,
26 the level on mix of services that are to be purchased and,
27 second, the imposition of the KPIs.

28 A. Mmm.

29
30 Q. Can I ask you to go to paragraph 15. When you are
31 having the discussions, or when discussions are being had
32 around those two things - level and mix of service and
33 imposition of KPIs - you tell us that allocations are based
34 on the best available data and evidence. What is the best
35 available data and evidence at the moment?

36 A. Well, the best available data is the data that we
37 collect through a variety of branches in the ministry.
38 It's not just SIA that have tremendously accurate and
39 well-accepted relevance of the data, so, I'm - fortunately,
40 I'm working in a system where we're not debating the data
41 but rather debating what the data is telling us, which in
42 my past experience isn't always the case in large
43 organisations. So that's a key one.

44
45 The collection of data around safety and quality,
46 hospital-acquired complications, that's overseen by the CEC
47 and directors of clinical governance. Data around disease

1 prevalence by individual communities that come out of
2 branches under Kerry Chant's leadership, as well as
3 planning data from state planning organisations around
4 population projections for purposes of sharing and feeding
5 in to LHDs for their clinical service planning purposes.
6

7 THE COMMISSIONER: Q. Can I just ask, because this may
8 be a transcript issue that doesn't necessarily get
9 corrected - when you said you are working in a system
10 "where we're not debating the data but rather debating what
11 the data is telling us" --

12 A. Yes.

13
14 Q. Did you say "fortunately" or "unfortunately", "I'm
15 working in that system"?

16 A. No, absolutely "fortunately".
17

18 Q. That's what I thought. It says "unfortunately" [in
19 the draft transcript], so we'll get that corrected.

20 A. Good pick up.
21

22 Q. Well, I was listening.

23 A. You proved that.
24

25 MR MUSTON: Q. As part of that array of data, do you
26 have access to information about the particular health
27 needs or particular and unique health needs of the
28 community within each LHD or the communities within each
29 LHD?

30 A. Yes, they are better informed because they run units
31 around multicultural health peculiar to their populations,
32 and so I know that there are very active units in most, if
33 not all, LHDs that do specialise on those peculiar needs of
34 those populations, and they feed that into the chief
35 executive.
36

37 From a state level, I could probably get access, but
38 as we negotiate the LHDs on a district by district basis,
39 I don't think we tend to, but I could be corrected around
40 that. Certainly from a state perspective, you know, Kerry
41 is very vigilant in relation to state trends and needs
42 around multicultural and other groups' health.
43

44 Q. Does part of the negotiation process with the LHD,
45 though, involve the LHD providing you with information
46 about the particular health needs of the community that it
47 serves?

1 A. Sorry, that?

2

3 Q. Does part of that negotiation with each LHD around the
4 service level agreement each year involve the LHD providing
5 you with detailed information about the particular health
6 needs of the community which it serves?

7 A. Yes, they would feed that into the process of saying
8 that there is a particular, you know, disease prevalence of
9 a particular subset of their population that requires
10 service enhancement or likely - "service enhancement" isn't
11 the right term, but likely demand enhancement that the LHD
12 would need to respond to, in other words, actually provide
13 services for a growing need of a disease cohort, and it's
14 up to them to guide us, but remembering that we're always
15 constrained to the budget envelope in terms of the amount
16 of activity that we can agree to, because we're all under
17 budgets.

18

19 Q. What about more general information about, say, the
20 extent to which the population requires access to primary
21 health care, specialist care, other health services which
22 might be delivered within the LHD?

23 A. Primary health care less so; specialist care, because
24 that is a secondary care service that NSW Health is
25 responsible for, yes, they would - they may have data on it
26 depending on how they collect data. I know some districts
27 do collect reasonably robust data on outpatients, but it's
28 in a format by LHD by LHD. That's why we've got a team
29 working to introduce an outpatient waiting list system that
30 will be uniform, so we're all counting the same things the
31 same way, and that we will have line of sight on
32 a statewide basis, just as we do for planned surgery
33 breaches.

34

35 Q. Because information about the particular health needs
36 of the community within the LHD is going to be quite
37 important, having regard to the statutory purpose of the
38 LHDs, would you agree?

39 A. Yes.

40

41 Q. And the LHD's ability to perform its statutory
42 function would be significantly constrained if it didn't
43 have access to information about the health needs at any
44 particular point in time of its community. Would you agree
45 with that?

46 A. Yes, I've not - I can't recall in my, you know, nearly
47 two years back in NSW Health any particular complaint or

1 observation from a chief executive about not having that.
2 That's not to say that there aren't difficulties in getting
3 it. But it's more than one branch in the ministry that can
4 provide data, depending on the need of that particular LHD
5 or chief executive.
6

7 Q. That data which is available, though, to what extent,
8 in a realistic sense, is it actually featuring in
9 negotiations around budget allocations and service level
10 agreements?

11 A. Well, it would be - it would be the catalyst and
12 motivator and evidence base for why a chief executive would
13 wish to negotiate a change in those product lines that
14 I talked about and any growth in, say, the acute NWAU would
15 be evidenced by a growth of a particular disease prevalence
16 for a particular population growth - population group in
17 their LHD, and that is best known to the chief executive of
18 that LHD.
19

20 Q. Do you have a sense that that is actually happening in
21 practice, though, as part of these negotiations?

22 A. Oh, yes, yes. And they often - "they" - I shouldn't
23 talk about them as a homogeneous group, but, you know,
24 chief executives will often reflect on population cohorts
25 and the peculiar health needs of that population. You
26 know, there is a very big refugee presence in a couple of
27 our LHDs and that requires, you know, a very different
28 response in terms of both primary care but also secondary
29 care for that population group. So I would suggest that
30 they are pretty sensitive to it.
31

32 Q. What about information about the extent to which the
33 health needs of communities are being met by services
34 delivered external to the LHDs, is that something that you
35 have access to?

36 A. More at the local level. I know Kerry engages at
37 a state level with groups around refugee health,
38 multicultural health, Aboriginal health, but I would think
39 the more practical engagement and hence response would be
40 at the local level with the district.
41

42 Q. Dealing not just with subcommunities within the LHD
43 but the population wide within an LHD, to what extent,
44 insofar as you are aware, is information made available
45 about the extent to which their various health needs are
46 being met by, say, primary health care delivered through
47 GPs, specialists operating out of their rooms, allied

1 health operating within the private market, et cetera?

2 A. I don't - I don't see a great deal of data
3 particularly in relation to the private sector, and even
4 GPs, unless how we've translated it into the growing
5 population base of general practitioners under Lumos.
6

7 Q. Would you accept that that information is going to be
8 important for an LHD in determining what services it needs
9 to deliver in performing its statutory function?

10 A. Yes, it would - it would be useful, as they tweak
11 their service profile and service response. You know,
12 a lot of these groups are very small in number. It doesn't
13 make their needs any less important, but in my experience,
14 health doesn't respond to revolution but it does respond to
15 evolution, and the beauty of the annual performance
16 agreement, whether it be adjusting the both volume and mix
17 on a yearly basis, is on the advice of the evidence and
18 line of sight that chief executives have around their
19 population and those changes, as it does also incrementally
20 addressing equity in the system through a disproportionate
21 distribution of equity funding - sorry, growth funding,
22 based on equity needs.
23

24 Q. To what extent, if any, is the negotiation around
25 service level agreements picking up a consideration of the
26 LHD's need to meet unmet service delivery for, say, primary
27 health care within the geographic boundary of the LHD?

28 A. I don't believe chief executives have in the past, nor
29 probably should they be, investing in primary care. That
30 is the responsibility of the Commonwealth. I guess where
31 we've seen leadership in New South Wales is by government
32 policy around urgent care services that is very much
33 jumping in to the primary care market, where it's failed,
34 and I think there is increasing evidence around the ED
35 avoidance that that program has been able to deliver that
36 otherwise would have seen patients in EDs.
37

38 Q. You say the delivery of primary care is the
39 responsibility of the Commonwealth. Why do you say that?

40 A. Because it is - has traditionally been; its funding is
41 from the Commonwealth; we don't attract any funding from
42 the Commonwealth under the National Health Reform Agreement
43 for anything that resembles primary care. The national
44 administrator and the independent hospital pricing and aged
45 care authority polices that and we have had models of care
46 rejected for Commonwealth funding because it was too like
47 primary care services that the Commonwealth is responsible

1 for.

2

3 Q. Do you have some examples of those models of care that
4 were rejected by the Commonwealth?

5 A. I would need to resurrect them, which wouldn't be too
6 difficult, but I couldn't tell you off the top of my head.

7

8 THE COMMISSIONER: We can get that later.

9

10 MR MUSTON: Q. The Commonwealth clearly provides
11 a source of funding for primary care through the MBS.

12 A. (Witness nods).

13

14 Q. But as to who is responsible for the delivery of
15 primary care to the extent that the market-based system
16 funded by the MBS might not be working, does it not get
17 picked up by the broad function of the LHD provided for in
18 section 9 of the Health Services Act?

19 A. Well, I guess ultimately, depending upon the level of
20 that primary care market failure, the LHD does pick it up,
21 because it lands in the ED. It's like most social
22 determinants and problems, it's the last port of call, and
23 that is the volume that we have been working to divert to
24 better care settings than the emergency departments.

25

26 Q. The best care setting for that problem is a primary
27 health care setting which provides continuity of care to
28 those patients?

29 A. That might be the case, yes, if it is a need for
30 a continuum of care. If it is a chronic disease, then yes
31 is the answer. If it is aged care, then yes, to your
32 question. If it is kind of a one-off, that's where kind of
33 urgent care clinics come into play, where there isn't any
34 GP, or there is a means and a feature of the single digital
35 front door is actually about getting people either into
36 appointments, which the urgent care service facilitates
37 through a contracted arrangement, where you would be
38 assessed and say, "Right, you need to see a GP for that
39 cut", sprain, whatever it might be, "between two and 12
40 hours, and we can get you an appointment at X GP practice
41 because we have blocks of availability."

42

43 Q. What about the delivery of specialist services to the
44 extent that the MBS-funded private system is not delivering
45 on the needs of the community, would you agree that that's
46 also picked up by a function of the LHD under section 9 of
47 the Health Services Act?

1 A. In those services that I mentioned around chronic care
2 and aged care. Other specialist services for an MBS
3 payment is requiring referral from a GP, or referral from
4 an emergency department, which is why people like to land
5 there, because they know it's a one-stop shop. But in
6 order to tap into MBS payments for a specialist occasional
7 service, it would need a GP referral.

8
9 Q. To the extent that the specialists who the referral is
10 sent to are not able to meet the demands or the needs of
11 a community, though, do you accept that the delivery of
12 those services not otherwise being delivered by the market
13 falls within the broad reach of section 9 of the Health
14 Services Act and the obligations of the LHD?

15 A. Not verbatim familiar with section 9 of the Health
16 Services Act. Could you rephrase that question?

17
18 Q. To promote and protect and maintain the health of the
19 community, for example, or provide relief to sick and
20 injured people through the provision of care and treatment
21 take this example: patient living within an LHD requires
22 treatment by a specialist. They have a referral, but for
23 reasons associated with their own economic position or the
24 thinness of the specialist market, they are not able to get
25 in to see a specialist within a reasonable period of time,
26 so there is a gap in the availability of that specialist
27 treatment. That gap, would you accept, is something which
28 ought be picked up by the function of the LHD?

29 A. If a patient can't be seen, either at all, because not
30 every LHD has every full range of specialties, or the delay
31 is so long, then it is the responsibility of the LHD to
32 give other referral options back to that referrer.

33
34 Q. For example, by standing up a public outpatient clinic
35 for that particular specialisation to the extent that
36 workforce pressures enables it to do so; would you agree?

37 A. That might be a solution, yes.

38
39 Q. So in terms of the negotiations around the funding of
40 the LHDs, is any information about those gaps within
41 medical services available within an LHD being taken into
42 account?

43 A. Oh, if the chief executive wishes to introduce it,
44 knowing their population, knowing their waiting lists,
45 knowing particularly from their clinicians where there are
46 those gaps, you know, make no doubt, chief executives get
47 a whole raft of recommendations and guidance on service

1 profiles of their services and their hospitals from their
2 senior clinicians every day. If they are not, there is
3 a problem.
4

5 Q. But to your observation over the past two years, has
6 that resulted routinely in an increase to the funding of
7 LHDs to enable them to add these services to the service
8 array being offered?

9 A. No. A change of service or the introduction of
10 a service does not necessarily mean an increase in funding.
11 What does trigger an increase in funding is an increase in
12 activity and if, for instance, establishing a non-inpatient
13 service, like you are referring to, was a priority of that
14 LHD, then we would tag - we would calculate and agree on
15 the additional activity and then apply the appropriate
16 weighted NWAU to that activity that forms then the funding
17 envelope for the district.
18

19 Q. So the decisions around the funding envelope for the
20 district are driven primarily by an assessment of activity?

21 A. Significantly by activity, yes.
22

23 Q. And that's important because it triggers an obligation
24 on the part of the Commonwealth to make a contribution
25 towards that activity or the funding of that activity?

26 A. Mmm-hmm.
27

28 Q. What about health needs within the population which
29 can't be met through the delivery of services that generate
30 activity?

31 A. Sorry, I'm not sure I understand the question.
32

33 Q. So there are health services which are delivered, for
34 example, in an inpatient setting, which are recognised as
35 generating activity for the purposes of the funding model.
36 There are other health services delivered routinely to
37 people within communities that don't generate activity, in
38 that strict sense of the word, and therefore don't attract
39 a Commonwealth contribution to the funding of that
40 activity.

41 A. Mmm-hmm.
42

43 Q. To what extent are considerations around the delivery
44 of health needs which cannot be met through services that
45 generate activity forming part of the considerations as to
46 how much money should be provided to LHDs as part of their
47 annual funding envelope?

1 A. Activity comes in a variety of forms, and I'm not sure
2 what evidence has been provided to the Commission around
3 that, but, you know, non-admitted patient activity, which
4 is really what you are referring to, is a major component
5 of one of the product lines, as I talked about before, that
6 make up the total amount of activity. As a non-admitted
7 patient occasion of service, it can be funded, if you like,
8 in two ways - one under NWAU, with an appropriate weight
9 that obviously would be low, given it's a face-to-face -
10 may only be a face-to-face consultation, or it could be
11 where the service is provided as a privately referred
12 non-inpatient, and that's where a patient will come with
13 a GP referral to see a specialist, and that hospital can
14 bill on the specialist's behalf, the MBS, but they've got
15 to have that referral, and it's a local decision as to
16 whether they will count the activity as an NWAU or whether
17 they will generate revenue. It's also part of their budget
18 settings, both expense and revenue, and provide that
19 service by way of a privately referred non-inpatient bulk
20 billing, if you like.

21

22 Q. So that decision around whether to treat a particular
23 service as generating activity or accessing MBS money,
24 being made locally, to what extent does that feed into
25 decisions around the funding of LHDs as part of the annual
26 envelope that they are given?

27 A. I think it would be not insignificant for a chief
28 executive to consider, and I guess he or she would get
29 advice on the relative revenue streams of it being part of
30 the Commonwealth scope of funding and what that would
31 translate to for that occasion of service, as opposed to
32 bulk billing Medicare for a privately referred
33 non-inpatient service.

34

35 I mean, they can certainly set those services up.
36 They would need to make sure they've got the specialist,
37 you know, engaged to be able to provide the service; they
38 would need to have the systems to ensure that referrals are
39 received with the patient for purposes of that bulk
40 billing. But it's really a decision locally as to what
41 model. We would give advice, but it's up to the chief
42 executive, because they are responsible for the budget.

43

44 Q. So primary care, though, is one that is not generating
45 activity in the strict sense of the word?

46 A. Generally, yes.

47

1 Q. So to the extent that an LHD perceived the need to
2 stand up a primary care service to meet a gap in health
3 services available within its community, how would that be
4 funded by the ministry, or how would the need for that
5 feature in discussions around funding by the ministry of
6 the LHD?

7 A. Well, I guess I can point to probably nine of the 25
8 urgent care services are probably - are in that urgent care
9 clinic space where it's not urgent enough or clinically
10 indicated that you need to get to an emergency department,
11 but the nature of the condition or injury has been triaged
12 and assessed at needing to be seen within two and 12 hours,
13 and then they will be directed - if they can't get them in
14 to their GP, which is the preference and always the
15 preference, then we'd refer them, if there is one
16 geographically convenient to them, into an urgent care
17 clinic that is set up under this government program.

18
19 Q. But if you can't get them into a GP because there is
20 no GP readily available to them, the urgent care centre or
21 service is not really a substitute for primary care, is it,
22 other than in that immediate episode?

23 A. Well, it is a substitute for primary care because
24 there is not a primary care opportunity and hence the
25 urgent care clinic generates that primary care opportunity
26 for that particular patient for that condition.

27

28 Q. But I think, as you tell us in paragraph 53, it is
29 intended to provide short-term one-off care for people with
30 urgent health needs that are not life threatening?

31 A. Yes, because it's not our intent that that would be an
32 ongoing relationship. I mean, one of the - and this is an
33 opinion --

34

35 THE COMMISSIONER: Q. Sorry, I don't understand that
36 answer. "It's not our intent that that would be an ongoing
37 relationship", I don't understand that in relation to what
38 is in 53. What do you mean by that?

39 A. That if you have a condition like a sprain, fracture,
40 that generally doesn't require an ongoing relationship with
41 your GP. It requires correction, setting, whatever it
42 might be.

43

44 Q. Okay, I understand, thanks.

45 A. Yes.

46

47 MR MUSTON: Q. The purpose of that is, I think we've

1 already covered it, to divert people away from emergency
2 departments into a slightly less acute setting to deal with
3 health issues that are better suited to that slightly less
4 acute setting?

5 A. Yes, and in a far more timely fashion.

6
7 Q. But it is not intended that, other than in relation to
8 that - well, I withdraw that. When you said that these
9 services are intended in that case to replace primary care,
10 is that because, at least in relation to that episodic
11 attendance, it is something that, by and large, a GP could
12 have dealt with had they been available?

13 A. Yes. In the majority of cases, yes.

14
15 Q. But it is not intended that, where those GPs are not
16 available because the market has not provided sufficient of
17 them to meet the needs of the community in that area, the
18 urgent care services will replace the role played --

19 A. Yes.

20
21 Q. -- which would have been played by those absent GPs?

22 A. Yes, but it's more so availability of an appointment
23 within a reasonable time for that condition to be responded
24 to. The biggest pressure is about getting in to see a GP
25 in a timely fashion, to be frank, and the urgent care
26 clinics provide that interim, at which point then they
27 would be referred back to their GP, where the time to have
28 that appointment is not as pressing and if there is a need
29 for ongoing care of that condition.

30
31 Q. The situation I was exploring with you was a situation
32 where an LHD, perhaps in collaboration with a PHN, had
33 identified that there was a gap in the GP market that meant
34 that primary health care needs of part of the LHD's
35 community were not being met by GPs operating within the
36 private market.

37 A. Mmm.

38
39 Q. To the extent that the LHD identifies that and decides
40 that it needs, as part of its function, to deliver that
41 care, it doesn't generate activity; is that right?

42 A. Mmm - no, generally wouldn't.

43
44 Q. To what extent is the LHD's perceived need to deliver
45 that form of care something which features in discussions
46 around the budget that is to be delivered each year to the
47 LHD by the ministry?

1 A. Well, I guess the policy response is the establishment
2 of those 25 urgent care services that are principally
3 driven around ED diversion, that if it didn't - if it
4 didn't geographically fall into one of those urgent care
5 services, then that patient would continue to default to,
6 as still happens in various parts of the state today,
7 because 25 doesn't cover the entire population of New South
8 Wales - then they would, if they couldn't get into a GP or
9 a medical centre, however titled, would default, as they
10 have been for some years, to the emergency department.

11

12 Q. So the LHD has identified that gap. Patients who have
13 their sprained finger or their nasty episode of gastro turn
14 up or are diverted to the emergency care centre and are
15 dealt with there, and then discharged, they are still not
16 receiving good continuity primary health care because of an
17 absence of GPs within the market in this hypothetical area.
18 Do you understand those as the parameters?

19 A. Yes, I guess I hark back to an earlier comment, that
20 most of the pressing need for urgent care is because care
21 or treatment is needed within a relatively short period of
22 time, and the biggest problem with primary care is not so
23 much being able to get in, but get in when you need to see
24 them, and that's why people then just naturally default to
25 the ED, and so the design of either the LHD-run urgent care
26 clinics under the urgent care service program or contracted
27 with - through PHNs to general practices, is about having
28 access to blocks of appointment times in order to be able
29 to get people in within that two to 12-hour period.

30

31 Q. But there are certainly some areas within the state
32 where it's not just a question of the timeliness of getting
33 an appointment, but there are patients who simply can't get
34 access to primary care at all.

35 A. Mmm.

36

37 Q. Are you aware of that?

38 A. I'm sure there are instances across the state, which
39 is why EDs turn no-one away.

40

41 Q. And the LHDs are best placed to identify where those
42 pockets of the state that are not adequately served by
43 primary care are?

44 A. I suspect they would know them fairly intimately.

45

46 Q. To the extent that they identify those areas and say
47 to themselves there is a need, as part of our statutory

1 function, to deliver that care because the market is not
2 delivering it, to what extent is that need something which
3 features, if any, in discussions about how much money the
4 LHD should be receiving as part of its annual funding
5 allocation?

6 A. I mean, LHDs still have the capacity within their
7 service agreements to fund activity, but it needs to be
8 within the budget envelope that we receive from treasury.
9 I can think of a number of urgent care clinics in the state
10 that were set up by LHDs well before the urgent care
11 service program - that only started about a year and a half
12 ago.

13
14 Q. I want to divert attention away from urgent care to
15 the delivery of more stable primary care where GPs are not
16 available. So I understand the urgent care centres are set
17 up to divert people from emergency into another
18 emergency-like setting which can deal with their illness in
19 a short period of time, but just talking at the moment
20 about situations where, whether it be urgent or non-urgent,
21 there is not a sufficient market of GPs available to meet
22 the primary health care needs of a community.

23 A. Mmm.

24
25 Q. You said a moment that LHDs can fund those sorts of
26 services from their budget if they wish to.

27 A. Yes. I mean, it is a very small number of occasions
28 in my experience that has happened, but it has happened.

29
30 Q. But is that because in funding a service that doesn't
31 generate activity, they are reducing their ability to get
32 access to a pool of funding which is provided to them
33 through the service level agreement negotiation process --

34 A. Well, as the vast majority of the funding is tied up
35 in activity under an activity-based funding agreement with
36 the Commonwealth, they would direct most of their activity,
37 if they had a very large gap and funding - activity funding
38 was available, we can negotiate changes to that, but
39 I suspect there is probably a belief that - for them to
40 jump into provision of primary care, where does that start
41 and where does that end.

42
43 Q. Well, LHDs might take the view that it should start
44 where the need exists and end when that need is met.

45 A. Mmm.

46
47 Q. But then there is a question about the funding source

1 for it. The LHDs are not in a position to negotiate with
2 the Commonwealth about freeing up access to the MBS money
3 for primary health care, the delivery of primary health
4 care by staff specialists employed by the LHD; is that
5 right?

6 A. Can be, yes.

7
8 Q. The LHDs are not themselves in a position to engage in
9 that negotiation with the Commonwealth?

10 A. Generally not, no, but I mean the engagement of staff
11 specialists for billing for privately referred
12 non-inpatients, I mean that's a Medicare process which
13 a registered specialist can choose to participate in, and
14 there would be many clinics, specialist clinics, right
15 across the state that are run by predominantly staff
16 specialists, but not always, that would provide that
17 service, given the social conscience they hold, and do so
18 by way of bulk billing.

19
20 The reality in health is you will always be able to
21 establish a need, which are virtually endless.
22 Government's capacity, like every organisation, to fund
23 those endless needs is obviously limited, and so chief
24 executives make that decision every year.

25
26 Q. In making that decision, though, they are incentivised
27 to deliver services which generate activity over those that
28 don't by the funding model that exists?

29 A. Well, they are incentivised by a lot of things. They
30 are incentivised by the expectation around meeting KPIs,
31 around transfer of care in emergency departments, unplanned
32 surgery, patients not breaching their clinically
33 recommended care. They are incentivised around quality of
34 care. The Commonwealth doesn't pay the states for poor
35 care, so some of the indicators like unplanned
36 readmissions, you know, the Commonwealth clips the ticket
37 on that and pays less for it. We don't actually pass that
38 on to the LHDs, but certainly we monitor the KPIs and, you
39 know, would occasionally even share that, should this be in
40 a true ABM environment, the Commonwealth would have
41 deducted X number, or did deduct from the state, but we
42 don't pass that on.

43
44 Q. So in terms of the monitoring of the KPIs there, it's
45 predominantly the financial KPIs where that discussion is
46 happening; is that right?

47 A. The financial KPIs in relation --

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. The KPI requiring that services be delivered within the budgetary envelope.

A. Well, any responsible chief executive needs to know how they're going to resource and fund a service. As I said, the need can often be easy to establish. The resources either to be redirected or attracted is the challenge we all face.

Q. Can we move to the KPIs. In paragraph 23 --

THE COMMISSIONER: Can I just ask a question first?

MR MUSTON: Please do.

THE COMMISSIONER: Q. With regard to what you said about the reality in health is that you will always be able to establish a need, which are virtually endless, and that government's capacity, like every organisation, to fund those endless needs is obviously limited - and before that you had talked about the funding envelope that "we" - that is, health - is provided by treasury. Can I just ask you what you can tell me about treasury's role in this.

What I'm interested in is the last NSW Intergenerational Report makes the point that funding of health care is the greatest part of the budget and it's also the one that's increasing the most - so accept that. But it also says that we need greater investment in early intervention and prevention of chronic disease if we're going to have a sustainable healthcare system. And this isn't a criticism, that report doesn't say how that is done, but that fundamental theme is echoed in dozens and dozens of reports over the years.

What I'm interested to know is, are you aware of any, for want of a better expression, cost/benefit analysis that might have been done by treasury or anyone else about how much more investment might be needed to have early interventions and bring down rates of chronic disease, and what the (a) health benefits of that might be; but also what the spillover economic benefits might be of having a healthier population - you know, increased productivity gains. Are you aware of any work being done by New South Wales treasury or the Commonwealth on that theme?

A. Not specifically, Commissioner, no.

1 Q. Anywhere in the world?

2 A. Well, my mind does go back to studies in Scandinavia
3 where, in essence, what they had to do, and did, and what
4 any system, contemporary system, would need to do, would be
5 to fund the current system as BAU for almost a generational
6 period, in order to then develop those other programs for
7 one to then transfer from the acute side into the
8 preventative side. The risk, obviously, is that an over
9 investment in prevention will lead to adverse outcomes
10 during the acute phase, but it is a generational change and
11 it was a generational investment that I studied some years
12 ago, Scandinavian countries having taken that step. I'm
13 working from my memory now.

14
15 Q. If you have time to think about it after your
16 evidence, or if you could refer us to any of those
17 Scandinavian studies.

18 A. Yes, okay.

19

20 Q. But if we were seeking this sort of material from NSW
21 Treasury, at least to your knowledge, we might come back
22 with a blank in terms of --

23 A. Yes, although that might not be a fair assessment.

24

25 Q. Who knows. It just seems to me there is a tension
26 between the historic nature of the funding of LHDs and
27 their funding based on activity, when, on the other hand,
28 what is needed is an investment that actually would
29 decrease the level of activity?

30 A. Mmm.

31

32 Q. Or is designed to, or cause a different type of
33 activity. And I'm curious to know what work's been done
34 both on a health outcome side but also on an economic
35 analysis of if there was, as we're told in the
36 intergenerational report, a need for significant early
37 intervention and prevention of chronic disease, well, who's
38 done the analysis about (a) how much money's needed; and
39 (b) what the economic outcomes would be.

40 A. Mmm.

41

42 THE COMMISSIONER: Anyway, that's something we'll have to
43 follow up. That's what I wanted to ask. Thanks.

44

45 MR MUSTON: Q. That probably brings it back around to
46 the questions I was asking you earlier around primary care.
47 To the extent that primary care is a means by which the

1 progress and development of some of these developing health
2 problems can be arrested, we have heard routinely in the
3 evidence that we are given that primary health is
4 a Commonwealth issue, and I guess what I really want to
5 explore with you is whether an alternate approach would be
6 for LHDs to step in and meet the needs, to the extent not
7 being met by the market, of primary health care, followed
8 by a negotiation with the Commonwealth around exactly how
9 that might be funded in terms of freeing up the MBS money
10 for the state.

11 A. It would certainly require a not insignificant
12 Commonwealth intervention and support for that to happen,
13 effectively.

14
15 Q. But is it not intervention which would be better
16 facilitated if the services were being delivered and there
17 was a real discussion about how they were to be funded
18 rather than an ideological debate which seems to hover
19 around about whose responsibility it is to fund primary
20 care?

21 A. I think where LHDs have for some years and continue to
22 grow is in that integrated care area for chronic disease,
23 and it is about better chronic disease management; it is
24 about partnership with a GP, with the chronic care and
25 specialist support coming out of the LHDs. So that's
26 a very common model. Is it uniform across the state? No,
27 it's not. But, you know, it is an objective, regardless of
28 where you live, that you would have access to a reasonable
29 suite of chronic care programs.

30
31 Q. But those integrated care programs, at least to the
32 extent that we've seen or heard about them in the evidence,
33 tend to be targeted at that cohort of patients who is
34 struggling under a heavy burden of chronic disease and
35 requires the full wrap-around service that they might not
36 be receiving in order to manage it. I guess what I'm
37 asking about is patients who are not quite there yet but
38 might be on their way because of an absence of primary
39 care, to what extent - would it not be better if LHDs
40 stepped in and delivered that primary care, where the
41 market is not delivering it, and thereafter a discussion
42 was had with the Commonwealth about, say, freeing up the
43 MBS money for the doctors or for the state health system,
44 which is delivering that care in lieu of a market-based
45 system which, were it viable, would be funded by the MBS?

46 A. Conceptually I totally agree. The reality is that
47 I've not seen the Commonwealth Government responsive in

1 that type of scenario and it would be a courageous chief to
2 jump in, in the anticipation of Commonwealth support at
3 some point in the future, because we find it very hard to
4 stop doing things in health.

5
6 Q. In relation to that, do you have examples of areas in
7 which the service has actually been delivered and there is
8 then a discussion around, say, freeing up access to the MBS
9 money as opposed to talked about as a concept?

10 A. Something very, very close to what you have described,
11 and very contemporary, which Deb Willcox successfully led
12 with the chief executive in the Illawarra Shoalhaven, and
13 that was where there was a significant failure of the aged
14 care market and Illawarra Shoalhaven hospitals had an
15 extraordinary number - I would mislead you if I quoted the
16 number, but certainly proportionally much higher than any
17 LHD by a factor of at least 2 to 3 of their ED accessible
18 beds occupied by aged care residents awaiting transfer back
19 to an aged care setting. But because of market failure,
20 closure of nursing homes in that region, restriction on
21 particularly very difficult patients, for which there must
22 be some financial disincentive because the number of beds,
23 in particular dementia care, seemed to dry up awfully more
24 quickly than other aged care beds - that Deb led
25 negotiations with the chief executive, with the
26 Commonwealth, that saw them responding to the tune of
27 funding 30 beds in a private hospital - Figtree Private,
28 from memory, is the name of it - and so they funded those
29 beds as aged care beds. They also provided additional aged
30 care packages, Commonwealth funding, to support people in
31 their homes.

32
33 Was it effective? Yes, it improved things. As of
34 last week, I think there were still 116 patients in those
35 hospitals in the Illawarra Shoalhaven who were ready for
36 discharge but, you know, good negotiation from Deb and
37 Margot, the chief executive, at least got a partial
38 response in that regard.

39
40 Q. In the primary care space, we have heard some evidence
41 of some programs where primary care is delivered by LHDs
42 through employing salaried generalists, and the
43 Commonwealth funding has been made available. Are you
44 familiar with what is called the four-Ts model?

45 A. Yes, I've heard about it. I'm not terribly familiar,
46 to be honest.

47

1 Q. I think we've been told it is an arrangement of LHDs
2 delivering primary care and funding through the
3 Commonwealth is being made available exactly in the same
4 way as it would be were the market delivering that care
5 through the 19(2) exemption?

6 A. That's right, yes, the single employer model.

7
8 Q. Similarly, the single employer model is another one
9 I think where there has been an agreement reached with the
10 Commonwealth whereby funding for that primary health care
11 delivered through the LHD is being provided?

12 A. Yes, and for which they get access to Medicare bulk
13 billing whilst also being employed by the district, which
14 is a no-no unless Commonwealth approval's been --

15

16 Q. And I guess my question - you may not know - is are
17 you aware of any situation in which the LHD has stepped in
18 to provide primary care, in circumstances where it is not
19 otherwise - it has formed the view that it is not otherwise
20 being delivered through the market, and had the
21 Commonwealth refuse to contribute the MBS money to the
22 provision of that care?

23 A. The short answer is probably no. I know that it is
24 a tortuous route to secure Commonwealth agreement on those
25 19(2) type of employment arrangements. Deb could
26 probably - and workforce could speak very - wax lyrical,
27 I'm sure, about it. But I don't pretend to be an expert in
28 that area on current knowledge.

29

30 Q. Queensland has, to a significant degree, stepped in to
31 the delivery of primary health care, particularly in rural
32 and regional areas. Are you familiar with the arrangement
33 that Queensland has with the Commonwealth around that?

34 A. No, I'm not.

35

36 Q. Can we move to the KPIs. Perhaps can we go to
37 paragraph 23 of your statement. Do you see you tell us
38 there as part of the process, the KPIs are reviewed to
39 ensure appropriateness and alignment with the strategic
40 focus of NSW Health. I just want to ask you, in that
41 context, what do you mean by "appropriateness", and what is
42 the strategic focus that you had in mind?

43 A. Well, we have an evolving health strategy and so
44 that's quite well advanced, so that's advanced enough to
45 guide KPIs.

46

47 The KPIs in this current financial year total I think

1 about 103, but certainly over 100, and we've undertaken
2 a review across the system and with chief executive input
3 to try and rationalise that down, and it's likely we've got
4 it down to about 80 KPIs.

5
6 There are various policy owners, if you like, of those
7 KPIs in various branches of the ministry. Certainly chief
8 executives are applauding of a reduction in KPIs.
9 I frankly don't think they have anything to complain about.
10 When I was a chief executive I had over 320 KPIs, including
11 the consumption of green vegetables for the population
12 I was meant to be caring for. How that was ever going to
13 be managed, let alone enforced, was beyond me, but that was
14 a little while ago now. So I think rationalising on those
15 that make a real difference, are peculiar and responsive to
16 their population needs, as well as the broader NSW Health
17 strategy needs, is what has driven the reduction down to
18 80.

19
20 Q. So I think you said it is different units within the
21 ministry that are responsible for different KPIs that exist
22 in the service level agreements. But as a general concept,
23 can I ask, to what extent are the KPIs being formulated
24 with an eye to the statutory function of the LHDs?

25 A. The KPIs, once there's agreement, if I can call it
26 that, because it is not agreed until the secretary agrees
27 to it, comes back to the ministry executive where other
28 branches, including legal, I'm sure - well, not sure,
29 I know, because they contribute to the finalisation of
30 those KPIs.

31
32 Q. I guess putting it more bluntly, to what extent is
33 consideration being given to whether the KPIs are measuring
34 the extent to which an LHD is promoting, protecting and
35 maintaining the health of the community, for example?

36 A. Well, given it's the legislation that the chief
37 executives work under and empowers them to do so, I have no
38 doubt that they would be sensitive to what their statutory
39 obligations are. Have I seen a checklist to ensure each
40 KPI supports each part of the legislation? No, I haven't.

41
42 Q. Can we go to, perhaps as an example, the service level
43 agreement with the Central Coast, which is
44 [MOH.9999.0859.0001]?

45 A. Sorry, is that an exhibit?

46
47 Q. It is going to pop up on the screen. It is in

1 volume 8. Do you recognise that document as, just as an
2 example, the service level agreement for the Central Coast
3 LHD?

4 A. Yes.

5

6 Q. If we jump forward to page 21, which is .0021, that
7 you recognise as the KPIs that we're talking about inserted
8 into the service level agreement, or at least the
9 commencement of them?

10 A. Mmm-hmm.

11

12 Q. Perhaps if you could scroll through down to page 0024,
13 do you see under the heading "3. People are healthy and
14 well", you have there what seem to be the only KPIs which
15 are directly focused on that objective of - or potentially
16 focused on that objective of promoting, protecting and
17 maintaining the health of the community?

18 A. Mmm-hmm.

19

20 Q. Can I suggest that those KPIs don't really provide any
21 sort of empirical measure of the extent to which that
22 objective is being met by the LHD?

23 A. I am not sure I could argue for or against that,
24 I would seek advice from someone like Kerry. You see,
25 these KPIs come from, you know, various parts, as I said,
26 policy owners. Knowing Kerry as I do, I dare say there is
27 some empirical basis to the KPIs that her and her branches
28 propose and oversee, and should there be significant
29 variance of concern, they would escalate that into the
30 milieu of the performance agreement for discussion and
31 someone from population health would be there for that
32 conversation.

33

34 Q. I certainly don't mean to suggest that these KPIs are
35 not important to the extent that they identify particular
36 targeted objectives, but my point is more, you could comply
37 with all of these KPIs but still arguably be failing to be
38 promoting, protecting and maintaining the health of the
39 community in that wider sense?

40 A. I don't know that I can comment on that, really.

41

42 THE COMMISSIONER: By "wider", you mean in a more complete
43 sense than these individual?

44

45 MR MUSTON: Yes.

46

47 Q. Undoubtedly to take the second one down, encouraging

1 smoking cessation during pregnancy amongst those two
2 populations is plainly a positive health outcome for the
3 community, but it's a very small health outcome for a very
4 targeted slice of the community and doesn't really assess
5 the extent to which the LHD in a broader sense is, through
6 its operations, promoting, protecting and maintaining the
7 health of the community that it serves.

8
9 THE COMMISSIONER: So your question was: do the totality
10 of these individual targeted actions broadly encompass
11 protecting, et cetera, the health of the community?
12

13 MR MUSTON: Yes.

14
15 THE COMMISSIONER: Q. And you didn't feel that you could
16 answer that?

17 A. I'm sure Kerry would have a view.

18
19 MR MUSTON: Q. Is anything else being monitored by the
20 service level branch other than the performance against the
21 KPIs contained in the service level agreement?

22 A. Well, they oversee the framework, they facilitate the
23 framework, which then enables, you know, areas - other
24 areas of the ministry to escalate into the formal
25 performance management framework that we operate. That's
26 not to say that would be their only course of action. I'm
27 sure Kerry, with examples like that, would be engaging -
28 not directly but probably indirectly through her executive
29 directors - with LHDs where trends and outcomes would be of
30 concern to her. But the formal process is the performance
31 management framework that results in non-performance being
32 escalated on either a quarterly or monthly basis, depending
33 on where the district is at.

34
35 Q. And that's performance as against the KPIs?

36 A. Against the KPIs, yes - in those examples, yes.

37
38 Q. So in order to get moved through the levels that you
39 tell us about in paragraph 30 - you say level 0, "nil
40 performance concerns", all the way down to level 4, "health
41 service challenged and failing", those things are measured
42 against the performance by the LHD of its KPIs?

43 A. Predominantly against its KPIs, yes.

44
45 Q. When you say "predominantly", is there anything else
46 that you are monitoring in order to allocate a particular
47 performance level?

1 A. What - the process by which a recommendation is made
2 to the secretary around escalation or de-escalation,
3 because we do get better sometimes, is that the appropriate
4 executive director, whether it be for finance, for access,
5 for surgery, for safety and quality, for mental health, for
6 Aboriginal health, and that's probably not exhaustive, come
7 together and assess the district's performance in their
8 relative area of specialty and then they would come to
9 a conclusion that if there were a number that were in - you
10 know, they use a colour-code - in a red zone, that's not
11 performing by X percentage points, that sufficient number
12 of those may prompt that group to make a recommendation to
13 the secretary about change in the performance level of that
14 district.

15

16 Q. But if an LHD is meeting its KPIs, it will sit at
17 a performance level of 0, won't it?

18 A. Generally, yes.

19

20 Q. So if it is meeting all of its KPIs, is there any
21 other factor that could take it outside a 0 and have it
22 demoted to a 1 or a 2?

23 A. It's pretty KPI driven. There are non-KPIs in the
24 service agreement that I'm sure you've seen, things like -
25 and this is around strategic direction - around a greater
26 take-up and delivery of service through virtual care means.
27 We've had a concerted effort of expanding hospital in the
28 home - it's been around for donkeys' years, but expanding
29 it at the true marginal cost, which is what virtual care
30 can provide, but with some relatively small capital
31 investment we've enhanced virtual hospital in the home care
32 programs across I think 11 of the LHDs in the last
33 18 months, and the expectation obviously for return on
34 investment sees an enhancement, and I'm overdue for
35 a report giving that feedback of the second tranche of
36 those LHDs where we invested - in other words, provided
37 funding for investment in additional virtual care
38 equipment - to grow the amount of activity. Because the
39 amount of time obviously taken for - it might be
40 a community nurse or any other health practitioner - to be
41 driving across a district, even metropolitan Sydney, as
42 opposed to providing care services virtually, their
43 productivity is two- and three-fold. So there are non-KPI
44 performance aspects. Would it be a reason for them to be
45 escalated? I doubt it. No.

46

47 Q. Has it ever happened, to your knowledge - that is to

1 say, an LHD meeting its KPIs but it's been reduced to
2 anything other than an 0 performance level?

3 A. No, I mean, I can get cranky if they don't return on
4 investment, if I strip some capital out of my own branch to
5 fund these programs, which is exactly what I did, but, you
6 know, they are all good eggs and they are trying hard and
7 they all have different impediments to delivering in a time
8 frame that my impatience might want.

9

10 Q. It's possible that an LHD could be sitting on
11 a performance level 0 and complying or meeting all of its
12 KPIs but, nevertheless, failing to meet some aspect of the
13 health needs of its population that are not otherwise being
14 met by sources external to the LHD, is it not?

15 A. I dare say there are some health needs in every
16 district, in every district in every jurisdiction of the
17 Commonwealth, where that would be the case.

18

19 Q. And the KPIs - maybe the answer is that it's just very
20 difficult to turn into an empirical KPI, but the KPIs are
21 not necessarily well directed to pick up on that unmet need
22 within a community?

23 A. That - yes, that could be the case. I'm not equipped
24 to really say.

25

26 Q. In terms of the dropping down in the performance
27 levels, as you move down through 1, 2, 3 and 4, what are
28 the consequences for the LHD for noncompliance or
29 non-performance?

30 A. For - as they move through escalation?

31

32 Q. Yes.

33 A. Well, it is a lot more than just having to meet with
34 me more often than quarterly. It's often about
35 a performance improvement team going in. We've got some
36 performance improvement teams that are specialised in ED
37 performance, and when I say "ED performance", read
38 "back-of-house patient flow", because the problem is not
39 always in the emergency department, it's often whole of
40 hospital flow. We have specialist teams around - team -
41 around planned surgery. We have an efficiency team that
42 goes in and assists districts with a poor budget
43 performance. That's also very much guided by the CFO as
44 well. You know, he sets any priorities about that
45 particular team going into districts where he has concerns
46 around their financial performance. But they go in not as
47 a bunch of accountants; they go in as experienced

1 operational leaders in the health system that actually know
2 what the levers are that drive costs, and it's not having
3 your head in a general ledger, although that's where the
4 outcome manifests itself.

5
6 Q. Can I ask you some questions quickly about the patient
7 safety first unit that you tell us about --

8
9 THE COMMISSIONER: Should we take a break?

10
11 MR MUSTON: Sorry, Commissioner, yes.

12
13 THE COMMISSIONER: Is this a convenient time?

14
15 MR MUSTON: It is a convenient time.

16
17 THE COMMISSIONER: We will take a break until 5 to 12.

18
19 **SHORT ADJOURNMENT**

20
21 THE COMMISSIONER: When you are ready.

22
23 MR MUSTON: Q. If we could scroll back to the statement
24 and maybe have a look at paragraph 32. You tell us there
25 about the patient safety first unit. What I'm interested
26 to know is, what are the advantages, as you see it, of
27 having both the patient safety first unit and the CEC
28 delivering the role that you describe in paragraph 32?

29 A. Well, their role, whilst in a macro sense, is the
30 same, their execution is different. Also the relative
31 size - I think there is either three or four staff in the
32 patient safety first unit and it's equipped with people -
33 again, very much from the operational side of clinical
34 governance, the head of the patient safety first unit,
35 Sue-Anne Redmond, she's an ex director of clinical
36 governance in the LHDs, and the roles are different
37 inasmuch as the CEC has responsibility for system-wide
38 oversight, it is responsible for trend analysis, deep
39 dives. The role of the patient safety first unit is more
40 around, well, firstly they oversee statewide coronial
41 matters on behalf of the secretary, because a coroner's
42 case may not always be in the clinical governance realm -
43 often is but equally may not also be. And they also act on
44 behalf of the secretary around system reviews.

45
46 So the CEC, because they've got the resources, they
47 collect the data, they do the analysis on the data, they

1 would undertake the deep dive, the patient safety first
2 unit would direct the nature of that review in accordance
3 with the secretary's directions.
4

5 They also are a very speedy way by which they escalate
6 adverse events, adverse outcomes directly to me, whereas
7 the CEC will collect that but they will provide much
8 in-depth data but not as quickly, if that makes sense.
9 That's not a criticism of the CEC, it's just the nature of
10 the data they are looking at on behalf of the system.
11

12 Q. Could we move to the affiliated health organisations
13 and I will ask you some questions about them. You touch on
14 them at paragraph 16?

15 A. Sorry, which one?
16

17 Q. Paragraph 16 of your statement. You tell us there
18 that purchasing services from AHOs is managed by the
19 respective LHDs in which they sit, except for St Vincent's.

20 A. Yes.
21

22 Q. Just in terms of the AHOs, they broadly seem to fall
23 within two categories, St Vincent's aside - those that
24 provide a supplement to services solely within an LHD, for
25 example, a privately owned hospital that might be
26 delivering some acute care within an LHD as part of the
27 network of hospitals within that LHD on the one hand -
28 that's a type of AHO?

29 A. Mmm-hmm.
30

31 Q. On the other, there are AHOs that deliver services
32 across a wider range of LHDs, for example, Tresillian and
33 Karitane deliver services within their LHDs but also across
34 a wide range of LHDs. Can I ask, what role, if any, does
35 the ministry have in decisions around the volume and nature
36 of services that are to be purchased by AHOs, maybe
37 starting with the first category, that is, the hospital
38 that's delivering services, as a hospital, within the
39 footprint of an LHD?

40 A. And I guess there are AHOs that actually traverse both
41 those examples.
42

43 Q. Yes.

44 A. Royal Rehab is one example. The majority of their
45 services is very much entwined into delivery to the local
46 community of Northern Sydney, whilst they also have
47 statewide remit as it relates to spinal rehab.

- 1
2 Q. We will come back to that in a minute, because in
3 terms of the spinal rehab beds at Royal Rehab, they are
4 delivering rehabilitation services to patients that are not
5 confined to the Northern Sydney LHD?
6 A. Yes.
7
8 Q. And perhaps don't even come predominantly from the
9 Northern Sydney LHD?
10 A. Mmm-hmm.
11
12 Q. Would that be right?
13 A. Probably. I haven't seen the patient mix but
14 I suspect you would be right.
15
16 Q. Are you aware of Royal Rehab providing any other
17 services, public services, to patients within Northern
18 Sydney LHD, other than the spinal rehab?
19 A. Well, rehabilitation services, they provide. It's
20 been a long time since I've worked with Royal Rehab and
21 their service profile could have changed, but certainly
22 they were a major rehab provider, both public and private.
23
24 Q. In the time that you were involved with Northern
25 Sydney as a wider entity?
26 A. Yes.
27
28 Q. Royal Rehab was at that time providing some more
29 general rehabilitation care?
30 A. Yes, they were.
31
32 Q. Are you aware of whether they are still providing that
33 more general rehabilitation care?
34 A. I believe they did, but, you know, they could have
35 changed.
36
37 Q. Not sure?
38 A. I haven't had cause to do a deep dive into Royal
39 Rehab.
40
41 Q. Coming back to - let's start with the easy ones. An
42 LHD has within its footprint an AHO hospital which is
43 delivering care as part of the hospital network within that
44 LHD.
45 A. Mmm-hmm.
46
47 Q. What involvement, if any, does the ministry have in

1 deciding the volume and nature of services that are to be
2 purchased from that AHO?

3 A. Just in that example as opposed to the statewide?
4

5 Q. Just that example first.

6 A. Just that. Well, the performance management framework
7 is the same, in essence, as you have seen for the LHDs and
8 special care networks.
9

10 Q. So in terms of service level agreement that the LHD
11 has with the AHO, it's required that the KPIs mirror,
12 effectively, those which are contained in the LHD's --

13 A. If relevant, but given, you know, the boutique nature
14 of some of the AHOs, you know, they are doing stuff that
15 most of the system aren't, which is why obviously the
16 system, you know, engages boutique providers like that
17 rather than create themselves, and I think that's wise. So
18 the framework is applied. The framework is provided but
19 the LHDs actually exercise the service agreement to meet
20 their local needs, staying with example 1 --
21

22 Q. Yes.

23 A. -- and then use the framework. They advise me on an
24 annual basis, just as an agenda item through their
25 performance, the performance management meeting, around -
26 confirming that they are exercising the service agreement
27 using the framework, and we do an annual survey in terms
28 of - not that I doubt what a chief executive would ever
29 tell me - but collect evidence to give me the confidence,
30 and we've got a survey - I don't know when it was done but
31 a few months ago now - that confirmed what the arrangements
32 were, what the KPIs were and how it operates, to allow me
33 and my people to confirm that it's operating under the same
34 framework as the rest of the system.
35

36 Q. So example 1, small AHO hospital as part of the
37 network of hospitals delivering business as usual treatment
38 within an LHD, how are decisions - decisions are made at
39 the LHD level about how much activity to purchase from that
40 hospital; is that right?

41 A. Yes, because often it will be, you know, a strategy
42 around moving patients. I know when I was at Northern
43 Sydney Central Coast, the role of Greenwich Graythwaite as
44 part of HammondCare at the time was about ensuring that
45 they provided that flow capacity outside of Royal North
46 Shore where it must cost twice as much to care for
47 a patient under rehab or in palliation, whatever the

1 circumstances were, than housed in a facility operated by
2 Greenwich Graythwaite, as it was at the time.

3
4 Q. In terms of the price paid for the activity, is that
5 price the state efficient price which is applied or is it
6 the NWAU?

7 A. Well, we all operate on the state efficient price.

8
9 Q. Including the AHOs?

10 A. I was just about to say, we all operate on that. How
11 that is translated into the AHO's service/funding
12 agreement, I would need to get some advice on. I don't
13 want to mislead you.

14
15 Q. Let's move to the second category, organisations like,
16 say, Tresillian, Karitane and at least the spinal services
17 of Royal Rehab that are being delivered across a wider
18 footprint than a single LHD. What role, if any, does the
19 ministry have in decisions around the volume and nature of
20 services that are to be purchased from those AHOs?

21 A. If they are services that are recognised as
22 a statewide service, there is a unit in the ministry under
23 Deb Willcox that specialises in engagement with and
24 analyses activity, demand, but it's not the only source of
25 advice. I mean, a lot of this is, you know, very clinician
26 driven, and they tend to come together through ACI clinical
27 networks, so, you know, specialist providers of that
28 statewide service would come together to give advice to the
29 ministry through that unit in the --

30
31 Q. What role, if any, does the ministry have in making
32 decisions around how much an AHO of that second category is
33 to be paid for the services that it delivers?

34 A. I believe that is largely driven by the LHDs, yes.

35
36 Q. So taking Royal Rehab as an example, it sits within,
37 physically, the footprint of Northern Sydney LHD?

38 A. Mmm.

39
40 Q. Delivers services to patients across the state, or at
41 least the northern part of the state, who require
42 rehabilitation services after a serious spinal injury, but
43 decisions around how much to pay Royal Rehab for the
44 services that are being delivered through that facility are
45 made primarily within the Northern Sydney LHD; is that
46 right?

47 A. Yes, I believe so. You know, I'd need to get that

1 confirmed, but in determining the funding envelope, I know
2 that, you know, in the Royal Rehab - because, I mean, it is
3 a bigger facility than most of our AHOs and it is kind of
4 unique because it does provide a community role as part of
5 Northern Sydney and it5 also provides, as you pointed out,
6 that statewide role - that they tend to be shielded from
7 things like efficiency targets by the LHDs. So whilst
8 efficiency targets are passed on, you know, by treasury on
9 to health, as it does to many other government agencies, my
10 understanding is the LHDs tend to shield them from that,
11 and I guess I see why. When you are that small, it's a bit
12 hard to actually, you know, take a dollar out of a place
13 without dramatically impacting on the service provision.
14 So I know in the Royal Rehab example, they are shielded by
15 the engagement and the service agreement and funding
16 agreement being developed with the LHD.

17
18 Q. Is that something that the ministry requires of the
19 LHDs, or is that just an act of grace, as it were, by the
20 CEs of the LHDs as part of the negotiation process?

21 A. We have no requirement other than treasury obligation
22 that health, as an entity, needs to deliver on whatever
23 those efficiency targets might be.

24
25 Q. We've heard evidence from several AHOs that provide
26 services well beyond the LHD with which they have a service
27 level agreement or its loose equivalent - I will just
28 identify them to make sure our understanding of where they
29 sit in the family tree is correct: Karitane provides
30 mother and baby services under a service level agreement
31 which it enters into with South Western Sydney LHD,
32 although the service it delivers extends beyond South
33 Western Sydney's LHD's footprint. Is that consistent with
34 your understanding?

35 A. That's what I understand.

36
37 Q. Tresillian, similar services, albeit through a service
38 level agreement with Sydney LHD and other - an array of
39 other agreements it seems to have with other LHDs for the
40 provision of bits and pieces of service, or the gathering
41 of bits and pieces of funding is probably a more accurate
42 way of putting it?

43 A. Mmm.

44
45 Q. Is that broadly consistent with your understanding?

46 A. I believe so.

47

1 Q. And Royal Rehab we've been through, sits within
2 Northern Sydney LHD. Are you aware that Royal Rehab has
3 not actually had a service level agreement with Northern
4 Sydney LHD for more than a decade?

5 A. I understand they haven't had a signed service
6 agreement. It hasn't interrupted the flow of funding or
7 activity. They've just chosen not to sign it, and I don't
8 know the reasons why, though.

9
10 Q. In relation to the reasons, what we've been told by
11 all of those entities is that the funds provided through
12 the service level agreements which are proffered to them
13 are insufficient to deliver the services that are being
14 required of them under the agreements. Is that something
15 that's filtered through to you?

16 A. No.

17
18 Q. Well, what we're told is that in order to meet the
19 requirements of the service level agreements for those who
20 have signed them, and to meet the prospective service level
21 required of Royal Rehab under the looser arrangement, it's
22 necessary for each of them to call upon their own sources
23 of - alternate sources of funding which is available to
24 them, say benefaction and the like.

25 A. Which has been a longstanding feature of third
26 schedule, as we used to call them, hospitals. Often they
27 were in the charitable space and they actively engaged in
28 community and other fundraising in order to supplement the
29 services that government has been funding them for, and
30 that has been the situation for as long as I've been in
31 health.

32
33 Q. Can I just try and draw this distinction to make sure
34 I understand your answer. A long history of organisations
35 like, say, Karitane and Tresillian, raising their own funds
36 to supplement the services which are being provided
37 pursuant to the service level agreements, by that do you
38 mean to provide a wider array of services to a wider array
39 of people than those strictly required under the service
40 level agreement?

41 A. Well, it could be either. That's really a decision of
42 that board as a separate legal entity as to where they
43 direct those philanthropic funds into more activity than
44 what the state funds them for or broader activity because
45 they've identified a need or a population demand. I'm sure
46 it would vary from board to board.

1 Q. But it wouldn't be a particularly satisfactory
2 situation, would it, if the level of activity which was
3 required of these organisations under the service level
4 agreements proffered to them was not capable of being
5 delivered with the funds made available through the service
6 level agreement?

7 A. Sorry, I didn't quite understand that.

8

9 Q. To the extent that the funds made available through
10 the service level agreements are not sufficient to actually
11 deliver the services which are required by those agreements
12 to be delivered, that would not be a satisfactory
13 situation, would it?

14 A. Well, it's certainly not a common feature of service
15 agreements operating under the state efficient price.
16 Every facility and every service is funded the same way.
17 It's just the volume that varies, which determines the end
18 budget envelope.

19

20 Q. Could you explain - so first point, is it the case
21 that the activity that's being acquired through these
22 service level agreements with the AHOs is purchased at the
23 state efficient price? I think we might have gone through
24 that already.

25 A. I think you asked that earlier. I would need
26 confirmation of that.

27

28 Q. Do you know whether any attempt is made to ascertain
29 whether or not, whatever metric is applied to the activity,
30 whether it be the state efficient price or something else,
31 is actually sufficient to deliver the services which are
32 required under the service level agreements with the AHOs?

33 A. Sorry?

34

35 Q. Perhaps it was a poorly expressed question. Let's
36 take Royal Rehab as an example.

37 A. Sure.

38

39 Q. Providing highly specialised rehabilitation services
40 to people with severe spinal injuries. The cost of
41 delivering those services is going to be at the upper end
42 of the scale in terms of those services, which broadly fall
43 into the bucket to deliver an average price.

44 A. Mmm.

45

46 Q. That is to say, it's going to cost more than average,
47 the average bed, the state efficient price or even the

1 national price, to deliver those highly specialist spinal
2 care services?

3 A. Right, yes.

4

5 Q. Is any attempt made to ascertain whether or not
6 whatever money is being delivered to Royal Rehab in that
7 example is actually sufficient to deliver, or meet the cost
8 of delivering the services that are being required of them?

9 A. Well, the principle of activity-based funding or
10 management is the price multiplied by the weight, and the
11 weight takes into account length of stay, complexity and
12 that then will translate into a higher weighting, and so
13 services would be compensated for the nature of service
14 they deliver by recognition of a higher case weight for
15 that activity.

16

17 Q. That assumes that the model actually accurately
18 captures the price of delivering the service, or the cost
19 of delivering the service, doesn't it?

20 A. Well, cost data collections occur twice a year and,
21 for like services, my understanding is they are then
22 averaged and there wouldn't be too many spinal rehab
23 services - I think two or three in the state - and then
24 they would be averaged and then escalated prospectively for
25 CPI, depending on what CPI component, so that there could
26 be circumstances - I mean, it's not a perfect funding
27 system, but it's one that all states and the Commonwealth
28 have signed up to.

29

30 Q. The AHOs are private entities and haven't necessarily
31 signed up to the imperfect system, have they? That is to
32 say --

33 A. Not individually.

34

35 Q. -- the AHOs are a deliverer of service into a public
36 system?

37 A. Yes.

38

39 Q. They are a private entity with a board that has all of
40 the usual obligations under the Corporations Act to make
41 sure they are not trading whilst insolvent and the like.
42 So it would not be an entirely acceptable situation or
43 satisfactory situation if they were being required to
44 deliver services into the public system for the public
45 benefit at a cost which was insufficient, or a price which
46 was insufficient, to enable them to do that?

47 A. Yes. Well, I've not seen any evidence that that is

1 the case.

2

3 Q. And is that because evidence about whether or not
4 that's the case would sit at the LHD level?

5 A. Predominantly, yes, and, you know, that's not to say
6 the LHD wouldn't do anything. If they accepted the
7 evidence - and I don't know whether they have or haven't -
8 then there is an engagement opportunity through the
9 statewide services branch and/or finance in the ministry.
10 I'm not sure which of those they would choose to take or
11 would be the most appropriate one to take that to.

12

13 Q. The LHDs themselves are under significant budgetary
14 pressure?

15 A. Mmm.

16

17 Q. To deliver the essential services that they are
18 required to deliver within what I think we've already
19 canvassed is an insufficient envelope, budgetary envelope,
20 to meet all of their health needs, and so to the extent
21 that it's the LHD that's delivering or engaging in the
22 negotiation with AHOs around funding, would you accept that
23 they are not well incentivised to assess whether or not an
24 AHO should be paid more to deliver activity than they are
25 paid?

26 A. Well, I guess, two things - one, I mean, I've given
27 the example in Northern Sydney where they've shielded them
28 from treasury efficiency reductions and for reasons best
29 known to that chief executive. But if they were to do
30 that, then it would only be at the sacrifice of other LHD
31 activity that they would need to defund in order to provide
32 supplementary funding to any service - not just, you know,
33 the specialist statewide service, but anyone. It is
34 a matter of priorities and choices.

35

36 Q. Is there any reason why at least those AHOs which are
37 providing services across multiple LHDs, like say Royal
38 Rehab, for example, don't have a single service level
39 agreement with the ministry?

40 A. I've not discussed that concept with Matt Mackay, but
41 my understanding of the health system would be for one unit
42 of that hospital to be operating under a service agreement
43 in the ministry with its own nuances and potentially
44 micro-managing that unit within that hospital I think would
45 be extremely problematic for the organisation and the chief
46 executive but an even bigger problem with that based on
47 past experience in the early 2000s when the ministry

1 attempted to micro manage mental health as a statewide
2 service. Chief executives were subsequently disinvested in
3 support for mental health service and human beings, as they
4 are in fiscally tight times, ensured that every overhead
5 cost associated with that service was carried by that
6 service and that, I think, would be a major impediment to
7 the spinal service as it was for mental health, and that
8 decision was subsequently reversed after some years, so the
9 chief executives took ownership of --

10
11 Q. Mental health is a little bit different, though, isn't
12 it, because it relates to the delivery of a particular
13 health care service to people within the population of the
14 LHD?

15 A. Often but not always. I mean, mental health intensive
16 care units often have roles servicing patients. The nature
17 of many mental health, not all, clients is that they move,
18 they travel, they don't stay necessarily within their
19 geographic boundaries, but certainly the MHICUs - the
20 mental health intensive care units - provide broader than
21 LHD roles and some other specialist services that I won't
22 pretend to know all of. Similarly, we don't have all those
23 specialist services in every LHD, so there are a number of
24 services that provide multiple LHD clients with services.

25
26 Q. Is there not a risk that, to the extent that
27 a particular AHO is delivering services to a wide array of
28 people outside the LHD, perhaps even through physical
29 premises that are located outside the LHD, that the chief
30 executive of the LHD that, for perhaps historical reasons,
31 they've been aligned to, would be disinvested, to use your
32 language, in that aspect of the services?

33 A. Anything's possible. I can't think of any examples.

34
35 Q. My point is let's say Karitane is delivering services
36 outside of the South Western Sydney LHD and requires
37 funding to deliver those services, there is not a strong
38 incentive for the chief executive of the South Western
39 Sydney LHD to ensure that those services delivered to other
40 people in other LHDs are adequately funded, is there?

41 A. If Karitane established and engaged with that relevant
42 chief executive where the services were to be delivered for
43 that population and convinced them of that need and their
44 capacity to deliver it, then there is the capacity for the
45 LHD to actually purchase that, but rather than have
46 multiple service agreements and purchasing tools,
47 I suspect - not knowing, but suspect - it would be a means

1 of funding back through the home LHD for that service
2 agreement and budget envelope.

3
4 Q. So in that example, Karitane - to stick with that
5 example - delivering services in another LHD, if Karitane
6 persuaded the chief executive of that other LHD of the
7 value of their services, that other LHD could either
8 purchase them through a separate service level agreement
9 or, alternatively, through some meeting of the minds,
10 persuade the South Western Sydney LHD chief executive of
11 the benefits of providing more money to Karitane, which
12 would involve some sort of financial swings and roundabouts
13 between the LHDs?

14 A. Yes, and there are movement of funds between LHDs for
15 other examples of needs.

16
17 Q. Would it not potentially be a better way of managing
18 those relationships for there to be a single arrangement
19 between the AHO that is providing those services across
20 multiple LHDs and the ministry so that the ministry can
21 form a view - sorry, I will let you answer.

22 A. No great advantage jumps out at me, to be frank.
23 Being in the centre, we're a long way from community needs
24 and community understandings. Just because we are managed
25 from the centre doesn't mean it's going to be managed any
26 better, particularly in terms of financial advantage, to
27 that AHO.

28
29 Q. To the extent that either through liaising with LHDs
30 or through information that is available to it from other
31 sources, the centre might be able to identify where
32 particular needs for, say, mothers and babies' services
33 exist, and then make decisions around delivering the way in
34 which those needs are going to be delivered --

35 A. Mmm.

36
37 Q. -- would it not be potentially more advantageous for
38 the organisations that are delivering those services to
39 have a single point of contact with the ministry rather
40 than a single point of contact and negotiation point with
41 one of the CEs of one of the potentially many LHDs that
42 they are delivering services to?

43 A. I mean, if it was a statewide service, then yes, there
44 is a branch that actually facilitates that and assists in
45 negotiating volumes and hence price. If it is a service
46 that is not a statewide service, and it is outside that
47 home LHD, then it's really a matter of a funding source

1 that if the need was recognised and supported by that chief
2 executive at another LHD, there would be nothing to stop
3 movement of what is a relatively small amount of money, in
4 the scheme of things, from one LHD to the other to
5 supplement the service agreement that they are operating
6 under. As I said, it happens not infrequently.

7
8 Q. In the Karitane example, the chief executive of South
9 Western Sydney LHD would be in no better position than the
10 ministry, really, in terms of the centralisation of the
11 decision-making, to the extent that it relates to the
12 delivery of services in other LHDs?

13 A. Unless it's recognised as a statewide service and is
14 fundamentally a primary or quasi secondary care service
15 within that district, the ministry officers would have very
16 little or far less understanding and potential support,
17 being in the centre, rather than being in the district
18 where the population and the proposed services would be
19 delivered.

20
21 Q. What is it that enables something to be recognised as
22 a statewide service? What's the threshold?

23 A. Oh, in broad terms - Deb might give a clearer
24 explanation, but in broad terms, it's low volume, high
25 complexity, high cost.

26
27 Q. Can I ask you to go to paragraph 75 of your statement.

28 A. Yes.

29
30 Q. Do you see at the end of that paragraph - take your
31 time to read it - at the end of that paragraph you refer to
32 improvements which could be made to the NSW Health
33 performance framework to provide stronger guidance for LHDs
34 when assessing AHO performance. Can I ask, what did you
35 have in mind when you referred to "improvements"?

36 A. I'd need to take specific improvements that have been
37 implemented on advice.

38
39 Q. But when you say there that there are improvements
40 which could be made, did you have in mind any particular
41 change that you thought might be warranted?

42 A. Well, I guess I'd reflect on an earlier comment I made
43 around what has been custom and practice for many decades,
44 and that given the status, both as independent
45 organisations, their connections with their patient cohorts
46 and communities, that their philanthropic pull is much,
47 much stronger than a public hospital, and particularly

1 those organisations that are mission driven, I think they
2 can actually deliver better in some cases than the public
3 health system.
4

5 Q. We've talked about statewide services. Can I take you
6 back to paragraph 21 where you refer to the fact that some
7 statewide services are specifically funded, and you give
8 the example of the heart lung transplants.

9 A. Yes.

10
11 Q. So moving away from the AHOs now - and the answer may
12 be the same as the one you just gave - what is it that
13 enables something delivered wholly through the public
14 system to be identified as a statewide service? Is it the
15 same answer you gave earlier, or is there something else?

16 A. Yes, Deb would understand the detail better, but
17 certainly the ethos of that unit that oversees statewide
18 services is not to disadvantage the LHDs that just might,
19 by chance or in history, be hosting some of these statewide
20 services that are high cost, and they are servicing the
21 whole population, which is why, you know, specific activity
22 and hence weighted NWAU is funded into the service
23 agreement on advice from that branch.
24

25 Q. We heard some evidence last week from individuals
26 involved in the delivery of traumatic brain injury
27 rehabilitation and spinal cord injury rehabilitation
28 respectively. Have you apprised yourself of that evidence
29 as part of your preparation for today?

30 A. I got a summary from the staff. I have not read the
31 entire transcript.
32

33 Q. Are you aware of whether either of those two services
34 are specifically funded as a statewide service?

35 A. I thought spinal cord injury was. I don't know about
36 brain injury.
37

38 Q. Those involved in the delivery of both services have
39 said that implementation of a hub-and-spoke model with
40 centralised decision-making around resource allocation and
41 deployment, including a body of funding which attaches to
42 those decisions, would be of utility. Do you have a view
43 about that?

44 A. That was in the summary. I fail to actually see what
45 utility that will provide them, given that engagement with
46 the ministry is available through a number of ways. Their
47 chief executive - don't discount the influence and access

1 the chief executives have in the ministry; the branch that
2 oversees statewide services; and in the clinical network,
3 that is probably as, if not more, influential than the
4 other two, through the ACI clinical networks.

5
6 Q. But would there not potentially be an advantage in
7 having a central body making decisions about where to, say,
8 purchase beds and what type of beds should be purchased -
9 by which I don't mean physical beds - for rehabilitation,
10 for example, relative to the needs across the state?

11 A. Yes, my understanding is that that advice is obtained
12 through the clinical networks into that branch that
13 actually makes recommendation to Deb on any changes,
14 growth - changes to models of care in particular. So
15 I mean they have that utility now by using the existing
16 structures under Deb and the ACI.

17
18 Q. This might be a question for Ms Willcox, but it's also
19 suggested that a single point of data available in relation
20 to all patients within the system who might, for example,
21 have suffered from a severe spinal injury, would be useful,
22 because it would enable decisions to be made about where to
23 move patients, where beds are available, where they are
24 becoming available and the like. Is that something - was
25 that part of the briefing?

26 A. Well, given my earlier comments in relation to data,
27 I would be in furious agreement with you, if that's the
28 case, and I actually don't know the data position for that
29 particular statewide service. But, I mean, if it is
30 anomalous and if we're not debating widgets with widgets
31 and apples with apples, then we should fix that.

32
33 Q. Bringing it back to the practical, if you have - let's
34 deal with spinal injuries. An individual suffers from
35 a spinal injury, could be at any location in the state.
36 They will be taken to a trauma centre initially and
37 stabilised; correct?

38 A. May be the case.

39
40 Q. That trauma centre could again be located within
41 a range of hospitals within the state?

42 A. Yes, we have designated trauma centres in the state,
43 yes.

44
45 Q. Once stabilised and perhaps having spent some time in
46 a ward, that patient will be ready to progress to
47 a rehabilitation phase of their recovery?

1 A. Mmm-hmm.

2

3 Q. It would be useful, would it not, if those involved in
4 the delivery of the spinal rehabilitation services had
5 a real-time view of exactly how many patients there were in
6 the system approaching a need for rehabilitation and
7 exactly the nature of their injury, you would agree?

8 A. Mmm-hmm.

9

10 Q. And the stage in their recovery that they were at,
11 relative to when they might be entering a rehabilitation
12 facility?

13 A. Mmm.

14

15 Q. Do you agree?

16 A. Yes, I'm not familiar with how it operates across the
17 various brain injury units - sorry, spinal injury units.

18

19 Q. Conceptually, though, that information would be
20 a useful tool, would you not agree, for those managing the
21 rehabilitation of spinal injury services in New South
22 Wales?

23 A. Conceptually, but when you think about the number of
24 specialties and sub-specialties that exist in health care
25 across a jurisdiction as big as New South Wales, that
26 happens by nature of clinicians referring to clinicians,
27 clinicians knowing where the specialist services are - and
28 many of those specialties and sub-specialties don't have
29 formal, established networking arrangements other than
30 what's developed amongst the lead clinicians - in this case
31 of the three centres - who could readily come together, and
32 I suspect they do, otherwise they wouldn't really be
33 recognised as being a statewide service.

34

35 If what the assertion is is that there is a gap in
36 patients getting access or being referred, then that's
37 really around clinical referral to clinical receiver, if
38 you like.

39

40 Q. I think that they make three points. The first is,
41 there are insufficient rehabilitation beds available to
42 meet the need - albeit a small need, it nevertheless is
43 larger than the available rehabilitation beds. That's one
44 point they make, both in the case of spinal injury and
45 traumatic brain injury. The second point they make is that
46 the ad hoc communication and referral amongst clinical
47 colleagues is not really a sufficient way of sharing

1 information and managing patient flows. And the third
2 point they make is that a lack of centralised
3 decision-making around how the services are best to be
4 funded and delivered is something which compromises the
5 quality of the service which is being delivered. Taking
6 those three in order, do you have a response to them?
7 A. Oh, I'm not close to the detail to judge the efficacy
8 of those arguments at all.

9

10 MR MUSTON: Thank you. I have no further questions for
11 this witness, Commissioner.

12

13 THE COMMISSIONER: Thank you. Mr Chiu?

14

15 MR CHIU: No questions.

16

17 THE COMMISSIONER: Thank you. Thank you very much for
18 your time. We're very grateful. You are currently
19 excused.

20

21 THE WITNESS: Thank you.

22

23 <THE WITNESS WITHDREW

24

25 MR MUSTON: The next witness is Deborah Willcox, again.

26

27 <DEBORAH LEE WILLCOX, affirmed: [12.38pm]

28

29 <EXAMINATION BY MR MUSTON:

30

31 MR MUSTON: Q. Could I get you to state your full name
32 for the record again?

33 A. Thank you. Deborah Lee Willcox.

34

35 Q. You are the deputy secretary, health systems, strategy
36 and patient experience, within the Ministry of Health?

37 A. That's correct.

38

39 Q. A role you have held since September 2022?

40 A. Yes. Thank you.

41

42 Q. You have held a range of other roles within the health
43 system prior to that, including as the chief executive of
44 the Northern Sydney Local Health District for a time?

45 A. That's true.

46

47 Q. When did you hold that role?

1 A. From - I was acting from March 2017 for four months
2 and then was formally appointed when it went to recruitment
3 in November 2017.

4
5 Q. You have prepared a statement to assist the
6 Commission, dated 9 April 2024?

7 A. Thank you.

8
9 Q. Have you had a chance to read and refamiliarise
10 yourself with that statement?

11 A. I have indeed, thank you.

12
13 Q. Are you satisfied that the contents of it are, to the
14 best of your knowledge, true and correct?

15 A. It is.

16
17 MR MUSTON: In due course, Commissioner, that will form
18 part of the bulk tender.

19
20 THE COMMISSIONER: Yes.

21
22 MR MUSTON: In saying that, that due course will come this
23 afternoon, I am told by those that know.

24
25 Q. Perhaps if we can have the statement brought up on the
26 screen, or if it is easy for you to use your hard copy, you
27 can look at the screen, your hard copy or the big screen
28 over there, whichever works best for your eyes.

29 A. Thanks.

30
31 Q. Could we go forward to paragraph 8.

32 A. Yes.

33
34 Q. You tell us there that the health system strategy and
35 patient experience division is made up of six different
36 portfolio areas or branches. I just want to ask you some
37 particular questions at the moment about the health and
38 social policy branch. If we jump forward to paragraph 19,
39 you tell us that the purpose of that branch is to improve
40 the health and wellbeing of people and partners with
41 government and non-government agencies to develop equity
42 focused policies and programs for the New South Wales
43 health system.

44
45 Now, if I could jump forward again, that branch is
46 divided up into a number of units, one of which you tell us
47 at paragraph 20(d) on page 9 of your statement is the

1 community care and priority populations unit. After that
2 long introduction, can I ask, how does that unit engage on
3 a day-to-day basis with the services which are delivered by
4 LHDs?

5 A. Thank you. The policy areas that come from team
6 around identifying vulnerable populations, and the ones
7 that I've highlighted in my statement include LGBTQI+
8 communities, so as way of example, the team would then
9 consult with the relevant advocacy groups, local community
10 groups, LHD teams, and develop the policy framework that
11 supports better access to health, noting some of the health
12 issues that confront these communities, and set the policy
13 framework which then would inform the service delivery that
14 an LHD may do in providing services to this part of the
15 community, and from that, there are a number of measures
16 that fall into the service agreements around priority
17 populations that may be impacted by hepatitis C, by HPV,
18 you know, a variety of screening measures. So that would
19 be one example of a policy framework.
20

21 Q. So that's the priority populations bit of the unit.
22 What about the community care part of the unit, is the
23 title deceptive in that it only relates to the provision of
24 community care to these priority populations, or are there
25 two separate strands of work?

26 A. They are probably interwoven. It is a broad heading
27 but probably, in relation to this unit, it would refer in
28 part to the NGOs, the non-government organisations that
29 this part of the branch has a policy, oversight and
30 supporting role, and they are providing, in the main, care
31 within the community.
32

33 Q. You refer there in subparagraph (d) to one of the
34 aspects of the work of the unit being the delivery of
35 primary care. What is the unit's role in relation to
36 primary care?

37 A. So it is the policy, not the service delivery
38 component for primary care. If we take a broad definition
39 of primary care, it would include general practice, which
40 is clearly a federal government responsibility. In our
41 context, it would be within our community health centres,
42 where nurse-led models of care, allied health professionals
43 and other population health, health promotion activities,
44 occur in our community health centres, and some of the
45 policy frameworks that this unit is responsible for,
46 setting the framework for the nature of those services that
47 would be delivered in our community health centres.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Are you familiar with the statutory purposes of the LHDs as set out in section 9 of the Health Services Act?

A. I am.

Q. Those purposes do seem to strongly overlap with the objects of the health and social policy branch, as you have referred to in paragraph 19.

A. (Witness nods).

Q. In terms of performing those purposes, and in particular, the promotion, protection and maintenance of the health of the community, would you agree that an understanding of the detailed health needs of the community within an LHD is critical?

A. Could you just say that last bit again, I just couldn't hear you properly.

Q. In terms of performing that function and, in particular, the promotion, protection and maintenance of the health of the community, would you agree that a detailed understanding of the particular health needs of the community within the LHD is critical?

A. If I may frame the answer that at a state level, we are looking at population health and some of this, as you would understand, would be in the domain of the chief health officer, but some would fall into policy frameworks as some of the ones you have highlighted in my statement.

The local health districts themselves, most of which would have a population health or a health promotion strategy which would be linked to the statewide population health activities, that then would set their service model framework and approach to caring for the people in their community and the population health needs of their demographic. So I see it as a hierarchy of activities, and I don't think - it's not a disconnect between what they are required to do; it is just the nature of what we're doing is different. We set a framework and they are about service implementation and local community needs.

Q. So from the point of view of the LHD in performing its statutory function, it's critical that the LHD makes a careful assessment of the health needs of the population that it is serving?

A. Correct, yes.

1 Q. And your point is that, in terms of the work done by
2 your branch in setting policy, it doesn't necessarily need
3 to have that same detailed understanding of the health
4 needs of each LHD that hovers around within the health
5 system?

6 A. It would be fair to say that within the local health
7 district populations there is always going to be some
8 differences, and you would want local health districts in
9 our devolved model to be making sure they are designing
10 services and implementing care that meets the needs of that
11 community. But if you take an example, for instance,
12 around, for instance, you know, let's say smoking, that is
13 not in my division but as an example, you know, there is
14 a national strategy for health prevention which includes
15 cessation of smoking. At a state level, we have a suite of
16 policies as part of the local health districts, so Dr Chant
17 would be responsible for, and the local health district
18 would ensure that they had smoking cessation policies and
19 services within their population groups, and that may need
20 some targeted activities, perhaps in multicultural
21 communities, Aboriginal communities. So the policy and the
22 aims are the same but the delivery model may change
23 depending upon the community that you are in.

24
25 Q. So in identifying all of the particular health needs
26 of the population that exists within an LHD, it's also
27 important, is it not, for the LHD to make an assessment of
28 the extent to which those needs are being met by services
29 delivered externally to the LHD?

30 A. You would be referring perhaps to non-government
31 organisations and other partners.

32
33 Q. So take, for example, primary care.

34 A. Yes.

35
36 Q. An assessment needs to be made of the health needs,
37 the primary health care needs of the population as part of
38 the LHD's performance of its function. Having identified
39 those needs, stage 2 is to have a look at the extent to
40 which those needs are being met by something external to
41 the LHD --

42 A. Mmm-hmm.

43
44 Q. -- like the private GP market, for example. Would you
45 agree that those two integers or those two steps are
46 important steps for the LHD in performing its statutory
47 function?

1 A. Most definitely. But they would be somewhat iterative
2 as well, because in a local health district, if you were
3 designing your population health plan, you would be
4 engaging with your local general practice or primary health
5 network, you would be working with local advocacy groups,
6 particular, you know, health NGOs and the like, to garner
7 as much information as you can about your local community
8 and what other services and activities were going on that
9 you should take into account as you are designing a
10 population health plan for your community. It really is
11 not an LHD-alone in terms of how we care for our citizens,
12 it takes these partnerships and connections in community,
13 and local health districts best know those communities. So
14 I agree, they are very important components to bring
15 together, but they would be iterative in terms of
16 developing a plan and how those services are provided.

17

18 Q. So very important components to put together. As to
19 the information that one needs to draw together in order to
20 do that, it's coming from a disparate array of sources
21 including the PHN, information available to the LHD itself,
22 and no doubt many other sources?

23 A. Yes. It would be a process of learning and
24 understanding, gathering information and data. The LHDs
25 themselves hold a huge amount of information around their
26 populations and they would also work with the ministry to
27 access the relevant information from the ministry to
28 support that work as well. So, again, it is a hierarchy or
29 a tiering of activity, but they are linked.

30

31 Q. What is the assistance provided by the ministry in
32 relation to gathering data on each of those two things,
33 assessment of health needs on the one hand, extent to which
34 those health needs are being met by sources external to the
35 LHD on the other?

36 A. If I - an example of, if you are going to start
37 a planning process in a local health district around the
38 health needs, and if we keep it, say, on population health,
39 so we're talking about things around healthy diet,
40 exercise, obesity, smoking, drug and alcohol and the like,
41 the process is one in which, as I said, you would connect
42 with your own clinical teams and your local community and
43 consumers; you would have a stocktake, to use a crude term,
44 of the services you're currently provided - all of the
45 measures that are showing you how you are tracking against
46 all of these things, which you will have seen in the
47 service agreement a number of them are outlined there.

1
2 You would then need to interface with the ministry in
3 terms of what are the strategies that are being determined
4 from a national level through to the ministry, you know,
5 what datasets the ministry holds. Again, these are domains
6 more of the chief health officer, but I guess as a matter
7 of course, it would be - it would not be done in isolation.
8 You would be joining up on those things, getting
9 information from there to frame your strategy and make sure
10 you are consistent with the state, but again, capturing
11 those local needs from your community and other partners up
12 into the strategy so the two meet.
13

14 So you will have some bespoke activity and maybe
15 bespoke data that is important to your community, but not
16 so in a neighbouring community. But in theory, as a group
17 of local health districts, that strategic, I guess,
18 framework around what are the health needs and what are our
19 priorities that we're attending to should be very well
20 aligned.
21

22 Q. Taking that aligned information to the next step of
23 clinical services planning, by which I mean what particular
24 services are to be delivered by the LHD, come back to our
25 two important pieces of information - what services are
26 required by the population. You agree that that's
27 something that they, obviously enough, need to make an
28 assessment of?

29 A. Mmm-hmm.
30

31 Q. The second step, to what extent are those services
32 being met by sources other than the LHD, for example, the
33 GP market?

34 A. (Witness nods).
35

36 Q. So taking those two things, if the LHD identifies
37 gaps, what assistance, if any, is being provided by the
38 ministry in terms of informing the way that those gaps are
39 filled by the LHD? Perhaps let me take it - that was
40 a very poorly expressed question. Let me take it back
41 a step. The LHD looks at the services required of the
42 community?

43 A. Mmm-hmm.
44

45 Q. Identifies that those services are being delivered, by
46 and large, by services external to the LHD, other than
47 acute care in the hospital setting and the like, but says

1 "I've identified a pocket of my population here that is not
2 well served or served at all by GPs". So there is
3 a primary health care need within the community which is
4 not being met. The starting proposition: do you agree
5 that it is part of the LHD's function under section 9 of
6 the Act to meet that health need of its community which is
7 not otherwise being met?

8 A. It probably goes in some part to how you define
9 "primary care", as I said earlier, and general practice is
10 most definitely a key feature of primary care. General
11 practice is obviously under the domain of the federal
12 government. But the relationship of our local health
13 districts to primary health networks and general practice
14 is critical. Our patients move in and out of the system,
15 into general practice, back to us, and there is an
16 inordinate amount of focus on how we actually improve that
17 continuum of care for a patient.

18
19 If there is - I use the term "thin market" is one you
20 hear frequently around primary care or general practice,
21 and we are seeing that in all parts of the country, not
22 just in New South Wales or Sydney. Now, noting in a
23 metropolitan region that there is a general practice that
24 is closed or a GP has left, sometimes it will not be so
25 obvious in the immediacy, but in a rural town, that
26 sometimes is very obvious. It may well be the only general
27 practice in town.

28
29 So if you are in a rural community, our rural LHDs
30 are - very, very closely work with their general
31 practitioners in the area, and often general practitioners
32 work in our acute facilities as well. I will use the rural
33 example because I think it's more - goes more to your
34 question. If we note a loss of a GP or a loss of a general
35 practice in a town, what do we do then? Because we know
36 then that our patients are going to default to the public
37 health system and have to come to an emergency department,
38 which is not optimal for them and probably not optimal for
39 the emergency department.

40
41 Q. Pausing there, a patient who is no longer receiving
42 good continuity of care from a GP and is instead presenting
43 to emergency once they have reached an acute phase of their
44 illness or whatever is troubling them is not someone who is
45 being well served in terms of their health needs?

46 A. I would say that. That is a true comment, yes.

47

1 Q. So I think I interrupted you. You have got that
2 situation where, accepting that every rural town will be
3 different and there will be different levers that might be
4 pulled in each of them to try and restore quality primary
5 health care to the community, but to the extent that you
6 encounter one of the communities that I think you were
7 coming to where there is no GP and no lever can be pulled
8 which is going to provide a market of GPs in that
9 community, what does the LHD do?

10 A. This is a topic that has been of considerable
11 discussion and debate, well, for a very long time. I guess
12 one of the more recent events has been initiated by the
13 federal government through the Strengthening Medicare
14 Taskforce looking at workforce issues and incentives and
15 better, you know, primary care for citizens with chronic
16 disease, for instance, and getting multidisciplinary teams
17 in general practice. So there is a raft of work coming
18 down from the Commonwealth.

19
20 Intersecting that is, we're right now in the middle of
21 negotiating a national reform agreement, and this very
22 discussion around thin markets in primary care is
23 a centrepiece of what we will be working through as we work
24 through an interface schedule on the current - on the
25 soon-to-be developed National Health Reform Agreement.

26
27 One of the things that was just, again, literally last
28 week - how can we avoid situations where we suddenly find
29 out a general practitioner is leaving. Now, sometimes that
30 will happen because people have, you know, something happen
31 in their life and they have to leave at short notice, but
32 in the main there should be an opportunity to succession
33 plan and to manage a transition so we don't find ourselves
34 in these situations.

35
36 If I come back to a macro level then again with the
37 Commonwealth, the primary health networks are the principal
38 interface for local health districts to engage with general
39 practice, and that has had varying success, I think it
40 would be fair to say, across the state. Many would say,
41 and I would probably agree, that some of those
42 relationships have been more effective than others, but
43 basically it's been relationship driven.

44
45 In my role as the deputy secretary responsible for our
46 positioning in health reform, one of the things we've been
47 talking to the Commonwealth about is what are some of the

1 levers that you can provide a PHN to strengthen that
2 interface with general practice? How do we support general
3 practice better and how do we manage when we find ourselves
4 in particular parts of the country where markets are
5 starting to look thin and problematic, and how do we, you
6 know, jointly escalate these things and work on a solution
7 for the community and also for the acute public health
8 system? It is in all of our interests that these things
9 are managed well.

10
11 So I take your point that our stewardship of the
12 health system requires us to ensure the care of the
13 citizens in our area in whatever form that takes, and the
14 public health system will always be the default for where
15 there is failures in other parts or issues in other parts
16 of the sector that are unable to deliver care for whatever
17 reason.

18
19 But our other job and my role is to make sure that we
20 work with our Commonwealth partners to see what can we do
21 and what are some of the actions we can take to strengthen
22 the system, to mitigate that risk to community, and as
23 I said, the continuum of care between primary care and the
24 acute sector is something that we are very, very aligned
25 with on the Commonwealth and I'm hopeful that we can
26 actually make some good progress in reform in this area.

27
28 Q. Because dealing with situations where, to use your
29 term, the GP market has become so thin that it's not
30 actually delivering on the health needs of the community,
31 it is something that should be a feature of the service
32 planning process that you describe in paragraphs 45 to 52
33 of your statement, would it not?

34 A. Again, they are critical partners in care delivery,
35 and I don't wish to sound, you know "Oh, it is theirs, and
36 this is ours", but ultimately general practice is in the
37 legislative and regulatory domain of the federal
38 government, and for us to lean in on that would require us
39 using state funding, not that we could, because it's not
40 our area to do, but it would require us diverting resources
41 into an area that's not our domain and I think, you know,
42 working with the primary health care networks to strengthen
43 these relationships, to do joint planning, to have better
44 insights into what is happening in general practice, where
45 we're seeing areas where there, you know, are staffing
46 issues or a risk in a community, it's much better to have
47 a joined-up approach where we can work with the

1 Commonwealth and see what interventions are possible. And
2 again just going back to the Strengthening Medicare
3 Taskforce work, it will take some time to play out. You
4 probably heard the federal minister today pleased with the
5 bulk billing rates increasing across the country, but it
6 will take some time for some of these reforms to filter
7 through, but they have the optimum goal of dealing with
8 things that you have described, that we want to strengthen
9 and bolster the primary care general practice system
10 because it is better for patients and it also means that
11 the acute hospital setting is doing what it is designed to
12 do and that's to do with acute care.

13

14 Q. When you say that the primary care is not part of the
15 state's domain and it is part of the Commonwealth's domain
16 or responsibility, the Commonwealth has an obligation to
17 deliver funding through the MBS system?

18 A. MBS system, yes.

19

20 Q. But it doesn't actually have a positive service
21 delivery obligation itself - that is, the Commonwealth. It
22 provides the funding - rather, it provides the funding
23 source to a private market?

24 A. But they are responsible for the policy around primary
25 care, hence, again, the Medicare task force work. So they
26 look at the federal government has a role in workforce, in
27 retention, incentive payments, information systems, you
28 know, working with the colleges. That is all in the remit
29 of the Commonwealth Government when it comes to general
30 practice.

31

32 Q. To the extent, though, that that market-based system,
33 through perhaps the best delivery of that policy framework
34 as is possible, is not delivering primary health care to
35 citizens living within LHDs, it falls back to the LHD, as
36 the deliverer of services, to deliver that care, does it
37 not?

38 A. It doesn't fall back on us to provide general
39 practice, but our role is to care for the citizens that
40 come in to our services, and if the most unfortunate
41 sequelae of a depletion of general practice means that
42 somebody is unwell and has to come into an emergency
43 department, that might have otherwise received earlier
44 care, that is something that we all need to work to avoid,
45 and hence the work we're doing with the Commonwealth, with
46 PHNs. We have general practice represented on many, many
47 of our committees in the ministry so that we work together

1 and understand their needs and how we can better manage
2 patients in a more effective way. We have a joint group
3 that I chair with our state PHN representatives. We've
4 done some joint planning together on sort of key measures
5 that we want to see improve the population's health.
6

7 So we can work together on a policy level, we can
8 escalate together, we can work with the Commonwealth on
9 what we think needs to be done and contribute in
10 Commonwealth and state forums around this, which we
11 actively do, and work with the Commonwealth to implement
12 some of the things that they want to do, but ultimately, if
13 it comes to employing a general practitioner, that is not
14 something the state can do.
15

16 Now, we have done a number of things that have been -
17 I guess we'd call them workarounds, to try to help in
18 situations where a thin market is potentially impacting on
19 a community. You will have undoubtedly read about the
20 section 19(2) exemptions to allow MBS to apply to other
21 forms of health practitioners. There are things that we
22 can do together, and as I said, in rural and regional areas
23 with MPSs, slightly smaller populations, there is probably
24 a little bit more room for innovation, but just the same,
25 we're unable to recruit to general practice.
26

27 Q. But it is possible, is it not, to employ a salaried
28 staff specialist to deliver that primary care and then,
29 thereafter, it becomes a question of negotiating with the
30 Commonwealth about potentially providing access, through
31 19(2), for example, to the MBS funding for the delivery of
32 those services that the market is failing to deliver?

33 A. The employment of doctors to work in general practice
34 is not something that we would do. Yes, there are areas
35 where there are issues with general practice, there is no
36 doubt, as I said, mostly in rural and regional areas. Our
37 preferred approach would be to work with the local PHN and
38 the Commonwealth to see what we could do or what they could
39 do to support a general practice or a community in that
40 regard.
41

42 MR MUSTON: I note the time, Commissioner.
43

44 THE COMMISSIONER: We'll adjourn until 2 o'clock.
45 Thank you.
46

47 **LUNCHEON ADJOURNMENT**

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

THE COMMISSIONER: Yes, when you are ready.

MR MUSTON: Q. I think before lunch I was asking you some questions about the possibility that LHDs might step in to the provision of primary care where the GP market was so thin that it was not delivering.

A. Mmm.

Q. Your response a few times was that the LHD, or the Ministry of Health, doesn't go about employing people in general practice. I just want to make clear in case there is any cross purpose, I'm not suggesting that LHDs would be employing people to go and work in a private general practice somewhere within a town but, rather, that the primary health care services, traditionally delivered by a GP, might potentially be delivered by a salaried employee of NSW Health delivering services through one of the LHD's facilities in the town or community where there is no GP cover. Does that change in any way your answers to those questions?

A. There are some examples where that has occurred. The Balmain GP casualty could be an example of that. There are emergency doctors in there, but there is general practice within Balmain hospital, and that is used in that regard.

Q. In that example, is that used to provide good continuity of care for patients who might attend that service regularly, or is it more in the nature of an urgent service, an urgent care service?

A. It is primarily as an urgent care service. I'm a little rusty on the history, but way back when the services being provided at Balmain changed from being an acute hospital with an emergency department, as part of that, managing community's expectations at that time, was to continue to provide some sort of urgent care or casualty type service, and so there is a role there currently with GPs. And so it's not - it's mostly used like sort of a - I think an urgent care centre is probably the best way to describe it.

Q. So are you aware, with the Balmain example, has there been a negotiation with the Commonwealth about freeing up MBS money?

A. It is not an MBS model; it is wholly and solely run by the local health district.

1 Q. We've heard about the four-Ts model as well. That's
2 another area in which LHDs have stepped in to the provision
3 of primary care. In relation to the four-Ts model there
4 has been a section 19(2) exemption granted, is my
5 understanding right?

6 A. That's correct. I'm not close to the four-T model.
7 My colleague, who is a deputy secretary for regional
8 health, would have a lot more detail around that, but yes,
9 it is principally a section 19(2) exemption.

10
11 Q. Did your division have any involvement in the
12 negotiations with the Commonwealth around that exemption?

13 A. I don't know the answer to that directly. My
14 understanding is that the application was made by the local
15 health district. We may have provided some advice and
16 guidance along the way, but I'm not aware that we - what
17 the extent of our role in that was.

18
19 Q. To the extent that a local health district perceived
20 there to be a gap in the delivery of primary care which
21 needed to be filled, am I right in understanding that from
22 a funding perspective, it would be teams within the
23 government relations branch which would be negotiating with
24 the Commonwealth about accessing MBS payments for such
25 services?

26 A. The government relations branch doesn't deal with
27 direct negotiations with the Commonwealth on a particular
28 general practice where there might be an issue. Our role
29 in government relations branch is really more at the
30 policy, strategy and funding level, when we are working
31 through agreements with the Commonwealth or
32 cross-jurisdictional agreement, for instance, with Albury
33 Wodonga, or the ACT. They don't get involved in, I guess,
34 immediate operational funding or staffing issues in that
35 way.

36
37 Q. Is there any discussion happening between the
38 Commonwealth and members of that branch about the
39 adjustments to the accessibility of MBS money to enable
40 primary health care to be delivered by LHDs where the
41 market is so thin that GPs are not capable of delivering
42 it, that you are aware of?

43 A. No, we're not having those sorts of discussions. As
44 I mentioned, we are currently in an active negotiation with
45 the Commonwealth around national health reform, and it is -
46 the interface issue with primary care is one of the most,
47 should I say, lively discussions we are having with the

1 Commonwealth, and that - the point of that is to try and
2 unlock some of the current barriers, some of the
3 disincentives and some of the other reasons that might lead
4 to a market failure in a particular community, and what
5 we're trying to do is to work with the Commonwealth to
6 identify what are all the policy and structural things in
7 their gift that could support general practice and mitigate
8 some of the risk that we see, particularly in rural and
9 regional areas. So that's, I guess, the policy work that
10 we do at that level to influence the Commonwealth and its
11 role in general practice.
12

13 Q. Coming back to a question I asked a bit earlier, to
14 the extent that those policy efforts and the various gifts
15 available through the Commonwealth are insufficient to
16 develop a market or rehabilitate a market of GPs within
17 a community that needs primary care, are there discussions
18 happening in parallel with these conversations with the
19 Commonwealth around means by which that care might be
20 delivered by LHDs but funded through the MBS system?

21 A. Certainly where there would be a sudden loss of
22 a service in a community - and, again, I think rural and
23 regional communities, it's a much more profound event,
24 particularly in rural and remote communities - if a general
25 practice in metropolitan Sydney closes down, it's almost,
26 you know, not noticed by anybody - perhaps some patients
27 are disrupted and have to find a new general practitioner.
28 But in a small rural or remote community, these changes can
29 be quite profound. So having a mechanism with the
30 Commonwealth to escalate these issues is what we have and
31 what we do, and I think things like the four-Ts, the
32 section 19(2) exemptions, working with our multipurpose
33 services, working with the Commonwealth to, you know,
34 incentivise and promote a particular area to attract
35 people, these are the sorts of things we would do in
36 unison.
37

38 Q. In the metro areas, is there anything being done that
39 you are aware of to deal with the provision of primary care
40 to some of the priority populations that you referred to
41 that might not be able to get access to GP services through
42 the traditional markets, even where those markets are not
43 thin, for financial or other reasons?

44 A. I don't have any examples directly around general
45 practice, but I think when it comes to some of those more
46 vulnerable communities, local health districts meet that
47 need in terms of the nature of the sorts of clinics and

1 services that we might have for LGBTQI+ communities,
2 hepatitis, sexual health, drug and alcohol, mental health,
3 these types of services are definitely in the domain of our
4 local health districts to ensure equity of access for these
5 vulnerable communities. That's not to say there aren't
6 private providers and general practitioners providing these
7 types of services, but a local health district, in the
8 main, are well equipped to work with these communities.
9

10 Q. What about specialist services provided through public
11 outpatient clinics? To the extent that the LHD perceives
12 there to be a need for clinics delivered to members of the
13 population which is not being met by a private market, do
14 you know whether there is any - well, what, insofar as you
15 are aware, is the process for the LHD standing up public
16 outpatient clinics to meet that need?

17 A. I apologise if I'm not going to answer this question
18 exactly what you are needing. Public outpatient clinics
19 are a longstanding service of the public health system and
20 are there for members of the community that can't afford,
21 perhaps, or choose not to access private specialists, so go
22 to a rooms and pay sometimes out of pocket and see
23 a specialist after they've had an operation, or when they
24 have got a medical condition that requires specialist care.
25

26 The outpatients clinics or the ambulatory care clinics
27 that exist in our local health districts are there to
28 support public patients who either by choice or by
29 circumstance would not go to a private specialist. So it's
30 less about a market, a thinning of market, as such, but
31 a combination of options for care that are provided by
32 private and public sector.
33

34 Q. Looking at our rural and regional areas, there are,
35 we're told, in some areas significant shortages of
36 specialists, which means getting access to, even if you
37 want to, a private specialist in rooms is not something
38 which is necessarily achievable. Is that something which
39 is being assessed by LHDs as part of their planning, do you
40 know?

41 A. The question is probably moving somewhat outside of my
42 direct responsibilities. The lack of specialist services
43 has got - there is a range of reasons for that, and being
44 in rural areas and remote is always, you know,
45 a difficulty. The pipeline coming through, through the
46 colleges, what the quantum available to the sector - you
47 know, it is a multi-factorial reason why there may not be

1 enough in an area. But if we take a rural or remote area,
2 some of the things that we do in local health districts are
3 things such as virtual care. That might be a mechanism
4 where a patient can be referred to a specialist in Sydney
5 when they don't have access to that sort of specialist
6 locally, and avoids travel, where clinically appropriate.
7 Yes, there are multiple examples of virtual models of
8 specialist care that we've grown exponentially, really,
9 since COVID and they have been a fantastic mechanism to
10 enable access to services that people might not otherwise
11 have. It is unlikely that a small rural town will have
12 access to all of the specialists that might be needed at
13 a given time for a community.

14
15 Q. And in terms of funding those sorts of adaptation or
16 services, is it, at least at the moment, driven by an
17 ability to identify activity in the activity-based funding
18 sense, generated by the delivery of the services?

19 A. I might ask you to just explain that question again
20 for me.

21

22 Q. So it is identified that there is a need to provide
23 some specialist services through the LHD.

24 A. Mmm-hmm.

25

26 Q. You have given a number of examples of ways in which
27 that might happen, be it remotely, virtual care and the
28 like?

29 A. Mmm-hmm.

30

31 Q. Those services still need to be funded.

32 A. Yes.

33

34 Q. What is the mechanism by which those services are
35 funded, or mechanisms, if there is more than one?

36 A. So our public outpatients are funded by the local
37 health district. They are - the medical teams that work in
38 there are staff specialists or VMOs, but principally staff
39 specialists, with nursing and allied health, which are all
40 employees of NSW Health. Activity is provided through the
41 service level agreements to the districts for the range of
42 services that a district would provide, including
43 ambulatory care and it is described or purchased under the
44 ABF and the NWAU mechanism of non-admitted activity and
45 NWAU allocated to an LHD to distribute for them to provide
46 public outpatient services.

47

1 Q. So in the case of, say, your virtual care specialist
2 clinic, it is set up in a way that delivers, at least for
3 the purposes of the LHD, some activity, which is then
4 purchased through the funding mechanism that travels up to
5 the ministry; is that right?

6 A. There is a slight difference around the virtual care.
7 At the moment, in the discussions with the Commonwealth,
8 because virtual care is not being costed by the independent
9 health and ageing pricing authority, we don't have an NWAU
10 bucket for virtual care. So local health districts are
11 funding those from within their budget and, again, as part
12 of our negotiations with the Commonwealth, we're working to
13 see what other services are what we describe as in scope
14 for a contribution from the Commonwealth, and virtual care
15 is one of those things that we are actively working with
16 the Commonwealth on and they are looking at very
17 positively. So that would mean if you provided a virtual
18 in-reach into another community or into an aged care
19 facility, the Commonwealth would then come with
20 a contribution to the state to enable that service to be
21 provided.

22
23 Q. Could I move to another topic now and ask you about
24 the AHOs. We've heard some evidence from three AHOs that
25 provide services across a range of different LHDs -
26 Karitane, Tresillian and Royal Rehab. Are you broadly
27 familiar with the work of those three organisations?

28 A. I am, yes.

29
30 Q. Have you, in preparation for giving evidence today,
31 apprised yourself of evidence that has been given to the
32 Commission by the individuals representing Karitane,
33 Tresillian and Royal Rehab?

34 A. I have, yes.

35
36 Q. As you will know, each have reported that the funds
37 that are provided through the service level agreements that
38 they are proffered by the LHDs that they are associated
39 with are insufficient to meet the cost of delivering the
40 services required of them under that agreement. Could we
41 perhaps start with Royal Rehab.

42 A. Mmm.

43
44 Q. In your capacity as a CE, or former CE of Northern
45 Sydney LHD, did you have dealings with Royal Rehab?

46 A. Yes, multiple.

47

1 Q. And the period of time that you were the CE there,
2 Royal Rehab did not formally have a service level
3 agreement; is that right?

4 A. That's correct. Yes.

5
6 Q. How was that situation allowed to develop in that way?

7 A. The Royal Ryde Rehabilitation firstly I need to say
8 provides an outstanding service to very, very complex
9 patients. We were unable to settle an agreement around
10 what funding they felt was appropriate, and as you received
11 and you would have heard in the evidence from my colleague,
12 the CE of Northern Sydney, current CE of Northern Sydney,
13 there is an ABF funding model for Royal Ryde as well as
14 a transition payment, and that transition payment is in
15 recognition of the fact that the complex nature of the care
16 provided to those people with spinal and traumatic brain
17 injury did require this transition grant.

18
19 It was obviously disappointing not to have a service
20 agreement in place, but it did not impact on ongoing
21 service delivery, ongoing provision of funding, and an
22 ongoing relationship in terms of the provision of care to
23 the public patients that require that rehabilitation
24 service.

25
26 Q. But those services were able to be provided, at least
27 as we're told by Royal Rehab, because it dipped into
28 alternate sources of funding available to it to meet the
29 costs of delivering those services.

30 A. I'm not aware of that or the nature of that. Again,
31 I am aware of the work that we undertook, or was
32 undertaken, to have an independent review of the costings
33 around Royal Rehab and again --

34
35 Q. When was that?

36 A. Sorry?

37
38 Q. When was that independent review?

39 A. Taylor Fry did a review in 2023 and we had had
40 discussions with - in my time at Royal Rehab in terms of
41 getting some sort of independent review of the costings
42 because we had had a number of negotiations, worked very
43 closely with the ministry to try and get clarity around the
44 data and the activity, and still to no avail, unable to get
45 an agreement on a position. So subsequent to me, that
46 independent review has been done. Now, again, it's
47 slightly outside of my remit, but the advice that I've

1 received from the LHD, and I think it was provided, was
2 that there was nothing in that review that indicated there
3 was a substantial gap in terms of service provided and
4 funding provided.

5
6 Q. Are the AHOs funded on the basis, at least insofar as
7 you are aware, of the state efficient price?

8 A. No, I don't know the answer to that. The funded is
9 tended to be in block funding. I'm not aware of activity -
10 so activity purchased from them that is under ABF, but
11 I could take that on notice, if that were appropriate.

12
13 Q. So Royal Rehab I think had a component of its funding
14 which was ABF funding?

15 A. Royal Rehab, yes, sorry, pardon me. Tresillian and
16 Karitane is what was on my mind, my apologies.

17
18 Q. So dealing with Royal Rehab and the activity funding
19 that was provided, are you aware of whether that was funded
20 at the state efficient price or at some other price?

21 A. It would have been at the same price as the local
22 health districts, so the state price.

23
24 Q. At the time that you were dealing with Royal Rehab,
25 and you were presumably told by the individuals with whom
26 you were dealing that the moneys proffered under the
27 service level agreement were insufficient, did you take
28 steps - well, when were you first told about that?

29 A. I couldn't recall the specific date, but fairly early
30 in my appointment I made a point of meeting with all of our
31 AHO and NGO partners, of which there are a number in the
32 Northern Sydney Local Health District. So it would be, you
33 know, likely that in one of those early meetings it was
34 flagged.

35
36 We had quarterly performance meetings with Royal Ryde
37 Rehab where there was an opportunity to talk through all
38 manner of things including funding and undoubtedly it was
39 raised. We did, as I said, have a number of discussions
40 with them both internally, our finance team and our
41 activity team working with theirs, to try and work out what
42 the issues were and where there was a delta and what they
43 thought and what we thought and if there was any sort of
44 compromise position we could come to. I think there was
45 some additional funding, or at least funding was not - they
46 have a part of their service called Weemala, which is sadly
47 the number of patients there is slowly shrinking.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Diminishing?

A. Diminishing. And we, in good faith, at the time, and I think that has continued to, fund that at the same rate, even though the number of patients changes as basically just a step of good faith. We know that we can't get agreement on the funding model, we think we're okay, but we'll do this to support you in the meantime and, as I said, I think that's continued.

Q. Conceptually, putting Royal Rehab and its particular issue to one side, there is no reason why AHOs delivering services into the public system should not receive funds which are sufficient to meet the cost of delivering those services?

A. Yes, I would agree with that.

Q. And it's not the case, is it, that it would be an acceptable state of affairs for those AHOs to have to subsidise the cost of delivering services required of them under the service level agreement by dipping into other sources of revenue available to them - for example, private benefaction and the like?

A. Our intent and aim is to make sure that we pay what is appropriate for the services we are purchasing. Our intent is in no way to undercook that and to leave them exposed. Our obligation is to those public patients, and we are purchasing these services for those public patients. So we are completely committed to ensuring that it is at the right amount.

There is a disagreement with Royal Rehab. As I said, we tried to work our way through that. An independent review's been done. I can't comment any further because I'm not in the district anymore, but that's what I understand.

Q. In your current role, have you had any involvement with the equivalent complaint which has been made by Karitane and Tresillian about what is said to be the difference between the cost of delivering services required of each of those organisations and the funding made available to them under the service level agreements?

A. Yes, certainly with Karitane, most recently, we have had a number of meetings - in fact, there is one tomorrow - as we try and navigate their financial pressures at this point in time.

1
2 One of the first steps in all of this is to understand
3 the reasons, and I think if my colleague, the CE of
4 Karitane, were here, she would be happy if I articulated
5 the issues around declining private health insurance,
6 they've seen a significant drop in revenue for them, and
7 there have been some changes to their shared services model
8 that has also had an additional impact on their expenses.
9 So what we're doing right now is to get into the detail of
10 their deficit, understand what the drivers have been, and
11 we will negotiate with them as we come into this year's
12 funding agreement to make sure that we are more neatly
13 aligned.

14
15 Q. In relation to that negotiation, when we're dealing
16 with an organisation like Karitane or, say, Tresillian,
17 that is providing services across a wide range of LHDs,
18 would it potentially be more appropriate for those
19 organisations to have a single service level agreement with
20 the ministry rather than through a particular LHD that
21 perhaps, for historical reasons, they fell beneath?

22 A. Yes, I see the absolute efficiency and logic in that.
23 Some of them have a number of agreements with local health
24 districts, providing different services.

25
26 For the statewide services they provide on our behalf,
27 as you are aware, that runs through - if we talk Tresillian
28 and Karitane - between South Western Sydney and Sydney LHD,
29 and they hold that contract for the statewide services on
30 behalf of the state.

31
32 We have had some discussions over the past months with
33 both Tresillian and Karitane and the CEs of both local
34 health districts to see how we might streamline some of
35 this work, how we might get more cohesive planning for the
36 year ahead to mitigate against any of these financial
37 pressures that come, and a bit more alignment around the
38 services that they are providing and what we want them to
39 provide under First 2000 Days, for instance.

40
41 Q. So in terms of the services provided by Karitane and
42 Tresillian respectively, is there any centralised
43 assessment currently being made of the need for the
44 services and the way in which they should be deployed
45 across the state?

46 A. We have an annual process with both of the AHOs in
47 terms of what is being provided, the outcomes, their budget

1 position, and prepare for the next year's service model
2 that they are going to provide, so there is an annual
3 mechanism.
4

5 There are quarterly performance meetings with the
6 local health districts, and perhaps my colleague Mr Daly
7 made reference to this, and it's pretty early days, but our
8 intent is to make sure that those performance meetings with
9 those LHDs bring forward quarterly more information around
10 the functions of the AHO and performance and the like so it
11 is not just an annual process.
12

13 We do have a very close relationship with both
14 Tresillian and Karitane. I meet with them regularly. We
15 have an NGO committee on which they both sit. I recently
16 established what we're calling a health service association
17 group, so the AHOs, we come together and meet regularly to
18 talk about the statewide or thematic issues that they are
19 all confronting, so that we can try and navigate these
20 things collectively.
21

22 Q. In terms of the best way of deploying services,
23 mothers and babies' services delivered by Karitane and
24 Tresillian, for example, the respective LHDs that manage
25 those relationships, South West Sydney and Sydney, are no
26 better placed than the ministry to make decisions about
27 where those services should be delivered and what they
28 should be, to the extent they fall outside their own
29 geographic boundaries, are they?

30 A. Yes, and so the planning with Tresillian and Karitane
31 about where they might - if they are of a mind - so they
32 have a board and their own executive and they have their
33 own internal planning processes about where service need
34 might be and that's where we come together. So, you know,
35 for instance, Tresillian has recently launched some mobile
36 vans in regional New South Wales, so that will form part of
37 the service agreement with Tresillian that the local health
38 district will oversee, but there needs to be an escalation
39 pathway into the ministry if there are issues, and
40 Tresillian certainly has routine access with us and
41 certainly the chief executive can bring forward any issues
42 and we can work --
43

44 Q. I'm just wondering whether maybe cutting out the
45 middle person there might not make that relationship a
46 little bit more --

47 A. Yes.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. -- effective in terms of decision-making around service level and the level of funding that is to be provided for that service?

A. There is definitely some logic to that. There is benefit of them being embedded in local health districts, because they are the implementation arm of the ministry, so being within an LHD and in that environment, there are some benefits to that, and we have started some discussions internally around how we might - I guess it is this sort of - the tight noose or the devolution to central, thinking how we might actually - what might be an appropriate more centralised approach to supporting the AHOs in terms of delivering what they do and simplifying some of the administrative arrangements. So those sort of active discussions are on foot, but being in the LHDs has some significant advantages as well.

Q. We've heard a little bit of evidence around the delivery of some statewide services. Are there advantages in having decision-making and funding of statewide services centralised, as you see it?

A. So in terms of the statewide services, if we're referring to things such as intensive care and transplants and --

Q. Rehabilitation after serious spinal cord injuries, rehabilitation following a traumatic brain injury.

A. Yes. So there have been - traditionally the ministry has had a role in terms of the location and the funding of some of these large, you know - large and complex statewide services. The ones that you refer to, if I take traumatic brain injury, for instance, they - I think it was back in the early 2000s, there was a view that that needed to be a state coordinated service. Fairly fortunately, not high numbers of people were going through this experience - not insignificant, though. Complex care, long-term care.

At the time, there was a statewide directorate stood up to help coordinate that, and then in more recent times that has been moved across into the Agency for Clinical Innovation, and there is a dedicated network around traumatic brain injury.

The role of that network, amongst other things, is around, you know, designing consistent models of care, looking at demand and patient referral patterns, with

1 a mechanism to escalate those issues as required,
2 conversations with the ministry, so sort of a feedback
3 loop, as it were, to ensure that we are, you know,
4 delivering the level of service that is required to meet
5 demand and need.

6
7 Q. The evidence that has been given by individuals
8 involved in the delivery of those two services - the
9 traumatic brain injury and the serious spinal cord injury
10 rehabilitation services - is to the effect that, at least
11 in their view, those services would be more effectively
12 delivered through a hub-and-spoke model, where there was
13 centralised decision-making and funding, albeit with
14 delivery potentially delivered through a range of different
15 facilities coordinated by them throughout the LHDs. Do you
16 have a view about that?

17 A. Again, I can see the logic of that. Again, the spinal
18 and the traumatic brain injury are delivered slightly
19 differently. So they are spinal injury service, yes, has
20 an ACI network and their role not dissimilar to traumatic
21 brain injury in terms of the work they do and the
22 information they provide to support service development.
23 However, they are what we call supra local health district
24 services and they do sit within the service agreement with
25 activity attached to them for delivery arm through the
26 local health districts that provide spinal services.

27
28 Q. In terms of the services to be delivered and the way
29 in which funds are transferred for that delivery, where
30 does the decision-making rest with that, with the supra LHD
31 service?

32 A. So every year there is a mechanism around the
33 purchasing process, again in my colleague Matthew Daly's
34 team, and so the specialist service technology evaluation
35 unit that sits in my division would provide information,
36 for instance, on intensive care bed utilisation, patterns
37 across New South Wales to see whether the amount of beds we
38 were funding across the system were adequate for demand,
39 and that would feed then into the purchasing agreement and
40 then the appropriate amount of activity would go into that
41 for the LHD then to operate those intensive care services.

42
43 Q. Dealing with the, say, spinal injury rehabilitation
44 services, how does that information feed itself into the
45 process that you've described - that is to say, information
46 about the number of beds required and where they should be?

47 A. Could I take that in two parts?

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. Yes.

A. So for acute spinal injury, it's similar to intensive care services, that there would be an annual purchasing arrangement, a look at demand, forecast population, et cetera, and then the two local health districts that provide acute, Prince of Wales and Royal North Shore Hospital, would be given the amount of activity to care for their patients. Prince of Wales is a little bit different because it has its own rehab service as well. So that's probably a slightly cleaner service for the acute patients.

In terms of the rehabilitation services, again, Prince of Wales provides them, and as you well know, Royal Ryde Rehab does, and there is a - part of that spinal injury network is to look at rehab services. So, again, with the devolution of some of these activities into pillar agencies, the ACI work that they do would bring forward demand modelling, patient flow - they use the patient flow portals so they can see the referral patterns and how much activity is moving through these rehabilitation units - and that would inform the purchasing arrangements, including the work that Northern Sydney would do with Royal Ryde and what the ministry would do with South Eastern Sydney Local Health District to provide their rehab services.

Q. Is it your view that that arrangement, at least at an operational level, provides a sufficiently coordinated mechanism for the delivery of care to patients on a day-to-day basis?

A. Look, I would say there is always, you know, room to do things better. I think the - these linear processes probably don't adequately also describe the level of clinician and chief executive engagement with the ministry around these things as well, and with ACI. So, for instance, when I was - if I may just go back to my CE of Northern Sydney role - when there were issues around pressures within the spinal unit, we would work with ACI, we would work with the ministry, we would work with the clinical teams, we would bring forward a business case, it goes through the ministry processes and we got additional activity in our agreement.

Now, I guess that's a reactive approach as opposed to a proactive, but the aim would be of the planning work that's done annually for purchasing and the role of the ACI, that we had an effective coordination, because we have

1 a good understanding of where our patients are coming from,
2 the demand and what the need is in the system.

3
4 Q. I should probably clear up one other issue. In terms
5 of Royal Rehab, is Royal Rehab providing services into the
6 public system which extend beyond the spinal rehabilitation
7 services? Was there any general rehabilitation being
8 provided by Royal Rehab during your time?

9 A. My recollection is not. They do some brain injury
10 rehabilitation and there were some clinic services as well
11 for rehabilitation, but I think all associated with brain
12 injury, if my memory serves me right.

13
14 Q. But general rehabilitation for, say, patients who have
15 suffered strokes and the like are not being delivered by
16 Royal Rehab into the public system?

17 A. I would have to double-check. I think not.

18
19 Q. Can I take you to paragraph 95 of your statement. You
20 tell us there that you are the executive sponsor of Future
21 Health?

22 A. Mmm-hmm.

23
24 Q. To achieve the objectives of that policy, it is
25 necessary for implementation to occur through the LHDs; is
26 that right?

27 A. And the ministry and the pillars and shared services.
28 It's an entire system approach.

29
30 Q. So to the extent that the LHDs are - well, take it
31 back a step. LHDs are an important part of the delivery of
32 the objectives of that Future Health strategy?

33 A. Yes.

34
35 Q. In order to further that, or the objectives of that
36 strategy, each of the LHDs has its own strategic plan?

37 A. That's correct. Yes.

38
39 Q. Do you, or does your team, have an involvement in
40 assessing those strategic plans or reviewing them to form
41 a view about whether or not they do actually advance the
42 objects of the Future Health plan?

43 A. Yes, we don't - at the ministry level, we don't have
44 a sort of approval role around those strategic plans. They
45 are in the remit of the local health district chief
46 executive and their board. Our expectation, you know, as
47 you would expect, is that Future Health strategy, along

1 with the many other policies, are taken into consideration
2 and form part a district's strategic plan.

3

4 Q. Could we go to the Caring for the Coast plan,
5 [MOH.9999.0866.0001]. Hopefully it will come up on the
6 screen for you.

7 A. Yes.

8

9 Q. Do you recognise that document as the Central Coast
10 LHD's strategic plan?

11 A. Mmm-hmm.

12

13 Q. Could we jump forward to page 0008. What you see
14 there, as part of their strategic priorities they largely
15 rehearse a number of the strategic priorities that emerge
16 from the Future Health?

17 A. Mmm.

18

19 Q. Dealing with, for example, community, or in fact
20 dealing with any of them, if we look at them, both the
21 objectives and what are said to be the approach that is to
22 be taken to meet those objectives are cast at an extremely
23 high level, are they not?

24 A. Yes, they are.

25

26 Q. The document then does go forward, if we turn over,
27 for example, to page 0010 - do you see we have there
28 a description of the means by which some of these
29 objectives are to be met, but again, looking at the results
30 statement in the far left-hand corner, that's cast at
31 a pretty high level?

32 A. Mmm-hmm.

33

34 Q. Largely repeats what we saw in the first table. The
35 objectives again are difficult to measure. It's not
36 entirely clear, looking at the first of the objectives,
37 what good clinical outcomes means; would you agree?

38 A. From the brief scanning, yes, I think - I mean, they
39 are high level as a strategic plan. I probably should, if
40 it is alright just to point out, counsel, there is probably
41 a timing issue around this plan and when the Future Health
42 strategy was released. So you will see that the language
43 is very aligned but we didn't have a formal release so the
44 LHDs actually couldn't use the framework as the sort of
45 opening page of their strategic plan that subsequent
46 strategic plans have been --

47

1 Q. More closely aligned?

2 A. -- exactly replicated.

3

4 Q. Moving across to the measures of success that they
5 have identified in the far right-hand column, again,
6 looking at it, those things are first difficult to really
7 measure.

8 A. A number of those measures that are outlined are
9 indicators that we do collect data for that can be
10 measured. So there are, if I'm - in terms of unwarranted
11 clinical variation, patient experience, there is the PROMs
12 and PREMs as it mentions there, and our statewide patient
13 survey. Avoidable delays is looking at wait times. So
14 there are some - they won't perfectly align but there are
15 probably a suite of access and performance measures that
16 could sit up against that list.

17

18 I think the document is intended to be obviously for
19 all staff but also for the community to be able to get
20 a sense of what their local health district's aims and
21 objectives are and "How we're going to look after you and
22 how we're going to know that we've done what we intended to
23 do".

24

25 Q. Do you - accepting that this is not your document -
26 think that the measures of success which are identified
27 there really are any measure of the extent to which the
28 objectives that they have given themselves have been
29 achieved?

30 A. From just - again, just scanning sitting here, I mean
31 they are acceptable measures that would tell a community
32 how effective their services are. However, they would not
33 be the entirety, and there are many other measures that
34 chief executives and teams would be looking at on a daily,
35 monthly base that would tell the story of how they were
36 tracking against a strategy, but more importantly, against
37 a service capability.

38

39 Q. Are you confident that the - well, let me break it up.
40 The CEs of the various districts would be looking closely
41 at the KPIs set out in the service level agreement?

42 A. I do think that is the case.

43

44 Q. And their performance against those KPIs?

45 A. Indeed.

46

47 Q. Do you think that they would be assessing a wider

1 degree of - a wider range of metrics in order to consider
2 their success or failure as against their strategic
3 objectives?

4 A. Look, I do. I think it's variable, it depends on what
5 the issue is. If you take quality and safety, for
6 instance - and I can't see - you know, right place for
7 care, there are multiple quality and safety KPIs that, as
8 a chief executive, you keep a very, very close eye on, but
9 you also have directors of clinical governance or directors
10 of patient safety who are also mining this information,
11 tracking things and bringing it forward. We have
12 a Clinical Excellence Commission that is reporting on these
13 things. So it comes from a variety of sources.

14
15 But as a chief executive, there will be high level
16 measures. You will watch the trend. If things are staying
17 green, there may still be questions to ask, but if things
18 are starting to move into amber, you will start to ask more
19 questions, and if things are red, you will ask very
20 detailed questions. So I could say with confidence, having
21 been a CE but knowing my colleagues, these are things that
22 they track and monitor very closely.

23
24 MR MUSTON: Thank you. I have no further questions for
25 this witness, Commissioner.

26
27 THE COMMISSIONER: Thank you. Mr Chiu?

28
29 MR CHIU: No questions, thank you, Commissioner.

30
31 THE COMMISSIONER: Thank you very much, Ms Willcox, we're
32 very grateful for your time. Thank you.

33
34 THE WITNESS: Thank you.

35
36 THE COMMISSIONER: Do we adjourn until 3.30?

37
38 MR MUSTON: 3.30, I think, for Mr Danos - the return of
39 Mr Danos.

40
41 THE COMMISSIONER: We will adjourn until 3.30.

42
43 MR MUSTON: Oh, he might be outside, we're told.

44
45 THE COMMISSIONER: Oh, he is? Well, we won't adjourn
46 until 3.30, we'll just keep going.

47

1 <THE WITNESS WITHDREW

2
3 <TREVOR EGON DANOS, recalled, on former oath: [2.44pm]

4
5 <EXAMINATION BY MR MUSTON:

6
7 THE COMMISSIONER: Have a seat. Mr Danos, you are on your
8 former oath. Thank you for coming back.

9
10 I should say, if it hasn't been made clear to you, the
11 false alarms for you giving evidence and the reason you
12 have had to come back are entirely my fault. I apologise.
13 But that was largely due to a dental emergency, that I'm
14 still vaguely feeling.

15
16 THE WITNESS: My wife is a dentist.

17
18 THE COMMISSIONER: That's good to know. But if an
19 infection develops, I will get in touch. Otherwise,
20 hopefully not.

21
22 MR MUSTON: Q. I think - I just want to come back to
23 a couple of answers you gave the other day to make sure our
24 understanding of it is correct, Mr Danos. You indicated to
25 us in response to a question I asked you about the extent
26 to which the LHD might step in to deliver some primary care
27 if the market-based model was not working, that there was
28 nothing in the service level agreement that you were aware
29 of about the provision of primary care.

30 A. Look, there are some primary care services that we do
31 provide, for example, nursing in the home, diabetic wound
32 dressing and so on, but we don't run GP clinics as such.
33 But if there were a failure, if there were not insufficient
34 GPs around or people couldn't make bookings or there
35 weren't bulk billing practices, our expectation is that
36 people would turn up to the emergency department, and that
37 is in fact what happens.

38
39 Q. Because the situation is, is it not, that decisions
40 are made at a ministry level about how to divide the
41 available funding resources between the various LHDs?

42 A. Correct.

43
44 Q. And then the devolved nature of the delivery of health
45 care in this state means that it's up to the LHDs,
46 ultimately, to decide how that money is to be spent
47 within - in meeting the needs of their population?

1 A. Well, within the service agreement we are given what
2 I might describe a number of buckets of money for different
3 purposes, expressed in terms of NWAUs and the like. There
4 is also a small amount of what I will call block funding.
5 I think we are expected to spend the money for the purpose
6 that it is given, with some flexibility within the
7 movement, but we're not there to take one bucket and
8 redesignate it as another bucket and do something
9 differently with it.

10
11 Q. But in terms of the prioritisation of services and
12 which services are to be provided, it is something which is
13 to be determined based on an assessment made by the LHD of
14 the needs of its particular community?

15 A. Yes, and that would be reflected in the negotiations
16 that would be had with the ministry, where we would be
17 saying that we need - you know, we think we need a certain
18 number of NWAUs for particular activities as part of the
19 negotiation of the service agreement.

20
21 Q. But the ministry is not dictating which services are
22 and are not to be provided through that process?

23 A. Well, look, some - so, for example, we don't do heart
24 transplants at Northern Sydney. If some patient within
25 Northern Sydney required a heart transplant, that would be
26 done in a different LHD. But we have a detailed service
27 agreement which, at the beginning of the year, says these
28 are the services we are expected to perform within the
29 district.

30
31 Q. Could we bring up Mr Danos's statement, please,
32 operator. [MOH.9999.0765.0001] and jump all the way
33 forward to paragraph 54 on page 18?

34 A. I've got that, thank you.

35
36 Q. You identify there a number of things that you want to
37 highlight. I want to take you particularly to
38 subparagraph (c).

39 A. Yes.

40
41 Q. What's the purpose of that document in terms of your
42 engagement with the CEs --

43 A. So this started - so there is no requirement under the
44 service agreement or anywhere else for such a letter, but
45 it was something that I conceived quite early on at the
46 commencement of my chairman role, that it is a good way to
47 keep a very focused conversation with the chief executive,

1 and so we develop one at the beginning of each year and we
2 socialise it with the board to make sure that the board is
3 happy with it; we socialise it with the chief executive,
4 and, going forward through the year, when I meet with the
5 chief executive weekly and on a six-monthly basis when the
6 chief executive puts out a traffic light report - which is
7 separate to the traffic light report that I spoke about on
8 Wednesday which relates to the strategic plan - it's
9 a focus on those, what the board regards as the key
10 activities and priorities within the district.

11
12 Q. Could we go to [MOH.9999.1109.0001]?

13 A. Yes. I've got that, thank you.

14
15 Q. That's a letter dated 11 September 2023 from you to
16 Mr Schembri?

17 A. Yes.

18
19 Q. Or Adjunct Professor Schembri. Is this one of the -
20 a letter which falls into the category that --

21 A. Look, this is an unusual letter, because last year was
22 an unusual year. First of all, Anthony only commenced as
23 the chief executive in July, and then, secondly, because -
24 well, because Labor was elected earlier in the year, the
25 budget was only going to be held after 30 June, and
26 therefore the actual service agreement would only be
27 entered into after 30 June. So this is a - I will call it
28 a bridging letter pending seeing the final service
29 agreement and I think, after that, I issued a more
30 extensive, probably about a five- or six-page letter.

31
32 Q. We'll come to that one in a moment. Could I just ask
33 you to pick up the 11 September 2023 letter. Do you see
34 the first - the second paragraph commencing "I am writing
35 to you now"?

36 A. Yes. I brought a hard copy with me.

37
38 Q. Whichever is most convenient to you.

39 A. Okay, yes.

40
41 Q. I just want to ask, what is it that, in that last
42 sentence of that paragraph, you were needing or inviting
43 Mr Schembri to be on the front foot in relation to, and
44 what is the inevitable --

45 A. We were expecting a tough budget from the state and
46 that that would be reflected in the service agreement for
47 2023/2024, albeit starting in September.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. So if we move down two paragraphs where you refer to the harsh budget and a correspondingly severe service agreement, that's the essence of what you were referring to?

A. Yes, correct.

Q. When you say "severe", you mean there, do you, a service agreement which provided less funding than might be ordinarily expected?

A. Yes, the expectations of the services that we would deliver were not going to be a surprise. That rarely changes from year to year. But the amount of available funds to deliver those services were expected to be quite a bit lower than in previous years, yes.

Q. When you refer then in that paragraph commencing "This time the State will face", to "customary juggling", what is it you are referring to there as the "customary juggling"?

A. Look, it is a very large budget that we have - it's north of \$2 billion per annum for our opex, and in the ordinary course, one can find some savings, defer some expenditure, maybe move some money around between buckets as is permitted and, you know, within that framework, hopefully still bring the budget in - still bring the district in on budget.

Those movements might be, you know, half a million dollars here or a quarter of a million dollars here, but still you can move things around. We were expecting the degree of difficulty to do those manoeuvres to be considerably harder with the budget that we were expecting to get.

Q. So by "customary juggling" you weren't talking about withdrawing services which --

A. No, no, no.

Q. -- the community had a need for?

A. No, no, absolutely not. It is just, you know, in the ebb and flow of a \$2 billion budget, some amounts go up, some amounts go down during the year. You still manage to deliver the services, but you can find maybe some savings along the way or some expenditure that you thought you were going to have in a particular year is deferred or less than you expected it to be.

1 Q. But that customary juggling, in your expectation,
2 wasn't going to be sufficient in light of what you
3 anticipated to be a severe budget?

4 A. We were expecting it to be a lot harder than in past
5 years.

6
7 Q. And it was your view, you tell Mr Schembri, that
8 inevitably, there would need to be cut-backs, sacrifices
9 and the deprioritisation of service?

10 A. Yes.

11

12 Q. In your view - well, was it your view that the
13 severity of the budget would mean that the LHD was not able
14 to deliver on the objects, on its statutory function?

15 A. No, I don't think that's right. Because, first of
16 all, we were at the beginning of the year and you only
17 really know at the end of the year what you have done and
18 what you haven't done, but it was almost to be on guard
19 that this was going to be a tough year and that we had
20 better be monitoring very closely and rigorously all of our
21 expenditure along the way, rather than maybe hope that part
22 of the way through the year we could do some catching up.

23

24 Q. Your reference in the paragraph to "cutbacks,
25 sacrifices and the deprioritisation of services" - I'm
26 assuming that that doesn't refer to services which were not
27 otherwise required?

28 A. No, no. And in fact, on the top of the next
29 page I give some examples against the bullet points on the
30 second page, of the sorts of things that we were hoping the
31 chief executive would be willing to look at as a way to
32 work within the budget that we had been given.

33

34 Q. Was it your view that as a board, you had any capacity
35 to engage with ministry about the extent to which the
36 function of the LHD could be performed within the budgetary
37 envelope that was to be provided?

38 A. Oh, I would have had some conversations with the
39 secretary, particularly - I think, from memory,
40 particularly around things like dialysis within the
41 district. We were also responsible for a major component
42 of the delivery of services around voluntary assisted
43 dying, and it was critical that we not drop the ball on
44 that in any way, particularly as it was - as the service
45 was going to be launched in December of last year. So yes,
46 I would have spoken to the secretary on those things. But
47 one also, you know, has to be realistic that you've got -

1 you're working within a budget.

2
3 Q. When it comes to cutbacks, sacrifices and services
4 that are to be deprioritised, does the board have a role in
5 that or is that an operational issue which is left to the
6 CE?

7 A. Look, it's a "yes" and "no" answer. The board
8 ultimately wants the district to come in on budget. The
9 board doesn't want the district to come in at a loss. So
10 that is front of mind for the board in its monthly
11 discussions with the chief executive and in the monthly
12 written report from the chief executive there is
13 highlighted in his report the net cost of service, the
14 operating expenditure and any revenue that might have come
15 in, and we follow that very closely and those numbers are
16 constantly communicated to the ministry and they form part
17 of the monthly performance assessment of the district by
18 the ministry.

19
20 So in one sense, yes, the board of course will be
21 concerned about overall financial performance, and I think
22 that's consistent with section 28 of the Act.

23
24 At the same time, it's not the role of the board to
25 get involved in operational matters, so it would not be the
26 role of the board to say, you know "Let's stop a particular
27 service", or cut back a particular service, but we would
28 expect the chief executive to keep the board informed if
29 there were any, you know, major or material decisions.

30
31 So, for example, you know, we talk about high cost,
32 low value services. We've been talking as a district, the
33 chairs of boards have been talking about that for as long
34 as I can remember, because there are high cost, low value
35 services, and I think up until now the discussion has more
36 been hypothetical, or theoretical, you know, how could we
37 do those sorts of things. The events of last year's budget
38 would have been a prompt to really bring forward those
39 sorts of discussions and see what we might be able to do
40 within that domain.

41
42 Q. Because reducing the amount of high cost, low value
43 service delivered isn't really a tough or radical decision
44 for an LHD to make, is it?

45 A. Well, I think it is in the sense that we have a lot
46 of - you know, we all have staff who are devoted and
47 dedicated and delivering these services, and there is

1 a very human element to possibly winding back a service or
2 changing the frequency or the scope or - of the particular
3 service. Plus there would be community expectations, if
4 the district has always provided a particular service. So
5 I think it - it's a challenge and it goes to communication
6 and it goes to ensuring that the district maintains a good
7 relationship with its stakeholders, with all of its
8 patients and carers and so on.

9
10 Q. Could I just ask you to help us with the fourth bullet
11 point down, "Patient presentations that are likely to lead
12 to fee waivers and bad debt write-offs." What does that
13 relate to?

14 A. So this is the quite annoying issue that we have
15 people who turn up to the emergency department, often
16 people who are tourists, often who give their permanent
17 address as care of the Qantas lounge and who get quite
18 substantial medical treatment, and then just walk out of
19 the hospital without paying. It's a well-known fact. To
20 my mind it flows from the fact that the Commonwealth
21 regulates visitors to the country, the Commonwealth doesn't
22 mandate health insurance for visitors to the country. Some
23 visitors to the country will be covered under Medicare
24 reciprocal agreements, but we, I think routinely, write off
25 about \$3 million or \$4 million a year for people who come
26 in and - because we - because we are a health service that
27 doesn't turn people away and we don't ask them, when they
28 come into the hospital, "Are you a resident or
29 a non-resident." We might ask to see their Medicare card
30 but if they are in distress, we will treat them and
31 whatever financial compensation is required will happen
32 later, and as I said, we have this issue where people do
33 come into the hospital, see it as a free service and then
34 walk away.

35
36 Q. These are patients who are presenting say in emergency
37 with an acute need for care?

38 A. Yes, yes, yes, and I should say, it's something that
39 has been taken up by the Council of Board Chairs with the
40 secretary and with the chief financial officer. We're very
41 aware of the quantum and, you know, that \$4 million or
42 \$5 million that we might write off for the district
43 annually is four or five million dollars that we think we
44 could spend better or more wisely on the residents of
45 Northern Sydney LHD.

46
47 Q. What was the potentially radical decision that needed

1 to be made in relation to those patient presentations, as
2 you saw it?

3 A. It's really a conversation with the federal
4 government, between the state government and the federal
5 government. Look, this would not be a unique problem for
6 my district. It would not be a unique problem for our
7 state. Interestingly, you know, one of the areas --

8

9 Q. Just in relation to that, you weren't anticipating
10 that Mr Schembri would be having conversations with the
11 federal government, were you?

12 A. Oh, no, no.

13

14 Q. I think just looking at the text of your letter,
15 you're referring to "potentially radical decisions" being
16 made by Mr Schembri in relation to the patient
17 presentations?

18 A. No, no, no, absolutely not.

19

20 Q. What did you have in mind when you referred to
21 "potentially radical decisions" that he might have been
22 making in relation to those patients?

23 A. Perhaps the bullet point might have been separated
24 out, but this has been a particular bugbear for me and for
25 other chairs, and I think we were very keen that the
26 secretary and the ministry see what was within its power to
27 try to address this. But ultimately, as I said, if the
28 Commonwealth is not cooperating in this, it is very, very
29 hard for the state or for a local health district to have
30 any impact on those matters.

31

32 Q. Going down to the next full paragraph commencing "For
33 the two preceding paragraphs", do you see you refer there
34 to the board's encouragement of Mr Schembri to investigate
35 and pursue the use of existing and new technologies to
36 bring about or enhance the desired outcomes. Was that
37 something that you thought was realistic in light of the
38 very tight budgetary constraints that you anticipated would
39 be imposed upon the LHD?

40 A. Sorry, could you repeat that.

41

42 Q. In an investigation and pursuit of existing and new
43 technologies to bring about or enhance a desired outcome
44 something which was realistic in light of the very tight
45 budgetary constraints that you anticipated?

46 A. Look, I think if the chief executive had identified
47 some new technology that - you know, the classic, I think

1 I might have used this in a later letter, the classic, you
2 know, spend a penny to save a pound, the board was very
3 supportive of that. We didn't have any particular
4 technology in mind, but we wanted Anthony Schembri to feel
5 that he was supported to look at all options.
6

7 Q. Spending pennies requires a degree of financial
8 headroom. Spending pennies requires a degree of financial
9 headroom.

10 A. Yes, it does.
11

12 Q. Did you feel that the budget would likely provide that
13 headroom?

14 A. Well, I think it is part of the, you know,
15 prioritisation that the chief executive would undertake,
16 but we were supportive and we are supportive of the notion
17 of spending a penny to save a pound.
18

19 Q. Can we move on to the next letter, which is
20 [MOH.9999.0832.0001].

21 A. Yes, thank you.
22

23 Q. This is the more comprehensive letter that I think you
24 have referred to a moment ago?

25 A. That's correct, yes.
26

27 Q. It is not dated directly, it seems to be dated some
28 date in January 2024, at least on my --

29 A. Yes, I can explain if you wish. In January, we were
30 doing - as board chair I was doing the annual performance
31 appraisal of the chief executive with the secretary - a
32 little unusual because the annual performance appraisal
33 looks back to the previous financial year, and Anthony
34 Schembri had only started in July. But anyhow, I raised
35 that with the secretary and she thought we should have the
36 meeting anyhow to just set the framework, see how Anthony
37 was going. So I prepared a draft letter, which as it turns
38 out wasn't signed, but I checked my records, it went
39 through the normal process of socialisation, and that is
40 the undated January letter to which you currently refer.
41

42 Q. The normal process of socialisation being what?

43 A. Oh, so I would prepare a draft, usually as a mark-up
44 of the previous year's letter. I would run it past the
45 deputy chair. Once the deputy chair and I were happy with
46 it, we would share it with the chief executive to see if he
47 had any particular concerns about it. Once he was

1 provisionally happy with it, I would share it with the
2 board, which I'm currently doing, for the letter for July
3 this year, 2024, give the board about a four- to six-week
4 period to turn it around and give me any comments, and then
5 finalise it, sign it, and send it.
6

7 Q. Do you have a copy of that letter in front of you?

8 A. Yes, I do, thank you.
9

10 Q. Do you see the first list of bullet points which
11 identifies items you wanted to call out in particular? Can
12 I invite you to go down to the second from the bottom,
13 where you commend him on how quickly he had come to
14 understand the issues and challenges with the Northern
15 Beaches Hospital PPP?

16 A. Yes.
17

18 Q. What were those issues and challenges, as you
19 understand them, or what are they?

20 A. Well, you probably are aware, there was
21 a parliamentary inquiry into Northern Beaches Hospital,
22 which I think teased out a lot of the challenges. This is
23 the major health PPP within New South Wales. Our role as
24 the health district is to administer it, because Northern
25 Beaches is part of Northern Sydney, and it replaced Manly
26 and Mona Vale as acute services hospitals. Well, it's
27 a very complicated commercial arrangement. The project
28 deed runs to 500 or 600 pages from memory, plus the
29 schedules that go with it. There is a service agreement
30 between the district and Northern Beaches Hospital, just as
31 there is a service agreement between the ministry and
32 Northern Sydney LHD. It's complicated.
33

34 There are issues not only for payment of services, but
35 if services aren't performed to the required standard,
36 there are abatement of those payments. There are issues
37 around demand management plans, how Northern Beaches
38 interfaces with the community and with community services
39 including things like mental health. It's a complicated
40 deal and I think Anthony got on top of it fairly quickly.
41

42 Q. This letter was sent after the budget had actually
43 been delivered?

44 A. Oh, yes.
45

46 Q. So, by this stage, were your expectations - did your
47 expectations around the severe service agreement become

1 a reality or --

2 A. Yes, look, maybe on reflection "severe" wasn't quite
3 the right word or is not quite the right word to describe
4 it, but it was a tough service agreement and, as we
5 expected, it manifested itself as a tough service
6 agreement. It was still one that we as a district were
7 satisfied that we could operate within and we could manage,
8 but it was not going to be an easy year under that service
9 agreement, within the budget he had set.

10

11 Q. Going over to the second page, the first complete
12 paragraph commencing "Whilst the board is pleased" - do you
13 see that paragraph?

14 A. Yes, thank you.

15

16 Q. At the end you conclude by making reference to lessons
17 learned and the "new normal"?

18 A. Yes.

19

20 Q. What's the "new normal" that had you in mind? Is it
21 an ongoing tight budget?

22 A. No, it was more - no, because there had been,
23 actually, plenty of funding during the pandemic, but no, it
24 was more the fact that people who once came to the hospital
25 for ambulatory care were no longer coming, or were often
26 discouraged from coming. Presentations in the emergency
27 department were often more complex than they had been in
28 the past. There were challenges around workforce because
29 members of the nursing profession had left the profession.

30

31 So it was - I think that's the - you know, the "new
32 normal", rather than some financial - I wasn't suggesting
33 any financial element of the new normal coming out of the
34 pandemic.

35

36 Q. Can I ask you to track down to the table that appears
37 or commences at the foot of that page?

38 A. Yes.

39

40 Q. There is a reference again to the Northern Beaches
41 Hospital in the first of the rows.

42 A. Yes.

43

44 Q. You were concerned to have Mr Schembri identify and
45 implement actions to ensure no financial detriment to the
46 district. What was the financial detriment that you
47 perceived might flow to the district through the Northern

1 Beaches Hospital?

2 A. Well, we pay for services to Healthscope, who operate
3 Northern Beaches Hospital. Perhaps they at times have
4 expectations that we will pay for things, pay for services
5 beyond what we think is an appropriate amount or the
6 appropriate measure or the appropriate number of NWAUs.
7 Issues, for example, around demand management, you know,
8 how they should treat people, there's a major element
9 around the PPP around the use of private insurance,
10 conversion of patients to use their private insurance. So
11 we just wanted to make sure that the service agreement that
12 we had between ourselves and Northern Beaches was honoured
13 in a way, and perhaps implemented in a way and administered
14 in a way, that it would take those swings and roundabouts
15 into consideration, rather than just whatever the operator
16 thought they wanted to be paid, they should be paid.

17

18 Q. Are you aware of a similar issue in terms of a debate
19 around the cost to be provided or the payment to be
20 provided for the delivery of service which has emerged in
21 relation to Royal Rehab?

22 A. Look, I am aware of the Royal Rehab situation, yes.

23

24 Q. What involvement, if any, has the board had in the
25 Royal Rehab situation?

26 A. So I only became aware of this probably weeks ago,
27 maybe a month ago or so. So becoming aware of it, I sat
28 down with Anthony and I was briefed on it, and what we've
29 subsequently done is we're in the process of briefing both
30 the audit and risk committee and the finance risk and
31 performance committee of the board - they're the
32 appropriate first line of briefing. Certainly the FRAP,
33 the finance risk and performance committee, has had its
34 briefing and the intention then is to bring the matter to
35 the board for a full briefing.

36

37 Q. Are you aware that Royal Rehab has not entered into
38 a service level agreement since 2012?

39 A. As of a month or so ago, yes, I am aware of that.

40 I mean, I'm also aware that it doesn't - look, that is, you
41 know, unusual, abnormal and not how it should be. I don't
42 want to - I don't know the history of it and I don't think
43 there is any benefit in trawling through the history, but
44 I would like to see it normalised. I mean, equally I am
45 aware that there has been work done. I think consulting
46 actuaries have been engaged to look at the level of service
47 that they provide and whether they can operate within the

1 budget allocated. So I am aware that Anthony has been
2 speaking with his counterpart at Royal Rehab.

3
4 Q. As an AHO, you would accept, wouldn't you, that Royal
5 Rehab should be reimbursed sufficiently to enable the
6 delivery of the services which are required under the
7 service agreement?

8 A. I would have to qualify that statement to say
9 depending on what their cost structure is. They are
10 clearly providing a very important service and it ties in
11 with North Shore being the state spinal service. I've been
12 to Royal Rehab probably two or three times, I have met
13 their chairman and their chief exec and I've walked around.
14 It is a very impressive facility. But I don't think the
15 intention is for us to have some sort of cost-plus contract
16 with them. That's not the nature of our service agreement
17 with the ministry and, therefore, it wouldn't be the nature
18 of any flow-down service agreement. So --

19
20 Q. My question was more directed at you don't suggest
21 that it should be a cost-minus agreement?

22 A. A?

23
24 Q. A cost-minus agreement?

25 A. A cost-minus?

26
27 Q. You said you don't want a cost-plus agreement. I'm
28 not sure that there is any complaint about that from Royal
29 Rehab. I think what Royal Rehab is saying at the moment is
30 that the sum being proffered under the service level
31 agreement requires them to deliver the services
32 contemplated by that agreement at less than cost.

33 A. I can't comment on that beyond saying that I'm aware
34 of the issue. I'm aware that there has been some external
35 accounting and actuarial advice to look at their books.
36 I think they've said we can look at them transparently.
37 I would have to - that issue would have to come to some
38 resolution before there could be a final determination
39 made.

40
41 But the Ministry of Health, through the districts, has
42 arrangements with a whole number of AHOs, plus a whole
43 number of NGOs who are not AHOs who provide very valuable
44 services to the people who live within the district. But
45 we're not there to guarantee the solvency or the financial
46 profitability of any third party contractor. We're there
47 to have a fair bargain with them.

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

Q. To the extent that an AHO like Royal Rehab is providing services across the state, albeit predominantly from a footprint within your LHD, do you see there might be some utility in Royal Rehab having its service level agreement direct with the ministry rather than with your LHD?

A. Well, the structure of health is to devolve health services down through the LHDs and to have the governance within the LHD, the administration of contracts within the LHD. So I think the current structure is the right structure. I can't explain, as I said, why this anomaly with Royal Rehab is what it is, but I don't know that having the contract with the ministry would necessarily improve things. At the end of the day, it is the district who is dealing with the very sad cases of people who are in the spinal unit who need to be moved to Royal Rehab. They are much more on the ground and aware of those circumstances. I used the word "localised" the other day. They have the local knowledge. I think the local knowledge is very important and you wouldn't have that local knowledge if the contract were administered through the ministry.

Q. Can we turn over to the next page, page 0003, which is 3 of 5 I think in your copy?

A. Yes.

Q. Do you see there at point 7 "CORE values and culture"?

A. Yes.

Q. Then the very last point you make at L:

Revitalise the district's medical staff councils and the medical staff executive council.

In writing that, was it your view that those bodies had become stale in some way?

A. Yes. You know, the - as the board, we get the minutes of the medical staff executive council, and I can't remember - and I don't say that with any drama - you know, the last time there was a meeting of the medical staff executive council. So there is some - one could be sympathetic and say trying to get busy doctors and leading doctors together from four or five sites to meet and discuss things - but it is a great opportunity for us as

1 a board to hear directly from the medical staff executive
2 council. The chair of the medical staff executive council
3 has, in effect, de facto board status and can - and attends
4 all the board meetings. For so long as I've been chair,
5 we've never excluded that person for any agenda item,
6 except where we're discussing the chief executive
7 performance and an employee shouldn't be in the room. So
8 I think - yes, I think it is - I'd love to see the medical
9 staff executive council contribute to the full capacity
10 that it can, and I want - we as a board were keen for the
11 chief executive to have that on his work slate.
12

13 Q. So to the extent that the medical staff council and
14 the medical staff executive council might be seen as
15 a bridge between clinicians and hospital administration or
16 LHD administration, at least as at the date of this letter,
17 it is a bridge that was not working particularly
18 effectively; would that be right?

19 A. Look, there are many bridges. Medical staff are not
20 shy in picking up the phone to me or the chief executive or
21 knocking on our door if they've got something to raise.
22 But this is meant to be the structure, the peak structure
23 which brings up to it the concerns of all the medical staff
24 within our hospitals and services, both surgical and
25 medical, and there is an opportunity to right it and get it
26 back to the vibrant council that it could be.
27

28 Q. And, finally, do you think that the delivery of health
29 care to the community within your LHD would suffer if there
30 was no board within the management structure?

31 A. I think it would.
32

33 Q. In what way?

34 A. Well, it's interesting how people - people regard the
35 board - you know, when I go to events and the like, they
36 seem to attach an importance to the board. I don't know
37 whether that's because it's just seen as in parallel to how
38 boards work in other parts of the economy and the
39 community. I think it also gives them a line of -
40 a pathway of communication away from management. So we
41 have - so I'm contacted regularly by staff, medical staff,
42 non-medical staff, who want to talk about things. I think
43 if there was no board, that line of communication would be
44 lost. Of course, they could speak directly to Anthony and
45 his team, but it is a slightly different conversation when
46 you are speaking ultimately to your employer.
47

1 We have a number of events in the district where we
2 celebrate success, our exceptional people awards. It seems
3 to be incredibly well appreciated when members of the board
4 come along and present at those things, speak at events,
5 when we have Sorry day, and so on. People attach - seem to
6 attach - quite a lot of significance to the board and their
7 ability to communicate with the board. And, conversely,
8 you would have seen reference in my statement to board
9 breakfasts. So we have - we used to have them once a month
10 and now once every six weeks or eight weeks, a breakfast
11 where the board hosts the breakfast for staff. I think
12 that's a great way of communicating.

13
14 What makes a great hospital I think is ultimately
15 culture and staff engagement and I think the board, a good
16 board, contributes to significantly improve culture and
17 a high level of staff engagement.

18
19 THE COMMISSIONER: Q. How many hours a week, on average,
20 are you spending on activities related to fulfilling your
21 obligations as a board chair?

22 A. As a chair?

23
24 Q. Yes.

25 A. Somewhere between a day and a half and two days
26 a week. It's - as I said, it's an enterprise, \$2 billion
27 enterprise with a staff close to 14,000, spread across six,
28 seven or eight sites, so yes, I would say between a day and
29 a half and two days.

30
31 Q. And making the assumption which I think I should, that
32 your other board directors are efficient and diligent --

33 A. Yes.

34
35 Q. -- in fulfilling their obligations, do you know how
36 long, on average, they are spending in their duties as
37 board members?

38 A. Well, normally they are - they tend to self-allocate
39 to a particular committee. So, given the focus on - two
40 very heavy duty, heavy lifting committees are safety and
41 quality, because we are constantly celebrating that, we're
42 looking at reports; and then the consumer engagement
43 committee. Consumer engagement committee, we've put out
44 a lot of papers this year, we've got active consumer
45 advisers, we've just started paying the consumer advisers
46 for their attendance. We have an annual forum. There is
47 cross-membership between the consumer committee and the

1 health care quality committee. So I would think for
2 a committee chair it's probably three-quarters of a day to
3 a day a week.
4

5 Q. That includes the reading that is done and --
6 A. That includes?
7

8 Q. That includes the reading that might have to be done,
9 reading in for board meetings and those sort of things or
10 is that --

11 A. Yes, our last board pack, which included our draft
12 clinical services plan, ran to 700 pages. Now, we've
13 started issuing our board members with iPads so they can
14 read these things on screen and save the paper. But board
15 members, by and large, are very diligent. Being involved
16 in health administration ultimately becomes quite
17 addictive, I think. You feel that you can make
18 a difference.
19

20 Q. And you have meetings with chairs of other LHD boards?

21 A. So once a quarter we have a body called the Council of
22 Board Chairs.
23

24 Q. And based on anything that is said to you, is the time
25 that you spend as a board chair consistent with what your
26 colleagues and other chairs --

27 A. Yes, so there was a paper that we tendered to the
28 Commission.
29

30 Q. A submission?

31 A. A submission, which four of the board chairs signed
32 off on that.
33

34 Q. Yes.

35 A. Yes. What I'm saying - look, it takes a bit of time
36 when you become a board chair to get into the routine and
37 it is a big job, but yes, I think - well, they were happy
38 to put their name to it and within that paper we said it is
39 a day and a half to two days for a board chair.
40

41 THE COMMISSIONER: Okay, thank you.
42

43 MR MUSTON: Q. One last question. I asked you last week
44 about ways in which you as a board monitor the extent to
45 which health services being offered by the LHD were
46 continuing to meet the needs of the population, and in your
47 answer you referred to reports from the chief executive.

1 Could I show you a document?
2 A. So is that the monthly report from the chief
3 executive?
4
5 Q. I will hand it to you and you can have a look at it.
6 A. Yes.
7
8 Q. When you were referring to reports from the chief
9 executive, is that the document you had in mind?
10 A. Yes. Well, over and above, you know, any verbal
11 communication, that's the formal monthly report that we get
12 from the chief executive.
13
14 MR MUSTON: Might that be marked? I think we're up to
15 MFI 8.
16
17 THE COMMISSIONER: Shall we describe it? What is it
18 called?
19
20 MR MUSTON: It's a chief executive's board report
21 dated April 2024
22
23 **MFI #8 CHIEF EXECUTIVE'S BOARD REPORT DATED APRIL 2024**
24
25 MR MUSTON: I have no further questions for this witness.
26
27 THE COMMISSIONER: Mr Chiu, do you have any questions?
28
29 MR CHIU: No questions.
30
31 THE COMMISSIONER: Thank you very much for your time,
32 Mr Danos, we're very grateful. Sorry you've been messed
33 around.
34
35 THE WITNESS: Thank you.
36
37 <THE WITNESS WITHDREW
38
39 THE COMMISSIONER: Is that it for these hearings?
40
41 MR MUSTON: I think we have a list of documents to tender,
42 but otherwise --
43
44 MR GLOVER: Commissioner, in the usual way, I hand up
45 a list of documents to tender, which will become, once
46 marked, exhibit D and they've all had exhibit numbers
47 notionally assigned to them.

1
2 THE COMMISSIONER: All right. They are admitted into
3 evidence with the exhibit numbers that are allocated.
4
5 MR GLOVER: Thank you, Commissioner. That completes the
6 evidence for this hearing.
7
8 THE COMMISSIONER: That was your role for today?
9
10 MR GLOVER: That was it. That's why I'm here, to add
11 value.
12
13 THE COMMISSIONER: Very good. And do we adjourn to
14 Monday, 13 May? Is that the next - someone is nodding at
15 the back.
16
17 MR GLOVER: Yes, in Dubbo.
18
19 THE COMMISSIONER: So we will adjourn until Monday,
20 13 May, at 10am in Dubbo - somewhere in Dubbo.
21
22 MR GLOVER: Yes.
23
24 THE COMMISSIONER: Very good. Thank you. We'll adjourn
25 to then.
26
27 **AT 3.27PM THE COMMISSION WAS ADJOURNED TO MONDAY, 13 MAY**
28 **2024 AT 10AM IN DUBBO**
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47

0
0^[5] - 2511:39, 2512:17, 2512:21, 2513:2, 2513:11
0003^[1] - 2573:25
0008^[1] - 2557:13
0010^[1] - 2557:27
0021^[1] - 2510:6
0024^[1] - 2510:12
024^[1] - 2479:24

1
1^[4] - 2512:22, 2513:27, 2517:20, 2517:36
10.01am^[1] - 2479:22
10.03am^[1] - 2480:6
100^[1] - 2509:1
103^[1] - 2509:1
10am^[1] - 2578:20
10AM^[1] - 2578:28
11^[3] - 2512:32, 2562:15, 2562:33
116^[1] - 2507:34
12^[3] - 2495:39, 2499:12, 2514:17
12-hour^[1] - 2501:29
12.38pm^[1] - 2530:27
121^[1] - 2479:18
13^[3] - 2578:14, 2578:20, 2578:27
14,000^[1] - 2575:27
15^[1] - 2490:30
16^[2] - 2515:14, 2515:17
18^[2] - 2512:33, 2561:33
19^[2] - 2531:38, 2533:8
19(2)^[7] - 2508:5, 2508:25, 2541:20, 2541:31, 2543:4, 2543:9, 2544:32

2
2^[11] - 2479:18, 2480:45, 2481:12, 2507:17, 2512:22, 2513:27, 2534:39, 2541:44, 2563:21, 2563:41, 2575:26
2.44pm^[1] - 2560:3
20(d)^[1] - 2531:47
2000^[1] - 2551:39
2000s^[2] - 2523:47, 2553:34
2012^[1] - 2571:38

2017^[2] - 2531:1, 2531:3
2022^[2] - 2480:22, 2530:39
2023^[3] - 2548:39, 2562:15, 2562:33
2023/2024^[1] - 2562:47
2024^[8] - 2479:22, 2480:26, 2531:6, 2568:28, 2569:3, 2577:21, 2577:23, 2578:28
21^[2] - 2510:6, 2527:6
23^[2] - 2504:10, 2508:37
25^[4] - 2485:47, 2499:7, 2501:2, 2501:7
28^[1] - 2565:22
29^[1] - 2479:22

3
3^[6] - 2482:6, 2507:17, 2510:13, 2513:27, 2566:25, 2573:26
3.27PM^[1] - 2578:27
3.30^[4] - 2559:36, 2559:38, 2559:41, 2559:46
30^[5] - 2487:28, 2507:27, 2511:39, 2562:25, 2562:27
32^[2] - 2514:24, 2514:28
320^[1] - 2509:10
35^[1] - 2485:33

4
4^[5] - 2482:5, 2511:40, 2513:27, 2566:25, 2566:41
45^[1] - 2539:32
4s^[1] - 2482:6

5
5^[4] - 2482:5, 2514:17, 2566:42, 2573:26
500^[1] - 2569:28
52^[1] - 2539:32
53^[2] - 2499:28, 2499:38
54^[1] - 2561:33
5s^[1] - 2482:7

6
60^[1] - 2485:40
600^[1] - 2569:28

7
7^[2] - 2482:40, 2573:29
700^[1] - 2576:12
75^[1] - 2526:27

8
8^[5] - 2483:42, 2510:1, 2531:31, 2577:15, 2577:23
8(a)^[2] - 2484:2, 2486:9
80^[2] - 2509:4, 2509:18

9
9^[10] - 2480:26, 2489:21, 2495:18, 2495:46, 2496:13, 2496:15, 2531:6, 2531:47, 2533:3, 2537:5
95^[1] - 2556:19

A
abatement^[1] - 2569:36
ABF^[4] - 2546:44, 2548:13, 2549:10, 2549:14
ability^[4] - 2492:41, 2502:31, 2546:17, 2575:7
able^[16] - 2487:43, 2487:47, 2494:35, 2496:10, 2496:24, 2498:37, 2501:23, 2501:28, 2503:20, 2504:17, 2525:31, 2544:41, 2548:26, 2558:19, 2564:13, 2565:39
ABM^[2] - 2486:21, 2503:40
abnormal^[1] - 2571:41
Aboriginal^[3] - 2493:38, 2512:6, 2534:21
absence^[2] - 2501:17, 2506:38

absent^[1] - 2500:21
absolute^[1] - 2551:22
absolutely^[3] - 2491:16, 2563:40, 2567:18
accept^[6] - 2494:7, 2496:11, 2496:27, 2504:28, 2523:22, 2572:4
acceptable^[3] - 2522:42, 2550:19, 2558:31
accepted^[2] - 2490:39, 2523:6
accepting^[2] - 2538:2, 2558:25
access^[33] - 2487:33, 2487:38, 2487:40, 2487:43, 2488:8, 2489:14, 2491:26, 2491:37, 2492:20, 2492:43, 2493:35, 2501:28, 2501:34, 2502:32, 2503:2, 2506:28, 2507:8, 2508:12, 2512:4, 2527:47, 2529:36, 2532:11, 2535:27, 2541:30, 2544:41, 2545:4, 2545:21, 2545:36, 2546:5, 2546:10, 2546:12, 2552:40, 2558:15
accessibility^[1] - 2543:39
accessible^[1] - 2507:17
accessing^[2] - 2498:23, 2543:24
accordance^[1] - 2515:2
account^[4] - 2489:32, 2496:42, 2522:11, 2535:9
accountants^[1] - 2513:47
accounting^[1] - 2572:35
accuracy^[1] - 2482:47
accurate^[2] - 2490:38, 2519:41
accurately^[1] - 2522:17
achievable^[1] - 2545:38
achieve^[1] - 2556:24
achieved^[1] - 2558:29
ACI^[10] - 2482:2, 2483:35, 2518:26, 2528:4, 2528:16,

2554:20, 2555:18, 2555:35, 2555:38, 2555:47
acquired^[2] - 2490:46, 2521:21
ACT^[1] - 2543:33
Act^[9] - 2489:22, 2495:18, 2495:47, 2496:14, 2496:16, 2522:40, 2533:3, 2537:6, 2565:22
act^[2] - 2514:43, 2519:19
acting^[1] - 2531:1
action^[2] - 2484:18, 2511:26
actions^[3] - 2511:10, 2539:21, 2570:45
active^[4] - 2491:32, 2543:44, 2553:15, 2575:44
actively^[3] - 2520:27, 2541:11, 2547:15
activities^[11] - 2481:40, 2482:7, 2532:43, 2533:33, 2533:36, 2534:20, 2535:8, 2555:17, 2561:18, 2562:10, 2575:20
activity^[66] - 2484:14, 2485:40, 2486:14, 2486:16, 2492:16, 2497:12, 2497:15, 2497:16, 2497:20, 2497:21, 2497:25, 2497:30, 2497:35, 2497:37, 2497:40, 2497:45, 2498:1, 2498:3, 2498:6, 2498:16, 2498:23, 2498:45, 2500:41, 2502:7, 2502:31, 2502:35, 2502:36, 2502:37, 2503:27, 2505:27, 2505:29, 2505:33, 2512:38, 2517:39, 2518:4, 2518:24, 2520:7, 2520:43, 2520:44, 2521:2, 2521:21, 2521:29, 2522:9, 2522:15, 2523:24, 2523:31, 2527:21, 2535:29, 2536:14, 2546:17, 2546:40, 2546:44, 2547:3, 2548:44, 2549:9, 2549:10, 2549:18, 2549:41, 2554:25,

2554:40, 2555:8,
2555:21, 2555:42
activity-based [4] -
2486:16, 2502:35,
2522:9, 2546:17
actual [1] - 2562:26
actuarial [1] - 2572:35
actuaries [1] -
2571:46
acute [26] - 2485:9,
2485:12, 2485:13,
2485:38, 2485:39,
2486:17, 2493:14,
2500:2, 2500:4,
2505:7, 2505:10,
2515:26, 2536:47,
2537:32, 2537:43,
2539:7, 2539:24,
2540:11, 2540:12,
2542:33, 2555:3,
2555:7, 2555:11,
2566:37, 2569:26
ad [1] - 2529:46
adaptation [1] -
2546:15
add [3] - 2482:12,
2497:7, 2578:10
addictive [1] - 2576:17
additional [6] -
2497:15, 2507:29,
2512:37, 2549:45,
2551:8, 2555:41
address [5] - 2484:16,
2484:20, 2484:21,
2566:17, 2567:27
addressing [1] -
2494:20
adequate [1] -
2554:38
adequately [3] -
2501:42, 2524:40,
2555:33
adjourn [7] - 2541:44,
2559:36, 2559:41,
2559:45, 2578:13,
2578:19, 2578:24
Adjunct [1] - 2562:19
adjusted [1] - 2484:35
adjusting [1] -
2494:16
adjustments [1] -
2543:39
administer [1] -
2569:24
administered [2] -
2571:13, 2573:22
administration [4] -
2573:10, 2574:15,
2574:16, 2576:16
administrative [1] -
2553:15
administrator [1] -
2494:44
admissions [1] -
2487:28
admitted [4] - 2498:3,
2498:6, 2546:44,
2578:2
advance [2] - 2489:36,
2556:41
advanced [2] -
2508:44
advantage [4] -
2487:13, 2525:22,
2525:26, 2528:6
advantageous [1] -
2525:37
advantages [3] -
2514:26, 2553:17,
2553:20
adverse [3] - 2505:9,
2515:6
advice [16] - 2486:15,
2488:18, 2489:16,
2494:17, 2498:29,
2498:41, 2510:24,
2518:12, 2518:25,
2518:28, 2526:37,
2527:23, 2528:11,
2543:15, 2548:47,
2572:35
advise [2] - 2486:19,
2517:23
advisers [2] - 2575:45
advocacy [2] - 2532:9,
2535:5
affairs [1] - 2550:19
affiliated [1] - 2515:12
affirmed [1] - 2530:27
afford [1] - 2545:20
afternoon [1] -
2531:23
age [1] - 2485:27
aged [11] - 2489:39,
2494:44, 2495:31,
2496:2, 2507:13,
2507:18, 2507:19,
2507:24, 2507:29,
2547:18
ageing [2] - 2484:22,
2547:9
agencies [3] - 2519:9,
2531:41, 2555:18
Agency [1] - 2553:41
agenda [2] - 2517:24,
2574:5
ago [10] - 2484:28,
2488:45, 2502:12,
2505:12, 2509:14,
2517:31, 2568:24,
2571:26, 2571:27,
2571:39
agree [19] - 2492:16,
2492:38, 2492:44,
2495:45, 2496:36,
2497:14, 2506:46,
2529:7, 2529:15,
2529:20, 2533:13,
2533:21, 2534:45,
2535:14, 2536:26,
2537:4, 2538:41,
2550:16, 2557:37
agreed [1] - 2509:26
Agreement [2] -
2494:42, 2538:25
agreement [80] -
2484:8, 2490:24,
2492:4, 2494:16,
2502:33, 2502:35,
2508:9, 2508:24,
2509:25, 2509:43,
2510:2, 2510:8,
2510:30, 2511:21,
2512:24, 2517:10,
2517:19, 2517:26,
2518:12, 2519:15,
2519:16, 2519:27,
2519:30, 2519:38,
2520:3, 2520:6,
2520:40, 2521:6,
2523:39, 2523:42,
2525:2, 2525:8,
2526:5, 2527:23,
2528:27, 2535:47,
2538:21, 2543:32,
2547:40, 2548:3,
2548:9, 2548:20,
2548:45, 2549:27,
2550:7, 2550:21,
2551:12, 2551:19,
2552:37, 2554:24,
2554:39, 2555:42,
2558:41, 2560:28,
2561:1, 2561:19,
2561:27, 2561:44,
2562:26, 2562:29,
2562:46, 2563:4,
2563:9, 2569:29,
2569:31, 2569:47,
2570:4, 2570:6,
2570:9, 2571:11,
2571:38, 2572:7,
2572:16, 2572:18,
2572:21, 2572:24,
2572:27, 2572:31,
2572:32, 2573:6
agreements [29] -
2483:32, 2484:7,
2486:13, 2486:40,
2486:42, 2487:24,
2493:10, 2494:25,
2502:7, 2509:22,
2519:39, 2520:12,
2520:14, 2520:19,
2520:37, 2521:4,
2521:10, 2521:11,
2521:15, 2521:22,
2521:32, 2524:46,
2532:16, 2543:31,
2546:41, 2547:37,
2550:43, 2551:23,
2566:24
Agreements [1] -
2483:36
agrees [1] - 2509:26
ahead [1] - 2551:36
AHO [15] - 2515:28,
2516:42, 2517:2,
2517:11, 2517:36,
2518:32, 2523:24,
2524:27, 2525:19,
2525:27, 2526:34,
2549:31, 2552:10,
2572:4, 2573:2
AHO's [1] - 2518:11
AHOs [27] - 2515:18,
2515:22, 2515:31,
2515:36, 2515:40,
2517:14, 2518:9,
2518:20, 2519:3,
2519:25, 2521:22,
2521:32, 2522:30,
2522:35, 2523:22,
2523:36, 2527:11,
2547:24, 2549:6,
2550:12, 2550:19,
2551:46, 2552:17,
2553:13, 2572:42,
2572:43
aim [2] - 2550:24,
2555:45
aimed [3] - 2481:1,
2482:26, 2482:34
aims [2] - 2534:22,
2558:20
alarms [1] - 2560:11
albeit [5] - 2519:37,
2529:42, 2554:13,
2562:47, 2573:3
Albury [1] - 2543:32
alcohol [2] - 2535:40,
2545:2
algorithm [1] -
2484:46
align [1] - 2558:14
aligned [7] - 2524:31,
2536:20, 2536:22,
2539:24, 2551:13,
2557:43, 2558:1
alignment [3] -
2480:47, 2508:39,
2551:37
allied [3] - 2493:47,
2532:42, 2546:39
allocate [2] - 2511:46,
2575:38
allocated [3] -
2546:45, 2572:1,
2578:3
allocation [3] -
2489:31, 2502:5,
2527:40
allocations [2] -
2490:33, 2493:9
allow [2] - 2517:32,
2541:20
allowed [1] - 2548:6
almost [4] - 2486:30,
2505:5, 2544:25,
2564:18
alone [2] - 2509:13,
2535:11
alright [1] - 2557:40
alternate [3] - 2506:5,
2520:23, 2548:28
alternatively [1] -
2525:9
amber [1] - 2559:18
Ambulance [2] -
2486:42, 2488:46
ambulance [5] -
2487:4, 2487:8,
2487:15, 2488:32,
2488:34
ambulances [1] -
2489:3
ambulatory [3] -
2545:26, 2546:43,
2570:25
amount [16] - 2484:33,
2492:15, 2498:6,
2512:38, 2512:39,
2526:3, 2535:25,
2537:16, 2550:30,
2554:37, 2554:40,
2555:8, 2561:4,
2563:13, 2565:42,
2571:5
amounts [2] -
2563:41, 2563:42
analyses [1] - 2518:24
analysis [5] - 2504:37,
2505:35, 2505:38,
2514:38, 2514:47
anecdote [1] - 2486:6
Anne [1] - 2514:35
annoying [1] -
2566:14
annual [15] - 2484:7,
2486:39, 2494:15,

- 2497:47, 2498:25,
2502:4, 2517:24,
2517:27, 2551:46,
2552:2, 2552:11,
2555:4, 2568:30,
2568:32, 2575:46
annually [2] - 2555:46,
2566:43
annum [1] - 2563:21
anomalous [1] -
2528:30
anomaly [1] - 2573:12
answer [15] - 2495:31,
2499:36, 2508:23,
2511:16, 2513:19,
2520:34, 2525:21,
2527:11, 2527:15,
2533:24, 2543:13,
2545:17, 2549:8,
2565:7, 2576:47
answers [2] - 2542:20,
2560:23
Anthony [8] - 2562:22,
2568:4, 2568:33,
2568:36, 2569:40,
2571:28, 2572:1,
2574:44
anticipated [3] -
2564:3, 2567:38,
2567:45
anticipating [1] -
2567:9
anticipation [1] -
2507:2
anyhow [2] - 2568:34,
2568:36
anyway [1] - 2505:42
apologies [1] -
2549:16
apologise [2] -
2545:17, 2560:12
applauding [1] -
2509:8
apples [2] - 2528:31
application [1] -
2543:14
applied [3] - 2517:18,
2518:5, 2521:29
apply [2] - 2497:15,
2541:20
appointed [1] - 2531:2
appointment [8] -
2488:20, 2488:21,
2495:40, 2500:22,
2500:28, 2501:28,
2501:33, 2549:30
appointments [2] -
2488:6, 2495:36
appraisal [2] -
2568:31, 2568:32
appreciated [1] -
2575:3
apprised [2] -
2527:28, 2547:31
approach [8] - 2506:5,
2533:34, 2539:47,
2541:37, 2553:13,
2555:44, 2556:28,
2557:21
approaching [1] -
2529:6
appropriate [15] -
2497:15, 2498:8,
2512:3, 2523:11,
2546:6, 2548:10,
2549:11, 2550:25,
2551:18, 2553:12,
2554:40, 2571:5,
2571:6, 2571:32
appropriateness [2] -
2508:39, 2508:41
approval [1] - 2556:44
approval's [1] -
2508:14
April [4] - 2479:22,
2480:26, 2531:6,
2577:21
APRIL [1] - 2577:23
area [19] - 2486:30,
2488:29, 2488:40,
2489:11, 2489:12,
2500:17, 2501:17,
2506:22, 2508:28,
2512:8, 2537:31,
2539:13, 2539:26,
2539:40, 2539:41,
2543:2, 2544:34,
2546:1
areas [19] - 2484:16,
2501:31, 2501:46,
2507:6, 2508:32,
2511:23, 2511:24,
2531:36, 2532:5,
2539:45, 2541:22,
2541:34, 2541:36,
2544:9, 2544:38,
2545:34, 2545:35,
2545:44, 2567:7
arguably [1] - 2510:37
argue [1] - 2510:23
arguments [1] -
2530:8
arm [2] - 2553:7,
2554:25
arm's [1] - 2486:34
arms [1] - 2485:35
arrangement [8] -
2495:37, 2508:1,
2508:32, 2520:21,
2525:18, 2555:5,
2555:27, 2569:27
arrangements [6] -
2508:25, 2517:31,
2529:29, 2553:15,
2555:22, 2572:42
array [7] - 2491:25,
2497:8, 2519:38,
2520:38, 2524:27,
2535:20
arrested [1] - 2506:2
articulated [1] -
2551:4
ascertain [2] -
2521:28, 2522:5
aside [1] - 2515:23
aspect [3] - 2485:25,
2513:12, 2524:32
aspects [3] - 2483:44,
2512:44, 2532:34
assertion [2] - 2486:6,
2529:35
assess [3] - 2511:4,
2512:7, 2523:23
assessed [3] -
2495:38, 2499:12,
2545:39
assessing [3] -
2526:34, 2556:40,
2558:47
assessment [10] -
2497:20, 2505:23,
2533:44, 2534:27,
2534:36, 2535:33,
2536:28, 2551:43,
2561:13, 2565:17
assigned [1] -
2577:47
assist [2] - 2480:25,
2531:5
assistance [2] -
2535:31, 2536:37
assisted [1] - 2564:42
Assisting [5] -
2479:26, 2479:27,
2479:28, 2479:29,
2479:30
assists [3] - 2488:12,
2513:42, 2525:44
associated [4] -
2496:23, 2524:5,
2547:38, 2556:11
association [1] -
2552:16
assume [1] - 2483:4
assumes [1] - 2522:17
assuming [1] -
2564:26
assumption [1] -
2575:31
AT [2] - 2578:27,
2578:28
attach [3] - 2574:36,
2575:5, 2575:6
attached [1] - 2554:25
attaches [1] - 2527:41
attempt [2] - 2521:28,
2522:5
attempted [1] - 2524:1
attend [1] - 2542:28
attendance [2] -
2500:11, 2575:46
attending [1] -
2536:19
attends [1] - 2574:3
attention [1] - 2502:14
attract [3] - 2494:41,
2497:38, 2544:34
attracted [1] - 2504:7
audio [1] - 2490:8
audit [1] - 2571:30
authority [2] -
2494:45, 2547:9
avail [1] - 2548:44
availability [5] -
2487:5, 2487:15,
2495:41, 2496:26,
2500:22
available [39] -
2484:13, 2486:46,
2488:32, 2489:9,
2489:11, 2489:18,
2490:34, 2490:35,
2490:36, 2493:7,
2493:44, 2496:41,
2499:3, 2499:20,
2500:12, 2500:16,
2502:16, 2502:21,
2502:38, 2507:43,
2508:3, 2520:23,
2521:5, 2521:9,
2525:30, 2527:46,
2528:19, 2528:23,
2528:24, 2529:41,
2529:43, 2535:21,
2544:15, 2545:46,
2548:28, 2550:22,
2550:43, 2560:41,
2563:13
average [5] - 2521:43,
2521:46, 2521:47,
2575:19, 2575:36
averaged [2] -
2522:22, 2522:24
avoid [2] - 2538:28,
2540:44
avoidable [1] -
2558:13
avoidance [10] -
2481:1, 2481:13,
2481:17, 2481:37,
2481:40, 2482:7,
2482:18, 2482:25,
2482:34, 2494:35
avoids [1] - 2546:6
awaiting [2] - 2488:9,
2507:18
awards [1] - 2575:2
aware [35] - 2493:44,
2501:37, 2504:36,
2504:44, 2508:17,
2516:16, 2516:32,
2520:2, 2527:33,
2542:42, 2543:16,
2543:42, 2544:39,
2545:15, 2548:30,
2548:31, 2549:7,
2549:9, 2549:19,
2551:27, 2560:28,
2566:41, 2569:20,
2571:18, 2571:22,
2571:26, 2571:27,
2571:37, 2571:39,
2571:40, 2571:45,
2572:1, 2572:33,
2572:34, 2573:18
awfully [1] - 2507:23
-
- ## B
-
- babies'** [2] - 2525:32,
2552:23
baby [1] - 2519:30
back-of-house [1] -
2513:38
backs [1] - 2564:8
bad [1] - 2566:12
ball [1] - 2564:43
Balmain [4] - 2542:23,
2542:25, 2542:33,
2542:42
bargain [1] - 2572:47
barriers [2] - 2485:34,
2544:2
base [4] - 2484:18,
2493:12, 2494:5,
2558:35
based [17] - 2481:46,
2483:35, 2484:29,
2486:16, 2490:33,
2494:22, 2495:15,
2502:35, 2505:27,
2506:44, 2522:9,
2523:46, 2540:32,
2546:17, 2560:27,
2561:13, 2576:24
basis [11] - 2481:28,
2491:38, 2492:32,
2494:17, 2510:27,
2511:32, 2517:24,
2532:3, 2549:6,

- 2555:30, 2562:5
BAU [1] - 2505:5
bays [1] - 2487:9
Beaches [9] -
 2569:15, 2569:21,
 2569:25, 2569:30,
 2569:37, 2570:40,
 2571:1, 2571:3,
 2571:12
Beasley [1] - 2479:14
beauty [1] - 2494:15
became [1] - 2571:26
become [5] - 2539:29,
 2569:47, 2573:39,
 2576:36, 2577:45
becomes [2] -
 2541:29, 2576:16
becoming [2] -
 2528:24, 2571:27
bed [4] - 2487:5,
 2487:15, 2521:47,
 2554:36
beds [17] - 2487:10,
 2488:32, 2507:18,
 2507:22, 2507:24,
 2507:27, 2507:29,
 2516:3, 2528:8,
 2528:9, 2528:23,
 2529:41, 2529:43,
 2554:37, 2554:46
beginning [3] -
 2561:27, 2562:1,
 2564:16
behalf [7] - 2483:8,
 2498:14, 2514:41,
 2514:44, 2515:10,
 2551:26, 2551:30
beings [1] - 2524:3
belief [1] - 2502:39
beneath [1] - 2551:21
benefaction [2] -
 2520:24, 2550:23
benefit [4] - 2481:32,
 2522:45, 2553:6,
 2571:43
benefits [5] - 2489:2,
 2504:41, 2504:42,
 2525:11, 2553:9
bespoke [2] -
 2536:14, 2536:15
best [19] - 2480:34,
 2486:4, 2486:15,
 2486:18, 2489:10,
 2490:34, 2490:36,
 2493:17, 2495:26,
 2501:41, 2523:28,
 2530:3, 2531:14,
 2531:28, 2535:13,
 2540:33, 2542:39,
 2552:22
Better [1] - 2481:43
better [28] - 2481:9,
 2481:34, 2482:21,
 2483:17, 2491:30,
 2495:24, 2500:3,
 2504:37, 2506:15,
 2506:23, 2506:39,
 2512:3, 2525:17,
 2525:26, 2526:9,
 2527:2, 2527:16,
 2532:11, 2538:15,
 2539:3, 2539:43,
 2539:46, 2540:10,
 2541:1, 2552:26,
 2555:32, 2564:20,
 2566:44
between [25] -
 2481:20, 2483:10,
 2483:32, 2485:34,
 2486:22, 2495:39,
 2505:26, 2525:13,
 2525:14, 2525:19,
 2533:37, 2539:23,
 2543:37, 2550:41,
 2551:28, 2560:41,
 2563:23, 2567:4,
 2569:30, 2569:31,
 2571:12, 2574:15,
 2575:25, 2575:28,
 2575:47
beyond [7] - 2488:45,
 2509:13, 2519:26,
 2519:32, 2556:6,
 2571:5, 2572:33
big [4] - 2493:26,
 2529:25, 2531:27,
 2576:37
bigger [2] - 2519:3,
 2523:46
biggest [2] - 2500:24,
 2501:22
bill [1] - 2498:14
billing [8] - 2498:20,
 2498:32, 2498:40,
 2503:11, 2503:18,
 2508:13, 2540:5,
 2560:35
billion [3] - 2563:21,
 2563:41, 2575:26
bit [18] - 2481:6,
 2481:8, 2482:43,
 2483:24, 2484:27,
 2519:11, 2524:11,
 2532:21, 2533:16,
 2541:24, 2544:13,
 2551:37, 2552:46,
 2553:19, 2555:9,
 2563:15, 2576:35
bits [2] - 2519:40,
 2519:41
blank [1] - 2505:22
block [2] - 2549:9,
 2561:4
blocks [2] - 2495:41,
 2501:28
bluntly [1] - 2509:32
board [56] - 2488:34,
 2520:42, 2520:46,
 2522:39, 2552:32,
 2556:46, 2562:2,
 2562:9, 2564:34,
 2565:4, 2565:7,
 2565:9, 2565:10,
 2565:20, 2565:24,
 2565:26, 2565:28,
 2568:2, 2568:30,
 2569:2, 2569:3,
 2570:12, 2571:24,
 2571:31, 2571:35,
 2573:40, 2574:1,
 2574:3, 2574:4,
 2574:10, 2574:30,
 2574:35, 2574:36,
 2574:43, 2575:3,
 2575:6, 2575:7,
 2575:8, 2575:11,
 2575:15, 2575:16,
 2575:21, 2575:32,
 2575:37, 2576:9,
 2576:11, 2576:13,
 2576:14, 2576:25,
 2576:31, 2576:36,
 2576:39, 2576:44,
 2577:20
BOARD [1] - 2577:23
Board [2] - 2566:39,
 2576:22
board's [1] - 2567:34
boards [3] - 2565:33,
 2574:38, 2576:20
bodies [1] - 2573:38
body [4] - 2488:41,
 2527:41, 2528:7,
 2576:21
bolster [1] - 2540:9
bookings [1] -
 2560:34
books [1] - 2572:35
bottom [1] - 2569:12
boundaries [2] -
 2524:19, 2552:29
boundary [1] -
 2494:27
boutique [2] -
 2517:13, 2517:16
brain [13] - 2527:26,
 2527:36, 2529:17,
 2529:45, 2548:16,
 2553:28, 2553:33,
 2553:43, 2554:9,
 2554:18, 2554:21,
 2556:9, 2556:11
branch [24] - 2484:1,
 2486:10, 2486:37,
 2486:46, 2488:25,
 2489:29, 2493:3,
 2511:20, 2513:4,
 2523:9, 2525:44,
 2527:23, 2528:1,
 2528:12, 2531:38,
 2531:39, 2531:45,
 2532:29, 2533:7,
 2534:2, 2543:23,
 2543:26, 2543:29,
 2543:38
branches [9] -
 2481:22, 2481:24,
 2483:44, 2490:37,
 2491:2, 2509:7,
 2509:28, 2510:27,
 2531:36
breaches [1] -
 2492:33
breaching [1] -
 2503:32
break [3] - 2514:9,
 2514:17, 2558:39
breakfast [2] -
 2575:10, 2575:11
breakfasts [1] -
 2575:9
bridge [2] - 2574:15,
 2574:17
bridges [1] - 2574:19
bridging [1] - 2562:28
brief [1] - 2557:38
briefed [1] - 2571:28
briefing [5] - 2528:25,
 2571:29, 2571:32,
 2571:34, 2571:35
bring [15] - 2480:42,
 2481:26, 2504:40,
 2535:14, 2552:9,
 2552:41, 2555:18,
 2555:40, 2561:31,
 2563:25, 2565:38,
 2567:36, 2567:43,
 2571:34
bringing [4] - 2481:35,
 2482:7, 2528:33,
 2559:11
brings [2] - 2505:45,
 2574:23
broad [6] - 2495:17,
 2496:13, 2526:23,
 2526:24, 2532:26,
 2532:38
broader [4] - 2509:16,
 2511:5, 2520:44,
 2524:20
broadly [5] - 2511:10,
 2515:22, 2519:45,
 2521:42, 2547:26
brought [4] - 2480:47,
 2489:35, 2531:25,
 2562:36
bucket [4] - 2521:43,
 2547:10, 2561:7,
 2561:8
buckets [2] - 2561:2,
 2563:23
budget [33] - 2489:32,
 2492:15, 2493:9,
 2498:17, 2498:42,
 2500:46, 2502:8,
 2502:26, 2504:27,
 2513:42, 2521:18,
 2525:2, 2547:11,
 2551:47, 2562:25,
 2562:45, 2563:3,
 2563:20, 2563:25,
 2563:26, 2563:32,
 2563:41, 2564:3,
 2564:13, 2564:32,
 2565:1, 2565:8,
 2565:37, 2568:12,
 2569:42, 2570:9,
 2570:21, 2572:1
budgetary [6] -
 2504:3, 2523:13,
 2523:19, 2564:36,
 2567:38, 2567:45
budgets [1] - 2492:17
bugbear [1] - 2567:24
built [1] - 2485:3
bulk [10] - 2480:38,
 2484:14, 2498:19,
 2498:32, 2498:39,
 2503:18, 2508:12,
 2531:18, 2540:5,
 2560:35
bullet [4] - 2564:29,
 2566:10, 2567:23,
 2569:10
bunch [1] - 2513:47
burden [1] - 2506:34
business [2] -
 2517:37, 2555:40
busy [1] - 2573:45
BY [3] - 2480:8,
 2530:29, 2560:5

C

- c** [1] - 2561:38
cab [1] - 2480:4
calculate [1] - 2497:14
cannot [1] - 2497:44
canvassed [1] -
 2523:19

capability [1] - 2558:37	2502:14, 2502:15, 2502:16, 2502:22, 2502:40, 2503:3, 2503:4, 2503:31, 2503:33, 2503:34, 2503:35, 2504:27, 2505:46, 2505:47, 2506:7, 2506:20, 2506:22, 2506:24, 2506:29, 2506:31, 2506:39, 2506:40, 2506:44, 2507:14, 2507:18, 2507:19, 2507:23, 2507:24, 2507:29, 2507:30, 2507:40, 2507:41, 2508:2, 2508:4, 2508:10, 2508:18, 2508:22, 2508:31, 2512:26, 2512:29, 2512:31, 2512:37, 2512:42, 2515:26, 2516:29, 2516:33, 2516:43, 2517:8, 2517:46, 2522:2, 2524:13, 2524:16, 2524:20, 2526:14, 2528:14, 2529:24, 2532:1, 2532:22, 2532:24, 2532:30, 2532:35, 2532:36, 2532:38, 2532:39, 2532:42, 2534:10, 2534:33, 2534:37, 2535:11, 2536:47, 2537:3, 2537:9, 2537:10, 2537:17, 2537:20, 2537:42, 2538:5, 2538:15, 2538:22, 2539:12, 2539:16, 2539:23, 2539:34, 2539:42, 2540:9, 2540:12, 2540:14, 2540:25, 2540:34, 2540:36, 2540:39, 2540:44, 2541:28, 2542:6, 2542:16, 2542:28, 2542:30, 2542:31, 2542:36, 2542:39, 2543:3, 2543:20, 2543:40, 2543:46, 2544:17, 2544:19, 2544:39, 2545:24, 2545:26, 2545:31, 2546:3, 2546:8, 2546:27, 2546:43, 2547:1, 2547:6, 2547:8, 2547:10, 2547:14, 2547:18, 2548:15, 2548:22,	2553:24, 2553:37, 2553:46, 2554:36, 2554:41, 2555:4, 2555:8, 2555:29, 2559:7, 2560:26, 2560:29, 2560:30, 2560:45, 2566:17, 2566:37, 2570:25, 2574:29, 2576:1 cared [1] - 2482:21 careful [1] - 2533:44 carers [1] - 2566:8 caring [2] - 2509:12, 2533:34 Caring [1] - 2557:4 carried [1] - 2524:5 case [19] - 2490:42, 2495:29, 2500:9, 2513:17, 2513:23, 2514:42, 2521:20, 2522:14, 2523:1, 2523:4, 2528:28, 2528:38, 2529:30, 2529:44, 2542:12, 2547:1, 2550:18, 2555:40, 2558:42 cases [3] - 2500:13, 2527:2, 2573:16 cast [2] - 2557:22, 2557:30 casualty [2] - 2542:23, 2542:36 cat [1] - 2482:6 catalyst [1] - 2493:11 catching [1] - 2564:22 categories [1] - 2515:23 category [6] - 2482:5, 2482:6, 2515:37, 2518:15, 2518:32, 2562:20 CE [9] - 2547:44, 2548:1, 2548:12, 2551:3, 2555:36, 2559:21, 2565:6 ceased [2] - 2489:47, 2490:6 CEC [6] - 2490:46, 2514:27, 2514:37, 2514:46, 2515:7, 2515:9 celebrate [1] - 2575:2 celebrating [1] - 2575:41 cent [2] - 2485:40, 2487:28 central [2] - 2528:7, 2553:11 Central [4] - 2509:43, 2510:2, 2517:43,	2557:9 centralisation [1] - 2526:10 centralised [6] - 2527:40, 2530:2, 2551:42, 2553:13, 2553:22, 2554:13 centre [11] - 2489:15, 2499:20, 2501:9, 2501:14, 2525:23, 2525:25, 2525:31, 2526:17, 2528:36, 2528:40, 2542:39 centrepiece [1] - 2538:23 centres [6] - 2502:16, 2528:42, 2529:31, 2532:41, 2532:44, 2532:47 certain [1] - 2561:17 certainly [23] - 2484:46, 2485:26, 2486:32, 2486:34, 2488:17, 2491:40, 2498:35, 2501:31, 2503:38, 2506:11, 2507:16, 2509:1, 2509:7, 2510:34, 2516:21, 2521:14, 2524:19, 2527:17, 2544:21, 2550:44, 2552:40, 2552:41, 2571:32 CEs [5] - 2519:20, 2525:41, 2551:33, 2558:40, 2561:42 cessation [3] - 2511:1, 2534:15, 2534:18 cetera [6] - 2486:18, 2486:40, 2488:33, 2494:1, 2511:11, 2555:6 CFO [1] - 2513:43 chair [12] - 2541:3, 2568:30, 2568:45, 2574:2, 2574:4, 2575:21, 2575:22, 2576:2, 2576:25, 2576:36, 2576:39 chairman [2] - 2561:46, 2572:13 Chairs [2] - 2566:39, 2576:22 chairs [5] - 2565:33, 2567:25, 2576:20, 2576:26, 2576:31 challenge [2] - 2504:8, 2566:5 challenged [1] -	2511:41 challenges [4] - 2569:14, 2569:18, 2569:22, 2570:28 chance [2] - 2527:19, 2531:9 change [9] - 2481:3, 2485:5, 2493:13, 2497:9, 2505:10, 2512:13, 2526:41, 2534:22, 2542:20 changed [3] - 2516:21, 2516:35, 2542:33 changes [11] - 2481:19, 2485:4, 2486:22, 2494:19, 2502:38, 2528:13, 2528:14, 2544:28, 2550:5, 2551:7, 2563:13 changing [1] - 2566:2 Chant [2] - 2489:38, 2534:16 Chant's [1] - 2491:2 charitable [1] - 2520:27 check [1] - 2556:17 checked [1] - 2568:38 checklist [1] - 2509:39 chief [70] - 2486:27, 2489:44, 2491:34, 2493:1, 2493:5, 2493:12, 2493:17, 2493:24, 2494:18, 2494:28, 2496:43, 2496:46, 2498:27, 2498:41, 2503:23, 2504:4, 2507:1, 2507:12, 2507:25, 2507:37, 2509:2, 2509:7, 2509:10, 2509:36, 2517:28, 2523:29, 2523:45, 2524:2, 2524:9, 2524:29, 2524:38, 2524:42, 2525:6, 2525:10, 2526:1, 2526:8, 2527:47, 2528:1, 2530:43, 2533:26, 2536:6, 2552:41, 2555:34, 2556:45, 2558:34, 2559:8, 2559:15, 2561:47, 2562:3, 2562:5, 2562:6, 2562:23, 2564:31, 2565:11, 2565:12, 2565:28, 2566:40, 2567:46, 2568:15,
------------------------------------	--	---	---	--

2568:31, 2568:46,
2572:13, 2574:6,
2574:11, 2574:20,
2576:47, 2577:2,
2577:8, 2577:12,
2577:20

CHIEF [1] - 2577:23

CHIU [3] - 2530:15,
2559:29, 2577:29

Chiu [4] - 2479:36,
2530:13, 2559:27,
2577:27

choice [2] - 2482:4,
2545:28

choices [1] - 2523:34

choose [3] - 2503:13,
2523:10, 2545:21

chosen [1] - 2520:7

chronic [11] - 2495:30,
2496:1, 2504:30,
2504:40, 2505:37,
2506:22, 2506:23,
2506:24, 2506:29,
2506:34, 2538:15

circumstance [1] -
2545:29

circumstances [4] -
2508:18, 2518:1,
2522:26, 2573:19

citizens [5] - 2535:11,
2538:15, 2539:13,
2540:35, 2540:39

clarity [1] - 2548:43

classic [2] - 2567:47,
2568:1

clean [1] - 2484:37

cleaner [1] - 2555:11

clear [5] - 2485:22,
2542:12, 2556:4,
2557:36, 2560:10

clearer [1] - 2526:23

clearly [3] - 2495:10,
2532:40, 2572:10

clients [2] - 2524:17,
2524:24

clinic [6] - 2496:34,
2499:9, 2499:17,
2499:25, 2547:2,
2556:10

Clinical [2] - 2553:41,
2559:12

clinical [19] - 2490:47,
2491:5, 2514:33,
2514:35, 2514:42,
2518:26, 2528:2,
2528:4, 2528:12,
2529:37, 2529:46,
2535:42, 2536:23,
2555:40, 2557:37,
2558:11, 2559:9,
2576:12

clinically [4] -
2481:46, 2499:9,
2503:32, 2546:6

clinician [2] - 2518:25,
2555:34

clinicians [7] -
2496:45, 2497:2,
2529:26, 2529:27,
2529:30, 2574:15

clinics [15] - 2487:42,
2495:33, 2500:26,
2501:26, 2502:9,
2503:14, 2544:47,
2545:11, 2545:12,
2545:16, 2545:18,
2545:26, 2560:32

clips [1] - 2503:36

close [6] - 2507:10,
2530:7, 2543:6,
2552:13, 2559:8,
2575:27

closed [1] - 2537:24

closely [8] - 2488:35,
2537:30, 2548:43,
2558:1, 2558:40,
2559:22, 2564:20,
2565:15

closer [1] - 2486:23

closes [1] - 2544:25

closure [1] - 2507:20

Coast [5] - 2509:43,
2510:2, 2517:43,
2557:4, 2557:9

code [1] - 2512:10

cohesive [1] - 2551:35

cohort [2] - 2492:13,
2506:33

cohorts [2] - 2493:24,
2526:45

collaboration [1] -
2500:32

collaborative [1] -
2481:42

colleague [5] -
2543:7, 2548:11,
2551:3, 2552:6,
2554:33

colleagues [3] -
2529:47, 2559:21,
2576:26

collect [7] - 2490:37,
2492:26, 2492:27,
2514:47, 2515:7,
2517:29, 2558:9

collection [2] -
2485:32, 2490:45

collections [1] -
2522:20

collectively [1] -
2552:20

colleges [2] - 2540:28,
2545:46

colour [1] - 2512:10

colour-code [1] -
2512:10

column [1] - 2558:5

combination [1] -
2545:31

coming [17] - 2482:13,
2484:41, 2484:42,
2485:29, 2489:20,
2506:25, 2516:41,
2535:20, 2538:7,
2538:17, 2544:13,
2545:45, 2556:1,
2560:8, 2570:25,
2570:26, 2570:33

commas [1] - 2483:4

commenced [1] -
2562:22

commencement [2] -
2510:9, 2561:46

commences [1] -
2570:37

commencing [4] -
2562:34, 2563:17,
2567:32, 2570:12

commend [1] -
2569:13

comment [6] -
2501:19, 2510:40,
2526:42, 2537:46,
2550:34, 2572:33

comments [2] -
2528:26, 2569:4

commercial [1] -
2569:27

COMMISSION [1] -
2578:27

Commission [6] -
2479:7, 2498:2,
2531:6, 2547:32,
2559:12, 2576:28

commission [1] -
2483:38

Commissioner [14] -
2479:13, 2480:3,
2480:26, 2480:37,
2489:47, 2504:46,
2514:11, 2530:11,
2531:17, 2541:42,
2559:25, 2559:29,
2577:44, 2578:5

COMMISSIONER [42] -
2480:1, 2480:40,
2490:6, 2490:10,
2490:15, 2490:21,
2491:7, 2495:8,
2499:35, 2504:12,
2504:16, 2505:42,
2510:42, 2511:9,
2511:15, 2514:9,
2514:13, 2514:17,
2514:21, 2530:13,
2530:17, 2531:20,
2541:44, 2542:2,
2559:27, 2559:31,
2559:36, 2559:41,
2559:45, 2560:7,
2560:18, 2575:19,
2576:41, 2577:17,
2577:27, 2577:31,
2577:39, 2578:2,
2578:8, 2578:13,
2578:19, 2578:24

commissioning [1] -
2481:42

committed [1] -
2550:29

committee [10] -
2552:15, 2571:30,
2571:31, 2571:33,
2575:39, 2575:43,
2575:47, 2576:1,
2576:2

committees [2] -
2540:47, 2575:40

common [2] -
2506:26, 2521:14

Commonwealth [73] -
2485:34, 2494:30,
2494:39, 2494:41,
2494:42, 2494:46,
2494:47, 2495:4,
2495:10, 2497:24,
2497:39, 2498:30,
2502:36, 2503:2,
2503:9, 2503:34,
2503:36, 2503:40,
2504:45, 2506:4,
2506:8, 2506:12,
2506:42, 2506:47,
2507:2, 2507:26,
2507:30, 2507:43,
2508:3, 2508:10,
2508:14, 2508:21,
2508:24, 2508:33,
2513:17, 2522:27,
2538:18, 2538:37,
2538:47, 2539:20,
2539:25, 2540:1,
2540:16, 2540:21,
2540:29, 2540:45,
2541:8, 2541:10,
2541:11, 2541:30,
2541:38, 2542:43,
2543:12, 2543:24,
2543:27, 2543:31,
2543:38, 2543:45,
2544:1, 2544:5,
2544:10, 2544:15,
2544:19, 2544:30,
2544:33, 2547:7,
2547:12, 2547:14,
2547:16, 2547:19,
2566:20, 2566:21,
2567:28

Commonwealth's [1] -
2540:15

communicate [1] -
2575:7

communicated [1] -
2565:16

communicating [1] -
2575:12

communication [5] -
2529:46, 2566:5,
2574:40, 2574:43,
2577:11

communities [18] -
2486:33, 2491:1,
2491:28, 2493:33,
2497:37, 2526:46,
2532:8, 2532:12,
2534:21, 2535:13,
2538:6, 2544:23,
2544:24, 2544:46,
2545:1, 2545:5,
2545:8

community [86] -
2482:36, 2484:39,
2485:4, 2486:35,
2487:43, 2489:28,
2491:28, 2491:46,
2492:6, 2492:36,
2492:44, 2495:45,
2496:11, 2496:19,
2499:3, 2500:17,
2500:35, 2502:22,
2509:35, 2510:17,
2510:39, 2511:3,
2511:4, 2511:7,
2511:11, 2512:40,
2513:22, 2515:46,
2519:4, 2520:28,
2525:23, 2525:24,
2532:1, 2532:9,
2532:15, 2532:22,
2532:24, 2532:31,
2532:41, 2532:44,
2532:47, 2533:13,
2533:14, 2533:21,
2533:23, 2533:35,
2533:40, 2534:11,
2534:23, 2535:7,
2535:10, 2535:12,
2535:42, 2536:11,
2536:15, 2536:16,
2536:42, 2537:3,

2537:6, 2537:29,
 2538:5, 2538:9,
 2539:7, 2539:22,
 2539:30, 2539:46,
 2541:19, 2541:39,
 2542:19, 2544:4,
 2544:17, 2544:22,
 2544:28, 2545:20,
 2546:13, 2547:18,
 2557:19, 2558:19,
 2558:31, 2561:14,
 2563:39, 2566:3,
 2569:38, 2574:29,
 2574:39
community's [1] -
 2542:35
compared [1] -
 2483:20
compensated [1] -
 2522:13
compensation [1] -
 2566:31
complain [1] - 2509:9
complaint [3] -
 2492:47, 2550:39,
 2572:28
complete [2] -
 2510:42, 2570:11
completely [1] -
 2550:29
completes [1] -
 2578:5
complex [5] - 2548:8,
 2548:15, 2553:31,
 2553:37, 2570:27
complexity [2] -
 2522:11, 2526:25
complicated [3] -
 2569:27, 2569:32,
 2569:39
complications [1] -
 2490:46
complicators [1] -
 2488:3
comply [1] - 2510:36
complying [1] -
 2513:11
component [5] -
 2498:4, 2522:25,
 2532:38, 2549:13,
 2564:41
components [2] -
 2535:14, 2535:18
comprehensive [1] -
 2568:23
compromise [1] -
 2549:44
compromises [1] -
 2530:4
conceived [1] -
 2561:45
concept [3] - 2507:9,
 2509:22, 2523:40
conceptually [4] -
 2506:46, 2529:19,
 2529:23, 2550:11
concern [2] - 2510:29,
 2511:30
concerned [2] -
 2565:21, 2570:44
concerns [4] -
 2511:40, 2513:45,
 2568:47, 2574:23
concerted [1] -
 2512:27
conclude [1] -
 2570:16
conclusion [1] -
 2512:9
condition [6] -
 2499:11, 2499:26,
 2499:39, 2500:23,
 2500:29, 2545:24
confidence [2] -
 2517:29, 2559:20
confident [1] -
 2558:39
confined [1] - 2516:5
confirm [1] - 2517:33
confirmation [1] -
 2521:26
confirmed [2] -
 2517:31, 2519:1
confirming [1] -
 2517:26
confront [1] - 2532:12
confronting [1] -
 2552:19
connect [1] - 2535:41
connections [2] -
 2526:45, 2535:12
conscience [1] -
 2503:17
conscious [1] -
 2484:15
consequences [1] -
 2513:28
consider [3] -
 2486:46, 2498:28,
 2559:1
considerable [1] -
 2538:10
considerably [1] -
 2563:32
consideration [6] -
 2484:25, 2486:9,
 2494:25, 2509:33,
 2557:1, 2571:15
considerations [3] -
 2487:20, 2497:43,
 2497:45
consistent [6] -
 2519:33, 2519:45,
 2536:10, 2553:46,
 2565:22, 2576:25
constantly [2] -
 2565:16, 2575:41
constrained [2] -
 2492:15, 2492:42
constraints [2] -
 2567:38, 2567:45
consult [1] - 2532:9
consultation [1] -
 2498:10
consulting [1] -
 2571:45
consumer [5] -
 2575:42, 2575:43,
 2575:44, 2575:45,
 2575:47
consumers [1] -
 2535:43
consumption [1] -
 2509:11
contact [3] - 2482:29,
 2525:39, 2525:40
contacted [1] -
 2574:41
contained [6] -
 2483:31, 2486:13,
 2486:41, 2487:23,
 2511:21, 2517:12
contemplated [1] -
 2572:32
contemporary [2] -
 2505:4, 2507:11
contents [2] -
 2480:33, 2531:13
context [4] - 2481:17,
 2482:26, 2508:41,
 2532:41
continue [4] -
 2490:10, 2501:5,
 2506:21, 2542:36
continued [2] -
 2550:4, 2550:9
continuing [1] -
 2576:46
continuity [4] -
 2495:27, 2501:16,
 2537:42, 2542:28
continuum [3] -
 2495:30, 2537:17,
 2539:23
contract [4] - 2551:29,
 2572:15, 2573:14,
 2573:22
contracted [2] -
 2495:37, 2501:26
contractor [1] -
 2572:46
contracts [1] -
 2573:10
contribute [4] -
 2508:21, 2509:29,
 2541:9, 2574:9
contributes [1] -
 2575:16
contribution [4] -
 2497:24, 2497:39,
 2547:14, 2547:20
control [3] - 2483:14,
 2483:16, 2483:17
convenient [4] -
 2499:16, 2514:13,
 2514:15, 2562:38
conversation [4] -
 2510:32, 2561:47,
 2567:3, 2574:45
conversations [8] -
 2481:20, 2487:7,
 2487:11, 2489:35,
 2544:18, 2554:2,
 2564:38, 2567:10
conversely [1] -
 2575:7
conversion [1] -
 2571:10
convinced [1] -
 2524:43
cooperating [1] -
 2567:28
coordinate [1] -
 2553:40
coordinated [3] -
 2553:35, 2554:15,
 2555:28
coordination [1] -
 2555:47
coordinator [2] -
 2488:29, 2488:40
copy [5] - 2531:26,
 2531:27, 2562:36,
 2569:7, 2573:26
cord [4] - 2527:27,
 2527:35, 2553:27,
 2554:9
CORE [1] - 2573:29
corner [1] - 2557:30
coroner's [1] -
 2514:41
coronial [1] - 2514:40
Corporations [1] -
 2522:40
correct [15] - 2480:20,
 2480:34, 2482:38,
 2519:29, 2528:37,
 2530:37, 2531:14,
 2533:46, 2543:6,
 2548:4, 2556:37,
 2560:24, 2560:42,
 2563:6, 2568:25
corrected [3] - 2491:9,
 2491:19, 2491:39
correction [1] -
 2499:41
correspondingly [1] -
 2563:3
cost [28] - 2484:38,
 2512:29, 2517:46,
 2521:40, 2521:46,
 2522:7, 2522:18,
 2522:20, 2522:45,
 2524:5, 2526:25,
 2527:20, 2547:39,
 2550:14, 2550:20,
 2550:41, 2565:13,
 2565:31, 2565:34,
 2565:42, 2571:19,
 2572:9, 2572:15,
 2572:21, 2572:24,
 2572:25, 2572:27,
 2572:32
cost-minus [3] -
 2572:21, 2572:24,
 2572:25
cost-plus [2] -
 2572:15, 2572:27
cost/benefit [1] -
 2504:37
costed [1] - 2547:8
costings [2] -
 2548:32, 2548:41
costs [2] - 2514:2,
 2548:29
Council [2] - 2566:39,
 2576:21
council [9] - 2573:36,
 2573:41, 2573:44,
 2574:2, 2574:9,
 2574:13, 2574:14,
 2574:26
councils [1] - 2573:35
Counsel [5] - 2479:26,
 2479:27, 2479:28,
 2479:29, 2479:30
counsel [1] - 2557:40
count [1] - 2498:16
counterpart [1] -
 2572:2
counting [1] - 2492:30
countries [1] -
 2505:12
country [7] - 2485:35,
 2537:21, 2539:4,
 2540:5, 2566:21,
 2566:22, 2566:23
couple [2] - 2493:26,
 2560:23
courageous [2] -

2484:18, 2507:1
course [11] - 2480:37, 2490:2, 2490:19, 2490:21, 2511:26, 2531:17, 2531:22, 2536:7, 2563:22, 2565:20, 2574:44
cover [2] - 2501:7, 2542:20
covered [2] - 2500:1, 2566:23
covering [1] - 2487:1
COVID [1] - 2546:9
CPI [2] - 2522:25
cranky [1] - 2513:3
create [1] - 2517:17
critical [6] - 2533:15, 2533:23, 2533:43, 2537:14, 2539:34, 2564:43
criticism [2] - 2504:32, 2515:9
cross [3] - 2542:13, 2543:32, 2575:47
cross-jurisdictional [1] - 2543:32
cross-membership [1] - 2575:47
crude [1] - 2535:43
culture [3] - 2573:29, 2575:15, 2575:16
curious [1] - 2505:33
current [8] - 2505:5, 2508:28, 2508:47, 2538:24, 2544:2, 2548:12, 2550:38, 2573:11
custom [1] - 2526:43
customary [4] - 2563:18, 2563:19, 2563:35, 2564:1
cut [3] - 2495:39, 2564:8, 2565:27
cut-backs [1] - 2564:8
cutbacks [2] - 2564:24, 2565:3
cutting [1] - 2552:44

D

daily [2] - 2481:28, 2558:34
Daly [3] - 2480:4, 2480:12, 2552:6
DALY [1] - 2480:6
Daly's [1] - 2554:33
Dan [1] - 2479:30
Danos [5] - 2559:38, 2559:39, 2560:7, 2560:24, 2577:32
DANOS [1] - 2560:3
Danos's [1] - 2561:31
dare [2] - 2510:26, 2513:15
dashboard [1] - 2486:45
data [44] - 2485:2, 2485:7, 2485:17, 2485:21, 2485:25, 2485:32, 2486:1, 2486:6, 2488:11, 2488:12, 2489:9, 2489:14, 2490:34, 2490:35, 2490:36, 2490:39, 2490:40, 2490:41, 2490:45, 2490:47, 2491:3, 2491:10, 2491:11, 2491:25, 2492:25, 2492:26, 2492:27, 2493:4, 2493:7, 2494:2, 2514:47, 2515:8, 2515:10, 2522:20, 2528:19, 2528:26, 2528:28, 2535:24, 2535:32, 2536:15, 2548:44, 2558:9
datasets [1] - 2536:5
date [3] - 2549:29, 2568:28, 2574:16
DATED [1] - 2577:23
dated [6] - 2480:26, 2531:6, 2562:15, 2568:27, 2577:21
day-to-day [2] - 2532:3, 2555:30
days [5] - 2489:15, 2552:7, 2575:25, 2575:29, 2576:39
Days [1] - 2551:39
de [2] - 2512:2, 2574:3
de-escalation [1] - 2512:2
deal [8] - 2483:44, 2494:2, 2500:2, 2502:18, 2528:34, 2543:26, 2544:39, 2569:40
dealing [13] - 2482:18, 2482:32, 2493:42, 2539:28, 2540:7, 2549:18, 2549:24, 2549:26, 2551:15, 2554:43, 2557:19, 2557:20, 2573:16
dealings [1] - 2547:45
dealt [2] - 2500:12, 2501:15
Deb [11] - 2481:20, 2489:40, 2507:11, 2507:24, 2507:36, 2508:25, 2518:23, 2526:23, 2527:16, 2528:13, 2528:16
Deb's [2] - 2481:21, 2481:34
debate [3] - 2506:18, 2538:11, 2571:18
debating [5] - 2490:40, 2490:41, 2491:10, 2528:30
Deborah [2] - 2530:25, 2530:33
DEBORAH [1] - 2530:27
debt [1] - 2566:12
decade [1] - 2520:4
decades [1] - 2526:43
December [1] - 2564:45
deceptive [1] - 2532:23
decide [1] - 2560:46
decides [1] - 2500:39
deciding [1] - 2517:1
decision [17] - 2484:15, 2498:15, 2498:22, 2498:40, 2503:24, 2503:26, 2520:41, 2524:8, 2526:11, 2527:40, 2530:3, 2553:2, 2553:21, 2554:13, 2554:30, 2565:43, 2566:47
decision-making [7] - 2526:11, 2527:40, 2530:3, 2553:2, 2553:21, 2554:13, 2554:30
decisions [21] - 2483:15, 2485:46, 2486:5, 2489:31, 2497:19, 2498:25, 2515:35, 2517:38, 2518:19, 2518:32, 2518:43, 2525:33, 2527:42, 2528:7, 2528:22, 2552:26, 2560:39, 2565:29, 2567:15, 2567:21
declining [1] - 2551:5
decrease [1] - 2505:29
dedicated [2] - 2553:42, 2565:47
deduct [1] - 2503:41
deducted [1] - 2503:41
deed [1] - 2569:28
deemed [1] - 2482:9
deep [3] - 2514:38, 2515:1, 2516:38
default [5] - 2501:5, 2501:9, 2501:24, 2537:36, 2539:14
defer [2] - 2489:16, 2563:22
deferred [1] - 2563:45
deficit [1] - 2551:10
define [1] - 2537:8
definitely [4] - 2535:1, 2537:10, 2545:3, 2553:5
definition [1] - 2532:38
defund [1] - 2523:31
degree [8] - 2482:6, 2482:30, 2482:33, 2508:30, 2559:1, 2563:31, 2568:7, 2568:8
delay [1] - 2496:30
delays [3] - 2487:8, 2487:16, 2558:13
deliver [37] - 2483:8, 2483:10, 2484:38, 2494:9, 2494:35, 2500:40, 2500:44, 2502:1, 2503:27, 2515:31, 2515:33, 2519:22, 2520:13, 2521:11, 2521:31, 2521:43, 2522:1, 2522:7, 2522:14, 2522:44, 2523:17, 2523:18, 2523:24, 2524:37, 2524:44, 2527:2, 2539:16, 2540:17, 2540:36, 2541:28, 2541:32, 2560:26, 2563:12, 2563:14, 2563:43, 2564:14, 2572:31
delivered [47] - 2483:13, 2484:33, 2492:22, 2493:34, 2493:46, 2496:12, 2497:33, 2497:36, 2500:46, 2504:2, 2506:16, 2506:40, 2507:7, 2507:41, 2508:11, 2508:20, 2518:17, 2518:44, 2521:5, 2521:12, 2522:6, 2524:39, 2524:42, 2525:34, 2526:19, 2527:13, 2530:4, 2530:5, 2532:3, 2532:47, 2534:29, 2536:24, 2536:45, 2542:16, 2542:17, 2543:40, 2544:20, 2545:12, 2552:23, 2552:27, 2554:12, 2554:14, 2554:18, 2554:28, 2556:15, 2565:43, 2569:43
deliverer [2] - 2522:35, 2540:36
delivering [38] - 2495:44, 2502:2, 2506:41, 2506:44, 2508:2, 2508:4, 2513:7, 2514:28, 2515:26, 2515:38, 2516:4, 2516:43, 2517:37, 2521:41, 2522:8, 2522:18, 2522:19, 2523:21, 2524:27, 2524:35, 2525:5, 2525:33, 2525:38, 2525:42, 2539:30, 2540:34, 2542:7, 2542:18, 2543:41, 2547:39, 2548:29, 2550:12, 2550:14, 2550:20, 2550:41, 2553:14, 2554:4, 2565:47
delivers [4] - 2518:33, 2518:40, 2519:32, 2547:2
delivery [42] - 2485:35, 2486:11, 2494:26, 2494:38, 2495:14, 2495:43, 2496:11, 2497:29, 2497:43, 2502:15, 2503:3, 2508:31, 2512:26, 2515:45, 2524:12, 2526:12, 2527:26, 2527:38, 2529:4, 2532:13, 2532:34, 2532:37, 2534:22, 2539:34, 2540:21, 2540:33, 2541:31, 2543:20, 2546:18, 2548:21, 2553:20, 2554:8, 2554:14, 2554:25, 2554:29, 2555:29, 2556:31, 2560:44, 2564:42, 2571:20, 2572:6, 2574:28
delta [1] - 2549:42
demand [11] - 2492:11, 2518:24, 2520:45, 2553:47,

2554:5, 2554:38,
2555:5, 2555:19,
2556:2, 2569:37,
2571:7
demands [1] -
2496:10
dementia [1] -
2507:23
demographic [1] -
2533:36
demoted [1] - 2512:22
dental [1] - 2560:13
dentist [1] - 2560:16
department [17] -
2482:16, 2482:19,
2482:23, 2485:12,
2485:37, 2487:21,
2496:4, 2499:10,
2501:10, 2513:39,
2537:37, 2537:39,
2540:43, 2542:34,
2560:36, 2566:15,
2570:27
departments [6] -
2487:15, 2487:29,
2488:32, 2495:24,
2500:2, 2503:31
depletion [1] -
2540:41
deployed [1] -
2551:44
deploying [1] -
2552:22
deployment [1] -
2527:41
deprioritisation [2] -
2564:9, 2564:25
deprioritised [1] -
2565:4
depth [1] - 2515:8
deputy [9] - 2480:14,
2481:21, 2489:42,
2530:35, 2538:45,
2543:7, 2568:45
describe [8] -
2514:28, 2539:32,
2542:40, 2547:13,
2555:33, 2561:2,
2570:3, 2577:17
described [4] -
2507:10, 2540:8,
2546:43, 2554:45
description [1] -
2557:28
design [1] - 2501:25
designated [1] -
2528:42
designed [2] -
2505:32, 2540:11
designing [4] -
2534:9, 2535:3,
2535:9, 2553:46
desired [2] - 2567:36,
2567:43
detail [6] - 2483:25,
2484:28, 2527:16,
2530:7, 2543:8,
2551:9
detailed [7] - 2485:22,
2492:5, 2533:14,
2533:22, 2534:3,
2559:20, 2561:26
determinants [1] -
2495:22
determination [1] -
2572:38
determined [2] -
2536:3, 2561:13
determines [1] -
2521:17
determining [2] -
2494:8, 2519:1
detriment [2] -
2570:45, 2570:46
develop [7] - 2481:23,
2505:6, 2531:41,
2532:10, 2544:16,
2548:6, 2562:1
developed [4] -
2485:2, 2519:16,
2529:30, 2538:25
developing [3] -
2485:25, 2506:1,
2535:16
development [3] -
2484:6, 2506:1,
2554:22
develops [1] - 2560:19
deviation [1] -
2484:47
devolution [2] -
2553:11, 2555:17
devolve [1] - 2573:8
devolved [6] -
2482:47, 2486:26,
2486:28, 2486:29,
2534:9, 2560:44
devoted [1] - 2565:46
diabetic [1] - 2560:31
dialysis [1] - 2564:40
dictating [1] - 2561:21
diet [1] - 2535:39
difference [4] -
2509:15, 2547:6,
2550:41, 2576:18
differences [1] -
2534:8
different [23] -
2481:23, 2482:22,
2483:43, 2483:44,
2493:27, 2505:32,
2509:20, 2509:21,
2513:7, 2514:30,
2514:36, 2524:11,
2531:35, 2533:39,
2538:3, 2547:25,
2551:24, 2554:14,
2555:9, 2561:2,
2561:26, 2574:45
differentiation [1] -
2483:10
differently [2] -
2554:19, 2561:9
difficult [5] - 2495:6,
2507:21, 2513:20,
2557:35, 2558:6
difficulties [1] -
2493:2
difficulty [4] -
2486:30, 2486:32,
2545:45, 2563:31
digital [3] - 2482:13,
2482:29, 2495:34
diligent [2] - 2575:32,
2576:15
diminishing [2] -
2550:2, 2550:3
dipped [1] - 2548:27
dipping [1] - 2550:21
direct [6] - 2502:36,
2515:2, 2520:43,
2543:27, 2545:42,
2573:6
directed [3] - 2499:13,
2513:21, 2572:20
direction [1] - 2512:25
directions [1] - 2515:3
directly [8] - 2510:15,
2511:28, 2515:6,
2543:13, 2544:44,
2568:27, 2574:1,
2574:44
director [2] - 2512:4,
2514:35
directorate [1] -
2553:39
directors [5] -
2490:47, 2511:29,
2559:9, 2575:32
disadvantage [1] -
2527:18
disagreement [1] -
2550:32
disappointing [1] -
2548:19
disaster [2] - 2488:43
discharge [1] -
2507:36
discharged [1] -
2501:15
disconnect [1] -
2533:37
discount [1] - 2527:47
discouraged [1] -
2570:26
discuss [1] - 2573:47
discussed [1] -
2523:40
discussing [1] -
2574:6
discussion [9] -
2503:45, 2506:17,
2506:41, 2507:8,
2510:30, 2538:11,
2538:22, 2543:37,
2565:35
discussions [17] -
2484:9, 2490:31,
2499:5, 2500:45,
2502:3, 2543:43,
2543:47, 2544:17,
2547:7, 2548:40,
2549:39, 2551:32,
2553:9, 2553:16,
2565:11, 2565:39
disease [13] - 2485:3,
2490:47, 2492:8,
2492:13, 2493:15,
2495:30, 2504:30,
2504:40, 2505:37,
2506:22, 2506:23,
2506:34, 2538:16
disincentive [1] -
2507:22
disincentives [1] -
2544:3
disinvested [2] -
2524:2, 2524:31
disparate [1] -
2535:20
disproportionate [1] -
2494:20
disrupted [1] -
2544:27
dissimilar [1] -
2554:20
distinction [1] -
2520:33
distress [1] - 2566:30
distribute [2] - 2489:9,
2546:45
distribution [1] -
2494:21
district [50] - 2489:5,
2491:38, 2493:40,
2497:17, 2497:20,
2508:13, 2511:33,
2512:14, 2512:41,
2513:16, 2526:15,
2526:17, 2534:7,
2534:17, 2535:2,
2535:37, 2542:46,
2543:15, 2543:19,
2545:7, 2546:37,
2546:42, 2550:35,
2552:38, 2554:23,
2555:25, 2556:45,
2561:29, 2562:10,
2563:26, 2564:41,
2565:8, 2565:9,
2565:17, 2565:32,
2566:4, 2566:6,
2566:42, 2567:6,
2567:29, 2569:24,
2569:30, 2570:6,
2570:46, 2570:47,
2572:44, 2573:15,
2575:1
District [2] - 2530:44,
2549:32
district's [4] - 2512:7,
2557:2, 2558:20,
2573:34
districts [27] -
2485:28, 2486:15,
2492:26, 2513:42,
2513:45, 2533:30,
2534:8, 2534:16,
2535:13, 2536:17,
2537:13, 2538:38,
2544:46, 2545:4,
2545:27, 2546:2,
2546:41, 2547:10,
2549:22, 2551:24,
2551:34, 2552:6,
2553:6, 2554:26,
2555:6, 2558:40,
2572:41
dive [2] - 2515:1,
2516:38
diversion [1] - 2501:3
divert [4] - 2495:23,
2500:1, 2502:14,
2502:17
diverted [1] - 2501:14
diverting [1] - 2539:40
dives [1] - 2514:39
divide [1] - 2560:40
divided [2] - 2483:43,
2531:46
division [6] - 2480:19,
2481:4, 2531:35,
2534:13, 2543:11,
2554:35
divvying [1] - 2484:34
do [1] - 2558:23
doctors [5] - 2506:43,
2541:33, 2542:24,
2573:45, 2573:46
document [9] -

- 2480:43, 2510:1,
2557:9, 2557:26,
2558:18, 2558:25,
2561:41, 2577:1,
2577:9
- documents** [2] -
2577:41, 2577:45
- dollar** [1] - 2519:12
- dollars** [3] - 2563:29,
2566:43
- domain** [8] - 2533:26,
2537:11, 2539:37,
2539:41, 2540:15,
2545:3, 2565:40
- domains** [1] - 2536:5
- done** [23] - 2504:33,
2504:38, 2504:44,
2505:33, 2505:38,
2517:30, 2534:1,
2536:7, 2541:4,
2541:9, 2541:16,
2544:38, 2548:46,
2550:34, 2555:46,
2558:22, 2561:26,
2564:17, 2564:18,
2571:29, 2571:45,
2576:5, 2576:8
- donkeys'** [1] - 2512:28
- door** [7] - 2482:14,
2482:29, 2484:41,
2484:43, 2488:46,
2495:35, 2574:21
- double** [1] - 2556:17
- double-check** [1] -
2556:17
- doubt** [7] - 2490:1,
2496:46, 2509:38,
2512:45, 2517:28,
2535:22, 2541:36
- down** [22] - 2486:37,
2488:24, 2504:40,
2509:3, 2509:4,
2509:17, 2510:12,
2510:47, 2511:40,
2513:26, 2513:27,
2538:18, 2544:25,
2563:2, 2563:42,
2566:11, 2567:32,
2569:12, 2570:36,
2571:28, 2572:18,
2573:9
- dozens** [2] - 2504:33,
2504:34
- Dr** [2] - 2479:28,
2534:16
- draft** [4] - 2491:19,
2568:37, 2568:43,
2576:11
- drama** [1] - 2573:42
- dramatically** [2] -
2485:5, 2519:13
- draw** [2] - 2520:33,
2535:19
- dress** [1] - 2560:32
- drive** [1] - 2514:2
- driven** [11] - 2481:36,
2484:14, 2497:20,
2501:3, 2509:17,
2512:23, 2518:26,
2518:34, 2527:1,
2538:43, 2546:16
- drivers** [1] - 2551:10
- driving** [1] - 2512:41
- drop** [2] - 2551:6,
2564:43
- dropped** [1] - 2488:47
- dropping** [1] -
2513:26
- drug** [2] - 2535:40,
2545:2
- dry** [1] - 2507:23
- dual** [1] - 2489:22
- Dubbo** [3] - 2578:17,
2578:20
- DUBBO** [1] - 2578:28
- due** [7] - 2480:37,
2482:3, 2490:2,
2490:18, 2531:17,
2531:22, 2560:13
- during** [5] - 2505:10,
2511:1, 2556:8,
2563:42, 2570:23
- duties** [1] - 2575:36
- duty** [1] - 2575:40
- dying** [1] - 2564:43
-
- E**
-
- early** [9] - 2504:29,
2504:39, 2505:36,
2523:47, 2549:29,
2549:33, 2552:7,
2553:34, 2561:45
- easily** [1] - 2487:13
- Eastern** [1] - 2555:24
- easy** [4] - 2504:6,
2516:41, 2531:26,
2570:8
- ebb** [1] - 2563:41
- echoed** [1] - 2504:33
- economic** [4] -
2496:23, 2504:42,
2505:34, 2505:39
- economy** [1] -
2574:38
- ED** [13] - 2482:2,
2484:45, 2486:18,
2487:3, 2487:4,
2487:9, 2494:34,
2495:21, 2501:3,
2501:25, 2507:17,
2513:36, 2513:37
- Ed** [1] - 2479:26
- EDs** [2] - 2494:36,
2501:39
- effect** [2] - 2554:10,
2574:3
- effective** [7] - 2482:9,
2507:33, 2538:42,
2541:2, 2553:2,
2555:47, 2558:32
- effectively** [4] -
2506:13, 2517:12,
2554:11, 2574:18
- efficacy** [1] - 2530:7
- efficiency** [6] -
2513:41, 2519:7,
2519:8, 2519:23,
2523:28, 2551:22
- efficient** [9] - 2518:5,
2518:7, 2521:15,
2521:23, 2521:30,
2521:47, 2549:7,
2549:20, 2575:32
- effort** [1] - 2512:27
- efforts** [1] - 2544:14
- eggs** [1] - 2513:6
- EGON** [1] - 2560:3
- eight** [2] - 2575:10,
2575:28
- either** [13] - 2485:38,
2487:25, 2495:35,
2496:29, 2501:25,
2504:7, 2511:32,
2514:31, 2520:41,
2525:7, 2525:29,
2527:33, 2545:28
- elected** [1] - 2562:24
- element** [3] - 2566:1,
2570:33, 2571:8
- elsewhere** [1] -
2482:36
- embedded** [1] -
2553:6
- emerge** [1] - 2557:15
- emerged** [1] - 2571:20
- emergency** [3] - 1 -
2482:16, 2482:19,
2482:23, 2484:44,
2485:12, 2485:37,
2487:15, 2487:21,
2487:29, 2488:32,
2495:24, 2496:4,
2499:10, 2500:1,
2501:10, 2501:14,
2502:17, 2502:18,
2503:31, 2513:39,
2537:37, 2537:39,
2537:43, 2540:42,
2542:24, 2542:34,
2560:13, 2560:36,
2566:15, 2566:36,
2570:26
- emergency-like** [1] -
2502:18
- empirical** [5] - 2486:6,
2486:14, 2510:21,
2510:27, 2513:20
- employ** [1] - 2541:27
- employed** [2] -
2503:4, 2508:13
- employee** [2] -
2542:17, 2574:7
- employees** [1] -
2546:40
- employer** [3] - 2508:6,
2508:8, 2574:46
- employing** [4] -
2507:42, 2541:13,
2542:11, 2542:14
- employment** [2] -
2508:25, 2541:33
- empowers** [1] -
2509:37
- empty** [1] - 2487:9
- enable** [7] - 2497:7,
2522:46, 2528:22,
2543:39, 2546:10,
2547:20, 2572:5
- enables** [5] - 2486:46,
2496:36, 2511:23,
2526:21, 2527:13
- encompass** [1] -
2511:10
- encounter** [1] - 2538:6
- encouragement** [1] -
2567:34
- encouraging** [1] -
2510:47
- end** [10] - 2486:9,
2502:41, 2502:44,
2521:17, 2521:41,
2526:30, 2526:31,
2564:17, 2570:16,
2573:15
- endless** [4] - 2503:21,
2503:23, 2504:18,
2504:20
- enforced** [1] - 2509:13
- engage** [5] - 2483:21,
2503:8, 2532:2,
2538:38, 2564:35
- engaged** [5] -
2481:28, 2498:37,
2520:27, 2524:41,
2571:46
- engagement** [15] -
2488:18, 2489:1,
2489:43, 2493:39,
2503:10, 2518:23,
2519:15, 2523:8,
2527:45, 2555:34,
2561:42, 2575:15,
2575:17, 2575:42,
2575:43
- engages** [2] -
2493:36, 2517:16
- engaging** [4] -
2486:32, 2511:27,
2523:21, 2535:4
- enhance** [2] -
2567:36, 2567:43
- enhanced** [1] -
2512:31
- enhancement** [4] -
2492:10, 2492:11,
2512:34
- enshrined** [1] - 2483:2
- ensure** [9] - 2498:38,
2508:39, 2509:39,
2524:39, 2534:18,
2539:12, 2545:4,
2554:3, 2570:45
- ensured** [1] - 2524:4
- ensuring** [4] -
2481:45, 2517:44,
2550:29, 2566:6
- entered** [3] - 2483:32,
2562:27, 2571:37
- entering** [1] - 2529:11
- enterprise** [2] -
2575:26, 2575:27
- enters** [1] - 2519:31
- entire** [3] - 2501:7,
2527:31, 2556:28
- entirely** [3] - 2522:42,
2557:36, 2560:12
- entirety** [1] - 2558:33
- entities** [2] - 2520:11,
2522:30
- entity** [4] - 2516:25,
2519:22, 2520:42,
2522:39
- entwined** [1] -
2515:45
- envelope** [15] -
2484:12, 2492:15,
2497:17, 2497:19,
2497:47, 2498:26,
2502:8, 2504:3,
2504:21, 2519:1,
2521:18, 2523:19,
2525:2, 2564:37
- environment** [2] -
2503:40, 2553:8
- episode** [2] - 2499:22,
2501:13
- episodes** [2] -
2486:17
- episodic** [1] - 2500:10

- equally** [4] - 2482:21, 2490:3, 2514:43, 2571:44
- equipment** [1] - 2512:38
- equipped** [3] - 2513:23, 2514:32, 2545:8
- equity** [7] - 2484:20, 2484:21, 2494:20, 2494:21, 2494:22, 2531:41, 2545:4
- equivalent** [2] - 2519:27, 2550:39
- eroding** [1] - 2484:18
- erosion** [1] - 2485:34
- escalate** [7] - 2510:29, 2511:24, 2515:5, 2539:6, 2541:8, 2544:30, 2554:1
- escalated** [3] - 2511:32, 2512:45, 2522:24
- escalation** [4] - 2512:2, 2513:30, 2552:38
- essence** [3] - 2505:3, 2517:7, 2563:4
- essential** [1] - 2523:17
- essentially** [1] - 2483:43
- establish** [3] - 2503:21, 2504:6, 2504:18
- established** [3] - 2524:41, 2529:29, 2552:16
- establishing** [2] - 2485:47, 2497:12
- establishment** [1] - 2501:1
- et** [6] - 2486:18, 2486:40, 2488:33, 2494:1, 2511:11, 2555:6
- ethnicity** [1] - 2485:27
- ethos** [1] - 2527:17
- evaluation** [1] - 2554:34
- event** [3] - 2488:43, 2488:44, 2544:23
- events** [6] - 2515:6, 2538:12, 2565:37, 2574:35, 2575:1, 2575:4
- evidence** [29] - 2480:30, 2481:46, 2483:35, 2490:34, 2490:35, 2493:12, 2494:17, 2494:34, 2498:2, 2505:16, 2506:3, 2506:32, 2507:40, 2517:29, 2519:25, 2522:47, 2523:3, 2523:7, 2527:25, 2527:28, 2547:24, 2547:30, 2547:31, 2548:11, 2553:19, 2554:7, 2560:11, 2578:3, 2578:6
- evidenced** [1] - 2493:15
- evolution** [1] - 2494:15
- evolving** [1] - 2508:43
- ex** [1] - 2514:35
- exactly** [8] - 2484:42, 2506:8, 2508:3, 2513:5, 2529:5, 2529:7, 2545:18, 2558:2
- example** [51] - 2487:14, 2487:20, 2487:21, 2487:42, 2496:19, 2496:21, 2496:34, 2497:34, 2509:35, 2509:42, 2510:2, 2515:25, 2515:32, 2515:44, 2517:3, 2517:5, 2517:20, 2517:36, 2518:36, 2519:14, 2521:36, 2522:7, 2523:27, 2523:38, 2525:4, 2525:5, 2526:8, 2527:8, 2528:10, 2528:20, 2532:8, 2532:19, 2534:11, 2534:13, 2534:33, 2534:44, 2535:36, 2536:32, 2537:33, 2541:31, 2542:23, 2542:27, 2542:42, 2550:22, 2552:24, 2557:19, 2557:27, 2560:31, 2561:23, 2565:31, 2571:7
- examples** [12] - 2495:3, 2507:6, 2511:27, 2511:36, 2515:41, 2524:33, 2525:15, 2542:22, 2544:44, 2546:7, 2546:26, 2564:29
- Excellence** [1] - 2559:12
- except** [2] - 2515:19, 2574:6
- exceptional** [1] - 2575:2
- excluded** [1] - 2574:5
- excused** [1] - 2530:19
- exec** [1] - 2572:13
- execution** [4] - 2481:24, 2481:33, 2482:8, 2514:30
- executionally** [1] - 2481:25
- executive** [65] - 2489:36, 2489:42, 2491:35, 2493:1, 2493:5, 2493:12, 2493:17, 2496:43, 2498:28, 2498:42, 2504:4, 2507:12, 2507:25, 2507:37, 2509:2, 2509:10, 2509:27, 2511:28, 2512:4, 2517:28, 2523:29, 2523:46, 2524:30, 2524:38, 2524:42, 2525:6, 2525:10, 2526:2, 2526:8, 2527:47, 2530:43, 2552:32, 2552:41, 2555:34, 2556:20, 2556:46, 2559:8, 2559:15, 2561:47, 2562:3, 2562:5, 2562:6, 2562:23, 2564:31, 2565:11, 2565:12, 2565:28, 2567:46, 2568:15, 2568:31, 2568:46, 2573:35, 2573:41, 2573:44, 2574:1, 2574:2, 2574:6, 2574:9, 2574:11, 2574:14, 2574:20, 2576:47, 2577:3, 2577:9, 2577:12
- executive's** [1] - 2577:20
- EXECUTIVE'S** [1] - 2577:23
- executives** [11] - 2493:24, 2494:18, 2494:28, 2496:46, 2503:24, 2509:8, 2509:37, 2524:2, 2524:9, 2528:1, 2558:34
- exemption** [4] - 2508:5, 2543:4, 2543:9, 2543:12
- exemptions** [2] - 2541:20, 2544:32
- exercise** [2] - 2517:19, 2535:40
- exercising** [2] - 2483:26, 2517:26
- exhaustive** [1] - 2512:6
- exhibit** [4] - 2509:45, 2577:46, 2578:3
- exist** [4] - 2509:21, 2525:33, 2529:24, 2545:27
- existing** [3] - 2528:15, 2567:35, 2567:42
- exists** [3] - 2502:44, 2503:28, 2534:26
- expand** [1] - 2482:43
- expanding** [3] - 2482:12, 2512:27, 2512:28
- expect** [2] - 2556:47, 2565:28
- expectation** [5] - 2503:30, 2512:33, 2556:46, 2560:35, 2564:1
- expectations** [7] - 2486:12, 2542:35, 2563:11, 2566:3, 2569:46, 2569:47, 2571:4
- expected** [6] - 2561:5, 2561:28, 2563:10, 2563:14, 2563:46, 2570:5
- expecting** [4] - 2562:45, 2563:30, 2563:32, 2564:4
- expenditure** [4] - 2563:23, 2563:44, 2564:21, 2565:14
- expense** [1] - 2498:18
- expenses** [1] - 2551:8
- experience** [12] - 2481:26, 2481:31, 2481:34, 2485:7, 2490:42, 2494:13, 2502:28, 2523:47, 2530:36, 2531:35, 2553:36, 2558:11
- experienced** [1] - 2513:47
- expert** [1] - 2508:27
- explain** [4] - 2521:20, 2546:19, 2568:29, 2573:12
- explanation** [1] - 2526:24
- explore** [1] - 2506:5
- exploring** [1] - 2500:31
- exponentially** [1] - 2546:8
- exposed** [1] - 2550:26
- expressed** [3] - 2521:35, 2536:40, 2561:3
- expression** [1] - 2504:37
- extend** [1] - 2556:6
- extends** [1] - 2519:32
- extensive** [1] - 2562:30
- extent** [58] - 2482:35, 2483:25, 2484:8, 2484:11, 2485:13, 2486:41, 2488:12, 2489:30, 2492:20, 2493:7, 2493:32, 2493:43, 2493:45, 2494:24, 2495:15, 2495:44, 2496:9, 2496:35, 2497:43, 2498:24, 2499:1, 2500:39, 2500:44, 2501:46, 2502:2, 2505:47, 2506:6, 2506:32, 2506:39, 2509:23, 2509:32, 2509:34, 2510:21, 2510:35, 2511:5, 2521:9, 2523:20, 2524:26, 2525:29, 2526:11, 2534:28, 2534:39, 2535:33, 2536:31, 2538:5, 2540:32, 2543:17, 2543:19, 2544:14, 2545:11, 2552:28, 2556:30, 2558:27, 2560:25, 2564:35, 2573:2, 2574:13, 2576:44
- external** [7] - 2487:41, 2493:34, 2513:14, 2534:40, 2535:34, 2536:46, 2572:34
- externally** [1] - 2534:29
- extraordinary** [2] - 2488:15, 2507:15
- extremely** [2] - 2523:45, 2557:22
- eye** [2] - 2509:24, 2559:8
- eyes** [1] - 2531:28

F

2563:18
face-to-face [2] - 2498:9, 2498:10
facilitate [1] - 2511:22
facilitated [1] - 2506:16
facilitates [2] - 2495:36, 2525:44
facilitating [2] - 2489:5, 2489:8
facilities [3] - 2537:32, 2542:19, 2554:15
facility [7] - 2518:1, 2518:44, 2519:3, 2521:16, 2529:12, 2547:19, 2572:14
fact [10] - 2488:7, 2527:6, 2548:15, 2550:45, 2557:19, 2560:37, 2564:28, 2566:19, 2566:20, 2570:24
facto [1] - 2574:3
factor [2] - 2507:17, 2512:21
factorial [1] - 2545:47
fail [1] - 2527:44
failed [1] - 2494:33
failing [4] - 2510:37, 2511:41, 2513:12, 2541:32
failure [8] - 2482:3, 2486:29, 2495:20, 2507:13, 2507:19, 2544:4, 2559:2, 2560:33
failures [1] - 2539:15
fair [5] - 2487:29, 2505:23, 2534:6, 2538:40, 2572:47
fairly [5] - 2485:28, 2501:44, 2549:29, 2553:35, 2569:40
faith [2] - 2550:3, 2550:6
fall [7] - 2501:4, 2515:22, 2521:42, 2532:16, 2533:27, 2540:38, 2552:28
falls [3] - 2496:13, 2540:35, 2562:20
false [1] - 2560:11
familiar [8] - 2489:20, 2496:15, 2507:44, 2507:45, 2508:32, 2529:16, 2533:2, 2547:27
family [1] - 2519:29
fantastic [1] - 2546:9
far [7] - 2481:22, 2482:9, 2486:2, 2500:5, 2526:16, 2557:30, 2558:5
fashion [2] - 2500:5, 2500:25
fault [1] - 2560:12
feature [6] - 2495:34, 2499:5, 2520:25, 2521:14, 2537:10, 2539:31
features [3] - 2490:24, 2500:45, 2502:3
featuring [1] - 2493:8
federal [9] - 2532:40, 2537:11, 2538:13, 2539:37, 2540:4, 2540:26, 2567:3, 2567:4, 2567:11
fee [1] - 2566:12
feed [5] - 2491:34, 2492:7, 2498:24, 2554:39, 2554:44
feedback [2] - 2512:35, 2554:2
feeding [1] - 2491:4
fell [2] - 2488:47, 2551:21
felt [2] - 2481:21, 2548:10
few [2] - 2517:31, 2542:10
Figtree [1] - 2507:27
filled [2] - 2536:39, 2543:21
filter [1] - 2540:6
filtered [1] - 2520:15
final [2] - 2562:28, 2572:38
finalisation [1] - 2509:29
finalise [1] - 2569:5
finally [1] - 2574:28
finance [5] - 2512:4, 2523:9, 2549:40, 2571:30, 2571:33
financial [21] - 2503:45, 2503:47, 2507:22, 2508:47, 2513:46, 2525:12, 2525:26, 2544:43, 2550:46, 2551:36, 2565:21, 2566:31, 2566:40, 2568:7, 2568:8, 2568:33, 2570:32, 2570:33, 2570:45, 2570:46, 2572:45
finger [1] - 2501:13
finishing [1] - 2486:9
First [1] - 2551:39
first [29] - 2480:3, 2484:1, 2485:33, 2489:25, 2490:25, 2504:12, 2514:7, 2514:25, 2514:27, 2514:32, 2514:34, 2514:39, 2515:1, 2515:37, 2517:5, 2521:20, 2529:40, 2549:28, 2551:2, 2557:34, 2557:36, 2558:6, 2562:22, 2562:34, 2564:15, 2569:10, 2570:11, 2570:41, 2571:32
firstly [2] - 2514:40, 2548:7
fiscally [1] - 2524:4
five [3] - 2562:30, 2566:43, 2573:46
fix [1] - 2528:31
fixed [1] - 2490:2
flag [2] - 2483:21, 2488:19
flagged [1] - 2549:34
flags [1] - 2483:21
flexibility [1] - 2561:6
floods [1] - 2489:4
flow [12] - 2488:27, 2489:2, 2489:15, 2513:38, 2513:40, 2517:45, 2520:6, 2555:19, 2563:41, 2570:47, 2572:18
flow-down [1] - 2572:18
flow-on [1] - 2489:2
flows [2] - 2530:1, 2566:20
focus [5] - 2508:40, 2508:42, 2537:16, 2562:9, 2575:39
focused [4] - 2510:15, 2510:16, 2531:42, 2561:47
fold [1] - 2512:43
follow [2] - 2505:43, 2565:15
followed [1] - 2506:7
following [1] - 2553:28
fool [1] - 2484:40
foot [3] - 2553:16, 2562:43, 2570:37
footprint [6] - 2515:39, 2516:42, 2518:18, 2518:37, 2519:33, 2573:4
force [1] - 2540:25
forecast [1] - 2555:5
form [10] - 2480:37, 2483:6, 2500:45, 2525:21, 2531:17, 2539:13, 2552:36, 2556:40, 2557:2, 2565:16
formal [5] - 2511:24, 2511:30, 2529:29, 2557:43, 2577:11
formally [2] - 2531:2, 2548:2
format [1] - 2492:28
formed [1] - 2508:19
former [3] - 2547:44, 2560:3, 2560:8
forming [1] - 2497:45
forms [3] - 2497:16, 2498:1, 2541:21
formulated [1] - 2509:23
fortunately [3] - 2490:39, 2491:14, 2553:35
fortunately" [1] - 2491:16
forum [1] - 2575:46
forums [1] - 2541:10
forward [16] - 2481:8, 2482:40, 2510:6, 2531:31, 2531:38, 2531:45, 2552:9, 2552:41, 2555:18, 2555:40, 2557:13, 2557:26, 2559:11, 2561:33, 2562:4, 2565:38
four [11] - 2507:44, 2514:31, 2531:1, 2543:1, 2543:3, 2543:6, 2544:31, 2566:43, 2569:3, 2573:46, 2576:31
four-T [1] - 2543:6
four-Ts [4] - 2507:44, 2543:1, 2543:3, 2544:31
fourth [1] - 2566:10
fracture [1] - 2499:39
frame [3] - 2513:8, 2533:24, 2536:9
framework [26] - 2486:39, 2489:34, 2489:41, 2511:22, 2511:23, 2511:25, 2511:31, 2517:6, 2517:18, 2517:23, 2517:27, 2517:34, 2526:33, 2532:10, 2532:13, 2532:19, 2532:46, 2533:34, 2533:39, 2536:18, 2540:33, 2557:44, 2563:24, 2568:36
frameworks [2] - 2532:45, 2533:27
frank [2] - 2500:25, 2525:22
frankly [1] - 2509:9
FRAP [1] - 2571:32
Fraser [1] - 2479:29
Fred [1] - 2481:47
free [1] - 2566:33
freeing [5] - 2503:2, 2506:9, 2506:42, 2507:8, 2542:43
frequency [1] - 2566:2
frequently [2] - 2481:27, 2537:20
front [7] - 2482:13, 2482:29, 2488:46, 2495:35, 2562:43, 2565:10, 2569:7
fronting [1] - 2482:22
Fry [1] - 2548:39
fulfilling [2] - 2575:20, 2575:35
full [8] - 2480:10, 2487:1, 2496:30, 2506:35, 2530:31, 2567:32, 2571:35, 2574:9
Fuller [1] - 2479:30
function [16] - 2489:21, 2492:42, 2494:9, 2495:17, 2495:46, 2496:28, 2500:40, 2502:1, 2509:24, 2533:19, 2533:43, 2534:38, 2534:47, 2537:5, 2564:14, 2564:36
functional [2] - 2488:29, 2488:40
functions [4] - 2480:47, 2488:26, 2489:22, 2552:10
fund [9] - 2502:7, 2502:25, 2503:22, 2504:5, 2504:19, 2505:5, 2506:19, 2513:5, 2550:4
fundamental [1] - 2504:33
fundamentally [3] - 2483:29, 2486:43, 2526:14
funded [21] - 2495:16, 2495:44, 2498:7, 2499:4, 2506:9, 2506:17, 2506:45,

2507:28, 2521:16,
2524:40, 2527:7,
2527:22, 2527:34,
2530:4, 2544:20,
2546:31, 2546:35,
2546:36, 2549:6,
2549:8, 2549:19

Funding [1] - 2479:9
funding [90] -

2484:21, 2486:16,
2494:21, 2494:40,
2494:41, 2494:46,
2495:11, 2496:39,
2497:6, 2497:10,
2497:11, 2497:16,
2497:19, 2497:25,
2497:35, 2497:39,
2497:47, 2498:25,
2498:30, 2499:5,
2502:4, 2502:30,
2502:32, 2502:34,
2502:35, 2502:37,
2502:47, 2503:28,
2504:21, 2504:26,
2505:26, 2505:27,
2507:27, 2507:30,
2507:43, 2508:2,
2508:10, 2512:37,
2519:1, 2519:15,
2519:41, 2520:6,
2520:23, 2520:29,
2522:9, 2522:26,
2523:22, 2523:32,
2524:37, 2525:1,
2525:47, 2527:41,
2539:39, 2540:17,
2540:22, 2541:31,
2543:22, 2543:30,
2543:34, 2546:15,
2546:17, 2547:4,
2547:11, 2548:10,
2548:13, 2548:21,
2548:28, 2549:4,
2549:9, 2549:13,
2549:14, 2549:18,
2549:38, 2549:45,
2550:7, 2550:42,
2551:12, 2553:3,
2553:21, 2553:30,
2554:13, 2554:38,
2560:41, 2561:4,
2563:9, 2570:23

fundraising [1] -
2520:28

funds [11] - 2520:11,
2520:35, 2520:43,
2520:44, 2521:5,
2521:9, 2525:14,
2547:36, 2550:13,
2554:29, 2563:14

furious [1] - 2528:27
Future [6] - 2556:20,
2556:32, 2556:42,
2556:47, 2557:16,
2557:41
future [1] - 2507:3

G

gains [1] - 2504:44
gap [9] - 2496:26,
2496:27, 2499:2,
2500:33, 2501:12,
2502:37, 2529:35,
2543:20, 2549:3
gaps [4] - 2496:40,
2496:46, 2536:37,
2536:38
garner [1] - 2535:6
gastro [1] - 2501:13
gather [1] - 2488:29
gathering [3] -
2519:40, 2535:24,
2535:32
general [51] - 2482:28,
2486:4, 2488:21,
2492:19, 2494:5,
2501:27, 2509:22,
2514:3, 2516:29,
2516:33, 2532:39,
2535:4, 2537:9,
2537:10, 2537:13,
2537:15, 2537:20,
2537:23, 2537:26,
2537:30, 2537:31,
2537:34, 2538:17,
2538:29, 2538:38,
2539:2, 2539:36,
2539:44, 2540:9,
2540:29, 2540:38,
2540:41, 2540:46,
2541:13, 2541:25,
2541:33, 2541:35,
2541:39, 2542:12,
2542:14, 2542:24,
2543:28, 2544:7,
2544:11, 2544:24,
2544:27, 2544:44,
2545:6, 2556:7,
2556:14
generalists [1] -
2507:42
generally [4] -
2498:46, 2499:40,
2500:42, 2512:18
Generally [1] -
2503:10
generate [7] -
2497:29, 2497:37,
2497:45, 2498:17,

2500:41, 2502:31,
2503:27
generated [1] -
2546:18
generates [1] -
2499:25
generating [3] -
2497:35, 2498:23,
2498:44
generational [3] -
2505:5, 2505:10,
2505:11
geographic [5] -
2489:11, 2494:27,
2524:19, 2552:29
geographical [1] -
2485:46
geographically [2] -
2499:16, 2501:4
gift [1] - 2544:7
gifts [1] - 2544:14
given [25] - 2481:31,
2482:2, 2482:47,
2486:33, 2498:9,
2498:26, 2503:17,
2506:3, 2509:33,
2509:36, 2517:13,
2523:26, 2526:44,
2527:45, 2528:26,
2546:13, 2546:26,
2547:31, 2554:7,
2555:8, 2558:28,
2561:1, 2561:6,
2564:32, 2575:39
Glover [1] - 2479:27
GLOVER [5] -
2577:44, 2578:5,
2578:10, 2578:17,
2578:22
goal [1] - 2540:7
governance [7] -
2486:26, 2490:47,
2514:34, 2514:36,
2514:42, 2559:9,
2573:9
government [24] -
2482:11, 2483:8,
2483:40, 2484:13,
2494:31, 2499:17,
2519:9, 2520:29,
2531:41, 2532:28,
2532:40, 2534:30,
2537:12, 2538:13,
2539:38, 2540:26,
2543:23, 2543:26,
2543:29, 2567:4,
2567:5, 2567:11
Government [2] -
2506:47, 2540:29
government's [2] -

2503:22, 2504:19
GP [34] - 2485:40,
2485:41, 2488:17,
2488:19, 2495:34,
2495:38, 2495:40,
2496:3, 2496:7,
2498:13, 2499:14,
2499:19, 2499:20,
2499:41, 2500:11,
2500:24, 2500:27,
2500:33, 2501:8,
2506:24, 2534:44,
2536:33, 2537:24,
2537:34, 2537:42,
2538:7, 2539:29,
2542:6, 2542:17,
2542:19, 2542:23,
2544:41, 2560:32
GPs [15] - 2484:23,
2488:12, 2493:47,
2494:4, 2500:15,
2500:21, 2500:35,
2501:17, 2502:15,
2502:21, 2538:8,
2542:38, 2543:41,
2544:16, 2560:34
GPs" [1] - 2537:2
grace [1] - 2519:19
grant [1] - 2548:17
granted [1] - 2543:4
grateful [3] - 2530:18,
2559:32, 2577:32
Graythwaite [2] -
2517:43, 2518:2
great [5] - 2494:2,
2525:22, 2573:47,
2575:12, 2575:14
greater [3] - 2486:3,
2504:29, 2512:25
greatest [4] - 2482:35,
2485:29, 2486:29,
2504:27
green [2] - 2509:11,
2559:17
Greenwich [2] -
2517:43, 2518:2
ground [1] - 2573:18
group [8] - 2487:5,
2493:16, 2493:23,
2493:29, 2512:12,
2536:16, 2541:2,
2552:17
groups [6] - 2493:37,
2494:12, 2532:9,
2532:10, 2534:19,
2535:5
groups' [1] - 2491:42
grow [2] - 2506:22,
2512:38
growing [2] - 2492:13,

2494:4
grown [1] - 2546:8
growth [9] - 2482:2,
2484:20, 2484:21,
2484:36, 2493:14,
2493:15, 2493:16,
2494:21, 2528:14
guarantee [1] -
2572:45
guard [1] - 2564:18
guess [26] - 2483:16,
2485:29, 2489:34,
2494:30, 2495:19,
2498:28, 2499:7,
2501:1, 2501:19,
2506:4, 2506:36,
2508:16, 2509:32,
2515:40, 2519:11,
2523:26, 2526:42,
2536:6, 2536:17,
2538:11, 2541:17,
2543:33, 2544:9,
2553:10, 2555:44
guidance [4] -
2489:43, 2496:47,
2526:33, 2543:16
guide [5] - 2483:9,
2483:12, 2486:22,
2492:14, 2508:45
guided [1] - 2513:43
guises [1] - 2481:41

H

half [5] - 2502:11,
2563:28, 2575:25,
2575:29, 2576:39
HammondCare [1] -
2517:44
hand [8] - 2480:44,
2505:27, 2515:27,
2535:33, 2557:30,
2558:5, 2577:5,
2577:44
hands [1] - 2490:4
happy [6] - 2490:1,
2551:4, 2562:3,
2568:45, 2569:1,
2576:37
hard [7] - 2507:3,
2513:6, 2519:12,
2531:26, 2531:27,
2562:36, 2567:29
harder [2] - 2563:32,
2564:4
hark [1] - 2501:19
harsh [1] - 2563:3
head [3] - 2495:6,
2514:3, 2514:34
heading [2] - 2510:13,

2532:26
headroom [3] -
 2568:8, 2568:9,
 2568:13
Health [32] - 2479:36,
 2480:15, 2482:41,
 2483:36, 2486:38,
 2488:42, 2489:22,
 2492:24, 2492:47,
 2494:42, 2495:18,
 2495:47, 2496:13,
 2496:15, 2508:40,
 2509:16, 2526:32,
 2530:36, 2530:44,
 2533:3, 2538:25,
 2542:11, 2542:18,
 2546:40, 2549:32,
 2556:21, 2556:32,
 2556:42, 2556:47,
 2557:16, 2557:41,
 2572:41
health [213] - 2482:42,
 2483:1, 2484:38,
 2484:41, 2485:18,
 2485:22, 2485:23,
 2485:33, 2485:35,
 2486:30, 2487:40,
 2488:28, 2488:40,
 2489:5, 2489:9,
 2489:10, 2489:27,
 2490:15, 2491:26,
 2491:27, 2491:31,
 2491:42, 2491:46,
 2492:5, 2492:21,
 2492:23, 2492:35,
 2492:43, 2493:25,
 2493:33, 2493:37,
 2493:38, 2493:45,
 2493:46, 2494:1,
 2494:14, 2494:27,
 2495:27, 2496:18,
 2497:28, 2497:33,
 2497:36, 2497:44,
 2499:2, 2499:30,
 2500:3, 2500:34,
 2501:16, 2502:22,
 2503:3, 2503:20,
 2504:17, 2504:22,
 2504:27, 2504:41,
 2505:34, 2506:1,
 2506:3, 2506:7,
 2506:43, 2507:4,
 2508:10, 2508:31,
 2508:43, 2509:35,
 2510:17, 2510:31,
 2510:38, 2511:2,
 2511:3, 2511:7,
 2511:11, 2511:40,
 2512:5, 2512:6,
 2512:40, 2513:13,
 2513:15, 2514:1,
 2515:12, 2519:9,
 2519:22, 2520:31,
 2523:20, 2523:41,
 2524:1, 2524:3,
 2524:7, 2524:11,
 2524:13, 2524:15,
 2524:17, 2524:20,
 2527:3, 2529:24,
 2530:35, 2530:42,
 2531:34, 2531:37,
 2531:40, 2531:43,
 2532:11, 2532:41,
 2532:42, 2532:43,
 2532:44, 2532:47,
 2533:7, 2533:13,
 2533:14, 2533:21,
 2533:22, 2533:25,
 2533:27, 2533:30,
 2533:31, 2533:33,
 2533:35, 2533:44,
 2534:3, 2534:4,
 2534:6, 2534:8,
 2534:14, 2534:16,
 2534:17, 2534:25,
 2534:36, 2534:37,
 2535:2, 2535:3,
 2535:4, 2535:6,
 2535:10, 2535:13,
 2535:33, 2535:34,
 2535:37, 2535:38,
 2536:6, 2536:17,
 2536:18, 2537:3,
 2537:6, 2537:12,
 2537:13, 2537:37,
 2537:45, 2538:5,
 2538:37, 2538:38,
 2538:46, 2539:7,
 2539:12, 2539:14,
 2539:30, 2539:42,
 2540:34, 2541:5,
 2541:21, 2542:16,
 2542:46, 2543:8,
 2543:15, 2543:19,
 2543:40, 2543:45,
 2544:46, 2545:2,
 2545:4, 2545:7,
 2545:19, 2545:27,
 2546:2, 2546:37,
 2546:39, 2547:9,
 2547:10, 2549:22,
 2551:5, 2551:23,
 2551:34, 2552:6,
 2552:16, 2552:37,
 2553:6, 2554:23,
 2554:26, 2555:6,
 2555:25, 2556:45,
 2558:20, 2560:44,
 2566:22, 2566:26,
 2567:29, 2569:23,
 2569:24, 2569:39,
 2573:8, 2574:28,
 2576:1, 2576:16,
 2576:45
healthcare [1] -
 2504:31
Healthcare [1] -
 2479:9
healthier [1] - 2504:43
Healthscope [1] -
 2571:2
healthy [2] - 2510:13,
 2535:39
hear [3] - 2533:17,
 2537:20, 2574:1
heard [11] - 2506:2,
 2506:32, 2507:40,
 2507:45, 2519:25,
 2527:25, 2540:4,
 2543:1, 2547:24,
 2548:11, 2553:19
hearing [1] - 2578:6
hearings [1] - 2577:39
heart [4] - 2482:18,
 2527:8, 2561:23,
 2561:25
heavy [3] - 2506:34,
 2575:40
held [5] - 2480:22,
 2488:7, 2530:39,
 2530:42, 2562:25
help [3] - 2541:17,
 2553:40, 2566:10
hence [7] - 2487:29,
 2493:39, 2499:24,
 2525:45, 2527:22,
 2540:25, 2540:45
hepatitis [2] -
 2532:17, 2545:2
hierarchy [2] -
 2533:36, 2535:28
high [13] - 2484:2,
 2526:24, 2526:25,
 2527:20, 2553:35,
 2557:23, 2557:31,
 2557:39, 2559:15,
 2565:31, 2565:34,
 2565:42, 2575:17
higher [3] - 2507:16,
 2522:12, 2522:14
highlight [1] - 2561:37
highlighted [3] -
 2532:7, 2533:28,
 2565:13
highly [2] - 2521:39,
 2522:1
Hilbert [1] - 2479:36
historic [1] - 2505:26
historical [3] -
 2489:30, 2524:30,
 2551:21
historically [4] -
 2484:14, 2484:29,
 2484:34, 2485:2
history [6] - 2485:39,
 2520:34, 2527:19,
 2542:32, 2571:42,
 2571:43
hit [1] - 2485:37
hmm [20] - 2481:14,
 2484:4, 2484:30,
 2497:26, 2497:41,
 2510:10, 2510:18,
 2515:29, 2516:10,
 2516:45, 2529:1,
 2529:8, 2534:42,
 2536:29, 2536:43,
 2546:24, 2546:29,
 2556:22, 2557:11,
 2557:32
hoc [1] - 2529:46
hold [4] - 2503:17,
 2530:47, 2535:25,
 2551:29
holds [1] - 2536:5
home [5] - 2512:28,
 2512:31, 2525:1,
 2525:47, 2560:31
homes [2] - 2507:20,
 2507:31
homogeneous [1] -
 2493:23
honest [2] - 2482:4,
 2507:46
honoured [1] -
 2571:12
hope [1] - 2564:21
hopeful [1] - 2539:25
hopefully [3] - 2557:5,
 2560:20, 2563:25
hoping [1] - 2564:30
hospital [40] - 2481:1,
 2481:12, 2481:17,
 2481:37, 2481:40,
 2482:18, 2482:25,
 2482:28, 2482:33,
 2482:35, 2484:24,
 2485:8, 2488:8,
 2490:46, 2494:44,
 2498:13, 2507:27,
 2512:27, 2512:31,
 2513:40, 2515:25,
 2515:37, 2515:38,
 2516:42, 2516:43,
 2517:36, 2517:40,
 2523:42, 2523:44,
 2526:47, 2536:47,
 2540:11, 2542:25,
 2542:34, 2566:19,
 2566:28, 2566:33,
 2570:24, 2574:15,
 2575:14
Hospital [7] - 2555:8,
 2569:15, 2569:21,
 2569:30, 2570:41,
 2571:1, 2571:3
hospital-acquired [1]
 - 2490:46
hospitals [12] -
 2487:7, 2488:33,
 2489:3, 2497:1,
 2507:14, 2507:35,
 2515:27, 2517:37,
 2520:26, 2528:41,
 2569:26, 2574:24
hosting [1] - 2527:19
hosts [1] - 2575:11
hours [3] - 2495:40,
 2499:12, 2575:19
house [2] - 2487:10,
 2513:38
housed [1] - 2518:1
hover [1] - 2506:18
hovers [1] - 2534:4
HPV [1] - 2532:17
HSFAC [4] - 2488:42,
 2488:47, 2489:1,
 2489:13
hub [2] - 2527:39,
 2554:12
hub-and-spoke [2] -
 2527:39, 2554:12
huge [1] - 2535:25
human [2] - 2524:3,
 2566:1
hypothetical [2] -
 2501:17, 2565:36

|

lan [1] - 2479:29
identified [10] -
 2500:33, 2501:12,
 2520:45, 2527:14,
 2534:38, 2537:1,
 2546:22, 2558:5,
 2558:26, 2567:46
identifies [4] -
 2500:39, 2536:36,
 2536:45, 2569:11
identify [10] - 2483:36,
 2501:41, 2501:46,
 2510:35, 2519:28,
 2525:31, 2544:6,
 2546:17, 2561:36,
 2570:44
identifying [2] -
 2532:6, 2534:25
ideological [1] -
 2506:18
ii [1] - 2488:24
Illawarra [3] -

2507:12, 2507:14,
 2507:35
illness [2] - 2502:18,
 2537:44
immediacy [1] -
 2537:25
immediate [2] -
 2499:22, 2543:34
immediately [1] -
 2480:44
impact [4] - 2488:44,
 2548:20, 2551:8,
 2567:30
impacted [2] - 2489:6,
 2532:17
impacting [2] -
 2519:13, 2541:18
impotence [1] -
 2513:8
impediment [1] -
 2524:6
impediments [1] -
 2513:7
imperfect [1] -
 2522:31
implement [2] -
 2541:11, 2570:45
implementation [4] -
 2527:39, 2533:40,
 2553:7, 2556:25
implemented [2] -
 2526:37, 2571:13
implementing [2] -
 2482:10, 2534:10
implied [1] - 2487:25
importance [1] -
 2574:36
important [24] -
 2487:2, 2487:19,
 2487:22, 2487:25,
 2487:26, 2487:27,
 2487:30, 2487:32,
 2487:34, 2490:24,
 2492:37, 2494:8,
 2494:13, 2497:23,
 2510:35, 2534:27,
 2534:46, 2535:14,
 2535:18, 2536:15,
 2536:25, 2556:31,
 2572:10, 2573:21
importantly [1] -
 2558:36
imposed [1] - 2567:39
imposition [2] -
 2490:27, 2490:33
impressive [1] -
 2572:14
improve [5] - 2531:39,
 2537:16, 2541:5,
 2573:15, 2575:16
improved [1] -
 2507:33
improvement [2] -
 2513:35, 2513:36
improvements [4] -
 2526:32, 2526:35,
 2526:36, 2526:39
IN [1] - 2578:28
in-depth [1] - 2515:8
in-reach [1] - 2547:18
inability [1] - 2486:31
inappropriate [1] -
 2489:1
inasmuch [2] -
 2488:3, 2514:37
incentive [2] -
 2524:38, 2540:27
incentives [1] -
 2538:14
incentivise [1] -
 2544:34
incentivised [5] -
 2503:26, 2503:29,
 2503:30, 2503:33,
 2523:23
include [2] - 2532:7,
 2532:39
included [1] - 2576:11
includes [4] -
 2534:14, 2576:5,
 2576:6, 2576:8
including [11] -
 2484:45, 2509:10,
 2509:28, 2518:9,
 2527:41, 2530:43,
 2535:21, 2546:42,
 2549:38, 2555:22,
 2569:39
increase [4] - 2497:6,
 2497:10, 2497:11
increased [1] -
 2504:43
increasing [3] -
 2494:34, 2504:28,
 2540:5
increasingly [1] -
 2482:15
incredibly [1] - 2575:3
incremental [1] -
 2484:20
incrementally [2] -
 2484:35, 2494:19
indeed [3] - 2480:35,
 2531:11, 2558:45
independent [8] -
 2494:44, 2526:44,
 2547:8, 2548:32,
 2548:38, 2548:41,
 2548:46, 2550:33
indicate [1] - 2488:19
indicated [5] -
 2481:46, 2489:30,
 2499:10, 2549:2,
 2560:24
indicator [1] - 2487:30
indicators [7] -
 2487:32, 2487:35,
 2487:36, 2487:37,
 2487:38, 2503:35,
 2558:9
indirectly [1] -
 2511:28
individual [5] -
 2487:6, 2491:1,
 2510:43, 2511:10,
 2528:34
individually [1] -
 2522:33
individuals [4] -
 2527:25, 2547:32,
 2549:25, 2554:7
inequity [1] - 2484:16
inevitable [1] -
 2562:44
inevitably [1] - 2564:8
infection [1] - 2560:19
influence [2] -
 2527:47, 2544:10
influential [1] - 2528:3
inform [2] - 2532:13,
 2555:22
information [29] -
 2491:26, 2491:45,
 2492:5, 2492:19,
 2492:35, 2492:43,
 2493:32, 2493:44,
 2494:7, 2496:40,
 2525:30, 2529:19,
 2530:1, 2535:7,
 2535:19, 2535:21,
 2535:24, 2535:25,
 2535:27, 2536:9,
 2536:22, 2536:25,
 2540:27, 2552:9,
 2554:22, 2554:35,
 2554:44, 2554:45,
 2559:10
information's [1] -
 2485:42
informed [3] -
 2489:46, 2491:30,
 2565:28
informing [1] -
 2536:38
infrequently [1] -
 2526:6
initiated [1] - 2538:12
initiatives [1] -
 2489:39
injured [2] - 2489:25,
 2496:20
injuries [3] - 2521:40,
 2528:34, 2553:27
injury [28] - 2499:11,
 2518:42, 2527:26,
 2527:27, 2527:35,
 2527:36, 2528:21,
 2528:35, 2529:7,
 2529:17, 2529:21,
 2529:44, 2529:45,
 2548:17, 2553:28,
 2553:33, 2553:43,
 2554:9, 2554:18,
 2554:19, 2554:21,
 2554:43, 2555:3,
 2555:15, 2556:9,
 2556:12
innovation [1] -
 2541:24
Innovation [1] -
 2553:42
inordinate [1] -
 2537:16
inpatient [5] -
 2497:12, 2497:34,
 2498:12, 2498:19,
 2498:33
inpatients [1] -
 2503:12
input [3] - 2489:38,
 2489:43, 2509:2
inputs [1] - 2483:19
inquiry [1] - 2569:21
Inquiry [1] - 2479:7
inserted [1] - 2510:7
insight [2] - 2486:3,
 2487:6
insights [2] - 2485:29,
 2539:44
insignificant [3] -
 2498:27, 2506:11,
 2553:37
insofar [3] - 2493:44,
 2545:14, 2549:6
insolvent [1] -
 2522:41
instance [12] -
 2488:21, 2497:12,
 2534:11, 2534:12,
 2538:16, 2543:32,
 2551:39, 2552:35,
 2553:33, 2554:36,
 2555:36, 2559:6
instances [1] -
 2501:38
instead [1] - 2537:42
insufficient [9] -
 2520:13, 2522:45,
 2522:46, 2523:19,
 2529:41, 2544:15,
 2547:39, 2549:27,
 2560:33
insurance [4] -
 2551:5, 2566:22,
 2571:9, 2571:10
integers [1] - 2534:45
integrated [5] -
 2481:35, 2481:42,
 2488:35, 2506:22,
 2506:31
intended [6] -
 2499:29, 2500:7,
 2500:9, 2500:15,
 2558:18, 2558:22
intensive [6] -
 2524:15, 2524:20,
 2553:24, 2554:36,
 2554:41, 2555:3
intent [5] - 2499:31,
 2499:36, 2550:24,
 2550:25, 2552:8
intention [3] -
 2487:27, 2571:34,
 2572:15
intentions [1] -
 2489:41
interested [3] -
 2504:25, 2504:36,
 2514:25
interesting [1] -
 2574:34
interestingly [1] -
 2567:7
interests [1] - 2539:8
interface [5] - 2536:2,
 2538:24, 2538:38,
 2539:2, 2543:46
interfaces [1] -
 2569:38
intergenerational [1] -
 2505:36
Intergenerational [1] -
 2504:26
interim [1] - 2500:26
internal [2] - 2480:47,
 2552:33
internally [2] -
 2549:40, 2553:10
internationally [1] -
 2485:32
internationally-
leading [1] - 2485:32
interrupted [2] -
 2520:6, 2538:1
intersecting [1] -
 2538:20
intervention [4] -
 2504:30, 2505:37,
 2506:12, 2506:15
interventions [2] -

2504:40, 2540:1
interwoven [1] - 2532:26
intimately [1] - 2501:44
introduce [2] - 2492:29, 2496:43
introduction [2] - 2497:9, 2532:2
inverted [1] - 2483:4
invested [1] - 2512:36
investigate [1] - 2567:34
investigation [1] - 2567:42
investing [1] - 2494:29
investment [9] - 2504:29, 2504:39, 2505:9, 2505:11, 2505:28, 2512:31, 2512:34, 2512:37, 2513:4
invite [1] - 2569:12
inviting [1] - 2562:42
involve [3] - 2491:45, 2492:4, 2525:12
involved [8] - 2516:24, 2527:26, 2527:38, 2529:3, 2543:33, 2554:8, 2565:25, 2576:15
involvement [5] - 2516:47, 2543:11, 2550:38, 2556:39, 2571:24
iPads [1] - 2576:13
isolation [1] - 2536:7
issue [14] - 2491:8, 2506:4, 2543:28, 2543:46, 2550:12, 2556:4, 2557:41, 2559:5, 2565:5, 2566:14, 2566:32, 2571:18, 2572:34, 2572:37
issued [1] - 2562:29
issues [20] - 2500:3, 2532:12, 2538:14, 2539:15, 2539:46, 2541:35, 2543:34, 2544:30, 2549:42, 2551:5, 2552:18, 2552:39, 2552:41, 2554:1, 2555:37, 2569:14, 2569:18, 2569:34, 2569:36, 2571:7
issuing [1] - 2576:13
it5 [1] - 2519:5

item [2] - 2517:24, 2574:5
items [1] - 2569:11
iterative [2] - 2535:1, 2535:15
itself [6] - 2488:8, 2514:4, 2535:21, 2540:21, 2554:44, 2570:5

J

January [3] - 2568:28, 2568:29, 2568:40
Jean [1] - 2481:47
Jean-Fred [1] - 2481:47
job [2] - 2539:19, 2576:37
joined [1] - 2539:47
joined-up [1] - 2539:47
joining [1] - 2536:8
joint [3] - 2539:43, 2541:2, 2541:4
jointly [1] - 2539:6
journey [1] - 2486:1
judge [1] - 2530:7
juggling [4] - 2563:18, 2563:19, 2563:35, 2564:1
July [4] - 2480:22, 2562:23, 2568:34, 2569:2
jump [7] - 2502:40, 2507:2, 2510:6, 2531:38, 2531:45, 2557:13, 2561:32
jumping [1] - 2494:33
jumps [1] - 2525:22
June [2] - 2562:25, 2562:27
jurisdiction [2] - 2513:16, 2529:25
jurisdictional [1] - 2543:32
justification [1] - 2481:3

K

Karitane [23] - 2515:33, 2518:16, 2519:29, 2520:35, 2524:35, 2524:41, 2525:4, 2525:5, 2525:11, 2526:8, 2547:26, 2547:32, 2549:16, 2550:40, 2550:44, 2551:4,

2551:16, 2551:28, 2551:33, 2551:41, 2552:14, 2552:23, 2552:30
keen [2] - 2567:25, 2574:10
keep [10] - 2482:27, 2483:45, 2484:17, 2490:1, 2490:16, 2535:38, 2559:8, 2559:46, 2561:47, 2565:28
keeping [2] - 2482:19, 2482:34
Kerry [8] - 2489:38, 2491:2, 2491:40, 2493:36, 2510:24, 2510:26, 2511:17, 2511:27
key [5] - 2488:42, 2490:43, 2537:10, 2541:4, 2562:9
kind [5] - 2484:47, 2485:31, 2495:32, 2519:3
knocking [1] - 2574:21
knowing [7] - 2496:44, 2496:45, 2510:26, 2524:47, 2529:27, 2559:21
knowledge [8] - 2480:34, 2505:21, 2508:28, 2512:47, 2531:14, 2573:20, 2573:22
known [4] - 2485:26, 2493:17, 2523:29, 2566:19
knows [1] - 2505:25
KPI [5] - 2504:2, 2509:40, 2512:23, 2512:43, 2513:20
KPIs [58] - 2483:18, 2483:24, 2483:28, 2483:31, 2483:34, 2486:13, 2486:41, 2486:47, 2487:1, 2487:2, 2487:23, 2487:26, 2487:27, 2490:27, 2490:33, 2503:30, 2503:38, 2503:44, 2503:45, 2503:47, 2504:10, 2508:36, 2508:38, 2508:45, 2508:47, 2509:4, 2509:7, 2509:8, 2509:10, 2509:21, 2509:23, 2509:25, 2509:30,

2509:33, 2510:7, 2510:14, 2510:20, 2510:25, 2510:27, 2510:34, 2510:37, 2511:21, 2511:35, 2511:36, 2511:42, 2511:43, 2512:16, 2512:20, 2512:23, 2513:1, 2513:12, 2513:19, 2513:20, 2517:11, 2517:32, 2558:41, 2558:44, 2559:7

L

Labor [1] - 2562:24
lack [2] - 2530:2, 2545:42
land [1] - 2496:4
lands [1] - 2495:21
language [2] - 2524:32, 2557:42
large [8] - 2490:42, 2500:11, 2502:37, 2536:46, 2553:31, 2563:20, 2576:15
largely [5] - 2489:30, 2518:34, 2557:14, 2557:34, 2560:13
larger [2] - 2486:29, 2529:43
last [16] - 2495:22, 2504:25, 2507:34, 2512:32, 2527:25, 2533:16, 2538:27, 2562:21, 2562:41, 2564:45, 2565:37, 2573:32, 2573:43, 2576:11, 2576:43
launched [2] - 2552:35, 2564:45
lead [5] - 2488:42, 2505:9, 2529:30, 2544:3, 2566:11
leaders [1] - 2514:1
leadership [2] - 2491:2, 2494:31
leading [4] - 2484:6, 2485:31, 2485:32, 2573:45
Leading [1] - 2481:43
lean [2] - 2481:8, 2539:38
learned [1] - 2570:17
learning [1] - 2535:23
least [21] - 2484:2, 2485:33, 2485:39, 2500:10, 2505:21, 2506:31, 2507:17,

2507:37, 2510:8, 2518:16, 2518:41, 2523:36, 2546:16, 2547:2, 2548:26, 2549:6, 2549:45, 2554:10, 2555:27, 2568:28, 2574:16
leave [2] - 2538:31, 2550:26
leaving [1] - 2538:29
led [3] - 2507:11, 2507:24, 2532:42
ledger [1] - 2514:3
LEE [1] - 2530:27
Lee [1] - 2530:33
left [4] - 2537:24, 2557:30, 2565:5, 2570:29
left-hand [1] - 2557:30
legal [2] - 2509:28, 2520:42
legislation [3] - 2483:2, 2509:36, 2509:40
legislative [1] - 2539:37
length [2] - 2486:34, 2522:11
less [11] - 2486:28, 2492:23, 2494:13, 2500:2, 2500:3, 2503:37, 2526:16, 2545:30, 2563:9, 2563:45, 2572:32
less-devolved [1] - 2486:28
lessons [1] - 2570:16
letter [18] - 2561:44, 2562:15, 2562:20, 2562:21, 2562:28, 2562:30, 2562:33, 2567:14, 2568:1, 2568:19, 2568:23, 2568:37, 2568:40, 2568:44, 2569:2, 2569:7, 2569:42, 2574:16
Level [1] - 2479:18
level [8] - 2483:13, 2483:15, 2483:32, 2484:3, 2484:8, 2485:14, 2486:13, 2486:41, 2487:23, 2490:24, 2490:26, 2490:32, 2491:37, 2492:4, 2493:9, 2493:36, 2493:37, 2493:40, 2494:25, 2495:19, 2502:33, 2505:29, 2509:22,

2509:42, 2510:2,
2510:8, 2511:20,
2511:21, 2511:39,
2511:40, 2511:47,
2512:13, 2512:17,
2513:2, 2513:11,
2517:10, 2517:39,
2519:27, 2519:30,
2519:38, 2520:3,
2520:12, 2520:19,
2520:20, 2520:37,
2520:40, 2521:2,
2521:3, 2521:6,
2521:10, 2521:22,
2521:32, 2523:4,
2523:38, 2525:8,
2533:24, 2534:15,
2536:4, 2538:36,
2541:7, 2543:30,
2544:10, 2546:41,
2547:37, 2548:2,
2549:27, 2550:21,
2550:43, 2551:19,
2553:3, 2554:4,
2555:28, 2555:33,
2556:43, 2557:23,
2557:31, 2557:39,
2558:41, 2559:15,
2560:28, 2560:40,
2571:38, 2571:46,
2572:30, 2573:5,
2575:17
levels [2] - 2511:38,
2513:27
lever [1] - 2538:7
levers [3] - 2514:2,
2538:3, 2539:1
LGBTQI [2] - 2532:7,
2545:1
LHD [163] - 2483:15,
2483:21, 2483:27,
2483:33, 2484:33,
2484:39, 2485:24,
2486:47, 2487:41,
2487:42, 2488:45,
2489:3, 2489:12,
2489:32, 2489:33,
2489:44, 2491:28,
2491:29, 2491:44,
2491:45, 2492:3,
2492:4, 2492:11,
2492:22, 2492:28,
2492:36, 2493:4,
2493:17, 2493:18,
2493:42, 2493:43,
2494:8, 2494:27,
2495:17, 2495:20,
2495:46, 2496:14,
2496:21, 2496:28,
2496:30, 2496:31,
2496:41, 2497:14,
2499:1, 2499:6,
2500:32, 2500:39,
2500:47, 2501:12,
2501:25, 2502:4,
2503:4, 2507:17,
2508:11, 2508:17,
2509:34, 2510:3,
2510:22, 2511:5,
2511:42, 2512:16,
2513:1, 2513:10,
2513:14, 2513:28,
2515:24, 2515:26,
2515:27, 2515:39,
2516:5, 2516:9,
2516:18, 2516:42,
2516:44, 2517:10,
2517:38, 2517:39,
2518:18, 2518:37,
2518:45, 2519:16,
2519:26, 2519:31,
2519:38, 2520:2,
2520:4, 2523:4,
2523:6, 2523:21,
2523:30, 2524:14,
2524:21, 2524:23,
2524:24, 2524:28,
2524:29, 2524:30,
2524:36, 2524:39,
2524:45, 2525:1,
2525:5, 2525:6,
2525:7, 2525:10,
2525:47, 2526:2,
2526:4, 2526:9,
2532:10, 2532:14,
2533:15, 2533:23,
2533:42, 2533:43,
2534:4, 2534:26,
2534:27, 2534:29,
2534:41, 2534:46,
2535:11, 2535:21,
2535:35, 2536:24,
2536:32, 2536:36,
2536:39, 2536:41,
2536:46, 2538:9,
2540:35, 2542:10,
2545:11, 2545:15,
2546:23, 2546:45,
2547:3, 2547:45,
2549:1, 2551:20,
2551:28, 2553:8,
2554:30, 2554:41,
2560:26, 2561:13,
2561:26, 2564:13,
2564:36, 2565:44,
2566:45, 2567:39,
2569:32, 2573:4,
2573:7, 2573:10,
2573:11, 2574:16,
2574:29, 2576:20,
2576:45
LHD's [11] - 2483:27,
2492:41, 2494:26,
2500:34, 2500:44,
2517:12, 2519:33,
2534:38, 2537:5,
2542:18, 2557:10
LHD-alone [1] -
2535:11
LHD-run [1] - 2501:25
LHDs [89] - 2481:28,
2483:7, 2484:8,
2484:9, 2486:21,
2486:35, 2486:42,
2489:20, 2489:21,
2490:23, 2491:5,
2491:33, 2491:38,
2492:38, 2493:27,
2493:34, 2496:40,
2497:7, 2497:46,
2498:25, 2501:41,
2502:6, 2502:10,
2502:25, 2502:43,
2503:1, 2503:8,
2503:38, 2505:26,
2506:6, 2506:21,
2506:25, 2506:39,
2507:41, 2508:1,
2509:24, 2511:29,
2512:32, 2512:36,
2514:36, 2515:19,
2515:32, 2515:33,
2515:34, 2517:7,
2517:19, 2518:34,
2519:7, 2519:10,
2519:19, 2519:20,
2519:39, 2523:13,
2523:37, 2524:40,
2525:13, 2525:14,
2525:20, 2525:29,
2525:41, 2526:12,
2526:33, 2527:18,
2532:4, 2533:3,
2535:24, 2537:29,
2540:35, 2542:5,
2542:13, 2543:2,
2543:40, 2544:20,
2545:39, 2547:25,
2547:38, 2551:17,
2552:9, 2552:24,
2553:16, 2554:15,
2556:25, 2556:30,
2556:31, 2556:36,
2557:44, 2560:41,
2560:45, 2573:9
liaising [1] - 2525:29
lieu [1] - 2506:44
life [2] - 2499:30,
2538:31
lifting [1] - 2575:40
light [5] - 2562:6,
2562:7, 2564:2,
2567:37, 2567:44
likely [7] - 2485:7,
2492:10, 2492:11,
2509:3, 2549:33,
2566:11, 2568:12
limited [2] - 2503:23,
2504:20
limiting [1] - 2484:13
line [10] - 2485:36,
2487:45, 2487:47,
2488:17, 2488:36,
2492:31, 2494:18,
2571:32, 2574:39,
2574:43
linear [1] - 2555:32
lines [4] - 2486:16,
2486:19, 2493:13,
2498:5
linked [2] - 2533:32,
2535:29
Lismore [1] - 2489:4
list [5] - 2492:29,
2558:16, 2569:10,
2577:41, 2577:45
listening [1] - 2491:22
lists [7] - 2488:1,
2488:2, 2488:5,
2488:6, 2488:9,
2496:44
literally [1] - 2538:27
live [4] - 2487:3,
2489:47, 2506:28,
2572:44
lively [1] - 2543:47
living [2] - 2496:21,
2540:35
Local [2] - 2530:44,
2549:32
local [50] - 2493:36,
2493:40, 2498:15,
2515:45, 2517:20,
2532:9, 2533:30,
2533:40, 2534:6,
2534:8, 2534:16,
2534:17, 2535:2,
2535:4, 2535:5,
2535:7, 2535:13,
2535:37, 2535:42,
2536:11, 2536:17,
2537:12, 2538:38,
2541:37, 2542:46,
2543:14, 2543:19,
2544:46, 2545:4,
2545:7, 2545:27,
2546:2, 2546:36,
2547:10, 2549:21,
2551:23, 2551:33,
2552:6, 2552:37,
2553:6, 2554:23,
2554:26, 2555:6,
2555:24, 2556:45,
2558:20, 2567:29,
2573:20, 2573:21
localised [1] - 2573:19
locally [4] - 2486:32,
2498:24, 2498:40,
2546:6
located [2] - 2524:29,
2528:40
location [2] - 2528:35,
2553:30
locations [1] -
2485:46
logic [3] - 2551:22,
2553:5, 2554:17
long-term [1] -
2553:37
longer-term [1] -
2482:27
longstanding [2] -
2520:25, 2545:19
look [30] - 2480:45,
2514:24, 2531:27,
2534:39, 2539:5,
2540:26, 2555:5,
2555:16, 2555:31,
2557:20, 2558:21,
2559:4, 2560:30,
2561:23, 2562:21,
2563:20, 2564:31,
2565:7, 2567:5,
2567:46, 2568:5,
2570:2, 2571:22,
2571:40, 2571:46,
2572:35, 2572:36,
2574:19, 2576:35,
2577:5
looking [14] - 2515:10,
2533:25, 2538:14,
2545:34, 2547:16,
2553:47, 2557:29,
2557:36, 2558:6,
2558:13, 2558:34,
2558:40, 2567:14,
2575:42
looks [2] - 2536:41,
2568:33
loop [1] - 2554:3
loose [1] - 2519:27
looser [1] - 2520:21
loss [4] - 2537:34,
2544:21, 2565:9
lost [1] - 2574:44
lounge [1] - 2566:17
love [1] - 2574:8
low [5] - 2498:9,
2526:24, 2565:32,
2565:34, 2565:42
lower [1] - 2563:15

Lumos [8] - 2485:30,
2485:45, 2486:1,
2486:5, 2488:11,
2488:17, 2494:5
lunch [1] - 2542:4
lung [1] - 2527:8
lyrical [1] - 2508:26

M

Mackay [1] - 2523:40
Macquarie [1] -
2479:18
macro [2] - 2514:29,
2538:36
main [3] - 2532:30,
2538:32, 2545:8
maintain [2] -
2489:27, 2496:18
maintaining [4] -
2509:35, 2510:17,
2510:38, 2511:6
maintains [1] - 2566:6
maintenance [2] -
2533:12, 2533:20
major [7] - 2498:4,
2516:22, 2524:6,
2564:41, 2565:29,
2569:23, 2571:8
majority [3] - 2500:13,
2502:34, 2515:44
manage [8] - 2506:36,
2524:1, 2538:33,
2539:3, 2541:1,
2552:24, 2563:42,
2570:7
managed [5] -
2509:13, 2515:18,
2525:24, 2525:25,
2539:9
management [14] -
2483:45, 2486:37,
2488:25, 2488:44,
2506:23, 2511:25,
2511:31, 2517:6,
2517:25, 2522:10,
2569:37, 2571:7,
2574:30, 2574:40
manager [4] -
2482:42, 2482:45,
2482:46, 2483:2
managing [5] -
2523:44, 2525:17,
2529:20, 2530:1,
2542:35
mandate [1] - 2566:22
manifest [1] - 2483:15
manifested [1] -
2570:5
manifests [1] - 2514:4

Manly [1] - 2569:25
manner [1] - 2549:38
manoeuvres [1] -
2563:31
March [1] - 2531:1
marginal [1] - 2512:29
Margot [1] - 2507:37
mark [1] - 2568:43
mark-up [1] - 2568:43
marked [2] - 2577:14,
2577:46
market [38] - 2487:44,
2494:1, 2494:33,
2495:15, 2495:20,
2496:12, 2496:24,
2500:16, 2500:33,
2500:36, 2501:17,
2502:1, 2502:21,
2506:7, 2506:41,
2506:44, 2507:14,
2507:19, 2508:4,
2508:20, 2534:44,
2536:33, 2537:19,
2538:8, 2539:29,
2540:23, 2540:32,
2541:18, 2541:32,
2542:6, 2543:41,
2544:4, 2544:16,
2545:13, 2545:30,
2560:27
market-based [4] -
2495:15, 2506:44,
2540:32, 2560:27
markets [4] - 2538:22,
2539:4, 2544:42
massive [1] - 2488:46
material [2] - 2505:20,
2565:29
maternity [1] -
2489:39
Matt [1] - 2523:40
matter [4] - 2523:34,
2525:47, 2536:6,
2571:34
matters [3] - 2514:41,
2565:25, 2567:30
Matthew [3] - 2480:4,
2480:12, 2554:33
MATTHEW [1] -
2480:6
MAY [1] - 2578:27
MBS [22] - 2495:11,
2495:16, 2495:44,
2496:2, 2496:6,
2498:14, 2498:23,
2503:2, 2506:9,
2506:43, 2506:45,
2507:8, 2508:21,
2540:17, 2540:18,
2541:20, 2541:31,

2542:44, 2542:45,
2543:24, 2543:39,
2544:20
MBS-funded [1] -
2495:44
mean [35] - 2481:17,
2482:22, 2482:43,
2485:3, 2497:10,
2498:35, 2499:32,
2499:38, 2502:6,
2502:27, 2503:10,
2503:12, 2508:41,
2510:34, 2510:42,
2513:3, 2518:25,
2519:2, 2520:38,
2522:26, 2523:26,
2524:15, 2525:25,
2525:43, 2528:9,
2528:15, 2528:29,
2536:23, 2547:17,
2557:38, 2558:30,
2563:8, 2564:13,
2571:40, 2571:44
meaning [1] - 2484:32
means [11] - 2495:34,
2505:47, 2512:26,
2524:47, 2540:10,
2540:41, 2544:19,
2545:36, 2557:28,
2557:37, 2560:45
meant [3] - 2500:33,
2509:12, 2574:22
meantime [1] - 2550:8
measurable [1] -
2487:14
measure [5] -
2510:21, 2557:35,
2558:7, 2558:27,
2571:6
measured [2] -
2511:41, 2558:10
measurements [2] -
2483:18, 2483:19
measures [12] -
2486:14, 2532:15,
2532:18, 2535:45,
2541:4, 2558:4,
2558:8, 2558:15,
2558:26, 2558:31,
2558:33, 2559:16
measuring [1] -
2509:33
mechanism [10] -
2544:29, 2546:3,
2546:9, 2546:34,
2546:44, 2547:4,
2552:3, 2554:1,
2554:32, 2555:29
mechanisms [1] -
2546:35

medical [19] -
2496:41, 2501:9,
2545:24, 2546:37,
2566:18, 2573:34,
2573:35, 2573:41,
2573:43, 2574:1,
2574:2, 2574:8,
2574:13, 2574:14,
2574:19, 2574:23,
2574:25, 2574:41,
2574:42
Medicare [8] -
2498:32, 2503:12,
2508:12, 2538:13,
2540:2, 2540:25,
2566:23, 2566:29
meet [28] - 2494:26,
2496:10, 2499:2,
2500:17, 2502:21,
2506:6, 2513:12,
2513:33, 2517:19,
2520:18, 2520:20,
2522:7, 2523:20,
2529:42, 2536:12,
2537:6, 2544:46,
2545:16, 2547:39,
2548:28, 2550:14,
2552:14, 2552:17,
2554:4, 2557:22,
2562:4, 2573:46,
2576:46
meeting [11] -
2503:30, 2512:16,
2512:20, 2513:1,
2513:11, 2517:25,
2525:9, 2549:30,
2560:47, 2568:36,
2573:43
meetings [8] -
2549:33, 2549:36,
2550:45, 2552:5,
2552:8, 2574:4,
2576:9, 2576:20
meets [1] - 2534:10
members [8] -
2543:38, 2545:12,
2545:20, 2570:29,
2575:3, 2575:37,
2576:13, 2576:15
membership [1] -
2575:47
memory [6] - 2480:31,
2505:13, 2507:28,
2556:12, 2564:39,
2569:28
mental [10] - 2512:5,
2524:1, 2524:3,
2524:7, 2524:11,
2524:15, 2524:17,
2524:20, 2545:2,

2569:39
mentioned [4] -
2484:28, 2485:27,
2496:1, 2543:44
mentions [1] -
2558:12
messed [1] - 2577:32
met [20] - 2486:42,
2487:41, 2493:33,
2493:46, 2497:29,
2497:44, 2500:35,
2502:44, 2506:7,
2510:22, 2513:14,
2534:28, 2534:40,
2535:34, 2536:32,
2537:4, 2537:7,
2545:13, 2557:29,
2572:12
metric [1] - 2521:29
metrics [1] - 2559:1
metro [1] - 2544:38
metropolitan [3] -
2512:41, 2537:23,
2544:25
MFI [2] - 2577:15,
2577:23
MHICUs [1] - 2524:19
micro [2] - 2523:44,
2524:1
micro-managing [1] -
2523:44
middle [3] - 2480:46,
2538:20, 2552:45
might [76] - 2481:18,
2482:11, 2483:35,
2484:27, 2484:35,
2486:31, 2487:8,
2487:43, 2492:22,
2495:16, 2495:29,
2495:39, 2496:37,
2499:42, 2502:43,
2504:38, 2504:39,
2504:41, 2504:42,
2505:21, 2505:23,
2506:9, 2506:35,
2506:38, 2512:39,
2513:8, 2515:25,
2519:23, 2521:23,
2525:31, 2526:23,
2526:41, 2527:18,
2528:18, 2528:20,
2529:11, 2538:3,
2540:43, 2542:5,
2542:17, 2542:28,
2543:28, 2544:3,
2544:19, 2544:41,
2545:1, 2546:3,
2546:10, 2546:12,
2546:19, 2546:27,
2551:34, 2551:35,

- 2552:31, 2552:34,
2552:45, 2553:10,
2553:12, 2559:43,
2560:26, 2561:2,
2563:9, 2563:28,
2565:14, 2565:39,
2566:29, 2566:42,
2567:21, 2567:23,
2568:1, 2570:47,
2573:4, 2574:14,
2576:8, 2577:14
- milieu** [2] - 2482:8,
2510:30
- million** [7] - 2563:28,
2563:29, 2566:25,
2566:41, 2566:42,
2566:43
- mind** [12] - 2505:2,
2508:42, 2526:35,
2526:40, 2549:16,
2552:31, 2565:10,
2566:20, 2567:20,
2568:4, 2570:20,
2577:9
- minds** [1] - 2525:9
- mining** [1] - 2559:10
- minister** [1] - 2540:4
- Ministry** [4] - 2482:41,
2530:36, 2542:11,
2572:41
- ministry** [7] -
2481:36, 2482:44,
2483:6, 2483:14,
2483:25, 2483:33,
2484:19, 2486:28,
2489:35, 2489:42,
2490:37, 2493:3,
2499:4, 2499:5,
2500:47, 2509:7,
2509:21, 2509:27,
2511:24, 2515:35,
2516:47, 2518:19,
2518:22, 2518:29,
2518:31, 2519:18,
2523:9, 2523:39,
2523:43, 2523:47,
2525:20, 2525:39,
2526:10, 2526:15,
2527:46, 2528:1,
2535:26, 2535:27,
2535:31, 2536:2,
2536:4, 2536:5,
2536:38, 2540:47,
2547:5, 2548:43,
2551:20, 2552:26,
2552:39, 2553:7,
2553:29, 2554:2,
2555:24, 2555:34,
2555:39, 2555:41,
2556:27, 2556:43,
- 2560:40, 2561:16,
2561:21, 2564:35,
2565:16, 2565:18,
2567:26, 2569:31,
2572:17, 2573:6,
2573:14, 2573:23
- minus** [3] - 2572:21,
2572:24, 2572:25
- minute** [2] - 2486:45,
2516:2
- minutes** [1] - 2573:40
- mirror** [1] - 2517:11
- mislead** [2] - 2507:15,
2518:13
- mission** [1] - 2527:1
- mitigate** [3] - 2539:22,
2544:7, 2551:36
- mix** [7] - 2485:1,
2485:46, 2486:19,
2490:26, 2490:32,
2494:16, 2516:13
- mmm-hmm** [20] -
2481:14, 2484:4,
2484:30, 2497:26,
2497:41, 2510:10,
2510:18, 2515:29,
2516:10, 2516:45,
2529:1, 2529:8,
2534:42, 2536:29,
2536:43, 2546:24,
2546:29, 2556:22,
2557:11, 2557:32
- mobile** [1] - 2552:35
- model** [23] - 2486:26,
2497:35, 2498:41,
2503:28, 2506:26,
2507:44, 2508:6,
2508:8, 2522:17,
2527:39, 2533:33,
2534:9, 2534:22,
2542:45, 2543:1,
2543:3, 2543:6,
2548:13, 2550:7,
2551:7, 2552:1,
2554:12, 2560:27
- modelling** [1] -
2555:19
- models** [6] - 2494:45,
2495:3, 2528:14,
2532:42, 2546:7,
2553:46
- MOH.9999.0765.0001**
[1] - 2561:32
- MOH.9999.0832.0001**
[1] - 2568:20
- MOH.9999.0859.0001**
[1] - 2509:44
- MOH.9999.0866.0001**
[1] - 2557:5
- MOH.9999.0976.0001**
[1] - 2480:44
- MOH.9999.1109.0001**
[1] - 2562:12
- moment** [13] -
2484:28, 2486:26,
2489:14, 2489:46,
2490:35, 2502:19,
2502:25, 2531:37,
2546:16, 2547:7,
2562:32, 2568:24,
2572:29
- Mona** [1] - 2569:26
- MONDAY** [1] -
2578:27
- Monday** [3] - 2479:22,
2578:14, 2578:19
- money** [19] - 2484:33,
2484:35, 2497:46,
2498:23, 2502:3,
2503:2, 2506:9,
2506:43, 2507:9,
2508:21, 2522:6,
2525:11, 2526:3,
2542:44, 2543:39,
2560:46, 2561:2,
2561:5, 2563:23
- money's** [1] - 2505:38
- money's** [1] - 2549:26
- monitor** [3] - 2503:38,
2559:22, 2576:44
- monitored** [1] -
2511:19
- monitoring** [11] -
2483:27, 2486:39,
2486:40, 2487:2,
2487:4, 2488:26,
2488:30, 2488:31,
2503:44, 2511:46,
2564:20
- monitors** [1] - 2489:15
- month** [3] - 2571:27,
2571:39, 2575:9
- monthly** [8] - 2511:32,
2558:35, 2562:5,
2565:10, 2565:11,
2565:17, 2577:2,
2577:11
- months** [4] - 2512:33,
2517:31, 2531:1,
2551:32
- morning** [2] - 2480:1,
2480:3
- most** [15] - 2491:32,
2495:21, 2501:20,
2502:36, 2504:28,
2517:15, 2519:3,
2523:11, 2533:30,
2535:1, 2537:10,
2540:40, 2543:46,
2550:44, 2562:38
- mostly** [2] - 2541:36,
2542:38
- mother** [1] - 2519:30
- mothers** [2] - 2525:32,
2552:23
- motivator** [1] -
2493:12
- move** [15] - 2504:10,
2508:36, 2513:27,
2513:30, 2515:12,
2518:15, 2524:17,
2528:23, 2537:14,
2547:23, 2559:18,
2563:2, 2563:23,
2563:30, 2568:19
- moved** [3] - 2511:38,
2553:41, 2573:17
- movement** [3] -
2525:14, 2526:3,
2561:7
- movements** [1] -
2563:28
- moving** [6] - 2486:37,
2517:42, 2527:11,
2545:41, 2555:21,
2558:4
- MPSs** [1] - 2541:23
- multi** [1] - 2545:47
- multi-factorial** [1] -
2545:47
- multicultural** [4] -
2491:31, 2491:42,
2493:38, 2534:20
- multidisciplinary** [1] -
2538:16
- multiple** [7] - 2523:37,
2524:24, 2524:46,
2525:20, 2546:7,
2547:46, 2559:7
- multiplied** [1] -
2522:10
- multipurpose** [1] -
2544:32
- must** [2] - 2507:21,
2517:46
- Muston** [1] - 2479:26
- MUSTON** [37] -
2480:3, 2480:8,
2480:10, 2480:37,
2480:42, 2490:13,
2490:18, 2490:23,
2491:25, 2495:10,
2499:47, 2504:14,
2505:45, 2510:45,
2511:13, 2511:19,
2514:11, 2514:15,
2514:23, 2530:10,
2530:25, 2530:29,
2530:31, 2531:17,
2531:22, 2541:42,
- 2542:4, 2559:24,
2559:38, 2559:43,
2560:5, 2560:22,
2576:43, 2577:14,
2577:20, 2577:25,
2577:41
-
- ## N
-
- name** [5] - 2480:10,
2481:3, 2507:28,
2530:31, 2576:38
- names** [1] - 2481:41
- nasty** [1] - 2501:13
- nation** [1] - 2485:31
- nation-leading** [1] -
2485:31
- National** [3] - 2483:36,
2494:42, 2538:25
- national** [7] - 2483:38,
2494:43, 2522:1,
2534:14, 2536:4,
2538:21, 2543:45
- natural** [1] - 2488:43
- naturally** [1] - 2501:24
- nature** [22] - 2483:1,
2499:11, 2505:26,
2515:2, 2515:9,
2515:35, 2517:1,
2517:13, 2518:19,
2522:13, 2524:16,
2529:7, 2529:26,
2532:46, 2533:38,
2542:29, 2544:47,
2548:15, 2548:30,
2560:44, 2572:16,
2572:17
- navigate** [2] - 2550:46,
2552:19
- near** [1] - 2488:46
- nearly** [1] - 2492:46
- neatly** [1] - 2551:12
- necessarily** [9] -
2488:8, 2491:8,
2497:10, 2513:21,
2522:30, 2524:18,
2534:2, 2545:38,
2573:14
- necessary** [2] -
2520:22, 2556:25
- need** [65] - 2482:20,
2485:38, 2489:9,
2492:12, 2492:13,
2493:4, 2494:26,
2495:5, 2495:29,
2495:38, 2496:7,
2498:36, 2498:38,
2499:1, 2499:4,
2499:10, 2500:28,
2500:44, 2501:20,

- 2501:23, 2501:47,
2502:2, 2502:44,
2503:21, 2504:6,
2504:18, 2504:29,
2505:4, 2505:36,
2513:21, 2518:12,
2518:47, 2520:45,
2521:25, 2523:31,
2524:43, 2526:1,
2526:36, 2529:6,
2529:42, 2534:2,
2534:19, 2536:2,
2536:27, 2537:3,
2537:6, 2540:44,
2544:47, 2545:12,
2545:16, 2546:22,
2546:31, 2548:7,
2551:43, 2552:33,
2554:5, 2556:2,
2561:17, 2563:39,
2564:8, 2566:37,
2573:17
- needed** [8] - 2501:21,
2504:39, 2505:28,
2505:38, 2543:21,
2546:12, 2553:34,
2566:47
- needing** [4] - 2482:27,
2499:12, 2545:18,
2562:42
- needs** [71] - 2484:38,
2485:23, 2491:27,
2491:33, 2491:41,
2491:46, 2492:6,
2492:35, 2492:43,
2493:25, 2493:33,
2493:45, 2494:8,
2494:13, 2494:22,
2495:45, 2496:10,
2497:28, 2497:44,
2499:30, 2500:17,
2500:34, 2500:40,
2502:7, 2502:22,
2503:23, 2504:4,
2504:20, 2506:6,
2509:16, 2509:17,
2513:13, 2513:15,
2517:20, 2519:22,
2523:20, 2525:15,
2525:23, 2525:32,
2525:34, 2528:10,
2533:14, 2533:22,
2533:35, 2533:40,
2533:44, 2534:4,
2534:10, 2534:25,
2534:28, 2534:36,
2534:37, 2534:39,
2534:40, 2535:19,
2535:33, 2535:34,
2535:38, 2536:11,
2536:18, 2537:45,
- 2539:30, 2541:1,
2541:9, 2544:17,
2552:38, 2560:47,
2561:14, 2576:46
- negotiate** [5] -
2491:38, 2493:13,
2502:38, 2503:1,
2551:11
- negotiating** [4] -
2525:45, 2538:21,
2541:29, 2543:23
- negotiation** [17] -
2484:7, 2484:9,
2484:29, 2491:44,
2492:3, 2494:24,
2502:33, 2503:9,
2506:8, 2507:36,
2519:20, 2523:22,
2525:40, 2542:43,
2543:44, 2551:15,
2561:19
- negotiations** [10] -
2490:25, 2493:9,
2493:21, 2496:39,
2507:25, 2543:12,
2543:27, 2547:12,
2548:42, 2561:15
- neighbouring** [1] -
2536:16
- neonatal** [1] - 2489:40
- net** [1] - 2565:13
- network** [9] - 2515:27,
2516:43, 2517:37,
2528:2, 2535:5,
2553:42, 2553:45,
2554:20, 2555:16
- networking** [1] -
2529:29
- networks** [7] - 2517:8,
2518:27, 2528:4,
2528:12, 2537:13,
2538:37, 2539:42
- never** [1] - 2574:5
- nevertheless** [2] -
2513:12, 2529:42
- New** [12] - 2479:19,
2483:1, 2494:31,
2501:7, 2504:44,
2529:21, 2529:25,
2531:42, 2537:22,
2552:36, 2554:37,
2569:23
- new** [9] - 2485:42,
2544:27, 2567:35,
2567:42, 2567:47,
2570:17, 2570:20,
2570:31, 2570:33
- next** [8] - 2530:25,
2536:22, 2552:1,
2564:28, 2567:32,
- 2568:19, 2573:25,
2578:14
- NGO** [2] - 2549:31,
2552:15
- NGOs** [3] - 2532:28,
2535:6, 2572:43
- nil** [1] - 2511:39
- nine** [1] - 2499:7
- no-one** [1] - 2501:39
- nods** [3] - 2495:12,
2533:9, 2536:34
- non** [18] - 2497:12,
2498:3, 2498:6,
2498:12, 2498:19,
2498:33, 2502:20,
2503:12, 2511:31,
2512:23, 2512:43,
2513:29, 2531:41,
2532:28, 2534:30,
2546:44, 2566:29,
2574:42
- non-admitted** [3] -
2498:3, 2498:6,
2546:44
- non-government** [3] -
2531:41, 2532:28,
2534:30
- non-inpatient** [4] -
2497:12, 2498:12,
2498:19, 2498:33
- non-inpatients** [1] -
2503:12
- non-KPI** [1] - 2512:43
- non-KPIs** [1] -
2512:23
- non-medical** [1] -
2574:42
- non-performance** [2]
- 2511:31, 2513:29
- non-resident** [1] -
2566:29
- non-urgent** [1] -
2502:20
- non-compliance** [1] -
2513:28
- noose** [1] - 2553:11
- normal** [6] - 2568:39,
2568:42, 2570:17,
2570:20, 2570:32,
2570:33
- normalised** [1] -
2571:44
- normally** [1] - 2575:38
- north** [1] - 2563:21
- North** [3] - 2517:45,
2555:7, 2572:11
- Northern** [32] -
2515:46, 2516:5,
2516:9, 2516:17,
2516:24, 2517:42,
- 2518:37, 2518:45,
2519:5, 2520:2,
2520:3, 2523:27,
2530:44, 2547:44,
2548:12, 2549:32,
2555:37, 2561:24,
2561:25, 2566:45,
2569:14, 2569:21,
2569:24, 2569:25,
2569:30, 2569:32,
2569:37, 2570:40,
2570:47, 2571:3,
2571:12
- northern** [2] -
2518:41, 2555:23
- note** [2] - 2537:34,
2541:42
- nothing** [4] - 2487:33,
2526:2, 2549:2,
2560:28
- notice** [2] - 2538:31,
2549:11
- noticed** [1] - 2544:26
- noting** [2] - 2532:11,
2537:22
- notion** [1] - 2568:16
- notionally** [1] -
2577:47
- November** [1] - 2531:3
- NSW** [14] - 2479:36,
2480:15, 2486:38,
2486:42, 2488:42,
2492:24, 2492:47,
2504:25, 2505:20,
2508:40, 2509:16,
2526:32, 2542:18,
2546:40
- nuances** [1] - 2523:43
- number** [41] -
2480:43, 2484:47,
2487:1, 2487:9,
2487:10, 2487:46,
2488:2, 2494:12,
2502:9, 2502:27,
2503:41, 2507:15,
2507:16, 2507:22,
2512:9, 2512:11,
2524:23, 2527:46,
2529:23, 2531:46,
2532:15, 2535:47,
2541:16, 2546:26,
2548:42, 2549:31,
2549:39, 2549:47,
2550:5, 2550:45,
2551:23, 2554:46,
2557:15, 2558:8,
2561:2, 2561:18,
2561:36, 2571:6,
2572:42, 2572:43,
2575:1
- numbers** [4] -
2553:36, 2565:15,
2577:46, 2578:3
- nurse** [2] - 2512:40,
2532:42
- nurse-led** [1] -
2532:42
- nursing** [4] - 2507:20,
2546:39, 2560:31,
2570:29
- NWAW** [9] - 2493:14,
2497:16, 2498:8,
2498:16, 2518:6,
2527:22, 2546:44,
2546:45, 2547:9
- NWAWs** [3] - 2561:3,
2561:18, 2571:6
-
- O**
-
- o'clock** [1] - 2541:44
- oath** [2] - 2560:3,
2560:8
- obesity** [1] - 2535:40
- objective** [4] -
2506:27, 2510:15,
2510:16, 2510:22
- objectives** [12] -
2510:36, 2556:24,
2556:32, 2556:35,
2557:21, 2557:22,
2557:29, 2557:35,
2557:36, 2558:21,
2558:28, 2559:3
- objects** [3] - 2533:7,
2556:42, 2564:14
- obligation** [5] -
2497:23, 2519:21,
2540:16, 2540:21,
2550:27
- obligations** [5] -
2496:14, 2509:39,
2522:40, 2575:21,
2575:35
- observation** [2] -
2493:1, 2497:5
- observing** [1] -
2488:14
- obtained** [1] - 2528:11
- obvious** [2] - 2537:25,
2537:26
- obviously** [12] -
2484:11, 2498:9,
2503:23, 2504:20,
2505:8, 2512:33,
2512:39, 2517:15,
2536:27, 2537:11,
2548:19, 2558:18
- occasion** [2] - 2498:7,
2498:31

occasional [1] - 2496:6
occasionally [1] - 2503:39
occasions [1] - 2502:27
occupied [1] - 2507:18
occur [3] - 2522:20, 2532:44, 2556:25
occurred [1] - 2542:22
offered [2] - 2497:8, 2576:45
officer [3] - 2533:27, 2536:6, 2566:40
officers [1] - 2526:15
official [1] - 2486:20
offloading [1] - 2487:8
offloads [1] - 2487:4
offs [1] - 2566:12
often [17] - 2485:41, 2493:22, 2493:24, 2504:6, 2513:34, 2513:39, 2514:43, 2517:41, 2520:26, 2524:15, 2524:16, 2537:31, 2566:15, 2566:16, 2570:25, 2570:27
once [10] - 2509:25, 2528:45, 2537:43, 2568:45, 2568:47, 2570:24, 2575:9, 2575:10, 2576:21, 2577:45
one [72] - 2481:45, 2482:46, 2484:36, 2484:46, 2485:5, 2485:44, 2486:20, 2486:25, 2486:27, 2487:46, 2488:25, 2488:34, 2489:46, 2490:43, 2493:3, 2495:32, 2496:5, 2498:5, 2498:8, 2498:44, 2499:15, 2499:29, 2499:32, 2501:4, 2501:39, 2504:28, 2505:7, 2508:8, 2510:47, 2515:15, 2515:27, 2515:44, 2522:27, 2523:11, 2523:26, 2523:41, 2525:41, 2526:4, 2527:12, 2529:43, 2531:46, 2532:19, 2532:33, 2535:19, 2535:33, 2535:41, 2537:19, 2538:6, 2538:12, 2538:27, 2538:46, 2542:18, 2543:46, 2546:35, 2547:15, 2549:33, 2550:12, 2550:45, 2551:2, 2556:4, 2561:7, 2562:1, 2562:19, 2562:32, 2563:22, 2564:47, 2565:20, 2567:7, 2570:6, 2573:44, 2576:43
one-off [2] - 2495:32, 2499:29
one-stop [1] - 2496:5
ones [4] - 2516:41, 2532:6, 2533:28, 2553:32
ongoing [8] - 2499:32, 2499:36, 2499:40, 2500:29, 2548:20, 2548:21, 2548:22, 2570:21
opening [1] - 2557:45
operate [8] - 2484:45, 2511:25, 2518:7, 2518:10, 2554:41, 2570:7, 2571:2, 2571:47
operated [1] - 2518:1
operates [2] - 2517:32, 2529:16
operating [9] - 2484:17, 2493:47, 2494:1, 2500:35, 2517:33, 2521:15, 2523:42, 2526:5, 2565:14
operation [1] - 2545:23
operational [10] - 2481:26, 2481:28, 2482:8, 2483:14, 2514:1, 2514:33, 2543:34, 2555:28, 2565:5, 2565:25
operationalised [1] - 2483:5
operations [2] - 2483:26, 2511:6
OPERATOR [1] - 2490:8
operator [2] - 2561:32, 2571:15
opex [1] - 2563:21
opinion [3] - 2484:19, 2488:5, 2499:33
opportunity [8] - 2480:29, 2499:24, 2499:25, 2523:8, 2538:32, 2549:37, 2573:47, 2574:25
opposed [5] - 2498:31, 2507:9, 2512:42, 2517:3, 2555:44
optimal [2] - 2537:38
optimum [1] - 2540:7
options [3] - 2496:32, 2545:31, 2568:5
order [15] - 2484:16, 2484:21, 2496:6, 2501:28, 2505:6, 2506:36, 2511:38, 2511:46, 2520:18, 2520:28, 2523:31, 2530:6, 2535:19, 2556:35, 2559:1
ordinarily [1] - 2563:10
ordinary [1] - 2563:22
organisation [4] - 2503:22, 2504:19, 2523:45, 2551:16
organisations [15] - 2486:33, 2490:43, 2491:3, 2515:12, 2518:15, 2520:34, 2521:3, 2525:38, 2526:45, 2527:1, 2532:28, 2534:31, 2547:27, 2550:42, 2551:19
oriented [2] - 2481:22, 2481:25
otherwise [13] - 2488:43, 2494:36, 2496:12, 2508:19, 2513:13, 2529:32, 2537:7, 2540:43, 2546:10, 2560:19, 2564:27, 2577:42
ought [1] - 2496:28
ourselves [4] - 2484:40, 2538:33, 2539:3, 2571:12
outcome [6] - 2489:34, 2505:34, 2511:2, 2511:3, 2514:4, 2567:43
outcomes [7] - 2505:9, 2505:39, 2511:29, 2515:6, 2551:47, 2557:37, 2567:36
outlined [2] - 2535:47, 2558:8
outpatient [8] - 2488:1, 2488:6, 2492:29, 2496:34, 2545:11, 2545:16, 2545:18, 2546:46
outpatients [3] - 2492:27, 2545:26, 2546:36
outputs [1] - 2483:19
outside [10] - 2512:21, 2517:45, 2524:28, 2524:29, 2524:36, 2525:46, 2545:41, 2548:47, 2552:28, 2559:43
outstanding [1] - 2548:8
overall [1] - 2565:21
overdue [1] - 2512:34
overhead [1] - 2524:4
overlap [1] - 2533:6
oversee [4] - 2510:28, 2511:22, 2514:40, 2552:38
overseen [1] - 2490:46
oversees [2] - 2527:17, 2528:2
oversight [4] - 2483:16, 2483:26, 2514:38, 2532:29
own [11] - 2496:23, 2513:4, 2520:22, 2520:35, 2523:43, 2535:42, 2552:28, 2552:32, 2552:33, 2555:10, 2556:36
owned [1] - 2515:25
owners [3] - 2489:37, 2509:6, 2510:26
ownership [1] - 2524:9

P

pack [1] - 2576:11
packages [1] - 2507:30
page [14] - 2510:6, 2510:12, 2531:47, 2557:13, 2557:27, 2557:45, 2561:33, 2562:30, 2564:29, 2564:30, 2570:11, 2570:37, 2573:25
pages [2] - 2569:28, 2576:12
paid [6] - 2518:4, 2518:33, 2523:24, 2523:25, 2571:16
palliation [1] - 2517:47
pandemic [2] - 2570:23, 2570:34
paper [4] - 2484:37, 2576:14, 2576:27, 2576:38
papers [1] - 2575:44
paragraph [32] - 2480:45, 2480:46, 2481:12, 2482:40, 2483:42, 2484:2, 2490:30, 2499:28, 2504:10, 2508:37, 2511:39, 2514:24, 2514:28, 2515:14, 2515:17, 2526:27, 2526:30, 2526:31, 2527:6, 2531:31, 2531:38, 2531:47, 2533:8, 2556:19, 2561:33, 2562:34, 2562:42, 2563:17, 2564:24, 2567:32, 2570:12, 2570:13
paragraphs [3] - 2539:32, 2563:2, 2567:33
parallel [2] - 2544:18, 2574:37
parameters [1] - 2501:18
pardon [1] - 2549:15
parliamentary [1] - 2569:21
part [55] - 2480:38, 2481:35, 2482:3, 2484:34, 2491:25, 2491:44, 2492:3, 2493:21, 2497:24, 2497:45, 2497:46, 2498:17, 2498:25, 2498:29, 2500:34, 2500:40, 2501:47, 2502:4, 2504:27, 2508:38, 2509:40, 2515:26, 2516:43, 2517:36, 2517:44, 2518:41, 2519:4, 2519:20, 2527:29, 2528:25, 2531:18, 2532:14, 2532:22, 2532:28, 2532:29, 2534:16, 2534:37, 2537:5, 2537:8, 2540:14, 2540:15, 2542:34, 2545:39, 2547:11, 2549:46, 2552:36, 2555:15, 2556:31, 2557:2, 2557:14, 2561:18, 2564:21, 2565:16, 2568:14, 2569:25
partial [1] - 2507:37

participate [1] - 2503:13	2574:40	2496:6, 2540:27, 2543:24, 2569:36	2511:35, 2511:40, 2511:42, 2511:47, 2512:7, 2512:13, 2512:17, 2512:44, 2513:2, 2513:11, 2513:26, 2513:29, 2513:35, 2513:36, 2513:37, 2513:43, 2513:46, 2517:6, 2517:25, 2526:33, 2526:34, 2534:38, 2549:36, 2552:5, 2552:8, 2552:10, 2558:15, 2558:44, 2565:17, 2565:21, 2568:30, 2568:32, 2571:31, 2571:33, 2574:7	2520:43, 2526:46
particular [50] - 2491:26, 2491:27, 2491:46, 2492:5, 2492:8, 2492:9, 2492:35, 2492:44, 2492:47, 2493:4, 2493:15, 2493:16, 2496:35, 2498:22, 2499:26, 2507:23, 2510:35, 2511:46, 2513:45, 2524:12, 2524:27, 2525:32, 2526:40, 2528:14, 2528:29, 2531:37, 2533:12, 2533:20, 2533:22, 2534:25, 2535:6, 2536:23, 2539:4, 2543:27, 2544:4, 2544:34, 2550:11, 2551:20, 2561:14, 2561:18, 2563:45, 2565:26, 2565:27, 2566:2, 2566:4, 2567:24, 2568:3, 2568:47, 2569:11, 2575:39	patient [43] - 2481:31, 2481:33, 2486:2, 2488:27, 2488:35, 2489:15, 2496:21, 2496:29, 2498:3, 2498:7, 2498:12, 2498:39, 2499:26, 2501:5, 2513:38, 2514:6, 2514:25, 2514:27, 2514:32, 2514:34, 2514:39, 2515:1, 2516:13, 2517:47, 2526:45, 2528:46, 2530:1, 2530:36, 2531:35, 2537:17, 2537:41, 2546:4, 2553:47, 2555:19, 2558:11, 2558:12, 2559:10, 2561:24, 2566:11, 2567:1, 2567:16	pays [1] - 2503:37	performances [1] - 2487:4	philosophies [1] - 2481:43
particularly [17] - 2482:5, 2482:9, 2487:3, 2494:3, 2496:45, 2507:21, 2508:31, 2521:1, 2525:26, 2526:47, 2544:8, 2544:24, 2561:37, 2564:39, 2564:40, 2564:44, 2574:17	patients [46] - 2482:5, 2484:47, 2485:8, 2488:9, 2488:13, 2488:14, 2494:36, 2495:28, 2501:12, 2501:33, 2503:32, 2506:33, 2506:37, 2507:21, 2507:34, 2516:4, 2516:17, 2517:42, 2518:40, 2524:16, 2528:20, 2528:23, 2529:5, 2529:36, 2537:14, 2537:36, 2540:10, 2541:2, 2542:28, 2544:26, 2545:28, 2548:9, 2548:23, 2549:47, 2550:5, 2550:27, 2550:28, 2555:9, 2555:11, 2555:29, 2556:1, 2556:14, 2566:8, 2566:36, 2567:22, 2571:10	pending [1] - 2562:28	performed [2] - 2564:36, 2569:35	philosophy [1] - 2481:44
partners [6] - 2531:40, 2534:31, 2536:11, 2539:20, 2539:34, 2549:31	patterns [3] - 2553:47, 2554:36, 2555:20	pennies [2] - 2568:7, 2568:8	performing [7] - 2486:47, 2494:9, 2512:11, 2533:11, 2533:19, 2533:42, 2534:46	PHN [5] - 2500:32, 2535:21, 2539:1, 2541:3, 2541:37
partnership [2] - 2486:3, 2506:24	pause [1] - 2489:46	penny [2] - 2568:2, 2568:17	perhaps [23] - 2480:42, 2500:32, 2508:36, 2509:42, 2510:12, 2516:8, 2521:35, 2524:28, 2524:30, 2528:45, 2531:25, 2534:20, 2534:30, 2536:39, 2540:33, 2544:26, 2545:21, 2547:41, 2551:21, 2552:6, 2567:23, 2571:3, 2571:13	PHNs [3] - 2486:3, 2501:27, 2540:46
partnerships [1] - 2535:12	pay [7] - 2503:34, 2518:43, 2545:22, 2550:24, 2571:2, 2571:4	people [53] - 2482:13, 2482:19, 2482:27, 2482:30, 2482:32, 2483:7, 2485:40, 2487:42, 2489:25, 2489:37, 2490:15, 2495:35, 2496:4, 2496:20, 2497:37, 2499:29, 2500:1, 2501:24, 2501:29, 2502:17, 2507:30, 2510:13, 2514:32, 2517:33, 2520:39, 2521:40, 2524:13, 2524:28, 2524:40, 2531:40, 2533:34, 2538:30, 2542:11, 2542:14, 2544:35, 2546:10, 2548:16, 2553:36, 2560:34, 2560:36, 2566:15, 2566:16, 2566:25, 2566:27, 2566:32, 2570:24, 2571:8, 2572:44, 2573:16, 2574:34, 2575:2, 2575:5	period [7] - 2496:25, 2501:21, 2501:29, 2502:19, 2505:6, 2548:1, 2569:4	phone [1] - 2574:20
parts [8] - 2501:6, 2510:25, 2537:21, 2539:4, 2539:15, 2554:47, 2574:38	paying [2] - 2566:19, 2575:45	per [3] - 2485:40, 2487:28, 2563:21	periods [1] - 2488:15	physical [2] - 2524:28, 2528:9
party [1] - 2572:46	payment [5] - 2496:3, 2548:14, 2569:34, 2571:19	perceived [4] - 2499:1, 2500:44, 2543:19, 2570:47	permanent [1] - 2566:16	physically [1] - 2518:37
pass [2] - 2503:37, 2503:42	payments [4] -	perfectly [1] - 2558:14	persuade [1] - 2525:10	pick [4] - 2491:20, 2495:20, 2513:21, 2562:33
passed [1] - 2519:8		perform [2] - 2492:41, 2561:28	persuaded [1] - 2525:6	picked [4] - 2483:3, 2495:17, 2495:46, 2496:28
past [8] - 2490:42, 2494:28, 2497:5, 2523:47, 2551:32, 2564:4, 2568:44, 2570:28		performance [51] - 2480:19, 2483:28, 2484:45, 2486:11, 2486:38, 2486:39, 2487:3, 2488:27, 2494:15, 2510:30, 2511:20, 2511:25, 2511:30, 2511:31,	perspective [2] - 2491:40, 2543:22	PHNs [3] - 2486:3, 2501:27, 2540:46
pathway [2] - 2552:39,			persuade [1] - 2525:10	PHNs [3] - 2486:3, 2501:27, 2540:46
			phase [3] - 2505:10, 2528:47, 2537:43	physical [2] - 2524:28, 2528:9
			philanthropic [2] -	physically [1] - 2518:37
				planned [7] - 2484:43, 2484:44, 2486:18, 2487:33, 2488:2, 2492:32, 2513:41
				plans [4] - 2556:40, 2556:44, 2557:46, 2569:37
				play [2] - 2495:33, 2540:3
				played [2] - 2500:18, 2500:21
				plays [1] - 2489:4

pleased [2] - 2540:4, 2570:12
plenty [1] - 2570:23
plotting [1] - 2486:1
plus [5] - 2566:3, 2569:28, 2572:15, 2572:27, 2572:42
pocket [2] - 2537:1, 2545:22
pockets [1] - 2501:42
point [28] - 2482:32, 2490:23, 2492:44, 2499:7, 2500:26, 2504:26, 2507:3, 2510:36, 2521:20, 2524:35, 2525:39, 2525:40, 2528:19, 2529:44, 2529:45, 2530:2, 2533:42, 2534:1, 2539:11, 2544:1, 2549:30, 2550:47, 2557:40, 2566:11, 2567:23, 2573:29, 2573:32
pointed [2] - 2487:11, 2519:5
points [4] - 2512:11, 2529:40, 2564:29, 2569:10
polices [1] - 2494:45
policies [4] - 2531:42, 2534:16, 2534:18, 2557:1
policy [30] - 2481:22, 2481:23, 2481:32, 2481:34, 2489:37, 2489:40, 2494:32, 2501:1, 2509:6, 2510:26, 2531:38, 2532:5, 2532:10, 2532:12, 2532:19, 2532:29, 2532:37, 2532:45, 2533:7, 2533:27, 2534:2, 2534:21, 2540:24, 2540:33, 2541:7, 2543:30, 2544:6, 2544:9, 2544:14, 2556:24
pool [2] - 2484:34, 2502:32
poor [2] - 2503:34, 2513:42
poorly [2] - 2521:35, 2536:40
pop [1] - 2509:47
population [48] - 2484:22, 2485:17, 2485:21, 2485:23, 2485:36, 2486:23, 2491:4, 2492:9, 2492:20, 2493:16, 2493:24, 2493:25, 2493:29, 2493:43, 2494:5, 2494:19, 2496:44, 2497:28, 2501:7, 2504:43, 2509:11, 2509:16, 2510:31, 2513:13, 2520:45, 2524:13, 2524:43, 2526:18, 2527:21, 2532:43, 2533:25, 2533:31, 2533:32, 2533:35, 2533:44, 2534:19, 2534:26, 2534:37, 2535:3, 2535:10, 2535:38, 2536:26, 2537:1, 2545:13, 2555:5, 2560:47, 2576:46
population's [1] - 2541:5
populations [12] - 2491:31, 2491:34, 2511:2, 2532:1, 2532:6, 2532:17, 2532:21, 2532:24, 2534:7, 2535:26, 2541:23, 2544:40
port [1] - 2495:22
portal [1] - 2488:35
portals [1] - 2555:20
portfolio [3] - 2481:2, 2483:43, 2531:36
position [8] - 2496:23, 2503:1, 2503:8, 2526:9, 2528:28, 2548:45, 2549:44, 2552:1
positioning [1] - 2538:46
positive [2] - 2511:2, 2540:20
positively [1] - 2547:17
possibility [1] - 2542:5
possible [8] - 2481:5, 2482:35, 2486:4, 2513:10, 2524:33, 2540:1, 2540:34, 2541:27
possibly [1] - 2566:1
pot [1] - 2484:35
potential [1] - 2526:16
potentially [14] - 2510:15, 2523:43, 2525:17, 2525:37, 2525:41, 2528:6, 2541:18, 2541:30, 2542:17, 2551:18, 2554:14, 2566:47, 2567:15, 2567:21
pound [2] - 2568:2, 2568:17
power [1] - 2567:26
PPP [3] - 2569:15, 2569:23, 2571:9
practical [3] - 2482:45, 2493:39, 2528:33
practice [37] - 2485:44, 2493:21, 2495:40, 2526:43, 2532:39, 2535:4, 2537:9, 2537:11, 2537:13, 2537:15, 2537:20, 2537:23, 2537:27, 2537:35, 2538:17, 2538:39, 2539:2, 2539:3, 2539:36, 2539:44, 2540:9, 2540:30, 2540:39, 2540:41, 2540:46, 2541:25, 2541:33, 2541:35, 2541:39, 2542:12, 2542:15, 2542:24, 2543:28, 2544:7, 2544:11, 2544:25, 2544:45
practices [3] - 2486:4, 2501:27, 2560:35
practitioner [4] - 2512:40, 2538:29, 2541:13, 2544:27
practitioners [5] - 2494:5, 2537:31, 2541:21, 2545:6
preceding [1] - 2567:33
predominantly [9] - 2481:26, 2482:6, 2503:15, 2503:45, 2511:43, 2511:45, 2516:8, 2523:5, 2573:3
preference [2] - 2499:14, 2499:15
preferred [1] - 2541:37
pregnancy [1] - 2511:1
premier's [1] - 2483:39
premises [1] - 2524:29
PREMs [1] - 2558:12
preparation [2] - 2527:29, 2547:30
prepare [2] - 2552:1, 2568:43
prepared [3] - 2480:25, 2531:5, 2568:37
prescribe [4] - 2483:9, 2483:13, 2483:37, 2483:38
presence [1] - 2493:26
present [2] - 2479:34, 2575:4
presentations [5] - 2482:3, 2566:11, 2567:1, 2567:17, 2570:26
presenting [5] - 2485:8, 2485:41, 2537:42, 2566:36
pressing [2] - 2500:28, 2501:20
pressure [2] - 2500:24, 2523:14
pressures [4] - 2496:36, 2550:46, 2551:37, 2555:38
presumably [1] - 2549:25
pretend [2] - 2508:27, 2524:22
pretty [4] - 2493:30, 2512:23, 2552:7, 2557:31
prevalence [4] - 2485:4, 2491:1, 2492:8, 2493:15
preventative [1] - 2505:8
prevention [5] - 2489:37, 2504:30, 2505:9, 2505:37, 2534:14
previous [3] - 2563:15, 2568:33, 2568:44
price [19] - 2518:4, 2518:5, 2518:7, 2521:15, 2521:23, 2521:30, 2521:43, 2521:47, 2522:1, 2522:10, 2522:18, 2522:45, 2525:45, 2549:7, 2549:20, 2549:21, 2549:22
pricing [2] - 2494:44, 2547:9
primarily [4] - 2483:27, 2497:20, 2518:45, 2542:31
primary [81] - 2482:3, 2486:2, 2492:20, 2492:23, 2493:28, 2493:46, 2494:26, 2494:29, 2494:33, 2494:38, 2494:43, 2494:47, 2495:11, 2495:15, 2495:20, 2495:26, 2498:44, 2499:2, 2499:21, 2499:23, 2499:24, 2499:25, 2500:9, 2500:34, 2501:16, 2501:22, 2501:34, 2501:43, 2502:15, 2502:22, 2502:40, 2503:3, 2505:46, 2505:47, 2506:3, 2506:7, 2506:19, 2506:38, 2506:40, 2507:40, 2507:41, 2508:2, 2508:10, 2508:18, 2508:31, 2526:14, 2532:35, 2532:36, 2532:38, 2532:39, 2534:33, 2534:37, 2535:4, 2537:3, 2537:9, 2537:10, 2537:13, 2537:20, 2538:4, 2538:15, 2538:22, 2538:37, 2539:23, 2539:42, 2540:9, 2540:14, 2540:24, 2540:34, 2541:28, 2542:6, 2542:16, 2543:3, 2543:20, 2543:40, 2543:46, 2544:17, 2544:39, 2560:26, 2560:29, 2560:30
Prince [3] - 2555:7, 2555:9, 2555:13
principal [1] - 2538:37
principally [3] - 2501:2, 2543:9, 2546:38
principle [1] - 2522:9
priorities [7] - 2483:39, 2513:44, 2523:34, 2536:19, 2557:14, 2557:15, 2562:10
prioritisation [2] - 2561:11, 2568:15
priority [6] - 2497:13, 2532:1, 2532:16, 2532:21, 2532:24, 2544:40
Private [1] - 2507:27

- private** [24] - 2484:24, 2487:44, 2488:7, 2494:1, 2494:3, 2495:44, 2500:36, 2507:27, 2516:22, 2522:30, 2522:39, 2534:44, 2540:23, 2542:14, 2545:6, 2545:13, 2545:21, 2545:29, 2545:32, 2545:37, 2550:22, 2551:5, 2571:9, 2571:10
- privately** [5] - 2498:11, 2498:19, 2498:32, 2503:11, 2515:25
- proactive** [1] - 2555:45
- problem** [7] - 2495:26, 2497:3, 2501:22, 2513:38, 2523:46, 2567:5, 2567:6
- problematic** [2] - 2523:45, 2539:5
- problems** [2] - 2495:22, 2506:2
- process** [23] - 2484:9, 2488:31, 2491:44, 2492:7, 2502:33, 2503:12, 2508:38, 2511:30, 2512:1, 2519:20, 2535:23, 2535:37, 2535:41, 2539:32, 2545:15, 2551:46, 2552:11, 2554:33, 2554:45, 2561:22, 2568:39, 2568:42, 2571:29
- processes** [3] - 2552:33, 2555:32, 2555:41
- product** [4] - 2486:16, 2486:19, 2493:13, 2498:5
- productivity** [2] - 2504:43, 2512:43
- profession** [2] - 2570:29
- professionals** [1] - 2532:42
- Professor** [1] - 2562:19
- proffer** [1] - 2488:4
- proffered** [5] - 2520:12, 2521:4, 2547:38, 2549:26, 2572:30
- profile** [2] - 2494:11, 2516:21
- profiles** [1] - 2497:1
- profitability** [1] - 2572:46
- profound** [2] - 2544:23, 2544:29
- program** [6] - 2481:44, 2485:30, 2494:35, 2499:17, 2501:26, 2502:11
- programs** [8] - 2481:1, 2505:6, 2506:29, 2506:31, 2507:41, 2512:32, 2513:5, 2531:42
- progress** [3] - 2506:1, 2528:46, 2539:26
- project** [1] - 2569:27
- projections** [1] - 2491:4
- promote** [3] - 2489:27, 2496:18, 2544:34
- promoting** [4] - 2509:34, 2510:16, 2510:38, 2511:6
- promotion** [4] - 2532:43, 2533:12, 2533:20, 2533:31
- prompt** [2] - 2512:12, 2565:38
- PROMs** [1] - 2558:11
- properly** [1] - 2533:17
- proportionally** [1] - 2507:16
- propose** [1] - 2510:28
- proposed** [1] - 2526:18
- proposition** [1] - 2537:4
- prospective** [1] - 2520:20
- prospectively** [1] - 2522:24
- protect** [2] - 2489:27, 2496:18
- protecting** [5] - 2509:34, 2510:16, 2510:38, 2511:6, 2511:11
- protection** [2] - 2533:12, 2533:20
- proved** [1] - 2491:23
- provide** [44] - 2489:25, 2492:12, 2493:4, 2496:19, 2498:18, 2498:37, 2499:29, 2500:26, 2503:16, 2508:18, 2510:20, 2512:30, 2515:7, 2515:24, 2516:19, 2519:4, 2519:25, 2520:38, 2523:31, 2524:20, 2524:24, 2526:33, 2527:45, 2538:8, 2539:1, 2540:38, 2542:27, 2542:36, 2546:22, 2546:42, 2546:45, 2547:25, 2551:26, 2551:39, 2552:2, 2554:22, 2554:26, 2554:35, 2555:7, 2555:25, 2560:31, 2568:12, 2571:47, 2572:43
- provided** [46] - 2481:45, 2482:13, 2488:39, 2495:17, 2497:46, 2498:2, 2498:11, 2500:16, 2502:32, 2504:22, 2507:29, 2508:11, 2512:36, 2517:18, 2517:45, 2520:11, 2520:36, 2535:16, 2535:31, 2535:44, 2536:37, 2542:33, 2543:15, 2545:10, 2545:31, 2546:40, 2547:17, 2547:21, 2547:37, 2548:16, 2548:26, 2549:1, 2549:3, 2549:4, 2549:19, 2551:41, 2551:47, 2553:4, 2556:8, 2561:12, 2561:22, 2563:9, 2564:37, 2566:4, 2571:19, 2571:20
- provider** [1] - 2516:22
- providers** [3] - 2517:16, 2518:27, 2545:6
- provides** [9] - 2495:10, 2495:27, 2519:5, 2519:29, 2540:22, 2548:8, 2555:14, 2555:28
- providing** [21] - 2485:22, 2491:45, 2492:4, 2512:42, 2516:16, 2516:28, 2516:32, 2521:39, 2523:37, 2525:11, 2525:19, 2532:14, 2532:30, 2541:30, 2545:6, 2551:17, 2551:24, 2551:38, 2556:5, 2572:10, 2573:3
- provision** [13] - 2489:26, 2496:20, 2502:40, 2508:22, 2519:13, 2519:40, 2532:23, 2542:6, 2543:2, 2544:39, 2548:21, 2548:22, 2560:29
- provisionally** [1] - 2569:1
- public** [28] - 2482:42, 2487:42, 2496:34, 2516:17, 2516:22, 2522:35, 2522:44, 2526:47, 2527:2, 2527:13, 2537:36, 2539:7, 2539:14, 2545:10, 2545:15, 2545:18, 2545:19, 2545:28, 2545:32, 2546:36, 2546:46, 2548:23, 2550:13, 2550:27, 2550:28, 2556:6, 2556:16
- pull** [1] - 2526:46
- pulled** [2] - 2538:4, 2538:7
- purchase** [4] - 2517:39, 2524:45, 2525:8, 2528:8
- purchased** [9] - 2490:26, 2515:36, 2517:2, 2518:20, 2521:22, 2528:8, 2546:43, 2547:4, 2549:10
- purchasing** [17] - 2483:8, 2483:12, 2484:1, 2486:10, 2489:29, 2489:31, 2489:34, 2489:35, 2515:18, 2524:46, 2550:25, 2550:28, 2554:33, 2554:39, 2555:4, 2555:22, 2555:46
- purpose** [6] - 2492:37, 2499:47, 2531:39, 2542:13, 2561:5, 2561:41
- purposes** [12] - 2488:20, 2489:32, 2489:33, 2491:4, 2491:5, 2497:35, 2498:39, 2533:2, 2533:6, 2533:11, 2547:3, 2561:3
- pursuant** [1] - 2520:37
- pursue** [1] - 2567:35
- pursuit** [1] - 2567:42
- put** [5] - 2483:4, 2485:44, 2535:18, 2575:43, 2576:38
- puts** [1] - 2562:6
- putting** [3] - 2509:32, 2519:42, 2550:11
-
- ## Q
-
- Qantas** [1] - 2566:17
- quality** [1] - 2572:8
- quality** [15] - 2483:18, 2483:38, 2487:34, 2487:35, 2487:37, 2488:28, 2490:45, 2503:33, 2512:5, 2530:5, 2538:4, 2559:5, 2559:7, 2575:41, 2576:1
- quantum** [2] - 2545:46, 2566:41
- quarter** [2] - 2563:29, 2576:21
- quarterly** [5] - 2511:32, 2513:34, 2549:36, 2552:5, 2552:9
- quarters** [1] - 2576:2
- quasi** [1] - 2526:14
- Queensland** [2] - 2508:30, 2508:33
- questions** [16] - 2505:46, 2514:6, 2515:13, 2530:10, 2530:15, 2531:37, 2542:5, 2542:21, 2559:17, 2559:19, 2559:20, 2559:24, 2559:29, 2577:25, 2577:27, 2577:29
- quickly** [5] - 2507:24, 2514:6, 2515:8, 2569:13, 2569:40
- quite** [16] - 2485:13, 2487:11, 2490:1, 2492:36, 2506:37, 2508:44, 2521:7, 2544:29, 2561:45, 2563:14, 2566:14, 2566:17, 2570:2, 2570:3, 2575:6, 2576:16
- quoted** [1] - 2507:15
-
- ## R
-
- radical** [4] - 2565:43, 2566:47, 2567:15, 2567:21
- raft** [2] - 2496:47, 2538:17

raise [1] - 2574:21
raised [2] - 2549:39, 2568:34
raising [1] - 2520:35
ran [1] - 2576:12
range [11] - 2496:30, 2515:32, 2515:34, 2528:41, 2530:42, 2545:43, 2546:41, 2547:25, 2551:17, 2554:14, 2559:1
ranges [1] - 2485:28
rank [1] - 2480:4
rarely [1] - 2563:12
rate [2] - 2484:13, 2550:4
rate-limiting [1] - 2484:13
rates [2] - 2504:40, 2540:5
rather [17] - 2481:44, 2484:20, 2486:6, 2490:41, 2491:10, 2506:18, 2517:17, 2524:45, 2525:39, 2526:17, 2540:22, 2542:15, 2551:20, 2564:21, 2570:32, 2571:15, 2573:6
rationale [1] - 2481:19
rationalise [1] - 2509:3
rationalising [1] - 2509:14
reach [3] - 2485:38, 2496:13, 2547:18
reached [3] - 2482:32, 2508:9, 2537:43
reactive [1] - 2555:44
read [7] - 2490:18, 2513:37, 2526:31, 2527:30, 2531:9, 2541:19, 2576:14
readily [2] - 2499:20, 2529:31
reading [3] - 2576:5, 2576:8, 2576:9
readmissions [1] - 2503:36
ready [4] - 2507:35, 2514:21, 2528:46, 2542:2
real [7] - 2487:2, 2488:27, 2488:30, 2489:8, 2506:17, 2509:15, 2529:5
real-time [5] - 2487:2, 2488:27, 2488:30, 2489:8, 2529:5
realistic [4] - 2493:8, 2564:47, 2567:37, 2567:44
reality [5] - 2484:42, 2503:20, 2504:17, 2506:46, 2570:1
really [29] - 2481:24, 2481:26, 2481:36, 2482:20, 2487:2, 2489:4, 2498:4, 2498:40, 2499:21, 2506:4, 2510:20, 2510:40, 2511:4, 2513:24, 2520:41, 2525:47, 2526:10, 2529:32, 2529:37, 2529:47, 2535:10, 2543:29, 2546:8, 2558:6, 2558:27, 2564:17, 2565:38, 2565:43, 2567:3
realm [1] - 2514:42
reason [6] - 2512:44, 2523:36, 2539:17, 2545:47, 2550:12, 2560:11
reasonable [3] - 2496:25, 2500:23, 2506:28
reasonably [1] - 2492:27
reasons [11] - 2487:46, 2496:23, 2520:8, 2520:10, 2523:28, 2524:30, 2544:3, 2544:43, 2545:43, 2551:3, 2551:21
recalled [1] - 2560:3
receive [2] - 2502:8, 2550:13
received [4] - 2498:39, 2540:43, 2548:10, 2549:1
receiver [1] - 2529:37
receiving [5] - 2482:35, 2501:16, 2502:4, 2506:36, 2537:41
recent [2] - 2538:12, 2553:40
recently [3] - 2550:44, 2552:15, 2552:35
reciprocal [1] - 2566:24
recognise [3] - 2510:1, 2510:7, 2557:9
recognised [6] - 2497:34, 2518:21, 2526:1, 2526:13, 2526:21, 2529:33
recognition [2] - 2522:14, 2548:15
recollection [1] - 2556:9
recommendation [3] - 2512:1, 2512:12, 2528:13
recommendations [1] - 2496:47
recommended [1] - 2503:33
record [2] - 2480:11, 2530:32
recording [1] - 2488:13
records [1] - 2568:38
recovery [2] - 2528:47, 2529:10
recruit [1] - 2541:25
recruitment [1] - 2531:2
red [3] - 2483:21, 2512:10, 2559:19
redesignate [1] - 2561:8
redirected [1] - 2489:3
redirected [1] - 2504:7
Redmond [1] - 2514:35
reduced [1] - 2513:1
reducing [2] - 2502:31, 2565:42
reduction [2] - 2509:8, 2509:17
reductions [1] - 2523:28
refamiliarise [1] - 2531:9
refer [17] - 2480:46, 2481:12, 2482:44, 2483:12, 2484:2, 2499:15, 2505:16, 2526:31, 2527:6, 2532:27, 2532:33, 2553:32, 2563:2, 2563:17, 2564:26, 2567:33, 2568:40
reference [6] - 2486:12, 2552:7, 2564:24, 2570:16, 2570:40, 2575:8
referral [13] - 2488:20, 2496:3, 2496:7, 2496:9, 2496:22, 2496:32, 2498:13, 2498:15, 2529:37, 2529:46, 2553:47, 2555:20
referrals [1] - 2498:38
referred [14] - 2487:19, 2498:11, 2498:19, 2498:32, 2500:27, 2503:11, 2526:35, 2529:36, 2533:8, 2544:40, 2546:4, 2567:20, 2568:24, 2576:47
referrer [1] - 2496:32
referring [12] - 2482:26, 2488:13, 2488:30, 2497:13, 2498:4, 2529:26, 2534:30, 2553:24, 2563:4, 2563:19, 2567:15, 2577:8
refers [1] - 2484:6
reflect [2] - 2493:24, 2526:42
reflected [2] - 2561:15, 2562:46
reflection [1] - 2570:2
reform [4] - 2538:21, 2538:46, 2539:26, 2543:45
Reform [3] - 2483:36, 2494:42, 2538:25
reforms [1] - 2540:6
refresh [1] - 2480:31
refugee [2] - 2493:26, 2493:37
refuse [1] - 2508:21
regard [7] - 2482:2, 2492:37, 2504:16, 2507:38, 2541:40, 2542:25, 2574:34
regardless [1] - 2506:27
regards [1] - 2562:9
regime [1] - 2481:34
region [2] - 2507:20, 2537:23
regional [8] - 2508:32, 2541:22, 2541:36, 2543:7, 2544:9, 2544:23, 2545:34, 2552:36
registered [1] - 2503:13
regularly [4] - 2542:29, 2552:14, 2552:17, 2574:41
regulates [1] - 2566:21
regulatory [1] - 2539:37
Rehab [48] - 2515:44, 2516:3, 2516:16, 2516:20, 2516:28, 2516:39, 2518:17, 2518:36, 2518:43, 2519:2, 2519:14, 2520:1, 2520:2, 2520:21, 2521:36, 2522:6, 2523:38, 2547:26, 2547:33, 2547:41, 2547:45, 2548:2, 2548:27, 2548:33, 2548:40, 2549:13, 2549:15, 2549:18, 2549:24, 2550:11, 2550:32, 2556:5, 2556:8, 2556:16, 2571:21, 2571:22, 2571:25, 2571:37, 2572:2, 2572:5, 2572:12, 2572:29, 2573:2, 2573:5, 2573:13, 2573:17
rehab [11] - 2515:47, 2516:3, 2516:18, 2516:22, 2517:47, 2522:22, 2549:37, 2555:10, 2555:15, 2555:16, 2555:25
rehabilitate [1] - 2544:16
rehabilitation [29] - 2516:4, 2516:19, 2516:29, 2516:33, 2518:42, 2521:39, 2527:27, 2528:9, 2528:47, 2529:4, 2529:6, 2529:11, 2529:21, 2529:41, 2529:43, 2548:7, 2548:23, 2553:27, 2553:28, 2554:10, 2554:43, 2555:13, 2555:21, 2556:6, 2556:7, 2556:10, 2556:11, 2556:14
rehearse [1] - 2557:15
reimbursed [1] - 2572:5
rejected [2] - 2494:46, 2495:4
relate [1] - 2566:13
related [1] - 2575:20
relates [5] - 2515:47, 2524:12, 2526:11, 2532:23, 2562:8
relation [22] - 2489:28, 2491:41, 2494:3, 2499:37, 2500:7, 2500:10, 2503:47, 2507:6, 2520:10, 2528:19, 2528:26, 2532:27, 2532:35,

- 2535:32, 2543:3,
2551:15, 2562:43,
2567:1, 2567:9,
2567:16, 2567:22,
2571:21
- relations** [3] -
2543:23, 2543:26,
2543:29
- relationship** [9] -
2499:32, 2499:37,
2499:40, 2537:12,
2538:43, 2548:22,
2552:13, 2552:45,
2566:7
- relationships** [4] -
2525:18, 2538:42,
2539:43, 2552:25
- relative** [5] - 2498:29,
2512:8, 2514:30,
2528:10, 2529:11
- relatively** [4] -
2485:42, 2501:21,
2512:30, 2526:3
- release** [1] - 2557:43
- released** [1] - 2557:42
- relevance** [1] -
2490:39
- relevant** [4] - 2517:13,
2524:41, 2532:9,
2535:27
- relief** [2] - 2489:25,
2496:19
- remember** [2] -
2565:34, 2573:42
- remembering** [1] -
2492:14
- remit** [4] - 2515:47,
2540:28, 2548:47,
2556:45
- remote** [4] - 2544:24,
2544:28, 2545:44,
2546:1
- remotely** [1] - 2546:27
- repeat** [1] - 2567:40
- repeats** [1] - 2557:34
- rephrase** [1] - 2496:16
- replace** [2] - 2500:9,
2500:18
- replaced** [1] - 2569:25
- replicated** [1] - 2558:2
- Report** [1] - 2504:26
- REPORT** [1] - 2577:23
- report** [10] - 2504:32,
2505:36, 2512:35,
2562:6, 2562:7,
2565:12, 2565:13,
2577:2, 2577:11,
2577:20
- reported** [1] - 2547:36
- reporting** [1] -
2559:12
- reports** [4] - 2504:34,
2575:42, 2576:47,
2577:8
- representatives** [2] -
2490:16, 2541:3
- represented** [1] -
2540:46
- representing** [1] -
2547:32
- require** [8] - 2482:33,
2499:40, 2506:11,
2518:41, 2539:38,
2539:40, 2548:17,
2548:23
- required** [24] -
2517:11, 2520:14,
2520:21, 2520:39,
2521:3, 2521:11,
2521:32, 2522:8,
2522:43, 2523:18,
2533:38, 2536:26,
2536:41, 2547:40,
2550:20, 2550:41,
2554:1, 2554:4,
2554:46, 2561:25,
2564:27, 2566:31,
2569:35, 2572:6
- requirement** [2] -
2519:21, 2561:43
- requirements** [1] -
2520:19
- requires** [13] - 2492:9,
2492:20, 2493:27,
2496:21, 2499:41,
2506:35, 2519:18,
2524:36, 2539:12,
2545:24, 2568:7,
2568:8, 2572:31
- requiring** [3] -
2482:30, 2496:3,
2504:2
- resembles** [1] -
2494:43
- resident** [2] - 2566:28,
2566:29
- residents** [2] -
2507:18, 2566:44
- resolution** [1] -
2572:38
- resource** [2] - 2504:5,
2527:40
- resources** [5] -
2484:12, 2504:7,
2514:46, 2539:40,
2560:41
- respective** [2] -
2515:19, 2552:24
- respectively** [2] -
2527:28, 2551:42
- respond** [3] - 2492:12,
2494:14
- responded** [1] -
2500:23
- responding** [2] -
2482:4, 2507:26
- response** [9] - 2489:5,
2493:28, 2493:39,
2494:11, 2501:1,
2507:38, 2530:6,
2542:10, 2560:25
- responsibilities** [1] -
2545:42
- responsibility** [10] -
2480:18, 2489:38,
2489:40, 2494:30,
2494:39, 2496:31,
2506:19, 2514:37,
2532:40, 2540:16
- responsible** [13] -
2486:38, 2492:25,
2494:47, 2495:14,
2498:42, 2504:4,
2509:21, 2514:38,
2532:45, 2534:17,
2538:45, 2540:24,
2564:41
- responsive** [2] -
2506:47, 2509:15
- rest** [4] - 2483:20,
2484:17, 2517:34,
2554:30
- restore** [1] - 2538:4
- restricted** [1] -
2484:11
- restriction** [1] -
2507:20
- resulted** [1] - 2497:6
- results** [2] - 2511:31,
2557:29
- resurrect** [1] - 2495:5
- retention** [1] - 2540:27
- return** [3] - 2512:33,
2513:3, 2559:38
- revenue** [6] - 2498:17,
2498:18, 2498:29,
2550:22, 2551:6,
2565:14
- reversed** [1] - 2524:8
- review** [9] - 2480:29,
2509:2, 2515:2,
2548:32, 2548:38,
2548:39, 2548:41,
2548:46, 2549:2
- review's** [1] - 2550:34
- reviewed** [1] - 2508:38
- reviewing** [1] -
2556:40
- reviews** [1] - 2514:44
- revitalise** [1] - 2573:34
- revolution** [1] -
2494:14
- Richard** [1] - 2479:14
- right-hand** [1] -
2558:5
- rightly** [1] - 2488:4
- rigorously** [1] -
2564:20
- risk** [8] - 2505:8,
2524:26, 2539:22,
2539:46, 2544:8,
2571:30, 2571:33
- robust** [1] - 2492:27
- role** [41] - 2480:22,
2483:3, 2483:6,
2488:41, 2489:4,
2500:18, 2504:23,
2514:28, 2514:29,
2514:39, 2515:34,
2517:43, 2518:18,
2518:31, 2519:4,
2519:6, 2530:39,
2530:47, 2532:30,
2532:35, 2538:45,
2539:19, 2540:26,
2540:39, 2542:37,
2543:17, 2543:28,
2544:11, 2550:38,
2553:30, 2553:45,
2554:20, 2555:37,
2555:46, 2556:44,
2561:46, 2565:4,
2565:24, 2565:26,
2569:23, 2578:8
- roles** [4] - 2514:36,
2524:16, 2524:21,
2530:42
- room** [3] - 2541:24,
2555:31, 2574:7
- rooms** [4] - 2488:7,
2493:47, 2545:22,
2545:37
- Ross** [1] - 2479:27
- roughly** [1] - 2487:28
- roundabouts** [2] -
2525:12, 2571:14
- route** [1] - 2508:24
- routine** [2] - 2552:40,
2576:36
- routinely** [4] - 2497:6,
2497:36, 2506:2,
2566:24
- rows** [1] - 2570:41
- Royal** [55] - 2515:44,
2516:3, 2516:16,
2516:20, 2516:28,
2516:38, 2517:45,
2518:17, 2518:36,
2518:43, 2519:2,
2519:14, 2520:1,
2520:2, 2520:21,
2521:36, 2522:6,
2523:37, 2547:26,
2547:33, 2547:41,
2547:45, 2548:2,
2548:7, 2548:13,
2548:27, 2548:33,
2548:40, 2549:13,
2549:15, 2549:18,
2549:24, 2549:36,
2550:11, 2550:32,
2555:7, 2555:14,
2555:23, 2556:5,
2556:8, 2556:16,
2571:21, 2571:22,
2571:25, 2571:37,
2572:2, 2572:4,
2572:12, 2572:28,
2572:29, 2573:2,
2573:5, 2573:13,
2573:17
- RPA** [2] - 2488:46,
2489:2
- run** [6] - 2491:30,
2501:25, 2503:15,
2542:45, 2560:32,
2568:44
- running** [1] - 2486:34
- runs** [2] - 2551:27,
2569:28
- rural** [16] - 2508:31,
2537:25, 2537:29,
2537:32, 2538:2,
2541:22, 2541:36,
2544:8, 2544:22,
2544:24, 2544:28,
2545:34, 2545:44,
2546:1, 2546:11
- rusty** [1] - 2542:32
- Ryde** [5] - 2548:7,
2548:13, 2549:36,
2555:14, 2555:23

S

- sacrifice** [1] - 2523:30
- sacrifices** [3] - 2564:8,
2564:25, 2565:3
- sad** [1] - 2573:16
- sadly** [1] - 2549:46
- safe** [1] - 2484:17
- safety** [19] - 2483:18,
2483:38, 2487:34,
2487:36, 2487:37,
2488:28, 2490:45,
2512:5, 2514:7,
2514:25, 2514:27,
2514:32, 2514:34,
2514:39, 2515:1,
2559:5, 2559:7,

2559:10, 2575:40
salaried [3] - 2507:42,
 2541:27, 2542:17
sat [1] - 2571:27
satisfactory [3] -
 2521:1, 2521:12,
 2522:43
satisfied [3] -
 2480:33, 2531:13,
 2570:7
save [3] - 2568:2,
 2568:17, 2576:14
savings [2] - 2563:22,
 2563:43
saw [3] - 2507:26,
 2557:34, 2567:2
SC [2] - 2479:14,
 2479:26
scale [1] - 2521:42
Scandinavia [1] -
 2505:2
Scandinavian [2] -
 2505:12, 2505:17
scanning [2] -
 2557:38, 2558:30
scenario [1] - 2507:1
schedule [2] -
 2520:26, 2538:24
schedules [1] -
 2569:29
Schembri [10] -
 2562:16, 2562:19,
 2562:43, 2564:7,
 2567:10, 2567:16,
 2567:34, 2568:4,
 2568:34, 2570:44
scheme [1] - 2526:4
scope [3] - 2498:30,
 2547:13, 2566:2
screen [7] - 2480:43,
 2509:47, 2531:26,
 2531:27, 2557:6,
 2576:14
screening [1] -
 2532:18
scroll [2] - 2510:12,
 2514:23
seat [1] - 2560:7
second [12] - 2489:27,
 2490:27, 2510:47,
 2512:35, 2518:15,
 2518:32, 2529:45,
 2536:31, 2562:34,
 2564:30, 2569:12,
 2570:11
secondary [4] -
 2486:2, 2492:24,
 2493:28, 2526:14
secondly [1] - 2562:23
secretaries' [1] -
 2489:43
secretary [19] -
 2480:14, 2481:20,
 2481:21, 2484:19,
 2509:26, 2512:2,
 2512:13, 2514:41,
 2514:44, 2530:35,
 2538:45, 2543:7,
 2564:39, 2564:46,
 2566:40, 2567:26,
 2568:31, 2568:35
secretary's [1] -
 2515:3
section [12] - 2489:21,
 2495:18, 2495:46,
 2496:13, 2496:15,
 2533:3, 2537:5,
 2541:20, 2543:4,
 2543:9, 2544:32,
 2565:22
sector [6] - 2484:24,
 2494:3, 2539:16,
 2539:24, 2545:32,
 2545:46
secure [1] - 2508:24
see [54] - 2480:45,
 2481:12, 2484:1,
 2486:9, 2486:14,
 2486:25, 2487:8,
 2487:10, 2488:15,
 2494:2, 2495:38,
 2496:25, 2498:13,
 2500:24, 2501:23,
 2508:37, 2510:13,
 2510:24, 2514:26,
 2519:11, 2526:30,
 2527:44, 2533:36,
 2539:20, 2540:1,
 2541:5, 2541:38,
 2544:8, 2545:22,
 2547:13, 2551:22,
 2551:34, 2553:22,
 2554:17, 2554:37,
 2555:20, 2557:13,
 2557:27, 2557:42,
 2559:6, 2562:33,
 2565:39, 2566:29,
 2566:33, 2567:26,
 2567:33, 2568:36,
 2568:46, 2569:10,
 2570:13, 2571:44,
 2573:4, 2573:29,
 2574:8
seeing [3] - 2537:21,
 2539:45, 2562:28
seek [1] - 2510:24
seeking [1] - 2505:20
seem [5] - 2510:14,
 2515:22, 2533:6,
 2574:36, 2575:5
sees [1] - 2512:34
self [1] - 2575:38
self-allocate [1] -
 2575:38
send [1] - 2569:5
Senior [1] - 2479:26
senior [1] - 2497:2
sense [17] - 2481:28,
 2482:45, 2484:43,
 2487:33, 2493:8,
 2493:20, 2497:38,
 2498:45, 2510:39,
 2510:43, 2511:5,
 2514:29, 2515:8,
 2546:18, 2558:20,
 2565:20, 2565:45
sensitive [2] -
 2493:30, 2509:38
sent [2] - 2496:10,
 2569:42
sentence [1] - 2562:42
separate [4] -
 2520:42, 2525:8,
 2532:25, 2562:7
separated [1] -
 2567:23
September [4] -
 2530:39, 2562:15,
 2562:33, 2562:47
sequelae [1] - 2540:41
series [2] - 2481:19,
 2486:16
serious [3] - 2518:42,
 2553:27, 2554:9
served [4] - 2501:42,
 2537:2, 2537:45
serves [4] - 2491:47,
 2492:6, 2511:7,
 2556:12
service [195] -
 2483:32, 2484:7,
 2484:8, 2486:11,
 2486:13, 2486:39,
 2486:41, 2487:23,
 2490:24, 2490:32,
 2491:5, 2492:4,
 2492:10, 2492:24,
 2493:9, 2494:11,
 2494:25, 2494:26,
 2495:36, 2496:7,
 2496:47, 2497:7,
 2497:9, 2497:10,
 2497:13, 2498:7,
 2498:11, 2498:19,
 2498:23, 2498:31,
 2498:33, 2498:37,
 2499:2, 2499:21,
 2501:26, 2502:7,
 2502:11, 2502:30,
 2502:33, 2503:17,
 2504:5, 2506:35,
 2507:7, 2509:22,
 2509:42, 2510:2,
 2510:8, 2511:20,
 2511:21, 2511:41,
 2512:24, 2512:26,
 2516:21, 2517:10,
 2517:19, 2517:26,
 2518:22, 2518:28,
 2519:13, 2519:15,
 2519:26, 2519:30,
 2519:32, 2519:37,
 2519:40, 2520:3,
 2520:5, 2520:12,
 2520:19, 2520:20,
 2520:37, 2520:39,
 2521:3, 2521:5,
 2521:10, 2521:14,
 2521:16, 2521:22,
 2521:32, 2522:13,
 2522:18, 2522:19,
 2522:35, 2523:32,
 2523:33, 2523:38,
 2523:42, 2524:2,
 2524:3, 2524:5,
 2524:6, 2524:7,
 2524:13, 2524:46,
 2525:1, 2525:8,
 2525:43, 2525:45,
 2525:46, 2526:5,
 2526:13, 2526:14,
 2526:22, 2527:14,
 2527:22, 2527:34,
 2528:29, 2529:33,
 2530:5, 2532:13,
 2532:16, 2532:37,
 2533:33, 2533:40,
 2535:47, 2539:31,
 2540:20, 2542:29,
 2542:30, 2542:31,
 2542:37, 2544:22,
 2545:19, 2546:41,
 2547:20, 2547:37,
 2548:2, 2548:8,
 2548:19, 2548:21,
 2548:24, 2549:3,
 2549:27, 2549:46,
 2550:21, 2550:43,
 2551:19, 2552:1,
 2552:16, 2552:33,
 2552:37, 2553:3,
 2553:4, 2553:35,
 2554:4, 2554:19,
 2554:22, 2554:24,
 2554:31, 2554:34,
 2555:10, 2555:11,
 2558:37, 2558:41,
 2560:28, 2561:1,
 2561:19, 2561:26,
 2561:44, 2562:26,
 2562:28, 2562:46,
 2563:3, 2563:9,
 2564:9, 2564:44,
 2565:13, 2565:27,
 2565:43, 2566:1,
 2566:3, 2566:4,
 2566:26, 2566:33,
 2569:29, 2569:31,
 2569:47, 2570:4,
 2570:5, 2570:8,
 2571:11, 2571:20,
 2571:38, 2571:46,
 2572:7, 2572:10,
 2572:11, 2572:16,
 2572:18, 2572:30,
 2573:5
service's [1] - 2488:29
service/funding [1] -
 2518:11
Services [6] -
 2489:22, 2495:18,
 2495:47, 2496:14,
 2496:16, 2533:3
services [221] -
 2482:10, 2482:12,
 2483:8, 2483:9,
 2483:12, 2485:47,
 2486:8, 2486:30,
 2487:40, 2488:40,
 2490:26, 2492:13,
 2492:21, 2493:33,
 2494:8, 2494:32,
 2494:47, 2495:43,
 2496:1, 2496:2,
 2496:12, 2496:41,
 2497:1, 2497:7,
 2497:29, 2497:33,
 2497:36, 2497:44,
 2498:35, 2499:3,
 2499:8, 2500:9,
 2500:18, 2501:2,
 2501:5, 2502:26,
 2503:27, 2504:2,
 2506:16, 2512:42,
 2515:18, 2515:24,
 2515:31, 2515:33,
 2515:36, 2515:38,
 2515:45, 2516:4,
 2516:17, 2516:19,
 2517:1, 2518:16,
 2518:20, 2518:21,
 2518:33, 2518:40,
 2518:42, 2518:44,
 2519:26, 2519:30,
 2519:37, 2520:13,
 2520:29, 2520:36,
 2520:38, 2521:11,
 2521:31, 2521:39,
 2521:41, 2521:42,
 2522:2, 2522:8,
 2522:13, 2522:21,
 2522:23, 2522:44,

- 2523:9, 2523:17,
2523:37, 2524:21,
2524:23, 2524:24,
2524:27, 2524:32,
2524:35, 2524:37,
2524:39, 2524:42,
2525:5, 2525:7,
2525:19, 2525:32,
2525:38, 2525:42,
2526:12, 2526:18,
2527:5, 2527:7,
2527:18, 2527:20,
2527:33, 2527:38,
2528:2, 2529:4,
2529:21, 2529:27,
2530:3, 2532:3,
2532:14, 2532:46,
2534:10, 2534:19,
2534:28, 2535:8,
2535:16, 2535:44,
2536:23, 2536:24,
2536:25, 2536:31,
2536:41, 2536:45,
2536:46, 2540:36,
2540:40, 2541:32,
2542:16, 2542:18,
2542:32, 2543:25,
2544:33, 2544:41,
2545:1, 2545:3,
2545:7, 2545:10,
2545:42, 2546:10,
2546:16, 2546:18,
2546:23, 2546:31,
2546:34, 2546:42,
2546:46, 2547:13,
2547:25, 2547:40,
2548:26, 2548:29,
2550:13, 2550:15,
2550:20, 2550:25,
2550:28, 2550:41,
2551:7, 2551:17,
2551:24, 2551:26,
2551:29, 2551:38,
2551:41, 2551:44,
2552:22, 2552:23,
2552:27, 2553:20,
2553:21, 2553:23,
2553:32, 2554:8,
2554:10, 2554:11,
2554:24, 2554:26,
2554:28, 2554:41,
2554:44, 2555:4,
2555:13, 2555:16,
2555:25, 2556:5,
2556:7, 2556:10,
2556:27, 2558:32,
2560:30, 2561:11,
2561:12, 2561:21,
2561:28, 2563:11,
2563:14, 2563:36,
2563:43, 2564:25,
2564:26, 2564:42,
2565:3, 2565:32,
2565:35, 2565:47,
2569:26, 2569:34,
2569:35, 2569:38,
2571:2, 2571:4,
2572:6, 2572:31,
2572:44, 2573:3,
2573:9, 2574:24,
2576:12, 2576:45
servicing [2] -
2524:16, 2527:20
serving [1] - 2533:45
set [14] - 2487:27,
2489:21, 2498:35,
2499:17, 2502:10,
2502:16, 2532:12,
2533:3, 2533:33,
2533:39, 2547:2,
2558:41, 2568:36,
2570:9
sets [4] - 2481:22,
2481:23, 2486:11,
2513:44
setting [15] - 2481:32,
2482:15, 2482:22,
2495:26, 2495:27,
2497:34, 2499:41,
2500:2, 2500:4,
2502:18, 2507:19,
2532:46, 2534:2,
2536:47, 2540:11
settings [2] - 2495:24,
2498:18
settle [1] - 2548:9
seven [2] - 2489:15,
2575:28
several [2] - 2483:43,
2519:25
severe [7] - 2521:40,
2528:21, 2563:3,
2563:8, 2564:3,
2569:47, 2570:2
severity [1] - 2564:13
sexual [1] - 2545:2
shall [1] - 2577:17
share [3] - 2503:39,
2568:46, 2569:1
shared [2] - 2551:7,
2556:27
sharing [2] - 2491:4,
2529:47
Sharon [1] - 2485:30
sheet [1] - 2484:37
shield [1] - 2519:10
shielded [3] - 2519:6,
2519:14, 2523:27
SHNs [1] - 2486:42
Shoalhaven [3] -
2507:12, 2507:14,
2507:35
shop [1] - 2496:5
Shore [3] - 2517:46,
2555:7, 2572:11
short [5] - 2499:29,
2501:21, 2502:19,
2508:23, 2538:31
short-term [1] -
2499:29
shortages [1] -
2545:35
show [1] - 2577:1
showing [1] - 2535:45
shrinking [1] -
2549:47
shy [1] - 2574:20
SIA [1] - 2490:38
sick [2] - 2489:25,
2496:19
side [5] - 2505:7,
2505:8, 2505:34,
2514:33, 2550:12
sight [7] - 2485:36,
2487:45, 2487:47,
2488:17, 2488:36,
2492:31, 2494:18
sign [2] - 2520:7,
2569:5
signed [6] - 2520:5,
2520:20, 2522:28,
2522:31, 2568:38,
2576:31
significance [1] -
2575:6
significant [9] -
2483:20, 2505:36,
2507:13, 2508:30,
2510:28, 2523:13,
2545:35, 2551:6,
2553:17
significantly [3] -
2492:42, 2497:21,
2575:16
similar [3] - 2519:37,
2555:3, 2571:18
similarly [4] - 2481:35,
2489:39, 2508:8,
2524:22
simple [1] - 2483:6
simplifies [1] -
2486:21
simplifying [1] -
2553:14
simply [1] - 2501:33
single [14] - 2481:2,
2482:29, 2486:29,
2488:45, 2495:34,
2508:6, 2508:8,
2518:18, 2523:38,
2525:18, 2525:39,
2525:40, 2528:19,
2551:19
sit [7] - 2512:16,
2515:19, 2519:29,
2523:4, 2552:15,
2554:24, 2558:16
sites [2] - 2573:46,
2575:28
sits [3] - 2518:36,
2520:1, 2554:35
sitting [2] - 2513:10,
2558:30
situation [14] -
2484:36, 2500:31,
2508:17, 2520:30,
2521:2, 2521:13,
2522:42, 2522:43,
2538:2, 2548:6,
2560:39, 2571:22,
2571:25
situations [5] -
2502:20, 2538:28,
2538:34, 2539:28,
2541:18
six [6] - 2531:35,
2562:5, 2562:30,
2569:3, 2575:10,
2575:27
six-monthly [1] -
2562:5
six-page [1] - 2562:30
six-week [1] - 2569:3
size [3] - 2484:12,
2486:33, 2514:31
skewing [1] - 2484:21
skill [2] - 2481:22,
2481:23
slate [1] - 2574:11
slice [1] - 2511:4
slight [2] - 2481:3,
2547:6
slightly [7] - 2500:2,
2500:3, 2541:23,
2548:47, 2554:18,
2555:11, 2574:45
slowly [1] - 2549:47
small [11] - 2494:12,
2502:27, 2511:3,
2512:30, 2517:36,
2519:11, 2526:3,
2529:42, 2544:28,
2546:11, 2561:4
smaller [1] - 2541:23
Smith [1] - 2485:30
smoking [5] - 2511:1,
2534:12, 2534:15,
2534:18, 2535:40
social [4] - 2495:21,
2503:17, 2531:38,
2533:7
socialisation [2] -
2568:39, 2568:42
socialise [2] - 2562:2,
2562:3
sociodemographics
[1] - 2484:22
solely [2] - 2515:24,
2542:45
solution [2] - 2496:37,
2539:6
solvency [1] - 2572:45
someone [4] -
2510:24, 2510:31,
2537:44, 2578:14
sometimes [7] -
2484:40, 2488:15,
2512:3, 2537:24,
2537:26, 2538:29,
2545:22
somewhat [2] -
2535:1, 2545:41
somewhere [3] -
2542:15, 2575:25,
2578:20
soon [2] - 2483:25,
2538:25
soon-to-be [1] -
2538:25
sorry [18] - 2481:5,
2485:19, 2492:1,
2494:21, 2497:31,
2499:35, 2509:45,
2514:11, 2515:15,
2521:7, 2521:33,
2525:21, 2529:17,
2548:36, 2549:15,
2567:40, 2575:5,
2577:32
sort [16] - 2505:20,
2510:21, 2525:12,
2541:4, 2542:36,
2542:38, 2546:5,
2548:41, 2549:43,
2553:10, 2553:15,
2554:2, 2556:44,
2557:44, 2572:15,
2576:9
sorts [8] - 2502:25,
2543:43, 2544:35,
2544:47, 2546:15,
2564:30, 2565:37,
2565:39
sound [1] - 2539:35
source [6] - 2482:37,
2495:11, 2502:47,
2518:24, 2525:47,
2540:23
sources [13] -
2483:34, 2487:41,
2513:14, 2520:22,

2520:23, 2525:31,
2535:20, 2535:22,
2535:34, 2536:32,
2548:28, 2550:22,
2559:13

South [21] - 2479:19,
2483:1, 2494:31,
2501:7, 2504:44,
2519:31, 2519:32,
2524:36, 2524:38,
2525:10, 2526:8,
2529:21, 2529:25,
2531:42, 2537:22,
2551:28, 2552:25,
2552:36, 2554:37,
2555:24, 2569:23

space [4] - 2482:9,
2499:9, 2507:40,
2520:27

speaking [3] - 2482:1,
2572:2, 2574:46

special [1] - 2517:8

Special [1] - 2479:7

specialisation [1] -
2496:35

specialise [1] -
2491:33

specialised [2] -
2513:36, 2521:39

specialises [1] -
2518:23

specialist [38] -
2485:38, 2487:42,
2487:44, 2488:13,
2492:21, 2492:23,
2495:43, 2496:2,
2496:6, 2496:22,
2496:24, 2496:25,
2496:26, 2498:13,
2498:36, 2503:13,
2503:14, 2506:25,
2513:40, 2518:27,
2522:1, 2523:33,
2524:21, 2524:23,
2529:27, 2541:28,
2545:10, 2545:23,
2545:24, 2545:29,
2545:37, 2545:42,
2546:4, 2546:5,
2546:8, 2546:23,
2547:1, 2554:34

specialist's [1] -
2498:14

specialists [12] -
2488:4, 2488:16,
2493:47, 2496:9,
2503:4, 2503:11,
2503:16, 2545:21,
2545:36, 2546:12,
2546:38, 2546:39

specialties [5] -
2496:30, 2529:24,
2529:28

specialty [2] - 2487:5,
2512:8

specific [3] - 2526:36,
2527:21, 2549:29

specifically [5] -
2481:37, 2488:19,
2504:46, 2527:7,
2527:34

speedy [1] - 2515:5

spend [4] - 2561:5,
2566:44, 2568:2,
2576:25

spending [5] - 2568:7,
2568:8, 2568:17,
2575:20, 2575:36

spent [2] - 2528:45,
2560:46

spillover [1] - 2504:42

spinal [31] - 2515:47,
2516:3, 2516:18,
2518:16, 2518:42,
2521:40, 2522:1,
2522:22, 2524:7,
2527:27, 2527:35,
2528:21, 2528:34,
2528:35, 2529:4,
2529:17, 2529:21,
2529:44, 2548:16,
2553:27, 2554:9,
2554:17, 2554:19,
2554:26, 2554:43,
2555:3, 2555:15,
2555:38, 2556:6,
2572:11, 2573:17

spoken [2] - 2481:47,
2564:46

sponsor [1] - 2556:20

sprain [2] - 2495:39,
2499:39

sprained [1] - 2501:13

spread [1] - 2575:27

St [2] - 2515:19,
2515:23

stabilised [2] -
2528:37, 2528:45

stable [1] - 2502:15

staff [28] - 2503:4,
2503:10, 2503:15,
2514:31, 2527:30,
2541:28, 2546:38,
2558:19, 2565:46,
2573:34, 2573:35,
2573:41, 2573:43,
2574:1, 2574:2,
2574:9, 2574:13,
2574:14, 2574:19,
2574:23, 2574:41,
2574:42, 2575:11,
2575:15, 2575:17,
2575:27

staffing [2] - 2539:45,
2543:34

stage [3] - 2529:10,
2534:39, 2569:46

stakeholders [1] -
2566:7

stale [1] - 2573:39

stand [1] - 2499:2

standard [3] -
2484:47, 2485:28,
2569:35

standards [1] -
2483:37

standing [2] -
2496:34, 2545:15

start [6] - 2502:40,
2502:43, 2516:41,
2535:36, 2547:41,
2559:18

started [6] - 2502:11,
2553:9, 2561:43,
2568:34, 2575:45,
2576:13

starting [5] - 2515:37,
2537:4, 2539:5,
2559:18, 2562:47

starts [1] - 2484:37

state [59] - 2480:10,
2482:11, 2485:34,
2488:28, 2488:40,
2491:3, 2491:37,
2491:40, 2491:41,
2493:37, 2501:6,
2501:31, 2501:38,
2501:42, 2502:9,
2503:15, 2503:41,
2506:10, 2506:26,
2506:43, 2518:5,
2518:7, 2518:40,
2518:41, 2520:44,
2521:15, 2521:23,
2521:30, 2521:47,
2522:23, 2528:10,
2528:35, 2528:41,
2528:42, 2530:31,
2533:24, 2534:15,
2536:10, 2538:40,
2539:39, 2541:3,
2541:10, 2541:14,
2547:20, 2549:7,
2549:20, 2549:22,
2550:19, 2551:30,
2551:45, 2553:35,
2560:45, 2562:45,
2563:18, 2567:4,
2567:7, 2567:29,
2572:11, 2573:3

state's [1] - 2540:15

statement [21] -
2480:25, 2480:29,
2480:42, 2480:45,
2482:41, 2508:37,
2514:23, 2515:17,
2526:27, 2531:5,
2531:10, 2531:25,
2531:47, 2532:7,
2533:28, 2539:33,
2556:19, 2557:30,
2561:31, 2572:8,
2575:8

states [2] - 2503:34,
2522:27

statewide [33] -
2492:32, 2514:40,
2515:47, 2517:3,
2518:22, 2518:28,
2519:6, 2523:9,
2523:33, 2524:1,
2525:43, 2525:46,
2526:13, 2526:22,
2527:5, 2527:7,
2527:14, 2527:17,
2527:19, 2527:34,
2528:2, 2528:29,
2529:33, 2533:32,
2551:26, 2551:29,
2552:18, 2553:20,
2553:21, 2553:23,
2553:31, 2553:39,
2558:12

status [2] - 2526:44,
2574:3

statutory [12] -
2489:21, 2489:33,
2492:37, 2492:41,
2494:9, 2501:47,
2509:24, 2509:38,
2533:2, 2533:43,
2534:46, 2564:14

stay [2] - 2522:11,
2524:18

staying [2] - 2517:20,
2559:16

step [11] - 2481:18,
2484:14, 2505:12,
2506:6, 2536:22,
2536:31, 2536:41,
2542:5, 2550:6,
2556:31, 2560:26

stepped [4] - 2506:40,
2508:17, 2508:30,
2543:2

steps [4] - 2534:45,
2534:46, 2549:28,
2551:2

stewardship [1] -
2539:11

stick [1] - 2525:4

still [15] - 2501:6,
2501:15, 2502:6,
2507:34, 2510:37,
2516:32, 2546:31,
2548:44, 2559:17,
2560:14, 2563:25,
2563:30, 2563:42,
2570:6

stocktake [1] -
2535:43

stood [1] - 2553:39

stop [4] - 2496:5,
2507:4, 2526:2,
2565:26

story [1] - 2558:35

strands [1] - 2532:25

strategic [16] -
2508:39, 2508:42,
2512:25, 2536:17,
2556:36, 2556:40,
2556:44, 2557:2,
2557:10, 2557:14,
2557:15, 2557:39,
2557:45, 2557:46,
2559:2, 2562:8

strategies [2] -
2482:34, 2536:3

strategy [15] -
2508:43, 2509:17,
2517:41, 2530:35,
2531:34, 2533:32,
2534:14, 2536:9,
2536:12, 2543:30,
2556:32, 2556:36,
2556:47, 2557:42,
2558:36

stream [1] - 2489:47

streamline [1] -
2551:34

streams [1] - 2498:29

Street [1] - 2479:18

strengthen [4] -
2539:1, 2539:21,
2539:42, 2540:8

Strengthening [2] -
2538:13, 2540:2

strengths [1] -
2486:25

strict [2] - 2497:38,
2498:45

strictly [1] - 2520:39

strip [1] - 2513:4

strokes [1] - 2556:15

strong [2] - 2481:26,
2524:37

stronger [3] - 2481:32,
2526:33, 2526:47

strongly [1] - 2533:6

structural [1] - 2544:6

- structure** [7] - 2572:9, 2573:8, 2573:11, 2573:12, 2574:22, 2574:30
- structures** [1] - 2528:16
- struggling** [1] - 2506:34
- studied** [1] - 2505:11
- studies** [2] - 2505:2, 2505:17
- stuff** [1] - 2517:14
- sub** [5] - 2485:12, 2485:39, 2486:17, 2529:24, 2529:28
- sub-acute** [3] - 2485:12, 2485:39, 2486:17
- sub-specialties** [2] - 2529:24, 2529:28
- subcommunities** [1] - 2493:42
- submission** [2] - 2576:30, 2576:31
- subparagraph** [3] - 2488:24, 2532:33, 2561:38
- subsequent** [2] - 2548:45, 2557:45
- subsequently** [3] - 2524:2, 2524:8, 2571:29
- subset** [1] - 2492:9
- subsidiary** [1] - 2550:20
- substantial** [2] - 2549:3, 2566:18
- substantive** [1] - 2485:44
- substitute** [2] - 2499:21, 2499:23
- success** [5] - 2538:39, 2558:4, 2558:26, 2559:2, 2575:2
- successfully** [1] - 2507:11
- succession** [1] - 2538:32
- sudden** [1] - 2544:21
- suddenly** [1] - 2538:28
- Sue** [1] - 2514:35
- Sue-Anne** [1] - 2514:35
- suffer** [1] - 2574:29
- suffered** [2] - 2528:21, 2556:15
- suffers** [1] - 2528:34
- sufficient** [9] - 2500:16, 2502:21, 2512:11, 2521:10, 2521:31, 2522:7, 2529:47, 2550:14, 2564:2
- sufficiently** [2] - 2555:28, 2572:5
- suggest** [5] - 2487:36, 2493:29, 2510:20, 2510:34, 2572:20
- suggested** [1] - 2528:19
- suggesting** [2] - 2542:13, 2570:32
- suite** [5] - 2482:12, 2487:1, 2506:29, 2534:15, 2558:15
- suited** [1] - 2500:3
- sum** [1] - 2572:30
- summary** [2] - 2527:30, 2527:44
- supplement** [4] - 2515:24, 2520:28, 2520:36, 2526:5
- supplementary** [1] - 2523:32
- support** [15] - 2482:11, 2488:39, 2506:12, 2506:25, 2507:2, 2507:30, 2524:3, 2526:16, 2535:28, 2539:2, 2541:39, 2544:7, 2545:28, 2550:8, 2554:22
- supported** [2] - 2526:1, 2568:5
- supporting** [4] - 2488:26, 2488:28, 2532:30, 2553:13
- supportive** [3] - 2568:3, 2568:16
- supports** [2] - 2509:40, 2532:11
- supra** [2] - 2554:23, 2554:30
- surgeon** [1] - 2488:21
- surgery** [8] - 2484:44, 2486:18, 2487:33, 2488:2, 2492:32, 2503:32, 2512:5, 2513:41
- surgical** [1] - 2574:24
- surprise** [1] - 2563:12
- survey** [3] - 2517:27, 2517:30, 2558:13
- suspect** [6] - 2501:44, 2502:39, 2516:14, 2524:47, 2529:32
- sustainability** [1] - 2480:18
- sustainable** [1] - 2504:31
- swings** [2] - 2525:12, 2571:14
- sworn** [1] - 2480:6
- Sydney** [41] - 2479:19, 2489:3, 2512:41, 2515:46, 2516:5, 2516:9, 2516:18, 2516:25, 2517:43, 2518:37, 2518:45, 2519:5, 2519:31, 2519:38, 2520:2, 2520:4, 2523:27, 2524:36, 2524:39, 2525:10, 2526:9, 2530:44, 2537:22, 2544:25, 2546:4, 2547:45, 2548:12, 2549:32, 2551:28, 2552:25, 2555:23, 2555:24, 2555:37, 2561:24, 2561:25, 2566:45, 2569:25, 2569:32
- Sydney's** [1] - 2519:33
- sympathetic** [1] - 2573:45
- system** [77] - 2480:18, 2481:29, 2482:42, 2482:44, 2482:46, 2483:1, 2483:2, 2483:19, 2483:21, 2483:39, 2483:44, 2484:1, 2484:15, 2484:17, 2484:45, 2485:8, 2486:10, 2486:28, 2486:37, 2487:14, 2487:47, 2488:25, 2488:27, 2489:29, 2490:40, 2491:9, 2491:15, 2492:29, 2494:20, 2495:15, 2495:44, 2504:31, 2505:4, 2505:5, 2506:43, 2506:45, 2509:2, 2514:1, 2514:37, 2514:44, 2515:10, 2517:15, 2517:16, 2517:34, 2522:27, 2522:31, 2522:36, 2522:44, 2523:41, 2527:3, 2527:14, 2528:20, 2529:6, 2530:43, 2531:34, 2531:43, 2534:5, 2537:14, 2537:37, 2539:8, 2539:12, 2539:14, 2539:22, 2540:9, 2540:17, 2540:18, 2540:32, 2544:20, 2545:19, 2550:13, 2554:38, 2556:2, 2556:6, 2556:16, 2556:28
- system-wide** [2] - 2488:27, 2514:37
- systems** [6] - 2485:26, 2488:34, 2488:36, 2498:38, 2530:35, 2540:27
-
- ## T
-
- table** [2] - 2557:34, 2570:36
- tag** [1] - 2497:14
- take-up** [1] - 2512:26
- Tamsin** [1] - 2479:28
- tap** [1] - 2496:6
- targeted** [5] - 2506:33, 2510:36, 2511:4, 2511:10, 2534:20
- targets** [3] - 2519:7, 2519:8, 2519:23
- task** [1] - 2540:25
- Taskforce** [2] - 2538:14, 2540:3
- Taylor** [1] - 2548:39
- team** [17] - 2481:25, 2483:4, 2487:46, 2489:13, 2492:28, 2513:35, 2513:40, 2513:41, 2513:45, 2532:5, 2532:8, 2549:40, 2549:41, 2554:34, 2556:39, 2574:45
- teams** [10] - 2482:7, 2513:36, 2513:40, 2532:10, 2535:42, 2538:16, 2543:22, 2546:37, 2555:40, 2558:34
- teased** [1] - 2569:22
- technologies** [2] - 2567:35, 2567:43
- technology** [3] - 2554:34, 2567:47, 2568:4
- tend** [6] - 2491:39, 2506:33, 2518:26, 2519:6, 2519:10, 2575:38
- tended** [1] - 2549:9
- tender** [4] - 2480:38, 2531:18, 2577:41, 2577:45
- tendered** [1] - 2576:27
- tends** [1] - 2484:14
- tension** [1] - 2505:25
- term** [11] - 2482:27, 2482:46, 2483:2, 2483:45, 2486:20, 2492:11, 2499:29, 2535:43, 2537:19, 2539:29, 2553:37
- terms** [52] - 2483:3, 2483:5, 2484:12, 2484:20, 2485:1, 2485:22, 2492:15, 2493:28, 2496:39, 2503:44, 2505:22, 2506:9, 2513:26, 2515:22, 2516:3, 2517:10, 2517:27, 2518:4, 2521:42, 2525:26, 2526:10, 2526:23, 2526:24, 2533:11, 2533:19, 2534:1, 2535:11, 2535:15, 2536:3, 2536:38, 2537:45, 2544:47, 2546:15, 2548:22, 2548:40, 2549:3, 2551:41, 2551:47, 2552:22, 2553:2, 2553:13, 2553:23, 2553:30, 2554:21, 2554:28, 2555:13, 2556:4, 2558:10, 2561:3, 2561:11, 2561:41, 2571:18
- terribly** [1] - 2507:45
- text** [1] - 2567:14
- theirs** [2] - 2539:35, 2549:41
- thematic** [1] - 2552:18
- theme** [2] - 2504:33, 2504:45
- themselves** [8] - 2483:15, 2501:47, 2503:8, 2517:17, 2523:13, 2533:30, 2535:25, 2558:28
- theoretical** [1] - 2565:36
- theory** [1] - 2536:16
- thereafter** [2] - 2506:41, 2541:29
- therefore** [3] - 2497:38, 2562:26, 2572:17
- they have** [17] - 2496:22, 2501:9, 2509:9, 2519:26, 2523:7, 2528:15, 2537:43, 2538:31,

- 2540:7, 2545:23,
2546:9, 2549:45,
2552:31, 2552:32,
2558:4, 2558:28,
2573:20
they've [12] - 2498:14,
2498:36, 2514:46,
2520:7, 2520:45,
2523:27, 2524:31,
2545:23, 2551:6,
2572:36, 2574:21,
2577:46
thin [8] - 2537:19,
2538:22, 2539:5,
2539:29, 2541:18,
2542:7, 2543:41,
2544:43
thinking [1] - 2553:11
thinness [1] - 2496:24
thinning [1] - 2545:30
third [3] - 2520:25,
2530:1, 2572:46
THOMAS [1] - 2480:6
Thomas [1] - 2480:12
threatening [1] -
2499:30
three [10] - 2512:43,
2514:31, 2522:23,
2529:31, 2529:40,
2530:6, 2547:24,
2547:27, 2572:12,
2576:2
three-fold [1] -
2512:43
three-quarters [1] -
2576:2
threshold [1] -
2526:22
throughout [1] -
2554:15
ticket [1] - 2503:36
tied [1] - 2502:34
tiering [1] - 2535:29
ties [1] - 2572:10
tight [5] - 2524:4,
2553:11, 2567:38,
2567:44, 2570:21
timeliness [1] -
2501:32
timely [2] - 2500:5,
2500:25
timing [1] - 2557:41
title [1] - 2532:23
titled [1] - 2501:9
TO [1] - 2578:27
today [8] - 2480:4,
2480:31, 2486:35,
2501:6, 2527:29,
2540:4, 2547:30,
2578:8
together [17] - 2481:2,
2482:8, 2512:7,
2518:26, 2518:28,
2529:31, 2535:15,
2535:18, 2535:19,
2540:47, 2541:4,
2541:7, 2541:8,
2541:22, 2552:17,
2552:34, 2573:46
tomorrow [1] -
2550:45
took [1] - 2524:9
tool [1] - 2529:20
tools [1] - 2524:46
top [3] - 2495:6,
2564:28, 2569:40
topic [2] - 2538:10,
2547:23
tortuous [1] - 2508:24
total [2] - 2498:6,
2508:47
totality [1] - 2511:9
totally [1] - 2506:46
touch [2] - 2515:13,
2560:19
tough [5] - 2562:45,
2564:19, 2565:43,
2570:4, 2570:5
tourists [1] - 2566:16
towards [2] - 2480:46,
2497:25
town [7] - 2537:25,
2537:27, 2537:35,
2538:2, 2542:15,
2542:19, 2546:11
track [2] - 2559:22,
2570:36
tracking [3] - 2535:45,
2558:36, 2559:11
trading [1] - 2522:41
traditional [1] -
2544:42
traditionally [3] -
2494:40, 2542:16,
2553:29
traffic [2] - 2562:6,
2562:7
tranche [1] - 2512:35
transcends [1] -
2488:44
transcript [4] -
2490:18, 2491:8,
2491:19, 2527:31
transfer [3] - 2503:31,
2505:7, 2507:18
transferred [1] -
2554:29
transition [4] -
2538:33, 2548:14,
2548:17
translate [2] -
2498:31, 2522:12
translated [2] -
2494:4, 2518:11
transparently [1] -
2572:36
transplant [1] -
2561:25
transplants [3] -
2527:8, 2553:24,
2561:24
trauma [3] - 2528:36,
2528:40, 2528:42
traumatic [9] -
2527:26, 2529:45,
2548:16, 2553:28,
2553:32, 2553:43,
2554:9, 2554:18,
2554:20
travel [2] - 2524:18,
2546:6
travels [1] - 2547:4
traverse [1] - 2515:40
trawling [1] - 2571:43
Treasury [1] - 2505:21
treasury [7] - 2502:8,
2504:22, 2504:38,
2504:45, 2519:8,
2519:21, 2523:28
treasury's [1] -
2504:23
treat [3] - 2498:22,
2566:30, 2571:8
treatment [7] -
2489:26, 2496:20,
2496:22, 2496:27,
2501:21, 2517:37,
2566:18
tree [2] - 2488:46,
2519:29
tremendous [2] -
2485:2, 2487:6
tremendously [1] -
2490:38
trend [2] - 2514:38,
2559:16
trends [2] - 2491:41,
2511:29
Tresillian [18] -
2515:32, 2518:16,
2519:37, 2520:35,
2547:26, 2547:33,
2549:15, 2550:40,
2551:16, 2551:27,
2551:33, 2551:42,
2552:14, 2552:24,
2552:30, 2552:35,
2552:37, 2552:40
TREVOR [1] - 2560:3
triage [1] - 2485:1
triaged [1] - 2499:11
tried [1] - 2550:33
trigger [1] - 2497:11
triggers [1] - 2497:23
troubling [1] -
2537:44
true [8] - 2480:33,
2485:34, 2486:31,
2503:40, 2512:29,
2530:45, 2531:14,
2537:46
truly [1] - 2484:9
try [10] - 2509:3,
2520:33, 2538:4,
2541:17, 2544:1,
2548:43, 2549:41,
2550:46, 2552:19,
2567:27
trying [3] - 2513:6,
2544:5, 2573:45
Ts [4] - 2507:44,
2543:1, 2543:3,
2544:31
tune [1] - 2507:26
turn [10] - 2481:5,
2501:13, 2501:39,
2513:20, 2557:26,
2560:36, 2566:15,
2566:27, 2569:4,
2573:25
turns [1] - 2568:37
tweak [1] - 2494:10
twice [2] - 2517:46,
2522:20
two [36] - 2483:10,
2488:34, 2488:36,
2489:32, 2490:24,
2490:32, 2492:47,
2495:39, 2497:5,
2498:8, 2499:12,
2501:29, 2511:1,
2512:43, 2515:23,
2522:23, 2523:26,
2527:33, 2528:4,
2532:25, 2534:45,
2535:32, 2536:12,
2536:25, 2536:36,
2554:8, 2554:47,
2555:6, 2563:2,
2567:33, 2572:12,
2575:25, 2575:29,
2575:39, 2576:39
type [6] - 2505:32,
2507:1, 2508:25,
2515:28, 2528:8,
2542:37
types [2] - 2545:3,
2545:7

U
ultimately [9] -
2495:19, 2539:36,
2541:12, 2560:46,
2565:8, 2567:27,
2574:46, 2575:14,
2576:16
unable [4] - 2539:16,
2541:25, 2548:9,
2548:44
undated [1] - 2568:40
under [42] - 2481:2,
2491:2, 2492:16,
2494:5, 2494:42,
2495:46, 2498:8,
2499:17, 2501:26,
2502:35, 2506:34,
2509:37, 2510:13,
2517:33, 2517:47,
2518:22, 2519:30,
2520:14, 2520:21,
2520:39, 2521:3,
2521:15, 2521:32,
2522:40, 2523:13,
2523:42, 2526:6,
2528:16, 2537:5,
2537:11, 2546:43,
2547:40, 2549:10,
2549:26, 2550:21,
2550:43, 2551:39,
2561:43, 2566:23,
2570:8, 2572:6,
2572:30
undercook [1] -
2550:26
understandings [1] -
2525:24
undertake [2] -
2515:1, 2568:15
undertaken [2] -
2509:1, 2548:32
undertook [1] -
2548:31
undoubtedly [3] -
2510:47, 2541:19,
2549:38
unfairness [1] -
2490:10
unfortunate [1] -
2540:40
unfortunately [2] -
2491:14, 2491:18
uniform [2] - 2492:30,
2506:26
unique [4] - 2491:27,
2519:4, 2567:5,
2567:6
unison [1] - 2544:36
unit [2] - 2514:7,

- 2514:25, 2514:27,
2514:32, 2514:34,
2514:39, 2515:2,
2518:22, 2518:29,
2523:41, 2523:44,
2527:17, 2532:1,
2532:2, 2532:21,
2532:22, 2532:27,
2532:34, 2532:45,
2554:35, 2555:38,
2573:17
- unit's** [1] - 2532:35
- units** [9] - 2491:30,
2491:32, 2509:20,
2524:16, 2524:20,
2529:17, 2531:46,
2555:21
- unless** [3] - 2494:4,
2508:14, 2526:13
- unlikely** [1] - 2546:11
- unlock** [1] - 2544:2
- unmet** [2] - 2494:26,
2513:21
- unplanned** [2] -
2503:31, 2503:35
- unusual** [4] - 2562:21,
2562:22, 2568:32,
2571:41
- unwarranted** [1] -
2558:10
- unwell** [1] - 2540:42
- up** [64] - 2480:42,
2481:5, 2482:22,
2483:3, 2483:43,
2484:34, 2486:45,
2491:20, 2492:14,
2494:25, 2495:17,
2495:20, 2495:46,
2496:28, 2496:34,
2498:6, 2498:35,
2498:41, 2499:2,
2499:17, 2501:14,
2502:10, 2502:17,
2502:34, 2503:2,
2505:43, 2506:9,
2506:42, 2507:8,
2507:23, 2509:47,
2512:26, 2513:21,
2522:28, 2522:31,
2531:25, 2531:35,
2531:46, 2536:8,
2536:11, 2539:47,
2542:43, 2545:15,
2547:2, 2547:4,
2553:40, 2556:4,
2557:5, 2558:16,
2558:39, 2560:36,
2560:45, 2561:31,
2562:33, 2563:41,
2564:22, 2565:35,
2566:15, 2566:39,
2568:43, 2574:20,
2574:23, 2577:14,
2577:44
- up-to-the-minute** [1] -
2486:45
- upper** [1] - 2521:41
- urgent** [31] - 2482:10,
2485:47, 2486:8,
2494:32, 2495:33,
2495:36, 2499:8,
2499:9, 2499:16,
2499:20, 2499:25,
2499:30, 2500:18,
2500:25, 2501:2,
2501:4, 2501:20,
2501:25, 2501:26,
2502:9, 2502:10,
2502:14, 2502:16,
2502:20, 2542:29,
2542:30, 2542:31,
2542:36, 2542:39
- useful** [4] - 2494:10,
2528:21, 2529:3,
2529:20
- uses** [1] - 2489:8
- usual** [3] - 2517:37,
2522:40, 2577:44
- utilisation** [3] -
2484:23, 2554:36
- utilises** [1] - 2489:10
- utility** [4] - 2527:42,
2527:45, 2528:15,
2573:5
-
- V**
-
- vacant** [1] - 2487:10
- vaguely** [1] - 2560:14
- Vale** [1] - 2569:26
- valuable** [1] - 2572:43
- Value** [1] - 2481:43
- value** [5] - 2525:7,
2565:32, 2565:34,
2565:42, 2578:11
- values** [1] - 2573:29
- vans** [1] - 2552:36
- variable** [1] - 2559:4
- variance** [3] - 2483:20,
2483:22, 2510:29
- variation** [1] - 2558:11
- varies** [2] - 2485:3,
2521:17
- variety** [5] - 2483:34,
2490:37, 2498:1,
2532:18, 2559:13
- various** [11] - 2480:47,
2483:32, 2493:45,
2501:6, 2509:6,
2509:7, 2510:25,
2529:17, 2544:14,
2558:40, 2560:41
- vary** [1] - 2520:46
- varying** [1] - 2538:39
- vast** [1] - 2502:34
- vegetables** [1] -
2509:11
- verbal** [1] - 2577:10
- verbatim** [1] - 2496:15
- viable** [1] - 2506:45
- vibrant** [1] - 2574:26
- view** [19] - 2488:5,
2490:23, 2502:43,
2508:19, 2511:17,
2525:21, 2527:42,
2529:5, 2533:42,
2553:34, 2554:11,
2554:16, 2555:27,
2556:41, 2564:7,
2564:12, 2564:34,
2573:38
- vigilant** [1] - 2491:41
- Vincent's** [2] -
2515:19, 2515:23
- virtual** [15] - 2481:1,
2481:41, 2512:26,
2512:29, 2512:31,
2512:37, 2546:3,
2546:7, 2546:27,
2547:1, 2547:6,
2547:8, 2547:10,
2547:14, 2547:17
- virtually** [3] - 2503:21,
2504:18, 2512:42
- visitors** [2] - 2566:21,
2566:22, 2566:23
- VMOs** [1] - 2546:38
- VMOs'** [1] - 2488:7
- volume** [10] - 2481:5,
2487:29, 2494:16,
2495:23, 2510:1,
2515:35, 2517:1,
2518:19, 2521:17,
2526:24
- volumes** [2] - 2482:5,
2525:45
- voluntary** [1] -
2564:42
- vulnerable** [3] -
2532:6, 2544:46,
2545:5
-
- W**
-
- wait** [4] - 2487:14,
2487:21, 2488:15,
2558:13
- waiting** [9] - 2488:1,
2488:2, 2488:5,
2488:6, 2488:31,
2490:3, 2492:29,
2496:44
- waivers** [1] - 2566:12
- Wales** [15] - 2479:19,
2483:1, 2494:31,
2501:8, 2504:45,
2529:22, 2529:25,
2531:42, 2537:22,
2552:36, 2554:37,
2555:7, 2555:9,
2555:14, 2569:23
- walk** [2] - 2566:18,
2566:34
- walked** [1] - 2572:13
- wants** [2] - 2490:18,
2565:8
- ward** [2] - 2487:5,
2528:46
- warranted** [1] -
2526:41
- watch** [2] - 2487:30,
2559:16
- Waterhouse** [1] -
2479:28
- wax** [1] - 2508:26
- ways** [4] - 2498:8,
2527:46, 2546:26,
2576:44
- Wednesday** [1] -
2562:8
- week** [9] - 2489:15,
2507:34, 2527:25,
2538:28, 2569:3,
2575:19, 2575:26,
2576:3, 2576:43
- weekly** [1] - 2562:5
- weeks** [3] - 2571:26,
2575:10
- Weemala** [1] - 2549:46
- weight** [4] - 2498:8,
2522:10, 2522:11,
2522:14
- weighted** [2] -
2497:16, 2527:22
- weighting** [1] -
2522:12
- well-accepted** [1] -
2490:39
- well-known** [1] -
2566:19
- wellbeing** [1] -
2531:40
- West** [1] - 2552:25
- Western** [7] - 2519:31,
2519:33, 2524:36,
2524:38, 2525:10,
2526:9, 2551:28
- whereas** [1] - 2515:6
- whereby** [1] - 2508:10
- whichever** [2] -
2531:28, 2562:38
- whilst** [6] - 2508:13,
2514:29, 2515:46,
2519:7, 2522:41,
2570:12
- whole** [5] - 2496:47,
2513:39, 2527:21,
2572:42
- wholly** [2] - 2527:13,
2542:45
- wide** [6] - 2488:27,
2493:43, 2514:37,
2515:34, 2524:27,
2551:17
- wider** [13] - 2485:17,
2485:21, 2489:11,
2489:12, 2510:39,
2510:42, 2515:32,
2516:25, 2518:17,
2520:38, 2558:47,
2559:1
- widgets** [2] - 2528:30
- wife** [1] - 2560:16
- Willcox** [8] - 2481:21,
2489:40, 2507:11,
2518:23, 2528:18,
2530:25, 2530:33,
2559:31
- WILLCOX** [1] -
2530:27
- willing** [1] - 2564:31
- winding** [1] - 2566:1
- wise** [1] - 2517:17
- wisely** [1] - 2566:44
- wish** [4] - 2493:13,
2502:26, 2539:35,
2568:29
- wishes** [1] - 2496:43
- withdraw** [1] - 2500:8
- withdrawing** [1] -
2563:36
- WITHDREW** [3] -
2530:23, 2560:1,
2577:37
- witness** [7] - 2495:12,
2530:11, 2530:25,
2533:9, 2536:34,
2559:25, 2577:25
- WITNESS** [7] -
2530:21, 2530:23,
2559:34, 2560:1,
2560:16, 2577:35,
2577:37
- Wodonga** [1] -
2543:33
- wondering** [2] -
2481:16, 2552:44
- word** [9] - 2483:17,
2483:26, 2486:31,
2487:25, 2497:38,

2498:45, 2570:3,
2573:19

words [2] - 2492:12,
2512:36

work's [1] - 2505:33

workarounds [1] -
2541:17

workforce [5] -
2496:36, 2508:26,
2538:14, 2540:26,
2570:28

works [1] - 2531:28

world [1] - 2505:1

wound [1] - 2560:31

wrap [1] - 2506:35

wrap-around [1] -
2506:35

write [3] - 2566:12,
2566:24, 2566:42

write-offs [1] -
2566:12

writing [2] - 2562:34,
2573:38

written [1] - 2565:12

wrongly [1] - 2488:4

Z

zone [1] - 2512:10

Y

year [31] - 2483:39,
2484:35, 2485:5,
2492:4, 2500:46,
2502:11, 2503:24,
2508:47, 2522:20,
2551:36, 2554:32,
2561:27, 2562:1,
2562:4, 2562:21,
2562:22, 2562:24,
2563:13, 2563:42,
2563:45, 2564:16,
2564:17, 2564:19,
2564:22, 2564:45,
2566:25, 2568:33,
2569:3, 2570:8,
2575:44

year's [4] - 2551:11,
2552:1, 2565:37,
2568:44

yearly [1] - 2494:17

years [12] - 2485:33,
2488:45, 2492:47,
2497:5, 2501:10,
2504:34, 2505:11,
2506:21, 2512:28,
2524:8, 2563:15,
2564:5

yourself [3] - 2527:28,
2531:10, 2547:31