

**Special Commission of Inquiry
into Healthcare Funding**

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

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

Friday, 14 June 2024 at 10.00am

(Day 035)

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

Also present:

**Mr Hilbert Chiu for NSW Health
Mr Oliver Jones for St Vincent's Health Australia**

1 THE COMMISSIONER: Good morning. Apologies for being a
2 few minutes late. I was looking at a variety of ties and
3 settled on this one.
4
5 MR GLOVER: I'm glad you found one suitable, Commissioner.
6
7 THE COMMISSIONER: It was better than the one you offered,
8 so.
9
10 MR GLOVER: The first witness today is Associate Professor
11 John Preddy, and he is in the witness box.
12
13 <JOHN SPENCER PREDDY, affirmed [10.07am]
14
15 <EXAMINATION BY MR GLOVER:
16
17 MR GLOVER: Q. Can you state your full name for the
18 record, please?
19 A. John Spencer Preddy.
20
21 Q. And you are currently the clinical director of
22 paediatrics at Wagga Wagga Base Hospital; is that right?
23 A. Indeed.
24
25 Q. And to assist the Commission in its work you provided
26 a statement dated 30 May 2024; correct?
27 A. Yes, mmm-hmm.
28
29 Q. I'll just have that brought up on the screen. It's
30 [SCI.0011.0067.0001]. Commissioner, if you are working in
31 hard copy, it's G33.
32
33 THE COMMISSIONER: Thank you.
34
35 MR GLOVER: Q. Have you had a chance to read the
36 statement again before giving your evidence today?
37 A. I have, thank you.
38
39 Q. Is it true and correct to the best of your knowledge
40 and belief?
41 A. It is.
42
43 MR GLOVER: Commissioner, that will form part of
44 the tender in due course.
45
46 THE COMMISSIONER: Thanks.
47

1 MR GLOVER: Q. If we can start with paragraph 4 of this,
2 Professor. There amongst your many roles you tell us that
3 you're the co-chair of the Agency for Clinical Innovation's
4 Paediatric Network. What does that network do?

5 A. It's a clinician-based network with over a thousand
6 clinicians as members, and we discuss issues that are
7 relevant to the delivery of paediatric care across the
8 state and also undertake specific areas of investigation.
9 So there's a number of areas we're looking at at the
10 moment, including outpatient services statewide in the
11 public system, for instance.
12

13 Q. Once those investigations of that kind and discussions
14 of that kind are held, what is the output of that work
15 through that committee or that network?

16 A. Such a good question. Thank you. There is a little
17 bit of frustration for us in that I think we draw - we put
18 together very good submissions, but there is - there is no
19 pathway to advance them. So it is a little bit
20 frustrating. I think we've come up with very good ideas -
21 obviously I do because I'm the co-chair - but it's very
22 difficult to escalate ideas into the system.
23

24 Q. So it's an advisory body?

25 A. It's an advisory body. We're not quite sure who we're
26 advising. That's part of it. That is part of the problem.
27

28 Q. Can I take you then to paragraph 5. In the second
29 sentence there you tell us your view is it's important that
30 the scope of roles across the delivery of paediatric care
31 in New South Wales "is clearly delineated, optimised and
32 coordinated in a way that takes advantage of their
33 different strengths"; do you see that?

34 A. Yes.
35

36 Q. Why is that important in your view?

37 A. Because I think there is potential in complex systems
38 for siloed health - well, health particularly for siloed
39 health care to occur, and it does, and I think it's very
40 important that we look at this system and understand ways
41 that different parts of the system can work better
42 together. That's how I see --
43

44 Q. And is that particularly acute in paediatric care in
45 your view?

46 A. I think paediatric care is reasonably unique. We're a
47 fairly small area of health care largely working in an

1 adult-focused system. So I think it's very important that
2 we as clinicians work very clearly together, and I see that
3 that breaks down at times.
4

5 Q. When you say it's a small area of practice in an
6 adult-focused system, what particular challenges does that
7 give rise to in the delivery of paediatric care across the
8 state.

9 A. I think there are many. I'll just give one or two
10 examples, if I may. One might be in my hospital, for
11 instance, there's a large emergency department that treats
12 everything from an unwell baby to an adult with all their
13 variety of health issues, and it is a very hostile place
14 for children, it's not designed for children, and with
15 increasing pressure on the system time spent in those areas
16 is greater and greater, and we receive immense amount of
17 feedback from families saying, "We spent 19 hours in your
18 emergency department. It was hell." Okay. It's not
19 designed for children. Adult hospitals are not designed
20 for children. So we've got paediatric bits, okay, and
21 I think the focus from health care planners is they are
22 generally overwhelmed with a burden of aged care disease.
23 Therefore, we are much less of a priority, I think, for
24 health care planners and budgets.
25

26 Q. And in circumstances where paediatrics is less of a
27 focus perhaps for - I'll withdraw that. That observation
28 you just made about health care planners being overwhelmed
29 with increasing aging population, we've heard some evidence
30 about the increase of chronic disease in aging population.
31 I take it from the last observation you made that presents
32 a particular challenge in the delivery and planning of
33 paediatric care in that context?

34 A. It does, and I think largely it comes down to
35 relationships, actually, like a lot of planning does, and
36 I enjoy a very good relationship with my executives in my
37 town. Others do not. So I think I'm in a much better
38 position than some.
39

40 Q. Does it also create challenges in securing funding for
41 paediatric care?

42 A. Unquestionably. There's challenges securing funding
43 anywhere but I think particularly in the preventive space.
44 You know, preventive health for us is we'd like to prevent
45 old people having problems by treating young people at a
46 younger age. The investment is a 50-year investment. It's
47 not seen as a priority in the system.

1
2 Q. Can I ask you some questions about how the system
3 operates at the moment before coming to your observations
4 about how it might be improved?
5 A. Mmm'hmm.
6
7 Q. I might show you a document. It's the "Paediatric
8 Service Capability (Paediatric Medicine and Surgery for
9 Children) Guideline". We'll bring it up on the screen.
10 It's [MOH.0002.0144.0001] and, Commissioner, it's G106.
11
12 THE COMMISSIONER: Just before you go on.
13
14 MR GLOVER: Yes.
15
16 THE COMMISSIONER: I tried to do this subtly by sending a
17 message on Teams, but Teams isn't working. I can't get the
18 running transcript up on - I assume everyone else is
19 getting it so it's just me, but --
20
21 MR GLOVER: I don't have it either.
22
23 MR MUSTON: I was informed yesterday afternoon,
24 Commissioner, that the two individuals who have been taking
25 the transcript before us so valiantly and effectively over
26 the past few weeks --
27
28 THE COMMISSIONER: I knew that, yes. No, you don't -
29 I know that. Is that why it's not live?
30
31 MR MUSTON: It's being dealt with remotely, but that means
32 that we don't have a live stream today.
33
34 THE COMMISSIONER: Right. Okay.
35
36 MR MUSTON: So the transcript is being recorded but we
37 don't have access to a live stream today.
38
39 THE COMMISSIONER: All right. So it's not me. When
40 I sent my Teams message it said it would be delivered on
41 Saturday at 8 am, which would make it fairly useless. But
42 maybe that's linked to that. I don't know.
43
44 MR MUSTON: I don't think it is.
45
46 THE COMMISSIONER: There's no reason to further interrupt
47 this evidence, so let's proceed.

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MR GLOVER: Q. The document is on the screen to your right, Professor. Is this a document with which you are familiar?

A. It is.

Q. Can I take you ahead in the document to internal page 0012, and there under 2.1 do you see, "Clinical care and interhospital transfers for infants, children and adolescents are delivered through a statewide system of networked care." See that --

A. Yes.

Q. -- in that first paragraph? And then a little bit lower, last sentence of that same paragraph, "Services are linked through local networking arrangements"; do you see that?

A. Yes.

Q. Can you just tell us as a practical matter what are those networked arrangements?

A. I think when it comes to escalation of very sick children there's a very clear networked arrangement, which is we as a receiving hospital might talk to the newborn emergency transport service, have a discussion about optimising care locally and have a discussion about managing care prior to transfer to and thereafter in a children's hospital. That's a very well-oiled system. It works well. It's incredibly important. Okay.

I think the other thing I'd say about role delineation is it's very important we understand what various paediatric roles need in terms of services. What it does not do is examine optimising scope of practice and providing better care particularly in larger level 4 centres, which is where - something I'm very interested in. So if we treat every centre the same then what you're then doing is treating everyone to the lowest common denominator, because you have to, okay, whereas I think health care doesn't work like that. So for me part of providing care is optimising care delivery in the various facilities we have across the state, and that might --

THE COMMISSIONER: Q. Sorry, just for the purpose of the transcript can you just define level 4?

A. So a level 4 service is the service that I would run in Wagga, which is - has a dedicated children's ward,

1 dedicated paediatricians, paediatric-trained staff and
2 allied health support and investigative support to provide
3 a whole range of services. That would be level 4. Level 6
4 would be a children's hospital with a much higher scope of
5 services and practice.
6

7 Q. Now, I interrupted you. Hopefully you haven't lost
8 your train of thought?

9 A. Completely lost it.

10
11 Q. Yes, of course. And we can't read the transcript
12 back.

13
14 MR GLOVER: We can't read transcript.

15
16 THE COMMISSIONER: Sorry about that.

17
18 MR GLOVER: Just to perhaps close out the answer to the
19 Commissioner's question, if we go ahead in the document to
20 internal page 0023. Professor, in this section of
21 the document it identifies and defines the levels of care
22 from 2 and then through to 6, and then the same for surgery
23 later in the document; is that right?

24 A. Yes, with respect, I don't think it actually defines
25 level of care. I think it defines the services that are
26 available to deliver care, and the two things are
27 different.
28

29 Q. In what way?

30 A. Well, I mean, I think that the care scope that we
31 deliver in my town, for instance, would be very different
32 from another level 4 unit in a smaller town, yet the
33 facilities in terms of the levels might be the same. So
34 what the levels talk about is what facilities you have, not
35 what scope of practice you have.
36

37 Q. And is that - well, with that limitation to this
38 guideline and the role delineation through levels, is that
39 one of the reasons why you perceived there needs to be a
40 more clear role delineation for facilities across the
41 state?

42 A. I think what there needs to be is a mechanism for
43 providing higher level of care within a level 4 structure.
44 So that's what, for instance, I talk to my team about, how
45 do we optimise care, how do we deliver world-class care in
46 my town knowing the limitations, and my limitations will be
47 different from other places. So where you have a document

1 that says, "You're all going to be this," it doesn't allow
2 for individual facilities to up their scope safely.

3
4 Q. How might that be facilitated?

5 A. Well, I think it's genuinely a discussion where each
6 of us should be responsible for saying how do we deliver a
7 certain level of care, how do we make sure that's delivered
8 safely - and when I say "each of us" I'm talking about
9 clinical directors of facilities - how do we keep that
10 safe, how do we keep it world class, how do we maintain
11 connections with level 6 facilities to facilitate us to do
12 that; does that make sense?

13
14 Q. Yes, it does.

15 A. Okay.

16
17 Q. Would that be facilitated by a statewide strategic and
18 operational plan for the delivery of paediatric care across
19 New South Wales?

20 A. Unquestionably, if it allowed that flexibility to take
21 place, yes.

22
23 Q. Just before I leave the policies, you mentioned in an
24 earlier answer that the arrangements for the transfer of
25 patients for specialised care work well in your view; have
26 I understood your evidence correctly?

27 A. What I stated was emergency care is very well dealt
28 with at a state level.

29
30 Q. I see. And you draw a distinction with more
31 specialised care, do you?

32 A. I draw a distinction with a situation where I might be
33 managing a patient and I need more specialised care at some
34 point in that patient's journey. That's more problematic.
35 There is no statewide approach to that.

36
37 Q. Can we just bring up another document. It's the "New
38 South Wales Paediatric Clinical Care and Inter-Hospital
39 Transfer Arrangements". It's [MOH.0002.0146.0001]. Next
40 page, please, Operator. This is a document that you're
41 familiar with?

42 A. Perhaps not as familiar as I should be, looking at it.

43
44 Q. Well, that might follow the challenge, perhaps.

45
46 THE COMMISSIONER: It will come back to you.

47

1 MR GLOVER: Sorry?

2

3 THE COMMISSIONER: I said it will come back to the witness
4 when you take him through it.

5

6 MR GLOVER: Yes.

7

8 Q. If we have a look under the summary at policy
9 requirements, just perhaps read, if you wouldn't mind, the
10 first three paragraphs to yourself and let me know when
11 you've done that.

12 A. Yep, I think I've speed read them.

13

14 Q. If you need to go to any other part of it let me know,
15 but this policy directive describes the type of
16 arrangements for the transfer of patients into more
17 specialised care. How does that work in practice at the
18 moment?

19 A. It doesn't work in practice as stated in the first
20 three paragraphs in this document. In practice, if I wish
21 to rather than transfer care but involve care from
22 subspecialists it generally means that I would phone
23 somebody on call, I'd phone a friend, I'd phone a junior
24 doctor as part of a team and discuss the care needs.
25 Sometimes it would involve emailing, sometimes it would
26 involve sending a referral, and often it would involve
27 barriers and wait.

28

29 Q. And from that do I take it that you perceive that
30 those arrangements rely significantly on relationships
31 between clinicians?

32 A. They do. Not entirely. There is always in kids'
33 hospitals someone on call for particular services with whom
34 you can speak some of the time.

35

36 Q. If we go back to your statement, please, and to
37 paragraph 9. Some of the challenges you've been describing
38 in your last answers, do they feed into the conclusion you
39 reach in paragraph 9?

40 A. They do very much. I often think of health care as
41 being like a gearbox. You've got gear number 4, which is
42 where I work, and gear number 4 has to work closely with
43 gear 5/6, and it needs to be oiled and there needs to be a
44 very good collaborative system between those people. They
45 have different jobs, but they work in the same system, and
46 what I see is that there's a breakdown in collaboration
47 often between level 6 care and level 4 care, and if we

1 better utilised level 2/level 4 care there will be less
2 pressure on level 6 care. That's how I see it. So if
3 I can up my scope of practice, if I can look after patients
4 in my town well with the assistance of subspecialists
5 either by phone, by video or even transfer for periods of
6 time then that would give a much better level of care,
7 I believe, to individual patients, if that makes sense.

8

9 THE COMMISSIONER: Q. When you say a breakdown in
10 communication, can you give us an example and an opinion
11 about the cause of it?

12 A. I can give you an example quite easily. I had a child
13 recently who clearly had an inflammatory bowel disease,
14 which is inflammation of the colon --

15

16 Q. Yes.

17 A. -- and what I needed was for a specialist
18 gastroenterologist to undertake some investigations and
19 give me some advice about management, and it probably took
20 six months for that to happen.

21

22 Q. A specialist at either Westmead or Randwick?

23 A. Yes, as it happens this was in Melbourne.

24

25 Q. Right.

26 A. But that's because the family had connections in
27 Melbourne.

28

29 Q. Right.

30 A. But trying to navigate my way through a system where
31 it was clear what I needed --

32

33 Q. Yes.

34 A. -- it was clear that I wanted to collaborate with
35 somebody --

36

37 Q. Yes.

38 A. -- but it just couldn't happen. It wasn't happening.
39 I couldn't talk to the right person, and there were a
40 number of --

41

42 Q. But why not? Why not?

43 A. Because sometimes the system is almost designed to
44 prevent that from happening. I know that sounds a bit
45 whiny but --

46

47 Q. In what way?

1 A. That I'll make a phone call, I'll be directed to a
2 secretary, to a junior doctor as part of a team.

3

4 Q. Right. There's no clear route?

5 A. There's no clear route.

6

7 Q. Right.

8 A. There's no clear responsibility for people to say,
9 "That guy in Wagga needs my help. This is what I'm going
10 to do."

11

12 Q. Yes.

13 A. You know, and one of the things I think in health care
14 is we all need to understand what we give to the system,
15 but we need to understand our responsibility, and
16 I think - and accountability, and I think sometimes that
17 breaks down.

18

19 Q. So a solution for what you're identifying for someone
20 like you that's head of paediatrics at a large regional
21 hospital but needs to at least consult a specialist because
22 a child has a particular health problem is - let's call it
23 a network - a network where there's a clear direct route
24 where you can easily and quickly get in contact with that
25 specialist, discuss the case, work out whether the child
26 can be safely treated where the child is, in your hospital,
27 regional hospital, or, "This looks more serious, might need
28 a transfer to a quaternary hospital," that sort of thing?

29 A. Those things plus, "Looks like I need you to do
30 this" --

31

32 Q. Right.

33 A. -- "and when you've done this, I'm happy to then
34 collaborate with ongoing care."

35

36 Q. Again, yes.

37 A. And those things break down.

38

39 Q. Like a form of case management; yes?

40 A. Yes. Exactly.

41

42 MR GLOVER: Q. Building on that last passage of answers,
43 if we go ahead to paragraph 22 of your statement, perhaps
44 directly to the heart of the proposition, this is where you
45 describe you can see the system operating in an optimal
46 way; correct?

47 A. Yes.

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Q. Aside from the barriers that you've described to the Commissioner in terms of a look of a pathway to achieve that type of system, are there any other barriers to achieving what you've set out in paragraph 22?

A. Look, I've reflected on this, and I think one part of this piece of evidence is a little impractical. I think there should be a statewide children's, if you like, website or electronic facility so that I can go on there and say, "Oh, at Westmead so and so is on call for gastroenterology, and this is how I contact them," so that would be very helpful for me, and, similarly, to have on the same server, if you like, all of the protocols and procedures I need to manage children effectively, that would be very helpful.

In terms of bed management, which is included here, I don't think it's practical to have bed management stuff on a website. I just don't think it would work. But I think services that are available, how to contact those services, who is on call, procedures and policies, all of those things in one place across the state would be very helpful.

Q. All right.

THE COMMISSIONER: Q. Sorry to be difficult, but if someone can get this for me. This is no doubt my fault, but I obviously have an earlier version of Professor Preddy's statement because I don't have a paragraph 23 and what's in paragraph 22 is in my paragraph 20. So if someone can just grab that for me now I'd appreciate it. But keep going. Keep going.

MR GLOVER: Q. All right. So from that answer we understand that the suggestion of a centralised database with real-time referral is one that you've reflected on and perhaps see some challenges in implementing?

A. I just can't see it being practical. It sort of came out of the moment, but I can't see that being updated. But I think processes, who to speak to, how to speak to, et cetera, would be very helpful.

Q. I take it then that you remain of the view that, to the extent that a patient requires subspecialty opinion, discussions should occur between the general paediatric service and the appropriate subspecialist?

- 1 A. Hundred per cent.
2
- 3 Q. And that ability to identify who that might be at any
4 given point in time of day or night is something that would
5 be very helpful to you?
6 A. Without question, and I think it's a two-way
7 conversation.
8
- 9 Q. Yes.
10 A. Okay. And as a two-way conversation it can't happen
11 with someone who's not in control of the service.
12
- 13 Q. And then a collaborative care plan should be drawn up,
14 including appropriate use of children's hospital beds;
15 correct?
16 A. Yes.
17
- 18 Q. And would that include plans to return the patient to
19 your care if it were you?
20 A. Absolutely. Absolutely. I mean, it's very
21 frustrating, as a paediatrician sometimes I send a child
22 for an opinion, to find them three years later having
23 active treatment that we could deliver safely and
24 effectively local. It's a very frustrating thing to see in
25 the system.
26
- 27 Q. To facilitate this type of approach, do I take it that
28 you would agree that there's benefit in there being a
29 statewide operational plan that identifies this approach
30 and sets out roles, responsibilities, expectations and the
31 like?
32 A. Absolutely. I think what we have statewide is a
33 number of plans which are a series of aspirational
34 statements. They are not plans on how to deliver care. So
35 your comment about operational planning is really
36 important.
37
- 38 Q. At paragraph 14 of the statement - and this perhaps
39 goes back a step in the pathway that we've just been
40 discussing, but there you describe a lack of consistent
41 referral pathways from general practitioners to
42 specialists, et cetera. Can you just describe what in
43 practice that looks like?
44 A. Yes, look, I have quite a strong view that GPs have a
45 very difficult case load. They manage people from babies
46 through to 97 years of age or whatever, and there are times
47 when they need the help of paediatricians, and my view is

1 that GPs should refer to their local paediatric service.
2 It's our responsibility to then see those patients and,
3 where necessary, refer them for quaternary care in a
4 children's hospital. That's how I believe the system
5 should work. Often times, for a variety of reasons, GPs
6 will refer directly to children's hospitals'
7 subspecialists, and I think that's inefficient and what it
8 does is it clogs up quaternary services with tertiary
9 services, which is my domain, if you like, and I think what
10 that leads to is kids' hospitals that are overwhelmed with
11 patients that are unsorted, if you like - that's a bad
12 word, it's a bit medical, but not thought about, if you
13 like, and it just clogs their systems up, and a better
14 system herefore does that. They refer to see me and my
15 team, we sort that out and then where necessary we escalate
16 care with an agreed care plan. That's how I think - it's
17 more - it's more about using what we have more efficiently,
18 okay?

19
20 The other major advantage of that is most families
21 don't want to travel five hours every second week to see
22 someone about their health care, most families actually
23 want to stay where they live, and understand they can get
24 as good care locally as they can by travel.

25
26 Q. You see there being great benefits to patient care in
27 it being delivered close to home?

28 A. In ways that I don't think are really obvious. So
29 there's clearly an advantage in terms of using services
30 more effectively. But if I have a child in my hospital
31 their grandparents can visit, their siblings can be part of
32 care. As they improve I can send them home and deliver
33 care at home, okay, which might be 500 metres down the
34 road, okay? So from a regional centre we can deliver care
35 much more effectively. It's better for physical outcomes,
36 it's certainly better for family outcomes and it's
37 undoubtedly better for mental health outcomes for patients
38 and their families. We know there are restrictions to what
39 we can do, and that's when we would say, "We need to
40 escalate care. But when it is appropriate we will accept
41 care back again."

42
43 Q. Is this, what you've set out in paragraph 14, perhaps
44 the first step - that is, the referral pathways from GPs to
45 someone like you or someone in your department who can then
46 determine whether escalation is required, is that perhaps
47 the first step in achieving a system in operation that --

1 A. I think that's one of the first steps because that -
2 that is a first step, but it goes hand in hand then with
3 much better collaborative care, which means that if I'm now
4 a gastroenterologist in a kids' hospital and say, "I've
5 done my bit. Now we're going to share doing ongoing care."
6 So I think both of those things are needed.

7
8 Q. Are there any barriers to achieving the situation that
9 you describe in paragraph 14; that is, GPs effectively
10 coming to general paediatricians first and then the
11 decision to escalate being made from there?

12 A. I think there are barriers in that some general
13 paediatricians are so overworked that's troublesome. But
14 so are our subspecialty colleagues, okay, and so I think
15 our job then is to receive that, look at the referral,
16 speak to the GP and make sure we provide right care at the
17 right time in the right place. So that's a barrier. Other
18 than that, it's really about good communication, and good
19 communication often does break down - good communication,
20 good clinical hand-over.

21
22 Q. Is there anything that can be done at a system-wide
23 level to advance the aim that you identified in
24 paragraph 14?

25 A. I - which one's paragraph 14?

26
27 Q. Having a clear referral pathway from GPs to general
28 paediatricians and then --

29 A. At a system-wide level I think that would depend on my
30 subspecialty colleagues saying, "With respect" - to a GP -
31 "you should refer that patient to your local paediatric
32 service. They will do what they need to do initially, and
33 then send them on to our care if they need to." So it
34 would require everyone in the system to have the same level
35 of thinking, okay, and say, "No, that child is not
36 appropriate for our service. It is more appropriate to see
37 your paediatrician in Dubbo," or Tamworth or wherever,
38 "first, and maybe only."

39
40 Q. Again, something that might be dealt with in a
41 statewide operational plan for the delivery of paediatric
42 care?

43 A. Hundred per cent.

44
45 THE COMMISSIONER: Q. The sort of things you've just
46 been discussing with Mr Glover, are they discussed at the
47 paediatric network, at the ACI, or is that a different --

1 A. No, no, sometimes we do discuss these issues, and
2 I think the issue is - the problem for us is there's no
3 easy way to escalate that to a solution.
4
5 Q. I see.
6 A. So we can talk about it, and then we --
7
8 Q. You talk about it, you agree with each other and then
9 it goes nowhere?
10 A. Correct.
11
12 Q. Okay.
13
14 MR GLOVER: Q. I'm going to take you to a slightly
15 different topic. Are you familiar with what's described as
16 the Alexander review?
17 A. I am.
18
19 Q. I'll bring up the report. It's [SCI.0010.0004.0001];
20 Commissioner, G17. Can I take you straight to page 20,
21 please.
22
23 THE COMMISSIONER: 20 of the report?
24
25 MR GLOVER: Yes.
26
27 THE COMMISSIONER: Yes. Does the witness have a copy?
28
29 MR GLOVER: It's on the screen.
30
31 THE COMMISSIONER: Right, okay.
32
33 MR GLOVER: Q. Here are a series of recommendations that
34 the expert panel made in June 2019. You indicated in
35 answer to my earlier question that it's a document - you
36 were familiar with the review. In what circumstances have
37 you become familiar with it?
38 A. A number of - a number of times - I think this was
39 published some four or five years ago, so I would have read
40 through the recommendations, and I wasn't involved in the
41 report in terms of giving information, and I would have
42 read through that more recently. Unclear why, actually.
43 Probably in relation to the Henry review, which I was
44 involved within to some extent.
45
46 Q. I just want to ask you about a few of the
47 recommendations that were made and get your views about

1 them. Recommendation 1, paragraph 1 there on the screen,
2 the first part of it recommends a continued networked
3 approach between the hospitals at Randwick and Westmead.
4 It then goes on to say that approach continue within a
5 clearly articulated strategy for paediatrics in New South
6 Wales which provides direction for the range of paediatric
7 providers in the state. I take it from the answers you've
8 given today that that is something with which you agree?

9 A. Absolutely agree.

10
11 Q. And it was clear to the reviewers in June 2019 that it
12 was required. Why is it clear to you today that it's
13 required?

14 A. I think it was clear in 1966 it was required, and
15 I say that deliberately because there was a review of
16 children's health services in 1966 and when you read it it
17 says largely the same as reviews today, okay, so the issue
18 has not resolved. I think there are a couple of
19 contradictions in the recommendations, but I think having a
20 statewide plan, operation plan, for delivering care is
21 extremely important if we are to be efficient.

22
23 Q. When you say you think there are a couple of
24 contradictions within the recommendations, what do you have
25 in mind?

26 A. Well, I think in this particular document it was
27 stated that there should be - the network should be renamed
28 and it should focus on kids' hospital quaternary level
29 care. I entirely agree with that. But then it says - and
30 then it almost says it should be a broader network across
31 the state. I think the two things are slightly different.
32 They're connected, and I do think that kids' hospitals
33 should really focus on delivering quaternary care well and
34 collaborating with other services in the state, and that
35 should be part of a broad operational plan. So I think the
36 contradiction is the network is a couple of kids' hospitals
37 with some bolt-ons, right? But then there's a much larger
38 network which requires some cohesion.

39
40 THE COMMISSIONER: Q. I think you've probably got to
41 read these recommendations together --

42 A. Yes, I think that's --

43
44 Q. -- and then they're perhaps not contradictory, but --

45 A. I believe that's true.

46
47 Q. But, yes - isolated, yes.

1
2 MR GLOVER: Q. Yes, and perhaps if we come to
3 recommendations 4 to 6, which are on pages 21 and across to
4 22. Just have a read of 4, 5, and then when you're ready
5 let us know and we'll have the operator turn over to 6?
6 A. Yes. No, I am familiar with these and --
7
8 THE COMMISSIONER: Q. 4 is the core recommendation,
9 I think?
10 A. Pardon?
11
12 Q. 4 might be the core recommendation, I think, 4 and on?
13 A. Yeah.
14
15 Q. Creating a New South Wales paediatric care network.
16
17 MR GLOVER: Q. Operator, if we can turn over the page,
18 please, thank you, and then into 6. Do you see that?
19 A. Yes, I was familiar with that.
20
21 Q. Are they concepts with which you agree?
22 A. Yes.
23
24 Q. And one way perhaps to read the report is to say,
25 well, the panel recommended that the children's hospitals
26 remain connected, they focus on highly specialised care,
27 but that in parallel a New South Wales wide network in the
28 true sense be developed along the lines of 4, 5 and 6;
29 would you accept that as a reasonable reading of the
30 recommendations?
31 A. Yes, I do, and I think that fits nicely with the
32 statement that I have made, actually.
33
34 THE COMMISSIONER: Q. It seems - you'd agree that those
35 recommendations are consistent with the matters you've been
36 discussing with Mr Glover so far in your evidence?
37 A. Absolutely. I do.
38
39 MR GLOVER: Q. You mentioned earlier the Henry review,
40 and we might turn to that now. Bring up the report. It's
41 [SCI.0010.0001.0001]. I think in answer to an earlier
42 question you said that you had some involvement in this
43 review; is that right?
44 A. I have.
45
46 Q. What was that involvement?
47 A. Well, the ACI was tasked with investigating several of

1 the recommendations for implementation.

2

3 Q. Any in particular that come to mind?

4 A. There are some. There was a recommendation around
5 about rehabilitation services. There were recommendations
6 around prescribing medication for children with ADHD.
7 There were recommendations around level 4 hospitals
8 providing outpatient services and how to coordinate those
9 things. There was also recommendations with respect to
10 developmental assessment of children, who should do that
11 and how that would relate to the NDIS.

12

13 Q. Can I take you in the report to page 43, please. Here
14 Professor Henry observes about halfway down the page under
15 the heading "Children, young people and family committees"
16 that at the stage in his review and report there are over
17 60 committees and networks related to child, youth and
18 family services, et cetera; do you see that?

19 A. Yes.

20

21 Q. And then there's a rather complicated diagram that
22 follows?

23 A. Yes.

24

25 Q. And then over the page under that next diagram, "An
26 overarching formal statewide committee for children, young
27 people and family services does not currently exist"; do
28 you see that?

29 A. Yes.

30

31 Q. Is that still the case today?

32 A. Look, I think we've made progress. I don't think it's
33 ideal. I think forming an executive level committee to
34 oversee paediatric health care has been helpful. I - so
35 that's the Children, Young Persons and Families Executive
36 Steering Committee - it's a mouthful - and I'm a member on
37 that committee. So I do see that as helpful. I think it
38 is difficult for elements within the system to escalate
39 concerns to a point of action. I think that still exists,
40 and I think committees probably are larger than they
41 perhaps could be, and I think they're overrepresented at
42 times by the ministry and from quaternary children's
43 hospitals, and underrepresented from other services.
44 That's all I would say. But I think there has been - there
45 has been some moves made that are helpful. But there are
46 more things I think that could happen, particularly if we
47 reflect back on the Alexander report saying there should be

1 a system - an organisational plan at a state level, and
2 I think in that report it mentions involving LHDs more.
3 So, for instance, my LHD, which is Murrumbidgee, might be
4 involved saying, "Okay, how are we going to run a
5 paediatric service well," for instance.
6

7 Q. In that answer you mentioned that it was difficult for
8 people to escalate issues, concerns. Is that because
9 there's no clear point at which those can be escalated to a
10 decision maker?

11 A. I think that's one of the reasons, yes --
12

13 Q. What are the others?

14 A. So, for instance, the ACI clinical network which
15 I co-chair, we have, as I said, over a thousand clinicians
16 involved with that. I think we come to some very clear and
17 evidence-based proposals. I don't know where to take that.
18 The system doesn't allow me to ring or to communicate with
19 a higher committee to say, "These are things we need
20 discussion for implementation."
21

22 Q. If we go back in the report to page 0005, please.
23

24 THE COMMISSIONER: Is that actually page 5?
25

26 MR GLOVER: This one does match, yes.
27

28 THE COMMISSIONER: Yes, okay.
29

30 MR GLOVER: Q. And you'll see a heading about halfway
31 down the PAGE "MOH structures and governance"; do you see
32 that?

33 A. I'm getting there.
34

35 Q. Operator, we might see if we can make it a little
36 larger.

37 A. So this is "MOH structures and governance"; that's
38 this one?
39

40 Q. Yes.

41 A. Okay, yes.
42

43 Q. And then there's a first subheading "Issue" and then
44 some blue text headed "Recommendation 9"; do you have that?

45 A. Yes.
46

47 Q. If you could read down to the end of the blue text in

1 recommendation 9 and let me know when you've done that,
2 please.

3 A. Yes. Yes, read that.

4

5 Q. The first proposition that Professor Henry makes is
6 there's no systemic approach that drives decision making
7 and provides focus for direction for children, young people
8 and family health services; would you agree?

9 A. I would have agreed. I think that has been partly
10 addressed by forming the CYPFESC committee that we spoke
11 about earlier.

12

13 Q. When you say partly, what more work is to be done?

14 A. If you read through the rest of the recommendation it
15 says, "Okay, reconfigure" - tick, done. But the other
16 things, develop standardised guidelines, [indistinct]
17 statewide policy and planning, I don't believe has been
18 done and I don't believe the committee really has the time
19 to focus on that. Community representatives are present on
20 the committee.

21

22 Q. What about its role as a peak decision-making body?

23 Is that its function at the moment?

24 A. I think it's its function, yes.

25

26 Q. In what way is it a decision-making committee as
27 opposed to an advisory committee?

28 A. That's a good question. I think one of the issues
29 with decision making from that committee is it's not
30 empowered to make a decision. It's empowered to recommend,
31 and then it's unclear to whom they're recommending. So,
32 for instance - and this gets a bit complex, I think - we
33 might recommend things to the ministry, the ministry often
34 can't in and of itself enact those recommendations because
35 in truth LHDs need to enact some of those recommendations,
36 and LHDs are largely independent bodies. So let me give
37 you an example of that.

38

39 If we state that paediatric rehabilitation for
40 children with major brain injuries should occur close to
41 home, which is a sensible recommendation, okay, then that
42 would require LHDs to employ and have facilities to do that
43 locally. So it can be recommended that that be done but
44 actually doing it is an LHD responsibility.

45

46 Q. Well, if the recommendation was made to the ministry
47 and the ministry accepted it, would it not then be the

1 ministry's function to ensure the LHDs had the resources
2 available to them to comply?

3 A. Possibly. But I think - I mean, the ministry can make
4 a recommendation to an LHD. The LHD - my LHD is
5 \$25 million in the red at the moment - will say, "We don't
6 have the resources to do that," and that's where the
7 conversation may end, unless the ministry says, "We'd like
8 you to do this. Here's the money to do it."
9

10 Q. Right. I'll just take you to the terms of reference
11 of the Children, Young People and Families Executive
12 Steering Committee - I cannot pronounce the acronym in the
13 way that you did; perhaps in the world of acronyms there
14 might be a better one - [MOH.9999.3132.0001].
15 Commissioner, I think you might have been provided with a
16 hard copy. It's a relatively recent document.
17

18 THE COMMISSIONER: I'm sure I was, but whether I can lay
19 my hand on it. I can see the screen. It's here somewhere.
20

21 MR GLOVER: Q. These terms of reference have been
22 approved only last month, so relatively new. Are you
23 familiar with them?

24 A. Yes.
25

26 Q. Turn over the page, please, to the responsibilities of
27 the committee. Prior to these terms of reference being
28 adopted what was the function and responsibility of the
29 committee?

30 A. I think the function is the same as it was when these
31 were adopted. I mean, obviously when we first met we had a
32 discussion about, "Okay, what are we here for," and it was
33 clear from the outset that we needed to provide guidance to
34 the system. It was unclear perhaps how that was going to
35 happen, but it was clear what we were trying to achieve,
36 and I think with time it is now - the instruments to
37 recommend change are becoming clearer, okay, from a
38 committee perspective. Actually doing that on an
39 organisational basis is less clear. But the instruments
40 are clearer, what are we going to discuss, what power do we
41 have in the system to get things looked at, and that's
42 coming together, I would say.
43

44 Q. And once that work is done, looking at the issues,
45 looking at the areas of focus, do I understand your
46 evidence to be at the moment there needs to be more work
47 done on what is the next step, where does that go, who is

1 the recommendation being made to --

2 A. Yes, I do believe that, and I think one of the issues
3 in health care is everyone wants more all of the time, but
4 I think if we're a responsible committee what we would say
5 is, "How do we do more with the same," and I think that's
6 what we should focus on. Does that make sense?

7

8 Q. It does.

9 A. So how do we work the system better is really what we
10 should be - I think we should be focusing on.

11

12 Q. I just ask you about the fourth dot point:

13

14 *Provide direction and leadership to ensure*
15 *the achievement of outcomes in priority*
16 *areas.*

17

18 Firstly, how are those priority areas to be identified?

19 A. I think we have a list of or a number of priority
20 areas that had been identified by the committee.
21 Particularly looking at Indigenous care, remote care for
22 children are high priority areas for us. Developmental
23 strategy and early intervention is a high priority area for
24 us.

25

26 Q. So these are priority areas identified by the
27 committee?

28 A. Correct.

29

30 Q. And how do they come to the committee?

31 A. I'm not quite sure. I think people raise them.

32

33 Q. But there's no - it's an informal organic process, is
34 it?

35 A. Yes, I believe so.

36

37 THE COMMISSIONER: Q. When you say work the system
38 better with the same, I perfectly understand that. You
39 might be able to make recommendations where things are
40 re-arranged and the cost is the same but the outcome is
41 better --

42 A. Yes.

43

44 Q. -- because you're doing it in a different way. But
45 the other example you gave of, for example, rehabilitation
46 of children with brain injuries closer to home of course is
47 one where if closer to home there's no funding or FD for an

1 appropriate clinician, that's where either a reallocation
2 of funding might be needed or extra funding is needed?

3 A. Yes, look, I think that's true. I think reallocation
4 is important, and I often believe if we use technology
5 better sometimes than kids' hospitals, children's hospital
6 clinicians could better support remote care.

7
8 Q. Yes.

9 A. And that is being done to an extent.

10
11 Q. Yes, sure.

12 A. Okay? But I think we could do better.

13
14 MR GLOVER: I have no further questions for this witness,
15 Commissioner.

16
17 THE COMMISSIONER: All right. Mr Chiu, do you have any
18 questions? Yes, go ahead.

19
20 **<EXAMINATION BY MR CHIU:**

21
22 MR CHIU: Q. Dr Preddy, could I take you back to the
23 evidence you gave earlier about what's missing in the
24 system at the moment, which is a system for shared care
25 between the general paediatrician in the district and the
26 more specialised paediatrician in the Sydney Children's
27 Hospitals Network?

28 A. Mmm'hmm.

29
30 Q. And you gave the example there of where you have a
31 patient who probably ideally should remain in your facility
32 but you need that assistance from a specialist somewhere
33 else. Is it correct to say that at the moment the system
34 operates reasonably well with transferring patients, so
35 from a facility to another facility? I think that was your
36 evidence earlier?

37 A. I think it depends which you look at. If you're
38 looking at incredibly sick children, yes. If you're
39 looking at children who have subacute problems, then the
40 transport is not an issue. They catch a plane, a train or
41 a car. That's easy. It's the system that's the problem --

42
43 THE COMMISSIONER: Q. By "incredibly sick children" you
44 mean children that need the sort of highly specialised care
45 that is provided at Westmead or Randwick?

46 A. Intensive care facilities, yes.

47

- 1 MR CHIU: Q. But in the less sick children the
2 difficulty is then to get that assistance from someone else
3 you have to transfer the patient to another doctor?
4 A. Yes.
5
6 Q. That patient then goes away from out of your sight,
7 the patient may or may not come back at some other time?
8 A. Correct.
9
10 Q. But there's no capacity for shared care across
11 facilities?
12 A. Well, it's not - there is capacity. It's just not
13 done --
14
15 Q. It's not done; right.
16 A. -- okay, and I think, you know, we have - it's
17 interesting in health. We have strange incentives for the
18 system not to work well. So if I make myself into a
19 tertiary care doctor based in a kids' hospital it is easier
20 for me sometimes to say, "Come back to see me next month",
21 "Come back in two months, and we'll put you in the ward and
22 give you this", "Come back in three months and we'll see
23 you again," rather than say, "Do you know what, a lot of
24 this care can be delivered locally."
25
26 Q. Yes.
27 A. There are models for that. So if you look at oncology
28 services, for instance, in Victoria they now have a very
29 clear shared care model for kids' cancer treatment.
30
31 Q. Right.
32 A. And what that needs is subspecialists in kids'
33 hospitals to say, "We are part of this system. We believe
34 in it. We're going to do it." There's - or if they don't
35 believe in it, if they don't want to engage in it, it will
36 not happen.
37
38 Q. Could it potentially be facilitated by direct
39 agreement arrangements between districts and the sick
40 children's hospital network.
41 A. I think it could be facilitated by that.
42
43 Q. Yes.
44 A. I think ultimately it will come down to good
45 communication. But definitely facilitated by it.
46
47 Q. Thank you.

1
2 THE COMMISSIONER: Nothing arose out of that? Thank you
3 very much for your time, Professor. We're very grateful.
4
5 THE WITNESS: My pleasure.
6
7 THE COMMISSIONER: You're excused.
8
9 THE WITNESS: Thank you.
10
11 <THE WITNESS WITHDREW
12
13 MR GLOVER: The next witness, Commissioner, is Dr Paul
14 Craven.
15
16 THE COMMISSIONER: Dr Craven, good morning.
17
18 <PAUL DAVID CRAVEN, affirmed: [11.01am]
19
20 MR GLOVER: Q. State your full name, please?
21 A. Paul David Craven.
22
23 Q. Amongst a number of roles, you are the executive
24 director of children, young people and families, medical
25 services of - networks - I'll withdraw that and start
26 again - the executive director of Children, Young People
27 and Families, Medical Services and of Networks and Streams,
28 Hunter New England Local Health District?
29 A. I am. I'm the executive director of Children, Young
30 People and Families, but separate to that the executive
31 director of Medical Services, Networks and Streams for
32 Hunter New England.
33
34 Q. We'll unpack that in a moment. To assist the work of
35 the Commission you've made a statement dated 7 June;
36 correct?
37 A. That is correct.
38
39 Q. Have you read it again before giving your evidence
40 today?
41 A. I have.
42
43 Q. Are you satisfied that it's true and correct?
44 A. I am.
45
46 Q. Bring it up on the screen. It's [MOH.9999.1289.0001];
47 Commissioner, it's G95.

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THE COMMISSIONER: Mmm'hmm.

MR GLOVER: Q. If we start with the roles that you've identified in paragraph 2, come back to director of Children, Young People and Families, what is the role of executive director of Networks and Streams?

A. So the executive director of Networks and Streams, we have eight networks that work across the whole of Hunter New England. One of those is Children, Young People and Families, but the others are women's health and maternity, chronic disease network. We've got a palliative and end-of-life care network, a procedural network, and a critical care network as well. So I'm the executive director of all of those networks together, but they would have managers and medical leads within those networks as well.

Q. And these are networks within the LHD?

A. They're networks within the LHD.

Q. All right. In paragraph 3 you tell us that you host the New South Wales Child Health Network Northern; do you see that?

A. That's true, yes.

Q. What is that network?

A. So within New South Wales we currently, and it is changing, have three children's healthcare networks, the northern, the southern and the western, and they are children's healthcare networks too that work between different LHDs. So the northern incorporates northern New South Wales, the Mid North Coast, Hunter New England, and is in transition to incorporating the Central Coast LHD as well, and we employ medical leads, nursing leads, allied health leads and administrative staff, and within each of those local health districts we have nursing leads, a clinical nurse consultant, and we work in a networked fashion to ensure that we provide high-quality care throughout New South Wales.

The northern network is hosted by John Hunter Children's Hospital, and the other two networks are hosted by one of the - Sydney Children's Hospital, either Westmead or Sydney Children's Hospital in Randwick at that stage, and we are, following the Henry review recommendations, in transition at the moment from three networks in New South

1 Wales to a single network in New South Wales.

2

3 Q. We'll come back to that in a moment. But in that
4 answer you said within these networks, currently framed --

5 A. Yep.

6

7 Q. -- those involved work together to deliver care across
8 that region. How does that happen in practice?

9 A. In practice those networks are relatively small
10 networks with limited staffing in those networks. So it
11 would be more of a strategic view of health care. So it
12 will be either looking at how to standardise some of the
13 practice we perform across the different LHDs in that
14 region. It would be looking about trying to standardise
15 some of the guidelines that we have in that area, some of
16 the education we have, some of the quality improvement and
17 potentially some of the research we perform in that region
18 as well. So it wouldn't be direct patient care we're
19 providing through that, but we are trying to coordinate the
20 care we provide for the children, young people and families
21 in the north of the state through it.

22

23 Q. And the Henry review made some recommendations about
24 those networks; correct?

25 A. It did.

26

27 Q. And part of the function of the Children, Young People
28 and Families Executive Steering Committee has been to
29 review those networks; is that right?

30 A. That is correct, yes.

31

32 Q. And in an earlier answer you were about to tell us
33 that there's going to be some change to that structure?

34 A. I think that the three children's networks were set up
35 21 years ago, and probably the original terms of reference
36 for those children's healthcare networks have been a bit
37 lost within the system over 21 years, and so in review in
38 2020/2021 there was recognition that potentially what those
39 were established to do is not currently required and the
40 function of the networks needs to change.

41

42 Following the review and wide consultation across New
43 South Wales it was recommended a single network was formed
44 and a change in the actual structure of the network, but
45 really looking at the functions was still to provide
46 high-quality and coordinated and integrated care across New
47 South Wales. So there is going to be a single network,

1 which is in consultation at the moment about that network,
2 there will be coordinators within that network --

3

4 Q. Just pausing there. I'll come to the detail in just a
5 moment --

6 A. Sure.

7

8 Q. -- but the review that you've spoken about of
9 the three developing into one, that was work done through
10 the Children, Young People and Families Executive Steering
11 Committee; correct?

12 A. That is true.

13

14 Q. Building on the recommendations in the Henry report;
15 is that right?

16 A. That is true.

17

18 Q. All right. So building to what the - that structure
19 will look like in the future, accepting that it is out to
20 consultation and perhaps hasn't been finalised, but where
21 is it heading?

22 A. It's heading to be a single network for New South
23 Wales. There will be a --

24

25 Q. "Network" is used a lot. What does that mean?

26 A. It's going to - it's the - so in New South Wales the
27 strategic planning network or steering network in New South
28 Wales or committee is Children, Young People and Families
29 Executive Steering Committee, as you have alluded to. You
30 alluded previously to a lot of committees with children,
31 young people and families in New South Wales, and we now
32 have identified probably five lead committees in New South
33 Wales which will report up to the Children, Young People
34 and Families Executive Steering Committee.

35

36 Q. Five that exist or five that will exist?

37 A. Five that will exist.

38

39 Q. And that is a rationalisation of - Professor Henry
40 nominated 60, but the numerous that are currently in
41 existence; is that right?

42 A. That is right, and there will be five lead, but there
43 will be some subsidiary committees reporting to those lead
44 committees, so there is a structure for children, young
45 people and families in New South Wales, and the new
46 children's health network, what we were talking about
47 originally, is called the Children, Young People and

1 Families Healthcare Network for New South Wales. Just a
2 single network. There's a lot of networks in New South
3 Wales, and this is a single network which is an operational
4 network of decisions made - the strategic decisions made by
5 the executive steering committee will be operationalised
6 through the children's healthcare network that is being
7 developed.

8
9 THE COMMISSIONER: Q. Which recommendation of Henry does
10 that come from?

11 A. That will be under the children's healthcare network
12 reviews from Professor Henry. Sorry, I don't know exactly
13 which number.

14
15 MR GLOVER: Perhaps if we go to the Henry report to build
16 in the Commissioner's questions.

17
18 THE COMMISSIONER: Yes. It's under the heading
19 "Children's healthcare networks", is it?

20
21 MR GLOVER: Yes, it would be. [SCI.0010.0001.0001].

22
23 THE COMMISSIONER: So, "The Children's Healthcare Network
24 Northern Region be expanded to include Central Coast"; that
25 alone doesn't sound like one network is being created.
26 Where's the --

27
28 MR GLOVER: Operator, page 6, please.

29
30 THE COMMISSIONER: I think it starts at, yes,
31 recommendation 17. Yes.

32
33 MR GLOVER: Q. So there's the recommendation 17 and 18
34 was one that you've referred to in your statement and it's
35 one that caused some concern?

36 A. Yes.

37
38 Q. Is that no longer being pursued, I take it, in this
39 current model?

40 A. I think that within that recommendation 17, "The
41 Children's Healthcare Network Northern expand to include
42 the Central Coast", within the body of the Henry review
43 there was recommendation that services that are required,
44 some of the tertiary services required, for the Central
45 Coast will be sought from John Hunter Children's Hospital
46 in the future, where previously they may have been sought
47 from the Sydney Children's Hospitals Network. So that

1 still needs to be pursued at that stage because that is
2 about care that we're providing to the children of
3 the local region. So we are looking at the opportunities
4 to provide some of those tertiary services for those
5 children in those regions. Incorporating the children's -
6 Central Coast into the Children's Healthcare Network
7 Northern is not going to be possible because we're going to
8 have one single network working together for the children
9 of New South Wales --

10
11 THE COMMISSIONER: Q. What I'm struggling with is to
12 work out where that comes from Henry. Is it 9?

13 A. I think it may --

14
15 MR GLOVER: If I can assist, Commissioner, page 44 and
16 following of the Henry review report --

17
18 THE COMMISSIONER: Yes.

19
20 MR GLOVER: There's a section that deals with these
21 networks. As I read it, there's no express recommendation
22 in Henry that says, "You should have one, not three."

23
24 THE COMMISSIONER: No, I can't see that either. That's
25 why I'm asking the question. There is in the Alexander
26 review. I can see that. But I can't see it in the Henry
27 review.

28
29 MR GLOVER: I might be able to explore it with Dr Craven
30 in this way.

31
32 THE COMMISSIONER: Sure.

33
34 MR GLOVER: Q. After the Henry review there was an
35 implementation committee stood up; is that right?

36 A. There was, yes, that's right.

37
38 Q. And you were a member of that?

39 A. I was.

40
41 Q. And then that implementation committee turned into the
42 Children, Young People and Families Executive Steering
43 Committee; is that right?

44 A. That was one of the recommendations of the
45 implementation plan, to develop a peak leadership committee
46 for New South Wales for children, young people and
47 families.

1
2 Q. And that committee was stood up?
3 A. It was.
4
5 Q. And you're a member?
6 A. I am.
7
8 Q. And you remain a member?
9 A. I am the co-chair of that committee.
10
11 Q. And part of the --
12
13 THE COMMISSIONER: This is the committee you were asking
14 Professor Preddy about; yes.
15
16 MR GLOVER: This is the one with the very long name and --
17
18 THE WITNESS: Yes, that's right.
19
20 MR GLOVER: -- unpronounceable acronym.
21
22 Q. The immediate function or one of the early functions
23 of that committee was to oversee the implementation of the
24 Henry review recommendations; is that right?
25 A. That is correct.
26
27 Q. And is it the case that in the implementation of the
28 Henry review recommendations that committee also undertook
29 a review of the operations of the children's healthcare
30 networks that are set out on pages 44 and following of the
31 Henry review report?
32 A. That is correct.
33
34 Q. And is it the case that in that process of review the
35 committee determined that there should be a new model of,
36 one, not three?
37 A. That is absolutely correct, yes.
38
39 MR GLOVER: Does that assist?
40
41 THE COMMISSIONER: Yes.
42
43 MR GLOVER: Q. Now, before we got to that passage we
44 were exploring what the new structure will look like and
45 how it will operate, and I asked you some questions along
46 those lines, so if we just revisit that. Once established,
47 accepting that it's still under review and consultation,

1 but what is the vision for that single network across the
2 state?

3 A. The vision for that single network for the state is to
4 operationalise the strategies identified by the Children,
5 Young People and Families Executive Steering Committee, and
6 they will only be operationalised by working in
7 consultation with all of the 15 local health districts and
8 the two specialist health networks in New South Wales.

9

10 Q. When you say operationalise recommendations from the
11 committee, the committee as it currently stands isn't a
12 decision-making body; is that right?

13 A. The committee has identified two strategies within New
14 South Wales that we would like to roll out at the moment.
15 One of those strategies is the service capability
16 framework, so mapping the service capability framework and
17 identifying issues within New South Wales; and the second
18 one is to look at outreach services, something we've talked
19 about through this process, and how we provide outreach
20 services from tertiary children's hospitals to paediatric
21 services around New South Wales.

22

23 Q. So once the committee does that work, makes its
24 recommendation, what is the process or what will the
25 process be for it then to become operationalised through
26 the forthcoming network?

27 A. The network - the children's - the new Children Young
28 People and Families Healthcare Network will work with the
29 local health districts and will work with identifying
30 members within every LHD and specialist network in New
31 South Wales to implement and map the service capability,
32 and that will be the responsibility of each of the local
33 health districts, and the Children Young People and
34 Families Health Network, the new network, will also help
35 map the current outreach services that exist within New
36 South Wales Health. They will then - because they are
37 built from medical, nursing and allied health
38 representatives within that network, they will look for
39 what would be necessary for New South Wales and they will
40 look for where the gaps exist in New South Wales from what
41 we provide to what would be ideal at the moment, and they
42 will make a recommendation back through the Children's
43 Healthcare Network to CYPFESC, and obviously one of the
44 principles of CYPFESC is to escalate problems to the
45 minister of health about --

46

47 THE COMMISSIONER: Q. What should I understand to be the

1 differences between the network proposed and what
2 Dr Alexander, Dr Steer and Ms Peter recommended in their
3 review regarding the paediatric care network? Are there
4 any differences, or is it the same thing with a different
5 name?

6 A. I would have to take that on notice because I'm not
7 sure about what the initial recommendation in the Alexander
8 report was.

9
10 Q. Well, we can get that up.

11 A. Yes.

12
13 MR GLOVER: [SCI.0010.0004.0001], at page 20, please.

14
15 THE COMMISSIONER: Q. So drop down to 4:

16
17 *To review and consolidate existing*
18 *committees to create a streamlined and*
19 *coordinated New South Wales paediatric care*
20 *network to provide advice on.*

21
22 And then I'll let you read the rest.

23 A. Yes.

24
25 Q. But what's there in 4, 5 and 6 seems something like
26 what you're telling me as distinct from at least what I can
27 read and understand from the Henry review?

28 A. I read what number 4 is saying as we have identified
29 the Children, Young People and Families Executive Steering
30 Committee.

31
32 Q. Yes.

33 A. Which is doing and performing those functions that are
34 outlined there.

35
36 Q. Yes.

37 A. The new Children Young People and Families Network is
38 trying to operationalise the plans being made by that
39 committee.

40
41 Q. Yes.

42
43 MR GLOVER: Q. When you use the word "operationalise"
44 what do you mean?

45 A. There are lots of strategies in New South Wales and
46 there's lots of plans which we'd like to implement through
47 15 LHDs and two specialist health networks. The -

1 "operationalise" for me is actually ensuring what we say we
2 are going to do gets done in a local LHD; so, you know,
3 when we have 77 recommendations in the Henry review how do
4 we know that those recommendations are filtering down to
5 the LHD and occurring in every single site where those
6 recommendations are pertinent to that region.

7
8 Q. So building on the practical examples you gave us
9 earlier, the capability mapping exercise, so it's the case
10 if the committee says, "Well, this is something that" -
11 oversimplified significantly, tell me if we go astray, but
12 the committee says this is something that we - should be
13 done and should be done within a certain time?

14 A. Yes.

15
16 Q. And then it will be the function of the network to
17 ensure that it is done?

18 A. Yes.

19
20 Q. And then fed back to the committee for consideration
21 and then recommendation?

22 A. That's right.

23
24 Q. Is that a fair summary?

25 A. That is a fair summary, yes

26
27 Q. And is that the way you envisage it working in all
28 areas of the committee's work?

29 A. Yes, it is. The network will function in
30 collaboration with the LHDs. The --

31
32 Q. Why do you put that qualifier on it?

33 A. Because the network has got - the network employs two
34 coordinators, one nurse lead, one medical lead and one
35 allied health lead. They are never going to be able to
36 implement very complex recommendations in every LHD, and
37 with a devolved governance system in New South Wales we
38 need to work with those LHD because it's partly their
39 responsibility to actually enact those plans as well.

40
41 Q. I take you back to your statement, please. Just a
42 point of clarification in paragraph 9. So it's, "Within
43 Hunter New England LHD, John Hunter Children's Hospital
44 operates at the centre of the CYPF Network"?

45 A. Mmm-hmm.

46
47 Q. That's a network within the LHD, is it?

1 A. Yes, I can see where it's going. So Hunter
2 New England is a local health district. Within the local
3 health district we have a children's hospital which is
4 funded by the local health district.

5
6 Q. Yes.

7 A. Different to the Sydney Children's Hospitals Network.
8 We work as a networked service. So we are the level 6
9 provider, and within our own LHD we have to obviously
10 provide services to our local population as well, and so we
11 work, as previously discussed, as a network service. We
12 provide level 6 services, level 4 services, but we also
13 support our services within Maitland, Tamworth, Armidale
14 and the region as well. So that's how that Children Young
15 People and Families Network works in Hunter New England and
16 the children's healthcare network works beyond Hunter
17 New England for the north of the state.

18
19 Q. And, to the extent that there's level 6 services being
20 provided at John Hunter Children's Hospital, that's not
21 limited, of course, to those people within the district?

22 A. Absolutely.

23
24 Q. That's a statewide service; correct?

25 A. It is a statewide service, and it truly is statewide.
26 You know, we will have transfers in from the whole of the
27 state, and some of our services in fact from Newcastle and
28 from the John Hunter Children's Hospital will provide
29 services for southern New South Wales and Murrumbidgee.
30 But the majority of our tertiary services are provided to
31 the Central Coast upwards.

32
33 Q. I take you ahead to paragraph 11. There you tell us
34 at the start of the paragraph that the "John Hunter
35 Children's Hospital is within the clinical governance
36 structure of the ... LHD and does not form part of Sydney
37 Children's Hospital Network". Does that provide any
38 challenges for the operation of the children's hospital?

39 A. It does provide challenges.

40
41 Q. In what way?

42 A. I think that as a - to talk about the history of John
43 Hunter's Children's Hospital, it evolved as a paediatric
44 ward in a large hospital, John Hunter, and so the
45 children's hospital was established in 1995. So it's been
46 a children's hospital for nearly 30 years, but it's grown
47 up within a large tertiary hospital which is an adult-based

1 hospital and within an LHD which provides both adult and
2 paediatric services, and I think we've heard this morning
3 some of the complexity from our point of view is there are
4 many pressures on the healthcare system at the moment and
5 there are many pressures at a local health district level
6 as well. Some of those are about service provision, some
7 of those are about the KPIs we have to meet and some of
8 those are financial pressures as well, and so trying to run
9 a tertiary children's hospital within a large adult-based
10 LHD does come with its challenges.

11
12 Q. You were here when Professor Preddy gave his evidence?

13 A. I was.

14
15 Q. And you heard him describe some of the challenges of
16 operating a paediatric service in - I hope I accurately
17 quote him - a adults-focused planning process. Would you
18 agree with his observations?

19 A. I agree with the challenges we're facing. We have an
20 aging population, we have some significant challenges in
21 the flow of patients coming through our emergency
22 departments and getting surgery done in New South Wales at
23 the moment, and a lot of attention is naturally and quite
24 rightly on those challenges we're facing. And the aging
25 population, 70 per cent of our growth is over 70. So
26 trying to advocate for really important paediatric
27 preventative, early intervention services when there's an
28 aging population is extremely difficult, and I think what
29 John alluded to is saying that, you know, if we do
30 intervene early we actually prevent some of the things
31 we're treating later on in life as well. And we do have
32 some processes where we are working on early intervention
33 at the moment, but a focus on paediatrics sometimes gets a
34 little lost in a large LHD with some other pressures.

35
36 Q. Does it still get a little lost, to pick up your term,
37 when you're operating a specialist children's hospital
38 within the LHD environment?

39 A. It does. I have great support from the executive of
40 the LHD. But it is funded as an LHD; it's not funded as a
41 tertiary children's hospital in the same terms as
42 potentially - in the Sydney Children's Hospitals Network,
43 that's a purely children's healthcare network, whereas in
44 Hunter New England obviously the funding is for both adults
45 and children at that stage, and it's also in a local health
46 district, and we're then providing services beyond that
47 local health district as well.

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Q. Are you aware if there's been any consideration as to whether the John Hunter Children's Hospital should remain within the LHD or form part of the wider perhaps Sydney Children's Hospitals Network?

A. Look, I am aware and I can see it has been reported in the Alexander report in the past about considerations. Personally, the Sydney Children's Hospitals Network is two children's hospitals in Sydney, and we are Newcastle children's hospital, and I don't think anywhere in the world you would have a children's hospital in another city called under the Sydney's Children Hospital - grouped with another children's hospital in another city. I do think, however, the concept of thinking about how three children's hospitals work together is a concept we should think more about and how we plan some of the tertiary services we provide together.

Q. Building on that answer, accepting your view that you would not deem it as practical or appropriate that the children's hospital in Newcastle be put together with two children's hospitals in Sydney. Building on that then, how does one overcome the challenges that you've described earlier about operating a specialist children's facility within the LHD environment and the challenges that brings?

A. I think there has been - there's definitely been examples of how we've overcome that in recent years, and there has been some planning around some specialised paediatric services that we've introduced in the last couple of years, and I'll talk about gender services, palliative end-of-life care services for children and some of the virtual care services we're providing for children as well. Some of those have been coordinated and funded as a three children's hospital model, and it doesn't need to just be children's hospitals, and I apologise just for talking about children's hospitals at that time. But they have been funded together and we collaborate together as three children's hospitals at that stage. The problem at the moment is some of the historical services we have provided for a very long time aren't worked in the same way, so --

Q. What do you mean by that?

A. So we would have many tertiary services. So at the moment we're funding gender services and palliative end-of-life care and virtual care, and money is provided and we're staffing those services within our three

1 children's hospitals and working together in that system.
2 We've historically got other tertiary services, such as
3 immunology, cardiology, gastroenterology, oncology and the
4 list goes on, and I think that we now in New South Wales
5 are providing more specialist paediatric care than we've
6 probably ever provided before and, you know, there was a
7 time I think probably a lot of that care was provided by
8 general paediatricians. Those services now are provided by
9 three children's hospitals and also some larger level 4
10 services, but I'm not sure we have coordinated provision of
11 those tertiary services well in New South Wales at this
12 stage.

13

14 Q. Is that why in an earlier answer you mentioned there's
15 scope to look at how the three children's hospitals work
16 together?

17 A. I think - yes, absolutely. I think it's - we've got
18 some what's called super-regional services which we - you
19 know, neonatal intensive care, paediatric intensive care.
20 So it's coordinated for the state. We've got some
21 specialised services that have come onboard, and they seem
22 to be coordinated for the state at the moment. But we do
23 have some historical services that are not coordinated and
24 I think would benefit from being coordinated centrally.

25

26 Q. What improvements can be made to the way that the
27 three hospitals, that is the three children's hospitals,
28 work together, in your view?

29 A. I mean, I think we have - we have an excellent
30 relationship between us. We meet on a regular basis. We
31 have a heads of agreement between us about how we will work
32 together, some guiding principles of how we work together.
33 I do think - I think that if we could have some service
34 planning around some of those tertiary services for New
35 South Wales and consider where the services are required in
36 New South Wales, who should provide those services, where
37 they should provide them and where the funding would come
38 from in that situation I think that would really help us
39 work together collaboratively.

40

41 Q. Statewide operational and services planned for the
42 delivery of paediatric care which includes how the three
43 hospitals work together; is that what you had in mind?

44 A. Absolutely --

45

46 THE COMMISSIONER: Q. Also more than how just those
47 three hospitals work together; how paediatric departments

1 in other LHDs work?

2 A. And I was just going to say, for me, I'm talking about
3 three children's hospitals because that's what we talk
4 about, but the reality is it doesn't have to be provided in
5 children's hospitals. The whole emphasis is providing care
6 close to home.

7

8 Q. Yes.

9 A. So how can we think about providing, in John's
10 situation, good paediatric care and good community care,
11 but how do we provide tertiary care, and of course for me
12 at the moment it's providing tertiary care, because there's
13 great demand for tertiary care and we have long waiting
14 listing for children wanting to access tertiary care,
15 because at the moment with a lack of some planning it's
16 difficult to meet the demand.

17

18 MR GLOVER: Q. I take it from that answer that you would
19 adopt Professor Preddy's point about there being benefit in
20 clear role delineation and pathways for referral into
21 specialist facilities like yours and then back to level 4
22 facilities like his?

23 A. Absolutely. I think we have got some good - I think
24 we have got some good systems. We've got some good systems
25 of how GPs could refer effectively. I'm just not sure it's
26 consistent across the state, so I think some consistency
27 with our primary healthcare providers. I think there will
28 be some consistency and there is some suggestion around
29 what a children's hospital should provide, would be good to
30 continue some work on at the moment at that stage, and
31 I think some consistency around who and where we should
32 provide good outreach services would be a sensible
33 approach, because bringing children into children's
34 hospitals is not the right thing to do. Keeping them up
35 close to home would be a much preferred system.

36

37 MR GLOVER: Is that a convenient time?

38

39 THE COMMISSIONER: It is. Yes. We'll adjourn until
40 11.50.

41

42 **SHORT ADJOURNMENT**

43

44 MR GLOVER: Q. If we can turn back to your statement and
45 to paragraph 11, building on some of the evidence before
46 lunch, halfway down that paragraph you tell us there's no
47 centralised planning of tertiary paediatric services in New

1 South Wales; do you see that?

2 A. Yes.

3

4 Q. We've touched on that already. What I want to explore
5 with you is what improvements you see could be made in a
6 formalised sense to overcome that lack of centralised
7 planning?

8 A. I think that we have done some really good planning.

9 So I will state that I think with some of the newer
10 services that have been introduced recently we've had a
11 really good look at where services need to be provided, by
12 whom, how, and have looked at the staffing of what we would
13 require to provide those services. That's been excellent,
14 I'd have to say.

15

16 So I think maybe what I'd say is maybe learn from some
17 of our successes to think about retrospectively applying
18 them to some of the things which we're currently providing
19 but maybe struggling to provide within New South Wales.
20 I think like services such as - John Preddy and myself have
21 both talked about gastroenterology services, but it will be
22 the same for most paediatric subspecialty services at the
23 moment, so gastroenterology, oncology, immunology, the list
24 could keep going on at that stage, and maybe a staged
25 approach to how are we going to provide these services,
26 where are we going to provide these services, and who is
27 going to provide those services as well.

28

29 Q. So at the end of paragraph 11 you tell us that joint
30 meetings are important to ensure the three children's
31 hospitals work collaboratively.

32 A. Mmm'hmm.

33

34 Q. Is a more formal structure for joint planning across
35 those three facilities required, in your view?

36 A. Look, I think at the moment they are quite informal
37 meetings, the three children's hospital meetings, and they
38 are only the three children's hospitals. And we've learnt
39 this morning that so much work occurs beyond the three
40 children's hospitals, and we have to be really cognisant of
41 that. So I think maybe we have to be aware that maybe just
42 the three of us trying to sit together and think about what
43 we're going to do together you might end up with the same
44 answer every single time, and I think maybe broadening
45 where those conversations and who is orchestrating some of
46 those conversations will be a good thing as well.

47

1 Q. Accepting that planning for paediatric care across the
2 state must necessarily involve those who deliver it across
3 the state, what I'm really focusing on though is the
4 particular type of care that is delivered through the three
5 children's hospitals. Is there scope for more formalised
6 coordination and planning across those hospitals?

7 A. There's definitely scope, and I think we're making
8 some good progress already. I think we have looked at the
9 governance of children, young people and family services
10 across the whole of New South Wales as well at the moment,
11 and I think we're making some good progress.
12

13 I think that formalising some of that planning would
14 be a good opportunity. I think the service capability
15 framework, when we've mapped it we will know where some of
16 the gaps are. So I think that's an important opportunity.
17 It is important to recognise, however, that the service
18 capability framework doesn't really map tertiary services
19 provided. So that is very much around some of our general
20 paediatric and community paediatric services provided, not
21 tertiary.
22

23 Q. When you say there's been good progress made in this
24 direction where do you see that ending? What's the end
25 goal of that progress?

26 A. I mean, I think there's a recognition through the
27 Children Young People and Families Executive Steering
28 Committee. I will say that that committee is very much
29 focused on the Henry review, and there are 77
30 recommendations in the Henry review and there's been an
31 incredible amount of progress in trying to achieve many of
32 those actions.
33

34 I guess one of the things I reflect on is the Henry
35 review was 2019. And so the issues that were pertaining in
36 2019 have changed. We know that health care has changed,
37 especially post-COVID at that stage. So maybe
38 understanding some of the newer challenges we are facing
39 across New South Wales is one of the elements of that
40 committee is now doing, and the first two things we're
41 going to look at operationalising at the moment is that
42 service capability framework and also the outreach
43 services. So it is very much similar to what we're
44 actually - what I'm outlining here to trying to plan some
45 of those tertiary services.
46

47 THE COMMISSIONER: Q. What are the key newer challenges

1 that you were just referring to?

2 A. I think challenges at the moment is how - the models
3 of care. So I think, you know, we've had this very
4 traditional, "Doctors have to see a patient; should be in a
5 children's hospital." So I think virtual care is really,
6 you know, pertinent for the future. I think we have to
7 think about workforce. We've got many challenges, and
8 I think the challenges are disproportionate with our rural
9 and regional colleagues at the moment. So I think we
10 should be thinking about where we provide services, how we
11 provide services, but most of all who should provide those
12 services because what we've historically done we shouldn't
13 probably do for the future.

14
15 We've currently got some excellent models of care, and
16 it is coming out of the Henry review still, but we've been
17 looking at models for ADHD. John Preddy, you know,
18 referred to models for rehabilitation care. We've been
19 looking at models for complex health care, how do we
20 coordinate that better. So there are really good things
21 occurring in New South Wales at this moment in time, and
22 I think what we need to think about is when we've got the
23 evidence that something's working how do we spread it and
24 make it consistent across the system.

25
26 MR GLOVER: Q. You were here when I took
27 Professor Preddy through the paediatric service capability
28 document?

29 A. Yes.

30
31 Q. And the inter-hospital transfer arrangements document;
32 correct?

33 A. Yes, I was.

34
35 Q. Is part of the review of service or the mapping of
36 service capability that the committee has suggested and
37 will be operationalised by the new single network when it's
38 up and running, what's the vision for the endpiece of that
39 work? What is it going to be used for and where do you see
40 it developing the network structure across New South Wales?

41 A. Look, I think when we map the service capability we
42 will - that service capability outlines the minimum level
43 of care that's to be provided between levels 1 and 6 at
44 that stage. And I think there are services in New South
45 Wales now that would be declaring they are providing a
46 level of service that when we map them they won't be able
47 to do. And so I think it will give us a realistic

1 impression of what services are being provided, where
2 they're provided, and ensuring that they are provided
3 safely at all times. And I think that will then allow us
4 to identify the gaps, where they exist. And then I think
5 behind that there are some models that we have to consider,
6 and I think that's that work that Professor Preddy is
7 working on at the moment, looking at new models of care and
8 how we can spread those across the system. So I think it's
9 good we'll have a baseline of where we sit at the moment
10 and it will be good to have a baseline of where maybe some
11 of those gaps exist, and therefore we can try and adapt the
12 system.

13

14 Q. What about putting some more formal structure around
15 the networks that are referred to in those two policy
16 documents? Is that part of that process?

17 A. Can I ask which networks you're --

18

19 Q. Well, that's a good question. If we go to the
20 paediatric service capability document.

21 A. I apologise.

22

23 Q. [MOH.0002.0144.0001], page 12. You see there under
24 the first paragraph the policy tells us that clinical care
25 and inter-hospital transfers for infants et cetera are
26 delivered through a statewide system of networked care; and
27 then later in that paragraph services are linked through
28 local networking arrangements. Can you assist on what
29 those networking arrangements are?

30 A. I can in my own district. Look, I can really say that
31 for the north of the state. I guess when we map the
32 service capability we're mapping the minimal level of
33 service they've all provided at that stage. Within that
34 document there is a process of identifying how you will
35 escalate care between different services. And it might not
36 all be moving them to a children's hospital. It would
37 absolutely be moving them from a lower level of care to a
38 higher level of care and ensuring you have the back
39 transfer, once the patient is improving, move them back
40 again.

41

42 I think some of those networks are probably formalised
43 in some areas and I think some of them are based on
44 relationships. So I think formalising some of those and
45 ensuring we have them documented would be very useful.

46

47 Q. Because would you accept that it's important that

1 arrangements like that are not heavily based on
2 relationships between particular clinicians but are rather
3 part of business as usual?

4 A. I think in the past we have had a lot of networking
5 based on relationships, and I think things are changing at
6 the moment based on many things. We've got quite often a
7 newer workforce at the moment and a different workforce.
8 So I think formalising some of those networks would be very
9 important.

10
11 Q. Is that part of the work of the committee, that is the
12 Children Young People and Families Executive Steering
13 Committee, at the moment?

14 A. Yes, it is because it is part of the service
15 capability framework to ensure that within that document we
16 not only ensure that we have a mapping of what service they
17 can provide; it is actually ensuring that we have an
18 education framework and a transfer framework and a
19 framework of supporting smaller services by larger
20 services.

21
22 Q. I take you back to your statement, please, and to
23 paragraphs 14 and 15. We've discussed already today some
24 of the challenges that might arise from being a specialised
25 children's facility within a LHD structure. I just want to
26 touch briefly on paragraph 15 where you describe some of
27 the challenges associated with securing funding. In the
28 second sentence of paragraph 15 you tell us that:

29
30 *... growth in activity should translate to*
31 *increased National Weighted Activity Unit*
32 *allocations [that the] funding is*
33 *incremental which creates challenges for*
34 *investing in services and growing the*
35 *workforce ... to provide such services.*

36
37 Do you see that?

38 A. Yep.

39
40 Q. Can you just explain what you mean by that?

41 A. At the moment the majority of our - as I said before,
42 a lot of what has previously been service provided by a
43 general paediatrician potentially is now becoming a very
44 specialised paediatric service provided by dedicated
45 specialists.

46
47 I think within the John Hunter Children's Hospital

1 certainly we have grown that specialised workforce
2 incrementally and slowly, and so we have extremely small
3 teams of specialists. So we often have anywhere from one
4 specialist in a team trying to provide service 24 hours a
5 day, seven days a week, and even some of our larger
6 specialist services have got very little FTE to provide
7 that service at the moment.

8
9 We find ourselves getting to a situation where we
10 would work those services when we have two people to the
11 maximum, and we just can't generate any more activity with
12 two people at that moment in time. So as much as we could
13 say if we did more we might be able to generate more
14 activity and more funding that we could reinvest at that
15 stage, I think we've shown by new models coming in and
16 specialised services coming in having funding up front to
17 establish a service is really important. I don't know how
18 a hospital is started, but most hospitals have teams at the
19 beginning, and I think trying to grow a team from nothing
20 is very difficult to try to provide a service.

21
22 Q. And is part of the challenge in growing a team to be
23 able to then increase activity and it becomes somewhat
24 circular perhaps; correct?

25 A. Absolutely. I mean, I think that we want to provide
26 the service to the children. The most important thing we
27 want to do is provide a service to sick children in the
28 north of the state. We recognise that. I think it's
29 extremely frustrating for clinicians to be able to provide
30 part of that service and know that they have got children
31 waiting to be seen, who need to be seen, but when there's
32 one or two people it's just impossible to get to them. And
33 so we do have children waiting for a long period of time.

34
35 Q. Is part of that challenge heightened by the fact that
36 within the LHD environment those services compete for
37 funding with the range of other services provided with the
38 LHD?

39 A. We do, and we advocate for all our services, and we
40 advocate for all our services with our colleagues
41 advocating for adult services, community services and
42 various other services across that area. And it is a very
43 difficult time at the moment to try and advocate for some
44 of those services. So I recognise the pressures and
45 I recognise how frustrating it is for some of the
46 clinicians to try and provide and meet the expectations of
47 the population we're serving. And that expectation is not

1 only within the LHD; it's outside the LHD as well.

2

3 Q. When you say it's difficult at the moment to advocate
4 for those services what do you mean?

5 A. I think it would be fair to say at the moment there
6 are some financial challenges in many areas of health care
7 at the moment and everybody at the moment is asking for
8 more. We recognise at times we have to be realistic. So
9 I think what we said earlier is we have to try to think
10 about what we do with what we've got and try to do it
11 better with what we've got at that stage.

12

13 THE COMMISSIONER: Q. There's a health acronym which is
14 CFE that we keep getting told about: challenging financial
15 environment.

16 A. Yes. I like to be consistent.

17

18 MR GLOVER: Q. When you use challenging financial
19 environment what do you mean?

20 A. Look, I think I recognise there's areas that
21 I believe - I have looked at every which way to try to
22 provide a good clinical service. We could re-design the
23 service. We have used new models of care. We have looked
24 at different staffing models to try to provide that
25 service. But at some stage there's a recognition that the
26 only fix for that service is you actually do need more
27 people to provide it, and there are some of our services
28 where we have reached that situation.

29

30 Q. And to provide more people do I take it that you need
31 more funding?

32 A. I would need more funding to provide that service.
33 But I equally understand that all my colleagues are doing
34 the same thing and advocating for the patients they care
35 for at the same time.

36

37 Q. I take you ahead to paragraph 22. There you summarise
38 the challenges, and we've covered all of them in your
39 evidence today. What I want to explore with you is whether
40 statewide approach to operational and service planning that
41 we've discussed might assist you in meeting some of those
42 challenges and, if so, in what way?

43 A. I think it has shown - I think we have already
44 demonstrated with some of the specialist services where we
45 have already planned on a statewide level that we are
46 providing excellent care for the patients and we are
47 providing it in the right locations by the right people,

1 and those services have been funded, and I think we have
2 some good models where we could reflect on in that
3 situation. I do --

4
5 Q. Just pausing there, do I take it you agree then --

6 A. Yes, I do.

7
8 Q. -- that there is benefit in a statewide approach
9 across the board rather than just in relation to specific
10 services --

11 A. I feel some statewide planning from some of the
12 specialised services we provide would be very sensible.
13 I think when there are services provided - for example, in
14 the Hunter New England region we provide some services to
15 the local population which every LHD provides, and
16 I understand that we will continue to provide those
17 services as part of a LHD. But when you're providing
18 tertiary services, providing very few centres in New South
19 Wales with a very limited workforce, I think some planning
20 around how we use that workforce effectively would be good
21 and I think that would be good centrally.

22
23 Q. And how that service and workforce is then linked to
24 other paediatric care provided across the state, as you
25 mentioned earlier?

26 A. Absolutely. And, as I said before, it may be to
27 provide it not in a tertiary service.

28
29 Q. Would that approach also assist in advocating for
30 funding for paediatric care?

31 A. I think we have shown already we've advocated for
32 funding for some of our specialised services that have been
33 very effective.

34
35 Q. By that do you mean where there's been statewide
36 planning for certain services that has assisted in securing
37 funding for them?

38 A. We have shown that where we plan for intensive care
39 for beds, for neo-natal or paediatric intensive care we
40 allocate funds to where the activity is increasing at that
41 stage, and we have had some very good specialised services
42 which have been funded statewide. And I think about the
43 gender services, palliative and end of life care, and
44 currently the virtual care we're providing for children in
45 this state where we're providing some urgent care virtually
46 for children, and that has been centralised planning.

47

1 Q. And has that centralised planning assisted in securing
2 funding for those services?

3 A. It has.
4

5 Q. And do you see benefit in more wide-ranging
6 centralised planning also providing a greater strength to
7 advocate for resources being allocated to paediatric care
8 more broadly?

9 A. I think centralised planning then allocates the
10 funding to where it's required at that stage. It will be
11 remiss of me to say that obviously, you know, we have to
12 recognise that there are things in health care potentially
13 that we will stop doing as well. As a service we have to
14 think very carefully about the models that we have employed
15 in the past and could we do things better and what do we
16 stop doing to actually start doing things we want to do as
17 well.
18

19 Q. And part of that process - that process would commence
20 with assessing the needs across the state, would it?

21 A. Absolutely. I think assessing needs.
22

23 Q. And then determining the resources available to meet
24 that need across the state?

25 A. I think assessing needs, assessing models is really
26 important as well because we shouldn't just keep
27 replicating what we've always done; I think assessing where
28 we should be putting models at that stage; and really
29 building it that way and then advocating for funding for
30 tertiary care or community care where it's provided.
31

32 MR GLOVER: I have no further questions for this witness.
33

34 THE COMMISSIONER: Thank you. Mr Chiu?
35

36 MR CHIU: No questions, Commissioner.
37

38 THE COMMISSIONER: Thank you very much, Doctor. We're
39 very grateful for your time.
40

41 THE WITNESS: Thank you very much.
42

43 **<THE WITNESS WITHDREW**
44

45 MR GLOVER: Dr Lyons is the next witness, Commissioner.
46
47

1 <NIGEL JOSEPH LYONS, sworn: [12.12 pm]

2

3 <EXAMINATION BY MR GLOVER:

4

5 MR GLOVER: Q. State your full name again for the
6 record?

7 A. Nigel Joseph Lyons.

8

9 Q. And you're still a special adviser to the Ministry of
10 Health?

11 A. I am.

12

13 Q. And to assist the Commission in its work you have
14 provided a statement dated 7 June; correct?

15 A. I did.

16

17 Q. [MOH.9999.1870.0001], G105. Did you have a chance to
18 read it again before giving your evidence today?

19 A. I have.

20

21 Q. Is it true and correct to the best of your knowledge
22 and belief?

23 A. It is.

24

25 MR GLOVER: It will form part of the bulk tender,
26 Commissioner.

27

28 THE COMMISSIONER: Yes.

29

30 MR GLOVER: Q. May I take you to paragraph 3, Dr Lyons.
31 There you tell us that between October '16 and August '22
32 you held the position of Deputy Secretary, Health System
33 Strategy and Planning, and then at the end of that
34 paragraph that that included responsibility for the
35 direction of child and family health policy; do you see
36 that?

37 A. I do.

38

39 Q. Just focusing on the responsibility for child and
40 family health policy, what was the scope of your role in
41 that position?

42 A. So I was responsible for the health and social policy
43 branch, which had responsibility for child and family
44 health. That was brought back into the ministry following
45 New South Wales Kids and Family dissolution in 2015. But
46 my involvement actually goes back longer. We've talked
47 about paediatric networking a lot today. My initial

1 involvement in paediatrics and its networking was in the
2 year 2000 when I was actually seconded into the ministry,
3 the then Department of Health, to write the plan to
4 establish the three paediatric networks which people have
5 talked about today. So that was back in 2000.

6
7 The issues around networking have existed, as we
8 heard, from the 1960s onwards. They are the ongoing
9 challenge. And how we actually support the appropriate
10 networking of services within districts across networks,
11 specialty health networks, and across the state is an
12 ongoing challenge which we've heard lots about during this
13 hearing.

14
15 Q. Coming back to that. Since leaving the deputy
16 secretary role and your specialist advisor role, I take it
17 you're still up to date with issues in this area?

18 A. Somewhat, but not to the level of detail of others who
19 have been directly involved in those meetings. So
20 Dr Craven, for instance, has been part of some of those
21 discussions. I haven't been directly involved in those
22 since I left --

23
24 Q. So you were on, for example, the Children Young People
25 and Families Executive Steering Committee for a time?

26 A. At that stage it was actually the Henry review
27 implementation group. So it involved, I think, into the
28 executive steering committee subsequently. But I did
29 co-chair it.

30
31 Q. And that role for you ceased in about August 2022?

32 A. That's right. That's right.

33
34 Q. If I ask you a question that is now beyond your
35 knowledge, feel free to say so. Touching on the networking
36 issue, coming back to your time in the ministry when the
37 children's health networks were being revised and
38 implemented, do you recall what led to that development
39 within the New South Wales health?

40 A. The purpose of the paediatric networks was to
41 recognise, as we have heard today, that the care of
42 children needs to be supported and needs to be supported in
43 a way which allows the care to be delivered as close as
44 possible to where they live, and that is a challenge
45 because you need to have the workforce in place but you
46 need to have the workforce supported by access to advice
47 and higher levels of care when that's required, and for

1 those things to be provided in a way that enables the child
2 to get the care they need where they are, but if the care
3 they need is beyond where they are that there's an easy way
4 for that referral for the transfer to occur; or,
5 alternatively, for the clinician who's involved in
6 delivering that care locally to get the advice to be able
7 to deliver the care safely in that place. So those things
8 were recognised and have been recognised.

9
10 The way to achieve that is, you know, through the
11 really important role that our tertiary and quaternary
12 services play and the expertise that they have being made
13 more available to the people who are actually providing
14 that more general care. I think the challenge of that has
15 increased over the last few years, and we've heard about
16 the increasing subspecialisation. That's occurring in
17 every sphere of medical care. It's occurring in
18 paediatrics. It certainly has created increased challenges
19 because what was previously done by a general paediatrician
20 in a level 4 unit often now is needing to have the referral
21 or back -up of those subspecialties.

22
23 I think what's highlighted over the last few days of
24 evidence and listening to witnesses is that issue around
25 the connection between the subspecialties that exist and
26 how they might better support what is happening across our
27 local health districts in terms of provision of paediatric
28 care is probably something which we really need to focus on
29 now as the next phase of, you know, the priorities for
30 service support, planning might need to be put around that
31 and there might need to be some more definition and clarity
32 around how that is supported across the state.

33
34 Q. What is it about the delivery of paediatric care in
35 the last few years that you've mentioned that has perhaps
36 brought that into sharper focus than might have been
37 previously?

38 A. Well, I think every area of subspecialty medicine has
39 grown because of the depth of knowledge that now exists;
40 the capability to do things that weren't able to be done
41 before, the application of technologies to support that;
42 and the need for those to be done in a highly specialised
43 environment with a team with skills and capability around
44 you. So that shift has inevitably meant that patients are
45 being transferred more into the Sydney Children's Hospitals
46 Network. As we heard today, even referrals for outpatient
47 care, those are often to specialists in those setting.

1
2 So what that means is how do you create the connection
3 so that access to that advice, that care and support is
4 appropriate, but how do you then support the transfer of
5 care back to somebody who can actually deliver that,
6 whether that's a specialist paediatrician locally, a
7 generalist, or even to general practice in some cases
8 because there won't be a specialist paediatrician in those
9 environments. So how do we create that networking and that
10 support for the overall care of the patient and their
11 family, because the family are an important component of
12 that, and how is that done in a way that enables everyone
13 who needs to be a part of that to be aware of what's going
14 on and to play their part appropriately.

15
16 Q. You were here while Professor Preddy and Dr Craven
17 gave their evidence?

18 A. I was.

19
20 Q. And I took Professor Preddy in particular to the
21 "Paediatric Service Capability (Paediatric Medicine and
22 Surgery for Children) Guideline"?

23 A. Yes.

24
25 Q. I can take you to it if you need, but that document
26 I took Dr Preddy and I think Dr Craven through refers to
27 networks in a variety of senses.

28 A. Mmm'hmm.

29
30 Q. Do I take it from the answers that you've just given
31 that you would agree that there is now time to perhaps put
32 some more structure around those networks, more clarity
33 about how they operate, without of course interfering with
34 clinical decision-making?

35 A. Absolutely. We should not interfere with clinical
36 decision-making and nobody should interfere with that, and
37 I think referral patterns will always occur between
38 clinicians. It's about how the system supports the
39 appropriate networking and arrangements between clinical
40 services to enable clinicians to access easily that support
41 and make those referrals where required.

42
43 Look, I think, on reflection, the Northern Child
44 Health Network, as came out in the Henry review, was
45 probably more mature in terms of how it's operating. And
46 on reflection, you know, the changes that occurred in the
47 governance of the two children's hospitals in Sydney with

1 the establishment of the Sydney Children's Hospitals
2 Network probably disrupted the networks that used to occur
3 at Randwick and Westmead for the southern and western parts
4 of the state.

5
6 Q. Why do you say that?

7 A. Because I think there became a focus on - very
8 importantly a focus on how the two hospitals were brought
9 together which created a more inward-looking focus of the
10 executive management and the clinicians, and the whole idea
11 of the paediatric networks was to be more outward-looking.
12 And so by necessity through the establishment of the Sydney
13 Children's Hospitals Network the outward-looking didn't get
14 as much focus as perhaps occurred in John Hunter through
15 the fact that that wasn't disrupted by that change.

16
17 Q. Dealing with that issue directly, perhaps, I'll take
18 you to what's been described as the report of the Alexander
19 review at [SCI.0010.0004.0001]. That's up on the screen,
20 if you have it there. Are you familiar with this document?

21 A. I am.

22
23 Q. And were you involved in the commissioning of this
24 review?

25 A. I wasn't involved in the commissioning but I was
26 consulted as part of the consultation process with
27 the panel and was involved after the report was received.

28
29 Q. What was your understanding of the purpose of this
30 review?

31 A. It was really focused around whether or not the
32 decision that was made - if I step back to the Phillips
33 review actually. Ron Phillips actually did a review in
34 2012 which was subsequent to the last Special Commission of
35 Inquiry where there were recommendations made around the
36 establishment of a new quaternary hospital and a new basis
37 on which children's services should be sort of centralised
38 and coordinated across the state.

39
40 Ron Phillips, who was a previous Minister for Health,
41 was commissioned to actually undertake a review and provide
42 advice to the department/ministry around what was the
43 appropriate course of action, and there were a range of
44 options considered around how that would be supported, one
45 of which was to have the Sydney Children's Hospitals
46 Network take the leadership role for the state from a
47 network perspective. But ultimately there was a decision

1 made to establish an authority within the ministry or a
2 separate pillar, actually, with its own board which would
3 have the responsibility called New South Wales Kids and
4 Families. So that was actually set up but subsequently
5 disbanded in 2015.

6
7 The Children's Hospitals Network, which was
8 established during that time or just before that time
9 actually, had been set up with the view that it should look
10 to how the services that were provided at each of
11 the hospitals in Sydney could be better coordinated and
12 managed and look at that linking of them to more
13 effectively provide services for not just metropolitan
14 Sydney but the state, and during --

15
16 Q. As opposed to Commissioner Garling's recommendation of
17 a single hospital --

18 A. Yes. So I think it was done in recognition of that
19 need to bring services together, whether that was
20 physically or through an organisational arrangement. So
21 the decision was made to create the network. There was
22 certainly a lot of unrest and disquiet around a particular
23 service: cardiothoracic surgery.

24
25 Q. What was the unrest and disquiet?

26 A. It was around the fact that the service had
27 historically been provided at both sites and,
28 internationally, there was a trend towards consolidating
29 these services because of issues around volume and outcome
30 and the need to have a skilled workforce to provide the
31 service and a certain number of patients to be actually
32 cared for to enable the skills to be maintained.

33
34 Q. And is that a trend that exists not just in that
35 particular field but across specialist medicine generally?

36 A. It happens in other areas as well. It's a trend
37 that's actually, yes, occurring everywhere. The fact, you
38 know, two hospitals trying to provide 24 hours, seven days
39 a week cover, 365 days a year, meant that there would be
40 needing to be a minimum of three, probably, surgeons on
41 each site to cover an after-hours roster. There wasn't
42 enough work to enable all of those surgeons to be
43 maintaining all of their skills.

44
45 So there's a need to think about how the service was
46 delivered differently, but that created a lot of concern
47 which played out publicly. And there was actually

1 criticism of the network in that process, that the network
2 wasn't resolving this, the network hadn't delivered any
3 benefits. And so the secretary and I think through the
4 board chair of the network commissioned this review to
5 assess was the networking of the services still the right
6 way to go in terms of governing them.

7
8 Q. In addition to the disquiet that you've described
9 about that particular service, were there also challenges
10 in bringing the two hospitals together given that they had
11 existed separately perhaps with their own cultures and
12 approaches and philosophies?

13 A. Absolutely. So they were very - and they are amazing
14 services at both ends, and with really passionate people
15 with huge skills, and they're very dedicated to their
16 sites. This is not uncommon in health. People really are
17 passionate about what they do and where they work. And
18 bringing people together to be part of something bigger and
19 different without having a sense of losing things is a
20 challenge.

21
22 And so I think, you know, the history was that they
23 were very strong, both of those hospitals, in terms of
24 their internal culture and in some ways you could argue
25 were in competition with each other. And so to come
26 together as one network and to work as one service was
27 incredibly challenging to deliver.

28
29 Q. Aside from those two issues, were there any others
30 that prompted the commissioning of the Alexander review as
31 far as you're aware?

32 A. I think they were the major drivers for it, as
33 I understand it. The other issue of course would be that
34 as with all - and we've heard about it today - there would
35 not be one service across the state that I'm aware of that
36 wouldn't argue that they should do better if they had more
37 resources. So there would have been I think a sense coming
38 out of the network and the hospitals that perhaps the
39 resources had not been provided to enable it to be
40 successful. So I think that will be another driver that
41 would have been behind the review.

42
43 Q. I think in an earlier answer you said once the review
44 had been completed you had some role in considering it, did
45 you?

46 A. I was the deputy secretary who had responsibility for
47 child and family health. So it was concluded and had a

1 series of recommendations which probably went beyond the
2 initial envisaged scope of the review because --

3

4 Q. We might just go to the recommendations on that topic.
5 They start at page 20. Just refresh yourself on them
6 generally and then go to the scope of the review. I'll ask
7 the operator to scroll down slowly.

8 A. Mmm'hmm. So it's when we come to the recommendations
9 that start talking about the statewide reform program and
10 the need for that more expansive --

11

12 Q. That's where you --

13 A. Yes.

14

15 Q. All right. If we go to the terms of reference of
16 the review, which are on page 27.

17 A. Mmm'hmm.

18

19 Q. So there there's the subheading "Advice sought":

20

21 *The advice for the Panel is sought to*
22 *identify the most effective governance of*
23 *[the network] to maximise the benefit --*

24 A. Yep.

25

26 Q. Then it goes on.

27

28 *... including advancing local service*
29 *accessibility and excellence as well as*
30 *improving the integration of paediatric*
31 *services across levels of care and across*
32 *the State.*

33 A. Yep.

34

35 Q. So in what sense do you perceive that the
36 recommendations made in the Alexander review went beyond
37 the scope?

38 A. In that they were not referencing the role of the
39 network in relation to those things; it was more a general
40 statement about what the state should provide in terms of
41 the overall care of children. So I think the intent of
42 that advice sought was initially around how the network
43 should have a role in supporting that rather than those
44 broader recommendations around --

45

46 Q. Go back to the recommendations and I want to ask you
47 about a couple of them. Back to recommendation 1. Before

1 I do that, so once the report was received what was your
2 role in considering the recommendations and then moving
3 forward?

4 A. I was not actively involved in the decision. I think
5 that was more a discussion between the secretary at the
6 time, and the minister certainly had been appraised of the
7 review. And I've seen correspondence that went back to the
8 acting board chair of the network at the time providing the
9 report and indicating that at that stage there was not a
10 desire to progress the recommendations that were beyond the
11 network.

12
13 So the specific recommendations that related to the
14 network, the executive management and the board and the
15 governance of the network, were handed to the board for
16 consideration. But there was a decision made not to
17 progress the other recommendations. And my understanding
18 was that that was because at the time this whole issue of
19 the need for a statewide planning process and review of
20 paediatric services generally had come to the fore, and it
21 was being envisaged that there would be a review
22 commissioned to look at those things, and that's where
23 Professor Henry was subsequently appointed to undertake
24 that review. It was almost within a few months of this
25 report being received that that one was initiated.

26
27 Q. Well, from a timeline perspective when do you recall
28 that the Alexander review was first commenced?

29 A. I thought it was in late 2018/early 2019, that sort of
30 timeframe.

31
32 Q. And the report itself was delivered in June 2019.

33 A. Correct.

34
35 Q. Is it the case that in February 2019 then
36 Minister Hazzard announced the Henry review?

37 A. There was - I don't know that he announced the Henry
38 review. He announced that if the government won the
39 election there would be a review of services. He didn't
40 indicate who would undertake it.

41
42 Q. I see. And are you aware of the catalyst for that
43 announcement?

44 A. My recollection is that it was because there was a lot
45 of consultation going on around the cardiothoracic surgery
46 issue, including having roundtables with lots of clinicians
47 and people involved and stakeholders involved in delivering

1 child health care and paediatric care, and there was
2 certainly a view expressed that there needed to be an
3 overall review of what was happening across the state. So
4 I think that was the genesis for the committee to a broader
5 review.
6

7 Q. Who had expressed the review that there needed to be
8 an overall review of what was happening across the state?

9 A. I think the roundtables; it was coming from the
10 clinicians involved in providing care that there was
11 needing to be further review undertaken.
12

13 Q. Was that a recommendation that came from your
14 directorate?

15 A. No, it wasn't something that we initiated. It came
16 I think from that feedback that was coming from clinicians
17 involved in the roundtables.
18

19 Q. Were you consulted about the announcement made by
20 Minister Hazzard in February 2019?

21 A. I was aware that that was being committed to.
22

23 Q. You were told; is that right?

24 A. I was aware that that was being committed to.
25

26 Q. Do I take it that you weren't asked before the
27 decision was made?

28 A. I don't recall being involved in a conversation about
29 whether or not there was - what my opinion was about the
30 need for it.
31

32 Q. All right. And is it the case then that the
33 announcement having been made in February 2019
34 work - I withdraw that. Once the announcement had been
35 made, did you have any involvement in what became the Henry
36 review thereafter?

37 A. Yes. I mean, I was involved in developing the scope
38 and terms of reference for that review; was involved in
39 appointing Professor Henry to undertake the review; was
40 involved in regular meetings with Professor Henry as he
41 undertook the review; was involved in establishing a
42 reference group to support him in that work. So all of
43 that was my direct responsibility.
44

45 Q. And do you recall whether the scope for the Henry
46 review was developed after the Alexander report had been
47 delivered?

1 A. It was around the same time, and we certainly were
2 aware of the recommendations in the Alexander review which
3 were broader in nature, and it was considered that those
4 should absolutely be part of what Professor Henry's review
5 should consider.
6

7 Q. In an earlier answer you gave some evidence that, once
8 the Alexander report was delivered, a decision was made
9 that to the extent that those recommendations extended
10 beyond governance within the children's network they were
11 to be parked, for want of a better term, pending the
12 subsequent review; have I understood you correctly?

13 A. That's my assessment of things, because the timing was
14 so close. It was almost within a matter of months that the
15 other review commenced. And there was a sense that the
16 Henry review would be a broader consultation than that had
17 occurred with the Alexander review, which had been
18 relatively narrow by comparison.
19

20 Q. Who made the decision not to action the
21 recommendations made in the Alexander review that it
22 extended to statewide issues?

23 A. It certainly was not at my level that decision was
24 made. So I don't know whether it was at the secretary or
25 minister level, but it was some point above where I was
26 operating that the decision was made not to progress them.
27

28 Q. After the Alexander report was received was there any
29 formal response to it by the ministry?

30 A. The only documentation I've seen is the letter that
31 went back to the acting board chair of the Sydney
32 Children's Hospitals Network. I haven't seen any other
33 formal documentation, and we've reviewed the correspondence
34 at the time and can't find any evidence of there being any
35 formal documentation around the response other than to the
36 network.
37

38 Q. In hindsight, this review having been commissioned by
39 the ministry, do you consider that there should have been a
40 formal response to it by the ministry?

41 A. I think that's a matter for the people who
42 commissioned the review as to what they do with the review.
43 It's a review commissioned by them for their use. So I'm
44 not really in a position to answer whether there should or
45 shouldn't have been. It was certainly --
46

47 Q. Well, let's take it outside of this scenario. Would

1 you accept that where a review is commissioned by the
2 ministry with public funds it is appropriate that, once
3 that review is received, some formal response to it
4 indicating whether the recommendations are accepted or
5 rejected and why should be given?

6 A. I would put it this way, that I think the
7 recommendations that related to the governance of the
8 network, which was the critical issue, were certainly acted
9 on and the people who were responsible for that were asked
10 to provide feedback and be involved in making the changes.

11
12 The broader recommendations, my sense is that there
13 was a view that there needed to be further testing of those
14 recommendations for the broader constituency. Now, the
15 question is whether you go out and say you're responding to
16 those by not responding and having this further review
17 undertaken. The timing of things is the issue there.
18 I don't know that the timing meant that that really
19 occurred in the way that was enabling that formal response
20 to be given. The commitment to a further review was made
21 in February. So it was anticipated this further review was
22 likely to be undertaken. So I'm not sure as to whether or
23 not a formal response was required and to whom it would
24 have been given.

25
26 Q. It might have been given to those who were consulted
27 in the Alexander review or the authors of the report
28 perhaps?

29 A. And I don't know the answer to whether or not they
30 were provided with any of that. There's no formal evidence
31 of it, though, that I've seen.

32
33 THE COMMISSIONER: Q. Frequently with government
34 reviews, royal commissions, those sorts of things there's
35 usually a government response to them indicating what's
36 accepted, what's not, what's going to be done to implement
37 what's accepted, that sort of thing. That wasn't something
38 that happened with the Alexander review that you're aware
39 of?

40 A. No, and I would say that in terms of it being a review
41 it was not so much a public review for the consumption of
42 the broader community but more to provide advice to the
43 secretary around whether the governance arrangements that
44 existed were still appropriate. And so I don't think it's
45 unreasonable that it wasn't more broadly communicated, the
46 response, to the recommendations that were in it.

47

1 MR GLOVER: Q. I take you back to the recommendations,
2 which are still on the screen. I just want to ask your
3 view about them from your experience. Recommendation 1:

4
5 *To maintain the networked approach to*
6 *governance of paediatric services across*
7 *the two hospitals.*

8
9 What I want to ask you about is the next passage:

10
11 *... within a clearly articulated strategy*
12 *for paediatrics in New South Wales which*
13 *provides direction for the range of*
14 *paediatric providers in the State.*

15
16 Do you see that?

17 A. Yes.

18
19 Q. You would have heard some of the evidence about those
20 matters today. Is that a proposition that you would agree
21 with?

22 A. I would, yes.

23
24 Q. Why is it important, in your view?

25 A. Well, it's really important to understand how the
26 relationship occurs between the services that are providing
27 care to children, whether that's within a district, across
28 districts or across the state. I would say to you that
29 there was a lot of documentation to support that, because
30 we've already noted there were role delineation documents
31 that exist which define levels of care. We know that local
32 health districts have a primary responsibility to provide
33 paediatric care and child health as a core responsibility
34 of their roles as local health districts. They do clinical
35 service planning. They define how those services are
36 provided across their sites that they're responsible for.

37
38 There was a lot of work done to support how that's
39 delivered. The development of the paediatric capability
40 framework was one such effort to actually assist the
41 districts to assess how they should provide that care and
42 what appropriate support should be in place to deliver that
43 safely and effectively. There were guidelines about
44 inter-hospital transfer to make sure that the care was safe
45 and escalated appropriately. These things were part of a
46 statewide strategy.

1 I think the issue here is specifically around the role
2 of the Sydney Children's Hospitals Network in the context
3 of that statewide strategy. That's the thing which I think
4 people are pointing to as being required.

5
6 Q. And further than that, though, isn't it, the
7 identification about how all those parts work together
8 across the state?

9 A. Well, you could argue that within a local health
10 district and across many local health districts they do
11 work. They don't always work easily, but they work.

12
13 Q. I wasn't intending to suggest they don't work but
14 rather that there's a need, isn't there, for a overarching
15 statewide operational and delivery plan for the delivery of
16 paediatric care which includes things like clear role
17 delineation, how the various services across the state will
18 operate together in a cohesive way to deliver the care
19 that's required?

20 A. So I think, you know, if we go back to the fact that
21 role delineation defines that, being always in place, the
22 districts were clear of what the role delineation of all
23 the services were across the state. There's a statewide
24 compendium of all of the services and the level that they
25 are provided at. There is documentation --

26
27 Q. There's more to that than just saying, "Well, that
28 service can be provided safely in a particular hospital,"
29 isn't there?

30 A. So that's what the paediatric capability framework was
31 about as well. I think the question here is - and there
32 was the development of paediatric networks which were
33 established in the year 2000 with an aim to start to create
34 the links between the three children's hospitals, the two
35 in Sydney and John Hunter Children's Hospital, and the area
36 health services at the time that referred patients to them
37 to create those connections to support that care being
38 delivered.

39
40 So it's not that these things didn't exist. I think
41 it's a fact that, you know, they did exist. It's a need to
42 strengthen them up and make sure people are also - as
43 things changed that the evolution of those changes, people
44 are aware of those and that they're refined and further
45 developed as time goes on.

46
47 Q. And, consistent with some earlier answers, you

1 perceive that need to have been heightened in recent years
2 with developments in how care is provided, including
3 increased subspecialisation?

4 A. I think that's the critical driver. The
5 subspecialisation is certainly a major factor driving the
6 need for that to be redefined, as we've heard in evidence
7 this morning. The other thing I would say is that the
8 establishment of the paediatric inpatient unit at
9 Campbelltown I think is another driver for us to start to
10 redefine that for the purposes of understanding its role in
11 relation to the Sydney Children's Hospitals Network.
12

13 Q. Why do you say that?

14 A. Because the relationship is going to be key and the
15 relationship between the services, and there may need to be
16 cross-appointments and agreements about what level of care
17 is provided at different sites. That might need to be
18 reassessed with the establishment of a 100-bed inpatient
19 unit at Campbelltown. And I think it's important as those
20 service changes occur that we revisit how things are
21 delivered to ensure that we've got the right care being
22 delivered in the right place and that people understand how
23 those relationships will work and that there's some
24 documentation to support that.
25

26 Q. So some planning and analysis of how that facility
27 links in with the existing children's hospital --

28 A. Correct.
29

30 Q. -- facility both in Sydney and in Newcastle?

31 A. Correct. And how it will relate to the services that
32 exist in the districts, because they may start to refer
33 into that hospital rather than to one of the other
34 hospitals.
35

36 Q. I take it from the answers that you've just given that
37 you don't disagree with the proposition that there is
38 benefit in developing a strategic and operational plan for
39 the delivery of paediatric care across New South Wales that
40 covers quaternary and tertiary hospital care as well as
41 local paediatric care within the LHDs?

42 A. I think the local paediatric care within the LHDs is
43 well covered by the LHDs. I mean, I think we've got to be
44 really clear about what we want this plan to deliver for
45 us. We have a lot of plans in New South Wales Health
46 and --
47

1 Q. Understatement of the century.

2 A. -- a planning process doesn't necessarily deliver the
3 outcomes that people are looking for. They'll point to a
4 planning process as a solution. I think there's a need to
5 define up the relationship between those tertiary and
6 quaternary services and what is provided at the local
7 health districts. And I think we heard in evidence from
8 the Sydney Children's Hospitals Network earlier in the week
9 that they are establishing agreements between themselves
10 and the districts about how those things will actually work
11 in practice. That's good practice and I commend them for
12 having done that. It is one of those things that provides
13 that clarity and establishes quite clearly the relationship
14 between the various services and how the services on the
15 ground will operate.

16

17 The issue in the statewide planning process is trying
18 to do that on a state when issues in each of the districts
19 are different and the level of capability of the service
20 will be different. And it will change over time often due
21 to changes in workforce availability. So a paediatrician
22 or two might leave a certain district, and then they
23 struggle to provide the level of service that they
24 previously used to. And we know that, increasingly, it's
25 difficult to attract general paediatricians and it's more
26 challenging to attract paediatricians into rural and
27 regional environments. So it's a dynamic state of affairs
28 that a planning process of itself will not resolve.

29

30 So I think we do need definition. We do need clarity.
31 We need to delineate those things and agree on how they are
32 going to operate at this point in time. And we need to
33 have an ongoing process for assessment and review that
34 they're actually operating effectively.

35

36 Q. If we scroll down to the next page, Operator, I want
37 you to have a look at recommendations 4 and 5. Just let me
38 know when you've read them.

39 A. Yep.

40

41 Q. They're the sort of principles and concepts that could
42 be included in a statewide plan for the delivery of
43 paediatric care across the state, aren't they, without
44 unduly limiting the ability of the LHDs to deliver the care
45 that is needed in their regions?

46 A. There's elements of what's in there which you would
47 certainly incorporate into a process to establish the

1 definition around things I've just talked about. Whether
2 or not that needs to be a broad statewide plan - the risk
3 is it will be so high level that it actually won't deliver
4 the solutions to the issues that people have been raising.
5 No-one will disagree about having principles that underpin
6 things. But actually how that translates into the care of
7 a patient when someone's got someone in front of them that
8 they need to access, you know, a higher level of specialist
9 advice or referral, the principles won't necessarily fix
10 that.

11
12 Q. Is the starting point then determining how
13 paediatric - I'll withdraw that. Is the starting point
14 then identifying the vision for paediatric care across New
15 South Wales, where it is to be delivered and how it is to
16 be delivered, and go from there?

17 A. I have a vision for that which is that we should be --

18
19 Q. I'm not suggesting you don't, but is that the starting
20 point?

21 A. Well, it is already a given that where we want to
22 provide care is firstly in a primary care setting,
23 secondary care - specialist as close as possible to the
24 home so that families, you know, are provided the best
25 possible care as close as possible to where they live.
26 Those things are enshrined in everything we do. I think
27 we've got to be really clear that some of these things in
28 here, yes, you would argue you could put into a process at
29 the state level that will assist us in defining what we do,
30 and others of them won't necessarily make any difference.

31
32 Q. Won't make any difference because they are high-level
33 concepts; is that what you mean?

34 A. That's right. And I think we have plans that have a
35 lot of these principles and high-level concepts. It's the
36 translation of the plan into what it means for clinical
37 care and service delivery that is the critical issue. And
38 my view would be that, you know, having established better
39 governance across the state, the Children Young People and
40 Families Executive Steering Committee will be starting to
41 look at these issues and think about how they could be
42 applied in practice.

43
44 Q. You express some caution in the development and
45 utility of a statewide plan. What is the source of that
46 caution? What is the risk that you are guarding against?

47 A. Well, it consumes a lot of people's time. It's

1 another process which will take significant effort and
2 resource to complete. And the benefit - I mean, I've been
3 involved in a lot of planning processes over the years.
4 They of themselves don't necessarily lead to a better
5 outcome around the issues that people are expressing a
6 concern at the moment. I think it can be of some support,
7 but not necessarily the only answer to the issues that are
8 before us.

9
10 Q. You've followed the evidence on these issues over the
11 week and today, you've been here; correct?

12 A. Yes.

13
14 Q. You've heard some of the challenges in the delivery of
15 paediatric care being described by witnesses; correct?

16 A. I have.

17
18 Q. Are there other mechanisms, other than the statewide
19 plan that has been suggested by a number of witnesses, that
20 you would see as being capable of being deployed to meet
21 those challenges?

22 A. I would use the example of the Northern Child Health
23 Network as an example of what could be done, which is where
24 the relationships between the children's hospital concerned
25 and the referring districts and the support for agreement
26 around how the care is delivered across those services,
27 what the access points are, what the referral pathways are
28 being documented and clearer, who is available to provide
29 advice to the clinicians on the ground when that advice is
30 required, having those agreements documented and clear as a
31 part of the networking arrangements could actually address
32 some of or many of the issues that have been raised today.
33 A statewide plan may also do that subsequently, but it of
34 itself won't necessarily deliver it.

35
36 THE COMMISSIONER: Q. Do I get the impression that -
37 I think one of the things you said about the statewide plan
38 is they can be so high level that their practical utility
39 might be a question mark. But your preference is and you
40 alluded to the heads of agreement that have been agreed
41 between the network and particular LHDs being perhaps a
42 better way because they're more bespoke to the needs of
43 that LHD which might, for example, be a regional LHD; would
44 that be right?

45 A. That's correct. That's what I'm alluding to,
46 Commissioner. And I think those were negotiated directly
47 between the parties. So the clarity around those is

1 contemporaneous and relevant to the circumstances.

2

3 Q. And the benefit of that sort of heads of agreement and
4 then developing more detailed agreements is that those
5 agreements talk to the population needs of that LHD, what's
6 already available as services, what might be desirable to
7 develop?

8 A. Correct.

9

10 Q. All those sorts of more detailed nitty-gritty type
11 plans?

12 A. Absolutely. As we've heard this morning from
13 Professor Preddy, how can the general paediatric unit in
14 that district be supported by the subspecialties to have
15 care transferred for there to be ongoing involvement of the
16 care of those children who need enduring and ongoing care
17 with chronic conditions. Those --

18

19 Q. Noting the size of what the Wagga base serves, the
20 health needs of the children there et cetera that might be
21 slightly different to another LHD?

22 A. That's correct.

23

24 Q. Yes.

25 A. That's correct.

26

27 MR GLOVER: Q. Can I just explore that with you a
28 little. Professor Preddy gave some examples this morning
29 of challenges he faces in providing care in Wagga and
30 referrals in and out of the children's hospitals. Do
31 I take it from the answers that you've just given that you
32 see those challenges being met by bespoke arrangements
33 between the LHD and the network?

34 A. They need to be tailored to the local circumstances
35 because what is available in the environment that
36 Professor Preddy works at won't be available necessarily in
37 the environment that somebody in Tamworth or Lismore has in
38 place. So it does need to be in some respects bespoke to
39 the circumstances.

40

41 And I think the relationships - we heard about
42 relationships today. We should never underestimate the
43 criticality of the relationships. In my experience of
44 establishing networks and having effective networking
45 relationships both the referring party and the person who
46 receives the referral need to have trust and confidence and
47 an ongoing and enduring relationship about how they provide

1 care for their patients. That's why referrals often occur
2 to individuals that have a relationship already.

3
4 When you're trying to organise that at the system
5 level you've got to create the enablers around that that
6 enable that to occur no matter who's in the role. And, in
7 part, that needs to be done by the services accepting that
8 they have a responsibility to that. They need to be aware
9 of what's available. They need to know who is there and is
10 capable of delivering care. So on both ends there needs to
11 be a knowledge and an awareness and a commitment that, "If
12 we're going to make this work, we are in it together."

13
14 Q. All the networks that are referred to in documents and
15 all the committees and all the policies, what currently
16 exists to provide that structure for people like
17 Professor Preddy and his colleagues?

18 A. Well, I think as I said, you know, the whole concept
19 of the paediatric networks which were established 24 years
20 ago was to establish that process. It's occurred well in
21 one part of the state. We need to replicate that in the
22 other parts where it doesn't currently exist. It's at a
23 variable level. And, if it's working well in one part of
24 the state, what is the reason why it's working well in that
25 part of the state that we need then to transfer to the
26 other parts where it's not working.

27
28 Q. And I appreciate you're no longer a member of the
29 Children Young People and Families Executive Steering
30 Committee, but is to your understanding part of the work in
31 that area the development of the single network that
32 Dr Craven told us about earlier today?

33 A. I think that will assist, but it needs to go beyond
34 just having a network overarching. It needs to get into
35 the agreements that need to be in place to support that
36 occurring and how those relationships and referral pathways
37 will be maintained and sustained; how they'll be monitored
38 and managed in an ongoing way; and, where there are issues
39 where things aren't working well, how and where they'll be
40 escalated to for resolution.

41
42 Q. Can I perhaps try and summarise what I think is the
43 substance of your answers, that you accept that there's a
44 scope for structures and the identification of support
45 mechanisms to be done at a system level, but the individual
46 arrangements should be able to be dealt with at a district
47 level to meet the particular need and service availability

1 in that area?

2 A. You've said it much better than I did.

3

4 THE COMMISSIONER: Q. For the issue that
5 Professor Preddy raised concerning a better route to
6 assistance, a bespoke agreement between the Sydney
7 Children's Hospitals Network and the paediatric department
8 of Murrumbidgee would be far more useful to him than an
9 overall state plan. There might be some benefit in an
10 overall state plan, but to directly address the needs and
11 the desirability of the change that he's talking about it's
12 that lower level more detailed whether it's a plan or a
13 network structure individually to that LHD would be better?

14 A. That's my view.

15

16 Q. Yes. And also a state plan just won't talk to or is
17 unlikely to talk to - it maybe have some worth, but it also
18 won't talk to the kinds of demographic changes we're seeing
19 in regional and rural New South Wales that might cause
20 needs for different health services, including different
21 health services for children or different workplace
22 problems as people seem to be gravitating to the bigger
23 regional centres and for various reasons leaving the
24 smaller rural towns, which could be driven by a number of
25 things including not least climate change. But, having
26 individual plans that can be constantly updated, those sort
27 of bespoke plans we're talking about would be far more
28 useful; do you agree with that?

29 A. That's my view, Commissioner.

30

31 MR GLOVER: Q. Supported perhaps by some guidance from
32 the system as to the development of those plans?

33 A. Yes.

34

35 Q. The identification of roles and responsibilities in
36 delivering those plans?

37 A. Yes.

38

39 Q. Such that if one day when Professor Preddy retires his
40 successor can slip into that role seamlessly?

41 A. Correct.

42

43 MR GLOVER: No further questions.

44

45 THE COMMISSIONER: Q. Can I just ask your opinion on one
46 thing, and it is just a curiosity. Please don't think I'm
47 about to recommend that there should be a new single

1 children's hospital costing \$5 billion in New South Wales.
2 But when you were talking about - I'll take it this way.

3
4 We all know Justice Garling, Commissioner Garling at
5 the time, recommended the one hospital. But I think in the
6 Henry review there's a discussion about there's not much
7 political will for that and, secondly, "We've spent all
8 this money on infrastructure at two sites, and so it just
9 might not be feasible to unpick." But you talked about the
10 trend towards subspecialisation and also with highly
11 specialised services, and I think you mentioned - the
12 example you gave was cardiothoracic and the need for volume
13 and constant use of skills to get the best health outcomes.

14
15 If in an impossible situation we were starting again
16 and planning again - and I've read papers, and I can't
17 remember which one it is but it talks about cities and
18 populations up to 10 million it's better to have the one
19 quaternary children's hospital for the reasons I've just
20 discussed and you gave in your evidence. If you're
21 starting again, in your opinion would it be better just to
22 have the one big children's hospital in Sydney serving the
23 metropolitan area for those sort of highly specialised
24 treatments?

25 A. It would be I think advantageous to have the one
26 tertiary quaternary hospital.

27
28 Q. Yes.

29 A. Not providing secondary care. I think the --

30
31 Q. No, I didn't mean that.

32 A. Absolutely. And I think then you would look at what
33 the other hospitals did in relation to secondary care. The
34 issue for Westmead in particular, I think, that occurred
35 once it opened was that people voted with their feet. They
36 thought they were getting better quality care if they took
37 their children to Westmead Children's Hospital. So they
38 bypassed all the local hospitals. So the work that was
39 previously done in a lot of the paediatric units around
40 that reduced. And that has not been a good thing either
41 for The Children's Hospital or for the surrounding
42 services.

43
44 So I think having a clearer understanding of what the
45 role of that service would be, how it's accessed and
46 ensuring that the secondary and tertiary care that could be
47 provided locally was done and that it actually had a very

1 clear role. The challenge for the Children's Hospitals
2 Network at the moment is it's doing a whole lot of
3 secondary care as well, and that's putting pressure on its
4 services.

5
6 THE COMMISSIONER: Thank you. Mr Chiu?

7
8 MR CHIU: Commissioner, I have no questions. On Tuesday
9 you asked me about some matters arising from the Alexander
10 review and the Henry review.

11
12 THE COMMISSIONER: Some of it's been clarified. I asked a
13 question about - and feel free to explore it if you want
14 to. What I said was, from my reading of the Henry review
15 in relation to the governance issue, I thought - still
16 think - that there's been a misinterpretation of what
17 Dr Alexander and her colleagues recommended regarding an
18 expansion of governance of the Sydney Children's Hospitals
19 Network. That's my view. If there's any more clarity - we
20 don't need to explore that if there's --

21
22 MR CHIU: I don't think there's anything I can get out of
23 Dr Lyons that would assist on that. I also don't --

24
25 THE COMMISSIONER: I'm happy to hear from Dr Lyons if I've
26 misread or I don't understand. But, if it is what it is,
27 it just is what it is and we don't need to go into --

28
29 MR CHIU: That will ultimately be our position. It is
30 what it is and we can't explain it without --

31
32 THE COMMISSIONER: Yes. I don't think there's any need to
33 explore it with Dr Lyons.

34
35 MR CHIU: Yes.

36
37 MR GLOVER: Q. There's just one question arising not
38 from that but the last answer Dr Lyons gave, the issue of
39 children's hospital - whether it should be limited to
40 quaternary care or secondary care and the example you gave
41 of people attending at Westmead because they felt like they
42 were getting better care for their child. Could that risk
43 be alleviate if specialist quaternary children's hospitals
44 did not have the emergency department at which people could
45 present?

46 A. If the quaternary service that was established as a
47 standalone didn't have an emergency department, it could

1 be. However, I don't think that's an option in our current
2 environment.

3

4 Q. Why?

5 A. Because the Westmead service has been built around
6 having the emergency department services as well as all of
7 the other components, and I don't think we could change
8 that now.

9

10 Q. Is it also because there's --

11

12 THE COMMISSIONER: Q. When you say you don't think we
13 could change it, is that we could change it but there might
14 be some political problems --

15 A. I think it might be a step too far, Commissioner.

16

17 MR GLOVER: That follows up the last question I have,
18 Commissioner

19

20 THE COMMISSIONER: Okay. Anything come out of that?

21

22 MR CHIU: No, Commissioner.

23

24 THE COMMISSIONER: Thank you very much again for your
25 time, Dr Lyons. We're very grateful. You're excused.

26

27 THE WITNESS: Thank you, Commissioner.

28

29 <THE WITNESS WITHDREW

30

31 MR GLOVER: Commissioner, we're just finalising some
32 tender bundles and some non-publication orders relating
33 to some --

34

35 THE COMMISSIONER: The ones the other day disappeared.

36

37 MR GLOVER: There are. But there are some issues with
38 some particular documents which we're working through. We
39 propose to deal with that in chambers, if convenient.

40

41 THE COMMISSIONER: Yes.

42

43 MR GLOVER: Otherwise that completes the evidence for this
44 hearing block.

45

46 THE COMMISSIONER: Dealing in chambers I take it means
47 that everyone is in agreement as to what should happen?

1
2 MR GLOVER: I think we are, but I just want to be clear
3 about it because I haven't had myself the opportunity to
4 review it.
5
6 THE COMMISSIONER: Okay. Is that it then?
7
8 MR GLOVER: That's it for this hearing block.
9
10 THE COMMISSIONER: I have no idea when we're adjourning
11 to. When are we adjourning to?
12
13 MR GLOVER: Someone will tell me.
14
15 THE COMMISSIONER: To a date to be confirmed?
16
17 MR GLOVER: Yes. Sine die. To a date to be confirmed,
18 Commissioner.
19
20 THE COMMISSIONER: I've actually got 24 June.
21
22 MR GLOVER: Yes. Thank you.
23
24 THE COMMISSIONER: We'll adjourn, unless corrected, to
25 10 am on 24 June.
26
27 MR GLOVER: Thank you, Commissioner.
28
29 THE COMMISSIONER: Sorry, just before we adjourn, do
30 I need to say anything about the one extra witness that we
31 haven't called? That can just be --
32
33 MR GLOVER: I think that can be managed in the next round.
34
35 THE COMMISSIONER: All right. We'll adjourn.
36
37 **AT 1.06PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
38 **TO MONDAY, 24 JUNE 2024 AT 10AM**
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\$	2000 [3] - 3689:2, 3689:5, 3701:33	3658:24, 3672:25, 3703:37, 3709:1	3699:1, 3707:43	ADJOURNED [1] - 3712:37
\$25 [1] - 3660:5	2012 [1] - 3692:34	5/6 [1] - 3647:43	accepted [4] - 3659:47, 3699:4, 3699:36, 3699:37	adjourning [2] - 3712:10, 3712:11
.	2015 [2] - 3688:45, 3693:5	50-year [1] - 3642:46	accepting [5] - 3667:19, 3670:47, 3676:19, 3680:1, 3707:7	ADJOURNMENT [1] - 3678:42
*16 [1] - 3688:31	2018/early [1] - 3696:29	500 [1] - 3652:33	access [7] - 3643:37, 3678:14, 3689:46, 3691:3, 3691:40, 3704:8, 3705:27	administrative [1] - 3665:36
*22 [1] - 3688:31	2019 [9] - 3654:34, 3655:11, 3680:35, 3680:36, 3696:29, 3696:32, 3696:35, 3697:20, 3697:33	6	accessed [1] - 3709:45	adolescents [1] - 3644:10
0	2020/2021 [1] - 3666:38	6 [15] - 3645:3, 3645:22, 3646:11, 3647:47, 3648:2, 3656:3, 3656:5, 3656:18, 3656:28, 3668:28, 3672:25, 3674:8, 3674:12, 3674:19, 3681:43	accessibility [1] - 3695:29	adopt [1] - 3678:19
0005 [1] - 3658:22	2022 [1] - 3689:31	60 [2] - 3657:17, 3667:40	accountability [1] - 3649:16	adopted [2] - 3660:28, 3660:31
0012 [1] - 3644:8	2024 [3] - 3639:22, 3640:26, 3712:38	7	accurately [1] - 3675:16	adult [8] - 3642:1, 3642:6, 3642:12, 3642:19, 3674:47, 3675:1, 3675:9, 3684:41
0023 [1] - 3645:20	21 [3] - 3656:3, 3666:35, 3666:37	7 [2] - 3664:35, 3688:14	achieve [4] - 3650:3, 3660:35, 3680:31, 3690:10	adult-based [2] - 3674:47, 3675:9
035 [1] - 3639:24	22 [5] - 3649:43, 3650:5, 3650:31, 3656:4, 3685:37	70 [2] - 3675:25	achievement [1] - 3661:15	adult-focused [2] - 3642:1, 3642:6
1	23 [1] - 3650:31	77 [2] - 3673:3, 3680:29	achieving [3] - 3650:5, 3652:47, 3653:8	adults [2] - 3675:17, 3675:44
1 [5] - 3655:1, 3681:43, 3695:47, 3700:3	24 [6] - 3684:4, 3693:38, 3707:19, 3712:20, 3712:25, 3712:38	8	ACI [3] - 3653:47, 3656:47, 3658:14	adults-focused [1] - 3675:17
1.06PM [1] - 3712:37	27 [1] - 3695:16	8 [1] - 3643:41	acronym [3] - 3660:12, 3670:20, 3685:13	advance [2] - 3641:19, 3653:23
10 [2] - 3709:18, 3712:25	3	9	acronyms [1] - 3660:13	advancing [1] - 3695:28
10.00am [1] - 3639:22	3 [2] - 3665:22, 3688:30	9 [6] - 3647:37, 3647:39, 3658:44, 3659:1, 3669:12, 3673:42	acted [1] - 3699:8	advantage [3] - 3641:32, 3652:20, 3652:29
10.07am [1] - 3640:13	30 [2] - 3640:26, 3674:46	97 [1] - 3651:46	acting [2] - 3696:8, 3698:31	advantageous [1] - 3709:25
100-bed [1] - 3702:18	365 [1] - 3693:39	A	action [3] - 3657:39, 3692:43, 3698:20	advice [13] - 3648:19, 3672:20, 3689:46, 3690:6, 3691:3, 3692:42, 3695:19, 3695:21, 3695:42, 3699:42, 3704:9, 3705:29
10AM [1] - 3712:38	4	ability [2] - 3651:3, 3703:44	actions [1] - 3680:32	adviser [1] - 3688:9
11 [3] - 3674:33, 3678:45, 3679:29	4 [26] - 3641:1, 3644:35, 3644:45, 3644:46, 3645:3, 3645:32, 3645:43, 3647:41, 3647:42, 3647:47, 3648:1, 3656:3, 3656:4, 3656:8, 3656:12, 3656:28, 3657:7, 3672:15, 3672:25, 3672:28, 3674:12, 3677:9, 3678:21, 3690:20, 3703:37	able [10] - 3661:39, 3669:29, 3673:35, 3681:46, 3684:13, 3684:23, 3684:29, 3690:6, 3690:40, 3707:46	active [1] - 3651:23	advising [1] - 3641:26
11.01am [1] - 3664:18	43 [1] - 3657:13	absolutely [19] - 3651:20, 3651:32, 3655:9, 3656:37, 3670:37, 3674:22, 3677:17, 3677:44, 3678:23, 3682:37, 3684:25, 3686:26, 3687:21, 3691:35, 3694:13, 3698:4, 3706:12, 3709:32	actively [1] - 3696:4	advisor [1] - 3689:16
11.50 [1] - 3678:40	44 [2] - 3669:15, 3670:30	accept [5] - 3652:40, 3656:29, 3682:47,	activity [6] - 3683:30, 3683:31, 3684:11, 3684:14, 3684:23, 3686:40	advisory [3] - 3641:24, 3641:25, 3659:27
12 [1] - 3682:23	5	3658:24, 3672:25, 3703:37, 3709:1	actual [1] - 3666:44	advocate [6] - 3675:26, 3684:39, 3684:40, 3684:43, 3685:3, 3687:7
12.12 [1] - 3688:1	5 [7] - 3641:28, 3656:4, 3656:28,	5/6 [1] - 3647:43	acute [1] - 3641:44	advocated [1] - 3686:31
12.12 [1] - 3688:1		50-year [1] - 3642:46	adapt [1] - 3682:11	advocating [4] - 3684:41, 3685:34, 3686:29, 3687:29
121 [1] - 3639:18		500 [1] - 3652:33	addition [1] - 3694:8	affairs [1] - 3703:27
14 [7] - 3639:22, 3651:38, 3652:43, 3653:9, 3653:24, 3653:25, 3683:23			address [2] - 3705:31, 3708:10	affirmed [2] - 3640:13, 3664:18
15 [5] - 3671:7, 3672:47, 3683:23, 3683:26, 3683:28			addressed [1] - 3659:10	
17 [3] - 3668:31, 3668:33, 3668:40			ADHD [2] - 3657:6, 3681:17	
18 [1] - 3668:33			adjourn [4] - 3678:39, 3712:24, 3712:29, 3712:35	
19 [1] - 3642:17				
1960s [1] - 3689:8				
1966 [2] - 3655:14, 3655:16				
1995 [1] - 3674:45				
2				
2 [3] - 3639:18, 3645:22, 3665:5				
2.1 [1] - 3644:8				
2/level [1] - 3648:1				
20 [5] - 3650:32, 3654:20, 3654:23, 3672:13, 3695:5				

<p>after-hours [1] - 3693:41 afternoon [1] - 3643:23 age [2] - 3642:46, 3651:46 aged [1] - 3642:22 Agency [1] - 3641:3 aging [5] - 3642:29, 3642:30, 3675:20, 3675:24, 3675:28 ago [3] - 3654:39, 3666:35, 3707:20 agree [15] - 3651:28, 3654:8, 3655:8, 3655:9, 3655:29, 3656:21, 3656:34, 3659:8, 3675:18, 3675:19, 3686:5, 3691:31, 3700:20, 3703:31, 3708:28 agreed [3] - 3652:16, 3659:9, 3705:40 agreement [7] - 3663:39, 3677:31, 3705:25, 3705:40, 3706:3, 3708:6, 3711:47 agreements [6] - 3702:16, 3703:9, 3705:30, 3706:4, 3706:5, 3707:35 ahead [6] - 3644:7, 3645:19, 3649:43, 3662:18, 3674:33, 3685:37 aim [2] - 3653:23, 3701:33 Alexander [20] - 3654:16, 3657:47, 3669:25, 3672:2, 3672:7, 3676:7, 3692:18, 3694:30, 3695:36, 3696:28, 3697:46, 3698:2, 3698:8, 3698:17, 3698:21, 3698:28, 3699:27, 3699:38, 3710:9, 3710:17 alleviate [1] - 3710:43 allied [4] - 3645:2, 3665:35, 3671:37, 3673:35 allocate [1] - 3686:40 allocated [1] - 3687:7 allocates [1] - 3687:9 allocations [1] - 3683:32 allow [3] - 3646:1, 3658:18, 3682:3</p>	<p>allowed [1] - 3646:20 allows [1] - 3689:43 alluded [4] - 3667:29, 3667:30, 3675:29, 3705:40 alluding [1] - 3705:45 almost [4] - 3648:43, 3655:30, 3696:24, 3698:14 alone [1] - 3668:25 alternatively [1] - 3690:5 amazing [1] - 3694:13 amount [2] - 3642:16, 3680:31 analysis [1] - 3702:26 announced [3] - 3696:36, 3696:37, 3696:38 announcement [4] - 3696:43, 3697:19, 3697:33, 3697:34 answer [18] - 3645:18, 3646:24, 3650:35, 3654:35, 3656:41, 3658:7, 3666:4, 3666:32, 3676:19, 3677:14, 3678:18, 3679:44, 3694:43, 3698:7, 3698:44, 3699:29, 3705:7, 3710:38 answers [8] - 3647:38, 3649:42, 3655:7, 3691:30, 3701:47, 3702:36, 3706:31, 3707:43 anticipated [1] - 3699:21 apologies [1] - 3640:1 apologise [2] - 3676:35, 3682:21 application [1] - 3690:41 applied [1] - 3704:42 applying [1] - 3679:17 appointed [1] - 3696:23 appointing [1] - 3697:39 appointments [1] - 3702:16 appraised [1] - 3696:6 appreciate [2] - 3650:33, 3707:28 approach [12] - 3646:35, 3651:27, 3651:29, 3655:3, 3655:4, 3659:6, 3678:33, 3679:25,</p>	<p>3685:40, 3686:8, 3686:29, 3700:5 approaches [1] - 3694:12 appropriate [14] - 3650:47, 3651:14, 3652:40, 3653:36, 3662:1, 3676:20, 3689:9, 3691:4, 3691:39, 3692:43, 3699:2, 3699:44, 3700:42 appropriately [2] - 3691:14, 3700:45 approved [1] - 3660:22 area [11] - 3641:47, 3642:5, 3661:23, 3666:15, 3684:42, 3689:17, 3690:38, 3701:35, 3707:31, 3708:1, 3709:23 areas [14] - 3641:8, 3641:9, 3642:15, 3660:45, 3661:16, 3661:18, 3661:20, 3661:22, 3661:26, 3673:28, 3682:43, 3685:6, 3685:20, 3693:36 argue [4] - 3694:24, 3694:36, 3701:9, 3704:28 arise [1] - 3683:24 arising [2] - 3710:9, 3710:37 Armidale [1] - 3674:13 arose [1] - 3664:2 arranged [1] - 3661:40 arrangement [2] - 3644:23, 3693:20 arrangements [15] - 3644:16, 3644:21, 3646:24, 3647:16, 3647:30, 3663:39, 3681:31, 3682:28, 3682:29, 3683:1, 3691:39, 3699:43, 3705:31, 3706:32, 3707:46 arrangements" [1] - 3646:39 articulated [2] - 3655:5, 3700:11 aside [2] - 3650:2, 3694:29 aspirational [1] - 3651:33 assess [2] - 3694:5, 3700:41</p>	<p>assessing [5] - 3687:20, 3687:21, 3687:25, 3687:27 assessment [3] - 3657:10, 3698:13, 3703:33 assist [12] - 3640:25, 3664:34, 3669:15, 3670:39, 3682:28, 3685:41, 3686:29, 3688:13, 3700:40, 3704:29, 3707:33, 3710:23 assistance [4] - 3648:4, 3662:32, 3663:2, 3708:6 assisted [2] - 3686:36, 3687:1 Assisting [5] - 3639:26, 3639:27, 3639:28, 3639:29, 3639:30 Associate [1] - 3640:10 associated [1] - 3683:27 assume [1] - 3643:18 astray [1] - 3673:11 AT [2] - 3712:37, 3712:38 attending [1] - 3710:41 attention [1] - 3675:23 attract [2] - 3703:25, 3703:26 August [2] - 3688:31, 3689:31 Australia [1] - 3639:36 authority [1] - 3693:1 authors [1] - 3699:27 availability [2] - 3703:21, 3707:47 available [10] - 3645:26, 3650:20, 3660:2, 3687:23, 3690:13, 3705:28, 3706:6, 3706:35, 3706:36, 3707:9 aware [13] - 3676:2, 3676:6, 3679:41, 3691:13, 3694:31, 3694:35, 3696:42, 3697:21, 3697:24, 3698:2, 3699:38, 3701:44, 3707:8 awareness [1] - 3707:11</p>	<p style="text-align: center;">B</p> <p>babies [1] - 3651:45 baby [1] - 3642:12 bad [1] - 3652:11 barrier [1] - 3653:17 barriers [5] - 3647:27, 3650:2, 3650:4, 3653:8, 3653:12 Base [1] - 3640:22 base [1] - 3706:19 based [9] - 3641:5, 3658:17, 3663:19, 3674:47, 3675:9, 3682:43, 3683:1, 3683:5, 3683:6 baseline [2] - 3682:9, 3682:10 basis [3] - 3660:39, 3677:30, 3692:36 Beasley [1] - 3639:14 became [2] - 3692:7, 3697:35 become [2] - 3654:37, 3671:25 becomes [1] - 3684:23 becoming [2] - 3660:37, 3683:43 bed [2] - 3650:17, 3650:18 beds [2] - 3651:14, 3686:39 beginning [1] - 3684:19 behind [2] - 3682:5, 3694:41 belief [2] - 3640:40, 3688:22 benefit [10] - 3651:28, 3677:24, 3678:19, 3686:8, 3687:5, 3695:23, 3702:38, 3705:2, 3706:3, 3708:9 benefits [2] - 3652:26, 3694:3 bespoke [5] - 3705:42, 3706:32, 3706:38, 3708:6, 3708:27 best [4] - 3640:39, 3688:21, 3704:24, 3709:13 better [35] - 3640:7, 3641:41, 3642:37, 3644:35, 3648:1, 3648:6, 3652:13, 3652:35, 3652:36, 3652:37, 3653:3, 3660:14, 3661:9,</p>
---	--	---	---	---

<p>3661:38, 3661:41, 3662:5, 3662:6, 3662:12, 3681:20, 3685:11, 3687:15, 3690:26, 3693:11, 3694:36, 3698:11, 3704:38, 3705:4, 3705:42, 3708:2, 3708:5, 3708:13, 3709:18, 3709:21, 3709:36, 3710:42</p> <p>between [30] - 3647:31, 3647:44, 3647:47, 3650:46, 3655:3, 3662:25, 3663:39, 3665:31, 3672:1, 3677:30, 3677:31, 3681:43, 3682:35, 3683:2, 3688:31, 3690:25, 3691:37, 3691:39, 3696:5, 3700:26, 3701:34, 3702:15, 3703:5, 3703:9, 3703:14, 3705:24, 3705:41, 3705:47, 3706:33, 3708:6</p> <p>beyond [10] - 3674:16, 3675:46, 3679:39, 3689:34, 3690:3, 3695:1, 3695:36, 3696:10, 3698:10, 3707:33</p> <p>big [1] - 3709:22</p> <p>bigger [2] - 3694:18, 3708:22</p> <p>billion [1] - 3709:1</p> <p>bit [8] - 3641:17, 3641:19, 3644:14, 3648:44, 3652:12, 3653:5, 3659:32, 3666:36</p> <p>bits [1] - 3642:20</p> <p>block [2] - 3711:44, 3712:8</p> <p>blue [2] - 3658:44, 3658:47</p> <p>board [7] - 3686:9, 3693:2, 3694:4, 3696:8, 3696:14, 3696:15, 3698:31</p> <p>bodies [1] - 3659:36</p> <p>body [5] - 3641:24, 3641:25, 3659:22, 3668:42, 3671:12</p> <p>bolt [1] - 3655:37</p> <p>bolt-ons [1] - 3655:37</p> <p>bowel [1] - 3648:13</p> <p>box [1] - 3640:11</p> <p>brain [2] - 3659:40,</p>	<p>3661:46</p> <p>branch [1] - 3688:43</p> <p>break [2] - 3649:37, 3653:19</p> <p>breakdown [2] - 3647:46, 3648:9</p> <p>breaks [2] - 3642:3, 3649:17</p> <p>briefly [1] - 3683:26</p> <p>bring [6] - 3643:9, 3646:37, 3654:19, 3656:40, 3664:46, 3693:19</p> <p>bringing [3] - 3678:33, 3694:10, 3694:18</p> <p>brings [1] - 3676:25</p> <p>broad [2] - 3655:35, 3704:2</p> <p>broadening [1] - 3679:44</p> <p>broader [8] - 3655:30, 3695:44, 3697:4, 3698:3, 3698:16, 3699:12, 3699:14, 3699:42</p> <p>broadly [2] - 3687:8, 3699:45</p> <p>brought [4] - 3640:29, 3688:44, 3690:36, 3692:8</p> <p>budgets [1] - 3642:24</p> <p>build [1] - 3668:15</p> <p>building [8] - 3649:42, 3667:14, 3667:18, 3673:8, 3676:19, 3676:22, 3678:45, 3687:29</p> <p>built [2] - 3671:37, 3711:5</p> <p>bulk [1] - 3688:25</p> <p>bundles [1] - 3711:32</p> <p>burden [1] - 3642:22</p> <p>business [1] - 3683:3</p> <p>BY [3] - 3640:15, 3662:20, 3688:3</p> <p>bypassed [1] - 3709:38</p>	<p>3681:42, 3682:20, 3682:32, 3683:15, 3690:40, 3690:43, 3700:39, 3701:30, 3703:19</p> <p>Capability [2] - 3643:8, 3691:21</p> <p>capable [2] - 3705:20, 3707:10</p> <p>capacity [2] - 3663:10, 3663:12</p> <p>car [1] - 3662:41</p> <p>cardiology [1] - 3677:3</p> <p>cardiothoracic [3] - 3693:23, 3696:45, 3709:12</p> <p>care [199] - 3641:7, 3641:30, 3641:39, 3641:44, 3641:46, 3641:47, 3642:7, 3642:21, 3642:22, 3642:24, 3642:28, 3642:33, 3642:41, 3644:8, 3644:11, 3644:26, 3644:27, 3644:35, 3644:40, 3644:41, 3645:21, 3645:25, 3645:26, 3645:30, 3645:43, 3645:45, 3646:7, 3646:18, 3646:25, 3646:27, 3646:31, 3646:33, 3646:38, 3647:17, 3647:21, 3647:24, 3647:40, 3647:47, 3648:1, 3648:2, 3648:6, 3649:13, 3649:34, 3651:13, 3651:19, 3651:34, 3652:3, 3652:16, 3652:22, 3652:24, 3652:26, 3652:32, 3652:33, 3652:34, 3652:40, 3652:41, 3653:3, 3653:5, 3653:16, 3653:33, 3653:42, 3655:20, 3655:29, 3655:33, 3656:15, 3656:26, 3657:34, 3661:3, 3661:21, 3662:6, 3662:24, 3662:44, 3662:46, 3663:10, 3663:19, 3663:24, 3663:29, 3665:13, 3665:14, 3665:39, 3666:7, 3666:11, 3666:18, 3666:20, 3666:46,</p>	<p>3669:2, 3672:3, 3672:19, 3676:31, 3676:32, 3676:46, 3677:5, 3677:7, 3677:19, 3677:42, 3678:5, 3678:10, 3678:11, 3678:12, 3678:13, 3678:14, 3680:1, 3680:4, 3680:36, 3681:3, 3681:5, 3681:15, 3681:18, 3681:19, 3681:43, 3682:7, 3682:24, 3682:26, 3682:35, 3682:37, 3682:38, 3685:6, 3685:23, 3685:34, 3685:46, 3686:24, 3686:30, 3686:38, 3686:39, 3686:43, 3686:44, 3686:45, 3687:7, 3687:12, 3687:30, 3689:41, 3689:43, 3689:47, 3690:2, 3690:6, 3690:7, 3690:14, 3690:17, 3690:28, 3690:34, 3690:47, 3691:3, 3691:5, 3691:10, 3695:31, 3695:41, 3697:1, 3697:10, 3700:27, 3700:31, 3700:33, 3700:41, 3700:44, 3701:16, 3701:18, 3701:37, 3702:2, 3702:16, 3702:21, 3702:39, 3702:40, 3702:41, 3702:42, 3703:43, 3703:44, 3704:6, 3704:14, 3704:22, 3704:23, 3704:25, 3704:37, 3705:15, 3705:26, 3706:15, 3706:16, 3706:29, 3707:1, 3707:10, 3709:29, 3709:33, 3709:36, 3709:46, 3710:3, 3710:40, 3710:42</p> <p>cared [1] - 3693:32</p> <p>carefully [1] - 3687:14</p> <p>case [9] - 3649:25, 3649:39, 3651:45, 3657:31, 3670:27, 3670:34, 3673:9, 3696:35, 3697:32</p> <p>cases [1] - 3691:7</p> <p>catalyst [1] - 3696:42</p> <p>catch [1] - 3662:40</p>	<p>caused [1] - 3668:35</p> <p>caution [2] - 3704:44, 3704:46</p> <p>ceased [1] - 3689:31</p> <p>cent [3] - 3651:1, 3653:43, 3675:25</p> <p>Central [6] - 3665:34, 3668:24, 3668:42, 3668:44, 3669:6, 3674:31</p> <p>centralised [8] - 3650:36, 3678:47, 3679:6, 3686:46, 3687:1, 3687:6, 3687:9, 3692:37</p> <p>centrally [2] - 3677:24, 3686:21</p> <p>centre [3] - 3644:37, 3652:34, 3673:44</p> <p>centres [3] - 3644:36, 3686:18, 3708:23</p> <p>century [1] - 3703:1</p> <p>certain [5] - 3646:7, 3673:13, 3686:36, 3693:31, 3703:22</p> <p>certainly [12] - 3652:36, 3684:1, 3690:18, 3693:22, 3696:6, 3697:2, 3698:1, 3698:23, 3698:45, 3699:8, 3702:5, 3703:47</p> <p>cetera [5] - 3650:42, 3651:42, 3657:18, 3682:25, 3706:20</p> <p>CFE [1] - 3685:14</p> <p>chair [8] - 3641:3, 3641:21, 3658:15, 3670:9, 3689:29, 3694:4, 3696:8, 3698:31</p> <p>challenge [10] - 3642:32, 3646:44, 3684:22, 3684:35, 3689:9, 3689:12, 3689:44, 3690:14, 3694:20, 3710:1</p> <p>challenges [31] - 3642:6, 3642:40, 3642:42, 3647:37, 3650:38, 3674:38, 3674:39, 3675:10, 3675:15, 3675:19, 3675:20, 3675:24, 3676:23, 3676:25, 3680:38, 3680:47, 3681:2, 3681:7, 3681:8, 3683:24, 3683:27, 3683:33, 3685:6, 3685:38,</p>
<p>C</p>				
<p>Campbelltown [2] - 3702:9, 3702:19</p> <p>cancer [1] - 3663:29</p> <p>cannot [1] - 3660:12</p> <p>capability [19] - 3671:15, 3671:16, 3671:31, 3673:9, 3680:14, 3680:18, 3680:42, 3681:27, 3681:36, 3681:41,</p>				

<p>3685:42, 3690:18, 3694:9, 3705:14, 3705:21, 3706:29, 3706:32 challenging [4] - 3685:14, 3685:18, 3694:27, 3703:26 chambers [2] - 3711:39, 3711:46 chance [2] - 3640:35, 3688:17 change [11] - 3660:37, 3666:33, 3666:40, 3666:44, 3692:15, 3703:20, 3708:11, 3708:25, 3711:7, 3711:13 changed [3] - 3680:36, 3701:43 changes [6] - 3691:46, 3699:10, 3701:43, 3702:20, 3703:21, 3708:18 changing [2] - 3665:29, 3683:5 child [16] - 3648:12, 3649:22, 3649:25, 3649:26, 3651:21, 3652:30, 3653:35, 3657:17, 3688:35, 3688:39, 3688:43, 3690:1, 3694:47, 3697:1, 3700:33, 3710:42 Child [3] - 3665:23, 3691:43, 3705:22 children [50] - 3642:14, 3642:19, 3642:20, 3644:9, 3644:23, 3650:14, 3657:6, 3657:10, 3657:15, 3657:26, 3659:7, 3659:40, 3661:22, 3661:46, 3662:38, 3662:39, 3662:43, 3662:44, 3663:1, 3664:24, 3666:20, 3667:30, 3667:44, 3669:2, 3669:5, 3669:8, 3669:46, 3675:45, 3676:31, 3676:32, 3678:14, 3678:33, 3680:9, 3683:12, 3684:26, 3684:27, 3684:30, 3684:33, 3686:44, 3686:46, 3689:42, 3695:41, 3700:27, 3704:39, 3706:16, 3706:20,</p>	<p>3707:29, 3708:21, 3709:37 Children [23] - 3643:9, 3657:35, 3660:11, 3664:26, 3664:29, 3665:6, 3665:10, 3666:27, 3667:10, 3667:28, 3667:33, 3667:47, 3669:42, 3671:4, 3671:27, 3671:33, 3672:29, 3672:37, 3674:14, 3676:12, 3680:27, 3689:24, 3691:22 children's [75] - 3644:28, 3644:47, 3645:4, 3650:8, 3651:14, 3652:4, 3652:6, 3655:16, 3656:25, 3657:42, 3662:5, 3663:40, 3665:29, 3665:31, 3666:34, 3666:36, 3667:46, 3668:6, 3668:11, 3669:5, 3670:29, 3671:20, 3671:27, 3674:3, 3674:16, 3674:38, 3674:45, 3674:46, 3675:9, 3675:37, 3675:41, 3675:43, 3676:9, 3676:10, 3676:11, 3676:13, 3676:14, 3676:21, 3676:22, 3676:24, 3676:34, 3676:35, 3676:36, 3676:38, 3677:1, 3677:9, 3677:15, 3677:27, 3678:3, 3678:5, 3678:29, 3678:33, 3679:30, 3679:37, 3679:38, 3679:40, 3680:5, 3681:5, 3682:36, 3683:25, 3689:37, 3691:47, 3692:37, 3698:10, 3701:34, 3701:35, 3702:27, 3705:24, 3706:30, 3709:1, 3709:19, 3709:22, 3709:37, 3710:39, 3710:43 Children's [36] - 3662:26, 3665:43, 3665:44, 3665:45, 3668:19, 3668:23, 3668:41, 3668:45, 3668:47, 3669:6, 3671:42, 3673:43, 3674:7, 3674:20,</p>	<p>3674:28, 3674:35, 3674:37, 3674:43, 3675:42, 3676:3, 3676:5, 3676:8, 3683:47, 3690:45, 3692:1, 3692:13, 3692:45, 3693:7, 3698:32, 3701:2, 3702:11, 3703:8, 3708:7, 3709:41, 3710:1, 3710:18 Chiu [1] - 3639:35 chiu [3] - 3662:17, 3687:34, 3710:6 CHIU [9] - 3662:20, 3662:22, 3663:1, 3687:36, 3710:8, 3710:22, 3710:29, 3710:35, 3711:22 chronic [3] - 3642:30, 3665:12, 3706:17 circular [1] - 3684:24 circumstances [5] - 3642:26, 3654:36, 3706:1, 3706:34, 3706:39 cities [1] - 3709:17 city [2] - 3676:11, 3676:13 clarification [1] - 3673:42 clarified [1] - 3710:12 clarity [6] - 3690:31, 3691:32, 3703:13, 3703:30, 3705:47, 3710:19 class [2] - 3645:45, 3646:10 clear [26] - 3644:23, 3645:40, 3648:31, 3648:34, 3649:4, 3649:5, 3649:8, 3649:23, 3653:27, 3655:11, 3655:12, 3655:14, 3658:9, 3658:16, 3660:33, 3660:35, 3660:39, 3663:29, 3678:20, 3701:16, 3701:22, 3702:44, 3704:27, 3705:30, 3710:1, 3712:2 clearer [4] - 3660:37, 3660:40, 3705:28, 3709:44 clearly [7] - 3641:31, 3642:2, 3648:13, 3652:29, 3655:5, 3700:11, 3703:13 climate [1] - 3708:25</p>	<p>Clinical [2] - 3641:3, 3644:8 clinical [14] - 3640:21, 3646:9, 3646:38, 3653:20, 3658:14, 3665:38, 3674:35, 3682:24, 3685:22, 3691:34, 3691:35, 3691:39, 3700:34, 3704:36 clinician [3] - 3641:5, 3662:1, 3690:5 clinician-based [1] - 3641:5 clinicians [15] - 3641:6, 3642:2, 3647:31, 3658:15, 3662:6, 3683:2, 3684:29, 3684:46, 3691:38, 3691:40, 3692:10, 3696:46, 3697:10, 3697:16, 3705:29 clogs [2] - 3652:8, 3652:13 close [9] - 3645:18, 3652:27, 3659:40, 3678:6, 3678:35, 3689:43, 3698:14, 3704:23, 3704:25 closely [1] - 3647:42 closer [2] - 3661:46, 3661:47 co [5] - 3641:3, 3641:21, 3658:15, 3670:9, 3689:29 co-chair [5] - 3641:3, 3641:21, 3658:15, 3670:9, 3689:29 Coast [7] - 3665:33, 3665:34, 3668:24, 3668:42, 3668:45, 3669:6, 3674:31 cognisant [1] - 3679:40 cohesion [1] - 3655:38 cohesive [1] - 3701:18 collaborate [3] - 3648:34, 3649:34, 3676:37 collaborating [1] - 3655:34 collaboration [2] - 3647:46, 3673:30 collaborative [3] - 3647:44, 3651:13, 3653:3 collaboratively [2] - 3677:39, 3679:31</p>	<p>colleagues [7] - 3653:14, 3653:30, 3681:9, 3684:40, 3685:33, 3707:17, 3710:17 colon [1] - 3648:14 coming [12] - 3643:3, 3653:10, 3660:42, 3675:21, 3681:16, 3684:15, 3684:16, 3689:15, 3689:36, 3694:37, 3697:9, 3697:16 commence [1] - 3687:19 commenced [2] - 3696:28, 3698:15 commend [1] - 3703:11 comment [1] - 3651:35 Commission [5] - 3639:7, 3640:25, 3664:35, 3688:13, 3692:34 COMMISSION [1] - 3712:37 commissioned [7] - 3692:41, 3694:4, 3696:22, 3698:38, 3698:42, 3698:43, 3699:1 commissioner [3] - 3640:30, 3640:43, 3660:15 Commissioner [25] - 3639:13, 3640:5, 3643:10, 3643:24, 3650:3, 3654:20, 3662:15, 3664:13, 3664:47, 3669:15, 3687:36, 3687:45, 3688:26, 3693:16, 3705:46, 3708:29, 3709:4, 3710:8, 3711:15, 3711:18, 3711:22, 3711:27, 3711:31, 3712:18, 3712:27 COMMISSIONER [73] - 3640:1, 3640:7, 3640:33, 3640:46, 3643:12, 3643:16, 3643:28, 3643:34, 3643:39, 3643:46, 3644:44, 3645:16, 3646:46, 3647:3, 3648:9, 3650:27, 3653:45, 3654:23, 3654:27, 3654:31,</p>
---	---	--	---	---

<p>3655:40, 3656:8, 3656:34, 3658:24, 3658:28, 3660:18, 3661:37, 3662:17, 3662:43, 3664:2, 3664:7, 3664:16, 3665:2, 3668:9, 3668:18, 3668:23, 3668:30, 3669:11, 3669:18, 3669:24, 3669:32, 3670:13, 3670:41, 3671:47, 3672:15, 3677:46, 3678:39, 3680:47, 3685:13, 3687:34, 3687:38, 3688:28, 3699:33, 3705:36, 3708:4, 3708:45, 3710:6, 3710:12, 3710:25, 3710:32, 3711:12, 3711:20, 3711:24, 3711:35, 3711:41, 3711:46, 3712:6, 3712:10, 3712:15, 3712:20, 3712:24, 3712:29, 3712:35</p> <p>Commissioner's [2] - 3645:19, 3668:16</p> <p>commissioning [3] - 3692:23, 3692:25, 3694:30</p> <p>commissions [1] - 3699:34</p> <p>commitment [2] - 3699:20, 3707:11</p> <p>committed [2] - 3697:21, 3697:24</p> <p>committee [46] - 3641:15, 3657:26, 3657:33, 3657:37, 3658:19, 3659:10, 3659:18, 3659:20, 3659:26, 3659:27, 3659:29, 3660:27, 3660:29, 3660:38, 3661:4, 3661:20, 3661:27, 3661:30, 3667:28, 3668:5, 3669:35, 3669:41, 3669:45, 3670:2, 3670:9, 3670:13, 3670:23, 3670:28, 3670:35, 3671:11, 3671:13, 3671:23, 3672:39, 3673:10, 3673:12, 3673:20, 3680:28, 3680:40, 3681:36, 3683:11, 3683:13, 3689:28,</p>	<p>3697:4, 3704:40, 3707:30</p> <p>Committee [11] - 3657:36, 3660:12, 3666:28, 3667:11, 3667:29, 3667:34, 3669:43, 3671:5, 3672:30, 3680:28, 3689:25</p> <p>committee's [1] - 3673:28</p> <p>committees [9] - 3657:15, 3657:17, 3657:40, 3667:30, 3667:32, 3667:43, 3667:44, 3672:18, 3707:15</p> <p>common [1] - 3644:38</p> <p>communicate [1] - 3658:18</p> <p>communicated [1] - 3699:45</p> <p>communication [5] - 3648:10, 3653:18, 3653:19, 3663:45</p> <p>community [6] - 3659:19, 3678:10, 3680:20, 3684:41, 3687:30, 3699:42</p> <p>comparison [1] - 3698:18</p> <p>compendium [1] - 3701:24</p> <p>compete [1] - 3684:36</p> <p>competition [1] - 3694:25</p> <p>complete [1] - 3705:2</p> <p>completed [1] - 3694:44</p> <p>completely [1] - 3645:9</p> <p>completes [1] - 3711:43</p> <p>complex [4] - 3641:37, 3659:32, 3673:36, 3681:19</p> <p>complexity [1] - 3675:3</p> <p>complicated [1] - 3657:21</p> <p>comply [1] - 3660:2</p> <p>component [1] - 3691:11</p> <p>components [1] - 3711:7</p> <p>concept [3] - 3676:14, 3676:15, 3707:18</p> <p>concepts [4] - 3656:21, 3703:41, 3704:33, 3704:35</p>	<p>concern [3] - 3668:35, 3693:46, 3705:6</p> <p>concerned [1] - 3705:24</p> <p>concerning [1] - 3708:5</p> <p>concerns [2] - 3657:39, 3658:8</p> <p>concluded [1] - 3694:47</p> <p>conclusion [1] - 3647:38</p> <p>conditions [1] - 3706:17</p> <p>confidence [1] - 3706:46</p> <p>confirmed [2] - 3712:15, 3712:17</p> <p>connected [2] - 3655:32, 3656:26</p> <p>connection [2] - 3690:25, 3691:2</p> <p>connections [3] - 3646:11, 3648:26, 3701:37</p> <p>consider [4] - 3677:35, 3682:5, 3698:5, 3698:39</p> <p>consideration [3] - 3673:20, 3676:2, 3696:16</p> <p>considerations [1] - 3676:7</p> <p>considered [2] - 3692:44, 3698:3</p> <p>considering [2] - 3694:44, 3696:2</p> <p>consistency [3] - 3678:26, 3678:28, 3678:31</p> <p>consistent [6] - 3651:40, 3656:35, 3678:26, 3681:24, 3685:16, 3701:47</p> <p>consolidate [1] - 3672:17</p> <p>consolidating [1] - 3693:28</p> <p>constant [1] - 3709:13</p> <p>constantly [1] - 3708:26</p> <p>constituency [1] - 3699:14</p> <p>consult [1] - 3649:21</p> <p>consultant [1] - 3665:38</p> <p>consultation [8] - 3666:42, 3667:1, 3667:20, 3670:47, 3671:7, 3692:26,</p>	<p>3696:45, 3698:16</p> <p>consulted [3] - 3692:26, 3697:19, 3699:26</p> <p>consumes [1] - 3704:47</p> <p>consumption [1] - 3699:41</p> <p>contact [3] - 3649:24, 3650:11, 3650:20</p> <p>contemporaneous [1] - 3706:1</p> <p>context [2] - 3642:33, 3701:2</p> <p>continue [3] - 3655:4, 3678:30, 3686:16</p> <p>continued [1] - 3655:2</p> <p>contradiction [1] - 3655:36</p> <p>contradictions [2] - 3655:19, 3655:24</p> <p>contradictory [1] - 3655:44</p> <p>control [1] - 3651:11</p> <p>convenient [2] - 3678:37, 3711:39</p> <p>conversation [4] - 3651:7, 3651:10, 3660:7, 3697:28</p> <p>conversations [2] - 3679:45, 3679:46</p> <p>coordinate [3] - 3657:8, 3666:19, 3681:20</p> <p>coordinated [11] - 3641:32, 3666:46, 3672:19, 3676:33, 3677:10, 3677:20, 3677:22, 3677:23, 3677:24, 3692:38, 3693:11</p> <p>coordination [1] - 3680:6</p> <p>coordinators [2] - 3667:2, 3673:34</p> <p>copy [3] - 3640:31, 3654:27, 3660:16</p> <p>core [3] - 3656:8, 3656:12, 3700:33</p> <p>correct [32] - 3640:26, 3640:39, 3649:46, 3651:15, 3654:10, 3661:28, 3662:33, 3663:8, 3664:36, 3664:37, 3664:43, 3666:24, 3666:30, 3667:11, 3670:25, 3670:32, 3670:37, 3674:24, 3681:32, 3684:24, 3688:14,</p>	<p>3688:21, 3696:33, 3702:28, 3702:31, 3705:11, 3705:15, 3705:45, 3706:8, 3706:22, 3706:25, 3708:41</p> <p>corrected [1] - 3712:24</p> <p>correctly [2] - 3646:26, 3698:12</p> <p>correspondence [2] - 3696:7, 3698:33</p> <p>cost [1] - 3661:40</p> <p>costing [1] - 3709:1</p> <p>Counsel [5] - 3639:26, 3639:27, 3639:28, 3639:29, 3639:30</p> <p>couple [5] - 3655:18, 3655:23, 3655:36, 3676:30, 3695:47</p> <p>course [8] - 3640:44, 3645:11, 3661:46, 3674:21, 3678:11, 3691:33, 3692:43, 3694:33</p> <p>cover [2] - 3693:39, 3693:41</p> <p>covered [2] - 3685:38, 3702:43</p> <p>covers [1] - 3702:40</p> <p>COVID [1] - 3680:37</p> <p>Craven [8] - 3664:14, 3664:16, 3664:21, 3669:29, 3689:20, 3691:16, 3691:26, 3707:32</p> <p>CRAVEN [1] - 3664:18</p> <p>create [8] - 3642:40, 3672:18, 3691:2, 3691:9, 3693:21, 3701:33, 3701:37, 3707:5</p> <p>created [4] - 3668:25, 3690:18, 3692:9, 3693:46</p> <p>creates [1] - 3683:33</p> <p>creating [1] - 3656:15</p> <p>critical [4] - 3665:14, 3699:8, 3702:4, 3704:37</p> <p>criticality [1] - 3706:43</p> <p>criticism [1] - 3694:1</p> <p>cross [1] - 3702:16</p> <p>cross-appointments [1] - 3702:16</p> <p>culture [1] - 3694:24</p> <p>cultures [1] - 3694:11</p> <p>curiosity [1] - 3708:46</p> <p>current [3] - 3668:39,</p>
--	---	--	---	--

<p>3671:35, 3711:1 CYPF [1] - 3673:44 CYPFESC [3] - 3659:10, 3671:43, 3671:44</p>	<p>3704:1 deliberately [1] - 3655:15 delineate [1] - 3703:31 delineated [1] - 3641:31 delineation [8] - 3644:31, 3645:38, 3645:40, 3678:20, 3700:30, 3701:17, 3701:21, 3701:22 deliver [20] - 3645:26, 3645:31, 3645:45, 3646:6, 3651:23, 3651:34, 3652:32, 3652:34, 3666:7, 3680:2, 3690:7, 3691:5, 3694:27, 3700:42, 3701:18, 3702:44, 3703:2, 3703:44, 3704:3, 3705:34 delivered [20] - 3643:40, 3644:10, 3646:7, 3652:27, 3663:24, 3680:4, 3682:26, 3689:43, 3693:46, 3694:2, 3696:32, 3697:47, 3698:8, 3700:39, 3701:38, 3702:21, 3702:22, 3704:15, 3704:16, 3705:26 delivering [6] - 3655:20, 3655:33, 3690:6, 3696:47, 3707:10, 3708:36 delivery [15] - 3641:7, 3641:30, 3642:7, 3642:32, 3644:41, 3646:18, 3653:41, 3677:42, 3690:34, 3701:15, 3702:39, 3703:42, 3704:37, 3705:14 demand [2] - 3678:13, 3678:16 demographic [1] - 3708:18 demonstrated [1] - 3685:44 denominator [1] - 3644:39 department [7] - 3642:11, 3642:18, 3652:45, 3708:7, 3710:44, 3710:47, 3711:6 Department [1] -</p>	<p>3689:3 department/ministry [1] - 3692:42 departments [2] - 3675:22, 3677:47 deployed [1] - 3705:20 depth [1] - 3690:39 deputy [3] - 3688:32, 3689:15, 3694:46 describe [6] - 3649:45, 3651:40, 3651:42, 3653:9, 3675:15, 3683:26 described [6] - 3650:2, 3654:15, 3676:23, 3692:18, 3694:8, 3705:15 describes [1] - 3647:15 describing [1] - 3647:37 design [1] - 3685:22 designed [4] - 3642:14, 3642:19, 3648:43 desirability [1] - 3708:11 desirable [1] - 3706:6 desire [1] - 3696:10 detail [2] - 3667:4, 3689:18 detailed [3] - 3706:4, 3706:10, 3708:12 determine [1] - 3652:46 determined [1] - 3670:35 determining [2] - 3687:23, 3704:12 develop [3] - 3659:16, 3669:45, 3706:7 developed [4] - 3656:28, 3668:7, 3697:46, 3701:45 developing [5] - 3667:9, 3681:40, 3697:37, 3702:38, 3706:4 development [6] - 3689:38, 3700:39, 3701:32, 3704:44, 3707:31, 3708:32 developmental [2] - 3657:10, 3661:22 developments [1] - 3702:2 devolved [1] - 3673:37 diagram [2] - 3657:21, 3657:25</p>	<p>die [1] - 3712:17 difference [2] - 3704:30, 3704:32 differences [2] - 3672:1, 3672:4 different [25] - 3641:33, 3641:41, 3645:27, 3645:31, 3645:47, 3647:45, 3653:47, 3654:15, 3655:31, 3661:44, 3665:32, 3666:13, 3672:4, 3674:7, 3682:35, 3683:7, 3685:24, 3694:19, 3702:17, 3703:19, 3703:20, 3706:21, 3708:20, 3708:21 differently [1] - 3693:46 difficult [11] - 3641:22, 3650:27, 3651:45, 3657:38, 3658:7, 3675:28, 3678:16, 3684:20, 3684:43, 3685:3, 3703:25 difficulty [1] - 3663:2 direct [4] - 3649:23, 3663:38, 3666:18, 3697:43 directed [1] - 3649:1 direction [6] - 3655:6, 3659:7, 3661:14, 3680:24, 3688:35, 3700:13 directive [1] - 3647:15 directly [7] - 3649:44, 3652:6, 3689:19, 3689:21, 3692:17, 3705:46, 3708:10 director [9] - 3640:21, 3664:24, 3664:26, 3664:29, 3664:31, 3665:5, 3665:7, 3665:8, 3665:15 directorate [1] - 3697:14 directors [1] - 3646:9 disagree [2] - 3702:37, 3704:5 disappeared [1] - 3711:35 disbanded [1] - 3693:5 discuss [5] - 3641:6, 3647:24, 3649:25, 3654:1, 3660:40 discussed [5] - 3653:46, 3674:11, 3683:23, 3685:41,</p>	<p>3709:20 discussing [3] - 3651:40, 3653:46, 3656:36 discussion [7] - 3644:25, 3644:26, 3646:5, 3658:20, 3660:32, 3696:5, 3709:6 discussions [3] - 3641:13, 3650:46, 3689:21 disease [4] - 3642:22, 3642:30, 3648:13, 3665:12 disproportionate [1] - 3681:8 disquiet [3] - 3693:22, 3693:25, 3694:8 disrupted [2] - 3692:2, 3692:15 dissolution [1] - 3688:45 distinct [1] - 3672:26 distinction [2] - 3646:30, 3646:32 district [14] - 3662:25, 3674:2, 3674:3, 3674:4, 3674:21, 3675:5, 3675:46, 3675:47, 3682:30, 3700:27, 3701:10, 3703:22, 3706:14, 3707:46 District [1] - 3664:28 districts [18] - 3663:39, 3665:37, 3671:7, 3671:29, 3671:33, 3689:10, 3690:27, 3700:28, 3700:32, 3700:34, 3700:41, 3701:10, 3701:22, 3702:32, 3703:7, 3703:10, 3703:18, 3705:25 doctor [4] - 3647:24, 3649:2, 3663:3, 3663:19 Doctor [1] - 3687:38 doctors [1] - 3681:4 document [21] - 3643:7, 3644:2, 3644:3, 3644:7, 3645:19, 3645:21, 3645:23, 3645:47, 3646:37, 3646:40, 3647:20, 3654:35, 3655:26, 3660:16, 3681:28, 3681:31, 3682:20, 3682:34,</p>
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<p>3683:15, 3691:25, 3692:20 documentation [6] - 3698:30, 3698:33, 3698:35, 3700:29, 3701:25, 3702:24 documented [3] - 3682:45, 3705:28, 3705:30 documents [4] - 3682:16, 3700:30, 3707:14, 3711:38 domain [1] - 3652:9 done [36] - 3647:11, 3649:33, 3653:5, 3653:22, 3659:1, 3659:13, 3659:15, 3659:18, 3659:43, 3660:44, 3660:47, 3662:9, 3663:13, 3663:15, 3667:9, 3673:2, 3673:13, 3673:17, 3675:22, 3679:8, 3681:12, 3687:27, 3690:19, 3690:40, 3690:42, 3691:12, 3693:18, 3699:36, 3700:38, 3703:12, 3705:23, 3707:7, 3707:45, 3709:39, 3709:47 dot [1] - 3661:12 doubt [1] - 3650:28 down [15] - 3642:3, 3642:34, 3649:17, 3649:37, 3652:33, 3653:19, 3657:14, 3658:31, 3658:47, 3663:44, 3672:15, 3673:4, 3678:46, 3695:7, 3703:36 Dr [20] - 3639:28, 3662:22, 3664:13, 3664:16, 3669:29, 3672:2, 3687:45, 3688:30, 3689:20, 3691:16, 3691:26, 3707:32, 3710:17, 3710:23, 3710:25, 3710:33, 3710:38, 3711:25 draw [3] - 3641:17, 3646:30, 3646:32 drawn [1] - 3651:13 driven [1] - 3708:24 driver [3] - 3694:40, 3702:4, 3702:9 drivers [1] - 3694:32 drives [1] - 3659:6 driving [1] - 3702:5</p>	<p>drop [1] - 3672:15 Dubbo [1] - 3653:37 due [2] - 3640:44, 3703:20 during [3] - 3689:12, 3693:8, 3693:14 dynamic [1] - 3703:27</p> <hr/> <p style="text-align: center;">E</p> <hr/> <p>early [5] - 3661:23, 3670:22, 3675:27, 3675:30, 3675:32 easier [1] - 3663:19 easily [4] - 3648:12, 3649:24, 3691:40, 3701:11 easy [3] - 3654:3, 3662:41, 3690:3 Ed [1] - 3639:26 education [2] - 3666:16, 3683:18 effective [3] - 3686:33, 3695:22, 3706:44 effectively [11] - 3643:25, 3650:14, 3651:24, 3652:30, 3652:35, 3653:9, 3678:25, 3686:20, 3693:13, 3700:43, 3703:34 efficient [1] - 3655:21 efficiently [1] - 3652:17 effort [2] - 3700:40, 3705:1 eight [1] - 3665:9 either [8] - 3643:21, 3648:5, 3648:22, 3662:1, 3665:44, 3666:12, 3669:24, 3709:40 election [1] - 3696:39 electronic [1] - 3650:9 elements [3] - 3657:38, 3680:39, 3703:46 emailing [1] - 3647:25 emergency [8] - 3642:11, 3642:18, 3644:25, 3646:27, 3675:21, 3710:44, 3710:47, 3711:6 emphasis [1] - 3678:5 employ [2] - 3659:42, 3665:35 employed [1] - 3687:14 employs [1] - 3673:33 empowered [2] -</p>	<p>3659:30 enable [5] - 3691:40, 3693:32, 3693:42, 3694:39, 3707:6 enablers [1] - 3707:5 enables [2] - 3690:1, 3691:12 enabling [1] - 3699:19 enact [3] - 3659:34, 3659:35, 3673:39 end [10] - 3658:47, 3660:7, 3665:13, 3676:31, 3676:46, 3679:29, 3679:43, 3680:24, 3686:43, 3688:33 end-of-life [3] - 3665:13, 3676:31, 3676:46 ending [1] - 3680:24 endpiece [1] - 3681:38 ends [2] - 3694:14, 3707:10 enduring [2] - 3706:16, 3706:47 engage [1] - 3663:35 England [10] - 3664:28, 3664:32, 3665:10, 3665:33, 3673:43, 3674:2, 3674:15, 3674:17, 3675:44, 3686:14 enjoy [1] - 3642:36 enshrined [1] - 3704:26 ensure [8] - 3660:1, 3661:14, 3665:39, 3673:17, 3679:30, 3683:15, 3683:16, 3702:21 ensuring [6] - 3673:1, 3682:2, 3682:38, 3682:45, 3683:17, 3709:46 entirely [2] - 3647:32, 3655:29 environment [9] - 3675:38, 3676:25, 3684:36, 3685:15, 3685:19, 3690:43, 3706:35, 3706:37, 3711:2 environments [2] - 3691:9, 3703:27 envisage [1] - 3673:27 envisaged [2] - 3695:2, 3696:21 equally [1] - 3685:33 escalate [9] - 3641:22,</p>	<p>3652:15, 3652:40, 3653:11, 3654:3, 3657:38, 3658:8, 3671:44, 3682:35 escalated [3] - 3658:9, 3700:45, 3707:40 escalation [2] - 3644:22, 3652:46 especially [1] - 3680:37 establish [5] - 3684:17, 3689:4, 3693:1, 3703:47, 3707:20 established [8] - 3666:39, 3670:46, 3674:45, 3693:8, 3701:33, 3704:38, 3707:19, 3710:46 establishes [1] - 3703:13 establishing [3] - 3697:41, 3703:9, 3706:44 establishment [5] - 3692:1, 3692:12, 3692:36, 3702:8, 3702:18 et [5] - 3650:42, 3651:42, 3657:18, 3682:25, 3706:20 everywhere [1] - 3693:37 evidence [27] - 3640:36, 3642:29, 3643:47, 3646:26, 3650:7, 3656:36, 3658:17, 3660:46, 3662:23, 3662:36, 3664:39, 3675:12, 3678:45, 3681:23, 3685:39, 3688:18, 3690:24, 3691:17, 3698:7, 3698:34, 3699:30, 3700:19, 3702:6, 3703:7, 3705:10, 3709:20, 3711:43 evidence-based [1] - 3658:17 evolution [1] - 3701:43 evolved [1] - 3674:43 exactly [2] - 3649:40, 3668:12 eXAMINATION [1] - 3662:20 EXAMINATION [2] - 3640:15, 3688:3 examine [1] - 3644:34</p>	<p>example [13] - 3648:10, 3648:12, 3659:37, 3661:45, 3662:30, 3686:13, 3689:24, 3705:22, 3705:23, 3705:43, 3709:12, 3710:40 examples [4] - 3642:10, 3673:8, 3676:27, 3706:28 excellence [1] - 3695:29 excellent [4] - 3677:29, 3679:13, 3681:15, 3685:46 excused [2] - 3664:7, 3711:25 executive [16] - 3657:33, 3664:23, 3664:26, 3664:29, 3664:30, 3665:7, 3665:8, 3665:14, 3668:5, 3675:39, 3683:12, 3689:28, 3692:10, 3696:14, 3704:40, 3707:29 Executive [11] - 3657:35, 3660:11, 3666:28, 3667:10, 3667:29, 3667:34, 3669:42, 3671:5, 3672:29, 3680:27, 3689:25 executives [1] - 3642:36 exercise [1] - 3673:9 exist [14] - 3657:27, 3667:36, 3667:37, 3671:35, 3671:40, 3682:4, 3682:11, 3690:25, 3700:31, 3701:40, 3701:41, 3702:32, 3707:22 existed [3] - 3689:7, 3694:11, 3699:44 existence [1] - 3667:41 existing [2] - 3672:17, 3702:27 exists [4] - 3657:39, 3690:39, 3693:34, 3707:16 expand [1] - 3668:41 expanded [1] - 3668:24 expansion [1] - 3710:18 expansive [1] - 3695:10 expectation [1] -</p>
---	---	--	---	---

<p>3684:47 expectations [2] - 3651:30, 3684:46 experience [2] - 3700:3, 3706:43 expert [1] - 3654:34 expertise [1] - 3690:12 explain [2] - 3683:40, 3710:30 explore [7] - 3669:29, 3679:4, 3685:39, 3706:27, 3710:13, 3710:20, 3710:33 exploring [1] - 3670:44 express [2] - 3669:21, 3704:44 expressed [2] - 3697:2, 3697:7 expressing [1] - 3705:5 extended [2] - 3698:9, 3698:22 extent [5] - 3650:45, 3654:44, 3662:9, 3674:19, 3698:9 extra [2] - 3662:2, 3712:30 extremely [4] - 3655:21, 3675:28, 3684:2, 3684:29</p>	<p>factor [1] - 3702:5 fair [3] - 3673:24, 3673:25, 3685:5 fairly [2] - 3641:47, 3643:41 familiar [10] - 3644:4, 3646:41, 3646:42, 3654:15, 3654:36, 3654:37, 3656:6, 3656:19, 3660:23, 3692:20 families [13] - 3642:17, 3652:20, 3652:22, 3652:38, 3664:24, 3666:20, 3667:31, 3667:45, 3669:47, 3693:4, 3704:24, 3704:40, 3707:29 Families [21] - 3657:35, 3660:11, 3664:27, 3664:30, 3665:6, 3665:11, 3666:28, 3667:10, 3667:28, 3667:34, 3668:1, 3669:42, 3671:5, 3671:28, 3671:34, 3672:29, 3672:37, 3674:15, 3680:27, 3683:12, 3689:25 family [14] - 3648:26, 3652:36, 3657:15, 3657:18, 3657:27, 3659:8, 3680:9, 3688:35, 3688:40, 3688:43, 3688:45, 3691:11, 3694:47 far [5] - 3656:36, 3694:31, 3708:8, 3708:27, 3711:15 fashion [1] - 3665:39 fault [1] - 3650:28 FD [1] - 3661:47 feasible [1] - 3709:9 February [4] - 3696:35, 3697:20, 3697:33, 3699:21 fed [1] - 3673:20 feed [1] - 3647:38 feedback [3] - 3642:17, 3697:16, 3699:10 feet [1] - 3709:35 felt [1] - 3710:41 few [8] - 3640:2, 3643:26, 3654:46, 3686:18, 3690:15, 3690:23, 3690:35, 3696:24</p>	<p>field [1] - 3693:35 filtering [1] - 3673:4 finalised [1] - 3667:20 finalising [1] - 3711:31 financial [4] - 3675:8, 3685:6, 3685:14, 3685:18 first [17] - 3640:10, 3644:14, 3647:10, 3647:19, 3652:44, 3652:47, 3653:1, 3653:2, 3653:10, 3653:38, 3655:2, 3658:43, 3659:5, 3660:31, 3680:40, 3682:24, 3696:28 firstly [2] - 3661:18, 3704:22 fits [1] - 3656:31 five [7] - 3652:21, 3654:39, 3667:32, 3667:36, 3667:37, 3667:42 fix [2] - 3685:26, 3704:9 flexibility [1] - 3646:20 flow [1] - 3675:21 focus [16] - 3642:21, 3642:27, 3655:28, 3655:33, 3656:26, 3659:7, 3659:19, 3660:45, 3661:6, 3675:33, 3690:28, 3690:36, 3692:7, 3692:8, 3692:9, 3692:14 focused [5] - 3642:1, 3642:6, 3675:17, 3680:29, 3692:31 focusing [3] - 3661:10, 3680:3, 3688:39 follow [1] - 3646:44 followed [1] - 3705:10 following [5] - 3665:46, 3666:42, 3669:16, 3670:30, 3688:44 follows [2] - 3657:22, 3711:17 fore [1] - 3696:20 form [5] - 3640:43, 3649:39, 3674:36, 3676:4, 3688:25 formal [11] - 3657:26, 3679:34, 3682:14, 3698:29, 3698:33, 3698:35, 3698:40, 3699:3, 3699:19,</p>	<p>3699:23, 3699:30 formalised [3] - 3679:6, 3680:5, 3682:42 formalising [3] - 3680:13, 3682:44, 3683:8 formed [1] - 3666:43 forming [2] - 3657:33, 3659:10 forthcoming [1] - 3671:26 forward [1] - 3696:3 four [1] - 3654:39 fourth [1] - 3661:12 framed [1] - 3666:4 framework [11] - 3671:16, 3680:15, 3680:18, 3680:42, 3683:15, 3683:18, 3683:19, 3700:40, 3701:30 Fraser [1] - 3639:29 free [2] - 3689:35, 3710:13 frequently [1] - 3699:33 Friday [1] - 3639:22 friend [1] - 3647:23 front [2] - 3684:16, 3704:7 frustrating [5] - 3641:20, 3651:21, 3651:24, 3684:29, 3684:45 frustration [1] - 3641:17 FTE [1] - 3684:6 full [3] - 3640:17, 3664:20, 3688:5 Fuller [1] - 3639:30 function [10] - 3659:23, 3659:24, 3660:1, 3660:28, 3660:30, 3666:27, 3666:40, 3670:22, 3673:16, 3673:29 functions [3] - 3666:45, 3670:22, 3672:33 funded [7] - 3674:4, 3675:40, 3676:33, 3676:37, 3686:1, 3686:42 Funding [1] - 3639:9 funding [2] - 3642:40, 3642:42, 3661:47, 3662:2, 3675:44, 3676:45, 3677:37, 3683:27,</p>	<p>3683:32, 3684:14, 3684:16, 3684:37, 3685:31, 3685:32, 3686:30, 3686:32, 3686:37, 3687:2, 3687:10, 3687:29 funds [2] - 3686:40, 3699:2 future [4] - 3667:19, 3668:46, 3681:6, 3681:13</p>
F		G		
<p>faces [1] - 3706:29 facilitate [2] - 3646:11, 3651:27 facilitated [5] - 3646:4, 3646:17, 3663:38, 3663:41, 3663:45 facilities [13] - 3644:42, 3645:33, 3645:34, 3645:40, 3646:2, 3646:9, 3646:11, 3659:42, 3662:46, 3663:11, 3678:21, 3678:22, 3679:35 facility [8] - 3650:9, 3662:31, 3662:35, 3676:24, 3683:25, 3702:26, 3702:30 facing [3] - 3675:19, 3675:24, 3680:38 fact [7] - 3674:27, 3684:35, 3692:15, 3693:26, 3693:37, 3701:20, 3701:41</p>				<p>G105 [1] - 3688:17 G106 [1] - 3643:10 G17 [1] - 3654:20 G33 [1] - 3640:31 G95 [1] - 3664:47 gaps [4] - 3671:40, 3680:16, 3682:4, 3682:11 Garling [2] - 3709:4 Garling's [1] - 3693:16 gastroenterologist [2] - 3648:18, 3653:4 gastroenterology [4] - 3650:11, 3677:3, 3679:21, 3679:23 gear [3] - 3647:41, 3647:42, 3647:43 gearbox [1] - 3647:41 gender [3] - 3676:30, 3676:45, 3686:43 general [15] - 3650:46, 3651:41, 3653:10, 3653:12, 3653:27, 3662:25, 3677:8, 3680:19, 3683:43, 3690:14, 3690:19, 3691:7, 3695:39, 3703:25, 3706:13 generalist [1] - 3691:7 generally [5] - 3642:22, 3647:22, 3693:35, 3695:6, 3696:20 generate [2] - 3684:11, 3684:13 genesis [1] - 3697:4 genuinely [1] - 3646:5 given [11] - 3651:4, 3655:8, 3691:30, 3694:10, 3699:5, 3699:20, 3699:24, 3699:26, 3702:36, 3704:21, 3706:31 glad [1] - 3640:5 Glover [3] - 3639:27, 3653:46, 3656:36</p>

<p>GLOVER [71] - 3640:5, 3640:10, 3640:15, 3640:17, 3640:35, 3640:43, 3641:1, 3643:14, 3643:21, 3644:2, 3645:14, 3645:18, 3647:1, 3647:6, 3649:42, 3650:35, 3654:14, 3654:25, 3654:29, 3654:33, 3656:2, 3656:17, 3656:39, 3658:26, 3658:30, 3660:21, 3662:14, 3664:13, 3664:20, 3665:4, 3668:15, 3668:21, 3668:28, 3668:33, 3669:15, 3669:20, 3669:29, 3669:34, 3670:16, 3670:20, 3670:39, 3670:43, 3672:13, 3672:43, 3678:18, 3678:37, 3678:44, 3681:26, 3685:18, 3687:32, 3687:45, 3688:3, 3688:5, 3688:25, 3688:30, 3700:1, 3706:27, 3708:31, 3708:43, 3710:37, 3711:17, 3711:31, 3711:37, 3711:43, 3712:2, 3712:8, 3712:13, 3712:17, 3712:22, 3712:27, 3712:33</p> <p>goal [1] - 3680:25</p> <p>governance [15] - 3658:31, 3658:37, 3673:37, 3674:35, 3680:9, 3691:47, 3695:22, 3696:15, 3698:10, 3699:7, 3699:43, 3700:6, 3704:39, 3710:15, 3710:18</p> <p>governing [1] - 3694:6</p> <p>government [3] - 3696:38, 3699:33, 3699:35</p> <p>GP [2] - 3653:16, 3653:30</p> <p>GPs [7] - 3651:44, 3652:1, 3652:5, 3652:44, 3653:9, 3653:27, 3678:25</p> <p>grab [1] - 3650:32</p> <p>grandparents [1] - 3652:31</p>	<p>grateful [3] - 3664:3, 3687:39, 3711:25</p> <p>gravitating [1] - 3708:22</p> <p>great [3] - 3652:26, 3675:39, 3678:13</p> <p>greater [3] - 3642:16, 3687:6</p> <p>gritty [1] - 3706:10</p> <p>ground [2] - 3703:15, 3705:29</p> <p>group [2] - 3689:27, 3697:42</p> <p>grouped [1] - 3676:12</p> <p>grow [1] - 3684:19</p> <p>growing [2] - 3683:34, 3684:22</p> <p>grown [3] - 3674:46, 3684:1, 3690:39</p> <p>growth [2] - 3675:25, 3683:30</p> <p>guarding [1] - 3704:46</p> <p>guess [2] - 3680:34, 3682:31</p> <p>guidance [2] - 3660:33, 3708:31</p> <p>guideline [1] - 3645:38</p> <p>Guideline [1] - 3691:22</p> <p>Guideline" [1] - 3643:9</p> <p>guidelines [3] - 3659:16, 3666:15, 3700:43</p> <p>guiding [1] - 3677:32</p> <p>guy [1] - 3649:9</p>	<p>Health [10] - 3639:35, 3639:36, 3664:28, 3665:23, 3671:34, 3671:36, 3689:3, 3691:44, 3692:40, 3705:22</p> <p>health [70] - 3641:38, 3641:39, 3641:47, 3642:13, 3642:21, 3642:24, 3642:28, 3642:44, 3644:40, 3645:2, 3647:40, 3649:13, 3649:22, 3652:22, 3652:37, 3655:16, 3657:34, 3659:8, 3661:3, 3663:17, 3665:11, 3665:36, 3665:37, 3666:11, 3667:46, 3671:7, 3671:8, 3671:29, 3671:33, 3671:37, 3671:45, 3672:47, 3673:35, 3674:2, 3674:3, 3674:4, 3675:5, 3675:45, 3675:47, 3680:36, 3681:19, 3685:6, 3685:13, 3687:12, 3688:10, 3688:32, 3688:35, 3688:40, 3688:42, 3688:44, 3689:11, 3689:37, 3689:39, 3690:27, 3694:16, 3694:47, 3697:1, 3700:32, 3700:33, 3700:34, 3701:9, 3701:10, 3701:36, 3702:45, 3703:7, 3706:20, 3708:20, 3708:21, 3709:13</p> <p>healthcare [11] - 3665:29, 3665:31, 3666:36, 3668:6, 3668:11, 3668:19, 3670:29, 3674:16, 3675:4, 3675:43, 3678:27</p> <p>Healthcare [7] - 3639:9, 3668:1, 3668:23, 3668:41, 3669:6, 3671:28, 3671:43</p> <p>hear [1] - 3710:25</p> <p>heard [15] - 3642:29, 3675:2, 3675:15, 3689:8, 3689:12, 3689:41, 3690:15, 3690:46, 3694:34, 3700:19, 3702:6,</p>	<p>3703:7, 3705:14, 3706:12, 3706:41</p> <p>hearing [3] - 3689:13, 3711:44, 3712:8</p> <p>heart [1] - 3649:44</p> <p>heavily [1] - 3683:1</p> <p>heightened [2] - 3684:35, 3702:1</p> <p>held [2] - 3641:14, 3688:32</p> <p>hell [1] - 3642:18</p> <p>help [4] - 3649:9, 3651:47, 3671:34, 3677:38</p> <p>helpful [8] - 3650:12, 3650:15, 3650:23, 3650:42, 3651:5, 3657:34, 3657:37, 3657:45</p> <p>Henry [39] - 3654:43, 3656:39, 3657:14, 3659:5, 3665:46, 3666:23, 3667:14, 3667:39, 3668:9, 3668:12, 3668:15, 3668:42, 3669:12, 3669:16, 3669:22, 3669:26, 3669:34, 3670:24, 3670:28, 3670:31, 3672:27, 3673:3, 3680:29, 3680:30, 3680:34, 3681:16, 3689:26, 3691:44, 3696:23, 3696:36, 3696:37, 3697:35, 3697:39, 3697:40, 3697:45, 3698:16, 3709:6, 3710:10, 3710:14</p> <p>Henry's [1] - 3698:4</p> <p>heretofore [1] - 3652:14</p> <p>high [8] - 3661:22, 3661:23, 3665:39, 3666:46, 3704:3, 3704:32, 3704:35, 3705:38</p> <p>high-level [2] - 3704:32, 3704:35</p> <p>high-quality [2] - 3665:39, 3666:46</p> <p>higher [6] - 3645:4, 3645:43, 3658:19, 3682:38, 3689:47, 3704:8</p> <p>highlighted [1] - 3690:23</p> <p>highly [5] - 3656:26, 3662:44, 3690:42, 3709:10, 3709:23</p> <p>Hilbert [1] - 3639:35</p>	<p>hindsight [1] - 3698:38</p> <p>historical [2] - 3676:39, 3677:23</p> <p>historically [3] - 3677:2, 3681:12, 3693:27</p> <p>history [2] - 3674:42, 3694:22</p> <p>hmm [2] - 3640:27, 3673:45</p> <p>home [9] - 3652:27, 3652:32, 3652:33, 3659:41, 3661:46, 3661:47, 3678:6, 3678:35, 3704:24</p> <p>hope [1] - 3675:16</p> <p>hopefully [1] - 3645:7</p> <p>Hospital [15] - 3640:22, 3665:43, 3665:44, 3665:45, 3668:45, 3673:43, 3674:20, 3674:28, 3674:35, 3674:37, 3674:43, 3676:3, 3676:12, 3683:47, 3709:41</p> <p>hospital [55] - 3642:10, 3644:24, 3644:28, 3645:4, 3646:38, 3649:21, 3649:26, 3649:27, 3649:28, 3651:14, 3652:4, 3652:30, 3653:4, 3655:28, 3662:5, 3663:19, 3663:40, 3674:3, 3674:38, 3674:44, 3674:47, 3675:1, 3675:9, 3675:37, 3675:41, 3676:10, 3676:11, 3676:13, 3676:21, 3676:34, 3678:29, 3679:37, 3681:5, 3681:31, 3682:25, 3682:36, 3684:18, 3692:36, 3693:17, 3700:44, 3701:28, 3701:35, 3702:27, 3702:33, 3702:40, 3705:24, 3709:1, 3709:5, 3709:19, 3709:22, 3709:26, 3709:37, 3710:39</p> <p>Hospitals [15] - 3668:47, 3674:7, 3675:42, 3676:5, 3676:8, 3690:45,</p>
<p>H</p>		<p>halfway [3] - 3657:14, 3658:30, 3678:46</p> <p>hand [4] - 3653:2, 3653:20, 3660:19</p> <p>hand-over [1] - 3653:20</p> <p>handed [1] - 3696:15</p> <p>happy [2] - 3649:33, 3710:25</p> <p>hard [2] - 3640:31, 3660:16</p> <p>Hazzard [2] - 3696:36, 3697:20</p> <p>head [1] - 3649:20</p> <p>headed [1] - 3658:44</p> <p>heading [5] - 3657:15, 3658:30, 3667:21, 3667:22, 3668:18</p> <p>heads [3] - 3677:31, 3705:40, 3706:3</p>	<p>Healthcare [7] - 3639:9, 3668:1, 3668:23, 3668:41, 3669:6, 3671:28, 3671:43</p> <p>hear [1] - 3710:25</p> <p>heard [15] - 3642:29, 3675:2, 3675:15, 3689:8, 3689:12, 3689:41, 3690:15, 3690:46, 3694:34, 3700:19, 3702:6,</p>	<p>high [8] - 3661:22, 3661:23, 3665:39, 3666:46, 3704:3, 3704:32, 3704:35, 3705:38</p> <p>high-level [2] - 3704:32, 3704:35</p> <p>high-quality [2] - 3665:39, 3666:46</p> <p>higher [6] - 3645:4, 3645:43, 3658:19, 3682:38, 3689:47, 3704:8</p> <p>highlighted [1] - 3690:23</p> <p>highly [5] - 3656:26, 3662:44, 3690:42, 3709:10, 3709:23</p> <p>Hilbert [1] - 3639:35</p>

<p>3692:1, 3692:45, 3693:7, 3698:32, 3701:2, 3702:11, 3708:7, 3710:1, 3710:18</p> <p>hospitals [51] - 3642:19, 3647:33, 3652:10, 3655:3, 3655:32, 3655:36, 3656:25, 3657:7, 3657:43, 3662:5, 3662:27, 3663:33, 3671:20, 3676:9, 3676:15, 3676:22, 3676:35, 3676:36, 3676:38, 3677:1, 3677:9, 3677:15, 3677:27, 3677:43, 3677:47, 3678:3, 3678:5, 3678:34, 3679:31, 3679:38, 3679:40, 3680:5, 3680:6, 3684:18, 3691:47, 3692:8, 3692:13, 3693:11, 3693:38, 3694:10, 3694:23, 3694:38, 3700:7, 3701:34, 3702:34, 3703:8, 3706:30, 3709:33, 3709:38, 3710:43</p> <p>hospitals' [1] - 3652:6</p> <p>host [1] - 3665:22</p> <p>hosted [2] - 3665:42, 3665:43</p> <p>hostile [1] - 3642:13</p> <p>hours [5] - 3642:17, 3652:21, 3684:4, 3693:38, 3693:41</p> <p>huge [1] - 3694:15</p> <p>hundred [2] - 3651:1, 3653:43</p> <p>Hunter [21] - 3664:28, 3664:32, 3665:9, 3665:33, 3665:42, 3668:45, 3673:43, 3674:1, 3674:15, 3674:16, 3674:20, 3674:28, 3674:34, 3674:44, 3675:44, 3676:3, 3683:47, 3686:14, 3692:14, 3701:35</p> <p>Hunter's [1] - 3674:43</p>	<p>ideal [2] - 3657:33, 3671:41</p> <p>ideally [1] - 3662:31</p> <p>ideas [2] - 3641:20, 3641:22</p> <p>identification [3] - 3701:7, 3707:44, 3708:35</p> <p>identified [9] - 3653:23, 3661:18, 3661:20, 3661:26, 3665:5, 3667:32, 3671:4, 3671:13, 3672:28</p> <p>identifies [2] - 3645:21, 3651:29</p> <p>identify [3] - 3651:3, 3682:4, 3695:22</p> <p>identifying [5] - 3649:19, 3671:17, 3671:29, 3682:34, 3704:14</p> <p>immediate [1] - 3670:22</p> <p>immense [1] - 3642:16</p> <p>immunology [2] - 3677:3, 3679:23</p> <p>implement [4] - 3671:31, 3672:46, 3673:36, 3699:36</p> <p>implementation [8] - 3657:1, 3658:20, 3669:35, 3669:41, 3669:45, 3670:23, 3670:27, 3689:27</p> <p>implemented [1] - 3689:38</p> <p>implementing [1] - 3650:38</p> <p>important [23] - 3641:29, 3641:36, 3641:40, 3642:1, 3644:29, 3644:32, 3651:36, 3655:21, 3662:4, 3675:26, 3679:30, 3680:16, 3680:17, 3682:47, 3683:9, 3684:17, 3684:26, 3687:26, 3690:11, 3691:11, 3700:24, 3700:25, 3702:19</p> <p>importantly [1] - 3692:8</p> <p>impossible [2] - 3684:32, 3709:15</p> <p>impractical [1] - 3650:7</p> <p>impression [2] - 3682:1, 3705:36</p>	<p>improve [1] - 3652:32</p> <p>improved [1] - 3643:4</p> <p>improvement [1] - 3666:16</p> <p>improvements [2] - 3677:26, 3679:5</p> <p>improving [2] - 3682:39, 3695:30</p> <p>incentives [1] - 3663:17</p> <p>include [3] - 3651:18, 3668:24, 3668:41</p> <p>included [3] - 3650:17, 3688:34, 3703:42</p> <p>includes [2] - 3677:42, 3701:16</p> <p>including [7] - 3641:10, 3651:14, 3695:28, 3696:46, 3702:2, 3708:20, 3708:25</p> <p>incorporate [1] - 3703:47</p> <p>incorporates [1] - 3665:32</p> <p>incorporating [2] - 3665:34, 3669:5</p> <p>increase [2] - 3642:30, 3684:23</p> <p>increased [4] - 3683:31, 3690:15, 3690:18, 3702:3</p> <p>increasing [4] - 3642:15, 3642:29, 3686:40, 3690:16</p> <p>increasingly [1] - 3703:24</p> <p>incredible [1] - 3680:31</p> <p>incredibly [4] - 3644:29, 3662:38, 3662:43, 3694:27</p> <p>incremental [1] - 3683:33</p> <p>incrementally [1] - 3684:2</p> <p>indeed [1] - 3640:23</p> <p>independent [1] - 3659:36</p> <p>indicate [1] - 3696:40</p> <p>indicated [1] - 3654:34</p> <p>indicating [3] - 3696:9, 3699:4, 3699:35</p> <p>Indigenous [1] - 3661:21</p> <p>indistinct [1] - 3659:16</p>	<p>individual [4] - 3646:2, 3648:7, 3707:45, 3708:26</p> <p>individually [1] - 3708:13</p> <p>individuals [2] - 3643:24, 3707:2</p> <p>inefficient [1] - 3652:7</p> <p>inevitably [1] - 3690:44</p> <p>infants [2] - 3644:9, 3682:25</p> <p>inflammation [1] - 3648:14</p> <p>inflammatory [1] - 3648:13</p> <p>informal [2] - 3661:33, 3679:36</p> <p>information [1] - 3654:41</p> <p>informed [1] - 3643:23</p> <p>infrastructure [1] - 3709:8</p> <p>initial [3] - 3672:7, 3688:47, 3695:2</p> <p>initiated [2] - 3696:25, 3697:15</p> <p>injuries [2] - 3659:40, 3661:46</p> <p>Innovation's [1] - 3641:3</p> <p>inpatient [2] - 3702:8, 3702:18</p> <p>Inquiry [2] - 3639:7, 3692:35</p> <p>INQUIRY [1] - 3712:37</p> <p>instance [10] - 3641:11, 3642:11, 3645:31, 3645:44, 3658:3, 3658:5, 3658:14, 3659:32, 3663:28, 3689:20</p> <p>instruments [2] - 3660:36, 3660:39</p> <p>integrated [1] - 3666:46</p> <p>integration [1] - 3695:30</p> <p>intending [1] - 3701:13</p> <p>intensive [5] - 3662:46, 3677:19, 3686:38, 3686:39</p> <p>intent [1] - 3695:41</p> <p>inter [4] - 3646:38, 3681:31, 3682:25, 3700:44</p> <p>inter-hospital [4] - 3646:38, 3681:31, 3682:25, 3700:44</p>	<p>interested [1] - 3644:36</p> <p>interesting [1] - 3663:17</p> <p>interfere [2] - 3691:35, 3691:36</p> <p>interfering [1] - 3691:33</p> <p>interhospital [1] - 3644:9</p> <p>internal [3] - 3644:7, 3645:20, 3694:24</p> <p>internationally [1] - 3693:28</p> <p>interrupt [1] - 3643:46</p> <p>interrupted [1] - 3645:7</p> <p>intervene [1] - 3675:30</p> <p>intervention [3] - 3661:23, 3675:27, 3675:32</p> <p>introduced [2] - 3676:29, 3679:10</p> <p>investigating [1] - 3656:47</p> <p>Investigation [1] - 3641:8</p> <p>investigations [2] - 3641:13, 3648:18</p> <p>investigative [1] - 3645:2</p> <p>investing [1] - 3683:34</p> <p>investment [2] - 3642:46</p> <p>involve [5] - 3647:21, 3647:25, 3647:26, 3680:2</p> <p>involved [24] - 3654:40, 3654:44, 3658:4, 3658:16, 3666:7, 3689:19, 3689:21, 3689:27, 3690:5, 3692:23, 3692:25, 3692:27, 3696:4, 3696:47, 3697:10, 3697:17, 3697:28, 3697:37, 3697:38, 3697:40, 3697:41, 3699:10, 3705:3</p> <p>involvement [6] - 3656:42, 3656:46, 3688:46, 3689:1, 3697:35, 3706:15</p> <p>involving [1] - 3658:2</p> <p>inward [1] - 3692:9</p> <p>inward-looking [1] - 3692:9</p>
I				
<p>Ian [1] - 3639:29</p> <p>idea [2] - 3692:10, 3712:10</p>				

<p>isolated [1] - 3655:47 Issue [1] - 3658:43 issue [18] - 3654:2, 3655:17, 3662:40, 3689:36, 3690:24, 3692:17, 3694:33, 3696:18, 3696:46, 3699:8, 3699:17, 3701:1, 3703:17, 3704:37, 3708:4, 3709:34, 3710:15, 3710:38 issues [23] - 3641:6, 3642:13, 3654:1, 3658:8, 3659:28, 3660:44, 3661:2, 3671:17, 3680:35, 3689:7, 3689:17, 3693:29, 3694:29, 3698:22, 3703:18, 3704:4, 3704:41, 3705:5, 3705:7, 3705:10, 3705:32, 3707:38, 3711:37 itself [4] - 3659:34, 3696:32, 3703:28, 3705:34</p>	<p style="text-align: center;">K</p> <p>keep [7] - 3646:9, 3646:10, 3650:33, 3679:24, 3685:14, 3687:26 keeping [1] - 3678:34 key [2] - 3680:47, 3702:14 kids [2] - 3688:45, 3693:3 kids' [10] - 3647:32, 3652:10, 3653:4, 3655:28, 3655:32, 3655:36, 3662:5, 3663:19, 3663:29, 3663:32 kind [2] - 3641:13, 3641:14 kinds [1] - 3708:18 knowing [1] - 3645:46 knowledge [5] - 3640:39, 3688:21, 3689:35, 3690:39, 3707:11 KPIs [1] - 3675:7</p>	<p>3665:16, 3665:35, 3665:36, 3665:37 learn [1] - 3679:16 learnt [1] - 3679:38 least [3] - 3649:21, 3672:26, 3708:25 leave [2] - 3646:23, 3703:22 leaving [2] - 3689:15, 3708:23 led [1] - 3689:38 left [1] - 3689:22 less [5] - 3642:23, 3642:26, 3648:1, 3660:39, 3663:1 letter [1] - 3698:30 Level [1] - 3639:18 level [56] - 3644:35, 3644:45, 3644:46, 3645:3, 3645:25, 3645:32, 3645:43, 3646:7, 3646:11, 3646:28, 3647:47, 3648:1, 3648:2, 3648:6, 3653:23, 3653:29, 3653:34, 3655:28, 3657:7, 3657:33, 3658:1, 3674:8, 3674:12, 3674:19, 3675:5, 3677:9, 3678:21, 3681:42, 3681:46, 3682:32, 3682:37, 3682:38, 3685:45, 3689:18, 3690:20, 3698:23, 3698:25, 3701:24, 3702:16, 3703:19, 3703:23, 3704:3, 3704:8, 3704:29, 3704:32, 3704:35, 3705:38, 3707:5, 3707:23, 3707:45, 3707:47, 3708:12 levels [8] - 3645:21, 3645:33, 3645:34, 3645:38, 3681:43, 3689:47, 3695:31, 3700:31 LHD [38] - 3658:3, 3659:44, 3660:4, 3665:19, 3665:20, 3665:34, 3671:30, 3673:2, 3673:5, 3673:36, 3673:38, 3673:43, 3673:47, 3674:9, 3674:36, 3675:1, 3675:10, 3675:34, 3675:38, 3675:40, 3676:4,</p>	<p>3676:25, 3683:25, 3684:36, 3684:38, 3685:1, 3686:15, 3686:17, 3705:43, 3706:5, 3706:21, 3706:33, 3708:13 LHDs [15] - 3658:2, 3659:35, 3659:36, 3659:42, 3660:1, 3665:32, 3666:13, 3672:47, 3673:30, 3678:1, 3702:41, 3702:42, 3702:43, 3703:44, 3705:41 life [5] - 3665:13, 3675:31, 3676:31, 3676:46, 3686:43 likely [1] - 3699:22 limitation [1] - 3645:37 limitations [2] - 3645:46 limited [4] - 3666:10, 3674:21, 3686:19, 3710:39 limiting [1] - 3703:44 lines [2] - 3656:28, 3670:46 linked [4] - 3643:42, 3644:16, 3682:27, 3686:23 linking [1] - 3693:12 links [2] - 3701:34, 3702:27 Lismore [1] - 3706:37 list [3] - 3661:19, 3677:4, 3679:23 listening [1] - 3690:24 listing [1] - 3678:14 live [6] - 3643:29, 3643:32, 3643:37, 3652:23, 3689:44, 3704:25 load [1] - 3651:45 Local [1] - 3664:28 local [30] - 3644:16, 3651:24, 3652:1, 3653:31, 3665:37, 3669:3, 3671:7, 3671:29, 3671:32, 3673:2, 3674:2, 3674:4, 3674:10, 3675:5, 3675:45, 3675:47, 3682:28, 3686:15, 3690:27, 3695:28, 3700:31, 3700:34, 3701:9, 3701:10, 3702:41, 3702:42, 3703:6, 3706:34, 3709:38</p>	<p>locally [7] - 3644:26, 3652:24, 3659:43, 3663:24, 3690:6, 3691:6, 3709:47 locations [1] - 3685:47 look [31] - 3641:40, 3647:8, 3648:3, 3650:3, 3650:6, 3651:44, 3653:15, 3657:32, 3662:3, 3662:37, 3663:27, 3667:19, 3670:44, 3671:18, 3671:38, 3671:40, 3676:6, 3677:15, 3679:11, 3679:36, 3680:41, 3681:41, 3682:30, 3685:20, 3691:43, 3693:9, 3693:12, 3696:22, 3703:37, 3704:41, 3709:32 looked [5] - 3660:41, 3679:12, 3680:8, 3685:21, 3685:23 looking [19] - 3640:2, 3641:9, 3646:42, 3660:44, 3660:45, 3661:21, 3662:38, 3662:39, 3666:12, 3666:14, 3666:45, 3669:3, 3681:17, 3681:19, 3682:7, 3692:9, 3692:11, 3692:13, 3703:3 looks [2] - 3649:27, 3651:43 Looks [1] - 3649:29 losing [1] - 3694:19 lost [5] - 3645:7, 3645:9, 3666:37, 3675:34, 3675:36 lower [3] - 3644:15, 3682:37, 3708:12 lowest [1] - 3644:38 lunch [1] - 3678:46 Lyons [6] - 3687:45, 3688:7, 3710:23, 3710:33, 3710:38, 3711:25 LYONS [1] - 3688:1 lyons [2] - 3688:30, 3710:25</p>
<p style="text-align: center;">J</p> <p>job [1] - 3653:15 jobs [1] - 3647:45 John [17] - 3640:11, 3640:19, 3665:42, 3668:45, 3673:43, 3674:20, 3674:28, 3674:34, 3674:42, 3674:44, 3675:29, 3676:3, 3679:20, 3681:17, 3683:47, 3692:14, 3701:35 JOHN [1] - 3640:13 John's [1] - 3678:9 joint [2] - 3679:29, 3679:34 Jones [1] - 3639:36 JOSEPH [1] - 3688:1 Joseph [1] - 3688:7 journey [1] - 3646:34 June [8] - 3639:22, 3654:34, 3655:11, 3664:35, 3688:14, 3696:32, 3712:20, 3712:25 JUNE [1] - 3712:38 junior [2] - 3647:23, 3649:2 justice [1] - 3709:4</p>	<p style="text-align: center;">L</p> <p>lack [3] - 3651:40, 3678:15, 3679:6 large [6] - 3642:11, 3649:20, 3674:44, 3674:47, 3675:9, 3675:34 largely [4] - 3641:47, 3642:34, 3655:17, 3659:36 larger [7] - 3644:35, 3655:37, 3657:40, 3658:36, 3677:9, 3683:19, 3684:5 last [12] - 3642:31, 3644:15, 3647:38, 3649:42, 3660:22, 3676:29, 3690:15, 3690:23, 3690:35, 3692:34, 3710:38, 3711:17 late [2] - 3640:2, 3696:29 lay [1] - 3660:18 lead [7] - 3667:32, 3667:42, 3667:43, 3673:34, 3673:35, 3705:4 leadership [3] - 3661:14, 3669:45, 3692:46 leads [6] - 3652:10,</p>			<p style="text-align: center;">M</p> <p>Macquarie [1] - 3639:18 maintain [2] - 3646:10, 3700:5</p>

<p>maintained [2] - 3693:32, 3707:37</p> <p>maintaining [1] - 3693:43</p> <p>Maitland [1] - 3674:13</p> <p>major [4] - 3652:20, 3659:40, 3694:32, 3702:5</p> <p>majority [2] - 3674:30, 3683:41</p> <p>maker [1] - 3658:10</p> <p>manage [2] - 3650:14, 3651:45</p> <p>managed [3] - 3693:12, 3707:38, 3712:33</p> <p>management [6] - 3648:19, 3649:39, 3650:17, 3650:18, 3692:10, 3696:14</p> <p>managers [1] - 3665:16</p> <p>managing [2] - 3644:27, 3646:33</p> <p>map [6] - 3671:31, 3671:35, 3680:18, 3681:41, 3681:46, 3682:31</p> <p>mapped [1] - 3680:15</p> <p>mapping [5] - 3671:16, 3673:9, 3681:35, 3682:32, 3683:16</p> <p>mark [1] - 3705:39</p> <p>match [1] - 3658:26</p> <p>maternity [1] - 3665:11</p> <p>matter [4] - 3644:20, 3698:14, 3698:41, 3707:6</p> <p>matters [3] - 3656:35, 3700:20, 3710:9</p> <p>mature [1] - 3691:45</p> <p>maximise [1] - 3695:23</p> <p>maximum [1] - 3684:11</p> <p>mean [20] - 3645:30, 3651:20, 3660:3, 3660:31, 3662:44, 3667:25, 3672:44, 3676:43, 3677:29, 3680:26, 3683:40, 3684:25, 3685:4, 3685:19, 3686:35, 3697:37, 3702:43, 3704:33, 3705:2, 3709:31</p> <p>means [6] - 3643:31, 3647:22, 3653:3,</p>	<p>3691:2, 3704:36, 3711:46</p> <p>meant [3] - 3690:44, 3693:39, 3699:18</p> <p>mechanism [1] - 3645:42</p> <p>mechanisms [2] - 3705:18, 3707:45</p> <p>medical [7] - 3652:12, 3664:24, 3665:16, 3665:35, 3671:37, 3673:34, 3690:17</p> <p>Medical [2] - 3664:27, 3664:31</p> <p>medication [1] - 3657:6</p> <p>Medicine [2] - 3643:8, 3691:21</p> <p>medicine [2] - 3690:38, 3693:35</p> <p>meet [7] - 3675:7, 3677:30, 3678:16, 3684:46, 3687:23, 3705:20, 3707:47</p> <p>meeting [1] - 3685:41</p> <p>meetings [5] - 3679:30, 3679:37, 3689:19, 3697:40</p> <p>Melbourne [2] - 3648:23, 3648:27</p> <p>member [5] - 3657:36, 3669:38, 3670:5, 3670:8, 3707:28</p> <p>members [2] - 3641:6, 3671:30</p> <p>mental [1] - 3652:37</p> <p>mentioned [7] - 3646:23, 3656:39, 3658:7, 3677:14, 3686:25, 3690:35, 3709:11</p> <p>mentions [1] - 3658:2</p> <p>message [2] - 3643:17, 3643:40</p> <p>met [2] - 3660:31, 3706:32</p> <p>metres [1] - 3652:33</p> <p>metropolitan [2] - 3693:13, 3709:23</p> <p>Mid [1] - 3665:33</p> <p>might [45] - 3642:10, 3643:4, 3643:7, 3644:24, 3644:42, 3645:33, 3646:4, 3646:32, 3646:44, 3649:27, 3651:3, 3652:33, 3653:40, 3656:12, 3656:40, 3658:3, 3658:35, 3659:33, 3660:14,</p>	<p>3660:15, 3661:39, 3662:2, 3669:29, 3679:43, 3682:35, 3683:24, 3684:13, 3685:41, 3690:26, 3690:30, 3690:31, 3690:36, 3695:4, 3699:26, 3702:17, 3703:22, 3705:39, 3705:43, 3706:6, 3706:20, 3708:9, 3708:19, 3709:9, 3711:13, 3711:15</p> <p>million [2] - 3660:5, 3709:18</p> <p>mind [4] - 3647:9, 3655:25, 3657:3, 3677:43</p> <p>minimal [1] - 3682:32</p> <p>minimum [2] - 3681:42, 3693:40</p> <p>Minister [3] - 3692:40, 3696:36, 3697:20</p> <p>minister [3] - 3671:45, 3696:6, 3698:25</p> <p>ministry [16] - 3657:42, 3659:33, 3659:46, 3659:47, 3660:3, 3660:7, 3688:9, 3688:44, 3689:2, 3689:36, 3693:1, 3698:29, 3698:39, 3698:40, 3699:2</p> <p>minister's [1] - 3660:1</p> <p>minutes [1] - 3640:2</p> <p>misinterpretation [1] - 3710:16</p> <p>misread [1] - 3710:26</p> <p>missing [1] - 3662:23</p> <p>mmm'hmm [7] - 3643:5, 3662:28, 3665:2, 3679:32, 3691:28, 3695:8, 3695:17</p> <p>mmm-hmm [2] - 3640:27, 3673:45</p> <p>model [4] - 3663:29, 3668:39, 3670:35, 3676:34</p> <p>models [15] - 3663:27, 3681:2, 3681:15, 3681:17, 3681:18, 3681:19, 3682:5, 3682:7, 3684:15, 3685:23, 3685:24, 3686:2, 3687:14, 3687:25, 3687:28</p> <p>MOH [2] - 3658:31, 3658:37</p>	<p>MOH.0002.0144.0001 [2] - 3643:10, 3682:23</p> <p>MOH.0002.0146.0001] [1] - 3646:39</p> <p>MOH.9999.1289.0001 [1] - 3664:46</p> <p>MOH.9999.1870.0001 [1] - 3688:17</p> <p>MOH.9999.3132.0001] [1] - 3660:14</p> <p>moment [47] - 3641:10, 3643:3, 3647:18, 3650:40, 3659:23, 3660:5, 3660:46, 3662:24, 3662:33, 3664:34, 3665:47, 3666:3, 3667:1, 3667:5, 3671:14, 3671:41, 3675:4, 3675:23, 3675:33, 3676:39, 3676:45, 3677:22, 3678:12, 3678:15, 3678:30, 3679:23, 3679:36, 3680:10, 3680:41, 3681:2, 3681:9, 3681:21, 3682:7, 3682:9, 3683:6, 3683:7, 3683:13, 3683:41, 3684:7, 3684:12, 3684:43, 3685:3, 3685:5, 3685:7, 3705:6, 3710:2</p> <p>MONDAY [1] - 3712:38</p> <p>money [3] - 3660:8, 3676:46, 3709:8</p> <p>monitored [1] - 3707:37</p> <p>month [2] - 3660:22, 3663:20</p> <p>months [5] - 3648:20, 3663:21, 3663:22, 3696:24, 3698:14</p> <p>morning [7] - 3640:1, 3664:16, 3675:2, 3679:39, 3702:7, 3706:12, 3706:28</p> <p>most [7] - 3652:20, 3652:22, 3679:22, 3681:11, 3684:18, 3684:26, 3695:22</p> <p>mouthful [1] - 3657:36</p> <p>move [1] - 3682:39</p> <p>moves [1] - 3657:45</p> <p>moving [3] - 3682:36, 3682:37, 3696:2</p> <p>MR [84] - 3640:5,</p>	<p>3640:10, 3640:15, 3640:17, 3640:35, 3640:43, 3641:1, 3643:14, 3643:21, 3643:23, 3643:31, 3643:36, 3643:44, 3644:2, 3645:14, 3645:18, 3647:1, 3647:6, 3649:42, 3650:35, 3654:14, 3654:25, 3654:29, 3654:33, 3656:2, 3656:17, 3656:39, 3658:26, 3658:30, 3660:21, 3662:14, 3662:20, 3662:22, 3663:1, 3664:13, 3664:20, 3665:4, 3668:15, 3668:21, 3668:28, 3668:33, 3669:15, 3669:20, 3669:29, 3669:34, 3670:16, 3670:20, 3670:39, 3670:43, 3672:13, 3672:43, 3678:18, 3678:37, 3678:44, 3681:26, 3685:18, 3687:32, 3687:36, 3687:45, 3688:3, 3688:5, 3688:25, 3688:30, 3700:1, 3706:27, 3708:31, 3708:43, 3710:8, 3710:22, 3710:29, 3710:35, 3710:37, 3711:17, 3711:22, 3711:31, 3711:37, 3711:43, 3712:2, 3712:8, 3712:13, 3712:17, 3712:22, 3712:27, 3712:33</p> <p>Murrumbidgee [3] - 3658:3, 3674:29, 3708:8</p> <p>must [1] - 3680:2</p> <p>Muston [1] - 3639:26</p> <p>MUSTON [4] - 3643:23, 3643:31, 3643:36, 3643:44</p>
N				
<p>name [5] - 3640:17, 3664:20, 3670:16, 3672:5, 3688:5</p> <p>narrow [1] - 3698:18</p> <p>natal [1] - 3686:39</p> <p>national [1] - 3683:31</p> <p>naturally [1] - 3675:23</p>				

<p>nature [1] - 3698:3 navigate [1] - 3648:30 NDIS [1] - 3657:11 nearly [1] - 3674:46 necessarily [8] - 3680:2, 3703:2, 3704:9, 3704:30, 3705:4, 3705:7, 3705:34, 3706:36 necessary [3] - 3652:3, 3652:15, 3671:39 necessity [1] - 3692:12 need [67] - 3644:33, 3646:33, 3647:14, 3649:14, 3649:15, 3649:27, 3649:29, 3650:14, 3651:47, 3652:39, 3653:32, 3653:33, 3658:19, 3659:35, 3662:32, 3662:44, 3673:38, 3676:34, 3679:11, 3681:22, 3684:31, 3685:26, 3685:30, 3685:32, 3687:24, 3689:45, 3689:46, 3690:2, 3690:3, 3690:28, 3690:30, 3690:31, 3690:42, 3691:25, 3693:19, 3693:30, 3693:45, 3695:10, 3696:19, 3697:30, 3701:14, 3701:41, 3702:1, 3702:6, 3702:15, 3702:17, 3703:4, 3703:30, 3703:31, 3703:32, 3704:8, 3706:16, 3706:34, 3706:38, 3706:46, 3707:8, 3707:9, 3707:21, 3707:25, 3707:35, 3707:47, 3709:12, 3710:20, 3710:27, 3710:32, 3712:30 needed [10] - 3648:17, 3648:31, 3653:6, 3660:33, 3662:2, 3697:2, 3697:7, 3699:13, 3703:45 needing [3] - 3690:20, 3693:40, 3697:11 needs [27] - 3645:39, 3645:42, 3647:24, 3647:43, 3649:9, 3649:21, 3660:46, 3663:32, 3666:40,</p>	<p>3669:1, 3687:20, 3687:21, 3687:25, 3689:42, 3691:13, 3704:2, 3705:42, 3706:5, 3706:20, 3707:7, 3707:10, 3707:33, 3707:34, 3708:10, 3708:20 negotiated [1] - 3705:46 neo [1] - 3686:39 neo-natal [1] - 3686:39 neonatal [1] - 3677:19 Network [22] - 3641:4, 3665:23, 3668:1, 3668:23, 3668:41, 3669:6, 3671:28, 3671:34, 3671:43, 3672:37, 3673:44, 3674:15, 3690:46, 3691:44, 3692:2, 3698:32, 3701:2, 3702:11, 3703:8, 3705:23, 3708:7, 3710:19 network [91] - 3641:4, 3641:5, 3641:15, 3649:23, 3653:47, 3655:27, 3655:30, 3655:36, 3655:38, 3656:15, 3656:27, 3658:14, 3662:27, 3663:40, 3665:12, 3665:13, 3665:14, 3665:27, 3665:42, 3666:1, 3666:43, 3666:44, 3666:47, 3667:1, 3667:2, 3667:22, 3667:25, 3667:27, 3667:46, 3668:2, 3668:3, 3668:4, 3668:6, 3668:11, 3668:25, 3668:47, 3669:8, 3671:1, 3671:3, 3671:26, 3671:27, 3671:30, 3671:34, 3671:38, 3672:1, 3672:3, 3672:20, 3673:16, 3673:29, 3673:33, 3673:47, 3674:7, 3674:11, 3674:16, 3675:42, 3675:43, 3676:5, 3676:8, 3681:37, 3681:40, 3692:13, 3692:46, 3692:47, 3693:7, 3693:21, 3694:1, 3694:2,</p>	<p>3694:4, 3694:26, 3694:38, 3695:23, 3695:39, 3695:42, 3696:8, 3696:11, 3696:14, 3696:15, 3698:10, 3698:36, 3699:8, 3705:41, 3706:33, 3707:31, 3707:34, 3708:13, 3710:2 Network" [1] - 3674:37 networked [8] - 3644:11, 3644:21, 3644:23, 3655:2, 3665:38, 3674:8, 3682:26, 3700:5 networking [14] - 3644:16, 3682:28, 3682:29, 3683:4, 3688:47, 3689:1, 3689:7, 3689:10, 3689:35, 3691:9, 3691:39, 3694:5, 3705:31, 3706:44 Networks [4] - 3664:27, 3664:31, 3665:7, 3665:8 networks [43] - 3657:17, 3664:25, 3665:9, 3665:15, 3665:16, 3665:19, 3665:20, 3665:29, 3665:31, 3665:43, 3665:47, 3666:4, 3666:9, 3666:10, 3666:24, 3666:29, 3666:34, 3666:36, 3666:40, 3668:2, 3668:19, 3669:21, 3670:30, 3671:8, 3672:47, 3682:15, 3682:17, 3682:42, 3683:8, 3689:4, 3689:10, 3689:11, 3689:37, 3689:40, 3691:27, 3691:32, 3692:2, 3692:11, 3701:32, 3706:44, 3707:14, 3707:19 never [2] - 3673:35, 3706:42 new [14] - 3660:22, 3667:45, 3670:35, 3670:44, 3671:27, 3671:34, 3672:37, 3681:37, 3682:7, 3684:15, 3685:23, 3692:36, 3708:47 New [69] - 3639:19,</p>	<p>3641:31, 3646:19, 3646:37, 3655:5, 3656:15, 3656:27, 3664:28, 3664:32, 3665:10, 3665:23, 3665:28, 3665:32, 3665:33, 3665:40, 3665:47, 3666:1, 3666:42, 3666:46, 3667:22, 3667:26, 3667:27, 3667:31, 3667:32, 3667:45, 3668:1, 3668:2, 3669:9, 3669:46, 3671:8, 3671:13, 3671:17, 3671:21, 3671:30, 3671:35, 3671:39, 3671:40, 3672:19, 3672:45, 3673:37, 3673:43, 3674:2, 3674:15, 3674:17, 3674:29, 3675:22, 3675:44, 3677:4, 3677:11, 3677:34, 3677:36, 3678:47, 3679:19, 3680:10, 3680:39, 3681:21, 3681:40, 3681:44, 3686:14, 3686:18, 3688:45, 3689:39, 3693:3, 3700:12, 3702:39, 3702:45, 3704:14, 3708:19, 3709:1 newborn [1] - 3644:24 Newcastle [4] - 3674:27, 3676:9, 3676:21, 3702:30 newer [4] - 3679:9, 3680:38, 3680:47, 3683:7 next [10] - 3646:39, 3657:25, 3660:47, 3663:20, 3664:13, 3687:45, 3690:29, 3700:9, 3703:36, 3712:33 nicely [1] - 3656:31 NIGEL [1] - 3688:1 Nigel [1] - 3688:7 night [1] - 3651:4 nitty [1] - 3706:10 nitty-gritty [1] - 3706:10 no-one [1] - 3704:5 nobody [1] - 3691:36 nominated [1] - 3667:40 non [1] - 3711:32 non-publication [1] -</p>	<p>3711:32 North [1] - 3665:33 north [4] - 3666:21, 3674:17, 3682:31, 3684:28 Northern [6] - 3665:23, 3668:24, 3668:41, 3669:7, 3691:43, 3705:22 northern [4] - 3665:30, 3665:32, 3665:42 noted [1] - 3700:30 nothing [2] - 3664:2, 3684:19 notice [1] - 3672:6 noting [1] - 3706:19 nowhere [1] - 3654:9 NSW [1] - 3639:35 number [14] - 3641:9, 3647:41, 3647:42, 3648:40, 3651:33, 3654:38, 3661:19, 3664:23, 3668:13, 3672:28, 3693:31, 3705:19, 3708:24 numerous [1] - 3667:40 nurse [2] - 3665:38, 3673:34 nursing [3] - 3665:35, 3665:37, 3671:37</p> <hr/> <p style="text-align: center;">O</p> <p>observation [2] - 3642:27, 3642:31 observations [2] - 3643:3, 3675:18 observes [1] - 3657:14 obvious [1] - 3652:28 obviously [7] - 3641:21, 3650:29, 3660:31, 3671:43, 3674:9, 3675:44, 3687:11 occur [9] - 3641:39, 3650:46, 3659:40, 3690:4, 3691:37, 3692:2, 3702:20, 3707:1, 3707:6 occurred [6] - 3691:46, 3692:14, 3698:17, 3699:19, 3707:20, 3709:34 occurring [6] - 3673:5, 3681:21, 3690:16, 3690:17, 3693:37, 3707:36</p>
--	---	--	--	--

<p>occurs [2] - 3679:39, 3700:26</p> <p>October [1] - 3688:31</p> <p>OF [1] - 3712:37</p> <p>offered [1] - 3640:7</p> <p>often [13] - 3647:26, 3647:40, 3647:47, 3652:5, 3653:19, 3659:33, 3662:4, 3683:6, 3684:3, 3690:20, 3690:47, 3703:20, 3707:1</p> <p>oiled [2] - 3644:28, 3647:43</p> <p>old [1] - 3642:45</p> <p>Oliver [1] - 3639:36</p> <p>onboard [1] - 3677:21</p> <p>once [11] - 3641:13, 3660:44, 3670:46, 3671:23, 3682:39, 3694:43, 3696:1, 3697:34, 3698:7, 3699:2, 3709:35</p> <p>oncology [3] - 3663:27, 3677:3, 3679:23</p> <p>one [63] - 3640:3, 3640:5, 3640:7, 3642:9, 3642:10, 3645:39, 3649:13, 3650:6, 3650:22, 3650:37, 3653:1, 3656:24, 3658:11, 3658:26, 3658:38, 3659:28, 3660:14, 3661:2, 3661:47, 3665:10, 3665:44, 3667:9, 3668:25, 3668:34, 3668:35, 3669:8, 3669:22, 3669:44, 3670:16, 3670:22, 3670:36, 3671:15, 3671:18, 3671:43, 3673:34, 3676:23, 3680:34, 3680:39, 3684:3, 3684:32, 3692:44, 3694:26, 3694:35, 3696:25, 3700:40, 3702:33, 3703:12, 3704:5, 3705:37, 3707:21, 3707:23, 3708:39, 3708:45, 3709:5, 3709:17, 3709:18, 3709:22, 3709:25, 3710:37, 3712:30</p> <p>one's [1] - 3653:25</p> <p>ones [1] - 3711:35</p> <p>ongoing [9] - 3649:34,</p>	<p>3653:5, 3689:8, 3689:12, 3703:33, 3706:15, 3706:16, 3706:47, 3707:38</p> <p>ons [1] - 3655:37</p> <p>onwards [1] - 3689:8</p> <p>opened [1] - 3709:35</p> <p>operate [5] - 3670:45, 3691:33, 3701:18, 3703:15, 3703:32</p> <p>operates [3] - 3643:3, 3662:34, 3673:44</p> <p>operating [7] - 3649:45, 3675:16, 3675:37, 3676:24, 3691:45, 3698:26, 3703:34</p> <p>operation [3] - 3652:47, 3655:20, 3674:38</p> <p>operational [10] - 3646:18, 3651:29, 3651:35, 3653:41, 3655:35, 3668:3, 3677:41, 3685:40, 3701:15, 3702:38</p> <p>operationalise [5] - 3671:4, 3671:10, 3672:38, 3672:43, 3673:1</p> <p>operationalised [4] - 3668:5, 3671:6, 3671:25, 3681:37</p> <p>operationalising [1] - 3680:41</p> <p>operations [1] - 3670:29</p> <p>Operator [1] - 3646:40</p> <p>operator [6] - 3656:5, 3656:17, 3658:35, 3668:28, 3695:7, 3703:36</p> <p>opinion [6] - 3648:10, 3650:45, 3651:22, 3697:29, 3708:45, 3709:21</p> <p>opportunities [1] - 3669:3</p> <p>opportunity [3] - 3680:14, 3680:16, 3712:3</p> <p>opposed [2] - 3659:27, 3693:16</p> <p>optimal [1] - 3649:45</p> <p>optimise [1] - 3645:45</p> <p>optimised [1] - 3641:31</p> <p>optimising [3] - 3644:26, 3644:34, 3644:41</p>	<p>option [1] - 3711:1</p> <p>options [1] - 3692:44</p> <p>orchestrating [1] - 3679:45</p> <p>orders [1] - 3711:32</p> <p>organic [1] - 3661:33</p> <p>organisational [3] - 3658:1, 3660:39, 3693:20</p> <p>organise [1] - 3707:4</p> <p>original [1] - 3666:35</p> <p>originally [1] - 3667:47</p> <p>otherwise [1] - 3711:43</p> <p>ourselves [1] - 3684:9</p> <p>outcome [3] - 3661:40, 3693:29, 3705:5</p> <p>outcomes [6] - 3652:35, 3652:36, 3652:37, 3661:15, 3703:3, 3709:13</p> <p>outlined [1] - 3672:34</p> <p>outlines [1] - 3681:42</p> <p>outlining [1] - 3680:44</p> <p>outpatient [3] - 3641:10, 3657:8, 3690:46</p> <p>output [1] - 3641:14</p> <p>outreach [5] - 3671:18, 3671:19, 3671:35, 3678:32, 3680:42</p> <p>outset [1] - 3660:33</p> <p>outside [2] - 3685:1, 3698:47</p> <p>outward [2] - 3692:11, 3692:13</p> <p>outward-looking [2] - 3692:11, 3692:13</p> <p>overall [6] - 3691:10, 3695:41, 3697:3, 3697:8, 3708:9, 3708:10</p> <p>overarching [3] - 3657:26, 3701:14, 3707:34</p> <p>overcome [3] - 3676:23, 3676:27, 3679:6</p> <p>overrepresented [1] - 3657:41</p> <p>oversee [2] - 3657:34, 3670:23</p> <p>oversimplified [1] - 3673:11</p> <p>overwhelmed [3] - 3642:22, 3642:28, 3652:10</p>	<p>overworked [1] - 3653:13</p> <p>own [4] - 3674:9, 3682:30, 3693:2, 3694:11</p>	<p>3703:25, 3703:26</p> <p>paediatrics [8] - 3640:22, 3642:26, 3649:20, 3655:5, 3675:33, 3689:1, 3690:18, 3700:12</p> <p>PAGE [1] - 3658:31</p> <p>page [18] - 3644:8, 3645:20, 3646:40, 3654:20, 3656:17, 3657:13, 3657:14, 3657:25, 3658:22, 3658:24, 3660:26, 3668:28, 3669:15, 3672:13, 3682:23, 3695:5, 3695:16, 3703:36</p> <p>pages [2] - 3656:3, 3670:30</p> <p>palliative [4] - 3665:12, 3676:31, 3676:45, 3686:43</p> <p>panel [4] - 3654:34, 3656:25, 3692:27, 3695:21</p> <p>papers [1] - 3709:16</p> <p>paragraph [32] - 3641:1, 3641:28, 3644:14, 3644:15, 3647:37, 3647:39, 3649:43, 3650:5, 3650:31, 3650:32, 3651:38, 3652:43, 3653:9, 3653:24, 3653:25, 3655:1, 3665:5, 3665:22, 3673:42, 3674:33, 3674:34, 3678:45, 3678:46, 3679:29, 3682:24, 3682:27, 3683:26, 3683:28, 3685:37, 3688:30, 3688:34</p> <p>paragraphs [3] - 3647:10, 3647:20, 3683:23</p> <p>parallel [1] - 3656:27</p> <p>Pardon [1] - 3656:10</p> <p>parked [1] - 3698:11</p> <p>part [40] - 3640:43, 3641:26, 3644:40, 3647:14, 3647:24, 3649:2, 3650:6, 3652:31, 3655:2, 3655:35, 3663:33, 3666:27, 3670:11, 3674:36, 3676:4, 3681:35, 3682:16, 3683:3, 3683:11, 3683:14, 3684:22,</p>
P				
<p>Paediatric [5] - 3641:4, 3643:7, 3643:8, 3691:21</p> <p>paediatric [75] - 3641:7, 3641:30, 3641:44, 3641:46, 3642:7, 3642:20, 3642:33, 3642:41, 3644:33, 3645:1, 3646:18, 3646:38, 3650:46, 3652:1, 3653:31, 3653:41, 3653:47, 3655:6, 3656:15, 3657:34, 3658:5, 3659:39, 3671:20, 3672:3, 3672:19, 3674:43, 3675:2, 3675:16, 3675:26, 3676:29, 3677:5, 3677:19, 3677:42, 3677:47, 3678:10, 3678:47, 3679:22, 3680:1, 3680:20, 3681:27, 3682:20, 3683:44, 3686:24, 3686:30, 3686:39, 3687:7, 3688:47, 3689:4, 3689:40, 3690:27, 3690:34, 3692:11, 3695:30, 3696:20, 3697:1, 3700:6, 3700:14, 3700:33, 3700:39, 3701:16, 3701:30, 3701:32, 3702:8, 3702:39, 3702:41, 3702:42, 3703:43, 3704:13, 3704:14, 3705:15, 3706:13, 3707:19, 3708:7, 3709:39</p> <p>paediatric-trained [1] - 3645:1</p> <p>paediatrician [9] - 3651:21, 3653:37, 3662:25, 3662:26, 3683:43, 3690:19, 3691:6, 3691:8, 3703:21</p> <p>paediatricians [8] - 3645:1, 3651:47, 3653:10, 3653:13, 3653:28, 3677:8,</p>				

<p>3684:30, 3684:35, 3686:17, 3687:19, 3688:25, 3689:20, 3691:13, 3691:14, 3692:26, 3694:18, 3698:4, 3700:45, 3705:31, 3707:7, 3707:21, 3707:23, 3707:25, 3707:30</p> <p>particular [17] - 3642:6, 3642:32, 3647:33, 3649:22, 3655:26, 3657:3, 3680:4, 3683:2, 3691:20, 3693:22, 3693:35, 3694:9, 3701:28, 3705:41, 3707:47, 3709:34, 3711:38</p> <p>particularly [6] - 3641:38, 3641:44, 3642:43, 3644:35, 3657:46, 3661:21</p> <p>parties [1] - 3705:47</p> <p>partly [3] - 3659:9, 3659:13, 3673:38</p> <p>parts [5] - 3641:41, 3692:3, 3701:7, 3707:22, 3707:26</p> <p>party [1] - 3706:45</p> <p>passage [3] - 3649:42, 3670:43, 3700:9</p> <p>passionate [2] - 3694:14, 3694:17</p> <p>past [4] - 3643:26, 3676:7, 3683:4, 3687:15</p> <p>pathway [4] - 3641:19, 3650:3, 3651:39, 3653:27</p> <p>pathways [5] - 3651:41, 3652:44, 3678:20, 3705:27, 3707:36</p> <p>patient [14] - 3646:33, 3650:45, 3651:18, 3652:26, 3653:31, 3662:31, 3663:3, 3663:6, 3663:7, 3666:18, 3681:4, 3682:39, 3691:10, 3704:7</p> <p>patient's [1] - 3646:34</p> <p>patients [15] - 3646:25, 3647:16, 3648:3, 3648:7, 3652:2, 3652:11, 3652:37, 3662:34, 3675:21, 3685:34, 3685:46, 3690:44,</p>	<p>3693:31, 3701:36, 3707:1</p> <p>patterns [1] - 3691:37</p> <p>Paul [2] - 3664:13, 3664:21</p> <p>PAUL [1] - 3664:18</p> <p>pausing [2] - 3667:4, 3686:5</p> <p>peak [2] - 3659:22, 3669:45</p> <p>pending [1] - 3698:11</p> <p>people [46] - 3642:45, 3647:44, 3649:8, 3651:45, 3657:15, 3657:27, 3658:8, 3659:7, 3661:31, 3664:24, 3666:20, 3667:31, 3667:45, 3669:46, 3674:21, 3680:9, 3683:12, 3684:10, 3684:12, 3684:32, 3685:27, 3685:30, 3685:47, 3689:4, 3690:13, 3694:14, 3694:16, 3694:18, 3696:47, 3698:41, 3699:9, 3701:4, 3701:42, 3701:43, 3702:22, 3703:3, 3704:4, 3704:39, 3705:5, 3707:16, 3707:29, 3708:22, 3709:35, 3710:41, 3710:44</p> <p>People [19] - 3660:11, 3664:26, 3664:30, 3665:6, 3665:10, 3666:27, 3667:10, 3667:28, 3667:33, 3667:47, 3669:42, 3671:5, 3671:28, 3671:33, 3672:29, 3672:37, 3674:15, 3680:27, 3689:24</p> <p>people's [1] - 3704:47</p> <p>per [3] - 3651:1, 3653:43, 3675:25</p> <p>perceive [3] - 3647:29, 3695:35, 3702:1</p> <p>perceived [1] - 3645:39</p> <p>perfectly [1] - 3661:38</p> <p>perform [2] - 3666:13, 3666:17</p> <p>performing [1] - 3672:33</p> <p>perhaps [30] - 3642:27, 3645:18, 3646:42, 3646:44, 3647:9, 3649:43,</p>	<p>3650:38, 3651:38, 3652:43, 3652:46, 3655:44, 3656:2, 3656:24, 3657:41, 3660:13, 3660:34, 3667:20, 3668:15, 3676:4, 3684:24, 3690:35, 3691:31, 3692:14, 3692:17, 3694:11, 3694:38, 3699:28, 3705:41, 3707:42, 3708:31</p> <p>period [1] - 3684:33</p> <p>periods [1] - 3648:5</p> <p>person [2] - 3648:39, 3706:45</p> <p>personally [1] - 3676:8</p> <p>Persons [1] - 3657:35</p> <p>perspective [3] - 3660:38, 3692:47, 3696:27</p> <p>pertaining [1] - 3680:35</p> <p>pertinent [2] - 3673:6, 3681:6</p> <p>Peter [1] - 3672:2</p> <p>phase [1] - 3690:29</p> <p>Phillips [3] - 3692:32, 3692:33, 3692:40</p> <p>philosophies [1] - 3694:12</p> <p>phone [5] - 3647:22, 3647:23, 3648:5, 3649:1</p> <p>physical [1] - 3652:35</p> <p>physically [1] - 3693:20</p> <p>pick [1] - 3675:36</p> <p>piece [1] - 3650:7</p> <p>pillar [1] - 3693:2</p> <p>place [11] - 3642:13, 3646:21, 3650:22, 3653:17, 3689:45, 3690:7, 3700:42, 3701:21, 3702:22, 3706:38, 3707:35</p> <p>places [1] - 3645:47</p> <p>plan [28] - 3646:18, 3651:13, 3651:29, 3652:16, 3653:41, 3655:20, 3655:35, 3658:1, 3669:45, 3676:16, 3680:44, 3686:38, 3689:3, 3701:15, 3702:38, 3702:44, 3703:42, 3704:2, 3704:36, 3704:45, 3705:19, 3705:33, 3705:37,</p>	<p>3708:9, 3708:10, 3708:12, 3708:16</p> <p>plane [1] - 3662:40</p> <p>planned [2] - 3677:41, 3685:45</p> <p>planners [3] - 3642:21, 3642:24, 3642:28</p> <p>planning [35] - 3642:32, 3642:35, 3651:35, 3659:17, 3667:27, 3675:17, 3676:28, 3677:34, 3678:15, 3678:47, 3679:7, 3679:8, 3679:34, 3680:1, 3680:6, 3680:13, 3685:40, 3686:11, 3686:19, 3686:36, 3686:46, 3687:1, 3687:6, 3687:9, 3688:33, 3690:30, 3696:19, 3700:35, 3702:26, 3703:2, 3703:4, 3703:17, 3703:28, 3705:3, 3709:16</p> <p>plans [13] - 3651:18, 3651:33, 3651:34, 3672:38, 3672:46, 3673:39, 3702:45, 3704:34, 3706:11, 3708:26, 3708:27, 3708:32, 3708:36</p> <p>play [2] - 3690:12, 3691:14</p> <p>played [1] - 3693:47</p> <p>pleasure [1] - 3664:5</p> <p>plus [1] - 3649:29</p> <p>pm [1] - 3688:1</p> <p>point [14] - 3646:34, 3651:4, 3657:39, 3658:9, 3661:12, 3673:42, 3675:3, 3678:19, 3698:25, 3703:3, 3703:32, 3704:12, 3704:13, 3704:20</p> <p>pointing [1] - 3701:4</p> <p>points [1] - 3705:27</p> <p>policies [3] - 3646:23, 3650:21, 3707:15</p> <p>policy [8] - 3647:8, 3647:15, 3659:17, 3682:15, 3682:24, 3688:35, 3688:40, 3688:42</p> <p>political [2] - 3709:7, 3711:14</p> <p>population [9] -</p>	<p>3642:29, 3642:30, 3674:10, 3675:20, 3675:25, 3675:28, 3684:47, 3686:15, 3706:5</p> <p>populations [1] - 3709:18</p> <p>position [5] - 3642:38, 3688:32, 3688:41, 3698:44, 3710:29</p> <p>possible [5] - 3669:7, 3689:44, 3704:23, 3704:25</p> <p>possibly [1] - 3660:3</p> <p>post [1] - 3680:37</p> <p>post-COVID [1] - 3680:37</p> <p>potential [1] - 3641:37</p> <p>potentially [6] - 3663:38, 3666:17, 3666:38, 3675:42, 3683:43, 3687:12</p> <p>power [1] - 3660:40</p> <p>practical [6] - 3644:20, 3650:18, 3650:39, 3673:8, 3676:20, 3705:38</p> <p>practice [16] - 3642:5, 3644:34, 3645:5, 3645:35, 3647:17, 3647:19, 3647:20, 3648:3, 3651:43, 3666:8, 3666:9, 3666:13, 3691:7, 3703:11, 3704:42</p> <p>practitioners [1] - 3651:41</p> <p>Predy [18] - 3640:11, 3640:19, 3662:22, 3670:14, 3675:12, 3679:20, 3681:17, 3681:27, 3682:6, 3691:16, 3691:20, 3691:26, 3706:13, 3706:28, 3706:36, 3707:17, 3708:5, 3708:39</p> <p>PREDDY [1] - 3640:13</p> <p>Predy's [2] - 3650:30, 3678:19</p> <p>preference [1] - 3705:39</p> <p>preferred [1] - 3678:35</p> <p>prescribing [1] - 3657:6</p> <p>present [3] - 3639:33, 3659:19, 3710:45</p> <p>presents [1] - 3642:31</p> <p>pressure [3] -</p>
--	--	--	---	--

<p>3642:15, 3648:2, 3710:3 pressures [5] - 3675:4, 3675:5, 3675:8, 3675:34, 3684:44 prevent [3] - 3642:44, 3648:44, 3675:30 preventative [1] - 3675:27 preventive [2] - 3642:43, 3642:44 previous [1] - 3692:40 previously [8] - 3667:30, 3668:46, 3674:11, 3683:42, 3690:19, 3690:37, 3703:24, 3709:39 primary [3] - 3678:27, 3700:32, 3704:22 principles [6] - 3671:44, 3677:32, 3703:41, 3704:5, 3704:9, 3704:35 priorities [1] - 3690:29 priority [8] - 3642:23, 3642:47, 3661:15, 3661:18, 3661:19, 3661:22, 3661:23, 3661:26 problem [5] - 3641:26, 3649:22, 3654:2, 3662:41, 3676:38 problematic [1] - 3646:34 problems [5] - 3642:45, 3662:39, 3671:44, 3708:22, 3711:14 procedural [1] - 3665:13 procedures [2] - 3650:14, 3650:21 proceed [1] - 3643:47 process [22] - 3661:33, 3670:34, 3671:19, 3671:24, 3671:25, 3675:17, 3682:16, 3682:34, 3687:19, 3692:26, 3694:1, 3696:19, 3703:2, 3703:4, 3703:17, 3703:28, 3703:33, 3703:47, 3704:28, 3705:1, 3707:20 processes [3] - 3650:41, 3675:32, 3705:3 professor [2] -</p>	<p>3691:20, 3708:39 Professor [25] - 3640:10, 3641:2, 3644:3, 3645:20, 3650:30, 3657:14, 3659:5, 3664:3, 3667:39, 3668:12, 3670:14, 3675:12, 3678:19, 3681:27, 3682:6, 3691:16, 3696:23, 3697:39, 3697:40, 3698:4, 3706:13, 3706:28, 3706:36, 3707:17, 3708:5 program [1] - 3695:9 progress [9] - 3657:32, 3680:8, 3680:11, 3680:23, 3680:25, 3680:31, 3696:10, 3696:17, 3698:26 prompted [1] - 3694:30 pronounce [1] - 3660:12 proposals [1] - 3658:17 propose [1] - 3711:39 proposed [1] - 3672:1 proposition [4] - 3649:44, 3659:5, 3700:20, 3702:37 protocols [1] - 3650:13 Provide [1] - 3661:14 provide [61] - 3645:2, 3653:16, 3660:33, 3665:39, 3666:20, 3666:45, 3669:4, 3671:19, 3671:41, 3672:20, 3674:10, 3674:12, 3674:28, 3674:37, 3674:39, 3676:17, 3677:36, 3677:37, 3678:11, 3678:29, 3678:32, 3679:13, 3679:19, 3679:25, 3679:26, 3679:27, 3681:10, 3681:11, 3683:17, 3683:35, 3684:4, 3684:6, 3684:20, 3684:25, 3684:27, 3684:29, 3684:46, 3685:22, 3685:24, 3685:27, 3685:30, 3685:32, 3686:12, 3686:14, 3686:16, 3686:27, 3692:41,</p>	<p>3693:13, 3693:30, 3693:38, 3695:40, 3699:10, 3699:42, 3700:32, 3700:41, 3703:23, 3704:22, 3705:28, 3706:47, 3707:16 provided [39] - 3640:25, 3660:15, 3662:45, 3674:20, 3674:30, 3676:40, 3676:46, 3677:6, 3677:7, 3677:8, 3678:4, 3679:11, 3680:19, 3680:20, 3681:43, 3682:1, 3682:2, 3682:33, 3683:42, 3683:44, 3684:37, 3686:13, 3686:24, 3687:30, 3688:14, 3690:1, 3693:10, 3693:27, 3694:39, 3699:30, 3700:36, 3701:25, 3701:28, 3702:2, 3702:17, 3703:6, 3704:24, 3709:47 provider [1] - 3674:9 providers [3] - 3655:7, 3678:27, 3700:14 provides [6] - 3655:6, 3659:7, 3675:1, 3686:15, 3700:13, 3703:12 providing [27] - 3644:35, 3644:41, 3645:43, 3657:8, 3666:19, 3669:2, 3675:46, 3676:32, 3677:5, 3678:5, 3678:9, 3678:12, 3679:18, 3681:45, 3685:46, 3685:47, 3686:17, 3686:18, 3686:44, 3686:45, 3687:6, 3690:13, 3696:8, 3697:10, 3700:26, 3706:29, 3709:29 provision [3] - 3675:6, 3677:10, 3690:27 public [3] - 3641:11, 3699:2, 3699:41 publication [1] - 3711:32 publicly [1] - 3693:47 published [1] - 3654:39 purely [1] - 3675:43 purpose [3] - 3644:44,</p>	<p>3689:40, 3692:29 purposes [1] - 3702:10 pursued [2] - 3668:38, 3669:1 put [8] - 3641:17, 3663:21, 3673:32, 3676:21, 3690:30, 3691:31, 3699:6, 3704:28 putting [3] - 3682:14, 3687:28, 3710:3 <hr/> <p style="text-align: center;">Q</p> <hr/> qualifier [1] - 3673:32 quality [4] - 3665:39, 3666:16, 3666:46, 3709:36 quaternary [15] - 3649:28, 3652:3, 3652:8, 3655:28, 3655:33, 3657:42, 3690:11, 3692:36, 3702:40, 3703:6, 3709:19, 3709:26, 3710:40, 3710:43, 3710:46 questions [9] - 3643:2, 3662:14, 3662:18, 3668:16, 3670:45, 3687:32, 3687:36, 3708:43, 3710:8 quickly [1] - 3649:24 quite [8] - 3641:25, 3648:12, 3651:44, 3661:31, 3675:23, 3679:36, 3683:6, 3703:13 quote [1] - 3675:17 <hr/> <p style="text-align: center;">R</p> <hr/> raise [1] - 3661:31 raised [2] - 3705:32, 3708:5 raising [1] - 3704:4 Randwick [5] - 3648:22, 3655:3, 3662:45, 3665:45, 3692:3 range [5] - 3645:3, 3655:6, 3684:37, 3692:43, 3700:13 ranging [1] - 3687:5 rather [8] - 3647:21, 3657:21, 3663:23, 3683:2, 3686:9, 3695:43, 3701:14,</p>	<p>3702:33 rationalisation [1] - 3667:39 re [2] - 3661:40, 3685:22 re-arranged [1] - 3661:40 re-design [1] - 3685:22 reach [1] - 3647:39 reached [1] - 3685:28 read [22] - 3640:35, 3645:11, 3645:14, 3647:9, 3647:12, 3654:39, 3654:42, 3655:16, 3655:41, 3656:4, 3656:24, 3658:47, 3659:3, 3659:14, 3664:39, 3669:21, 3672:22, 3672:27, 3672:28, 3688:18, 3703:38, 3709:16 reading [2] - 3656:29, 3710:14 ready [1] - 3656:4 real [1] - 3650:37 real-time [1] - 3650:37 realistic [2] - 3681:47, 3685:8 reality [1] - 3678:4 reallocation [2] - 3662:1, 3662:3 really [30] - 3651:35, 3652:28, 3653:18, 3655:33, 3659:18, 3661:9, 3666:45, 3675:26, 3677:38, 3679:8, 3679:11, 3679:40, 3680:3, 3680:18, 3681:5, 3681:20, 3682:30, 3684:17, 3687:25, 3687:28, 3690:11, 3690:28, 3692:31, 3694:14, 3694:16, 3698:44, 3699:18, 3700:25, 3702:44, 3704:27 reason [2] - 3643:46, 3707:24 reasonable [1] - 3656:29 reasonably [2] - 3641:46, 3662:34 reasons [5] - 3645:39, 3652:5, 3658:11, 3708:23, 3709:19 reassessed [1] - 3702:18</p>
--	---	--	---	--

<p>receive [2] - 3642:16, 3653:15</p> <p>received [5] - 3692:27, 3696:1, 3696:25, 3698:28, 3699:3</p> <p>receives [1] - 3706:46</p> <p>receiving [1] - 3644:24</p> <p>recent [3] - 3660:16, 3676:27, 3702:1</p> <p>recently [3] - 3648:13, 3654:42, 3679:10</p> <p>recognise [8] - 3680:17, 3684:28, 3684:44, 3684:45, 3685:8, 3685:20, 3687:12, 3689:41</p> <p>recognised [2] - 3690:8</p> <p>recognition [4] - 3666:38, 3680:26, 3685:25, 3693:18</p> <p>recollection [1] - 3696:44</p> <p>recommend [4] - 3659:30, 3659:33, 3660:37, 3708:47</p> <p>recommendation [24] - 3655:1, 3656:8, 3656:12, 3657:4, 3659:1, 3659:14, 3659:41, 3659:46, 3660:4, 3661:1, 3668:9, 3668:31, 3668:33, 3668:40, 3668:43, 3669:21, 3671:24, 3671:42, 3672:7, 3673:21, 3693:16, 3695:47, 3697:13, 3700:3</p> <p>Recommendation [1] - 3658:44</p> <p>recommendations [49] - 3654:33, 3654:40, 3654:47, 3655:19, 3655:24, 3655:41, 3656:3, 3656:30, 3656:35, 3657:1, 3657:5, 3657:7, 3657:9, 3659:34, 3659:35, 3661:39, 3665:46, 3666:23, 3667:14, 3669:44, 3670:24, 3670:28, 3671:10, 3673:3, 3673:4, 3673:6, 3673:36, 3680:30, 3692:35, 3695:1, 3695:4, 3695:8, 3695:36,</p>	<p>3695:44, 3695:46, 3696:2, 3696:10, 3696:13, 3696:17, 3698:2, 3698:9, 3698:21, 3699:4, 3699:7, 3699:12, 3699:14, 3699:46, 3700:1, 3703:37</p> <p>recommended [6] - 3656:25, 3659:43, 3666:43, 3672:2, 3709:5, 3710:17</p> <p>recommending [1] - 3659:31</p> <p>recommends [1] - 3655:2</p> <p>reconfigure [1] - 3659:15</p> <p>record [2] - 3640:18, 3688:6</p> <p>recorded [1] - 3643:36</p> <p>red [1] - 3660:5</p> <p>redefine [1] - 3702:10</p> <p>redefined [1] - 3702:6</p> <p>reduced [1] - 3709:40</p> <p>refer [7] - 3652:1, 3652:3, 3652:6, 3652:14, 3653:31, 3678:25, 3702:32</p> <p>reference [7] - 3660:10, 3660:21, 3660:27, 3666:35, 3695:15, 3697:38, 3697:42</p> <p>referencing [1] - 3695:38</p> <p>referral [14] - 3647:26, 3650:37, 3651:41, 3652:44, 3653:15, 3653:27, 3678:20, 3690:4, 3690:20, 3691:37, 3704:9, 3705:27, 3706:46, 3707:36</p> <p>referrals [4] - 3690:46, 3691:41, 3706:30, 3707:1</p> <p>referred [5] - 3668:34, 3681:18, 3682:15, 3701:36, 3707:14</p> <p>referring [3] - 3681:1, 3705:25, 3706:45</p> <p>refers [1] - 3691:26</p> <p>refined [1] - 3701:44</p> <p>reflect [3] - 3657:47, 3680:34, 3686:2</p> <p>reflected [2] - 3650:6, 3650:37</p> <p>reflection [2] - 3691:43, 3691:46</p>	<p>reform [1] - 3695:9</p> <p>refresh [1] - 3695:5</p> <p>regarding [2] - 3672:3, 3710:17</p> <p>region [7] - 3666:8, 3666:14, 3666:17, 3669:3, 3673:6, 3674:14, 3686:14</p> <p>Region [1] - 3668:24</p> <p>regional [9] - 3649:20, 3649:27, 3652:34, 3677:18, 3681:9, 3703:27, 3705:43, 3708:19, 3708:23</p> <p>regions [2] - 3669:5, 3703:45</p> <p>regular [2] - 3677:30, 3697:40</p> <p>rehabilitation [4] - 3657:5, 3659:39, 3661:45, 3681:18</p> <p>reinvest [1] - 3684:14</p> <p>rejected [1] - 3699:5</p> <p>relate [2] - 3657:11, 3702:31</p> <p>related [3] - 3657:17, 3696:13, 3699:7</p> <p>relating [1] - 3711:32</p> <p>relation [6] - 3654:43, 3686:9, 3695:39, 3702:11, 3709:33, 3710:15</p> <p>relationship [9] - 3642:36, 3677:30, 3700:26, 3702:14, 3702:15, 3703:5, 3703:13, 3706:47, 3707:2</p> <p>relationships [12] - 3642:35, 3647:30, 3682:44, 3683:2, 3683:5, 3702:23, 3705:24, 3706:41, 3706:42, 3706:43, 3706:45, 3707:36</p> <p>relatively [4] - 3660:16, 3660:22, 3666:9, 3698:18</p> <p>relevant [2] - 3641:7, 3706:1</p> <p>rely [1] - 3647:30</p> <p>remain [5] - 3650:44, 3656:26, 3662:31, 3670:8, 3676:3</p> <p>remember [1] - 3709:17</p> <p>remiss [1] - 3687:11</p> <p>remote [2] - 3661:21, 3662:6</p> <p>remotely [1] - 3643:31</p>	<p>renamed [1] - 3655:27</p> <p>replicate [1] - 3707:21</p> <p>replicating [1] - 3687:27</p> <p>report [27] - 3654:19, 3654:23, 3654:41, 3656:24, 3656:40, 3657:13, 3657:16, 3657:47, 3658:2, 3658:22, 3667:14, 3667:33, 3668:15, 3669:16, 3670:31, 3672:8, 3676:7, 3692:18, 3692:27, 3696:1, 3696:9, 3696:25, 3696:32, 3697:46, 3698:8, 3698:28, 3699:27</p> <p>reported [1] - 3676:6</p> <p>reporting [1] - 3667:43</p> <p>representatives [2] - 3659:19, 3671:38</p> <p>require [3] - 3653:34, 3659:42, 3679:13</p> <p>required [16] - 3652:46, 3655:12, 3655:13, 3655:14, 3666:39, 3668:43, 3668:44, 3677:35, 3679:35, 3687:10, 3689:47, 3691:41, 3699:23, 3701:4, 3701:19, 3705:30</p> <p>requirements [1] - 3647:9</p> <p>requires [2] - 3650:45, 3655:38</p> <p>research [1] - 3666:17</p> <p>resolution [1] - 3707:40</p> <p>resolve [1] - 3703:28</p> <p>resolved [1] - 3655:18</p> <p>resolving [1] - 3694:2</p> <p>resource [1] - 3705:2</p> <p>resources [6] - 3660:1, 3660:6, 3687:7, 3687:23, 3694:37, 3694:39</p> <p>respect [3] - 3645:24, 3653:30, 3657:9</p> <p>respects [1] - 3706:38</p> <p>responding [2] - 3699:15, 3699:16</p> <p>response [8] - 3698:29, 3698:35, 3698:40, 3699:3, 3699:19, 3699:23, 3699:35, 3699:46</p> <p>responsibilities [3] -</p>	<p>3651:30, 3660:26, 3708:35</p> <p>responsibility [16] - 3649:8, 3649:15, 3652:2, 3659:44, 3660:28, 3671:32, 3673:39, 3688:34, 3688:39, 3688:43, 3693:3, 3694:46, 3697:43, 3700:32, 3700:33, 3707:8</p> <p>responsible [5] - 3646:6, 3661:4, 3688:42, 3699:9, 3700:36</p> <p>rest [2] - 3659:14, 3672:22</p> <p>restrictions [1] - 3652:38</p> <p>retires [1] - 3708:39</p> <p>retrospectively [1] - 3679:17</p> <p>return [1] - 3651:18</p> <p>review [93] - 3654:16, 3654:36, 3654:43, 3655:15, 3656:39, 3656:43, 3657:16, 3665:46, 3666:23, 3666:29, 3666:37, 3666:42, 3667:8, 3668:42, 3669:16, 3669:26, 3669:27, 3669:34, 3670:24, 3670:28, 3670:29, 3670:31, 3670:34, 3670:47, 3672:3, 3672:17, 3672:27, 3673:3, 3680:29, 3680:30, 3680:35, 3681:16, 3681:35, 3689:26, 3691:44, 3692:19, 3692:24, 3692:30, 3692:33, 3692:41, 3694:4, 3694:30, 3694:41, 3694:43, 3695:2, 3695:6, 3695:16, 3695:36, 3696:7, 3696:19, 3696:21, 3696:24, 3696:28, 3696:36, 3696:38, 3696:39, 3697:3, 3697:5, 3697:7, 3697:8, 3697:11, 3697:36, 3697:38, 3697:39, 3697:41, 3697:46, 3698:2, 3698:4, 3698:12, 3698:15, 3698:16, 3698:17, 3698:21,</p>
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3698:38, 3698:42, 3698:43, 3699:1, 3699:3, 3699:16, 3699:20, 3699:21, 3699:27, 3699:38, 3699:40, 3699:41, 3703:33, 3709:6, 3710:10, 3710:14, 3712:4 reviewed [1] - 3698:33 reviewers [1] - 3655:11 reviews [3] - 3655:17, 3668:12, 3699:34 revised [1] - 3689:37 revisit [2] - 3670:46, 3702:20 Richard [1] - 3639:14 rightly [1] - 3675:24 ring [1] - 3658:18 rise [1] - 3642:7 risk [3] - 3704:2, 3704:46, 3710:42 road [1] - 3652:34 role [26] - 3644:31, 3645:38, 3645:40, 3659:22, 3665:6, 3678:20, 3688:40, 3689:16, 3689:31, 3690:11, 3692:46, 3694:44, 3695:38, 3695:43, 3696:2, 3700:30, 3701:1, 3701:16, 3701:21, 3701:22, 3702:10, 3707:6, 3708:40, 3709:45, 3710:1 roles [8] - 3641:2, 3641:30, 3644:33, 3651:30, 3664:23, 3665:4, 3700:34, 3708:35 roll [1] - 3671:14 Ron [2] - 3692:33, 3692:40 Ross [1] - 3639:27 roster [1] - 3693:41 round [1] - 3712:33 roundtables [3] - 3696:46, 3697:9, 3697:17 route [4] - 3649:4, 3649:5, 3649:23, 3708:5 royal [1] - 3699:34 run [3] - 3644:46, 3658:4, 3675:8 running [2] - 3643:18, 3681:38 rural [4] - 3681:8,	3703:26, 3708:19, 3708:24 S safe [2] - 3646:10, 3700:44 safely [8] - 3646:2, 3646:8, 3649:26, 3651:23, 3682:3, 3690:7, 3700:43, 3701:28 satisfied [1] - 3664:43 Saturday [1] - 3643:41 SC [2] - 3639:14, 3639:26 scare [1] - 3677:19 scenario [1] - 3698:47 SCI.0010.0001.0001 [2] - 3656:41, 3668:21 SCI.0010.0004.0001 [2] - 3654:19, 3672:13 SCI.0010.0004.0001 [1] - 3692:19 SCI.0011.0067.0001 [1] - 3640:30 scope [17] - 3641:30, 3644:34, 3645:4, 3645:30, 3645:35, 3646:2, 3648:3, 3677:15, 3680:5, 3680:7, 3688:40, 3695:2, 3695:6, 3695:37, 3697:37, 3697:45, 3707:44 screen [9] - 3640:29, 3643:9, 3644:2, 3654:29, 3655:1, 3660:19, 3664:46, 3692:19, 3700:2 scroll [2] - 3695:7, 3703:36 seamlessly [1] - 3708:40 second [4] - 3641:28, 3652:21, 3671:17, 3683:28 secondary [6] - 3704:23, 3709:29, 3709:33, 3709:46, 3710:3, 3710:40 secondly [1] - 3689:2 secretary [8] - 3649:2, 3688:32, 3689:16, 3694:3, 3694:46, 3696:5, 3698:24, 3699:43	section [2] - 3645:20, 3669:20 securing [5] - 3642:20, 3642:42, 3683:27, 3686:36, 3687:1 see [49] - 3641:33, 3641:42, 3642:2, 3644:8, 3644:11, 3644:16, 3646:30, 3647:46, 3648:2, 3649:45, 3650:38, 3650:39, 3650:40, 3651:24, 3652:2, 3652:12, 3652:21, 3652:26, 3653:36, 3654:5, 3656:18, 3657:18, 3657:28, 3657:37, 3658:30, 3658:31, 3658:35, 3660:19, 3663:20, 3663:22, 3665:24, 3669:24, 3669:26, 3674:1, 3676:6, 3679:1, 3679:5, 3680:24, 3681:4, 3681:39, 3682:23, 3683:37, 3687:5, 3688:35, 3696:42, 3700:16, 3705:20, 3706:32 seeing [1] - 3708:18 seem [2] - 3677:21, 3708:22 send [3] - 3651:21, 3652:32, 3653:33 sending [2] - 3643:16, 3647:26 Senior [1] - 3639:26 sense [10] - 3646:12, 3648:7, 3656:28, 3661:6, 3679:6, 3694:19, 3694:37, 3695:35, 3698:15, 3699:12 senses [1] - 3691:27 sensible [3] - 3659:41, 3678:32, 3686:12 sent [1] - 3643:40 sentence [3] - 3641:29, 3644:15, 3683:28 separate [2] - 3664:30, 3693:2 separately [1] - 3694:11 series [3] - 3651:33, 3654:33, 3695:1 serious [1] - 3649:27 server [1] - 3650:13	serves [1] - 3706:19 Service [2] - 3643:8, 3691:21 service [70] - 3644:25, 3644:46, 3650:47, 3651:11, 3652:1, 3653:32, 3653:36, 3658:5, 3671:15, 3671:16, 3671:31, 3674:8, 3674:11, 3674:24, 3674:25, 3675:6, 3675:16, 3677:33, 3680:14, 3680:17, 3680:42, 3681:27, 3681:35, 3681:36, 3681:41, 3681:42, 3681:46, 3682:20, 3682:32, 3682:33, 3683:14, 3683:16, 3683:42, 3683:44, 3684:4, 3684:7, 3684:17, 3684:20, 3684:26, 3684:27, 3684:30, 3685:22, 3685:23, 3685:25, 3685:26, 3685:32, 3685:40, 3686:23, 3686:27, 3687:13, 3690:30, 3693:23, 3693:26, 3693:31, 3693:45, 3694:9, 3694:26, 3694:35, 3695:28, 3700:35, 3701:28, 3702:20, 3703:19, 3703:23, 3704:37, 3707:47, 3709:45, 3710:46, 3711:5 services [147] - 3641:10, 3644:15, 3644:33, 3645:3, 3645:5, 3645:25, 3647:33, 3650:20, 3650:21, 3652:8, 3652:9, 3652:29, 3655:16, 3655:34, 3657:5, 3657:8, 3657:18, 3657:27, 3657:43, 3659:8, 3663:28, 3664:25, 3668:43, 3668:44, 3669:4, 3671:18, 3671:20, 3671:21, 3671:35, 3674:10, 3674:12, 3674:13, 3674:19, 3674:27, 3674:29, 3674:30, 3675:2, 3675:27, 3675:46, 3676:16, 3676:29, 3676:30, 3676:31, 3676:32,	3676:39, 3676:44, 3676:45, 3676:47, 3677:2, 3677:8, 3677:10, 3677:11, 3677:18, 3677:21, 3677:23, 3677:34, 3677:35, 3677:36, 3677:41, 3678:32, 3678:47, 3679:10, 3679:11, 3679:13, 3679:20, 3679:21, 3679:22, 3679:25, 3679:26, 3679:27, 3680:9, 3680:18, 3680:20, 3680:43, 3680:45, 3681:10, 3681:11, 3681:12, 3681:44, 3682:1, 3682:27, 3682:35, 3683:19, 3683:20, 3683:34, 3683:35, 3684:6, 3684:10, 3684:16, 3684:36, 3684:37, 3684:39, 3684:40, 3684:41, 3684:42, 3684:44, 3685:4, 3685:27, 3685:44, 3686:1, 3686:10, 3686:12, 3686:13, 3686:14, 3686:17, 3686:18, 3686:32, 3686:36, 3686:41, 3686:43, 3687:2, 3689:10, 3690:12, 3691:40, 3692:37, 3693:10, 3693:13, 3693:19, 3693:29, 3694:5, 3694:14, 3695:31, 3696:20, 3696:39, 3700:6, 3700:26, 3700:35, 3701:17, 3701:23, 3701:24, 3701:36, 3702:15, 3702:31, 3703:6, 3703:14, 3705:26, 3706:6, 3707:7, 3708:20, 3708:21, 3709:11, 3709:42, 3710:4, 3711:6 Services [2] - 3664:27, 3664:31 servicing [2] - 3684:47, 3709:22 set [6] - 3650:5, 3652:43, 3666:34, 3670:30, 3693:4, 3693:9 sets [1] - 3651:30 setting [2] - 3690:47,
--	--	--	---	--

<p>3704:22 settled [1] - 3640:3 seven [2] - 3684:5, 3693:38 several [1] - 3656:47 share [1] - 3653:5 shared [3] - 3662:24, 3663:10, 3663:29 sharper [1] - 3690:36 shift [1] - 3690:44 SHORT [1] - 3678:42 show [1] - 3643:7 shown [4] - 3684:15, 3685:43, 3686:31, 3686:38 siblings [1] - 3652:31 sick [6] - 3644:22, 3662:38, 3662:43, 3663:1, 3663:39, 3684:27 sight [1] - 3663:6 significant [2] - 3675:20, 3705:1 significantly [2] - 3647:30, 3673:11 siloed [2] - 3641:38 similar [1] - 3680:43 similarly [1] - 3650:12 sine [1] - 3712:17 single [15] - 3666:1, 3666:43, 3666:47, 3667:22, 3668:2, 3668:3, 3669:8, 3671:1, 3671:3, 3673:5, 3679:44, 3681:37, 3693:17, 3707:31, 3708:47 sit [2] - 3679:42, 3682:9 site [2] - 3673:5, 3693:41 sites [5] - 3693:27, 3694:16, 3700:36, 3702:17, 3709:8 situation [8] - 3646:32, 3653:8, 3677:38, 3678:10, 3684:9, 3685:28, 3686:3, 3709:15 six [1] - 3648:20 size [1] - 3706:19 skilled [1] - 3693:30 skills [5] - 3690:43, 3693:32, 3693:43, 3694:15, 3709:13 slightly [3] - 3654:14, 3655:31, 3706:21 slip [1] - 3708:40 slowly [2] - 3684:2, 3695:7</p>	<p>small [4] - 3641:47, 3642:5, 3666:9, 3684:2 smaller [3] - 3645:32, 3683:19, 3708:24 social [1] - 3688:42 solution [3] - 3649:19, 3654:3, 3703:4 solutions [1] - 3704:4 someone [11] - 3647:33, 3649:19, 3650:28, 3650:32, 3651:11, 3652:22, 3652:45, 3663:2, 3704:7, 3712:13 something's [1] - 3681:23 sometimes [9] - 3647:25, 3648:43, 3649:16, 3651:21, 3654:1, 3662:5, 3663:20, 3675:33 somewhat [2] - 3684:23, 3689:18 somewhere [2] - 3660:19, 3662:32 sorry [6] - 3644:44, 3645:16, 3647:1, 3650:27, 3668:12, 3712:29 sort [12] - 3649:28, 3650:39, 3652:15, 3653:45, 3662:44, 3692:37, 3696:29, 3699:37, 3703:41, 3706:3, 3708:26, 3709:23 sorts [2] - 3699:34, 3706:10 sought [5] - 3668:45, 3668:46, 3695:19, 3695:21, 3695:42 sound [1] - 3668:25 sounds [1] - 3648:44 source [1] - 3704:45 South [59] - 3639:19, 3641:31, 3646:19, 3646:38, 3655:5, 3656:15, 3656:27, 3665:23, 3665:28, 3665:33, 3665:40, 3665:47, 3666:1, 3666:43, 3666:47, 3667:22, 3667:26, 3667:27, 3667:31, 3667:32, 3667:45, 3668:1, 3668:2, 3669:9, 3669:46, 3671:8, 3671:14, 3671:17, 3671:21,</p>	<p>3671:31, 3671:36, 3671:39, 3671:40, 3672:19, 3672:45, 3673:37, 3674:29, 3675:22, 3677:4, 3677:11, 3677:35, 3677:36, 3679:1, 3679:19, 3680:10, 3680:39, 3681:21, 3681:40, 3681:44, 3686:18, 3688:45, 3689:39, 3693:3, 3700:12, 3702:39, 3702:45, 3704:15, 3708:19, 3709:1 southern [3] - 3665:30, 3674:29, 3692:3 space [1] - 3642:43 SPECIAL [1] - 3712:37 Special [2] - 3639:7, 3692:34 special [1] - 3688:9 specialised [19] - 3646:25, 3646:31, 3646:33, 3647:17, 3656:26, 3662:26, 3662:44, 3676:28, 3677:21, 3683:24, 3683:44, 3684:1, 3684:16, 3686:12, 3686:32, 3686:41, 3690:42, 3709:11, 3709:23 specialist [22] - 3648:17, 3648:22, 3649:21, 3649:25, 3662:32, 3671:8, 3671:30, 3672:47, 3675:37, 3676:24, 3677:5, 3678:21, 3684:4, 3684:6, 3685:44, 3689:16, 3691:6, 3691:8, 3693:35, 3704:8, 3704:23, 3710:43 specialists [4] - 3651:42, 3683:45, 3684:3, 3690:47 specialty [1] - 3689:11 specific [3] - 3641:8, 3686:9, 3696:13 specifically [1] - 3701:1 speed [1] - 3647:12 SPENCER [1] - 3640:13 Spencer [1] - 3640:19 spent [3] - 3642:15, 3642:17, 3709:7</p>	<p>sphere [1] - 3690:17 spoken [1] - 3667:8 spread [2] - 3681:23, 3682:8 St [1] - 3639:36 staff [2] - 3645:1, 3665:36 staffing [4] - 3666:10, 3676:47, 3679:12, 3685:24 stage [19] - 3657:16, 3665:45, 3669:1, 3675:45, 3676:38, 3677:12, 3678:30, 3679:24, 3680:37, 3681:44, 3682:33, 3684:15, 3685:11, 3685:25, 3686:41, 3687:10, 3687:28, 3689:26, 3696:9 staged [1] - 3679:24 stakeholders [1] - 3696:47 standalone [1] - 3710:47 standardise [2] - 3666:12, 3666:14 standardised [1] - 3659:16 stands [1] - 3671:11 start [10] - 3641:1, 3664:25, 3665:4, 3674:34, 3687:16, 3695:5, 3695:9, 3701:33, 3702:9, 3702:32 started [1] - 3684:18 starting [6] - 3704:12, 3704:13, 3704:19, 3704:40, 3709:15, 3709:21 starts [1] - 3668:30 state [58] - 3640:17, 3641:8, 3642:8, 3644:42, 3645:41, 3646:28, 3650:22, 3655:7, 3655:31, 3655:34, 3658:1, 3659:39, 3664:20, 3666:21, 3671:2, 3671:3, 3674:17, 3674:27, 3677:20, 3677:22, 3678:26, 3679:9, 3680:2, 3680:3, 3682:31, 3684:28, 3686:24, 3686:45, 3687:20, 3687:24, 3688:5, 3689:11, 3690:32, 3692:4, 3692:38,</p>	<p>3692:46, 3693:14, 3694:35, 3695:32, 3695:40, 3697:3, 3697:8, 3700:14, 3700:28, 3701:8, 3701:17, 3701:23, 3703:18, 3703:27, 3703:43, 3704:29, 3704:39, 3707:21, 3707:24, 3707:25, 3708:9, 3708:10, 3708:16 statement [14] - 3640:26, 3640:36, 3647:36, 3649:43, 3650:30, 3651:38, 3656:32, 3664:35, 3668:34, 3673:41, 3678:44, 3683:22, 3688:14, 3695:40 statements [1] - 3651:34 statewide [36] - 3641:10, 3644:10, 3646:17, 3646:35, 3650:8, 3651:29, 3651:32, 3653:41, 3655:20, 3657:26, 3659:17, 3674:24, 3674:25, 3677:41, 3682:26, 3685:40, 3685:45, 3686:8, 3686:11, 3686:35, 3686:42, 3695:9, 3696:19, 3698:22, 3700:46, 3701:3, 3701:15, 3701:23, 3703:17, 3703:42, 3704:2, 3704:45, 3705:18, 3705:33, 3705:37 stay [1] - 3652:23 steer [1] - 3672:2 steering [6] - 3667:27, 3668:5, 3683:12, 3689:28, 3704:40, 3707:29 Steering [11] - 3657:36, 3660:12, 3666:28, 3667:10, 3667:29, 3667:34, 3669:42, 3671:5, 3672:29, 3680:27, 3689:25 step [7] - 3651:39, 3652:44, 3652:47, 3653:2, 3660:47, 3692:32, 3711:15 steps [1] - 3653:1 still [13] - 3657:31,</p>
---	--	--	--	--

<p>3657:39, 3666:45, 3669:1, 3670:47, 3675:36, 3681:16, 3688:9, 3689:17, 3694:5, 3699:44, 3700:2, 3710:15</p> <p>stood [2] - 3669:35, 3670:2</p> <p>stop [2] - 3687:13, 3687:16</p> <p>straight [1] - 3654:20</p> <p>strange [1] - 3663:17</p> <p>strategic [5] - 3646:17, 3666:11, 3667:27, 3668:4, 3702:38</p> <p>strategies [4] - 3671:4, 3671:13, 3671:15, 3672:45</p> <p>Strategy [1] - 3688:33</p> <p>strategy [5] - 3655:5, 3661:23, 3700:11, 3700:46, 3701:3</p> <p>stream [2] - 3643:32, 3643:37</p> <p>streamlined [1] - 3672:18</p> <p>Streams [4] - 3664:27, 3664:31, 3665:7, 3665:8</p> <p>Street [1] - 3639:18</p> <p>strength [1] - 3687:6</p> <p>strengthen [1] - 3701:42</p> <p>strengths [1] - 3641:33</p> <p>strong [2] - 3651:44, 3694:23</p> <p>structure [14] - 3645:43, 3666:33, 3666:44, 3667:18, 3667:44, 3670:44, 3674:36, 3679:34, 3681:40, 3682:14, 3683:25, 3691:32, 3707:16, 3708:13</p> <p>structures [3] - 3658:31, 3658:37, 3707:44</p> <p>struggle [1] - 3703:23</p> <p>struggling [2] - 3669:11, 3679:19</p> <p>stuff [1] - 3650:18</p> <p>subacute [1] - 3662:39</p> <p>subheading [2] - 3658:43, 3695:19</p> <p>submissions [1] - 3641:18</p> <p>subsequent [2] -</p>	<p>3692:34, 3698:12</p> <p>subsequently [4] - 3689:28, 3693:4, 3696:23, 3705:33</p> <p>subsidiary [1] - 3667:43</p> <p>subspecialisation [4] - 3690:16, 3702:3, 3702:5, 3709:10</p> <p>subspecialist [1] - 3650:47</p> <p>subspecialists [4] - 3647:22, 3648:4, 3652:7, 3663:32</p> <p>subspecialties [3] - 3690:21, 3690:25, 3706:14</p> <p>subspecialty [5] - 3650:45, 3653:14, 3653:30, 3679:22, 3690:38</p> <p>substance [1] - 3707:43</p> <p>subtly [1] - 3643:16</p> <p>successes [1] - 3679:17</p> <p>successful [1] - 3694:40</p> <p>successor [1] - 3708:40</p> <p>suggest [1] - 3701:13</p> <p>suggested [2] - 3681:36, 3705:19</p> <p>suggesting [1] - 3704:19</p> <p>suggestion [2] - 3650:36, 3678:28</p> <p>suitable [1] - 3640:5</p> <p>summarise [2] - 3685:37, 3707:42</p> <p>summary [3] - 3647:8, 3673:24, 3673:25</p> <p>super [1] - 3677:18</p> <p>super-regional [1] - 3677:18</p> <p>support [23] - 3645:2, 3662:6, 3674:13, 3675:39, 3689:9, 3690:26, 3690:30, 3690:41, 3691:3, 3691:4, 3691:10, 3691:40, 3697:42, 3700:29, 3700:38, 3700:42, 3701:37, 3702:24, 3705:6, 3705:25, 3707:35, 3707:44</p> <p>supported [7] - 3689:42, 3689:46, 3690:32, 3692:44,</p>	<p>3706:14, 3708:31</p> <p>supporting [2] - 3683:19, 3695:43</p> <p>supports [1] - 3691:38</p> <p>surgeons [2] - 3693:40, 3693:42</p> <p>Surgery [2] - 3643:8, 3691:22</p> <p>surgery [4] - 3645:22, 3675:22, 3693:23, 3696:45</p> <p>surrounding [1] - 3709:41</p> <p>sustained [1] - 3707:37</p> <p>sworn [1] - 3688:1</p> <p>Sydney [28] - 3639:19, 3662:26, 3665:44, 3665:45, 3668:47, 3674:7, 3674:36, 3675:42, 3676:4, 3676:8, 3676:9, 3676:22, 3690:45, 3691:47, 3692:1, 3692:12, 3692:45, 3693:11, 3693:14, 3698:31, 3701:2, 3701:35, 3702:11, 3702:30, 3703:8, 3708:6, 3709:22, 3710:18</p> <p>Sydney's [1] - 3676:12</p> <p>system [52] - 3641:11, 3641:22, 3641:40, 3641:41, 3642:1, 3642:6, 3642:15, 3642:47, 3643:2, 3644:10, 3644:28, 3647:44, 3647:45, 3648:30, 3648:43, 3649:14, 3649:45, 3650:4, 3651:25, 3652:4, 3652:14, 3652:47, 3653:22, 3653:29, 3653:34, 3657:38, 3658:1, 3658:18, 3660:34, 3660:41, 3661:9, 3661:37, 3662:24, 3662:33, 3662:41, 3663:18, 3663:33, 3666:37, 3673:37, 3675:4, 3677:1, 3678:35, 3681:24, 3682:8, 3682:12, 3682:26, 3688:32, 3691:38, 3707:4, 3707:45, 3708:32</p> <p>system-wide [2] - 3653:22, 3653:29</p>	<p>systemic [1] - 3659:6</p> <p>systems [4] - 3641:37, 3652:13, 3678:24</p> <hr/> <p style="text-align: center;">T</p> <hr/> <p>tailored [1] - 3706:34</p> <p>talks [1] - 3709:17</p> <p>Tamsin [1] - 3639:28</p> <p>Tamworth [3] - 3653:37, 3674:13, 3706:37</p> <p>tasked [1] - 3656:47</p> <p>team [8] - 3645:44, 3647:24, 3649:2, 3652:15, 3684:4, 3684:19, 3684:22, 3690:43</p> <p>Teams [3] - 3643:17, 3643:40</p> <p>teams [2] - 3684:3, 3684:18</p> <p>technologies [1] - 3690:41</p> <p>technology [1] - 3662:4</p> <p>tender [3] - 3640:44, 3688:25, 3711:32</p> <p>term [2] - 3675:36, 3698:11</p> <p>terms [19] - 3644:33, 3645:33, 3650:3, 3650:17, 3652:29, 3654:41, 3660:10, 3660:21, 3660:27, 3666:35, 3675:41, 3690:27, 3691:45, 3694:6, 3694:23, 3695:15, 3695:40, 3697:38, 3699:40</p> <p>tertiary [30] - 3652:8, 3663:19, 3668:44, 3669:4, 3671:20, 3674:30, 3674:47, 3675:9, 3675:41, 3676:16, 3676:44, 3677:2, 3677:11, 3677:34, 3678:11, 3678:12, 3678:13, 3678:14, 3678:47, 3680:18, 3680:21, 3680:45, 3686:18, 3686:27, 3687:30, 3690:11, 3702:40, 3703:5, 3709:26, 3709:46</p> <p>testing [1] - 3699:13</p> <p>text [2] - 3658:44, 3658:47</p> <p>THE [82] - 3640:1,</p>	<p>3640:7, 3640:33, 3640:46, 3643:12, 3643:16, 3643:28, 3643:34, 3643:39, 3643:46, 3644:44, 3645:16, 3646:46, 3647:3, 3648:9, 3650:27, 3653:45, 3654:23, 3654:27, 3654:31, 3655:40, 3656:8, 3656:34, 3658:24, 3658:28, 3660:18, 3661:37, 3662:17, 3662:43, 3664:2, 3664:5, 3664:7, 3664:9, 3664:11, 3664:16, 3665:2, 3668:9, 3668:18, 3668:23, 3668:30, 3669:11, 3669:18, 3669:24, 3669:32, 3670:13, 3670:18, 3670:41, 3671:47, 3672:15, 3677:46, 3678:39, 3680:47, 3685:13, 3687:34, 3687:38, 3687:41, 3687:43, 3688:28, 3699:33, 3705:36, 3708:4, 3708:45, 3710:6, 3710:12, 3710:25, 3710:32, 3711:12, 3711:20, 3711:24, 3711:27, 3711:29, 3711:35, 3711:41, 3711:46, 3712:6, 3712:10, 3712:15, 3712:20, 3712:24, 3712:29, 3712:35, 3712:37</p> <p>themselves [2] - 3703:9, 3705:4</p> <p>thereafter [2] - 3644:27, 3697:36</p> <p>therefore [2] - 3642:23, 3682:11</p> <p>they've [1] - 3682:33</p> <p>thinking [3] - 3653:35, 3676:14, 3681:10</p> <p>thousand [2] - 3641:5, 3658:15</p> <p>three [31] - 3647:10, 3647:20, 3651:22, 3663:22, 3665:29, 3665:47, 3666:34, 3667:9, 3669:22, 3670:36, 3676:14, 3676:34, 3676:38, 3676:47, 3677:9,</p>
---	---	--	--	--

<p>3677:15, 3677:27, 3677:42, 3677:47, 3678:3, 3679:30, 3679:35, 3679:37, 3679:38, 3679:39, 3679:42, 3680:4, 3689:4, 3693:40, 3701:34</p> <p>throughout [1] - 3665:40</p> <p>tick [1] - 3659:15</p> <p>ties [1] - 3640:2</p> <p>timeframe [1] - 3696:30</p> <p>timeline [1] - 3696:27</p> <p>timing [3] - 3698:13, 3699:17, 3699:18</p> <p>TO [1] - 3712:38</p> <p>today [22] - 3640:10, 3640:36, 3643:32, 3643:37, 3655:8, 3655:12, 3655:17, 3657:31, 3664:40, 3683:23, 3685:39, 3688:18, 3688:47, 3689:5, 3689:41, 3690:46, 3694:34, 3700:20, 3705:11, 3705:32, 3706:42, 3707:32</p> <p>together [31] - 3641:18, 3641:42, 3642:2, 3655:41, 3660:42, 3665:15, 3666:7, 3669:8, 3676:15, 3676:17, 3676:21, 3676:37, 3677:1, 3677:16, 3677:28, 3677:32, 3677:39, 3677:43, 3677:47, 3679:42, 3679:43, 3692:9, 3693:19, 3694:10, 3694:18, 3694:26, 3701:7, 3701:18, 3707:12</p> <p>took [5] - 3648:19, 3681:26, 3691:20, 3691:26, 3709:36</p> <p>topic [2] - 3654:15, 3695:4</p> <p>touch [1] - 3683:26</p> <p>touching [1] - 3679:4</p> <p>touching [1] - 3689:35</p> <p>towards [2] - 3693:28, 3709:10</p> <p>town [5] - 3642:37, 3645:31, 3645:32, 3645:46, 3648:4</p> <p>towns [1] - 3708:24</p>	<p>traditional [1] - 3681:4</p> <p>train [2] - 3645:8, 3662:40</p> <p>trained [1] - 3645:1</p> <p>transcript [6] - 3643:18, 3643:25, 3643:36, 3644:45, 3645:11, 3645:14</p> <p>transfer [15] - 3644:27, 3646:24, 3646:39, 3647:16, 3647:21, 3648:5, 3649:28, 3663:3, 3681:31, 3682:39, 3683:18, 3690:4, 3691:4, 3700:44, 3707:25</p> <p>transferred [2] - 3690:45, 3706:15</p> <p>transferring [1] - 3662:34</p> <p>transfers [3] - 3644:9, 3674:26, 3682:25</p> <p>transition [2] - 3665:34, 3665:47</p> <p>translate [1] - 3683:30</p> <p>translates [1] - 3704:6</p> <p>translation [1] - 3704:36</p> <p>transport [2] - 3644:25, 3662:40</p> <p>travel [2] - 3652:21, 3652:24</p> <p>treat [1] - 3644:37</p> <p>treated [1] - 3649:26</p> <p>treating [3] - 3642:45, 3644:38, 3675:31</p> <p>treatment [2] - 3651:23, 3663:29</p> <p>treatments [1] - 3709:24</p> <p>treats [1] - 3642:11</p> <p>trend [4] - 3693:28, 3693:34, 3693:36, 3709:10</p> <p>tried [1] - 3643:16</p> <p>troublesome [1] - 3653:13</p> <p>true [9] - 3640:39, 3655:45, 3656:28, 3662:3, 3664:43, 3665:25, 3667:12, 3667:16, 3688:21</p> <p>truly [1] - 3674:25</p> <p>trust [1] - 3706:46</p> <p>truth [1] - 3659:35</p> <p>try [9] - 3682:11, 3684:20, 3684:43, 3684:46, 3685:9, 3685:10, 3685:21,</p>	<p>3685:24, 3707:42</p> <p>trying [15] - 3648:30, 3660:35, 3666:14, 3666:19, 3672:38, 3675:8, 3675:26, 3679:42, 3680:31, 3680:44, 3684:4, 3684:19, 3693:38, 3703:17, 3707:4</p> <p>Tuesday [1] - 3710:8</p> <p>turn [5] - 3656:5, 3656:17, 3656:40, 3660:26, 3678:44</p> <p>turned [1] - 3669:41</p> <p>two [28] - 3642:9, 3643:24, 3645:26, 3651:6, 3651:10, 3655:31, 3663:21, 3665:43, 3671:8, 3671:13, 3672:47, 3673:33, 3676:8, 3676:22, 3680:40, 3682:15, 3684:10, 3684:12, 3684:32, 3691:47, 3692:8, 3693:38, 3694:10, 3694:29, 3700:7, 3701:34, 3703:22, 3709:8</p> <p>two-way [2] - 3651:6, 3651:10</p> <p>type [5] - 3647:15, 3650:4, 3651:27, 3680:4, 3706:10</p>	<p>3692:41, 3696:23, 3696:40, 3697:39</p> <p>undertaken [3] - 3697:11, 3699:17, 3699:22</p> <p>undertook [2] - 3670:28, 3697:41</p> <p>undoubtedly [1] - 3652:37</p> <p>unduly [1] - 3703:44</p> <p>unique [1] - 3641:46</p> <p>unit [6] - 3645:32, 3683:31, 3690:20, 3702:8, 3702:19, 3706:13</p> <p>units [1] - 3709:39</p> <p>unless [2] - 3660:7, 3712:24</p> <p>unlikely [1] - 3708:17</p> <p>unpack [1] - 3664:34</p> <p>unpick [1] - 3709:9</p> <p>unpronounceable [1] - 3670:20</p> <p>unquestionably [2] - 3642:42, 3646:20</p> <p>unreasonable [1] - 3699:45</p> <p>unrest [2] - 3693:22, 3693:25</p> <p>unsorted [1] - 3652:11</p> <p>unwell [1] - 3642:12</p> <p>up [33] - 3640:29, 3641:20, 3643:9, 3643:18, 3646:2, 3646:37, 3648:3, 3651:13, 3652:8, 3652:13, 3654:19, 3656:40, 3664:46, 3666:34, 3667:33, 3669:35, 3670:2, 3672:10, 3674:47, 3675:36, 3678:34, 3679:43, 3681:38, 3684:16, 3689:17, 3690:21, 3692:19, 3693:4, 3693:9, 3701:42, 3703:5, 3709:18, 3711:17</p> <p>updated [2] - 3650:40, 3708:26</p> <p>upwards [1] - 3674:31</p> <p>urgent [1] - 3686:45</p> <p>useful [3] - 3682:45, 3708:8, 3708:28</p> <p>useless [1] - 3643:41</p> <p>usual [1] - 3683:3</p> <p>utilised [1] - 3648:1</p> <p>utility [2] - 3704:45, 3705:38</p>	<p style="text-align: center;">V</p> <p>valiantly [1] - 3643:25</p> <p>variable [1] - 3707:23</p> <p>variety [4] - 3640:2, 3642:13, 3652:5, 3691:27</p> <p>various [6] - 3644:32, 3644:41, 3684:42, 3701:17, 3703:14, 3708:23</p> <p>version [1] - 3650:29</p> <p>Victoria [1] - 3663:28</p> <p>video [1] - 3648:5</p> <p>view [21] - 3641:29, 3641:36, 3641:45, 3646:25, 3650:44, 3651:44, 3651:47, 3666:11, 3675:3, 3676:19, 3677:28, 3679:35, 3693:9, 3697:2, 3699:13, 3700:3, 3700:24, 3704:38, 3708:14, 3708:29, 3710:19</p> <p>views [1] - 3654:47</p> <p>Vincent's [1] - 3639:36</p> <p>virtual [4] - 3676:32, 3676:46, 3681:5, 3686:44</p> <p>virtually [1] - 3686:45</p> <p>vision [5] - 3671:1, 3671:3, 3681:38, 3704:14, 3704:17</p> <p>visit [1] - 3652:31</p> <p>volume [2] - 3693:29, 3709:12</p> <p>voted [1] - 3709:35</p>
		<p>U</p>		
		<p>ultimately [3] - 3663:44, 3692:47, 3710:29</p> <p>unclear [3] - 3654:42, 3659:31, 3660:34</p> <p>uncommon [1] - 3694:16</p> <p>under [9] - 3644:8, 3647:8, 3657:14, 3657:25, 3668:11, 3668:18, 3670:47, 3676:12, 3682:23</p> <p>underestimate [1] - 3706:42</p> <p>underpin [1] - 3704:5</p> <p>underrepresented [1] - 3657:43</p> <p>understatement [1] - 3703:1</p> <p>understood [2] - 3646:26, 3698:12</p> <p>undertake [6] - 3641:8, 3648:18,</p>		
		<p>W</p>		
		<p>Wagga [6] - 3640:22, 3644:47, 3649:9, 3706:19, 3706:29</p> <p>wait [1] - 3647:27</p> <p>waiting [3] - 3678:13, 3684:31, 3684:33</p> <p>Wales [59] - 3639:19, 3641:31, 3646:19, 3646:38, 3655:6, 3656:15, 3656:27, 3665:23, 3665:28, 3665:33, 3665:40, 3666:1, 3666:43, 3666:47, 3667:23, 3667:26, 3667:28, 3667:31, 3667:33, 3667:45, 3668:1, 3668:3, 3669:9,</p>		

<p>3669:46, 3671:8, 3671:14, 3671:17, 3671:21, 3671:31, 3671:36, 3671:39, 3671:40, 3672:19, 3672:45, 3673:37, 3674:29, 3675:22, 3677:4, 3677:11, 3677:35, 3677:36, 3679:1, 3679:19, 3680:10, 3680:39, 3681:21, 3681:40, 3681:45, 3686:19, 3688:45, 3689:39, 3693:3, 3700:12, 3702:39, 3702:45, 3704:15, 3708:19, 3709:1</p> <p>wants [1] - 3661:3</p> <p>ward [3] - 3644:47, 3663:21, 3674:44</p> <p>WAS [1] - 3712:37</p> <p>Waterhouse [1] - 3639:28</p> <p>ways [3] - 3641:40, 3652:28, 3694:24</p> <p>website [2] - 3650:9, 3650:19</p> <p>week [5] - 3652:21, 3684:5, 3693:39, 3703:8, 3705:11</p> <p>weeks [1] - 3643:26</p> <p>weighted [1] - 3683:31</p> <p>well-oiled [1] - 3644:28</p> <p>western [2] - 3665:30, 3692:3</p> <p>Westmead [10] - 3648:22, 3650:10, 3655:3, 3662:45, 3665:44, 3692:3, 3709:34, 3709:37, 3710:41, 3711:5</p> <p>whereas [2] - 3644:39, 3675:43</p> <p>whiny [1] - 3648:45</p> <p>whole [9] - 3645:3, 3665:9, 3674:26, 3678:5, 3680:10, 3692:10, 3696:18, 3707:18, 3710:2</p> <p>wide [5] - 3653:22, 3653:29, 3656:27, 3666:42, 3687:5</p> <p>wide-ranging [1] - 3687:5</p> <p>wider [1] - 3676:4</p> <p>wish [1] - 3647:20</p> <p>withdraw [4] -</p>	<p>3642:27, 3664:25, 3697:34, 3704:13</p> <p>WITHDREW [3] - 3664:11, 3687:43, 3711:29</p> <p>witness [9] - 3640:10, 3640:11, 3647:3, 3654:27, 3662:14, 3664:13, 3687:32, 3687:45, 3712:30</p> <p>WITNESS [8] - 3664:5, 3664:9, 3664:11, 3670:18, 3687:41, 3687:43, 3711:27, 3711:29</p> <p>witnesses [3] - 3690:24, 3705:15, 3705:19</p> <p>women's [1] - 3665:11</p> <p>won [1] - 3696:38</p> <p>word [2] - 3652:12, 3672:43</p> <p>workforce [12] - 3681:7, 3683:7, 3683:35, 3684:1, 3686:19, 3686:20, 3686:23, 3689:45, 3689:46, 3693:30, 3703:21</p> <p>workplace [1] - 3708:21</p> <p>works [4] - 3644:29, 3674:15, 3674:16, 3706:36</p> <p>world [4] - 3645:45, 3646:10, 3660:13, 3676:11</p> <p>world-class [1] - 3645:45</p> <p>worth [1] - 3708:17</p> <p>write [1] - 3689:3</p>	<p>3680:9, 3683:12, 3704:39, 3707:29</p> <p>Young [20] - 3657:35, 3660:11, 3664:26, 3664:29, 3665:6, 3665:10, 3666:27, 3667:10, 3667:28, 3667:33, 3667:47, 3669:42, 3671:5, 3671:27, 3671:33, 3672:29, 3672:37, 3674:14, 3680:27, 3689:24</p> <p>younger [1] - 3642:46</p> <p>yourself [2] - 3647:10, 3695:5</p> <p>youth [1] - 3657:17</p>
Y		
<p>whereas [2] - 3644:39, 3675:43</p> <p>whiny [1] - 3648:45</p> <p>whole [9] - 3645:3, 3665:9, 3674:26, 3678:5, 3680:10, 3692:10, 3696:18, 3707:18, 3710:2</p> <p>wide [5] - 3653:22, 3653:29, 3656:27, 3666:42, 3687:5</p> <p>wide-ranging [1] - 3687:5</p> <p>wider [1] - 3676:4</p> <p>wish [1] - 3647:20</p> <p>withdraw [4] -</p>	<p>year [3] - 3689:2, 3693:39, 3701:33</p> <p>years [13] - 3651:22, 3651:46, 3654:39, 3666:35, 3666:37, 3674:46, 3676:27, 3676:30, 3690:15, 3690:35, 3702:1, 3705:3, 3707:19</p> <p>yesterday [1] - 3643:23</p> <p>young [13] - 3642:45, 3657:15, 3657:26, 3659:7, 3664:24, 3666:20, 3667:31, 3667:44, 3669:46,</p>	