

**Special Commission of Inquiry
into Healthcare Funding**

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

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

Monday, 22 July 2024 at 10.00am

(Day 036)

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 Richard Cheney SC with Mr Hilbert Chiu for NSW Health

1 THE COMMISSIONER: Good morning, everyone. In a moment,
2 I will invite Mr Muston SC to deliver an opening statement
3 for this hearing block for the Special Commission of
4 Inquiry into Healthcare Funding, but before I do that,
5 I acknowledge the Gadigal people of the Eora nation,
6 traditional owners of the land on which we gather today and
7 pay my respects to their Elders, past, present and
8 emerging.

9
10 Mr Muston?

11
12 MR MUSTON: Thank you, Commissioner.

13
14 Today we embark on our first hearing, which deals
15 specifically with workforce issues. It is by no means the
16 first time we're hearing about workforce challenges within
17 the public health system. They have been extensively
18 addressed in evidence given during both the opening hearing
19 block last November but also they've been a recurring theme
20 in our regional and rural hearings, where many of the
21 workforce challenges are particularly acute.

22
23 A clear picture is already emerging that workforce
24 challenges are both endemic and have a pernicious effect on
25 the public health system.

26
27 In saying that, that's from the perspective not only
28 of its ability to deliver the care that it needs to
29 deliver, but also in terms of its long-term economic
30 viability.

31
32 But these issues are not only not new to this Inquiry,
33 they are not new to the health system. Much of what we
34 will be hearing fairly closely reflects the content of
35 a report of the NSW Health Council prepared in March 2000,
36 which is proposed to be exhibit H2.1. I won't take you to
37 that now but park it in your mind because it does, at
38 least, as best as we interpret it, seem to reflect fairly
39 closely the same challenges as we are being told exist and
40 proposes some of the same solutions that we anticipate
41 going forward people will suggest ought be applied to those
42 challenges.

43
44 But during this hearing block, we will be taking
45 a closer look at some of the particular challenges.

46
47 Before touching on the areas that we're going to

1 examine over the next few weeks, we think it might be worth
2 noting something about the approach we intend to take.

3
4 In this hearing block, we're going to look at the
5 current state and composition of the health workforce in
6 New South Wales, and in particular, its medical staff,
7 nurses, midwives and allied health professionals; and
8 a current approach to the training, recruitment and
9 engagement of the health workforce within the public
10 system; and, finally, current and future issues and
11 challenges relating to training, recruitment and retention
12 of a suitable health workforce and one which is capable of
13 meeting the current and future health needs of the
14 population.

15
16 In essence what we're seeking to do is establish
17 something of a baseline and then pick out of that some key
18 challenges, or at least some pervasive systemic challenges
19 that this Inquiry might usefully make some recommendations
20 about.

21
22 In relation to the baseline, we have received and
23 propose to tender a report prepared by Rian Thompson.
24 Mr Thompson is a director of the workforce insight and
25 transformation workforce planning and talent development
26 branch, which is a bit of a mouthful, but his report
27 provides a useful point in time snapshot of much of what
28 we've just stepped through - that is to say, the
29 composition of the existing health workforce. It can be
30 found at [MOH.0010.0377.0001]. I won't take you to it now
31 but in due course, it will be tendered.

32
33 I should add, it is not our current intention to call
34 Mr Thompson to speak to his report. It is essentially
35 a report which sets out his work analysing much of the data
36 that is kept by NSW Health and setting it out in what we
37 think is a more digestible form for our purposes.

38
39 That's the baseline. Identifying some of the key
40 challenges is obviously going to be a slightly more
41 elaborate exercise, but - and this is in the context of
42 explaining our approach - having identified those
43 challenges or identified challenges that we think the
44 Inquiry can usefully or potentially make some
45 recommendations in relation to, it's our intention to
46 return to them in hearings scheduled for October, in which
47 we propose to focus on the identification and consideration

1 of some potential responses or solutions to those
2 challenges.

3
4 Now, as part of that process, we intend to release
5 a discussion paper well in advance of those hearings, which
6 identifies what we see as the key challenges rattling out
7 of this immediate hearing block, in the hope that by doing
8 so, we will be able to better direct the exercise we're
9 undertaking in October from an evidentiary perspective, if
10 nothing else.

11
12 But moving to the particular issues we intend to
13 explore during the immediate hearing block, the first,
14 which I described a few moments ago as "setting the
15 baseline" is, as I noted, the current state and composition
16 of the health workforce.

17
18 We intend to examine the number and distribution of
19 employees within the health workforce, differentiated by
20 their discipline in the LHD or specialty network in which
21 they work. In each case we'll endeavour to understand how
22 workforce shortages affect the delivery of care through the
23 public health system in the LHDs and specialty networks and
24 potentially the reasons for those shortages.

25
26 As I said not a few moments ago, our workforce
27 shortages and maldistribution have each been very much
28 recurring themes in the evidence received by the Inquiry to
29 date and particularly in the rural and regional areas.

30
31 We intend to touch on the utilisation of what has been
32 described as "premium labour", which broadly captures
33 overtime agency staff and medical locums. And related to
34 this, we'll have a look at the different ways in which the
35 medical workforce is retained, the divide between salaried
36 staff specialists, VMOs and locums and the role that each
37 of those particular forms of retention does, or ideally
38 should play, within the health system.

39
40 As I've already noted, much of that, what I have just
41 been through, is addressed in Mr Thompson's report.

42
43 Building a little bit on Mr Thompson's report, we are
44 also going to look at the types of workforce data which are
45 being collected by NSW Health and the extent to which
46 they're being utilised in the context of workforce planning
47 at a statewide and at a local level, and if so, how they're

1 being used. We'll look a little bit more broadly in that
2 context at the nature and efficacy of some of the existing
3 planning activities insofar as they relate to workforce.
4

5 That probably brings us to the next core issue that
6 we're going to touch on during this hearing block, which is
7 training. We anticipate there's going to be fairly broad
8 agreement between all of the relevant stakeholders that
9 good training pathways are critical to meeting many of the
10 workforce challenges.

11
12 The evidence that we will hear over the coming weeks
13 will touch on a wide range of training issues and some
14 initiatives across the workforce, but we do intend to look
15 a little bit more closely at several issues which appear to
16 have been a more prominent feature of some of the
17 submissions received.

18
19 The first is vocational training of medical
20 specialists. Shortages and maldistribution of particular
21 specialists and sub-specialists again have been a strong
22 feature of both the evidence that the Inquiry has received
23 to date and also the submissions received, particularly in
24 rural and regional areas.

25
26 Against that background, it's our view that training
27 pathways, insofar as they relate to those specialists and
28 sub-specialists, are particularly important.

29
30 Specialist training pathways do vary from one area of
31 specialisation to another and appear to have many moving
32 parts, as we will discover as the evidence rolls out, but
33 it has been suggested that there are some blockages in some
34 of these training pathways which are contributing to the
35 workforce challenges, particularly the shortages and
36 maldistribution.

37
38 That is probably not an enormously controversial
39 proposition. What is more controversial, or the area in
40 which there seemed to be strongly conflicting views, is the
41 source of these blockages. We don't intend to go too far
42 into the wrongs and rights of any particular training
43 decision made regarding any particular specialisation at
44 any particular facility, but we will hear from a number of
45 specialist colleges regarding their involvement in the
46 training of their prospective fellows and we will hear
47 their view as to where they think some of the potential

1 blockages or what some of the limiting factors are in terms
2 of their ability or the ability for the broader system to
3 train and deliver more specialists and sub-specialists.
4

5 We'll also hear from LHD and ministry witnesses
6 involved in the training of these specialists with a view
7 to understanding their perspective on where those potential
8 blockages lie and what the key integers in the training
9 pathways are so that we can try and make some assessment of
10 where the challenges might realistically lie.
11

12 I should say in this area, we are building on a very
13 substantial body of work which has already been done by the
14 National Health Practitioner Ombudsman, who has issued
15 a report dealing with it. It's certainly not our intention
16 to traverse ground already covered extensively by that work
17 and, if so, certainly not to any significant degree.
18

19 We'll also be building on evidence that we've gathered
20 during our regional hearings in relation to the
21 relationship between universities and other tertiary
22 training entities in the public system, particularly
23 insofar as not so much specialist training is concerned, or
24 the vocational training for specialists is concerned, but
25 more the training of medical graduates, interaction between
26 the universities and public health system for the delivery
27 of clinical placements, and the training of medical
28 graduates during that first PGY1 year that they have, but
29 also interactions between the universities and LHDs in
30 other parts of the public health system which deal with the
31 training of allied health professionals and nursing staff.
32

33 Now, one particular issue that has been touched on in
34 submissions and discussions that the Inquiry team has had
35 with various stakeholders in that space, particularly the
36 allied health space, is the availability of clinical
37 placement positions.
38

39 Something that we will explore is the extent to which
40 the availability of those clinical placements, particularly
41 for allied health professionals, is operating as a limiting
42 factor in the system's ability to produce more allied
43 health professionals across a range of disciplines and
44 shortages and maldistribution of allied health
45 professionals, particularly against the background of the
46 pressure being imposed upon that particular sector of the
47 workforce by aged care and the NDIS, for example, which is

1 an issue that does, we think, need to be grappled with.

2
3 Now, before moving on from training, it's probably
4 worth observing that the public health system, and
5 especially public hospitals, do play a very significant
6 role in the training of the state's health workforce. But
7 for various reasons, it does appear that the public system
8 struggles to retain within its own workforce many of the
9 people it has committed significant time, money and effort
10 to training, which probably leads us nicely to the next
11 issue that we intend to explore over the coming weeks,
12 which is recruitment and retention of the health workforce
13 within the public system.

14
15 There is an obvious overlap between the training
16 pathways and recruitment. Having said that, recruitment
17 also occurs from outside of these training pathways,
18 including recruitment of internationally trained and
19 qualified health workers. We will have a look at some of
20 those other pathways into the health workforce, although
21 again, we note that a significant amount of work,
22 particularly in relation to internationally trained medical
23 graduates, has been done in Kruk review, and we don't
24 intend to revisit work done there.

25
26 Evidence is going to touch on recruitment practices,
27 but also, and perhaps more significantly, on some of the
28 issues driving retention issues within the workforce, once
29 people have been recruited. These retention issues we
30 anticipate are multifactorial and messily human, but we'll
31 look at a range of issues which have been touched on in the
32 submissions and are picked up in the evidence, including
33 the way that NSW Health and its component parts assess the
34 satisfaction of its workforce; the manner in which those
35 administering the public health system consult with the
36 workforce on issues of planning; and in addressing concerns
37 and grievances that the workforce might have about the way
38 in which the system's operating; and the handling of
39 complaints against members of the workforce.

40
41 Obviously in respect of that last piece, very
42 difficult to assess at a systemic level, and it's not our
43 intention to dive into, at least not in too much detail,
44 the rights and wrongs of any particular disciplinary matter
45 which has been determined, although we are alive to the
46 suggestion which has been made in several submissions that
47 the disciplinary system is, to use the term that's

1 repeatedly been used, "weaponised" against those who speak
2 out, and we just intend to try to come to understand, at
3 least so far as that is suggested, what that means and what
4 it might broadly look like from the perspective not only of
5 the clinician but also of the system dealing with the
6 complaints. Undoubtedly the views in respect of those
7 issues will differ depending on the perspective you are
8 looking at them from.

9
10 Other issues which are central to recruitment and
11 retention are remuneration of working conditions which are
12 available to prospective and existing members of the health
13 workforce in New South Wales. We anticipate on these
14 fronts that we will be told both present very serious
15 challenges and, interestingly, we anticipate that there's
16 probably going to be some uniformity in the evidence which
17 is given on these issues by witnesses from within the
18 Ministry of Health on the one hand and also from groups
19 representing different elements of the workforce on the
20 other, including the Health Services Union, the Australian
21 Medical Association and ASMOF, the industrial body that
22 represents salaried medical professionals, in essence, the
23 staff specialists.

24
25 We expect the Inquiry will be told from both sides of
26 the ledger that the cap on public sector wage increases in
27 New South Wales over the past decade or so has had a very
28 serious and negative impact on recruitment and retention of
29 the permanent health workforce.

30
31 We also expect the Inquiry will be told that many of
32 the industrial awards governing employment conditions
33 within the health sector are outdated and in need of total
34 reform. The sense one gets from the submissions received
35 and an examination of the industrial awards is that the
36 awards have simply failed to adapt to very significant
37 changes in the way in which health care is delivered within
38 a contemporary environment and the way in which the health
39 workforce is utilised for that purpose.

40
41 One thing that is potentially symptomatic of that is
42 the emergence of what have been described as "non-standard"
43 arrangements, essentially arrangements with members of the
44 health workforce which sit in some respects slightly
45 uncomfortably with the strict terms of the industrial
46 awards. In some cases, those arrangements are approved via
47 a formal process by the health secretary. In other cases,

1 they would appear to have grown more organically.

2
3 We will examine the non-standard arrangements at
4 a relatively high level with a view to identifying some of
5 the particular challenges they present, rather than getting
6 into the, again, rights and wrongs of whether a particular
7 payment made to a particular person at a particular
8 facility is appropriate or inappropriate. That's not
9 really the role of this Inquiry.

10
11 The particular challenges that the non-standard
12 arrangements present, at least potentially, include the
13 following: first, people within the public sector being
14 paid differently or enjoying different conditions whilst
15 doing the same job, albeit in a different part of the same
16 health system, appears to have the potential to cause
17 friction and impact on workforce satisfaction and
18 retention.

19
20 THE COMMISSIONER: The allegedly outdated awards and the,
21 as a matter of fact, public sector wage freeze, have they
22 driven these arrangements that you're talking about?

23
24 MR MUSTON: That's something we will need to explore.
25 I infer that's a possibility, which is why I said a moment
26 ago that these non-standard arrangements are potentially
27 symptomatic of the level of remuneration within the public
28 system when compared to the private system and potentially
29 when compared with public sector remuneration in our
30 neighbour states and likewise, to the extent that the
31 industrial awards do not actually reflect the contemporary
32 practice in terms of the delivery of medicine, adaptation
33 which might be made --

34
35 THE COMMISSIONER: By "the contemporary practice of
36 medicine" you mean the fact that hospitals run 24 hours
37 a day seven days a week?

38
39 MR MUSTON: And staff specialists in many areas,
40 I suspect, don't work eight to five.

41
42 THE COMMISSIONER: Yes.

43
44 MR MUSTON: They work much longer hours, as is necessary
45 for them to maintain the continuity of service that is
46 offered through public hospitals in this state.

47

1 So the first issue is the potential impact or the
2 friction that paying people differently in different
3 facilities to do the same job has the capacity to cause.
4 The second issue is, particularly in relation to those more
5 organically developed non-standard arrangements, any
6 attempt to rectify or wind them back has the potential, we
7 would think, to cause workforce dissatisfaction and
8 industrial disputation, both of which have a knock-on
9 effect in terms of retention and recruitment to the public
10 health system.

11
12 What we intend to do at the end of this hearing block
13 is round it out by looking at some recent events at Concord
14 Hospital which potentially present a neat case study of how
15 many of the issues that we've just touched on come together
16 to produce what is potentially a spiralling and negative
17 impact on the health workforce and the delivery of care at
18 that particular site.

19
20 We don't say that site's picked out for any reason
21 other than it was drawn to our attention in some of the
22 submissions and it would appear to be a useful example of
23 a situation in which a number of these issues that we've
24 just touched on come together in a way which has produced
25 an impact on the workforce there and it gives us an
26 opportunity to have a little bit of a look at exactly how
27 that might work in a practical sense.

28
29 Now, despite our best efforts to group the witnesses
30 thematically, we've again been defeated by a fairly complex
31 array of availability issues.

32
33 THE COMMISSIONER: That's fine.

34
35 MR MUSTON: It goes without saying that, to the greatest
36 extent possible, we have sought to accommodate these and
37 avoid any unnecessary disruption to the important work that
38 various witnesses are doing, many of whom, as we speak,
39 within the public health system. But hopefully, this
40 slightly broader outline of the issues to be explored
41 during this hearing will help contextualise the evidence
42 given by the various witnesses as they come forward.

43
44 We can say that the Concord witnesses have, at least
45 at this stage, usefully been grouped at the end.

46
47 THE COMMISSIONER: Okay.

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MR MUSTON: It is the other earlier issues where we will be jumping around a little bit.

You should have a list of the witnesses we propose to call, which provides some indication of the timing and the order in which they will appear.

THE COMMISSIONER: I do, yes.

MR MUSTON: As always, no-one in the room should assume the timing is precise and it's given as an indication, but --

THE COMMISSIONER: So when it says "not sitting" Friday 26 July or Monday 29 July, first of all, that's reflecting an availability problem and enabling some preparation, is it - both?

MR MUSTON: It is in two parts. It's reflecting some availability issues; it's essentially attempting to avoid a situation where we all come in for potentially a very short burst of evidence from one witness who happens to be available, if they can be accommodated elsewhere.

THE COMMISSIONER: Am I right in assuming that when we finish on this Thursday, the 25th, if there was any spillover, it would be on Tuesday, the 30th, it won't be on Friday, the 26th. So we're definitely not sitting Friday, the 26th or Monday, the 29th?

MR MUSTON: That's correct. To the second part of your question, it's to enable, as best as possible, those sitting to my left to have a bit of time to consider the evidence in relation to the Concord case study, which, despite everyone's best efforts, as with the evidence in connection with these hearing blocks, does continue rolling in until quite late.

THE COMMISSIONER: Yes, and acknowledging that there is a certain amount of guesswork that goes into this schedule, other than the dates, but in terms of the timing, the expectation is that we will finish this block some time on Tuesday, the 6th?

MR MUSTON: Yes. We may finish on the Monday, but --

1 THE COMMISSIONER: More likely finish on the Monday than
2 the Wednesday?

3
4 MR MUSTON: Yes, absolutely. To the extent that we have
5 a half an hour to go on the Monday, we'll endeavour to sit
6 long to avoid Mr Minns, who I think is the last witness,
7 having to come back, but out of an abundance of caution
8 we've had him drifting over into the Tuesday just in case.

9
10 THE COMMISSIONER: Thank you.

11
12 MR MUSTON: That brings us to I think the first of the
13 witnesses that we're calling, Dr Dustin Halse, the division
14 secretary (strategy research and projects) of the Health
15 Services Union for New South Wales, ACT and Queensland.

16
17 <DUSTIN HALSE, sworn: [10.26am]

18
19 <EXAMINATION BY MR MUSTON:

20
21 MR MUSTON: Q. Dr Halse, you are employed as the
22 division secretary (strategy, research and projects) of the
23 Health Services Union for New South Wales, ACT and
24 Queensland?

25 A. Correct.

26
27 Q. That's a role I think you have held since 2023?

28 A. Correct.

29
30 Q. You have prepared a statement to assist the Inquiry
31 with its work dated 15 July 2024?

32 A. Correct.

33
34 Q. Do you have a copy of that statement handy?

35 A. I do.

36
37 Q. To the best of your knowledge, are the contents of
38 that statement true and correct?

39 A. To the best of my knowledge.

40
41 MR MUSTON: In the fullness of time, Commissioner,
42 that statement will form part of the bulk tender. It is
43 up on the screen but for the transcript it is
44 [SCI.0011.0197.0001].

45
46 Q. Can I ask you to go --

47

1 THE COMMISSIONER: The bulk tender, you are referring to,
2 is the 13 volumes of material on my left, is it?
3
4 MR MUSTON: I think, yes, I think the actual physical act
5 of the bulk tender will probably be somewhat --
6
7 THE COMMISSIONER: Is the Dawson report of 1920 in that
8 tender bundle?
9
10 MR MUSTON: That's going to get a special marking.
11
12 THE COMMISSIONER: It definitely will feature in the final
13 report.
14
15 MR MUSTON: The bulk tender will, I think, as a practical
16 matter, involve someone standing up before you and
17 tendering the index to those volumes.
18
19 I should say, before we descend in Mr Halse's
20 evidence, it is not intended that we will be taking you
21 through in abundant detail during the next few weeks all of
22 the documents in that 13 folders. There are aspects of it
23 which create a useful library of documents which are
24 relevant to workforce issues, including a welter of past
25 reports.
26
27 THE COMMISSIONER: It is just that I noted you referring
28 to a year 2000 report in your opening statement --
29
30 MR MUSTON: It is in there.
31
32 THE COMMISSIONER: -- which is a relatively modern report
33 talking about the problems of health care funding.
34
35 MR MUSTON: There are several folders which contain the
36 relevant awards. The key folders as far as the witnesses
37 are concerned are probably the first three or four which
38 contain a chronological list, the documents which are
39 referred to by various people in their statements.
40
41 Q. Sorry, Doctor Halse. If I could take you to
42 paragraph 4 of your statement, you tell us a little bit
43 about the union, the HSU, and the in excess of 50,000
44 health workers it represents, and give us some indication
45 of what they are not, in particular, they don't include
46 nurse, midwives, members of the medical profession. What
47 roles are typically held by members within the public

1 health system that are in your union?

2 A. It is an extensive response because outside of the
3 medical fraternity, outside of nursing, there are literally
4 hundreds of unique occupations that encompass what health
5 work is in the public health system. So you think about
6 allied health, for example, and the 23 unique bodies or
7 groupings within allied health and the sub-groupings with
8 those - everything from physiotherapy to clinical
9 psychology, for example. And then there's the myriad of
10 workers who work in the public health system that acquit
11 all the responsibilities, from administrators to cleaning
12 staff to food and laundry staff - all of the component
13 parts that make a health system work. So I could not tell
14 you the number of workers that we represent because it's
15 literally hundreds, and that's reflective of the diversity
16 of the workforce and what it takes to run a health system
17 at a modern hospital in New South Wales.

18

19 Q. When you said a moment ago "literally hundreds", it's
20 hundreds of different --

21 A. Categories, yes.

22

23 Q. -- classifications of roles within the health system?

24 A. Correct.

25

26 Q. Can I ask you to go down to paragraph 6. You see you
27 indicate there a concern about the absence of an
28 independent body or mechanism to capture real-time data on
29 the health workforce, workforce vacancies and service
30 demand. Can I ask you a series of questions about that.
31 The first is: what is the data that you think could
32 usefully be captured?

33 A. Can I premise this by saying that there is a trove of
34 data that's already captured on the health workforce.
35 Whether that's the national workforce dataset, whether
36 that's the work of NSW Health stats, whether it's ABS data,
37 ATO data, census data, there is a huge body of work done on
38 capturing data.

39

40 HSU is of the opinion that there are gaps in the
41 capturing of workforce-related data. I don't think it's
42 just our opinion, but it's one that is reflected through
43 the attitudes of our membership.

44

45 Q. What do you think those gaps are?

46 A. One of the critical areas is to capture data on
47 workforce vacancies, current vacancies, how long there have

1 been staff vacancies and the willingness of workers
2 particularly to work across the entire health system. Are
3 they willing to work across regional or remote settings?
4 So these are areas of data that our members have told us in
5 the qualitative research that we've captured. It's also
6 reflected in the Commonwealth Department of Health and Aged
7 Care's reporting about data gap analysis - that we don't
8 have enough data particularly on vacancies.

9
10 Q. So a moment ago you referred to data around the
11 willingness of people to work, say, in rural and regional
12 areas. Were you referring there to data about the
13 particular motivations of individuals or rather data about
14 that which is derived from something else - for example,
15 vacancy rates within those locations?

16 A. We would suggest that it's an important dataset to
17 capture the motivation and intention of workers to work
18 across health systems.

19
20 Q. How do you think that could be done?

21 A. Well, it's a question that's been put by others. We
22 think that there is a capacity to expand the data that's
23 captured here in New South Wales. The methodologies in
24 which you might engage to do that are relatively simple,
25 but nevertheless extensive. It might be data capture
26 techniques that emerge in both on-boarding or, a worker
27 leaving a position within the health workforce, through
28 survey, and both quantitative and qualitative work. It
29 might be distilling down into some of the metrics that
30 already exist and pulling out data from those metrics. It
31 might also be the creation of a different mechanism within
32 an existing body or a new independent body that can capture
33 data that's relevant to - relevant for policymakers to make
34 informed decisions.

35
36 Q. One of the challenges with capturing information or
37 data around the motivations of particular individuals to
38 work, say, in rural and regional areas, is potentially that
39 the body of people who you would be seeking that
40 information from might extend well beyond those already
41 working in the public health system.

42 A. Correct.

43
44 Q. Would you agree with that?

45 A. Yes.

46
47 Q. So in terms of these what you perceive to be the data

1 gaps, the vacancy rates, the length of time that vacancies
2 remain open and the motivations of people to work in
3 different sectors or different parts of the health system,
4 how do you think that information might productively be
5 used?

6 A. Well, it's important to realise that for health system
7 design, that data is a central point. It might be the
8 first point in any systems design framework that's engaged
9 or employed, because data informs or creates information
10 which generates knowledge, which then translates to the
11 ability for policymakers to make decisions which lead to
12 actions which affect patients and workers across New South
13 Wales.

14
15 We think that policymakers more broadly at times on
16 certain questions might struggle to capture the data that
17 is required to most accurately make decisions across
18 a whole range of health policy questions.

19
20 Q. What leads you to that conclusion, that policymakers
21 struggle to gather comprehensive data?

22 A. Well, firstly, we do see gaps in the data-capturing
23 process. We don't have clear information on an integral
24 question like workforce vacancies or staff vacancies.

25
26 We tendered a document to this Inquiry which was
27 a GIPAA application recently, which pertained to NSW
28 Ambulance, and when asking that body could they identify
29 staff vacancies within that integral component of the
30 New South Wales public health system, the response we
31 received was "No data exists".

32
33 That, for us as an industrial body, as a trade union,
34 is an alarming response. We would suggest that health
35 policymakers would be advantaged by having access to
36 real-time contemporaneous data on staff vacancies in order
37 to inform decisions. If we're simply relying upon the
38 existing national datasets and state datasets, they present
39 good information on headcounts, they present good
40 information on the number of a particular worker within
41 a particular LHD or a location, but it might be - that's
42 relevant to address a number of questions, but when we're
43 talking about acquitting the responsibilities of the health
44 service and meeting KPIs, the role of staff vacancies is
45 hugely important.

46
47 Q. It's your belief that NSW Health doesn't have access

1 to real-time data on vacancies. What's that belief based
2 on, other than the GIPAA example you've just given? Is
3 that a particular reason that you held that belief?

4 A. I should note that that's one GIPAA example that we've
5 obviously furnished to this Inquiry. That is wholly
6 uncommon, as you might expect, for responses to be received
7 in that fashion. I suspect, indeed I know, that we've got,
8 as an organisation, a number of GIPAAAs asking this exact
9 same question to LHDs and others, and we await their
10 response.

11
12 There's a theme there that has emerged, and again,
13 without having that access to accurate data on vacancies,
14 what it means is that groups like ourselves will have to
15 identify gaps in the system, so it will be a delegate or an
16 organiser who will identify that a particular hospital
17 service is short-staffed by 25 cleaners, for example, and
18 it will require the activism or the organising or the
19 engagement of a trade union like ours to rectify an issue.
20 It might require industrial action. A level of disputation
21 that is inefficient, that might have been overcome if
22 datasets were available to inform decision-makers or policy
23 makers.

24
25 THE COMMISSIONER: Q. Can I just ask so that
26 I understand, a number, particularly, of the regional LHDs
27 have either, in the evidence we've gathered when we've gone
28 to see them, or in their submissions, have said to us - and
29 I'm generalising and not thinking of any particular LHD -
30 "We have X number of vacancies for nursing staff and we've
31 had those X number of vacancies for quite some time and
32 it's a really difficult problem for us and we're having to
33 use agency staff to get by, which is costing us a hell of
34 a lot more money than it would if we had permanent staff in
35 these vacant positions."

36
37 When you're talking about the issue you've raised in 6
38 of your statement that you've been discussing with
39 Mr Muston, are you talking about a lack of a central
40 database, or - and perhaps and - a lack of a good source of
41 data in relation to the workers your union represents?

42 A. Probably both.

43
44 MR MUSTON: Q. Would you have any reason to doubt that
45 NSW Health gathers information about, say, vacancy rates
46 and the length of time that vacancies sit open in real-time
47 but is simply not sharing that information with you?

1 A. That would be a question that you would have to put to
2 them. In the tenor of the responses that --

3
4 Q. Just coming back to my question, we will be putting
5 that question to them. My question for you is, do you have
6 any reason to think that that is not a possible explanation
7 for what you are seeing as a data gap?

8 A. We would contend that whether it's in direct
9 discussions with a hospital's HR department, whether it's
10 a formal application, GIPAA application, that there is
11 a sense of obstructionist, or obstruction, that is
12 sometimes picked up by our union in terms of being able to
13 ascertain this data.

14
15 I suspect that much of it exists, as the Commissioner
16 just referenced, talking to another LHD. There's a sense
17 of vacancies. It's there, it's in the system, that
18 information is there, but to our knowledge, it's not
19 publicly available. It's not collated in a methodical
20 manner that's presented to the public and provides
21 confidence to the public with respect to the operation and
22 the performance of a health service. We think that the
23 more transparent, clear and accurate the data that can be
24 presented, broadly to the community but also to health
25 experts, policymakers, those in the political class, will
26 aid in the design of more equitable and more accessible
27 health systems and services.

28
29 Q. That picks up on something you have touched on in
30 paragraph 8 of your statement, the public availability of
31 the data. Is that a key feature of your complaint that the
32 data that is retained by NSW Health or collected by
33 NSW Health such as it might be is not shared publicly?

34 A. Correct.

35
36 Q. What information do you say should be shared publicly?

37 A. So we, again, distilling it back down to - and I'm
38 conscious that there are hundreds of data points that you
39 can collect across a system like NSW Health, but we think
40 that absolutely, that capturing data on workplace
41 vacancies, staff vacancies, on the time needed to fill
42 those vacancies and breaking that question down, and then,
43 as I mentioned, the capacity of workers or the intention of
44 workers to potentially move beyond and to work in remote or
45 regional settings, is a very important question for anyone
46 in workforce planning, anyone in the ministerial wing who
47 is responsible for health.

1
2 We would say that a consequence of a previous Special
3 Commission of Inquiry 15 years ago was a very good
4 recommendation, a bold recommendation, to create the Bureau
5 of Health Information. That data is presented in a
6 disinterested, unbiased manner, at quarterly intervals, as
7 you will be aware, and it provokes discussion and debate
8 within the community, within the press, within the halls of
9 parliament. It's a tool that can be used to provide
10 greater information and transparency about what's occurring
11 within the New South Wales health system.
12

13 Q. So what would be the potential public benefit of
14 having published, say, the number of vacancies in nursing
15 staff in Broken Hill and the amount of time that those
16 vacancies have been sitting open and unfilled? What do you
17 perceive would be the public benefit of having that
18 information out there for the purposes of debate?

19 A. In the feedback from our members, in accessing health
20 services themselves, people want to have confidence that
21 when they seek health services, there is a capacity to meet
22 the particular needs that they have.
23

24 It should be the case that irrespective of your
25 location throughout a state like New South Wales - and we
26 know this not to be the case, through the data, indeed
27 through the data captured through NSW Health stats. There
28 are varying levels of health service that are offered to
29 people based on where they might access that service or how
30 they might access that service.
31

32 So we think that consumers of public health services
33 have a right to be aware of effectively the health of that
34 health service, how it is performing. We think that it's
35 not just the public but it's the whole field of health
36 policy, of labour - economists, of those who are engaged in
37 that process of managing and commenting on the health
38 system and how it operates here in New South Wales.
39

40 Q. Just picking up on your comment about the confidence
41 that people need to have in the health system, is there not
42 a risk that some publicly available information, for
43 example, number of nursing vacancies in Broken Hill -
44 I don't mean to pick on Broken Hill - and the amount of
45 time that it has taken to fill them would erode confidence
46 in that health system in a way which perhaps doesn't
47 reflect reality?

1 A. It might also be a motivation for policymakers to
2 address systemic issues.

3

4 Q. Like what?

5 A. Well, we're talking about the staff vacancies - to
6 address those and to create or to try and explore methods,
7 processes, to fill those vacancies, to provide a more
8 optimal level of care.

9

10 THE COMMISSIONER: It's not like - when you say the amount
11 of time that it's taken to fill them would erode confidence
12 in the health system, it's not as though this is a complete
13 secret, though, is it?

14

15 MR MUSTON: Is that a question for me?

16

17 THE COMMISSIONER: Well, it is an observation to you.
18 I didn't quite understand the question but the witness
19 answered it anyway.

20

21 MR MUSTON: The question perhaps - there is a further
22 integer in the question, which is the fact that --

23

24 THE COMMISSIONER: The LHD management will know what the
25 vacancies are; the doctors, the nurses, the other workers
26 will have a general idea, and by dint of that, in a town
27 like Broken Hill, many members of the public will know it
28 to.

29

30 MR MUSTON: Perhaps I will put the question in a slightly
31 different way.

32

33 Q. The fact that there is a vacancy which is unfilled
34 doesn't necessarily mean that there is one less nurse on
35 a shift or that there are any fewer nurses on a shift than
36 is appropriate and required for the proper delivery of
37 care, say, through the utilisation of overtime, agencies
38 nurses and the like, as an example?

39 A. As an example, correct.

40

41 Q. So in that case, is there not a risk that by putting
42 in an uncontextualised way information out there about
43 nursing vacancies in a particular location runs the risk
44 that people might think, "If I turn up at that hospital,
45 I won't be confident in the care that I'm going to receive
46 because they don't have enough nurses"?

47

A. No, we wouldn't - I wouldn't agree with that premise.

1 We do think that there is a set of questions that
2 executives, that the ministry, needs to be held accountable
3 to. We believe that if we were to survey the people across
4 this state and ask them what type of information they would
5 like about the health services in their region, in their
6 backyard, how they are performing, how they are performing
7 comparable to other health services, if they can acquit the
8 responsibilities or the measures that are put in as KPIs,
9 they would want to have access to that data.

10
11 It's not about undermining any area of health workers.
12 I think it's broadly, if we think about the health
13 workforce, there are few more trusted occupations than
14 those who work in health within our community. That is
15 a well-established data trend and research finding. It's
16 not those individuals that are being targeted, and it's not
17 being targeted, but it's providing information that will
18 inform those in leadership positions that ultimately make
19 these decisions, because people are not going to be -
20 they're not going to - the response is not to question the
21 role of health workers, it will be to potentially see how
22 we can improve the system to make it more efficient so that
23 those services can be met in a more complete way in
24 whatever community that might be.

25
26 Q. But just seizing on the public availability of that
27 information, at one level, decision-makers within health
28 are capable of receiving and using that information in the
29 way that you've just described, without it being part of
30 a public dataset. Perhaps picking up on something you said
31 a moment ago in terms of entities being able to hold those
32 decision-makers to account, what would your organisation do
33 with information that it received in relation to vacancy
34 numbers and the period of time it takes to fill vacancies
35 at a particular facility?

36 A. We would want to work collaboratively with the
37 service. We would want to identify - just in walking down
38 to this hearing today, one of our officials mentioned
39 a scenario many years back, but where there was an
40 identification of a huge number of cleaners, roles, that
41 weren't filled at Westmead, and it took the agitation of
42 the union to engage with that hospital and the executive of
43 that hospital, to ensure that positions were filled at an
44 expedited rate.

45
46 So it's not a case of, you know, this is a back door
47 for trade unions to agitate for greater staff. We think

1 that there is - indeed, we know that all of the research
2 suggests that we are in a difficult situation with respect
3 to meeting the supply of health workers right across the
4 system. It's felt across every LHD. It's more acute in
5 some sectors of New South Wales, particularly those in
6 regional or remote sectors. And we feel that absolutely,
7 this type of data can be beneficial.

8
9 I might - and you might pull me up - note that, upon
10 the establishment of the BHI, which releases some very
11 sensitive data, data that health systems or health services
12 might not ordinarily want in the public domain, with
13 respect to surgical wait times, ED presentations, ambulance
14 wait times, that data is presented in an unbiased and
15 disinterested manner and it provides that wealth of
16 knowledge.

17
18 Now, as a consequence of that body being established,
19 have we seen an erosion of the confidence in the role of
20 a NSW Ambulance worker? No, we haven't. People still
21 avail themselves OF that service and the demand continues
22 to increase. So we don't think that there's - there might
23 be elements of this type of data capture that might be
24 sensitive, but we think it's broadly in the public
25 interest. We know that the Commonwealth Government, in
26 that report I referenced before, thinks that this is a gap
27 that should be made available, and we broadly think it will
28 be a useful tool for the community but also for governance.

29
30 Q. I should probably just clarify one matter. Where you
31 talk about "vacancies", are you talking about positions
32 within an LHD which have been advertised and not filled?

33 A. Yes.

34
35 Q. So the vacancy that you refer to is not a debate about
36 whether or not a particular facility is sufficiently
37 staffed in circumstances where views might differ about
38 that; it's where the LHD itself has made a decision, "We
39 need another cleaner. We've put an ad out for that cleaner
40 and we have not filled that position"?

41 A. At the base level, what our members are communicating
42 to us is that it's a challenge to meet existing staff
43 positions, let alone project into whatever expansion might
44 be required into a particular health service. So just to
45 ensure the current staffing levels that are attached to
46 KPIs of that particular health service are being met with
47 respect to that staff profile, that is particularly useful.

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Q. You point to the lack of an independent body to capture this sort of data. Is it important that it is an independent body that is delivering this data, in your view?

A. Yes, and we think that, again, to cite the model of the BHI and how in its charter it proudly proclaims its independence and its capacity to present data irrespective of - data without any interference.

Q. So is the BHI potentially a vehicle that could add to its existing datasets some further information over and above that which it reports on at the moment?

A. It could be, or a model like the BHI.

Q. Can I take you to paragraph 7 of your statement. Do you see at the very end of that paragraph you say that the existing NSW Health workforce ought to have a role in the capture of workforce data to ensure its accuracy and transparency?

A. Yes.

Q. What would that role be?

A. I think it's important we as an employee organisation - we think that it's always important, when you are talking about a health system, to capture the attitudes and opinions and the expertise of health workers. We might be concerned to a certain degree that not enough of the feedback of our health workers, those who are directly engaged in the provision of health services to members of the New South Wales community, are not captured. We appreciate that the Public Service Commission does its "People Matters" report and particularly along cultural lines and a cultural understanding of the particular area of the public service, capture very good data and huge datasets, which are again reported, debated in a range of different forums, but what our members tell us is that they would like to be more engaged at the local level, particularly, but also at a statewide level, in presenting their feedback, their information, into that policy-making process.

Q. What might that look like? Is it a survey of health workforce or speaking forums where people are entitled to come and express their views and grievances about their workplace? What do you have in mind in terms of the particular role?

1 A. A whole range of methodologies, including surveys,
2 direct interviews, focus groups, standing committees, to
3 feed into certain processes. We were interested recently
4 in going through the 2022-2032 NSW Health workforce
5 strategy document to see that, in the supplemental guide to
6 that document, a link to a workforce consultation that
7 occurred statewide that only included 126 workers of the
8 health workforce, for a system that's worth \$33 billion
9 a year.

10
11 Now, I'm not suggesting that's the only bit of
12 workforce data captured, but to inform that report that's
13 publicly available, the 10-year plan for NSW Health, we
14 don't see any linked data that captures more than this
15 workforce snapshot that they have produced. It might be
16 emblematic of the way in which workers are engaged and
17 consulted in processes that directly impact them and in
18 which workers are best placed to speak about a whole range
19 of issues, irrespective of the knowledge and the capacity
20 of those who might sit in senior executive positions but we
21 think that if we want to design a health - a more equitable
22 health workforce, that workers have to be central to that
23 process and invited to be in that process.

24
25 Q. So is this a workforce planning tool, that is, the
26 input that you say will be received from the existing
27 workforce, or is it more a tool which is to be used for
28 service delivery, planning and decision-making?

29 A. Well, health is dynamic, isn't it? It changes daily,
30 weekly. I don't think it necessarily needs to be either
31 one or the other.

32
33 Q. I'm just trying to get a little bit of a handle on
34 exactly what information would be fed up through the
35 workforce to inform what sort of decisions?

36 A. Yes, and I would point you to the workforce
37 consultation paper that informed the 10-year New South
38 Wales plan and the type of work that they have done, which
39 was informed by an external consultancy, but we think
40 there's a range of questions that health workers can talk
41 into. It's about the current state of their place of
42 location - everything from infrastructure in that setting,
43 everything from skills mix in that setting, everything from
44 particular practices and policies that have been
45 implemented in that setting.

46
47 I'm conscious that they are best placed to inform us

1 and inform others as to the type of models and the type of
2 practices that best support and enable optimal health care.
3

4 Q. In the context of a devolved system where a lot of
5 these decisions are being made, say, in a facility or
6 potentially even in a department, is it not possible that
7 a lot of that information around, for example, skills mix,
8 to pick up on one of your examples, is not already being
9 discussed and debated within a department and informing
10 decision-making in that department about the skill mix that
11 they should best adopt for the purpose of delivering care?

12 A. Yes, and again I'm not suggesting that none of that
13 work exists. That's not the testimony I'm providing.
14 There are consultative committees at the local level, in
15 the department level, across LHDs, right through to the
16 broader whole-system level. I'm simply relying upon the
17 attitudes and the feedback that our members have responded
18 to the research work that we have conducted in which,
19 universally, they want to be more engaged in processes.
20

21 So it might be the process itself is not - is
22 inadequate; the process might not be as comprehensive as it
23 otherwise would be; it might not give health workers the
24 opportunity or the agency to talk into matters that they
25 want to talk into; it might be controlled or contained in a
26 manner that is set by individuals who don't work in that
27 particular department or who have no knowledge of
28 a particular health - the duties or responsibilities of
29 a particular health professional.
30

31 All of those things have been reflected to us, that we
32 want to be more engaged because we have a wealth of
33 information and data that we can impart. And what that
34 looks like we don't have a perfect template, but what we
35 can translate is that that's what they're saying, not 100,
36 not 200, but thousands of workers.
37

38 Q. In a good workplace which is well managed, decisions
39 are made collaboratively, these sorts of issues won't be
40 a problem, presumably - that is, you are unlikely to have
41 your members complaining about a lack of consultation in a
42 workplace where they are being consulted?

43 A. That's a reasonable statement.
44

45 Q. Would it be fair to say that there probably are a lot
46 of departments and particular units in the wide and
47 devolved system that is NSW Health which are actually

1 functioning well in that respect?

2 A. Yes, and again, that's a fair assumption but it
3 doesn't stray away or it doesn't diminish the point that,
4 en masse, there are thousands of health workers who we have
5 spoken to, discussed, these people who are right across
6 that unique occupational list, who have expressed to us
7 that that consultation is either incomplete, that it's not
8 as extensive as it could be, and that they have
9 information, they have data, they have knowledge and
10 passion and commitment that they can feed into a process -
11 not an adversarial process but a process to improve health
12 services. These are passionate health workers. We
13 represent tens of thousands of them across this state and
14 they have a skill set and a knowledge and they rock up as
15 health workers because they care about the provision of
16 services that they can provide to patients.

17

18 Q. Sometimes, even where there is adequate consultation,
19 decisions will be made which don't line up with what the
20 particular health workers who are consulted think should
21 happen?

22 A. Mmm.

23

24 Q. Would you agree with that?

25 A. That's an accurate comment.

26

27 Q. And sometimes, that might, at least in the minds of
28 those health workers, manifest itself as an impression, "We
29 have not been listened to or adequately consulted with"?

30 A. Yes.

31

32 Q. And so teasing out which side of that line, the
33 particular feedback that you have received from your
34 members is something which is never going to be
35 particularly easy, is it?

36 A. There will always be a contest. That's the nature of
37 the work that we perform as a trade union. Again, we would
38 simply reflect that we - alongside other health workers,
39 that we are the workforce, our members are the health
40 workforce.

41

42 Q. In relation to the consultation, you don't - or do
43 you - suggest that there should be some centrally
44 administered policy that deals with the way in which the
45 health workforce is to be consulted on the no doubt wide
46 array of different issues that crop up in all of the
47 different departments across the health system, or is it

1 more you think that it should just be done better locally?
2 A. More so the latter, that it should be a more robust
3 process that engages with health workers, that gives agency
4 to their voice and expertise.

5
6 THE COMMISSIONER: Can I just make an observation - and
7 this isn't for you, Dr Halse - that might assist you and
8 also Mr Cheney and Mr Chiu on this topic. I've just, first
9 of all, satisfied myself again as the evidence is being
10 given that we are well and truly in the terms of reference,
11 and there are - because we have to inquire into, amongst
12 other things, shortages of workers and particular skill
13 sets in any location. To inquire into that, we obviously
14 need data and facts.

15
16 Those representing health might eventually tell me,
17 and I, sitting here, just don't know, that all of this data
18 is available for vacancies, for example, somewhere - maybe
19 not in a centralised spot but various places. But if it's
20 not, it would be good if either through Dr Halse, or some
21 other witness or witnesses, I was convinced that it was
22 a good thing that all this data be publicly available, but
23 I'm not sure they have to convince me of that. I mean,
24 this is a public health system, and if there are vacancies
25 for any particular position, I think I'd have to be
26 convinced there is a really bad reason for making that
27 public, because otherwise, it doesn't seem to me that this
28 sort of area we're discussing ought to be a state secret.
29 We ought to know - that is, everyone, every citizen of
30 New South Wales ought to be able to know - I would have
31 thought, what the vacancy rates are for particular
32 positions in the public medical workforce, regardless of
33 the position.

34
35 There's a lot of stuff that government keeps secret
36 that there is an arguable case there is no good reason
37 other than a political one for it being kept secret from
38 us, but it would be nice to know that there would be a good
39 reason - and there might well be some good reasons - for
40 this information being public, but I don't even know that
41 I need to be convinced about that. If it is not, it
42 probably ought to be, because it's not a state secret.

43
44 But I'm also conscious that I might be told, and as
45 I said, sitting here I am a bit ignorant about what the
46 data actually is, but we're obviously going need it to
47 answer that terms of reference. I don't know whether that

1 helps or not but I will just leave it there.

2

3 MR MUSTON: I think Mr Thompson's report reveals a great
4 deal about what data is actually available. When I say
5 "available", I mean available to the ministry.

6

7 THE COMMISSIONER: Yes, true.

8

9 MR MUSTON: Q. Could I ask you, Dr Halse, to go to
10 paragraph 9 of your statement. This is just to clear up
11 a matter of semantics, but you refer in that first sentence
12 to a widespread and current labour crunch across all parts
13 of the New South Wales public health system. For my
14 benefit at least, what are you referring to as a "labour
15 crunch"?

16 A. I could have amended that, a labour shortage;
17 a challenge to supply.

18

19 Q. More jobs than there are people to fill them or
20 willing to take them?

21 A. Yes.

22

23 Q. What do you think the causes of that labour crunch are
24 or that shortage?

25 A. A whole range of reasons - the capacity of the
26 training system, the health training systems in Australia
27 to provide adequate numbers and train adequate numbers of
28 health workers right across the system. I think it is
29 a universally accepted finding that we're struggling to
30 keep pace with the number of health workers we require.

31

32 It would also go to the competitive nature of health
33 care. Health care is not just a domestic market; it is an
34 international market as well. It goes to the opportunity
35 cost of workers that can work in other sectors of the
36 economy that have superior wages or settings - wage
37 settings or conditions of work and they elect to work in
38 those industries as opposed to pursuing a course of action
39 to undertake study in a health field. So a multifaceted
40 challenge to meet demand.

41

42 There is also domestic competition for health workers,
43 and we've seen this, and again through the focus group work
44 of our research at HSU, indications of workers, not huge
45 amounts but an indication, this theme emerging, that "If
46 I can jump over the border into a different jurisdiction,
47 almost automatically, I can earn a higher rate of pay or

1 a different set of conditions that might suit me. So
2 a whole range of factors. They're just a few.

3
4 Q. Just in relation to that last factor, is the sense you
5 get from your dealings with your members that that jumping
6 over the border for higher pay in a particular discipline
7 is something which extends to a great degree beyond those
8 living in border regions?

9 A. Most likely not those who are extending outside of
10 those border towns or those border regions, but it is
11 something that has been frequently articulated to us as
12 union officials. It was writ large during the recent
13 paramedics pay dispute with the New South Wales Government
14 when paramedics universally identified the different rates
15 of pay and different conditions between particularly
16 Victoria and Queensland and here, the conditions that they
17 were receiving in New South Wales, but particularly focused
18 on those border regions where there is a capacity to move
19 up and down between jurisdictions.

20
21 Q. So using that paramedic example, if you've got people
22 who are living up near the Queensland border, is it the
23 feedback that you have received from your members that they
24 will drive that extra little bit to cross the border and
25 work as a paramedic in Queensland where they might be able
26 to get paid more?

27 A. Well, prior to the historic intergenerational wage
28 increase that has just been negotiated for paramedics here
29 in New South Wales, that was clear feedback that was
30 received by the union.

31
32 Q. In terms of those who are not living in a border area
33 either to the north or to the south, you said feedback was
34 routinely received from members about the pay disparity,
35 but was the feedback that you were receiving suggesting
36 that that pay disparity was causing a significant number of
37 people who were not living in those border areas, say
38 someone who was living in Sydney, to up stumps and move to
39 a different jurisdiction altogether to work or was it more
40 just a source of an increasing source of irritation and
41 unhappiness within the workforce in New South Wales?

42 A. I don't want to over-egg the situation or the
43 response. It definitely was a live discussion from members
44 within the service. Obviously, those who had the capacity
45 to move across jurisdictions more easily, it was a very
46 real consideration. For those who were domiciled in a
47 central location where it wasn't as - you weren't as able

1 to do so, I suspect it's a logical conclusion that it
2 wasn't as strongly felt, but it was a live discussion right
3 throughout that paramedic wage dispute.
4

5 Q. Could I ask you, in paragraph 10 you tell us about the
6 Reform Critical Report, and in particular, the outputs of
7 some modelling that was done. I don't intend this
8 critically in any way, but the modelling which is done
9 obviously is built around a range of assumptions which
10 build or form the model; would that be right?

11 A. Yes.
12

13 Q. Is there anywhere where those assumptions, or the
14 assumptions which underpin the model, are publicly
15 available or could be made available to the Inquiry?

16 A. So the Commission has the report in annexure 2,
17 I think, there is the modelling framework that Dr Angela
18 Jackson put together to come to this set of figures.
19

20 Q. Perhaps it is my poor understanding of it, but does
21 the framework articulate clearly all of the assumptions
22 which have been made in the model?

23 A. The model that she has prepared indicates the type of
24 datasets that have been relied upon, so the assumptions.
25 It's an extrapolation of a whole range of datasets,
26 particularly with respect to population data, ABS data,
27 a whole range of other areas of data. I'm happy to get it
28 out and go through it, but this is a model that she has
29 come up with, and it might indicate again the contested
30 nature of workforce projections, that Dr Angela Jackson,
31 a senior health economist in this country, who has just
32 been leading the federal government's COVID-19 inquiry, and
33 her team have produced these figures, there might be other
34 figures housed within other sections of the public service,
35 and it might go to the contestability of the current
36 situation.
37

38 It goes back to what we think is the importance of
39 having foundations right and data - it might sound a bit
40 repetitive here, but data is the one thing that you can
41 capture in the full extent, in the comprehensive extent,
42 that can truly inform policymakers.
43

44 Q. So whilst potentially contestable in terms of the
45 assumptions you make and the methodology you apply, your
46 ultimate point is really that decisions should be made
47 based on some sort of a hard foundation of data, not just

1 reacting to a situation that might emerge --

2 A. Absolutely.

3

4 Q. -- at any particular point in time?

5 A. And I'm reluctant to bring this up, but most acutely,
6 in my work experience, the absence of data can have huge
7 ramifications on health systems. We saw that most
8 acutely - and I don't want to trigger trauma for anyone -
9 but through the COVID-19 crisis, the acute phase of that,
10 where policymakers, politicians, senior executives,
11 hospitals, were trying to engage in a decision-making
12 process without complete data because some of that didn't
13 exist or that it hadn't been captured.

14

15 Q. In paragraph 13 of your statement you express some
16 views about the nature of the collaboration between
17 NSW Health and the HSU. Without wanting to traverse what
18 you consider to be the current state of that collaboration,
19 what do you think would be a good way for your union and
20 NSW Health to be collaborating productively? How do you
21 think the relationship should work to produce positive
22 outcomes?

23 A. We think that - I mean, you might not want me to talk
24 about the specific application here, but we think that it's
25 a wholly reasonable application to make on a critical area
26 of NSW Health, in NSW Ambulance, to be aware of staff
27 vacancies. We think that a collaborative model might be to
28 have data available, existing data that is tracked, that is
29 evaluated, that is monitored, available to not just the HSU
30 but other groups within the community who might find it
31 useful, for us to be able to access that data and to engage
32 on the back of that data with health services or, sections
33 of the health service, as opposed to always going through
34 a process, through freedom of information, GIPAA,
35 et cetera, to ascertain an accurate picture of a particular
36 issue that we are seeking to address.

37

38 Q. It's always going to be a challenge, isn't it? in
39 what I think you observed a moment ago is often contested
40 space, organisations like yours will often be in contest
41 with the ministry in relation to the making of decisions
42 and the like. Does that contested nature of your
43 respective roles in the broader ecosystem run against the
44 possibility of meaningful collaboration?

45 A. No, I wouldn't accept that universally. I think that
46 there are areas in which industrial bodies, employee
47 representations, can work very constructively with

1 employers and --

2

3 Q. In examples that you have of where that has happened,
4 what is it about those that - the relationship, which has
5 been so successful?

6 A. I think there is an openness - there are cultural
7 dimensions. Culture is very difficult to measure, but
8 there is an openness to partner with groups like the HSU to
9 address a particular problem and a willingness to reach
10 out, to talk to not only our members but our officials, to
11 find pathways to move forward to address particular issues.
12

13 Often, that is not the case. Often, it is a case of,
14 you know, we'd like to know, we think it's relevant that we
15 should know, the number of vacancies across NSW Ambulance.
16 We might have a contribution to make in that space because
17 we represent those paramedics. We might have a range of
18 solutions or ideas that could be implemented, but we can't
19 even get beyond that juncture of, "Can you please just tell
20 us how many staff vacancies exist?"
21

22 So the process from the beginning can be adversarial,
23 and that, that culture that might focus on that or might
24 have elements of being adversarial as opposed to being
25 collaborative or working in partnership - we will always
26 advocate for our members to receive fair pay and fair
27 conditions of work, and that will always put us, to
28 a certain degree, in contest with governments and with
29 others, with employer groups.
30

31 But that's not to say that just because of that, that
32 we can't collaborate or partner with elements of the health
33 service every single day on unique issues in which our
34 feedback should be imperative to providing solutions. We
35 would think that it's a logical conclusion to make that if
36 you've got staff shortages or vacancies within NSW
37 Ambulance, that you would ask the union that represents
38 ambulance members and ask directly for their feedback and
39 how they may have unique insights to overcome particular
40 problems. That's just one example of obviously a plethora
41 that emerge throughout NSW Health.
42

43 Q. In terms of consulting with members, you tell us in
44 paragraph 14 about a survey that the HSU conducted recently
45 of its membership, raising some of the issues addressed in
46 the Inquiry's Issues Paper 1/2024. I think you have now
47 had an opportunity to collate some responses to that

1 survey. Can I provide a copy of a document headed "HSU
2 Special Report - A NSW Health Workforce at Breaking Point",
3 to you.

4 A. Thank you.

5
6 MR MUSTON: I will provide a copy to the Commissioner as
7 well.

8
9 THE COMMISSIONER: Just before you go on to that, you
10 asked the witness some questions about the reform critical
11 "fragmented health system at breaking point" report
12 prepared by Impact Economics. Is that in the tender
13 bundle?

14
15 MR MUSTON: It is.

16
17 THE COMMISSIONER: Right. Okay. I mean, that report -
18 I mean, the questions you asked about that report and
19 particularly the assumptions regarding the modelling, what
20 ultimately is made of that report we will see, but in terms
21 of its big-picture findings, such as the spend on health is
22 growing at a rate that's higher than other areas of public
23 expenditure, that the percentage of the budget dedicated to
24 health spending is rising and that unless we get some
25 progress on the number of years that people spend, for
26 example, in chronic disease at an acute level, that that
27 expenditure on health is going to continue to grow, perhaps
28 unsustainably - all of those things that you can take out
29 of the report, whether the exact figures are one way or
30 another, they're all consistent with a myriad of other
31 reports, including government reports themselves, aren't
32 they?

33
34 MR MUSTON: That's absolutely right. I don't want to
35 over-emphasise or unintentionally over-emphasise the point
36 around the modelling but I was more concerned with the
37 precise numbers which have been repeated in Dr Halse's
38 statement, that - for example, just looking at the
39 penultimate line of paragraph 10, the 41,800 nurses, 19,400
40 diagnostic and allied health professionals. As to the way
41 one reaches those particular numbers, I think Dr Halse --

42
43 THE COMMISSIONER: It would be a stretch to make
44 a particular finding about those numbers based only on the
45 reform critical. My point was that in terms of what you'd
46 call perhaps generalisations but big-picture challenges,
47 the report's conclusions are consistent with many other

1 reports, including intergenerational reports, Commonwealth
2 and state.

3
4 MR MUSTON: My learned friend Mr Cheney might tell you
5 otherwise but I don't anticipate there is going to be any
6 dispute about the proposition that without adjustment, the
7 cost of delivering health care is going to continue to
8 increase as we move forward.

9
10 At one level, important considerations of this Inquiry
11 are what systemic adjustments might potentially be made to
12 try and control that. I don't think it's realistic to
13 think it can be avoided. But there needs ideally to be
14 control to enable the health system to function both
15 practically and in a manner which is economically viable.

16
17 THE COMMISSIONER: Yes. Unhelpfully or not, I've
18 interrupted again, but I'm wondering if my interruption is
19 a good time to take the morning tea break.

20
21 MR MUSTON: I think that will be an excellent time.

22
23 THE COMMISSIONER: I have just noticed a moment ago - it
24 may be that there is a more updated version of this - the
25 witness list I've got has Dr Halse at 10 but it's got
26 Ms Annette Solman and Dr Josephine Burnand also at 10.
27 That's obviously a typo. I know they follow this witness,
28 but there is also Professor Twigg on the list for today.
29 Are we going to get through all these witnesses today?

30
31 MR MUSTON: I think we will. In terms of them being
32 listed at 10, I think the Inquiry team was trying to avoid
33 a situation where hard and fast times were given, because
34 we end up with gaps.

35
36 THE COMMISSIONER: I see, that's fine. So that people
37 weren't online, for example. Okay. We'll take a break
38 until 10 to 12.

39
40 MR MUSTON: Before we do that, can we mark for
41 identification the document --

42
43 THE COMMISSIONER: I have no idea what MFI we are up to.

44
45 MR MUSTON: MFI 10.

46
47 THE COMMISSIONER: HSU Special Report "A NSW Health

1 Workforce at Breaking Point". What's the date of this?

2

3 MR MUSTON: I don't know whether it has a date.

4

5 THE COMMISSIONER: We will just call it that. MFI 10.

6

7 **MFI #10 HSU SPECIAL REPORT "A NSW HEALTH WORKFORCE AT**
8 **BREAKING POINT" BARCODED [SCI.0011.0266.0001]**

9

10 MR MUSTON: Just to finish on that.

11

12 Q. The document that has just been marked MFI 10, are we
13 correct in our assumption that this is a collation by the
14 Health Services Union of the responses received to the
15 survey which is referred to in paragraph 14 of your
16 statement?

17

A. Correct.

18

19 THE COMMISSIONER: Thank you. 11.50.

20

21 **SHORT ADJOURNMENT**

22

23 THE COMMISSIONER: Yes, please go ahead.

24

25 MR MUSTON: Q. Dr Halse, shortly before the break you
26 were telling us about some of the challenges that are
27 presented in terms of addressing workforce shortages, and
28 one of them that you identified was the ability of training
29 institutions to produce graduates in these various
30 disciplines, something you touched on in paragraph 16 of
31 your statement?

32

A. Correct.

33

34 Q. Just in relation to that, what are the observations,
35 what sorts of observations, have been made by members which
36 have led you to reach the conclusion that you've expressed
37 in the first sentence there of paragraph 16.

38

39 A. They are - many members have expressed to us that they
40 are experiencing what they may consider a shortage within
41 a particular department or work setting with respect to the
42 number of particular health professionals in that setting
43 or general or public health members. So that's borne out
44 of that observation, and again that's quite a universal
45 observation, that to varying extents across the system, but
46 a huge proportion of our membership are indicating that
47 there are shortages of staff and that includes allied
health staff who require more formal processes of training.

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Q. Is there in addition in particular about those observations around staff shortages which led you to the conclusion that you have expressed there, that it's the training institutions that are not able to produce enough graduates or provide an adequate supply, recognising that there is a connection between the two, but anything in particular that has been passed on to you about the capacity of institutions to produce graduates?

A. It's a reflection of the growing demand in the system and in the sector, the exponential demand for health services right across all of the sectors of health, and our members are saying quite clearly to us that there are - the gaps in the workforce continue to exist irrespective of the current training output from the university or the vocational sector.

Q. In the last sentence you refer to the time it takes to obtain qualifications and, in some cases, the need to obtain postgraduate qualifications to practise. Just so I can understand your position in relation to that, do you suggest that anything should be changed about that? Is it your position that the time it takes, say, for a physiotherapist to qualify as a physiotherapist should or could sensibly be reduced in any way, just as an example?

A. I don't think I'm best skilled to respond to that question. I know many of our members would be. It is a reflection, however, that many of our members have postgraduate level qualifications that require four, five, six-plus years of training, clinical training, and that's a significant investment for the health system, it's a significant commitment for them as individual workers. If it's not planned or projected accurately, you can very quickly find yourself in a position in which there is a workforce challenge to meet demand.

Q. Just tracking down to the next issue that you raise in paragraph 17, which relates to the clinical placements and the need for clinical placements to be made available as part of the training of the future workforce, you allude to what is described as "a lack of coordination between local health districts and education institutions" as one of the concerns that you have about the access to training clinical placement positions. What is your understanding of the existing arrangements that exist - existing arrangements between LHDs and training organisations?

A. What we've been told through our members is that there

1 is real challenge and complexity in marrying up the role of
2 the education provider and the services that are provided
3 within a health setting. Central to that are clinical
4 educators.

5
6 In discussion with an associate professor of clinical
7 psychology the other day, a HSU member, noted that that's
8 a unique position to acquire within the health service -
9 that we're not training enough of those individuals, in her
10 estimation, and that directly impacts that whole chain of
11 the capacity to get workers into the system.

12
13 As noted, members have also indicated that as we
14 expand, particularly allied health services, as new
15 services that 20, 30, 40 years ago did not exist come on
16 line and become a central part of health care, that there
17 are both physical infrastructure needs within hospital
18 settings or health settings, but there are also human
19 capital needs that are required to meet that demand.

20
21 Q. Just looking at each of them, the physical
22 infrastructure, for example, you need sufficient desks and
23 computers for the clinical placement students to be able to
24 come in and participate in the workforce to the extent that
25 they need to participate in order to have a meaningful
26 clinical placement - that no doubt varies from one
27 discipline to another, but that's what you are referring to
28 as your sort of physical constraints?

29 A. Correct.

30
31 Q. In terms of the number of suitably qualified people
32 available to supervise students is to the point that you
33 made a moment ago, that if there are shortages of
34 particular skill sets within a workforce, then that will
35 not only result in sufficient people potentially to deliver
36 care in those areas but also reduces the number of people
37 who can provide supervision for the next generation of
38 workers within that particular discipline?

39 A. Correct.

40
41 Q. What I want to ask you about is the first of the
42 points that you allude to, though, which is the
43 coordination between local health districts and educational
44 institutions. Have you had any particular discussions or
45 engagement with either LHDs or educational institutions
46 which have informed your understanding of what the current
47 nature of collaboration between those two entities or

1 groups of entities is in terms of harvesting as many
2 clinical placement positions and providing them to students
3 as is possible?

4 A. So this is more feedback that we've gained through
5 focus group work and direct interviews with our members as
6 opposed to direct feedback or conversation with education
7 providers, to link those two, but it is a clear area of
8 feedback for our members, and we note that recently, the
9 Australian College of Deans of Health Science noted that
10 clinical supervision is one of the huge problems within
11 particularly allied health care, and they list a myriad of
12 issues that the sector, the 23-plus unique professions or
13 groupings, encounter.

14
15 One of the reasons that a HSU member put to me the
16 other day is that in health professions outside of medicine
17 and outside of nursing and midwifery, there is not the
18 scale, and there hasn't been often in the history, because
19 of the development of some of these industries, so they're
20 playing catch-up with respect to the manner in which
21 infrastructure, both physical and human, is made available
22 and it's applicable to that cohort of workers, and it's
23 a reflection of the emerging nature of health care.

24
25 Q. Just coming back to that point, though, has any
26 particular observation or repeated observation been made to
27 you by members which criticises or identifies a particular
28 flaw in the collaboration between LHDs and educational
29 institutions insofar as that collaboration occurs at the
30 moment?

31 A. Apart from a general comment, not that I can pinpoint.

32
33 Q. Could I ask you to go to paragraph 19 of your
34 statement. You refer there to the lack of paid placements.
35 I think the Commission has heard a lot about the concept of
36 placement poverty and understands what you are addressing
37 there, but I just want to ask you about the next issue you
38 identify, which is the lack of structural programs to enter
39 into allied health professionals - what are the structural
40 programs that you have in mind there?

41 A. Well, it is a reflection of, number one, a lack of
42 clinical placements. So there are structured programs
43 across all of the various health profession areas.

44
45 Q. Just pausing there, a structured program, when you
46 allude to that term there, are you talking about there is
47 a structured program of study, at a particular university,

1 at the end of which you could become, say, a professional
2 physiotherapist?

3 A. That's correct, and there will be that collaboration
4 between the education provider or trainer and the health
5 system to provide the capacity to train those health
6 professionals.

7
8 Q. And so, again, if the structured program that you are
9 alluding to there in paragraph 19 is that structured
10 program of study being delivered by a particular
11 institution, is your point that there are not enough
12 student places available within institutions at the end of
13 which is a qualification as an allied health professional
14 of some particular description?

15 A. Yes, there's a challenge to meet the current demands.
16 When we have a rapidly growing complement of allied health
17 workers that needs to meet that exponential demand, it
18 requires that mirroring within that clinical placement
19 experience, and what our members have demonstrated to us,
20 or portrayed to us, is that it is growing so rapidly that
21 they are concerned that we cannot meet the pace of demand;
22 that if we increase university places, which is necessary,
23 we also need to ensure that there is that infrastructure
24 available to train these health professionals.

25
26 We are concerned, as you reference, that the federal
27 government recently has announced that some areas of health
28 care will be supported through clinical placements but not
29 allied health professionals. That's again a real challenge
30 that involves levels of government and training
31 institutions, and in an era in which we cannot afford to
32 lose too many health workers, that we are again
33 deprioritising, to a certain degree, knowing the budget
34 constraints and that there are finite resources available,
35 but we would advocate passionately that they are more
36 completely drawn into that health landscape.

37
38 Q. Maybe going back to something we were discussing
39 before the break, but in paragraph 20 you tell us that the
40 HSU considers, based on what it is told by members, that
41 recruitment within the New South Wales public health sector
42 is reactive and not proactive. What do you mean by that,
43 in a practical sense?

44 A. It is an observation that is drawn from the huge
45 number, from a percentage wise, of our members who indicate
46 that there are, to go back to our previous line, staff
47 vacancies within departments, and the common response we

1 hear from members is, "We have just filled a vacancy,
2 another one has emerged." "We haven't planned that someone
3 is retiring, someone is intending to leave the workforce -
4 no-one was aware of that", because we don't capture really
5 good data, it goes back to that central question of data.
6 We don't have that information. And then health services,
7 doing a wonderful job as administrators who we represent,
8 are trying to plug gaps within a particular department to
9 acquit the duties.

10
11 So as a statement, I have seldom met a health worker
12 who said, "We are over prescribed, that we have a large
13 contingency of workers in this department who are
14 permanently engaged so that if there is an escalation in
15 demand that we need to meet or if individuals, for whatever
16 reason, leave the service, we can immediately or quite
17 easily meet that demand." In my experience, I've not - I'm
18 not sure I've met a health worker who would say that.

19
20 Q. In paragraph 22 you tell us about concerns raised by
21 your members about the time that the recruitment process
22 takes within NSW Health. Could you be a little bit more
23 specific about the particular concerns which have been
24 raised with you on that topic?

25 A. Yes. Of course, unlike other occupational groupings
26 or industries, to fill placements within the health service
27 is quite important. If you don't have enough cleaning and
28 administrative staff, the surgical wards can't operate. So
29 it's been reflected to us that it often takes too long to
30 fill existing vacancies, and there might be - there would
31 be a myriad of reasons for that.

32
33 One reason that was cited to me recently by a HSU
34 official was the time it took to complete a criminal record
35 check, and if it's taking multiple weeks or longer to
36 perform that function, then you can't fill a spot, whatever
37 it is, within a health service. Then again, it goes back
38 to that sort of relationship that groups like ours have
39 with the health service, that we need to engage in a more
40 adversarial approach to ensure that existing vacancies are
41 met. So that's a small little example of how, for example,
42 the recruitment process might be expedited.

43
44 But the simple premise being that, in health services,
45 often it's paramount to be expeditious in the recruitment
46 to fill gaps, otherwise those departments, that provision
47 of health care, cannot be met.

1
2 Q. Could I ask you to go over to paragraph 24 of your
3 statement. You acknowledge the need for flexibility
4 through a temporary workforce but express concern about the
5 dependence in New South Wales on temporary staff, such as
6 VMOs, locums and agency staff. I think we understand the
7 issues insofar as they apply to locums and agency staff,
8 but could I ask you to explain what your particular concern
9 is with respect to visiting medical officers?

10 A. So we have as a central argument that we believe
11 a permanently domiciled workforce provides the level of
12 continuity of care that provides optimal patient outcomes.
13 We think that that's quite clearly demonstrated in some of
14 the research that is publicly available, external research.
15

16 When we compare - and this is a finding through our
17 research report "Reform Critical", when we compare the
18 New South Wales jurisdiction compared to Victoria and
19 Queensland, we observe a much higher level of VMOs and the
20 use of VMOs. We're not suggesting that they don't perform
21 excellent work, but what we're suggesting is that there
22 might be some structural elements within NSW Health that
23 prioritise VMOs over permanency, which may not lead to more
24 optimal care for patients.
25

26 Q. Do you have a view about what those structural issues
27 might be or a little bit beyond your remit?

28 A. That might be slightly beyond my remit.
29

30 Q. Could I ask you to go down to the final paragraph,
31 paragraph 27 of your statement, where you indicate that the
32 HSU considers that many NSW Health worker awards are
33 outdated and require modernisation. Do you have any
34 particular examples that you think illustrate that point
35 well?

36 A. We know that there's a current process of award
37 modernisation occurring in New South Wales. We support
38 that process, and our members across a whole range of
39 professions are deeply involved in that. But to give you
40 one clear example, there are some members, health workers,
41 who are not captured by the current award structure. So
42 a mental health peer support worker is not captured within
43 the current award structure.
44

45 Q. So how are they employed currently?

46 A. My understanding is that they are employed as a health
47 education officer - I can double-check that - but it is

1 a demonstration of the development and the dynamism of
2 health that it's always moving, it's always evolving,
3 always changing, and that the award structure has often
4 been playing catch-up to the roles and the functions that
5 our members perform.
6

7 Q. In terms of award reform, what do you think that might
8 look like as a process, for it to be effective? Are we
9 talking about a log of claims where things are debated in
10 relation to the existing awards or is it your view that
11 a different process should be embarked upon which
12 essentially commences with a blank sheet of paper?

13 A. Well, that process is under way, it's commencing,
14 we're involved in submitting logs of claims and working
15 with the relevant areas to ensure that the settings within
16 an award - everything from pay and wages and the conditions
17 under which workers are engaged and the skill sets and the
18 level of professionalisation which can be observed within
19 an award structure - is being observed. Simply because if
20 these processes aren't undertaken repeatedly and often, as
21 I said, given the nature of the health workforce, there are
22 elements that will be missed.
23

24 What our members are saying to us is that there are
25 elements of our scope of practice, there are elements of
26 the work that we do every day that's just not captured in
27 the current awards, so we'll go through that process with
28 government and ensure that it's more reflective of the
29 current workforce that we have, let alone the projection of
30 what the workforce might look like in 15 or 20 years' time.
31

32 THE COMMISSIONER: Q. It might be captured in the answer
33 you've just given, and I understand your answer. I think
34 Mr Muston's question was more fundamental, in the sense
35 that what he was asking was whether the awards as they
36 are - whether you've got a log of claims or you're amending
37 the current awards, or whether a better process would be
38 just to start anew?

39 A. Yes --
40

41 Q. His wording was a blank piece of paper?

42 A. A blank piece of paper. And there is that process of
43 streamlining, where there is a capacity to streamline
44 awards, make them clearer, make them more reflective of the
45 current nature of work, that's the intent of HSU to
46 participate in that program, to ensure that we don't have
47 awards that are outdated, that are not applicable, so to

1 ensure that they are modern, they are relevant, they are
2 capturing all the things that members require.

3
4 Q. So either way, we're not looking at minor amendments
5 or tinkering. It's a fundamental process?

6 A. A fundamental change to the structure is required.

7
8 MR MUSTON: Q. What do you anticipate the timing of that
9 exercise will be? When will it concluded?

10
11 THE COMMISSIONER: We'll have to ask upstairs.

12
13 THE WITNESS: You might have to. You might have to. Our
14 members have prepared huge amounts of - huge troves of
15 research informed by internal workforce committees,
16 presenting claims, engaged in that process of negotiation,
17 are fully participating in a collaborative way in a process
18 to ensure that we have a structure that sets up, that is
19 responsive and reflective for not only the current
20 workforce but potentially can anticipate some of the
21 challenges that will confront the future.

22
23 So it is not an easy process. Any award reform
24 process in any sector, whether it's health or otherwise,
25 can be complex, it can be laborious, but it's very clear
26 that in health particularly, given again the rapid changes
27 in the nature of work, that the structure is out of date,
28 it needs to be not tinkered, it needs to engage in a
29 process of wholesale reform.

30
31 Q. Do you think there would be any benefit in setting
32 a sunset date for that award reform process to focus
33 people's minds on achieving reform as quickly as is
34 reasonably practicable?

35 A. Any mechanism that can reasonably expedite a process
36 and meet the concerns of those negotiating parties, all
37 negotiating parties, would be a reasonable conclusion to
38 draw.

39
40 MR MUSTON: I have no further questions for this witness,
41 Commissioner.

42
43 THE COMMISSIONER: Can I just ask, though, how should
44 I understand that last question about a sunset date? Is
45 that some sort of legislative sunset date?

46
47 MR MUSTON: Yes.

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THE COMMISSIONER: Q. Did you understand it that way?

A. I did, yes.

MR MUSTON: Q. I should ask this question: are you aware of legislative sunset dates of that type having been utilised as a tool in other jurisdictions in the context of the award reform processes?

A. It's a good question. Off the top of my head I can't pinpoint one but it would be wholly unremarkable.

MR MUSTON: Thank you, Commissioner.

THE COMMISSIONER: Thank you. Mr Cheney, do you have any questions?

MR CHENEY: Yes, Commissioner.

<EXAMINATION BY MR CHENEY:

MR CHENEY: Q. Sir, could I ask you first about something you said quite late in your evidence about the, first of all, the lament, I think, in paragraph 27 of your statement that many health awards are outdated and require organisation - I think you understand that to be an observation that's shared by NSW Health?

A. Correct.

Q. You've gleaned that perception from your dealings with NSW Health about award amendment?

A. That's a common reflection within our organisation.

THE COMMISSIONER: That's the Inquiry's understanding, too.

MR CHENEY: Yes.

Q. You were asked some questions, in a different context, about HSU's desire to be collaborative and you were asked what you perceive to be the benefits of such collaboration and that different context related, I think, to staffing arrangements, but you recognise that collaboration is needed also on this question of award modernisation?

A. Yes.

Q. And you would have perceived, I gather, that there are aspects of outdated awards that impede the efficient

1 delivery of health care?

2 A. Correct.

3

4 Q. That need to be modernised or changed?

5 A. Correct.

6

7 Q. Sir, you've spoken about the perceived benefits of an
8 independent body that might capture what you describe as
9 "real-time data". I just wasn't clear what you had in mind
10 by that phrase "real-time data", if you can help us?

11 A. Yeah, sure. So it might be considered as
12 contemporaneous data. So that might be, for example, a
13 dataset that's captured over the course of the year with
14 multiple intervals, a little bit like what the BHI
15 captures, so quarterly data that might be considered
16 real-time data. It's not historic, it's not from the last
17 financial year, it's not from multiple years ago, but
18 captures as, a course of its work, repeated data. How
19 quickly you might be able to capture that data is
20 a question, but a model is there, obviously, in a different
21 context, with the work of the BHI. But we think that for
22 data to be most powerful, it should be contemporaneous and
23 real-time, and again, I'm stressing this point, the change
24 is often required rapidly within health so that real-time
25 data can inform policymakers.

26

27 Q. But by real-time data you're not contemplating, for
28 example, daily or weekly or even monthly reports from
29 various LHDs about vacancy rates?

30 A. It might be difficult on a daily schedule, but --

31

32 THE COMMISSIONER: It might not be particularly useful
33 either.

34

35 THE WITNESS: I'm not sure it would be either. But within
36 reasonable - a reasonable time frame that might be
37 considered real-time or contemporaneous, valid, current
38 data is the point we're trying to get to, so it's not
39 a finding from 15 months ago. Someone can confidently say
40 that within two months or six weeks or three months, that
41 this is an accurate picture of what might be occurring in
42 the section within the health service.

43

44 Q. And I think in an answer you gave quite early on you
45 observed that there's already a - I think you used the
46 term - "trove" of data available to the public, including
47 your union, obviously enough?

- 1 A. Correct. And we use that, we observe it, we use it
2 and it's very helpful.
3
- 4 Q. And you cited, I think, as sources of such data the
5 ABS, the ATO, the census and NSW Health statistics?
6 A. Yes, and the National Health Workforce Dataset.
7
- 8 Q. And in addition, you might also cite, I suppose, the
9 Australian Health Practitioner Registration Agency data?
10 A. Correct.
11
- 12 Q. The Australian Institute of Health and Welfare data?
13 A. Correct.
14
- 15 Q. The Independent Health and Aged Care Pricing
16 Authority's data?
17 A. Correct.
18
- 19 Q. And various other Commonwealth Government agencies?
20 A. That's right.
21
- 22 Q. So is your real objective to have a process for
23 assimilating all that data or presenting it in one coherent
24 form?
25 A. That has been put by health experts and academics and
26 researchers more broadly, who are analysing the Australian
27 health system or a particular jurisdictional health system.
28 It's not simply that, in a number of the areas we're
29 seeking an expansion of the data. But anything that can
30 collate datasets in a manner which makes them more readily
31 understood by more groups is a good thing for statistical
32 research health we do - we highlight the manner in which
33 the BHI presents a lot of data. It deliberately presents
34 data that can be accessible, that's clear, that's
35 transparent, that is disinterested.
36
- 37 Q. That's directed to clinical outcomes?
38 A. Yes. Some of the data --
39
- 40 Q. Not matters of workforce?
41 A. No. Some of the data that is captured, from
42 a perspective as a researcher, is quite clunky. It's not
43 easily understood or accessible, and I think going to your
44 point, a collation, to give a broader picture, is a valid
45 pursuit.
46
- 47 Q. But to be clear, you contemplate a body that collates

1 this material gathered by others; is that right? In other
2 words, you are not contemplating replicating the work
3 that's already done by those various bodies and authorities
4 that we've just discussed?

5 A. If it data exists there is no point to replicate it
6 through a different body. Where the data doesn't exist on
7 matters such as vacancies, or if it does exist and is not
8 publicly available, that's a different question that
9 I think we've traversed. But there are elements that we
10 think that public policy experts, industrial groups,
11 employer groups, indeed, the NSW Health department, the
12 ministry, would find useful.

13

14 Q. You were asked by way of example, I think adopting
15 Broken Hill Hospital as an example, in what way the HSU
16 having insight into vacancies for cleaners, for example, at
17 Broken Hill Hospital would assist the process of
18 recruitment for those positions. Do you recall being asked
19 about that?

20 A. So our members at a hospital setting are acutely aware
21 of staff vacancies or staff shortages, for example. We
22 believe that the information that they hold, or that data
23 that they hold, effectively, that's what it is, it's data
24 that leads to information, can be useful, can be translated
25 within a particular process.

26

27 Q. But that acutely held information - that is, held by
28 your members working at these facilities - I assume the HSU
29 has a process by which it gleans that information from its
30 members from time to time; is that right?

31 A. We have processes constantly afoot - sometimes it's
32 reflected in direct representation because there might be
33 a short - an issue of staffing at a particular facility, so
34 it might require an industrial officer to go and
35 communicate and negotiate with a hospital management
36 structure; it might be ascertained through the research
37 work that centrally we put to members to ask for their feed
38 back. We constantly do that. We constantly engage in
39 survey work, both survey work, focus group work, research
40 that's both quantitative and qualitative that gives us
41 a picture and that informs the work that we do and the
42 information that we present at forums like this.

43

44 Q. So the absence of an independent body of the type you
45 contemplate is not a complete impediment to your union
46 ascertaining the state of affairs at any given health
47 facility, because you can rely upon your existing members

1 to report back to you - on the ground?

2 A. I would suggest that it's not the responsibility of
3 our members to report on staff vacancies. We asked them,
4 after hours --

5
6 THE COMMISSIONER: That's a bit more of a difficult
7 process, isn't it, to go back to the membership all the
8 time, rather than having the data readily available, isn't
9 it?

10
11 MR CHENEY: Well, it might be, Commissioner, but we'll
12 come to that.

13
14 THE COMMISSIONER: Anyway, keep going.

15
16 MR CHENEY: Q. You do have that capacity to obtain from
17 your members at the coalface, as it were, what the
18 situation is in any given discipline?

19 A. We have a capacity to invite our members to
20 participate in the research and the survey work that we do,
21 and that gives us a picture. I think, as I referenced in
22 my witness statement, we're not suggesting that we have
23 complete datasets, and again, going back, the work of
24 a clinical psychologist, a physical therapist, a cleaner,
25 someone who is working in food services, might not be to
26 capture this in a manner which is hugely structured, but
27 they can be involved in that process.

28
29 We don't think - perhaps more accurately, the point
30 that I'm making is it's not the function of HSU to capture
31 data on these areas. We think that a state-based body has
32 the capacity, the expertise to do that, not a trade union.

33
34 Q. I wasn't suggesting for a moment that it was the role
35 of your members or the HSU to procure this data, but can
36 I ask you to assume for the purpose of the exercise that
37 NSW Health holds data relating to vacancies and that data
38 informs recruitment policies. I'm struggling with what it
39 is that you see would be the public benefit of the HSU
40 having insight into that material, in circumstances where
41 NSW Health has that data.

42
43 THE COMMISSIONER: Before you answer that, what is your
44 client's position, that there has to be some public benefit
45 for this information to be made publicly available in.

46
47 MR CHENEY: Yes, in circumstances, Commissioner, where,

1 among other things, my client is competing with similar
2 organisations in other states for recruitment data. There
3 may well be aspects of this that are commercially
4 sensitive, and it's not a general - it ought not to be a
5 general --

6
7 THE COMMISSIONER: But vacancy rate for particular workers
8 in the health system is commercially sensitive because --

9
10 MR CHENEY: For example, if it is perceived that there is
11 an inordinate number of vacancies in a particular LHD or
12 a particular region, that it becomes publicly known, that
13 may well feed in to the expectations of those who might
14 otherwise be interested in fulfilling those roles.

15
16 THE COMMISSIONER: There might be pros and cons of any
17 release of information to the public that's about a public
18 health system, but - I mean, I can think, for example, the
19 people involved in local government, particularly in a
20 regional or rural LHD, might want to know what the vacancy
21 rates are for particular workers in the health workforce,
22 because they are the people that get hauled up in
23 supermarkets and in the street and told, "There's not
24 enough X in our hospital", and they have to answer those
25 questions to the citizens, the residents of their local
26 government areas.

27
28 There will no doubt be, as I said, pros and cons of
29 releasing public information, but I can't quite see how
30 it's acutely commercially sensitive at the moment, but you
31 will obviously have an opportunity to convince me otherwise
32 at some stage if you want to.

33
34 MR CHENEY: Q. Dr Halse, the HSU is not a benevolent arm
35 of NSW Health, is it? It operates with a mandate of
36 improving the conditions of its members?

37 A. I'm not sure what a benevolent arm - what you're
38 referring to there.

39
40 Q. Well, accept the proposition --

41
42 THE COMMISSIONER: Q. You are a trade union, right? You
43 represent your workers, your members --

44 A. Exactly.

45
46 Q. -- and you try and get the best deals for employment
47 conditions as you can for them?

1 A. That's correct.
2
3 Q. Is that the fundamental job?
4 A. Absolutely.
5
6 MR CHENEY: Q. You mentioned candidly enough that from
7 time to time it is necessary to resort to industrial action
8 to improve those conditions?
9 A. That's correct.
10
11 Q. And you would acknowledge, would you not, that there
12 would be circumstances in which there would be information
13 known to NSW Health that it may not be in its interests, as
14 opposed to your members' interests, for the HSU to know?
15 A. That could be an argument put by NSW Health. I don't
16 think it's in the public interest. I don't think it's in
17 the interest of workers.
18
19 Q. Sir, in paragraph 18 of your statement, you refer to
20 there being an increasing concentration of health services
21 in metro areas, and you give, I think, an example of
22 Woollahra having twice as many GPs per thousand head of
23 population than does Liverpool.
24 A. Correct.
25
26 Q. You, in a former life, worked in the Victorian system;
27 is that right?
28 A. I worked in the Victorian government, yes.
29
30 Q. It would, I gather, be a common feature of the health
31 system in Victoria that there is a greater supply of
32 medicos in the metro areas than there are in the regions?
33 A. I think most of the established research across the
34 country, which reflects on the number of medical
35 practitioners or even allied health practitioners, does
36 indicate clearly that areas of higher socioeconomic status
37 have more, proportionally. I think that's a wholly
38 uncontroversial finding across all jurisdictions.
39
40 Q. And in your work as a Victorian parliamentarian, you
41 would have had occasion to observe that the fact that the
42 responsibility for general practitioner workforce supply
43 falls to the federal government, can cause some tension
44 with state health systems?
45
46 THE COMMISSIONER: I don't understand that question.
47 "Your work as a Victorian parliamentarian, you would have

1 had occasion to observe that the fact that the
2 responsibility for the GP workforce supply falls to the
3 federal government can cause some tension - can you have
4 another crack at that question

5
6 MR CHENEY: Yes, Commissioner.

7
8 Q. GP distribution workforce is largely a matter for
9 Commonwealth Government; correct?

10 A. Through the primary health network.

11
12 THE COMMISSIONER: I mean, I have to say, I'm not sure
13 I accept the premise of that question. The witness can
14 answer however he likes, but in the end, I'm the
15 Commissioner.

16
17 MR CHENEY: Q. You are aware that NSW Health --

18
19 THE COMMISSIONER: I mean, the Commonwealth runs Medicare
20 and it supplies an MBS, which is an insurance scheme, which
21 is tapped into by GPs using certain coding for whatever
22 service they are providing, medical service they are
23 providing, to patients, and it relies on there being
24 a market. It is not a general primary care provider - the
25 Commonwealth is not. It has an insurance scheme that we
26 call Medicare. That's just a fact.

27
28 MR CHENEY: I was about to volunteer that it is at least
29 recognised as a responsibility for primary care --

30
31 THE COMMISSIONER: Who is, the Commonwealth?

32
33 MR CHENEY: -- falling on the Commonwealth.

34
35 THE COMMISSIONER: Well, I'm not sure - what do you mean
36 by that? I mean, I don't know whether it is relevant to
37 debate this in front of the witness. Certainly Medicare
38 exists. We know that. But the responsibility for primary
39 care might fall on more than just the Commonwealth.

40
41 MR CHENEY: And we've seen evidence that, in fact, it
42 does.

43
44 THE COMMISSIONER: Yes, exactly.

45
46 MR CHENEY: Q. I'm sorry, Dr Halse, you're aware that
47 NSW Health has invested in significant programs to assist

- 1 the relocation of general practitioners or rural
2 generalists to the regions?
- 3 A. Yes.
4
- 5 Q. And including scholarships for GP training?
6 A. Yes.
7
- 8 Q. Or trainees, and the single employer model?
9 A. Yes.
10
- 11 Q. And the union, I gather, would be supportive of those
12 initiatives?
13 A. We're supportive of all initiatives that meet the
14 unique distribution requirements to provide health care
15 across New South Wales.
16
- 17 Q. And I think in paragraph 19 you speak about there
18 being a lack of paid placements and a lack of structured
19 programs for allied health professionals to enter?
20 A. Correct.
21
- 22 Q. You are aware that within NSW Health there are some
23 recognised allied health professions?
24 A. Yes, I think I reference that.
25
- 26 Q. And each has a different training pathway and
27 different clinical placement requirements?
28 A. That's right.
29
- 30 Q. And I think that's in part why you have found it
31 difficult, at the start of your evidence, to nominate the
32 number of different areas that are covered by your members?
33 A. I wouldn't say struggled, I think I referenced that we
34 have such an expansive membership, with unique occupations,
35 obviously there are 23 or so allied health professions that
36 are recognised, or groupings that are recognised, but the
37 point I was stressing is that up and down the health system
38 there is a huge number of distinct groupings. That's the
39 point I was making.
40
- 41 Q. And nationally, all the allied health professional
42 university training courses are accredited by the
43 professions' peak associations?
44 A. The peak bodies, the accreditation arms will have
45 a role in dictating the accreditation process and a role in
46 coordinating with the university or vocational sector the
47 requirements that are unique to a student's clinical

1 education.

2

3 Q. But the governance over the education curriculum for
4 allied health practitioners rests with the individual
5 universities and the education providers; correct?

6 A. Predominantly, yes.

7

8 Q. By reference to standards set by independent
9 regulatory authorities?

10 A. Yes.

11

12 Q. Such as the Australian Health Practitioner Regulation
13 Agency?

14 A. Correct, yes.

15

16 Q. And the accreditation standards that universities have
17 to adhere to include a minimum number of clinical placement
18 hours that the allied health professionals must complete to
19 be deemed competent to practise?

20 A. Absolutely, and across the - I think we have a letter
21 tendered through my witness statement that goes into some
22 of the detail, the various hours that are required across
23 a distinct range of allied health professions.

24

25 Q. And for many allied health professions, at least
26 a portion of the students' clinical placement time must be
27 spent in large tertiary hospitals?

28 A. We appreciate that the concentration of existing
29 clinical staff may be in those larger tertiary hospitals,
30 and we understand that there is efficacy in having training
31 set in those areas or those hospitals. We don't contend
32 that.

33

34 Q. But that's in part, is it not, because the
35 accreditation requirements demand that, that some of the
36 clinical placement be in tertiary hospital setting?

37 A. It is in part but I'm not sure it is solely. I think
38 it is in part but not sure it is solely.

39

40 Q. I wasn't putting solely, sir. I was suggesting
41 a portion of the clinical placement time must be spent in
42 large tertiary hospitals?

43 A. That's my understanding. I'm reluctant to delve into
44 every single allied health process and go through all the
45 clinical requirements. I know that there are others who
46 are better placed to comment on those matters.

47

1 Q. But in your position, you are aware that many of those
2 positions are hosted by NSW Health?

3 A. Yes.
4

5 Q. And there are other initiatives that, to your
6 knowledge, are in place by NSW Health to support allied
7 health students financially?

8 A. Financially - I couldn't list off the top of my head
9 all of the initiatives, but it would be of absolutely no
10 surprise that - I'm sure you'd be - to distil through
11 a range of initiatives, and that is a good thing, and it's
12 a common practice among many jurisdictions, state
13 jurisdictions across the country, that they are supporting
14 or they are looking for avenues to support health workers
15 or allied health workers in whatever way.
16

17 Q. Including in the form of Aboriginal allied health
18 cadetships?

19 A. Yes.
20

21 Q. And tertiary health study subsidies that are paid by
22 NSW Health?

23 A. Yes, to the extent - I'm not - I can't confirm the
24 extent of that, but if you are putting it to me.
25

26 Q. There's also, in addition to those who would be
27 classified as allied health practitioners, there are those
28 who are labelled, for want of a better term, "allied health
29 assistants"; is that a phrase that describes a category of
30 your membership?

31 A. Yes. Yes, people will classify themselves in that
32 manner.
33

34 Q. And they typically work under the supervision of an
35 allied health professional?

36 A. Yes, they typically would.
37

38 Q. And there is currently no formal training pathway for
39 transitioning those assistants to become allied health
40 professionals; is that right?

41 A. That sounds accurate but I can't say with specificity.
42

43 Q. In addition, there's been recent Commonwealth
44 Government initiatives to improve the training position of
45 allied health practitioners in the form of a Commonwealth
46 prac payment; is that right?

47 A. Yes.

- 1
2 Q. And that supports a selected group of students
3 undertaking mandatory work placements?
4 A. Yes, teaching, nursing and social work students.
5
6 Q. And --
7 A. And midwives.
8
9 Q. And midwives, and that's a payment of about \$320 per
10 week while they are training?
11 A. I think it is pegged to Austudy.
12
13 Q. You have made the point I think in paragraph 20 that,
14 as you perceive it, the public health system is reactive
15 not proactive with its identifying its recruitment needs.
16 You would accept that - and I think you have acknowledged
17 as much already - there are significant constraints on the
18 recruitment capacity of NSW Health arising from workforce
19 shortages?
20 A. It's a challenging area.
21
22 Q. You have also observed --
23
24 THE COMMISSIONER: That's been well and truly established
25 already in this Inquiry.
26
27 MR CHENEY: Q. You have observed in paragraph 22 that
28 there's a lengthy - or at least your members perceive that
29 there is a lengthy recruitment process involved in filling
30 some positions?
31 A. Yes, as articulated by our members, the feedback that
32 we have received is that - a sense that it takes some time
33 to fill certain positions.
34
35 Q. Are you aware that there is a formal policy about it,
36 known as the recruitment and selection of staff to
37 NSW Health service?
38 A. Yes.
39
40 Q. And it's, as you understand it, directed to ensuring
41 that there is at least a fair process for identifying and
42 selecting candidates?
43 A. We acknowledge that there must be a fair process, that
44 the process must meet the expectations of a particular
45 health service, that the process may - that it must ensure
46 that those who are engaged can engage in safe and proper
47 practice within the context of the service they are

1 delivering.

2

3 Q. And are you aware that NSW Health has set a target of
4 a 40-day time to fill positions?

5 A. Vaguely aware of that, yes.

6

7 Q. You would recognise that as an initiative that's at
8 least directed to addressing the concern that you refer to
9 in paragraph 22?

10 A. It's a noble intent.

11

12 THE COMMISSIONER: I think the length of time for
13 recruitment - a concern about that in a general sense, is
14 not limited to the HSU, I think people within LHDs have
15 shared the frustration, if I can call it that.

16

17 MR CHENEY: Yes. Somewhat of a dilemma.

18

19 Q. Just finally, Doctor, you refer in paragraph 24 to the
20 health system having a high dependency on temporary staff
21 and you include in your examples of such visiting medical
22 officers. You understand that they are contracted staff --

23 A. Yes, I do.

24

25 Q. -- engaged via a VMO determination?

26 A. Yes.

27

28 Q. And they encompass approximately 50 per cent of the
29 senior medical workforce in New South Wales?

30 A. We understand it is a huge component, yes.

31

32 THE COMMISSIONER: Q. You would accept that whilst in
33 the statement, without being critical, you have used VMOs,
34 locums and agency staff together - you would accept there
35 are separate considerations for VMOs --

36 A. Yes.

37

38 Q. -- as compared to locums and agency staff?

39 A. Correct.

40

41 MR CHENEY: Nothing further, Commissioner.

42

43 THE COMMISSIONER: Can I just before I go back to
44 Mr Muston - and this isn't for the witness but just while
45 he's still in the box, prompted by something, a message
46 sent to me and something I said back at transcript
47 page 3755, Mr Cheney, you asked the witness:

1 ... I gather, that there are aspects of
2 outdated awards that impede the
3 efficient ...

4
5 Sorry, you asked the witness about what he said in
6 paragraph 27 of his statement, that many health awards are
7 outdated and require organisation, it might be
8 reorganisation that you meant, and the witness agreed with
9 that proposition, and you said:

10
11 You've gleaned that perception from your
12 dealings with NSW Health about award
13 amendment?

14
15 And the witness said:

16
17 That's a common reflection within our
18 organisation.

19
20 And I said:

21
22 That's the Inquiry's understanding too.

23
24 That is, in a general sense, the Inquiry's understanding
25 from things we've been told. But you went on to ask the
26 witness at line 24:

27
28 And you would have perceived, I gather,
29 that there are aspects of outdated awards
30 that impede the efficient delivery of
31 health care?

32
33 And the witness agreed with that proposition.

34
35 I think what would help me, though, in relation to
36 that - and it is not for the witness to give me this help -
37 but it would help if NSW Health could identify for me and
38 this Inquiry what specific awards, or what parts, aspects,
39 of specific awards "impede the efficient delivery of health
40 care", in your client's view, so that we had that, some
41 form of documents with that listed out in table form, or
42 whatever.

43
44 MR CHENEY: Yes, Commissioner.

45
46 THE COMMISSIONER: So that I've got - no doubt that's your
47 client's view, because you've asked the question, but I'd

1 Like the specifics of it if I could, please

2

3 MR CHENEY: Yes, Commissioner.

4

5 THE COMMISSIONER: Thank you. Did anything arise out of
6 the questions from Mr Cheney?

7

8 MR MUSTON: No.

9

10 THE COMMISSIONER: Thank you very much, Dr Halse, we're
11 very grateful for your attendance and you are excused.

12

13 <THE WITNESS WITHDREW

14

15 MR MUSTON: The next witness I think is Annette Solman.
16 We'll need five minutes just do get her up on the screen,
17 is what I'm told.

18

19 THE COMMISSIONER: Do we start or start at 2? I'm happy
20 to start now, I'm just asking you what your preference is?

21

22 MR MUSTON: I'm happy to start now, we'll get her up on
23 the screen --

24

25 THE COMMISSIONER: I'll just sit here but we'll adjourn
26 until the witness is on the screen.

27

28 **SHORT ADJOURNMENT**

29

30 <ANNETTE SOLMAN, SWORN: [12.50pm]

31

32 THE COMMISSIONER: Ms Solman, if at any stage you don't
33 hear Mr Muston, who is about to ask some questions,
34 clearly, please let me know and I'll get the question
35 repeated. Thank you. Go ahead.

36

37 <EXAMINATION BY MR MUSTON:

38

39 MR MUSTON: Q. Ms Solman, you are the chief executive of
40 the Health Education and Training Institute?

41 A. Yes, I am.

42

43 Q. Referred to in the business as HETI?

44 A. Yes.

45

46 Q. And that's a role that you have held since June 2015?

47 A. Yes.

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Q. You have prepared a statement to assist the Inquiry with its work dated 9 July 2024?

A. I have.

Q. Do you have a copy of that statement handy?

A. I have it in front of me.

Q. Have you had an opportunity to review it before giving your evidence today?

A. Yes, I have.

Q. Are you satisfied that the contents of that statement are, to the best of your knowledge, true and correct?

A. Yes.

MR MUSTON: In due course, Commissioner, that statement will be tendered.

Q. Could I ask you to go to paragraph 7 of that statement.

A. Yes.

Q. Do you see you tell us there that the primary role of HETI is to provide leadership to LHDs, specialty health networks and other NSW Health organisations and training providers on the development and delivery of education and training across the New South Wales public health system?

A. Yes.

Q. Could I just understand, what do you mean when you use the words "provide leadership"? What is the nature of the leadership which is provided by HETI in that domain?

A. Well, HETI is highly skilled in education and training and the development of education and training, and also the development of education and training that's fit for a number of the professions. So we do provide leadership out to the New South Wales health system in relation to our education and training and we engage people from the New South Wales health system who are experts in particular fields to work with us to ensure that the products that we develop in collaboration, advised by experts, are fit for purpose and safe and patient centred. So I do think, you know, when we're talking about leadership, it is that leading with others.

Q. That's a reference I understand to education that's

1 being delivered by HETI into the system?

2 A. Yes.

3

4 Q. Is there anything else that HETI is doing to provide
5 leadership in the education space to LHDs, specialty health
6 networks and other New South Wales public health
7 organisations?

8 A. We hold a series of seminars as well around
9 contemporary education and training. So we have speakers,
10 they come in, and that's available to anyone across
11 NSW Health. So we do have certain digital events, virtual
12 events that staff can access.

13

14 In addition to that, there is also medical
15 accreditation and that's an area where there are certain
16 requirements to be met for medical education and training,
17 and HETI is also there to support LHDs and specialty health
18 networks in understanding what that means.

19

20 Q. We might return to that. Could I ask you to track
21 down to paragraph 9 of your statement where you tell us
22 about some of HETI's main functions. Do you have that?

23 A. Yes.

24

25 Q. I just want to take you down to subparagraph (b).

26 A. Yes.

27

28 Q. Where you tell us that one of HETI's functions is to
29 establish governance for whole of health education and
30 training programs. What does that mean in a practical
31 sense, the establishment of governance for whole of health
32 education?

33 A. Well, when it's whole of health education and training
34 that we develop, so I'm talking about development now, we
35 have the governance of the development of those modules.
36 There's also health education and training programs that
37 come into the system and we review those education and
38 training programs that are put up by others to ensure that
39 they are fit for purpose and that they are programs that
40 would be suitable to the New South Wales health system.

41

42 Q. How does that work in a practical sense? Let's say
43 a regional LHD or a particular hospital has some training
44 that it wants to deliver to a section of its workforce.
45 What does HETI do to establish governance in respect of
46 that particular training?

47 A. Well, it may not be that this would be something that

1 HETI would establish governance of. It may be something
2 that's a local issue that can be addressed through local
3 expertise and is then provided within an LHD. If it was --
4

5 Q. In that context - sorry to interrupt you, but in that
6 context does HETI have any particular role to play in the
7 delivery of that education output?

8 A. No, not unless they invited us in. There is
9 a number - there is education and training that occurs in
10 LHDs and specialty health networks that they determine as
11 a local need and that they then address that local need
12 with their education and training staff taking the lead.
13 If they want to or they seek to come to HETI for advice and
14 support, we have very strong relationships across the whole
15 system.
16

17 Q. Does that routinely happen, to your knowledge?

18 A. It has happened on occasion. Sometimes it's not
19 actually in a formal sense. Because we have staff placed
20 all over New South Wales, health, you know, people can
21 engage with others and talk about education and training,
22 so it may not be something that we would be seeking
23 governance of, because it's about responding to a local
24 issue and it's also about not taking away from the LHDs the
25 opportunity for them to respond to their local needs, which
26 may be peculiar to that particular organisation and
27 wouldn't lend itself to a statewide development.
28

29 Q. What's the threshold for HETI taking governance of
30 a particular educational output insofar as your view is
31 concerned?

32 A. Well, within HETI, we have - we design the education
33 and training with the expertise that is available to us and
34 then those programs are offered by HETI, quite often, so
35 the governance stays with HETI. That means that the
36 program is not changed from the evidence-based practice
37 from which it was developed, and we provide that out into
38 the system.
39

40 There has been some programs where the staff of the
41 system have implemented at a local level and at a local
42 level they still need to, you know, inform us if they're
43 making any or want to make any significant changes to HETI
44 products.
45

46 Q. But if we're dealing with non-HETI original products
47 here, training exercises or training outputs which are

1 being delivered through the LHDs, for example, is there
2 a particular threshold that you see beyond which they
3 shouldn't be dealt with locally but, rather, they should
4 have HETI governance, and, if so, what is that threshold?

5 A. Yes, I think there is - anything that could lend
6 itself to a statewide program is something that we are
7 always interested in the LHDs coming forward to see if that
8 has been a request somewhere else. But in relation to
9 governance at a local level, the LHDs can develop education
10 and training that is relevant to meet their specific needs
11 without coming to HETI.

12
13 Q. Is there any way that HETI seeks to ascertain whether
14 LHDs are delivering in their own unique way training and
15 education on similar topics across the system, without HETI
16 necessarily having been consulted?

17 A. There are forums where educational staff come together
18 and certainly a lead from HETI attends those forums, where
19 they may talk about education - well, they talk about
20 education and training. But we don't have a threshold of
21 what an LHD can and can't do in relation to education and
22 training. We encourage them to use the HETI products and
23 not duplicate - that's one thing. But the other is, if
24 there is something they would like developed, there is
25 a process for them to go through and do that, but they
26 still have to be able to respond to local emerging needs
27 themselves.

28
29 MR MUSTON: Commissioner, I'm about five minutes off
30 moving on to another topic. Would it be convenient to take
31 those five minutes and then adjourn?

32
33 THE COMMISSIONER: Yes, all right.

34
35 Ms Solman, we're going to adjourn now for the lunch
36 break so we'll get you back at 2 o'clock.

37
38 THE WITNESS: Thank you.

39
40 THE COMMISSIONER: We'll adjourn until then.

41
42 THE WITNESS: Thank you very much.

43
44 MR MUSTON: As the Commissioner pleases.

45
46 THE COMMISSIONER: All right. We'll adjourn until 2.
47

1 **LUNCHEON ADJOURNMENT**

2
3 THE COMMISSIONER: Yes, Mr Muston.

4
5 MR MUSTON: Q. Do you still have your statement
6 available, Ms Solman?

7 A. I do, thank you.

8
9 Q. Could I ask you to go next to paragraph 9 subparagraph
10 (c) and at the top, of at least what on mine is page 3, do
11 you see the Roman numeral (iv) there, which commences
12 "Statewide oversight coordination"? Do you see that
13 paragraph?

14 A. Yes.

15
16 Q. Could you just explain to us in the context of
17 reforming and improving workforce capacity and the quality
18 of clinical and non-clinical training, what you mean in
19 that subparagraph there?

20 A. So HETI has had a role in simulation for quite some
21 time and has developed simulation standards because there
22 are - simulation occurs in many areas of NSW Health. So
23 there is best practice learning standards for creating
24 simulated learning environments as a teaching and
25 debriefing mechanism.

26
27 Q. That's the simulated learning. I see immediately
28 before that you have used the word "including", so is there
29 anything else you were referring to in that paragraph other
30 than simulated learning environments?

31 A. Well, we do have oversight, working - looking at any
32 new - to make sure the policy - make sure the education and
33 training is up to date with policy.

34
35 Q. How do you do that?

36 A. Well, we do get notified of policy changes through the
37 Ministry of Health functions and we do regularly review the
38 content. Quite often, if there are going to be some
39 changes, particularly from ACI or the Ministry of Health
40 they have actually spoken to us if we already have training
41 in place and have included us in those conversations.

42
43 Q. So that's - to the extent, if I've understood you
44 correctly - that HETI is delivering courses itself --

45 A. Yes.

46
47 Q. -- the oversight that you are referring to there is

1 ensuring that the courses being delivered by HETI are kept
2 up to date with any changes or developments which come from
3 the ACI or elsewhere?

4 A. Or any policy owner where we have a program of
5 learning that's associated with the policy, yes.
6

7 Q. What about education and training which is not being
8 delivered by HETI but is being delivered by other
9 organisations within NSW Health? Does HETI have any
10 statewide oversight, coordination or implementation of best
11 practice in respect of that?

12 A. Through the RTO, if it's a registered training
13 organisation level course, courses will come up through
14 that process, if that is a qualification, it will come up
15 through HETI's processes. Generally the LHD, specialty
16 health networks and Ministry of Health, they alert us well
17 in advance of something like that happening and they do
18 include us in those conversations.
19

20 Q. In what way through those conversations does HETI
21 exercise statewide oversight coordination and
22 implementation of best practice?

23 A. Of those particular programs - through direct
24 involvement, if that's required, but also ensuring that
25 they do meet the standards for an RTO course which has its
26 own set of standards.
27

28 Q. So just to make sure we're not at cross-purposes, are
29 the RTO courses being delivered by HETI or by other
30 organisations?

31 A. They could be both, by other organisation or by HETI.
32

33 Q. In what sort of context would another organisation
34 within health be delivering an RTO course?

35 A. If they identify a specific need in their LHD that's
36 peculiar to them, they may develop an RTO course, it may be
37 a succession planning or building capacity of a particular
38 workforce in that area. They may do that through an RTO
39 mechanism.
40

41 Q. What sort of course would be delivered for the purpose
42 of succession planning and delivering workforce in a
43 particular area?

44 A. Well, succession planning is thinking about, well,
45 what is the workforce now and into the future. So through
46 the RTO there are a number of courses that, you know, look
47 toward ensuring that people have the capabilities, so it

1 could be in a management course; it could be in a
2 leadership course that has particular needs. So if it is
3 going through the RTO processes, it means that it meets the
4 criterion for a qualification.

5
6 Q. So HETI is an RTO; is that right?

7 A. Yes.

8
9 Q. Which other entities within health are formally
10 recognised as RTOs, to your knowledge?

11 A. None to my knowledge.

12
13 Q. None, did you say? Sorry, I missed that.

14 A. None, to my knowledge, are RTOs.

15
16 Q. So when we're talking about RTO courses, we're
17 essentially still dealing with those courses which are
18 being delivered by HETI, aren't we?

19 A. No. LHDs may be able to deliver the courses, if they
20 have the necessary qualification and experience. So, yes,
21 they can deliver courses locally.

22
23 Q. That would be delivering a course, though, that was
24 a course provided through HETI as an RTO, wouldn't it?

25 A. Well, it could be, unless it was an RTO that was
26 privately engaged. But I'm not really seeing that these
27 days.

28
29 Q. Have you in the past had an experience of
30 organisations within NSW Health engaging other RTOs, that
31 is to say, other than HETI, to deliver courses to their
32 workforce?

33 A. Well, I've seen - I've seen organisations go outside
34 of health to have an RTO course written for their needs.

35
36 Q. But in terms of the delivery of that course, for it to
37 be recognised as an accreditation, it would need to have
38 been delivered by an RTO, would it not?

39 A. Yes.

40
41 THE COMMISSIONER: Q. I think some of the confusion
42 might be coming from where you said that the LHDs are able
43 to deliver the courses if they have the necessary
44 qualifications. What did you mean by that?

45 A. Well, there are qualifications required to deliver
46 different levels of courses, and I'm just thinking back,
47 when you asked me the question about the RTO, there were

1 a couple of LHDs who can deliver RT0 courses because they
2 are registered.

3

4 Q. That's something that they do outside of HETI?

5 A. Outside of HETI, yes.

6

7 MR MUSTON: Q. Can we move down to subparagraph (d) in
8 paragraph 9, where you identify one of the roles and
9 functions of HETI being to institute, coordinate, oversee
10 and evaluate education and training networks. Can I ask,
11 what are those training networks that you're referring to
12 in that paragraph?

13 A. They're the medical training networks.

14

15 Q. So when you say "medical training", what type of
16 medical training are we talking about there when you are
17 alluding to those networks?

18 A. Junior officer medical training.

19

20 Q. Prevocational PGY1, PGY2?

21 A. Yes.

22

23 Q. We might come back to that. Is it that same medical
24 training that you are alluding to when you refer in the
25 next paragraph down, subparagraph (e), to setting standards
26 for education and training, and training including medical
27 training?

28 A. Yes, and that sits within the medical portfolio of
29 HETI.

30

31 Q. So what is the standard-setting role that HETI has?

32 A. That is to ensure that the standards are met by the
33 institution to ensure safe practice and support for
34 pre-vocational education and the person is getting adequate
35 supervision.

36

37 Q. So I understand conceptually that making sure
38 standards are met is an important consideration in
39 training, but what does HETI do to set - by way of the
40 setting of standards?

41 A. Yes, so there are prevocational standards that need to
42 be --

43

44 Q. And just pausing there, what's the source of those
45 standards? Are they something that HETI comes up with or
46 are they externally derived?

47 A. I believe they're externally derived but I think that

1 Dr Jo Burnand from medicine will be best placed to answer
2 that question.

3

4 Q. Just to the extent that you have alluded to in your
5 statement in relation to HETI having a role in setting
6 standards for education and training, I'm just trying to
7 understand what that role is.

8

9 THE COMMISSIONER: It may be the drafting of the statement
10 is not quite right.

11

12 MR MUSTON: Maybe.

13

14 Q. Do you have that at subparagraph (e)?

15

16

17 THE COMMISSIONER: Q. When it says "to set standards",
18 do you mean that HETI is setting the standards, where
19 you've got that in (e), or is it HETI ensuring that other
20 standards are maintained or met?

21

22

23 A. That other standards are maintained and met.
24 THE COMMISSIONER: I think it is just a drafting
25 issue - maybe.

26

27 MR MUSTON: Q. Moving down to paragraph (f), HETI's role
28 to maintain registration as a higher education provider -
29 is that its RTO role that we're talking about or is that
30 a different role?

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1 course that had been - the courses that had been delivered
2 by the predecessor organisation?
3 A. Yes.
4
5 Q. Have you developed any new courses?
6 A. Yes, applied mental health course, which is
7 non-medical staff - medical staff could do it as well, but
8 it's mainly for health professionals.
9
10 Q. Could the witness be shown on the screen exhibit A.048
11 from the November hearings, which is document
12 [SCI.0001.0043.0001]. Ms Solman, can you see that document
13 on your screen?
14 A. It's a bit small. So the workforce plan?
15
16 Q. Yes. Are you able to see that? Do you recognise that
17 as the NSW Health Workforce Plan 2022-2032?
18 A. Yes.
19
20 Q. Could I ask that we go forward to page 7. That's
21 0007. Do you see there there's a reference to three
22 horizons, being the phases of the plan as I read it. You
23 would be familiar with the concept of the three horizons in
24 the workforce plan?
25 A. Yes.
26
27 Q. If we can turn over now to page 8, do you see the
28 three horizons are described in a little bit more detail
29 there, the first horizon being the 1 to 3 year period,
30 where it's proposed to develop and embed?
31 A. I can't read the writing.
32
33 MR MUSTON: Perhaps we could zoom in on, if possible, the
34 one --
35
36 THE COMMISSIONER: The witness is having to read it on the
37 screen.
38
39 Q. You are looking at it on the screen, are you?
40 A. Yes.
41
42 THE COMMISSIONER: We'll try to make it as big as
43 possible.
44
45 MR MUSTON: Q. Is that any better, you see "Horizon 1,
46 Years 1-3, Develop and Embed"?
47 A. Yes.

1
2 Q. You are familiar with that period, which I think we
3 must be just approaching the end of - that is, the first
4 horizon, the first three years of the plan?
5 A. Yes.
6
7 Q. Is that your understanding of it, we've got 2022,
8 2023, 2024?
9 A. Yes. Sorry, I'm just --
10
11 THE COMMISSIONER: Is there any significance to the symbol
12 above horizon 1? I wonder what that cost. Anyway.
13
14 MR MUSTON: Keep your eyes peeled.
15
16 THE COMMISSIONER: Yes, something like that.
17
18 MR MUSTON: Q. Perhaps if we go over to page 10. Do you
19 recognise that --
20 A. I do recognise the document, yes.
21
22 Q. -- page as setting out the various priorities which
23 are sought to be advanced through the workforce plan?
24 A. Yes, yes, I do.
25
26 Q. And then if we go to page 11, do you see a slightly
27 more detailed --
28 A. Yes.
29
30 Q. -- description of how those various objectives and the
31 particular outcomes which are identified are sought to be
32 achieved?
33 A. Yes.
34
35 MR MUSTON: Can we perhaps zoom in, operator, as best as
36 we can on 1.1 at the top of the table, just so Ms Solman
37 can see it. It might be a little bit too much. Let's
38 pause there for a minute.
39
40 Q. Do you see there 1.1, "Strong leadership embedded
41 across the system to sustain a progressive, inclusive,
42 safe, healthy workplace"?
43 A. Yes.
44
45 Q. Then the first of the bullet points:
46
47 *Train senior employees in leadership,*

1 *mentoring and coaching to support on the*
2 *job learning.*

3

4 A. Yes.

5

6 Q. If we then move across a little bit to the right, you
7 see that's an outcome which was to be achieved by
8 2024 - that is, by now?

9 A. Mmm-hmm.

10

11 Q. If I've understood this document correctly, the lead,
12 or the organisation within health who's responsible for
13 achieving that outcome, is HETI?

14 A. Yes.

15

16 Q. In respect of that one, what has HETI done?

17 A. Well, we have got programs of learning around
18 mentoring and in leadership. We've also been developing up
19 the just in time resources, and the wellbeing leadership
20 program to ensure leaders have the skills to support
21 resilience in the workplace - that is something that we
22 have been working on but wellbeing is also woven into other
23 leadership programs.

24

25 Q. So when you talk about programs, are these online
26 courses that people can do or what are they?

27 A. Well, they're more interactive than an online course.

28

29 Q. In what way?

30 A. So online learning can be just looking - looking at
31 a screen and going through and doing something on your own,
32 whereas, you know, the wellbeing - looking at leadership
33 programs, coaching and mentoring, they are more active
34 types of programs where people are involved in doing
35 things.

36

37 THE COMMISSIONER: Q. Does that mean there is, for
38 example, with coaching, an actual coach, a human being?

39 A. People may have coaches out into the system, but
40 it's - if I go to training employees in leadership, there
41 has been a number of leadership programs across the state
42 offered and delivered. Mentoring is also offered and
43 delivered and coaching to support on the job learning, that
44 is something that pretty much most people would think was
45 important.

46

47 Q. Everyone does on the job learning, or most people do,

1 but the leadership courses - are these - when you say they
2 are interactive, are they online and interactive some way,
3 or are they with the support and involvement of human
4 beings that are doing the leadership training?

5 A. So the leadership courses have been more likely to be
6 face-to-face over a period of time, and the mentoring as
7 well, a component of that. Coaching is something that can
8 be online certainly. With the current environment, we are
9 not really going out into the system to deliver programs;
10 we are running them centrally, or from another area, where
11 people dial in. So they are still face-to-face. The
12 content is still there. The learning objectives are still
13 there. So the opportunities to engage with people are
14 still there, it's just a different way of doing business.

15
16 Q. What did you mean by "current environment"?

17 A. Well, to go out into LHDs and travel, I mean, that has
18 a travel cost, it has accommodation costs quite often, and
19 it has a time cost.

20
21 Q. Yes.

22 A. One of the things that HETI has - I'm very proud that
23 HETI has done really well is it has developed up its
24 capability in designing and delivering programs across the
25 state that are best practice level using the virtual
26 medium. For that to work obviously we need to partner with
27 the organisation we're working with to do that, whereas
28 before there would have been a team of people who
29 travelled, who probably had to stay a night or two to do
30 that. So it's more efficient, we do have the expertise to
31 do this, it ' convenient for learners, they don't miss out
32 on content, they're not missing out at all, and it also
33 reduces potentially travel time for participants if they
34 were going to be coming in to do a program.

35
36 So I do think the way that we have recreated the way
37 we're doing our business also gives us time back that would
38 be travel time to actually focus on, you know, doing more
39 work in the system.

40
41 MR MUSTON: Q. Perhaps we could jump forward to page 14
42 of that document. Do you see there 4.1,

43
44 *Ongoing opportunities to learn and upskill*
45 *so our workforce are fit for purpose for*
46 *now and the future.*
47

1 A. Mmm-hmm.

2

3 Q. Do you see there there are three - if we move across
4 just a tiny bit to the right, you see there are three
5 particular activities which HETI got lead responsibility
6 for. Working through them, the first, measuring and
7 assessing workforce capability. That's something that
8 apparently is happening this year. What's HETI doing in
9 relation to its measurement and assessment of workforce
10 capability against the New South Wales Public Service
11 capability framework?

12 A. Well, it's about ensuring that someone who has
13 undertaken a particular program, that we're mapping the
14 public service capability framework to our existing
15 programs so that people either in the public service or
16 in - health is part of the public service, obviously - that
17 they will have the same capabilities.

18

19 Q. What does that actually mean, though, in terms of what
20 HETI's in the process of doing? Is it collecting a list of
21 courses and accreditations taken by people who are within
22 the health system and making that centrally available to
23 the public service, or is it about changing the nature of
24 the courses that are being delivered so that they align
25 with particular public service objectives? What is HETI
26 actually doing?

27 A. Mapping against the public service capability
28 framework.

29

30 Q. What does that mean in terms of someone sitting at
31 a desk and doing something?

32 A. It means that they're looking at the public service
33 capability framework and they're looking at the content and
34 the objectives of a HETI program and mapping that to see
35 where, if, in fact, there are gaps.

36

37 Q. What about the next point up, "Uplift workforce
38 capability through a standardised approach to
39 organisational learning" - that's something that was to be
40 achieved last year. What did HETI do on that front?

41 A. Well, we had to set a standardised approach to
42 organisational learning. So we do have statewide resources
43 that are standardised across the state so that people are
44 learning the same thing no matter where they work. So
45 that's one of the things that we're doing. There has been
46 a mapping exercise as well. I don't have that information
47 on me --

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Q. Mapping of what?

A. Well, looking at what are the standardised approaches to organisational learning. So ensuring that the program is fit for purpose, that the objectives of the program are being met and that the workforce can translate the program into practice, because you can read something, but superficially it makes no change. This is a --

Q. Can I just ask, are these comments that you are making in respect of programs and courses that are being delivered by HETI?

A. Yes.

Q. Is any attempt being made to uplift workforce capability through a standardised approach to organisational learning insofar as that learning might be occurring outside of HETI through either the LHDs or any other aspect of the wider public health system, or that's not part of your understanding of that activity?

A. That's not how I have read that activity.

Q. What about the last point in that box:

Establish a Community of Practice to create, design and build a culture of organisational learning.

That should have been done, according to this, last year. What did HETI do on that front? Let me ask this question in two ways. First of all, what do you understand that last bullet point to mean?

A. Well, it's about having people come together to create a community of practice and to look at how to encourage and support cultures of learning.

Q. So in what sense are these cultures of learning being encouraged or is it seeking to encourage cultures of learning?

A. Yes, so there's, for example, collaboratives that occur, so there is the allied health team that comes together at different times and --

Q. That's a community of practice, I gather?

A. Yes, more along the lines of community of practice, or it could be professional development.

1 THE COMMISSIONER: Q. What should I understand
2 "Community of Practice" means? Is there any significance
3 in the fact that "community" has a capital C and "practice"
4 has a capital P? Is it some document or --

5 A. Well, "community of practice" is a term that is used
6 and that is generally people coming together to co-design,
7 who have the expertise - I'm only talking about education
8 now - and to encourage health professionals, in this
9 instance, to continue their professional development. So,
10 you know, organisational learning, "build a culture of
11 organisational learning", for me, is about how do you
12 encourage and support people to continue their professional
13 development ongoing, because that's what is required of
14 health professionals to do.

15
16 MR MUSTON: Q. So what has HETI done to encourage that
17 as part of this process?

18
19 THE COMMISSIONER: Well, it's - "establish" is what's
20 meant to happen. I don't know.

21
22 MR MUSTON: Q. What has HETI established?
23 A. I'd have to come back to you on that one, if I may.
24 I don't have that --

25
26 Q. So as you sit there, you are not aware of any
27 particular work that HETI has done to establish communities
28 of practice to create, design and build a culture of
29 organisational learning?

30 A. No, sorry.

31
32 Q. Moving down to 4.5, the very last point there:

33
34 *We focus on social determinants of health*
35 *and preventative care.*

36
37 and the last point is:

38
39 *Work with tertiary and VET sector education*
40 *providers to incorporate a focus on the*
41 *social determinants of health and*
42 *preventative care at tertiary institutions.*

43
44 Do you see that?

45 A. Yes, I can see that.

46
47 Q. And do you see that according to what follows, it

- 1 seems HETI was to take the lead on achieving that by the
2 end of last year.
- 3 A. I can't comment if we did that or not. I'd have to
4 come back to you.
- 5
- 6 Q. Do you know whether HETI's done any work with tertiary
7 or VET sector education providers to incorporate a focus on
8 the social determinants of health and preventative care at
9 tertiary institutions?
- 10 A. I don't know.
- 11
- 12 Q. Okay. Move down to 5.1. Do you see the last bullet
13 point there:
- 14
- 15 *Upskill key workforce segments to create*
16 *base-level capability to interpret, use and*
17 *report data to inform decisions?*
- 18
- 19 A. Mmm-hmm.
- 20
- 21 Q. Do you see again that's HETI project for 2024? What's
22 HETI done on that thus far?
- 23 A. I really can't comment on that, I'd have to go back --
- 24
- 25 Q. That's not something you have been involved in?
- 26 A. I haven't been directly involved in it, no.
- 27
- 28 THE COMMISSIONER: Q. What do you mean to convey by
29 saying you haven't been directly involved in it? Does that
30 mean you know something about it?
- 31 A. It means that I don't recall this piece of work.
- 32
- 33 THE COMMISSIONER: All right.
- 34
- 35 MR MUSTON: Q. So can I just try and make sure our
36 understanding of HETI's role within the public health
37 system is right. First, you have a role as a training
38 organisation delivering a range of courses to employees of
39 NSW Health.
- 40 A. Yes.
- 41
- 42 Q. And they are online or virtually delivered courses?
- 43 A. And some have been face-to-face.
- 44
- 45 Q. And some have been face-to-face. How many courses, in
46 total, does HETI deliver?
- 47 A. Oh, there is a lot of courses.

1
2 THE COMMISSIONER: Q. You don't have to give a specific
3 answer to that, it can be ballpark.
4
5 MR MUSTON: Q. Ballpark is fine. Is it 10? Is it 100?
6 Is it 1,000?
7 A. Well, if you are looking at courses, there's a lot of
8 courses that are developed in the digital medium, and there
9 are courses, then, that are offered in the virtual medium,
10 and then there's some a sprinkling of courses that have
11 been offered in the face-to-face medium. So it would be
12 quite substantial, the number of courses that have been
13 developed by HETI.
14
15 Q. So just to make sure we're not at cross-purposes,
16 there are courses that have been developed and there are
17 courses that have been delivered?
18 A. Yes.
19
20 Q. When you refer to a substantial number of courses,
21 these are courses which, on any given day, HETI is
22 delivering - have we understood that correctly?
23 A. We may not be delivering the same course every day,
24 but - because it doesn't work like that, but we would be
25 delivering them over a period of time.
26
27 Q. So the next thing I think you tell us that HETI has
28 a role in, at paragraph 47 and following of your statement,
29 is the management of scholarships and grants.
30 A. Yes.
31
32 Q. What are the grants that you refer to being given for?
33 A. The grants generally are from the Ministry of Health,
34 and --
35
36 Q. Yes, for what?
37 A. They could be for travel, they could be for - to
38 attend something, and scholarships are also offered, and
39 they can be to undertake a program of learning. So there's
40 a whole range of things that fit under that category.
41
42 Q. Who decides who gets a grant for travel, say?
43 A. Well --
44
45 Q. Is it HETI?
46 A. Well, if HETI was administering something for travel -
47 travel is probably a bad example, to be quite honest. So

1 the grants - whoever is eligible to apply for the grants
2 can apply for the grants, is how I would frame it. The
3 grants may be used for different reasons. It might be to
4 further or upskill your clinical capabilities, something
5 along those lines; or it could be to have a qualification,
6 a further qualification. So that's what generally those
7 grants are about. They are about opportunities for staff
8 development.

9
10 Q. So members of the workforce apply for those grants.
11 Who decides whether or not the applicants get the grant?

12 A. It depends on who is managing the scholarship. So if
13 I go to nursing and midwifery as an example, they have
14 a working group who look over and make recommendations.
15 And then if I look at allied health, they've got something
16 similar. So they're two examples I can put out there
17 about --

18
19 Q. So when you say there are working groups, are they
20 working groups within HETI or are they working groups
21 within the wider health system?

22 A. Well, they are actually conducted by the nursing and
23 midwifery office.

24
25 Q. So in relation to, say, a nursing grant or
26 scholarship, applicants make an application for
27 a scholarship, it's assessed by the working group,
28 a decision is made by the working group about whether or
29 not to give someone the scholarship or the grant. What's
30 HETI's role?

31 A. HETI's role is to administer the scholarships once
32 they have been decided. We don't - and we are not the
33 sponsors of the scholarships. We are not the owners of the
34 money.

35
36 Q. So when you say "administer the scholarships", do you
37 mean make sure the money gets paid?

38 A. Yes, that's what I mean. And there's quite a number
39 of scholarships that are offered by NSW Health for
40 different reasons.

41
42 Q. Is there a particular skill set or capability that
43 HETI has which means it's well placed to be administering
44 the scholarships in the sense that you've just described?

45 A. Well, HETI has been administering scholarships for
46 many years, so HETI does have the expertise to do that.
47

1 Q. But the expertise - the only expertise - that is
2 required to administer the scholarship is to pay the money,
3 as I understood your answer, but maybe I misunderstood you.

4 A. Well, that's part of the process, but it's also data
5 entering everything for others to make a decision.
6

7 Q. But that's - sorry, I may have misunderstood it.

8 A. Processing.
9

10 Q. That's a decision around granting the scholarship?

11 A. It's about receiving the applications for scholarship,
12 ensuring that they meet the criteria in broad terms, and
13 then we - then someone else will then look at those,
14 a group of people generally. If I think about the nursing
15 and midwifery office, they make the decision about who -
16 through a group, they will make a decision about what
17 scholarships will be awarded to these people.
18

19 Q. But I think we've perhaps already traversed this, but
20 that group is not a group within HETI, I think you told us;
21 that's a group outside of HETI that's making that decision?

22 A. It's - it is a working - it is an advisory group who
23 makes that decision. So there is representation from HETI
24 but there's representation from a whole lot of other people
25 as well.
26

27 Q. Can we jump forward to paragraph 50 of your statement,
28 where you tell us about the role that HETI plays in the
29 clinical placement of students. Do you see paragraph 50,
30 you tell us that HETI's role is as the central body that
31 administers student placements in consultation with the
32 Ministry of Health. Do you see that?

33 A. I'm just coming - what number was that?
34

35 Q. Fifty, 5-0.
36

37 THE COMMISSIONER: Page 12, I think.
38

39 MR MUSTON: Q. Do you see that paragraph?

40 A. Which paragraph was it, sorry?
41

42 THE COMMISSIONER: Q. Paragraph 50. It commences
43 "HETI's role is as the central body"?

44 A. Yes.
45

46 MR MUSTON: Q. I just want to ask if you could then go
47 down to paragraph 54 where you tell us the student

1 placements are undertaken and governed at a local level
2 between the public health organisation and educational
3 institution, and that HETI does not have any role in this
4 process.

5 A. Yes.

6
7 Q. Do you see that? It's not entirely clear what HETI's
8 role - what HETI is doing in its role as a central body
9 administering student placements having regard to what you
10 tell us at paragraph 54?

11 A. At paragraph 54 there - well, basically what we do
12 is - so there's a number of players who are involved here
13 in a student placement. So we collect - we don't really do
14 a lot of what is here.

15
16 Q. Sorry, I misheard that. Did you say "we don't really
17 do a lot of what is here", in paragraphs 51, 52 and 53?

18 A. Well, we do. The ClinConnect system is what we use
19 for clinical placements, and universities and TAFEs will
20 put in their requests. The LHDs determine how many
21 placements they have, and then HETI has that information
22 and uses that information for student placement.

23
24 Q. But the universities and educational institutions
25 often have their own stand-alone agreement with LHDs, don't
26 they, that govern issues like student placements?

27 A. They may have arrangements. I couldn't talk to that.
28 They usually - yes. There's usually feeder universities,
29 geographic feeder universities that, from my experience,
30 local health districts have that would - naturally you want
31 to, if you've been studying in a local area, you would be
32 looking at potentially having your clinical placement in
33 that area, if that's the area that you want to work in,
34 because the university would have that relationship with
35 the LHD.

36
37 Q. And the university and the LHD in that context make
38 arrangements for a number of placements that they can offer
39 and the areas in which those placements are able to be
40 offered; is that right?

41 A. We don't have anything to do with that. That would be
42 the LHDs determining placements, I would suggest.

43
44 Q. Which brings me back to my original question: when
45 you say in paragraph 50 that HETI's role is as the central
46 body that administers student placements in consultation
47 with the Ministry of Health, what does that --

1 A. We have a central --

2

3 Q. -- central role as an administrator actually involve?

4 A. It involves in making the system available to the
5 providers and it also --

6

7 THE COMMISSIONER: Q. Sorry, "making the system
8 available"? What's the system?

9 A. Well, sorry, the ClinConnect system, which is to book
10 and manage placements in New South Wales, and part of that
11 is ensuring that certain documents are submitted, but
12 really, the work of the ClinConnect will be determined by
13 the LHD and the provider. So it's really - HETI hasn't got
14 a big role here apart from administering the ClinConnect
15 system.

16

17 MR MUSTON: Q. So next topic you tell us about at
18 paragraph 56 is medical intern recruitment.

19 A. Yes.

20

21 Q. These are the graduates of medicine who are commencing
22 their PGY1 year; is that right?

23 A. Yes, yes.

24

25 Q. And when you say HETI manages the applications and
26 allocation of medical graduates applying for their
27 internship positions, what does HETI actually do on that
28 front?

29 A. I've gone blank, I'm sorry. (Reads document). So the
30 applications would come to HETI and then the allocation of
31 the graduates - yes, I would have to look at the detail on
32 that one --

33

34 Q. So you are not immediately familiar with HETI's role
35 in relation to the management of application and allocation
36 of medical graduates applying for internship positions; is
37 that right?

38 A. We do have a process, that's --

39

40 Q. No, my question is you're not, as you sit there now,
41 able to call to mind what that process is?

42 A. No. Let me just think about this.

43

44 Q. Can I take you to paragraph 62 of your statement. You
45 see you tell us there that:

46

47 *HETI would welcome greater consultation*

1 with LHDs planning training and development
2 to identify where it is duplicative or
3 where it could be developed and shared
4 statewide.
5

6 What's the current nature of the consultation that occurs
7 between LHDs and HETI other than the occasional meeting of
8 education providers that you told us about earlier?

9 A. Oh, HETI has a lot to do with the local health
10 districts, and specialty health networks, particularly in
11 product development. We utilise the experts in the system
12 so they - very close relationship overall.
13

14 Some of the LHDs let us know about what they're doing
15 in relation to perhaps creating or updating a hospital and
16 they may have increased - thinking they may have increased
17 training needs, so that then impacts on how many junior
18 doctors might be available, et cetera, and also any
19 training that might be required in any other area. So it's
20 just - some of the work that we do has been duplicated
21 elsewhere, but there's less of that occurring now, and some
22 that we don't know about, and it's been very good quality
23 work, would have benefited many people by being a statewide
24 product over a local product.
25

26 MR MUSTON: I have no further questions for this witness,
27 Commissioner.
28

29 THE COMMISSIONER: Thank you. Mr Cheney?
30

31 MR CHENEY: Nothing, Commissioner.
32

33 THE COMMISSIONER: There's no further questions for you,
34 Ms Solman, so thank you very much for your attendance.
35 We're very grateful for your time.
36

37 THE WITNESS: Thank you.
38

39 THE COMMISSIONER: You are excused.
40

41 THE WITNESS: Thank you.
42

43 <THE WITNESS WITHDREW
44

45 MR MUSTON: The next witness is Dr Josephine Burnand.
46
47

1 <JOSEPHINE BURNAND, affirmed: [2.47pm]

2

3 <EXAMINATION BY MR MUSTON:

4

5 MR MUSTON: Q. Dr Burnand, you are the acting medical
6 director of HETI at the moment?

7 A. I am.

8

9 Q. Only just?

10 A. Only just. Three weeks ago.

11

12 Q. And when you are not acting in that role, you are the
13 deputy medical director of HETI?

14 A. Correct.

15

16 Q. Which I think is a role you have held since 1 November
17 2021?

18 A. That's correct.

19

20 Q. You have prepared a statement dated 11 July 2024 to
21 assist the Inquiry with its work?

22 A. I have.

23

24 Q. Do you have a copy of that statement with you?

25 A. I do.

26

27 Q. Have you had an opportunity to review it before giving
28 your evidence today?

29 A. I have.

30

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

33 A. It is.

34

35 MR MUSTON: That will be tendered in due course,
36 Commissioner.

37

38 THE COMMISSIONER: Yes.

39

40 MR MUSTON: Q. You tell us in paragraph 3 of that
41 statement that you are responsible for the medical
42 portfolio within HETI?

43 A. Correct.

44

45 Q. Is that essentially a focus on, as I think you tell us
46 in paragraph 3, the training of or delivering education to
47 doctors within the system?

1 A. It's the medical portfolio oversight the delivery of
2 training for prevocational trainees across the state.

3

4 Q. So I think there are three things you identify in
5 paragraph 3. The first is overseeing the allocation of
6 final year medical students to intern positions?

7 A. That's correct.

8

9 Q. The second is providing support for early career
10 doctors during the prevocational period?

11 A. Correct.

12

13 Q. I'll come back to that, but that's training that
14 they're receiving during PGY1, PGY2?

15 A. Correct.

16

17 Q. And then the third is managing a number of
18 prevocational and vocational training networks in New South
19 Wales?

20 A. That's right.

21

22 Q. I might touch on each of them separately. Starting
23 with the allocation to intern positions, which you tell us
24 about in paragraph 10 and following. The first very small
25 question in paragraph 10, you tell us there that HETI has
26 a delegated authority from the ministry to allocate
27 graduates to intern positions, but the employer of each
28 intern is the relevant LHD.

29 A. (Witness nods).

30

31 Q. Just in respect of that last concept, is it not right
32 that the employer of each intern is the secretary?

33 A. Well, the LHD actually are - my understanding is the
34 LHD are the actual employers of interns.

35

36 Q. Perhaps we need not get caught up on the
37 technicalities of who the official employer is, is the
38 concept that you're seeking to convey there that there is
39 a budgetary allocation within each LHD for a particular
40 number of interns, and the interns, having identified
41 that - sorry, the LHD, having identified that budgetary
42 allocation, then tell you, "We would like to take on, in
43 our LHD, X number of interns"?

44 A. Correct. The LHD determine the number of intern
45 positions.

46

47 Q. Could I ask you to jump forward to paragraph 13. The

1 starting point is, as you have just told us, the LHDs and
2 St Vincent's determine the number of interns. So is my
3 understanding correct in saying that if they say, southern
4 LHD might say, "We need 150" - "We've got capacity for 150
5 interns", another LHD might give you a different number,
6 and you then collate all of those numbers centrally?
7 A. We seek - at the commencement of the process of
8 allocation of intern positions, we seek approval from each
9 LHD, signed off by the chief executive of the number of
10 positions that they have capacity for.

11
12 Q. So having done that, you then --

13
14 THE COMMISSIONER: Q. Can I just ask, when you say "have
15 capacity for", does that mean the need to meet the demand
16 for the provision of the health services that the interns
17 are providing, or does it mean the budgetary capacity? Or
18 is it some combination?

19 A. It's probably some combination of that. So each LHD
20 determines the number of intern positions that they wish to
21 have.

22
23 Q. Wish to have because of the need to provide the
24 medical services they do or because of the budget they
25 either have or are going to have?

26 A. Interns have a role in providing direct clinical care
27 for patients under the supervision of more senior doctors.

28
29 Q. Yes.

30 A. They are not the only junior doctor in the team,
31 though. So PGY1 or intern positions are at the sort of
32 most junior of the team.

33
34 MR MUSTON: Q. Another consideration is the capacity to
35 actually provide training opportunities for these PGY1
36 interns, presumably?

37 A. Correct.

38
39 Q. It's not the case that you could, say, send a PGY1
40 intern out to man an otherwise unmanned or "unpersoned"
41 emergency department in a remote area, for example?

42
43 THE COMMISSIONER: "Undoctored".

44
45 MR MUSTON: Q. A doctor-less emergency department?

46 A. Well, they are doctors, they are provisionally
47 registered and by the way of being provisionally

1 registered, they are required to be appropriately
2 supervised by more senior doctors.

3
4 Q. So if you have a remote, or even not that remote,
5 emergency department that doesn't have sufficient number of
6 senior doctors on site, you can't use your intern workforce
7 to fill those sorts of gaps?

8 A. Correct.

9
10 Q. So having identified the number of interns which the
11 various LHDs and St Vincent's are willing to take and the
12 way in which those intern positions are distributed, how
13 does - what is HETI's involvement in determining how many
14 interns to take and where to send them? Perhaps if you
15 could talk us through it from a perspective of someone who
16 has just grasped their degree and they are about to become
17 a PGY1 intern. What do they do?

18 A. So HETI provides the overall coordination for
19 New South Wales for intern applicants, and, you know, there
20 are a number of other New South Wales entities that
21 contribute to that work, but essentially, HETI, having
22 sought the number of available intern positions, there is
23 a portal which is a module of ROB, which is our recruitment
24 and on-boarding system run through HealthShare. An intern
25 would go on to the site, or a final year medical graduate,
26 sorry, correct me - a final year medical graduate would go
27 on to the website and there is an application process under
28 one of those four pathways that I mentioned at
29 paragraph 11.

30
31 Q. So just dealing with those four pathways, the
32 Aboriginal medical workforce pathway alluded to in
33 subparagraph (a) is for medical students who identify as
34 being First Nations people?

35 A. Correct.

36
37 Q. The rural preferential recruitment pathway is for
38 medical students who have expressed a preference to work in
39 a rural area?

40 A. We have a number of sites through New South Wales that
41 allow direct merit-based selection, if you like, ahead of
42 our optimised allocation pathway. So hospitals such as
43 Orange, Wagga, Tweed Heads, Lismore - there's a number of
44 them - are part of our rural preferential pathway. They
45 are also part of our networks, but that pathway is
46 specifically for final-year medical students who have
47 a wish to work in a rural location.

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Q. And are they students who might have been - might have completed the clinical component of their university training through one of the clinical schools out in a regional rural area, for example in Orange or Wagga?

A. Typically but not always.

Q. So if, hypothetically, a metro-based medical student decided that they really wanted to go and work in Tweed Heads, they would apply through the rural preferential recruitment pathway?

A. They are eligible to apply, correct.

Q. And you referred to a merit-based appointment. What is it about that process? What are the merits that are being assessed in the context of a fresh graduate?

A. Each of the rural preferential - like, the participating hospitals in the rural preferential recruitment pathway basically run a recruitment process that is not dissimilar to other employment processes. So they would apply through that pathway, they are then usually, typically, interviewed and a merit list of the - from the hospital's perspective of the preferred applicants is constructed and from there they are offered according to the number of vacancies.

Q. Is that offer made by HETI or made by the --

A. No, that offer is made by the recruiting hospital, LHD.

Q. So having entered the system through the HETI portal, the hospital then gets connected with these students who have expressed a desire to be there and, assuming that they match up, HETI's at least immediate role in the placement of those students --

A. This is quite complex. A final-year medical student wanting to apply for the rural preferential pathway would actually put an application in for that pathway, to whichever hospital - so that might be multiple hospitals - as well as generally also through the optimised allocation pathway, which is where they would default if they were not successful in obtaining a rural preferential pathway position.

Q. So they go through the interview process at each of the hospitals that they have applied to. If they get offered an intern position there, they essentially fall out

1 of the scheme and take up that position. If they are not
2 offered an intern position at one of those hospitals or
3 don't take one up, then they just default to the normal
4 pathway taken by all other candidates?

5 A. That's more or less correct. I mean, HETI continue to
6 oversight until - and obviously HealthShare, we have an
7 actual portal that is run through eHealth called MIRA,
8 which is the medical intern recruitment allocation, that's
9 a module of ROB, so all of the interns are through that
10 portal, but essentially what you have described is correct.

11
12 Q. We'll come back to the optimised allocation pathway in
13 a moment, but the next one you allude to is the direct
14 regional allocation pathway. What is that?

15 A. That's the third pathway, which is intended to allow
16 for hospitals who might not be part of the rural
17 preferential pathway, but there are a number of hospitals
18 that traditionally and historically have been less
19 population, if you like, in terms of preferences that final
20 year medical students would give when they're nominating
21 which network, prevocational training network, they would
22 like to go to, and so there are a number of facilities that
23 are part of that pathway.

24
25 In terms of the way that that is - so - and you would
26 have seen in my submission, there's a priority list, which
27 is set by NSW Health, which describes the priority order in
28 which interns, or final year medical students, are
29 allocated.

30
31 Any category 1 to 4 student is eligible to be
32 appointed directly through that regional pathway. So they
33 have nominated one of those facilities, such as Gosford
34 Wyong, and they are category 1, they will be appointed to
35 that ahead of the algorithm being used for the optimised
36 pathway.

37
38 Q. So for the candidates who don't find their way into an
39 intern position through one of those first three pathways,
40 they're in the mix as part of the optimised allocation
41 pathway?

42 A. Correct.

43
44 Q. You mentioned a moment ago that there is an algorithm.
45 How does that pathway go about identifying which students
46 go where?

47 A. Each student will preference, as part of their

1 application process, which of the prevocational training
2 networks they would like to go to, so there are 15
3 prevocational accreditation networks, and each network
4 comprises a number of facilities within it. So they will
5 preference that and there is an algorithm which is run
6 through the MIRA eHealth portal which basically allocates,
7 and the idea is that the algorithm is designed to provide
8 the most number of final year medical students with their
9 higher preferences.

10
11 Q. So it's not based on the results you got at
12 university, for example, or --

13 A. No.

14
15 Q. -- necessarily where you live or where you studied,
16 it; rather, each candidate who wants to get an intern
17 position will allocate preference 1 down to four, five,
18 whatever it is?

19 A. Fifteen, yes.

20
21 Q. And then the system will - the algorithm will run
22 through and work out what combination of allocations can be
23 made to ensure that as many students as possible get as
24 close to their top preference, if not their top preference,
25 as can be accommodated across the system?

26 A. Correct.

27
28 Q. And having been offered one of those positions, unless
29 you want to go interstate to take up an offer that might
30 have been made by some other state public health system for
31 a training position, you take what you get?

32 A. Correct. You accept the offer that you are provided.

33
34 Q. You mentioned a moment ago the networks, the
35 15 training networks. How do those networks operate?
36 I think you touch on it in paragraph 28 of your statement,
37 if that helps - the prevocational training networks.
38 Again, perhaps explain it from the perspective of a trainee
39 or an intern who has applied for their preferences and
40 maybe been given preference number 2, which sees them
41 starting at - pick a hospital that would be a good example,
42 RPA is an easy example for me to come up with, but might
43 not be a good one. Tell me if it's not. So the student
44 starts at RPA. What does the network mean in terms of how
45 their training progresses over the next two years?

46 A. So the first thing to say is that they're actually
47 allocated to a network. So they're not specifically

1 allocated to Royal Prince Alfred Hospital, they're
2 allocated to the network. The networks are numbered 1 to
3 15, not in order of popularity. So when they are allocated
4 to that network that has Prince Alfred Hospital, it also
5 has a number of other hospitals within that network, so,
6 for example, for Prince Alfred, it has Canterbury Hospital
7 and also Dubbo. So it has a regional facility as well.

8
9 Q. Pausing there, do all of the networks have that spread
10 across metro and regional/rural hospitals?

11 A. Generally, yes. Most will. I mean, there are, for
12 example, some - Hunter New England is a good example where
13 they have both John Hunter Hospital and a number of
14 networks across Hunter New England LHD. Many of the other
15 networks across the prevocational training networks
16 actually also cross LHD boundaries, so they may not be all
17 within a specific LHD.

18
19 Q. So just in relation to that, when we started in our
20 discussion earlier and you were talking about the LHDs
21 identifying the number of positions that they have, do they
22 need to tell you that by reference to the actual hospitals
23 that those positions are available in?

24 A. Correct, yes.

25
26 Q. So for the purpose of the network, you know, for
27 example - the example you have just given - that you might
28 have X number of interns that can be accommodated at Dubbo,
29 four-X at RPA, two-X at Canterbury, and so that gives you
30 a total number, which is the pool of available intern
31 positions in network number whatever it might be?

32 A. That's correct.

33
34 Q. So as part of that allocation of students into the
35 networks, the allocation allocates only the number of
36 students as can be accommodated by that - by the summing of
37 each of those various parts of the network?

38 A. That's right. That's exactly right.

39
40 Q. In terms of the training itself and which hospital
41 particular candidates go to and in what order, how does all
42 of that work?

43 A. Within the network?

44
45 Q. Within the network?

46 A. Is that the question? So that generally, I mean, each
47 intern, if we're talking about interns, but also

1 prevocational trainees in their second postgraduate year,
2 so an intern is allocated - well, a final year medical
3 student is allocated, they're on a two-year contract, and
4 they will complete in their first year five terms of
5 approximately 10 weeks duration, and the same again in
6 their second postgraduate year.

7
8 So those terms will be in any of the participating
9 facilities within that network and generally that's worked
10 out in, if I use the North Shore example, probably, that
11 would be worked out by their central JMO unit so, the term
12 allocations for the year, including any terms that they're
13 doing outside of North Shore hospital in that example.

14
15 Q. So the networks are administered at a more local
16 level?

17 A. Correct.

18
19 Q. Once HETI has done the allocation of candidates into
20 each of these various networks, the precise way in which
21 those candidates might roll through RPA, Dubbo, Canterbury
22 is determined by --

23 A. That's right.

24
25 Q. -- those hospitals?

26 A. (Witness nods).

27
28 Q. With a view to ensuring, presumably, that each of the
29 candidates gets their full exposure to everything that they
30 are required to be exposed to as part of their PGY1 year?

31 A. That's right. Yes.

32
33 Q. In terms of the rural component that might be part of
34 a network, say the RPA/Canterbury/Dubbo, it's a relatively
35 short period of time potentially that a candidate might be
36 spending as an intern in Dubbo under that arrangement?

37 A. An individual JMO, that's correct. They may be there
38 for 10 or 11 weeks.

39
40 Q. Is there any consideration given as parts of the JMO
41 training to the potential desirability of exposing JMOs to
42 longer - even those who might not have expressed
43 a preference, to longer periods of training within rural
44 and regional areas?

45 A. Not all - well, the first thing to say is not all
46 prevocational trainees will necessarily complete a rotation
47 in a rural facility. Has there been any consideration

1 given to longer - well, certainly through our - for those
2 that desire to work regionally, in fact, the system was
3 changed many years ago to, through the development of the
4 regional - the rural preferential pathway, to accommodate
5 those prevocational trainees who, in fact, wanted to remain
6 in a regional location.

7
8 Q. To some extent, the system is preaching to the choir
9 in terms of exposing them to the desirability of working in
10 a regional area - that is to say, those who have expressed
11 a preference to do so, the system might not need to work
12 too hard to persuade them that their decision has been
13 a good one. I'm more interested in those candidates who
14 have not expressed that preference. Has the system given
15 any consideration, so far as you are aware, to the
16 desirability of compelling JMOs to spend a longer period
17 than, say, 10 weeks in a regional or rural area to
18 potentially expose them to the benefits of working in such
19 an area longer term?

20 A. When you say "the system", has the --

21
22 Q. HETI and the prevocational medical training
23 arrangements?

24 A. I could speak more broadly, that it's certainly across
25 the medical education continuum, it's certainly been
26 a topic of conversation, if you like, in educational fora
27 around the desirability. There are a number of challenges
28 to compelling, you know, prevocational trainees to move to
29 regional locations, as in compelling them, and certainly
30 the feedback we get from trainees is that, you know, for
31 some, they're really interested in having a short-term, and
32 even if they're not necessarily wanting to go there in the
33 first instance, they come back from those terms and have
34 had really good training experiences.

35
36 But it goes to - I mean, again, it's complex. There
37 are a number of - I think there are a number of challenges
38 in requiring people in their, you know, first, second year,
39 to go for long periods of time. Most can accommodate
40 10 weeks.

41
42 Q. So in terms of requiring, for someone who is - just to
43 stick with our earlier example - RPA/Canterbury/Dubbo --

44 A. Mmm-hmm.

45
46 Q. -- if the dice fall out in a way which means they get
47 a 10-week stint in Dubbo, they don't have an ability, do

1 they, to say, "I'm not going to Dubbo, I'm going to stay at
2 RPA"?

3 A. No, they are generally - I mean, they are an employee
4 and part of the deal, if you like, is that there may be
5 a chance and an expectation that you will be allocated.
6 But rather than seeing that as a negative thing, you know,
7 obviously, experiences people get in regional and rural
8 hospitals are incredibly valuable training, and they're
9 different experiences to what they might get in a big metro
10 tertiary facility.

11
12 Q. So doctors get to the end of their PGY1 and they get
13 general registration as a consequence of that?

14 A. That's right, if they have met the requirements for
15 Medical Board of Australia's general registration
16 requirements, then they will be recommended by the sort of
17 administrative hospital, if you like - there is a process -
18 if they have met the requirements they will be recommended
19 to be moved from provisional registration to general
20 registration with the Medical Board.

21
22 Q. And after that point, do they have to go on to do
23 PGY2, a further year of five rotations, or are they able to
24 go out and work, say, as a locum?

25 A. They don't have to, in a - I mean, they obviously have
26 a two-year contract. In New South Wales, they are provided
27 with a two-year contract. They can obviously resign from
28 that contract and seek work elsewhere.

29
30 Q. In your role with HETI, do you see that as something
31 which is happening often - that is to say, students who
32 have received their general registration at the end of
33 their PGY1 year are not continuing to the end of their PGY2
34 year because alternative opportunities are available to
35 them?

36 A. In my current role I don't have any direct visibility
37 of the attrition, if you like, of PGY2s. We certainly
38 anecdotally hear of PGY2s leaving their posts some time
39 during the PGY2 year.

40
41 Q. Is it possible for someone to leave their post during
42 the PGY2 year to take up a vocational training position or
43 is that not something that is typically an option for them?

44 A. It is an option for them. So some colleges will have
45 entry into vocational training in the PGY2 year.
46 Sometimes, in the case if I can use the College of General
47 Practitioners, they can be accepted on to the college

1 training program but they remain in their prevocational
2 accredited post doing their hospital year in their second
3 year. The College of Pathology has historically, as has
4 the College of Psychiatry, accepted PGY2s on to their
5 program. In the case of the College of Psychiatry, they
6 have recently made a change that from the 2025 clinical
7 year, they won't be accepting PGY2s into their training
8 program, but they would need to, in fact, under the
9 national framework, which I have also mentioned in my
10 statement, have a certain of completion. It would be
11 expected that they would have a certificate of completion
12 of the PGY2 year.

13
14 Q. I was going to ask you next about the national
15 framework. In a practical sense through, the eyes of our
16 hypothetical intern, what will be the change brought about
17 by the national framework?

18 A. There are a number of changes with the national
19 framework, and probably from the eyes of the intern, it is
20 intended to provide a two-year period of consolidation of
21 skills across a broad range of - you know, give them
22 opportunity across a broad range of clinical disciplines.
23 It is intended to strengthen supervision and feedback
24 through the introduction, which will come hopefully next
25 year of entrustable professional activities, supported by a
26 national ePortfolio, and finally there is a very strong
27 emphasis on cultural safety through the national framework.

28
29 Q. Would the national framework mean it is necessary for
30 interns to complete their PGY2 year without breaking their
31 contracts?

32 A. Importantly, the national framework is not a two-year
33 internship. So the timing of move from provisional to
34 general registration still occurs at the end of the first
35 12 months. But it is intended to give an additional year
36 to consolidate those skills under the supervision prior to
37 entry, for those cohort of doctors that are going into
38 vocational training.

39
40 Q. Does the introduction effort national framework
41 operate, or will it, do you think, to disincentivise in any
42 way the exodus, to the extent there is one, during that
43 PGY2 year into other roles such as locum roles?

44 A. That's probably difficult for me to answer. It wasn't
45 the intended - the intent of the national framework. It
46 may be a second-order impact. Colleges - with the College
47 of Psychiatry being a good example - have now suggested

1 that they would expect an Australian graduate to have
2 a certificate of completion as a pre-entry requirement.
3 Obviously the more colleges that recognise the value of
4 that two-year period of consolidation of skills prior to
5 entering vocational training, we might expect there would
6 be more incentives to complete, because it would, you know,
7 obviously ensure that you've got what you're going to need
8 to enter vocational training going forward. That's really
9 difficult to say.

10
11 Q. I'll come to vocational training in a moment. In
12 paragraph 36 of your statement you tell us that HETI does
13 not have a direct role in the private health system in
14 New South Wales but as a prevocational accreditation
15 authority it accredits prevocational training sites which
16 include some private hospitals and general practices. What
17 is the role played by private hospitals in general
18 practices in the prevocational training of medical
19 graduates in New South Wales?

20 A. So we have a number of private hospitals that have
21 rotations available for interns and PGY2s.

22
23 Q. Are they part of the networks or do they sit outside
24 the networks?

25 A. In some cases they're part of networks, in other cases
26 they actually recruit directly through a Commonwealth
27 scheme to intern positions, but after the pathways that
28 I've - well, towards the end of those pathways I've just
29 spoken to you about.

30
31 Q. So I assume we're not talking about St Vincent's, as
32 a privately owned albeit part of the public health system;
33 we're talking about other private hospitals --

34 A. Correct.

35
36 Q. -- out there in the health system?

37 A. Yes, yes.

38
39 Q. Are interns able to get their full suite of five
40 rotations solely within a private hospital setting or is it
41 just part of a rotation that they need to do which will
42 necessarily involve the public system?

43 A. In some cases they are able to get, but they also -
44 the private hospitals where they are not an emergency
45 medicine have historically been, until the introduction of
46 the national framework, a place where they might be rotated
47 to the local public hospital to complete that.

- 1
2 Q. Just so we can get some sense of the scale of the
3 private hospitals we're talking about, in New South Wales,
4 what would be an example of a private hospital where
5 interns are retained and able to obtain their training?
6 A. So if I use the example of Macquarie hospital, private
7 hospital, Macquarie University private hospital, although
8 they do have some rotate, so although they directly recruit
9 some interns, they are also part of a broader network and
10 they are part of a secondment arrangement with other
11 hospitals.
12
- 13 Q. I probably should have raised this earlier but in
14 terms of that allocation of graduates to intern positions,
15 our understanding of it is that students who have completed
16 a degree in New South Wales, which is a fully Commonwealth
17 funded degree are, guaranteed an intern position in
18 New South Wales somewhere?
19 A. So if they've completed in a New South Wales based
20 university, correct.
21
- 22 Q. Sorry, I have jumped that step. Attended a New South
23 Wales university on a Commonwealth funded position,
24 graduated with a degree in medicine, they're guaranteed an
25 intern position in the New South Wales public health system
26 somewhere?
27 A. If they are - according to the priority list which was
28 provided in my submission, which is the NSW Health policy,
29 if they are an Australian citizen or permanent resident.
30
- 31 Q. Candidates from interstate institutions, who have
32 completed a degree in medicine, either a Commonwealth
33 funded position or a non-Commonwealth funded position, can
34 make application but have no guarantee of an intern
35 position within New South Wales hospitals?
36 A. So - sorry, could you just repeat the first part of
37 that question?
38
- 39 Q. A candidate who has qualified at an interstate
40 university, so someone who might have attended the
41 University of Queensland, for example, obtained a medicine
42 degree --
43 A. Yes.
44
- 45 Q. -- they're either Commonwealth funded or --
46 A. Full fee paying.
47

1 Q. -- it might not be possible, full fee paying, I don't
2 know whether the University of Queensland does that, but
3 either way, they could apply for a position within
4 New South Wales but they have no guarantee of getting
5 a position?

6 A. Correct. They have a guarantee of getting, in the
7 Queensland case, a position in Queensland.

8

9 Q. Maybe just teasing out the fully funded Commonwealth
10 position as opposed to the self-funded position, a
11 candidate who has obtained a degree from a university in
12 New South Wales, having paid for that degree themselves,
13 they can apply --

14 A. It can be a full fee paying or a CSP, so
15 a Commonwealth funded position.

16

17 Q. So a full fee paying student, do they have a guarantee
18 of an intern position in New South Wales?

19 A. As a category 1, that's my understanding.

20

21 Q. And at the other end of the spectrum, there are
22 internationally trained medical graduates who can make an
23 application for an intern position within New South Wales.
24 No doubt there are complexities which arise depending on
25 which jurisdiction they've obtained their training, but
26 assuming that those complexities are overcome, they have
27 a right to apply but no guarantee to an intern position in
28 New South Wales?

29 A. That's right.

30

31 Q. From your perspective at HETI, how do things sit at
32 the moment in terms of supply and demand for intern
33 positions in New South Wales hospitals?

34 A. So I can't give you the exact numbers, but we started
35 this clinical year off the intern allocation of last year
36 with quite a large number of vacancies in New South Wales,
37 that we understand from our interstate colleagues has been
38 replicated across the country. So in other words, at the
39 moment, we exhausted all of the categories according to -
40 in terms of allocation for last year, and we still had
41 vacancies at the end of that process.

42

43 Q. So if we take a few steps forward into the vocational
44 training space, our hypothetical intern has completed their
45 PGY1, hopefully we've managed to keep them in PGY2, they
46 then have a desire to become a specialist and practise in
47 some area. Pausing there, they don't have to become

1 a specialist if they don't want to?

2 A. No.

3

4 Q. They can become a career medical officer, working in
5 the hospital system?

6 A. They can become - they can continue to work in the
7 hospital system as an unstreamed doctor, so not everybody
8 enters vocational specialist training in their PGY3 year.

9

10 Q. So those who do have a desire to pursue specialist
11 training, putting to one side the general practitioners
12 which have a slightly different pathway, for those within
13 hospital based specialisations, they get to the end of
14 their prevocational training, how do they go about pursuing
15 vocational training? What's the process?

16 A. Are you asking with respect to the HETI prevocational
17 training networks or broadly across the system?

18

19 Q. Let's start in general. I appreciate different
20 colleges might have different requirements, but at a very
21 general level, if I was sitting there as a recently
22 finished PGY3 person, what would my process be in terms of
23 deciding whether I wanted to become a specialist and,
24 having decided I did, pursuing that objective?

25 A. So you would apply to both - in general terms, you
26 would apply to both the college, the relevant specialty
27 college, as an applicant - and colleges have different
28 stages at which they will accept entry, they have different
29 prerequisite requirements - and, in addition to that or
30 sometimes it's a parallel process, again, depending on the
31 specialty, you also would apply for a job that was
32 a vocational accredited position within, in this instance -
33 I mean, I've spoken very broadly across the country, but in
34 New South Wales you would apply through our annual medical
35 recruitment for a training position.

36

37 Q. So, just to unpack that a little bit, there seem to be
38 two, if not three, elements. The first is there needs to
39 be a registrar position funded out of a site somewhere
40 within the particular area of specialisation that you wish
41 to pursue?

42 A. Yes. I mean, this is not a HETI responsibility, so
43 I'm relying on my broader information in answering these
44 questions.

45

46 Q. So second, the site needs to have been accredited by
47 the relevant college --

1 A. Correct.

2

3 Q. -- for that training position. And the third is, the
4 college needs to have accepted you as a trainee or
5 vocational trainee?

6 A. If you're going to be accessing an accredited training
7 position, that's generally the way it works, correct.

8

9 Q. So in terms of decision-making, putting to one side
10 the site accreditation, which is obviously a matter that's
11 outside of our control of our hypothetical JMO, are there -
12 who makes decisions about whether or not to accept the JMO
13 into the college, on the one hand, and whether to accept
14 them into the registrar's position, on the other? If it's
15 different people, what happens then, if they make different
16 decisions?

17 A. They are different people, they are different
18 decisions, and they are made in different ways. So in some
19 colleges, they - particularly in the advanced training
20 component - they might accept a trainee and then allocate
21 them to specific jobs. Now, they are still subject,
22 obviously, to all of the usual pre-employment checks that
23 one would expect, and processes in on-boarding them.

24

25 In other examples, the trainee would apply, again,
26 through the annual medical recruitment, to a position.
27 They may get accepted to a position and then they apply to
28 the college following that. So it is different and has
29 different timings for --

30

31 Q. So in some cases, the college has accredited a range
32 of positions which are funded by the LHDs, those registrar
33 salaries, notionally funded in the LHDs at sites accredited
34 by the college, and the college accepts a candidate and
35 then delivers that candidate up to one of those positions?

36 A. That might be one mechanism.

37

38 Q. And in an alternative that you're aware of, an LHD or
39 particular department within a particular hospital employs
40 someone in their registrar position and that then triggers,
41 in a practical sense, the acceptance of that person onto
42 the training program --

43 A. Provided they have met the prerequisites, and
44 sometimes, in the case of psychiatry, those processes
45 happen at the same time, so the same interview for
46 selection - or employment is used for selection into
47 training, so there is the appropriate representation of

1 LHDs and the college.

2

3 Q. So coming to HETI's role, you have told us about some
4 vocational training networks that HETI is involved in the
5 administering of. Outside of those networks does HETI have
6 any role to play in relation to the vocational training of
7 specialists?

8 A. No.

9

10 Q. In terms of the vocational training networks, you
11 describe them in paragraph 38, but perhaps in a practical
12 sense and through the eyes of our hypothetical JMO now
13 registrar, how do they work?

14 A. The training networks are all quite different and -
15 I mean, I've mentioned in my statement the basic physician
16 training, which was the initial network training to be
17 established in New South Wales, as probably the most
18 mature, if I can use that terminology.

19

20 But in addition to that, we have psychiatry,
21 paediatrics - basic training in paediatrics, medical
22 administration, advanced training in general medicine, and
23 emergency medicine and radiology, so those - they all
24 operate a little bit differently.

25

26 Q. So each of the colleges which hover above those
27 training plans have, through the delegation that they have,
28 set upon a particular set of standards or a course of study
29 that an individual needs to satisfy in order to become
30 a specialist in their given field?

31 A. So the colleges are responsible for setting the
32 standards and the requirements for fellowship; correct.

33

34 Q. And so in the context of some areas of specialisation
35 there is a need to, much like your intern year but albeit
36 on a larger scale, rotate through a range of different
37 areas, say paediatrics, for example, might be a necessary
38 component of a training schedule?

39 A. Yes, correct.

40

41 Q. How does that operate in the context of the networks,
42 the vocational training networks, that HETI is involved in?
43 Perhaps to cut to the chase, I'll tell what you
44 I understand to be the case and you can tell me if I'm
45 wrong. The networks and the positions associated with the
46 training networks contemplate a registrar effectively being
47 guaranteed a job which will take them through each of those

1 various elements of the training that they are required to
2 complete in order to become a fellow of the college.
3 A. Yes. They - each trainee will have different
4 requirements and different rotations, so the networks
5 provide the mechanism by which it's an integrated training
6 program, if you like. Not all of your vocational training
7 is necessarily done, if I use your example before, at Royal
8 Prince Alfred. In fact, there's great value in having
9 experience in outer metropolitan hospitals, in regional
10 facilities. So networks bring together those groups of
11 facilities and, you know, coordinate the rotations, if you
12 like.

13

14 Q. So a candidate who has been accepted to a network
15 position at, say, Royal Prince Alfred Hospital, to use that
16 example, a general physician or basic physician training,
17 will rotate through whatever departments they need to
18 rotate through as part of that training and then they might
19 be sent to the Children's Hospital at Westmead for
20 a rotation potentially?

21 A. Not for basic physician training. For paediatric,
22 they would be at one of the two - three children's
23 hospitals anyway. But they might be sent to Dubbo, for
24 example, but for a longer period of time. Their terms tend
25 to be three to six months.

26

27 Q. And part of that, the benefit of the network, is that
28 the student or the registrar who has been accepted into the
29 network position will know that, throughout the course of
30 their vocational training, everything that they need to
31 have delivered to them in order to satisfy that training
32 will be delivered to them in a position that they have been
33 employed in around a range of facilities?

34 A. That's correct. The networks are set up so as to meet
35 the college accreditation requirements and enable and
36 facilitate, if you like, individual trainees meeting their
37 requirements for gaining the sorts of clinical experiences
38 that they need to get for fellowship requirements, but at
39 the same time, obviously, they are also providing direct
40 clinical care of patients in those facilities.

41

42 Q. And so as they move from one of those clinical
43 requirements to the next, which may be in a different
44 facility, they don't need to go and apply for another job
45 in that facility and hope that they are employed in that
46 next little requirement; it seamlessly happens for them?

47 A. For the majority of those networks that I have

1 described.

2

3 Q. What's HETI's role in the administration of those
4 networks?

5 A. We - well, HETI - oversight, so the broad governance
6 structure, and again it's a bit different for each of the
7 networks. So what we've just described is correct for
8 basic physician training and paediatric training, but not
9 for medical administration training. So they're very much
10 individual sites rather than a training network, and
11 trainees will apply at each stage, at each year, for
12 a position. So that's a bit different.

13

14 But generally, HETI's role is in oversight and the
15 governance of those training networks to ensure that
16 trainees have the, you know, opportunity to rotate and
17 also, I mean, our focus at HETI is obviously on the
18 education that has been delivered to them, that there are
19 opportunities to ensure that trainees, no matter where they
20 are in New South Wales, have access to the same education
21 and training opportunities. So there's a coordinating
22 function, if you like.

23

24 Q. Colleges whose vocational training is not one of
25 HETI's networks do nevertheless sometimes have a range of
26 different requirements that need to be satisfied in order
27 to achieve fellowship?

28 A. Correct.

29

30 Q. For example, I think I recall reading in the evidence
31 that the anaesthetists are required to complete, amongst
32 other things, a paediatric rotation and a cardiac rotation,
33 I think?

34 A. I'm not across the specifics of the current ANZCA
35 requirements for training. I can't answer that question.

36

37 Q. My question in relation to it, without needing to
38 descend into the precision of it, are there networked
39 arrangements that sit outside of those administered by HETI
40 whereby registrars who have been accepted onto a training
41 program, say, by the anaesthetists, have that same
42 opportunity to seamlessly rotate through each of the
43 different rotations that they need to rotate through in
44 order to obtain fellowship?

45 A. I am aware that there are - I mean, in some of the
46 other specialty training networks rotations are organised
47 in that way.

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Q. Do you know how those rotations are organised outside of the work done by HETI?

A. No.

Q. We've seen several times a reference to what seems to be described as an unaccredited registrar. As we understand that term - and again, tell me if you've a different understanding of the term - it seems to be a registrar or junior medical officer employed in a position in a department that doesn't actually have an accredited training position available?

A. Available?

Q. Or they are not on a training pathway?

A. They are not on a formal training pathway.

Q. What's the difference between a formal training pathway and a not formal training pathway in terms of the career progress of the hypothetical registrar?

A. So again, broadly speaking, "unaccredited registrars" is a term that's used for junior doctors in their PGY3-plus year generally, who are often working as part of a broader team which may have accredited registrars, but that's not always the case, sometimes they might be working in a facility where there isn't an accredited vocational trainee working in the same team.

Again I'm going to speak broadly rather than specifically. Unaccredited registrars positions are often occupied by people who have a desire to get on to a training scheme - so surgery is a good example of that - and they are providing within those clinical departments important clinical service, you know, direct care of patients.

Q. But in so doing they are not achieving anything in terms of their progress towards fellowship other than potentially bringing themselves closer to a point where they might be successfully able to obtain entry into a training pathway?

A. That would, in general terms, be a reasonable statement to make. They are gaining, though, important clinical experience. They are still under the supervision of more senior doctors in their provision of care, so they are actually gaining experience, which will undoubtedly assist them in their future career endeavours.

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Q. But in terms of collecting each of the tokens of experience that one has to collect in order to get to the end of the road and say, "I now wish to be a fellow", this unaccredited registrar position doesn't actually give you any of those tokens; it just gives you learned experience which no doubt will make you a better doctor in the long term?

A. In general terms, it doesn't - that's correct. It's correct to say that that experience or time is not counted towards your accreditation, in general terms.

Q. In paragraph 50, you tell us about the funding of some of the HETI vocational training networks and the various ways in which that operates. Can I just ask this question: where a network exists, are LHDs funded by the ministry to employ registrars who are being trained in the network, insofar as you are aware? Is it the ministry who delivers that funding for that training position to the LHD?

A. In general terms, that's correct, it would be as part of their budget. Not always. There are some registrar positions that are provided through - particularly in regional places - Commonwealth funding under the specialist training program.

Q. In relation to --

THE COMMISSIONER: Sorry to interrupt, can I just check, no doubt this has been done, but Professor Twigg, has he been given a message?

MR MUSTON: He is going to be very quick, and I won't be very long.

THE COMMISSIONER: Is he? Right. Okay.

MR MUSTON: Q. In terms of decisions about where those trainees are employed and where the networked trainees are deployed, who makes those decisions?

A. Sorry, could you repeat the question, please?

Q. Registrars are brought into a network. Registrars who have a networked training position are obviously able to be employed out in the system at various parts of the network as it sort of is formed and no doubt is a dynamic thing. But how are decisions made about which hospitals, for example, and which LHDs, networked vocational trainees go

1 to?

2 A. Is that question in relation to the vocational
3 training networks that HETI has --

4
5 Q. Yes. Yes.

6 A. Yes. So in some cases - I mean, it's always the
7 decision of the local health district or facility that they
8 want to create an additional position, and then there is
9 a process that occurs in terms of - and obviously they need
10 to, if they're going to have an accredited trainee, seek
11 accreditation of that site through the college, and in
12 addition to that, the state training council - they use the
13 physician basic training, state training council - would
14 have a look at the positions in that network and approve
15 the addition, if you like, of those positions.

16
17 Q. Could I ask you to go to paragraph 70 of your
18 statement. Just briefly, could you develop what you tell
19 us in that last sentence, your belief that one of the key
20 challenges relates to the limited time available to senior
21 doctors to provide both direct patient care and training?
22 What is the real issue and the cause of the issue that you
23 identify there?

24 A. Well, I think what we have seen - and, you know,
25 I have some direct visibility of this in previous roles,
26 less in my current role - is increasing demand on our
27 clinical services. I think that's well documented across
28 the system. Senior doctors make a really significant
29 contribution, you know, they're training and supervising
30 across the whole training trajectory from medical students
31 right through.

32
33 The colleges have a number - for vocational trainees,
34 have a number of requirements and assessments that need to
35 be completed, likewise, the national framework going
36 forward will - they currently are required to complete
37 mid-term and end-of-term assessments for our prevocational
38 trainees. But just on a day-to-day interaction with
39 trainees in a busy clinical environment, what we're hearing
40 back at HETI through our senior doctors on all of our
41 committees is that there is less and less time to have
42 those conversations with trainees, because of the clinical
43 demands. Now, there's got to be always a balance, of
44 course.

45
46 THE COMMISSIONER: Q. Can I just ask a question about
47 that, and it may sound like a very naive question, but I'm

1 a lawyer, not a clinician, so I'm going ask it. Where you
2 say the key challenge is the impact of increasing community
3 demand on clinical services and the conflict between the
4 time available for senior doctors to provide direct patient
5 care - now, I understand that, senior doctor providing
6 direct patient care - and then the time available for the
7 same doctors to supervise and train junior doctors, I
8 imagine there are at least times where the senior doctor is
9 both providing direct patient care but is also supervising
10 and training junior doctors, because they are there as part
11 of that process, maybe, but there's obviously a separate
12 time requirement for training that you're talking about
13 with senior doctors. Can you just explain that to me?
14 A. Yes, it's actually --

15
16 Q. Where they're doing something that supervises or
17 trains a junior doctor but it doesn't involve them
18 providing direct patient care?

19 A. So those same junior doctors - if we put medical
20 students aside, but the same junior doctors are providing
21 the clinical care of the patients, generally, under which
22 those senior doctors are ultimately responsible. So in
23 many ways they are supervising whilst caring for the same
24 cohort of patients.

25
26 The time aside is to, in probably - and this is not
27 a HETI specific thing and I'm speaking a little bit
28 anecdotally here but just to sort of give by way of
29 example. A surgeon providing - take the example of an
30 emergency physician providing care in an emergency
31 department, doing a procedure, may do that themselves or
32 they may supervise a trainee doctor undertaking that
33 procedure, which is obviously a slower - not obviously, but
34 in many cases, that might take longer than if they were
35 doing it themselves, if I can explain.

36
37 Q. So an example I can give of tripping outside a hotel
38 and needing some stitches inside my nose, when I went to
39 the hospital, a junior doctor saw me, looked inside my nose
40 and sort of went, "Gee, I'm not touching that", and came
41 back with what I think was the registrar or a more senior
42 doctor, who said, "Yeah, you can touch it, provided I'm
43 standing here and watching you stitch up". That's part of
44 the training?

45 A. Correct.

46
47 Q. But there are other aspects where the senior doctor

1 isn't actually involved with the patient but is still
2 providing training to junior doctors; is that by way of
3 conversations or what are we talking about?
4 A. Yes, by way of conversations, by assessment processes,
5 providing feedback. You know, they may have collected -
6 a director of training, if you like, may have collected
7 information about an individual trainee from their senior
8 colleagues and providing them feedback, explaining
9 particular aspects of, you know, if I use your example of
10 an injury --
11
12 Q. It's important we get my entire medical history onto
13 the transcript for this Inquiry. Go on.
14
15 MR MUSTON: There can't be much left.
16
17 THE COMMISSIONER: I will get to my psoriasis in a minute.
18
19 Q. Yes.
20 A. I think the point I'm trying to make here is that that
21 can sometimes take longer to have those reflective
22 discussions, but they are really critical to that
23 individual junior doctor's professional development and
24 learning in terms of actually learning how to treat
25 patients.
26
27 THE COMMISSIONER: Yes, thank you.
28
29 MR MUSTON: I have no further questions for this witness,
30 Commissioner.
31
32 THE COMMISSIONER: Nothing arose out of that?
33
34 MR MUSTON: No.
35
36 THE COMMISSIONER: Mr Cheney, do you have any questions?
37
38 MR CHENEY: No, Commissioner.
39
40 THE COMMISSIONER: There are no further questions for you
41 doctor, thank you very much. We are very grateful for your
42 time. You are excused.
43
44 **<THE WITNESS WITHDREW**
45
46 THE COMMISSIONER: So Professor Twigg is here?
47

1 MR GLOVER: Yes.

2

3 <STEPHEN MAURICE TWIGG, sworn: [3.48pm]

4

5 <EXAMINATION BY MR GLOVER:

6

7 MR GLOVER: Q. Professor, if you just state your full
8 name for the record, please?

9 A. Professor Stephen Maurice Twigg.

10

11 Q. You are the head of department of endocrinology at
12 RPA?

13 A. That's correct.

14

15 Q. And also the head of the central clinical school,
16 which is part of the Sydney medical school of the
17 University of Sydney?

18 A. Yes.

19

20 Q. And to assist the Commissioner in its work, you made
21 a statement dated 11 July of this year; correct?

22 A. That's correct.

23

24 Q. That's [MOH.0011.0014.0001]. There is a screen to
25 your right there but you might have a hard copy with you.
26 Feel free to use whichever you prefer.

27 A. Thank you.

28

29 Q. Have you had a chance to read it again before giving
30 your evidence today?

31 A. I have, thank you.

32

33 Q. Is it true and correct to the best of your knowledge
34 and belief?

35 A. It is.

36

37 Q. If we can start at paragraph 3, and there you tell us
38 about the experience that I've just taken you through.
39 Just briefly, can you just describe the role of the central
40 clinical school and how it fits in with the broader Sydney
41 medical school?

42 A. Certainly. So the central clinical school, if you
43 like, is the frontline for the delivery of the medical
44 education, the curriculum, the learnings for medical
45 students within that clinical school at the University of
46 Sydney, and there's at least seven clinical schools that
47 feed into Sydney medical school, which, if you like, is the

1 next level up in the University of Sydney in medicine.

2
3 Sydney medical school is responsible for the
4 development of the curriculum, the syllabus, the learning
5 objectives and the assessment processes. Central clinical
6 school is responsible for the delivery of the educational
7 program, within both the university and particularly at
8 Royal Prince Alfred Hospital, in the setting of central
9 clinical school across the four years of the medical
10 degree.

11
12 Q. Is part of that process the placement of medical
13 students in clinical placements at RPA, for example?

14 A. That's correct.

15
16 Q. And you have an involvement in that processes, do you?

17 A. I certainly do, from the point of view of directly and
18 to some degree indirectly organising the placements of the
19 students across all the different specialty areas in RPA,
20 there are tutorials, lectures, ward-based programs and
21 placements as well, and in addition to that, then, the
22 teachers, the educationalists, the academics, the
23 affiliates who undertake the education. So the
24 organisation of the educational program from the point of
25 view of the physical environment where the students learn,
26 but also realising then the educators to enable the
27 students to learn particularly in a hospital setting at
28 RPAH.

29
30 Q. We'll come back to some of those features in a moment,
31 but just in terms of the process about how a medical
32 student comes to be placed in a clinical placement at RPA,
33 could you just tell the Commissioner in general terms how
34 that operates?

35 A. Initially the medical students are recognised as
36 medical students at the University of Sydney into
37 admissions by making an application, and depending upon
38 their success with the process of application, then they
39 will be formally accepted into their medical degree, which
40 is a postgraduate degree at the University of Sydney.
41 Then, subsequent to that, the students identify their
42 preferred clinical school in which they would undertake the
43 placement and the Sydney medical school helps determine the
44 distribution of the students across the different clinical
45 schools.

46
47 Q. And in terms of whether a student ends up in a

1 placement at RPA or elsewhere, is that a decision made by
2 the university or is the hospital involved as well?

3 A. The university typically will make those decisions
4 and - but communicate with the hospital as to medical
5 students who have been allocated initially for year 1. And
6 then usually, if a student commences in year 1 at
7 a clinical school, they will progress into years 2, 3 and
8 4, recognising that some students will end up in, if you
9 like, placements, rural and regional placements, and there
10 are some electives during that time.

11
12 Q. We'll come back to rural and regional placements in
13 just a moment. In paragraph 7 of your statement you
14 describe in general terms the nature of the education
15 delivered to students in a clinical placement and you
16 described some of those earlier. I just want to touch on
17 some of them briefly with you for those of us in this room,
18 all of us, most of us, who are lawyers, not doctors,

19 A. Yes.

20
21 Q. In terms of the education delivered in the hospital
22 setting, you describe lectures, classroom tutorials,
23 tutorials on the ward, simulations and hands-on experiences
24 in paragraph 7. Could you just in general terms take us
25 through what that might look like on a practical level?

26 A. Thank you. So one key example would be the tutoring
27 of students where they are allocated in a small group,
28 often three, four or five students, to a tutor. There
29 would often be a process in which, with the tutor, the
30 students will attend the wards in the hospital. They will
31 be able to see patients in terms of making medical
32 assessments and determine provisional diagnoses and then
33 a management plan.

34
35 So under a closely supervised format, those students
36 will learn different aspects of medicine. Say it was
37 a respiratory, a lung problem presenting with shortness of
38 breath, they will see a series of patients who have been
39 admitted with those problems and then take an appropriate
40 medical history, undertake an examination, in a structured
41 way, and then work through the assessment management plan.
42 So that would be a tutorial with a tutor.

43
44 Q. Who fills the role of the tutor? Is that a clinician
45 employed by the LHD?

46 A. Usually it is, and practically always, but it can be
47 a salaried academic through the University of Sydney or it

1 can be a salaried academic through the Sydney LHD, and
2 sometimes we have admixtures. For example, I'm a clinical
3 academic, I'm employed by both. So that is, for example,
4 the tutoring process.

5
6 In other settings, students have ward-based placements
7 in which they will link in with the junior medical staff
8 and they will then undertake the ward rounds with the more
9 junior staff, the consultations and learn, if you like,
10 from that perspective with a ward designation.

11
12 They are two key examples, ward-based placements and
13 tutoring, that will occur to enable the students to
14 understand how the health care delivery occurs in an
15 inpatient setting and also to be able to interact with the
16 people with medical conditions.

17
18 In an ambulatory care setting as well, students often
19 end up in placements, so, for example, I'm an
20 endocrinologist, diabetes is our most common condition and
21 we have medical student placements within our diabetes
22 centre and they will sit in with the doctors, the nurse
23 educators and learn in that way.

24
25 Q. When you say "sit in with the doctors and the nurse
26 educators", these are staff of the relevant facility in
27 which the placements are being undertaken?

28 A. That's correct, and with consent of the patients and
29 approval of the staff, they will accompany the staff member
30 in the assessment process of the patient in an ambulatory
31 setting.

32
33 Q. And are there any arrangements between the university
34 and the facility to ensure that those students are being
35 exposed to a broad range of experiences in those
36 placements?

37 A. Yes. Each placement, there is a careful working
38 through by particularly the University of Sydney and
39 central clinical school. We have education support
40 officers and managers. We have processes to ensure that
41 our tutors are teaching the curriculum, quite a clearly
42 prescribed curriculum in each - every day is carefully
43 designed across the entire medical degree. It is a very
44 tight time frame for the students to learn all the
45 materials.

46
47 Q. You touched on this earlier, but in paragraph 9 you

1 tell us that in some cases, students might train for
2 limited periods in rural and regional areas.

3 A. Yes.

4
5 Q. How might the student come to undertake a placement in
6 a rural and regional area?

7 A. Some clinical schools are positioned at those sites,
8 but from the point of view of central clinical school, the
9 students can make a submission that in their third or
10 fourth year of their training they would request an entire
11 year of placement in one of the clinical schools, and that
12 happens with a minority but a significant minority of
13 students.

14
15 Others request that during their elective periods,
16 which are typically approximately eight-week periods in
17 year 3 or 4, that they have a medical placement in a rural
18 or regional setting. And then we also have general
19 practice and community blocks as well, where students can
20 request their general practice placements would occur not
21 in a hospital setting but in a primary care setting in a
22 rural and regional site.

23
24 Q. So in each of the examples that you have just
25 described, these are initiated by students themselves
26 making the request to undertake placements in rural and
27 regional settings; correct?

28 A. Yes, except that opportunities are provided to the
29 students who can then indicate if they are keen, willing to
30 take up the opportunity, and it doesn't always match, but
31 very often, opportunities who are interested and prioritise
32 the placement will be successful in the placement.

33
34 Q. Do you see benefit in students being encouraged to
35 train rurally and regionally as part of their careers?

36 A. Certainly and we strongly encourage students to do so
37 in our central clinical school and in Sydney medical
38 school, and not all students take up the opportunity, but
39 I would say a majority do over the course of their degree.

40
41 Q. What do you see as being the benefit to students at
42 this stage of their training undertaking placements in
43 rural and regional areas?

44 A. Rural and regional health care is a challenging area
45 related to the geography in New South Wales, and we know
46 that to provide specialist care in those sites is
47 difficult, and also primary care. It can be a highly

1 rewarding experience where students and more junior
2 doctors, in some ways, can have a greater ability in
3 clinical management to get more involved and immerse
4 themselves in the experience. By the same token, some
5 students find that sometimes they can be isolated, though,
6 in that situation, and some respond better than others.

7
8 Students who originate from a rural and regional
9 setting - and that's approximately 20 per cent of the
10 students at the University of Sydney - are much more likely
11 to commence then as medical doctors in a rural and regional
12 setting, but we have seen some students, from having the
13 immersive experience, then willing to and keen to take on
14 the rural and regional placement.

15
16 You might have noticed my CV, I undertake care and
17 have for more than 10 years in the Far West of New South
18 Wales, an Aboriginal healthcare facility, and I'm very
19 familiar with the demands and the needs of health care,
20 particularly outside urban settings, particularly in the
21 environments where I've been lending support.

22
23 Q. So do I take it from that answer that you have
24 directly observed a correlation between students, as early
25 as this stage of their career, undertaking training in
26 rural and regional areas to then going on to practise as
27 practitioners in those areas?

28 A. Yes.

29
30 Q. In paragraph 5 of your statement you describe your
31 functions as head of department at RPA?

32 A. Yes.

33
34 Q. And towards the end of the third line, you tell us
35 that one of the functions of the department is advanced
36 trainee supervision for those undertaking endocrinology
37 training. Do you see that?

38 A. Yes.

39
40 Q. These are trainees on a specialist program with the
41 Royal Australian College of Physicians, are they?

42 A. That's correct.

43
44 Q. Can you just describe in general terms, what are the
45 supervision requirements of those trainees within your
46 department?

47 A. So there is an accredited training program for each of

1 the training positions from the Royal Australasian College
2 of Physicians through the specialist advisory committee and
3 so there is a weekly timetable which describes the
4 inpatient/outpatient activity; the number of patients that
5 are seen, new patients and follow-up patients; the
6 supervisory arrangements of those doctors in training; and
7 also the consultations spectrum that is undertaken.
8

9 So the accreditation program occurs each five years
10 through the College of Physicians. In the nuts and bolts
11 on a day-to-day basis, there are two allocated supervisors
12 in the department of endocrinology. I'm one of them for
13 two of our trainees and then we have a co-supervisor.
14

15 We meet formally with these students at least four
16 times a year, but in reality much more often than that,
17 formally and informally, and we - every clinic that occurs
18 for our advanced trainees in endocrinology has a supervised
19 consultant who is on site, will supervise the advanced
20 trainee in terms of their assessment and management of the
21 patient and provide advice on a regular basis.
22

23 So we have, in total, fractions of 20 endocrinologists
24 in our department and the vast majority of them contribute
25 in the clinic supervision of the advanced trainees, and
26 then we have the two formal supervisors for each advanced
27 trainee through the College of Physicians. We provide
28 a biannual report, formal report, to the Royal Australasian
29 College of Physicians regarding the progress of each
30 trainee during their training and their allocations to us
31 are on nearly a calendar year training; the training starts
32 often in February and completes the next February.
33

34 Q. Can I just ask you a couple of things about that
35 answer. You said, I think, you meet formally four times
36 a year but more frequently informally; did I understand you
37 correctly?

38 A. Yes, yes, that's correct. I mean, we - I will leave
39 it at that. We even have more often other formal meetings,
40 but the college has a requirement of at least four dates
41 indicated for meetings, and we easily meet that quota.
42

43 Q. And you said also that there are fractions of
44 20 endocrinologists in the department who contribute to the
45 supervision of those trainees; is that right?

46 A. From clinic to clinic, in terms of the reporting and
47 undertaking responsibility for the advanced trainee

1 progress, there are two allocated supervisors. That's
2 correct.

3

4 Q. But everybody in the department assists in the
5 training of those trainees?

6 A. Practically everyone. Practically everyone.

7

8 Q. Are they all staff specialists within your department
9 or are there VMOs as well?

10 A. No. We have two VMOs, these days, otherwise
11 practically all staff specialists. We also have some
12 clinical academics. I'm one of that rarer breed.

13

14 Q. Do the VMOs contribute to the supervision of those
15 trainees in the clinic setting that you have described?

16 A. The advanced trainees attend some of the clinics of
17 the VMOs, and in that setting, then, purely from a clinical
18 point of view, the VMOs contribute to that training; that's
19 correct.

20

21 Q. In paragraph 11 of your statement, you tell us that
22 there are three accredited advanced trainees in the
23 department; correct?

24 A. Yes.

25

26 Q. And I think in an answer you gave a moment ago, you
27 said that the cycle is yearly, so there will be three new
28 trainees each calendar year, if I understood you correctly?

29 A. That's typically the case. Now, I will just comment
30 briefly. There are two very similar training positions and
31 there is one a bit different. Two of them are called
32 required clinical years, very extensive breadth and depth
33 of training. There is one position called a core year
34 which has less breadth and more depth.

35

36 It is possible for an advanced trainee, for example,
37 within our department to undertake two consecutive years of
38 training in two different positions, but normally the case,
39 and what is encouraged, is that the advanced trainees would
40 undertake one year of training out of their three at one
41 site and then move to another site. This is within
42 endocrinology, but I think it's generally reflective of
43 many medical disciplines.

44

45 Q. I'm just going to ask you some general questions about
46 the selection and appointment of those trainees and if you
47 need to distinguish between the two in the way that you

1 just have, please feel free to do so. But are you familiar
2 with the process of how the trainees who might start, let's
3 say, January 1, 2025, would be selected to those three
4 positions?

5 A. Yes, I am, and I'm a member of the centralised
6 selection panel for the advanced trainees in endocrinology.
7 Most hospitals in New South Wales will have representatives
8 on that selection panel.

9
10 Q. If we take it from step by step, what's the process
11 for a doctor to become - start in the program in your
12 department, say, of 1 January next year?

13 A. Certainly. So a doctor needs to make a formal
14 submission to be considered for advanced training in
15 endocrinology, and that is to the centralised selection
16 process. Now --

17
18 Q. Just pausing there, the centralised selection process
19 is a process conducted by NSW Health?

20 A. And ACT, yes. New South Wales and ACT Health. Once
21 that submission is made, then there is a process by which
22 the centralised selection panel have a pre-meeting prior to
23 the formal day of interviews, determined based on their
24 qualifications and experience which applicants will be
25 short listed, and then they are interviewed, those
26 applicants are interviewed, on the day.

27
28 Now, there is a somewhat dual process I need to talk
29 about. There is a two-year contracted arrangement for
30 advanced trainees, so those that are in the contracted
31 arrangement, once they have done one year, they can discuss
32 actually with the departments as to the second year where
33 they might undertake their training. So that's approved by
34 NSW Health.

35
36 However, all the other potential applicants are unable
37 to approach the department, the heads of department, and
38 for reasons of equity, for fairness, they place their
39 written submission, the process of assessment and culling
40 occurs at a centralised level and then they attend the
41 interviews on the day which are late August this year.

42
43 Q. So this is a centralised process for facilities across
44 New South Wales and the ACT?

45 A. Yes.

46
47 Q. So a doctor says, "All right. I want to go on the

- 1 endocrinologist training pathway"?
2 A. Yes.
3
4 Q. One applies through the centralised process.
5 A. (Witness nods).
6
7 Q. Say they are successful, what happens next?
8 A. Then on the day of the interviews, the provisional
9 allocations are made for the advanced trainees who are
10 successful across all the different hospital positions.
11
12 Q. Who decides where they go?
13 A. The combination of the priority listing from the
14 centralised panel selection process and then the preference
15 of the advanced trainees and what's called a matching
16 process between the preference of heads of department of
17 particular sites and the advanced trainees and - or
18 advanced trainees to be.
19
20 Q. So you might have one trainee who wants to go to
21 a facility, there is one spot, that's a relatively
22 straightforward matching process?
23 A. Agreed.
24
25 Q. And you might have three in your department but
26 10 people who want to go there. That's a slightly
27 different process?
28 A. Agreed.
29
30 Q. What involvement, if any, does the college have in
31 this process?
32 A. The --
33
34 Q. As you understand it?
35 A. Yes, certainly. No, I was on the SAC in endocrinology
36 so I'm trying to think back. The college is much more
37 involved with accreditation of the particular training
38 sites within the hospitals themselves. Then after that,
39 I think to ensure that the process has equity and is
40 transparent, NSW Health more so than I think the colleges,
41 are directly involved with the selection process in that
42 setting. So I think the college has relatively little
43 involvement in the selection process, but I'm not as
44 directly involved in that. So I think it's much more
45 NSW Health than the heads of department.
46
47 Q. In paragraph 11 of your statement, you tell us that

1 there's currently three trainees, as we have touched on,
2 but there is capacity to take a fourth?

3 A. Yes.

4
5 Q. Are you familiar with the process of the determination
6 of whether it's three or four within your department?

7 A. Yes.

8
9 Q. Firstly, does that involve both the college and
10 NSW Health?

11 A. Yes.

12
13 Q. Is the college side of the equation directed to
14 accrediting the facility to have four training positions?

15 A. Yes. Would you like me to expand upon that briefly?

16
17 Q. Yes, briefly.

18 A. So, for example, with the site accreditation we need
19 to complete a template - the head of department and the
20 supervisory arrangements - as to what our current
21 accreditation program is and then we can add a paragraph to
22 indicate if we have the capacity to potentially undertake
23 a further advanced training position.

24
25 The site visitors then, once the date is allocated,
26 attend the site on behalf of the college and they make
27 their assessment as to whether the site will be
28 accredited - in this case, the department of
29 endocrinology - and, if so, for how many advanced trainee
30 positions, and they are given the capacity to make comment
31 if they feel as though there would be an appropriate
32 opportunity for another advanced training position.

33
34 That occurred about three years ago within our
35 department, that recognition that there would be capacity
36 for a fourth training position, which could work out well
37 from the point of view of service delivery and training of
38 our - of a fourth advanced trainee in endocrinology.

39
40 Q. And that's why you tell us --

41
42 THE COMMISSIONER: Q. So how precisely should
43 I understand your statement when it says "if we were able
44 to attract funding for a fourth, that would be 'optimal for
45 service needs'", does that mean that it would be nice or
46 does it mean that it's stronger than that, it's actually
47 needed to meet the medical demand?

1 A. Thank you, Commissioner. The direct answer is that it
2 would be nice rather than essential. We have a carefully
3 organised triage system in which patients can be seen same
4 business day if needed to help prevent hospital admissions.
5 It would reduce the waiting periods for a number of -
6 intermediate waiting periods of weeks and months for some
7 patients in our system. It would expand the volume of the
8 service that is provided under supervised conditions and
9 would enable a further advanced trainee to be trained, when
10 the ratio is about three to one in terms of doctors seeking
11 advanced training positions in endocrinology compared with
12 the number of placements across the state.

13
14 Q. That sounds slightly stronger than it would be nice
15 but maybe just less than absolutely necessary?

16 A. Thank you. Thanks for that.

17
18 MR GLOVER: Q. So that's the college side of the
19 equation?

20 A. Yes.

21
22 Q. What is your understanding of NSW Health's involvement
23 in the process that would see an extra training place in
24 your department?

25 A. So our approach has been to determine methods by which
26 we can make a business case or a submission for funding for
27 an advanced trainee in endocrinology, and over the years,
28 we tried recurrently for a specialist advanced trainee
29 post, an STP position, which had a rural and regional
30 element to it as well as urban component within our
31 department.

32
33 Even though we thought we had fashioned the
34 submissions appropriately, we were recurrently
35 unsuccessful, making the submission jointly out of RPA
36 Hospital and a rural and regional site.

37
38 We had an example about - just before COVID where we
39 obtained a temporary further 12 months advanced trainee
40 position from an internal medicine doctor who was keen to
41 undertake dual training in internal medicine and
42 endocrinology. The funding largely came from the Dubbo
43 area, they had the majority, 100K plus funding, and then we
44 negotiated with our executive at our hospital that we would
45 take a hit on one of our accounts and balance that up in
46 terms of other budgetary needs within our cost centre.

1 So we do have a precedent there of a fourth advanced
2 trainee but for a one-year period only, and that was
3 specifically within diabetes training. So, sorry for that
4 further part, but maybe it added clarification.

5
6 Q. So the need to attract funding that you speak of in
7 paragraph 11 is a need to attract funding from within the
8 NSW Health system?

9 A. And typically through our local health district and
10 through our executive, unless we can realise one of the
11 opportunities for advanced training that come up in
12 advanced training post rural and regional health.

13
14 MR GLOVER: Thank you, Professor. I've no further
15 questions, Commissioner.

16
17 THE COMMISSIONER: Q. Can I just ask again perhaps
18 a naive question, but I will ask it anyway: is the demand
19 for the services, health services, that are provided by
20 endocrinologists something that's increasing?

21 A. The short answer is yes, because with an ageing
22 population - many of our conditions are strongly age
23 related. So, for example, diabetes; osteoporosis; to
24 a degree as well obesity is age related; and then the
25 cardiovascular and kidney complications, et cetera. So
26 overall, within ageing, that specialty, yes.

27
28 Q. Ageing and lifestyle related are they?

29 A. Both, yes. Thank you.

30
31 THE COMMISSIONER: Nothing emerged out of that?

32
33 MR GLOVER: No.

34
35 THE COMMISSIONER: Do you have any questions?

36
37 MR CHENEY: No, Commissioner.

38
39 THE COMMISSIONER: Thank you very much for your time,
40 Professor, we're very grateful. You are excused.

41
42 THE WITNESS: Thank you, Commissioner.

43
44 <THE WITNESS WITHDREW

45
46 THE COMMISSIONER: No-one should think there is anything
47 dramatic in this, there is not, it is just to request some

1 help, but it's best I do it not on the transcript. Could
2 I just have a five-minute meeting with all counsel in my
3 chambers when we adjourn. That can include counsel that
4 weren't at the Bar table, there's enough room, and
5 listening online, if they are, but it's just to discuss
6 some help I want. So if we could do that, it should only
7 take five minutes.

8
9 Is there anything else for today?

10
11 MR MUSTON: No.

12
13 THE COMMISSIONER: All right. I will see the barristers
14 in my room, I should say, shortly.

15
16 **AT 4.17PM THE SPECIAL COMMISSION OF INQUIRY WAS ADJOURNED**
17 **ACCORDINGLY**

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#10 [1] - 3747:7

\$

\$320 [1] - 3767:9
\$33 [1] - 3736:8

,

'optimal [1] - 3829:44

0

0007 [1] - 3780:21
036 [1] - 3713:24

1

1 [13] - 3780:29,
3780:45, 3781:12,
3794:16, 3799:31,
3799:34, 3800:17,
3801:2, 3808:19,
3821:5, 3821:6,
3827:3, 3827:12
1,000 [1] - 3788:6
1-3 [1] - 3780:46
1.1 [2] - 3781:36,
3781:40
1/2024 [1] - 3744:46
10 [19] - 3742:5,
3745:39, 3746:25,
3746:26, 3746:32,
3746:38, 3746:45,
3747:5, 3747:12,
3781:18, 3788:5,
3795:24, 3795:25,
3802:5, 3802:38,
3803:17, 3803:40,
3824:17, 3828:26
10-week [1] - 3803:47
10-year [2] - 3736:13,
3736:37
10.00am [1] - 3713:22
10.26am [1] - 3724:17
100 [2] - 3737:35,
3788:5
100K [1] - 3830:43
11 [8] - 3781:26,
3794:20, 3797:29,
3802:38, 3819:21,
3826:21, 3828:47,
3831:7
11.50 [1] - 3747:19
12 [4] - 3746:38,
3790:37, 3805:35,
3830:39
12.50pm [1] - 3770:30

121 [1] - 3713:18
126 [1] - 3736:7
13 [4] - 3725:2,
3725:22, 3743:15,
3795:47
14 [3] - 3744:44,
3747:15, 3783:41
15 [7] - 3724:31,
3731:3, 3754:30,
3757:39, 3800:2,
3800:35, 3801:3
150 [2] - 3796:4
16 [2] - 3747:30,
3747:37
17 [1] - 3748:38
18 [1] - 3762:19
19 [3] - 3750:33,
3751:9, 3764:17
19,400 [1] - 3745:39
1920 [1] - 3725:7

2

2 [7] - 3713:18,
3742:16, 3770:19,
3774:36, 3774:46,
3800:40, 3821:7
2.47pm [1] - 3794:1
20 [7] - 3749:15,
3751:39, 3754:30,
3767:13, 3824:9,
3825:23, 3825:44
200 [1] - 3737:36
2000 [2] - 3714:35,
3725:28
2015 [1] - 3770:46
2021 [1] - 3794:17
2022 [1] - 3781:7
2022-2032 [2] -
3736:4, 3780:17
2023 [2] - 3724:27,
3781:8
2024 [7] - 3713:22,
3724:31, 3771:3,
3781:8, 3782:8,
3787:21, 3794:20
2025 [2] - 3805:6,
3827:3
22 [4] - 3713:22,
3752:20, 3767:27,
3768:9
23 [3] - 3726:6,
3764:23, 3764:35
23-plus [1] - 3750:12
24 [4] - 3721:36,
3753:2, 3768:19,
3769:26
25 [1] - 3729:17
25th [1] - 3723:27
26 [1] - 3723:16

26th [2] - 3723:29,
3723:30
27 [3] - 3753:31,
3756:23, 3769:6
28 [1] - 3800:36
29 [1] - 3723:16
29th [1] - 3723:30

3

3 [8] - 3775:10,
3780:29, 3794:40,
3794:46, 3795:5,
3819:37, 3821:7,
3823:17
3.48pm [1] - 3819:3
30 [1] - 3749:15
30th [1] - 3723:28
36 [1] - 3806:12
3755 [1] - 3768:47
38 [1] - 3811:11

4

4 [4] - 3725:42,
3799:31, 3821:8,
3823:17
4.1 [1] - 3783:42
4.17PM [1] - 3832:16
4.5 [1] - 3786:32
40 [1] - 3749:15
40-day [1] - 3768:4
41,800 [1] - 3745:39
47 [1] - 3788:28

5

5 [1] - 3824:30
5-0 [1] - 3790:35
5.1 [1] - 3787:12
50 [6] - 3768:28,
3790:27, 3790:29,
3790:42, 3791:45,
3815:13
50,000 [1] - 3725:43
51 [1] - 3791:17
52 [1] - 3791:17
53 [1] - 3791:17
54 [3] - 3790:47,
3791:10, 3791:11
56 [1] - 3792:18

6

6 [2] - 3726:26,
3729:37
62 [1] - 3792:44
6th [1] - 3723:44

7

7 [5] - 3735:16,
3771:20, 3780:20,
3821:13, 3821:24
70 [1] - 3816:17

8

8 [2] - 3730:30,
3780:27

9

9 [6] - 3740:10,
3771:3, 3772:21,
3775:9, 3778:8,
3822:47

A

A.048 [1] - 3780:10
ability [8] - 3714:28,
3718:2, 3718:42,
3728:11, 3747:28,
3803:47, 3824:2
able [26] - 3716:8,
3730:12, 3733:31,
3739:30, 3741:25,
3741:47, 3743:31,
3748:5, 3749:23,
3757:19, 3774:26,
3777:19, 3777:42,
3779:45, 3780:16,
3791:39, 3792:41,
3804:23, 3806:39,
3806:43, 3807:5,
3814:40, 3815:43,
3821:31, 3822:15,
3829:43
Aboriginal [3] -
3766:17, 3797:32,
3824:18
ABS [3] - 3726:36,
3742:26, 3758:5
absence [3] - 3726:27,
3743:6, 3759:44
absolutely [9] -
3724:4, 3730:40,
3734:6, 3743:2,
3745:34, 3762:4,
3765:20, 3766:9,
3830:15
abundance [1] -
3724:7
abundant [1] -
3725:21
academic [3] -
3821:47, 3822:1,
3822:3

academics [3] -
3758:25, 3820:22,
3826:12
accept [11] - 3743:45,
3761:40, 3763:13,
3767:16, 3768:32,
3768:34, 3800:32,
3809:28, 3810:12,
3810:13, 3810:20
acceptance [1] -
3810:41
accepted [9] -
3740:29, 3804:47,
3805:4, 3810:4,
3810:27, 3812:14,
3812:28, 3813:40,
3820:39
accepting [1] - 3805:7
accepts [1] - 3810:34
access [10] - 3728:35,
3728:47, 3729:13,
3731:29, 3731:30,
3733:9, 3743:31,
3748:43, 3772:12,
3813:20
accessible [3] -
3730:26, 3758:34,
3758:43
accessing [2] -
3731:19, 3810:6
accommodate [3] -
3722:36, 3803:4,
3803:39
accommodated [4] -
3723:24, 3800:25,
3801:28, 3801:36
accommodation [1] -
3783:18
accompany [1] -
3822:29
according [5] -
3785:29, 3786:47,
3798:24, 3807:27,
3808:39
account [1] - 3733:32
accountable [1] -
3733:2
accounts [1] -
3830:45
accreditation [18] -
3764:44, 3764:45,
3765:16, 3765:35,
3772:15, 3777:37,
3779:31, 3779:45,
3800:3, 3806:14,
3810:10, 3812:35,
3815:11, 3816:11,
3825:9, 3828:37,
3829:18, 3829:21
accreditations [1] -

3784:21
accredited [15] -
3764:42, 3779:36,
3805:2, 3809:32,
3809:46, 3810:6,
3810:31, 3810:33,
3814:12, 3814:24,
3814:26, 3816:10,
3824:47, 3826:22,
3829:28
accrediting [1] -
3829:14
accredits [1] -
3806:15
accuracy [1] - 3735:19
accurate [6] -
3729:13, 3730:23,
3738:25, 3743:35,
3757:41, 3766:41
accurately [3] -
3728:17, 3748:33,
3760:29
achieve [2] - 3779:45,
3813:27
achieved [4] -
3779:47, 3781:32,
3782:7, 3784:40
achieving [4] -
3755:33, 3782:13,
3787:1, 3814:37
ACI [2] - 3775:39,
3776:3
acknowledge [4] -
3714:5, 3753:3,
3762:11, 3767:43
acknowledged [1] -
3767:16
acknowledging [1] -
3723:40
acquit [4] - 3726:10,
3733:7, 3749:8,
3752:9
acquitting [1] -
3728:43
ACT [5] - 3724:15,
3724:23, 3827:20,
3827:44
act [1] - 3725:4
acting [2] - 3794:5,
3794:12
action [3] - 3729:20,
3740:38, 3762:7
actions [1] - 3728:12
active [1] - 3782:33
activism [1] - 3729:18
activities [3] - 3717:3,
3784:5, 3805:25
activity [3] - 3785:20,
3785:21, 3825:4
actual [5] - 3725:4,
3782:38, 3795:34,
3799:7, 3801:22
acute [4] - 3714:21,
3734:4, 3743:9,
3745:26
acutely [5] - 3743:5,
3743:8, 3759:20,
3759:27, 3761:30
ad [1] - 3734:39
adapt [1] - 3720:36
adaptation [1] -
3721:32
add [3] - 3715:33,
3735:11, 3829:21
added [1] - 3831:4
addition [10] - 3748:2,
3758:8, 3766:26,
3766:43, 3772:14,
3809:29, 3811:20,
3816:12, 3816:15,
3820:21
additional [2] -
3805:35, 3816:8
address [7] - 3728:42,
3732:2, 3732:6,
3743:36, 3744:9,
3744:11, 3773:11
addressed [4] -
3714:18, 3716:41,
3744:45, 3773:2
addressing [4] -
3719:36, 3747:27,
3750:36, 3768:8
adequate [5] -
3738:18, 3740:27,
3748:6, 3778:34
adequately [1] -
3738:29
adhere [1] - 3765:17
adjourn [6] - 3770:25,
3774:31, 3774:35,
3774:40, 3774:46,
3832:3
adjustment [1] -
3746:6
adjustments [1] -
3746:11
administer [3] -
3789:31, 3789:36,
3790:2
administered [3] -
3738:44, 3802:15,
3813:39
administering [7] -
3719:35, 3788:46,
3789:43, 3789:45,
3791:9, 3792:14,
3811:5
administers [2] -
3790:31, 3791:46
administration [3] -
3811:22, 3813:3,
3813:9
administrative [2] -
3752:28, 3804:17
administrator [1] -
3792:3
administrators [2] -
3726:11, 3752:7
admissions [2] -
3820:37, 3830:4
admitted [1] - 3821:39
admixtures [1] -
3822:2
adopt [1] - 3737:11
adopting [1] - 3759:14
advance [2] - 3716:5,
3776:17
advanced [32] -
3781:23, 3810:19,
3811:22, 3824:35,
3825:18, 3825:19,
3825:25, 3825:26,
3825:47, 3826:16,
3826:22, 3826:36,
3826:39, 3827:6,
3827:14, 3827:30,
3828:9, 3828:15,
3828:17, 3828:18,
3829:23, 3829:29,
3829:32, 3829:38,
3830:9, 3830:11,
3830:27, 3830:28,
3830:39, 3831:1,
3831:11, 3831:12
advantaged [1] -
3728:35
adversarial [4] -
3738:11, 3744:22,
3744:24, 3752:40
advertised [1] -
3734:32
advice [2] - 3773:13,
3825:21
advised [1] - 3771:42
advisory [2] -
3790:22, 3825:2
advocate [2] -
3744:26, 3751:35
affairs [1] - 3759:46
affect [2] - 3716:22,
3728:12
affiliates [1] - 3820:23
affirmed [1] - 3794:1
afford [1] - 3751:31
afoot [1] - 3759:31
age [2] - 3831:22,
3831:24
Aged [2] - 3727:6,
3758:15
aged [1] - 3718:47
ageing [3] - 3831:21,
3831:26, 3831:28
agencies [2] -
3732:37, 3758:19
agency [8] - 3716:33,
3729:33, 3737:24,
3739:3, 3753:6,
3753:7, 3768:34,
3768:38
Agency [2] - 3758:9,
3765:13
agitate [1] - 3733:47
agitation [1] - 3733:41
ago [19] - 3716:14,
3716:26, 3721:26,
3726:19, 3727:10,
3731:3, 3733:31,
3743:39, 3746:23,
3749:15, 3749:33,
3757:17, 3757:39,
3794:10, 3799:44,
3800:34, 3803:3,
3826:26, 3829:34
agree [3] - 3727:44,
3732:47, 3738:24
agreed [4] - 3769:8,
3769:33, 3828:23,
3828:28
agreement [2] -
3717:8, 3791:25
ahead [4] - 3747:23,
3770:35, 3797:41,
3799:35
aid [1] - 3730:26
alarming [1] - 3728:34
albeit [3] - 3721:15,
3806:32, 3811:35
alert [1] - 3776:16
Alfred [6] - 3801:1,
3801:4, 3801:6,
3812:8, 3812:15,
3820:8
algorithm [5] -
3799:35, 3799:44,
3800:5, 3800:7,
3800:21
align [1] - 3784:24
alive [1] - 3719:45
allegedly [1] - 3721:20
allied [36] - 3715:7,
3718:31, 3718:36,
3718:41, 3718:42,
3718:44, 3726:6,
3726:7, 3745:40,
3747:46, 3749:14,
3750:11, 3750:39,
3751:13, 3751:16,
3751:29, 3762:35,
3764:19, 3764:23,
3764:35, 3764:41,
3765:4, 3765:18,
3765:23, 3765:25,
3765:44, 3766:6,
3766:15, 3766:17,
3766:27, 3766:28,
3766:35, 3766:39,
3766:45, 3785:41,
3789:15
allocate [3] - 3795:26,
3800:17, 3810:20
allocated [13] -
3799:29, 3800:47,
3801:1, 3801:2,
3801:3, 3802:2,
3802:3, 3804:5,
3821:5, 3821:27,
3825:11, 3826:1,
3829:25
allocates [2] - 3800:6,
3801:35
allocation [20] -
3792:26, 3792:30,
3792:35, 3795:5,
3795:23, 3795:39,
3795:42, 3796:8,
3797:42, 3798:40,
3799:8, 3799:12,
3799:14, 3799:40,
3801:34, 3801:35,
3802:19, 3807:14,
3808:35, 3808:40
allocations [4] -
3800:22, 3802:12,
3825:30, 3828:9
allow [2] - 3797:41,
3799:15
allude [4] - 3748:40,
3749:42, 3750:46,
3799:13
alluded [2] - 3779:4,
3797:32
alluding [3] - 3751:9,
3778:17, 3778:24
almost [1] - 3740:47
alone [3] - 3734:43,
3754:29, 3791:25
alongside [1] -
3738:38
alternative [2] -
3804:34, 3810:38
altogether [1] -
3741:39
Ambulance [5] -
3728:28, 3734:20,
3743:26, 3744:15,
3744:37
ambulance [2] -
3734:13, 3744:38
ambulatory [2] -

3822:18, 3822:30
amended [1] -
3740:16
amending [1] -
3754:36
amendment [2] -
3756:30, 3769:13
amendments [1] -
3755:4
amount [5] - 3719:21,
3723:41, 3731:15,
3731:44, 3732:10
amounts [2] -
3740:45, 3755:14
anaesthetists [2] -
3813:31, 3813:41
analysing [2] -
3715:35, 3758:26
analysis [1] - 3727:7
anecdotally [2] -
3804:38, 3817:28
anew [1] - 3754:38
Angela [2] - 3742:17,
3742:30
Annette [2] - 3746:26,
3770:15
ANNETTE [1] -
3770:30
annexure [1] -
3742:16
announced [1] -
3751:27
annual [2] - 3809:34,
3810:26
answer [17] - 3739:47,
3754:32, 3754:33,
3757:44, 3760:43,
3761:24, 3763:14,
3779:1, 3788:3,
3790:3, 3805:44,
3813:35, 3824:23,
3825:35, 3826:26,
3830:1, 3831:21
answered [1] -
3732:19
answering [1] -
3809:43
anticipate [8] -
3714:40, 3717:7,
3719:30, 3720:13,
3720:15, 3746:5,
3755:8, 3755:20
anyway [5] - 3732:19,
3760:14, 3781:12,
3812:23, 3831:18
ANZCA [1] - 3813:34
apart [2] - 3750:31,
3792:14
appear [6] - 3717:15,
3717:31, 3719:7,
3721:1, 3722:22,
3723:7
applicable [2] -
3750:22, 3754:47
applicant [1] -
3809:27
applicants [7] -
3789:11, 3789:26,
3797:19, 3798:23,
3827:24, 3827:26,
3827:36
application [14] -
3728:27, 3730:10,
3743:24, 3743:25,
3789:26, 3792:35,
3797:27, 3798:38,
3800:1, 3807:34,
3808:23, 3820:37,
3820:38
applications [3] -
3790:11, 3792:25,
3792:30
applied [4] - 3714:41,
3780:6, 3798:46,
3800:39
applies [1] - 3828:4
apply [20] - 3742:45,
3753:7, 3789:1,
3789:2, 3789:10,
3798:10, 3798:12,
3798:21, 3798:37,
3808:3, 3808:13,
3808:27, 3809:25,
3809:26, 3809:31,
3809:34, 3810:25,
3810:27, 3812:44,
3813:11
applying [2] -
3792:26, 3792:36
appointed [2] -
3799:32, 3799:34
appointment [2] -
3798:14, 3826:46
appreciate [3] -
3735:32, 3765:28,
3809:19
approach [9] - 3715:2,
3715:8, 3715:42,
3752:40, 3784:38,
3784:41, 3785:16,
3827:37, 3830:25
approaches [1] -
3785:3
approaching [1] -
3781:3
appropriate [5] -
3721:8, 3732:36,
3810:47, 3821:39,
3829:31
appropriately [2] -
3797:1, 3830:34
approval [2] - 3796:8,
3822:29
approve [1] - 3816:14
approved [2] -
3720:46, 3827:33
area [29] - 3717:30,
3717:39, 3718:12,
3733:11, 3735:34,
3739:28, 3741:32,
3743:25, 3750:7,
3767:20, 3772:15,
3776:38, 3776:43,
3783:10, 3791:31,
3791:33, 3793:19,
3796:41, 3797:39,
3798:5, 3803:10,
3803:17, 3803:19,
3808:47, 3809:40,
3823:6, 3823:44,
3830:43
areas [34] - 3714:47,
3716:29, 3717:24,
3721:39, 3726:46,
3727:4, 3727:12,
3727:38, 3741:37,
3742:27, 3743:46,
3745:22, 3749:36,
3750:43, 3751:27,
3754:15, 3758:28,
3760:31, 3761:26,
3762:21, 3762:32,
3762:36, 3764:32,
3765:31, 3775:22,
3791:39, 3802:44,
3811:34, 3811:37,
3820:19, 3823:2,
3823:43, 3824:26,
3824:27
arguable [1] - 3739:36
argument [2] -
3753:10, 3762:15
arise [2] - 3770:5,
3808:24
arising [1] - 3767:18
arm [2] - 3761:34,
3761:37
arms [1] - 3764:44
arose [1] - 3818:32
arrangement [4] -
3802:36, 3807:10,
3827:29, 3827:31
arrangements [18] -
3720:43, 3720:46,
3721:3, 3721:12,
3721:22, 3721:26,
3722:5, 3748:45,
3748:46, 3756:42,
3791:27, 3791:38,
3803:23, 3813:39,
3822:33, 3825:6,
3829:20
array [2] - 3722:31,
3738:46
articulate [1] -
3742:21
articulated [2] -
3741:11, 3767:31
ascertain [3] -
3730:13, 3743:35,
3774:13
ascertained [1] -
3759:36
ascertaining [1] -
3759:46
aside [2] - 3817:20,
3817:26
ASMOF [1] - 3720:21
aspect [1] - 3785:19
aspects [9] - 3725:22,
3756:47, 3761:3,
3769:1, 3769:29,
3769:38, 3817:47,
3818:9, 3821:36
assess [2] - 3719:33,
3719:42
assessed [2] -
3789:27, 3798:16
assessing [1] - 3784:7
assessment [10] -
3718:9, 3779:32,
3784:9, 3818:4,
3820:5, 3821:41,
3822:30, 3825:20,
3827:39, 3829:27
assessments [3] -
3816:34, 3816:37,
3821:32
assimilating [1] -
3758:23
assist [8] - 3724:30,
3739:7, 3759:17,
3763:47, 3771:2,
3794:21, 3814:47,
3819:20
assistants [2] -
3766:29, 3766:39
Assisting [5] -
3713:26, 3713:27,
3713:28, 3713:29,
3713:30
assists [1] - 3826:4
associate [1] - 3749:6
associated [2] -
3776:5, 3811:45
Association [1] -
3720:21
associations [1] -
3764:43
assume [4] - 3723:11,
3759:28, 3760:36,
3806:31
assuming [3] -
3723:26, 3798:33,
3808:26
assumption [2] -
3738:2, 3747:13
assumptions [7] -
3742:9, 3742:13,
3742:14, 3742:21,
3742:24, 3742:45,
3745:19
AT [2] - 3747:7,
3832:16
ATO [2] - 3726:37,
3758:5
attached [1] - 3734:45
attempt [2] - 3722:6,
3785:15
attempting [1] -
3723:21
attend [5] - 3788:38,
3821:30, 3826:16,
3827:40, 3829:26
attendance [2] -
3770:11, 3793:34
attended [2] -
3807:22, 3807:40
attends [1] - 3774:18
attention [1] - 3722:21
attitudes [3] -
3726:43, 3735:27,
3737:17
attract [3] - 3829:44,
3831:6, 3831:7
attrition [1] - 3804:37
August [1] - 3827:41
Australasian [2] -
3825:1, 3825:28
Australia [1] - 3740:26
Australia's [1] -
3804:15
Australian [9] -
3720:20, 3750:9,
3758:9, 3758:12,
3758:26, 3765:12,
3806:1, 3807:29,
3824:41
Austudy [1] - 3767:11
authorities [2] -
3759:3, 3765:9
authority [2] -
3795:26, 3806:15
Authority's [1] -
3758:16
automatically [1] -
3740:47
avail [1] - 3734:21
availability [7] -
3718:36, 3718:40,

- 3722:31, 3723:17,
3723:21, 3730:30,
3733:26
- available** [44] -
3720:12, 3723:24,
3729:22, 3730:19,
3731:42, 3734:27,
3736:13, 3739:18,
3739:22, 3740:4,
3740:5, 3742:15,
3743:28, 3743:29,
3748:39, 3749:32,
3750:21, 3751:12,
3751:24, 3751:34,
3753:14, 3757:46,
3759:8, 3760:8,
3760:45, 3772:10,
3773:33, 3775:6,
3784:22, 3792:4,
3792:8, 3793:18,
3797:22, 3801:23,
3801:30, 3804:34,
3806:21, 3814:12,
3814:13, 3816:20,
3817:4, 3817:6
- avenues** [1] - 3766:14
- avoid** [4] - 3722:37,
3723:21, 3724:6,
3746:32
- avoided** [1] - 3746:13
- await** [1] - 3729:9
- award** [13] - 3753:36,
3753:41, 3753:43,
3754:3, 3754:7,
3754:16, 3754:19,
3755:23, 3755:32,
3756:8, 3756:30,
3756:43, 3769:12
- awarded** [1] - 3790:17
- awards** [21] - 3720:32,
3720:35, 3720:36,
3720:46, 3721:20,
3721:31, 3725:36,
3753:32, 3754:10,
3754:27, 3754:35,
3754:37, 3754:44,
3754:47, 3756:24,
3756:47, 3769:2,
3769:6, 3769:29,
3769:38, 3769:39
- aware** [18] - 3731:7,
3731:33, 3743:26,
3752:4, 3756:6,
3759:20, 3763:17,
3763:46, 3764:22,
3766:1, 3767:35,
3768:3, 3768:5,
3786:26, 3803:15,
3810:38, 3813:45,
3815:18
- B**
- b** [1] - 3772:25
- background** [2] -
3717:26, 3718:45
- backyard** [1] - 3733:6
- bad** [2] - 3739:26,
3788:47
- balance** [2] - 3816:43,
3830:45
- ballpark** [2] - 3788:3,
3788:5
- Bar** [1] - 3832:4
- BARCODED** [1] -
3747:8
- barristers** [1] -
3832:13
- base** [2] - 3734:41,
3787:16
- base-level** [1] -
3787:16
- based** [17] - 3729:1,
3731:29, 3742:47,
3745:44, 3751:40,
3760:31, 3773:36,
3797:41, 3798:8,
3798:14, 3800:11,
3807:19, 3809:13,
3820:20, 3822:6,
3822:12, 3827:23
- baseline** [4] - 3715:17,
3715:22, 3715:39,
3716:15
- basic** [6] - 3811:15,
3811:21, 3812:16,
3812:21, 3813:8,
3816:13
- basis** [2] - 3825:11,
3825:21
- Beasley** [1] - 3713:14
- become** [12] -
3749:16, 3751:1,
3766:39, 3797:16,
3808:46, 3808:47,
3809:4, 3809:6,
3809:23, 3811:29,
3812:2, 3827:11
- becomes** [1] - 3761:12
- beginning** [1] -
3744:22
- behalf** [1] - 3829:26
- beings** [1] - 3783:4
- belief** [5] - 3728:47,
3729:1, 3729:3,
3816:19, 3819:34
- beneficial** [1] - 3734:7
- benefit** [9] - 3731:13,
3731:17, 3740:14,
3755:31, 3760:39,
3760:44, 3812:27,
3823:34, 3823:41
- benefited** [1] -
3793:23
- benefits** [3] - 3756:40,
3757:7, 3803:18
- benevolent** [2] -
3761:34, 3761:37
- best** [22] - 3714:38,
3722:29, 3723:33,
3723:36, 3724:37,
3724:39, 3736:18,
3736:47, 3737:2,
3737:11, 3748:26,
3761:46, 3771:14,
3775:23, 3776:10,
3776:22, 3779:1,
3781:35, 3783:25,
3794:32, 3819:33,
3832:1
- better** [8] - 3716:8,
3739:1, 3754:37,
3765:46, 3766:28,
3780:45, 3815:7,
3824:6
- between** [24] -
3716:35, 3717:8,
3718:21, 3718:25,
3718:29, 3719:15,
3741:15, 3741:19,
3743:16, 3748:7,
3748:41, 3748:46,
3749:43, 3749:47,
3750:28, 3751:4,
3791:2, 3793:7,
3814:18, 3817:3,
3822:33, 3824:24,
3826:47, 3828:16
- beyond** [7] - 3727:40,
3730:44, 3741:7,
3744:19, 3753:27,
3753:28, 3774:2
- BHI** [7] - 3734:10,
3735:7, 3735:11,
3735:14, 3757:14,
3757:21, 3758:33
- biannual** [1] - 3825:28
- big** [5] - 3745:21,
3745:46, 3780:42,
3792:14, 3804:9
- big-picture** [2] -
3745:21, 3745:46
- billion** [1] - 3736:8
- bit** [28] - 3715:26,
3716:43, 3717:1,
3717:15, 3722:26,
3723:3, 3723:34,
3725:42, 3736:11,
3736:33, 3739:45,
3741:24, 3742:39,
3752:22, 3753:27,
3757:14, 3760:6,
3780:14, 3780:28,
3781:37, 3782:6,
3784:4, 3809:37,
3811:24, 3813:6,
3813:12, 3817:27,
3826:31
- blank** [4] - 3754:12,
3754:41, 3754:42,
3792:29
- block** [9] - 3714:3,
3714:19, 3714:44,
3715:4, 3716:7,
3716:13, 3717:6,
3722:12, 3723:43
- blockages** [4] -
3717:33, 3717:41,
3718:1, 3718:8
- blocks** [2] - 3723:37,
3823:19
- Board** [2] - 3804:15,
3804:20
- boarding** [3] -
3727:26, 3797:24,
3810:23
- bodies** [4] - 3726:6,
3743:46, 3759:3,
3764:44
- body** [21] - 3718:13,
3720:21, 3726:28,
3726:37, 3727:32,
3727:39, 3728:28,
3728:33, 3734:18,
3735:2, 3735:4,
3757:8, 3758:47,
3759:6, 3759:44,
3760:31, 3790:30,
3790:43, 3791:8,
3791:46
- bold** [1] - 3731:4
- bolts** [1] - 3825:10
- book** [1] - 3792:9
- border** [10] - 3740:46,
3741:6, 3741:8,
3741:10, 3741:18,
3741:22, 3741:24,
3741:32, 3741:37
- borne** [1] - 3747:42
- boundaries** [1] -
3801:16
- box** [2] - 3768:45,
3785:23
- branch** [1] - 3715:26
- breadth** [2] - 3826:32,
3826:34
- break** [5] - 3746:19,
3746:37, 3747:25,
3751:39, 3774:36
- Breaking** [2] - 3745:2,
3747:1
- breaking** [3] -
3730:42, 3745:11,
3805:30
- BREAKING** [1] -
3747:8
- breath** [1] - 3821:38
- breed** [1] - 3826:12
- briefly** [6] - 3816:18,
3819:39, 3821:17,
3826:30, 3829:15,
3829:17
- bring** [2] - 3743:5,
3812:10
- bringing** [1] - 3814:39
- brings** [3] - 3717:5,
3724:12, 3791:44
- broad** [6] - 3717:7,
3790:12, 3805:21,
3805:22, 3813:5,
3822:35
- broader** [9] - 3718:2,
3722:40, 3737:16,
3743:43, 3758:44,
3807:9, 3809:43,
3814:23, 3819:40
- broadly** [14] - 3716:32,
3717:1, 3720:4,
3728:15, 3730:24,
3733:12, 3734:24,
3734:27, 3758:26,
3803:24, 3809:17,
3809:33, 3814:21,
3814:29
- Broken** [6] - 3731:15,
3731:43, 3731:44,
3732:27, 3759:15,
3759:17
- brought** [2] - 3805:16,
3815:42
- budget** [4] - 3745:23,
3751:33, 3796:24,
3815:21
- budgetary** [4] -
3795:39, 3795:41,
3796:17, 3830:46
- build** [4] - 3742:10,
3785:26, 3786:10,
3786:28
- building** [4] - 3716:43,
3718:12, 3718:19,
3776:37
- built** [1] - 3742:9
- bulk** [4] - 3724:42,
3725:1, 3725:5,
3725:15
- bullet** [3] - 3781:45,
3785:32, 3787:12
- bundle** [2] - 3725:8,
3745:13
- Bureau** [1] - 3731:4

- BURNAND** [1] - 3794:1
Burnand [4] - 3746:26, 3779:1, 3793:45, 3794:5
burst [1] - 3723:23
business [5] - 3770:43, 3783:14, 3783:37, 3830:4, 3830:26
busy [1] - 3816:39
BY [5] - 3724:19, 3756:19, 3770:37, 3794:3, 3819:5
-
- C**
-
- cadetships** [1] - 3766:18
calendar [2] - 3825:31, 3826:28
candidate [7] - 3800:16, 3802:35, 3807:39, 3808:11, 3810:34, 3810:35, 3812:14
candidates [9] - 3767:42, 3799:4, 3799:38, 3801:41, 3802:19, 3802:21, 3802:29, 3803:13, 3807:31
candidly [1] - 3762:6
cannot [3] - 3751:21, 3751:31, 3752:47
Canterbury [3] - 3801:6, 3801:29, 3802:21
cap [1] - 3720:26
capabilities [3] - 3776:47, 3784:17, 3789:4
capability [11] - 3783:24, 3784:7, 3784:10, 3784:11, 3784:14, 3784:27, 3784:33, 3784:38, 3785:16, 3787:16, 3789:42
capable [2] - 3715:12, 3733:28
capacity [28] - 3722:3, 3727:22, 3730:43, 3731:21, 3735:8, 3736:19, 3740:25, 3741:18, 3741:44, 3748:9, 3749:11, 3751:5, 3754:43, 3760:16, 3760:19, 3760:32, 3767:18, 3775:17, 3776:37, 3796:4, 3796:10, 3796:15, 3796:17, 3796:34, 3829:2, 3829:22, 3829:30, 3829:35
capital [3] - 3749:19, 3786:3, 3786:4
capture [17] - 3726:28, 3726:46, 3727:17, 3727:25, 3727:32, 3728:16, 3734:23, 3735:3, 3735:19, 3735:26, 3735:35, 3742:41, 3752:4, 3757:8, 3757:19, 3760:26, 3760:30
captured [14] - 3726:32, 3726:34, 3727:5, 3727:23, 3731:27, 3735:31, 3736:12, 3743:13, 3753:41, 3753:42, 3754:26, 3754:32, 3757:13, 3758:41
captures [4] - 3716:32, 3736:14, 3757:15, 3757:18
capturing [6] - 3726:38, 3726:41, 3727:36, 3728:22, 3730:40, 3755:2
cardiac [1] - 3813:32
cardiovascular [1] - 3831:25
Care [1] - 3758:15
care [52] - 3714:28, 3716:22, 3718:47, 3720:37, 3722:17, 3725:33, 3732:8, 3732:37, 3732:45, 3737:2, 3737:11, 3738:15, 3740:33, 3746:7, 3749:16, 3749:36, 3750:11, 3750:23, 3751:28, 3752:47, 3753:12, 3753:24, 3757:1, 3763:24, 3763:29, 3763:39, 3764:14, 3769:31, 3769:40, 3786:35, 3786:42, 3787:8, 3796:26, 3812:40, 3814:34, 3814:45, 3816:21, 3817:5, 3817:6, 3817:9, 3817:18, 3817:21, 3817:30, 3822:14, 3822:18, 3823:21, 3823:44, 3823:46, 3823:47, 3824:16, 3824:19
Care's [1] - 3727:7
career [5] - 3795:9, 3809:4, 3814:20, 3814:47, 3824:25
careers [1] - 3823:35
careful [1] - 3822:37
carefully [2] - 3822:42, 3830:2
caring [1] - 3817:23
case [22] - 3716:21, 3722:14, 3723:35, 3724:8, 3731:24, 3731:26, 3732:41, 3733:46, 3739:36, 3744:13, 3796:39, 3804:46, 3805:5, 3808:7, 3810:44, 3811:44, 3814:25, 3826:29, 3826:38, 3829:28, 3830:26
cases [10] - 3720:46, 3720:47, 3748:19, 3806:25, 3806:43, 3810:31, 3816:6, 3817:34, 3823:1
catch [2] - 3750:20, 3754:4
catch-up [2] - 3750:20, 3754:4
categories [2] - 3726:21, 3808:39
category [5] - 3766:29, 3788:40, 3799:31, 3799:34, 3808:19
caught [1] - 3795:36
causes [1] - 3740:23
causing [1] - 3741:36
caution [1] - 3724:7
ceased [1] - 3779:41
census [2] - 3726:37, 3758:5
cent [2] - 3768:28, 3824:9
central [24] - 3720:10, 3728:7, 3729:39, 3736:22, 3741:47, 3749:3, 3749:16, 3752:5, 3753:10, 3790:30, 3790:43, 3791:8, 3791:45, 3792:1, 3792:3, 3802:11, 3819:15, 3819:39, 3819:42, 3820:5, 3820:8, 3822:39, 3823:8, 3823:37
centralised [9] - 3739:19, 3827:5, 3827:15, 3827:18, 3827:22, 3827:40, 3827:43, 3828:4, 3828:14
centrally [5] - 3738:43, 3759:37, 3783:10, 3784:22, 3796:6
centre [2] - 3822:22, 3830:46
centred [1] - 3771:43
certain [13] - 3723:41, 3728:16, 3735:28, 3736:3, 3744:28, 3751:33, 3763:21, 3767:33, 3772:11, 3772:15, 3779:39, 3792:11, 3805:10
certainly [15] - 3718:15, 3718:17, 3763:37, 3774:18, 3783:8, 3803:1, 3803:24, 3803:25, 3803:29, 3804:37, 3819:42, 3820:17, 3823:36, 3827:13, 3828:35
certificate [2] - 3805:11, 3806:2
cetera [4] - 3743:35, 3779:35, 3793:18, 3831:25
chain [1] - 3749:10
challenge [9] - 3734:42, 3740:17, 3740:40, 3743:38, 3748:35, 3749:1, 3751:15, 3751:29, 3817:2
challenges [27] - 3714:16, 3714:21, 3714:24, 3714:39, 3714:42, 3714:45, 3715:11, 3715:18, 3715:40, 3715:43, 3716:2, 3716:6, 3717:10, 3717:35, 3718:10, 3720:15, 3721:5, 3721:11, 3727:36, 3745:46, 3747:26, 3755:21, 3803:27, 3803:37, 3816:20
challenging [2] - 3767:20, 3823:44
chambers [1] - 3832:3
chance [2] - 3804:5, 3819:29
change [5] - 3755:6, 3757:23, 3785:8, 3805:6, 3805:16
changed [4] - 3748:22, 3757:4, 3773:36, 3803:3
changes [8] - 3720:37, 3736:29, 3755:26, 3773:43, 3775:36, 3775:39, 3776:2, 3805:18
changing [2] - 3754:3, 3784:23
charter [1] - 3735:7
chase [1] - 3811:43
check [3] - 3752:35, 3753:47, 3815:28
checks [1] - 3810:22
CHENEY [24] - 3756:17, 3756:19, 3756:21, 3756:36, 3760:11, 3760:16, 3760:47, 3761:10, 3761:34, 3762:6, 3763:6, 3763:17, 3763:28, 3763:33, 3763:41, 3763:46, 3767:27, 3768:17, 3768:41, 3769:44, 3770:3, 3793:31, 3818:38, 3831:37
Cheney [8] - 3713:35, 3739:8, 3746:4, 3756:14, 3768:47, 3770:6, 3793:29, 3818:36
chief [2] - 3770:39, 3796:9
Children's [1] - 3812:19
children's [1] - 3812:22
Chiu [2] - 3713:35, 3739:8
choir [1] - 3803:8
chronic [1] - 3745:26
chronological [1] - 3725:38
circumstances [4] - 3734:37, 3760:40, 3760:47, 3762:12
cite [2] - 3735:6, 3758:8
cited [2] - 3752:33, 3758:4
citizen [2] - 3739:29, 3807:29
citizens [1] - 3761:25
claims [4] - 3754:9, 3754:14, 3754:36, 3755:16

clarification [1] - 3831:4
clarify [1] - 3734:30
class [1] - 3730:25
classifications [1] - 3726:23
classified [1] - 3766:27
classify [1] - 3766:31
classroom [1] - 3821:22
cleaner [3] - 3734:39, 3760:24
cleaners [3] - 3729:17, 3733:40, 3759:16
cleaning [2] - 3726:11, 3752:27
clear [12] - 3714:23, 3728:23, 3730:23, 3740:10, 3741:29, 3750:7, 3753:40, 3755:25, 3757:9, 3758:34, 3758:47, 3791:7
clearer [1] - 3754:44
clearly [6] - 3742:21, 3748:13, 3753:13, 3762:36, 3770:34, 3822:41
client [1] - 3761:1
client's [3] - 3760:44, 3769:40, 3769:47
ClinConnect [4] - 3791:18, 3792:9, 3792:12, 3792:14
clinic [5] - 3825:17, 3825:25, 3825:46, 3826:15
clinical [73] - 3718:27, 3718:36, 3718:40, 3726:8, 3748:30, 3748:38, 3748:39, 3748:44, 3749:3, 3749:6, 3749:23, 3749:26, 3750:2, 3750:10, 3750:42, 3751:18, 3751:28, 3758:37, 3760:24, 3764:27, 3764:47, 3765:17, 3765:26, 3765:29, 3765:36, 3765:41, 3765:45, 3775:18, 3789:4, 3790:29, 3791:19, 3791:32, 3796:26, 3798:3, 3798:4, 3805:6, 3805:22, 3808:35, 3812:37, 3812:40, 3812:42, 3814:33, 3814:34, 3814:44, 3816:27, 3816:39, 3816:42, 3817:3, 3817:21, 3819:15, 3819:40, 3819:42, 3819:45, 3819:46, 3820:5, 3820:9, 3820:13, 3820:32, 3820:42, 3820:44, 3821:7, 3821:15, 3822:2, 3822:39, 3823:7, 3823:8, 3823:11, 3823:37, 3824:3, 3826:12, 3826:17, 3826:32
clinician [3] - 3720:5, 3817:1, 3821:44
clinics [1] - 3826:16
close [2] - 3793:12, 3800:24
closely [4] - 3714:34, 3714:39, 3717:15, 3821:35
closer [2] - 3714:45, 3814:39
clunky [1] - 3758:42
co [2] - 3786:6, 3825:13
co-design [1] - 3786:6
co-supervisor [1] - 3825:13
coach [1] - 3782:38
coaches [1] - 3782:39
coaching [5] - 3782:1, 3782:33, 3782:38, 3782:43, 3783:7
coalface [1] - 3760:17
coding [1] - 3763:21
coherent [1] - 3758:23
cohort [3] - 3750:22, 3805:37, 3817:24
collaborate [1] - 3744:32
collaborating [1] - 3743:20
collaboration [10] - 3743:16, 3743:18, 3743:44, 3749:47, 3750:28, 3750:29, 3751:3, 3756:40, 3756:42, 3771:42
collaborative [4] - 3743:27, 3744:25, 3755:17, 3756:39
collaboratively [2] - 3733:36, 3737:39
collaboratives [1] - 3785:40
collate [3] - 3744:47, 3758:30, 3796:6
collated [1] - 3730:19
collates [1] - 3758:47
collation [2] - 3747:13, 3758:44
colleagues [2] - 3808:37, 3818:8
collect [3] - 3730:39, 3791:13, 3815:3
collected [4] - 3716:45, 3730:32, 3818:5, 3818:6
collecting [2] - 3784:20, 3815:2
college [22] - 3804:47, 3809:26, 3809:27, 3809:47, 3810:4, 3810:13, 3810:28, 3810:31, 3810:34, 3811:1, 3812:2, 3812:35, 3816:11, 3825:40, 3828:30, 3828:36, 3828:42, 3829:9, 3829:13, 3829:26, 3830:18
College [11] - 3750:9, 3804:46, 3805:3, 3805:4, 3805:5, 3805:46, 3824:41, 3825:1, 3825:10, 3825:27, 3825:29
colleges [12] - 3717:45, 3804:44, 3805:46, 3806:3, 3809:20, 3809:27, 3810:19, 3811:26, 3811:31, 3813:24, 3816:33, 3828:40
combination [4] - 3796:18, 3796:19, 3800:22, 3828:13
coming [11] - 3717:12, 3719:11, 3730:4, 3750:25, 3774:7, 3774:11, 3777:42, 3783:34, 3786:6, 3790:33, 3811:3
commence [1] - 3824:11
commencement [1] - 3796:7
commences [4] - 3754:12, 3775:11, 3790:42, 3821:6
commencing [2] - 3754:13, 3792:21
comment [8] - 3731:40, 3738:25, 3750:31, 3765:46, 3787:3, 3787:23, 3826:29, 3829:30
commenting [1] - 3731:37
comments [1] - 3785:10
commercially [3] - 3761:3, 3761:8, 3761:30
Commission [6] - 3713:7, 3714:3, 3731:3, 3735:32, 3742:16, 3750:35
COMMISSION [1] - 3832:16
Commissioner [29] - 3713:13, 3714:12, 3724:41, 3730:15, 3745:6, 3755:41, 3756:12, 3756:17, 3760:11, 3760:47, 3763:6, 3763:15, 3768:41, 3769:44, 3770:3, 3771:17, 3774:29, 3774:44, 3793:27, 3793:31, 3794:36, 3818:30, 3818:38, 3819:20, 3820:33, 3830:1, 3831:15, 3831:37, 3831:42
COMMISSIONER [106] - 3714:1, 3721:20, 3721:35, 3721:42, 3722:33, 3722:47, 3723:9, 3723:15, 3723:26, 3723:40, 3724:1, 3724:10, 3725:1, 3725:7, 3725:12, 3725:27, 3725:32, 3729:25, 3732:10, 3732:17, 3732:24, 3739:6, 3740:7, 3745:9, 3745:17, 3745:43, 3746:17, 3746:23, 3746:36, 3746:43, 3746:47, 3747:5, 3747:19, 3747:23, 3754:32, 3755:11, 3755:43, 3756:2, 3756:14, 3756:33, 3757:32, 3760:6, 3760:14, 3760:43, 3761:7, 3761:16, 3761:42, 3762:46, 3763:12, 3763:19, 3763:31, 3763:35, 3763:44, 3767:24, 3768:12, 3768:32, 3768:43, 3769:46, 3770:5, 3770:10, 3770:19, 3770:25, 3770:32, 3774:33, 3774:46, 3775:3, 3777:41, 3779:9, 3779:17, 3779:23, 3780:36, 3780:42, 3781:11, 3781:16, 3782:37, 3786:1, 3786:19, 3787:28, 3787:33, 3788:2, 3790:37, 3790:42, 3792:7, 3793:29, 3793:33, 3793:39, 3794:38, 3796:14, 3796:43, 3815:28, 3815:35, 3816:46, 3818:17, 3818:27, 3818:32, 3818:36, 3818:40, 3818:46, 3829:42, 3831:17, 3831:31, 3831:35, 3831:39, 3831:46, 3832:13
commitment [2] - 3738:10, 3748:32
committed [1] - 3719:9
committee [1] - 3825:2
committees [4] - 3736:2, 3737:14, 3755:15, 3816:41
common [6] - 3751:47, 3756:31, 3762:30, 3766:12, 3769:17, 3822:20
Commonwealth [21] - 3727:6, 3734:25, 3746:1, 3758:19, 3763:9, 3763:19, 3763:25, 3763:31, 3763:33, 3763:39, 3766:43, 3766:45, 3806:26, 3807:16, 3807:23, 3807:32, 3807:33, 3807:45, 3808:9, 3808:15, 3815:23
communicate [2] - 3759:35, 3821:4
communicating [1] - 3734:41
communities [1] - 3786:27
community [13] - 3730:24, 3731:8, 3733:14, 3733:24, 3734:28, 3735:31, 3743:30, 3785:34, 3785:44, 3785:45,

- 3786:3, 3817:2,
3823:19
Community [2] -
3785:25, 3786:2
comparable [1] -
3733:7
compare [2] -
3753:16, 3753:17
compared [5] -
3721:28, 3721:29,
3753:18, 3768:38,
3830:11
compelling [3] -
3803:16, 3803:28,
3803:29
competent [1] -
3765:19
competing [1] -
3761:1
competition [1] -
3740:42
competitive [1] -
3740:32
complaining [1] -
3737:41
complaint [1] -
3730:31
complaints [2] -
3719:39, 3720:6
complement [1] -
3751:16
complete [16] -
3732:12, 3733:23,
3743:12, 3752:34,
3759:45, 3760:23,
3765:18, 3802:4,
3802:46, 3805:30,
3806:6, 3806:47,
3812:2, 3813:31,
3816:36, 3829:19
completed [6] -
3798:3, 3807:15,
3807:19, 3807:32,
3808:44, 3816:35
completely [1] -
3751:36
completes [1] -
3825:32
completion [3] -
3805:10, 3805:11,
3806:2
complex [4] -
3722:30, 3755:25,
3798:36, 3803:36
complexities [2] -
3808:24, 3808:26
complexity [1] -
3749:1
complications [1] -
3831:25
- component** [10] -
3719:33, 3726:12,
3728:29, 3768:30,
3783:7, 3798:3,
3802:33, 3810:20,
3811:38, 3830:30
composition [3] -
3715:5, 3715:29,
3716:15
comprehensive [3] -
3728:21, 3737:22,
3742:41
comprises [1] -
3800:4
computers [1] -
3749:23
concentration [2] -
3762:20, 3765:28
concept [4] - 3750:35,
3780:23, 3795:31,
3795:38
conceptually [1] -
3778:37
concern [5] - 3726:27,
3753:4, 3753:8,
3768:8, 3768:13
concerned [8] -
3718:23, 3718:24,
3725:37, 3735:28,
3745:36, 3751:21,
3751:26, 3773:31
concerns [5] -
3719:36, 3748:43,
3752:20, 3752:23,
3755:36
concluded [1] -
3755:9
conclusion [6] -
3728:20, 3742:1,
3744:35, 3747:36,
3748:4, 3755:37
conclusions [1] -
3745:47
Concord [3] -
3722:13, 3722:44,
3723:35
condition [1] -
3822:20
conditions [15] -
3720:11, 3720:32,
3721:14, 3740:37,
3741:1, 3741:15,
3741:16, 3744:27,
3754:16, 3761:36,
3761:47, 3762:8,
3822:16, 3830:8,
3831:22
conducted [4] -
3737:18, 3744:44,
3789:22, 3827:19
- confidence** [6] -
3730:21, 3731:20,
3731:40, 3731:45,
3732:11, 3734:19
confident [1] -
3732:45
confidently [1] -
3757:39
confirm [1] - 3766:23
conflict [1] - 3817:3
conflicting [1] -
3717:40
confront [1] - 3755:21
confusion [1] -
3777:41
connected [1] -
3798:32
connection [2] -
3723:37, 3748:7
cons [2] - 3761:16,
3761:28
conscious [3] -
3730:38, 3736:47,
3739:44
consecutive [1] -
3826:37
consent [1] - 3822:28
consequence [3] -
3731:2, 3734:18,
3804:13
consider [3] -
3723:34, 3743:18,
3747:39
consideration [7] -
3715:47, 3741:46,
3778:38, 3796:34,
3802:40, 3802:47,
3803:15
considerations [2] -
3746:10, 3768:35
considered [4] -
3757:11, 3757:15,
3757:37, 3827:14
considers [2] -
3751:40, 3753:32
consistent [2] -
3745:30, 3745:47
consolidate [1] -
3805:36
consolidation [2] -
3805:20, 3806:4
constantly [3] -
3759:31, 3759:38
constraints [3] -
3749:28, 3751:34,
3767:17
constructed [1] -
3798:24
constructively [1] -
3743:47
- consult** [1] - 3719:35
consultancy [1] -
3736:39
consultant [1] -
3825:19
consultation [10] -
3736:6, 3736:37,
3737:41, 3738:7,
3738:18, 3738:42,
3790:31, 3791:46,
3792:47, 3793:6
consultations [2] -
3822:9, 3825:7
consultative [1] -
3737:14
consulted [6] -
3736:17, 3737:42,
3738:20, 3738:29,
3738:45, 3774:16
consulting [1] -
3744:43
consumers [1] -
3731:32
contain [2] - 3725:35,
3725:38
contained [1] -
3737:25
contemplate [3] -
3758:47, 3759:45,
3811:46
contemplating [2] -
3757:27, 3759:2
contemporaneous [4]
- 3728:36, 3757:12,
3757:22, 3757:37
contemporary [4] -
3720:38, 3721:31,
3721:35, 3772:9
contend [2] - 3730:8,
3765:31
content [5] - 3714:34,
3775:38, 3783:12,
3783:32, 3784:33
contents [3] -
3724:37, 3771:13,
3794:31
contest [3] - 3738:36,
3743:40, 3744:28
contestability [1] -
3742:35
contestable [1] -
3742:44
contested [3] -
3742:29, 3743:39,
3743:42
context [17] - 3715:41,
3716:46, 3717:2,
3737:4, 3756:7,
3756:38, 3756:41,
3757:21, 3767:47,
- 3773:5, 3773:6,
3775:16, 3776:33,
3791:37, 3798:16,
3811:34, 3811:41
contextualise [1] -
3722:41
contingency [1] -
3752:13
continue [8] -
3723:37, 3745:27,
3746:7, 3748:14,
3786:9, 3786:12,
3799:5, 3809:6
continues [1] -
3734:21
continuing [1] -
3804:33
continuity [2] -
3721:45, 3753:12
continuum [1] -
3803:25
contract [4] - 3802:3,
3804:26, 3804:27,
3804:28
contracted [3] -
3768:22, 3827:29,
3827:30
contracts [1] -
3805:31
contribute [5] -
3797:21, 3825:24,
3825:44, 3826:14,
3826:18
contributing [1] -
3717:34
contribution [2] -
3744:16, 3816:29
control [3] - 3746:12,
3746:14, 3810:11
controlled [1] -
3737:25
controversial [2] -
3717:38, 3717:39
convenient [2] -
3774:30, 3783:31
conversation [2] -
3750:6, 3803:26
conversations [6] -
3775:41, 3776:18,
3776:20, 3816:42,
3818:3, 3818:4
convey [2] - 3787:28,
3795:38
convince [2] -
3739:23, 3761:31
convinced [3] -
3739:21, 3739:26,
3739:41
coordinate [2] -
3778:9, 3812:11

coordinating [2] - 3746:7, 3781:12, 3783:18, 3783:19, 3830:46
coordination [6] - 3748:41, 3749:43, 3775:12, 3776:10, 3776:21, 3797:18
copy [6] - 3724:34, 3745:1, 3745:6, 3771:6, 3794:24, 3819:25
core [2] - 3717:5, 3826:33
correct [80] - 3723:32, 3724:25, 3724:28, 3724:32, 3724:38, 3726:24, 3727:42, 3730:34, 3732:39, 3747:13, 3747:17, 3747:32, 3749:29, 3749:39, 3751:3, 3756:27, 3757:2, 3757:5, 3758:1, 3758:10, 3758:13, 3758:17, 3762:1, 3762:9, 3762:24, 3763:9, 3764:20, 3765:5, 3765:14, 3768:39, 3771:14, 3794:14, 3794:18, 3794:32, 3794:43, 3795:7, 3795:11, 3795:15, 3795:44, 3796:3, 3796:37, 3797:8, 3797:26, 3797:35, 3798:12, 3799:5, 3799:10, 3799:42, 3800:26, 3800:32, 3801:24, 3801:32, 3802:17, 3802:37, 3806:34, 3807:20, 3808:6, 3810:1, 3810:7, 3811:32, 3811:39, 3812:34, 3813:7, 3813:28, 3815:9, 3815:10, 3815:20, 3817:45, 3819:13, 3819:21, 3819:22, 3819:33, 3820:14, 3822:28, 3823:27, 3824:42, 3825:38, 3826:2, 3826:19, 3826:23
correctly [5] - 3775:44, 3782:11, 3788:22, 3825:37, 3826:28
correlation [1] - 3824:24
cost [6] - 3740:35, 3746:7, 3781:12, 3783:18, 3783:19, 3830:46
costing [1] - 3729:33
costs [1] - 3783:18
council [2] - 3816:12, 3816:13
Council [1] - 3714:35
Counsel [5] - 3713:26, 3713:27, 3713:28, 3713:29, 3713:30
counsel [2] - 3832:2, 3832:3
counted [1] - 3815:10
country [5] - 3742:31, 3762:34, 3766:13, 3808:38, 3809:33
couple [2] - 3778:1, 3825:34
course [26] - 3715:31, 3740:38, 3752:25, 3757:13, 3757:18, 3771:17, 3776:13, 3776:25, 3776:34, 3776:36, 3776:41, 3777:1, 3777:2, 3777:23, 3777:24, 3777:34, 3777:36, 3780:1, 3780:6, 3782:27, 3788:23, 3794:35, 3811:28, 3812:29, 3816:44, 3823:39
courses [36] - 3764:42, 3775:44, 3776:1, 3776:13, 3776:29, 3776:46, 3777:16, 3777:17, 3777:19, 3777:21, 3777:31, 3777:43, 3777:46, 3778:1, 3779:39, 3780:1, 3780:5, 3782:26, 3783:1, 3783:5, 3784:21, 3784:24, 3785:11, 3787:38, 3787:42, 3787:45, 3787:47, 3788:7, 3788:8, 3788:9, 3788:10, 3788:12, 3788:16, 3788:17, 3788:20, 3788:21
covered [2] - 3718:16, 3764:32
COVID [1] - 3830:38
COVID-19 [2] - 3742:32, 3743:9
crack [1] - 3763:4
create [8] - 3725:23, 3731:4, 3732:6, 3785:26, 3785:33, 3786:28, 3787:15, 3816:8
creates [1] - 3728:9
creating [2] - 3775:23, 3793:15
creation [1] - 3727:31
criminal [1] - 3752:34
crisis [1] - 3743:9
criteria [1] - 3790:12
criterion [1] - 3777:4
Critical [2] - 3742:6, 3753:17
critical [7] - 3717:9, 3726:46, 3743:25, 3745:10, 3745:45, 3768:33, 3818:22
critically [1] - 3742:8
criticises [1] - 3750:27
crop [1] - 3738:46
cross [4] - 3741:24, 3776:28, 3788:15, 3801:16
cross-purposes [2] - 3776:28, 3788:15
crunch [3] - 3740:12, 3740:15, 3740:23
CSP [1] - 3808:14
culling [1] - 3827:39
cultural [4] - 3735:33, 3735:34, 3744:6, 3805:27
culture [5] - 3744:7, 3744:23, 3785:26, 3786:10, 3786:28
cultures [3] - 3785:35, 3785:37, 3785:38
current [31] - 3715:5, 3715:8, 3715:10, 3715:13, 3715:33, 3716:15, 3726:47, 3734:45, 3736:41, 3740:12, 3742:35, 3743:18, 3748:15, 3749:46, 3751:15, 3753:36, 3753:41, 3753:43, 3754:27, 3754:29, 3754:37, 3754:45, 3755:19, 3757:37, 3783:8, 3783:16, 3793:6, 3804:36, 3813:34, 3816:26, 3829:20
curriculum [5] - 3765:3, 3819:44, 3820:4, 3822:41, 3822:42
cut [1] - 3811:43
CV [1] - 3824:16
cycle [1] - 3826:27

D

daily [3] - 3736:29, 3757:28, 3757:30
Daniel [1] - 3713:30
data [113] - 3715:35, 3716:44, 3726:28, 3726:31, 3726:34, 3726:36, 3726:37, 3726:38, 3726:41, 3726:46, 3727:4, 3727:7, 3727:8, 3727:10, 3727:12, 3727:13, 3727:22, 3727:25, 3727:30, 3727:33, 3727:37, 3727:47, 3728:7, 3728:9, 3728:16, 3728:21, 3728:22, 3728:31, 3728:36, 3729:1, 3729:13, 3729:41, 3730:7, 3730:13, 3730:23, 3730:31, 3730:32, 3730:38, 3730:40, 3731:5, 3731:26, 3731:27, 3733:9, 3733:15, 3734:7, 3734:11, 3734:14, 3734:23, 3735:3, 3735:4, 3735:8, 3735:9, 3735:19, 3735:35, 3736:12, 3736:14, 3737:33, 3738:9, 3739:14, 3739:17, 3739:22, 3739:46, 3740:4, 3742:26, 3742:27, 3742:39, 3742:40, 3742:47, 3743:6, 3743:12, 3743:28, 3743:31, 3743:32, 3752:5, 3757:10, 3757:12, 3757:15, 3757:16, 3757:18, 3757:19, 3757:22, 3757:25, 3757:27, 3757:38, 3757:46, 3758:4, 3758:9, 3758:12, 3758:16, 3758:23, 3758:29, 3758:33, 3758:34, 3758:38, 3758:41, 3759:5, 3759:6, 3759:22, 3759:23, 3760:8, 3760:31, 3760:35, 3760:37, 3760:41, 3761:2, 3787:17, 3790:4
data [1] - 3757:9
data-capturing [1] - 3728:22
database [1] - 3729:40
Dataset [1] - 3758:6
dataset [4] - 3726:35, 3727:16, 3733:30, 3757:13
datasets [9] - 3728:38, 3729:22, 3735:12, 3735:36, 3742:24, 3742:25, 3758:30, 3760:23
date [11] - 3716:29, 3717:23, 3747:1, 3747:3, 3755:27, 3755:32, 3755:44, 3755:45, 3775:33, 3776:2, 3829:25
dated [4] - 3724:31, 3771:3, 3794:20, 3819:21
dates [3] - 3723:42, 3756:6, 3825:40
Dawson [1] - 3725:7
day-to-day [2] - 3816:38, 3825:11
days [3] - 3721:37, 3777:27, 3826:10
deal [3] - 3718:30, 3740:4, 3804:4
dealing [5] - 3718:15, 3720:5, 3773:46, 3777:17, 3797:31
dealings [3] - 3741:5, 3756:29, 3769:12
deals [3] - 3714:14, 3738:44, 3761:46
dealt [1] - 3774:3
Deans [1] - 3750:9
debate [4] - 3731:7, 3731:18, 3734:35, 3763:37
debated [3] - 3735:36, 3737:9, 3754:9
debriefing [1] - 3775:25
decade [1] - 3720:27
decided [3] - 3789:32, 3798:9, 3809:24
decides [3] - 3788:42, 3789:11, 3828:12
deciding [1] - 3809:23
decision [19] - 3717:43, 3729:22, 3733:27, 3733:32, 3734:38, 3736:28, 3737:10, 3743:11, 3789:28, 3790:5, 3790:10, 3790:15, 3790:16, 3790:21,

3790:23, 3803:12,
3810:9, 3816:7,
3821:1
decision-makers [3] -
3729:22, 3733:27,
3733:32
decision-making [4] -
3736:28, 3737:10,
3743:11, 3810:9
decisions [19] -
3727:34, 3728:11,
3728:17, 3728:37,
3733:19, 3736:35,
3737:5, 3737:38,
3738:19, 3742:46,
3743:41, 3747:17,
3810:12, 3810:16,
3810:18, 3815:37,
3815:39, 3815:46,
3821:3
dedicated [1] -
3745:23
deemed [1] - 3765:19
deeply [1] - 3753:39
default [2] - 3798:41,
3799:3
defeated [1] - 3722:30
definitely [3] -
3723:29, 3725:12,
3741:43
degree [20] - 3718:17,
3735:28, 3741:7,
3744:28, 3751:33,
3797:16, 3807:16,
3807:17, 3807:24,
3807:32, 3807:42,
3808:11, 3808:12,
3820:10, 3820:18,
3820:39, 3820:40,
3822:43, 3823:39,
3831:24
delegate [1] - 3729:15
delegated [1] -
3795:26
delegation [1] -
3811:27
deliberately [1] -
3758:33
deliver [14] - 3714:2,
3714:28, 3714:29,
3718:3, 3749:35,
3772:44, 3777:19,
3777:21, 3777:31,
3777:43, 3777:45,
3778:1, 3783:9,
3787:46
delivered [24] -
3720:37, 3751:10,
3772:1, 3774:1,
3776:1, 3776:8,
3776:29, 3776:41,
3777:18, 3777:38,
3779:39, 3780:1,
3782:42, 3782:43,
3784:24, 3785:11,
3787:42, 3788:17,
3812:31, 3812:32,
3813:18, 3821:15,
3821:21
delivering [16] -
3735:4, 3737:11,
3746:7, 3768:1,
3774:14, 3775:44,
3776:34, 3776:42,
3777:23, 3779:47,
3783:24, 3787:38,
3788:22, 3788:23,
3788:25, 3794:46
delivers [2] - 3810:35,
3815:18
delivery [18] -
3716:22, 3718:26,
3721:32, 3722:17,
3732:36, 3736:28,
3757:1, 3769:30,
3769:39, 3771:27,
3773:7, 3777:36,
3779:38, 3795:1,
3819:43, 3820:6,
3822:14, 3829:37
delve [1] - 3765:43
demand [18] -
3726:30, 3734:21,
3740:40, 3748:10,
3748:11, 3748:35,
3749:19, 3751:17,
3751:21, 3752:15,
3752:17, 3765:35,
3796:15, 3808:32,
3816:26, 3817:3,
3829:47, 3831:18
demands [3] -
3751:15, 3816:43,
3824:19
demonstrated [2] -
3751:19, 3753:13
demonstration [1] -
3754:1
department [39] -
3730:9, 3737:6,
3737:9, 3737:10,
3737:15, 3737:27,
3747:40, 3752:8,
3752:13, 3759:11,
3796:41, 3796:45,
3797:5, 3810:39,
3814:11, 3817:31,
3819:11, 3824:31,
3824:35, 3824:46,
3825:12, 3825:24,
3825:44, 3826:4,
3826:8, 3826:23,
3826:37, 3827:12,
3827:37, 3828:16,
3828:25, 3828:45,
3829:6, 3829:19,
3829:28, 3829:35,
3830:24, 3830:31
Department [1] -
3727:6
departments [7] -
3737:46, 3738:47,
3751:47, 3752:46,
3812:17, 3814:33,
3827:32
dependence [1] -
3753:5
dependency [1] -
3768:20
deployed [1] -
3815:39
deprioritising [1] -
3751:33
depth [2] - 3826:32,
3826:34
deputy [1] - 3794:13
derived [3] - 3727:14,
3778:46, 3778:47
descend [2] -
3725:19, 3813:38
describe [7] - 3757:8,
3811:11, 3819:39,
3821:14, 3821:22,
3824:30, 3824:44
described [14] -
3716:14, 3716:32,
3720:42, 3733:29,
3748:41, 3780:28,
3789:44, 3799:10,
3813:1, 3813:7,
3814:7, 3821:16,
3823:25, 3826:15
describes [3] -
3766:29, 3799:27,
3825:3
description [2] -
3751:14, 3781:30
design [8] - 3728:7,
3728:8, 3730:26,
3736:21, 3773:32,
3785:26, 3786:6,
3786:28
designation [1] -
3822:10
designed [2] - 3800:7,
3822:43
designing [1] -
3783:24
desirability [4] -
3802:41, 3803:9,
3803:16, 3803:27
desire [6] - 3756:39,
3798:33, 3803:2,
3808:46, 3809:10,
3814:31
desk [1] - 3784:31
desks [1] - 3749:22
despite [2] - 3722:29,
3723:36
detail [5] - 3719:43,
3725:21, 3765:22,
3780:28, 3792:31
detailed [1] - 3781:27
determinants [3] -
3786:34, 3786:41,
3787:8
determination [2] -
3768:25, 3829:5
determine [7] -
3773:10, 3791:20,
3795:44, 3796:2,
3820:43, 3821:32,
3830:25
determined [4] -
3719:45, 3792:12,
3802:22, 3827:23
determines [1] -
3796:20
determining [2] -
3791:42, 3797:13
Develop [1] - 3780:46
develop [7] - 3771:42,
3772:34, 3774:9,
3776:36, 3779:35,
3780:30, 3816:18
developed [10] -
3722:5, 3773:37,
3774:24, 3775:21,
3780:5, 3783:23,
3788:8, 3788:13,
3788:16, 3793:3
developing [1] -
3782:18
development [18] -
3715:25, 3750:19,
3754:1, 3771:27,
3771:35, 3771:36,
3772:34, 3772:35,
3773:27, 3785:46,
3786:9, 3786:13,
3789:8, 3793:1,
3793:11, 3803:3,
3818:23, 3820:4
developments [1] -
3776:2
devolved [2] - 3737:4,
3737:47
diabetes [4] -
3822:20, 3822:21,
3831:3, 3831:23
diagnoses [1] -
3821:32
diagnostic [1] -
3745:40
dial [1] - 3783:11
dice [1] - 3803:46
dictating [1] - 3764:45
differ [2] - 3720:7,
3734:37
difference [1] -
3814:18
different [64] -
3716:34, 3720:19,
3721:14, 3721:15,
3722:2, 3726:20,
3727:31, 3728:3,
3732:31, 3735:37,
3738:46, 3738:47,
3740:46, 3741:1,
3741:14, 3741:15,
3741:39, 3754:11,
3756:38, 3756:41,
3757:20, 3759:6,
3759:8, 3764:26,
3764:27, 3764:32,
3777:46, 3779:29,
3783:14, 3785:42,
3789:3, 3789:40,
3796:5, 3804:9,
3809:12, 3809:19,
3809:20, 3809:27,
3809:28, 3810:15,
3810:17, 3810:18,
3810:28, 3810:29,
3811:14, 3811:36,
3812:3, 3812:4,
3812:43, 3813:6,
3813:12, 3813:26,
3813:43, 3814:9,
3820:19, 3820:44,
3821:36, 3826:31,
3826:38, 3828:10,
3828:27
differentiated [1] -
3716:19
differently [3] -
3721:14, 3722:2,
3811:24
difficult [10] - 3719:42,
3729:32, 3734:2,
3744:7, 3757:30,
3760:6, 3764:31,
3805:44, 3806:9,
3823:47
digestible [1] -
3715:37
digital [2] - 3772:11,
3788:8
dilemma [1] - 3768:17
dimensions [1] -

- 3744:7
diminish [1] - 3738:3
dint [1] - 3732:26
direct [21] - 3716:8, 3730:8, 3736:2, 3750:5, 3750:6, 3759:32, 3776:23, 3796:26, 3797:41, 3799:13, 3804:36, 3806:13, 3812:39, 3814:34, 3816:21, 3816:25, 3817:4, 3817:6, 3817:9, 3817:18, 3830:1
directed [4] - 3758:37, 3767:40, 3768:8, 3829:13
directly [13] - 3735:30, 3736:17, 3744:38, 3749:10, 3787:26, 3787:29, 3799:32, 3806:26, 3807:8, 3820:17, 3824:24, 3828:41, 3828:44
director [4] - 3715:24, 3794:6, 3794:13, 3818:6
disciplinary [2] - 3719:44, 3719:47
discipline [5] - 3716:20, 3741:6, 3749:27, 3749:38, 3760:18
disciplines [4] - 3718:43, 3747:30, 3805:22, 3826:43
discover [1] - 3717:32
discuss [2] - 3827:31, 3832:5
discussed [3] - 3737:9, 3738:5, 3759:4
discussing [3] - 3729:38, 3739:28, 3751:38
discussion [6] - 3716:5, 3731:7, 3741:43, 3742:2, 3749:6, 3801:20
discussions [4] - 3718:34, 3730:9, 3749:44, 3818:22
disease [1] - 3745:26
disincentivise [1] - 3805:41
disinterested [3] - 3731:6, 3734:15, 3758:35
disparity [2] - 3741:34, 3741:36
disputation [2] - 3722:8, 3729:20
dispute [3] - 3741:13, 3742:3, 3746:6
disruption [1] - 3722:37
dissatisfaction [1] - 3722:7
dissimilar [1] - 3798:20
distil [1] - 3766:10
distilling [2] - 3727:29, 3730:37
distinct [2] - 3764:38, 3765:23
distinguish [1] - 3826:47
distributed [1] - 3797:12
distribution [4] - 3716:18, 3763:8, 3764:14, 3820:44
district [2] - 3816:7, 3831:9
districts [4] - 3748:42, 3749:43, 3791:30, 3793:10
dive [1] - 3719:43
diversity [1] - 3726:15
divide [1] - 3716:35
division [2] - 3724:13, 3724:22
Doctor [2] - 3725:41, 3768:19
doctor [16] - 3796:30, 3796:45, 3809:7, 3815:7, 3817:5, 3817:8, 3817:17, 3817:32, 3817:39, 3817:42, 3817:47, 3818:41, 3827:11, 3827:13, 3827:47, 3830:40
doctor's [1] - 3818:23
doctor-less [1] - 3796:45
doctors [31] - 3732:25, 3793:18, 3794:47, 3795:10, 3796:27, 3796:46, 3797:2, 3797:6, 3804:12, 3805:37, 3814:22, 3814:45, 3816:21, 3816:28, 3816:40, 3817:4, 3817:7, 3817:10, 3817:13, 3817:19, 3817:20, 3817:22, 3818:2, 3821:18, 3822:22, 3822:25, 3824:2, 3824:11, 3825:6, 3830:10
document [12] - 3728:26, 3736:5, 3736:6, 3745:1, 3746:41, 3747:12, 3780:11, 3780:12, 3781:20, 3782:11, 3783:42, 3786:4
document) [1] - 3792:29
documented [1] - 3816:27
documents [5] - 3725:22, 3725:23, 3725:38, 3769:41, 3792:11
domain [2] - 3734:12, 3771:33
domestic [2] - 3740:33, 3740:42
domiciled [2] - 3741:46, 3753:11
done [23] - 3718:13, 3719:23, 3719:24, 3726:37, 3727:20, 3736:38, 3739:1, 3742:7, 3742:8, 3759:3, 3782:16, 3783:23, 3785:29, 3786:16, 3786:27, 3787:6, 3787:22, 3796:12, 3802:19, 3812:7, 3814:3, 3815:29, 3827:31
door [1] - 3733:46
double [1] - 3753:47
double-check [1] - 3753:47
doubt [9] - 3729:44, 3738:45, 3749:26, 3761:28, 3769:46, 3808:24, 3815:7, 3815:29, 3815:45
down [18] - 3726:26, 3727:29, 3730:37, 3730:42, 3733:37, 3741:19, 3748:37, 3753:30, 3764:37, 3772:21, 3772:25, 3778:7, 3778:25, 3779:26, 3786:32, 3787:12, 3790:47, 3800:17
Dr [19] - 3713:28, 3724:13, 3724:21, 3739:7, 3739:20, 3740:9, 3742:17, 3742:30, 3745:37, 3745:41, 3746:25, 3746:26, 3747:25, 3761:34, 3763:46, 3770:10, 3779:1, 3793:45, 3794:5
drafting [2] - 3779:9, 3779:23
dramatic [1] - 3831:47
draw [1] - 3755:38
drawn [3] - 3722:21, 3751:36, 3751:44
drifting [1] - 3724:8
drive [1] - 3741:24
driven [1] - 3721:22
driving [1] - 3719:28
dual [2] - 3827:28, 3830:41
Dubbo [8] - 3801:7, 3801:28, 3802:21, 3802:36, 3803:47, 3804:1, 3812:23, 3830:42
due [3] - 3715:31, 3771:17, 3794:35
duplicate [1] - 3774:23
duplicated [1] - 3793:20
duplicative [1] - 3793:2
duration [1] - 3802:5
during [17] - 3714:18, 3714:44, 3716:13, 3717:6, 3718:20, 3718:28, 3722:41, 3725:21, 3741:12, 3795:10, 3795:14, 3804:39, 3804:41, 3805:42, 3821:10, 3823:15, 3825:30
Dustin [1] - 3724:13
DUSTIN [1] - 3724:17
duties [2] - 3737:28, 3752:9
dynamic [2] - 3736:29, 3815:45
dynamism [1] - 3754:1
-
- E**
-
- early** [3] - 3757:44, 3795:9, 3824:24
earn [1] - 3740:47
easily [4] - 3741:45, 3752:17, 3758:43, 3825:41
easy [3] - 3738:35, 3755:23, 3800:42
economic [1] - 3714:29
economically [1] - 3746:15
Economics [1] - 3745:12
economist [1] - 3742:31
economists [1] - 3731:36
economy [1] - 3740:36
ecosystem [1] - 3743:43
ED [1] - 3734:13
Ed [1] - 3713:26
education [54] - 3748:42, 3749:2, 3750:6, 3751:4, 3753:47, 3765:1, 3765:3, 3765:5, 3771:27, 3771:34, 3771:35, 3771:36, 3771:39, 3771:47, 3772:5, 3772:9, 3772:16, 3772:29, 3772:32, 3772:33, 3772:36, 3772:37, 3773:7, 3773:9, 3773:12, 3773:21, 3773:32, 3774:9, 3774:15, 3774:19, 3774:20, 3774:21, 3775:32, 3776:7, 3778:10, 3778:26, 3778:34, 3779:6, 3779:27, 3779:30, 3779:36, 3786:7, 3786:39, 3787:7, 3793:8, 3794:46, 3803:25, 3813:18, 3813:20, 3819:44, 3820:23, 3821:14, 3821:21, 3822:39
Education [1] - 3770:40
educational [10] - 3749:43, 3749:45, 3750:28, 3773:30, 3774:17, 3791:2, 3791:24, 3803:26, 3820:6, 3820:24
educationalists [1] - 3820:22
educators [4] - 3749:4, 3820:26, 3822:23, 3822:26
effect [2] - 3714:24, 3722:9
effective [1] - 3754:8
effectively [3] - 3731:33, 3759:23,

3811:46
efficacy [2] - 3717:2, 3765:30
efficient [6] - 3733:22, 3756:47, 3769:3, 3769:30, 3769:39, 3783:30
effort [2] - 3719:9, 3805:40
efforts [2] - 3722:29, 3723:36
egg [1] - 3741:42
eHealth [2] - 3799:7, 3800:6
eight [2] - 3721:40, 3823:16
eight-week [1] - 3823:16
either [15] - 3729:27, 3736:30, 3738:7, 3739:20, 3741:33, 3749:45, 3755:4, 3757:33, 3757:35, 3784:15, 3785:18, 3796:25, 3807:32, 3807:45, 3808:3
elaborate [1] - 3715:41
Elders [1] - 3714:7
elect [1] - 3740:37
elective [1] - 3823:15
electives [1] - 3821:10
element [1] - 3830:30
elements [11] - 3720:19, 3734:23, 3744:24, 3744:32, 3753:22, 3754:22, 3754:25, 3759:9, 3809:38, 3812:1
eligible [3] - 3789:1, 3798:12, 3799:31
elsewhere [5] - 3723:24, 3776:3, 3793:21, 3804:28, 3821:1
embark [1] - 3714:14
embarked [1] - 3754:11
embed [1] - 3780:30
Embed [1] - 3780:46
embedded [1] - 3781:40
emblematic [1] - 3736:16
emerge [3] - 3727:26, 3743:1, 3744:41
emerged [3] - 3729:12, 3752:2, 3831:31
emergence [1] - 3720:42
emergency [7] - 3796:41, 3796:45, 3797:5, 3806:44, 3811:23, 3817:30
emerging [5] - 3714:8, 3714:23, 3740:45, 3750:23, 3774:26
emphasis [1] - 3805:27
emphasise [2] - 3745:35
employ [1] - 3815:17
employed [11] - 3724:21, 3728:9, 3753:45, 3753:46, 3812:33, 3812:45, 3814:10, 3815:38, 3815:44, 3821:45, 3822:3
employee [3] - 3735:24, 3743:46, 3804:3
employees [4] - 3716:19, 3781:47, 3782:40, 3787:38
employer [6] - 3744:29, 3759:11, 3764:8, 3795:27, 3795:32, 3795:37
employers [2] - 3744:1, 3795:34
employment [5] - 3720:32, 3761:46, 3798:20, 3810:22, 3810:46
employs [1] - 3810:39
en [1] - 3738:4
enable [7] - 3723:33, 3737:2, 3746:14, 3812:35, 3820:26, 3822:13, 3830:9
enabling [1] - 3723:17
encompass [2] - 3726:4, 3768:28
encounter [1] - 3750:13
encourage [7] - 3774:22, 3785:34, 3785:38, 3786:8, 3786:12, 3786:16, 3823:36
encouraged [3] - 3785:38, 3823:34, 3826:39
end [22] - 3722:12, 3722:45, 3735:17, 3746:34, 3751:1, 3751:12, 3763:14, 3781:3, 3787:2, 3804:12, 3804:32, 3804:33, 3805:34, 3806:28, 3808:21, 3808:41, 3809:13, 3815:4, 3816:37, 3821:8, 3822:19, 3824:34
end-of-term [1] - 3816:37
endeavour [2] - 3716:21, 3724:5
endeavours [1] - 3814:47
endemic [1] - 3714:24
endocrinologist [2] - 3822:20, 3828:1
endocrinologists [3] - 3825:23, 3825:44, 3831:20
endocrinology [13] - 3819:11, 3824:36, 3825:12, 3825:18, 3826:42, 3827:6, 3827:15, 3828:35, 3829:29, 3829:38, 3830:11, 3830:27, 3830:42
ends [1] - 3820:47
engage [11] - 3727:24, 3733:42, 3743:11, 3743:31, 3752:39, 3755:28, 3759:38, 3767:46, 3771:39, 3773:21, 3783:13
engaged [13] - 3728:8, 3731:36, 3735:30, 3735:38, 3736:16, 3737:19, 3737:32, 3752:14, 3754:17, 3755:16, 3767:46, 3768:25, 3777:26
engagement [3] - 3715:9, 3729:19, 3749:45
engages [1] - 3739:3
engaging [1] - 3777:30
England [2] - 3801:12, 3801:14
enjoying [1] - 3721:14
enormously [1] - 3717:38
ensure [23] - 3733:43, 3734:45, 3735:19, 3751:23, 3752:40, 3754:15, 3754:28, 3754:46, 3755:1, 3755:18, 3767:45, 3771:41, 3772:38, 3778:32, 3778:33, 3782:20, 3800:23, 3806:7, 3813:15, 3813:19, 3822:34, 3822:40, 3828:39
ensuring [10] - 3767:40, 3776:1, 3776:24, 3776:47, 3779:19, 3784:12, 3785:4, 3790:12, 3792:11, 3802:28
enter [3] - 3750:38, 3764:19, 3806:8
entered [1] - 3798:31
entering [2] - 3790:5, 3806:5
enters [1] - 3809:8
entire [4] - 3727:2, 3818:12, 3822:43, 3823:10
entirely [1] - 3791:7
entities [6] - 3718:22, 3733:31, 3749:47, 3750:1, 3777:9, 3797:20
entitled [1] - 3735:44
entrustable [1] - 3805:25
entry [5] - 3804:45, 3805:37, 3806:2, 3809:28, 3814:40
environment [5] - 3720:38, 3783:8, 3783:16, 3816:39, 3820:25
environments [3] - 3775:24, 3775:30, 3824:21
Eora [1] - 3714:5
ePortfolio [1] - 3805:26
equation [2] - 3829:13, 3830:19
equitable [2] - 3730:26, 3736:21
equity [2] - 3827:38, 3828:39
era [1] - 3751:31
erode [2] - 3731:45, 3732:11
erosion [1] - 3734:19
escalation [1] - 3752:14
especially [1] - 3719:5
essence [2] - 3715:16, 3720:22
essential [1] - 3830:2
essentially [9] - 3715:34, 3720:43, 3723:21, 3754:12, 3777:17, 3794:45, 3797:21, 3798:47, 3799:10
establish [7] - 3715:16, 3772:29, 3772:45, 3773:1, 3785:25, 3786:19, 3786:27
established [6] - 3733:15, 3734:18, 3762:33, 3767:24, 3786:22, 3811:17
establishment [2] - 3734:10, 3772:31
estimation [1] - 3749:10
et [4] - 3743:35, 3779:35, 3793:18, 3831:25
evaluate [1] - 3778:10
evaluated [1] - 3743:29
events [3] - 3722:13, 3772:11, 3772:12
eventually [1] - 3739:16
evidence [24] - 3714:18, 3716:28, 3717:12, 3717:22, 3717:32, 3718:19, 3719:26, 3719:32, 3720:16, 3722:41, 3723:23, 3723:35, 3723:36, 3725:20, 3729:27, 3739:9, 3756:22, 3763:41, 3764:31, 3771:10, 3773:36, 3794:28, 3813:30, 3819:30
evidence-based [1] - 3773:36
evidentiary [1] - 3716:9
evolving [1] - 3754:2
exact [3] - 3729:8, 3745:29, 3808:34
exactly [5] - 3722:26, 3736:34, 3761:44, 3763:44, 3801:38
examination [2] - 3720:35, 3821:40
examine [3] - 3715:1, 3716:18, 3721:3
example [74] - 3718:47, 3722:22, 3726:6, 3726:9, 3727:14, 3729:2, 3729:4, 3729:17, 3731:43, 3732:38, 3732:39, 3737:7, 3739:18, 3741:21,

- 3744:40, 3745:26,
3745:38, 3746:37,
3748:25, 3749:22,
3752:41, 3753:40,
3757:12, 3757:28,
3759:14, 3759:15,
3759:16, 3759:21,
3761:10, 3761:18,
3762:21, 3774:1,
3782:38, 3785:40,
3788:47, 3789:13,
3796:41, 3798:5,
3800:12, 3800:41,
3800:42, 3801:6,
3801:12, 3801:27,
3802:10, 3802:13,
3803:43, 3805:47,
3807:4, 3807:6,
3807:41, 3811:37,
3812:7, 3812:16,
3812:24, 3813:30,
3814:32, 3815:47,
3817:29, 3817:37,
3818:9, 3820:13,
3821:26, 3822:2,
3822:3, 3822:19,
3826:36, 3829:18,
3830:38, 3831:23
- examples** [8] - 3737:8,
3744:3, 3753:34,
3768:21, 3789:16,
3810:25, 3822:12,
3823:24
- excellent** [2] -
3746:21, 3753:21
- except** [1] - 3823:28
- excess** [1] - 3725:43
- excused** [4] - 3770:11,
3793:39, 3818:42,
3831:40
- executive** [6] -
3733:42, 3736:20,
3770:39, 3796:9,
3830:44, 3831:10
- executives** [2] -
3733:2, 3743:10
- exercise** [6] - 3715:41,
3716:8, 3755:9,
3760:36, 3776:21,
3784:46
- exercises** [1] -
3773:47
- exhausted** [1] -
3808:39
- exhibit** [2] - 3714:36,
3780:10
- exist** [10] - 3714:39,
3727:30, 3743:13,
3744:20, 3748:14,
3748:45, 3749:15,
3759:6, 3759:7,
3779:41
- existing** [18] -
3715:29, 3717:2,
3720:12, 3727:32,
3728:38, 3734:42,
3735:12, 3735:18,
3736:26, 3743:28,
3748:45, 3752:30,
3752:40, 3754:10,
3759:47, 3765:28,
3784:14
- exists** [5] - 3730:15,
3737:13, 3759:5,
3763:38, 3815:16
- exists"** [1] - 3728:31
- exodus** [1] - 3805:42
- expand** [4] - 3727:22,
3749:14, 3829:15,
3830:7
- expansion** [2] -
3734:43, 3758:29
- expansive** [1] -
3764:34
- expect** [6] - 3720:25,
3720:31, 3729:6,
3806:1, 3806:5,
3810:23
- expectation** [2] -
3723:43, 3804:5
- expectations** [2] -
3761:13, 3767:44
- expected** [1] - 3805:11
- expedite** [1] - 3755:35
- expedited** [2] -
3733:44, 3752:42
- expeditious** [1] -
3752:45
- expenditure** [2] -
3745:23, 3745:27
- experience** [17] -
3743:6, 3751:19,
3752:17, 3777:20,
3777:29, 3791:29,
3812:9, 3814:44,
3814:46, 3815:3,
3815:6, 3815:10,
3819:38, 3824:1,
3824:4, 3824:13,
3827:24
- experiences** [6] -
3803:34, 3804:7,
3804:9, 3812:37,
3821:23, 3822:35
- experiencing** [1] -
3747:39
- expertise** [10] -
3735:27, 3739:4,
3760:32, 3773:3,
3773:33, 3783:30,
3786:7, 3789:46,
3790:1
- experts** [6] - 3730:25,
3758:25, 3759:10,
3771:40, 3771:42,
3793:11
- explain** [5] - 3753:8,
3775:16, 3800:38,
3817:13, 3817:35
- explaining** [2] -
3715:42, 3818:8
- explanation** [1] -
3730:6
- explore** [5] - 3716:13,
3718:39, 3719:11,
3721:24, 3732:40
- explored** [1] - 3722:40
- exponential** [2] -
3748:11, 3751:17
- expose** [1] - 3803:18
- exposed** [2] -
3802:30, 3822:35
- exposing** [2] -
3802:41, 3803:9
- exposure** [1] -
3802:29
- express** [3] - 3735:45,
3743:15, 3753:4
- expressed** [9] -
3738:6, 3747:36,
3747:38, 3748:4,
3797:38, 3798:33,
3802:42, 3803:10,
3803:14
- extend** [1] - 3727:40
- extending** [1] - 3741:9
- extends** [1] - 3741:7
- extensive** [4] - 3726:2,
3727:25, 3738:8,
3826:32
- extensively** [2] -
3714:17, 3718:16
- extent** [14] - 3716:45,
3718:39, 3721:30,
3722:36, 3724:4,
3742:41, 3749:24,
3766:23, 3766:24,
3775:43, 3779:4,
3803:8, 3805:42
- extents** [1] - 3747:44
- external** [2] - 3736:39,
3753:14
- externally** [2] -
3778:46, 3778:47
- extra** [2] - 3741:24,
3830:23
- extrapolation** [1] -
3742:25
- eyes** [4] - 3781:14,
3805:15, 3805:19,
3811:12
-
- ## F
-
- face** [10] - 3783:6,
3783:11, 3787:43,
3787:45, 3788:11
- face-to-face** [5] -
3783:6, 3783:11,
3787:43, 3787:45,
3788:11
- facilitate** [1] - 3812:36
- facilities** [11] - 3722:3,
3759:28, 3799:22,
3799:33, 3800:4,
3802:9, 3812:10,
3812:11, 3812:33,
3812:40, 3827:43
- facility** [19] - 3717:44,
3721:8, 3733:35,
3734:36, 3737:5,
3759:33, 3759:47,
3801:7, 3802:47,
3804:10, 3812:44,
3812:45, 3814:26,
3816:7, 3822:26,
3822:34, 3824:18,
3828:21, 3829:14
- fact** [14] - 3721:21,
3721:36, 3732:22,
3732:33, 3762:41,
3763:1, 3763:26,
3763:41, 3784:35,
3786:3, 3803:2,
3803:5, 3805:8,
3812:8
- factor** [2] - 3718:42,
3741:4
- factors** [2] - 3718:1,
3741:2
- facts** [1] - 3739:14
- failed** [1] - 3720:36
- fair** [6] - 3737:45,
3738:2, 3744:26,
3767:41, 3767:43
- fairly** [4] - 3714:34,
3714:38, 3717:7,
3722:30
- fairness** [1] - 3827:38
- fall** [3] - 3763:39,
3798:47, 3803:46
- falling** [1] - 3763:33
- falls** [2] - 3762:43,
3763:2
- familiar** [6] - 3780:23,
3781:2, 3792:34,
3824:19, 3827:1,
3829:5
- Far** [1] - 3824:17
- far** [5] - 3717:41,
3720:3, 3725:36,
3787:22, 3803:15
- fashion** [1] - 3729:7
- fashioned** [1] -
3830:33
- fast** [1] - 3746:33
- feature** [5] - 3717:16,
3717:22, 3725:12,
3730:31, 3762:30
- features** [1] - 3820:30
- February** [2] - 3825:32
- fed** [1] - 3736:34
- federal** [4] - 3742:32,
3751:26, 3762:43,
3763:3
- fee** [4] - 3807:46,
3808:1, 3808:14,
3808:17
- feed** [5] - 3736:3,
3738:10, 3759:37,
3761:13, 3819:47
- feedback** [19] -
3731:19, 3735:29,
3735:40, 3737:17,
3738:33, 3741:23,
3741:29, 3741:33,
3741:35, 3744:34,
3744:38, 3750:4,
3750:6, 3750:8,
3767:31, 3803:30,
3805:23, 3818:5,
3818:8
- feeder** [2] - 3791:28,
3791:29
- fellow** [2] - 3812:2,
3815:4
- fellows** [1] - 3717:46
- fellowship** [5] -
3811:32, 3812:38,
3813:27, 3813:44,
3814:38
- felt** [2] - 3734:4,
3742:2
- few** [7] - 3715:1,
3716:14, 3716:26,
3725:21, 3733:13,
3741:2, 3808:43
- fewer** [1] - 3732:35
- field** [3] - 3731:35,
3740:39, 3811:30
- fields** [1] - 3771:41
- fifteen** [1] - 3800:19
- fifty** [1] - 3790:35
- figures** [4] - 3742:18,
3742:33, 3742:34,
3745:29
- fill** [13] - 3730:41,
3731:45, 3732:7,
3732:11, 3733:34,
3740:19, 3752:26,

- 3752:30, 3752:36,
3752:46, 3767:33,
3768:4, 3797:7
filled [5] - 3733:41,
3733:43, 3734:32,
3734:40, 3752:1
filling [1] - 3767:29
fills [1] - 3821:44
final [11] - 3725:12,
3753:30, 3795:6,
3797:25, 3797:26,
3797:46, 3798:36,
3799:19, 3799:28,
3800:8, 3802:2
final-year [2] -
3797:46, 3798:36
finally [3] - 3715:10,
3768:19, 3805:26
financial [1] - 3757:17
financially [2] -
3766:7, 3766:8
findings [1] - 3745:21
fine [3] - 3722:33,
3746:36, 3788:5
finish [5] - 3723:27,
3723:43, 3723:46,
3724:1, 3747:10
finished [1] - 3809:22
finite [1] - 3751:34
First [1] - 3797:34
first [36] - 3714:14,
3714:16, 3716:13,
3717:19, 3718:28,
3721:13, 3722:1,
3723:16, 3724:12,
3725:37, 3726:31,
3728:8, 3739:8,
3740:11, 3747:37,
3749:41, 3756:21,
3756:23, 3780:29,
3781:3, 3781:4,
3781:45, 3784:6,
3785:31, 3787:37,
3795:5, 3795:24,
3799:39, 3800:46,
3802:4, 3802:45,
3803:33, 3803:38,
3805:34, 3807:36,
3809:38
firstly [2] - 3728:22,
3829:9
fit [6] - 3771:36,
3771:42, 3772:39,
3783:45, 3785:5,
3788:40
fits [1] - 3819:40
five [13] - 3721:40,
3748:29, 3770:16,
3774:29, 3774:31,
3800:17, 3802:4,
3804:23, 3806:39,
3821:28, 3825:9,
3832:2, 3832:7
five-minute [1] -
3832:2
flaw [1] - 3750:28
flexibility [1] - 3753:3
focus [13] - 3715:47,
3736:2, 3740:43,
3744:23, 3750:5,
3755:32, 3759:39,
3783:38, 3786:34,
3786:40, 3787:7,
3794:45, 3813:17
focused [1] - 3741:17
folders [3] - 3725:22,
3725:35, 3725:36
follow [2] - 3746:27,
3825:5
follow-up [1] - 3825:5
following [4] -
3721:13, 3788:28,
3795:24, 3810:28
follows [1] - 3786:47
food [2] - 3726:12,
3760:25
fora [1] - 3803:26
form [8] - 3715:37,
3724:42, 3742:10,
3758:24, 3766:17,
3766:45, 3769:41
formal [14] - 3720:47,
3730:10, 3747:47,
3766:38, 3767:35,
3773:19, 3814:16,
3814:18, 3814:19,
3825:26, 3825:28,
3825:39, 3827:13,
3827:23
formally [5] - 3777:9,
3820:39, 3825:15,
3825:17, 3825:35
format [1] - 3821:35
formed [1] - 3815:45
former [2] - 3762:26,
3779:33
forms [1] - 3716:37
forums [5] - 3735:37,
3735:44, 3759:42,
3774:17, 3774:18
forward [12] -
3714:41, 3722:42,
3744:11, 3746:8,
3774:7, 3780:20,
3783:41, 3790:27,
3795:47, 3806:8,
3808:43, 3816:36
foundation [1] -
3742:47
foundations [1] -
3742:39
four [13] - 3725:37,
3748:29, 3797:28,
3797:31, 3800:17,
3801:29, 3820:9,
3821:28, 3825:15,
3825:35, 3825:40,
3829:6, 3829:14
four-X [1] - 3801:29
fourth [6] - 3823:10,
3829:2, 3829:36,
3829:38, 3829:44,
3831:1
fractions [2] -
3825:23, 3825:43
fragmented [1] -
3745:11
frame [3] - 3757:36,
3789:2, 3822:44
framework [18] -
3728:8, 3742:17,
3742:21, 3784:11,
3784:14, 3784:28,
3784:33, 3805:9,
3805:15, 3805:17,
3805:19, 3805:27,
3805:29, 3805:32,
3805:40, 3805:45,
3806:46, 3816:35
Fraser [1] - 3713:29
fraternity [1] - 3726:3
free [2] - 3819:26,
3827:1
freedom [1] - 3743:34
freeze [1] - 3721:21
freely [2] -
3741:11, 3825:36
fresh [1] - 3798:16
friction [2] - 3721:17,
3722:2
Friday [3] - 3723:15,
3723:29
friend [1] - 3746:4
front [5] - 3763:37,
3771:7, 3784:40,
3785:30, 3792:28
frontline [1] - 3819:43
fronts [1] - 3720:14
frustration [1] -
3768:15
fulfilling [1] - 3761:14
full [8] - 3742:41,
3802:29, 3806:39,
3807:46, 3808:1,
3808:14, 3808:17,
3819:7
Fuller [1] - 3713:30
fullness [1] - 3724:41
fully [3] - 3755:17,
3807:16, 3808:9
function [4] - 3746:14,
3752:36, 3760:30,
3813:22
functioning [1] -
3738:1
functions [7] - 3754:4,
3772:22, 3772:28,
3775:37, 3778:9,
3824:31, 3824:35
fundamental [4] -
3754:34, 3755:5,
3755:6, 3762:3
funded [12] - 3807:17,
3807:23, 3807:33,
3807:45, 3808:9,
3808:10, 3808:15,
3809:39, 3810:32,
3810:33, 3815:16
funding [10] -
3725:33, 3815:13,
3815:19, 3815:23,
3829:44, 3830:26,
3830:42, 3830:43,
3831:6, 3831:7
Funding [2] - 3713:9,
3714:4
furnished [1] - 3729:5
future [7] - 3715:10,
3715:13, 3748:40,
3755:21, 3776:45,
3783:46, 3814:47
-
- G**
-
- Gadigal** [1] - 3714:5
gained [1] - 3750:4
gaining [3] - 3812:37,
3814:43, 3814:46
gap [3] - 3727:7,
3730:7, 3734:26
gaps [11] - 3726:40,
3726:45, 3728:1,
3728:22, 3729:15,
3746:34, 3748:14,
3752:8, 3752:46,
3784:35, 3797:7
gather [8] - 3714:6,
3728:21, 3756:46,
3762:30, 3764:11,
3769:1, 3769:28,
3785:44
gathered [3] -
3718:19, 3729:27,
3759:1
gathers [1] - 3729:45
gee [1] - 3817:40
General [1] - 3804:46
general [34] - 3732:26,
3747:42, 3750:31,
3761:4, 3761:5,
3762:42, 3763:24,
3764:1, 3768:13,
3769:24, 3804:13,
3804:15, 3804:19,
3804:32, 3805:34,
3806:16, 3806:17,
3809:11, 3809:19,
3809:21, 3809:25,
3811:22, 3812:16,
3814:42, 3815:9,
3815:11, 3815:20,
3820:33, 3821:14,
3821:24, 3823:18,
3823:20, 3824:44,
3826:45
generalisations [1] -
3745:46
generalising [1] -
3729:29
generalists [1] -
3764:2
generally [15] -
3776:15, 3786:6,
3788:33, 3789:6,
3790:14, 3798:40,
3801:11, 3801:46,
3802:9, 3804:3,
3810:7, 3813:14,
3814:23, 3817:21,
3826:42
generates [1] -
3728:10
generation [1] -
3749:37
geographic [1] -
3791:29
geography [1] -
3823:45
GIPAA [5] - 3728:27,
3729:2, 3729:4,
3730:10, 3743:34
GIPAA's [1] - 3729:8
given [22] - 3714:18,
3720:17, 3722:42,
3723:12, 3729:2,
3739:10, 3746:33,
3754:21, 3754:33,
3755:26, 3759:46,
3760:18, 3788:21,
3788:32, 3800:40,
3801:27, 3802:40,
3803:1, 3803:14,
3811:30, 3815:30,
3829:30
gleaned [2] - 3756:29,
3769:11
gleans [1] - 3759:29
GLOVER [6] - 3819:1,
3819:5, 3819:7,
3830:18, 3831:14,

- 3831:33
Glover [1] - 3713:27
Gosford [1] - 3799:33
govern [1] - 3791:26
governance [14] -
 3734:28, 3765:3,
 3772:29, 3772:31,
 3772:35, 3772:45,
 3773:1, 3773:23,
 3773:29, 3773:35,
 3774:4, 3774:9,
 3813:5, 3813:15
governed [1] - 3791:1
governing [1] -
 3720:32
government [10] -
 3739:35, 3745:31,
 3751:27, 3751:30,
 3754:28, 3761:19,
 3761:26, 3762:28,
 3762:43, 3763:3
Government [5] -
 3734:25, 3741:13,
 3758:19, 3763:9,
 3766:44
government's [1] -
 3742:32
governments [1] -
 3744:28
GP [3] - 3763:2,
 3763:8, 3764:5
GPs [2] - 3762:22,
 3763:21
graduate [4] -
 3797:25, 3797:26,
 3798:16, 3806:1
graduated [1] -
 3807:24
graduates [14] -
 3718:25, 3718:28,
 3719:23, 3747:29,
 3748:6, 3748:9,
 3792:21, 3792:26,
 3792:31, 3792:36,
 3795:27, 3806:19,
 3807:14, 3808:22
grant [4] - 3788:42,
 3789:11, 3789:25,
 3789:29
granting [1] - 3790:10
grants [9] - 3788:29,
 3788:32, 3788:33,
 3789:1, 3789:2,
 3789:3, 3789:7,
 3789:10
grappled [1] - 3719:1
grasped [1] - 3797:16
grateful [4] - 3770:11,
 3793:35, 3818:41,
 3831:40
great [3] - 3740:3,
 3741:7, 3812:8
greater [5] - 3731:10,
 3733:47, 3762:31,
 3792:47, 3824:2
greatest [1] - 3722:35
grievances [2] -
 3719:37, 3735:45
ground [2] - 3718:16,
 3760:1
group [15] - 3722:29,
 3740:43, 3750:5,
 3759:39, 3767:2,
 3789:14, 3789:27,
 3789:28, 3790:14,
 3790:16, 3790:20,
 3790:21, 3790:22,
 3821:27
grouped [1] - 3722:45
groupings [6] -
 3726:7, 3750:13,
 3752:25, 3764:36,
 3764:38
groups [15] - 3720:18,
 3729:14, 3736:2,
 3743:30, 3744:8,
 3744:29, 3750:1,
 3752:38, 3758:31,
 3759:10, 3759:11,
 3789:19, 3789:20,
 3812:10
grow [1] - 3745:27
growing [4] - 3745:22,
 3748:10, 3751:16,
 3751:20
grown [1] - 3721:1
guarantee [5] -
 3807:34, 3808:4,
 3808:6, 3808:17,
 3808:27
guaranteed [3] -
 3807:17, 3807:24,
 3811:47
guesswork [1] -
 3723:41
guide [1] - 3736:5
-
- H**
-
- H2.1** [1] - 3714:36
half [1] - 3724:5
halls [1] - 3731:8
Halse [12] - 3724:13,
 3724:21, 3725:41,
 3739:7, 3739:20,
 3740:9, 3745:41,
 3746:25, 3747:25,
 3761:34, 3763:46,
 3770:10
HALSE [1] - 3724:17
Halse's [2] - 3725:19,
 3745:37
hand [2] - 3720:18,
 3810:13
handle [1] - 3736:33
handling [1] - 3719:38
hands [1] - 3821:23
hands-on [1] -
 3821:23
handy [2] - 3724:34,
 3771:6
happy [3] - 3742:27,
 3770:19, 3770:22
hard [4] - 3742:47,
 3746:33, 3803:12,
 3819:25
harvesting [1] -
 3750:1
hat [1] - 3766:24
hailed [1] - 3761:22
head [7] - 3756:9,
 3762:22, 3766:8,
 3819:11, 3819:15,
 3824:31, 3829:19
headcounts [1] -
 3728:39
headed [1] - 3745:1
heads [3] - 3827:37,
 3828:16, 3828:45
Heads [2] - 3797:43,
 3798:10
health [272] - 3714:17,
 3714:25, 3714:33,
 3715:5, 3715:7,
 3715:9, 3715:12,
 3715:13, 3715:29,
 3716:16, 3716:19,
 3716:23, 3716:38,
 3718:26, 3718:30,
 3718:31, 3718:36,
 3718:41, 3718:43,
 3718:44, 3719:4,
 3719:6, 3719:12,
 3719:19, 3719:20,
 3719:35, 3720:12,
 3720:29, 3720:33,
 3720:37, 3720:38,
 3720:44, 3720:47,
 3721:16, 3722:10,
 3722:17, 3722:39,
 3725:33, 3725:44,
 3726:1, 3726:4,
 3726:5, 3726:6,
 3726:7, 3726:10,
 3726:13, 3726:16,
 3726:23, 3726:29,
 3726:34, 3727:2,
 3727:18, 3727:27,
 3727:41, 3728:3,
 3728:6, 3728:18,
 3728:30, 3728:34,
 3728:43, 3730:22,
 3730:24, 3730:27,
 3730:47, 3731:11,
 3731:19, 3731:21,
 3731:28, 3731:32,
 3731:33, 3731:34,
 3731:35, 3731:37,
 3731:41, 3731:46,
 3732:12, 3733:5,
 3733:7, 3733:11,
 3733:12, 3733:14,
 3733:21, 3733:27,
 3734:3, 3734:11,
 3734:44, 3734:46,
 3735:26, 3735:27,
 3735:29, 3735:30,
 3735:43, 3736:8,
 3736:21, 3736:22,
 3736:29, 3736:40,
 3737:2, 3737:23,
 3737:28, 3737:29,
 3738:4, 3738:11,
 3738:12, 3738:15,
 3738:20, 3738:28,
 3738:38, 3738:39,
 3738:45, 3738:47,
 3739:3, 3739:16,
 3739:24, 3740:13,
 3740:26, 3740:28,
 3740:30, 3740:32,
 3740:33, 3740:39,
 3740:42, 3742:31,
 3743:7, 3743:32,
 3743:33, 3744:32,
 3745:11, 3745:21,
 3745:24, 3745:27,
 3745:40, 3746:7,
 3746:14, 3747:41,
 3747:42, 3747:47,
 3748:11, 3748:12,
 3748:31, 3748:42,
 3749:3, 3749:8,
 3749:14, 3749:16,
 3749:18, 3749:43,
 3750:11, 3750:16,
 3750:23, 3750:39,
 3750:43, 3751:4,
 3751:5, 3751:13,
 3751:16, 3751:24,
 3751:27, 3751:29,
 3751:32, 3751:36,
 3751:41, 3752:6,
 3752:11, 3752:18,
 3752:26, 3752:37,
 3752:39, 3752:44,
 3752:47, 3753:40,
 3753:42, 3753:46,
 3754:2, 3754:21,
 3755:24, 3755:26,
 3756:24, 3757:1,
 3757:24, 3757:42,
 3758:25, 3758:27,
 3758:32, 3759:46,
 3761:8, 3761:18,
 3761:21, 3762:20,
 3762:30, 3762:35,
 3762:44, 3763:10,
 3764:14, 3764:19,
 3764:23, 3764:35,
 3764:37, 3764:41,
 3765:4, 3765:18,
 3765:23, 3765:25,
 3765:44, 3766:7,
 3766:14, 3766:15,
 3766:17, 3766:21,
 3766:27, 3766:28,
 3766:35, 3766:39,
 3766:45, 3767:14,
 3767:45, 3768:20,
 3769:6, 3769:31,
 3769:39, 3771:25,
 3771:28, 3771:38,
 3771:40, 3772:5,
 3772:6, 3772:17,
 3772:29, 3772:31,
 3772:33, 3772:36,
 3772:40, 3773:10,
 3773:20, 3776:16,
 3776:34, 3777:9,
 3777:34, 3780:6,
 3780:8, 3782:12,
 3784:16, 3784:22,
 3785:19, 3785:41,
 3786:8, 3786:14,
 3786:34, 3786:41,
 3787:8, 3787:36,
 3789:15, 3789:21,
 3791:2, 3791:30,
 3793:9, 3793:10,
 3796:16, 3800:30,
 3806:13, 3806:32,
 3806:36, 3807:25,
 3816:7, 3822:14,
 3823:44, 3824:19,
 3831:9, 3831:12,
 3831:19
Health [83] - 3713:35,
 3714:35, 3715:36,
 3716:45, 3718:14,
 3719:33, 3720:18,
 3720:20, 3724:14,
 3724:23, 3726:36,
 3727:6, 3728:47,
 3729:45, 3730:32,
 3730:33, 3730:39,
 3731:5, 3731:27,
 3735:18, 3736:4,
 3736:13, 3737:47,
 3743:17, 3743:20,
 3743:26, 3744:41,
 3745:2, 3746:47,

3747:14, 3750:9,
3752:22, 3753:22,
3753:32, 3756:26,
3756:30, 3758:5,
3758:6, 3758:9,
3758:12, 3758:15,
3759:11, 3760:37,
3760:41, 3761:35,
3762:13, 3762:15,
3763:17, 3763:47,
3764:22, 3765:12,
3766:2, 3766:6,
3766:22, 3767:18,
3767:37, 3768:3,
3769:12, 3769:37,
3770:40, 3771:26,
3772:11, 3775:22,
3775:37, 3775:39,
3776:9, 3776:16,
3777:30, 3780:17,
3787:39, 3788:33,
3789:39, 3790:32,
3791:47, 3799:27,
3807:28, 3827:19,
3827:20, 3827:34,
3828:40, 3828:45,
3829:10, 3831:8
HEALTH [1] - 3747:7
Health's [1] - 3830:22
healthcare [1] -
3824:18
Healthcare [2] -
3713:9, 3714:4
HealthShare [2] -
3797:24, 3799:6
healthy [1] - 3781:42
hear [7] - 3717:12,
3717:44, 3717:46,
3718:5, 3752:1,
3770:33, 3804:38
heard [1] - 3750:35
hearing [15] - 3714:3,
3714:14, 3714:16,
3714:18, 3714:34,
3714:44, 3715:4,
3716:7, 3716:13,
3717:6, 3722:12,
3722:41, 3723:37,
3733:38, 3816:39
hearings [5] -
3714:20, 3715:46,
3716:5, 3718:20,
3780:11
held [8] - 3724:27,
3725:47, 3729:3,
3733:2, 3759:27,
3770:46, 3794:16
hell [1] - 3729:33
help [8] - 3722:41,
3757:10, 3769:35,
3769:36, 3769:37,
3830:4, 3832:1,
3832:6
helpful [1] - 3758:2
helps [3] - 3740:1,
3800:37, 3820:43
HETI [119] - 3770:43,
3771:25, 3771:33,
3771:34, 3772:1,
3772:4, 3772:17,
3772:45, 3773:1,
3773:6, 3773:13,
3773:29, 3773:32,
3773:34, 3773:35,
3773:43, 3773:46,
3774:4, 3774:11,
3774:13, 3774:15,
3774:18, 3774:22,
3775:20, 3775:44,
3776:1, 3776:8,
3776:9, 3776:20,
3776:29, 3776:31,
3777:6, 3777:18,
3777:24, 3777:31,
3778:4, 3778:5,
3778:9, 3778:29,
3778:31, 3778:39,
3778:45, 3779:5,
3779:18, 3779:19,
3779:31, 3779:34,
3779:38, 3779:42,
3779:43, 3782:13,
3782:16, 3783:22,
3783:23, 3784:5,
3784:8, 3784:25,
3784:34, 3784:40,
3785:12, 3785:18,
3785:30, 3786:16,
3786:22, 3786:27,
3787:1, 3787:21,
3787:22, 3787:46,
3788:13, 3788:21,
3788:27, 3788:45,
3788:46, 3789:20,
3789:43, 3789:45,
3789:46, 3790:20,
3790:21, 3790:23,
3790:28, 3791:3,
3791:8, 3791:21,
3792:13, 3792:25,
3792:27, 3792:30,
3792:47, 3793:7,
3793:9, 3794:6,
3794:13, 3794:42,
3795:25, 3797:18,
3797:21, 3798:27,
3798:31, 3799:5,
3802:19, 3803:22,
3804:30, 3806:12,
3808:31, 3809:16,
3809:42, 3811:4,
3811:5, 3811:42,
3813:5, 3813:17,
3813:39, 3814:3,
3815:14, 3816:3,
3816:40, 3817:27
HETI's [20] - 3772:22,
3772:28, 3776:15,
3779:26, 3784:20,
3787:6, 3787:36,
3789:30, 3789:31,
3790:30, 3790:43,
3791:7, 3791:45,
3792:34, 3797:13,
3798:34, 3811:3,
3813:3, 3813:14,
3813:25
high [2] - 3721:4,
3768:20
higher [9] - 3740:47,
3741:6, 3745:22,
3753:19, 3762:36,
3779:27, 3779:30,
3779:36, 3800:9
highlight [1] - 3758:32
highly [2] - 3771:34,
3823:47
Hilbert [1] - 3713:35
Hill [6] - 3731:15,
3731:43, 3731:44,
3732:27, 3759:15,
3759:17
historic [2] - 3741:27,
3757:16
historically [3] -
3799:18, 3805:3,
3806:45
history [3] - 3750:18,
3818:12, 3821:40
hit [1] - 3830:45
hmm [4] - 3782:9,
3784:1, 3787:19,
3803:44
hold [4] - 3733:31,
3759:22, 3759:23,
3772:8
holds [1] - 3760:37
honest [1] - 3788:47
hope [2] - 3716:7,
3812:45
hopefully [3] -
3722:39, 3805:24,
3808:45
horizon [3] - 3780:29,
3781:4, 3781:12
Horizon [1] - 3780:45
horizons [3] -
3780:22, 3780:23,
3780:28
hospital [40] -
3726:17, 3729:16,
3732:44, 3733:42,
3733:43, 3749:17,
3759:20, 3759:35,
3761:24, 3765:36,
3772:43, 3793:15,
3798:28, 3798:32,
3798:39, 3800:41,
3801:40, 3802:13,
3804:17, 3805:2,
3806:40, 3806:47,
3807:4, 3807:6,
3807:7, 3809:5,
3809:7, 3809:13,
3810:39, 3817:39,
3820:27, 3821:2,
3821:4, 3821:21,
3821:30, 3823:21,
3828:10, 3830:4,
3830:44
Hospital [11] -
3722:14, 3759:15,
3759:17, 3801:1,
3801:4, 3801:6,
3801:13, 3812:15,
3812:19, 3820:8,
3830:36
hospital's [2] -
3730:9, 3798:23
hospitals [34] -
3719:5, 3721:36,
3721:46, 3743:11,
3765:27, 3765:29,
3765:31, 3765:42,
3797:42, 3798:18,
3798:39, 3798:46,
3799:2, 3799:16,
3799:17, 3801:5,
3801:10, 3801:22,
3802:25, 3804:8,
3806:16, 3806:17,
3806:20, 3806:33,
3806:44, 3807:3,
3807:11, 3807:35,
3808:33, 3812:9,
3812:23, 3815:46,
3827:7, 3828:38
hosted [1] - 3766:2
hotel [1] - 3817:37
hour [1] - 3724:5
hours [5] - 3721:36,
3721:44, 3760:4,
3765:18, 3765:22
housed [1] - 3742:34
hover [1] - 3811:26
HR [1] - 3730:9
HSU [24] - 3725:43,
3726:40, 3740:44,
3743:17, 3743:29,
3744:8, 3744:44,
3745:1, 3746:47,
3747:7, 3749:7,
3750:15, 3751:40,
3752:33, 3753:32,
3754:45, 3759:15,
3759:28, 3760:30,
3760:35, 3760:39,
3761:34, 3762:14,
3768:14
HSU's [1] - 3756:39
huge [12] - 3726:37,
3733:40, 3735:35,
3740:44, 3743:6,
3747:45, 3750:10,
3751:44, 3755:14,
3764:38, 3768:30
hugely [2] - 3728:45,
3760:26
human [5] - 3719:30,
3749:18, 3750:21,
3782:38, 3783:3
hundreds [5] - 3726:4,
3726:15, 3726:19,
3726:20, 3730:38
Hunter [3] - 3801:12,
3801:13, 3801:14
hypothetical [5] -
3805:16, 3808:44,
3810:11, 3811:12,
3814:20
hypothetically [1] -
3798:8

I

lan [1] - 3713:29
idea [3] - 3732:26,
3746:43, 3800:7
ideally [2] - 3716:37,
3746:13
ideas [1] - 3744:18
identification [3] -
3715:47, 3733:40,
3746:41
identified [8] -
3715:42, 3715:43,
3741:14, 3747:28,
3781:31, 3795:40,
3795:41, 3797:10
identifies [2] - 3716:6,
3750:27
identify [13] - 3728:28,
3729:15, 3729:16,
3733:37, 3750:38,
3769:37, 3776:35,
3778:8, 3793:2,
3795:4, 3797:33,
3816:23, 3820:41
identifying [6] -
3715:39, 3721:4,
3767:15, 3767:41,

3799:45, 3801:21
ignorant [1] - 3739:45
illustrate [1] - 3753:34
imagine [1] - 3817:8
immediate [3] -
 3716:7, 3716:13,
 3798:34
immediately [3] -
 3752:16, 3775:27,
 3792:34
immerse [1] - 3824:3
immersive [1] -
 3824:13
Impact [1] - 3745:12
impact [8] - 3720:28,
 3721:17, 3722:1,
 3722:17, 3722:25,
 3736:17, 3805:46,
 3817:2
impacts [2] - 3749:10,
 3793:17
impart [1] - 3737:33
impede [4] - 3756:47,
 3769:2, 3769:30,
 3769:39
impeding [1] -
 3759:45
imperative [1] -
 3744:34
implementation [2] -
 3776:10, 3776:22
implemented [3] -
 3736:45, 3744:18,
 3773:41
importance [1] -
 3742:38
important [16] -
 3717:28, 3722:37,
 3727:16, 3728:6,
 3728:45, 3730:45,
 3735:3, 3735:24,
 3735:25, 3746:10,
 3752:27, 3778:38,
 3782:45, 3814:34,
 3814:43, 3818:12
importantly [1] -
 3805:32
imposed [1] - 3718:46
impression [1] -
 3738:28
improve [4] - 3733:22,
 3738:11, 3762:8,
 3766:44
improving [2] -
 3761:36, 3775:17
inadequate [1] -
 3737:22
inappropriate [1] -
 3721:8
incentives [1] - 3806:6
include [7] - 3721:12,
 3725:45, 3765:17,
 3768:21, 3776:18,
 3806:16, 3832:3
included [2] - 3736:7,
 3775:41
includes [1] - 3747:46
including [13] -
 3719:18, 3719:32,
 3720:20, 3725:24,
 3736:1, 3745:31,
 3746:1, 3757:46,
 3764:5, 3766:17,
 3775:28, 3778:26,
 3802:12
inclusive [1] - 3781:41
incomplete [1] -
 3738:7
incorporate [2] -
 3786:40, 3787:7
increase [4] - 3734:22,
 3741:28, 3746:8,
 3751:22
increased [2] -
 3793:16
increases [1] -
 3720:26
increasing [5] -
 3741:40, 3762:20,
 3816:26, 3817:2,
 3831:20
incredibly [1] - 3804:8
indeed [4] - 3729:7,
 3731:26, 3734:1,
 3759:11
independence [1] -
 3735:8
independent [7] -
 3726:28, 3727:32,
 3735:2, 3735:4,
 3757:8, 3759:44,
 3765:8
Independent [1] -
 3758:15
index [1] - 3725:17
indicate [7] - 3726:27,
 3742:29, 3751:45,
 3753:31, 3762:36,
 3823:29, 3829:22
indicated [2] -
 3749:13, 3825:41
indicates [1] -
 3742:23
indicating [1] -
 3747:45
indication [4] -
 3723:6, 3723:12,
 3725:44, 3740:45
indications [1] -
 3740:44
indirectly [1] -
 3820:18
individual [8] -
 3748:32, 3765:4,
 3802:37, 3811:29,
 3812:36, 3813:10,
 3818:7, 3818:23
individuals [6] -
 3727:13, 3727:37,
 3733:16, 3737:26,
 3749:9, 3752:15
industrial [12] -
 3720:21, 3720:32,
 3720:35, 3720:45,
 3721:31, 3722:8,
 3728:33, 3729:20,
 3743:46, 3759:10,
 3759:34, 3762:7
industries [3] -
 3740:38, 3750:19,
 3752:26
inefficient [1] -
 3729:21
infer [1] - 3721:25
inform [11] - 3728:37,
 3729:22, 3733:18,
 3736:12, 3736:35,
 3736:47, 3737:1,
 3742:42, 3757:25,
 3773:42, 3787:17
informally [2] -
 3825:17, 3825:36
Information [1] -
 3731:5
information [43] -
 3727:36, 3727:40,
 3728:4, 3728:9,
 3728:23, 3728:39,
 3728:40, 3729:45,
 3729:47, 3730:18,
 3730:36, 3731:10,
 3731:18, 3731:42,
 3732:42, 3733:4,
 3733:17, 3733:27,
 3733:28, 3733:33,
 3735:12, 3735:40,
 3736:34, 3737:7,
 3737:33, 3738:9,
 3739:40, 3743:34,
 3752:6, 3759:22,
 3759:24, 3759:27,
 3759:29, 3759:42,
 3760:45, 3761:17,
 3761:29, 3762:12,
 3784:46, 3791:21,
 3791:22, 3809:43,
 3818:7
informed [5] -
 3727:34, 3736:37,
 3736:39, 3749:46,
 3755:15
informing [1] - 3737:9
informs [3] - 3728:9,
 3759:41, 3760:38
infrastructure [5] -
 3736:42, 3749:17,
 3749:22, 3750:21,
 3751:23
initial [1] - 3811:16
initiated [1] - 3823:25
initiative [1] - 3768:7
initiatives [7] -
 3717:14, 3764:12,
 3764:13, 3766:5,
 3766:9, 3766:11,
 3766:44
injury [1] - 3818:10
inordinate [1] -
 3761:11
inpatient [1] - 3822:15
inpatient/outpatient
 [1] - 3825:4
input [1] - 3736:26
inquire [2] - 3739:11,
 3739:13
Inquiry [23] - 3713:7,
 3714:4, 3714:32,
 3715:19, 3715:44,
 3716:28, 3717:22,
 3718:34, 3720:25,
 3720:31, 3721:9,
 3724:30, 3728:26,
 3729:5, 3731:3,
 3742:15, 3746:10,
 3746:32, 3767:25,
 3769:38, 3771:2,
 3794:21, 3818:13
INQUIRY [1] - 3832:16
inquiry [1] - 3742:32
Inquiry's [4] -
 3744:46, 3756:33,
 3769:22, 3769:24
inside [2] - 3817:38,
 3817:39
insight [3] - 3715:24,
 3759:16, 3760:40
insights [1] - 3744:39
insofar [8] - 3717:3,
 3717:27, 3718:23,
 3750:29, 3753:7,
 3773:30, 3785:17,
 3815:18
instance [3] - 3786:9,
 3803:33, 3809:32
institute [3] - 3778:9,
 3779:32, 3779:33
Institute [2] - 3758:12,
 3770:40
institution [3] -
 3751:11, 3778:33,
 3791:3
institutions [13] -
 3747:29, 3748:5,
 3748:9, 3748:42,
 3749:44, 3749:45,
 3750:29, 3751:12,
 3751:31, 3786:42,
 3787:9, 3791:24,
 3807:31
insurance [2] -
 3763:20, 3763:25
integer [1] - 3732:22
integers [1] - 3718:8
integral [2] - 3728:23,
 3728:29
integrated [1] - 3812:5
intend [12] - 3715:2,
 3716:4, 3716:12,
 3716:18, 3716:31,
 3717:14, 3717:41,
 3719:11, 3719:24,
 3720:2, 3722:12,
 3742:7
intended [6] -
 3725:20, 3799:15,
 3805:20, 3805:23,
 3805:35, 3805:45
intending [1] - 3752:3
intent [3] - 3754:45,
 3768:10, 3805:45
intention [6] -
 3715:33, 3715:45,
 3718:15, 3719:43,
 3727:17, 3730:43
interaction [1] - 3822:15
interaction [2] -
 3718:25, 3816:38
interactions [1] -
 3718:29
interactive [3] -
 3782:27, 3783:2
interest [3] - 3734:25,
 3762:16, 3762:17
interested [6] -
 3736:3, 3761:14,
 3774:7, 3803:13,
 3803:31, 3823:31
interestingly [1] -
 3720:15
interests [2] -
 3762:13, 3762:14
interference [1] -
 3735:9
intergenerational [2] -
 3741:27, 3746:1
intermediate [1] -
 3830:6
intern [41] - 3792:18,
 3795:6, 3795:23,
 3795:27, 3795:28,

- 3795:32, 3795:44,
3796:8, 3796:20,
3796:31, 3796:40,
3797:6, 3797:12,
3797:17, 3797:19,
3797:22, 3797:24,
3798:47, 3799:2,
3799:8, 3799:39,
3800:16, 3800:39,
3801:30, 3801:47,
3802:2, 3802:36,
3805:16, 3805:19,
3806:27, 3807:14,
3807:17, 3807:25,
3807:34, 3808:18,
3808:23, 3808:27,
3808:32, 3808:35,
3808:44, 3811:35
- internal** [3] - 3755:15,
3830:40, 3830:41
- international** [1] -
3740:34
- internationally** [3] -
3719:18, 3719:22,
3808:22
- interns** [20] - 3795:34,
3795:40, 3795:43,
3796:2, 3796:5,
3796:16, 3796:26,
3796:36, 3797:10,
3797:14, 3799:9,
3799:28, 3801:28,
3801:47, 3805:30,
3806:21, 3806:39,
3807:5, 3807:9
- internship** [3] -
3792:27, 3792:36,
3805:33
- interpret** [2] - 3714:38,
3787:16
- interrupt** [2] - 3773:5,
3815:28
- interrupted** [1] -
3746:18
- interruption** [1] -
3746:18
- interstate** [4] -
3800:29, 3807:31,
3807:39, 3808:37
- intervals** [2] - 3731:6,
3757:14
- interview** [2] -
3798:45, 3810:45
- interviewed** [3] -
3798:22, 3827:25,
3827:26
- interviews** [5] -
3736:2, 3750:5,
3827:23, 3827:41,
3828:8
- introduction** [3] -
3805:24, 3805:40,
3806:45
- invested** [1] - 3763:47
- investment** [1] -
3748:31
- invite** [2] - 3714:2,
3760:19
- invited** [2] - 3736:23,
3773:8
- involve** [5] - 3725:16,
3792:3, 3806:42,
3817:17, 3829:9
- involved** [19] - 3718:6,
3753:39, 3754:14,
3760:27, 3761:19,
3767:29, 3782:34,
3787:25, 3787:26,
3787:29, 3791:12,
3811:4, 3811:42,
3818:1, 3821:2,
3824:3, 3828:37,
3828:41, 3828:44
- involvement** [8] -
3717:45, 3776:24,
3783:3, 3797:13,
3820:16, 3828:30,
3828:43, 3830:22
- involves** [2] - 3751:30,
3792:4
- irrespective** [4] -
3731:24, 3735:8,
3736:19, 3748:14
- irritation** [1] - 3741:40
- isolated** [1] - 3824:5
- issue** [17] - 3717:5,
3718:33, 3719:1,
3719:11, 3722:1,
3722:4, 3729:19,
3729:37, 3743:36,
3748:37, 3750:37,
3759:33, 3773:2,
3773:24, 3779:24,
3816:22
- issued** [1] - 3718:14
- Issues** [1] - 3744:46
- issues** [32] - 3714:15,
3714:32, 3715:10,
3716:12, 3717:13,
3717:15, 3719:28,
3719:29, 3719:31,
3719:36, 3720:7,
3720:10, 3720:17,
3722:15, 3722:23,
3722:31, 3722:40,
3723:2, 3723:21,
3725:24, 3732:2,
3736:19, 3737:39,
3738:46, 3744:11,
3744:33, 3744:45,
- 3750:12, 3753:7,
3753:26, 3791:26
- itself** [7] - 3734:38,
3737:21, 3738:28,
3773:27, 3774:6,
3775:44, 3801:40
- iv** [1] - 3775:11
-
- ## J
-
- Jackson** [2] - 3742:18,
3742:30
- January** [2] - 3827:3,
3827:12
- JMO** [6] - 3802:11,
3802:37, 3802:40,
3810:11, 3810:12,
3811:12
- JMOs** [2] - 3802:41,
3803:16
- Jo** [1] - 3779:1
- job** [10] - 3721:15,
3722:3, 3752:7,
3762:3, 3782:2,
3782:43, 3782:47,
3809:31, 3811:47,
3812:44
- jobs** [2] - 3740:19,
3810:21
- John** [1] - 3801:13
- jointly** [1] - 3830:35
- Josephine** [2] -
3746:26, 3793:45
- JOSEPHINE** [1] -
3794:1
- July** [7] - 3713:22,
3723:16, 3724:31,
3771:3, 3794:20,
3819:21
- jump** [4] - 3740:46,
3783:41, 3790:27,
3795:47
- jumped** [1] - 3807:22
- jumping** [2] - 3723:3,
3741:5
- juncture** [1] - 3744:19
- June** [1] - 3770:46
- junior** [17] - 3778:18,
3793:17, 3796:30,
3796:32, 3814:10,
3814:22, 3817:7,
3817:10, 3817:17,
3817:19, 3817:20,
3817:39, 3818:2,
3818:23, 3822:7,
3822:9, 3824:1
- jurisdiction** [4] -
3740:46, 3741:39,
3753:18, 3808:25
- jurisdictional** [1] -
3758:27
- jurisdictions** [6] -
3741:19, 3741:45,
3756:7, 3762:38,
3766:12, 3766:13
-
- ## K
-
- keen** [3] - 3823:29,
3824:13, 3830:40
- keep** [4] - 3740:30,
3760:14, 3781:14,
3808:45
- keeps** [1] - 3739:35
- kept** [3] - 3715:36,
3739:37, 3776:1
- key** [11] - 3715:17,
3715:39, 3716:6,
3718:8, 3725:36,
3730:31, 3787:15,
3816:19, 3817:2,
3821:26, 3822:12
- kidney** [1] - 3831:25
- knock** [1] - 3722:8
- knock-on** [1] - 3722:8
- knowing** [1] - 3751:33
- knowledge** [17] -
3724:37, 3724:39,
3728:10, 3730:18,
3734:16, 3736:19,
3737:27, 3738:9,
3738:14, 3766:6,
3771:14, 3773:17,
3777:10, 3777:11,
3777:14, 3794:32,
3819:33
- known** [3] - 3761:12,
3762:13, 3767:36
- KPIs** [3] - 3728:44,
3733:8, 3734:46
- Kruk** [1] - 3719:23
-
- ## L
-
- labelled** [1] - 3766:28
- laborious** [1] -
3755:25
- labour** [6] - 3716:32,
3731:36, 3740:12,
3740:14, 3740:16,
3740:23
- lack** [10] - 3729:39,
3729:40, 3735:2,
3737:41, 3748:41,
3750:34, 3750:38,
3750:41, 3764:18
- lament** [1] - 3756:23
- land** [1] - 3714:6
- landscape** [1] -
3751:36
- large** [5] - 3741:12,
3752:12, 3765:27,
3765:42, 3808:36
- largely** [2] - 3763:8,
3830:42
- larger** [2] - 3765:29,
3811:36
- last** [19] - 3714:19,
3719:41, 3724:6,
3741:4, 3748:18,
3755:44, 3757:16,
3784:40, 3785:23,
3785:29, 3785:32,
3786:32, 3786:37,
3787:2, 3787:12,
3795:31, 3808:35,
3808:40, 3816:19
- late** [3] - 3723:38,
3756:22, 3827:41
- latter** [1] - 3739:2
- laundry** [1] - 3726:12
- lawyer** [1] - 3817:1
- lawyers** [1] - 3821:18
- lead** [7] - 3728:11,
3753:23, 3773:12,
3774:18, 3782:11,
3784:5, 3787:1
- leaders** [1] - 3782:20
- leadership** [19] -
3733:18, 3771:25,
3771:32, 3771:33,
3771:37, 3771:44,
3772:5, 3777:2,
3781:40, 3781:47,
3782:18, 3782:19,
3782:23, 3782:32,
3782:40, 3782:41,
3783:1, 3783:4,
3783:5
- leading** [2] - 3742:32,
3771:45
- leads** [3] - 3719:10,
3728:20, 3759:24
- learn** [7] - 3783:44,
3820:25, 3820:27,
3821:36, 3822:9,
3822:23, 3822:44
- learned** [2] - 3746:4,
3815:6
- learners** [1] - 3783:31
- learning** [28] -
3775:23, 3775:24,
3775:27, 3775:30,
3776:5, 3782:2,
3782:17, 3782:30,
3782:43, 3782:47,
3783:12, 3784:39,
3784:42, 3784:44,
3785:4, 3785:17,
3785:27, 3785:35,

- 3785:37, 3785:39,
3786:10, 3786:11,
3786:29, 3788:39,
3818:24, 3820:4
learnings [1] -
3819:44
lease [1] - 3819:46
least [18] - 3714:38,
3715:18, 3719:43,
3720:3, 3721:12,
3722:44, 3738:27,
3740:14, 3763:28,
3765:25, 3767:28,
3767:41, 3768:8,
3775:10, 3798:34,
3817:8, 3825:15,
3825:40
leave [5] - 3740:1,
3752:3, 3752:16,
3804:41, 3825:38
leaving [2] - 3727:27,
3804:38
lectures [2] - 3820:20,
3821:22
led [2] - 3747:36,
3748:3
ledger [1] - 3720:26
left [3] - 3723:34,
3725:2, 3818:15
legislative [2] -
3755:45, 3756:6
lend [2] - 3773:27,
3774:5
lending [1] - 3824:21
length [3] - 3728:1,
3729:46, 3768:12
lengthy [2] - 3767:28,
3767:29
less [10] - 3732:34,
3793:21, 3796:45,
3799:5, 3799:18,
3816:26, 3816:41,
3826:34, 3830:15
letter [1] - 3765:20
Level [1] - 3713:18
level [32] - 3716:47,
3719:42, 3721:4,
3721:27, 3729:20,
3732:8, 3733:27,
3734:41, 3735:38,
3735:39, 3737:14,
3737:15, 3737:16,
3745:26, 3746:10,
3748:29, 3753:11,
3753:19, 3754:18,
3773:41, 3773:42,
3774:9, 3776:13,
3779:31, 3783:25,
3787:16, 3791:1,
3802:16, 3809:21,
3820:1, 3821:25,
3827:40
levels [4] - 3731:28,
3734:45, 3751:30,
3777:46
LHD [38] - 3716:20,
3718:5, 3728:41,
3729:29, 3730:16,
3732:24, 3734:4,
3734:32, 3734:38,
3761:11, 3761:20,
3772:43, 3773:3,
3774:21, 3776:15,
3776:35, 3791:35,
3791:37, 3792:13,
3795:28, 3795:33,
3795:34, 3795:39,
3795:41, 3795:43,
3795:44, 3796:4,
3796:5, 3796:9,
3796:19, 3798:29,
3801:14, 3801:16,
3801:17, 3810:38,
3815:19, 3821:45,
3822:1
LHDs [38] - 3716:23,
3718:29, 3729:9,
3729:26, 3737:15,
3748:46, 3749:45,
3750:28, 3757:29,
3768:14, 3771:25,
3772:5, 3772:17,
3773:10, 3773:24,
3774:1, 3774:7,
3774:9, 3774:14,
3777:19, 3777:42,
3778:1, 3783:17,
3785:18, 3791:20,
3791:25, 3791:42,
3793:1, 3793:7,
3793:14, 3796:1,
3797:11, 3801:20,
3810:32, 3810:33,
3811:1, 3815:16,
3815:47
library [1] - 3725:23
lie [2] - 3718:8,
3718:10
life [1] - 3762:26
lifestyle [1] - 3831:28
likely [4] - 3724:1,
3741:9, 3783:5,
3824:10
likewise [2] - 3721:30,
3816:35
limited [3] - 3768:14,
3816:20, 3823:2
limiting [2] - 3718:1,
3718:41
line [7] - 3738:19,
3738:32, 3745:39,
3749:16, 3751:46,
3769:26, 3824:34
lines [3] - 3735:34,
3785:45, 3789:5
link [3] - 3736:6,
3750:7, 3822:7
linked [1] - 3736:14
Lismore [1] - 3797:43
list [11] - 3723:5,
3725:38, 3738:6,
3746:25, 3746:28,
3750:11, 3766:8,
3784:20, 3798:22,
3799:26, 3807:27
listed [3] - 3746:32,
3769:41, 3827:25
listened [1] - 3738:29
listening [1] - 3832:5
listing [1] - 3828:13
literally [3] - 3726:3,
3726:15, 3726:19
live [3] - 3741:43,
3742:2, 3800:15
Liverpool [1] -
3762:23
living [5] - 3741:8,
3741:22, 3741:32,
3741:37, 3741:38
local [26] - 3716:47,
3735:38, 3737:14,
3748:41, 3749:43,
3761:19, 3761:25,
3773:2, 3773:11,
3773:23, 3773:25,
3773:41, 3774:9,
3774:26, 3791:1,
3791:30, 3791:31,
3793:9, 3793:24,
3802:15, 3806:47,
3816:7, 3831:9
locally [3] - 3739:1,
3774:3, 3777:21
location [8] - 3728:41,
3731:25, 3732:43,
3736:42, 3739:13,
3741:47, 3797:47,
3803:6
locations [2] -
3727:15, 3803:29
locum [2] - 3804:24,
3805:43
locums [6] - 3716:33,
3716:36, 3753:6,
3753:7, 3768:34,
3768:38
log [2] - 3754:9,
3754:36
logical [2] - 3742:1,
3744:35
logs [1] - 3754:14
long-term [1] -
3714:29
look [21] - 3714:45,
3715:4, 3716:34,
3716:44, 3717:1,
3717:14, 3719:19,
3719:31, 3720:4,
3722:26, 3735:43,
3754:8, 3754:30,
3776:46, 3785:34,
3789:14, 3789:15,
3790:13, 3792:31,
3816:14, 3821:25
looked [1] - 3817:39
looking [16] - 3720:8,
3722:13, 3745:38,
3749:21, 3755:4,
3766:14, 3775:31,
3780:39, 3782:30,
3782:32, 3784:32,
3784:33, 3785:3,
3788:7, 3791:32
looks [1] - 3737:34
lose [1] - 3751:32
lunch [1] - 3774:35
lung [1] - 3821:37
-
- M**
-
- Macquarie** [3] -
3713:18, 3807:6,
3807:7
main [1] - 3772:22
maintain [2] -
3721:45, 3779:27
maintained [2] -
3779:20, 3779:21
majority [4] - 3812:47,
3823:39, 3825:24,
3830:43
makers [4] - 3729:22,
3729:23, 3733:27,
3733:32
maldistribution [4] -
3716:27, 3717:20,
3717:36, 3718:44
man [1] - 3796:40
manage [1] - 3792:10
managed [2] -
3737:38, 3808:45
management [9] -
3732:24, 3759:35,
3777:1, 3788:29,
3792:35, 3821:33,
3821:41, 3824:3,
3825:20
managers [1] -
3822:40
manages [1] - 3792:25
managing [3] -
3731:37, 3789:12,
3795:17
mandate [1] - 3761:35
mandatory [1] -
3767:3
manifest [1] - 3738:28
manner [11] - 3719:34,
3730:20, 3731:6,
3734:15, 3737:26,
3746:15, 3750:20,
3758:30, 3758:32,
3760:26, 3766:32
mapping [5] -
3784:13, 3784:27,
3784:34, 3784:46,
3785:2
March [1] - 3714:35
mark [1] - 3746:40
marked [1] - 3747:12
market [3] - 3740:33,
3740:34, 3763:24
marking [1] - 3725:10
marrying [1] - 3749:1
masse [1] - 3738:4
match [2] - 3798:34,
3823:30
matching [2] -
3828:15, 3828:22
material [3] - 3725:2,
3759:1, 3760:40
materials [1] -
3822:45
matter [9] - 3719:44,
3721:21, 3725:16,
3734:30, 3740:11,
3763:8, 3784:44,
3810:10, 3813:19
matters [4] - 3737:24,
3758:40, 3759:7,
3765:46
Matters [1] - 3735:33
mature [1] - 3811:18
MAURICE [1] - 3819:3
Maurice [1] - 3819:9
MBS [1] - 3763:20
mean [48] - 3721:36,
3731:44, 3732:34,
3739:23, 3740:5,
3743:23, 3745:17,
3745:18, 3751:42,
3761:18, 3763:12,
3763:19, 3763:35,
3763:36, 3771:31,
3772:30, 3775:18,
3777:44, 3779:18,
3782:37, 3783:16,
3783:17, 3784:19,
3784:30, 3785:32,
3787:28, 3787:30,

3789:37, 3789:38,
 3796:15, 3796:17,
 3799:5, 3800:44,
 3801:11, 3801:46,
 3803:36, 3804:3,
 3804:25, 3805:29,
 3809:33, 3809:42,
 3811:15, 3813:17,
 3813:45, 3816:6,
 3825:38, 3829:45,
 3829:46
meaningful [2] -
 3743:44, 3749:25
means [11] - 3714:15,
 3720:3, 3729:14,
 3772:18, 3773:35,
 3777:3, 3784:32,
 3786:2, 3787:31,
 3789:43, 3803:46
meant [2] - 3769:8,
 3786:20
measure [1] - 3744:7
measurement [1] -
 3784:9
measures [1] - 3733:8
measuring [1] -
 3784:6
mechanism [7] -
 3726:28, 3727:31,
 3755:35, 3775:25,
 3776:39, 3810:36,
 3812:5
Medical [3] - 3720:21,
 3804:15, 3804:20
medical [87] - 3715:6,
 3716:33, 3716:35,
 3717:19, 3718:25,
 3718:27, 3719:22,
 3720:22, 3725:46,
 3726:3, 3739:32,
 3753:9, 3762:34,
 3763:22, 3768:21,
 3768:29, 3772:14,
 3772:16, 3778:13,
 3778:15, 3778:16,
 3778:18, 3778:23,
 3778:26, 3778:28,
 3780:7, 3792:18,
 3792:26, 3792:36,
 3794:5, 3794:13,
 3794:41, 3795:1,
 3795:6, 3796:24,
 3797:25, 3797:26,
 3797:32, 3797:33,
 3797:38, 3797:46,
 3798:8, 3798:36,
 3799:8, 3799:20,
 3799:28, 3800:8,
 3802:2, 3803:22,
 3803:25, 3806:18,
 3808:22, 3809:4,
 3809:34, 3810:26,
 3811:21, 3813:9,
 3814:10, 3816:30,
 3817:19, 3818:12,
 3819:16, 3819:41,
 3819:43, 3819:44,
 3819:47, 3820:3,
 3820:9, 3820:12,
 3820:31, 3820:35,
 3820:36, 3820:39,
 3820:43, 3821:4,
 3821:31, 3821:40,
 3822:7, 3822:16,
 3822:21, 3822:43,
 3823:17, 3823:37,
 3824:11, 3826:43,
 3829:47
Medicare [3] -
 3763:19, 3763:26,
 3763:37
medicine [15] -
 3721:32, 3721:36,
 3750:16, 3779:1,
 3792:21, 3806:45,
 3807:24, 3807:32,
 3807:41, 3811:22,
 3811:23, 3820:1,
 3821:36, 3830:40,
 3830:41
medicos [1] - 3762:32
medium [4] - 3783:26,
 3788:8, 3788:9,
 3788:11
meet [22] - 3731:21,
 3734:42, 3740:40,
 3748:35, 3749:19,
 3751:15, 3751:17,
 3751:21, 3752:15,
 3752:17, 3755:36,
 3764:13, 3767:44,
 3774:10, 3776:25,
 3790:12, 3796:15,
 3812:34, 3825:15,
 3825:35, 3825:41,
 3829:47
meeting [8] - 3715:13,
 3717:9, 3728:44,
 3734:3, 3793:7,
 3812:36, 3827:22,
 3832:2
meetings [2] -
 3825:39, 3825:41
meets [1] - 3777:3
member [4] - 3749:7,
 3750:15, 3822:29,
 3827:5
members [60] -
 3719:39, 3720:12,
 3720:43, 3725:46,
 3725:47, 3727:4,
 3731:19, 3732:27,
 3734:41, 3735:31,
 3735:37, 3737:17,
 3737:41, 3738:34,
 3738:39, 3741:5,
 3741:23, 3741:34,
 3741:43, 3744:10,
 3744:26, 3744:38,
 3744:43, 3747:35,
 3747:38, 3747:42,
 3748:13, 3748:27,
 3748:28, 3748:47,
 3749:13, 3750:5,
 3750:8, 3750:27,
 3751:19, 3751:40,
 3751:45, 3752:1,
 3752:21, 3753:38,
 3753:40, 3754:5,
 3754:24, 3755:2,
 3755:14, 3759:20,
 3759:28, 3759:30,
 3759:37, 3759:47,
 3760:3, 3760:17,
 3760:19, 3760:35,
 3761:36, 3761:43,
 3764:32, 3767:28,
 3767:31, 3789:10
members' [1] -
 3762:14
membership [6] -
 3726:43, 3744:45,
 3747:45, 3760:7,
 3764:34, 3766:30
mental [2] - 3753:42,
 3780:6
mentioned [8] -
 3730:43, 3733:38,
 3762:6, 3797:28,
 3799:44, 3800:34,
 3805:9, 3811:15
mentoring [5] -
 3782:1, 3782:18,
 3782:33, 3782:42,
 3783:6
merit [3] - 3797:41,
 3798:14, 3798:22
merit-based [2] -
 3797:41, 3798:14
merits [1] - 3798:15
message [2] -
 3768:45, 3815:30
messily [1] - 3719:30
met [15] - 3733:23,
 3734:46, 3752:11,
 3752:18, 3752:41,
 3752:47, 3772:16,
 3778:32, 3778:38,
 3779:20, 3779:21,
 3785:6, 3804:14,
 3804:18, 3810:43
methodical [1] -
 3730:19
methodologies [2] -
 3727:23, 3736:1
methodology [1] -
 3742:45
methods [2] - 3732:6,
 3830:25
metrics [2] - 3727:29,
 3727:30
metro [5] - 3762:21,
 3762:32, 3798:8,
 3801:10, 3804:9
metro-based [1] -
 3798:8
metropolitan [1] -
 3812:9
MFI [5] - 3746:43,
 3746:45, 3747:5,
 3747:7, 3747:12
mid [1] - 3816:37
mid-term [1] - 3816:37
midwifery [4] -
 3750:17, 3789:13,
 3789:23, 3790:15
midwives [4] - 3715:7,
 3725:46, 3767:7,
 3767:9
might [138] - 3715:1,
 3715:19, 3718:10,
 3719:37, 3720:4,
 3721:33, 3722:27,
 3727:24, 3727:25,
 3727:29, 3727:31,
 3727:40, 3728:4,
 3728:7, 3728:16,
 3728:41, 3729:6,
 3729:20, 3729:21,
 3730:33, 3731:29,
 3731:30, 3732:1,
 3732:44, 3733:24,
 3734:9, 3734:12,
 3734:22, 3734:23,
 3734:37, 3734:43,
 3735:28, 3735:43,
 3736:15, 3736:20,
 3737:21, 3737:22,
 3737:23, 3737:25,
 3738:27, 3739:7,
 3739:16, 3739:39,
 3739:44, 3741:1,
 3741:25, 3742:29,
 3742:33, 3742:35,
 3742:39, 3743:1,
 3743:23, 3743:27,
 3743:30, 3744:16,
 3744:17, 3744:23,
 3746:4, 3746:11,
 3752:30, 3752:42,
 3753:22, 3753:27,
 3753:28, 3754:7,
 3754:30, 3754:32,
 3755:13, 3757:8,
 3757:11, 3757:12,
 3757:15, 3757:19,
 3757:30, 3757:32,
 3757:36, 3757:41,
 3758:8, 3759:32,
 3759:34, 3759:36,
 3760:11, 3760:25,
 3761:13, 3761:16,
 3761:20, 3763:39,
 3769:7, 3772:20,
 3777:42, 3778:23,
 3781:37, 3785:17,
 3789:3, 3793:18,
 3793:19, 3795:22,
 3796:4, 3796:5,
 3798:2, 3798:39,
 3799:16, 3800:29,
 3800:42, 3801:27,
 3801:31, 3802:21,
 3802:33, 3802:35,
 3802:42, 3803:11,
 3804:9, 3806:5,
 3806:46, 3807:40,
 3808:1, 3809:20,
 3810:20, 3810:36,
 3811:37, 3812:18,
 3812:23, 3814:25,
 3814:40, 3817:34,
 3819:25, 3821:25,
 3823:1, 3823:5,
 3824:16, 3827:2,
 3827:33, 3828:20,
 3828:25
mind [5] - 3714:37,
 3735:46, 3750:40,
 3757:9, 3792:41
minds [2] - 3738:27,
 3755:33
mine [1] - 3775:10
minimum [1] -
 3765:17
ministerial [1] -
 3730:46
ministry [8] - 3718:5,
 3733:2, 3740:5,
 3743:41, 3759:12,
 3795:26, 3815:16,
 3815:18
Ministry [7] - 3720:18,
 3775:37, 3775:39,
 3776:16, 3788:33,
 3790:32, 3791:47
Minns [1] - 3724:6
minor [1] - 3755:4
minority [2] - 3823:12
minute [3] - 3781:38,

- 3818:17, 3832:2
minutes [4] - 3770:16, 3774:29, 3774:31, 3832:7
MIRA [2] - 3799:7, 3800:6
mirroring [1] - 3751:18
misheard [1] - 3791:16
miss [1] - 3783:31
missed [2] - 3754:22, 3777:13
missing [1] - 3783:32
misunderstood [2] - 3790:3, 3790:7
mix [4] - 3736:43, 3737:7, 3737:10, 3799:40
mmm-hmm [4] - 3782:9, 3784:1, 3787:19, 3803:44
model [10] - 3735:6, 3735:14, 3742:10, 3742:14, 3742:22, 3742:23, 3742:28, 3743:27, 3757:20, 3764:8
modelling [5] - 3742:7, 3742:8, 3742:17, 3745:19, 3745:36
models [1] - 3737:1
modern [3] - 3725:32, 3726:17, 3755:1
modernisation [3] - 3753:33, 3753:37, 3756:43
modernised [1] - 3757:4
module [2] - 3797:23, 3799:9
modules [1] - 3772:35
MOH.0010.0377.0001 [1] - 3715:30
MOH.0011.0014.0001 [1] - 3819:24
moment [22] - 3714:1, 3721:25, 3726:19, 3727:10, 3733:31, 3735:13, 3743:39, 3746:23, 3749:33, 3750:30, 3760:34, 3761:30, 3794:6, 3799:13, 3799:44, 3800:34, 3806:11, 3808:32, 3808:39, 3820:30, 3821:13, 3826:26
moments [2] - 3716:14, 3716:26
Monday [6] - 3713:22, 3723:16, 3723:30, 3723:46, 3724:1, 3724:5
money [5] - 3719:9, 3729:34, 3789:34, 3789:37, 3790:2
monitored [1] - 3743:29
monthly [1] - 3757:28
months [7] - 3757:39, 3757:40, 3805:35, 3812:25, 3830:6, 3830:39
morning [2] - 3714:1, 3746:19
most [16] - 3728:17, 3741:9, 3743:5, 3743:7, 3757:22, 3762:33, 3782:44, 3782:47, 3796:32, 3800:8, 3801:11, 3803:39, 3811:17, 3821:18, 3822:20, 3827:7
motivation [2] - 3727:17, 3732:1
motivations [3] - 3727:13, 3727:37, 3728:2
mouthful [1] - 3715:26
move [14] - 3730:44, 3741:18, 3741:38, 3741:45, 3744:11, 3746:8, 3778:7, 3782:6, 3784:3, 3787:12, 3803:28, 3805:33, 3812:42, 3826:41
moved [1] - 3804:19
moving [7] - 3716:12, 3717:31, 3719:3, 3754:2, 3774:30, 3779:26, 3786:32
multifaceted [1] - 3740:39
multifactorial [1] - 3719:30
multiple [4] - 3752:35, 3757:14, 3757:17, 3798:39
must [7] - 3765:18, 3765:26, 3765:41, 3767:43, 3767:44, 3767:45, 3781:3
Muston [7] - 3713:26, 3714:2, 3714:10, 3729:39, 3768:44, 3770:33, 3775:3
MUSTON [81] - 3714:12, 3721:24, 3721:39, 3721:44, 3722:35, 3723:2, 3723:11, 3723:20, 3723:32, 3723:46, 3724:4, 3724:12, 3724:19, 3724:21, 3724:41, 3725:4, 3725:10, 3725:15, 3725:30, 3725:35, 3729:44, 3732:15, 3732:21, 3732:30, 3740:3, 3740:9, 3745:6, 3745:15, 3745:34, 3746:4, 3746:21, 3746:31, 3746:40, 3746:45, 3747:3, 3747:10, 3747:25, 3755:8, 3755:40, 3755:47, 3756:5, 3756:12, 3770:8, 3770:15, 3770:22, 3770:37, 3770:39, 3771:17, 3774:29, 3774:44, 3775:5, 3778:7, 3779:12, 3779:26, 3780:33, 3780:45, 3781:14, 3781:18, 3781:35, 3783:41, 3786:16, 3786:22, 3787:35, 3788:5, 3790:39, 3790:46, 3792:17, 3793:26, 3793:45, 3794:3, 3794:5, 3794:35, 3794:40, 3796:34, 3796:45, 3815:32, 3815:37, 3818:15, 3818:29, 3818:34, 3832:11
Muston's [1] - 3754:34
myriad [4] - 3726:9, 3745:30, 3750:11, 3752:31

N

naive [2] - 3816:47, 3831:18
name [1] - 3819:8
nation [1] - 3714:5
National [2] - 3718:14, 3758:6
national [14] - 3726:35, 3728:38, 3805:9, 3805:14, 3805:17, 3805:18, 3805:26, 3805:27, 3805:29, 3805:32, 3805:40, 3805:45, 3806:46, 3816:35
nationally [1] - 3764:41
Nations [1] - 3797:34
naturally [1] - 3791:30
nature [15] - 3717:2, 3738:36, 3740:32, 3742:30, 3743:16, 3743:42, 3749:47, 3750:23, 3754:21, 3754:45, 3755:27, 3771:32, 3784:23, 3793:6, 3821:14
NDIS [1] - 3718:47
near [1] - 3741:22
nearly [1] - 3825:31
neat [1] - 3722:14
necessarily [8] - 3732:34, 3736:30, 3774:16, 3800:15, 3802:46, 3803:32, 3806:42, 3812:7
necessary [8] - 3721:44, 3751:22, 3762:7, 3777:20, 3777:43, 3805:29, 3811:37, 3830:15
need [48] - 3719:1, 3720:33, 3721:24, 3731:41, 3734:39, 3739:14, 3739:41, 3739:46, 3748:19, 3748:39, 3749:22, 3749:25, 3751:23, 3752:15, 3752:39, 3753:3, 3757:4, 3770:16, 3773:11, 3773:42, 3776:35, 3777:37, 3778:41, 3783:26, 3795:36, 3796:4, 3796:15, 3796:23, 3801:22, 3803:11, 3805:8, 3806:7, 3806:41, 3811:35, 3812:17, 3812:30, 3812:38, 3812:44, 3813:26, 3813:43, 3816:9, 3816:34, 3826:47, 3827:28, 3829:18, 3831:6, 3831:7
needed [5] - 3730:41, 3756:43, 3779:42, 3829:47, 3830:4
needing [2] - 3813:37, 3817:38
needs [25] - 3714:28, 3715:13, 3731:22, 3733:2, 3736:30, 3746:13, 3749:17, 3749:19, 3751:17, 3755:28, 3767:15, 3773:25, 3774:10, 3774:26, 3777:2, 3777:34, 3793:17, 3809:38, 3809:46, 3810:4, 3811:29, 3824:19, 3827:13, 3830:46
needs' [1] - 3829:45
negative [3] - 3720:28, 3722:16, 3804:6
negotiate [1] - 3759:35
negotiated [2] - 3741:28, 3830:44
negotiating [2] - 3755:36, 3755:37
negotiation [1] - 3755:16
neighbour [1] - 3721:30
network [28] - 3716:20, 3763:10, 3799:21, 3800:3, 3800:44, 3800:47, 3801:2, 3801:4, 3801:5, 3801:26, 3801:31, 3801:37, 3801:43, 3801:45, 3802:9, 3802:34, 3807:9, 3811:16, 3812:14, 3812:27, 3812:29, 3813:10, 3815:16, 3815:17, 3815:42, 3815:44, 3816:14
networked [4] - 3813:38, 3815:38, 3815:43, 3815:47
networks [50] - 3716:23, 3771:26, 3772:6, 3772:18, 3773:10, 3776:16, 3778:10, 3778:11, 3778:13, 3778:17, 3793:10, 3795:18, 3797:45, 3800:2, 3800:3, 3800:34, 3800:35, 3800:37, 3801:2, 3801:9, 3801:14, 3801:15, 3801:35, 3802:15, 3802:20, 3806:23, 3806:24, 3806:25, 3809:17, 3811:4, 3811:5, 3811:10, 3811:14, 3811:41,

3811:42, 3811:45,
3811:46, 3812:4,
3812:10, 3812:34,
3812:47, 3813:4,
3813:7, 3813:15,
3813:25, 3813:46,
3815:14, 3816:3
never [1] - 3738:34
nevertheless [2] -
3727:25, 3813:25
new [9] - 3714:32,
3714:33, 3727:32,
3749:14, 3775:32,
3779:43, 3780:5,
3825:5, 3826:27
New [67] - 3713:19,
3715:6, 3720:13,
3720:27, 3724:15,
3724:23, 3726:17,
3727:23, 3728:12,
3728:30, 3731:11,
3731:25, 3731:38,
3734:5, 3735:31,
3736:37, 3739:30,
3740:13, 3741:13,
3741:17, 3741:29,
3741:41, 3751:41,
3753:5, 3753:18,
3753:37, 3764:15,
3768:29, 3771:28,
3771:38, 3771:39,
3772:6, 3772:40,
3773:20, 3784:10,
3792:10, 3795:18,
3797:19, 3797:20,
3797:40, 3801:12,
3801:14, 3804:26,
3806:14, 3806:19,
3807:3, 3807:16,
3807:18, 3807:19,
3807:22, 3807:25,
3807:35, 3808:4,
3808:12, 3808:18,
3808:23, 3808:28,
3808:33, 3808:36,
3809:34, 3811:17,
3813:20, 3823:45,
3824:17, 3827:7,
3827:20, 3827:44
next [24] - 3715:1,
3717:5, 3719:10,
3725:21, 3748:37,
3749:37, 3750:37,
3770:15, 3775:9,
3778:25, 3784:37,
3788:27, 3792:17,
3793:45, 3799:13,
3800:45, 3805:14,
3805:24, 3812:43,
3812:46, 3820:1,
3825:32, 3827:12,
3828:7
nice [4] - 3739:38,
3829:45, 3830:2,
3830:14
nicely [1] - 3719:10
night [1] - 3783:29
no-one [3] - 3723:11,
3752:4, 3831:46
noble [1] - 3768:10
nods [3] - 3795:29,
3802:26, 3828:5
nominate [1] -
3764:31
nominated [1] -
3799:33
nominating [1] -
3799:20
non [9] - 3720:42,
3721:3, 3721:11,
3721:26, 3722:5,
3773:46, 3775:18,
3780:7, 3807:33
non-clinical [1] -
3775:18
non-Commonwealth
[1] - 3807:33
non-HETI [1] -
3773:46
non-medical [1] -
3780:7
non-standard [5] -
3720:42, 3721:3,
3721:11, 3721:26,
3722:5
none [4] - 3737:12,
3777:11, 3777:13,
3777:14
normal [1] - 3799:3
normally [1] - 3826:38
North [2] - 3802:10,
3802:13
north [1] - 3741:33
nose [2] - 3817:38,
3817:39
note [4] - 3719:21,
3729:4, 3734:9,
3750:8
noted [6] - 3716:15,
3716:40, 3725:27,
3749:7, 3749:13,
3750:9
nothing [5] - 3716:10,
3768:41, 3793:31,
3818:32, 3831:31
noticed [2] - 3746:23,
3824:16
notified [1] - 3775:36
noting [1] - 3715:2
notionally [1] -
3810:33
November [3] -
3714:19, 3780:11,
3794:16
NSW [68] - 3713:35,
3714:35, 3715:36,
3716:45, 3719:33,
3726:36, 3728:27,
3728:47, 3729:45,
3730:32, 3730:33,
3730:39, 3731:27,
3734:20, 3735:18,
3736:4, 3736:13,
3737:47, 3743:17,
3743:20, 3743:26,
3744:15, 3744:36,
3744:41, 3745:2,
3746:47, 3747:7,
3752:22, 3753:22,
3753:32, 3756:26,
3756:30, 3758:5,
3759:11, 3760:37,
3760:41, 3761:35,
3762:13, 3762:15,
3763:17, 3763:47,
3764:22, 3766:2,
3766:6, 3766:22,
3767:18, 3767:37,
3768:3, 3769:12,
3769:37, 3771:26,
3772:11, 3775:22,
3776:9, 3777:30,
3780:17, 3787:39,
3789:39, 3799:27,
3807:28, 3827:19,
3827:34, 3828:40,
3828:45, 3829:10,
3830:22, 3831:8
number [76] -
3716:18, 3717:44,
3722:23, 3726:14,
3728:40, 3728:42,
3729:8, 3729:26,
3729:30, 3729:31,
3731:14, 3731:43,
3733:40, 3740:30,
3741:36, 3744:15,
3745:25, 3747:41,
3749:31, 3749:36,
3750:41, 3751:45,
3758:28, 3761:11,
3762:34, 3764:32,
3764:38, 3765:17,
3771:37, 3773:9,
3776:46, 3782:41,
3788:12, 3788:20,
3789:38, 3790:33,
3791:12, 3791:38,
3795:17, 3795:40,
3795:43, 3795:44,
3796:2, 3796:5,
3796:9, 3796:20,
3797:5, 3797:10,
3797:20, 3797:22,
3797:40, 3797:43,
3798:25, 3799:17,
3799:22, 3800:4,
3800:8, 3800:40,
3801:5, 3801:13,
3801:21, 3801:28,
3801:30, 3801:31,
3801:35, 3803:27,
3803:37, 3805:18,
3806:20, 3808:36,
3816:33, 3816:34,
3825:4, 3830:5,
3830:12
numbered [1] - 3801:2
numbers [8] -
3733:34, 3740:27,
3745:37, 3745:41,
3745:44, 3796:6,
3808:34
numeral [1] - 3775:11
nurse [4] - 3725:46,
3732:34, 3822:22,
3822:25
nurses [6] - 3715:7,
3732:25, 3732:35,
3732:38, 3732:46,
3745:39
nursing [12] -
3718:31, 3726:3,
3729:30, 3731:14,
3731:43, 3732:43,
3750:17, 3767:4,
3789:13, 3789:22,
3789:25, 3790:14
nuts [1] - 3825:10

O

o'clock [1] - 3774:36
obesity [1] - 3831:24
objective [2] -
3758:22, 3809:24
objectives [6] -
3781:30, 3783:12,
3784:25, 3784:34,
3785:5, 3820:5
observation [8] -
3732:17, 3739:6,
3747:43, 3747:44,
3750:26, 3751:44,
3756:26
observations [3] -
3747:34, 3747:35,
3748:3
observe [4] - 3753:19,
3758:1, 3762:41,
3763:1
observed [7] -
3743:39, 3754:18,
3754:19, 3757:45,
3767:22, 3767:27,
3824:24
observing [1] - 3719:4
obstruction [1] -
3730:11
obstructionist [1] -
3730:11
obtain [6] - 3748:19,
3748:20, 3760:16,
3807:5, 3813:44,
3814:40
obtained [4] -
3807:41, 3808:11,
3808:25, 3830:39
obtaining [1] -
3798:42
obvious [1] - 3719:15
obviously [30] -
3715:40, 3719:41,
3729:5, 3739:13,
3739:46, 3741:44,
3742:9, 3744:40,
3746:27, 3757:20,
3757:47, 3761:31,
3764:35, 3783:26,
3784:16, 3799:6,
3804:7, 3804:25,
3804:27, 3806:3,
3806:7, 3810:10,
3810:22, 3812:39,
3813:17, 3815:43,
3816:9, 3817:11,
3817:33
occasion [3] -
3762:41, 3763:1,
3773:18
occasional [1] -
3793:7
occupational [2] -
3738:6, 3752:25
occupations [3] -
3726:4, 3733:13,
3764:34
occupied [1] -
3814:31
occur [3] - 3785:41,
3822:13, 3823:20
occurred [2] - 3736:7,
3829:34
occurring [5] -
3731:10, 3753:37,
3757:41, 3785:18,
3793:21
occurs [11] - 3719:17,
3750:29, 3773:9,
3775:22, 3793:6,
3805:34, 3816:9,

- 3822:14, 3825:9,
3825:17, 3827:40
October [2] - 3715:46,
3716:9
OF [2] - 3734:21,
3832:16
offer [5] - 3791:38,
3798:27, 3798:28,
3800:29, 3800:32
offered [14] - 3721:46,
3731:28, 3773:34,
3782:42, 3788:9,
3788:11, 3788:38,
3789:39, 3791:40,
3798:24, 3798:47,
3799:2, 3800:28
office [2] - 3789:23,
3790:15
officer [5] - 3753:47,
3759:34, 3778:18,
3809:4, 3814:10
officers [3] - 3753:9,
3768:22, 3822:40
official [2] - 3752:34,
3795:37
officials [3] - 3733:38,
3741:12, 3744:10
often [24] - 3743:39,
3743:40, 3744:13,
3750:18, 3752:29,
3752:45, 3754:3,
3754:20, 3757:24,
3773:34, 3775:38,
3783:18, 3791:25,
3804:31, 3814:23,
3814:30, 3821:28,
3821:29, 3822:18,
3823:31, 3825:16,
3825:32, 3825:39
Ombudsman [1] -
3718:14
on-boarding [3] -
3727:26, 3797:24,
3810:23
once [6] - 3719:28,
3789:31, 3802:19,
3827:20, 3827:31,
3829:25
one [85] - 3715:12,
3717:30, 3718:33,
3720:18, 3720:34,
3720:41, 3723:11,
3723:23, 3726:42,
3726:46, 3727:36,
3729:4, 3732:34,
3733:27, 3733:38,
3734:30, 3736:31,
3737:8, 3739:37,
3742:40, 3744:40,
3745:29, 3745:41,
3746:10, 3747:28,
3748:42, 3749:26,
3750:10, 3750:15,
3750:41, 3752:2,
3752:4, 3752:33,
3753:40, 3756:10,
3758:23, 3772:28,
3774:23, 3778:8,
3780:34, 3782:16,
3783:22, 3784:45,
3786:23, 3792:32,
3797:28, 3798:4,
3799:2, 3799:3,
3799:13, 3799:33,
3799:39, 3800:28,
3800:43, 3803:13,
3805:42, 3809:11,
3810:9, 3810:13,
3810:23, 3810:35,
3810:36, 3812:22,
3812:42, 3813:24,
3815:3, 3816:19,
3821:26, 3823:11,
3824:35, 3825:12,
3826:12, 3826:31,
3826:33, 3826:40,
3827:31, 3828:4,
3828:20, 3828:21,
3830:10, 3830:45,
3831:2, 3831:10,
3831:46
one-year [1] - 3831:2
ongoing [2] - 3783:44,
3786:13
online [8] - 3746:37,
3782:25, 3782:27,
3782:30, 3783:2,
3783:8, 3787:42,
3832:5
open [3] - 3728:2,
3729:46, 3731:16
opening [3] - 3714:2,
3714:18, 3725:28
openness [2] -
3744:6, 3744:8
operate [5] - 3752:28,
3800:35, 3805:41,
3811:24, 3811:41
operates [4] -
3731:38, 3761:35,
3815:15, 3820:34
operating [2] -
3718:41, 3719:38
operation [1] -
3730:21
operator [1] - 3781:35
opinion [2] - 3726:40,
3726:42
opinions [1] - 3735:27
opportunities [10] -
3783:13, 3783:44,
3789:7, 3796:35,
3804:34, 3813:19,
3813:21, 3823:28,
3823:31, 3831:11
opportunity [14] -
3722:26, 3737:24,
3740:34, 3744:47,
3761:31, 3771:9,
3773:25, 3794:27,
3805:22, 3813:16,
3813:42, 3823:30,
3823:38, 3829:32
opposed [6] -
3740:38, 3743:33,
3744:24, 3750:6,
3762:14, 3808:10
optimal [4] - 3732:8,
3737:2, 3753:12,
3753:24
optimised [5] -
3797:42, 3798:40,
3799:12, 3799:35,
3799:40
option [2] - 3804:43,
3804:44
Orange [2] - 3797:43,
3798:5
order [13] - 3723:7,
3728:36, 3749:25,
3799:27, 3801:3,
3801:41, 3805:46,
3811:29, 3812:2,
3812:31, 3813:26,
3813:44, 3815:3
ordinarily [1] -
3734:12
organically [2] -
3721:1, 3722:5
organisation [19] -
3729:8, 3733:32,
3735:25, 3756:25,
3756:31, 3769:7,
3769:18, 3773:26,
3776:13, 3776:31,
3776:33, 3779:40,
3779:41, 3780:2,
3782:12, 3783:27,
3787:38, 3791:2,
3820:24
organisational [8] -
3784:39, 3784:42,
3785:4, 3785:17,
3785:27, 3786:10,
3786:11, 3786:29
organisations [9] -
3743:40, 3748:46,
3761:2, 3771:26,
3772:7, 3776:9,
3776:30, 3777:30,
3777:33
organised [3] -
3813:46, 3814:2,
3830:3
organiser [1] -
3729:16
organising [2] -
3729:18, 3820:18
original [2] - 3773:46,
3791:44
originate [1] - 3824:8
osteoporosis [1] -
3831:23
otherwise [9] -
3737:23, 3739:27,
3746:5, 3752:46,
3755:24, 3761:14,
3761:31, 3796:40,
3826:10
ought [7] - 3714:41,
3735:18, 3739:28,
3739:29, 3739:30,
3739:42, 3761:4
ourselves [1] -
3729:14
outcome [2] - 3782:7,
3782:13
outcomes [4] -
3743:22, 3753:12,
3758:37, 3781:31
outdated [9] -
3720:33, 3721:20,
3753:33, 3754:47,
3756:24, 3756:47,
3769:2, 3769:7,
3769:29
outer [1] - 3812:9
outline [1] - 3722:40
output [3] - 3748:15,
3773:7, 3773:30
outputs [2] - 3742:6,
3773:47
outside [19] - 3719:17,
3726:2, 3726:3,
3741:9, 3750:16,
3750:17, 3777:33,
3778:4, 3778:5,
3785:18, 3790:21,
3802:13, 3806:23,
3810:11, 3811:5,
3813:39, 3814:2,
3817:37, 3824:20
over-egg [1] - 3741:42
over-emphasise [2] -
3745:35
overall [3] - 3793:12,
3797:18, 3831:26
overcome [3] -
3729:21, 3744:39,
3808:26
overlap [1] - 3719:15
oversee [1] - 3778:9
overseeing [1] -
3795:5
oversight [8] -
3775:12, 3775:31,
3775:47, 3776:10,
3776:21, 3799:6,
3813:5, 3813:14
oversights [1] -
3795:1
overtime [2] -
3716:33, 3732:37
own [5] - 3719:8,
3774:14, 3776:26,
3782:31, 3791:25
owned [1] - 3806:32
owner [1] - 3776:4
owners [2] - 3714:6,
3789:33
-
- P**
-
- pace** [2] - 3740:30,
3751:21
paediatric [3] -
3812:21, 3813:8,
3813:32
paediatrics [3] -
3811:21, 3811:37
page [9] - 3768:47,
3775:10, 3780:20,
3780:27, 3781:18,
3781:22, 3781:26,
3783:41, 3790:37
paid [7] - 3721:14,
3741:26, 3750:34,
3764:18, 3766:21,
3789:37, 3808:12
panel [4] - 3827:6,
3827:8, 3827:22,
3828:14
paper [5] - 3716:5,
3736:37, 3754:12,
3754:41, 3754:42
Paper [1] - 3744:46
paragraph [71] -
3725:42, 3726:26,
3730:30, 3735:16,
3735:17, 3740:10,
3742:5, 3743:15,
3744:44, 3745:39,
3747:15, 3747:30,
3747:37, 3748:38,
3750:33, 3751:9,
3751:39, 3752:20,
3753:2, 3753:30,
3753:31, 3756:23,
3762:19, 3764:17,
3767:13, 3767:27,

- 3768:9, 3768:19,
3769:6, 3771:20,
3772:21, 3775:9,
3775:13, 3775:29,
3778:8, 3778:12,
3778:25, 3779:26,
3788:28, 3790:27,
3790:29, 3790:39,
3790:40, 3790:42,
3790:47, 3791:10,
3791:11, 3791:45,
3792:18, 3792:44,
3794:40, 3794:46,
3795:5, 3795:24,
3795:25, 3795:47,
3797:29, 3800:36,
3806:12, 3811:11,
3815:13, 3816:17,
3819:37, 3821:13,
3821:24, 3822:47,
3824:30, 3826:21,
3828:47, 3829:21,
3831:7
- paragraphs** [1] -
3791:17
- parallel** [1] - 3809:30
- paramedic** [3] -
3741:21, 3741:25,
3742:3
- paramedics** [4] -
3741:13, 3741:14,
3741:28, 3744:17
- paramount** [1] -
3752:45
- park** [1] - 3714:37
- parliament** [1] -
3731:9
- parliamentarian** [2] -
3762:40, 3762:47
- part** [43] - 3716:4,
3721:15, 3723:32,
3724:42, 3733:29,
3748:40, 3749:16,
3764:30, 3765:34,
3765:37, 3765:38,
3784:16, 3785:20,
3786:17, 3790:4,
3792:10, 3797:44,
3797:45, 3799:16,
3799:23, 3799:40,
3799:47, 3801:34,
3802:30, 3802:33,
3804:4, 3806:23,
3806:25, 3806:32,
3806:41, 3807:9,
3807:10, 3807:36,
3812:18, 3812:27,
3814:23, 3815:20,
3817:10, 3817:43,
3819:16, 3820:12,
3823:35, 3831:4
- participants** [1] -
3783:33
- participate** [4] -
3749:24, 3749:25,
3754:46, 3760:20
- participating** [3] -
3755:17, 3798:18,
3802:8
- particular** [102] -
3714:45, 3715:6,
3716:12, 3716:37,
3717:20, 3717:42,
3717:43, 3717:44,
3718:33, 3718:46,
3719:44, 3721:5,
3721:6, 3721:7,
3721:11, 3722:18,
3725:45, 3727:13,
3727:37, 3728:40,
3728:41, 3729:3,
3729:16, 3729:29,
3731:22, 3732:43,
3733:35, 3734:36,
3734:44, 3734:46,
3735:34, 3735:47,
3736:44, 3737:27,
3737:28, 3737:29,
3737:46, 3738:20,
3738:33, 3739:12,
3739:25, 3739:31,
3741:6, 3742:6,
3743:4, 3743:35,
3744:9, 3744:11,
3744:39, 3745:41,
3745:44, 3747:40,
3747:41, 3748:2,
3748:8, 3749:34,
3749:38, 3749:44,
3750:26, 3750:27,
3750:47, 3751:10,
3751:14, 3752:8,
3752:23, 3753:8,
3753:34, 3758:27,
3759:25, 3759:33,
3761:7, 3761:11,
3761:12, 3761:21,
3767:44, 3771:40,
3772:43, 3772:46,
3773:6, 3773:26,
3773:30, 3774:2,
3776:23, 3776:37,
3776:43, 3777:2,
3781:31, 3784:5,
3784:13, 3784:25,
3786:27, 3789:42,
3795:39, 3801:41,
3809:40, 3810:39,
3811:28, 3818:9,
3828:17, 3828:37
- particularly** [37] -
3714:21, 3716:29,
3717:23, 3717:28,
3717:35, 3718:22,
3718:35, 3718:40,
3718:45, 3719:22,
3722:4, 3727:2,
3727:8, 3729:26,
3734:5, 3734:47,
3735:33, 3735:39,
3738:35, 3741:15,
3741:17, 3742:26,
3745:19, 3749:14,
3750:11, 3755:26,
3757:32, 3761:19,
3775:39, 3793:10,
3810:19, 3815:22,
3820:7, 3820:27,
3822:38, 3824:20
- parties** [2] - 3755:36,
3755:37
- partner** [3] - 3744:8,
3744:32, 3783:26
- partnership** [1] -
3744:25
- parts** [11] - 3717:32,
3718:30, 3719:33,
3723:20, 3726:13,
3728:3, 3740:12,
3769:38, 3801:37,
3802:40, 3815:44
- passed** [1] - 3748:8
- passion** [1] - 3738:10
- passionate** [1] -
3738:12
- passionately** [1] -
3751:35
- past** [4] - 3714:7,
3720:27, 3725:24,
3777:29
- Pathology** [1] - 3805:3
- pathway** [32] -
3764:26, 3766:38,
3797:32, 3797:37,
3797:42, 3797:44,
3797:45, 3798:11,
3798:19, 3798:21,
3798:37, 3798:38,
3798:41, 3798:42,
3799:4, 3799:12,
3799:14, 3799:15,
3799:17, 3799:23,
3799:32, 3799:36,
3799:41, 3799:45,
3803:4, 3809:12,
3814:15, 3814:16,
3814:19, 3814:41,
3828:1
- pathways** [14] -
3717:9, 3717:27,
3717:30, 3717:34,
3718:9, 3719:16,
3719:17, 3719:20,
3744:11, 3797:28,
3797:31, 3799:39,
3806:27, 3806:28
- patient** [10] - 3753:12,
3771:43, 3816:21,
3817:4, 3817:6,
3817:9, 3817:18,
3818:1, 3822:30,
3825:21
- patients** [18] -
3728:12, 3738:16,
3753:24, 3763:23,
3796:27, 3812:40,
3814:35, 3817:21,
3817:24, 3818:25,
3821:31, 3821:38,
3822:28, 3825:4,
3825:5, 3830:3,
3830:7
- pause** [1] - 3781:38
- pausing** [5] - 3750:45,
3778:44, 3801:9,
3808:47, 3827:18
- pay** [10] - 3714:7,
3740:47, 3741:6,
3741:13, 3741:15,
3741:34, 3741:36,
3744:26, 3754:16,
3790:2
- paying** [5] - 3722:2,
3807:46, 3808:1,
3808:14, 3808:17
- payment** [3] - 3721:7,
3766:46, 3767:9
- peak** [2] - 3764:43,
3764:44
- peculiar** [2] - 3773:26,
3776:36
- peeled** [1] - 3781:14
- peer** [1] - 3753:42
- pegged** [1] - 3767:11
- penultimate** [1] -
3745:39
- People** [1] - 3735:33
- people** [60] - 3714:5,
3714:41, 3719:9,
3719:29, 3721:13,
3722:2, 3725:39,
3727:11, 3727:39,
3728:2, 3731:20,
3731:29, 3731:41,
3732:44, 3733:3,
3733:19, 3734:20,
3735:44, 3738:5,
3740:19, 3741:21,
3741:37, 3745:25,
3746:36, 3749:31,
3749:35, 3749:36,
3761:19, 3761:22,
3766:31, 3768:14,
3771:39, 3773:20,
3776:47, 3782:26,
3782:34, 3782:39,
3782:44, 3782:47,
3783:11, 3783:13,
3783:28, 3784:15,
3784:21, 3784:43,
3785:33, 3786:6,
3786:12, 3790:14,
3790:17, 3790:24,
3793:23, 3797:34,
3803:38, 3804:7,
3810:15, 3810:17,
3814:31, 3822:16,
3828:26
- people's** [1] - 3755:33
- per** [4] - 3762:22,
3767:9, 3768:28,
3824:9
- perceive** [5] - 3727:47,
3731:17, 3756:40,
3767:14, 3767:28
- perceived** [4] -
3756:46, 3757:7,
3761:10, 3769:28
- percentage** [2] -
3745:23, 3751:45
- perception** [2] -
3756:29, 3769:11
- perfect** [1] - 3737:34
- perform** [4] - 3738:37,
3752:36, 3753:20,
3754:5
- performance** [1] -
3730:22
- performing** [3] -
3731:34, 3733:6
- perhaps** [22] -
3719:27, 3729:40,
3731:46, 3732:21,
3732:30, 3733:30,
3742:20, 3745:27,
3745:46, 3760:29,
3780:33, 3781:18,
3781:35, 3783:41,
3790:19, 3793:15,
3795:36, 3797:14,
3800:38, 3811:11,
3811:43, 3831:17
- period** [12] - 3733:34,
3780:29, 3781:2,
3783:6, 3788:25,
3795:10, 3802:35,
3803:16, 3805:20,
3806:4, 3812:24,
3831:2
- periods** [7] - 3802:43,

3803:39, 3823:2,
3823:15, 3823:16,
3830:5, 3830:6
permanency [1] -
3753:23
permanent [3] -
3720:29, 3729:34,
3807:29
permanently [2] -
3752:14, 3753:11
pernicious [1] -
3714:24
person [4] - 3721:7,
3778:34, 3809:22,
3810:41
perspective [11] -
3714:27, 3716:9,
3718:7, 3720:4,
3720:7, 3758:42,
3797:15, 3798:23,
3800:38, 3808:31,
3822:10
persuade [1] -
3803:12
pertained [1] -
3728:27
pervasive [1] -
3715:18
PGY1 [12] - 3718:28,
3778:20, 3792:22,
3795:14, 3796:31,
3796:35, 3796:39,
3797:17, 3802:30,
3804:12, 3804:33,
3808:45
PGY2 [11] - 3778:20,
3795:14, 3804:23,
3804:33, 3804:39,
3804:42, 3804:45,
3805:12, 3805:30,
3805:43, 3808:45
PGY2s [5] - 3804:37,
3804:38, 3805:4,
3805:7, 3806:21
PGY3 [2] - 3809:8,
3809:22
PGY3-plus [1] -
3814:22
phase [1] - 3743:9
phases [1] - 3780:22
phrase [2] - 3757:10,
3766:29
physical [7] - 3725:4,
3749:17, 3749:21,
3749:28, 3750:21,
3760:24, 3820:25
physician [7] -
3811:15, 3812:16,
3812:21, 3813:8,
3816:13, 3817:30
Physicians [5] -
3824:41, 3825:2,
3825:10, 3825:27,
3825:29
physiotherapist [3] -
3748:24, 3751:2
physiotherapy [1] -
3726:8
pick [4] - 3715:17,
3731:44, 3737:8,
3800:41
picked [3] - 3719:32,
3722:20, 3730:12
picking [2] - 3731:40,
3733:30
picks [1] - 3730:29
picture [8] - 3714:23,
3743:35, 3745:21,
3745:46, 3757:41,
3758:44, 3759:41,
3760:21
piece [4] - 3719:41,
3754:41, 3754:42,
3787:31
pinpoint [2] - 3750:31,
3756:10
place [6] - 3736:41,
3766:6, 3775:41,
3806:46, 3827:38,
3830:23
placed [7] - 3736:18,
3736:47, 3765:46,
3773:19, 3779:1,
3789:43, 3820:32
placement [29] -
3718:37, 3748:44,
3749:23, 3749:26,
3750:2, 3750:36,
3751:18, 3764:27,
3765:17, 3765:26,
3765:36, 3765:41,
3790:29, 3791:13,
3791:22, 3791:32,
3798:34, 3820:12,
3820:32, 3820:43,
3821:1, 3821:15,
3822:37, 3823:5,
3823:11, 3823:17,
3823:32, 3824:14
placements [37] -
3718:27, 3718:40,
3748:38, 3748:39,
3750:34, 3750:42,
3751:28, 3752:26,
3764:18, 3767:3,
3790:31, 3791:1,
3791:9, 3791:19,
3791:21, 3791:26,
3791:38, 3791:39,
3791:42, 3791:46,
3792:10, 3820:13,
3820:18, 3820:21,
3821:9, 3821:12,
3822:6, 3822:12,
3822:19, 3822:21,
3822:27, 3822:36,
3823:20, 3823:26,
3823:42, 3830:12
places [4] - 3739:19,
3751:12, 3751:22,
3815:23
Plan [1] - 3780:17
plan [9] - 3736:13,
3736:38, 3780:14,
3780:22, 3780:24,
3781:4, 3781:23,
3821:33, 3821:41
planned [2] - 3748:33,
3752:2
planning [11] -
3715:25, 3716:46,
3717:3, 3719:36,
3730:46, 3736:25,
3736:28, 3776:37,
3776:42, 3776:44,
3793:1
plans [1] - 3811:27
play [4] - 3716:38,
3719:5, 3773:6,
3811:6
played [1] - 3806:17
players [1] - 3791:12
playing [2] - 3750:20,
3754:4
plays [1] - 3790:28
pleased [1] - 3779:44
pleases [1] - 3774:44
plethora [1] - 3744:40
plug [1] - 3752:8
plus [2] - 3748:30,
3830:43
POINT [1] - 3747:8
Point [1] - 3745:2
point [38] - 3715:27,
3728:7, 3728:8,
3735:2, 3736:36,
3738:3, 3742:46,
3743:4, 3745:11,
3745:35, 3745:45,
3749:32, 3750:25,
3751:11, 3753:34,
3757:23, 3757:38,
3758:44, 3759:5,
3760:29, 3764:37,
3764:39, 3767:13,
3784:37, 3785:23,
3785:32, 3786:32,
3786:37, 3787:13,
3796:1, 3804:22,
3814:39, 3818:20,
3820:17, 3820:24,
3823:8, 3826:18,
3829:37
Point" [1] - 3747:1
points [3] - 3730:38,
3749:42, 3781:45
policies [3] - 3736:44,
3760:38, 3779:35
policy [13] - 3728:18,
3729:22, 3731:36,
3735:40, 3738:44,
3759:10, 3767:35,
3775:32, 3775:33,
3775:36, 3776:4,
3776:5, 3807:28
policy-making [1] -
3735:40
policymakers [10] -
3727:33, 3728:11,
3728:15, 3728:20,
3728:35, 3730:25,
3732:1, 3742:42,
3743:10, 3757:25
political [2] - 3730:25,
3739:37
politicians [1] -
3743:10
pool [1] - 3801:30
poor [1] - 3742:20
popularity [1] - 3801:3
population [5] -
3715:14, 3742:26,
3762:23, 3799:19,
3831:22
portal [5] - 3797:23,
3798:31, 3799:7,
3799:10, 3800:6
portfolio [3] -
3778:28, 3794:42,
3795:1
portion [2] - 3765:26,
3765:41
portrayed [1] -
3751:20
position [59] -
3727:27, 3734:40,
3739:25, 3739:33,
3748:21, 3748:23,
3748:34, 3749:8,
3760:44, 3766:1,
3766:44, 3798:43,
3798:47, 3799:1,
3799:2, 3799:39,
3800:17, 3800:31,
3804:42, 3807:17,
3807:23, 3807:25,
3807:33, 3807:35,
3808:3, 3808:5,
3808:7, 3808:10,
3808:15, 3808:18,
3808:23, 3808:27,
3809:32, 3809:35,
3809:39, 3810:3,
3810:7, 3810:14,
3810:26, 3810:27,
3810:40, 3812:15,
3812:29, 3812:32,
3813:12, 3814:11,
3814:12, 3815:5,
3815:19, 3815:43,
3816:8, 3826:33,
3829:23, 3829:32,
3829:36, 3830:29,
3830:40
positioned [1] -
3823:7
positions [49] -
3718:37, 3729:35,
3733:18, 3733:43,
3734:31, 3734:43,
3736:20, 3739:32,
3748:44, 3750:2,
3759:18, 3766:2,
3767:30, 3767:33,
3768:4, 3792:27,
3792:36, 3795:6,
3795:23, 3795:27,
3795:45, 3796:8,
3796:10, 3796:20,
3796:31, 3797:12,
3797:22, 3800:28,
3801:21, 3801:23,
3801:31, 3806:27,
3807:14, 3808:33,
3810:32, 3810:35,
3811:45, 3814:30,
3815:22, 3816:14,
3816:15, 3825:1,
3826:30, 3826:38,
3827:4, 3828:10,
3829:14, 3829:30,
3830:11
positive [1] - 3743:21
possibility [2] -
3721:25, 3743:44
possible [11] -
3722:36, 3723:33,
3730:6, 3737:6,
3750:3, 3780:33,
3780:43, 3800:23,
3804:41, 3808:1,
3826:36
post [4] - 3804:41,
3805:2, 3830:29,
3831:12
postgraduate [5] -
3748:20, 3748:29,
3802:1, 3802:6,
3820:40
posts [1] - 3804:38

- potential** [9] - 3716:1, 3717:47, 3718:7, 3721:16, 3722:1, 3722:6, 3731:13, 3802:41, 3827:36
- potentially** [25] - 3715:44, 3716:24, 3720:41, 3721:12, 3721:26, 3721:28, 3722:14, 3722:16, 3723:22, 3727:38, 3730:44, 3733:21, 3735:11, 3737:6, 3742:44, 3746:11, 3749:35, 3755:20, 3783:33, 3791:32, 3802:35, 3803:18, 3812:20, 3814:39, 3829:22
- poverty** [1] - 3750:36
- powerful** [1] - 3757:22
- prac** [1] - 3766:46
- practicable** [1] - 3755:34
- practical** [9] - 3722:27, 3725:15, 3751:43, 3772:30, 3772:42, 3805:15, 3810:41, 3811:11, 3821:25
- practically** [5] - 3746:15, 3821:46, 3826:6, 3826:11
- Practice** [2] - 3785:25, 3786:2
- practice** [20] - 3721:32, 3721:35, 3754:25, 3766:12, 3767:47, 3773:36, 3775:23, 3776:11, 3776:22, 3778:33, 3783:25, 3785:7, 3785:34, 3785:44, 3785:45, 3786:3, 3786:5, 3786:28, 3823:19, 3823:20
- practices** [5] - 3719:26, 3736:44, 3737:2, 3806:16, 3806:18
- practise** [4] - 3748:20, 3765:19, 3808:46, 3824:26
- Practitioner** [3] - 3718:14, 3758:9, 3765:12
- practitioner** [1] - 3762:42
- Practitioners** [1] - 3804:47
- practitioners** [8] - 3762:35, 3764:1, 3765:4, 3766:27, 3766:45, 3809:11, 3824:27
- pre** [4] - 3778:34, 3806:2, 3810:22, 3827:22
- pre-employment** [1] - 3810:22
- pre-entry** [1] - 3806:2
- pre-meeting** [1] - 3827:22
- pre-vocational** [1] - 3778:34
- preaching** [1] - 3803:8
- precedent** [1] - 3831:1
- precise** [3] - 3723:12, 3745:37, 3802:20
- precisely** [1] - 3829:42
- precision** [1] - 3813:38
- predecessor** [1] - 3780:2
- predominantly** [1] - 3765:6
- prefer** [1] - 3819:26
- preference** [13] - 3770:20, 3797:38, 3799:47, 3800:5, 3800:17, 3800:24, 3800:40, 3802:43, 3803:11, 3803:14, 3828:14, 3828:16
- preferences** [3] - 3799:19, 3800:9, 3800:39
- preferential** [9] - 3797:37, 3797:44, 3798:10, 3798:17, 3798:18, 3798:37, 3798:42, 3799:17, 3803:4
- preferred** [2] - 3798:23, 3820:42
- premise** [4] - 3726:33, 3732:47, 3752:44, 3763:13
- premium** [1] - 3716:32
- preparation** [1] - 3723:17
- prepared** [8] - 3714:35, 3715:23, 3724:30, 3742:23, 3745:12, 3755:14, 3771:2, 3794:20
- prerequisite** [1] - 3809:29
- prerequisites** [1] - 3810:43
- prescribed** [2] - 3752:12, 3822:42
- present** [10] - 3713:33, 3714:7, 3720:14, 3721:5, 3721:12, 3722:14, 3728:38, 3728:39, 3735:8, 3759:42
- presentations** [1] - 3734:13
- presented** [5] - 3730:20, 3730:24, 3731:5, 3734:14, 3747:27
- presenting** [4] - 3735:39, 3755:16, 3758:23, 3821:37
- presents** [2] - 3758:33
- press** [1] - 3731:8
- pressure** [1] - 3718:46
- presumably** [3] - 3737:40, 3796:36, 3802:28
- pretty** [1] - 3782:44
- prevent** [1] - 3830:4
- preventative** [3] - 3786:35, 3786:42, 3787:8
- previous** [3] - 3731:2, 3751:46, 3816:25
- previously** [1] - 3779:39
- prevocational** [22] - 3778:20, 3778:41, 3795:2, 3795:10, 3795:18, 3799:21, 3800:1, 3800:3, 3800:37, 3801:15, 3802:1, 3802:46, 3803:5, 3803:22, 3803:28, 3805:1, 3806:14, 3806:15, 3806:18, 3809:14, 3809:16, 3816:37
- Pricing** [1] - 3758:15
- primary** [7] - 3763:10, 3763:24, 3763:29, 3763:38, 3771:24, 3823:21, 3823:47
- Prince** [6] - 3801:1, 3801:4, 3801:6, 3812:8, 3812:15, 3820:8
- priorities** [1] - 3781:22
- prioritise** [2] - 3753:23, 3823:31
- priority** [4] - 3799:26, 3799:27, 3807:27, 3828:13
- private** [12] - 3721:28, 3806:13, 3806:16, 3806:17, 3806:20, 3806:33, 3806:40, 3806:44, 3807:3, 3807:4, 3807:6, 3807:7
- privately** [2] - 3777:26, 3806:32
- proactive** [2] - 3751:42, 3767:15
- problem** [5] - 3723:17, 3729:32, 3737:40, 3744:9, 3821:37
- problems** [4] - 3725:33, 3744:40, 3750:10, 3821:39
- procedure** [2] - 3817:31, 3817:33
- process** [95] - 3716:4, 3720:47, 3728:23, 3731:37, 3735:41, 3736:23, 3737:21, 3737:22, 3738:10, 3738:11, 3739:3, 3743:12, 3743:34, 3744:22, 3752:21, 3752:42, 3753:36, 3753:38, 3754:8, 3754:11, 3754:13, 3754:27, 3754:37, 3754:42, 3755:5, 3755:16, 3755:17, 3755:23, 3755:24, 3755:29, 3755:32, 3755:35, 3758:22, 3759:17, 3759:25, 3759:29, 3760:7, 3760:27, 3764:45, 3765:44, 3767:29, 3767:41, 3767:43, 3767:44, 3767:45, 3774:25, 3776:14, 3779:32, 3784:20, 3786:17, 3790:4, 3791:4, 3792:38, 3792:41, 3796:7, 3797:27, 3798:15, 3798:19, 3798:45, 3800:1, 3804:17, 3808:41, 3809:15, 3809:22, 3809:30, 3816:9, 3817:11, 3820:12, 3820:31, 3820:38, 3821:29, 3822:4, 3822:30, 3827:2, 3827:10, 3827:16, 3827:18, 3827:19, 3827:21, 3827:28, 3827:39, 3827:43, 3828:4, 3828:14, 3828:16, 3828:22, 3828:27, 3828:31, 3828:39, 3828:41, 3828:43, 3829:5, 3830:23
- processes** [17] - 3732:7, 3736:3, 3736:17, 3737:19, 3747:47, 3754:20, 3756:8, 3759:31, 3776:15, 3777:3, 3798:20, 3810:23, 3810:44, 3818:4, 3820:5, 3820:16, 3822:40
- processing** [1] - 3790:8
- proclaims** [1] - 3735:7
- procure** [1] - 3760:35
- produce** [6] - 3718:42, 3722:16, 3743:21, 3747:29, 3748:5, 3748:9
- produced** [3] - 3722:24, 3736:15, 3742:33
- product** [3] - 3793:11, 3793:24
- productively** [2] - 3728:4, 3743:20
- products** [4] - 3771:41, 3773:44, 3773:46, 3774:22
- profession** [2] - 3725:46, 3750:43
- professional** [10] - 3737:29, 3751:1, 3751:13, 3764:41, 3766:35, 3785:46, 3786:9, 3786:12, 3805:25, 3818:23
- professionalisation** [1] - 3754:18
- professionals** [18] - 3715:7, 3718:31, 3718:41, 3718:43, 3718:45, 3720:22, 3745:40, 3747:41, 3750:39, 3751:6, 3751:24, 3751:29, 3764:19, 3765:18, 3766:40, 3780:8, 3786:8, 3786:14
- professions** [8] - 3750:12, 3750:16, 3753:39, 3764:23, 3764:35, 3765:23, 3765:25, 3771:37
- professions'** [1] - 3764:43

Professor [7] - 3746:28, 3815:29, 3818:46, 3819:7, 3819:9, 3831:14, 3831:40	proportion [1] - 3747:45	3814:33, 3817:5, 3817:9, 3817:18, 3817:20, 3817:29, 3817:30, 3818:2, 3818:5, 3818:8	3784:25, 3784:27, 3784:32, 3785:19, 3787:36, 3791:2, 3800:30, 3806:32, 3806:42, 3806:47, 3807:25	qualitative [3] - 3727:5, 3727:28, 3759:40
professor [1] - 3749:6	proportionally [1] - 3762:37	provision [5] - 3735:30, 3738:15, 3752:46, 3796:16, 3814:45	publicly [11] - 3730:19, 3730:33, 3730:36, 3731:42, 3736:13, 3739:22, 3742:14, 3753:14, 3759:8, 3760:45, 3761:12	quality [2] - 3775:17, 3793:22
profile [1] - 3734:47	propose [3] - 3715:23, 3715:47, 3723:5	provisional [4] - 3804:19, 3805:33, 3821:32, 3828:8	published [1] - 3731:14	quantitative [2] - 3727:28, 3759:40
program [30] - 3750:45, 3750:47, 3751:8, 3751:10, 3754:46, 3773:36, 3774:6, 3776:4, 3782:20, 3783:34, 3784:13, 3784:34, 3785:4, 3785:5, 3785:6, 3788:39, 3805:1, 3805:5, 3805:8, 3810:42, 3812:6, 3813:41, 3815:24, 3820:7, 3820:24, 3824:40, 3824:47, 3825:9, 3827:11, 3829:21	proposed [2] - 3714:36, 3780:30	provisionally [2] - 3796:46, 3796:47	pull [1] - 3734:9	quarterly [2] - 3731:6, 3757:15
programs [23] - 3750:38, 3750:40, 3750:42, 3763:47, 3764:19, 3772:30, 3772:36, 3772:38, 3772:39, 3773:34, 3773:40, 3776:23, 3782:17, 3782:23, 3782:25, 3782:33, 3782:34, 3782:41, 3783:9, 3783:24, 3784:15, 3785:11, 3820:20	proposes [1] - 3714:40	provokes [1] - 3731:7	pulling [1] - 3727:30	Queensland [10] - 3724:15, 3724:24, 3741:16, 3741:22, 3741:25, 3753:19, 3807:41, 3808:2, 3808:7
progress [6] - 3745:25, 3814:20, 3814:38, 3821:7, 3825:29, 3826:1	prospective [2] - 3717:46, 3720:12	psoriasis [1] - 3818:17	purely [1] - 3826:17	questions [23] - 3726:30, 3728:16, 3728:18, 3728:42, 3733:1, 3736:40, 3745:10, 3745:18, 3755:40, 3756:15, 3756:38, 3761:25, 3770:6, 3770:33, 3793:26, 3793:33, 3809:44, 3818:29, 3818:36, 3818:40, 3826:45, 3831:15, 3831:35
progresses [1] - 3800:45	proud [1] - 3783:22	psychiatry [3] - 3779:34, 3810:44, 3811:20	purpose [9] - 3720:39, 3737:11, 3760:36, 3771:43, 3772:39, 3776:41, 3783:45, 3785:5, 3801:26	quick [1] - 3815:32
progressive [1] - 3781:41	proudly [1] - 3735:7	Psychiatry [3] - 3805:4, 3805:5, 3805:47	purposes [4] - 3715:37, 3731:18, 3776:28, 3788:15	quickly [3] - 3748:34, 3755:33, 3757:19
project [2] - 3734:43, 3787:21	provide [25] - 3731:9, 3732:7, 3738:16, 3740:27, 3745:1, 3745:6, 3748:6, 3749:37, 3751:5, 3764:14, 3771:25, 3771:32, 3771:37, 3772:4, 3773:37, 3796:23, 3796:35, 3800:7, 3805:20, 3812:5, 3816:21, 3817:4, 3823:46, 3825:21, 3825:27	psychologist [1] - 3760:24	pursue [2] - 3809:10, 3809:41	quite [24] - 3723:38, 3729:31, 3732:18, 3747:43, 3748:13, 3752:16, 3752:27, 3753:13, 3756:22, 3757:44, 3758:42, 3761:29, 3773:34, 3775:20, 3775:38, 3779:10, 3783:18, 3788:12, 3788:47, 3789:38, 3798:36, 3808:36, 3811:14, 3822:41
projected [1] - 3748:33	provided [13] - 3749:2, 3771:33, 3773:3, 3777:24, 3800:32, 3804:26, 3807:28, 3810:43, 3815:22, 3817:42, 3823:28, 3830:8, 3831:19	psychology [2] - 3726:9, 3749:7	pursuing [3] - 3740:38, 3809:14, 3809:24	quota [1] - 3825:41
projection [1] - 3754:29	provider [6] - 3749:2, 3751:4, 3763:24, 3779:27, 3779:36, 3792:13	Public [2] - 3735:32, 3784:10	put [16] - 3727:21, 3730:1, 3732:30, 3733:8, 3734:39, 3742:18, 3744:27, 3750:15, 3758:25, 3759:37, 3762:15, 3772:38, 3789:16, 3791:20, 3798:38, 3817:19	
projections [1] - 3742:30	providers [7] - 3750:7, 3765:5, 3771:27, 3786:40, 3787:7, 3792:5, 3793:8	public [73] - 3714:17, 3714:25, 3715:9, 3716:23, 3718:22, 3718:26, 3718:30, 3719:4, 3719:5, 3719:7, 3719:13, 3719:35, 3720:26, 3721:13, 3721:21, 3721:27, 3721:29, 3721:46, 3722:9, 3722:39, 3725:47, 3726:5, 3726:10, 3727:41, 3728:30, 3730:20, 3730:21, 3730:30, 3731:13, 3731:17, 3731:32, 3731:35, 3732:27, 3733:26, 3733:30, 3734:12, 3734:24, 3735:35, 3739:24, 3739:27, 3739:32, 3739:40, 3740:13, 3742:34, 3745:22, 3747:42, 3751:41, 3757:46, 3759:10, 3760:39, 3760:44, 3761:17, 3761:29, 3762:16, 3767:14, 3771:28, 3772:6, 3784:14, 3784:15, 3784:16, 3784:23,	putting [6] - 3730:4, 3732:41, 3765:40, 3766:24, 3809:11, 3810:9	
projects [2] - 3724:14, 3724:22	provides [7] - 3715:27, 3723:6, 3730:20, 3734:15, 3753:11, 3753:12, 3797:18	qualified [3] - 3719:19, 3749:31, 3807:39	qualification [6] - 3751:13, 3776:14, 3777:4, 3777:20, 3789:5, 3789:6	
prominent [1] - 3717:16	providing [20] - 3733:17, 3737:13, 3744:34, 3750:2, 3763:22, 3763:23, 3795:9, 3796:17, 3796:26, 3812:39,	qualify [1] - 3748:24	qualifications [6] - 3748:19, 3748:20, 3748:29, 3777:44, 3777:45, 3827:24	
prompted [1] - 3768:45			radiology [1] - 3811:23	
proper [2] - 3732:36, 3767:46			raising [1] - 3744:45	
			ramifications [1] - 3743:7	
			range [26] - 3717:13, 3718:43, 3719:31, 3728:18, 3735:36,	

- 3736:1, 3736:18,
3736:40, 3740:25,
3741:2, 3742:9,
3742:25, 3742:27,
3744:17, 3753:38,
3765:23, 3766:11,
3787:38, 3788:40,
3805:21, 3805:22,
3810:31, 3811:36,
3812:33, 3813:25,
3822:35
- rapid** [1] - 3755:26
- rapidly** [3] - 3751:16,
3751:20, 3757:24
- rarer** [1] - 3826:12
- rate** [4] - 3733:44,
3740:47, 3745:22,
3761:7
- rates** [7] - 3727:15,
3728:1, 3729:45,
3739:31, 3741:14,
3757:29, 3761:21
- rather** [9] - 3721:5,
3727:13, 3760:8,
3774:3, 3800:16,
3804:6, 3813:10,
3814:29, 3830:2
- ratio** [1] - 3830:10
- rattling** [1] - 3716:6
- reach** [2] - 3744:9,
3747:36
- reaches** [1] - 3745:41
- reacting** [1] - 3743:1
- reactive** [2] - 3751:42,
3767:14
- read** [6] - 3780:22,
3780:31, 3780:36,
3785:7, 3785:21,
3819:29
- readily** [2] - 3758:30,
3760:8
- reading** [1] - 3813:30
- reads** [1] - 3792:29
- real** [16] - 3726:28,
3728:36, 3729:1,
3729:46, 3741:46,
3749:1, 3751:29,
3757:9, 3757:10,
3757:16, 3757:23,
3757:24, 3757:27,
3757:37, 3758:22,
3816:22
- real-time** [11] -
3726:28, 3728:36,
3729:1, 3729:46,
3757:9, 3757:10,
3757:16, 3757:23,
3757:24, 3757:27,
3757:37
- realise** [2] - 3728:6,
3831:10
- realising** [1] - 3820:26
- realistic** [1] - 3746:12
- realistically** [1] -
3718:10
- reality** [2] - 3731:47,
3825:16
- really** [19] - 3721:9,
3729:32, 3739:26,
3742:46, 3752:4,
3777:26, 3783:9,
3783:23, 3787:23,
3791:13, 3791:16,
3792:12, 3792:13,
3798:9, 3803:31,
3803:34, 3806:8,
3816:28, 3818:22
- reason** [9] - 3722:20,
3729:3, 3729:44,
3730:6, 3739:26,
3739:36, 3739:39,
3752:16, 3752:33
- reasonable** [6] -
3737:43, 3743:25,
3755:37, 3757:36,
3814:42
- reasonably** [2] -
3755:34, 3755:35
- reasons** [9] - 3716:24,
3719:7, 3739:39,
3740:25, 3750:15,
3752:31, 3789:3,
3789:40, 3827:38
- receive** [2] - 3732:45,
3744:26
- received** [17] -
3715:22, 3716:28,
3717:17, 3717:22,
3717:23, 3720:34,
3728:31, 3729:6,
3733:33, 3736:26,
3738:33, 3741:23,
3741:30, 3741:34,
3747:14, 3767:32,
3804:32
- receiving** [5] -
3733:28, 3741:17,
3741:35, 3790:11,
3795:14
- recent** [3] - 3722:13,
3741:12, 3766:43
- recently** [8] - 3728:27,
3736:3, 3744:44,
3750:8, 3751:27,
3752:33, 3805:6,
3809:21
- recognise** [6] -
3756:42, 3768:7,
3780:16, 3781:19,
3781:20, 3806:3
- recognised** [7] -
3763:29, 3764:23,
3764:36, 3777:10,
3777:37, 3820:35
- recognising** [2] -
3748:6, 3821:8
- recognition** [1] -
3829:35
- recommendation** [2] -
3731:4
- recommendations** [3]
- 3715:19, 3715:45,
3789:14
- recommended** [2] -
3804:16, 3804:18
- record** [2] - 3752:34,
3819:8
- recreated** [1] -
3783:36
- recruit** [2] - 3806:26,
3807:8
- recruited** [1] - 3719:29
- recruiting** [1] -
3798:28
- recruitment** [31] -
3715:8, 3715:11,
3719:12, 3719:16,
3719:18, 3719:26,
3720:10, 3720:28,
3722:9, 3751:41,
3752:21, 3752:42,
3752:45, 3759:18,
3760:38, 3761:2,
3767:15, 3767:18,
3767:29, 3767:36,
3768:13, 3792:18,
3797:23, 3797:37,
3798:11, 3798:19,
3799:8, 3809:35,
3810:26
- rectify** [2] - 3722:6,
3729:19
- recurrently** [2] -
3830:28, 3830:34
- recurring** [2] -
3714:19, 3716:28
- reduce** [1] - 3830:5
- reduced** [1] - 3748:25
- reduces** [2] - 3749:36,
3783:33
- refer** [10] - 3734:35,
3740:11, 3748:18,
3750:34, 3762:19,
3768:8, 3768:19,
3778:24, 3788:20,
3788:32
- reference** [9] -
3739:10, 3739:47,
3751:26, 3764:24,
3765:8, 3771:47,
3780:21, 3801:22,
3814:6
- referenced** [4] -
3730:16, 3734:26,
3760:21, 3764:33
- referred** [5] - 3725:39,
3727:10, 3747:15,
3770:43, 3798:14
- referring** [9] - 3725:1,
3725:27, 3727:12,
3740:14, 3749:27,
3761:38, 3775:29,
3775:47, 3778:11
- reflect** [4] - 3714:38,
3721:31, 3731:47,
3738:38
- reflected** [5] -
3726:42, 3727:6,
3737:31, 3752:29,
3759:32
- reflecting** [2] -
3723:16, 3723:20
- reflection** [6] -
3748:10, 3748:28,
3750:23, 3750:41,
3756:31, 3769:17
- reflective** [6] -
3726:15, 3754:28,
3754:44, 3755:19,
3818:21, 3826:42
- reflects** [2] - 3714:34,
3762:34
- Reform** [1] - 3742:6
- reform** [10] - 3720:34,
3745:10, 3745:45,
3753:17, 3754:7,
3755:23, 3755:29,
3755:32, 3755:33,
3756:8
- reforming** [1] -
3775:17
- regard** [1] - 3791:9
- regarding** [4] -
3717:43, 3717:45,
3745:19, 3825:29
- regardless** [1] -
3739:32
- region** [2] - 3733:5,
3761:12
- regional** [41] -
3714:20, 3716:29,
3717:24, 3718:20,
3727:3, 3727:11,
3727:38, 3729:26,
3730:45, 3734:6,
3761:20, 3772:43,
3798:5, 3799:14,
3799:32, 3801:7,
3802:44, 3803:4,
3803:6, 3803:10,
3803:17, 3803:29,
3804:7, 3812:9,
3815:23, 3821:9,
3821:12, 3823:2,
3823:6, 3823:18,
3823:22, 3823:27,
3823:43, 3823:44,
3824:8, 3824:11,
3824:14, 3824:26,
3830:29, 3830:36,
3831:12
- regional/rural** [1] -
3801:10
- regionally** [2] -
3803:2, 3823:35
- regions** [5] - 3741:8,
3741:10, 3741:18,
3762:32, 3764:2
- registered** [4] -
3776:12, 3778:2,
3796:47, 3797:1
- registrar** [12] -
3809:39, 3810:32,
3810:40, 3811:13,
3811:46, 3812:28,
3814:7, 3814:10,
3814:20, 3815:5,
3815:21, 3817:41
- registrar's** [1] -
3810:14
- registrars** [7] -
3813:40, 3814:21,
3814:24, 3814:30,
3815:17, 3815:42
- Registration** [1] -
3758:9
- registration** [7] -
3779:27, 3804:13,
3804:15, 3804:19,
3804:20, 3804:32,
3805:34
- regular** [1] - 3825:21
- regularly** [1] - 3775:37
- Regulation** [1] -
3765:12
- regulatory** [1] - 3765:9
- relate** [2] - 3717:3,
3717:27
- related** [7] - 3716:33,
3726:41, 3756:41,
3823:45, 3831:23,
3831:24, 3831:28
- relates** [2] - 3748:38,
3816:20
- relating** [2] - 3715:11,
3760:37
- relation** [28] - 3715:22,
3715:45, 3718:20,
3719:22, 3722:4,
3723:35, 3729:41,

3733:33, 3738:42,
 3741:4, 3743:41,
 3747:34, 3748:21,
 3754:10, 3769:35,
 3771:38, 3774:8,
 3774:21, 3779:5,
 3784:9, 3789:25,
 3792:35, 3793:15,
 3801:19, 3811:6,
 3813:37, 3815:26,
 3816:2
relationship [6] -
 3718:21, 3743:21,
 3744:4, 3752:38,
 3791:34, 3793:12
relationships [1] -
 3773:14
relatively [6] - 3721:4,
 3725:32, 3727:24,
 3802:34, 3828:21,
 3828:42
release [2] - 3716:4,
 3761:17
releases [1] - 3734:10
releasing [1] -
 3761:29
relevant [15] - 3717:8,
 3725:24, 3725:36,
 3727:33, 3728:42,
 3744:14, 3754:15,
 3755:1, 3763:36,
 3774:10, 3795:28,
 3809:26, 3809:47,
 3822:26
relied [1] - 3742:24
relies [1] - 3763:23
relocation [1] - 3764:1
reluctant [2] - 3743:5,
 3765:43
rely [1] - 3759:47
relying [3] - 3728:37,
 3737:16, 3809:43
remain [3] - 3728:2,
 3803:5, 3805:1
remit [2] - 3753:27,
 3753:28
remote [6] - 3727:3,
 3730:44, 3734:6,
 3796:41, 3797:4
remuneration [3] -
 3720:11, 3721:27,
 3721:29
reorganisation [1] -
 3769:8
repeat [2] - 3807:36,
 3815:40
repeated [4] -
 3745:37, 3750:26,
 3757:18, 3770:35
repeatedly [2] -
 3720:1, 3754:20
repetitive [1] -
 3742:40
replicate [1] - 3759:5
replicated [1] -
 3808:38
replicating [1] -
 3759:2
REPORT [1] - 3747:7
Report [3] - 3742:6,
 3745:2, 3746:47
report [28] - 3714:35,
 3715:23, 3715:26,
 3715:34, 3715:35,
 3716:41, 3716:43,
 3718:15, 3725:7,
 3725:13, 3725:28,
 3725:32, 3734:26,
 3735:33, 3736:12,
 3740:3, 3742:16,
 3745:11, 3745:17,
 3745:18, 3745:20,
 3745:29, 3753:17,
 3760:1, 3760:3,
 3787:17, 3825:28
report's [1] - 3745:47
reported [1] - 3735:36
reporting [2] - 3727:7,
 3825:46
reports [7] - 3725:25,
 3735:13, 3745:31,
 3746:1, 3757:28
represent [5] -
 3726:14, 3738:13,
 3744:17, 3752:7,
 3761:43
representation [4] -
 3759:32, 3790:23,
 3790:24, 3810:47
representations [1] -
 3743:47
representatives [1] -
 3827:7
representing [2] -
 3720:19, 3739:16
represents [4] -
 3720:22, 3725:44,
 3729:41, 3744:37
request [6] - 3774:8,
 3823:10, 3823:15,
 3823:20, 3823:26,
 3831:47
requests [1] - 3791:20
require [10] - 3729:18,
 3729:20, 3740:30,
 3747:47, 3748:29,
 3753:33, 3755:2,
 3756:24, 3759:34,
 3769:7
required [19] -
 3728:17, 3732:36,
 3734:44, 3749:19,
 3755:6, 3757:24,
 3765:22, 3776:24,
 3777:45, 3779:31,
 3786:13, 3790:2,
 3793:19, 3797:1,
 3802:30, 3812:1,
 3813:31, 3816:36,
 3826:32
requirement [4] -
 3806:2, 3812:46,
 3817:12, 3825:40
requirements [21] -
 3764:14, 3764:27,
 3764:47, 3765:35,
 3765:45, 3772:16,
 3804:14, 3804:16,
 3804:18, 3809:20,
 3809:29, 3811:32,
 3812:4, 3812:35,
 3812:37, 3812:38,
 3812:43, 3813:26,
 3813:35, 3816:34,
 3824:45
requires [1] - 3751:18
requiring [2] -
 3803:38, 3803:42
research [16] -
 3724:14, 3724:22,
 3727:5, 3733:15,
 3734:1, 3737:18,
 3740:44, 3753:14,
 3753:17, 3755:15,
 3758:32, 3759:36,
 3759:39, 3760:20,
 3762:33
researcher [1] -
 3758:42
researchers [1] -
 3758:26
resident [1] - 3807:29
residents [1] -
 3761:25
resign [1] - 3804:27
resilience [1] -
 3782:21
resort [1] - 3762:7
resources [4] -
 3751:34, 3779:35,
 3782:19, 3784:42
respect [17] - 3719:41,
 3720:6, 3730:21,
 3734:2, 3734:13,
 3734:47, 3738:1,
 3742:26, 3747:40,
 3750:20, 3753:9,
 3772:45, 3776:11,
 3782:16, 3785:11,
 3795:31, 3809:16
respective [1] -
 3743:43
respects [2] - 3714:7,
 3720:44
respiratory [1] -
 3821:37
respond [4] - 3748:26,
 3773:25, 3774:26,
 3824:6
responded [1] -
 3737:17
responding [1] -
 3773:23
response [7] - 3726:2,
 3728:30, 3728:34,
 3729:10, 3733:20,
 3741:43, 3751:47
responses [5] -
 3716:1, 3729:6,
 3730:2, 3744:47,
 3747:14
responsibilities [4] -
 3726:11, 3728:43,
 3733:8, 3737:28
responsibility [8] -
 3760:2, 3762:42,
 3763:2, 3763:29,
 3763:38, 3784:5,
 3809:42, 3825:47
responsible [7] -
 3730:47, 3782:12,
 3794:41, 3811:31,
 3817:22, 3820:3,
 3820:6
responsive [1] -
 3755:19
rests [1] - 3765:4
result [1] - 3749:35
results [1] - 3800:11
retain [1] - 3719:8
retained [3] - 3716:35,
 3730:32, 3807:5
retention [9] -
 3715:11, 3716:37,
 3719:12, 3719:28,
 3719:29, 3720:11,
 3720:28, 3721:18,
 3722:9
retiring [1] - 3752:3
return [2] - 3715:46,
 3772:20
reveals [1] - 3740:3
review [5] - 3719:23,
 3771:9, 3772:37,
 3775:37, 3794:27
revisit [1] - 3719:24
rewarding [1] - 3824:1
Rian [1] - 3715:23
Richard [2] - 3713:14,
 3713:35
rights [3] - 3717:42,
 3719:44, 3721:6
rising [1] - 3745:24
risk [3] - 3731:42,
 3732:41, 3732:43
road [1] - 3815:4
ROB [2] - 3797:23,
 3799:9
robust [1] - 3739:2
rock [1] - 3738:14
role [55] - 3716:36,
 3719:6, 3721:9,
 3724:27, 3728:44,
 3733:21, 3734:19,
 3735:18, 3735:23,
 3735:47, 3749:1,
 3760:34, 3764:45,
 3770:46, 3771:24,
 3773:6, 3775:20,
 3778:31, 3779:5,
 3779:7, 3779:26,
 3779:28, 3779:29,
 3779:30, 3787:36,
 3787:37, 3788:28,
 3789:30, 3789:31,
 3790:28, 3790:30,
 3790:43, 3791:3,
 3791:8, 3791:45,
 3792:3, 3792:14,
 3792:34, 3794:12,
 3794:16, 3796:26,
 3798:34, 3804:30,
 3804:36, 3806:13,
 3806:17, 3811:3,
 3811:6, 3813:3,
 3813:14, 3816:26,
 3819:39, 3821:44
roles [10] - 3725:47,
 3726:23, 3733:40,
 3743:43, 3754:4,
 3761:14, 3778:8,
 3805:43, 3816:25
roll [1] - 3802:21
rolling [1] - 3723:37
rolls [1] - 3717:32
Roman [1] - 3775:11
room [4] - 3723:11,
 3821:17, 3832:4,
 3832:14
Ross [1] - 3713:27
rotate [7] - 3807:8,
 3811:36, 3812:17,
 3812:18, 3813:16,
 3813:42, 3813:43
rotated [1] - 3806:46
rotation [5] - 3802:46,
 3806:41, 3812:20,
 3813:32
rotations [8] -
 3804:23, 3806:21,

- 3806:40, 3812:4,
3812:11, 3813:43,
3813:46, 3814:2
round [1] - 3722:13
rounds [1] - 3822:8
routinely [2] -
3741:34, 3773:17
Royal [7] - 3801:1,
3812:7, 3812:15,
3820:8, 3824:41,
3825:1, 3825:28
RPA [12] - 3800:42,
3800:44, 3801:29,
3802:21, 3804:2,
3819:12, 3820:13,
3820:19, 3820:32,
3821:1, 3824:31,
3830:35
**RPA/Canterbury/
Dubbo** [2] - 3802:34,
3803:43
RPAH [1] - 3820:28
RTO [17] - 3776:12,
3776:25, 3776:29,
3776:34, 3776:36,
3776:38, 3776:46,
3777:3, 3777:6,
3777:16, 3777:24,
3777:25, 3777:34,
3777:38, 3777:47,
3778:1, 3779:28
RTOs [3] - 3777:10,
3777:14, 3777:30
run [8] - 3721:36,
3726:16, 3743:43,
3797:24, 3798:19,
3799:7, 3800:5,
3800:21
running [1] - 3783:10
runs [2] - 3732:43,
3763:19
rural [40] - 3714:20,
3716:29, 3717:24,
3727:11, 3727:38,
3761:20, 3764:1,
3797:37, 3797:39,
3797:44, 3797:47,
3798:5, 3798:10,
3798:17, 3798:18,
3798:37, 3798:42,
3799:16, 3802:33,
3802:43, 3802:47,
3803:4, 3803:17,
3804:7, 3821:9,
3821:12, 3823:2,
3823:6, 3823:17,
3823:22, 3823:26,
3823:43, 3823:44,
3824:8, 3824:11,
3824:14, 3824:26,
3830:29, 3830:36,
3831:12
rurally [1] - 3823:35
-
- S**
-
- SAC** [1] - 3828:35
safe [4] - 3767:46,
3771:43, 3778:33,
3781:42
safety [1] - 3805:27
salaried [4] - 3716:35,
3720:22, 3821:47,
3822:1
salaries [1] - 3810:33
satisfaction [2] -
3719:34, 3721:17
satisfied [4] - 3739:9,
3771:13, 3794:31,
3813:26
satisfy [2] - 3811:29,
3812:31
saw [2] - 3743:7,
3817:39
SC [4] - 3713:14,
3713:26, 3713:35,
3714:2
scale [3] - 3750:18,
3807:2, 3811:36
scenario [1] - 3733:39
schedule [3] -
3723:41, 3757:30,
3811:38
scheduled [1] -
3715:46
scheme [5] - 3763:20,
3763:25, 3799:1,
3806:27, 3814:32
scholarship [7] -
3789:12, 3789:26,
3789:27, 3789:29,
3790:2, 3790:10,
3790:11
scholarships [10] -
3764:5, 3788:29,
3788:38, 3789:31,
3789:33, 3789:36,
3789:39, 3789:44,
3789:45, 3790:17
school [17] - 3819:15,
3819:16, 3819:40,
3819:41, 3819:42,
3819:45, 3819:47,
3820:3, 3820:6,
3820:9, 3820:42,
3820:43, 3821:7,
3822:39, 3823:8,
3823:37, 3823:38
schools [5] - 3798:4,
3819:46, 3820:45,
3823:7, 3823:11
SCI.0001.0043.0001
[1] - 3780:12
SCI.0011.0197.0001
[1] - 3724:44
SCI.0011.0266.0001
[1] - 3747:8
Science [1] - 3750:9
scope [1] - 3754:25
screen [10] - 3724:43,
3770:16, 3770:23,
3770:26, 3780:10,
3780:13, 3780:37,
3780:39, 3782:31,
3819:24
seamlessly [2] -
3812:46, 3813:42
second [10] - 3722:4,
3723:32, 3795:9,
3802:1, 3802:6,
3803:38, 3805:2,
3805:46, 3809:46,
3827:32
second-order [1] -
3805:46
secondment [1] -
3807:10
secret [5] - 3732:13,
3739:28, 3739:35,
3739:37, 3739:42
secretary [4] -
3720:47, 3724:14,
3724:22, 3795:32
section [2] - 3757:42,
3772:44
sections [2] -
3742:34, 3743:32
sector [14] - 3718:46,
3720:26, 3720:33,
3721:13, 3721:21,
3721:29, 3748:11,
3748:16, 3750:12,
3751:41, 3755:24,
3764:46, 3786:39,
3787:7
sectors [5] - 3728:3,
3734:5, 3734:6,
3740:35, 3748:12
see [49] - 3716:6,
3726:26, 3728:22,
3729:28, 3733:21,
3735:17, 3736:5,
3736:14, 3745:20,
3746:36, 3760:39,
3761:29, 3771:24,
3774:2, 3774:7,
3775:11, 3775:12,
3775:27, 3780:12,
3780:16, 3780:21,
3780:27, 3780:45,
3781:26, 3781:37,
3781:40, 3782:7,
3783:42, 3784:3,
3784:4, 3784:34,
3786:44, 3786:45,
3787:21, 3790:29,
3790:32, 3790:39,
3791:7, 3792:45,
3804:30, 3821:31,
3821:38, 3823:34,
3823:41, 3824:37,
3830:23, 3832:13
seeing [3] - 3730:7,
3777:26, 3804:6
seek [6] - 3731:21,
3773:13, 3796:7,
3796:8, 3804:28,
3816:10
seeking [8] - 3715:16,
3727:39, 3743:36,
3758:29, 3773:22,
3785:38, 3795:38,
3830:10
seeks [1] - 3774:13
seem [3] - 3714:38,
3739:27, 3809:37
sees [1] - 3800:40
segments [1] -
3787:15
seizing [1] - 3733:26
seldom [1] - 3752:11
selected [2] - 3767:2,
3827:3
selecting [1] -
3767:42
selection [13] -
3767:36, 3797:41,
3810:46, 3826:46,
3827:6, 3827:8,
3827:15, 3827:18,
3827:22, 3828:14,
3828:41, 3828:43
self [1] - 3808:10
self-funded [1] -
3808:10
semantics [1] -
3740:11
seminars [1] - 3772:8
send [2] - 3796:39,
3797:14
Senior [1] - 3713:26
senior [20] - 3736:20,
3742:31, 3743:10,
3768:29, 3781:47,
3796:27, 3797:2,
3797:6, 3814:45,
3816:20, 3816:28,
3816:40, 3817:4,
3817:5, 3817:8,
3817:13, 3817:22,
3817:41, 3817:47,
3818:7
sense [19] - 3720:34,
3722:27, 3730:11,
3730:16, 3741:4,
3751:43, 3754:34,
3767:32, 3768:13,
3769:24, 3772:31,
3772:42, 3773:19,
3785:37, 3789:44,
3805:15, 3807:2,
3810:41, 3811:12
sensibly [1] - 3748:25
sensitive [5] -
3734:11, 3734:24,
3761:4, 3761:8,
3761:30
sent [3] - 3768:46,
3812:19, 3812:23
sentence [4] -
3740:11, 3747:37,
3748:18, 3816:19
separate [2] -
3768:35, 3817:11
separately [1] -
3795:22
series [3] - 3726:30,
3772:8, 3821:38
serious [2] - 3720:14,
3720:28
service [41] - 3721:45,
3726:29, 3728:44,
3729:17, 3730:22,
3731:28, 3731:29,
3731:30, 3731:34,
3733:37, 3734:21,
3734:44, 3734:46,
3735:35, 3736:28,
3741:44, 3742:34,
3743:33, 3744:33,
3749:8, 3752:16,
3752:26, 3752:37,
3752:39, 3757:42,
3763:22, 3767:37,
3767:45, 3767:47,
3784:14, 3784:15,
3784:16, 3784:23,
3784:25, 3784:27,
3784:32, 3814:34,
3829:37, 3829:45,
3830:8
Service [2] - 3735:32,
3784:10
services [26] -
3730:27, 3731:20,
3731:21, 3731:32,
3733:5, 3733:7,
3733:23, 3734:11,
3735:30, 3738:12,

- 3738:16, 3743:32,
3748:12, 3749:2,
3749:14, 3749:15,
3752:6, 3752:44,
3760:25, 3762:20,
3796:16, 3796:24,
3816:27, 3817:3,
3831:19
- Services** [4] -
3720:20, 3724:15,
3724:23, 3747:14
- set** [17] - 3733:1,
3737:26, 3738:14,
3741:1, 3742:18,
3765:8, 3765:31,
3768:3, 3776:26,
3778:39, 3779:17,
3784:41, 3789:42,
3799:27, 3811:28,
3812:34
- sets** [5] - 3715:35,
3739:13, 3749:34,
3754:17, 3755:18
- setting** [33] - 3715:36,
3716:14, 3736:42,
3736:43, 3736:45,
3747:40, 3747:41,
3749:3, 3755:31,
3759:20, 3765:36,
3778:25, 3778:31,
3778:40, 3779:5,
3779:18, 3781:22,
3806:40, 3811:31,
3820:8, 3820:27,
3821:22, 3822:15,
3822:18, 3822:31,
3823:18, 3823:21,
3824:9, 3824:12,
3826:15, 3826:17,
3828:42
- settings** [10] - 3727:3,
3730:45, 3740:36,
3740:37, 3749:18,
3754:15, 3822:6,
3823:27, 3824:20
- seven** [2] - 3721:37,
3819:46
- several** [4] - 3717:15,
3719:46, 3725:35,
3814:6
- shared** [5] - 3730:33,
3730:36, 3756:26,
3768:15, 3793:3
- sharing** [1] - 3729:47
- sheet** [1] - 3754:12
- shift** [2] - 3732:35
- Shore** [2] - 3802:10,
3802:13
- short** [7] - 3723:23,
3729:17, 3759:33,
3802:35, 3803:31,
3827:25, 3831:21
- short-staffed** [1] -
3729:17
- short-term** [1] -
3803:31
- shortage** [3] -
3740:16, 3740:24,
3747:39
- shortages** [14] -
3716:22, 3716:24,
3716:27, 3717:20,
3717:35, 3718:44,
3739:12, 3744:36,
3747:27, 3747:46,
3748:3, 3749:33,
3759:21, 3767:19
- shortly** [2] - 3747:25,
3832:14
- shortness** [1] -
3821:37
- shown** [1] - 3780:10
- side** [5] - 3738:32,
3809:11, 3810:9,
3829:13, 3830:18
- sides** [1] - 3720:25
- signed** [1] - 3796:9
- significance** [2] -
3781:11, 3786:2
- significant** [13] -
3718:17, 3719:5,
3719:9, 3719:21,
3720:36, 3741:36,
3748:31, 3748:32,
3763:47, 3767:17,
3773:43, 3816:28,
3823:12
- significantly** [1] -
3719:27
- similar** [4] - 3761:1,
3774:15, 3789:16,
3826:30
- simple** [2] - 3727:24,
3752:44
- simply** [7] - 3720:36,
3728:37, 3729:47,
3737:16, 3738:38,
3754:19, 3758:28
- simulated** [3] -
3775:24, 3775:27,
3775:30
- simulation** [3] -
3775:20, 3775:21,
3775:22
- simulations** [1] -
3821:23
- single** [3] - 3744:33,
3764:8, 3765:44
- sit** [12] - 3720:44,
3724:5, 3729:46,
3736:20, 3770:25,
3786:26, 3792:40,
3806:23, 3808:31,
3813:39, 3822:22,
3822:25
- site** [16] - 3722:18,
3797:6, 3797:25,
3809:39, 3809:46,
3810:10, 3816:11,
3823:22, 3825:19,
3826:41, 3829:18,
3829:25, 3829:26,
3829:27, 3830:36
- site's** [1] - 3722:20
- sites** [8] - 3797:40,
3806:15, 3810:33,
3813:10, 3823:7,
3823:46, 3828:17,
3828:38
- sits** [1] - 3778:28
- sitting** [8] - 3723:15,
3723:29, 3723:34,
3731:16, 3739:17,
3739:45, 3784:30,
3809:21
- situation** [9] -
3722:23, 3723:22,
3734:2, 3741:42,
3742:36, 3743:1,
3746:33, 3760:18,
3824:6
- six** [3] - 3748:30,
3757:40, 3812:25
- six-plus** [1] - 3748:30
- skill** [6] - 3737:10,
3738:14, 3739:12,
3749:34, 3754:17,
3789:42
- skilled** [2] - 3748:26,
3771:34
- skills** [6] - 3736:43,
3737:7, 3782:20,
3805:21, 3805:36,
3806:4
- slightly** [9] - 3715:40,
3720:44, 3722:40,
3732:30, 3753:28,
3781:26, 3809:12,
3828:26, 3830:14
- slower** [1] - 3817:33
- small** [4] - 3752:41,
3780:14, 3795:24,
3821:27
- snapshot** [2] -
3715:27, 3736:15
- social** [4] - 3767:4,
3786:34, 3786:41,
3787:8
- socioeconomic** [1] -
3762:36
- solely** [4] - 3765:37,
3765:38, 3765:40,
3806:40
- Solman** [9] - 3746:26,
3770:15, 3770:32,
3770:39, 3774:35,
3775:6, 3780:12,
3781:36, 3793:34
- SOLMAN** [1] - 3770:30
- solutions** [4] -
3714:40, 3716:1,
3744:18, 3744:34
- someone** [15] -
3725:16, 3741:38,
3752:2, 3752:3,
3757:39, 3760:25,
3784:12, 3784:30,
3789:29, 3790:13,
3797:15, 3803:42,
3804:41, 3807:40,
3810:40
- sometimes** [13] -
3730:12, 3738:18,
3738:27, 3759:31,
3773:18, 3804:46,
3809:30, 3810:44,
3813:25, 3814:25,
3818:21, 3822:2,
3824:5
- somewhat** [3] -
3725:5, 3768:17,
3827:28
- somewhere** [5] -
3739:18, 3774:8,
3807:18, 3807:26,
3809:39
- sorry** [20] - 3725:41,
3763:46, 3769:5,
3773:5, 3777:13,
3781:9, 3786:30,
3790:7, 3790:40,
3791:16, 3792:7,
3792:9, 3792:29,
3795:41, 3797:26,
3807:22, 3807:36,
3815:28, 3815:40,
3831:3
- sort** [14] - 3735:3,
3736:35, 3739:28,
3742:47, 3749:28,
3752:38, 3755:45,
3776:33, 3776:41,
3796:31, 3804:16,
3815:45, 3817:28,
3817:40
- sorts** [4] - 3737:39,
3747:35, 3797:7,
3812:37
- sought** [4] - 3722:36,
3781:23, 3781:31,
3797:22
- sound** [2] - 3742:39,
3816:47
- sounds** [2] - 3766:41,
3830:14
- source** [5] - 3717:41,
3729:40, 3741:40,
3778:44
- sources** [1] - 3758:4
- south** [1] - 3741:33
- South** [65] - 3713:19,
3715:6, 3720:13,
3720:27, 3724:15,
3724:23, 3726:17,
3727:23, 3728:12,
3728:30, 3731:11,
3731:25, 3731:38,
3734:5, 3735:31,
3736:37, 3739:30,
3740:13, 3741:13,
3741:17, 3741:29,
3741:41, 3751:41,
3753:5, 3753:18,
3753:37, 3764:15,
3768:29, 3771:28,
3771:38, 3771:40,
3772:6, 3772:40,
3773:20, 3784:10,
3792:10, 3795:18,
3797:19, 3797:20,
3797:40, 3804:26,
3806:14, 3806:19,
3807:3, 3807:16,
3807:18, 3807:19,
3807:22, 3807:25,
3807:35, 3808:4,
3808:12, 3808:18,
3808:23, 3808:28,
3808:33, 3808:36,
3809:34, 3811:17,
3813:20, 3823:45,
3824:17, 3827:7,
3827:20, 3827:44
- southern** [1] - 3796:3
- space** [6] - 3718:35,
3718:36, 3743:40,
3744:16, 3772:5,
3808:44
- speakers** [1] - 3772:9
- speaking** [3] -
3735:44, 3814:21,
3817:27
- SPECIAL** [2] - 3747:7,
3832:16
- special** [1] - 3725:10
- Special** [5] - 3713:7,
3714:3, 3731:2,
3745:2, 3746:47
- specialisation** [4] -
3717:31, 3717:43,

3809:40, 3811:34
specialisations [1] - 3809:13
specialist [14] - 3717:30, 3717:45, 3718:23, 3808:46, 3809:1, 3809:8, 3809:10, 3809:23, 3811:30, 3815:23, 3823:46, 3824:40, 3825:2, 3830:28
specialists [15] - 3716:36, 3717:20, 3717:21, 3717:27, 3717:28, 3718:3, 3718:6, 3718:24, 3720:23, 3721:39, 3811:7, 3826:8, 3826:11
specialty [13] - 3716:20, 3716:23, 3771:25, 3772:5, 3772:17, 3773:10, 3776:15, 3793:10, 3809:26, 3809:31, 3813:46, 3820:19, 3831:26
specific [10] - 3743:24, 3752:23, 3769:38, 3769:39, 3774:10, 3776:35, 3788:2, 3801:17, 3810:21, 3817:27
specifically [5] - 3714:15, 3797:46, 3800:47, 3814:30, 3831:3
specificity [1] - 3766:41
specifics [2] - 3770:1, 3813:34
spectrum [2] - 3808:21, 3825:7
spent [3] - 3745:21, 3745:25, 3803:16
spending [2] - 3745:24, 3802:36
spent [2] - 3765:27, 3765:41
spillover [1] - 3723:28
spiralling [1] - 3722:16
spoken [5] - 3738:5, 3757:7, 3775:40, 3806:29, 3809:33
sponsors [1] - 3789:33
spot [3] - 3739:19, 3752:36, 3828:21
spread [1] - 3801:9
sprinkling [1] - 3788:10
St [3] - 3796:2, 3797:11, 3806:31
staff [57] - 3715:6, 3716:33, 3716:36, 3718:31, 3720:23, 3721:39, 3726:12, 3727:1, 3728:24, 3728:29, 3728:36, 3728:44, 3729:30, 3729:33, 3729:34, 3730:41, 3731:15, 3732:5, 3733:47, 3734:42, 3734:47, 3743:26, 3744:20, 3744:36, 3747:46, 3747:47, 3748:3, 3751:46, 3752:28, 3753:5, 3753:6, 3753:7, 3759:21, 3760:3, 3765:29, 3767:36, 3768:20, 3768:22, 3768:34, 3768:38, 3772:12, 3773:12, 3773:19, 3773:40, 3774:17, 3780:7, 3789:7, 3822:7, 3822:9, 3822:26, 3822:29, 3826:8, 3826:11
staffed [2] - 3729:17, 3734:37
staffing [3] - 3734:45, 3756:41, 3759:33
stage [6] - 3722:45, 3761:32, 3770:32, 3813:11, 3823:42, 3824:25
stages [1] - 3809:28
stakeholders [2] - 3717:8, 3718:35
stand [1] - 3791:25
stand-alone [1] - 3791:25
standard [6] - 3720:42, 3721:3, 3721:11, 3721:26, 3722:5, 3778:31
standard-setting [1] - 3778:31
standardised [5] - 3784:38, 3784:41, 3784:43, 3785:3, 3785:16
standards [19] - 3765:8, 3765:16, 3775:21, 3775:23, 3776:25, 3776:26, 3778:25, 3778:32, 3778:38, 3778:40, 3778:41, 3778:45, 3779:6, 3779:17, 3779:18, 3779:20, 3779:21, 3811:28, 3811:32
standing [3] - 3725:16, 3736:2, 3817:43
start [10] - 3754:38, 3764:31, 3770:19, 3770:20, 3770:22, 3809:19, 3819:37, 3827:2, 3827:11
started [2] - 3801:19, 3808:34
starting [3] - 3795:22, 3796:1, 3800:41
starts [2] - 3800:44, 3825:31
state [25] - 3715:5, 3716:15, 3721:46, 3728:38, 3731:25, 3733:4, 3736:41, 3738:13, 3739:28, 3739:42, 3743:18, 3746:2, 3759:46, 3760:31, 3762:44, 3766:12, 3782:41, 3783:25, 3784:43, 3795:2, 3800:30, 3816:12, 3816:13, 3819:7, 3830:12
state's [1] - 3719:6
state-based [1] - 3760:31
statement [53] - 3714:2, 3724:30, 3724:34, 3724:38, 3724:42, 3725:28, 3725:42, 3729:38, 3730:30, 3735:16, 3737:43, 3740:10, 3743:15, 3745:38, 3747:16, 3747:31, 3750:34, 3752:11, 3753:3, 3753:31, 3756:24, 3760:22, 3762:19, 3765:21, 3768:33, 3769:6, 3771:2, 3771:6, 3771:13, 3771:17, 3771:21, 3772:21, 3775:5, 3779:5, 3779:9, 3788:28, 3790:27, 3792:44, 3794:20, 3794:24, 3794:41, 3800:36, 3805:10, 3806:12, 3811:15, 3814:43, 3816:18, 3819:21, 3821:13, 3824:30, 3826:21, 3828:47, 3829:43
statements [1] - 3725:39
states [2] - 3721:30, 3761:2
statewide [11] - 3716:47, 3735:39, 3736:7, 3773:27, 3774:6, 3775:12, 3776:10, 3776:21, 3784:42, 3793:4, 3793:23
statistical [1] - 3758:31
statistics [1] - 3758:5
stats [2] - 3726:36, 3731:27
status [1] - 3762:36
stay [2] - 3783:29, 3804:1
stays [1] - 3773:35
step [3] - 3807:22, 3827:10
STEPHEN [1] - 3819:3
Stephen [1] - 3819:9
stepped [1] - 3715:28
steps [1] - 3808:43
stick [1] - 3803:43
still [15] - 3734:20, 3768:45, 3773:42, 3774:26, 3775:5, 3777:17, 3783:11, 3783:12, 3783:14, 3805:34, 3808:40, 3810:21, 3814:44, 3818:1
stint [1] - 3803:47
stitch [1] - 3817:43
stitches [1] - 3817:38
STP [1] - 3830:29
straightforward [1] - 3828:22
strategy [3] - 3724:14, 3724:22, 3736:5
stray [1] - 3738:3
streamline [1] - 3754:43
streamlining [1] - 3754:43
Street [1] - 3713:18
street [1] - 3761:23
strengthen [1] - 3805:23
stressing [2] - 3757:23, 3764:37
stretch [1] - 3745:43
strict [1] - 3720:45
strong [4] - 3717:21, 3773:14, 3781:40, 3805:26
stronger [2] - 3829:46, 3830:14
strongly [4] - 3717:40, 3742:2, 3823:36, 3831:22
structural [4] - 3750:38, 3750:39, 3753:22, 3753:26
structure [9] - 3753:41, 3753:43, 3754:3, 3754:19, 3755:6, 3755:18, 3755:27, 3759:36, 3813:6
structured [8] - 3750:42, 3750:45, 3750:47, 3751:8, 3751:9, 3760:26, 3764:18, 3821:40
struggle [2] - 3728:16, 3728:21
struggled [1] - 3764:33
struggles [1] - 3719:8
struggling [2] - 3740:29, 3760:38
student [21] - 3751:12, 3790:31, 3790:47, 3791:9, 3791:13, 3791:22, 3791:26, 3791:46, 3798:8, 3798:36, 3799:31, 3799:47, 3800:43, 3802:3, 3808:17, 3812:28, 3820:32, 3820:47, 3821:6, 3822:21, 3823:5
student's [1] - 3764:47
students [63] - 3749:23, 3749:32, 3750:2, 3766:7, 3767:2, 3767:4, 3790:29, 3795:6, 3797:33, 3797:38, 3797:46, 3798:2, 3798:32, 3798:35, 3799:20, 3799:28, 3799:45, 3800:8, 3800:23, 3801:34, 3801:36, 3804:31, 3807:15, 3816:30, 3817:20, 3819:45, 3820:13, 3820:19, 3820:25, 3820:27, 3820:35, 3820:36, 3820:41, 3820:44,

- 3821:5, 3821:8,
3821:15, 3821:27,
3821:28, 3821:30,
3821:35, 3822:6,
3822:13, 3822:18,
3822:34, 3822:44,
3823:1, 3823:9,
3823:13, 3823:19,
3823:25, 3823:29,
3823:34, 3823:36,
3823:38, 3823:41,
3824:1, 3824:5,
3824:8, 3824:10,
3824:12, 3824:24,
3825:15
- students'** [1] -
3765:26
- studied** [1] - 3800:15
- study** [7] - 3722:14,
3723:35, 3740:39,
3750:47, 3751:10,
3766:21, 3811:28
- studying** [1] - 3791:31
- stuff** [1] - 3739:35
- stumps** [1] - 3741:38
- sub** [4] - 3717:21,
3717:28, 3718:3,
3726:7
- sub-groupings** [1] -
3726:7
- sub-specialists** [3] -
3717:21, 3717:28,
3718:3
- subject** [1] - 3810:21
- submission** [8] -
3799:26, 3807:28,
3823:9, 3827:14,
3827:21, 3827:39,
3830:26, 3830:35
- submissions** [9] -
3717:17, 3717:23,
3718:34, 3719:32,
3719:46, 3720:34,
3722:22, 3729:28,
3830:34
- submitted** [1] -
3792:11
- submitting** [1] -
3754:14
- subparagraph** [7] -
3772:25, 3775:9,
3775:19, 3778:7,
3778:25, 3779:14,
3797:33
- subsequent** [1] -
3820:41
- subsidies** [1] -
3766:21
- substantial** [3] -
3718:13, 3788:12,
3788:20
- success** [1] - 3820:38
- successful** [5] -
3744:5, 3798:42,
3823:32, 3828:7,
3828:10
- successfully** [1] -
3814:40
- succession** [3] -
3776:37, 3776:42,
3776:44
- sufficient** [3] -
3749:22, 3749:35,
3797:5
- sufficiently** [1] -
3734:36
- suggest** [7] - 3714:41,
3727:16, 3728:34,
3738:43, 3748:22,
3760:2, 3791:42
- suggested** [3] -
3717:33, 3720:3,
3805:47
- suggesting** [8] -
3736:11, 3737:12,
3741:35, 3753:20,
3753:21, 3760:22,
3760:34, 3765:40
- suggestion** [1] -
3719:46
- suggests** [1] - 3734:2
- suit** [1] - 3741:1
- suitable** [2] - 3715:12,
3772:40
- suitably** [1] - 3749:31
- suite** [1] - 3806:39
- summing** [1] -
3801:36
- sunset** [4] - 3755:32,
3755:44, 3755:45,
3756:6
- superficially** [1] -
3785:8
- superior** [1] - 3740:36
- supermarkets** [1] -
3761:23
- supervise** [4] -
3749:32, 3817:7,
3817:32, 3825:19
- supervised** [4] -
3797:2, 3821:35,
3825:18, 3830:8
- supervises** [1] -
3817:16
- supervising** [3] -
3816:29, 3817:9,
3817:23
- supervision** [13] -
3749:37, 3750:10,
3766:34, 3778:35,
3796:27, 3805:23,
3805:36, 3814:44,
3824:36, 3824:45,
3825:25, 3825:45,
3826:14
- supervisor** [1] -
3825:13
- supervisors** [3] -
3825:11, 3825:26,
3826:1
- supervisory** [2] -
3825:6, 3829:20
- supplemental** [1] -
3736:5
- supplies** [1] - 3763:20
- supply** [7] - 3734:3,
3740:17, 3748:6,
3762:31, 3762:42,
3763:2, 3808:32
- support** [17] - 3737:2,
3753:37, 3753:42,
3766:6, 3766:14,
3772:17, 3773:14,
3778:33, 3782:1,
3782:20, 3782:43,
3783:3, 3785:35,
3786:12, 3795:9,
3822:39, 3824:21
- supported** [2] -
3751:28, 3805:25
- supporting** [1] -
3766:13
- supportive** [2] -
3764:11, 3764:13
- supports** [1] - 3767:2
- suppose** [1] - 3758:8
- surgeon** [1] - 3817:29
- surgery** [1] - 3814:32
- surgical** [2] - 3734:13,
3752:28
- surprise** [1] - 3766:10
- survey** [9] - 3727:28,
3733:3, 3735:43,
3744:44, 3745:1,
3747:15, 3759:39,
3760:20
- surveys** [1] - 3736:1
- suspect** [4] - 3721:40,
3729:7, 3730:15,
3742:1
- sustain** [1] - 3781:41
- SWORN** [1] - 3770:30
- sworn** [2] - 3724:17,
3819:3
- Sydney** [17] - 3713:19,
3741:38, 3819:16,
3819:17, 3819:40,
3819:46, 3819:47,
3820:1, 3820:3,
3820:36, 3820:40,
3820:43, 3821:47,
3822:1, 3822:38,
3823:37, 3824:10
- syllabus** [1] - 3820:4
- symbol** [1] - 3781:11
- symptomatic** [2] -
3720:41, 3721:27
- system** [117] -
3714:17, 3714:25,
3714:33, 3715:10,
3716:23, 3716:38,
3718:2, 3718:22,
3718:26, 3718:30,
3719:4, 3719:7,
3719:13, 3719:35,
3719:47, 3720:5,
3721:16, 3721:28,
3722:10, 3722:39,
3726:1, 3726:5,
3726:10, 3726:13,
3726:16, 3726:23,
3727:2, 3727:41,
3728:3, 3728:6,
3728:30, 3729:15,
3730:17, 3730:39,
3731:11, 3731:38,
3731:41, 3731:46,
3732:12, 3733:22,
3734:4, 3735:26,
3736:8, 3737:4,
3737:16, 3737:47,
3738:47, 3739:24,
3740:13, 3740:26,
3740:28, 3745:11,
3746:14, 3747:44,
3748:10, 3748:31,
3749:11, 3751:5,
3758:27, 3761:8,
3761:18, 3762:26,
3762:31, 3764:37,
3767:14, 3768:20,
3771:28, 3771:38,
3771:40, 3772:1,
3772:37, 3772:40,
3773:15, 3773:38,
3773:41, 3774:15,
3781:41, 3782:39,
3783:9, 3783:39,
3784:22, 3785:19,
3787:37, 3789:21,
3791:18, 3792:4,
3792:7, 3792:8,
3792:9, 3792:15,
3793:11, 3794:47,
3797:24, 3798:31,
3800:21, 3800:25,
3800:30, 3803:2,
3803:8, 3803:11,
3803:14, 3803:20,
3806:13, 3806:32,
3806:36, 3806:42,
3807:25, 3809:5,
3809:7, 3809:17,
3815:44, 3816:28,
3830:3, 3830:7,
3831:8
- system's** [2] -
3718:42, 3719:38
- systemic** [4] -
3715:18, 3719:42,
3732:2, 3746:11
- systems** [7] - 3727:18,
3728:8, 3730:27,
3734:11, 3740:26,
3743:7, 3762:44
-
- ## T
-
- table** [3] - 3769:41,
3781:36, 3832:4
- TAFEs** [1] - 3791:19
- talent** [1] - 3715:25
- Tamsin** [1] - 3713:28
- tapped** [1] - 3763:21
- target** [1] - 3768:3
- targeted** [2] - 3733:16,
3733:17
- tea** [1] - 3746:19
- teachers** [1] - 3820:22
- teaching** [3] - 3767:4,
3775:24, 3822:41
- team** [9] - 3718:34,
3742:33, 3746:32,
3783:28, 3785:41,
3796:30, 3796:32,
3814:24, 3814:27
- teasing** [2] - 3738:32,
3808:9
- technicalities** [1] -
3795:37
- techniques** [1] -
3727:26
- template** [2] -
3737:34, 3829:19
- temporary** [4] -
3753:4, 3753:5,
3768:20, 3830:39
- tend** [1] - 3812:24
- tender** [7] - 3715:23,
3724:42, 3725:1,
3725:5, 3725:8,
3725:15, 3745:12
- tendered** [5] -
3715:31, 3728:26,
3765:21, 3771:18,
3794:35
- tendering** [1] -
3725:17
- tenor** [1] - 3730:2
- tens** [1] - 3738:13
- tension** [2] - 3762:43,

3763:3
term [15] - 3714:29, 3719:47, 3750:46, 3757:46, 3766:28, 3786:5, 3802:11, 3803:19, 3803:31, 3814:8, 3814:9, 3814:22, 3815:8, 3816:37
terminology [1] - 3811:18
terms [67] - 3714:29, 3718:1, 3720:45, 3721:32, 3722:9, 3723:42, 3727:47, 3730:12, 3733:31, 3735:46, 3739:10, 3739:47, 3741:32, 3742:44, 3744:43, 3745:20, 3745:45, 3746:31, 3747:27, 3749:31, 3750:1, 3754:7, 3777:36, 3784:19, 3784:30, 3790:12, 3799:19, 3799:25, 3800:44, 3801:40, 3802:4, 3802:8, 3802:12, 3802:33, 3803:9, 3803:33, 3803:42, 3807:14, 3808:32, 3808:40, 3809:22, 3809:25, 3810:9, 3811:10, 3812:24, 3814:19, 3814:38, 3814:42, 3815:2, 3815:9, 3815:11, 3815:20, 3815:37, 3816:9, 3818:24, 3820:31, 3820:33, 3820:47, 3821:14, 3821:21, 3821:24, 3821:31, 3824:44, 3825:20, 3825:46, 3830:10, 3830:46
tertiary [12] - 3718:21, 3765:27, 3765:29, 3765:36, 3765:42, 3766:21, 3779:30, 3786:39, 3786:42, 3787:6, 3787:9, 3804:10
testimony [1] - 3737:13
thematically [1] - 3722:30
theme [3] - 3714:19, 3729:12, 3740:45
themes [1] - 3716:28
themselves [12] - 3731:20, 3734:21, 3745:31, 3766:31, 3774:27, 3808:12, 3814:39, 3817:31, 3817:35, 3823:25, 3824:4, 3828:38
therapist [1] - 3760:24
they have [36] - 3714:17, 3718:28, 3731:22, 3736:15, 3736:38, 3738:8, 3738:9, 3738:14, 3739:23, 3761:24, 3775:40, 3777:19, 3777:43, 3789:13, 3789:32, 3791:21, 3796:10, 3798:46, 3799:32, 3801:13, 3801:21, 3804:14, 3804:18, 3804:22, 3805:5, 3808:4, 3808:6, 3808:17, 3808:26, 3809:28, 3810:43, 3811:27, 3812:32, 3823:17, 3827:31
they've [4] - 3714:19, 3789:15, 3807:19, 3808:25
thinking [4] - 3729:29, 3776:44, 3777:46, 3793:16
thinks [1] - 3734:26
third [5] - 3795:17, 3799:15, 3810:3, 3823:9, 3824:34
Thompson [3] - 3715:23, 3715:24, 3715:34
Thompson's [3] - 3716:41, 3716:43, 3740:3
thousand [1] - 3762:22
thousands [3] - 3737:36, 3738:4, 3738:13
three [24] - 3725:37, 3757:40, 3780:21, 3780:23, 3780:28, 3781:4, 3784:3, 3784:4, 3794:10, 3795:4, 3799:39, 3809:38, 3812:22, 3812:25, 3821:28, 3826:22, 3826:27, 3826:40, 3827:3, 3828:25, 3829:1, 3829:6, 3829:34, 3830:10
threshold [4] - 3773:29, 3774:2, 3774:4, 3774:20
throughout [4] - 3731:25, 3742:3, 3744:41, 3812:29
Thursday [1] - 3723:27
tight [1] - 3822:44
timetable [1] - 3825:3
timing [5] - 3723:6, 3723:12, 3723:42, 3755:8, 3805:33
timings [1] - 3810:29
tinkered [1] - 3755:28
tinkering [1] - 3755:5
tiny [1] - 3784:4
today [9] - 3714:6, 3714:14, 3733:38, 3746:28, 3746:29, 3771:10, 3794:28, 3819:30, 3832:9
together [9] - 3722:15, 3722:24, 3742:18, 3768:34, 3774:17, 3785:33, 3785:42, 3786:6, 3812:10
token [1] - 3824:4
tokens [2] - 3815:2, 3815:6
took [3] - 3733:41, 3752:34, 3779:38
tool [5] - 3731:9, 3734:28, 3736:25, 3736:27, 3756:7
top [6] - 3756:9, 3766:8, 3775:10, 3781:36, 3800:24
topic [5] - 3739:8, 3752:24, 3774:30, 3792:17, 3803:26
topics [1] - 3774:15
total [4] - 3720:33, 3787:46, 3801:30, 3825:23
touch [8] - 3716:31, 3717:6, 3717:13, 3719:26, 3795:22, 3800:36, 3817:42, 3821:16
touched [8] - 3718:33, 3719:31, 3722:15, 3722:24, 3730:29, 3747:30, 3822:47, 3829:1
touching [2] - 3714:47, 3817:40
toward [1] - 3776:47
towards [4] - 3806:28, 3814:38, 3815:11, 3824:34
town [1] - 3732:26
towns [1] - 3741:10
track [1] - 3772:20
tracked [1] - 3743:28
tracking [1] - 3748:37
trade [6] - 3728:33, 3729:19, 3733:47, 3738:37, 3760:32, 3761:42
traditional [1] - 3714:6
traditionally [1] - 3799:18
train [8] - 3718:3, 3740:27, 3751:5, 3751:24, 3781:47, 3817:7, 3823:1, 3823:35
trained [5] - 3719:18, 3719:22, 3808:22, 3815:17, 3830:9
trainee [24] - 3800:38, 3810:4, 3810:5, 3810:20, 3810:25, 3812:3, 3814:26, 3816:10, 3817:32, 3818:7, 3824:36, 3825:20, 3825:27, 3825:30, 3825:47, 3826:36, 3828:20, 3829:29, 3829:38, 3830:9, 3830:27, 3830:28, 3830:39, 3831:2
trainees [39] - 3764:8, 3795:2, 3802:1, 3802:46, 3803:5, 3803:28, 3803:30, 3812:36, 3813:11, 3813:16, 3813:19, 3815:38, 3815:47, 3816:33, 3816:38, 3816:39, 3816:42, 3824:40, 3824:45, 3825:13, 3825:18, 3825:25, 3825:45, 3826:5, 3826:15, 3826:16, 3826:22, 3826:28, 3826:39, 3826:46, 3827:2, 3827:6, 3827:30, 3828:9, 3828:15, 3828:17, 3828:18, 3829:1
trainer [1] - 3751:4
training [218] - 3715:8, 3715:11, 3717:7, 3717:9, 3717:13, 3717:19, 3717:26, 3717:30, 3717:34, 3717:42, 3717:46, 3718:6, 3718:8, 3718:22, 3718:23, 3718:24, 3718:25, 3718:27, 3718:31, 3719:3, 3719:6, 3719:10, 3719:15, 3719:17, 3740:26, 3747:28, 3747:47, 3748:5, 3748:15, 3748:30, 3748:40, 3748:43, 3748:46, 3749:9, 3751:30, 3764:5, 3764:26, 3764:42, 3765:30, 3766:38, 3766:44, 3767:10, 3771:26, 3771:28, 3771:34, 3771:35, 3771:36, 3771:39, 3772:9, 3772:16, 3772:30, 3772:33, 3772:36, 3772:38, 3772:43, 3772:46, 3773:9, 3773:12, 3773:21, 3773:33, 3773:47, 3774:10, 3774:14, 3774:20, 3774:22, 3775:18, 3775:33, 3775:40, 3776:7, 3776:12, 3778:10, 3778:11, 3778:13, 3778:15, 3778:16, 3778:18, 3778:24, 3778:26, 3778:27, 3778:39, 3779:6, 3782:40, 3783:4, 3787:37, 3793:1, 3793:17, 3793:19, 3794:46, 3795:2, 3795:13, 3795:18, 3796:35, 3798:4, 3799:21, 3800:1, 3800:31, 3800:35, 3800:37, 3800:45, 3801:15, 3801:40, 3802:41, 3802:43, 3803:22, 3803:34, 3804:8, 3804:42, 3804:45, 3805:1, 3805:7, 3805:38, 3806:5, 3806:8, 3806:11, 3806:15, 3806:18, 3807:5, 3808:25, 3808:44, 3809:8, 3809:11, 3809:14, 3809:15, 3809:17, 3809:35, 3810:3, 3810:6, 3810:19, 3810:42, 3810:47, 3811:4,

- 3811:6, 3811:10,
3811:14, 3811:16,
3811:21, 3811:22,
3811:27, 3811:38,
3811:42, 3811:46,
3812:1, 3812:5,
3812:6, 3812:16,
3812:18, 3812:21,
3812:30, 3812:31,
3813:8, 3813:9,
3813:10, 3813:15,
3813:21, 3813:24,
3813:35, 3813:40,
3813:46, 3814:12,
3814:15, 3814:16,
3814:18, 3814:19,
3814:32, 3814:41,
3815:14, 3815:19,
3815:24, 3815:43,
3816:3, 3816:12,
3816:13, 3816:21,
3816:29, 3816:30,
3817:10, 3817:12,
3817:44, 3818:2,
3818:6, 3823:10,
3823:42, 3824:25,
3824:37, 3824:47,
3825:1, 3825:6,
3825:30, 3825:31,
3826:5, 3826:18,
3826:30, 3826:33,
3826:38, 3826:40,
3827:14, 3827:33,
3828:1, 3828:37,
3829:14, 3829:23,
3829:32, 3829:36,
3829:37, 3830:11,
3830:23, 3830:41,
3831:3, 3831:11,
3831:12
- Training** [1] - 3770:40
trains [1] - 3817:17
trajectory [1] -
3816:30
transcript [4] -
3724:43, 3768:46,
3818:13, 3832:1
transformation [1] -
3715:25
transitioning [2] -
3766:39, 3779:33
translate [2] -
3737:35, 3785:6
translated [1] -
3759:24
translates [1] -
3728:10
transparency [2] -
3731:10, 3735:20
transparent [3] -
3730:23, 3758:35,
3828:40
trauma [1] - 3743:8
travel [8] - 3783:17,
3783:18, 3783:33,
3783:38, 3788:37,
3788:42, 3788:46,
3788:47
travelled [1] - 3783:29
traverse [2] - 3718:16,
3743:17
traversed [2] - 3759:9,
3790:19
treat [1] - 3818:24
trend [1] - 3733:15
triage [1] - 3830:3
tried [1] - 3830:28
trigger [1] - 3743:8
triggers [1] - 3810:40
tripping [1] - 3817:37
trove [2] - 3726:33,
3757:46
troves [1] - 3755:14
true [5] - 3724:38,
3740:7, 3771:14,
3794:31, 3819:33
truly [3] - 3739:10,
3742:42, 3767:24
trusted [1] - 3733:13
try [7] - 3718:9,
3720:2, 3732:6,
3746:12, 3761:46,
3780:42, 3787:35
trying [8] - 3736:33,
3743:11, 3746:32,
3752:8, 3757:38,
3779:6, 3818:20,
3828:36
Tuesday [3] - 3723:28,
3723:44, 3724:8
turn [2] - 3732:44,
3780:27
tutor [4] - 3821:28,
3821:29, 3821:42,
3821:44
tutorial [1] - 3821:42
tutorials [3] - 3820:20,
3821:22, 3821:23
tutoring [3] - 3821:26,
3822:4, 3822:13
tutors [1] - 3822:41
Tweed [2] - 3797:43,
3798:9
twice [1] - 3762:22
Twigg [4] - 3746:28,
3815:29, 3818:46,
3819:9
TWIGG [1] - 3819:3
two [30] - 3723:20,
3748:7, 3749:47,
3750:7, 3757:40,
3783:29, 3785:31,
3789:16, 3800:45,
3801:29, 3802:3,
3804:26, 3804:27,
3805:20, 3805:32,
3806:4, 3809:38,
3812:22, 3822:12,
3825:11, 3825:13,
3825:26, 3826:1,
3826:10, 3826:30,
3826:31, 3826:37,
3826:38, 3826:47,
3827:29
two-X [1] - 3801:29
two-year [7] - 3802:3,
3804:26, 3804:27,
3805:20, 3805:32,
3806:4, 3827:29
type [10] - 3733:4,
3734:7, 3734:23,
3736:38, 3737:1,
3742:23, 3756:6,
3759:44, 3778:15
types [2] - 3716:44,
3782:34
typically [10] -
3725:47, 3766:34,
3766:36, 3798:6,
3798:22, 3804:43,
3821:3, 3823:16,
3826:29, 3831:9
typo [1] - 3746:27
-
- U**
-
- ultimate** [1] - 3742:46
ultimately [3] -
3733:18, 3745:20,
3817:22
unable [1] - 3827:36
unaccredited [4] -
3814:7, 3814:21,
3814:30, 3815:5
unbiased [2] - 3731:6,
3734:14
uncomfortably [1] -
3720:45
uncommon [1] -
3729:6
uncontextualised [1]
- 3732:42
uncontroversial [1] -
3762:38
under [14] - 3754:13,
3754:17, 3766:34,
3788:40, 3796:27,
3797:27, 3802:36,
3805:8, 3805:36,
3814:44, 3815:23,
3817:21, 3821:35,
3830:8
undermining [1] -
3733:11
underpin [1] - 3742:14
understood [7] -
3758:31, 3758:43,
3775:43, 3782:11,
3788:22, 3790:3,
3826:28
undertake [15] -
3740:39, 3779:32,
3788:39, 3820:23,
3820:42, 3821:40,
3822:8, 3823:5,
3823:26, 3824:16,
3826:37, 3826:40,
3827:33, 3829:22,
3830:41
undertaken [6] -
3754:20, 3779:44,
3784:13, 3791:1,
3822:27, 3825:7
undertaking [7] -
3716:9, 3767:3,
3817:32, 3823:42,
3824:25, 3824:36,
3825:47
undoctored" [1] -
3796:43
undoubtedly [2] -
3720:6, 3814:46
unfilled [2] - 3731:16,
3732:33
unhappiness [1] -
3741:41
unhelpfully [1] -
3746:17
uniformity [1] -
3720:16
unintentionally [1] -
3745:35
union [17] - 3725:43,
3726:1, 3728:33,
3729:19, 3729:41,
3730:12, 3733:42,
3738:37, 3741:12,
3741:30, 3743:19,
3744:37, 3757:47,
3759:45, 3760:32,
3761:42, 3764:11
Union [4] - 3720:20,
3724:15, 3724:23,
3747:14
unions [1] - 3733:47
unique [11] - 3726:4,
3726:6, 3738:6,
3744:33, 3744:39,
3749:8, 3750:12,
3764:14, 3764:34,
3764:47, 3774:14
unit [1] - 3802:11
units [1] - 3737:46
universal [1] -
3747:43
universally [4] -
3737:19, 3740:29,
3741:14, 3743:45
universities [9] -
3718:21, 3718:26,
3718:29, 3765:5,
3765:16, 3791:19,
3791:24, 3791:28,
3791:29
University [11] -
3807:7, 3807:41,
3808:2, 3819:17,
3819:45, 3820:1,
3820:36, 3820:40,
3821:47, 3822:38,
3824:10
university [17] -
3748:15, 3750:47,
3751:22, 3764:42,
3764:46, 3791:34,
3791:37, 3798:3,
3800:12, 3807:20,
3807:23, 3807:40,
3808:11, 3820:7,
3821:2, 3821:3,
3822:33
unless [5] - 3745:24,
3773:8, 3777:25,
3800:28, 3831:10
unlike [1] - 3752:25
unlikely [1] - 3737:40
unmanned [1] -
3796:40
unnecessary [1] -
3722:37
unpack [1] - 3809:37
unpersoned [1] -
3796:40
unremarkable [1] -
3756:10
unstreamed [1] -
3809:7
unsuccessful [1] -
3830:35
unsustainably [1] -
3745:28
up [58] - 3719:32,
3724:43, 3725:16,
3730:12, 3730:29,
3731:40, 3732:44,
3733:30, 3734:9,
3736:34, 3737:8,
3738:14, 3738:19,
3738:46, 3740:10,
3741:19, 3741:22,

3741:38, 3742:29,
3743:5, 3746:34,
3746:43, 3749:1,
3750:20, 3754:4,
3755:18, 3761:22,
3764:37, 3770:16,
3770:22, 3772:38,
3775:33, 3776:2,
3776:13, 3776:14,
3778:45, 3779:35,
3782:18, 3783:23,
3784:37, 3795:36,
3798:34, 3799:1,
3799:3, 3800:29,
3800:42, 3804:42,
3810:35, 3812:34,
3820:1, 3820:47,
3821:8, 3822:19,
3823:30, 3823:38,
3825:5, 3830:45,
3831:11
up^[1] - 3817:43
updated^[1] - 3746:24
updating^[1] - 3793:15
uplift^[2] - 3784:37,
3785:15
upskill^[3] - 3783:44,
3787:15, 3789:4
upstairs^[1] - 3755:11
urban^[2] - 3824:20,
3830:30
useful^[9] - 3715:27,
3722:22, 3725:23,
3734:28, 3734:47,
3743:31, 3757:32,
3759:12, 3759:24
usefully^[4] - 3715:19,
3715:44, 3722:45,
3726:32
uses^[1] - 3791:22
usual^[1] - 3810:22
utilisation^[2] -
3716:31, 3732:37
utilise^[1] - 3793:11
utilised^[3] - 3716:46,
3720:39, 3756:7

V

vacancies^[47] -
3726:29, 3726:47,
3727:1, 3727:8,
3728:1, 3728:24,
3728:29, 3728:36,
3728:44, 3729:1,
3729:13, 3729:30,
3729:31, 3729:46,
3730:17, 3730:41,
3730:42, 3731:14,
3731:16, 3731:43,
3732:5, 3732:7,
3732:25, 3732:43,
3733:34, 3734:31,
3739:18, 3739:24,
3743:27, 3744:15,
3744:20, 3744:36,
3751:47, 3752:30,
3752:40, 3759:7,
3759:16, 3759:21,
3760:3, 3760:37,
3761:11, 3798:25,
3808:36, 3808:41
vacancy^[11] -
3727:15, 3728:1,
3729:45, 3732:33,
3733:33, 3734:35,
3739:31, 3752:1,
3757:29, 3761:7,
3761:20
vacant^[1] - 3729:35
vaguely^[1] - 3768:5
valid^[2] - 3757:37,
3758:44
valuable^[1] - 3804:8
value^[2] - 3806:3,
3812:8
varies^[1] - 3749:26
various^[20] - 3718:35,
3719:7, 3722:38,
3722:42, 3725:39,
3739:19, 3747:29,
3750:43, 3757:29,
3758:19, 3759:3,
3765:22, 3781:22,
3781:30, 3797:11,
3801:37, 3802:20,
3812:1, 3815:14,
3815:44
vary^[1] - 3717:30
varying^[2] - 3731:28,
3747:44
vast^[1] - 3825:24
vehicle^[1] - 3735:11
version^[1] - 3746:24
VET^[2] - 3786:39,
3787:7
via^[2] - 3720:46,
3768:25
viability^[1] - 3714:30
viable^[1] - 3746:15
Victoria^[3] - 3741:16,
3753:18, 3762:31
Victorian^[4] -
3762:26, 3762:28,
3762:40, 3762:47
view^[16] - 3717:26,
3717:47, 3718:6,
3721:4, 3735:5,
3753:26, 3754:10,
3769:40, 3769:47,

3773:30, 3802:28,
3820:17, 3820:25,
3823:8, 3826:18,
3829:37
views^[5] - 3717:40,
3720:6, 3734:37,
3735:45, 3743:16
Vincent's^[3] - 3796:2,
3797:11, 3806:31
virtual^[3] - 3772:11,
3783:25, 3788:9
virtually^[1] - 3787:42
visibility^[2] - 3804:36,
3816:25
visiting^[2] - 3753:9,
3768:21
visitors^[1] - 3829:25
VMO^[1] - 3768:25
VMOs^[12] - 3716:36,
3753:6, 3753:19,
3753:20, 3753:23,
3768:33, 3768:35,
3826:9, 3826:10,
3826:14, 3826:17,
3826:18
vocational^[29] -
3717:19, 3718:24,
3748:16, 3764:46,
3778:34, 3795:18,
3804:42, 3804:45,
3805:38, 3806:5,
3806:8, 3806:11,
3808:43, 3809:8,
3809:15, 3809:32,
3810:5, 3811:4,
3811:6, 3811:10,
3811:42, 3812:6,
3812:30, 3813:24,
3814:26, 3815:14,
3815:47, 3816:2,
3816:33
voice^[1] - 3739:4
volume^[1] - 3830:7
volumes^[2] - 3725:2,
3725:17
volunteer^[1] -
3763:28

W

wage^[5] - 3720:26,
3721:21, 3740:36,
3741:27, 3742:3
wages^[2] - 3740:36,
3754:16
Wagga^[2] - 3797:43,
3798:5
wait^[2] - 3734:13,
3734:14
waiting^[2] - 3830:5,
3830:6
Wales^[65] - 3713:19,
3715:6, 3720:13,
3720:27, 3724:15,
3724:23, 3726:17,
3727:23, 3728:13,
3728:30, 3731:11,
3731:25, 3731:38,
3734:5, 3735:31,
3736:38, 3739:30,
3740:13, 3741:13,
3741:17, 3741:29,
3741:41, 3751:41,
3753:5, 3753:18,
3753:37, 3764:15,
3768:29, 3771:28,
3771:38, 3771:40,
3772:6, 3772:40,
3773:20, 3784:10,
3792:10, 3795:19,
3797:19, 3797:20,
3797:40, 3804:26,
3806:14, 3806:19,
3807:3, 3807:16,
3807:18, 3807:19,
3807:23, 3807:25,
3807:35, 3808:4,
3808:12, 3808:18,
3808:23, 3808:28,
3808:33, 3808:36,
3809:34, 3811:17,
3813:20, 3823:45,
3824:18, 3827:7,
3827:20, 3827:44
walking^[1] - 3733:37
wants^[3] - 3772:44,
3800:16, 3828:20
ward^[6] - 3820:20,
3821:23, 3822:6,
3822:8, 3822:10,
3822:12
ward-based^[3] -
3820:20, 3822:6,
3822:12
wards^[2] - 3752:28,
3821:30
watching^[1] -
3817:43
Waterhouse^[1] -
3713:28
ways^[6] - 3716:34,
3785:31, 3810:18,
3815:15, 3817:23,
3824:2
wealth^[2] - 3734:15,
3737:32
weaponised^[1] -
3720:1
website^[1] - 3797:27
Wednesday^[1] -

3724:2
week^[3] - 3721:37,
3767:10, 3823:16
weekly^[3] - 3736:30,
3757:28, 3825:3
weeks^[12] - 3715:1,
3717:12, 3719:11,
3725:21, 3752:35,
3757:40, 3794:10,
3802:5, 3802:38,
3803:17, 3803:40,
3830:6
welcome^[1] - 3792:47
Welfare^[1] - 3758:12
well,"community^[1] -
3786:5
well-established^[1] -
3733:15
wellbeing^[3] -
3782:19, 3782:22,
3782:32
welter^[1] - 3725:24
West^[1] - 3824:17
Westmead^[2] -
3733:41, 3812:19
whereas^[2] - 3782:32,
3783:27
whereby^[1] - 3813:40
whichever^[2] -
3798:39, 3819:26
whilst^[4] - 3721:14,
3742:44, 3768:32,
3817:23
whole^[18] - 3728:18,
3731:35, 3736:1,
3736:18, 3737:16,
3740:25, 3741:2,
3742:25, 3742:27,
3749:10, 3753:38,
3772:29, 3772:31,
3772:33, 3773:14,
3788:40, 3790:24,
3816:30
whole-system^[1] -
3737:16
wholesale^[1] -
3755:29
wholly^[4] - 3729:5,
3743:25, 3756:10,
3762:37
wide^[3] - 3717:13,
3737:46, 3738:45
wider^[2] - 3785:19,
3789:21
widespread^[1] -
3740:12
willing^[5] - 3727:3,
3740:20, 3797:11,
3823:29, 3824:13
willingness^[3] -

- 3727:1, 3727:11,
3744:9
- wind** [1] - 3722:6
- wing** [1] - 3730:46
- wise** [1] - 3751:45
- wish** [5] - 3796:20,
3796:23, 3797:47,
3809:40, 3815:4
- WITHDREW** [4] -
3770:13, 3793:43,
3818:44, 3831:44
- WITNESS** [11] -
3755:13, 3757:35,
3770:13, 3774:38,
3774:42, 3793:37,
3793:41, 3793:43,
3818:44, 3831:42,
3831:44
- witness** [30] -
3723:23, 3724:6,
3732:18, 3739:21,
3745:10, 3746:25,
3746:27, 3755:40,
3760:22, 3763:13,
3763:37, 3765:21,
3768:44, 3768:47,
3769:5, 3769:8,
3769:15, 3769:26,
3769:33, 3769:36,
3770:15, 3770:26,
3780:10, 3780:36,
3793:26, 3793:45,
3795:29, 3802:26,
3818:29, 3828:5
- witnesses** [11] -
3718:5, 3720:17,
3722:29, 3722:38,
3722:42, 3722:44,
3723:5, 3724:13,
3725:36, 3739:21,
3746:29
- wonder** [1] - 3781:12
- wonderful** [1] - 3752:7
- wondering** [1] -
3746:18
- Woollahra** [1] -
3762:22
- word** [1] - 3775:28
- wording** [1] - 3754:41
- words** [3] - 3759:2,
3771:32, 3808:38
- worker** [7] - 3727:26,
3728:40, 3734:20,
3752:11, 3752:18,
3753:32, 3753:42
- workers** [51] -
3719:19, 3725:44,
3726:10, 3726:14,
3727:1, 3727:17,
3728:12, 3729:41,
3730:43, 3730:44,
3732:25, 3733:11,
3733:21, 3734:3,
3735:27, 3735:29,
3736:7, 3736:16,
3736:18, 3736:22,
3736:40, 3737:23,
3737:36, 3738:4,
3738:12, 3738:15,
3738:20, 3738:28,
3738:38, 3739:3,
3739:12, 3740:28,
3740:30, 3740:35,
3740:42, 3740:44,
3748:32, 3749:11,
3749:38, 3750:22,
3751:17, 3751:32,
3752:13, 3753:40,
3754:17, 3761:7,
3761:21, 3761:43,
3762:17, 3766:14,
3766:15
- Workforce** [4] -
3745:2, 3747:1,
3758:6, 3780:17
- workforce** [111] -
3714:15, 3714:16,
3714:21, 3714:23,
3715:5, 3715:9,
3715:12, 3715:24,
3715:25, 3715:29,
3716:16, 3716:19,
3716:22, 3716:26,
3716:35, 3716:44,
3716:46, 3717:3,
3717:10, 3717:14,
3717:35, 3718:47,
3719:6, 3719:8,
3719:12, 3719:20,
3719:28, 3719:34,
3719:36, 3719:37,
3719:39, 3720:13,
3720:19, 3720:29,
3720:39, 3720:44,
3721:17, 3722:7,
3722:17, 3722:25,
3725:24, 3726:16,
3726:29, 3726:34,
3726:35, 3726:41,
3726:47, 3727:27,
3728:24, 3730:46,
3733:13, 3735:18,
3735:19, 3735:44,
3736:4, 3736:6,
3736:8, 3736:12,
3736:15, 3736:22,
3736:25, 3736:27,
3736:35, 3736:36,
3738:39, 3738:40,
3738:45, 3739:32,
3741:41, 3742:30,
3747:27, 3748:14,
3748:35, 3748:40,
3749:24, 3749:34,
3752:3, 3753:4,
3753:11, 3754:21,
3754:29, 3754:30,
3755:15, 3755:20,
3758:40, 3761:21,
3762:42, 3763:2,
3763:8, 3767:18,
3768:29, 3772:44,
3775:17, 3776:38,
3776:42, 3776:45,
3777:32, 3780:14,
3780:24, 3781:23,
3783:45, 3784:7,
3784:9, 3784:37,
3785:6, 3785:15,
3787:15, 3789:10,
3797:6, 3797:32
- WORKFORCE** [1] -
3747:7
- workforce-related** [1]
- 3726:41
- workplace** [6] -
3730:40, 3735:46,
3737:38, 3737:42,
3781:42, 3782:21
- works** [1] - 3810:7
- worth** [3] - 3715:1,
3719:4, 3736:8
- woven** [1] - 3782:22
- writ** [1] - 3741:12
- writing** [1] - 3780:31
- written** [2] - 3777:34,
3827:39
- wrongs** [3] - 3717:42,
3719:44, 3721:6
- Wyong** [1] - 3799:34
- 3805:2, 3805:3,
3805:7, 3805:12,
3805:20, 3805:25,
3805:30, 3805:32,
3805:35, 3805:43,
3806:4, 3808:35,
3808:40, 3809:8,
3811:35, 3813:11,
3814:23, 3819:21,
3821:5, 3821:6,
3823:10, 3823:11,
3823:17, 3825:16,
3825:31, 3825:36,
3826:28, 3826:33,
3826:40, 3827:12,
3827:29, 3827:31,
3827:32, 3827:41,
3831:2
- yearly** [1] - 3826:27
- Years** [1] - 3780:46
- years** [18] - 3731:3,
3733:39, 3745:25,
3748:30, 3749:15,
3757:17, 3781:4,
3789:46, 3800:45,
3803:3, 3820:9,
3821:7, 3824:17,
3825:9, 3826:32,
3826:37, 3829:34,
3830:27
- years'** [1] - 3754:30
- yourself** [1] - 3748:34

Z

zoom [2] - 3780:33,
3781:35

Y

year [71] - 3718:28,
3725:28, 3736:9,
3757:13, 3757:17,
3780:29, 3784:8,
3784:40, 3785:29,
3787:2, 3792:22,
3795:6, 3797:25,
3797:26, 3797:46,
3798:36, 3799:20,
3799:28, 3800:8,
3802:1, 3802:2,
3802:3, 3802:4,
3802:6, 3802:12,
3802:30, 3803:38,
3804:23, 3804:26,
3804:27, 3804:33,
3804:34, 3804:39,
3804:42, 3804:45,