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TRANSCRIPT OF PROCEEDINGS

O/N H-1166891

THE HONOURABLE T. PAGONE QC, Commissioner
MS L.J. BRIGGS AO, Commissioner

IN THE MATTER OF THE ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

ADELAIDE

9.05 AM, TUESDAY, 17 MARCH 2020

Continued from 16.3.20

DAY 79

MR P. ROZEN QC, Counsel Assisting, appears with MS E. HILL

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Good morning, Commissioners. Today marks the second and concluding day of our second Adelaide workshop into research, innovation and technology. In the Royal Commission's public hearings held in 2019, you heard how the deficiencies in aged care have resulted in substandard care and in the neglect of older Australians. Indeed, that was the title of the Royal Commission's interim report.

The third Melbourne hearing in October of last year focused on the aged care workforce. In that hearing, you will recall that you heard, among other things, how there are not enough people working in aged care and the workforce is not sufficiently skilled or trained. And you recall that I addressed you on recommendations that Counsel Assisting make about workforce matters on 21 February this year. The witnesses that you will hear from today are going to focus on solutions open to you in addressing the skill and training deficiencies of the aged care workforce. The aim of this evidence is to identify what needs to be done so that in the short-term but also in five, 10, perhaps longer – 10 years and perhaps longer, the aged care workforce is better skilled and better able to care for our older Australians.

The first witness you will hear from this morning is Dr Veronique Boscart of the Research Institute for Aging in Ontario, Canada. She is a gerontological nurse by training and has vast experience in aged care. Dr Boscart will give evidence from Canada via video link about the innovative approaches to aged care provision and staff training and development at the Schlegel Villages in Ontario, which you visited earlier this year, Commissioner Briggs.

There will be three panels of witnesses today, who I will call after hearing from Dr Boscart. The first two panels will consider the role of innovation in the education and training of aged care workers. The first panel comprises Dr Kate Barnett, Ms Helen Loffler and Ms Megan Corlis. Between 2012 and 2015, Dr Kate Barnett OAM led the three year national evaluation of the teaching and research aged care services project, which is commonly known as TRACS and about which you will hear a deal of evidence this morning. Despite a positive evaluation by Dr Barnett in 2015, this highly innovative approach to improving the aged care workforce was not continued by the Commonwealth Government in 2015. We will explore the circumstances surrounding that. Ms Loffler and Ms Corlis are both from Helping Hand, a not-for-profit medium-sized provider of aged care here in South Australia. They will describe the work they have done in the education and training of their workers both before and after the TRACS project.

The second panel will feature Professors James Vickers and Andrew Robinson, both of the Wicking Dementia and Research Centre at the University of Tasmania in Hobart and you will recall the evidence of Professor Vickers in Melbourne 3 hearing last year. The dementia and research centre was also the recipient of TRACS

funding and Professor Vickers and Professor Robinson will talk to us about what has happened to the projects since that funding ceased and how they've been able to maintain the projects, albeit without some aspects of them that were present when there was that funding.

The combined expertise of the witnesses on these two panels ensures that their vast knowledge of the history of teaching and aged care facilities in Australia is available to assist you in your work. We will test proposition 6 with them which, in summary, asks whether the TRACS project should be revived. If so, what can the Commissioners learn from the experience of 2012 to 2015 and are there features of that project that should not be replicated, in the event that you choose to revive it.

Finally, Commissioners, you will hear from a panel tasked with the objective of unpacking that oft-cited phrase, translation of research into practice. We will ask this panel just what is needed to achieve that, what could be done to implement the outcomes of research, how do we prioritize research so it is priority driven and relevant to the aged care sector? In particularly, we will ask this eminent panel of experts whether Australia needs a new aged care centre for growth and translational research. The establishment of such a body was proposed in June 2018 by the Aged Care Workforce Strategy Taskforce, which is chaired by Professor Pollaers, from whom you also heard in Melbourne Hearing 3.

Commissioners, in accordance with your desire actively to consider specific proposals, we are asking our witnesses today to focus on the future, to consider the detail around what you need to recommend to design a sustainable outcome for the future, so that older Australians receive high quality and safe aged care. Before I call Dr Boscart on the video link, I need to tender the general tender bundle, if for no other reason than to stop my junior reminding me that I have to do that.

COMMISSIONER PAGONE: Yes, the tender bundle will be Exhibit 16-1.

EXHIBIT #16-1 GENERAL TENDER BUNDLE

MR ROZEN: If the Commission pleases. I call Dr Veronique Boscart. Dr Boscart, good morning.

DR BOSCART: Good morning.

MR ROZEN: Good afternoon where you are, I think I should say.

DR BOSCART: Indeed.

MR ROZEN: Dr Boscart, before I commence to ask you questions, I will just ask the associate here to complete the formalities of swearing you in as a witness.

<VERONIQUE BOSCART, AFFIRMED [9.11 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Dr Boscart, there is a slight delay in the sound. I'm not sure if you are experiencing the same thing but I will apologise in advance for that. And hopefully that shouldn't distract us too much. Dr Boscart, if I could ask by – if I could commence by asking you a little bit about yourself. You are a gerontological nurse by training.

DR BOSCART: Correct, 27 years now.

MR ROZEN: And did you achieve that qualification in Canada or in your birth country in Belgium?

DR BOSCART: In Belgium.

MR ROZEN: In Belgium. And how long have you lived in Canada?

DR BOSCART: I've lived in Canada for about 20 years now.

MR ROZEN: All right. And after you qualified in Belgium, did you work in your capacity as a nurse in aged care?

DR BOSCART: I did, I worked as a nurse in a long-term Care Home, a nursing home, and I did that for a couple of years and I also worked for the government in more of a policy advisory role.

MR ROZEN: All right. And since you've been in Canada, have you also performed a mixture of clinical work and research and policy work?

DR BOSCART: Correct. So I work in two types of clinical environments. I work in a nursing home and I also work in the Emergency Department, specialising in geriatric care.

MR ROZEN: If I could deal with the first part of that, the work you do in a nursing home. Can you tell the Commissioners a little bit about that, where you work and the nature of the work that you do?

DR BOSCART: Right. I've worked in a variety of roles in long-term care over the time I've been in Canada. I actually in Canada started out as a personal support worker or an unregulated care provider for a while, until my nursing degree was recognised by the Canadian registration office for nursing. So I performed in that role. Then I worked as a licensed practical nurse or a registered practical nurse and then I worked as a registered nurse. So I've been ..... and then I have also functioned

in a couple of specialist roles and advanced clinical practice nurse or as a nurse who was really focussing on specific chronic items. Lately I've worked – I've done a lot of work around interRAI, looking at quality indicators, staffing, and safety and risk assessments for people in long-term care.

MR ROZEN: All right. And you hold a number of academic positions.

DR BOSCART: I do. I currently am the Executive Lead for the School of Health and Life Sciences at Conestoga College, which is a very large Community Colleague here in Ontario. We have about 40,000 students. And in that role – I also hold a research role and that is a National Research Chair that I have held for eight years right now to focus on workforce and capacity building in the senior sector. That is a renewable term of five years and that is handed out by the National Institute for Science and Research also. And then from a policy perspective, I am the president for the Canadian Association on Gerontology. That's a two year term, renewable. And I have just completed my presidency as the President for the Canadian Association of Gerontological Nursing here in Canada.

MR ROZEN: Thank you. And you are also the Director of the Schlegel Centre for Advancing Senior Care; is that right?

DR BOSCART: That's correct, yes. This is a research centre that is at the college, at the Community College, in which we do evaluative research to really make sure that the products that we are developing, from an educational perspective, are the right ones.

MR ROZEN: And could you please tell us a little bit about the Schlegel Centre.

DR BOSCART: Yes, absolutely. Our mandate is threefold. We are to bring innovation and education, and that is education across the sector, for aged care. I mainly focus on unregulated care providers but I also do some work in nursing and with police officers and with paramedics. The second goal of the Schlegel Centre is to do advanced knowledge dissemination, bringing what we learn into the workforce, so they can pick it up and disseminate that further. And our third goal is to influence and support policy decision-making. In that capacity, we are lobbying for nurse practitioners to be part of long-term care and to cause staffing changes in nursing homes, which are much needed.

MR ROZEN: All right. There's a lot there for us to discuss. Before we do, I would like to ask you a little bit about the Schlegel Villages setup and the concept of neighbourhoods. If you could describe that, please, for us.

DR BOSCART: Yes. So at Conestoga College, our main practice partner is Schlegel Villages and we do most of our work with Schlegel Villages, an organisation that provides nursing home care or long-term care, but in a continuum of care, so they also provide assisted living and retirement living. Most of my work is in the long-term care sector and they have a unique approach in that they are

focusing on specific teams of caregivers that deliver care to residents in a specific neighbourhood. So part of my role as a researcher is to work with Schlegel Villages to not only optimise care quality but build their teams to become strong leaders in the provision of high quality care. And to that extent, we have embarked on – what is now a 10 year journey in what we call culture change and person-centred care and we have really revamped the organisational model with the organisation to provide better care.

The organisation right now has 23 different homes or continuums of care, we call them villages, and there is about 7000 employees taking care of about, I would say, 9000 residents across the continuum. I could talk a little bit more about the neighbourhood model, if that is of interest. The neighbourhood model in long-term care are units, or traditionally known as units, of 32 residents and we have a dedicated team that provides care to those 32 neighbours and that team is a cross-functional team. So we have done a lot of support, training and learning for those teams to make sure that they feel competent and confident providing the care at a level that is needed.

And so these teams are consistent with those neighbourhoods and we try to keep the same teams, but at times there's a little bit of extra support necessary, if the complexity of the neighbourhood increases or decreases. And depending on the level of functionality of that neighbourhood team, those teams will do anything all the way up to staffing, planning and budgeting and providing care. And so they are very much involved in the quality of the care delivery and in protecting that quality from a quality indicator perspective. We set the goals once a year of what quality indicators they want to achieve and then, as a support office, we help them achieve that.

MR ROZEN: Thank you. That's .....

DR BOSCART: These neighbourhood teams – yes, sorry.

MR ROZEN: No, no, do go on, please.

DR BOSCART: Yes, that's okay. These neighbourhood teams, if they are functioning, also doing the hiring within their own team because they know what is really needed on the team and they also know who will be a good fit for the team. And so these interview panels are quite inclusive of residents' families, volunteers, anyone who will be in contact with that person and all have an equal say in deciding if that person will become part of the team.

MR ROZEN: Dr Boscart, did I understand you to say there's resident involvement in the selection process for - - -

DR BOSCART: Yes.

MR ROZEN: - - - employees?

DR BOSCART: Yes.

MR ROZEN: And can you tell us a bit about that. Has that been a successful initiative, in your view?

DR BOSCART: It has been very successful. Obviously hiring is a very important part for us because we want to have people that get on the train of our village, is what we describe it, and we want to make sure we have the right fit. And one can be very competent but not a very good fit for a team and the person who is on the receiving end of that good fit is the resident. So we have created an interview dynamic in which the resident feels comfortable enough to say, "This works well", or, "This is really not giving me a good feel about that". Depending on the level of involvement of the resident and/or a family, this might be a two or three minute interview or it might be longer.

How we normally set it up is a bit of – kind of a speed-dating situation in which the applicants kind of go around to all of the different people in the neighbourhoods, in a bigger room and they have four to five minutes or a little bit longer per person and once the applicants leave the room we sit together as a team and we discuss what we think about a certain applicant and everybody kind of gives their feedback and then together we decide if that person will come back for a second interview. A second interview might be more skills-focused or competency-focused, depending what is really necessary for that situation but it is definitely a group process to hire a new employee in a village.

MR ROZEN: That first interview process, if I could just ask you little bit more about that. The Royal Commission has heard evidence about the importance of people having the right attitude to work in the aged care sector, having empathy and passion, we have also heard about. Are they features that you're looking for when you are hiring?

DR BOSCART: Yes, yes, we are looking for very specific talents is what we like to call them. Are people interested in being meaningfully engaged on a team? Do people understand that their role is not task-focused? Do they understand and value the preferences of our residents and do they support autonomy for the residents? So those are the aspects and talents that we are looking for. At the end of the day, most people graduate with a certain skill competency and if necessary we can work on that but if people don't have the right engagement or investment in being part of our team, then that will not be a good fit.

MR ROZEN: If we can just go back to the model of care and the neighbourhoods, you told us they have about 32 residents in a neighbourhood. Can you describe the physical layout of what a neighbourhood looks like?

DR BOSCART: Yes. We have some of our older villages which is a bit more traditional and I assume you have similar ones in your country and then the newer ones are a bit more streamlined. We try to make sure that there is sufficient places

for people to take some time away from everything or to have a meal by themselves. So what we traditionally created, we have our long hallways and rooms and it's very hard to get away from that, but we try to maximise the spaces for shared living, where possible. We normally have a dining area in which there's an open pantry, so residents can actually smell the food or can participate where possible. We have also created what we call country kitchens. If residents prefer to eat by themselves or they like to have lunch with me as a staff member or the family just wants to prepare their own meal sit separately with the resident, they can do that. So it's a separate kitchen with everything that is available.

We have separate dining – we have a dining room and then we have separate living rooms where people can just watch TV by themselves or play the piano by themselves and then we have some wider open-spaced areas. In the centre of that neighbourhood is what we call the patio and the patio is a hip-level kind of larger desk and behind that desk are some of the computers and the medication and everything like that. And it's kind of a little bit away from some of where the residents are but it's not really closed off with a big door that people don't have access to. So it's created as an open environment. So what you often see is that residents sit across that desk and they kind of have a - - -

COMMISSIONER PAGONE: Just when it was getting interesting.

MR ROZEN: Dr Boscart, can you hear me? No. It might be an opportune time to play a short video that I was going to ask Dr Boscart about. She knows it. So by playing it now, it's not going to cause us a problem.

COMMISSIONER PAGONE: She is back.

MR ROZEN: She is back.

DR BOSCART: I can hear you. I can't see you but that's okay. There you are.

MR ROZEN: All right, I'm back. We are having some technical difficulties. We will ask you to just bear with us please

MR ROZEN: We're having some technical difficulties. We'll ask you to just bear with us, please. So you were just talking about the layout of the villages. You referred to the kitchens and the eating areas.

DR BOSCART: Yes. So, ideally, we like to keep our residents within the neighbourhood, but at times that's very difficult, because some of our buildings are a little bit older. So we're really trying to create what it is that we can. Our neighbourhoods all end in what we call a main street, and a main street is really built to mimic a village. So there's a little café with a happy hour, which is very important to the residents.

There is a library, there is some meeting rooms if people want to use those, there is a restaurant. Some of our villages have a movie theatre. So it really is mimicking a village and then, depending on the type of neighbourhood, say if they're on the main floor, there is gardens where people can grow their own vegetables, or where they can just walk without getting lost. So we try to do the best we can, depending on how old the village is, but there is lots of opportunities to create a village like environment where people live as opposed to wait.

MR ROZEN: Yes, and just one last question about the villages. The selection of residents to live in a particular neighbourhood. What methodology do you use to determine who lives where? Do you try and group the residents in any particular way?

DR BOSCART: Yeah. So in Canada, the waiting list for a nursing home is not managed by the home itself. So it's managed by a local health integration network. So as soon as a bed becomes available, the local health integration network selects who was on the waiting list and who's in need of a bed, and that person comes in. So for as much as we like to group people from certain cultures or different cultural backgrounds together in the same neighbourhood, at times that is difficult.

We like to have a full integration of people with some cognitive impairment or an Alzheimer's disease or ..... dementia in the regular neighbourhoods, but at times when that is very, very difficult for that resident, then we also have what we call a memory care neighbourhood, where it is a bit more of a higher complexity and a higher staffing, but it really, really depends on what a good fit is.

Sometimes, a neighbourhood team can carry a lot, and at times the neighbourhood team just needs to have a different fit. So we really like to see what works well with the team and what is happening at any given day, and then where the availability is. We have very high occupancy rates in our villages, just because of the nature of long-term care in Canada. I think when a bed becomes available it takes somewhere between 12 and 16 hours before it's filled up again.

MR ROZEN: Now, if I could ask you - - -

DR BOSCART: I assume that's the same here.

MR ROZEN: I'm sorry, I didn't catch the last thing you said, Doctor Boscart.

DR BOSCART: No, and I assume that's probably the same for Australia.

MR ROZEN: Yes, now, can I ask you a little bit about the Research Institute for Ageing. You made reference to it earlier and that's collocated with the villages that you've been describing. What's the relationship between the Research Institute and the villages and how does that work in practice?

DR BOSCART: So the Research Institute for Ageing has three main goals. The first goal is to develop innovative approaches, and that can be related to technology or to a new way of providing meals or to – really trying to protect those that are at high risk for falls. So very research specific, but innovative research. The second goal, then, is to incubate that research, to try it out to see if it works, and they do that in collaboration ..... villages. So RIA is a not for profit organisation that is funded through the Schlegel family, and so they then incubate that kind of research in a village, depending on where there is a team that wants to work with them, and then the third goal is to accelerate the findings. So once they have the findings of a research project then they accelerate that across all their villages to make sure that everybody benefits from the research being done.

So the secret sauce for RIA, if I may say so, is that they take on real problems that need real solutions, and they're not getting stuck in the seven years of intellectual developments of a great idea. They really look at something that can make a difference, and so ..... surge and that some residents ..... input ..... so RIA organises once a year an innovation summit, and during an innovation summit everybody from a village that has participated in a research project can come and present their findings and others can learn from it, and so very often a great idea in one village then transforms into an even better idea in another village.

MR ROZEN: And do you have any formal partnerships or relationships with universities or other, sort of, tertiary institutions?

DR BOSCART: Yes. The RIA has – so their primary care partner is Schlegel Villages. Their primary education partner is Conestoga College where I am, and then the third partner is the University of Waterloo. They have relationships with many other universities, but these are the three main partners, and so as a team we often come together and decide what really fits within the research, what is really going into the Schlegel centre, more focusing on education, and what is a real practice problem and stays within Schlegel villages, but as you can imagine there is a lot of back and forth between the research chairs, the practitioners, the unregulated care providers, the residents and the college. So it's a really neat team to get to together and discussion how we're going to do better.

MR ROZEN: Are you able to give us an example – and I know I didn't tell you in advance I was going to ask you this, but are you able to give us an example - - -

DR BOSCART: That's okay.

MR ROZEN: - - - of a research idea that has emerged from the villages where a particular problem has been identified and then research work done to find a solution, and then it has been incubated as you've described it?

DR BOSCART: Yeah. Actually, about three years ago the villages indicated that they had a very high transfer rate of residents to the hospital, and often it happens during the weekend and at night, and it was very stressful for the residents, also for

the family and, of course, for the team members. So they asked two of the clinical chairs, which is myself as nursing, and Dr George Heckman, who is a geriatrician and a cardiologist. They asked us to have a look at that data, why were people transferred out and what we found from a research perspective, looking through the datasets, were that most of these people had heart failure, and they kind of had going up and down for a little bit and suddenly a cardiac event happens and these people were transferred out to the acute care hospital, and after never came back to the village.

So we started to work with the village teams, with the neighbourhood teams, and we really went through the very basics of what is heart failure, how does one know that a resident has heart failure, if not diagnosed, and how, as an unregulated care provider, as a nursing assistant, will you be able to pick up something might start going wrong, and so we developed a bit of a teaching session and then we did clinical assessments with these nursing aides and we talked about what happens when somebody's fluid is starting to build up, why is it so important to actually measure the correct weight, and if you see it starts to go up, who are you going to inform and what are you going to say.

And so what we found very quickly is that the nursing aides had a very good understanding of what was happening, but didn't have the right documentation systems to indicate a problem was coming, and so once we were able to really sort that out, the nursing aides really took the lead in this and had a very good working relationships with the one registered nurse, who then could call the physician.

As a result they were able to really lower the transfer rates of people with heart failure into acute care hospitals. Decisions was – decision-making was happening earlier. So we developed the intervention protocol, and instead of it being a research study we then just rolled it out as a quality improvement project in some of the other villages, and I'm very proud to say that last year at the Canadian Cardiological Conference, which is a national organisation. We had nursing aides present on this project, and nothing can drive engagement and being very proud of what you can do for a nursing aide than actually standing in front of a whole auditorium of cardiologists saying, "This is absolutely amazing", and so those people now run with that. So it's a research project with a little bit of guidance from researchers that turned into a quality improvement project, and people can just take it out and fly with it.

MR ROZEN: If I can ask you – thank you, that's very interesting. Can I ask you a little bit about the unregulated care workforce which you've referred to. In Australia the evidence in this Royal Commission has been that somewhere around 70 to 80 per cent of the care workforce in long-term care homes, in nursing homes are unregulated care workers, and I think it's a similar proportion in Canada?

DR BOSCART: Yeah, correct.

MR ROZEN: And you've just given an example of the way in which members of that workforce can participate in research and, ultimately, I think we're all touched by the story you've told us about them presenting to a room full of cardiologists. Can I ask you a little bit about the general leadership qualities of the unregulated care workforce, particularly in the Schlegel context and in the neighbourhoods?

DR BOSCART: Yeah, absolutely. So our nursing aides, our unregulated care providers, receive a wide range of medications. So in order to work in a nursing home, these nursing assistants need to have a certificate. A certificate is a two semester college program. In the homecare setting or in retirement that is not the case. One can be working as a nursing aide after two days of training or eight weeks of training, it all depends what is happening, but what we did find is that a lot of these people come with great talents and great impact when in a team if they are given the opportunity to contribute, and so within Schlegel Villages we have worked very, very hard at shifting from a task focused job description to, "How can you be part of our team and how can we as a team together help create nurses, recreation therapy, all together serve the resident better".

And so the move from task to being part of a team is a very important one, because, just like everybody else, nursing assistants come with a different set of competencies and talents, and so we have some nursing aides that are great at organising events and we have some nursing aides that are very, very good at having the utmost patience providing a bath to somebody who really does not want to take a bath, and so really building on these trends that a nursing aide can bring really works that full potential.

If you give everybody the same job, no matter what, every day for a number of residents that they might or might not click with, that is not always – that doesn't always come across as a meaningful contribution, and so in every job there is components that you'll like and that you like a little less, I understand that, and I'm exactly the same, but if you can really build on how a nursing aide can contribute to a team, as opposed to, "You have to give four showers today or eight showers today", you shift that idea off, "We count on you as a valuable team member", and all too often that nursing aide level has been left behind.

So what we've been able to do at Schlegel Village is through lots of work and it's a journey, and there is always a lot of room to improve, and I want to be very upfront about that, is that if we come together in teams and we start, really, to look at what is it that you do really well and where will you like to have a little bit of support, that we just have a better team connection, and so sometimes people do need a break and sometimes people want to do something different, so as a result we have seen really interesting things happening.

When we first started to work with our neighbourhood team development idea, we wanted to make sure that teams understood that we're a cross-functional team. So if I work as a director of care and it is time for lunch, everybody needs to be in that dining room, because it's a stressful time, everybody wants to, like – likes to eat a

warm meal, and we want to support everybody. It doesn't matter if I'm a director of care or a nursing assistant or a volunteer, we're going to work together to provide a good warm meal to our residents who are interested in enjoying their meal with us.

However, if I then move into some of my tasks I might very well ask one of the nursing assistants, "Do you want to, kind of, give me a hand looking at the staffing here, because I think we're in trouble, and we're not going to have enough coverage. What are your ideas around that?" So cross-functional means that we all have a core set of things that need to get done at the end of the day, but we are not afraid to overlap in each other's roles, and so as a result when I'm in a neighbourhood, it doesn't matter if I'm an executive dean or a researcher, if there is a spill on the floor I know where the mop is to clean that up, and I will do so, and if a nursing assistant sees a family that is incredibly upset about not being able to do this or that, she will approach that family and say, "I am here for you, please explain to me what is that is happening and how can I help you with that?"

So in getting to that level we have to do a lot of neighbourhood team development, and a neighbourhood team development is that model of building teams. So ..... months we made a team commitment for ..... neighbourhood modules. The neighbourhood modules are never clinical competencies, they are, "What is our mission, vision and value, what is our ethics standards, what are our aspiration statements, how is our conflict resolution" – that's among the – that is a very popular one, "How do we deal with different cultures in the group and in-between the group?" and so we work through these modules so the team starts to get to know each other really well.

A very simple example, if we have the time for it, is that one of the first examples – one of the first exercises we do with these teams is we kind of let them decide who they are individually and we compare them to animals or to trees. You have oaks and you have willows, and you have maple trees. They all come with very different character traits.
An oak is sturdy, concise, is the pillar, and the willow is a bit more emotional and goes and bends with the winds.

So if I'm an oak and I would like to get something done right now, immediately, and I say to you – and you are a willow in this case – "This needs to get done right now", that message is too abrupt and you might get a little intimidated, and say, "I don't know what she wants and I don't understanding what is happening", and as a result between these two team members we have a communication breakdown, just because I did not truly understand how you are responding to a message.

It might be a very simple exercise, but I can still hear it today after eight years of neighbourhood training, I still hear team members say, "Careful, she's a willow, she likes you to talk calmly and explain to her why it's needed, that this needs to be done right away and that it's going to happen", and so what you really do in a team is you explore that different way of working in a group. You need a little bit of everything, but people just respond differently. Work with that, as opposed to say, "Why are you

not doing it the way I said you should be doing it?" So you explore people's work attitudes and behaviours and you bring them together and that's how you build a team. We're all different people, we all have different talents. Build on that, as opposed to saying, "Everybody does 10 baths in the morning".

MR ROZEN: All right. Thank you.

DR BOSCART: Work in progress.

MR ROZEN: I'm still trying to work out what kind of tree I am, Dr Boscart, but anyway. Can I ask you a little bit about the Living Lab, please, because that's - - -

DR BOSCART: Yeah, sure.

MR ROZEN: - - - another aspect of your work that we're very interested in, and we have a short video, which I think you might have sent us, and perhaps if that could be shown now, please, and then I'll ask you some questions about it, and it goes for about three minutes, I think.

DR BOSCART: Sure.

VIDEO SHOWN

MR ROZEN: Welcome back, Dr Boscart. You can hear me okay? Yes.

DR BOSCART: I can.

MR ROZEN: And I think you're probably familiar with the video that we've just seen, you feature in it.

DR BOSCART: Yes.

MR ROZEN: Are we to understand that what's being described there, what's encapsulated by the concept of a Living Lab is that the training of the workforce takes place in the villages?

DR BOSCART: That's correct. So this is the product of a collaboration between Schlegel Villages Conestoga College and the Research Institute for Ageing in which there was a variety of problems we had identified. From a college perspective we had identified that it's very hard to attract people that want to become nursing aides. There was a big stigma associated with long-term care and people were not interested in that any more. From Schlegel Village's perspective they couldn't find people to work for them, and from a researcher perspective there was kind of this mismatch between what we wanted to see in the workforce and the people that we were attracting.

And so, probably similar to Australia, a lot of the people in these roles are newcomers to Canada. English might not be their first language. They're often people that are coming a bit more from a vulnerable background and we just wanted to make sure that we could create a program in which people, students right away saw the application of their learning.

People traditionally attracted to these nursing assistant positions might not always have a good experience with the school environment, and so we wanted to make sure that we could provide an education in which there was an immediate relevance and application to the work – field they were going to go into.

So the living classrooms. We have two sites in which we run living classrooms, both with Schlegel Villages, and the classroom itself is within the nursing home. So students right away, when they apply are notified that they are not coming to a regular college campus, they are going to go to school in somebody's home. So we then have an integrated model of teaching in which faculty is teaching, team members from the village are invited to share some of their experiences and residents come in and out and participate in some of those learning experiences which, of course, for the students is a wonderful opportunity to really know why it's so important to understand what's written in that book, and then as soon as students have those concepts and principles understood, they then go and participate in the village.

So the first couple of weeks that is very minimal. Then it starts a little bit more about observing what is happening on a neighbourhood. By the end of the semester they are participating in actual care. By the time they graduate they have sat in on very difficult family conversations often, and have maybe participated or witnessed resident's passing. So it's a very integrated learning model.

We've right now graduated, probably, over a thousand of our living classroom students and we truly believe that they are the leaders for the workforce in the future, because they do come with a bit of a different concept about cross-functional teams and integrated learning and what is needed in these environments.

MR ROZEN: And over what period of time have those thousand graduates gone through the process?

DR BOSCART: Yeah. We started our first living classroom in 2009. That was with a group of 12 students, and little by little we have grown that into a much larger group. So right now we have our living classrooms for the – for nursing assistants. We also run living classrooms for practical nurses – licensed practical nurses and fall 2021 we are starting with a cohort of Bachelor prepared – undergraduate nurses. So we are slowly but surely starting to build that up.

We also provide workshops for ..... done well and even more of the things that we should have never done and why it didn't work, and so they can learn and skip the first six years of our trials and tribulations. The easiest way to start a living

classroom is definitely with nursing assistants, because it's a shorter focused program. I would not recommend to start with a full two-year or four-year nursing program, but once the living classroom is up and running one can certainly do that. Needless to say that our graduates are hired before they graduate, because they have a very good understanding of what their role will be once they are in long-term care.

So the researcher in me was, obviously, very interested in does it make a difference, and so we did a – some evaluative studies, and so while all of our graduates need to have a certain competency and knowledge level in order to graduate, we do see that these living classroom students are a lot more comfortable with people that, for example, have a dementia or an underlying symptom.

They also feel a lot more at ease when there is a conflict between team members or a family member. They understand the workloads. They understand what a culture is on a different unit, and they just have a different way of setting priorities when they start their day. So they are just better prepared to step into that field, and then hopefully to remain in that field. So it's very – it's always a great reward to see some of those graduates working within the villages that I work right now, and to work with them as colleagues and to see that they're doing a wonderful job.

MR ROZEN: And do you share the graduates from the Living Lab with other providers or do you keep them all to yourselves?

DR BOSCART: No, the idea is really that they do spread out, and that they, kind of, find their way in the landscape of long-term care, because the idea is, really, to start infusing long-term care organisations with some of that integrated thinking around teams and how we can provide better quality care and services. They do spread out. Traditionally, nursing assistants have a bit of a tendency to stay closer where they learn and study, but this living classroom concept is now picked up by a lot of other nursing homes across Ontario, and by other colleges, as well, and it's great to see that that is happening right now.

MR ROZEN: Yes, and, obviously, when you're investing in the workforce in the way that you do, retaining them as employees becomes very important, and we've heard a lot of evidence in Australia about the challenges of nursing homes retaining staff and particularly in the context of the importance of continuity of staffing to build relationships with residents and residents' families. Have you taken specific steps to improve retention rates, particularly of care workers – the unregulated care workers?

DR BOSCART: Yes. So for – and I do that research across Canada, not just for Schlegel Villages, but we've been able to identify what really matters to most of the nursing assistants in this sector, is the number one to people in this sector is that they can have a meaningful contribution, that they make a difference in people's lives and so knowing that we know that the work circumstances are not always ideal. The pay at times is not great and, having worked as a nursing assistant myself, it's not great,

and often I have to have two jobs in order to – at the time to meet the needs of my family.

So pay is a very difficult thing to change, because there is only so many resources in the care setting, but if one can offer a meaningful job, that will make the difference, and so we try to, for our nursing assistants, not talk about a job, but we're talking about a career. So we are preparing somebody for a career in our organisation, and that means that there might be different components in which a person will grow. They can – depending on where they want to go, they can take a leadership course or they can participate in training of students or different components.

In some organisations some of our nursing assistants have made it up all the way to becoming the general manager or the assistant director of care. In certain environments there is definitely a lot of nursing assistants that are neighbourhood coordinators, so they are in charge of a neighbourhood, not at a clinical level, but at a team level, and so that concept of really looking at what will your trajectory be in our village here is so much more important than just, "This is your job and this is what you have to do".

Of course, at the end of the day, a job needs to get done, but one can often put that all in the context of "what's really important to you". So we ask our people when they come on board, "What matters to you and where do you feel you can contribute your possible best?" and people have very interesting ideas. We all do certain things that have to get done throughout the day, and I'm thinking about just last week giving a shower to somebody who was not interested in receiving a shower, and that might have been a bit of a stressful situation. When that happens, having another nursing assistant come to me and say, "Hey, it looks – that went quite well, do you need a break for five minutes? I can take over for you".

Just really looking at what matters within a team can make a very, very big difference. Certain times of the day it is great to just sit down and have a cup of coffee with our residents, and that's quite all right. We don't all have to do anything all the time the same way, and to make sure that people understand that from each other. So as a result in our neighbourhood team development and trying to give meaningful engagement to all of our nursing assistants you see very interesting talents pop up. One of the interesting things that I have seen is that a lot of our nursing assistants have different cultural backgrounds, and they love to bring those interesting ideas back to the village, organising pot lucks and cultural events, and that has kind of grown into very active participation in some events, such as an Olympic games.

Right now, every time there is an Olympic event, all of our villages start competing with each other. The residents have – start training with a nursing assistants and for some residents that means that they learn to stand up and sit down again, and for others they have wheelchair hockey, but there is a whole training aspect to it that can take a couple of months, and then they compete against each other for gold and silver medals, and it's fascinating to see how some residents and some nursing assistants

come up with amazing ideas to really create meaning to their lives and to the lives of the nursing assistants.

And that's exactly what is happening when you have a good team. When you have a good team you can find that extra component that makes a person who wants to come to work to participate in somebody's life, as opposed to doing the job. In the most perfect world, it's always like that. That is not the situation. There is always a lot of growing to do and supporting each other, but I think looking at a role beyond the job is a very important start in order to attract and retain people in an organisation.

MR ROZEN: Thank you. And do you have any specific conditions of employment? You've talked about pay and the challenges of low pay, and we have that same issue in Australia, but are you able to offer any other conditions of employment, such as collocating childhood care facilities or something along those lines?

DR BOSCART: Yeah. Some of our villages we co-locate childcare, which is very important to nursing assistants in that group. Another thing that we have done, actually, in villages is that we've started a bit of a – it's – I forget the name now, but it's a bit of an emergency fund where teams come together, and every week they chip in $10 because sooner or later something will happen to a team member and they want to be able to support each other at that time, but they might not be able to contribute a larger amount. So there is a lot of support within the teams, and so having the opportunity to learn and to grow is very much valued by our nursing assistants, and then some of the things that we've done is we have village traditions, everybody who comes on board becomes part of what are our traditions in our village, what are our traditions in our neighbourhood and how will you fit in.

So it really is not about that competency focus. It really is about how are you part of our team, and then we create opportunities where nursing assistants can go and present at a conference or tell their story to the Alzheimer's Society. There's so many beautiful opportunities where nursing assistants can shine and present the voice of the organisation, as opposed to being behind the organisation.

MR ROZEN: Thank you, and one last question about the nursing assistants, or the personal care workers we call them in Australia.

DR BOSCART: Yeah.

MR ROZEN: You referred earlier to the move away from a task-focused workplace, and we understand what you mean by that, but the question that arises out of that for us is, is there an expectation of minimum contact time in a day between a personal care worker and residents?

DR BOSCART: Yes.

MR ROZEN: How is that organised?

DR BOSCART: There absolutely is. So there is a minimum standard that needs to be met, and so [inaudible] anything like that. Now, what we've seen with this flexibility, again in an ideal neighbourhood, is that people stagger their work a little bit differently, and there is some nursing assistants or personal care workers that start, maybe, having a cup of coffee with one of the residents, and then they start going and – with some of the residents, because they know the preferences quite well, it's quite all right to have a bath closer to 11 o'clock, as opposed to 6 o'clock.

On the other hand, one of the residents that I gave care to is a farmer. There is no way that that is going to work for that resident, so I was able to shift my hours a little bit, and I come in a little bit earlier, make sure all of the care for that gentleman is done and he is ready to go at 6.30 am ready at the breakfast table, because that's how things work for him. He has severe Alzheimer's disease, so he might not be able to express that, but if he would have to stay in his room until 6 o'clock, that would not work well for him. So by shifting the jobs, so to say, to what the resident's preferences and needs are, you see a whole mix and match of how personal care workers, kind of, bring all of that together, and as a result there is a lot more happening and a lot more collaborative practice on that neighbourhood.

You see people around because people have a bit of a different approach to what needs to get done at a certain time. Again, you need to have a team that is flexible, because depending on the residents, that will change and sometimes it takes a bit of an adjustment when a new resident comes in to try to figure that out. And sometimes it's a bit of detective work and see who's the right fit for that person. It helps that we have dedicated or consistent assignments. So we have the same people on the neighbourhood every day that stay with the same group of residents overall. So everybody knows everyone well.

MR ROZEN: I think when you started answering that question, the feed cut out briefly. So I just want to clarify what it is that you are saying. Am I understanding the position to be that time, the contact time that is expected by a personal care worker with residents is calculated across the resident group generally, rather than being related to one, a particular time for a particular residents; is that correct?

DR BOSCART: Yes, it is correct. It is calculated basis on the interRAI data that it gets collected for a cohort of residents, so it's always one quarter behind. But in general there is a certain number of complexity that requires a certain number of caregiver time and that would be personal care provider time, nursing time. So we work with our case indexes based on the interRAI data to calculate that. That is mandated across Canada and there is a certain minimum that everybody needs to reach at times because sometimes with staffing shortages, it's difficult to reach that. But there are certain numbers that you have to have in place based on the complexity of your residents.

Again, our villagers are 192 residents in general in a nursing home. So for that neighbourhood of 32 residents we probably would have between four and five personal care aides on a given day shift and then the same for night shift, a lot less during the evening. As a registered nurse, I would be by myself and there would be two registered practical nurses for that group. So the staffing is not very luxurious. We often hear that, though, from other organisations in Canada, when looking at Schlegel Villages and some of our retention rates, which are higher, I almost always get the question "do we pay them better?" and "do we have a different staffing ratio?" and the answer is "no" to both questions.

We do not have any more government funding than any other nursing home in Canada, nor do we have better rates. We just try to really look at how best to optimise the team, as opposed to the individual and investment in teams – what we have done in our neighbourhood team development and the research around quality is if you invest in a team, which is a costly investment from an organisational perspective, this leads to better care, therefore it does lead to better care outcomes. And so very often when we want to have better care outcomes in relation to quality of the care and safety, we focus on the very specific care practice that needs to change. If you would look at falls, for example. But if you don't have a staff team that is going to exemplify that practice, you will not get to better care outcomes because change in care is not going to happen by one specific group. It needs to be a team approach. So that's – there is no secret to having good quality care outcomes. The answer is investment in staff. That is really the answer to it.

MR ROZEN: One last question from me because we are running out of time and it concerns the home care dimension of aged care. You have talked a lot about the living classroom approach to training care workers who are going to be working in long-term care. Is there anything similar for the home care environment that you have looked at?

DR BOSCART: Not yet. It's on the to-do list.

MR ROZEN: Right.

DR BOSCART: We do have developed a training program, it's called enhancing person- or resident-centred care. And so it's very short clinical modules that personal support worker or personal care providers can log-in to and kind of get the snippets of what is important and we deliver that through a train the trainer approach. So we ask one personal care provider to really be the trainer and then have a group of personal care providers that work with them and then they work through some of those modules. And so we make those available through care organisations in the home.

The other thing we have done is we have created home care scenarios in our college environment and because it's very challenging for care provider students to go into somebody's home and learn all the tricks of the trade – tricks and trades. And so we are working with older people within our community, who become our actors, and

we roll out these scenarios and we have our students go through those scenarios in a safe environment where they can make a mistake and then the faculty and the older person themselves give feedback to the students to say, "This went well", or, "This was kind of a bit of an interesting scenario".

And so to that extent we have builded apartments and it comes with all the bells and the whistles and the dog who is in the apartment and the student has to go to the front door and provide a care scenario and the students get a care plan and they have to provide the care and then depending on the confidence level of the students, the actor comes with different challenges. And so we've – I think I shared with this group some of those scenarios. We found them very, very useful to really bring the reality into the students' perspective of thinking and trying to get to that problem solving because in our home care environments, care workers are on their own. They don't really have anybody else with them and they just have to figure it out on the spot and some of these situations are challenging.

MR ROZEN: Yes. Thank you, Dr Boscart. They are the questions that I have, Commissioners. Do you have any questions for Dr Boscart?

COMMISSIONER BRIGGS: Dr Boscart, it's Lynelle Briggs here, how are you, good to see you again.

DR BOSCART: Thank you. Good to see you.

COMMISSIONER BRIGGS: I'm wondering, picking up the question that counsel Rozen has just asked, do you think there are different skillsets required to work in a home care setting, as opposed to residential or nursing care setting?

DR BOSCART: Yes, I do believe so. I think it would be very important for a care worker in a home care environment to have a very good understanding of what can I observe, what can I do in this situation and where do I need to hand it off to somebody else, because that becomes a very different involvement. That care worker then needs to be able to document and provide an argument why a higher level caregiver or nurse is required. What I often see in long-term care environments, there is this very informal back and forth about, "She is kind of not okay, can you come and have a look, I think this is what is happening". You have that availability of other resources around you at all times. You don't have that in a home care environment. So that decision-making and priority setting needs to be pretty sharp for somebody who is in a home care environment.

COMMISSIONER BRIGGS: I agree and I fear that we are not, in this country at least, thinking about that independence of thought and more effective communication to raise these issues publicly. Are there examples of that kind of issue in Canada or how do you see it playing out?

DR BOSCART: I think one of the things I've seen happen in home care which has made strides towards better home care is a good system to document. What used to

happen is that there was a binder in the home of the older person and a care worker went in and provided care and wrote down what was important or what was changing or what was happening. And so the next day another care [inaudible] the same and all over again. It really wasn't a nurse that had a look at that binder. What I've seen is that care workers go into the home and they do [inaudible] yes, I provided ABL, yes, I did this, yes, I did that and is there anything else that has changed", and there is an opportunity there to actually document what has changed.

And sometimes what I've seen in that documentation is, "Ms Jones seems a little slower today", or, "Ms Jones didn't really do anything the same way she did yesterday", but that is an important indication that something is changing. That information is transferred immediately into the hands of somebody, I would say an RPN, who can triage what is important and what is not important. So you have that immediate response and validation to a care worker that what they observe is important and then one can act on that.

COMMISSIONER BRIGGS: Thank you.

DR BOSCART: Because as a nurse, if you have never seen the person that is at home and you come in and do an assessment, you would have no idea if things were different the day before, but a care worker would. So that documentation approach, I think, facilitates that decision-making because at least that personal care provider has been able to document what has changed since yesterday and then the RPN or the RN can judge if that is a relevant item to further assess or not.

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Dr Boscart, thank you very much for giving us your time. It has been very, very interesting and very informative. I have got no doubt that a lot of the material that you have shared with us will find its way one way or another into what we ultimately decide. Thank you again very much indeed.

DR BOSCART: You're welcome. Thank you.

<THE WITNESS WITHDREW [10.11 am]

COMMISSIONER BRIGGS: Thank you.

COMMISSIONER PAGONE: Could we adjourn now for reconfiguration?

MR ROZEN: Yes, please.

COMMISSIONER PAGONE: We will momentarily adjourn.

ADJOURNED **[10.11 am]**

RESUMED **[10.24 am]**

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Commissioners, I call Dr Kate Barnett, Ms Helen Loffler, and Ms Megan Corlis, who all appear by video link.

COMMISSIONER PAGONE: Or not, as the case may be.

MR ROZEN: We've just got to be patient, Commissioner. Good morning. Dr Barnett, we have met before, so I might address you now, just to make sure you can hear us all right.

DR BARNETT: Yes, I can, thank you, Peter.

MR ROZEN: Excellent. Thank you. And to your right and our left, we have Ms Corlis; is that correct?

MS CORLIS: Yes, that's right.

MR ROZEN: Yes. And Ms Loffler.

MS LOFFLER: Yes, hello.

MR ROZEN: Good morning. I would just ask the madam associate here to swear you in, please, and then I will ask you some questions.

<KATE BARNETT, AFFIRMED **[10.25 am]**

<HELEN LOFFLER, AFFIRMED **[10.26 am]**

<MEGAN CORLIS, AFFIRMED **[10.26 am]**

<EXAMINATION BY MR ROZEN

MR ROZEN: Thank you very much. Perhaps if I could start with you, Ms Corlis. I should thank you all for joining us this morning. Ms Corlis, can you please briefly tell us a little about your background and your current role, as is relevant to the topic

of research, innovation and technology in aged care, which is what the Commissioners are examining.

MS CORLIS: Yes. So I am a registered nurse by trade and spent a lot of my time in the health system. I moved into aged care about probably 15, 20 years ago to run a residential site and in the last probably 15 years, I've run research and development at Helping Hand. So I'm the executive manager of significant research, large national research partnership centres. We have an enterprise agreement with the University of South Australia and we're quite active nationally and within South Australia in the research and student participation area.

MR ROZEN: Wonderful. I will ask you an about bit that in a moment but if we could please go to you, Dr Barnett.

DR BARNETT: Yes, I've worked with the aged care sector for about 30 years so, I guess, you could say and aged in place with my job. It's given me a great corporate memory, I guess, of the sector and how it's evolved. I do broader social research as well but my specialty is always around ageing and aged care. And from 2012 to 2015 I led the national evaluation of Australia's first teaching nursing home program, which was called TRACS, Teaching Research and Aged Care Services. I've continued to work with that model as it has been left all around the country, one of which, of course, is Helping Hand, who are with us today.

MR ROZEN: And it would be remiss of me not to mention, Dr Barnett, that in 2014 you were a Churchill Fellow and you completed a report during your time, funded by the Churchill Fellowship, entitled The Teaching Nursing Home Model and its Place in the Aged Care System in the USA and Canada.

DR BARNETT: Thank you for reminding me, yes, I did.

MR ROZEN: All right. And I will ask you a bit about some of the findings in that presently. And Ms Loffler.

MS LOFFLER: Yes, so hi, I am Megan. I am also a registered nurse by trade and have worked over the last 20, 25 years in acute community and in residential care. Probably around the last 15 years I've worked within the training sector and so working in the vocational sector for TAFE SA and then came across, around nearly 10 years ago, to Helping Hand, with the project that had come about through increased clinical training capacity and came over to – as the role of inter-professional facilitator and have been here working on that program since and now work as the student participation manager here at Helping Hand, where we have a program of around 600 students every year, from secondary school right through to PhD level, coming through to develop the aged care toolkits, I guess, the aged care skills and knowledge, ready for them to hopefully use them at some point in their career.

MR ROZEN: Before I ask you some questions about the TRACS program and some other related matters, it might be helpful, from the Commissioners' perspective, to learn a little bit more about Helping Hand as an organisation. And I don't know – I'm sure both Ms Loffler and Ms Corlis could tell us the answer to that but I will let you perhaps decide between you who is better placed to explain the structure of Helping Hand, what sort of aged care services you provide and on what scale and what geographical area, please.

MS CORLIS: I think that's just defaulted to me. So we probably are considered moderate to large organisation in South Australia. We have around about 750 residential licences over nine residential sites. We have a large rural presence. So we go from pretty much Port Lincoln, right around through the mid-north and down into metropolitan Adelaide. And we have about three and a half thousand clients at any time in the community and those people receive anything from single services such as gardening, cleaning, through to high care packages, level 3 and 4 packages. So we deliver probably the whole gamut of service its across aged care. We have got a large mental health program, funded through SA health. And we also have very big allied health. We employ all our allied health professionals as well, which has given us some of our student capacity. Is that adequate?

MR ROZEN: That is more than adequate. Thank you, that is perfect. And if I could perhaps start the general questioning with you, Dr Barnett. You have told the Commissioners that you were involved in the evaluation of the TRACS program. Can you just remind us, TRACS is Teaching and Research Aged Care Services project; is that right?

DR BARNETT: Program, yes, that's right.

MR ROZEN: Program, I'm sorry. And can you explain to us, please, the background to that program, so far as you are aware of it?

DR BARNETT: Okay. If I go backwards from just before the program was funded, which was – it was funded to operate over 2012 to 2015. In 2011, the Department of Health – and I think it was Health and Ageing then – commissioned a scoping study to see what existed in terms of that model because up until then, there had never been any specific program of funding to support it. And I worked on that scoping review with Dr Jennifer Abbey and with [inaudible] what prompted the scoping review was two things, really. In 2011 – I'm pretty sure it was 2011 – there was the Productivity Commission report and that report commented that there was an absence, it seemed to be, of that kind of a model and perhaps it should be explored. And then right back in 2004 I found a Department of Health and Ageing – they might have been called something else then – report that also talked about exploring the potential of this model.

So without wanting to speak on behalf of the Department of Health and Ageing team in 2011, I'm fairly confident that those two reports had a big effect. Plus their own knowledge of the sector and who was doing what. So then when they funded

TRACS, they allocated just over $8 million and they funded 16 projects around the country and each project was a partnership between a university and an aged care facility. And they were all residential facilities because that has been very much the nature of the model in the past. But I believe we need to change that in future applications, it needs to include the whole gamut of aged care services. Anything else you want me to tell you about the program and how it was funded and why?

MR ROZEN: Sure. Let me just guide you in the particular interest we have. I should say we have, as part of the evidence, which is before the Commissioners, the report that you co-authored with Cecilia Moretti and Sara Howard in May 2015, TRACS to the Future, the National Evaluation of Teaching and Research Aged Care Services Models Supported Through the Aged Care Workforce Flexible Fund Final Report. So we have that detail in the report and I don't need to rehearse that now, but I do want to understand from you whether there was any relationship between what is referred to as the teaching nursing home model and the model that we probably all are familiar with, which is teaching hospitals.

DR BARNETT: Yes. Okay, the models are very similar in that neither is a universal model, it's a selected model, where a handpicked group of hospitals on the one hand and aged care services on the other are also designated teaching centres. It's not a model that you would want every hospital and every aged care service to do in a full-blown application of the model. Similarities – I think after that they kind of end there because the aged care sectors teaching nursing home model, if you compare with it teaching hospitals, is very much the poor cousin and it hasn't had the kind of funding support that the health sector model has had.

And that's a pity because there's huge scope, you know, if we want to break down silos between health and aged care and particularly acute care, to have teaching hospitals and teaching aged care services as considered fairly equal players in the field of educating current and future workforces. People forget that, you know, if you look at – the biggest difference to me is if you take students who go and do their clinical education in most aged care facilities, as opposed to most hospitals, and there's a difference in the experience that they get. Older people in acute care will be very different from people living in the community, perhaps involved in healthy ageing services, for example. So you can have students getting a very limited view of what ageing is about, very much a deficit model and I don't mean to be critical of hospitals and simply saying that if you go into acute care usually in some kind of crisis.

MR ROZEN: Yes.

DR BARNETT: The other big difference is that students coming into aged care for their student placements, education, you can tie the [inaudible] two groups, the VET trained group, who are coming here knowing that their future will be in aged care, that's why they're doing the course. But our health sciences students, you know, most of them are young, they are unlikely, when they first come in, to see themselves at this point in their lives of having a career working with older people. Because of

the lack of funding and a dedicated teaching program in aged care services, many of them in our research supported this, feel that they have drawn the short straw. It's like, "Well, I would rather have gone into a health care service but I've ended up in aged care". Our surveys with them – and Helen is here too – prior to coming in to start their placement can show a high level of fear of working with older people, purely because of the lack of familiarity. They might also have had some very negative messages from health sector professionals about working in the aged care sector.

So it's a very different placement clinical education experience if you compare the standard. Then if you look at teaching nursing homes – I will use that term for the moment – who have been funded and have got dedicated supervision and mentoring resources so that the student actually gets to learn something in a structured program, as opposed to possibly spending their days shadowing someone as they do their job, but a program that involves them from the word go, that links to the university curriculum and says – which is what I know happens here at Helping Hand – what are the student's learning goals, how can we facilitate them addressing those goals.

So that the two experiences are merged and that, without an appropriate funding program, really is not going to happen. So you would have to not blame many students getting many aged care placements for believing – which our surveys again have shown – that they're not going to learn a great deal. When we surveyed them – and this included in the TRACS evaluation and included some of the TRACS project surveys of their own students – the change in their attitudes towards the sector, towards older people, towards their expectations about what they might learn, had changed at statistically significant levels.

MR ROZEN: Thank you very much. Ms Corlis, if I could bring you in at this point, please. The Helping Hand – sorry, I withdraw that. Helping Hand was the beneficiary or received some funding under the TRACS program to fund an existing program that you already had in place. And it continues to be in place, despite the TRACS funding having ended in 2015. The Commissioners are interested to understand, firstly, the history of that and how it is that you have managed to maintain that program despite the Commonwealth funding no longer applying. So if I could start with the first part of that. What's the background and perhaps if you can describe to us the partnerships that have been developed by Helping Hand with the tertiary sector in Adelaide?

MS CORLIS: So the background of it was actually relatively simple. The traditional model of student placement occurred with – a teaching institution or a university would approach each of the residential sites. So at the moment we have got nine, probably back then it would have been, say, five or six, and they would have run separately, spoken to what was the director of nursing, the site manager, whoever, and then they would have negotiated a placement and then it would have been the responsibility of that particular site to have to run with that particular placement.

So it meant there was, from our perspective, a lack of consistency about how the placements were run but it also put significant onus on the – there was a lot of resource that goes into having to call people and negotiate. So essentially we centralised our models, so – and this predates both Helen and I in the program. And it was centralised through both databases and a range of other things that allowed – all our education providers would go through one central service which meant we could basically distribute people across the whole organisation.

And really from there it actually grew because we could see the opportunities within a centralised model and as we started to employ people that had expertise in the area, people could see more innovative ways that we could actually work with the students. At that time, it would have been straight clinical placements, which is your one-on-one supervised by someone within your own profession. And I always have to answer this question, in around 2010, we received quite a large amount of funding in partnership with the University of South Australia, over a million dollars, that we were able to use to expand our project and look at clinical placements through inter-professional model.

So inter-professional model allows us, from an aged care perspective to, for example, use registered nurses to supervise first year physios or second year pharmacists. Obviously, we had to make sure that it was – they were appropriately supervised but it allowed – it developed a really nice model of getting people to be more holistic in their approach to older people, which obviously, from our perspective, is really critical because of the complexity of our environments. And I just do need to say, taking Kate's point, we are talking about residential aged care. We are – at the moment, we are talking about how we take that out into the community because obviously that's where our greatest growth is going to be but at the moment it has been in residential aged care. So that relationship with Uni SA still exists, it is very strong. Helen has an excellent partnership at – a lot of time with all of the different schools and that sort of thing.

About probably a few years after that, Health Workforce Australia came into existence. We applied for funding with Flinders University for dietetics and speech pathology and we were successful with both of those and that allows to extend into, I suppose, slightly non-traditional model and still to this day – particularly we had very large contingent of speech pathologists. In fact, we would have probably the majority of speech pathologists at Flinders would have a placement at Helping Hand at some time during their course. So from a tertiary perspective we enjoyed really good relationships with both of those universities and have a whole range of students. The way we fund it, following the TRACS – so the TRACS was – Helping Hand decided to look specifically at VET students. So particularly the Cert III students at that time in – was aged care. That course has changed and Helen can talk more about that.

But we did focus on our Cert IIIs for obvious reasons. They are obviously the bulk of our workforce and we could more strongly look at some of the recruitment components within there. So we do try and achieve different – I suppose, different

objectives from the different groups of students who come out into the organisation. We sustain it simply because our board saw the benefits, the enormous benefits of the program and they decided to keep Helen on to manage the program following TRACS funding ceasing. And our other student facilitators are funded through money that we get either through nursing programs across the three South Australian universities or funding we get from some of the allied health from Flinders University.

MR ROZEN: Wonderful. Thanks very much. If I could perhaps bring you in, Ms Loffler, at this point. One of the things that comes through in the evaluation report that Dr Barnett co-authored and some of the other literature is that it's easy to see the benefits to universities of these sorts of collaborations. They have to place students. They want to place students so the students get a valuable and worthwhile placement experience as part of their education. We are particularly interested in this Royal Commission in understanding the benefits for the aged care provider of such collaborations and perhaps I could ask you to explain that to us, from the periods of Helping Hand.

MS LOFFLER: I think that's probably been – just referring to what Megan was speaking about before, perhaps one of the turning points for us was that slightly different viewpoint around thinking about, yes, we want to meet university's needs but what's going to be the win for our residents, what's going to be the reason that Helping Hand would want to keep a student program in place? And so the program that we have here, we look for needs within our organisation that – for residents. So for example, we might – in relation to the speech pathology placements, an example of this would be that we see that around 50 per cent of our residents have a dementia-related illness and we know that with dementia illness, people are losing their words.

And so that seemed to be – communication seemed to be a gap that perhaps we could be doing more for our residents and so the idea of thinking about a student placement that could offer us perhaps some additional low risk communication services for our older – for our residents, but also that the need to learn about communication techniques for a speech pathologist is also a need that they have. So it was about matching the need we have with the students that we possibly could partner with. And so that's – we have a model that we call student service enhancement and that is about putting together the needs and surveying and environmental scanning our organisation constantly for additional needs that might be occurring across sites and services and thinking really seriously, would there be other ways that we could meet that with perhaps partnerships with different student groups.

So that model has become really important for us in the way that makes it worthwhile for us to be having student placements and then, I guess, the resource from the organisation is put into that because they see that there's additional benefit for residents. Students are getting a real – a time in their early practice to actually make a difference to older people but also seeing the complexities. And I think that's another focus for us as well, is that we really want students to see the complexity of aged care. It's not that easy placement or the placement where you're

not going to learn any skills, which is what I think Kate was talking about, that sort of general sense before people come. So that idea of actually making a difference to us and to the residents' wellbeing is really key for that engagement and, I guess, that ongoing partnership and sustainability of the program.

MR ROZEN: Thank you. Just staying with the allied health topic for the moment. It's an area that the Commissioners are particularly interested in, the role of allied health workers in aged care and expanding that, with a view to aged care being more focused on reablement and assisting people to recover capacity. Is it important at Helping Hand for the quality of the placements – and take speech pathology as an example, perhaps – to have employed full-time speech pathologists who can then provide quality supervise for the students that are placed within Helping Hand?

MS LOFFLER: Look, I think it is and there is probably some points of interest in saying that, in that we, prior to having speech pathology students, we actually didn't have a speech pathology service at Helping Hand, so that partnership with the university and the Health Workforce Australia funding enabled us to see the position of a speech pathologists at a very small level. We then put in some additional inter-professional facilitation, so for some lower risk activities for the speech pathology students and that enabled that placement to go ahead.

But what we found as a result of that placement was the benefit of having onsite speech pathology were also shared with the organisation and that, I believe, helped the decision to be made to think about or adding speech pathology into our allied health department as something that was incredibly necessary and potentially also of a good business model for Helping Hand in providing that service, rather than using external contractors to do that. So that, again that opportunity with students was it was a good time to sort of test that out. But I think in terms of an inter-professional model within student placement within aged care, I think having allied health staff is absolutely critical for us to be able to offer that depth of experience. So yes, it is. But I guess I see ways of growing that perhaps differently to the idea of just setting those up in place.

MR ROZEN: We're interested in the impact that models such as the one that Helping Hand have been running over these years on the sort of the broader aged care sector and what I mean by that is whether you – perhaps starting with you, Ms Loffler – whether you have seen from the students that have been placed at Helping Hand over the years, a greater willingness to work in the aged care sector as a result of being exposed to the placement than they might have had when they came. We read in the literature of, you know, tertiary students not wanting placements in aged care because it's seen as not interesting or, you know, not somewhere where they want to pursue a career and what we are interested to know is whether the sort of programs you are running affect people's attitude that you've – in a tangible way that you have seen?

MS LOFFLER: Look, I absolutely do see that difference where – we do discussions at our induction program which is very specific around highlighting complexities of

aged care, because that's one of the fears, is that it's going to be too simple, where people won't learn anything. But we do some discussion around the induction and then we do some discussion at the end of placement around, you know, what it has been like, what has mattered to them in that process. And then I would feel very – I can say very strongly, that there is most usually a very – responses are very much along the lines of, "I had no idea, this was great, I really enjoyed it".

And I guess what we have been able to do is turn quite a number, particularly in the allied health area, of those student placements into potential employees. So we – at different times, we have had entire disciplines allied health have been all ex-students who have been through the different sorts of models, the student clinic models. So we have certainly seen that we are hearing that people – that we're hearing people are wanting to return, but again, yes. So it is, it's been really – that has been quite rewarding and to constantly be thinking, how do we generate a program that does do that.

COMMISSIONER BRIGGS: Might I just ask there if the salaries for allied health workers who work in aged care are pretty much on a par with the salaries to allied health workers who work in the wider community or in hospitals, please?

MS CORLIS: No, they're similar to registered nurses. We – organisations, to be competitive, will pitch the wages, obviously, to meet the health sector awards.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Sorry, can I just clarify that, Ms Corlis. Are you saying that the differential that exists between allied health workers working in aged care, compared to working in other sectors, is similar to the differential that exists between registered nurses working in aged care and registered nurses working, say, in the acute setting? In other words - - -

MS CORLIS: Not - - -

MR ROZEN: I was going to say, in other words, the evidence about nurses is that, you know, there's between a 10 and 15 per cent differential with wages being lower in aged care compared to the acute setting for nurses. Is it a similar difference with allied health?

MS CORLIS: I'm sorry, I can't answer. I'm not 100 per cent sure what the differential is.

MR ROZEN: Okay. Thank you. Sorry, go on, please.

MS CORLIS: Could I add just to Helen's answer as well.

MR ROZEN: Yes.

MS CORLIS: Specific professional groups prefer to work in aged care as well and I suspect there is, within the universities, and I don't want to sort of criticise my colleagues in the universities, but they are run very separately. So one of the challenges we have had is we've tried very, very hard to run what we call inter-professional placements because we find that the students gets enormous benefit from – so a pharmacy student and a physiotherapy student and a nursing student, you know, if they come together and work through a complex case of an older person, they get enormous benefit from that.

But our greatest struggle is they actually run quite separately and I know the universities have tried to sort of come up with core education in their early years, so we can bring them together but that's one of our challenges. So some students come and really enjoy – and speech pathology really enjoy coming into aged care but other groups of students are much more reluctant and that's a real challenge for us and that is evident as they graduate as well, their reluctance to come into the sector. So I think there's some work to be done in the universities to – around the stereotyping of older people and stereotyping of aged care.

MR ROZEN: Thank you, Ms Corlis. Dr Barnett, can I bring you in here on this issue about the impact of these sorts of placement initiatives on general attitudes to recent graduates and their preparedness to work in aged care. That was something that was part of the survey work that you did in the evaluation that we referred to earlier; is that right?

DR BARNETT: Yes, that's right. There is, and I can provide it for you, a specific report on the student surveys that we did. We've reflected it in the overall evaluation report which you have, but we were, yes – and what we did was we also worked with the TRACS projects, who had student placements as part of their project funding and who undertook surveys with their students. So University of Tasmania is one I can think of immediately that did those surveys and they had very similar findings to us with our national evaluation of students.

It was changes in attitudes but also changes in understanding of older people's needs and confidence in working with them, and many of them, you know, we also interviewed and many of them commented that the experience they had – and this is picking up on Megan's last point – stood in contrast to what their health science faculty had expected them to – even if it was not overt, it was there: that aged care is not something you would give centralised attention to. And if you look at the structure of most health sciences courses, if indeed there is an aging component, a module, it's never compulsory and yet we're living with an ageing population and whether or not our health science graduates end up working in aged care, they're going to be working with older people and they're going to be working with older people with complex and chronic health conditions and they need more than acute care preservice learning experience, I believe, to be able to work in that way when they graduate.

So I don't want to sound like I'm accusing but ageism – ageism is just such a prevalent issue in our community and it, I believe, underlies a lot of the issues we have with aged care, the system and how it's designed and what might be the implicit meanings behind the way the funding goes. Why is it perfectly acceptable to have a network of teaching hospitals but for the aged care sector it's a bit of a luxury and a bit of an add-on. Why isn't it a central part of an evidence-based quality system of care. So even if people don't intend to be ageist, it's there, and I think we're seeing it now with COVID-19, you know, with distinctions made about priorities for not treating people over of a certain age. It's there under the surface the whole time. People usually don't come out and say it like I am now, but there you go.

MR ROZEN: Thank you. No, it's a matter that has been raised by a number of witnesses in this Royal Commission, don't worry about that. Can I ask you, Dr Barnett, a little bit about the findings in the evaluation report, specifically in relation to the finding about the importance of having a student coordinator or someone, a leader within the residential aged care facility that has been part of the program?

DR BARNETT: Yes. Underscore it, I think Helen Loffler is a walking example of why you need it, in that it's most unlikely, if you haven't got resources dedicated to someone designing a program of education, working with VET providers and higher education providers to tailor that to their course learning goals, having added to that a commitment to people being trained in supervision and having some backfill, so that they've got time to support students, it's most unlikely it will happen. We know – and I'm sure you are hearing this every day – that you seek feedback from the sector and from consumers and their representatives that this is a very time-poor sector, as well as a resource-poor sector.

And if you have got to choose between a provision of care and designing a course for students, it's pretty easy to work out what your priorities will have to be, even if you don't want them to be that way. A course coordinator is also – I can let Helen speak if I have missed something – is an important bridge between two very different sectors: an aged care sector and an education sector. They have different funding budgets, goals, often value sets and I believe this role forms an important bridge, just as the coordinators who are paid in each of the 16 TRACS projects to be an essential part of replicating that model performed a really important communication and bridging service. So have I missed anything, Helen, about the importance of the role?

MS LOFFLER: No, I very much agree with what Kate has said. I would just say, sometimes there is a discussion from perhaps more the education end around the idea of putting facilitators in place, student facilitators and that the role of logistically working to make this a sustainable model on the ground in aged care, I think, has moved beyond the facilitation role. That it becomes – there is a facilitation component of ensuring that students are supported, sites are supported, that learning takes place.

But I think that there is a lot more to that role around that identifying need within organisations, setting up projects with students, that partnership with universities to find out where we might be able to come together to develop something that results in a win for both the placement and the resident. And I think that role of a student supervisor, student facilitator, perhaps, is at a point where, to make it sustainable, it needs to be redefined a little bit, because it involves a whole lot of other sort of components of thinking. So I think that's sort of where I'm at.

MR ROZEN: Thank you. Can I stay with you, Ms Loffler, and anyone else jump in at the end on this topic. One thing I would like to focus on briefly is the VET sector. So the discussion to date, there has been references to the VET sector, but of course we know from evidence before the Royal Commission that the unregulated care workforce, who are trained through the VET sector, make up about 70 per cent or perhaps a little more of the aged care workforce. A lot of the focus in the TRACS-funded projects seem to be about the university sector and so I want to just get an understanding at Helping Hand about how you go about building links with registered training organisations, for example, and what happens there with placements. Is it something similar to the experience with the universities or how does it compare?

MS LOFFLER: It certainly has some similar elements and I think the TRACS project enabled us to further build a partnership with a key training provider that we use and using that same model of finding out what needs – what student needs they have, what needs we have on the ground. But in addition, it has definitely been about finding out about their training – how their training delivery strategies, how does that fit with our standards here at Helping Hand? And so really a very – an understanding of the delivery methods, the training methods of that RTO and whether or not that's a fit for our organisation. And so we use that model to create some partnerships with some key RTOs where there is a synergy and then we can look at extending our student placements in that area.

However, at Helping Hand I think we do feel a sense of also concern for many, many hundreds of students who approach other training organisations where perhaps that level of training isn't perhaps at an area where – that we think it should be and that it isn't necessarily meeting industry needs. So at Helping – we have an online application system where anyone undertaking a VET course can actually apply and then when we do a screening with those students – so any VET student coming to Helping Hand actually undergoes an interview. We look at their training, we look at the requirements they would have on placement and then we look at a match into our organisation around values and attitudes and that's based on Helping Hand structure around that and that enables us also to link with students that perhaps, yes, perhaps it wasn't the best RTO but we can offer some gap training in that space and we believe it's worthwhile to do that.

So the VET student program has been set up specifically to offer additional training in some of the areas we know that perhaps are not quite so well covered from RTOs and then so we add that in additional. But we see that as value to our organisation

because there is the potential, perhaps, at the end of that placement to recruit. So there seems to be, again, a reason why we would put that additional effort in. So I guess there's two streams, there's the partnership stream, where we can do a similar model to what we have done with tertiary institutions, and then there is other big pool of VET students that we have put in place a different way of managing that to ensure the quality that perhaps isn't so well defined, unfortunately, in the training industry that we can sort of help to account for that but still take on those students.

MR ROZEN: I understand. Thank you. So if you can just unpack that little bit. Helping Hand is not a registered training organisation?

MS LOFFLER: That's correct.

MR ROZEN: No.

MS LOFFLER: We are not.

MR ROZEN: And if I understand what you're saying, Ms Loffler, the standard of training in the various RTOs with which Helping Hand deals varies considerably from good training to – I think the way you politely put it was there were some gaps in training from RTOs that you deal with; is that right?

MS LOFFLER: That's correct.

MR ROZEN: And part of the role you perform is to try and fill some of those perform by gaps by providing additional training. That is - - -

MS LOFFLER: That is true. I couldn't say it's – sorry.

MR ROZEN: No, no, do go on, please.

MS LOFFLER: I was just going to say some of those gaps – and I just do need to mention that is – I mentioned a couple of things around the content but it is also the ability of a training provider to work with students from different cultural, linguistic and cultural backgrounds and I think that we – that that part of the screening and training that we put in place is around that supporting training therefore to people with different linguistic backgrounds and I just want to add that into those gaps perhaps that we sometimes experience.

MR ROZEN: Thank you. Now, we focused to date – and time is running a little short. We have focused on the past and the present and I would like to turn the conversation to an examination of the future now, which is, of course, what the Royal Commissioners are grappling with, what sort of recommendations they should make in relation to future training needs of the workforce. I suppose a simple question but perhaps not a simple answer, if I could ask you, Dr Barnett, should the Commissioners be seeking to reinstate the TRACS program, for example, and if they

were minded to do that, are there some changes that you would recommend that are made?

DR BARNETT: Definitely yes. Without a doubt. But yes there are some differences that, from having evaluated the program, that I would recommend. The first is that it also involve partnerships with VET providers and not just the higher education partners. The second would be that it extends into home and community care and isn't just entirely – even though it's easier to control, but not entirely a residential model. The third would be that it considers also building partnerships with the health sector but particularly the acute sector. We have seen that model work, it works really well with the Veterans Administration in the US, which is one of the first teaching nursing home models, in the sixties I believe, and they were co-located next to acute care facilities.

And they didn't have the issue that we have of Commonwealth versus State funding for two different types of services. And so they are able to overcome those silos. But nevertheless – you know, I think I have said earlier on that there's quite a rigid barrier between the health and the aged care systems, you know, in terms of data it shares on a technology basis, lack of interoperability, which I'm sure Anne Livingstone and others have referred to, but also just a sharing of services that are quite seamless. So I think if you begin with the training of students, you set in place what you want for the system as a whole.

I would say that all services would need – only some did, this was one – that co-design with consumers has to be a key – a really valuable part. I haven't mentioned it before but it was part of our evaluation findings that when consumers have an active role, where they can, in student education it's a great win for students and for those consumers as a whole. With regard to partnerships, some of our partnerships were established prior to TRACS funding and some grabbed the funding and started partnerships.

If I was to redesign the program as a funder, I would say that it had to have a partnership that had been established for at least a year. And you can prove that by having worked together on, say, NHMRC research funding or that you have an MOU regarding your research and education. I think we have to do – and this is hard – we have to do some thinking around do we want this model to be a workforce model entirely. The R in TRACS is kind of secondary and that has been the case overseas as well. In Norway, with their model, they have actually just said, look, the only research component in this is going to be that aged care services partner with research organisations but we don't expect them to have the skill set of a research organisation, even though they will develop it where they have worked on a lot of major projects.

I want to see technology have a stronger role. We found where there were video conferencing centres that a much broader range of workforce were able to benefit from workforce education and there's a whole range that you would have heard from other witnesses around technology and how we could use that better. If you start that

again with student education in that program, you say, "This is how we want you to behave when you're employed". So that has to have a feature. What else? If possible, an inter-professional learning model is acquired so that you're teaching students about a holistic approach to the care of older people and that you are perhaps moving away from a workforce model that has brought allied health in more as sessional members of the workforce. If you are going to be a teaching centre I believe they must be part of your core workforce. Apart from anything else, you can't supervise students unless you have got people from those faculties.

If you have got clinical psychology, they will want one-on-one and they will want it only from another psychology. So just to work around all those vagaries. And what I finally would like to see and most importantly is applying what Norway have done with the hub and spokes model, whereby you fund a dedicated number of teaching facilities on a regional basis. You'd probably do it on population ratios. And they provide mentoring and are the centre for best practice in teaching and obviously with partnerships with research providers. But they are also funded to support the spokes of the wheel and help them, which is what happens in Norway.

And as I understand in Norway, it's quite a lean team, four to six people in each of those centres. So you would fund them on top of your existing aged care staff. So you have some kind of allocation. If we were going down that track it would give us an opportunity to fund some specialist centres. So Aboriginal – in Norway they fund a centre for the Sami indigenous people. You could look at culturally and linguistically diverse, you could look at dementia-specific. You obviously want to look at regional and rural, which also is a lot harder, but so is everything about aged care and the more remote you are because of scale and critical mass.

But we had some TRACS graduates, one in Victoria that did a great job of identifying the St John's Village project, how you work across the barriers of space and distance. I think that's all. And they were all things that I had conveyed to the department when presenting the report. The only other thing we recommended, which probably sounds a bit iffy and a bit wishy washy but I think it's important, is we realised towards the end of three years, that there's 16 projects, because we brought them together every six months, had formed a community of practice and because this is a group of people who don't really have a lot of peers to talk to, that exchange is really important. But what we found was in each of the workshops we ran that huge ideas were fertilised and cross-fertilised by bringing them all together.

So we would have liked to have seen a conference, at the very least, bringing together those projects to say what have you learned and what are you now still doing, but that that could be a stream within major national conferences and it kind of is. You know, when I have looked at the programs of AAG and ..... there has been – you can see the impact of the TRACS program because what people are talking about is what they got funding for. And what they got funding for, we found, was more of an investment than a cost because it's more like seed funding. People, if they're committed and most people are and they want to work on this model, provide huge in-kind support if they haven't got money but often add in financial and other

resources. So it's a model that is not going to be a bottomless pit of financial need. It's one that will generate and it will generate a lot of learning and if we are talking about redesigning quality aged care system I believe particularly education of our current and future workforce has to be central. And so I would also want to see it funding existing workforces as well as preservice workforce education.

MR ROZEN: Thank you very much. Just that notion of the sharing on a national basis of the experience from the TRACS program, presumably could also be expanded to any overseas similar ventures. You mentioned Norway. Earlier today we were hearing from Dr Veronique Boscart at the Schlegel Centre, where I think you visited as part of your Churchill Fellowship. Their initiatives are not that far removed from the sort of things that were looked at under the TRACS centre and presumably you would encourage that sort of sharing both nationally and internationally.

DR BARNETT: Absolutely. Apart from a national community practice, it's also important to support an international community practice and I talked to the people in Canada and Norway and North America and making Australia a fourth about possibly funding an international conference every two years and each country ..... hosting that. But we pretty much formed a virtual community towards the end of the TRACS project by people linking to people that they know and I know the Schlegel, which is one of three centres funded in Canada, had quite an impact on people here in the TRACS program and in the Department of Health and Ageing at the time.

MR ROZEN: Yes.

DR BARNETT: Just as ours did for the Ministry in Ottawa as well. So, yes, it was that ministerial level exchange.

MR ROZEN: Ms Corlis, can I just bring you in on the question or anything about the future that you want to share with the Commissioners, but specifically the notion of this hub and spokes model which might potentially, if it was implemented, might see Helping Hand being presumably a hub rather than a spoke. How would that work, do you think, and do you think that would be a valuable model, from your point of view?

MS CORLIS: Yes, I do think it would be – it would work well and as part of when Kate was running the TRACS projects, we actually did have two or three organisations that were less, I suppose, expert in running student programs and there was a lot to be learnt between the organisations. And a couple of those projects, I think, they have really struggled to sustain simply because you're just not big enough to have people there. So we have talked about at length about how we could actually run a hub and spoke model in the future. But of course, organisations just struggle to bring together the dollars to do that sort of thing.

And I love the idea because in aged care – I've been here for quite a long while and we often get done to. It's really nice for us to be actually engaged in the co-design of

a model where we actually have people coming into our facilities and our community work. So co-designing not only with older people is critical but also with us because the systems and the processes – you know, we can actually design things that make it very attractive for students to come in and be part of what we do. So I think that that's really, really important.

The other thing I would add is we've been able to actually put into place some very, I think, quite innovative components to our projects. We run things called conversational cafés where we can bring in very early students before they have had any exposure to older people often not even in their home lives, their usual lives. And we bring them in and have groups of older people come together and have morning tea, so we are offering this sort of change in some of the power dynamics and the professional stuff, I think.

But also simulation. I think we should look at simulation in relation to the community. We have toyed with the idea of having houses where we could have older people engaged in working with groups of students to actually simulate what would happen in a home and I think that's a huge enormous gap we are really lacking in our community programs at the moment about introducing brand new workers who are having to go out pretty much almost work-ready and they've never been into someone's home before, knocking on a door for the first time, engaging without all the other workers around you, that's a big critical piece that needs to be worked through. But yes, I love – having put my little piece in there, I do love – the hub and spoke model is a great idea.

DR BARNETT: And can I just pick up on Megan, when Megan talked about simulation and learning in the home. She is right. I mean, the only place I saw this was on my Churchill in Portland in Oregon and they have a huge simulation centre there to teach health and aged care students and they're part of the – and it involves mannequins, you know, those lifelike models of people that you can take blood and all kinds of things. But it had a whole room set up to look like a home and they used to run simulations with students of working with old people in their homes there. It's the only place I have seen it. I'm sure it does exist. Norway it might now.

MS CORLIS: They do have that for nursing and things like that.

COMMISSIONER BRIGGS: Can I ask the panel, why is that the case, given that most care for older people is provided in the community? Why is it that the home and community care sector seems to be divorced from this kind of, what would seem to be, essential training and education?

MS CORLIS: I think it's the difficulties around sending out students. So in the same way that we run – we would have students within our residential sites, it's a much less controlled environment for putting students into. So within a residential site, if we have got a Cert III student, we still have registered nurses and enrolled nurses and other health professionals around that can assist when things – someone has a fall or something happens. But in the home, it's an uncontrolled environment

and, to be honest, I think it's doable but nobody has had the time or the resource or the money to actually work through that.

MS LOFFLER: Yes, and I can just add, the time – we do have small pilots of students going into home care situations and we take students out into our respite houses, which are houses where people are coming in their home-like environments that they still do have a small staff. So it's sort of a halfway between residential and home care. But the difficulty for us in organising those trips into home care, which – is the logistics, it's the timing. It's about arranging a time that will suit the care worker that they will go with, to suit the resident, the person living in the home, that ensures transport. A lot of Certificate III students actually are – not yet have transport, often are newly arrived to Australia and have not got those things worked out. So the time that we spend organising that, we just – it's just an enormous time impost. Not impossible but we're not resourced to do it as much as we would like to.

DR BARNETT: .....

COMMISSIONER BRIGGS: And yet it's probably one of the greatest sources of learning how to operate for a professional in an autonomous way. So anyway, I interrupted you, Doctor, do you want to continue?

DR BARNETT: I was just going to say, absolutely agree with what Helen and Megan are saying. And I also think if you look back to the history of the model and how it evolved and what the key driver was, it came really from the university sector having huge influence on how people will be trained and wanting to change the balance of the workforce in aged care facilities because there have been huge problems with rates of infection, for example. And an almost absence of nursing and medical staff. So when you have got that thinking behind you, the next obvious place to train people would be in a residential centre, rather than in homes because of all of these problems.

And the early variance of the model also had people from the faculty located in the nursing home as directors of nursing, for example, or often they employ a nurse practitioner. So it came from that thinking but, you know, you are quite right, we have moved very much to more care in the community model. And it's interesting with the Norway system that, you know, it's now totally government funded forever as far as we know, that initially their hubs were all residential and then a few years later they said, hang on, we need to also focus on home and then home got added. So I think history does play a critical role.

MS CORLIS: Can I be clear, though, we were talking about Cert IIIs. We certainly have allied people who go out into the community. So a physio could take a physio student, so we were being most specific to their care.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Thank you. Just one last matter, probably for Dr Barnett, and that concerns numbers. There were 16 projects in the TRACS program, 2012 to 2015. How was that number arrived at, do you know?

DR BARNETT: Do you know, I think from my conversations with the team who were then, you know, they had a dedicated TRACS team in the department, it had largely been who put in applications, rather than them saying, "No, not that one, not that one". And I was surprised that, you know, there was some facilities that I would, you know, knew about from the scoping study who didn't apply for funding. So it's 16 – I think was just how it happened, you know. Them responding and then dividing the money up. If you look at proportions, you know, South Australia is a small state but SA got four out of 16 projects and New South Wales got four – three, something. So it depended on who tendered.

MR ROZEN: If you were designing a new system from the ground up along the lines of the hub and spokes regional model that you talked about earlier, do you have a number in mind? Presumably more than 16 for the country.

DR BARNETT: Gosh, that's really hard. Norway, I looked at their proportion and I can't remember what it was. It was something like one to every quarter of a million people but I'll need to check that and just check that with you. But I remember thinking at the time Australia would need, you know, 25 centres at least. So we have easily got the partnerships that already exist out there to do that. It wouldn't be a problem. It would be a funding issue. And I think the eight million for TRACS, people thought that was huge and I remember thinking as I was watching what the projects were doing that it wasn't really enough money and it wasn't a lot of money.

MR ROZEN: All right. Thank you very much.

DR BARNETT: So I don't know how many teaching hospitals we have got and maybe that's the comparison and funding they get.

MR ROZEN: Yes. Alright. We will explore that. Thank you very much, each of you. I should ask the Commissioners if there are any further questions you may have.

COMMISSIONER PAGONE: Yes, thank you to each of the panellists. It's wonderful you have been able to be with us, albeit a long way away. The camera seemed to work reasonably well. But thank you for sharing your experience and depths of knowledge. These are very important and interesting questions and we have learnt a lot from them. Thank you very much.

<THE WITNESSES WITHDREW [11.31 am]

COMMISSIONER PAGONE: We have now got a slight reconfiguration, I gather.

MR ROZEN: That's right.

COMMISSIONER PAGONE: But running out of time, so we might do that very quickly, Mr Rozen.

MR ROZEN: We will.

COMMISSIONER PAGONE: Alright. Adjourn temporarily.

ADJOURNED [11.31 am]

RESUMED [11.39 am]

MR ROZEN: I call Professor James Vickers and Professor Andrew Robinson, and they will appear together by video link. Good afternoon, Professor Vickers.

PROF VICKERS: Good afternoon.

MR ROZEN: And good afternoon Professor Robinson.

PROF ROBINSON: Good afternoon.

MR ROZEN: Afternoon your time. Just a little earlier here. I'll ask that you are sworn and then I'll ask you each to introduce yourselves to the Commissioners, please.

<JAMES VICKERS, AFFIRMED [11.40 am]

ASSOCIATE: If you have the webcast playing on your computer, can you please turn it off.

<ANDREW ROBINSON, AFFIRMED [11.41 am]

<EXAMINATION BY MR ROZEN

MR ROZEN: Thank you. It's me again, gentlemen. Professor Robinson, could I start with you, please, and ask you if you could – as briefly as you're able to, given your extensive background, if you're able to give us – the Commissioners a brief

description of your current role and relevant experience in relation to research innovation and technology in aged care, which is the topic that we are focusing on today.

PROF ROBINSON: Thank you. I am a professor emeritus at the Wicking Dementia Research and Education Centre at UTAS. I am a registered nurse. I have done a Master's in Nursing Science, I've done a PhD. I started working in aged care in the mid-90s. I started working specifically in dementia around 2000s. I started working on developing student placements in aged care in 2002. In 2008, James and I established the Wicking Dementia Research and Education Centre, and in 2011 we established the Wicking teaching aged care facility program.

We've also had a range of innovations in terms of our developing the understanding of dementia mood, the Bachelor of Dementia Care, now the Master's of Dementia. These are all firsts in this – in the world, really, in these areas and particularly in Australia – well, maybe not the world, the Bachelor of Dementia Care, but I think so – and I retired in August 2017.

MR ROZEN: And - - -

PROF ROBINSON: Sorry, I was also on the Aged Care Workforce Sector Taskforce. That's probably enough.

MR ROZEN: So it was a brief retirement, was it, professor?

PROF ROBINSON: Well, I retired in 2017, then I went back and I helped – I established Dementia Training Australia. I was one of the founding directors of Dementia Training Australia and then I – that – I concluded that in June 2019.

MR ROZEN: Thank you very much. I'll come back and ask you about a number of those things that you've identified, but if I could go to you, please, Professor Vickers, and welcome back to the Royal Commission. I think you gave evidence at our Melbourne 3 Hearing last October; is that right?

PROF VICKERS: I did, indeed, yes.

MR ROZEN: Yes. And if I could just trouble you briefly to describe your background in a similar way to what we heard from Professor Robinson, please.

PROF VICKERS: Certainly. So since Andrew retired I'm now the Director of the Wicking Dementia Research and Education Centre here at the University of Tasmania. My other role is Dean of the Tasmanian School of Medicine and I'm a board member of Glenview Community Services, which provides residential and community care. Andrew described a number of the things that we do in the Wicking Centre. We have research that's focused around the cause, prevention and care of dementia and we're very serious about our educational programs and looking,

really, to build capacity, particularly around dementia, at all levels of aged care workforce.

MR ROZEN: Thank you very much. Perhaps if I can stay with you for the moment, Professor Vickers. We are exploring today at the Royal Commission the general topic of innovative approaches to the education of aged care workers and we know just from the brief introduction that you've given us and also as you've detailed in the witness statement you provided to the Royal Commission last year that that's been a topic that has been central to the work of the Wicking Centre. Could I ask you perhaps to start by giving us an overview of the work that you have been doing in that area.

PROF VICKERS: Yes. So I guess one of the real reasons that we, in fact, established the Wicking Centre just over 10 years ago was research and evidence that indicated that there were really significant deficits in the knowledge about dementia, whether you be somebody who develops the condition, a family carer, aged care worker, health professional in the sector or outside the sector. This seemed to be an important issue, and rather disabling for providing quality care. So, again, a major strategy for the centre has been to try and ameliorate that deficit of dementia knowledge, and that began with free online courses – short free online courses called MOOCs. They have been running since 2013.

We've also developed a suite of undergraduate offerings, most popular is the Diploma of Dementia Care, which is largely targeted at aged care workers, and in recent – over the last year or so we developed a postgraduate program in dementia that is mostly targeted towards health professionals. The MOOCs in particular, I guess, have had significant uptake. While we're sitting here, we're running one of these MOOCs on understanding dementia and there's just shy of 28,000 people enrolled in that course from across the world. So that does demonstrate that – I think, at a certain level, that there is a strong desire out there to know more about dementia, and for people to improve their dementia knowledge, so they can then apply it in their work places.

On top of that, I guess, the other areas that we are very passionate about is in the research area. We do research around these MOOCs, and our other educational offerings, trying to determine whether, in fact, people's knowledge of dementia does improve as a consequence of doing these courses, and then how they might apply it in their – for example, in their professional lives.

In other areas – there's probably not enough time to go into all of them, but we do span neuroscience research, trying to come up with new drugs and interventions in terms of laboratory based research through to a substantial program now in trying to reduce people's risk of dementia, and then very importantly a very big program that's focused around the care of dementia and how can we improve care. Be it from one level education, right through to designing how the aged care system should work, build facilities and so forth.

MR ROZEN: Thank you. Can I just look in a little more detail at one of the matters that you've just raised, and that is the MOOCs. That's – remind me, M-O-O-C, stands for Massive Online - - -

PROF VICKERS: Yeah, so it was a new trend in education around about 10 years ago, so they've been around for a while now, but they're Massive Open Online Courses - - -

MR ROZEN: Yes.

PROF VICKERS: - - - and so they're designed to be delivered by the internet to large numbers of people and, most importantly, also, to be free and quite accessible. So you have to design these courses to – so that people from a variety of different educational backgrounds can do them, and, essentially, if you can engage with the internet, with Facebook, then you should be able to undertake one of these MOOCs.

There are over 40,000 MOOCs now in the world and delivered by all sorts of different institutions and the understanding dementia MOOC by user ratings is number five in the world, which I think speaks partly to its very well designed, it's designed for accessibility. It hopefully tells very important stories around dementia, but also I think out there in the community there is a significant need for high quality education that speaks to where people are living with dementia.

MR ROZEN: And are you able to share with us either now or perhaps after giving evidence today some data about the breakdown of the people that are doing the dementia MOOC? Is it mainly aged care workers, is it mainly family members, for example. Can you help us there?

PROF VICKERS: It's around about two-thirds of people are in Australia, one-third overseas, and then underneath that it's about one-third family carers, one-third, what you might call aged care workers, support workers, people with a – probably a vocational education, and about one-third health professionals, particularly nurses and allied health practitioners.

MR ROZEN: Can I bring you in, please, Professor Robinson, and ask you specifically about the teaching aged care facility program, which I know is something that the Wicking Centre has been actively involved in for a number of years. If you could perhaps take us back to the beginning of that process and indicate to the Commissioners what initially drove the interest in that program.

PROF ROBINSON: Well, in 2002 we were getting a lot of complaints because there were no nursing students in aged care doing placements. So we – I teamed up with two providers and we put students in on placements, and that was called Making Connections in Aged Care project and that had very good outcomes and we had big turnarounds, so from 30 per cent of students saying they'd consider a career in aged care, we ended up 90 per cent after a two week placement, three week placement, something like that.

We then extended that with further funding from the Department of Health in the Building Connections in Aged Care project, which we did in six facilities across Tasmania. We just had four students in each placement and again we had a really, really fantastic outcome while the project went in terms of students' experiences and staff professional development, and these were all research projects. So they were all – there was always a big evaluation component to them.

The next one – and there were three stages to that, plus a follow-up evaluation. Then we did the Modelling Connections in Aged Care where we looked at six facilities across Australia, the – previously it had all been in Tasmania, and we found that student experience in that project was characterised by fear and anxiety, and we found no contrary evidence to that, and we also found that the staff had a sense of inadequacy to actually effectively support students, and again that was just a really strong theme that came through that.

And from that and from the evidence that we developed that was a project with a number of investigators, including Professor Abbey. We developed the evidence based best practice model of clinical placements in aged care. After that, the funding then dried up and we did a number of projects on palliation, falls, you know, millions of dollars worth of funding, but when we went back into the aged care facilities we found that, by and large, there wasn't a good footprint of all the work we'd done.

Basically once we left and the project finished, we found that there wasn't that much left, and we found similarly the case with the other projects that we did, and that was what my colleagues also reported about their projects, as well. So we then – I then teamed up with an organisational consultant from Gravitas, Dr Cathy See, and we designed a program which would involve whole of organisation change, and that was the Wicking teaching aged care facility project. So instead of just having students – a student project which was about putting students and developing groups of mentors to support them, we had a second stream which was about building organisational capability for leadership and to become a learning organisation, and that project was the Wicking teaching aged care facility program.

We also changed the focus. Previously we would put four students in on a placement. This time we told, for example, a 140-bed nursing home they'd have to take 80 to be part of the program, and so – and they were interprofessional, so we expanded from nursing in Tasmania, medicine – to medicine and to paramedicine, and we ran that project for two years in two facilities in Tasmania, and we've seen really amazing – quite amazing transformations in those organisations. In terms of the student placements, we struggled, because I don't think we had enough funding and – with the organisational component, and the building leadership capability, that I'd say we – was difficult.

And then we got TRACS funding and we expanded that into other facilities, including Mount St Vincent's Nursing Home up in the northwest, which was a small remote one. The ones that we'd done previously were two standalone 140 bed

nursing homes, and we also expanded into WA with Juniper, which is large corporate. So our intent in that was to look at the applicability of the model across these different sorts of environments, and you – we have an evidence base that primarily relates to the impacts for residents, students and staff that I provided to the Royal Commission. That's 17 papers that were published in international journals, and we also publish a protocol, which is, really, how the project was organised and configured to make it successful, and in the way that it's outlined in the papers that we've published.

MR ROZEN: Thank you very much and we're very grateful for the papers, and you can be – rest assured that they'll all be read by the staff of the Royal Commission. If I can just identify some of the – what I've understood to be the key points that you've made in the evidence that you've just given; that is that for a teaching and aged care facility project to work, it's important to build up leadership capability within the particular facility; is that right?

PROF ROBINSON: I think that that certainly in the Aged Care Workforce Sector Taskforce we identified – concerns over the leadership capability came through as a very strong theme.

MR ROZEN: Yes.

PROF ROBINSON: That was a very strong theme that came through our work, as well, and for a whole range of reasons, and this is not to denigrate people that work in aged care. I have the utmost respect for them, and I think they – in the circumstances they do a fabulous job, but it certainly was an issue. I think when you look at your previous witness, Helping Hand, you can see that that organisation and the board are very much engaged in that program that they're doing.

So one of the things that we – that was critical for our work in order to have sustainability, because, you know, the four organisations still have those large interprofessional student placements - - -

MR ROZEN: Yes.

PROF ROBINSON: - - - to this day. So that sustainability was that you really have to have the board and you have to have the CEO and all the senior leaders actively engaged in an arm of the project, because to support the large-scale interprofessional placements in that complex environment you have – the organisation will have to change. It will have to adjust. So we changed all sorts of things. We changed the way staff were allocated. We changed all manner of organisational attributes in the organisation in order to enhance the placements, which, in turn enhanced the quality of life of residents, as our evidence demonstrates. If you couldn't change – and you could only do that by having very engaged senior managements and board, so we would meet regularly with the board, particularly in Tasmania and we are very close – work very closely with them.

So that way what we really did was a whole of organisation change, and our intent was to really try to develop learning organisations. So this was a new model of aged care and centres of excellence, much as teaching hospitals are centres of excellence. If you're really sick, you go to a teaching hospital. So these are the areas trying to then look at places that were really high performing with high performing staff and with leaders in every chair.

MR ROZEN: Thank you. I will come back to ask you about a couple of those things, but if I could go back to Professor Vickers now. One of the matters that you identify in the statement that you provided for us last year has been – is placements I think in fifth year for medical graduates – or, sorry, for medical students. Is that something that I could just ask you to explain the background to and the benefits that are derived from that for the students, but also for the aged care facilities where those placements take place?

PROF VICKERS: Yes. So most medical curricular around the country tend to be reasonably historically bound. So we tend to have a – teach a lot about the sort of things we've been teaching about for a number of decades. That's not a criticism. That often reflects your staffing profile, and so forth. So I think this was reasonably ground-breaking is that we identified residential aged care, and in this case, as a great learning experience for medical students, indeed, for other health professional students, as well, but for medical students in particular, they had, then, the opportunity to spend a good period of time, not just be visitors to the facility, turn up one day and disappear the next, but they were embedded and supported by GP tutors in – for their week in residential care and they really got to see things that they probably wouldn't easily see or be involved with in – even in the hospitals, where they got to spend time with old frail people with multimorbidities, often more so, of course, including dementia.

They got to be involved in assessing their needs, reviewing their medications, really, a much more, sort of, holistic approach to care that's – that you don't often see in teaching hospitals, because everybody's very busy. So you might spend a little bit of time by the bedside visiting a patient and hearing their story and checking for some signs, but when you're embedded in that residential facility you've got plenty of time to have a meaningful engagement with the resident, as well, too.

And Andrew was much more involved in the research around the medical students and their response and their effect on the facilities, but we know that this had a very positive effect on the facility. One of the reasons that teaching hospitals are really great places is because they do have medical students, and medical students have this way of keeping the health professionals and the other doctors on their toes, because they don't necessarily want to be caught out on a particular clinical scenario by the medical student. So this is, sort of, a virtuous cycle, if you like, between students on placement and, really, the quality of care that's provided by the whole medical team.

And so I guess that's something that we'd be aiming towards, I guess, with the teaching aged care facilities models, that a teaching aged care facility would have

this focus on quality, on provision of quality care and having students there and having the staff involved in teaching those students, you know, it helps again promote this virtuous cycle between providing an education, but also, you know, having that feedback from the students and their meaningful engagement providing some part of the care of that older person.

MR ROZEN: Thank you. Professor Robinson identified the importance of the, sort of, core leadership ability and commitment of the board, as we've seen with the Helping Hand example that we've looked at earlier today. Are there other features that you would identify, Professor Vickers, of an aged care facility that can be a teaching aged care facility? What is it that we're – that we should be looking at in identifying those facilities that could perhaps be designated as teaching aged care facilities?

PROF VICKERS: Yes, I think that that's – the commitment to being a learning organisation has to be paramount, along with the leadership dimension that Andrew described. You really have to make sure that all levels of your workforce, your admin staff, your boards, your management team, are, really, all committed to that organisation being a learning organisation. What's very different sometimes about residential care as compared to hospitals, that within hospitals a lot of the staff will engage in lifelong learning, if you like, they undertake postgraduate degrees, continuing professional development, they're involved in research, and that also again adds to the quality mix of the teaching hospital, because all of those things help to ferment a culture within the organisation that wants to promote, basically, again, quality care.

So I think in the residential sector it would be great to have staff – I guess, the idea of additional learning and professional development promoted, and then, perhaps, also reward, because, I think the Commission would know that in the acute care sector if a nurse obtains a particular postgraduate degree, then, at the end of the day they're actually paid a little bit more, so there are, sort of, financial incentives, as well, too. So if there was something, I guess, in our accreditation standards or how we fund residential care to promote that learning environment and promote some reward for staff engaging both in their own education and professional development and also then contributing to the education of various kinds of students that might come through that facility. I think again that would promote the sort of virtuous cycle.

MR ROZEN: Thank you. That's very helpful. If I can come back to you, Professor Robinson, and just ask you, drawing on the experience of those aged care facilities that you identified as in Tasmania and Western Australia was the other one. Was there also one in Victoria? Did I understand that correctly?

PROF ROBINSON: There was, yes.

MR ROZEN: Yes. Now, that – was that – that expansion was during the period when the TRACS funding was provided; is that correct?

PROF ROBINSON: Yes, we expanded to two extra facilities in Tasmania, one in Victoria and one in WA.

MR ROZEN: And how were they identified by you to expand into?

PROF ROBINSON: Well, basically, they were identified by the university partners that we had, and they had partnerships with those organisations. So that was Curtin University, ACU in WA, ACU in Victoria and, obviously, in the north-west of Tasmania with the UTAS.

MR ROZEN: Yes. Dr Barnett, who I think you know, Dr Kate Barnett, who did the evaluation of the TRACS program gave evidence earlier today about the importance of there being those sorts of existing partnerships in place before identification of a facility as being a teaching aged care facility, and she told us that in her evaluation work –and I think this is reflected in the report, I must say – that those organisations, like Helping Hand, like the Wicking Centre that had existing partnerships in place tended to be the most successful in relation to this teaching initiative. Is that something you would agree with?

PROF ROBINSON: Look, what – the methodology that we used was to go in and do an organisational health check, which started off – that's how we started this program.

MR ROZEN: Yes.

PROF ROBINSON: And so if you're working with somebody and you've been – like, I was – I'd worked for many years with a number of these organisations through the 2002 to 2011 period, and so we knew each other very well and so when we went in and did an organisational health check that was done by the organisational consultant, we had enough goodwill to deal with the tricky and difficult issues that were raised. When we had not a really strong pre-existing working relationship with an organisation that could get tricky and that could get difficult.

MR ROZEN: Yes.

PROF ROBINSON: So I agree with Kate that, yes, there needs to be some – it's not – because what we do in a lot of these things, we get a call for funding, we go out and find a partner, we all get into bed together and then we, sort of, don't – you know, we might like each other, but we might not. So you really do need to – you know, I always called it – it's like, you know, you get engaged and then you get married, you know. So it is about finding out – or you court, first, you know, so – because when you do a teaching aged care facility program – and I think they alluded to it well in the previous group that you talked with – it's very complex, very intense and, you know, to have 20 students in a 140-bed nursing home on one day, people can't get into the tea room. They can't get into the office.

These facilities aren't designed for that. If you look at a teaching hospital they are absolutely designed for that. You know, you look at a nurse's station or anything like that, they are designed for that, but, you know, so you've got to be able to deal with that sort of stuff. You have to be able to deal with how you're going to organise it. Again they talked about having facilitated, "Well, actually you need a high level person to facilitate the organisation. It can't – it has to be a senior person". So with the people we use, they were one level under the Director of Care.

MR ROZEN: Yes.

PROF ROBINSON: And they were the people that organised it, because you've got to be able to negotiate a lot of changes to make this sort of thing – to facilitate this sort of thing. So yes, it takes a lot of preparatory work. The other areas are universities, and, of course, the universities by and large are relatively unfamiliar with aged care. Now, there are ad hoc examples where they're good, but there's not – you know, if you look at universities, I don't think I'd be out of place to say most people doing the teaching are out of acute care clinical context, so – and they talked about that previously, about the attitudes of academics sometimes to aged care and aged care placements, etcetera, etcetera.

So you haven't got a very strong group of academics that come out of aged care, because that wasn't the high end area to go if you were a nurse, for example. You know, it's like general practice is generally low status in medicine. Aged care is low status in health, and so the universities really had no real familiarity with the sector. So you also needed a similar person in the university side that was going to actually orchestrate that, and again they had to be – you know, that was me, in a way. I was the person, I was the Professor, I was Co-Director of the Wicking Centre, and so because these are things that people haven't done and they're very unfamiliar.

So you sort of – you can't – you almost – you don't know what you don't know. So getting into it is a – there's an aspiration to be a centre of excellence, but the nitty-gritty of it – the devil is always in the detail, so you need a lot of structures and processes to support yourself through that or it can very quickly fall over.

MR ROZEN: Can I ask you about the question of design. Am I to understand you to be saying that when a hospital is designated as a teaching hospital, is it a formal process of accreditation where that comes about? How is it that if I built a hospital and I decide I want it to be a teaching hospital, what do I need to do to obtain that status?

PROF ROBINSON: Well, James could probably give you a better – you know, speak to that better than I could.

MR ROZEN: Yes.

PROF ROBINSON: But can I just say that I went to one organisation and I said, you know, "Do you – are you interested in this?" and they said to me "Yes, what we

need is to just get a whole lot of people in that know how to do teaching in aged care facilities", and, obviously, there's no one. But if you're in a teaching hospital and I go to the Royal Melbourne, for example, and I come from the Sydney North Shore, there's absolutely precedents and consistent ways of operating. I can move from one to the other. They have got very well established structures, processes, infrastructures, all of that stuff. None of that exists in aged care.

So we don't have people that are – we're really starting at the very bottom here. We're really starting, not at the bottom, we're starting at a baseline, which is a – which makes it difficult, but also means there's a fabulous opportunity, because you can set it up how you would like to, but there is – you know, honestly, there's – you know, if you look at Marit Kirkevold in Norway, her first – to just get that established was five years as a pilot. Just five years just to get it, you know, in place, and then after that another five years and then, you know, they went on.

Now, what they did in Norway was they took it out of the university sector. So Marit actually doesn't have a direct engagement any more, but that's a problem because then you haven't really got a good research base to guide the changes, so when you're wanting – so for us, for example, when we first started and we said we're going to have 80 students come in, everybody without exception said "Patient care or resident care will suffer, because we'll be spending all our time looking after the students". When we produced the evidence that showed that, really, the students supported each other a lot, and there was a –it worked – actually worked really well, and the facilities became alive, and the quality of life of residents in their eyes, and the eyes of their families improved. That turned around to saying, "We actually should have students all the time, not just in set blocks". That was a real cultural change, you know, that's a - - -

MR ROZEN: Yes.

PROF ROBINSON: But the evidence. If we didn't have that evidence about the impacts on students, the impacts on residents, the impacts for staff, and it was all credible evidence, not just what we reckoned, but it was published in peer-reviewed journals, then that was what they say, they – you know, because they are all interested in their residents. They all want to do their best for the residents, so here's a – if something that is happening that is really good for residents and really good for staff, then the board will absolutely buy into that and they did what Helping Hand did. They employed people in new positions to facilitate the program.

MR ROZEN: Now, Professor Robinson, thank you that is all very helpful. If I could turn to – sorry, I was hoping to stay with Professor Robinson for the moment, Professor Vickers, we will come to you in a moment. Professor Robinson, if I could just take up your suggestion about what a remarkable opportunity we have here and, of course, the Commissioners are keen to explore such opportunities, and the one that presents in the teaching aged care facility seems to be a very important one. Do I take it from your evidence that some of the building blocks that we ought to be

looking at are, firstly, the Norwegian model? Is that what you would recommend to us?

PROF ROBINSON: Well, that's where I went - - -

MR ROZEN: Yes.

PROF ROBINSON: - - - and I became good friends with Marit.

MR ROZEN: Yes.

PROF ROBINSON: I think that that certainly gives you an idea of how you can sustain this, and so one of the key elements that Marit always says is every year in the health budget, there's a budget line for teaching aged – teaching nursing homes.

MR ROZEN: Yes.

PROF ROBINSON: There's recurrent funding for teaching nursing homes. I think that – but we also have a fabulous evidence base in Australia. I mean, Kate has done a lot of work. I've done a lot of work. We don't need to reinvent the wheel with this. We have a very, very good – a good approach for making this happen. I think what we've done differently, though, is we've got a schema. Our work shows that, you know, there's a number of elements prior to actually doing the teaching aged care facility, and the first one is dementia literacy.

So the UD MOOC that James spoke of and the bachelor, they were actually designed as interventions, because our capacity to engage aged care staff in innovation was so limited because they had such poor knowledge, and why would they have good knowledge. They're not going to get it in uni, they're not going to get it at the RTO, you know.

So, you know, this improving dementia literacy – and the UD MOOC that James talked about, I mean that's rated, I think – you know, it's number five in the world, but you've got to remember that's been going since 2013 to today. Whilst we're sitting here it's got nearly 28,000 students. As far as I understand, that's more than all of the rest of UTAS.

So that's all these years on. So it's hundreds of thousands of people, and the completion rate is about 40 per cent, and, you know, if you've got a degree or you've got a primary school education, your chances of completing are the same. So that – and it's online and it's free, so, you know, that's sort of – one of the, really, starting points, because if you're going to put a whole lot of students in there, and I've supplied you with the paper we wrote on knowledge in aged care – dementia knowledge in aged care, the 'Who Knows, Who Cares' paper, and people don't know a lot about dementia, you know, they're doing – trying to do the best they can, then, you know, what sort of experience are students going to have.

So dementia literacy is a core. The second element is dementia friendly communities. The third element is dementia – is then developing the learning organisations which are the teaching aged care facilities, and our view was that once you've got them, you put in big lumps of students, which stress the organisation and they had change to cope with that and then exploit that, they became research ready, because you – they were always having access to the data. They were looking at how what they were doing was going. Then you get to the point where you can then go and investigate new models of care, because that's very threatening to look at how – "Is my care good?" It's very threatening to anyone that provides care, but once you're familiar and comfortable with ethics processes and all of these things, because you've got to understand, if there's no real engagement – this is with universities in aged care – then they don't understand any of this.

Whereas in teaching hospitals, of course, they do. The ethics committees are based in the hospital. So and then you get to new models of care, but what is perverse, in my mind, is that all the funding goes to that last area, new models of care. So, in my mind, we fund what should – we fund first what should be funded last, and hence no – hence the problem with sustainability of innovation.

MR ROZEN: You referred us to the Norwegian model. Dr Barnett earlier today told us that they utilise a hub and spokes model in Norway. Is that something that you would also commend to the Commissioners as an appropriate structure for any future program?

PROF ROBINSON: Yes. Yes, I mean, look I can provide you with a failed application to the Department of Health to do exactly that.

MR ROZEN: And when was that, out of interest, that you made that application?

PROF ROBINSON: That would've been 2013/2014, something like that.

MR ROZEN: Yes.

PROF ROBINSON: It is set up to build on what we had done to set up a hub and spokes model. Yes, I – you know, when you asked previously about how many teaching aged care facilities, so if I look at a place like Hobart, 500,000 people, I'd have two.

MR ROZEN: Yes.

PROF ROBINSON: You know, and geographically located, and – but what I'd do – you can't forget that the other partner is a university. So just like in the aged care facility, you'd want the board and the CEO and everybody absolutely on board and held accountable for what was happening. In the universities, I – look, because this is such a big change and they have no real meaningful engagement with the aged care sector – by and large, I mean, there will be some that do, you know, but by and

large, that it's the – actually the Vice-Chancellor and the Dean of the Faculty that have – that's – I would argue that's the level with – because it's going to require a big change for the university. A massive change and a massive reallocation of resources and a massive reallocation of interest.

And you don't get it at that level, and even at that level, at the council. So the university has this as a really key strategic priority, and then if you have adequate funding – not like we did it all, you know, like we had so little money relatively to what we needed – you know, it's funded properly, then that will be – you know, they will be interested. So we're talking about something where we're, you know, Lou Marcaka said that, you know, acute care and aged care are like ships in the night, you know, pass each other without seeing. Honestly, the university is on a different ocean.

MR ROZEN: Can I ask you about the VET sector, which is obviously of significance given the significant proportion of aged care workers who are trained through the VET sector, rather than through universities. What would you commend to the Commissioners as an approach that would appropriately bring Registered Training Organisations into a teaching aged care facility process?

PROF ROBINSON: Well, again, it would be – we didn't do that just because we didn't have funding. I mean, as you'll see from our publications, aged care workers were up to their neck in this, what we did. They were key players. You know, what happened as a consequence of what we did, that had impacts for the curriculum in the university in – at the – you know, when we did stuff, and it would be exactly the same for TAFE. So you need organisations that are going to step up.

Now, how you identify them, I'm not sure, but, yes, you could do exactly the same thing with TAFE organisations and bring them into that circle. So, for example, we would have meetings to plan the placements of students. That would be chaired by the Director of Care of the organisation, and all the universities would have to have their senior people come to attend those meetings, the coordinator. So this was a high level meeting to plan everything and how it was going to happen.

Previously, it was just off the side of the, you know, desk, because, you know, "Oh, yeah, we'll take students. We can take two or three", or something like that. This is like, you know, 80, 70, you know, but – so it was – you needed to have – and then you needed to have – but you needed to have their – you know, those people from the universities that come, you know, if the university – if this is just something that's going on because someone thinks it's a good idea, it's not a strategic priority. They will struggle with trying to get curriculums aligned and etc., etc., because as James talked about, the medical students, you know, we do have papers in there which highlight the interprofessional learning. The standard – you know, there's five levels of interprofessional learning. The level that we achieved was the highest level, was level 5, where we actually improved patient outcomes.

MR ROZEN: Thank you. Professor Vickers, if I could bring you in at this point and ask you to engage with us in a bit of co-design, which is a very popular term, and look at the future needs of the aged care sector and the need for high quality training. What would you draw to our attention, based on your extensive experience? Where should the Commissioners be looking for the future?

PROF VICKERS: Yes. So one of the things – I think I probably raised it previously, but it does – the Commonwealth does do this well in particular areas of need, and one of the great programs I think that the Commonwealth has is the Rural Health Multidisciplinary Training Program, and that was developed in response to the need to do, really, two things. One is to improve everybody's knowledge of how to provide high quality health care in rural environments, but also to bring along and develop those rural sites as excellent sources of clinical placements. And to bring in students from those regions into those health care courses.

So again it was all, sort of, fits well together in that you are creating a high quality practice experience in those rural sites, then there's a good chance that when these health care professionals graduate, that they might then be drawn to work in those rural sites, and this is a program that's been running for a while. It's organised either as rural clinical schools or university departments of rural health, and they do work on that hub and spoke idea. They are centres for excellence around rural health and they work very closely with health service providers in their region.

So the parallels with the teaching aged care facility concept are actually – are pretty good. So that would be my recommendation into the future, is the Commonwealth could look at funding teaching aged care facilities along the same way they already fund and accredit and evaluate that kind of model. It's not something, you know, you have to – you don't have to necessarily develop something completely new *de novo*, but as Andrew points out, too, you need to make sure that where you developed these, you know, whatever aged care multidisciplinary training sites and that they were well prepared to undertake that task meaningfully, because the real danger in this is if we set up lots of these things across the country, but they still provide those students on placement a not very good placement experience, then you can have more health professionals, or they could be aged care workers in training and so forth with a very negative view about aged care and, you know, run a mile once they graduate to work in that sector.

So it's something like that. Again, as the Commonwealth is used to having a program like that, and it would be – if you just swap rural for aged care, I think that you could potentially have a good model, but like Andrew has indicated, it needs to be funded substantially. What we did around teaching aged care facilities and, really, to this day is funded very – and supported very leanly in terms of budget and budget costs, because, you know, again a lot of, for example, medical curricula costs are modelled around supporting medical students on placement in traditional sites, like teaching hospitals and in general practice. So you kind of have to find money to, really, in a sense, in your budget to support these kinds of things. So it really does require a substantial additional funding outside our normal university budget.

MR ROZEN: Yes. Yes. If I could just take you up on what you've just said about the rural health funded program and the accreditation of regional hospitals as hubs in that hub and spoke model. Presumably, with teaching hospitals, which is something you're no doubt very familiar with, there is also an accreditation process. There are certain features that have to be present in a hospital before it is accepted, given the responsibility of being a teaching hospital. Would you see those sorts of accreditation processes adapted appropriately for aged care as being a useful guide for our - - -

PROF VICKERS: Yes, I think so. Yes. So the – I mean, for teaching hospitals the accreditation standards come from the Australian Commission for Safety and Quality in Healthcare, and – which is a – you know, a very good statutory body. So I guess the idea of having a statutory body of some kind that would oversee the, you know, the quality – and safety, but the quality of a potential program that relates to teaching aged care facilities would be a very good idea, rather than them all working, kind of, in isolation and, sort of, deciding for themselves what excellence, or at least what pretty good looks like. I think it would be better to have, potentially, something that looks like accreditation standards around that - - -

MR ROZEN: Yes.

PROF VICKERS: - - - or perhaps even better to build that into the current accreditation standards of – for aged care facilities.

MR ROZEN: So you could potentially have a general accreditation standard for all aged care facilities, category A, perhaps, and then category B would be those that are designated to perform this additional teaching role.

PROF VICKERS: Potentially, yes. Yes, so we have the eight new standards and you could think that, you know – that if you wanted to be recognised as a teaching aged care facility, here is the ninth standard - - -

MR ROZEN: Yes.

PROF VICKERS: - - - and here is the list of things that you need to adhere to and be evaluated on.

MR ROZEN: Yes. Yes, food for thought. Thank you. Commissioners, they're the questions that I have for Professor Vickers and Professor Robinson. I should actually invite each of you, if there's anything additional that you would like to say to the Commissioners, now is your chance. Perhaps I'll start with you, Professor Vickers. Is there anything you would like to say?

PROF VICKERS: Yes, if that's okay, because the thing is – of course, in the university we're working around the – sort of, the health professional space, but I think time and again through the Commission we are hearing about the educational

needs of aged care workers, and I think I just – food for thought, really, but we've had tens of thousands of aged care workers willingly give up their own time, very seldomly supported directly by their organisation to, for example, undertake the understanding dementia MOOC.

We've had also now a thousand graduates from our dementia care undergraduate program, the majority of which are aged care workers who, again, give up their own time to undertake a program of study, because essentially they don't feel they know enough to do their job properly. So I think, again, that's another piece of work we have to think about. Whether it's by VET or university, some sort of joined up model where we're supporting the educational ambitions of aged care workers, because you know, a lot of the nurses, they're at the front line of providing care for people in aged care, in the residential sector and in the community sector.

MR ROZEN: Professor Robinson, are there any last matters that you would like to raise with the Commissioners?

PROF ROBINSON: Yes. Look, I would say unequivocally that teaching aged care facilities, teaching nursing homes – teaching is probably the wrong word, because education of students and the preparation of students so they're equipped – properly equipped to do the job they will need to do into the future is a critical part of that, but like teaching – if you look at teaching hospitals, most clinical research takes place in teaching hospitals. That's where the innovations in health happen primarily, and certainly in terms of projects and studies and – that is exactly the same for – in teaching aged care facilities.

So they should be the sites where research is undertaken and then, as in Norway, those innovations would then be driven out of those teaching aged care facilities into the – from the hub out into the spokes. So they are sites for teaching and research, not – and I think we have to be very clear about that. So if we're looking at improving care, these would be the sites that have the capability to model and test and evaluate and then to actually disseminate and support other organisations to actually engage.

MR ROZEN: Thank you. Commissioners, any other questions that you have for the Professors?

COMMISSIONER BRIGGS: Yes. If I may, it's just one to Professor Vickers. I didn't really understand what you were saying just then about we need a joined up model that supports the education of workers. Does that mean a system of funding to do so or what does it mean?

PROF VICKERS: Well, I think, in the same way that I described a lot of our university health curriculum as being historically bound – we do what we've always done – I think the same is pretty true of aged care workers, and there is a view that a minimum qualification is probably the most that can be expected or rewarded. So the idea of a Certificate III, perhaps, that is sufficient and yet we don't have, I guess,

a structured way of providing that enormous band of critical workers with the opportunity to develop themselves professionally or, in fact, to – in the same way that nurses have a scope of practice that largely relates to clinical skills and expectations, aged care workers are out there providing personal care, but also person-centred care, and so I guess – I think that's the thing that we need to potentially be thinking about is these are the people working every day with older people in our community in the residential sector, so how can we support them to develop and, perhaps, specialise in a number of particular areas and, of course, our area of interest is dementia.

COMMISSIONER BRIGGS: So clearly what we're talking about here is structured education and learning of the sort that you both talked about, together with career pathways or – which are clearly career pathways, but salary increments that are associated with that, so there's some reward for that additional effort and skill.

PROF VICKERS: That's right. It's a very undifferentiated workforce that we have in aged care, which again we would contrast with a teaching hospital where there are multiple levels of specialisation within the same discipline, and not to say that people can't do a generic job, but if somebody is required to do something in a specific area, then somebody can be called upon, whereas we've got very low assumptions, sometimes, I think, about the capacity for, again the vast majority of these aged care workers, to take on more specialised tasks and roles.

COMMISSIONER BRIGGS: Thank you.

MR ROZEN: Sorry, Commissioner. I was just going to ask one last question of Professor Robinson which has been raised with me. Professor, I don't know if you can tell us this and if you need an opportunity to take some time to tell us that's fine, too, but the facilities that are designated as the hubs in the Norwegian model, are they government run aged care facilities or privately run, and if they're privately run, do you know whether they operate as for profit or not for profit facilities?

PROF ROBINSON: Look, I couldn't give you – I did visit them, a number of these hubs. I can't give you the specific details of how they're funded, but they – my understanding was that they were not government funded, although obviously they – were government funded, but they were not run by the government.

MR ROZEN: Yes, and in the Australian - - -

PROF ROBINSON: But - - -

MR ROZEN: I'm sorry, go on.

PROF ROBINSON: Yes, but what they had as part of the teaching they might have one, two, three, four, whatever number of people that were actually funded out of the health budget to facilitate the teaching aged care facility model. That's how that worked from what I observed in, I think, it was 2014 when I went around and looked

at them, and so that's the thing with aged care. You know, if you're starting a completely new role and function and jobs that don't exist it doesn't mean – what we did was pull money out of places to make those jobs, which made it very hard for everybody.

What you need, then, is to have a real design and to say, "How are we – what people do we need, what, what, etc., etc." Now, what we did – I heard that Health Workforce Australia was mentioned. In Tasmania in the three organisations that are currently going in Tasmania, Health Workforce Australia funded learning centres that I got funding for that were developed in each of the organisations. One of them was even a purpose-built facility up in the north-west of Tasmania. So that's where you had a university level infrastructure on site that supported students.

So I think that, you know, the funding is a real issue, and it needs to be recurrent and then you need it to be able to have these specific people employed, but then you need the capacity to also pull staff out of their day-to-day care to engage in professional development and to have ongoing activities where they're looking at how students are going and how they're best supported, etcetera. Yes. So it's a very different – and a teaching hospital will account for that. You look at that infrastructure at a teaching hospital, there are so many people employed, you know, to facilitate research, to facilitate teaching, all of that sort of stuff.

And it's a – you know, when you work – I worked in an acute ward. Wednesday morning, nothing happened, because that was when they had their meeting, you know, the consultants, so there wasn't any other activities going on. You know, but that was a set time. So you need to look at, you know – there's a good model there for how you actually drive high performance and – in that model. Not, I'm suggesting, with a medical model, but in an organisational model, but then to adapt that for this new context, because, you know, we don't know the – you know, we'd have to do some good work into looking at the applicability.

MR ROZEN: Thank you very much. Thank you. Commissioners.

COMMISSIONER PAGONE: Yes, thank you, Professors, for giving up your time and for our ability to delve into the expertise and knowledge that you bring to bear and thank you both for having done the work that you're doing and may it continue. Thank you.

PROF VICKERS: Thank you.

PROF ROBINSON: Thank you.

<THE WITNESSES WITHDREW [12.42 pm]

COMMISSIONER PAGONE: Mr Rozen, we are a little bit behind schedule and we do need to finish a little earlier than the scheduled time. I wonder whether we might aim to resume a little bit earlier. Perhaps quarter past 1.

MR ROZEN: I was going to suggest half past, but we can certainly resume at quarter past 1.

COMMISSIONER PAGONE: Well, I think half past was the scheduled resumption time.

MR ROZEN: Yes. If we - - -

COMMISSIONER PAGONE: ..... quarter past.

MR ROZEN: I'm conscious of the video arrangements that have been made with the witnesses this afternoon.

COMMISSIONER PAGONE: Yes, well that's why I put it as a possibility.

MR ROZEN: I think if we had a 1.30 resumption, we will comfortably finish by 10 to 3, which I think is the desired time.

COMMISSIONER PAGONE: Yes, it is.

MR ROZEN: We can do that.

COMMISSIONER PAGONE: All right. Well, if the video gets put on any earlier, we will be eagerly waiting to come back in.

MR ROZEN: We'll let you know.

COMMISSIONER PAGONE: Thank you. We'll adjourn for the moment.

ADJOURNED **[12.43 pm]**

RESUMED **[1.29 pm]**

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Commissioners, I call Professor Stephen Wesselingh, Professor Alison Kitson, Professor Briony Dow, Ms Julianne Parkinson and Dr Judy Lowthian. Ms Parkinson and Dr Lowthian appear by video and the other three members of the panel can be seen by you in the room. And I would ask, Madam Associate, for the panel members to be affirmed or sworn, please.

<STEPHEN WESSELINGH, AFFIRMED [1.29 pm]

<JULIANNE PARKINSON, AFFIRMED [1.30 pm]

<ALISON KITSON, SWORN [1.30 pm]

<BRIONY DOW, SWORN [1.31 pm]

<JUDY LOWTHIAN, AFFIRMED [1.31 pm]

<EXAMINATION BY MR ROZEN

MR ROZEN: Thank you. Dr Lowthian, if I could start with you, please. And I would like – and invite you to give a brief overview of your current position and your relevant background so far as it applies to research, innovation and technology in aged care, which is the topic that we are examining here today.

DR LOWTHIAN: For sure. So my name is Judy Lowthian and my involvement in the aged care system has been has a health professional, a researcher and as an informal carer to supplement formal home-based care for three parents and parents-in-laws. I am currently the Head of Research at Bolton Clarke, which is a large aged and community care provider providing community nursing and aged care services in residences. I was appointed Principal Research Fellow in 2016 and Head of Research in 2017. And I might point out that Bolton Clarke has had a research institute since 2003. I transitioned across to research after a 25 years career in speech pathology, principally in adult rehabilitation, in 2007. I then did my PhD and was employed at Monash University School of Public Health and Preventative Medicine up until 2016. I have had adjunct appointments at Monash University, the University of Queensland and Queensland University of Technology and my role as Head of Research involves direction and oversight of social and clinical gerontology research conducted in the community, in retirement living and residential care settings, including my own research into frailty, loneliness and social isolation, hospital avoidance, care transitions and models of care. Do you want me to say any more?

MR ROZEN: That's pretty thorough, I think, thank you, for our purposes. Professor Dow, if I could turn to you, please, and ask you to explain those matters to the Commissioners about yourself.

PROF DOW: Yes, thank you. So my full name is Francis Briony Dow but I'm known as Briony Dow. I'm the Director of the National Ageing Research Institute which is an independent medical research institute that focuses on translational

research on ageing and aged care. I also hold honorary positions, professorial positions at the University of Melbourne and Deakin University. I've been the Director of NARI for almost five years and, prior to that, have worked at NARI altogether for 17 years, since I completed my PhD in 2003. So at NARI, I oversee a large program of research which includes clinical and social gerontology and aged care and also a collaborative called the Melbourne Ageing Research Collaboration.

I'm a social worker by training and prior to my research career, I worked in both the health and aged care sectors with older people and their families in a range of roles. I also have personal experience with aged care. My 96 year old mother currently lives in residential aged care, in Adelaide, as it happens. And both she and my late mother-in-law had home care services and I was also involved in supplementing care for my mother-in-law. And I was also a community volunteer for 10 years, visiting an older resident of a residential care facility. My own research interest is quite broad, but in recent years I've focused a lot on elder abuse and mental health in older people and particularly the role of family carers.

MR ROZEN: Thank you, Professor. Professor Kitson.

PROF KITSON: My name is Alison Kitson, I'm the Vice-President and Executive Dean of the college of nursing and health sciences at Flinders University and also the Founding Director of the Caring Futures Research Institute. I'm also a board member of the Health Translation South Australia and Chair of their Capacity Building Group. I'm a nurse by background. I have a PhD and the topic of that was looking at the therapeutic role of the nurse in caring for older hospitalised people and my research areas are knowledge translation and fundamentals of care. I have had a number of academic research and executive leadership roles both in the United Kingdom and Australia. I've been a trustee of an aged care organisations both in the UK and Australia and I've recently been on the board of the Australian Commission for Safety and Quality in Health Care.

MR ROZEN: Thank you. Ms Parkinson.

MS PARKINSON: My name is Julianne Parkinson. I'm the founding CEO of the Global Centre for Modern Ageing. I'm a fellow of the Australian Institute of Company Directors and hold a Bachelor of Business from the University of South Australia. I am also an adjunct industry fellow of the University of South Australia. My work in this area has resulted from previous roles as well as a Director in two big four consultancy firms and also as the Executive Director of the Economic Development Board of South Australia, which was an independent board advising the government of the day on economic transformation.

I've been involved in at least two complex stakeholder engagements that have been about transitioning economies in societies towards the future, both under the guise of the shaping the future of South Australia, one focused on informing the 10 economic priorities of the day for South Australia and the second was specifically about ageing well, which has been a stream of work that the Economic Development Board had.

So the genesis of the ageing well work was from 2014 to 2017, which informed the establishment of a not-for-profit organisation that sits outside of government, that has been designed to inform how companies, governments, not-for-profits and research partners sit alongside citizens to co-design and co-create the products and services most wanted by those people and our focus is of people in the second half of life.

MR ROZEN: Thank you. Professor Wesselingh.

PROF HAMERS: Hi, I'm Steve Wesselingh. I'm the Executive Director of SAHMRI. We live in that cheese grater building just up the road, have about 800 researchers in the building, doing research ranging from discovery, all the way out to public health and policy. Prior to this job I was Dean of Medicine at Monash University and I trained as an infectious diseases physician and obtained a PhD at Flinders and a post doc at Hopkins. My major research interests have been around HIV but more recently around the bacteria that colonise our gut and how they influence our health and also played a role in ROSA, the Registry of Senior Australians, which I know you have had some dealings with.

But I think my primary role here today is actually as Chair of Research Committee for NHMRC. So Research Committees, the principal committee that advises the NHMRC and gives advice on funding, programs, the structure of the funding programs and the allocations of funds and NHMRC distributes about $900 million a year to Australian researchers across a variety of areas and so I feel my major contribution today will be to talk about NHMRC programs and the role NHMRC plays in the research sector in Australia.

MR ROZEN: Thank you very much. I think we're – and I think I can speak on behalf of the Commissioners to say we're very pleased to have such an eminent group of people to assist us with the work that we're doing this afternoon. Before I launch into substantive topics, Professor Dow, I'm not sure if you mentioned when you introduced yourself that you were actually engaged by the Royal Commission to do some work. I might just ask you to place that on the public record, if you wouldn't mind.

PROF DOW: Sure. So the National Research Institute is currently doing three projects commissioned by the Royal Commission. The first is a nationally representative survey of residents of aged care services, which we are doing in partnership with Ipsos, the surveying company. We are asking residents about their quality of life, their overall satisfaction and to provide feedback on the care they receive. We're also conducting – so the second project that NARI is conducting is a survey of home care clients and residential respite users, again to explore their experiences of care. So similar questions to the residential care survey. And the third project is a scoping study of models of integrated care, which is looking at real world examples of integrated care that combine health, social care and housing, including evaluations of these models. All of these are expected to be completed by 31 April.

MR ROZEN: Thank you.

PROF DOW: Is it 31 April? No, I think it's the 30th, isn't it? Sorry.

MR ROZEN: I think it's the 30th.

PROF DOW: Just gave myself an extra day.

MR ROZEN: Thank you. You've each been provided with a series of propositions which the staff of the Royal Commission have prepared and which we would like to use as the basis for discussion today. But before I refer to those with you, there's a few terms that have been used in some of the evidence we've heard in the Royal Commission generally and particularly over the last couple of days, which I thought I would just explore with you to get some clarification for us about what they actually mean. The first is the term co-design, which we've heard quite a bit about. I suspect the users of the term may well have meant different things and I thought it would be useful to explore the meaning with this group. And perhaps if I could start with you, Ms Parkinson, to assist us with what you understand by the term co-design.

MS PARKINSON: So the term co-design is to do with the processes and the methodologies that help to inform the development of products and services as they're innovated. Co-design, when best performed, brings together the existing or the aspirational end users who would consume a product or service, alongside a suite of professionals and they could include many stakeholders. So by way of example, they could be those that are involved in the regulation of a product or service to market. It could be the very provider, the product developer themselves, it could be local council communities. Almost anybody that is involved in that community, to ensure that that new product or service is delivered to market well and the ongoing use and maintenance and improvement that would be required is often the way in which strong co-design, when it's done well.

And it's the nexus between where the end user and the professionals come together, where they agree on the decisions for the next phase and it can be introduced at any time along the continuum, from ideation, all the way through to early prototype, to out in-market products and services and then a continual loop back in for those that may have been disappointed in market or disappointed the entrepreneurs, if not the customers, and then brought back in. And when it's done very well, this actually informs, by the end users – it is an equal playing field and equal platform of power and co-development that means that the product probably will meet the end user's real needs and wants. So the experience of that product and service, broader than just the technical and functional aspects is brought into space and that's an area of expertise at the Global Centre for Modern Ageing.

MR ROZEN: So if I can just make that a little more specific to our particular field of inquiry, the end user, in the context of some piece of new technology or some innovation in the delivery of residential aged care facilities would be the resident potentially and/or the staff that are utilising the technology.

MS PARKINSON: Absolutely. It could be – it would be very often in an aged care environment the resident and the staff. That includes front line staff but also back office staff that may have some implications to their workplace. It also extends to family and friends and in the decisions that they may make and as they interact. So absolutely, it's a holistic view as to which voices need to be listened to.

MR ROZEN: Thank you. That's very helpful. Dr Lowthian, could I bring you in here because I note that at the Bolton Clarke Research Institute, one of the four principles that are applied in the work of the institute is co-design. And I wonder if I ask you to perhaps give us an example of successful co-design in an initiative or bit of research that has been done by Bolton Clarke.

DR LOWTHIAN: Yes, for sure. So we're involved with co-design with all our projects, using our clients and our residents. Would you like me to talk about residential aged care or the community setting?

MR ROZEN: Look, either is fine. Whatever you think best illustrates the point.

DR LOWTHIAN: Okay. So in the community setting, we are currently conducting a project looking at frailty – and frailty, just to explain, is a state of vulnerability to stressors and ill health, which increases susceptibility to functional decline. And one in two older Australians are in fact pre-frail or frail. But the positive thing about frailty is that we can actually build resilience to help overcome these effects and slow down that trajectory of decline. So we are conducting a program at the moment that is based on one that was developed in Singapore and it has a holistic approach to looking at mobility, cognition, nutrition and social connection. But we're going to adapt that to the Australian context through co-design and what we have done so far is we have conducted co-design workshops with three hospital community partnership groups, as well as our own Bolton Clarke community partnership group, because we feel that each community will be slightly different where we're going to be running this trial.

And so therefore we have actually been able to develop this 'Being your Best' program which is going to focus on moving, thinking, eating and connecting well and we are going to link people with existing services. The good thing about it is that we had hoped the community groups would come up with the types of interventions that we know have evidence behind them, in terms of strength and condition of reconditioning, good nutrition, good cognition and being very well connected with your community. They came up with this, all of them, themselves, which was really refreshing and enlightening, showing that people, I think, are wanting to do their best as they get older and they do want to try and keep moving and thinking well. So we're about to roll out that program with three hospital groups, as well as our own community group. So the co-design has been started right from the get-go. They in fact helped us design the project right from the start, so we think we will have good success with uptake. Do you want me to give you any more?

MR ROZEN: Yes, well, I just want to explore that last observation you made because it seems very important. I mean, one could look at the principle of co-design in at least two ways, I suggest. In one sense, it's a good thing to do because it's always good to involve people who are going to be affected by any change at the outset and get their input. But another way of looking at it, not inconsistently, but another way of looking at it is that it makes it more likely that it will ultimately be successful and I think sustainable is a term that Ms Parkinson used. Is that part of the thinking that Bolton Clarke?

DR LOWTHIAN: Absolutely. And another project we are looking at is the CAT pin which is Conversation as Therapy and this is going to be a discrete wearable device that is in the form of a brooch that you wear on your lapel or it's a pendant it's designed to monitor social interaction for people who live by themselves because we know that loneliness that is a big impact on everybody's health outcomes. And so the aim is to identify people who are lonely through how many words they say in a day and that will go through the pendant and if the word count falls below an expected threshold, that wearable triggers an alert for someone to intervene with a telephone call or a visit.

So the tech at the moment has been designed by engineers at RMIT, who we're partnering with. And the wearable is currently being co-designed by jewellery designers from RMIT, with our Bolton Clarke community partnership group and our community partners at the moment have had a kit sent out to them, after their initial orientation to the device and we are going to come back together in a couple of weeks and have a two to three hour session with the jewellery people to work out what is the most appealing thing that someone would like to wear and is discreet. So then at the end of the year the Bolton Clarke Research Institute is going to conduct a proof of concept trial using this co-designed device and we are going to map the conversational geography of older people who live alone and those who live with others, so we can work out what the word count should be and look at the feasibility and acceptability of the device.

And I think that will have big uptake because older people have been involved in the design of it and our community partnership group was so excited to be given this opportunity and they had really interesting questions. "How will you know if it's me talking and not the person next to me?" And so the designers were able to say, "Well, we actually can measure your respiration while you are talking, so we know that it's you're voice, not someone else'". So it's really cutting-edge technology and I think this will go a long way perhaps to helping reduce isolation and loneliness in an increasing population who are living alone.

MR ROZEN: And just in relation to that, the older people who are living alone, are they ones who are in receipt of home care packages or is it a more general group of people?

DR LOWTHIAN: In the Bolton Clarke scenario, yes, they are, but in the general community there are a lot of people living alone who are not receiving any

assistance. And we have other programs at the moment where we're engaged with volunteer telephone organisations and they're providing social support on a weekly basis to people who have gone home from hospital. Now, they may not be in receipt of any packages whatsoever, but they are a large portion of the society and it's an increasingly growing group so we really need to try and increase that social connection if we can and volunteers are a really helpful way of doing that as well.

MR ROZEN: Professor Wesselingh, can I bring you in here, please, wearing your NHMRC hat and – or the South Australian Health and Medical Research Institute, either one, really. Is the principle of co-design an important one in the allocation of funding?

PROF WESSELINGH: Yes, I think it's a recent phenomena, and by recent I mean over the last 10 years or so, but I do think researchers are engaging much more with community and consumers and leading to co-design of research. I think what we heard about was co-design to lead to a product, but actually I think NHMRC is actually very interested in research that's being co-designed so that the questions are co-designed as well as the process to lead to answers to those questions. Which could be a product, but it could also be the use of data or it could be understanding a particular problem within aged care. But co-design is something that is happening across the board and, you know, some of the best examples of co-design are actually in indigenous health, where indigenous communities are playing a really important role in defining the questions that concern them and then defining the research that answers those questions.

MR ROZEN: Professor Kitson, no obligation, but if there's something you would like to add on this topic.

PROF KITSON: Yes, just to say that I would agree with Steve, that it is a relevantly recent phenomenon in the area of clinical trials and clinical research and I think that shouldn't be underestimated. The shift in thinking, because it challenges the paradigm of what objectivity is and what truth is, so we shouldn't underestimate the changes that are taking place but not only involving people in co-design, people with intellectual and physical disabilities is another huge group that really benefit from this. But equally, in terms of how you get knowledge into practice and – which is something we're going to be talking about – involving stakeholders right at the beginning is the most important factor for success. So co-design, knowledge, translation, you can't separate them.

MR ROZEN: Thank you. That's very helpful. And Professor Dow, at NARI, we heard earlier in the Royal Commission from – Dr Batchelor gave evidence at our Darwin hearings, specifically about her research in relation to falls. But there was some brief reference made to the general work that NARI does as part of that evidence, which is why we have asked you to come along today. Is NARI – rather, does co-design feature in the work of NARI, both the research work you do and other work that you fund?

PROF DOW: Yes, absolutely. It's one of the key principles by which we work as well. So picking up on Professor Wesselingh's point, we use it to design research questions for research projects as well as to design the outcomes of those projects, if you like. So we have a group of over 400 research volunteers. So they're older people who have been part of research projects who want to continue to be part of research and we meet with them annually and talk to them about what they think the key questions are that should be identified or should be explored in our research.

So that's sort of the broader co-design, if you like, identifying the question. And then on a project by project basis, we work with the end users of research to design the research questions, to help with the research methodology, to help interpret the findings. One of the things that I think hasn't been mentioned is the advantage of getting a range of stakeholders together. So to give you an example, we are working on an NHMRC-funded project called PITCH, which is ..... has involved co-designing a training program for home care workers, who I think has already been identified in previous hearings, are actually a group who have very limited training yet very high levels of responsibility, particularly going out to the homes of people living with dementia.

So we co-design the training program with people living with dementia. So taking up Professor Kitson's point, very important to have the voices of people with disabilities and vulnerable groups involved in co-design. People living with their dementia, their family carers, the frontline home care workers, the home care providers, as well as learning designers and researchers. And what that meant was we could find out (1) what the home care workers wanted to know, wanted to learn, what the people living with dementia and their carers thought they needed to know to provide good care, but also what was practical from a provider perspective.

So if you get all those groups together to discuss those collectively, you can actually come up with something. That may well be a compromise but something that everyone can live with because they understand each other's perspectives. So I think that's another key element of co-design that means that you end up with something that's practical and usable and is more likely to be taken up by the end users. And our training program, by the way, is going very well.

MR ROZEN: You anticipated my next question.

PROF DOW: Home Care workers are very thirsty for knowledge and, yes, what we are finding is because we ask them what they want to know, we're actually giving them what they want to know and it's face-to-face. One of the things they said they wouldn't do – and this is all relevant to this discussion – is how do you translate knowledge into practice. They said they wouldn't look at anything that was provided, pre-reading, or anything that was provided online, so that all the learning had to be actually in that face-to-face environment. So we have got two one and a-half – sorry, two three and a-half hour face-to-face workshops that are based on adult learning principles and so on.

MR ROZEN: Thank you. In amongst all of that, unfortunately, the sound cut out when you were just about to tell us PITCH stands for and I'm trying - - -

PROF DOW: Sorry promoting independent – sorry, I will let you finish your question.

MR ROZEN: No, that's all right. I was just saying, I was trying to guess but I couldn't even get close. Better if you tell us.

PROF DOW: It's Promoting Independence Through Quality Dementia Care in the Home.

MR ROZEN: Thank you. And can I ask what the timeframe is for that work?

PROF DOW: Well, yes, good question. We have had to delay a lot of our research data collection at the moment, as you can imagine. So the original finishing date was September this year but we think we will need another year to complete that. We are currently conducting a randomised controlled trial of the training program.

MR ROZEN: One of the conundrums, I suppose, in the evidence before the Royal Commission is that we have been told a number of times by different witnesses, both within the aged care sector and from outside of it, that the sector has been variously described as immature, as not generally interested in innovating, as unimaginative it has been described as also. And the conundrum is that we've got, you know, organisations like yours, Dr Lowthian, doing considerable research from within the sector and then we have got a range of bodies like NARI and others that are also extensively involved in research specifically about practical considerations, practical issues for the aged care sector. So I'm wondering, perhaps starting with you, Dr Lowthian, am I just imagining that there's a conundrum there or can you assist us with that?

DR LOWTHIAN: Well, all I can say is that Bolton Clarke is really committed to having research. I've got a team of 10 researchers. I've got two in Brisbane, eight in Melbourne, eight of them are PhD qualified. We are a multidisciplinary team, with most of them having worked in health services previously. So we, Bolton Clarke, has a strong commitment to research because they want to make sure that we are providing evidence-based care that is of a very high standard. So I'm aware, you know, we obviously partner with academics as well, with universities and also with other health services. But I suppose one of the things that could work is just to have some coordination of all these projects that are being done by numerous providers and by numerous universities and link things together because I'm just aware that there's lots of small projects going on across the country and if we could coordinate that in a really good way and have national projects with partnerships across the sector, I think we would go a long way to improve things.

MR ROZEN: I will take you up on that point in a moment, but before I do that, how is it that Bolton Clarke is able to put the resources into such an extensive research

program when we have been told by many other providers and others that there just isn't the money available, the funding is such that there isn't scope for innovating even if we wanted to do it. Is there some separate - - -

DR LOWTHIAN: Well, I think - - -

MR ROZEN: Sorry, go on.

DR LOWTHIAN: Sorry. I think it comes from the fact that our board and our chief executive are committed to research. As I said, we have had a research institute for 17 years. So the organisation is really committed to it. The whole board is committed, as is the whole executive team. Yes, our salaries are in excess of one million, for the people that I'm employing. We do try and seek external funding where we can and we have brought in close to a million dollars in philanthropic trust funding over the past 12 months. So that goes part way to support what we do, but we do have a committed board and a committed organisation because they can see the benefits of research and we know the benefits of research from the health service sector and I think people are starting to realise that, yes, the aged care and community care sector will benefit as well from having a higher quality delivery of care.

MR ROZEN: Is it part of the Bolton Clark mission to make the results of your research more widely available through the sector? How do you address that question?

DR LOWTHIAN: Yes, so at Bolton Clarke part of your dissemination strategy is through peer review publications, also academic and clinical conference presentations. We also deliver symposiums. We had a couple of symposiums last year on social connection, one up in Brisbane, one down in Melbourne, and that wasn't just our work that we were disseminating but it was other people that we partner with disseminating their work as well so we can create better networks. We also realise that the community itself needs to hear about what we are doing because peer reviewed publications have a limited audience, as do conference presentations. So we are out giving community talks, community presentations, industry talks, industry publications and we're getting out there in the media because everyone needs to know because someone has paid for the research and we have an obligation to share those learnings with others.

MR ROZEN: The first of the propositions that we have asked the panellists to consider – well, not the first of them, but one of the propositions identified in the list that was sent to you was proposition 5, which I will just read out for the benefit of the transcript and remind you of it. So proposition 5 is to establish a dedicated centre

for ageing research and innovation and the proposal is as follows: that a dedicated centre for ageing research and innovation should be funded by the Australian Government. It would have a governing board, set the national research and development strategy and priorities, allocate funding, facilitate networks between research and development entities, researchers and industry partners to facilitate research, technology pilots and translation of research into practice.

And the proposition has, at its genesis, strategic action number 12 from the aged care workforce taskforce report, which proposed the establishment of what was described as an aged care centre for growth and translational research. So perhaps if I can start with you, Professor Dow, because I know that NARI has had extensive discussions with the Commonwealth about this very topic. Do we need such a body in Australia? And, if so, what – I think you are telling us you can't hear me. Okay. All right. We will come back to you, Professor Dow. Hopefully we will sort that out. I don't know how good at lip reading you are. Anyone else want to take the running? Professor Kitson's got the hand up.

PROF KITSON: Yes, I am happy to.

MR ROZEN: Please do.

PROF KITSON: I suppose I want to be a bit controversial here and sort of say that form usually follows function and unless we change the way we think about delivering aged care services or thinking about industry then we will put all this money into a centre and it will just give the same. So unless we are clear what we want out of it then we're not going to do the paradigm shifting that we need to do. So I think there are a few truths that we need to identify. First, there is a hierarchy of knowledge. There is a hierarchy of methodologies and there is a hierarchy of problems to solve within the research community. And unless we can actually redesign the way we value, the way we perceive and the way we work together to solve this wicked problem of how we're going to look after our older people in our society, then we will not get the return on our investment.

And this isn't just this country but it's actually a global problem and it probably relates to the fact that we do not value caring in all its constituencies, in all its multiple manifestations and that has a number of consequences. One is that we have a very miniscule evidence base around caring interventions and, again, I'm quite sure the Royal Commission has heard this many times. So lack of evidence creates opinions and anecdotes and people struggling to find better ways. If there's no investment that will continue and then you will have kneejerk responses to try and solve problems when they become critical. So unless we can actually rethink the way we're talking about this and clarify how we are going to co-design, how we are going to get the right sort of investment, then just thinking that we're putting a new centre on to the map is not going to solve the problems.

COMMISSIONER PAGONE: And do you have a thought about how we should do that?

PROF KITSON: Yes, I've lots of thoughts about it. I think what we have to do is identify the value proposition of how we want to look after – care for people as they age in society and perhaps the real radical thought is that we don't separate people, as they get older, from all the other caring industries that are around because there may be very, very important truths around the construction of how we care for each other, how we care for ourselves, how we care for each other in our communities, how we care as we go through our own life cycle. So why is it that we have just decided that aged care is an entity in itself? That is a total social construction that is probably two generations out of date. So we need to be thinking in different ways.

COMMISSIONER PAGONE: Thank you.

MR ROZEN: I'm following some of what you are saying but perhaps not all of it, it's perhaps just me. If one didn't separate out aged care from other forms of caring, what's the alternative that you're proposing?

PROF KITSON: Well, again, if we take Julianne's description of co-design or others, so the wicked problem is how do we care? The wicked problem isn't only how do you care for people when they are at the end of their life. We know from all of the epidemiological studies that how you end up in your 70s is a culmination of how you've looked after yourself for the rest of your life. So wouldn't it be creative if we actually started to think about self-care. How do we learn how to look after ourselves, how do we learn to look after our families, how do we learn to care for older people in our family? Where is the evidence base of that? I actually know that we have very little evidence to help us develop good interventions and good policy. So these are some of the questions that we ought to be asking ourselves.

MR ROZEN: Thank you. Professor Wesselingh, if I could bring you in here. To my probably largely uninformed mind, a number of the functions that are identified that could be performed by this new body that's proposed in this proposition are functions that are already performed by NHMRC. Am I right there?

PROF WESSELINGH: Yes.

MR ROZEN: That's the funding and, to some extent, coordination. Is there benefit in a new body? And a sort of related question is does NHMRC do enough to fund aged care research? You knew that was coming.

PROF WESSELINGH: Yes, all big questions. So I think there is a separation between being a really good funding body and a really good peer review body, and a really good research entity. And I don't think they actually go necessarily totally together. And I think NHMRC – I have no doubt and obviously I chair a research committee but that NHMRC is the peak funding body and the peak peer review body in the country, and there's good – again, good evidence that you need transparency of peer review, you need transparency of funding allocations to get quality outcomes. And NHMRC, up until recently, has predominantly funded on the basis of investigator-driven research. In other words, investigators come with their ideas,

they are assessed and the highest quality ones get funded in any area that they come forward with.

More recently, as demonstrated by the dementia initiative, $200 million was allocated to the NHMRC from outside of its own budget to address the issue of dementia, and NHMRC coordinated and funded the dementia initiative, but obviously investigators around Australia did the research all over Australia and a lot of that research was done in networks across the country, which I do think are quite important. So I guess my – I would argue quite strongly that to develop a new funding body, not a new research excellence body, but a new funding body would be counterproductive and we have seen that happen a couple of times and it's quite hard to develop that level of skill in peer review and coordination required and the buy-in from the Australian research community, which is very much invested in the NHMRC, to achieve the quality the NHMRC does.

But I do think that there probably is a role for a more strategic view of aged care research and I will just give you some data. In the last 10 years, in terms of aged care and the quality of aged care, NHMRC has spent about $86 million over 10 years. In contrast, in neurological disease we have spent $1.8 billion. So working hard on neurological disease, that's all part of aged care, you know, Parkinson's disease, dementia, etcetera, so really good research. The actual questions about aged care quality and safety that you are addressing have received relatively little funding and I think that an initiative, a strategically directed initiative into issues around ageing and aged care and aged care quality could be something that NHMRC could easily take on and has taken on in other areas and would achieve, I think, the highest quality outcomes.

COMMISSIONER PAGONE: So Professor, there are three ways I think you can deal with the problem, in what you have been saying. One is that we create a new funding body which has as its task aged care issues. Another is to create a centre of excellence which might be doing the research. The third seems to be that we give you a whole heap of money. I take it that's your preferred option?

PROF WESSELINGH: Yes. I mean, the money doesn't come to me. NHMRC is a statutory body. But yes, I think your third option is the evidence - - -

COMMISSIONER PAGONE: How does that then solve the problem of the money that is given to you being used for the things that we might think it should be used for?

PROF WESSELINGH: So there are examples where NHMRC receives clear direction and moneys to obtain a particular outcome and that might be in PFAS contamination, as an example. So NHMRC can take strategic direction and utilise the money for a given area. We would take – and I'm talking for NHMRC, can take strategic direction and utilise the money for a given area. We would still – and I'm talking for NHMRC and I, you know, obviously can't entirely only talk for a research committee, but we would still want it to be peer reviewed and at the level of

excellence that we require, but the direction of the particular area of research can be given to NHMRC, along with the extra funding.

COMMISSIONER PAGONE: So doesn't that really dodge the point of the question, which is should there be somebody directing the kind of research and your third option doesn't seem to deal with where the direction is coming from.

PROF WESSELINGH: No, I think that through NHMRC, through research committee, and I think the dementia initiative is a good example, structures were formed that then looked at the needs in dementia research and the areas that required the most input and where also we should be looking at the areas where the biggest impact can be made. Those questions were asked in the dementia initiative. And so a number – it wasn't just investigator-initiated research there was, as I mentioned, a large clinical network was developed right across the country for enrolment of people with dementia in clinical trials. There was capacity building. I think that's something we haven't talked about.

For there to be quality research, you need quality researchers and any area that is underdone in research is usually underdone in capacity as well and I will use my own area of HIV. In 1980, HIV didn't exist. Australia invested in HIV but it invested in builded capacity and we became a leader in the area and I think the outcome for HIV patients in Australia was and has been shown to be one of the best outcomes in the world and that was about building capacity, something that NHMRC does very well through its investigated grants and other grants that fund people, because in the end it is a lot about people.

COMMISSIONER PAGONE: Mr Rozen, back to you.

MR ROZEN: Yes. Can I just take up Commissioner Pagone's question from a slightly different angle and ask why is there so little aged care quality research funded by NHMRC? What's the explanation for that?

PROF WESSELINGH: So I think it would be a combination of, as I said, a lack of capacity in the area. So not a lot of grants and high quality grants coming forward. And the competition. And in the last round, on average across the four funding schemes, the big funding schemes that NHMRC put out, the success rate's somewhere between 10 and 15 per cent. So that means 85 per cent don't get funded and a lot of the work in aged care presumably was in that 85 per cent. But I think it's a combination of the number going in, the quality going in and then the really low success rate. But if you – as was demonstrated by the dementia initiative, there the 200 million could only be spent on the dementia initiative, so the competition was less, the capacity building was greater and we trained a lot of young scientists in dementia research.

MR ROZEN: Just one last question on this point for you, Professor Wesselingh. In the report that proposed the aged care centre for growth and translational research,

the point that's made – and I will quote from – this is the report A Matter of Care, on page 84, the report authors called for, and I quote:

A priority-driven approach, not investigator-driven approach.

And I think this picks up on what Commissioner Pagone's – the point that Commissioner Pagone is making, that is, that there is a fundamental difference between the sort of body that seems to be envisaged by the report, that is, directing priorities and a funding body such as NHMRC, which is necessarily responding to investigator-driven requests for funding for research. So can that – would imposing an obligation on NHMRC to fund aged care research and a pot of money to do that, would that be address that issue? Would that get away from it being investigator-driven rather than some body determining what the priorities are, some external body?

PROF WESSELINGH: Yes, yes. And actually – and this is a personal view now, not an NHMRC view – I would welcome that because I do think that we have for the whole history of NHMRC been an investigator-driven organisation, up until recently. And then there's a few examples like PFAS and dementia but I do think that the strategy or strategically directed research by NHMRC is a component that NHMRC would be very good at and should do more of.

MR ROZEN: Thank you. I will come back to you, Professor Dow. We had a problem with the sound earlier, I think. Can you hear me okay now?

PROF DOW: Yes, I can hear you now but you are every now and again dropping out.

MR ROZEN: All right. So apologies for the technology. The question that I asked you earlier related to the proposal in the Aged Care Workforce Strategy Taskforce Report, A Matter of Care, which proposed in strategic number 12 the establishment of an aged care centre for growth and translational research. And I asked you for the NARI perspective on that because I know that NARI has been in quite extensive discussions with the Commonwealth Government about that very topic. So I suppose the first question for you is, from NARI's perspective, is such an additional body needed and, if so, what value would it add?

PROF DOW: Okay. So thank you for also declaring my interest again. So I think it's actually a really good idea. I think the reason that we don't have evidence is that we haven't had investment and that has been – I guess, the evidence for that has been just given to us by Professor Wesselingh. We also then don't have capacity, a great deal of capacity in ageing researchers and I think the reason for this is that – or there's a number of reasons but one is that we don't value older people. We don't think, as a society, that aged care is particularly important, so it hasn't ever been a priority. Hopefully it will become one post this Royal Commission.

And then that filters down to the way that aged care research is viewed by educators and researchers, so we don't – you know, it's not seen as a particularly attractive area and then that is reinforced by – again, it's circular. It's reinforced by lack of funding. So at NARI we have a number of brilliant young researchers – not necessarily young, I shouldn't say young. They're brilliant early career researchers who are absolutely committed to this area but the type of work that they do – so it's not only the topic of the work but it's the type of work they do. This co-design type of work means that their outputs and outcomes might be videos that – for nine different language groups that educate people from cultural and linguistically diverse backgrounds about how to understand and respond to dementia, for example.

Traditionally, the NHMRC, with due respect to what Professor Wesselingh said, will fund researchers, they can get fellowships, but their track record is based on their academic publications and their ability to attract research. So if you're doing something that that's outcomes-oriented, outcomes-focused like, you know, producing videos, for example – there's a number of different examples I could give you – it's not the sort of research that lends itself to higher level academic publications. You can publish but it's more difficult.

So the traditional trajectory for NHMRC lends itself much more to basic science and to clinical trials. The biggest – sorry, the most significant criteria for success at NHMRC is the scientific quality of the research and that describes research as well designed and flawless. If you're co-designing something, you can't necessarily identify the design that you're going to ultimately end up with because you are going to be co-designing that with the end users. The sorts of outcomes that we look at in our aged care research quality of care or quality of life are not flawless. They are not blood pressure or they're not the sorts of things that are objective measurements.

So a lot of the type of research that we do doesn't lend itself to easily getting NHMRC type of funding. And I think that's reflected in the figures that we just heard. So I actually think there are two things that is needed. I think we do need, as Judy alluded to earlier, a coordinating point, a point where all the research that's being done across the country and internationally, can be learnt about in one area. I think we need to expand those areas of research that are working well across the board. I think we need industry-driven priorities and priorities that are driven by the end users, the residents, the older people, the people living with dementia. They're the ones that need to be driving the research and then the researchers informing how best to go about that rather than actually identifying what the priorities are.

So I would see this centre as not necessarily funding research but rather having a coordinating role of bringing together all the research that's currently happening, of having a priority setting role and then, if there was funding, yes, potentially see funding new innovations and models of care that wouldn't otherwise be funded through organisations like NHMRC. So I think there is a clear role for this type of organisation or this type of centre. And I don't think it needs to be a new centre. I think you have the National Ageing Research Institute here in Australia and we can do it.

MR ROZEN: I thought you might say that. Can I – well, I think you have answered my next question, that is, that you are not envisaging some form of statutory body like NHMRC?

PROF DOW: No. And, I mean, one of your propositions was should NHMRC have a dedicated – I've got it here somewhere – the dedicated percentage of the funding devoted to aged care. I'm actually not sure that it's the right organisation to fund aged care research because of the reasons I've just given, because I think it's a different type of research that we want, this outcomes-focused research, priority driven by the aged care sector. Although I do take Professor Wesselingh's point about having the structures for peer review, which are very helpful if you can guide the criteria for peer review, which is what's happened in the dementia research area.

MR ROZEN: Ms Parkinson, can I bring you in here. We previously had a representative of the Global Centre. Dr Rungie gave evidence in our Perth Hearings, you may remember that, back in the middle of last year. What's your perspective on the need for an additional body along the lines of what has been proposed?

MS PARKINSON: If I just preface this by the experiences and what we have seen in the market since the Global Centre for Modern Ageing was established two years ago and also the work that we did in research in establishing the Centre for the three years prior. So hopefully today I can bring a five year perspective on wanting to bring about change in the lives of older people, which is what this is really about. A place where I want to live, a place where my loved ones want to visit and a place where the management and staff and those sitting outside of the gated community are so proud and so interested and so engaged.

To bring about this sort of transformational change that the Commission is helping to lead requires a different way of looking at it and to think that our existing players will be enough just isn't the case. In our experience at the Global Centre for Modern Ageing, we have had examples of work and Dementia Australia or dementia has been raised today. The way in which we have been able to view the market is different from many others that you may speak with. The Global Centre is independent, so we sit outside of government and we are not – we are research agnostic, partner agnostic. We are internationally accredited by the European Network of Living Labs. We don't have an aged care facility or have investments in one. In fact, we don't have or hold any investments in any vendor solution.

So we are a completely objective platform for validating and testing and initiating research that's in the form of applied research. And so when I read of this proposition around the creating the centre of research and innovation, I ask the question of where does it link to two what I believe to be fundamental factors that will need to be engaged or included in this conversation to actually improve the lives of the very people we're here to defend and contribute. One is what's the co-design process and linkage to the way in which things will be co-designed with ethical high process and methodologies. And I will also raise an issue that co-design is a term bandied about and it has many different definitions depending on who you speak

with. Living laboratories – and we have a life lab ourselves – is another term that's used.

So people can confuse co-design for focus groups, which, you know, are one part of a suite of processes and methodologies and not often and not always does that process actually inform the product development. People share points of view. So my question will be for the research centre, how will it engage in the next phase? Once you've got great research. Where did you get the idea from, was it created by the very people as part of that platform and if so – and if not, where was it tested and validated with evidence in real life environments or simulated ones as you graduate towards real life. The other part to this, I think, which is fascinating – I mentioned earlier in order to have this transformation we are going to need new leadership alongside existing leadership.

The ecosystem of people interested in the modern ageing narrative is forming and forming each day and week and particularly over the last two years we have grown from having 800 members post the Global Centre – sorry, members is not the right term. 800 people attached to our community to over 3000 now. Governments, individuals, entrepreneurs, researchers, all fascinated by either developing excellence or a curiosity for understanding people as they age throughout all of life's course, particularly the second half of life. So what I would suggest is that there is an ecosystem out there. The Global Centre is part of helping to bring that together, alongside many others around the globe, of the players of the future who will actually engage with the research centre. How it's funded I won't enter into today. But to ensure that that co-design element and access to those right eco-players that can bring these new products and services to the market, to the absolute delight and pleasure of the older people, staff and management, family and friends.

MR ROZEN: Thank you.

MS PARKINSON: If I may just add one more item and very quickly.

MR ROZEN: Of course.

MS PARKINSON: The reason why I think not leaving this just in the aged care domain alone is that most providers or many providers now are hedging business models that lean into residential villages and into care at home. The Global Centre itself just conducted 1000 Australian wide people surveying, all for people over the age of 55, of how they want to age in place or ageing in the right place. And there is an absolute trend that we have seen. We have captured it as house/home/haven, that looks at the way in which design and experiences that people want to live. And so I think these are other forms of research that are entering the market that can sit alongside the new vision and new horizons that we haven't created yet.

MR ROZEN: Thank you. Dr Lowthian, if I could bring you in here, please, and focus on a slightly different topic. And that is whether the Commissioners ought be looking at a way of addressing the lack of innovation and research that's taking place

in the aged care sector, the example of Bolton Clarke and a few others notwithstanding, whether there ought to be some government fund that's specifically providing money to the aged care sector for innovation, on the presentation of an appropriate business case and other criteria being satisfied. And if we were to have such a fund, what would be the conditions of access to it, from the point of view of the panellists?

DR LOWTHIAN: Well, I think Bolton Clarke is to be congratulated on its dedication to research and its commitment. I think what would be really effective – and I really like the idea of this centre that you're proposing, but in terms of the governing body and the people who are involved with it, it needs service providers to be involved, clinicians, researchers, educators, government, consumer advocacy groups, community members and perhaps different funders like philanthropic or private donors or whatever, so they are all feeding into what this centre might look like. But at the very centre of it will be the people that you targeting, whether it be the older person or the person with multiple morbidity, which starts probably about 45 in our community, plus their families and informal carers, so that you have got all stakeholders around the table.

It could be funded, you know, through the government saying, well, what are the priorities and this centre could establish what the priorities are by talking with the community that we are trying to serve and I really like what NARI – sorry, I have lost my brain – what Briony said about the coordinating role and having priority setting, etcetera. I don't think we do need a new funding body but I just think that the priorities need to be set by this centre by the people who know what's needed, know who is needed to conduct the research and how it's needed to be conducted and then government can delegate the funds accordingly to those priorities and perhaps NHMRC could administer it, I'm not sure, I don't know I would want them peer reviewing. They have great peer reviewers but they are not great peer reviewers for the type of research we are conducting.

COMMISSIONER BRIGGS: It depends, doesn't it? There's various sorts of research and we have just heard earlier on that there has been quite a lot of clinical work around dementia. I get that. And there may well be other forms of clinical work that might have a home in the right place. I'm just wondering, is the real dilemma – well, there are many dilemmas here but there's clearly been a shortfall of funding overall. And that's causing part of the problem because people are fighting over a smaller cake and we're working with a historical basis for allocation. When we fully understand that the aged care sector is growing out of sight and is desperately underfunded and unsupported without the capability across the board to do the work. I'm getting nods. You don't need to respond any more than that. Back to you, Counsel.

MR ROZEN: Thank you, Commissioner Briggs. In the time that we have got available, which on my calculation is about 10 minutes, I thought it would be appropriate to open it up to the panel to make some general closing observations about what you, from your perspectives, think the Commissioners' priorities ought to

be, particularly in the short-term. What is it that the Commissioners can recommend, from your perspectives, that would achieve the most for addressing the research deficit, particularly the translation of research into practice that will, to take up Ms Parkinson's observations, lead to improvement in the quality of life of older Australians. So perhaps I can start with you, Professor Kitson, if I could.

PROF KITSON: Thank you. I suppose I'll start off by saying that growing old is not a medical condition. It's something that we should celebrate. And therefore, it isn't only clinical research, clinical interventions that will improve our quality of life. We have to take transdisciplinary research and we know that more and more we need to get everyone involved in problem identification, in knowledge generation, using the appropriate methodology and peer reviewers and embrace a much more collaborative approach that really does put older people, families, industry in the driving seat and use researchers as the people they are, experts who can support and help generate new knowledge.

I think that we shouldn't underestimate the challenges we have to encourage society to value caring and I think that one thing the Commission should, could and hopefully is doing is changing the way we think and value caring and caring for people as they grow older. We won't actually improve the evidence base if we don't collect good data. And it is really quite embarrassing how little robust data we have about caring interventions and people's quality of life. We have developing good evidence, as seen through ROSA, around falls and other clinical interventions but we have nothing that we can really robustly use that gives us any indication of what a person's experience of being cared for is and that, to me, is something that this centre should have as a priority.

MR ROZEN: Thank you very much. Ms Parkinson, I saw you – I was very happy to see you writing down notes, so perhaps you can share those with the Commissioners.

MS PARKINSON: Yes, pleasure. I will preface this by the importance of care but balance with the words like support, so the theme is around how do we support people as they age in place, wherever that is, and I think when we add the word – not such a predominance on care, but support opens up a whole lot of different ways in the way in which we interact with residents, management and staff, the way that we'll recruit people in the future, the values and the culture of the organisations. I think, for the Commission, you know, to emphasise that this is absolutely an intergenerational opportunity and responsibility and not to limit the cohort of residents to be those that will be inclusive of the solutions of the future.

Our business is, and proudly, whilst we are a not-for-profit, we pride ourselves on the enterpriseness of our business and the connectivity with organisations who are in commercial environments and we believe that we do that for one clear reason: that engendering that group and industry players large and small is where the sustainability of change will come from the providers, of new providers who haven't entered into the realm of aged care supply chains in the past because it hasn't met

their strategic fit. But now things are changing. And you will see an increase in calibre, in breadth and depth of organisations and I think that the Commission should be alive to the opportunity of attracting those high performing, highly, you know, elegant ethical organisations with the right leadership to help forge the future.

MR ROZEN: Thank you. Professor Wesselingh.

PROF WESSELINGH: Yes, I think in research funding is a complex area but simplified, you essentially get what you measure and get what you pay for. And recently NHMRC has changed what it measures. So it was metrics were commented on and we have moved from traditional metrics to measuring what we call impact. And so impact is all about the impact on the health system, the impact on policy, the impact on the patient and so on. We have asked people – we have told people we are going to measure that and people have changed what they do in order to achieve those measurements. And so if you decide what you want and what you're going to measure, the research community will respond to that and deliver that. Secondly, I agree with the Commissioner in the sense that the amount of funding is obviously a player here. So if you have a small amount of funding distributed over a large number of areas and you have a low cut-off, 10 or 15 per cent, you won't get a lot of money going into aged care research. It's just a matter of numbers.

But if you proportion moneys to a given area, the research community does respond, like any other market responds, and so you do get what you pay for. And there are multiple examples in which the research community, both in Australia and internationally, has identified a capacity gap. Moneys have been put into that gap and that gap has been filled. And you know, the NIH in the United States does this on a regular basis and have formed sub-institutes, the National Institutes of Health and one of them is ageing and that has worked extraordinarily well in the United States. So those sorts of processes do work and the research community does pivot and you get people, more people working in a given area, providing quality research and quality outcomes right across the board. And, you know, I emphasise that I'm not talking about bioscience, clinical research or public health, I'm talking about the whole lot, including co-design and so on, because you just have to, as I mentioned, tell them what you're going to measure and that will determine the behaviour of the research community.

MR ROZEN: Thank you. Professor Dow, if I could bring you into this at this point, with some final observations that you would wish to share from the perspective of NARI.

PROF DOW: We have been looking at the literature and interviewing older people recently about what they think makes good aged care. And what we found is that they take the clinical elements of care for granted, that that's just a basic expectation that you will get adequate personal care and nursing care and the staff will be adequately trained and there will be adequate numbers of them. And what they're looking for – relationship-oriented care, having choice and control over their own care and, most importantly – and this is where I think there's a huge gap – it's

enabling them to have meaningful participation in the life of their community and their centre.

And so I think one of the important focuses in redesigning the system as it is now is to enable that, enable people to actually be able to make a contribution right to the end of life. And there are models that we could – that are already in some facilities but that we could expand more. And this is where I would see a role for a centre like that, looking at what's good, what is working well and what could be expanded. So I think that that's just a key element that is currently missing in our aged care services, apart from all the other problems that you have identified in your Interim Report.

So the voices of older people need to be heard and they need to be heard from right across the board, including when they are a resident in aged care, including when they have dementia. We really need to make sure that people who are from these vulnerable groups, people who don't – first language isn't English should be able to contribute to this debate. And I really take on Julianne's point too about the future. So our current aged care system needs a huge amount of reform for the current residents who live in it and for home care recipients but we also need to be thinking about what future generations of people who will grow old are going to be looking for and how we can age well as a community.

MR ROZEN: Thank you. And Dr Lowthian, the last word.

DR LOWTHIAN: Well, I concur with everything Briony has said. We have also conducted research with older people, but we have also conducted with middle-aged people, those in their 40s who have older people in their lives, and we have asked them how would they like to live a life of fulfilment and it keeps coming back to, yes, the clinical care they expect, but as Briony said, it's all about relationships, social connection and wanting to have meaning and purpose in their life right until the end and the majority of our communities that we have interviewed do want to stay living in the community. They don't necessarily want to go into aged care and I know that there is a push to keep people in the community. So I think we need to look at how we structure our communities and our neighbourhoods so that we can connect people together in a much more meaningful way so that we have people looking after people, looking out for each other, having compassionate communities that we activate and I don't know how the funders would fund that. We've tried.

MR ROZEN: Thank you very much. Commissioners, they're the questions that I have for the panel.

COMMISSIONER PAGONE: Thank you, Mr Rozen. Mr Rozen, we are indebted to you for your questioning and for your assistance and leadership over the last two days. Thank you. And do please pass on our gratitude and thanks, not only to other counsel who have led this discussion, but also to the teams of people who are behind the work that you do publicly. May I thank the panellists today. You have given us a great deal to think about and it's always interesting to see how research – the topic of research and its funding manages to raise such interesting heated issues and

debate, that, I must say, brought me back to my days many years ago as an academic. Thank you very much for your thoughts.

There are lots of people to thank today, for the last couple of days and including the people who are physically here. We are living in very difficult times. The ability for us to do what we're doing has been constrained because of the COVID-19 virus. And a great deal of cooperation has been shown in those of you who have been here, our staff who has continued to work behind the scenes, those who have made arrangements to be participants through technology, which has worked, if I may say so, tolerably well, with only a couple of glitches. So thank you to all those people. I speak for both of us and possibly the Australian community in saying thank you in that respect.

But work continues even in very difficult times. We should also thank the staff of the InterContinental Hotel and the security staff for making the space available and enabling us to work efficiently, carefully and safely. You have done a really good job and I thank you very much indeed. Well, I think that's probably all I need to do. Have I left anybody out? Usually Commissioner Briggs will remind me later on that I have forgotten somebody. So this time I think I have covered everybody. We now adjourn to a date to be fixed.

<THE WITNESSES WITHDREW **[2.49 pm]**

ADJOURNED **[2.49 pm]**

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