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TRANSCRIPT OF PROCEEDINGS

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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

10.02 AM, MONDAY, 16 MARCH 2020

Continued from 4.3.20

DAY 78

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

COMMISSIONER PAGONE: May we begin this session by acknowledging the Kaurna people, traditional custodians of the land on which we meet today and we also pay our respects to their elders, past, present and emerging and extend that respect to other Aboriginal and Torres Strait Island people who are present.

This hearing takes a different form in part because of the circumstances that have been imposed upon us by the coronavirus. Now, this is a hearing under the Royal Commissions Act 1902 and people who are appearing in person and by video link are witnesses for the purpose of that Act and for the purpose of the Royal Commissions Regulations 2019. What they say today will be in evidence before the Royal Commission. Mr Rozen.

MR ROZEN: Good morning, Commissioners. I appear to assist you with Ms Hill and Ms Bergin. Commissioners, today and tomorrow Counsel Assisting will call a number of witnesses as part of a hearing of this Royal Commission in the form of a workshop. The workshop, which is to be known as Adelaide Workshop 2, will be similar in style to the workshop which was conducted here on 10 and 11 of February of this year. In that workshop Counsel Assisting examined aged care program design. During this workshop we will focus on research, innovation and technology in aged care.

As my colleague Mr Gray QC explained on 10 February 2020 in Adelaide Workshop 1, these hearings, in the form of workshops, differ from the public hearings that were held by the Royal Commission in 2019. Commissioner Pagone noted on 4 March 2020 that at this stage of the work of the Royal Commission the Royal Commissioners are:

> *Actively considering specific proposals for reform of the aged care system.*

This workshop is part of that process of active consideration. Commissioners, your terms of reference require and authorise you to inquire into:

> *How best to deliver aged care services in a sustainable way including through innovative models of care, increased use of technology and investment in the aged care workforce and capital infrastructure.*

You are also directed to have regard to examples of good practice and innovative models in delivering aged care services and it's important to note, Commissioners, that the terms of reference do not refer to technology and innovation for their own sake, but, rather, to improve care.

Numerous reviews into the Australian aged care system during the last two decades have recognised the need for greater innovation in the way aged care services are delivered. Those reviews have highlighted the role that technological developments can play in improving the delivery of aged care, including by enabling elderly people

to remain in their own homes for longer, and also freeing up the time of carers to focus less on completing tasks and more on providing person-centred care.

The Royal Commission has itself commissioned work that is relevant to this hearing. Research Paper number 3, Review of Innovative Models of Aged Care, was undertaken by Flinders University, Bolton Clarke Research Institute, South Australian Health and Medical Research Institute and Stand Out Report for the Royal Commission. That paper includes a section on technology to support long-term care for older people and it concludes:

> *Some technology based models of care that have been shown to be viable internationally, but have not seen successful adoption at scale for the Australian ageing population include telehealth communications and monitoring technologies that enable better access to health care and integration of health care for older people less able to travel for services and remote support for independently living individuals who are ageing in place under the supervision of formal or informal carers.*

Commissioners, Research Paper number 3, which is on the Royal Commission's website, provides an overview of technology to support aged care, including assistive and supportive technologies, monitoring devices and systems, communications and connections technologies and intelligent health information systems. During the course of the next two days Counsel Assisting will call a number of witnesses who have extensive expertise in research, innovation and technology, especially as they apply to aged care. There will be four panels of witnesses. Two today and two tomorrow.

Each panel will be asked to examine specific propositions that have been formulated by the staff of the Royal Commission and circulated to the panellists in advance of today's workshop – today and tomorrow's workshop. These propositions are available on the Royal Commission's website. Interspersed between the panels will be a number of witnesses who will describe their own experiences of technology and innovation in aged care. You will also hear from a Canadian expert tomorrow morning from whom there is much we can learn.

In the course of the Royal Commission's hearings, older Australians, their families and aged care workers have explained how they use technology. Examples that you'll recall include some struggling to access the My Aged Care website, family members who use technology such as closed-circuit television to monitor their loved ones living in residential aged care. Homecare workers who log onto their employer's app from their phones to find their roster for the day and the care records of their clients and older Australians who use social media to keep in touch with families who might be far away.

The first witness this morning will discuss the use of technology in aged care. Mr Damien Harker's father is a home care client of ECH Inc, an approved aged care provider. Mr Harker will describe how the use of an application on his smart phone

provides him with peace of mind about his father's care. You will also hear from Ms Denise Griggs, who works for ECH Inc, and she will describe the use of the application from her perspective as a care worker. After a brief break you will hear from the first of our panels. Ms Hill will call four witnesses who work in the aged care sector and at universities.

They are Professor Sue Gordon, Ms Jennene Buckley, Dr Tanya Petrovich and Ms Daniella Greenwood. Each of those will introduce themselves to you, Commissioners. The panellists will be asked to consider four propositions concerning innovation and technology in the current aged care system. They will be asked to consider questions including, "How can aged care providers use technology to support the delivery of safe, high quality aged care in homes and residential aged care facilities?" "Are there barriers to the use of technology by older Australians, their informal carers and providers?" "Should the use of technology by aged care providers be regulated or subject to an accreditation process?" "How can greater use of technology, as well as innovation more generally, be encouraged?" "Are there unintended consequences associated with the use of different technologies?" and, finally, "How can technology and innovation be used so that workers have more time to care?"

It must be acknowledged, Commissioner, that technology in aged care, as in so many aspects of our lives, can be a mixed blessing. You will hear, Commissioners, that many older people and many care workers are apprehensive or ambivalent about innovation and technology. Those concerns are understandable. Just last week, a new report by the Australian Computer Society concluded that 50 per cent of jobs in the health care and social assistance sectors could be either automated out of existence, or augmented by robots and artificial intelligence by 2035.

The challenge for the sector is to engage its workforce and the residents so that the positive aspects of innovation and technology can be accentuated and the negatives addressed. To use technology in a way that preserves and supports care as human-centred. You will hear this can only be achieved with end users at the centre of development testing and adoption processes.

After the luncheon adjournment I will call Ms Barbara Hamilton Ramsay who is in receipt of aged care services in her own home in southern Queensland. Ms Hamilton Ramsay will describe how technology has broadened her world and improved her quality of life. After you hear from Ms Hamilton Ramsay, Ms Bergin will address the topics of data and research in the second of our panels. Commissioners, various witnesses last year gave evidence about the absence of a holistic approach to data collection and application.

For example in the Darwin hearing held in July last year, Professor Johanna Westbrook of Macquarie University said:

> *We do lots of collection of items of information, but really it doesn't become meaningful information until you start bringing it together in some sort of*

holistic way, and at the moment we have got lots of different data collections going on, but as a sector we really aren't able to use that data so it's not providing us with any real information about what is going on and I think it's come up time and again that we really don't have good indicators about what is the quality and safety in the sector, and yet that data itself is sitting in these data silos available ready to be used, but it's just not being used and brought together in that way.

she told us, and Professor Westbrook memorably said:

Aged care is data rich, but information poor.

In this workshop we propose to assist you to investigate the solutions available to address the issues with data, to improve quality and safety outcomes for residents of aged care. We will explore what data should be sourced, what standards should apply, how should data be collected and from whom, and further we will be examining the applications of data. How can good quality, standardised data be analysed and interpreted by researchers and policy analysts to improve service delivery, who should be the custodian of the data collection and management process and can data be applied to improve corporate governance by providers and oversight by government.

Commissioners, yours is not the first review to inquire into data capture and application in aged care service delivery. As long ago as 2004 the Review of Pricing Arrangements in Residential Aged Care by WP Hogan recommended that:

The existing aged care information infrastructure should be substantially expanded, building on the existing expertise within the Australian Institute of Health and Welfare and should include quality and financial performance data.

Similar recommendations were made in 2009 by the National Health and Hospitals Reform Commission, in 2011 by the Productivity Commission and in 2017 by both the Tune Review and the Carnell-Paterson reviews. You will hear from four witnesses in this afternoon's panel about the topic of data with a particular focus on its applications in research. Once again, the panellists will introduce themselves. They are Ms Louise York, Dr Rob Grenfell, Mr Ben Lancken and Associate Professor Maria Inacio. We expect that you'll hear this afternoon about the data capture, management and analysis gaps. No dataset or platform currently systematically links the needs assessed as part of an aged care assessment with the services provided by an aged care service provider.

Similarly changes in care needs over time are not tracked between an initial aged care assessment and the funding allocated under the aged care funding instrument, ACFI, about which you've heard so much. Such limits compromise the ability of policy makers and researchers to monitor system quality and performance and to assess the capacity of the system to meet future needs. Limits in data standards, collection and linkage mean they cannot monitor the delivery of person-centred care

by a uniform, valid and meaningful measure. Corporate governance, regulatory compliance and research activities would also benefit from improved data collection and analysis.

5 Commissioners, it's now part of your task to inquire through this workshop about future possible reform in relation to data, what, by whom, how and why. Ultimately, you will also need to form a view on the question of implementation and by when. Finally, I need to refer to the coronavirus and its impact on the work of this Royal Commission. As you've already alluded to, Commissioner Pagone, Commissioners
10 have taken the precautionary step of not permitting the public to attend public hearings and workshops from now on. This is due to the risk of the virus to public health.

This step has not been taken lightly, but it is intended to protect public health, and
15 especially the health of older frail people. The hearings will continue to be livestreamed via the Royal Commission's website. In addition Counsel Assisting will not require witnesses to appear in person where those witnesses receive aged care services or work in the aged care system or are in contact with people who receive services from the aged care system – or provide those services. Any such
20 witnesses will now be encouraged to appear by video link.

We acknowledge that this may detract from the free discussion of ideas and propositions that these workshops are designed to encourage. We ask for the public's forbearance and that of the Commissioners in that regard. Commissioners, I
25 will make some brief opening comments about the panels that will be called tomorrow at the commencement of the hearing tomorrow morning, but for the time being, I call Ms Denise Griggs and Mr Damien Harker.

COMMISSIONER PAGONE: Just before you do that, Mr Rozen.

30

MR ROZEN: Sorry.

COMMISSIONER PAGONE: I just want to make one slight correction. The way you have expressed the position in respect of the coronavirus is that we are not
35 allowing the public to attend. I think more accurately it is that we are allowing the public to attend, but electronically.

MR ROZEN: Yes, I stand corrected. That's certainly the case. And unless there are any other further matters, I will call Ms Denise Griggs and Mr Damien Harker,
40 both of whom appear by video link. Good morning, Mr Harker and Ms Griggs.

MR HARKER: Good morning.

MS GRIGGS: Good morning, Peter.

45

MR ROZEN: Hello. If I could start with you, Mr Harker. If you could please tell us your full name.

MR HARKER: My name is Damien Wilson Harker.

MR ROZEN: And, Ms Griggs, if I could ask you to state your full name, too,
5 please.

MS GRIGGS: Denise Helen Griggs.

MR ROZEN: Now, we need to have you either affirmed or sworn. I think we have
10 the capacity to do that there. So I'd ask that that be done now.

DAMIEN WILSON HARKER, AFFIRMED

15

DENISE HELEN GRIGGS, AFFIRMED

MR ROZEN: Thank you very much. Mr Harker, if I could perhaps start with you.
20 You live in Adelaide?

MR HARKER: That's correct, Peter, yes.

MR ROZEN: And your father, George, is an elderly gentleman. How old is he?
25

MR HARKER: He's 89.

MR ROZEN: All right. And he suffers from dementia?

30 MR HARKER: Yes, that's correct. Yes.

MR ROZEN: And how long ago was he diagnosed?

MR HARKER: He was diagnosed in 2016.
35

MR ROZEN: And do you have other family in Adelaide?

MR HARKER: I have one brother here.

40 MR ROZEN: Yes. And how far away – I'm sorry, I withdraw that. Your father
lives at home by himself; is that right?

MR HARKER: Yes. Yes, that's correct.

45 MR ROZEN: And how far away from where you live is your dad?

MR HARKER: He is about 10 to 15 minutes driving from my house and my brother lives about, probably, five minutes away in a car.

MR ROZEN: Okay. And your father is in receipt of a homecare package under the aged care system?

MR HARKER: Yes, that's correct. He's currently receiving a level 4 homecare package, which is managed by ECH.

MR ROZEN: Yes, and how long has he been in receipt of a level 4 package?

MR HARKER: Since 2016, June.

MR ROZEN: And just out of interest, was there a long wait between the time he was assessed as eligible for the level 4 package and the time that he received it?

MR HARKER: No. It happened quite quickly. He had some mental health issues at the time, which we were getting treated and through that process – we went through the ACAT process and I think within a few weeks it was actually acknowledged that he would be receiving that package.

MR ROZEN: You may not know the answer to this, but was he – were you told that he had been given a particular priority in - - -

MR HARKER: Yes, I wasn't aware at the time that was the case.

MR ROZEN: Okay. And without going into too much detail, can you tell us what sort of services your dad receives under the level 4 package, what sort of care does he get?

MR HARKER: Yes, sure. So he has personal care twice a day. So that includes help with meals, medication. He also domestic assistance once a week, just generally cleaning the house. He has some nursing visits twice a week to check on his health in that regard. He receives some gardening services every three weeks, just to maintain the property. And he has some physiotherapy every fortnight in-home, which is really good, and he has some podiatry visits, which is probably about every quarter – ECH help with that as well.

MR ROZEN: Okay. Time to bring you in here, Ms Griggs, if I could, please. You're a relationship manager working for ECH?

MS GRIGGS: Yes, that is correct.

MR ROZEN: And what does a relationship manager do?

MS GRIGGS: We manage home care packages that are assigned to members or people in the community. We work with the member and the family to provide

services to meet their needs and goals, to remain living confidently at home and remain connected socially to their communities as well.

MR ROZEN: And how many clients are you responsible for in your role as a
5 relationship manager?

MS GRIGGS: Around 40.

MR ROZEN: Okay. You are an enrolled nurse by profession; is that right?
10
MS GRIGGS: That is correct, yes.

MR ROZEN: And for how many years have you worked in aged care?

15 MS GRIGGS: Approximately 10 years. I started out as a carer, then went on to enrolled nursing and moved on to relationship management.

MR ROZEN: Yes. And just out of interest, why did you seek to move from being a personal care worker to an enrolled nurse? What was the motivation for that?
20
MS GRIGGS: Personal development and the wish to try and help people as well to be as independent as they possibly can.

MR ROZEN: Yes.
25
MS GRIGGS: Yes.

MR ROZEN: And was that with ECH or was that with a different provider that you worked as a care worker and then as an enrolled nurse?
30
MS GRIGGS: It was initially with ECH. I was a carer then while I was doing my enrolled nursing. And then ECH sold their nursing homes, their residential facilities in 2014, so that they could concentrate more in the community.

35 MR ROZEN: Yes.

MS GRIGGS: But I still work in residential at the moment as well.

MR ROZEN: Thank you. And when you were working as an enrolled nurse, was
40 Damien's father one of the residents that you were providing care for?

MS GRIGGS: Yes. Yes, I was seeing George under ECH as an enrolled nurse in-home.

45 MR ROZEN: Thank you. Now, if I could go back to you, Mr Harker. I will ask you in a moment about an app that you've got, which is what we particularly want to

focus on, but before I do that, was there a period of time between your father starting to receive the level 4 home care package and the app becoming available to you?

MR HARKER: Yes. It was approximately two years prior to that, yes.

MR ROZEN: Right. So I want to ask you a bit about that period of two years. How often would you have seen your dad, say, in an average week during that period of time?

MR HARKER: I personally probably three times a week and my brother would be visiting probably the same as well.

MR ROZEN: All right. And tell us a bit about the circumstances. Presumably some of them were just standard social calls, when you popped in to see how your dad was and had a cup of tea - - -

MR HARKER: Exactly.

MR ROZEN: - - - or beer or whatever. Were there other times where you had to go in more sort of emergency type situations?

MR HARKER: Yes, that's correct. So we have had a couple of times, with my dad's dementia, where he has left the house unknown and I've received calls from, you know, police or ambulance or from a hospital to say that, "We have your dad in with us and, you know, can you come and meet up and work through the issue".

MR ROZEN: Yes. And from your point of view, how was that experience? How would you describe finding yourself in those situations?

MR HARKER: Yes, it's very unsettling, of course. Just concern for my dad's safety and wellbeing. We're sort of constantly worrying after that point when the first time it happened and then it was – from time to time it happened again. So it was just not knowing what was actually going on in his home environment, whether or not he was home or whatever he was doing. So yes, very unsettling.

MR ROZEN: Putting those situations, those more extreme situations to one side, on a day-to-day basis, before you had access to this app which I will ask you about in a moment, were there other concerns that you had about your dad's welfare?

MR HARKER: Yes. So we just didn't know what was going on inside the house. Obviously ECH were present twice a day every day.

MR ROZEN: Yes.

MR HARKER: But we were just unaware of what things were going on, you know, as far as his eating habits, his going to the toilet, you know, having sleep, you know, what was his sort of general patterns, his routines around the house. We just had

really no idea and because when we got there, unfortunately with his dementia he was really unable to communicate succinctly what was going on whether or not he actually had any issues for that period of time. So it was, yes, just the knowledge, the lack of knowledge we had was, you know, a little concerning.

MR ROZEN: Now, I should have asked you at the outset, does your father have any other health concerns other than the dementia and the normal process of ageing?

MR HARKER: No, thankfully everything else is working quite well.

MR ROZEN: Okay. Now, if we can turn then to the app. The Commissioners heard some evidence about the Billy app at a hearing last year. So Mr Panter, who is ultimately your boss, Ms Griggs, gave evidence about the investment in the app actually being related to the sale of the residential care business. That was the context in which he was asked about that. And so from your point of view, Mr Harker, can you give us a brief description of how it came about that this app became available to you? Who initiated that discussion and what were you told?

MR HARKER: Yes, so it was through the ECH care manager that George had at the time. They made contact with myself and my brother and let us know about this new technology and whether or not we would be willing to trial it, and after reading through some of the brochures that were made available, we were very keen to have a go at it and see, you know, if it could provide any sort of positive results for us.

MR ROZEN: All right. And tell us a bit about it. What is it? How does it work?

MR HARKER: Yes, sure. So the app can work on either an Android or Apple device quite easily. Basically, there are a number of sensors throughout the house that are strategically placed. I think it's up to a number of six that are available and those sensors are put in places where if you want some feedback from a particular area, i.e., the front door or the fridge door or areas that will lead into the bathroom facility, so these sensors are there taking data in as persons walk past them. They also can tell you the temperature in that location as well. So based on all these inputs, the Billy app has a number of routines that are set up on a per user basis and that can give you some feedback about what is generally going on in the house for Dad.

MR ROZEN: Okay. Now, the sensors are, of course, in your father's home, not your home. They're recording his movements around the house; is that right?

MR HARKER: That's right. So there's an internet connection within the house. The sensors feed into that and then, yes, come back through the Billy app system.

MR ROZEN: All right. Is there any additional cost associated with the app over and above the package that your father is in receipt of?

MR HARKER: No, it's – all the costing is ongoing through the level 4 program.

MR ROZEN: All right. We will see in a moment that there are certain parameters that are set within the technology. How were they – was that something that there was consultation about with you – between ECH and yourself about what information should be recorded?

5

MR HARKER: Yes, there was. We spent a number of times with the ECH person who was actually running that process at the time. So we had a meeting. They came down to the house. We all had a look around to see what sort of information from a family perspective we would be interested in and they provided, you know, some
10 feedback to what, you know, generally some of the things that could be a good idea to use. But based on our input and their advice, we came up with what we have today.

MR ROZEN: All right. Now, a picture, of course, is worth a thousand words, so
15 you've been kind enough to give us some screenshots from your phone. Perhaps if the first of those could be put up on the screen. It is dated Sunday, 8 March 2020. I'm hoping you can still hear me, Mr Harker. Yes, there you are in the corner.

MR HARKER: Yes.

20

MR ROZEN: Can you see that screenshot, Sunday 8 March 2020?

MR HARKER: Yes.

25 MR ROZEN: Can you talk us through that please.

MR HARKER: Sure. So as part of the – as I mentioned before, as part of the five routines that are set up, which you will see in another screenshot, this picture shows a history of those routines and one of them in particular you can see is the fact that my
30 dad left the house at 2.09 pm and returned two hours, 15 minutes later. Now, this was thankfully a scheduled outing with myself and we took him out shopping. But that's the sort of feedback we can get, if that was an unscheduled exit from the house, which we would be notified to say that, you know, that's not quite right.

35 MR ROZEN: Thank you. If we look at the top of the screen we see home by 6 pm and then a tick. Is that a parameter that was resulted from those discussions that you had, that is, you wanted to know whether your dad on any given date was home by 6?

40 MR HARKER: Yes, so all of those things we worked through with ECH at the time and they're based on those five routines that you will see shortly on the other screenshots.

MR ROZEN: All right. Perhaps we can go to the second screen, Sunday, 15 March
45 2020. So that's the following Sunday and we can see the third of those, sitting in lounge room. There's a sensor in the lounge room that identifies whether or not he has spent any time in that room; is that right?

MR HARKER: That's correct. That's his general location throughout the day.

MR ROZEN: Yes.

MR HARKER: So yes, so we see if that's occurred at any given time.

MR ROZEN: All right. And the bottom of that screen, eat breakfast occurred at 11.46. Always nice to have a sleep in on Sunday.

MR HARKER: Yes, so basically there is a sensor on the fridge. So when the door is opened in the morning – obviously he had a bit of a sleep-in this day – we can educate or see that it's likely he's had something to eat in the morning.

MR ROZEN: All right. If we can go to the third screen please, the third screenshot. And at the top of the screen there we see one minute ago, living area. Do we understand that to be a real-time information that you're getting about where your father is at any point in time?

MR HARKER: That's correct. So it tells me that, yes, he is in the living area, the last recorded sensor change was one minute ago and you can see the current temperature in that room, 25 degrees, which is enormously helpful, especially on hot Adelaide days that we at least know he's got the air-conditioning on.

MR ROZEN: Yes, okay. And is there anything else on that page in particular that you draw our attention to?

MR HARKER: So, this is from the bottom left-hand corner, you can just see the routine. So these are the five routines that are set in place. You can only see four of those, unfortunately in this screenshot. But they're the ones that get tracked every day to see how he's going.

MR ROZEN: And what – do you know offhand what the fifth one is?

MR HARKER: The other one is home by 6 pm.

MR ROZEN: All right.

MR HARKER: That's not showing.

MR ROZEN: We saw that earlier.

MR HARKER: That's right, yes.

MR ROZEN: Yes. And then if we can go to the fourth screen, please. So at the top of the page there, we see little toilet symbol and then it says less than two times per night is ideal. George is averaging eight bathroom visits per night. So that's information based on the sensor that presumably is outside the toilet; is that right?

MR HARKER: That's right. So it's just on the entry to the toilet area. So yes, if for some reason George is visiting, you know, the toilet too much or not enough, we can get some, you know, some feedback to understand there's a potential issue in that area.

5

MR ROZEN: I might bring you in there, Denise, if I could, please. What, from your point of view, might that information be suggesting?

MS GRIGGS: With George going to the bathroom eight times a night?

10

MR ROZEN: Yes.

MS GRIGGS: If that's a normal pattern for George, then that would be okay, but if he normally goes less than two, but he's averaging eight bathroom visits that night,
15 then we would be having a discussion with the family regarding that and possibly looking at getting a urine sample from George and testing that.

MR ROZEN: What, because - - -

20 MS GRIGGS: Because that is ..... parameter of what's a normal pattern for George and it could be very indicative of a urinary tract infection if someone is going to the bathroom eight times a night.

MR ROZEN: Thank you. Now, just extrapolating from that, from your point of
25 view – I know you're not George's care manager at the moment, that's a role performed by someone else at ECH; is that right?

MS GRIGGS: That's correct, yes.

30 MR ROZEN: Can you assist us with the – what access that care manager would have to this sort of data? What's the relationship there?

MS GRIGGS: So we can pull through reports every morning on different systems and relationship managers will oversee the Billy. So we can have a look at all of our
35 clients in the morning and just have a run-through and see if there are any activities outside of normal parameters and then we could contact the family and let them know that we've noticed that there is an anomaly and just have a discussion with them about it. There may be a reason behind it that the family are aware of that we are not and we would document that. Otherwise we can have a discussion with them
40 about any follow ups that we think might be appropriate at that time.

MR ROZEN: Thank you. Damien, how often do you personally meet the ECH care manager?

45 MR HARKER: It would be a scheduled probably quarterly meeting. We get together to discuss any issues.

MR ROZEN: And what about between times? Presumably you can pick up the phone or email the care manager. Have you ever had cause to see something on the app and think it's worth having a conversation or a discussion with the care manager about it?

MR HARKER: We – I mean, yes, lots of conversations that go on. We've had, you know, more sometimes – some technical issues with a particular sensor.

MR ROZEN: Yes.

MR HARKER: And maybe providing unclear feedback. So I would ring up my care manager and she would work through that to get it sorted out. As far as George's health, we haven't at this stage needed to go down that track, which has been good.

MR ROZEN: Yes. But presumably that's something that you might want to avail yourself of at some point. In other words, if you saw something particularly unusual, it would be easy enough to pick up the phone or shoot an email through to ECH, just drawing that to their attention?

MR HARKER: Absolutely, yes.

MR ROZEN: I want to ask you a little bit about the implications of this technology for both your father, George, and for yourself and your brother. Would you like to tell the Commissioners what your experience has been, how it's impacted on your relationship with your father and generally the care experience.

MR HARKER: Yes. It has been a fantastic ability for us to see what's going on within – you know, make sure dad's wellbeing is being looked after. We have got a lot more information available to us. We can pick up that app at any time throughout the day or night and get some actual feedback into what's going on in the house for – in respect of George's wellbeing. My brother is of the same opinion to me that we've now using this app on such a daily basis or hourly basis, if you want to call it that, we would almost be a little bit lost without it these days. It's just provided so much assistance to us and peace of mind that, you know, we feel we can better manage dad's health care.

MR ROZEN: Mr Panter, when he gave evidence last year about this, told us that one of the positive spinoffs that there was less need for nagging by children of their elderly family members. I'm not suggesting you would have been a nagger, Mr Harker but does that ring true for you. Because you know more about what's going on, you don't have to be constantly at your dad about doing certain things or making sure he doesn't leave the house at inappropriate time or whatever.

MR HARKER: Yes, it's interesting for my dad his dementia is reasonably significant. He is not expressly aware that the system is in place. But between my brother and I, as, you know, it just – there is a lot less questions that we have to roll

around in my head to think about what potentially is going on. So it has been extremely helpful for us.

MR ROZEN: A lot of the evidence before the Royal Commission, Mr Harker, describes a pattern where people might get some assistance at home, elderly people might get some assistance at home but then get to a point where they need more care. Often associated with increasing dementia and the sorts of things you have described. And then the families often have no choice but to move their relatives into residential care even though they might not particularly want to do that. Has this technology had an effect on that in relation to your family? In other words, were you considering moving your dad into residential care because of him leaving the home and concerns about his safety before you got the app?

MR HARKER: Yes, that's correct, Peter. My brother and I had conversations about this because we are very concerned about him wandering the streets at all sorts of times and hours. And -- wandering the streets at all sorts of times and hours and it was an absolute conversation we had and with the ability of this app now to give us that feedback, it just makes it more understanding that we can have dad stay at home confident or relatively confident that he's not in any danger.

MR ROZEN: And Denise, is that your general experience, those 40 clients of yours, how many of those would be using the app?

MS GRIGGS: Approximately 10 at the moment are using it and I've had really positive feedback from family members to say how wonderful they think that this is, that they don't have to worry as much, they can be at work and they can have a look at their app on their phone and they know that mum and dad has gotten up for the day, that they are moving around, that they have opened the fridge and that they're doing things that were set up within normal daily activities for their parents.

MR ROZEN: And do other people have different parameters? In other words are they interested in information that's different to the information that Damien has described?

MS GRIGGS: Yes. So there are six sensors in the home and we work in consultation with the families to work out what they feel is the best use of those six sensors. So it may be that they might want one in the bedroom or there might be a place that mum and dad store their or have their medications and there might be a sensor there and that will alert the families to know that that sensor has been activated at certain times of the day. So mum or dad have had their medications or they have opened the fridge or that they – like, the temperature setting as well. One of my members live in the Adelaide Hills and they live quite remotely so families are very happy to know that there is temperature control in the home so they can always ring their parents and just say, dad, it's looking very warm in this room, have you got your air-conditioner on; things like that.

MR ROZEN: And have you had any experience, Denise, of families who, when offered the app rejected it because of concerns perhaps about privacy or an unwelcome sense that the elderly people are being watched all the time. Is that an issue that has arisen with any of your clients?

MS GRIGGS: It has with a couple of my clients. Some families like the idea of having the Billy system installed for their parents. But I'm finding that some of our, my elderly members, that still have reasonable cognition feel that it's an invasion of their privacy and that they feel that they're still a parent, not a child. So while the system works well for some people, for others they just, they don't like their privacy invaded.

MR ROZEN: And just finally back to you, Damien, if I could. Obviously the app doesn't prevent your father from leaving the house. So does he still leave from time to time other than on outings and so on with you?

MR HARKER: Yes, unfortunately, he does. He may, you know, go what he thinks is to check that the bins are out or go to get mail and inadvertently not close the front door behind him with no key to get back in. That's occurred on a number of times. And we see that, we see that he's left the house unscheduled. He also has access to a GPS pendant which is essentially a mobile phone around his neck. We can use that device to call him and to check to see if he is okay and unfortunately one of the problems is then we just need to get someone to the house to get him back into the house. So that will quite often mean that either my brother or myself will have to leave work to come home and let him in, unless ECH have a scheduled visit nearby.

MR ROZEN: Is there any possibility of some remote ability to unlock the front door if your dad found himself trapped outside? Is that something you have explored?

MR HARKER: Yes. The current technology as far as the Billy app is not there but my own investigations there is a lot of products on the market these days with smart home type devices, one of those is a Wi-Fi access door. So I have had discussions with my brother about the ability for us to simply just allow – get that contact with him through the GPS pendant, get him to go to the door and we can just simply unlock it and then lock it again remotely.

MR ROZEN: And one final questions for you, Denise. Do you know if there are any plans to augment this technology or improve it in any way in the foreseeable future?

MS GRIGGS: Not that I'm aware of but I don't work in the IT department or with business operations. So it's not to say that that won't occur in the future because technology is always improving and changing.

MR ROZEN: Yes. Alright. Thank you. Commissioners, they're the questions that I have for these two witnesses.

COMMISSIONER PAGONE: Thank you. Thank you to both of you. I must say it was very interesting to hear both the existence of the technology and the issues around them, and we are grateful that you have given up your time to tell us particularly the personal details of your dad. It's difficult to perhaps expose publicly but it's great that you have done it from our point of view. It has been very, very informative, so thank you both very much.

MR HARKER: You're welcome.

MS GRIGGS: You're welcome.

MR ROZEN: If Ms Harker and Ms Griggs could be released. I don't think they're on summons, actually. So we're having a break for morning tea, now, I think.

COMMISSIONER PAGONE: If I do need to release you, you are released. If I don't need to release you, you may go in any event. And we will have a short break to reconfigure the room.

MS GRIGGS: Thank you.

MR HARKER: Thank you.

THE WITNESSES WITHDREW

ADJOURNED **[11.49 am]**

RESUMED **[11.03 am]**

MS HILL: Commissioners, I call Professor Sue Gordon, Ms Jennene Buckley, Dr Tanya Petrovich and Ms Daniella Greenwood.

SUE GORDON, AFFIRMED **[11.03 am]**

JENNENE BUCKLEY, AFFIRMED **[11.03 am]**

TANYA PETROVICH, AFFIRMED **[11.03 am]**

DANIELLA GREENWOOD, SWORN **[11.03 am]**

COMMISSIONER PAGONE: Yes, Ms Hill.

MS HILL: Good morning, Ms Greenwood, Dr Petrovich, Ms Buckley and Professor Gordon. Starting with you, Dr Petrovich, could I ask you to briefly introduce yourself and your professional experience to the Royal Commission.

DR PETROVICH: So I am the business innovation manager for the Centre for Dementia Learning at Dementia Australia. We provide dementia education to aged care workers, nurses and allied health. My role in particular is to develop new products for – to improve our service delivery. I have a PhD in genetics, also a graduate diploma in education. I have worked in the education sector for over 30 years, and for the last 11 years in aged care.

MS HILL: Turning to you, Ms Buckley.

MS BUCKLEY: I'm Jennene Buckley, I'm the CEO of Feros Care. I've been the CEO of Feros Care for 20 years this year. I've been 28 years in the health and aged care sector. Before that I was in health business management with Queensland Health, and then with Blue Care, a large aged care organisation in Queensland. My qualifications are in business. I'm a fellow CPA. I'm a board member of the Aged Care Industry IT Council, and I'm also on Bond University's Health Care Innovations Advisory Board.

MS HILL: Ms Greenwood.

MS GREENWOOD: I'm Daniella Greenwood. I currently work as a consultant in aged care in Australia, and Canada and the USA. My experience in aged care over the last 15 years was, firstly, as a volunteer, and then as a personal care worker, and then as a lifestyle coordinator, and then national dementia strategy manager, and then strategy and innovation manager most recently for Arcare for about five years. My degree that I did at that time was in leisure and health, so therapeutic recreation. And I have recently graduated with a Bachelor of Arts first class Honours, and my dissertation looked at human rights as a model of practice for residents of aged care in Australia.

MS HILL: Professor Gordon.

PROF GORDON: Good morning everybody. I commenced my professional life as a physiotherapist, with over 20 years of clinical experience mainly in rural and remote areas. I then went into an academic role and so I've been conducting research for over 15 years. My current role is a co-funded position between Flinders University and ACH Group, who are an aged care provider here in South Australia so I live half my life in both worlds. Of particular relevance to today, I do a lot of work with the Flinders Digital Health Research Centre, and I'm a chief investigator with the Australian Research Council Digital Enhanced Living Hub. Thank you.

MS HILL: Ms Buckley, from your advantage point as the CEO of an approved provider, what is the role of technology and the approved provider?

MS BUCKLEY: Technology has become one of the most – you know, the
5 foundation of our service delivery models. Technology we use not only in the way that we operate and coordinate services, we use technology, we put it in the hands of our staff to be able to effectively provide the services and the care that they need to, and increasingly we are using technology, putting the technology in the hands of our clients and in their homes. So it really has been the foundation of our innovation and
10 it's – but it's also the future. And we are living in the 21st century, so it plays such an important role in everything that we do in our business, to be honest.

MS HILL: Professor Gordon, what do you observe as the role of technology for the older person?
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PROF GORDON: I think there are so many aspects to it in terms of communication assistive devices and I think talking about technology just one part of it actually misses the whole picture. But it's massive in terms of what it can do for improving aged care.
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MS HILL: Bearing those responses in mind, Dr Petrovich, where does dementia and Dementia Australia's work fit into how technology is being used?

DR PETROVICH: So, look from our point of view, technology is an enabler. So
25 it's a tool that we can improve outcomes with. So when we look at the breadth of aged care, so we look at the eight standards, for example, each of them can benefit from a technology solution. But it's always there to support the outcome which is a better quality of life for people. So, yes, from our point of view, it's a wonderful tool but it's always about improving quality of care. It's not technology for technology
30 sake, it's for improving the quality of care and quality of life.

MS HILL: Ms Greenwood, for the workforce who is delivering care, where does technology fit in, from your perspective?

35 MS GREENWOOD: I think there's confusion as to what technology is and what it isn't. So a lot of times I go to conferences where I will hear amazing ideas for the latest wearable technology or smart – and I'm specifically thinking about residential aged care now because I work with those workers a lot. So we're thinking electronic care plans, but when it's the real world of residential aged care, transferring that to
40 practice is something that isn't as easy or as easy as it may sound at the board level in terms of staff time, staff training around being able to use that technology and, yes, I think that there's a bit of a disconnect between the real day-to-day practice in aged care and this idea that it's definite that technology will save staff time, is there evidence for that.
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MS HILL: Ms Buckley, how do you use technology on the floor of your residential aged care facilities?

MS BUCKLEY: So we have very little technology in the day-to-day operations of our residential villages. We have three small villages. So Feros cares for approximately 8000 seniors and a majority of those are in their homes. 174 are in three small residential villages: a 40-bed, 64-bed and a 70-bed village. We – they have very little – they have a client management system but generally they are not using technology. They are still writing care notes in traditional systems. Of course, they have got call bells and they use technology when getting educated but generally on the floor they don't, and that's very different to our community based services. And I guess the difference is is that they are so busy every day just wanting to provide, so busy and focused on providing the care they need for the residents, they don't have a lot of other time to really want to engage with technology. It has been a difficult process for us when it has come to motivating managers and staff to really engage with technology in residential.

MS HILL: How do you undertake that level of engagement, Ms Buckley?

MS BUCKLEY: I guess it's really, when it comes to the implementation of technology in residential care it really has been, you know, really getting the managers behind the implementation of technology and, as I said, they are – funding is very tight and they are just focused on getting through their day at the moment. So it is not something that they really engage with, which has been quite a different story to our community based programs.

MS HILL: And what's the different story in the community based programs?

MS BUCKLEY: Well, with the community based programs, when I started at Feros care, we had 25 clients and community clients in one small locality and we needed to – we set ourselves a vision to grow our services. So this is back now 15 years ago and so technology was the tools that we put in the staff's hands way back at the beginning of our growth. And so it has been a part of the development of our community care programs over a number of years. And so it's just something that our staff have been used to and it has evolved and we have invested in and they have engaged in that. And so it has been – it's just been a very different journey than it has in our residential facilities.

MS HILL: Professor Gordon, what do you observe of ways the use of technology can be encouraged or incentivised?

PROF GORDON: Encouraged and incentivised by the organisations providing care?

MS HILL: By the organisations providing care.

PROF GORDON: It has to be a value proposition that improves efficiency and improves effectiveness but overall improves quality of care. I think coming back to the standards, that technology really needs to be embedded in those standards to actually achieve the outcomes that are needed. Thinking of technology as a separate

thing is not going to work. So I think going back to the standards, identifying where there's the best evidence that technology can improve outcomes and align with those standards would be something that would incentivise the aged care providers to incorporate it. The thing, of course, is always going to be money. We're talking about a sector where 51 per cent of aged care providers are in the red. So there needs to be support to basically incorporate anything.

MS HILL: We asked the panel to consider, Professor Gordon, whether an aged care quality standard that recognised technology in and of itself would be something that could encourage or incentivise the uptake and the use of technology in aged care; what's your view of that?

PROF GORDON: My view would be that technology is, as I think Tanya said, an enabler and a facilitator. Technology of itself is not going to improve the care. It's how it's embedded in the delivery of services. And it's about a value proposition for the aged care worker to implement it and also for the consumer to take it up. So it's quite a complex thing. I would be looking to embed best practice technology to support the attainment of those other eight aged care standards.

MS HILL: Dr Petrovich, do you agree?

DR PETROVICH: I think so, absolutely, yes. And just another point, when we're speaking about people living with dementia, obviously technology has limitations. I was just reflecting when Mr Harker was speaking earlier, whilst we can say that he was talking about his father going to the fridge, so the technology was letting him know that his father had gone to the fridge, that doesn't mean that his father actually ate a meal. So there are limitations particularly with dementia that we need to consider. The technology can only say so much. It can tell us where they've been but it doesn't tell us have they taken their medication, have they actually had a meal, have they met all their requirements that day.

So, yes, we just need to consider that. And also the fact that dementia changes on a daily basis. A person can have a good day and a bad day and the disease is progressive as well. So what's working today may not work in a month's time.

MS HILL: Is there a way, then, Dr Petrovich, to balance the benefits that we heard from Mr Harker's father's experience with the very real life considerations of someone with dementia where the situation is changing day-to-day?

DR PETROVICH: Sorry?

MS HILL: Is there a way to balance the concern around the shortfalls of technology and dementia?

DR PETROVICH: I think we just need to be aware that the technology is – it might alert us to something that has happened but it doesn't confirm that things have been done to a certain level or certain standard. So it can assist, without a doubt.

Obviously, if his father – and many people do want to live at home, so if we can assist people to live at home, absolutely, I agree. But we do need to have the other supports around that. It doesn't take away from the need for genuine human to human care.

MS HILL: Ms Greenwood, would you like to respond to some of the observations that have been made?

MS GREENWOOD: Your first point around incentivising the use of technology, I think that has been tried in the past, and I'm not sure if it was evaluated. I think there was $1000 given per bed, and there has been lots of incentives for using telehealth and all these sorts of things but I've never heard of an evaluation done of any of those projects or how they worked out. Being in the world, the main thing I'm hearing is the difference between home care – our true north is people staying at home. When we are talking about aged care it does change. Now we are talking efficiencies and quality of care and someone's understanding of what quality of care means, and I think they're two very different propositions.

Once you're in residential aged care, the use of technology does have a different meaning and it is linked to efficiencies in the market and it can then tend to shape care in the real world if it's created for efficiencies and to maximise funding it does actually shape behaviour, staff practice. So those things are maybe one of the unintended consequences and why technology may not have taken off when maybe it's in place because of poor design or because people aren't consistently with the same people.

MS HILL: And bearing that in mind as an unintended consequence, Ms Greenwood, what are the lessons for the Royal Commission in factoring in how technology can be used, can be supported in a residential setting?

MS GREENWOOD: That's – the piece that I see missing is developers; they work to create something and they don't spend enough investment in the person who will end up using this. No matter how good your development or your technology sounds it's mostly going to be a personal support worker who is putting that information in, and often these technologies wouldn't pass muster in any other industry. They are user friendly. The device that they – if it's something like care planning there's not enough training for staff. There's not enough consideration at that development point as to how that front-end user will experience that technology, especially when it's to do with putting data in and answering call bells. I mean we have had sensor mats for over 20 years and still staff have difficulty attaching those to the phone and then answering it.

So I think getting back to basics there and making sure that the person using it has the training and support and that the development is respectful to that front-end user, to the person putting the data in.

MS HILL: Dr Petrovich, Dementia Australia develops technology for use in residential aged care facilities for use by the workforce. Bearing in mind those observations of Ms Greenwood, what factors – or what are the guiding principles of Dementia Australia in the development of technology?

DR PETROVICH: I think number one is that we do co-design. So working with the end user is absolutely paramount. So whatever the product is to be, or the problem that we are setting out to provide a solution to, it must be co-designed with the user. That's without a doubt. And I've actually seen some really great developments happening outside of our field also. The person-centred software, for example, in terms of note-taking. I think there's some real movements in understanding what the end user needs and understanding the industry has a lot of PCAs or personal care workers who have come from a non-English-speaking background and having this person-centred software which uses icons for people to put care notes in, that's actually addressing the need. There is an issue with note-taking and having good English or an ability to write English. So we have overcome that with this type of software. So there's lots of examples, I think where that's still possible. Not that it's happened but it's possible to look at the solutions where you could do that.

MS HILL: Professor Gordon, could I ask you to respond to what has been said in respect of your role and the active role that co-design plays in your work.

PROF GORDON: It can't be underestimated. Without having co-design you are not actually going to address the real problems. But it goes beyond co-design. It has to be co-production and has to be co-implementation and it has to be evaluated as a partnership as well. So sometimes groups will get the co-design right but then they don't actually follow through. It's a quality cycle the whole way through. Has the technology that we have developed actually answered the problem, addressed the issue. So it's not just at the get-go. This is a long-term relationship that you need to really implement technology effectively to get the outcomes you want.

MS HILL: Ms Buckley, with the technology that Feros has developed and been using over the years, has it answered that question that Professor Gordon described, and how did you go about identifying what the question was?

MS BUCKLEY: So that's a very good point. How do we identify even what innovation or technology we wanted to use in the first place and certainly in the last four years Feros has got very good at this and our priorities in relation to technology has actually come from the priorities given by our clients. So we did quite a large project with our clients and developed a journey map, sitting in their homes. This is in the community, understanding what they liked about our services, what they didn't like about our services, what they wished that they could achieve in life, what was their frustrations. And from this journey map we identified a number of areas of improvement that Feros needed to look at in relation to our service delivery as well as some of the products and services that the clients were wanting. And that's what we created – sorry, from that we created our road map of innovation.

What has come from that is that it would not be unusual for me to turn around at my desk and see a family member sitting with our development team looking at wire frames for the client portal that they are developing or they're in a little workshop together talking about the virtual social centre what is not working and what is working. It would also, having ongoing panels of participants again for the virtual social centre, every week or month or fortnight feeding back. So they absolutely play a role in actually even prioritising our innovation, helping us design the innovation and telling us whether we have got it right or wrong. So it's just now been a part of how we work and we have got much better at that as an organisation and do that for both staff innovation as well as client innovation. It takes a lot of resources but the benefit is that you get the products that the client wants.

MS HILL: What motivated Feros, Ms Buckley, to take this approach at the get-go?

MS BUCKLEY: I guess it was – so we never did that well years ago. What we would do is we had to be careful with research is technology being imposed on us, as in this is a great idea let's try this for our client and that was probably what we started. That was our journey initially but it was really when we were leading into the changes in our home care in February '17 that we, a year before that, we said really are we positioned well for this? We need to listen to our clients. And it was a very – it was – yes, to go into the client's home and listen to what they had to say about our services was very confronting because we thought we were doing a good job and we realised there was a number of things as a provider we had to do differently. And I even went, in one situation, undercover CEO and sat for two hours and listened to the stories and I really then understood that if we do not work with our clients, then they will not stay with us, that we need to absolutely listen to them. And just now a, like I said a very big part of what we do, it's very important to us.

MS HILL: Looking at the role of technology, in the ability of technology to provide social support and connection of the older person to the community, of maintaining quality of life, of maintaining independence of the older person. Starting with you, Ms Greenwood, from your perspective, what are the questions that we need to be asking ourselves around the use of technology in aged care?

MS GREENWOOD: And I keep going back to the area that I know the best and have most experience in and work in and that would be residential aged care and specifically with residents who are no longer using words, a lot of them, to express what those preferences are. So understandings of things like co-design have completely different meanings. And so the technologies which become less about maintaining my independence and my freedom and a little bit more about surveillance and paternalism. So my thought for those vulnerable resident citizens who are often just disregarded as it's too hard to find out whether they want this in their lives or how this will affect their lives and, as Tanya said, making sure this technology does not take the place of human contact because that is a breach of human rights, if that is what you are aiming for in terms of vulnerable people.

So my focus would be on the percentage or the large percentage of people living in the later stages of dementia in residential aged care, for whom co-design, for whom engagement with technology, aside from a few different apps there, human contact is what makes a difference in those people's lives. So surveillance, where they get – is becoming a concern for people to be thinking about, less on what people can use and more about what they want in their lives and who makes that decision.

MS HILL: And how does that then play – what does that mean for the role of assistive technology in the care that an older person receives in that setting?

MS GREENWOOD: Well, assistive technology again, I haven't seen enough of the evidence around, and it is weird that it has been around so long and we are still having this conversation around what are the outcomes of the use of technology in this space for vulnerable people, particularly people living in residential aged care who cannot speak for themselves. So what are we calling success?

MS HILL: Professor Gordon, do you consider there should be contemplation of whether an older person receives particular technological supports as part of their assessment and ongoing care planning?

PROF GORDON: Absolutely. I think the opportunities for technology to improve the quality of care and the outcomes of care are massive. I think too we need to be thinking about who the next generation of people coming into care are going to be. So 80 year olds are not digital natives. Our 70 year olds are. And so the – one of the big barriers is actually the digital literacy of consumers and also the digital literacy of the workforce. So unless that's addressed you're not going to get the uptake of the technology and unless there's a value proposition for them, that they can see it's not going to happen. So they're parts of the jigsaw.

But I do believe that it should be part of the assessment. What is there in technology that can actually assist this person to have a better life? Technology is part of our everyday life. We recently did a focus group with older people in one of our council areas and it was quite interesting. We asked them if they were using apps, how digitally savvy were they. They said, "No, no, we don't use apps". And then we said, "How do you do your banking?" "Well, we do it on the phone". So there's also a need for them to understand technology what we are talking about when we talk about digital technologies and the different types of technologies, so there's an awful lot of education that is needed and an awful lot of training around digital literacy as well and training to use those assistive technologies. They're scared of them.

MS HILL: Would you like to respond, Ms Buckley.

MS BUCKLEY: I think they're hungry to learn. We have – we are very fortunate to have been funded for three small innovation grants under the Commonwealth Home Support Programme and one of them – and this stemmed from feedback from our clients when we visited them on a couple of other projects, that they've got

technology they don't know how to use and we are in the middle of a pilot at the moment and it's called let's get technical, which is what the clients wanted to call it, and it is where we go into a client's home one-on-one, five to 10 visits over a period of time and they set some goals about what they want to learn about internet life or
5 using technology.

And so we are in the middle of the pilot, we have 50 participants who have been onboarded. The average age is 82. 43 per cent of them live alone and they're not setting three goals, on average they're setting seven goals. They want to learn more
10 about, "How do you turn this phone on? How can I send a message? How can I send an email? How do I get on to myGov? How do I bank? How do I shop? How can I talk with my family?" There's – I have comments where they're just going, "Please don't stop this program". And we were overwhelmed by the number of people that we sent out to try and find 100 people to participate and we are
15 overwhelmed and now have – you know, now are trying to set expectations about how we can help a lot more people. It is –they're absolutely keen to learn, absolutely.

COMMISSIONER PAGONE: Can I ask you this question, not necessarily you, Ms
20 Buckley but you may well want to be the first to pipe up. So I'm getting the message, I think, pretty clearly. Technology have been useful, isn't always, has its limitations. Sometimes good ideas don't get picked up, can't get picked up and there are all sorts of problems. What do you think we should do?

25 MS BUCKLEY: I think – so it's probably – we mentioned a standard earlier and I think that is definitely what we need to do in the future. But imposing a standard at the moment is probably not the first step. I think we need to understand first the digital maturity of the sector. Understand with all the service providers that are providing support and care, how mature are they, are they still using paper, where are
30 they at? And we need to understand the digital literacy of our staff and, from that, we set ourselves a vision and a strategy on how we're going to improve the industry's capacity or confidence in using technology and do a little bit of a roadmap working out how we are going to fund that. And that is not just one-off grants.

35 We need to make sure the funding model and the pricing model of all aged care services allows an organisation to invest in technology and to invest in quality and we were lucky as an organisation in that, you know, that we have been able – our board has supported us to use reserves to build our technology capability. We still have some work to do in residential care in relation to client management systems,
40 but if you asked me today could I afford to invest this amount of money, if I had to start today, my answer would be no, that the funding models at the moment and the pricing models of care does not allow us to innovate. So I think it's a bigger industry – need to take a bigger industry view and then set ourselves a strategy.

45 DR PETROVICH: I was going to suggest one thing you could do immediately is ban nurses' stations in aged care. I think there's - - -

COMMISSIONER PAGONE: That will go down well.

DR PETROVICH: I just think there's a mindset there that is just not open enough to innovation. And there are lots of solutions currently that you could use so that you do not need a nurses' station and there are some providers who are actually going that way already. But I think that the industry as a whole in general is risk-averse and is not open to innovation in residential aged care. Interestingly, you mentioned in home and community care is actually your area of greatest innovation but residential aged care not so. They need to be encouraged to be more innovative. I understand there's monetary constraints but actually I think there are things that can be implemented now that would make a significant difference to aged care and it doesn't require a lot of money.

PROF GORDON: Can I chip in? There has been an awful lot of money that has been spent on small research projects, in-house ones, in many aged care providers. And even some of the rounds that we currently have, the CHSP grants that Jennene was talking to, we have got one as well, but it was for 30 pages for $2000 worth of technology to go into people's homes and it will be well evaluated. So I guess what I'm saying is that we need to actually bring together all the information that we have. You have competing businesses who have done evaluations internally. You have internal small amounts being spent. Externally you have some funding but when we go for funding, we are often up against, you know, rat lab-based research for vaccinations, which means that we are way, way down the pecking order. So some prioritisation around how the funding is actually provided.

And as an example of that, about three years ago Flinders led a CRC around ageing. We got to the last six in the country, which we were pretty pleased about, but we missed out and one of the main reasons we missed out was that we didn't have enough industry money to support what we wanted to do because the industry that we work with is not rich. And we were up against energy and transport companies. They were our competitors for a CRC. Clearly, the value of a CRC about ageing has much more social value and I think, you know, it is partly why we're here today. So I think we need to take a look at all of the research, bring it together. We then need the industry to really lead what the priorities are and then we do need some solid money that sits behind, doing some decent evaluations of scaleable and sustainable interventions.

COMMISSIONER PAGONE: Sorry, Ms Greenwood. You may wish to say something but I thought that you – anyway, if you do, please do. But I'm just going to, as a follow-up to that answer, ask – so we can probably assume that the industry will always have an internal incentive to do something either because, you know, they see an obstacle there that they want to get rid of or because they can see how they can do something more efficiently or cheaply or whatever the incentive is, and the bigger money for research is difficult for, amongst others, the reason that you have indicated. Is a solution to for us to recommend the establishment of some research body or think-tank? Is that a desirable thing or not a desirable thing?

PROF GORDON: I think it's a desirable thing to bring industry together with the technology industry, the aged care sector, the researchers, to bring them together so that we really can identify the priorities that run across the whole aged care sector, remembering we have got residential, we have got community, we have got very small organisations and then we have very large organisations. But some of the problems are common across those areas.

COMMISSIONER PAGONE: And do you have some view about what that would look like, would it be another government department? Would it be an off-shoot of the ACRC granting arrangement or do we give the task to Ms Buckley to look after because she has got form in this area?

PROF GORDON: I think a model like a CRC will work. But CRCs are funded for different priorities, would be how I would describe it currently.

COMMISSIONER BRIGGS: Could I – sorry.

COMMISSIONER PAGONE: I was just going to ask whether there any other comments you wanted to make, but by all means, hoe in.

COMMISSIONER BRIGGS: Thanks, Commissioner. Going back to what Ms Buckley said, we need a standard. Agreed, we need a standard, because technology needs to develop around a standard. We need to understand the digital maturity of the sector. We could do a lot of research on that but fundamentally I think we all know that the digital maturity of the sector is patchy, at best. So we should acknowledge that. But we understand as well that a lot of people use devices as part of their everyday life and that Australians take up technology at a faster rate than just about any other country in the world. So we have got a receptive population. So we could start with that basis.

Then we need to understand the digital literacy of our staff, absolutely. It's pretty fundamental because then you have got to design systems that – or applications that – or software, whatever you want to call it, that work with their – in ways that are attractive and useful for them to work with. And, you know, I picked up the views about co-design. I couldn't agree more. And I also picked up the issue about funding. People just feel short of funding to be able to do this.

So my question is, I think all of those things are solvable. So much of this is a cultural issue and it's a motivational and leadership issue. We heard from Ms Petrovich about get rid of the nurses' station, force people on their feet. Hospitals these days are using technology all the time. It's a fundamental piece of equipment. Why is it that nurses in nursing homes or personal care workers in nursing homes don't see this as a fundamental piece of your tools to do your job in the same way that they would see taking a temperature or recording what medications somebody has had?

DR PETROVICH: I don't know that I can answer that question but – and Jennene might be better to answer that, but part of the issue is the personal care workers don't feel comfortable. We actually did an evaluation recently. We asked them about computers and they thought no, don't want a computer, can't work a computer and don't show me something new, I don't want to know. But when we asked them about their mobile phones, they were using WhatsApp. They were using Facebook. They were all over their phones. So we are actually developing some technology using their phone because that's what they're comfortable with. So I actually think it's very – as you say, very solvable, you just need the piece of technology that they can use on the run. There are some solutions coming through now which I think will be really beneficial. But, Jennene, you probably - - -

COMMISSIONER BRIGGS: So Ms Buckley, is the technology you use on a tablet or a phone or what do they use? In your home care system.

MS BUCKLEY: In home care, yes, so a number of those. So you can use the technology on – for community care workers or staff, they use – they can use a tablet or they can use a mobile phone or they can use a laptop, depending on their role and depending on their technology of choice. And so that's certainly on an app, yes. But there's also technology that we put in the homes of the clients as well that can inform us of information. And you saw a good example, there's other technology than the one we saw this morning that can be used. And so – and also, a lot of medical devices that take vital signs that come back through to our virtual care team. So there's a range of technology that can be used. Does that answer your question?

COMMISSIONER BRIGGS: It does and I want to take it further to the question that, I think, or the comment that many of you started with, about the only point of using technology is to – one of the points of using technology is to improve the quality of life and the outcomes for older people. Now, it seems to me if data can be electronically submitted, including information about the care that people are getting and so on, alerts can come through when, as we saw earlier on, there was a case of the elderly gentleman using the toilet eight times in a night which might have indicated an infection and so on. So it seems to me that if those feedback loops which one of you talked about earlier was delivered in the technology so that the personal care workers and the nursing staff and allied health people and indeed the managers could see how technology could be used to improve outcomes, that is an important part of the cultural reform.

MS BUCKLEY: Absolutely. An example may be in our organisation, we – there's a lot of data that we can collect on a person, on a client now because the technology that we use as well as real-time information, real-time where a carer can be in the client's home, an incident can happen. They can let us know straightaway or can provide information. We – as an organisation, our focus this year is creating – we have a virtual care team, which is nurses who sit in our contact centre. I think there's six of them on a roster of a day. And we are developing a single pane of glass so that information that is coming from different devices or information from the field is coming in so that they can have a very clear picture of what is happening in a client's

home better than we've ever been able to do before. And so we are only, this is, yes we have been doing telehealth since 2009 but the technology is really coming of age and I think this virtual model is something that we are very excited and think will be the future in providing additional support that people need in the community because
5 we are not in their homes every day.

COMMISSIONER BRIGGS: Can I ask you another question? This is a bit sticky because I absolutely agree with what you have been saying. Sometimes there's a need for a bit of a nudge, meaning well, mum, have you thought about if we book
10 our tickets for the movies online, we will get a seat rather than go in there and not get a seat. Stuff like that. In the workforce, a bit of a nudge to do something that really should be done as a necessary part of improving the quality of care, is that reasonable?

15 MS BUCKLEY: Absolutely.

MS GREENWOOD: Are you thinking in residential aged care?

COMMISSIONER BRIGGS: Residential and Home and Community Care. I mean,
20 I see the use of technology as absolutely fundamental in Home and Community Care because of the dispersed, fragmented nature of the system. But ditto for residential care where we are dealing with people with very high levels of complex needs and often quite serious cognitive disabilities. And if the employees aren't embracing the opportunity, then there needs to be a bit of a nudge to get them there. How do we do
25 that?

MS GREENWOOD: There are stops and balances if you're working on the floor as a carer or a nurse. There is documentation that's an expectation. If you don't do that, there's consequences in the real world. Whether or not you, your organisation
30 is still using paper or one of the electronic care plans and they do vary. Some are really user friendly and some just aren't. So the usability of that product and how it has been implemented in terms of change management is everything. I've been with organisations in the last year, three of them have gone through the process of implementing new IT systems and it is really stressful and if they haven't allocated a
35 budget toward the end for staff training then that can be, you never get a second chance to implement that well. So how it's implemented and what product it is – in terms of staff practice, a lot of the things that, I guess I'm still trying to understand exactly what even you mean when you are talking about technology in residential aged care. So it is kind of just record keeping that you're thinking of when
40 something happens and then someone does, just in the residential aged care setting in terms of staff using it. Is that what you're referring to?

COMMISSIONER BRIGGS: Look, I think record keeping is pretty important in terms of the context of the quality of care and recording the care delivered and
45 providing data back into the centre. But we have heard numerous examples over our hearings about the opportunity for technologies to identify where people are, if

they've fallen out of bed, all those sorts of things. And I can't list them all from memory but I think it's way more than record keeping. Am I right or - - -

MS BUCKLEY: Absolutely ..... staff practice.

COMMISSIONER BRIGGS: ..... engagement with families, you know – yes, staff practice training - - -

DR PETROVICH: So just even to be able to monitor who is in greatest need at that moment. So for example, there are systems in emergency services where you can actually triage, if you like and it can work without who is the most important at that moment to be provided care with. You could have a similar system in aged care. You could have monitors and a system in place that could actually monitor who needs your attention at that time, since we will always be, you know, not sufficient funding and not sufficient staff, you could actually have a system that could help you with that sort of triage, if you like of who is in greatest need at that time.

MS BUCKLEY: The Aged Care IT Council, I know they had put in a submission and a part of that submission they, a group of CIOs had put together a list of technologies that one would expect to see in an aged care organisation, and I just wrote down because I thought it may be of interest, is that they are suggesting that for an aged care organisation with 500 employees they're estimating $25 to $50 million spent on technology over five years, when you start to look at the systems you need to run your business, to meet the quality standards, the technology you put in the hands of the clients and the staff, it is quite a significant investment. And if you look at training, we are a small – three small residential aged care facilities, 180 staff, a two-hour training session – just one training session would certainly be around $10,000. So if you are already making losses, and viability is an issue, just one training session is a lot to ask. So I think we need to think about understanding the true cost of operating an aged care business and make sure that funding is appropriate for them to be able to train and innovate and build capacity. I think it's an issue that needs to be looked at more clearly.

COMMISSIONER BRIGGS: That's a really good point. When does the aged care industry realise it's a big industry? If you have got 200 staff, that's a big organisation and we see many of these. There are many smaller than that, but these days, if you are running any other business, you would be properly IT enabled.

MS BUCKLEY: Absolutely. Can I say that with our home care package experience, there has been, I guess, criticism from media, from consumers, from politicians, in relation to the administration charges of home care packages and even charging a 10 per cent administration fee is frowned upon or has been frowned upon. The true cost of operating a business requires more than 10 per cent administration fee. For example, Deloitte had said that the average investment in business for technology is over 3 per cent and innovative organisations spend 7 per cent of their income just on technology innovation. We couldn't possibly do that with a 10 per cent admin fee. I think we need to understand that there's a cost to running a

business and we need to, the pricing needs to be much more ma tour and it needs to acknowledge that we want to be an aged care industry that can be innovative, that meets standards, more than meets standards and that we want to be innovative and provide a quality service. And that really does come at a price.

COMMISSIONER PAGONE: Ms Hill.

MS HILL: Professor Gordon, I would like to ask you to respond to the remarks that have been made by the panel but before I do, you mentioned earlier about a CRC, could I ask you for the benefit of transcript to spell out that acronym.

PROF GORDON: Cooperative Research Centre.

MS HILL: Thank you, Professor Gordon. Would you like to respond to those remarks that have just been made?

PROF GORDON: There are a number of things that come to mind that have influenced where we find ourselves. We have come from a very a task-focused culture that has been in response to the funding models that we have; that we, with the new Aged Care Quality Standards are moving to a person-centred care approach, which I think we all applaud. And so there's – so basically now we're actually giving aged care workers permission to actually build relationships and spend time with the people they're providing care for instead of putting them on a stop watch and saying you've got half an hour to do a shower. And that's a good thing.

So there are changes that will happen because of the new standards which will be very, very positive. With that, I do think comes the opportunity to incorporate the technologies that we have and the technologies that we have are massive. Most things that you can think of today technology can help you to achieve. And it's a matter of harnessing the ones that are going to be most effective. One of the other things I think has been a problem is that we haven't had – we have had apps or technology assistance to do this bit and that bit and this bit and there hasn't been a really good system that pulls it all together. We talk about interoperability and that has been a real challenge for the sector.

I think that's improving and certainly some of the projects that I'm involved with that Dementia Australia are involved with, the Australian Research Council Digital Enhanced Living Hub are looking at those areas. So I think we are moving forward with the standards but we do need to capitalise on them and this is the opportunity to capitalise on them. There's one other thing I would just like to ask, when we talk about standards and we talk about standards for technology, I think we need to remember that the aged care provider is a consumer of the technology and passes it on.

If you're going to be talking about standards, say to do with cyber security or privacy or how the data is collected, where the central repository is for the data, these are actually bigger questions for the IT industry, I think. You cannot expect an aged care

provider to take responsibility for those aspects of the digital technology they might use. I think that's perhaps another thing when we talk about standards where does the responsibility for different aspects of standards actually sit? I think that's all I would like to say, thank you.

MS HILL: How do we bring it all together, Professor Gordon? Is it through a centralised body that Commissioner Pagone referred to earlier?

PROF GORDON: I think that is the best way to go because we have talked about the different levels of maturity, of organisations, the different size of them and I think we do need to get everybody in the room to figure out what the priorities really are. I think this Royal Commission will have certainly a good overview of what those priorities might be but we need to bring the whole of industry on this journey of incorporating technology and improving care.

MS HILL: And who do you see should be taking leadership in this situation?

COMMISSIONER PAGONE: Can I ask you that question differently? I'm happy for you to answer that question in that form in a moment but, and it may be that it will be the same answer, but where do you see technology in this sector coming from at the moment?

PROF GORDON: It's coming from a number of different places. You have got technology industry driven products that are basically put under the noses of aged care providers and I think this is where we have this mismatch of what the user actually wants and whether that's the aged care provider or the consumer. So we have that happening. We have independent – but we do have some areas where good co-design is actually happening and we need to support those. I think certainly within the aged care sector they do have their information technology group who are represent – who have representatives from ACSA and LASA. And Jennene in fact sits on that committee. And in fact Flinders University worked with them – in 2017 we released the Technology Aged Care Roadmap to sit alongside the Aged Care Roadmap. It was actually adopted with bipartisan government support but it hasn't actually been implemented. When you go back to the recommendations about digital literacy of the workforce, digital literacy of consumers, co-design, coproduction, it's all there. So I think actually going back to that document and taking it on board and looking at how we implement it across the whole sector would be a real positive step.

COMMISSIONER PAGONE: Well, I will come back to Ms Hill's question again in a moment. But who might lead the research? Might end up affecting the particular interests of the leaders. I've certainly been involved in a former capacity as a judge where the leaders of innovation had been various government departments, which resulted in something that judges were not likely to be using, to give you an example. And similarly, if you leave the research, the leadership of the research to academics, you might get some really interesting stuff but not necessarily things that are going to be picked up. Hence, Ms Hill's question: who should lead it?

PROF GORDON: It really has to be a partnership. You get your industry partners, you get your academics and your industry partners are from technology, they're from the aged care sector and there will be other sectors that we would need to have representation from, particularly advocacy groups like Dementia Australia. You need to have the consumer voice there. That's got to be central to it as well. So it's not actually going to be a simple thing of one particular person or group leading it. It needs to be a cooperative that actually solves these issues.

COMMISSIONER BRIGGS: Isn't it also that it has got to be clear to the IT industry that the sector is open for business? I mean, you know, we can all start within each of our organisations building our own pieces of technology and invariably we fail because we are not experts at technology, they are. So the technology industry has to embrace the opportunity and engage with organisations like the council or a CRC or whatever to actually make this stuff happen. And when they do that, it seems to happen pretty quickly, in my experience. Yes or no, you're going to say that's right.

MS GREENWOOD: I feel there needs to be the standards around that to guide the IT industry. Because at the moment there is a lot of ideas out there and a lot of creative people and some cool app programmers. But they're developing technology that hasn't gone through a human rights lens. It actually hasn't considered what is okay to do in this space and what isn't. So you may have someone with a great idea. "I'm going to create this great piece of technology so that family can log in and see mum's complete care during the day, and that sounds like a really good idea to me". And without thinking, wait a minute, we are actually going to ask the resident citizen of – you know, there's rules around what people can see, what they can't see, how it's okay. But I'm really worried about that at the moment. I find out there it's a bit of an unintended consequence since this Commission has been in place that there's a lot of language around – most of the providers I speak to say, "Can you help us? We've got to find a way to connect families, so that we are giving family lots of information unquestioned". Whereas the resident citizen hasn't been asked.

Even residents – I did a focus group of about 15 residents recently and they said, "Well, what if we don't want people knowing our private stuff", and at the moment, unfortunately, I think technology is erring on the side of let's just let everybody know and keep everyone up to date about a citizen who may not want that discussed with others. So if we can – I think they need some principles and some – this is how we – these are our not negotiables if you are going to build tech for and this is including where they store it and all the safety around that. This is around privacy and human rights and no one is looking at it.

Three different providers in Australia, and they're big, have said to me, "We have got to find a way so that family can find out everything", whether the resident wants it or not. So when they change address, a lot of those powers are just – of attorney and guardianship are just seen to kick in just because a citizen moves to – and I don't see the eye on that ball at the moment with the technology, including surveys. People are coming up with surveys that are winning awards and they're value-laden.

You know, they will say, "To get a good score you have to say my family are called all the time and kept completely up to date with my care, whether I want to or not". Or you know, it might say, "I get good nutritious food". What if I like red wine and pizza or is that just me projecting? What I mean is they're value-laden around nutrition is good and your family always knowing all your private information is good.

COMMISSIONER PAGONE: Red wine and pizza are very good.

MS GREENWOOD: Thank you, I so appreciate that. Thank you. Not if you move into aged care.

MS HILL: Ms Greenwood, how do you - - -

DR PETROVICH: I just wanted to add that I actually think government has a significant role to play in this because they need to provide the guidelines. This is a highly regulated industry, it's unlike other industries, so you need those government guidelines as to how this should be developed or should not be developed. And I think we had an example the other day of a provider who is using My Health Records and it was a really great example of how – people obviously agreed they could use My Health Records. The provider was putting information in, the person ended up in hospital. All the information was in one place and when they were discharged again, the information went back to the provider via My Health Records, unlike the normal circumstance where a piece of paper goes with the client, the family takes the discharge notes or something else happens and the papers are lost and the notes are lost.

MS BUCKLEY: I feel that – I do think government plays a role. I think we need a shared vision and a strategy that both industry and government agree on and it's written and it's – a strategy is put in place so that we have grassroots, broad innovation happening from all – you know, all providers have the opportunity to innovate, not one particular research group. I think we need an ecosystem of researchers who are supporting this groundswell of innovation. So we need to create the environment to allow aged care providers to innovate with their clients and their staff, if we really want to see a change. It's not going to happen from one body because we need all providers to be able to innovate.

A piece of technology off the shelf, that's already been developed, comes into our service, there is so much work for a service provider to do to put that innovation in the hands of a client. We need to test it. We need to make sure we understand its limitations. The risks around the technology, who can it help, who can't it help. Then we have to develop assessment tools and guidelines and training material. There's a lot of work involved in just one small piece of technology. So we need to be able to create the ecosystem for that technology to be evaluated but then we need funding and systems to be able to allow providers to actually implement that innovation. It's not so simple.

MS HILL: What incentive is there, Ms Buckley, for Feros to share the best practice approach that Feros has developed with other providers of aged care, either in residential aged care or particularly in the community care setting?

5 MS BUCKLEY: I don't think that there is an incentive, but an aspiration for us to help the industry become a better industry. And so even with – I mentioned three innovation grants. When we put those grants together, it was Feros in the grants that said, "We will get this evaluated, we will create toolboxes and we will share that with the industry". That was something that was not required of us in the grant. It
10 was something that we wanted to do and thought that that would be a – you know, a very good thing for the industry, if they learn from us, because we were given the grant to be able to develop this product and service so we should share with it the industry. And so other than that, it was really just our, I guess, aspirations to make the industry a better, you know, a more innovative and better place for our clients
15 and older Australians to be able to be cared for.

MS HILL: And do you think that approved providers such as Feros, when they receive a grant of, in respect of innovation, should be obligated to share the findings, the outcomes?
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MS BUCKLEY: Absolutely. Absolutely.

PROF GORDON: Can I perhaps just comment on that because I think this is a great missed opportunity, that there has been a lot of work done internally, externally
25 funded but to actually find that information, it's almost impossible. Just as there has been, you know, a lot of resources developed to train the workforce to help consumers use technology – and I think a great example of bringing all of the information together is – there's a group called Care Search who have all of the information around palliative care. It's for consumers, it's for aged care providers,
30 it's for the public. And it brings together all the research, it brings together the grey literature, it brings together the pilot studies that have been done and I think we actually need a repository for aged care that is similar to that approach.

MS HILL: Dr Petrovich, Dementia Australia is involved significantly in the
35 development of training tools and the use of technology for the workforce. How does the work that Dementia Australia is doing in that regard fit in with the evidence that we have heard this morning about the sheer cost of training the workforce?

DR PETROVICH: We are actually addressing that right now. We are well aware of
40 the cost of workers having time from their work being backfilled to be available for education. I still feel that the gold standard in education is to have face-to-face education, particularly when you are talking about person-centred care. However, considering those constraints, we're actually looking at how we get engaging online education. We know that the existing online education – and there's lots of it that's
45 freely available – is actually not effective. We did a survey and we found that when we interviewed staff after four weeks and eight weeks, they recalled very little of what they learnt online.

However, we have used some new technology, which we are currently working on, which is an artificially intelligent avatar. That – they were able to recall to five key factors that they were supposed to recall, they recalled and after four weeks and eight weeks, and not only that, they talked about how they implemented that change. So it really is a challenge to come up with truly engaging education, using all the tools that are available, all the technology that's available, but in really engaging ways, particularly for the workforce. I mean, we can develop education that we think they need, but no, it has to be the education that, you know, speaks to them. And one of the things that we heard a lot of was, "Don't give me that, in quotes blah, blah, blah, show me or give me the experience", and that's really what they want. So that's what we are working on. We are trying to give them an experience digitally.

MS HILL: And of those experiences that you have referred to, and also drawing on the immersive technology and the virtual reality technology that Dementia Australia incorporates as part of its training available, does Dementia Australia place restrictions on the use of that technology through intellectual property rights and considerations?

DR PETROVICH: So yes, we are the only provider of that education in Australia so, yes, that's true. And part of that has been the investment that we have made in the development of that technology. I mean, the price we charge is actually, I think, quite minimal and when I speak to providers it's actually not the cost of delivery of the technology, it's actually the cost of workers being in that session to experience that virtual reality that's the issue, yes.

MS HILL: Professor Gordon, was there a response you would like to make?

PROF GORDON: I absolutely agree with Tanya that it needs to be immersive. We have done some work with simulation or coaching to prevent – or to equip aged care workers to prevent aggression in the aged care sector ,which we know is one of the problems. And basically, using that type of approach, 92 per cent of the care workers said that it had helped them to stay in their current roles six months later. So – and they all felt safer in the workplace from having had coaching and simulation and by that I mean high fidelity, with actors, actually placing them in an aggressive event and actually getting them to practice their skills. And I think that is – so you can have the online education component that might prepare them for the simulation and for the coaching but that model of education around preventing aggressive events was a pilot. It was small, but it was very effective.

MS HILL: Ms Greenwood, other panels were given the opportunity to tell Commissioner Briggs and Commissioner Pagone what it was that they thought the Commissioners should do. Would you like to take the opportunity to share with the Commission what you think could be done to address the broad issues that have been canvassed today.

MS GREENWOOD: Within the context of technology and innovation?

MS HILL: Yes.

COMMISSIONER PAGONE: Well, if you have got some other bright idea as well, now is the opportunity, but certainly in that context.

MS GREENWOOD: Thank you so much. I think it's vital to separate innovation and technology when we are talking aged care and residential aged care. And I think that what we have done to date hasn't worked. Again, I'm focusing on residential aged care. If you ask any Australian if they dread moving into a residential aged care home, most of them will tell you yes. There's something that we're doing that isn't right. I would separate innovation and technology and I would really refocus on knowledge innovation and technologies, knowledge technology.

So starting from scratch, there seems to be a lot of Band-Aids and when I first started there was a thing called Snoezelen rooms. Does anyone remember those? And all around the world, I go into each of these poor homes, these providers have invested lots of money in what used to be considered a great idea and they're now being used as storerooms and that's almost across the board, every one I visited, I think anyone who has had experience will agree. And that was a big investment industry made into innovation because we were told by really great technology people and some researchers who wanted to research it, that this was going to be really wonderful, that people could connect, they could have this immersive experience and it's almost like industry can be sitting ducks sometimes. Sometimes sitting ducks for research agenda, for people trying to sell us something, for people telling us we have to have evidence-based aged care.

Even if one of our clients wants something like consistent in staffing, we will find a researcher who will say, well, you need the evidence. But in residential aged care we say, no, actually, this is what the client wants. I'm not going to keep referring to the red wine and the pizza, but at the end of the day, looking again, I think now is the time for Australia to come together and to say how do we want to grow old together. It's that sort of innovation, going right back to the baseline, not tinkering around the edges with robots –and none of those things are wrong, they are all brilliant and fantastic ideas, but they are still all serving to put a band aid on a problem, a deeper problem that I think – wouldn't be exciting if it's Australia that had that conversation. How do we want to grow old together and how can we not dread moving into residential aged care. What might that mean. Starting innovation from knowledge and then getting back into the other parts of technology and innovation. That's my thoughts.

COMMISSIONER PAGONE: Thank you.

MS HILL: If there was a standard, Ms Greenwood, or technology was embedded into the Aged Care Quality Standards, is it your view that approved providers should be sanctioned or should be challenged where there is a failure to comply?

MS GREENWOOD: I think it's just 2020 and I think there should be no licences given out to people who don't commit to a technology plan, and to say, well, this is how we are going to keep records, this is what we're going to do. I mean, again, I'm talking about RAC, so why would you give a licence to someone – why are we still giving licences to people who are going to build areas for people living with dementia that we know they're going to get distressed in. Why are we still handing out licences to bad design when it's not even more expensive, and these are the people that are going to get drugged.

It's not the same thing living in a long corridor and living in a smaller home. If you have got a dementia you will have a much higher chance of being drugged in that environment, and I can kind of track your mobility based on your room number, how far you are from the dining room. So I would say do not give licences to people who don't commit to what we already know at least around design and around technology, and it would – I think it should be so embedded in the funding and how aged care reports will be reporting indicators. We shouldn't be taking paper-based versions of that. We do need to find a way once and for all to make that electronic. Then it wouldn't have to be standard.

Aside from it is heartbreaking to work on, because all the organisations that I work a double shift on the floor with carers before we do any work, and to go to a part of the building and to have a carer say to me, "Don't do your documentation there, that's a dead spot". Ad I say, "Excuse me?" So they can't even put data in. I would just say when we have all these wonderful ideas come in, I think the cynicism in aged care isn't cynicism it's a recognition that we have just wrenched 15 human beings out of bed because we can't even successfully navigate a flexible breakfast for real in, I would say – and these are the same staff who are waking residents up two hourly in the middle of the night, putting their hands down their pants. This is the same organisations that cannot arrange for older people to have as fewer people as possible having access to their naked bodies.

So when I do hear about all the innovation I think about what it's like to do the night duty that I did a couple of weeks ago, and watched people wake people up to check continence. When I watched them run in the morning to get them up for breakfast even though the organisation advertises flexible breakfast. So innovation is one thing, but having consistency in the people having access to your naked body, if you can help industry with flexible breakfasts, you have done half of the job, and having consistent staff and flexible breakfasts. These are the basics that industry are getting wrong; a really well-meaning industry.

So when we see this, it looks great but my heart and my memory is of who was woken up that morning who didn't want to wake up. And it's usually the people who aren't using words. They can't enjoy co-design. I stand in solidarity with those people who don't use words, who can't speak before you, and the carers who support them who often have to override their preferences for – because of institutional routines or because somebody's family might get angry at them because Mum is not awake. So I think those kind of solutions can happen first in terms of innovation,

knowledge innovation, and then support that through all of these wonderful amazing people.

MS HILL: Ms Buckley, how do you balance out a matter which Ms Greenwood raised earlier, which is the need and – the need for families to be provided with information about their loved ones and the desire of the families to have information about their loved ones with balancing the older person's rights and right to privacy within a community care setting?

MS BUCKLEY: Yes, gee whiz. That's a big – that's a big question. I guess for me it is around consent from our client themselves. So it is about – so even we have a client portal that has a lot of information about services, a lot of information, and the clients can access that information about their – about who is coming that day for their services. They can tell us also about what – they can list all their appointments for their whole life on the portal as well so that we don't roster over their very important events in that week. They can look at their budgets. They can look at – make complaints, give feedback. They can pretty much interact with us on that portal as well as just using voice.

So what we have done is we've also now allowed the family to participate but that really is at the consent of the client. So if the client says no, then the family may not – they just don't get access but if they do, they have created a lovely little environment where family and clients and us can all talk together about the care and their needs but it really just comes down, as it should, to the client's decision about what information their family see unless, of course, they don't have the cognitive ability and their family have an enduring power of attorney – enduring guardianship, then that's a different story. Does that answer the question?

MS HILL: Yes, thank you. Ms Buckley, do you think that there should be sanctions or consequences for approved providers who do not – if there was a standard or technology was embedded into the standards of the Aged Care Quality Standards for failure to comply?

MS BUCKLEY: Yes, okay. Well, I guess if there was – I guess if it becomes a standard, I think I mentioned earlier that it is probably not the first step. It may be what is the future that we do have some – have a minimum standard. Right now we need to help organisations get to that point so just imposing a standard right now would probably be a little bit of a disaster and if it was going to be serious consequences, if you didn't meet that standard then that would just put more and more pressure on providers who are already at a very, you know, at a very difficult point at the moment in operating services and just with all the, you know, with the requirements that have come down over these last two or three years. So I think in future state that may be reasonable.

MS HILL: What about what Ms Greenwood suggested, just stop giving out licences to approved providers that aren't up to scratch?

MS BUCKLEY: I think it is more than technology, though. I think it is about a bit more of a rigorous process in being able to apply for an approved provider and some evidence around systems and structures and processes and that that actually – you know, even potentially that the commission actually to and – I mean the safety agency go and have a look at that provider and possibly even audit them before they come in as an approved provider but much more stringent controls right at the beginning of the application but not just about technology. I mentioned earlier with our residential facilities they don't have a sophisticated client management system, they use technology – we use technology in our quality systems and our reporting systems and smart technologies and sensors but they provide a wonderful service.

So it's not just about – technology doesn't mean if you have technology you're not providing a wonderful care and support. So I don't think it's one or the other. So I'd be a bit careful to go just because you don't have that piece of technology you are not providing the best life you can for our residents; that doesn't make sense to me.

DR PETROVICH: But Daniella made a great point about the fact that, you know, buildings are being built which we know are not enabling, and yet these are places that are being funded to be built. And you think why is that the case. You know, it should not be allowed. I totally agree.

MS GREENWOOD: I think it's that attitude of we are nice people and we're doing lots for the residents. Wait a minute, you can't be grown-ups and have a market-based aged care industry and get away with saying that. You either have the technology, you build the right buildings, or you can't do business. I mean, we've got – what is it, something like a four to one ratio of people applying for beds, to people who are actually getting them. So if there's 4000 applicants, only a thousand will get it. We're not short of people thinking that this industry is lucrative. So I think to put a few more really just sensible boundaries – definitely that's not it but you can't enter the game unless you have this and this, because this is how the government want to communicate with you, and this is how we check things are being done and this is the expectation and the build. If you're going to say people living with dementia are here, there's certain things that we know for a fact work. So you can't build new buildings without that in mind.

MS HILL: Professor Gordon, would you like to share your insights into the comments that have been made?

PROF GORDON: Just reflecting on what the others have said. Certainly any integration and embedding of technology is going to take time. We've talked about the varying maturity across organisations. So there would need to be a transition plan, if you were going to actually have a standard in place around technology. Other accreditation processes that I've been involved in, or standards processes, if you don't meet it and you do have a plan that you're going to implement over one to two years to bring you up to a minimum standard of technology, might be one way of addressing it, I think, in terms of that.

I think Daniella raises some really good points and that is about the fact that we do have many aged care providers where the environment is very old. You know, some of the aged care providers are using facilities that were built 50 years ago that might not necessarily have been fully refurbished, and so we do have an issue about that,
5 even in terms of incorporating technology that we are talking about today, but also in providing best practice care. So I guess they're my reflections.

MS HILL: Ms Greenwood raised the question about how do we want to grow old and how technology and innovation figures in the answering of that question.
10 Starting with you, Dr Petrovich, could I ask you to tell the Commissioners is that question, "How do we want to grow old?" is that at the forefront of the work that Dementia Australia is doing?

DR PETROVICH: I think at the forefront of the work that we do is what our
15 consumers are telling us. So we listen to the people – sorry, the people living with dementia and their family carers and we ask them what it is that they want to see, and we actually had earlier – not this year, sorry, last year, we had a summit where we asked people what they saw as quality aged care for them, and the questions are very much, well, what you would expect, really. People want to have the best quality of
20 life that they're able to at that point, whatever that is at that time. So, you know – that's such a broad question. It's really hard to answer, but it is meeting the best quality of life that you can with the – under the conditions that you have at the time.

MS HILL: Ms Buckley, in your role as the CEO of Feros, are you having
25 discussions with families, with older people about the types of lives that they want to lead at this stage of their life?

MS BUCKLEY: Absolutely. That is the, I guess, the fundamental, it's the platform of our model of care. So we – our focus is and our mission is to help people – we
30 say to help people grow bold, and what we really mean in our aged care setting is that we want people to stay – you know, have the ability to stay independent, socially connected and living the best life they can for the rest of their lives, and that is an individual aspiration and there's no – and you need to understand what an individual wants and what does living your best life mean, and so for that to occur then we need
35 to, when we're – when we first meet that individual and we go on a journey with them is that we unpack what their goals are, not just for their health, but also, you know, what they are wanting to achieve for the rest of their lives, and that can change as they may get better or well and they may start to be more independent and so it's an ongoing discussion about their goals when we meet with them.
40
Their next set of goals. What's next for them. What's next for them, and so it's – and so at our reviews, it's what is your new – you know, if you've got new goals, what are they and let us help you achieve them, and so that is pretty much our – I guess our philosophy of care. We've got a – still got a long way to go, but it's
45 something that's very passionate within our organisation, our corporate – our company values are based on that and that's what keeps our staff with us, because they know that that aspiration of ours is genuine.

MS HILL: Ms Greenwood, looking at it from the rights-based lens that you've taken the Commissioners to in the course of the morning, how can the rights of the older person in technology and aged care intersect such as to answer that question,
5 "How do you want to grow old?"

MS GREENWOOD: I think we could all start from that – from the baseline and interrogate the very premise of what we're doing. The judgment, the clinical focus in residential aged care, the bossing people around for their own good, the
10 paternalism, all the things that we secretly fear under a behavioural paradigm of judging people. Maybe we could throw that all up in the air and see what happens when we put that rights-based lens on, which is at the forefront of every question, not managing people's deficits and seeing old age as a blessing, and dementia may not be a natural part of ageing, but it's certainly a natural part of our human story at the
15 moment, and we'll never be the same, even if they cure it next week. It's changed us forever.

So it may not be a natural part of ageing, but it's certainly a natural part of being human. Are we going to create communities that stop judging people and drugging
20 them and telling them to control and manage other people. None of us would want that for ourselves. None of us. And making sure we have rules around what – how – who can tell a person what to do, and just because people change address, I think we need some really clear principles drawn from rights-based instruments like the Convention on the Rights of Persons with Disabilities, some of those key principles
25 around how we protect people. We can't just give up on them and say they've fallen through the cracks, because they can't consent. We have got to do better and we can.

MS HILL: I'll conclude by asking each of you the same question, and I'll start with you Professor Gordon. What's the first step? What should we be doing as an
30 absolute priority?

PROF GORDON: That's a toughy, isn't it. As a first priority. Coming back to technology, supporting better quality of care and outcomes, it is that we need – we do need a conversation. We need a way of bringing together the information, the
35 technology, the evidence that we have and from that crafting what is going to work for our aged care sector. Now, whether that's a research centre, whether that's a collaborative, a cooperative, what that looks like, but we do need to understand the consumer's perspective, the aged care provider's perspective. I think that's where I would start.
40
MS HILL: Ms Buckley?

MS BUCKLEY: I think I've mentioned it a couple of times before, so – and I think the Aged Care Industry Council has said it in their road map and we just need to
45 understand where we are at as an industry, what are the – what is our maturity and our digital literacy so that we can then go, "Okay, this is where we are. Now, let's

set ourselves a vision – a shared vision. The government is behind us", and then we work out where we move from there.

MS HILL: Dr Petrovich.

5

DR PETROVICH: Yes, look, I would agree with Jennene. It's – I think the starting point is really understanding what people want – and that's the end consumer wants, you know, going to them and asking them what it is that they see that they want from technology and their quality of life and then from there we would look at workers
10 and the industry and take it forward from there.

MS HILL: Ms Greenwood, last word.

MS GREENWOOD: I would say I think we need to start again and I think we can
15 throw it all up in the air and work out moving beyond judgment and asking staff to separate from their own humanness when they have these professional clinical relationships. We are putting staff into a system that trains them around dementia, to judge people – did you know you're my first dementia trainer?

20 DR PETROVICH: No, I didn't.

MS GREENWOOD: Many years ago. I think it was your first day.

DR PETROVICH: It was.

25

MS GREENWOOD: Okay. Anyway, that's another story, but I've been through the training as a personal carer and I'm here to say it doesn't set people up to win. It doesn't set people up to treat older people well or people with dementia well. It sets us up to judge them. It really does, and cannot have a right – unless you have rights
30 come into that, you really need to support that deeply relational work that is people as equal citizens. Just human beings, hanging out with each other. I think that clinical focus, the judgmental focus is what we need need to move beyond, if we really seriously want to change this.

35 COMMISSIONER PAGONE: Thank you very much. That was an extraordinary session and no doubt in no small part due to you, Ms Hill, your questioning, but thank you for being so fully engaged, so open with your views and thoughts. We've learnt a great deal from what you have said, and a conversation will continue and the reflection will continue. So thank you very much. Listen, do I need to release
40 anybody?

MS HILL: No.

COMMISSIONER PAGONE: No. Thank you, you are all free to go. We will
45 adjourn until 2 o'clock.

ADJOURNED **[12.35 pm]**

RESUMED **[2.01 pm]**

5

COMMISSIONER PAGONE: Mr Rozen.

MR ROZEN: Good afternoon, Commissioners. I call Barbara Hamilton Ramsay.
10 Hello, Barbara, can you hear us okay?

COMMISSIONER PAGONE: It seems that we can't hear her, though.

MR ROZEN: I think we have still got you on mute.

15

MS HAMILTON RAMSAY: On mute, yes.

MR ROZEN: No, we have got you now. Thank you. If Ms Ramsay could please be sworn.

20

BARBARA HAMILTON RAMSAY, SWORN **[2.01 pm]**

25 MR ROZEN: Now, for the purposes of the transcript here, could you please state your full name.

MS HAMILTON RAMSAY: My name is Barbara Alison Hamilton Ramsay with an A.

30

MR ROZEN: Thank you. And I took the liberty of calling you Barbara before but I should clarify that that's okay with you.

MS HAMILTON RAMSAY: Fine, thank you.

35

MR ROZEN: And if you need to, please call me Peter. Now, Barbara, you live up on the Gold Coast.

MS HAMILTON RAMSAY: Indeed, yes.

40

MR ROZEN: And is that where you spent all of your life?

MS HAMILTON RAMSAY: No, no, no, northern New South Wales, a little town called Casino.

45

MR ROZEN: Yes.

MS HAMILTON RAMSAY: On the railway line. But you're in Adelaide, you wouldn't know.

MR ROZEN: Well, you are just north of the border now, I think, aren't you?

5

MS HAMILTON RAMSAY: Yes, I was south of the border before, yes.

MR ROZEN: So you are in – is it Robina? Is that how I pronounce it?

10 MS HAMILTON RAMSAY: That's indeed, yes, Robina.

MR ROZEN: And how long have you lived in Robina?

MS HAMILTON RAMSAY: Nearly 20 years now. Going on 20 years. 19,
15 probably.

MR ROZEN: And do you have family living up there near you?

MS HAMILTON RAMSAY: I'm very fortunate, currently I have a daughter and
20 son-in-law temporarily living with me until they get their own place. And I have a married daughter with two children. She and her husband actually live not far away. So I'm very fortunate.

MR ROZEN: Terrific. So you have two grandchildren; is that right?

25

MS HAMILTON RAMSAY: Yes, yes.

MR ROZEN: Wonderful.

30 MS HAMILTON RAMSAY: Don't see them much any more, so I'm grateful for the virtual senior centre because I don't get their company any more.

MR ROZEN: All right. Now, I know you are itching to talk about the virtual senior centre, but I will get to that in a moment, if that's all right.

35

MS HAMILTON RAMSAY: Okay, yes.

MR ROZEN: So can you tell the Commissioners a little bit more about yourself. You live on your own or currently with your - - -

40

MS HAMILTON RAMSAY: Normally I live on my own. I have for a lot of years, but currently – my daughter was married at the end of last year and she and her husband are here until they get their own place.

45 MR ROZEN: Right.

MS HAMILTON RAMSAY: They're saving, of course, and they want to go – he's a surfer. They want to go and live at Coolangatta.

MR ROZEN: Right. Okay.

MS HAMILTON RAMSAY: So they're here until – and I've got to say, I'm very grateful for the company. I don't see much of them, but the company is good.

MR ROZEN: Yes. And did you have work outside of the home when you were younger?

MS HAMILTON RAMSAY: Yes, I've been a school teacher.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: I've had two families. I've been councillor in local government. I have been involved with the PNC in New South Wales. I've had a pretty busy life, an enjoyable life.

MR ROZEN: It sounds it. And you are now retired and you receive some aged care help at home; is that right?

MS HAMILTON RAMSAY: I have a home care package. I am so grateful and very fortunate. I have a carer twice a week comes and helps me with housework and also takes me out, helps me with some shopping, takes me wherever I ask them, actually. It's really, really good. Gets me out of the house. You've got to be independent. You can't depend on your family. They're busy. So I'm extraordinarily – I have suffered quite acutely from depression, and this has helped enormously, as well as a few physical things. So this has happened – this has helped enormously.

MR ROZEN: And Barbara, can you tell us what level of home care package you are on? Do you know, whether it's - - -

MS HAMILTON RAMSAY: I think it's a 3. I think it's a 3, yes. Yes.

MR ROZEN: Right. And have you - - -

MS HAMILTON RAMSAY: Because currently I've got six hours a week. I have two bursts of three hours each, so - - -

MR ROZEN: All right. Now, you mentioned a moment ago the virtual social centre and I'm going to ask you a little bit about that in a moment. Before I do, though, I should have asked you, how long have you been in receipt of home care services?

MS HAMILTON RAMSAY: Come on, now you've put me on the spot. Not all that long. I received my package last year because I had some help before that, after I had knee operations. I had some help with housework and so on. And I got the home care package last year.

MR ROZEN: Right. And that's through Feros Aged Care; is that right?

MS HAMILTON RAMSAY: No, no. Barbara, I'm – I went to Wesley. I'm actually a Christian and I thought perhaps Wesley might be Christian. Wesley's foundations are Christian but that's fine. So I went to Wesley. I didn't go to Feros but I've been involved with the technological part of Feros for some years.

MR ROZEN: I see. Do you want to tell us about - - -

MS HAMILTON RAMSAY: I was involved with them before I got my home care package.

MR ROZEN: And what was that involvement?

MS HAMILTON RAMSAY: Well, with the virtual – what's called the virtual senior centre then, it's now the virtual social centre. That was my involvement.

MR ROZEN: Yes. And so okay, maybe I was a little bit confused. The access to that technology is not part of your home care package?

MS HAMILTON RAMSAY: No.

MR ROZEN: No ,it is not.

MS HAMILTON RAMSAY: No, it's separate altogether, no.

MR ROZEN: I see. Okay. And how did you come to be involved with Feros?

MS HAMILTON RAMSAY: Look, you ask me a real question now and I can't remember how I got involved, but I've been to meetings there. They've collected me to go to meetings and I really don't know. I wish I had known you were going to ask that, I would have researched it.

MR ROZEN: That's all right.

MS HAMILTON RAMSAY: But (a) I can't remember and that's the old age territory I'm in. I really – maybe somebody – I went on Feros trips because a friend introduced me to that and it could well have been through that.

MR ROZEN: Okay. All right.

MS HAMILTON RAMSAY: Through going on social outings with Feros, that was my connection with Feros and then the next step would have been into the virtue part.

5 MR ROZEN: Okay. And are you able to drive, Barbara?

MS HAMILTON RAMSAY: I still have a lovely old Mazda in my garage that my daughter thinks I should get rid of. But I can if I need to. I don't drive a lot any more but I was in the country, so I've been driving for a lot of years and I am still
10 compos mentis. So I drive if I have to. I don't drive unless I have to these days. I don't choose to.

MR ROZEN: All right. Well, that brings us to the virtual social centre. Just in your own words, Barbara, could you tell the Commissioners what that is?
15
MS HAMILTON RAMSAY: It is the gathering of older people, of seniors, for areas in instruction, physical movement, some challenges, which are good to keep us mentally well, and it's in this forum of – with a tablet and we have a presenter for the various sessions and the sessions are quite varied, which is wonderful. We've had –
20 there's art. You can dabble with art if you want to.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: Dabble – you do Tai Chi if you want to. I love it.
25 They've actually called one session Chair Chi. Chair Chi. Say that one quickly. And we sit and that suits me because I'm a bit wobbly with the walking stick. So I sit in the chair and I do the Tai Chi. I love it. There's meditation. I don't do that much but – currently there's a presenter who takes us places, you know, virtually, which is great. What have I missed out? I don't know, but I can't think currently but
30 – there's a book club.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: You can join and, you know, have a virtual book
35 club, that's what it is. I love it. Am I allowed to say why I particularly – I mean, do you want me to say why I particularly like it?

MR ROZEN: I do, please.

40 MS HAMILTON RAMSAY: Well, (a) sometimes it gives me a reason to get out of bed; (b) if you are lonely – okay, I have these two currently living with me but that hasn't been for long and, you know, I've been quite lonely. It's lovely to have someone call you by your name in the morning when you do – I like doing some exercise, come downstairs and do some exercise.
45
MR ROZEN: Yes.

MS HAMILTON RAMSAY: First thing in the morning, when I'm awake enough. And that's quite personal. That's – I find that very cheerful and that helps me a lot because my days are a lot better if I start them off in a cheerful way. So – and it's instructive too. There's a couple who are living at Lightning Ridge at the minute and they come on and last session they went for a swim in the mineral pool and so on and told us about the opal mining out there and I find that very instructive. So it's helped me a lot. It's helped my demeanour. It's instructed me, you know, it's very – and it's – I now do my banking on my phone.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: I wasn't very good with technology and my daughters don't have time to help me. They help me occasionally, if you ask enough times they will help you but they're busy. So, you know, they've got their busy lives. So I've found this has helped me a lot with technology. Help is just a call away. We've got a place on the screen where we can get help whenever we want it and there's somebody there who can, if we've got a hiccup, they can iron it out for us. Micaela has helped me with questions I've asked her about technology. Justin has. So it's helped an oldie who wasn't very familiar with a lot of things. It's helped me a lot.

MR ROZEN: Thanks Barbara, that's really helpful. You have got the tablet there handy, have you?

MS HAMILTON RAMSAY: Yes.

MR ROZEN: Can we have a look at it?

MS HAMILTON RAMSAY: Yes, sure. What would you like? Do you want me to put it on to something?

MR ROZEN: If you wouldn't mind, sure.

MS HAMILTON RAMSAY: So that's – I will go back one and I will just show you. That is – you go on and then there's various things usually there. That one is evening meditation. Here, we've got French for beginners. I forgot to mention that. Really lovely Italian guy gives that one, he's very enthusiastic. Then there's healthy life, sorry, program coaching, yes.

MR ROZEN: Barbara, can I ask you, so the presenters of the various sessions, where are they? Are they in at Feros, is that how it works?

MS HAMILTON RAMSAY: At Coolangatta. They're in a studio at Coolangatta.

MR ROZEN: Right.

MS HAMILTON RAMSAY: As far as I know. I'm not absolutely sure but that's where – I have been there, I have been there for meetings and there's a studio there.

There's also a studio at the offices at Coolangatta. There's two venues and then what they do quite a bit is, somehow or other, don't ask me about this technology because I don't have to know, but there's a camera goes home with the person. So at one stage, last year wasn't it, we had a person on a farm up near Dorrigo who was showing us her goats and chickens, and – it was wonderful, you know, just like this couple that are at Lightning Ridge now. That was pretty special. When we had the Lightning Ridge thing, there was somebody in Western Australia who had joined in. To this old duck, that was something pretty special, you know, to think we can be connected like that.

MR ROZEN: And when are they going to ask you to be a presenter, Barbara?

MS HAMILTON RAMSAY: They're not. I can talk a lot.

MR ROZEN: And so the gadget you have got there, that's obviously provided to you by Feros; is that right?

MS HAMILTON RAMSAY: That belongs to Feros, yes.

MR ROZEN: Yes. And is there any charge for that, for you?

MS HAMILTON RAMSAY: No.

MR ROZEN: Okay. And do you - - -

MS HAMILTON RAMSAY: I have not spent a penny for – you know, Feros have done everything that needs to be done.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: Even provide – when we did dot painting, even provided us with the stones to dot paint on and some paint. When I've done exercise in the past and Tai Chi, they've provided the bands to do the stretching. So they've been amazing. They've really been good. They've accommodated us clients or participants very, very well.

MR ROZEN: Now, speaking of the dot painting, Barbara, you're not telling the Commissioners the full story about the dot painting.

MS HAMILTON RAMSAY: Do you want to know who the tutor was?

MR ROZEN: No, I'm wondering what happened to your dot paintings after you finished them.

MS HAMILTON RAMSAY: My dot painting ended up going to China, which was lovely. I was given by a Chinese dad a picture of his – he's a great traveller and he went to Tibet, so they took a photo and framed it for me because I had given them

my dot painting and they took that back to China. They thought it was special. So I thought that was pretty good.

MR ROZEN: Yes, I see. And when you got the tablet that you are holding for us – you can put it down, it's probably pretty heavy. You can put that down, Barbara. Did some people from Feros come out and help you with some training?

MS HAMILTON RAMSAY: Yes, yes, yes.

MR ROZEN: And can you tell the Commissioners about that please, what did that involve?

MS HAMILTON RAMSAY: Well, just coming here. I'm at Robina, they're at Coolangatta. Linking me into the, well, virtual social centre as it's called now, showing me what buttons to push, you know, this and that. I didn't have a tablet. I haven't – I've had a computer in the past. I don't even have a laptop at the minute. But just showing me what I've got to do and how to operate it and just making me feel comfortable using it, which I do, you know, I feel quite comfortable now using it. Don't even think about it. Just get it off the shelf and I sit at the round table on the desk usually and use it. Leave myself room to move when I've got to move and I don't think twice about using it now. So, you know.

MR ROZEN: And we have got a little clip which has been provided to us by Feros, which shows a little bit about the device in operation, the social centre in operation. I might ask for that to be played now and then I will ask you some more questions.

MS HAMILTON RAMSAY: Certainly.

VIDEO SHOWN

MR ROZEN: That's it. Hi Barbara, were you able to see that at the same time we were watching it?

MS HAMILTON RAMSAY: Yes, there were things I forgot to tell you about.

MR ROZEN: You didn't tell us about meeting the emu. Or maybe it was the cassowary, was it?

MS HAMILTON RAMSAY: I don't know. I don't know about the emu or the cassowary.

MR ROZEN: It looked like a virtual trip to a zoo or something.

MS HAMILTON RAMSAY: That was – yes, okay. Remember the memory and the age, yes.

MR ROZEN: Got it. Now, you told the Commissioners a little while ago, Barbara, about how being comfortable using this tablet had led you to - - -

MS HAMILTON RAMSAY: Yes.

5

MR ROZEN: - - - be able to do other things on the internet, like use internet banking.

MS HAMILTON RAMSAY: Yes. Yes.

10

MR ROZEN: Are there other - - -

MS HAMILTON RAMSAY: I'm so grateful for that.

15 MR ROZEN: Yes, and how – from your point of view as a person, how has that made you feel, the ability to use that technology in that way?

MS HAMILTON RAMSAY: We used to – I used to have to get to Robina Town Centre, because I'm Commonwealth and Westpac, and you had to queue, which with
20 my legs isn't that much fun. The bank was upstairs in those days, and wait, you know, it was a special trip and everything. Now, I just put my – I refine my bills as much as I can and I just write on the calendar when it's due and then get my phone out and away I go. And, you know, it's wonderful. I'm very grateful for that. And what else – you know, I've – because of age I've refined my life as much as I can.

25

MR ROZEN: Yes.

MS HAMILTON RAMSAY: So that's helped me enormously.

30 MR ROZEN: And does it make you feel, I suppose, more in touch with the modern world? Is that one way of describing it?

MS HAMILTON RAMSAY: Well it makes me feel a bit competent - - -

35 MR ROZEN: Yes.

MS HAMILTON RAMSAY: - - - because that's something else you lose with old age. You feel inadequate quite a bit, and that I haven't got to ask my children. I haven't got to ask for help, because I know what to do now. Feros has helped me a
40 lot in that way. I'd rather ask these people here than my kids sometimes, and that helps me a lot, you know. Helps my mental state quite a bit.

MR ROZEN: And are there any things about the app that you think could be improved? Is there anything about the virtual social centre that you'd like to see?

45

MS HAMILTON RAMSAY: Just the variety of programs continues, because it is good to – when you're old to have your intellectual side, you know, kept alert. I

really like that. And the physical side I need, so I'm very grateful for that. But I guess I'm one of – you know, like all old people, my needs are similar to other old peoples'. So the healthy cooking and everything is good to keep me healthy. I enjoy having a naturopath, or something like that. We have had it in the past. Maybe even something to help us a little bit with the jolly – I won't say rot, that's going on at the minute that's in the supermarkets, keeping us up to date with some of the news about the health situation at the minute. That mightn't be a bad thing to give us.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: To make us feel comfortable and safe. You know, I think they do a pretty good job. So there's – I don't want for anything on the virtual social centre. There's nothing, because with catch-up – I didn't mention catch-up. Catch-up is wonderful. I can't do the session – or there's a session – say there were a session running now, I can't do that. Okay, I can watch that at my leisure with catch-up. So that's great. I can sit and hide if I want to and do the exercises that maybe I would have been doing now, or watch the healthy cooking that I may have been missing out on now. So that is a very good feature for me. Plus the fact that it's company, if you're by yourself.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: If you get sick of watching television or Netflicks. You can watch something on that, and you're watching people talking and you're doing something as you're instructed. So that's pretty good.

MR ROZEN: It sounds great. And we heard – you know Jennene Buckley, don't you, from Feros?

MS HAMILTON RAMSAY: Yes.

MR ROZEN: Ms Buckley, we had her - - -

MS HAMILTON RAMSAY: Yes.

MR ROZEN: She gave evidence earlier today in the hearing, and she referred to a program called Let's Get Technical. Are you familiar with that?

MS HAMILTON RAMSAY: Yes. I know it. It's coming up. That I will be – I'll book into it, because we have a way – you know, we book into a session and then we get a text to remind us.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: They're great. They realise we forget things.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: So they send us a text that we have it coming up, so we've got no excuse to not watch it when we've booked in, so I'll be in that one when it's up shortly.

5 MR ROZEN: And what's the attraction?

MS HAMILTON RAMSAY: Unless I've missed one.

MR ROZEN: And what's the attraction of that?

10

MS HAMILTON RAMSAY: What's the attraction of - - -

MR ROZEN: Yes.

15 MS HAMILTON RAMSAY: The Let's Get Technical?

MR ROZEN: Yes.

MS HAMILTON RAMSAY: I want to stay abreast of what's going on, within what
20 I can do, within what's – within my possible experience. That's what's of interest to me.

MR ROZEN: Yes. Jennene told us - - -

25 MS HAMILTON RAMSAY: I don't want to miss out on things, unless I've got to.

MR ROZEN: Yes. Jennene told us that as far as she was concerned a lot of older people, such as yourself, were hungry to learn about technology. Do you agree with that?

30

MS HAMILTON RAMSAY: Yes. Yes. Yes. Well, as I've said to you, my family don't have time to teach me. I love my family, don't get me wrong, but everybody is so busy these days. So great, here's a forum where I can learn things, which interests me a lot, because the other one – the other workshop that Jennene referred to, I very
35 much – I hope they repeat that, because I will join in.

MR ROZEN: Now, we know, Barbara, that not all aged care providers have a facility like this, but it would seem to be a pretty good idea, especially with how enthusiastic you are about it. How do you think it could be made more widespread,
40 this sort of part of aged care?

MS HAMILTON RAMSAY: So are you suggesting that there should be more providers than Feros doing this sort of thing?

45 MR ROZEN: Yes.

MS HAMILTON RAMSAY: Is that what you mean?

MR ROZEN: Yes. Do you think there would be - - -

MS HAMILTON RAMSAY: Well, I think it's beneficial. I think there are many
5 people who don't know about Feros.

MR ROZEN: Yes.

MS HAMILTON RAMSAY: I know Feros is looking into expanding in various
10 ways, which is great, to meet more needs of different people. I think this would be good with other providers. They'd need to well and truly canvass their area to find that the interest is there. That would need to be done, and yes, I think that a lot of oldies in inverted commas, could benefit from this. I guess I'm in the – some people are very savvy, some older people technologically, but I haven't been in that field,
15 and I think there's a lot like me. They, sort of, think it's too hard and they don't bother about it. You see these ads on TV and everything about all the stuff that's available and you think, "No, I'd never do that. Too hard for me".

MR ROZEN: Terrific.
20

MS HAMILTON RAMSAY: So this has helped me enormously, you know. Feros has.

MR ROZEN: Thank you. Alright. Commissioners, they're the questions that I
25 have for Barbara.

COMMISSIONER BRIGGS: Mrs Ramsay, it's Lynelle Briggs here, I'm one of the two Commissioners. It's terrific to hear what you've been learning and doing. I'm wondering, do you feel like you've made new friends through the use of the
30 technology?

MS HAMILTON RAMSAY: Yes, except I'm not a good one to ask that question, because I've had a few health issues that have, sort of, kept me not in the social scene. I've had to stay at home a bit. I'm on the mend now, and I do know I
35 know some people through the – you know, through this, through the social centre, and had I not had the interruption with health, I think I would have met more, because as – I can chat on this forum if I wish to. Now, I'm just getting back into it, I will do that. I will – you know, I will become more social, I will put it that way.

40 COMMISSIONER BRIGGS: Does the chattering involve actually talking, or do you do it by typing in? How does it work?

MS HAMILTON RAMSAY: No, no, no. Face-to-face.

45 COMMISSIONER BRIGGS: That's what I thought.

MS HAMILTON RAMSAY: We talk.

COMMISSIONER BRIGGS: Yes. That's terrific, isn't it?

MS HAMILTON RAMSAY: Yes. Yes. Yes, it's great. You see each other. You
5 see your lips moving. You know, just like you're seeing me. We do that. As though
we're sitting in the lounge room together, but we're not.

COMMISSIONER BRIGGS: And do you have to make a payment for the
availability of the technology or how does that work?
10
MS HAMILTON RAMSAY: No, Feros has been amazing. I have not contributed –
other than my time, I haven't contributed any finance at all.

COMMISSIONER BRIGGS: Terrific. Thank you very much.
15
COMMISSIONER PAGONE: Mrs Ramsay, thank you very much for making time
available to share your experience with us. It has been very, very interesting to hear
how you are using that and how the facility is being made available to you. It has
been really good. Thank you very, very much indeed.
20
MS HAMILTON RAMSAY: Okay.

COMMISSIONER PAGONE: I think we will adjourn for - - -

25 MR ROZEN: Thank you. Reconfiguring.

COMMISSIONER PAGONE: - - - reconfiguring.

MR ROZEN: Thank you.
30
MS HAMILTON RAMSAY: Thank you for listening, Commissioners.

THE WITNESSES WITHDREW [2.30 pm]
35

ADJOURNED [2.30 pm]

40 **RESUMED [2.45 pm]**

COMMISSIONER PAGONE: Who is taking these witnesses? Ms Bergin?

45 MS BERGIN: I call Dr Grenfell, Associate Professor Inacio, Mr Lancken and Ms
York. Associate, could you please swear in the witnesses, thank you.

ROB GRENFELL, AFFIRMED [2.45 pm]

LOUISE YORK, AFFIRMED [2.45 pm]

5

MARIA INACIO, SWORN [2.45 pm]

10 **BEN LANCKEN, AFFIRMED [2.45 pm]**

EXAMINATION BY MS BERGIN [2.45 pm]

15

MS BERGIN: Dr Grenfell, starting with you, could I ask each of you to please introduce yourselves, your organisation and disclose or describe any work you may have – your organisation may have done for the Royal Commission.

20 DR GRENFELL: I'm Dr Rob Grenfell. I'm the director of health and biosecurity for CSIRO's health and biosecurity business unit. I'm a public health physician and a GP. In the past in my experience and certainly have had 25 years practically in the aged care sector through system and also direct provider care. And my role currently with CSIRO is to provide directorship for, among other things, the centre for eHealth
25 research and also the nutrition and health program.

MS YORK: I'm Louise York. I'm head of the community services at the Australian Institute of Health and Welfare. The AIHW is independent statutory authority in the Commonwealth and our legislation requires us to work with others to
30 develop, collect, analyse and discriminate data with health and welfare, including aged care, which I'm responsible for, and a range of other areas, such as disability and child protection and a range of other health areas. And we conduct our work working with Commonwealth and State agencies and also directly with service providers to compile and curate data that's then used for research and policy
35 analysis.

We're also – I thought it was just worth mentioning in the opening – an accredited data integrating authority. So we also bring together data from different health and welfare areas to create those analysis datasets. The work that we have already done
40 for the Commission over the life of the Commission involves basically further analysing data that we have published to make it more useful for the Commission. So things like looking at the distance between where someone has their aged care assessment and where they're ultimately receiving aged care services. Thanks.

45 ASSOC PROF INACIO: I'm Maria Inacio. I'm an epidemiologist, I have been working on the area of registries and population surveillance for the last 20 years, both in Australia and the US. I am the director of the Registry of Senior Australians,

which is a data platform that we develop to monitor individuals that have entered the aged care sector in Australia that was established in 2017. The idea of ROSA was to understand individuals who have entered, monitor the quality and safety of care and services that are provided to them. ROSA is currently funded by the South Australian government and is housed at the South Australian Health and Medical Research Institute, but is a collaborative of 13 organisations throughout the state including the universities, different aged care providers, some consumer representations, as well as clinicians. The work that we have done for the Commission so far last year, we provided a report on the use of psychotropic medications for individuals that were residents of aged care services both before and after their entry into services. And this year we have been – we will be delivering a report that was commissioned on quality and safety indicators of care that are monitored internationally and how Australia performs in comparison to these other countries.

MS BERGIN: Mr Lancken. Before I go to you, Mr Lancken –

MR LANCKEN: .....

MS BERGIN: Sorry, could I ask you, Associate Professor Inacio, to describe any work you have done for the Commission.

ASSOC PROF INACIO: Describe in more detail?

MS BERGIN: Mr Lancken, could you please introduce yourself?

MR LANCKEN: My name is Ben Lancken. I'm the head of transformation at Opal Aged Care. Opal is an aged care provider operating in four states here in Australia, and with my about 9000 colleagues, we have the privilege and pleasure to care for about six and a half thousand residents across our care communities. Over the last 12 months we have had a bit of a new leadership change at Opal and, from that, we are working on a significant transformation across three key areas, being culture, being customer experience and being the physical design of the built form of our homes as well. My background specifically is in customer experience strategy and organisational development, primarily in the hospitality sector and more recently in the aged care sector and my role is to lead a cross-functional team at Opal to help shift our focus to become a customer experience-focused organisation and to help and enable the organisation to live our purpose, which is to bring joy to those we care for.

MS BERGIN: Thank you. Thank you all. Ms York, perhaps if I could start with you. Could you outline the current capture of data by the Aged Care Data Clearinghouse, as it currently stands in government at the moment.

MS YORK: Yes. So the AIHW has compiled data on aged care services since the mid-nineties but since about 2013 this has all been compiled under the banner of the National Aged Care Data Clearinghouse, and in that data collection, we include

information on things like the aged care assessment program, the various programs, residential aged care, the community packages, home care packages and community home support data, primarily that – and that involves a raft of databases that are all brought together in one place and there that information is produced into various reports that we make available on our website. People can access all of those reports and other information on specialised aged care data website called the GEN website. People can request data that they – if it's not available for them on that website, they're able to request information and that's made available to them free of charge.

And we also can use the information available in all of those – about all of those separate programs to link it into larger datasets that look at things like the connection of each of those programs. So for example, we have linked data about residential aged care, home care and community Commonwealth Home Support program data with things like PBS data and Medicare data and hospitals data to look at the interfaces between those types of services and we've also supplied that data to organisations such as my colleagues, SAHMRI here today, under ethical clearance of our ethics committee.

MS BERGIN: The data collected already by the aged care clearing house, can this be used as basis for standardising metrics within the aged care sector?

MS YORK: Yes, it can. So it can be used to – I think at the moment it's used a lot to report on activity. So it's used to report on numbers of people receiving care and where they're receiving that care, it – I think it's possible to do – and it's also can be used, once it's linked with other data such as hospital data or prescription data, to look at really important safety and quality aspects, such as prescribing rates. I think it more could be done to develop those metrics that can draw on this data to get more value out of it in future.

MS BERGIN: And Ms York, you mentioned that there are some linkages at the moment between the datasets collected by the clearing house. What relevant datasets are not yet linked?

MS YORK: This year we worked with the Aged Care Quality and Safety Commission to add some service level data to their consumer experience reporting data, which was one new linkage that is possible and if that were repeated in future that could add more value to directly collected consumer experience data. Going forward, in information from the quality indicators program could also conceivably be linked in with the information we already hold about the aged care activity and other health activity. It would be possible to link in further information about, say, Centrelink aged care payments, further information about veterans' care would be a useful addition. And potentially information about compliance and accreditation activities. So things like success of accreditation or complaints, that sort of information could conceivably be linked in to provide more information about the quality at the service level.

MS BERGIN: Associate Professor Inacio, could I ask you to respond to that, and in particular as a user of AIHW, could you comment on your experience and your experience of the linkages between datasets.

5 ASSOC PROF INACIO: Yes. So I think there is a lot of enormous amount of information on the datasets that are currently held by the Australian Institute of Health and Welfare and also that are held by other individuals and, brought together, we can examine a lot of things that we haven't, things that we have spent a couple of years already at ROSA trying to derive and infer from the data, that is entirely
10 possible. But this year what we will be doing, for example, is trying to add information from Centrelink because the Centrelink information, I think, has the last value – the last piece of the puzzle for us.

We have been very interested in understanding the populations. Aged care service
15 utilisation, health care service utilisation, and obviously understanding the social determinants of the reasons why what is happening to the individuals in our cohort are going to be really important. And I agree with Louise that adding information about the data that's going to come out from the compliance and accreditation is going to be incredibly valuable in the future to understand performance of facilities.
20 But there is a lot of other things I think that can be of extreme value too, like the workforce information that is currently not publicly available but would be of extreme value for us to understand, as well as potentially financial incentives. So I think there is some additional pieces that we could add to this data.

25 MS BERGIN: Mr Lancken, what's your perspective, from the perspective of a provider at Opal, what's your view about the data that's currently collected by the AIHW and by government generally and what are the gaps that might be missing?

MR LANCKEN: I'd support the comments of the other panellists there, that there's
30 a lot of data being collected and, as we just heard, it's very siloed and difficult to link together. In addition to that, we think the most important thing around data is to making sure we are measuring what matters and for us that's the views of people living in our care and the families. And I think there's a lot of data around at the moment around quality of care but not necessarily enough around quality of life and
35 subjective wellbeing for those living in care. So we think there's an opportunity there for us to capture more valuable data around quality of life and subjective wellbeing for people living in care. And to make that more transparent available to enable, you know, greater consumer choice.

40 MS BERGIN: Dr Grenfell – I'm sorry, Associate Professor Inacio, did you want to respond to Mr Lancken's comment.

ASSOC PROF INACIO: I just wanted to add a clarification, though, because none of these datas that we're talking about are actually collected by AIHW. They're
45 housed by AIHW. Data custodians of the Commonwealth, the states and other bodies. So I think that distinction needs to be made, because when we go to them for requests for that information we are actually adding them as the data custodians as it

currently stands on the agreements they have to link that information to other places and I think that is a distinction that needs to be made because they are not in charge of the collection process and they also don't hold any state hospitalisation records, only in the capacity that we have asked the states then to give permission for them to link to the datasets. So I just wanted to clarify.

MS BERGIN: Thank you, Associate Professor. It's an important clarification. Perhaps I could ask you, Ms York, to describe the different sources from which the AIHW is sourcing its data.

MS YORK: Thank you, yes. So the majority, the vast majority of the aged care data all come from the Commonwealth Department of Health and we do hold several years of linkable state/territory hospital data, which can be linked but long-term hospital data resides with the states and we generally act as a curator for all of that data but then need to go back to the original source in order to get it released to researchers or, indeed, to ourselves for analysis. Medicare and – so MBS and Pharmaceutical Benefits Scheme data, we also hold copies of those data but once again need to have some approval in order to release it. And these approvals are either both in terms of the purpose meeting privacy legislation and also in terms of the source data custodian being able to discharge their responsibilities with respect to releasing the data.

MS BERGIN: Thank you. Dr Grenfell, can I ask you from your perspective to describe what you see as the purpose of data collection by a clearinghouse.

DR GRENFELL: Yes, certainly. The journey we have heard already from data, data is complex, it's very hard to look at what have I collected and the – I guess the accuracy and also the stratification of it because there are large data pools but I guess, from a provider's perspective, is what are you actually going to use that data for and does it get fed back to where you are. We have got a lot of experience in the acute sector and also the primary care sector in how to look at data and where data comes from. The domains – I tend to like speaking in plain English – about thinking about the sets that we do have financial, what did we pay for. The quality of service, which is was it any good? The efficiency really is it optimised? Delivery is what you did and workforce is who does it. Essentially are the domains that you look at.

Are they linked? No. Are they actually readily sourced or are searchable? The answer is no for that as well. So curation of these datasets is vital just as the accuracy of collection and stratification of those. The terms that we use in between this in the acute and the primary care sector, we have used things such as interoperability, that is, do the systems talk to each other. That's a technical challenge that hasn't been solved in those two sectors but certainly is one that is being worked on. And the other one is accessibility and accessibility means you actually can go through the things, such as the privacy provisions, as we talked about, and also the other governance provisions that actually occur on the datasets. So this is no mean feat. We haven't done this in any setting to perfection but we have had a long journey and learnt a lot in the acute and the primary care sectors.

MS BERGIN: One of the propositions that we are testing in this panel refers to a mandatory minimum dataset and I wanted to ask each of you, perhaps starting with you, Associate Professor Inacio, what you consider should be included within a mandatory minimum dataset. The definition that we have got refers to care, finance, workforce and quality of life. What's missing from that list?

ASSOC PROF INACIO: This is a really tough question because the data that you are going to collect needs to be – needs to serve a specific purpose. So it depends what the purpose is. If the purpose is to provide care there is a very specific number of data elements that you need to collect. If the purpose is to monitor people generally so you can kind of get a population-level understanding of what is happening and the services that are provided and the general outcomes of that population, then it is a very different dataset as well. As it is the datasets and the financial area. So in our experience in ROSA, which was meant to understand, generally speaking, who are the people there at a population level, the needs that they have in regards to their general health needs and general functional needs, as well as the outcomes that they have, yes, absolutely there is a very specific number of minimum data elements that is important to us.

From our own experience, though, a lot of these elements are already available from the assessments that are currently collected at the point of an aged care eligibility assessment at the time of entering into the care through the ACFI assessments even though there are limitations, obviously, and biases in the way data is collected at the time and then with all of the general activity that these individuals have throughout their lives, they are seen by GP 20 plus times over a year. They are – 40 per cent, you know, will see a doctor, will be hospitalised within a year. They will use ambulance services, they will use emergency department and you learn a bit about them every one of those interactions. So for us, that information is – it's actually very useful. Things that would be wonderful is that some of them would be more regularly and systematically collected. So if the assessments that are done at the residential aged care facility, for example, the ACFIs, didn't only happen after somebody had a change in health care needs and happened more periodically and more systematically, so that way we could maybe understand what are some of the potential improvements that individuals had have over time in regards to their functional activities and things that are affecting their lives.

Home care recipients don't have any assessments in place. It would be wonderful to have a – similar to a needs-based assessments that was implemented for individual that are in the home care. But there are individuals in my groups that are clinicians, for example, the pharmacists would like to see things like a ..... periodically because they will tell you more about the clinical needs of these individuals that are deteriorating or the consumers that are involved with ROSA will tell you that quality of life measures and consumer experience measures obviously would be the most important things to monitor. So those are the things I would add in addition to things that are already part of what is already existing.

MS BERGIN: Ms York.

MS YORK: Thanks. That's an excellent summary. I think that's how I see a minimum dataset, is that it's the core number of data elements that are captured as a by-product of the activity that's going on for clinical or other transactional purposes, that's useful and it's useful for looking at both the individual service provider and the system level. But it does need to be a core set of information and a lot of it is there in the system at the moment but it's not – it just needs to be more timely and linked more regularly to get a better picture.

And I think – and the regularity of assessments over time, so that you can – and potentially the quality of the information that's in there about functional status would give more information about how people are faring over time. And then I agree, information on quality of life, experience of how people – you know, personal experience, self-reported experience and more information about workforce. There are a couple of things that are missing from the current picture and quality of services, having that more regularly integrated. Yes, that's probably enough.

MS BERGIN: Dr Grenfell, do you have anything to add to that list?

DR GRENFELL: Yes, just to stretch on to this is the value proposition of the data and then also the feedback of the data. So again, just to emphasise that there are multiple facets of everyone who is engaged with those datasets as to what they want from it and what it actually delivers and I think from the Opal perspective, that's a classic example. From the client or the engaged participant in the aged care sector, is what do they get from it by allowing their data to be collected on them and about the service provision that – where it is. This is a new area. The idea in fact in acute and primary care we are looking at patient recorded outcome metrics. This is new science. But it's certainly not something we actually should move away from.

And I reflect on the previous witness that we just had, that she mentioned loneliness as being one of those and we know loneliness is an antecedent cause for ill health in the aged and to that measure, the UK government has set up a ministry for loneliness to actually look at this as a way of addressing progression to ill health. So ways of assessing things such as that, so for her, clearly, loneliness is a metric that would mean something to her. That in fact was something that we should measure. And if you are a care provider, how do you actually measure that and know where we are on a loneliness scale. So I guess, in the sense of adding to that is what's the value for where they are. As a clinician, I want to know I'm doing a good job. I want to know that I have actually achieved what I set out to achieve. As an aged care provider you are looking at financial attributes that you've in fact actually are achieving, business propriety, but on the other side that you are also providing quality metrics of care.

MS BERGIN: Mr Lancken.

MR LANCKEN: So if I could just talk broadly to, I guess, the different types of data.
Opal has done a lot of work recently in designing a new balance scorecard that looks at five domains of data, the first and most important being customer, of course,

which is the aggregation of data from consumer generated reviews online from customer services and from our feedback and complaints data. The second is our team section of data, so looking at the engagement and ongoing development and education of our team members. The third is the quality role where we look at things like our – the effectiveness of our continuous improvements and plans for continuous improvements in each of our care homes. Of course, clinical is a section where we're looking at key clinical indicators. Of course, the three national quality indicators, but some additional indicators that we've had internally for some time, as well, and then, of course, the commercial and financial realm.

So I guess they're the five key areas, you know, and certainly Opal will support a mandatory dataset that would include all of those elements, but I will just stress the importance of, you know, measuring what matters to you, which at the end of the day is the experience of the people living in care and their families, and, you know, we need to focus more on that both through more regular survey of residents, the ability to publish more transparently, consumer reviews to enable greater choice and to – for organisations to really effectively look at all of that data to help inform continuous improvement, and that's certainly our focus at Opal at the moment.

MS BERGIN: Thank you, Mr Lancken. I want to ask you a bit later about how Opal uses its data capture for those CRM objectives that you've referred to in your submission. Perhaps, first could I ask you, Associate Professor Inacio, what workforce data you'd like to see included in the minimum dataset?

ASSOC PROF INACIO: I think there's quite a bit of evidence around not just numbers, but the level of education in the staff. So that would be the two things I would say. So the actual number of workforce per number of residents bed days, as well as the level of education and training that is provided to the staff.

MS BERGIN: Ms York, can I ask you about a slightly different purpose for a dataset. Thinking about regulatory compliance, both enforcement by the Aged Care Quality and Safety Commission and compliance by providers. What can a mandatory minimum dataset be used for to achieve a regulatory compliance type end?

MS YORK: I think there's great potential of linked up data to provide information about the risks that are being experienced by residents or people using a whole range of different aged care services, but that information about things like hospitalisations, attendances at emergency department, looking at prescribing rates at a facility level of antipsychotics, for example, that information can be interpreted in conjunction with information about number of complaints or accreditation status and so on, but it would be much more valuable and meaningful if it could be risk adjusted for the profile of the people using those services, and to have information about that you need to have regular assessment according to a comparable classification, and I know that Professor Kathy Eagar has done some work in this area, and I guess that comes back to the need for information standards in areas where you are really trying to collect comparable information that assists with running services, but also feeds back

into the entire service system, is that need, and so, I guess, in essence, those – that comparable information would form an important part of a minimum dataset.

MS BERGIN: Mr Lancken, do you have a response to the regulatory compliance
5 type information and what types of data could be collected to achieve that end from a provider's perspective, and perhaps what issues that might throw up for you?

MR LANCKEN: Yes, of course. So when we talk about our role delivering whole of person care and we support the new Aged Care Quality Standards wholeheartedly.
10 When we consider whole of person care and person centred outcomes, that's the thing we need to be measuring. We need to be measuring the whole picture. So whilst the national quality indicators are of a clinical nature at the moment we think we need to add more around quality of life and subject wellbeing, we think that's important, and we think that the mechanism by which operators collect and collate
15 that data needs to be made easy. You know, we live in a world where we're in the business of people caring for people and most of our time should be spent in doing that. So we just need to be conscious of the administrative burden placed on operators, as well, if we don't get this right, and it goes to comments earlier today about interoperability and the digital maturity of the sector to support that and make
20 it easy for us to capture that data and make it available to the regulator or whoever needs it.

MS BERGIN: And how would government make that easier for providers, Mr Lancken?
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MR LANCKEN: I think the first step is going back to that minimum dataset and having a standard around data, so that operators can with confidence invest in digital transformation based on those standards, and we can have a clear path forward in terms of what that looks like, so we can build our systems to enable the collection of
30 that data, and I think anything that government can do to make it easier for providers to submit that data, whether that be direct digital interface between providers and governments, all of those things would help. I think, as well, there's a part we have to play in empowering our team members with the ability to be able to capture data at the point of care, again, to help try and reduce that burden of administration .....
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MS BERGIN: So then turning to what Opal does at the moment, how does Opal capture, for example, information about its clients or aged care recipients to measure whether they're satisfied with services in?

40 MR LANCKEN: Yes. Good question. So at the moment we do that in a couple of ways. The first is we have a very robust feedback and complaints system that we've built in our new CRM system called Gem, building precious relationships, and that's based on creating lots of mechanisms for our residents, their families and members of our care community to give us their feedback, and it gives us the ability to make
45 sure that feedback is routed to the right person in the organisation, in most cases the manager of the care community, and it gives them the ability to really practically respond and close the inner loop – what we call the inner loop of feedback, where a

resident may give us some feedback and we can quickly resolve that. The second thing it enables us to do is focus on what we call the outer loop, which is being able to look at complaints and feedback trend data across the whole organisation to identify areas for us to improve at a systems level, as well.

The second part is customer surveying and we're about to launch a brand new customer surveying technology across all of our care homes in the coming months, and that's been designed specifically to enable accessibility for older people. It's got some great inbuilt functionality to enable our residents to, as independently as possible, give us their feedback. That information is captured on an iPad, a tablet device, and is aggregated in real time to a dashboard for managers to see insight straightaway in terms of what are the things they can focus on and improve, particularly focused on the quality of life aspects of our residents' experience.

MS BERGIN: And is Opal able to use that same data to report to the Aged Care Quality and Safety Commission under the standards?

MR LANCKEN: If required, we certainly can, and when we are assessed by the Aged Care Quality and Safety Commission they do ask for complaint data as part of their assessment visits and we're able to generate that directly out of that system that I spoke about.

MS BERGIN: Yes. Thank you, Mr Lancken. Ms York, you mentioned that one of the sources of data is provider data and, in particular, data captured by providers when doing ACFI assessments. How does – can that same data be used by the Aged Care Quality and Safety Commission to assess compliance by providers with its standards in?

MS YORK: I can't answer that, I'm sorry.

MS BERGIN: You can't answer that question. Mr Lancken, perhaps if I could go back to you. You talked about the administrative work required to do translation from time to time. What work is involved in that translation exercise?

MR LANCKEN: So I think you're referring to one of the symptoms of the national quality indicators being that the format or standard by which the national quality indicators are required by government was slightly different to the way we were collecting the data internally. Opal has had clinical indicators for a long time, and internal indicators in the three areas that the national quality indicators covered, but the approach that we were taking internally to collect the data was different to that of the government. So it just meant that we had to realign our systems and processes to enable that data to be collected as part of a delivery of care and trying to avoid it being done as a manual process, and we're still working through that. So to, sort of, combine the two, so we only have one of the measures that works both for the government and our internal purposes as well.

MS BERGIN: And how long has that work been going on for?

MR LANCKEN: Well, we've been reporting since the 1st of July, so it has been a number of months. You know, we've really focused on making sure we get the quality of the data right first in a much more manual process, and we're now moving
5 more towards looking at, "Okay, how can we now integrate this back into the – you know, the a day in the life of our team and of our care homes", to make that capture, you know, easier.

MS BERGIN: And so are you searching for a standard to apply, as it were?

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MR LANCKEN: I think having a clear standard to apply is very important. We do have clear standards in relation to the national quality indicators, so that's very clear. We know there are two more under consideration, and the more advanced notice we can have on those the better. I think the lack of data standards creates a bit of a
15 barrier for innovation in the technology space, both from a provider's perspective, as we, you know, have to try and predict the future a little bit of what's going to be required and we try to future proof our investment technology, and on the other side of the fence in terms of the IT industry and their investment in product development, if there are sets of standards that are agreed on at the sector level they can give them
20 confidence to go ahead and build products that can service operators really well.

MS BERGIN: Perhaps if I can ask you, Ms York, is there an existing model that we can turn to for standard references?

25 MS YORK: Yes. So, look, I think most sectors will end up having an outcomes framework, really, that sets out all of the outcomes they are trying to achieve and then under that a series of indicators or measures that will measure success in the direction of that area and then a minimum dataset of things that need to be collected in order to derive those indicators.

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One example where we actually set standards that are used to then accredit software is in the specialist homelessness services area where there has been a lot of agreement over time about what's going to be measured and then subsequent to that information about what is actually going to be collected on the ground, and so
35 software suppliers get good, long-term warning about what needs to go into their software packages to be of use in that sector and the AIHW then accredits those software packages.

MS BERGIN: Associate Professor Inacio.

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ASSOC PROF INACIO: I just want to make a comment. Right now, the Aged Care Quality and Safety Commission is collecting information directly from providers on three indicators of quality and safety of care and that's use of physical restraints and pressure injuries and malnutrition and weight loss. Two of those
45 indicators can be collected using information from other sources that would not be as sensitive as collecting directly from the providers, but will most definitely show you variation in practices nationally and that can be done by using all the hospitalisation

records and emergency room encounters these individuals invariably will have throughout the years.

As part of what we have done in ..... in the last two years now has developed a set of indicators of – that could potentially be used using the national data that's currently available in Australia. We came at a list of 23 different indicators that have been measured and reported internationally in other sectors, and we decided to settle on 12 of them that were things that, I think, we all agree will get the biggest bang for the buck and we consistently could do it and robustly do it. So yes pressure injuries will be under-ascertained because we won't get the ones that don't get reported, but absolutely the more severe cases will captured there.

But then there are things that are extremely easy to monitor, like the use of medicines in Australia, because of the PBS, that you can use the PBS dispensing records to capture and understand variation in practices really well. So we developed five indicators around the use of antibiotics, around the use of chronic opioid use, for people that don't have an indication for chronic opioid use, the use of antipsychotics and – I can't remember all the other ones now, because I'm really nervous. That's not part of – one of our indicators, yeah, but also a set of other indicators that – for example, if somebody has a fracture, they will never not be treated in a hospital. So that is – you don't have to ask a provider for that. That will come from the hospitalisation records.

Other hospitalisations for medication related adverse events, it's a serious indicator of you know, of care. Premature mortality, falls, those are all things that can be captured from the records that we already have. We don't have to ask the individuals to collect that information – with the understanding of the limitations, obviously – and then the other thing we spend time doing, then, was spend time doing what Louise referred to, which is spend time focusing on how do we risk adjust for each one of these indicators.

So what are the things that contribute to the baseline incidence of these things happening any ways that you need to be accounting for them when you're monitoring them. So the previous history of some of these medications used, the need for the medication used. You know, potentially other things about the individual, just general functional limitations that might make them at a higher risk. You can account for that, so you are comparing facilities that have very different profiles and residents, to facility – so you are comparing like for like from different facilities.

So we spent a lot of time thinking about that already. So with that being said, I think, we – as a first step, like, you should focus on what you can do and then build on that, on the things that you can't do by using existing data, and that is getting the individuals' quality of life estimates, you know, the workforce, all the other stuff that's not currently publicly available. So that's all.

MS BERGIN: Yes. Thank you, Associate Professor Inacio. I anticipate the Commissioners may be interested in the 23 indicators that you derived, and if I'm not mistaken, they're summarised in the article you published in 2019 in BMJ Open, which we have included in the general tender bundle; is that right?

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ASSOC PROF INACIO: No, it's not - - -

MS BERGIN: That's not it?

10 ASSOC PROF INACIO: It's not in there. Our paper on that – well, you have a report on our indicators already, that's part of the - - -

MS BERGIN: Yes.

15 ASSOC PROF INACIO: That we submitted to the Commission, but our paper is still currently under review. You know, it takes a while, so - - -

MS BERGIN: Thank you. Perhaps if we can turn to the question of how – who should be involved in designing the mandatory minimum dataset, and we've heard
20 about the importance of client involvement from Mr Lancken and from direct experience witnesses today in that task of being engaged in designing technology and other innovative ways to deliver aged care services. Who should be involved in the task of design of the mandatory minimum dataset? Perhaps I could start with you, Ms York.
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MS YORK: Sure. Well, I'm going to start with a, sort of, potentially self-serving statement that my organisation has a legislated function of designing such datasets in conjunction with relevant stakeholders. So it's – and what we would normally do in this situation is work with clinicians, policy makers, academics, people involved,
30 consumers, customers, older people and potentially the ICT sector, workforce, to work through, I think, as Maria said what's already – what they want to know, what's already available and then how we would go through the painstaking work of working out how to actually isolate those core pieces of information that need to be collected to really get that regular measurement over time of what we're trying to
35 achieve.

MS BERGIN: Dr Grenfell?

DR GRENFELL: Yes, this is a very complex area to work in so again it's purpose
40 driven for developing the indicators you need. The example I use is one that we have used in the acute care sector of looking at patient risk for readmission. That actually came from the sector but also from the patients themselves who don't like being readmitted and also came from the policy makers because it costs a lot of money and unnecessary expenditure. So if we were to break down bite-sized chunks of the
45 challenges that we face in the aged care sector, we would be saying who needs to be at the table to actually develop the indicators that will actually achieve the direct and where we go.

I reflect a lot because as you would have seen in so much of the hearings you have had today is we have a workforce that is challenged with digital, not challenged with compassion and care but challenged with in fact why would I collect the data. That will be the biggest barrier to any system that we put in to play for this. They need to be engaged and they need to understand what it does to help them do the wonderful work that they actually do. They won't shift otherwise, and that's echoed in the experience we have had even with the most eminent clinicians in the acute sector and also through the general practice sector. If they don't believe they need to collect it, they will not collect it and your datasets will be meaningless.

MS BERGIN: Mr Lancken, I can see you nodding there.

MR LANCKEN: I absolutely agree with those comments, both we need to involve the consumers and consumer representative groups in designing what this dataset looks like. That's really important. COTA did some great work in its report available in terms of exploring with consumers how we help them manage quality – or measure, I should say, quality of care, and I completely agree with the comments there around the workforce. It's really important that they are engaged and we apply a human-centred design approach to what's the information that is most required, how do we capture that most effectively to enable team members on the ground who are there to care for residents in a person-to-person way. We can enable them to do that, and if we ask them what's the information most important to you to be able to deliver great care to residents and to those receiving care, they will tell us and they will tell us it's not just those clinical indicators which are crucially important but it's also things like what are the things that our residents like to do and spend their time, what are their favourite foods. What are the types of activities they actually continue to engage in. And so all of those things are important to capture and I think older Australians and aged care residents as well as the workforce is really, really important.

MS BERGIN: Associate Professor Inacio.

ASSOC PROF INACIO: I think other than the obvious, which is the end users and the informed parties that are involved in this is really the providers of care. So if the providers are not part of the definitions that are created, you're going to get data that's not useful. I've worked again, as I said, in registries for 20 years now, and what we call the consumers were always the providers because those were the ones asking to change the behaviour so they have to be the ones that lead and accept that part of it. Now, the other parts of it and who should be in charge of the data collection and the linkage and all that, as it stands right now, the way I see it, it's the Commonwealth is in charge of most of the data collection that is available in Australia and then – of the publicly used data not just the provider level, the provider capture data. The Commonwealth owns it and the state own it.

And only the Australian Institute of Health and Welfare has the ability to do the linkage of all these datasets right now. I think there is a few other data integrating alternatives that connects some of the datasets were not all of the aged care data. So

that severely limits the access, the timeliness and the ability of us getting that information because there is one essentially holder of all that information that we can go to and get access to it. And then there's also prohibitive costs that are associated with that when there's only one place that you can go to for that. So I think having more, I guess, more options would also be needed for the future.

MS BERGIN: Mr Lancken, can I ask you – from the provider's perspective what are the risks or limits to aggregating a mandatory minimum dataset?

MR LANCKEN: I think one of the things is making sure it's agreed and implementable. I think there's lots of solutions and we start to talk about the challenges around digital maturity and interoperability we need to be realistic about where we are today and where we need to get to. And I think it's about taking measured steps in the right direction. I think we can get stuck in a little bit of analysis paralysis to try and solve it all at once so I think the big focus needs to be on how do we really understand where we are today and then build steps one at a time to get to where we need to go. I think that's what is needed. Just to comment on the earlier point, in terms of the custodians of the data, I think what is important from our perspective is that we make sure that as we design the new system there isn't any duplication, so having all the stakeholders around the table who are currently custodians and contributors of that data is really important because the last thing we want is data to be collected and duplicated again. We should be able to collect information once and use it across the system. So I think that's really important as well.

MS BERGIN: Yes it is, I want to come to that point about who should be the custodian in a moment. But before I do that, Dr Grenfell, what do you see as the risks or limits to a mandatory minimum dataset?

DR GRENFELL: To have one that's actually disengaged people who it is supposed to serve, and the second is particularly the workers as well; that's the biggest risk that we actually have with that. Privacy and governance are issues we need to look at, but I guess the curation – AIHW has been curating national datasets for a while. It's a matter of in fact actually what's coming in. The second is the feedback. The governance issue is the one you are alluding to which is the one that requires to be independent, and I reflect on what other sets or what other examples have we got in Australia, and I'm drawn to the Closing the Gap, the way that we have actually collected data there and have a national report card which puts responsibility back on the – certainly those in power to actually act on where the differences or the lack of action is.

Now, whether you actually achieve what you are after or not, and Close the Gap has been an example of some achievements and some non-achievements, with aged care I would argue that that actually requires some degree of enormity or responsibility right at the top level.

MS BERGIN: Ms York, what do you see as the risks or limits to the mandatory minimum dataset project?

MS YORK: Look, I think the main opportunity, I think one of the risks is if you don't specify that the outcomes you're trying to achieve and in fact try and achieve too much or if you don't use what you already have and build on that. And if I could just return to the issue of the distinction between governing what it is you measure and then curating what you then – the information you need to inform that. That is the role – the latter is the role that's filled by my agency. And one of the barriers at the moment to making that data accessible quite quickly is around governance and privacy and the country's ability to rapidly share information within privacy parameters and things are improving there. Yes, things are improving and that is a recognised issue.

MS BERGIN: Yes, privacy is often one of the risks identified in evidence we have heard to date. How can this risk be managed?

MS YORK: I think it's really important to draw a distinction between the sorts of information we're talking about for the sorts of reporting that might be useful for looking at quality of care. So things like complaints and attendances at hospital for certain health conditions, and the sorts of information about care planning that some of the panellists today were talking about where people are sitting – it's very personal care-oriented information, does not necessarily need to be shared to run a system that's safe and of high quality. That's their personal information. So consent is obviously really important. But with a lot of this by-product data consent is not directly sought because it is completely de-identified information. So there are ways to confidentialise that information so that it is used to inform a safer system but it's without contravening privacy law.

COMMISSIONER BRIGGS: Could I ask, Ms York, what's the average time to get approval for a new request for access to data?

MS YORK: I don't have the actual answer but I - - -

COMMISSIONER BRIGGS: Is it six months?

MS YORK: It's easily six months in some cases. If I could just say that some – without sounding defensive, that some of the issues that are being solved in that period of time are ensuring that the researchers have clearly articulated what the purposes for which they are going to use that information and that we have then conveyed that to the people who then have to release the use of the data for that purpose. So what our vision is, in the future, is that all of this information would be – there would be – it would be enduring and regularly linked information where all of those approvals have already been given upfront as long as you are meeting, you're conducting work that fits within those principles and those outcomes.

So there is a way to build that – that linked data and infrastructure once for use by multiple people, research community, governments, for projects that are considered to fit with the research and analysis agenda with the outcomes framework and with everything you're trying to achieve.

COMMISSIONER BRIGGS: After today, if it's not in your submission yet – I haven't had a chance to read those, having only got them last night when I arrived, but if it's not there, it would be quite sensible to articulate that approach because I'm very conscious of how long people have to wait for data. Can I also ask another question about the lags that are associated with collection of various datasets. I'm conscious, for example, workforce data is collected every, what, four or five years and I'm sure there are lags with the provision of other data. If we're looking at some of the basic data like MBS and PBS do we know what the lag is there? Do we know what the lag in getting the hospital data is and so on, so we have got a sense of this because what I'm struck by is assessing quality and wellbeing and so on is something that people are looking for information that's as near as possible to the present.

MS YORK: Yes. No, good point. Timeliness is an issue with all of the data we're talking about. So while information coming out of the aged care system, so the transactional, it's effectively the ACFI data and the payments data and so on; I will get you a definite answer, but say we get that ready for curation six months after the fact. Hospital data is not ready. It would be ready for inclusion in a national dataset after that, eight or nine months, I think. And Medicare data similarly we may have to wait for longer to get that all compiled. So – but I can get you definitive answers on what the lags are and also on our vision for how that could be pulled together more routinely.

COMMISSIONER BRIGGS: Thank you.

DR GRENFELL: So positive examples of where we are so in the acute sector or the primary care sector in the sense of what granularity do you need at what part of the system. So the work teams need to actually look at their performance against their agreed targets or directions. So that could be coming from the baseline with the great example we have had from Opal about how we actually feed at that level but then what do they feed to the next jurisdictional levels and that timeliness of the data as to where it is for that particular purpose. Because a digitised health system requires immediate feedback to the right person at the right time and that's in fact actually the data journey. Now, the data journey is one that is one that needs strict attention.

Stepping through the vagaries of privacy and quality need and registration needs and accreditation needs is actually a minefield but it can be done and has been attempted to a degree in other jurisdictions. But we still have a long journey in other settings. I think we have got a lot to learn from what we have tried to do in the other settings to where we are, but I really do appreciate the Opal model of feeding back the data they've collected to the team so they function on that, and then also being able and

freely able to feed that back into the accreditation areas; that's an example of exemplary behaviour.

COMMISSIONER BRIGGS: Thank you.

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ASSOC PROF INACIO: I just wanted to bring up one thing, though. The timeliness of these, they are collected and they are available quite quickly at the end of that. It takes some time to curate them, six months shouldn't be that big a deal to do real time assessments of what happened the year before. With that being said, the
10 aged care eligibility assessment data hasn't been made available since 2016 and that's a real issue. That's four years of delay and there's absolutely no excuse after four years for that data not to be available because you are making hundreds of ACAT assessors throughout the country to collect this information we all know is incredibly valuable. It feeds not just into the assessment itself but everything else
15 that we do as the basis of understanding who these individuals are at the point of entry into care, and it's an incredibly missed opportunity to not have that information available. So I just wanted to bring that up.

MS BERGIN: Associate Professor Inacio, could you describe ROSAs experience in
20 securing data from AIHW.

ASSOC PROF INACIO: Yes. So we approached AIHW as soon as we were funded in 2017 with the proposal of linking the aged care data to the health care data which hadn't been done in Australia before. And what developed from that process
25 on, is to date in order for us to have the aged care data linked to the health care data and thus the datasets owned by the Commonwealth as well as the datasets owned by the states from four states, New South Wales, Victoria, Queensland and South Australia, we have 30 open ethics applications, governance applications, and data custodian applications which is required for us to do. I have a full-time person who
30 is devoted to working on these applications in order for this to happen to provide reports now that we're providing and we have to supplement back to all these different bodies. And a couple hundred thousand dollars at this point. So it is – it's not an unsurmountable amount of work because we have done it but it is an incredibly demanding and trying process.

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MS BERGIN: And can that administrative burden of 30 applications for ethics approval, for example, can that place a dampener on the research work that you are trying to do?

40 ASSOC PROF INACIO: Yes, if we didn't have the support that we had to start this, it's not the kind of thing that a project usually – a research project ever gets money to support. With that being said, this is not just an issue with within the aged care – I do want to highlight that. This is a national issue with all of the datasets that are available in Australia. This is a problem that has been recognised by both the
45 Academy of Science and the Academy of Health and Medical Science and something that the Australian Institute of Health and Welfare has been trying to work towards

facilitating and making it easier in the future for people but it is an incredible challenge to make something like this happen.

COMMISSIONER BRIGGS: So there's an opportunity here, Ms York, for the material you come back to us with, to have the aged care sector become the exemplar, nationally.

MS YORK: In terms of ethical clearances and in terms of supply of data, yes. Can I just say that we also experience these issues about ethical clearance and the sorts of ethics clearances that Maria is talking about and not just our clearances but for all of the different university clearances and basically the assurance that the information is going to be used for ethical purposes and within privacy regimes and so on. And there have also been issues, I think, that have slowed down our own linkage over the years and in fact we had linked some of the information, much of the information that is now in ROSA in various elements over several years. But it is a reality that, at the moment, it takes longer than you would like to get all of the relevant approvals in place.

MS BERGIN: Ms York, is there anything else you wanted to respond to on that topic of the process of making an application for data or timeliness or securing ethics approval.

MS YORK: Look, I think the main delay in accessing data at the moment is getting approval from the data custodians. By the time you've spent considerable time specifying what you are trying to do and you have got that ethically cleared, that takes a certain chunk of time and getting all of the data custodians then to agree is one of the delays. And they are also working in an environment where they – and the Productivity Commission has talked about this, where they are – have been given a role to be a custodian for a dataset and they are attempting to discharge that role according to what they perceive is, you know, legislation and requirements placed on them. So there's work to do there across the whole system to make them less risk-averse or to organise things upfront so that they have already approved the, you know, release of the data for this purpose, this broad purpose and then all of these other projects can proceed because they align with that broad purpose.

MS BERGIN: Yes. Ms York, are the custodians you are referring to both state bodies such as hospitals and federal bodies such as the ABS?

MS YORK: The ABS doesn't release data outside of the ABS. So I'm mostly referring to state and Commonwealth data custodians – I am referring – that's what I'm referring to.

MS BERGIN: And is there a role for some sort of mutual recognition for ethics approval to streamline or harmonise the process that you're talking about of getting that consent from the data custodian for release?

MS YORK: They're just slightly separate issues around that. So there is mutual recognition of ethics, which is – in most cases it's the data which is the assessment of a project in terms of its human ethics and privacy, adherence to privacy. It's the – then data custodian release that is a separate issue.

MS BERGIN: Okay.

DR GRENFELL: So the other one is the future-proofing of the system. So we have heard a lot of technological applications that are occurring there and one of the things that concerns me in that area – and my team has worked a lot in digital applications and translation of that digital settings, is the actual privacy and the governance of those datasets. So with good intent, people are in fact actually collecting, as we saw an example just before here or the ones previous to that, that people are collecting data. One of the concerns there is what are the provisions around that. So primary care had to go through that from general practice and general practice settings so there are other – further down toward the level of actually how people are having custodians of their datasets and how those datasets are stored. This is a major problem for the NHMRC across all of health and medical research and especially as we move into having so-called disruptors moving into the research sector and not understanding the provisions that we have as health practitioners of the sanctity of the data that people give us.

MS BERGIN: And what sorts of disruptors are you referring to there?

DR GRENFELL: This is the collection of data. So we have got some examples. My team has been using sensors, so also interactive technology. So the example of the previous witness is one of an interactive one of dealing with – say, I'm putting data and it's feeding back and we are actually looking how you are going. You can see how someone is actually performing and how their health is going. And we have demonstrated reduction in hospital readmission by 30 per cent in trials in elders in the community by using interactive technologies. We are also using chatbots for socialism and also company and other areas are doing that. These are, like, quirky and you might think this is a toy but you can validate these things but then what do you do with the data that is actually feeding into there and the position and the behaviour?

The other one is monitoring. Now, monitoring with no touch sensors is a very effective way of looking for deterioration clinically. It could be used in facilities. Definitely has a role in the community, in fact, actually providing the team with greater insights. We know that the consumers do not want video. So that's one thing. So all of our studies are conducted within NHMRC ethical requirements for conducting health and medical research. I can't attest that that is occurring with others coming into the digital sector, that they are doing that. So standards of how to do that and also adherence to those is actually quite vital.

MS BERGIN: Associate Professor Inacio, we need to focus on solutions. Who would you suggest should be – should there be a single custodian of aged care data and if so who should that be?

5 ASSOC PROF INACIO: I think that's a really difficult question to answer but I think there should be easier access to data and I think there is an opportunity to have independent bodies to do the monitoring of that information. I know that the idea of setting up a centre that focuses on aged care quality and safety in general is a proposition for the Commission and I would envision a body like that. We want that
10 also as part of it, holds and managers the aged care data that is necessary, the aged care data that we are discussing today.

MS BERGIN: And when you say an independent body, how would such a body secure its independence? What are the features of an independent body?

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ASSOC PROF INACIO: I'm not sure if I'm qualified to answer that. But I think there are models of independent bodies, at least within the research environment. So something like the United States National Institute of Health. Within the institute there are several subsidiaries or smaller institutes that focus on very specific things
20 and they cover anything from the funding disbursement, to research, to larger things about the research aspects of that specific particular topic. In Australia there is the National Institute of Dementia Research that has been established for a couple of years and I'm not certain of how successful and how sustainable that model is here but it is something that I think would be incredibly helpful.

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MS BERGIN: Ms York?

MS YORK: Yes, look, I - - -

30 MS BERGIN: Who should be the data custodian? If we could design one would it be an existing body?

MS YORK: I obviously think that it is sensible that it is an existing body that has legislation and has infrastructure that's already set up to link and to curate and link in
35 and make accessible data through secure research environments. Not least because of the cost and problems that we have encountered in trying to make that information accessible to others. I do think that it should be, within privacy constraints, opened up so that it's useful for government and researchers and that it's more timely. And I do think that there should be continuous measurement of metrics such as, you know,
40 an agreed set of outcomes and indicators that are measured and I'm agnostic about who gets to measure those. As long as they are developed and agreed in a really multi-party way, you know. So consistent with what we have been speaking about today, that the sector and the academics and government and people who are receiving these services have input into what is important to measure.

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MS BERGIN: Mr Lancken what would the hallmarks be, from your perspective, of a data custodian and what would they be – what should they be charged with?

MR LANCKEN: Yes, so I think a couple of things. Firstly, I would just agree with what the panellists have perhaps said there. I think, you know, whilst we are agnostic as to who it is, we think it's important that those people have an understanding of what has been done in the past. We don't want to throw the baby
5 out with the bathwater and we certainly don't want any duplication of effort. We think that's very, very important. We think that the organisation should take a person-central approach. In other words, the data should start with the individual and work out from there. A lot of the data that is collected across the system at the moment is episodical and it's fragmented and if we start by designing from the
10 person out, we would be able to get a better picture care of the outcomes that are most important to people and certainly involving residents, aged care recipients and their families in the process of understanding what it is that matters to them, measuring that is most important.

15 MS BERGIN: Dr Grenfell.

DR GRENFELL: I feel that curation is one function and AIHW is doing an excellent role in that in health care and health care datasets, but there's more to datasets and data management than just the curation of the data. There's the actual
20 governance issue and we have talked about some of those. Should that function be separate from the curation? The answer is probably yes. So that actually is true independence in the sense of where it is. Should we be looking at a Commission for aged care performance data or should we call it something like that? Because as I've mentioned, the dataset has a whole range of domains being not just performance, as
25 to financial and quality and clinical, but it's also in fact looking at it from a client-focused or person-focused avenue. That's not delivered to us under the existing structures where we sit.

The other one that you would actually look at is for applied research in the sense of
30 not research for research's nature in a bespoke setting but research for actually solving the problems that need to be solved. So that's an industrial focus to this. We are looking at an industry that is in dire need and we heard before about the failed attempts to get CRCs up. The reason for that is that the industry is not engaged, for many reasons, in the idea of actually doing the research. So it needs an overarching.
35 We know what the problems are. You have heard most of these problems, I think, through the Commission. The question is how do we address those? With someone tasked to do this and a report card that is actually for all Australians to see about the functioning and mandated. Where does this sit? Is it under the Minister? I don't have those answers. I guess the department will be able to yield some of the
40 governance structures that fit. Closing the Gap, as I mentioned before, has been an example that has held the government accountable to where it is actually performing and do we view that aged care or what's actually happening to the elders in this country is of such enormity that we need to actually have such a focus.

45 MS BERGIN: Yes. Dr Grenfell, just on that point that you mentioned, and the risk of, I think, I put the label of "conflict" perhaps on it, collection of data for compliance purposes on the one hand and collection of data for quality measures on

the other hand, both data coming from or being requested of providers, how could conflict like that be measured on a model – be managed on a model where there's a single data custodian?

5 DR GRENFELL: We actually have a number of data custodians for those various areas. So compliance is already under the quality compliance areas or, if they're financial, they're under the financial system. And a lot of the clinical or at least performance metrics are under, say, AIHW in the setting, as we have heard. It's really bringing those together. Not putting them in the same set but it's bringing
10 those together for in fact actually a combined analysis and a combined report. Rather than separate ones which we actually have to search through and try to find.

MS BERGIN: So are you saying that a data custodian wouldn't be a single entity?

15 DR GRENFELL: Correct.

MS BERGIN: And what's your view about that, Ms York?

MS YORK: Well, I think that's part of the point of a minimum dataset. So a
20 compliance organisation will still capture all of the information it needs to perform its role and the service providers will capture all of the information they need to perform their role. The Department of Health, in terms of its funding role. It's a minimum component of each of those pieces that comes together into a curated set that's then made available for these multiple purposes. So it doesn't replace all of
25 those datasets. It takes aspects of them into a bigger group of datasets.

MS BERGIN: I see. Associate Professor Inacio, you mentioned the importance of independence. How much independence should the data custodian have from government?

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ASSOC PROF INACIO: That's again a tough question. I think, like I said, the data is collected to improve care, right? The individuals who are going to act on the care are the providers. So they have to be involved. To what degree they work with the regulators to develop these datasets – they should be heavily involved in it. So it
35 serves both purposes. I mean, the aim in the end is the same one, is to improve care and to collect enough information that we can understand what's happening so we can make inferences about it to improve what's going to happen in the future. So I think absolutely needs to work – has to be partnership between the regulators and the providers.

40

But then involve the content area experts in specific areas that will tell you, you know, maybe we don't need all these tools that you may capture the exact same information just in slightly different ways and you might simplify the data collection process. There is psychometrics that can help tell you that from a questionnaire of
45 100 questions there may be only 10 to tell you enough information about it that's useful. So take advantage of the individuals that have the expertise to develop these tools and be part of the process. So I guess, in short, my answer is it should be a

partnership between all the individuals that are ..... experts, the regulators and the providers who are going to be using the data.

MS BERGIN: Yes. Mr Lancken, how important is independence in the data
5 custodian?

MR LANCKEN: I think it's important that there is an independent body that's looking at that particularly from a governance perspective, and we will support that as a provider. And ensuring that there are some standards around, you know, the
10 timeliness of access to that information being used by the right people for the right purposes. I fully support that. If I could just touch on the Commissioner's question earlier around the challenge of getting the community information about aged care in a timely way. We think one of the best solutions there is to embrace consumer-generated reviews to do that. We know, you know, the importance of the regulatory
15 data and the information we have been talking about today, but we think that if consumer-generated reviews can be made more widely available we can encourage people to provide them, that's a source of information that families and the community can go to when trying to make decisions of where to place their loved ones in care.
20
Now, that's happening today in a fragmented way. We are working on getting online reviews publicly available on our website, which we will have in a couple of months' time so there's a big opportunity I think in that space for that consumer-generated data to be made available very quickly in real time for the community.
25
COMMISSIONER PAGONE: Perhaps I might ask Professor Inacio the question somewhat differently. Remember it was a question about the extent to which you need independence. What kinds of structures do you think you need, given your perspective to ensure that what you get in the data is reliable?
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ASSOC PROF INACIO: So right now the datasets that we use, for example, are transactional data and collected by ACAT assessors and some by providers, so the ACFI. The other ones are collected by individual – the state level hospitals' datasets. I believe it's – the data collection process itself is quite independent except for the
35 ACFI which I understand has – because of the model what it's supposed to do, it might have some bias in the way the data has been collected. The other ones I trust that they are actually being collected to just describe what happened. So there is very little bias there. But I guess if you're asking independence from the funding perspective and who should put that information and make that information available
40 to be independent, there shouldn't be just – again my point is as before it shouldn't just be the regulators doing it because if it is just the regulators from top down the providers will never act on that information the way you want them to.

They need to be part of the solution in order for them to use that information for
45 quality improvement. I think in health there has been a lot of really good examples of that being the case. I will use this – because that's my experience in Australia when I first came here was to work with the Australian Orthopaedic Association

National Joint Replacement Registry that has been available for – has been around in Australia for 20 years. It influences practices in orthopaedic surgery throughout the world and the way that they have gotten is that the providers will voluntarily share their information about the surgeries and will get information back about how they
5 perform and how they perform in comparison to other surgeons nationally. They are the only ones who know who they are, but they come together once a year and they discuss that information and they share that information with each other and they use that as a quality improvement tool.

10 When we developed our registry that was our intent as well, that we'll be able to give information back to providers that they will be able to act on. Now, I understand that regulators need to be part of monitoring that. As a consumer I would want to know what are the facilities that are performing better than the other facilities. I want transparency in reporting. So that's why I'm saying it needs to come from both
15 places. It needs to be the providers and it needs to be the regulators working together. So it serves both purposes. Does that answer your question?

COMMISSIONER PAGONE: I think so. Ms York, you want to add to that?

20 MS YORK: I think the independence of the curator is one thing. It's the independence of who is setting what is collected and what is being used to measure and who can use it for what purpose. So that's how I am seeing the governance that sits above this, that is really crucial, that that is, that no one player gets to specify that; that that is a board or a group of people where there's quite specific
25 membership and they have to chart the course of this, the measurement and then the curator implements that. Yes, that's how I'm seeing the distinction.

DR GRENFELL: So if we were to actually look at where some of the data might be. The pharmaceutical data is in the pharmaceutical benefit, the Medicare data is in
30 another set. It's not saying that that would all actually be in the one set. It's a matter of the curation of that is where do you get it. This is basically what AIHW has to do to actually bring some of those together. But there are other datasets that you don't get access to that would be of great value to actually an overarching governance for where it is. So it's a higher governance set of actually doing the directorial approach
35 that we would certainly support.

COMMISSIONER PAGONE: Thank you.

MS BERGIN: Ms York, would AIHW have the resources to curate a mandatory
40 minimum dataset that included information about workforce and quality of life as well as the existing datasets?

MS YORK: No, we but we have to build on what we already do, and scale that up to include additional data sources, and that's what we generally – that's our model.
45 We're half appropriation funded and half funded by special purpose grant, you know, project funding. And so normally we can stand up new teams or new work programs quite quickly in response to requests.

MS BERGIN: So if AIHW was provided with additional funding along those lines that you have described, how long ought it be allowed to curate the mandatory minimum dataset?

5 MS YORK: I think it largely depends on whether the first stage of that would be to collate everything that currently exists into a linked dataset that makes most use of what's currently available. And if that answer is based on what's currently going on with other datasets, such as we're building a big national disability dataset, then I would say you could bring a lot of the core of that together over a period of, say, two 10 years. But if you're talking about bringing in a lot of the data that's missing from the existing data, then that actually needs a bit of – a bit more work with all of the players who we have been talking about today to define what should be brought into the mandatory dataset. So I think there's some stages of work to be done and they could be done in – at the same time to try and start getting much more useful – or 15 more useful data together.

MS BERGIN: Thank you panellists. That concludes my questions, thank you Commissioners.

20 COMMISSIONER BRIGGS: I'm going to ask the dummy's question of Dr Grenfell. I well and truly understand transactional datasets. What I don't understand is digital datasets. Could you just give us the dummy's guide in this area to what sort of datasets we might be looking at that might feed into a minimum dataset, or might feed off or build on a minimum dataset of the sort that Ms York has talked about, 25 please.

DR GRENFELL: Correct. So some of the Medicare dataset – often people say that that's a clinical set. It's not; it's a transactional or a financial transactional one. Pharmaceutical benefit is also a transactional one in the sense of a drug that has been 30 sold. If we think about compliance to accreditation criteria, that's another set that was certainly eloquently explained about how those fit in from a couple of panellists here today. The other one is about workforce and workforce skillset so the health professionals datasets about what's collected registration and credentialing of various workforce elements across the sector. Adherence to workers compensation claim but 35 also complaints, health care services commissioners and others are collecting data that actually would be fitting into those.

The other one you need to mesh to is the hospitalisation datasets into the state systems acute systems or even whether the subacute care where a lot of aged care 40 residents are actually finding themselves in subacute settings. So that is picked up in state settings under state jurisdiction. So that would actually need to be collected or at least connected. Ambulance setting, and the big one which is the one that we really would like to actually look at organising and that's general practice, but more so the unchartered territories of allied health and particularly the allied health in the 45 community sector is about the services that are provided there.

That's really a snapshot. It gets more complex and I could go on for a while but for that is to give us the richness of experience and I think we have also heard we could collect a lot more from the person themselves and their family.

5 COMMISSIONER BRIGGS: And if I might ask between you, Dr Grenfell and Ms York, to bring in those extra elements would, I imagine, take some time. Are we talking four or five years or what are we talking here?

DR GRENFELL: I think we should look at digital transformation in a 10 year sort
10 of cycle and say what would we like to achieve in a stage-gated approach and what would be the ideal system that we would be aspiring for over a 10 year period. That would be a reasonable way of looking at it. Having said that, I guess, we have probably failed, I think, in the acute sector and the primary care sector because I think I've been a practitioner now for over 30 years and we have been under digital
15 transformation through my whole career in general and acute care. So I think it's actually a lot longer and ambitious to say 10. But we have made a lot of mistakes in those two sectors to actually tell us what we shouldn't do. And we should be in fact actually setting a good target of 10. Louise.

20 MS YORK: No, I think that's fair and starting with, you know, everybody would think that we had good information about primary care and we don't and so let alone the other enabling allied health in the community, that's going to be even harder. We might be a little bit closer with primary health care data than we have been in the past but as far as getting it in with the trust and in the format where you could link it to
25 the sorts of information we are talking about, to really look at how the person is experiencing that move between aged care and primary care, I think 10 years would be safe – safer.

DR GRENFELL: Safer.

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COMMISSIONER BRIGGS: And other countries have had a go at this, haven't they? I read somewhere the other day that after about 10 years of working at it, New Zealand thinks they are there. Would the sort of data we can get be internationally comparable – I can't remember what it's called. RANI or something like that?

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MS YORK: INTERI.

COMMISSIONER BRIGGS: Yes, that's it.

40 MS YORK: INTERI. I think INTERI – I've looked into that – is one aspect of this, which is looking at the care plan of the person and it is – you could repeatedly apply that in resi care settings or acute settings. And so you could look at how they're developing over time, in terms of their functioning and so on. And that is associated with a minimum dataset that pulls out the main attributes of that, so - - -

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COMMISSIONER BRIGGS: So that would help us to understand whether or not various allied health programs designed to improve or restore people's capabilities or maintain their capabilities were successful or not .....

5 MS YORK: Yes, I think any tool like that that gave repeated measures of functioning would be the – if you also had information about interventions to impact that functioning, so such as allied health or subacute care in hospitals or other rehab or other aged care, then that has potential. Some sort of standardisation of assessment, repeatedly .....

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COMMISSIONER BRIGGS: Well, that's very helpful and I'm sure my colleague, Commissioner Pagone, might ask this, but in addition to what you are coming back to us with, I would appreciate your guidance in those areas, because clearly these things are of great interest to the Royal Commission, please and thank you.

15

COMMISSIONER PAGONE: Well, I'm going to ask what might be a slightly different question and that is in relation to the collection and holding of data by a custodian, is there an example, a broad that you all look to and say, "That's what we want, what they've got over there"?

20

ASSOC PROF INACIO: I can start by talking about the review that we just currently conducted for the Royal Commission on the 11 countries that have quality and safety monitoring systems, so there are examples. There are examples – probably the one that I'm most familiar with that is the US, that uses the minimum
25 datasets that is collected on individuals the minute they go into nursing homes and then it has a set of 17 quality safety indicators of care, including five that are collected just from claims data and then the remaining that are collected from periodic assessments of these individuals. That is very robust and has been useful and in place for many years and now publicly available too.

30

There are obviously the Scandinavian countries, which have, you know, used registry-based data to assess not just the basics about quality and safety of care – and by that I mean care that is delivered in accord to evidence-based guidelines and care that doesn't cause harm, which is where we're at right now. But they have been
35 measuring things like the psychosocial wellbeing of individuals and other things that are at a much higher level, essentially, of monitoring at this point. And so, yes, there are 11 countries right now that currently do this, to a lot of different degrees that are – and some of them that are truly good examples of where we could be.

40 COMMISSIONER PAGONE: And do I understand you to say that any of the 11 would be a significant improvement to what we have at the moment?

ASSOC PROF INACIO: I wouldn't go as far as saying that because one thing that is unique about Australia – and I reiterate my point – is that a lot of these data are
45 available. These other countries are doing active data collection to get to where they're at. We already have the data, we just need to put infrastructure in place that is doing this periodically. So we are ways ahead of the curve, actually, in that

regards. And the information is very good that we have, so we could tap into that to build a system, which these other places had to painstakingly develop it to implement it.

5 DR GRENFELL: Some of those is the closed system approach. So some of those – when I say a closed system is a single financier, which is really where they fit. So the Veterans Affairs in the US has been a leader in quality across that sector and in fact has driven a lot of the safety and quality agenda. The not for profit sector in the US, so Kaiser is an example of how they manage across there. Their driver is to
10 improve obviously their financial exposure to a considerably rich source of actually expenditure of funds. So – and the other one is the Scandinavian countries, the way that, again, from a single-source focus of actually how they look at it. We tend to look at those. We don't have that in this country and that means that comparison across there or at least the implementation makes it actually a lot more difficult than
15 we would expect.

COMMISSIONER PAGONE: Thank you. Ms Bergin, thank you, you've been of great assistance and thank you to each of the panellists, including the one I can see on the screen, Mr Lancken. And the others, thank you very much indeed. It has
20 been very, very helpful. We are grateful for the ability to access your depth of knowledge and experience in helping clarify our thoughts.

MS BERGIN: Commissioner Pagone, my instructor informs me that Dr Grenfell and Ms York need to be excused from summonses.

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COMMISSIONER PAGONE: Yes, well, I formally excuse you both from your summonses.

30 **THE WITNESSES WITHDREW** **[4.17 pm]**

COMMISSIONER PAGONE: Till tomorrow morning.

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MATTER ADJOURNED at 4.17 pm UNTIL TUESDAY, 17 MARCH 2020