# LEADERSHIP INSIGHTS

ON HEALTH AND MEDICAL RESEARCH AND INNOVATION



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# Introduction to Leadership INSIGHTS First Edition

Research Australia is pleased to share the first of its INSIGHTS series of Leadership Opinion Editorials. INSIGHTS will feature various opinion pieces from the leaders of our member organisations from across the health and medical research pipeline.

The topics will vary depending on relevance and responses to external environments or internal challenges. They could be disease specific or broader commentary on issues germane to our sector. It is a view from the collective wisdom of the impressive leaders whose organisations are all part of the Research Australia alliance.

This edition shares insights from the immediacy of dealing with the pandemic challenges to how we can make things better as a result, whether its aged care or getting products to market.

Sincere thanks for these contributions and we look forward sharing INSIGHTS with you – enjoy the read. Even better, if you have not already, join Research Australia – the national Health and Medical research peak alliance - so your voice can be heard.

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# Let's applaud the aged care workforce – caring for older people in the COVID-19 pandemic

Older people living in residential care facilities often state that they "wouldn't want to have to care for old people like me". This is the ultimate in ageism, where negative views about age are internalised and directed against the self[1] . Ageism is rife in our community – it is the only expression of stereotyping and discrimination that still goes largely unnoticed – comments such as "silly old driver" or "it is about time we recruited some young people into our club/workplace etc" are commonplace and rarely challenged.

Recently I overheard a young friend of mine, talking to a group at a party about having been accepted into an Occupational Therapy course, saying, "of course, I don't want to work with old people", a comment which gathered murmurs of assent from her audience.

This prevailing ageism is reflected in how aged care is viewed and, in the worst of cases, how it is delivered. The latter has been well documented in the interim report of the Aged Care Quality and Safety Royal Commission (Neglect, 2019) so is not the focus of this article. Rather, I focus on how this ageism affects the care workforce, especially during the time of COVID - 19.

Older people, especially those who are vulnerable and frail, are not valued and neither are those who care for them. Australia's so called "quality indicators" for residential aged care are a pertinent example of this. We measure unintended weight loss, skin integrity and restraint use as indicators of quality of care. So if you are not suffering from malnutrition or skin lesions and no one is physically or chemically restraining you, are you experiencing quality care? Hardly…

In a recent attempt to address these obvious shortcomings, consumer-oriented standards were introduced in July 1, 2019. These require aged care services to comply with and report against a set of eight consumer-orientated standards that include, "consumer dignity and choice" and "ongoing assessment and planning with consumers". These signal the intention to focus regulation of the industry on higher-level measures of quality than the indicators mentioned above however there are no clear quantifiable measures specified.

Provision of quality care for residents in aged care is a highly skilled and multi-faceted undertaking. No one enters aged care as a lifestyle choice. Older people are admitted to aged care facilities because they can no longer live independently, and their family or community based services can no longer provide the level of care that they need. To be eligible for a residential aged care place, the older person has to have been assessed as requiring a level of care that cannot be achieved in a less restrictive environment.

A recent survey of 5000 people living in aged care found that over 80% of residents need help with personal activities of daily living, such as showering, dressing, eating or using the toilet. They also found that almost half of all residents had difficulty interacting with others and can become distressed or resist care staff's attempts to assist them. Over one third of residents were depressed and an even greater number were agitated (43%)[2].

The care needs of aged care residents are complex and personal care workers are at the front-line of addressing these needs. In any one day, a personal care worker may

[1] Voss, Bodner and Rothermund (2018), Ageism: The Relationship between Age Stereotypes and Age Discrimination, in Ayalon and Tesch-Roemer (eds) Contemporary Perspectives on Ageism. Springer Open

[2] Eagar, Westera & Kobel (2020) Australian residential aged care is understaffed. Med J Aust 2020; 212 (11) Published online: 1 June 2020

have to navigate the more straightforward tasks of showering and dressing an older person, helping them to eat and drink (although even these tasks require a level of interpersonal skill and empathy), through to the complex problem solving required to meet the care needs of a resident living with dementia who cannot express their needs verbally and may be agitated and/or even aggressive. They help residents with activities that we take-for-granted such as going to the toilet - not once, but several times a day and often at night.

Most residents will have a range of care needs, including clinical care needs, such as blood pressure monitoring, medication management, maintenance of mobility and independence and incontinence management. The so-called 'dirty work' of incontinence management is something most of us shun and is indeed, a common reason for carers to relinquish caregiving at home.

Aged care residents' social and mental wellbeing is also critically important. Care staff face the challenge of helping their residents maintain activities and relationships that are meaningful to them in an institutional environment.

They have to make decisions daily about how to encourage an older person's self-determination in the face of risks. The outcome of a fall can be devastating so it is tempting to dissuade a resident from moving about independently even though this might be the best way to avoid falls in the longer term, through building strength and mobility.

Care workers do all this whilst often negotiating a culture, language and aged care system that is unfamiliar to them as migrant workers account for around 50% of personal care workers in Australia. Their work is critically important to the wellbeing of aged care residents and to the broader community yet poorly understood or appreciated.

During the COVID - 19 pandemic, we have applauded the contributions of a range of front-line workers: health care workers, supermarket employees, the police have been lauded and applauded for bravely and selflessly continuing to work in spite of the risks to themselves and their families. I applaud them too. However, aged care workers have seen little of this type of appreciation, despite their contributions. They have not only continued to show up to work during the pandemic, but many have gone over and above the usual requirements of their role.

A wonderful example of this is a care home on the Isle of Wight, UK, where care staff moved in the care home to minimise risk of infection from the community to the care home. In Australia, during the peak of the lock down, care staff had to become everything to the residents: they have had to flexibly adapt their usual roles and become experts in IT, connecting residents to families, via zoom, window visits and courier services; event organisers, often the only ones to celebrate when residents had a significant birthday; pastoral care workers, connecting residents to on-line services when religious events, such as Easter chapel services, were cancelled; and palliative care workers when somebody died. In addition to all their usual responsibilities, they had to explain and reassure residents about the pandemic and the changing restrictions.

As I write, there has been a lifting of restrictions to allow visitors to residential care homes but at the height of the pandemic, many completely shut down and there are still strict limits on the extent to which residents can go out into the community. This has been very distressing, frustrating and confusing to residents, especially to residents who are living with dementia, and it is the front line staff who manage all of this.

In June 2018, the Aged Care Workforce Taskforce released "A Matter of Care" which reported on the taskforce's

extensive consultation about the issues facing the aged care workforce.

Apart from a comprehensive strategy, including actions to improve workforce training, career pathways and a Growth Centre to accelerate uptake of best evidence, the Taskforce identified the need for unified leadership in this sector, "focused on people, practices and recognition of why aged care matters to the community"[3].

I argue that reform of the aged care sector also requires challenging ageism, which underlies the lack of importance currently placed on care of older people. If older people were truly valued, those who care for them would be truly valued as well.




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[3] A Matter of Care Australia's Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce June 2018, p.vi

# Innovation needs funding to reach the market – the challenges are real

In a perfect world, the ideology of contributing to the betterment of mankind is appealing.

Financial desires to prove the validity of your contribution are never the issue. You understand why you chose your pathway; you are emotionally attached to your work and the benefit it will bestow on those who need it the most. As you think through your justification, your pathway, and the commercial potential, you believe you are truly embarking on an ethical program with untold riches.

In truth, the perfect world is a myth, medical innovation is tough, and whilst needed, it will not be an easy nor straightforward exercise. Cash is king, and as most Biotechs know, a lack of cash can quickly kill your innovation and research agenda.

My name is Dr Sean Hall, I am the Chief Executive Officer for an ASX small cap Biotech, Medlab Clinical LTD; allow me to share some insights on trying to balance research, product innovation and Investor markets.

All businesses start with an idea. For some organisations, that idea becomes more cultural and starts to mature into a concept - in early drug discovery this is especially true. The concept work subsequently triggers varying interests with questions like: What does this mean and how much money would it take to do it?

Depending how these questions are answered it can be somewhat easy to see a potentially, very strong emotive relationship develops between the idea, a business, and its commercial endpoint.

Where most ideas stop, is at the money needs question. Where most businesses fail is in under capitalising their needs to move through the various research gates.

The question is where (or how) do you access money? Normally, once timelines and budgets are prepared, a company will review its potential fund-raising options like private equity, debt funding, public capital markets.

Research is risky unto itself, but so are the public markets. You are now a new name, no track record, with a new potential product and your presentation is all about the potential predicated on significant investments in both time and money – thus ruling out a lot of “normal” or risk-averse investors.

Your pitch is sound; to you it makes perfect sense, god knows you are invested in the research program, and you need to have answers to the key questions – like how will you compete in the big boys market and when will we see the revenue? It is critical to ensure you’re pitching to the right investor base and effectively explaining the vision.

I can speak from experience that there are hard lessons to be learnt and whilst we are expected to be highly educated in our art, our investor community requires a simplified, easily digestible elevator pitch and it helps to have comparators to draw against.

Building the right share register to suit your company and its pathway is also crucial. It can sometimes feel like you are at the mercy of a shareholder and their trading habits. The right shareholder is one who is culturally aligned with your program and will be prepared to hold and wait for longer periods of time, as opposed to those more akin to day-trading. You want to bring shareholders on the journey with you.

Part of the challenge is that time and money move quickly. Whilst you can promise milestones at certain timepoints, you can’t always guarantee them. There are macros which are beyond your control, movements in time usually directly affect money, and in Biotech life that means cash out the door. So, know at some point you will return to the markets with another

capital raise offering to financially secure your next step.

The problem with this strategy is it can make shareholders uneasy, and uneasy shareholders tend to sell. Biotech is speculative stock which is based on promises – the promise of success and then the promise of some significant trade partnership and commercialisation strategy. Biotech to a potential investor is both a long haul and hit or miss.

Whilst Australia is a great marketplace in time the realisation of potential commercial opportunity abroad increases in significance as the journey continues and depending on the research opportunity, the ASX may not be the place to raise money – let's face it, the ASX is a great board for primaries, but Biotech is a very different game with very specific technicalities across many micro and macro facets.

The answer for most is either early commercialisation and/or listing on a board more tolerant to Biotechs. Both pathways have "pro's" and "con's" and both need to be carefully considered. Commercialising too early reduces the revenue potential in your project and effectively sets a pricing ceiling in the asset valuation. Dual listings (running on 2 boards) or relocation of one board to another can upset the existing shareholder base.

Whilst it's correct to say medical research is risky, so too are the public markets. Though public markets offer an array of various consultants to support your investor activities, and for many small caps, this is pure "Opex", it's important to remember that "cash is king" so for many Biotechs, investing in this type of "Opex" greatly reduces financial capabilities on the research front.

Accessing public money is not that difficult, maintaining shareholder interest over extended periods of time however is. From the Australian front, there are a lot of misconceptions surrounding research and trial progression pathways, and I for one deal with them on a regular basis. But this creates a unique opportunity to talk through and deep dive the topic, to which some fund or portfolio managers will welcome the conversation.

I reinforce that one cannot underestimate the value of your share registry.

Personally, Australia is a great country for research and development, strong academic desires to collaborate, strong regulatory models, access to R&D tax incentives, a unique Australian spirit to build, and a Government willing to listen. Where we fall down is there is a very small savvy Biotech investor market, Government research grants are slow and potentially arduous, and thus for Australia to be a true global Biotech hub, both need to change.




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# From business as unusual to the new business as usual – the ACRF journey

In March 2020, the Australian Cancer Research Foundation commenced its business as unusual way of operating. And how quickly our support staff adapted to connecting us with our stakeholders via zoom!

As information from various sources – including clinicians, researchers and investment managers assimilated, I realised we needed to determine a business continuity plan. Our donor services were provided from an office-based team, mostly using desk top computers, a file server and PBX located in the office in Sydney. Luckily our CRM and financial systems were already cloud based. Although we had a VPN, courtesy of nearby building works the NBN line had been cut and we were operating on back up connectivity – not ideal in the least.

We immediately set about developing a matrix summarising staff needs to continue workflows remotely. Pragmatism prevailed and we soon had a workable plan to share with our Chair to reassure him that our remote business as unusual plan was in full operation.

As CEO, my priority was the safety of the team so employing the appropriate technology we managed to continue interactions from home without too much disruption. Watching the pandemic unfold, I felt an enormous responsibility to look after the team, to care for our donors, to look out for the researchers – all of whom were being impacted by COVID -19.

In a previous role I had experienced fire, earthquakes and flood disasters which served me well in leading the organisation but as the situation elevated to global health, financial and economic crises I found myself recalling a skilled developed in my equestrian days of not letting the horse know of my true fears.

I will not hide the fact that the first couple of weeks were somewhat bumpy. People unused to working from home were thrust into this new situation, some of the team had childcare challenges and others were home schooling all on top of managing their concerns for immediate and extended family members at risk.

And we soon got into the rhythm of our new normal, communications remained regular and our online world was accepted, including our traditional Friday drinks. Our team are now highly skilled in running online trivia nights, virtual Jeopardy, and other fun games and quizzes. Interestingly, these sessions naturally became a forum for honest sharing where we talked about the emotional impact and shared coping strategies.

As a leader I was pleased to see the team have become stronger, we have leaned in, reprioritised and kept productive. We have expanded donor stewardship providing more frequent newsletters with high value content and hosting regular webinars featuring our esteemed researchers. We have activated new fundraising initiatives whilst in isolation and our “no hair dare” has brought many people closer.

Donor services have continued seamlessly, and we understand that some donors won’t be able to give as much or at all this year and that is to be expected. My heart goes out to those who have lost their livelihoods, whose investments have devalued, who have been hit hard by the pandemic.

I am thankful for the many providers of guidance and thought leadership helping navigate a range of topics, JobSeeker provisions, fundraising in a pandemic, mental health, the impact of COVID -19 on investment strategies – to name a few.

Our grant recipients, the awesome researchers whose bold ideas we back, have been affected in a range of ways. Changed operating activities include working from home, reduced travel to conferences, and laboratory shift working to reduce the risk of infecting whole team.

There has been some repurposing of equipment and seconding of personnel to help with COVID -19. Some research projects were put on hold, wherever possible clinical programs were retained. Lab staff have been rostered into shifts to minimise the impact of an outbreak and the balance has shifted to advancing dry lab work / writing papers.

Our grant round will continue this year, thanks to the prudent and focussed attention to good governance from the Board over many years. It might not be at quite the level of previous annual rounds, but it is so important to us to get our donors funds into use and addressing the cause. So we are pleased to continue and have received significant interest from research institutes across Australia.

So where to from here? Undoubtedly "business as new usual" will be different in the future. Our language has changed, and terms now commonly used include – pivoting, agile, rethinking, reshaping – and will certainly apply to how we raise funds. ACRF will adopt the new, improved practices in how we work as a team. Interestingly some of what is now assumed – more working from home, flexibility, changing our office footprint, moving files virtually – would previously have required a well thought through business case, anticipating how things would work and having sound change management practices in place. Job done. Tick.

I recall recently talking to Nadia Levin, CEO of Research Australia our national peak body, when she reminded me of Churchill's "never waste a good crisis". I think at ACRF we have done that.

COVID -19 has demonstrated the reliance we have on research – finding answers, and better ways to prevent, detect and treat. In this time, cancer will not rest, and neither should we. What will not change at all through the pandemic is our intent – speeding up progress and delivering better results to people affected by cancer.

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