ACSA
Aged & Community Services Australia

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Mr David Shoebridge MLC
Chair
Public Accountability Committee
NSW Parliament
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14 February 2022

Dear Mr Shoebridge

Re: Public Accountability Committee Inquiry into the NSW Government's Management of the COVID-19 Pandemic

I am writing to you to respond to the evidence of the Health Minister and Secretary, NSW Health following my evidence to the Public Accountability Committee on Friday 11 February 2022.

Aged & Community Services Australia (ACSA) has reviewed our records and can provide the following details for the Committee's consideration.

Letters re COVID to the Premier and Health Minister

- ACSA & Leading Age Services Australia (LASA) wrote to the Premier on 5 October 2021 providing a detailed document titled *Planning for Living with COVID-19 in Aged Care* on actions needed to strengthen the long-term response to COVID across the health and aged care sectors. This document specifically warned the NSW Government of the risks of reopening, even before Omicron – see the opening lines from the document:

> *A plan for living with COVID-19 in aged care is urgently needed.*
> *NSW will begin to incrementally reduce movement restrictions from 11 October, and other states are likely to follow soon thereafter.*
> *Aged care providers are concerned that this will lead to more infections among staff and care recipients. They are also concerned that access to staff – particularly surge capacity – will further deteriorate as health system capacity is ramped up to deal with increased case numbers.*

- This document was sent separately to the NSW Health Minister on 19 October 2021. We received a brief reply from Dr Nigel Lyons, Deputy Director, Health System Strategy & Planning, NSW Ministry of Health on behalf of the Minister dated 2 December 2021, which confirmed NSW Health had "begun internal work to consider future public health approaches to outbreak management in residential aged care facilities…"
- ACSA & LASA's next formal correspondence with the Health Minister was on 21 December 2021 seeking consistency of approach to furloughing of staff, visitation arrangements and access to Rapid Antigen Tests (RAT) in the light of the emerging Omicron wave.

Meetings and communication with Ministry of Health during first fortnight of December

- Email to members and forwarded to NSW Health for information on 6 December (summary of meeting with NSW Health re: festive season guidance and maintenance of status quo in light of Omicron).
- Emails with NSW Health on 15-17 December regarding implementation of Code Red for public residential aged care facilities and Multi-Purpose Services and questioning NSW Health as to whether the same advice would be issued to other aged care homes in NSW (the majority of providers).
- Regular fortnightly meeting between ACSA, LASA, NSW Ministry of Health and the Commonwealth Department of Health on 6 December. These meetings were stepped up to weekly from 17 December as the Omicron impact on aged care accelerated.
- Regular meetings between ACSA, ASCA members, NSW Ministry of Health representatives, the Commonwealth Department of Health and the Aged Care Quality and Safety Commission held on 1 and 15 December.

During our regular meetings with NSW Health, the following topics were canvassed in the first half of December:

- Member concerns re looming relaxation of social distancing and mask wearing requirements, in particular the risks of additional transmission into aged care and impact on staffing, as well as the implications for home care services.
- What was known about Omicron and its higher transmissibility than previous variants.
- How any relaxation of aged care specific requirements was to occur in the lead up to Christmas with festive season guidelines issued by NSW Health on 8 December and how Omicron would change that.
- Status of preparedness of aged care sector, including the slow rollout of RATs from the Federal Department of Health, the rollout of vaccine boosters to aged care homes (only reaching around one third of homes by 15 December) and the impact on aged care staffing which had already occurred pre-Omicron due to closed international borders and competition with vaccine clinics.

As indicated in my opening remarks, ACSA and our members were very happy with the level of communication occurring with the Ministry of Health by this phase of the pandemic. Our contention that the NSW Government knew of the risks attendant in aged care when the decision was taken to relax social distancing and mask requirements in no way reflects on the efforts of the fine public servants who were meeting with us during December 2021. They were doing their best to support the aged care sector and their assistance was and is appreciated by ACSA and our members.

Solutions

As proposed in my evidence to the Committee, ACSA believes there are a range of practical solutions available to reduce the exposure of older people and aged care staff. One of these is to ensure the National Cabinet decision on 10 February 2022 to support mandating a booster vaccination for aged care staff is implemented promptly.

I have attached for the Committee's consideration a copy of the LASA and ACSA proposal for a National Aged Care COVID Coordination Centre referenced in my evidence as well as the *Planning for Living with COVID-19 in Aged Care* document referred to earlier.

Yours sincerely,

Paul Sadler
CEO
Aged & Community Services Australia

ACSA
Aged & Community Services Australia

LASA
LEADING AGE SERVICES AUSTRALIA
The voice of aged care

Planning for living with COVID-19 in aged care

1 October 2021

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Why we need a plan

A plan for living with COVID-19 in aged care is urgently needed.

NSW will begin to incrementally reduce movement restrictions from 11 October, and other states are likely to follow soon thereafter.

Aged care providers are concerned that this will lead to more infections among staff and care recipients. They are also concerned that access to staff – particularly surge capacity – will further deteriorate as health system capacity is ramped up to deal with increased case numbers.

There has been extensive planning and modelling of COVID-19 cases in the community and the effect of this on the health care system – but there less information and planning has been made available on living with COVID-19 in aged care.

Some comfort can be taken from the knowledge that aged care is much better protected than it was during the initial COVID-19 outbreaks thanks to high vaccination rates and improvements in other protective measures. COVID-19 outbreaks in aged care in 2021 have clearly been much less severe than those in 2020.

However, protections are not perfect:

- Around 10 per cent of residents in residential care, and we expect a similar proportion of clients in home and community care, are not vaccinated (often based on medical advice)
- The risk from the Delta variant to even fully vaccinated frail older people also appear to remain relatively high
- Fading immunity is also a concern with many care recipients having been vaccinated in early 2021.

Protective measures are also costly:

- Restrictions on movement, such as visitations restrictions, can have significant and lasting effects on the health and wellbeing of older clients
- Single site arrangements, screening and furloughing measures exacerbate staff shortages
- Transfer of residents to hospital to limit spread within services uses hospital capacity and is likely to be less feasible if hospitals are already struggling with high numbers of community cases
- Most protective measures (e.g. RAT) require significant additional expenditure which is not funded unless an outbreak occurs, and this is difficult to absorb for a sector where many organisations were already in deficit.

The sector is making every effort to plan for living with COVID-19 but much of the sector's response depends on the decisions and support offered by State and Commonwealth governments.

This document outlines many of the solutions that need to be addressed. The sector will keep working on practical solutions that ensure protection for older people and are manageable for aged care providers and our staff.

Who needs to be involved?

Lack of consistency has been a key challenge throughout the pandemic. To create a plan for living with COVID-19 in aged care, engagement will be required across all governments and a number of agencies and it is important this work is not done in isolation to ensure there is consistency across the policy settings which aged care providers are required to navigate and implement.

The key stakeholders include:

- Communicable Diseases Network Australia (CDNA) (drive the guidance materials PHU, Res care)
- AHPPC and the Aged Care Advisory Group
- ATAGI
- Department of Health
- States/territories – health depts, PHUs, LHN/LHDs. Approach of states/territories for public health orders – post-enactment environment (emerge from state of emergency)
- Visitor Access Code Group
- WorkSafe organisations
- Aged Care Quality and Safety Commission
- Australian Commission for Safety and Quality in Health Care
- Unions

As part of the evidence gathering it will be important to understand the link between community modelling and aged care cases and how this affects the approach to relaxation of existing restrictions and a future risk-based approach.

National consistency, built on evidence should be foundational principles for all planning.

Priority issues

There are range of issues that need to be resolved as part of a move to living with COVID-19. Issues that need to be resolved within weeks. Other issues can be addressed through a more phased approach.

Issues that need to be resolved quickly are:

- Clear guidance from AHPPC on visitation requirements during the transition period as the community 'opens up' when target vaccinations percentages are reached, including guidance on vaccination status of visitors, role of RAT, differing restrictions requirements in hot spot locales etc.
- Clear COVID protocols between hospitals and providers, including issues such as transfer to hospital and transfer from hospital into residential care
- A clearly defined support protocol agreement between providers and health authorities in the event of an outbreak, including issues such as staffing and 'decanting' of active cases (in the context of reduced hospital capacity)
- Clear policies on movement and visitation, particularly with respect to the role of vaccination status
- Clear policies on maintaining workforce supply, including furloughing and single site arrangements
- Clear policies on RAT and PCR testing
- Clear policies for future funding of the significant additional costs aged care providers are incurring in protecting older Australians from COVID-19

Movement and visitation restrictions

Visitation in the residential aged care context

Visitation into residential aged care has been limited since the pandemic began due to the very real risks to the health and wellbeing of vulnerable residents and staff, as sadly demonstrated in mid-2020. With experience, better IPC, use of technology and the introduction of the Visitor Access Code, there has been an adjusted approach to ensuring that residents and their families and friends remain meaningfully connected. The emotional and social wellbeing of residents needs to be continually balanced with the physical risk to their health, particularly if we are to be tolerant to a level of ongoing community transmission.

With the introduction of high rates of resident vaccination and mandatory vaccination of the residential aged care workforce there is now a layer of protection. However, the risk of entry for the virus will not be eliminated and providers are rightly concerned that once visitation restrictions are relaxed, they will have little control over these risks and it will be the most vulnerable, residents who face the consequences.

Adjustments in NSW recently announced allow for the entry of two fully vaccinated visitors to a resident. Learning from this change will be an important input into possible future further relaxation. A number of considerations remain from the perspective of the aged care provider:

- How do providers balance risk with community expectation, resident rights and wishes of families?
- Entry regimes – who gets to determine these? In the longer term, in the absence of public health orders where does the determination of requirements sit? This clarity is required so that providers are able to communicate effectively with their residents and families so that there are clear expectations
- Physical distancing requirements/density quotients need to be revised in the light of high rates of vaccination. Will there be different requirements for residents who are not vaccinated?
- How should the Visitor Access Code be adjusted to reflect the new expectations?
- In the absence of vaccination, what other mitigation could be used to ensure that relationships are maintained e.g. will providers be able to establish PPE regimes?

Group activities in the community setting

Opening up in the general community brings with it expectations for community based activities delivered through aged care. What are the thresholds for the return of these activities? Physical distancing requirements/density quotients need to be revised in light of high rates of vaccination. If there are to be different standards for aged care based group activities these need to be clearly communicated based on evidence.

Group activities in the residential aged care setting

What are the thresholds for the return of these activities? Physical distancing requirements/density quotients to be revised in the light of high rates of vaccination. If there are to be different standards for aged care based group activities these need to be clearly communicated based on evidence.

Residents attending activities off site

Planning needs to take into account the role of risk-based decision making with residents and families and providers. Would there be an expectation that residents can leave a facility to engage with non-vaccinated family/friends? How would this be managed? Protocols on return of these residents once potentially exposed to unvaccinated community members also need to be revised.

Screening and testing protocols

The best COVID-19 response to date in aged care has been to prevent its encroachment into care environments. Screening has proved to be a fundamental element of this. To date screening has been driven partly by public health measures and by public health orders. The result has often been to limit entry but also to ensure that entry to services is appropriate and safe. New technology has been adopted to ensure the screening regimes are absorbed into business as usual as far as possible. Whilst vaccination is a protection against serious illness understanding the evidence as to whether there is a protective element to transmission needs to be clearly communicated. In the meantime, as even those vaccinated can transmit it is expected that screening will remain an ongoing feature, therefore, consideration needs to be given to the following:

Rapid Antigen Testing (RAT) testing implementation for the workforce proactively?

Whether, when and how rapid antigen testing could be a screening tool for the workforce needs to be addressed. There are rapidly evolving announcements around RAT and a definitive position with associated guidance will be needed by the sector quickly so that providers and staff can put in place the necessary arrangements. This will require issues of funding, supply and supervision to be addressed so that the benefits are not outweighed by the administration. Where there have been trials of their use in NSW the comfort factor of an additional alert has been welcomed, however, the costs, supervision requirements and staffing impacts are substantial. Consideration will need to be given to:

- Should RAT become a normal part of everyday activity for all staff? If so, this will need to be carefully managed and implemented so that the impact of implementation does not detract from delivery of care
- If not universally applied, would this be limited to staff who have an exemption to vaccine?
- How might this apply to visiting workers? Should this become a requirement for entry in the absence of vaccination for visiting workers and if so, how would this be enforced? This might be particularly relevant in regional or rural areas where access to vaccinated visiting workers may be limited.

RAT testing for entry by visitors to residential aged care facilities?

Similarly, the testing on entry by visitors could be an additional measure which would be acceptable to visitors and providers to enhance screening. However, similarly to the workforce, there needs to be a consideration of the cost, administration and supervision activities burden generated by its introduction. There would need to be clear protocols for when a result is returned positive and communication proactively established and shared with visitors as to expectations to be followed e.g. in terms of onward referral for a PCR test if that is the determined pathway.

Would this be limited to those who are not vaccinated e.g. because they have an exemption, cannot access the vaccine or should this become a routine feature of screening for entry? Understanding the evidence for RAT as a filter for safe entry in the absence of symptoms needs to be communicated to build acceptance.

Frequency and requirement for PCR based asymptomatic testing

Clear triggers for asymptomatic testing and arrangements for access to testing to be consistently applied. Consideration of issues which need to be factored in the management protocols in the future include:

- How will providers access testing?

- How will testing be applied in residential and community settings that reflects the different risk profiles?
- How will PCR testing interact with RAT testing regimes and the processes to manage contacts/furloughing of staff?
- Will testing on site in residential aged care continue as the most efficient method?

Given that it is likely over time that the mass testing facilities will be stood down ensuring there is an ongoing arrangement needs to be factored in.

QR code/other screening on entry requirements, attestation protocols

There needs to be planning for clarity and consistency for screening into the future, particularly when public health orders/directions are no longer in force. Currently, most screening activities are tailored to the local requirements for the state/territory. This has resulted in jurisdictional differentiation and regimes which also include double handling. QR codes are obligatory in some areas, however, they do not capture the required range of information with public health orders require of residential aged care providers nor that which the Australian Aged Care Quality and Safety Commission expect to see as part of their compliance monitoring. Providers have, therefore, had to have two screening regimes running alongside each other. Learning from the evidence what is the best regime and having this applied in all areas would allow for consistency, particularly when public health orders are lifted.

Other considerations include how providers are enabled to work with their residents, families and staff to determine a risk adjusted approach for their particular setting?

Vaccine status – for workers, residents, clients and families.

There is potential for conflict and these scenarios should be prepared for with clear communication and expectations e.g. who will be the ultimate authority for the provider to call on if a non-vaccinated family demands access to the facility or wants to take the resident to a family outing? Similarly, there are already calls from home and CHSP clients to be attended by only vaccinated staff. Guidance has already been sought from the Department of Health as to how to balance the rights of clients with the rights of the workforce to maintain their privacy. In the absence of a mandate for the home and CHSP workforce for vaccination or to report vaccination to their employers this is an issue which needs to be resolved to instil confidence in clients but also ensure that providers and their workforce are afforded the appropriate protections. For the avoidance of doubt, there is a strong commitment to vaccination as a first line of defence in the sector.

Contact tracing expectations and practices

With the expectation that definitions are to change for close, casual, secondary contacts and the associated isolation/quarantining requirements as 'roadmaps' are followed, the impact on aged care for response and practice will need to be adjusted. The experience to date has been that providers have initiated contact tracing on notification of a contact. Ensuring that the new expectations are clearly described will be essential so that practices can be adapted.

There are currently many discussions around 'vaccine passports' and it will be necessary to understand whether and what their role might be in aged care? For instance, will these be acceptable in the context of screening requirements? Will there be interoperability with screening technology? How will the community be supported to access the technology? In the absence of access to technology what will the alternative be – already providers are facing questions about access to vaccination status for those who do not have access to a computer.

Workforce supply

Workforce pressures were a constant in aged care prior to the introduction of COVID-19. The pandemic response has brought out the best in the aged care workforce as they have worked tirelessly and sacrificially to care for older vulnerable Australians. However, the pandemic has brought additional workforce pressures on supply, capacity in the system and training and expectations on practice. Whilst the roadmaps out of the crisis phase of the pandemic bring an expectation of relaxation of measures the impact of workforce will remain significant.

Ongoing surge workforce support

Surge workforce access has been required in previous outbreaks due to the loss of staff from furloughing and exposure. In the event that furloughing arrangements for contacts are revised (and relaxed) there may be less requirement for surge workforce.

Response to close/casual contact notification

Furloughing of staff has played an important control in the early COVID-19 outbreaks, notwithstanding the significant impact on services and the consequent reliance on access to a surge workforce. However, in the context of vaccination, better IPC approaches, community transmission as a constant, the impact on workforce is such that the arrangements should be reviewed. Given the pressures on workforce and the lack of a surge workforce in the sector this is an urgent consideration.

Impact on furloughing of staff should respond to the points of whether/when/duration/risk mitigation e.g. use of PPE.

Single site working as an infection prevention control activity

Single site arrangements need to be reviewed as cases rise in the community. There are a number of issues that need to be considered.

Community transmission/aged care involvement triggers would need to be adjusted as the current settings would otherwise not be able to be lifted.

Where would triggers now sit – would there be a risk-based approach/in event of an outbreak? The current tiers of escalation and single site stand up and de-escalation criteria are no longer fit for purpose in the context of continuing community transmission.

Given high rates of vaccination in residential aged care do the benefits outweigh the impact on workforce capacity?

If single site does continue – would grant funding follow to ensure that workers were not disadvantaged?

Collaboration between aged care and the public health system

There has been a strong expectation that the public health system will continue to provide support with workforce supply and the transfer of active cases to allow outbreaks within a facility to be managed but it is not clear whether this will continue in an environment where we anticipate more COVID related hospital admissions.

Protocols are required for:

- Transfer to hospital (and other settings) regimes and parameters – with overarching national principles and locally adapted protocols, MoUs, with clearly identified roles, responsibilities and decision makers. These should factor in wishes of the resident, alternative decision makers as well as the organisations involved in the care
- Return from hospital protocols for residents – following transfer for cohorting, treatment or in the event an outbreak had occurred at the hospital. Clear expectations on pre-return testing, cohorting/isolation requirements on return.

Communication with Home and CHSP clients in the community

Many older Australians living in the community receiving CHSP or HCP live in communal settings i.e. Retirement villages, Serviced Apartments, Assisted Living, Rooming Houses, etc. where they have greater exposure to communicable diseases generally and specifically COVID-19. Consideration of the ongoing vaccination and care and wellbeing for clients in their own homes should also feature in any planned given that much of aged care is delivered in these settings.

This includes consideration as to how to engage and protect the extended families, carers and volunteers who interact with the person receiving care. Clear community-based communication is needed so as to ensure that the wellbeing of staff working in these environments can be protected.

Funding

It is clear that aged care providers will continue to incur significant additional costs to protect older Australians from COVID-19 for the foreseeable future. There will be additional and ongoing costs to ensure preparation, prevention, response and recovery related activities which occur outside of an outbreak or active involvement of a provider as a result of COVID-19.

How these ongoing non-outbreaks related additional costs are to be factored into aged care funding needs to be addressed so that providers are equipped and enabled to continue to deliver care which is safe and of a quality which residents and their families expect and which providers are able to offer.

Medium term issues

Escalation tiers

A review of Aged Care Plan and tiers of escalation for the new operating context with concomitant review and adjustments of the intervention measures contained within is required.

The variety of policy documents which are captured in the Aged Care Plan need to be reviewed and updated in light of a renewed risk approach to COVID-19 with cross referencing to ensure consistency between. These need to be systematically reassessed based on the latest evidence and through a thorough understanding of the learnt experience of application. The yet to be published national review into COVID-19 (conducted by Professor Gilbert and Adjunct Professor Lilly) would provide helpful insights into the practical application of policy into real life/real time experiences of COVID-19.

Use of PPE

PPE as a barrier measure is expected to continue into the future. However, there needs to be an evidence and risk-based assessment in context of community transmission and vaccination. Existing measures that have meant high levels of PPE have been required in swarths of the country in the absence of any community transmission carry the risk of being counterproductive and building complacency. Providers also note the ongoing costs for supply chain management, storage, waste etc.

Within the tiers of escalation, new triggers/thresholds would need to be calibrated to reflect the new risk tolerance as determined by the evidence.

Ongoing access e.g. to fit testing, supplies needs to be comprehensively addressed nationally if these are to remain a feature of any PPE requirements.

IPC practices /protocols

Update to the CDNA guidance, Infection Control Guidelines and other support materials will be needed so that they better reflect the latest evidence, context of community transmission, references to vaccination status of staff, residents, visitors, and clients. As these are updated there will need to be clear communication and education on the changes. Consultation with the sector into the proposed changes for operational insight and practicality, consideration of unintended consequences would be helpful to ensure that the results have the best chance of successful implementation.

Ongoing access to (and funding for) IPC training will be required, and timely availability of IPC training courses must be addressed.

Ongoing workforce issues

Issues that will need to be factored as ongoing requirements for the workforce include:

- Access to and funding for ongoing training e.g. IPC formal training, fit testing/checking, PPE donning/doffing, screening protocols, clinical response
- Specialism in COVID so that evidence remains a driver of practice
- Outbreak management training including incident management, command and control training, leadership training
- Strategies to attract staff back into aged care who may have left during COVID will need to be factored given the loss due to fatigue, competing offers (vaccination and testing as well as acute care more generally) and vaccination mandate.

Ongoing outbreak management

Evidence from the 2021 outbreaks has been that predominantly an outbreak has involved one member of staff. Notwithstanding a full outbreak management approach has been implemented for these services which is not risk adjusted to the scale of the outbreak.

Should the evidence suggest that this is to be the pattern going forward consideration needs to be given as to how an outbreak is managed including:

- Cohorting requirements to be reviewed based on the evidence from high rates of vaccinated residents and staff. What does the evidence suggest as to the ongoing need?
- Ensuring arrangements for onsite PCR testing on site in the event of an outbreak be factored into planning
- PPE requirements be reviewed based on evidence

- Management and oversight of an outbreak – will this be calibrated to the scale of an outbreak e.g. experience through Delta has been that most outbreaks involve a single member of staff? Would a full- blown outbreak management plan be required once this became clear?
- Public health communication protocols and expected response times.

BAU for vaccination practices

It is expected that the state of emergency will eventually be stood down. Many of the requirements under which providers are now operating are enacted through public health orders/directions. Whether and how these measures will be continued needs to be considered. For instance, will there be a continuing mandatory regime for vaccination in the absence of the public health orders? What is the expectation? Will this requirement be transferred to e.g. aged care legislative requirements for approved providers?

New resident access to vaccination

Will this continue to be reliant on PHN coordination or become a normal feature of GP activity? Should all older Australians in hospital be offered a vaccination prior to entry into residential aged care?

Annual booster regimes

If/when required will these be introduced. Will these be embedded into standing practice such as for flu vaccination which providers deliver? Ensuring safe, effective and efficient access should be drivers of any roll out design into the future.

Ongoing Expectation

In the absence of public health orders will there be an expectation that any requirement for vaccination by e.g. visitors/community be ongoing, and if so, how?

New staff

Building into onboarding requirements will be a requirement should this requirement be ongoing. In the absence of public health orders this would need to be translated to employment requirements if not in any other legislative instrument?

Visiting professionals

Medical officers, allied health, tradies etc whilst community rates will soon be high if a booster regime is implemented, will prioritised access continue to be available, at least in the short term? Will there be acceptable exemption practices for ad hoc attendance at services?

CONCEPT PAPER - National Aged Care COVID Coordination Centre (NAT-ACCC)

WHY – A new approach is urgently needed to ensure the sector is effectively resourced, enabled and supported to deal with current and future COVID19 waves so that the risks to older Australians in care, and the staff that care for them, are better managed and mitigated.

Based on sound emergency management principles and practices, the proposed approach coordinates action and resources at the national to realise improved pandemic planning and prevention, accompanied by more effective and efficient outbreak response and recovery, in aged care services at the local level.

WHAT

The objective of the National Aged Care COVID Coordination Centre (NAT-ACCCC) is to provide oversight and control of the COVID response in aged care.

NAT-ACCCC provides a national approach ensuring that supports and responses are based on latest evidence and leading practice. Whilst also being targeted, nationally consistent and locally relevant. The Centre brings together all the organisations and resources required to support an emergency management response to COVID-19 in aged care services. It has the authority for the systematic acquisition and application of resources (organisations, people and equipment) to respond the COVID emergency in aged care for the duration of the pandemic. The underlying concept is built on internationally recognised approaches to emergency management.

The Centre would adopt recognised incident management doctrine in its approach so that:

- There is control - National control and coordination will allow line of sight for situational awareness and escalation of response should local circumstances require prioritisation. Control would mean clear decision making, clear lines of responsibility and accountability, and be action oriented.

- There is planning - The collection and analysis of information and the development of nationally consistent plans to coordinate the response with a national perspective, but which allows for locally appropriate deployment and redistribution of resources to where there are most effective and needed. This would include stress-testing local plans to support preparedness.

- There is timely, accurate and transparent information which can inform the coordination of support, provide lessons learnt to update planning processes, and ensure good data for public reporting

- There is a coordinated operational response - Ensuring the resources required to keep people safe (e.g.: staff, PPE, RATs, anti-virals, etc) are secured, correctly calibrated to the need/demand and then efficiently deployed.

- There is a nationally coordinated logistical response. Coordinating the acquisition and provision of human and physical resources, facilities, services and materials. This would include the deployment of the surge workforce, including ADF workforce should a nationally recognised trigger be reached. The securing, coordination and deployment of all resources necessary including PPE, RAT and the logistics associated e.g. to avoid a repetition of the failure of the supply chain between depot and service due to constraints in civilian logistics channels.

In short, underpinned by experienced and qualified leadership and expertise, the NAT-ACCCC will act to ensure that services and staff on the frontline in aged care are resourced and enabled to respond effectively to future waves of COVID19. Conceptually, this approach is similar to the National COVID Vaccine Taskforce led by Lieutenant General John Frewen.

HOW

At the national level, NAT-ACCCC will be responsible for command, control and coordination of COVID preparedness, prevention and outbreak responses in aged care. This role will be supported by 'nodes' in each state and territory (leveraging existing state level arrangements and structures, such as the Victorian Aged Care Response Centre).

In practice the NAT-ACCC would ensure:

- Prevention – coordinate state/territory level IPC training, maintain national program and stocks of consumables for supply and logistics (RAT, PPE, etc); stress-testing at local level outbreak response plans (including acute care, primary care, aged care interface); conduct outbreak preparedness and response audits; etc.
- Preparation – informed by AHPPC, CDNA and other experts, coordinate nationally consistent pro-active approaches to planning state/territory level COVID policies, processes and presumptions. Plan and enable surge workforce capacity and capability via the state/territory nodes;

- Response – in the event of widespread outbreak coordinate resource allocation (e.g.: surge workforce, RAT, PPE, etc) across states/territories. If surge workforce capacity is exhausted then coordinate deployment of ADF personnel for clinical care, on-site support and logistics roles, etc
- Recovery – coordinate supports to states/territories as they transition from 'response' to 'recovery'. Conduct lessons learned and feed outputs back into planning activities.

NEXT STEPS

Convene meetings with relevant officials to test the proposed NAT-ACCCC model for urgent consideration/implementation.

FURTHER INFORMATION

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