Australian Aged Care Collaboration

COVID-19 in aged care – situation report

2 February 2022

Overview

Aged care has always been a critical frontline in the fight against COVID-19. With infections rampant in most parts of the broader community, aged care providers are doing everything they can to keep their clients safe. But with staff and visitors regularly exposed to COVID-19 in their daily lives, there is only so much that aged care providers can do – particularly as infection control measures need to be balanced with continuity of essential services, and the effect that isolation may have on the wellbeing of people in care.

Key infection control measures include screening all staff, clients and visitors (for residential care) for COVID-19 symptoms and exposures, limiting the number of clients that staff interact with as much as possible, regular testing (where tests are available) and use of extensive PPE.

Measures to maintain services and address isolation include a risk-based approach to furloughing of staff in accordance with revised national guidelines, minimising restrictions on movement, (only limiting residents to their rooms as a last resort during an active outbreak in consultation with Public Health Units), regular welfare checks throughout the day and facilitation of remote visitation.

Commonwealth and State and Territory Government support is critical to the ability of aged care providers to protect and provide continuity of care to vulnerable older Australians. However, attempts to provide supports have struggled to scale with the increase in case numbers. This includes critical supports such as the supply of Rapid Antigen Tests (RAT), Personal Protective Equipment (PPE), surge workforce programs, booster clinics, allocation of Case Managers by government, and grants to services directly affected by COVID. In addition, there are further actions that governments (particularly the Commonwealth) need to take to ensure older Australians are protected as much as possible.

Data systems have also struggled to scale. Key information not being published, changes in definitions between reports, lack of consistent time series data and widespread inconsistencies make it very difficult to have a good understanding of what is happening in aged care.

This situation report provides an update on the current state of play and key actions needed from Government. It is supported by a supplementary report which provides more detailed recommendations and analysis of data and operational issues.

Residential care cases and deaths

- 1,261 care homes (47 per cent) had active outbreaks as of 28 January.
- Growth in active outbreaks slowed since 14 January, and growth in new cases has been declining since 20 January, now averaging about 270 cases per day in the week to 31 January.[1]
- Tragically, there were 499 new COVID-19 related deaths in residential care reported in January.
- COVID19 related deaths in aged care homes continue to be announced daily, but it appears that new daily deaths may have peaked around 27 January.
- Vaccinations mean that mortality is significantly lower than in 2020, but it is difficult to accurately estimate the current level of risk, given uncertainties about Omicron, the level of reduced risk from boosters, and gaps in data. **We are calling on states and the Commonwealth to publish more data on the vaccination status of cases and deaths in aged care, and the time period between detection and death so that providers and individuals can better understand the level of risk.**
- There have also been 13,589 new staff cases reported between 23 December 2021 and 28 January 2022.

[1] Note: active case numbers are not reliable and should not be used as explained in the supplementary report.

Home care cases and deaths

- There is no plausible official data on cases or deaths for clients receiving in home and community care, with just 18 cases added to official counts in January.
- Data from a sample of about 27,000 clients across 10 providers found 134 client cases and 330 staff cases in January, suggesting perhaps 5,000 client cases and 12,500 staff cases sector wide (assuming about 1 million total clients).

Operational issues

Vaccination

- Government has committed to providing in-reach booster clinics to all aged care homes by the end of January, and reports that 2,350 clinics have been completed as of 31 January. Resident vaccination levels in residential care have risen in January to more than 92 per cent, but the level of booster coverage is not yet known because it relies on reporting from providers still operating under severe workforce shortages.

Workforce shortages

- Workforce shortages remain a critical problem for the sector. Despite revised furloughing rules and a small expansion in surge workforce support (to about 1,250 shifts per week), providers report that on average a quarter of shifts (about 140,000 per week in residential care alone) are going unfilled. **The recently announced extension of the retention bonus payment to staff provides some additional pay to many staff, but it is much less than shift allowances offered in the Victorian public health system, and excludes reception staff, lifestyle staff, maintenance workers, and people delivering services through the Commonwealth Home Support Program.**

Prevention costs

- Providers have changed operational practices to mitigate the risks of infections and outbreaks occurring. These new pandemic related practices come at significant additional cost adding further financial pressure to already distressed services. Funding for COVID19 costs is limited to services with exposures. **The Commonwealth needs to make funding available (as it has previously) to cover the costs of infection prevention in residential care and home care services.**

RAT and PPE supplies

- Reports from providers about RAT and PPE supply issues remain common. Data suggests there has been a significant increase in the number of RATs, masks and face shields delivered in the week to 28 January. However, it is not clear if this is enough to match demand. **Real data on the number of orders, and volume of stock on order, and the average time to fill orders needs to be published to provide transparency and clarity about the supply situation and enable providers to meaningfully plan. Supply of PPE and RATs also needs to be extended to home care.**

Reducing isolation

- Isolation measures associated with ongoing outbreaks in aged care homes are also placing further strain on residents and staff. Ongoing isolation is not possible in the context of continuing community cases and exposures. **There needs to be nationally consistent and evidence-based guidelines on balancing the risks of COVID-19 and the risks of isolation, in residential care and the community.**

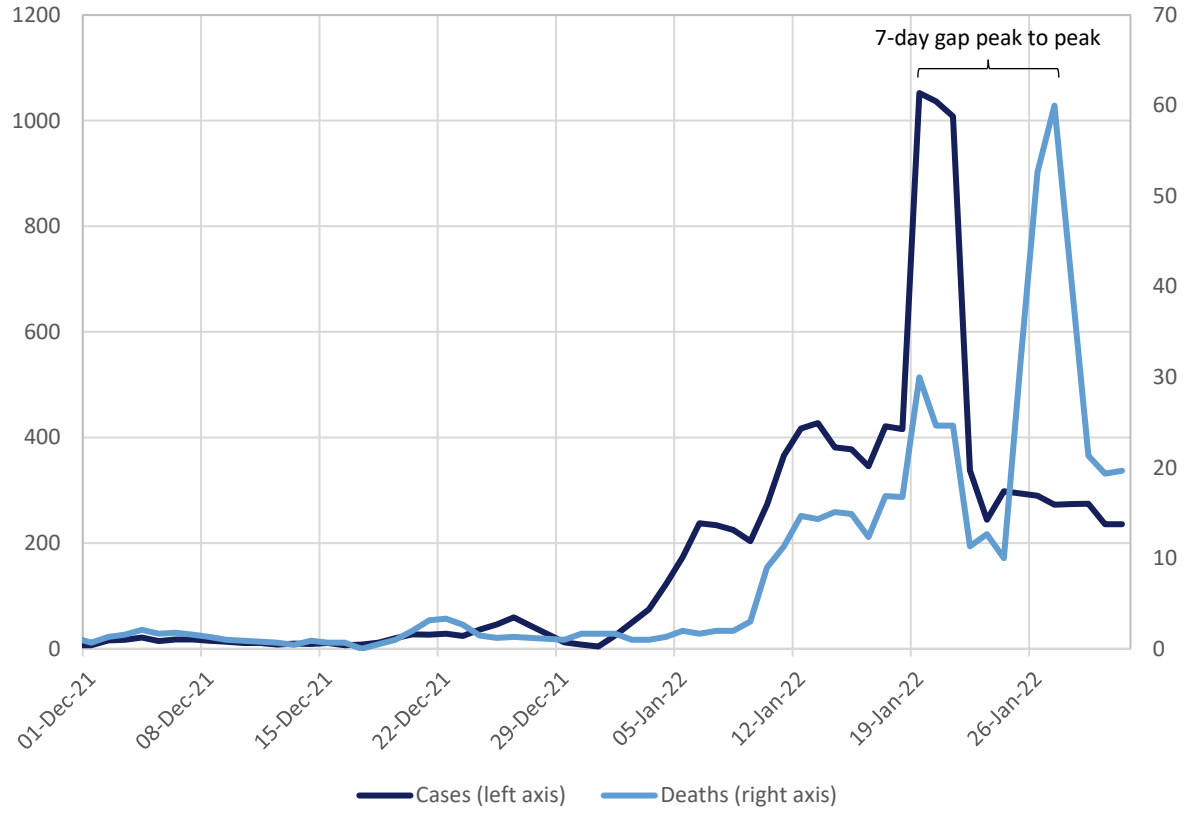
Access to antivirals

- Oral antivirals provisionally approved for use on 20 January have potential to greatly reduce risk for people in aged care. **Governments need to be clear about how and when these treatments will be available to the hundreds of people in aged care still being infected every day.**

Planning for next time

- We cannot continue responding to future COVID-19 waves while the outbreak is occurring, we need long-term, durable policy solutions that can provide certainty to both providers, workers and older people. **There need to be a transparent process to plan for future COVID-19 waves, including ensuring that supports are part of ongoing programs, rather than ad-hoc measures, and capacity constraints are tested and understood by all, including an adequate pool of surge workforce, RAT and PPE supplies, and agreed arrangements between health authorities at all levels of Government.**

Daily reported cases and deaths in residential care residents 1 December 2021 to 31 January 2022
(three point centred moving average, smoothed for weekends and public holidays)



Source: Commonwealth Department of Health Daily COVID at a Glance Infographics, AACC analysis

Total RATs delivered and implied daily deliveries from 1 December 2021 to 28 January 2022

	Total RATs delivered	Implied RATS per day since previous update
28-Jan-22	7,600,000	187,500
20-Jan-22	6,100,000	83,333
14-Jan-22	5,600,000	110,556
21-Dec-21	2,946,655	18,348
16-Dec-21	2,854,915	27,219
08-Dec-21	2,637,160	8,604
01-Dec-21	2,576,935	

Source: Commonwealth Department of Health Residential Care Outbreak Reports, AACC analysis

Total PPE delivered and implied daily deliveries from 29 November 2021 to 28 January 2022

	masks	gowns	gloves	googles/ shields
28-Jan-22	35,400,000	14,100,000	36,200,000	11,500,000
20-Jan-22	27,000,000	13,000,000	34,000,000	10,000,000
29-Nov-21	23,000,000	7,000,000	20,000,000	6,000,000
Implied daily deliveries most recent 8 days	1,050,000	137,500	275,000	187,500
Implied daily deliveries from 29 November to 20 January.	76,923	115,385	269,231	76,923

Source: Commonwealth Department of Health, Residential Care Outbreak Reports, AACC analysis

About the AACC

Everyone deserves quality care as they get older. All of us should be able to get quality care, with dignity, when we need it. That's why we need an aged care system that works. Aged care providers care for more than 1.3 million older Australians, employing more than 430,000 workers.

The Australian Aged Care Collaboration is a group of six aged care peak bodies: Aged & Community Services Australia (ACSA), Anglicare Australia, Baptist Care Australia, Catholic Health Australia, Leading Age Services Australia (LASA) and UnitingCare Australia. Collectively we represent more than 1,000 private, not-for-profit and government run organisations, accounting for about 70 per cent of aged care services in home and residential care.

COVID-19 in Aged Care – Situation Report: Supplementary Report

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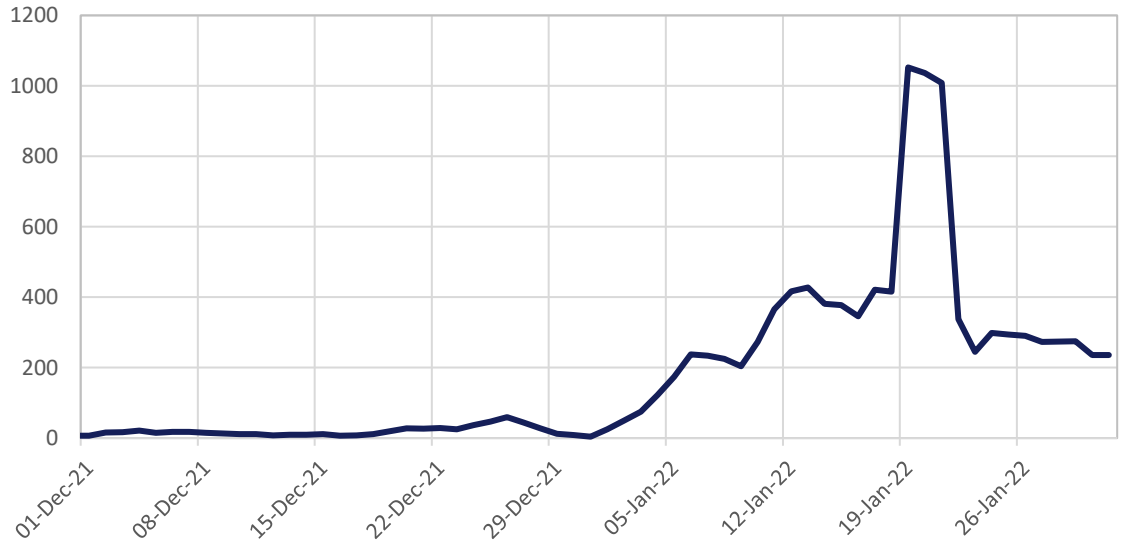
CASE NUMBERS

Cases in residential care and home and community care are reported in daily COVID-19 data[2], with past case counts available in the COVID at a glance infographic series.[3] There are also weekly reports on outbreaks in residential care, which also includes data on staff cases and outbreak numbers.[4]

Our view is that daily new case counts, with smoothing to account for weekend gaps and lumpiness in reporting, provide the best indicator of the current state of COVID-19 outbreaks. As explained below, we do not consider active case counts to be reliable because of issues with reporting recovered cases.

Given the level of surveillance in residential care we believe reports of new cases should be reasonably comprehensive. Another advantage of daily new case counts is that they provide a more forward-looking indicator than total active cases. We suspect that there are delays and 'lumpiness' in updating even new case figures, manifesting in days such as Thursday 20 January 2022, where 2,255 new cases were reported for a single day. There are also spikes after weekends and public holidays when new cases are not reported. Daily case counts therefore need to be smoothed to better represent trends.

The chart below shows the progression of new case numbers in residential aged care since 1 December 2021 (using smoothing of weekend / public holiday case and centred three-point moving average). It shows that new infections in aged care have been rising quickly since the start of 2022, accelerating between 16 and 20 January before declining. There were about 270 new cases on average number of new cases in the last seven days of January.



Home and community care cases

Unfortunately, we believe that case counts in home and community care are inaccurate given how few cases have been reported during the Omicron wave. Only a total of 205 home care cases have been recorded since the start of the pandemic, including only 18 cases in 2022 (as of 28 January).

[2] https://www.health.gov.au/health-alerts/covid-19/case-numbers-and-statistics
[3] https://www.health.gov.au/resources/collections/coronavirus-covid-19-at-a-glance-infographic-collection
[4] https://www.health.gov.au/resources/collections/covid-19-outbreaks-in-australian-residential-aged-care-facilities

Data on home care reflects the fact that home care providers will usually have a more limited role in managing and supporting a COVID-19 positive client than a residential aged care service. For example, home care providers do not report cases to local public health units, in the way that residential aged care services do, and are not generally involved in regular testing and clearing of outbreaks. It would not be appropriate to add these responsibilities to home care providers.

We have asked home care providers indicatively about the number of COVID-19 cases among their client base. Data from a sample of about 27,000 clients across 10 providers found 134 client cases and 330 staff cases in January. This suggests an infection rate of perhaps 0.5 per cent in home care and 0.4 per cent in Commonwealth Home Support Program since the start of January 2022. If this pattern holds across all clients in these programs, then as a rough estimate there would have been a bit under 5,000 infections in home and community care so far in 2022 (assuming about 1 million clients).

The ratio of reported staff to client cases is about 2.5, implying about 12,500 cases among home and community care staff.

Recommendation 1: Government should remove home and community care case numbers from official publications given the likely inaccuracy of these figures.

Problems with active case data

Often, active case numbers have been used to describe the current situation in residential aged care. We do not believe that data on active case numbers is reliable. Active case counts reflect total case counts less recoveries and deaths. Recovered case counts are no longer being published separately because they were inaccurate, but are still implicitly relied upon in calculating active case numbers. The latest outbreak report now describes this figure as 'cases associated with active outbreaks' rather than active cases per se.

For what it is worth, the currently reported number of active cases in the weekly outbreak report is 9,643 as of 20 January 2022. This seems too high. If all cases were resolved within the 7-day isolation period used for community isolation guidelines, the number of active cases would drop to about 2,000 (with smoothing). Recent Japanese data and an analysis of Omicron cases among NBA players in the United States suggests few people are likely to be infectious after 10 days.[5] If only cases in the previous 10 days are counted, the number of active cases would drop on 21 January would drop to bit over 5,000.

A more sophisticated approach to estimating the number of active cases would be to model the resolution of cases as a distribution (i.e., a certain percentage of cases is resolved each day). We believe that more needs to be done to understand the progression of Omicron and how long it takes to resolve in elderly groups, to inform management and testing strategies, and real time case data. The key point is that the headline numbers on active cases should be treated cautiously.

Recommendation 2: Government should either not report active case counts, or provide clear caveats about the uncertainty in this data.

[5] https://www.niid.go.jp/niid/en/2019-ncov-e/10884-covid19-66-en.html ; https://dash.harvard.edu/bitstream/handle/1/37370587/omicron_ct.1-13-22.4.pdf?sequence=1&isAllowed=y

OUTBREAKS IN RESIDENTIAL CARE

According to the outbreak reports as of 28 January 2022 there were 1,261 active outbreaks (covering roughly 47 per cent of facilities). However, the growth in the number of active outbreaks has slowed, with an increase of only 68 active outbreaks in the last week compared to an increase of 91 active outbreaks in the week before and 612 active outbreaks in the week before that.

The above figures represent the change in the total number of active outbreaks. This is different from the number new outbreaks. We should be able to calculate the number of new outbreaks by looking at the change in the number of total outbreaks. However, we cannot do this because there are inconsistencies in the data. For example, 2,616 total outbreaks were reported on 28 January, but the number of active and resolved outbreaks only adds up to 2,384. There are similar (but different) inconsistencies in data for previous weeks.

The various inconsistencies also make it very difficult to make us cautious in calculating the size of each outbreak. Taken at face value, the published figures suggest size of the average active outbreak has risen from 3.4 cases as of 14 January to 6.5 cases on 20 January and now to 7.6 cases on 28 January. Looking at all outbreaks and cases since the beginning of the pandemic, the average size of an outbreak has been 5.3 residents.

Recommendation 3: The Commonwealth should review again data on outbreaks to ensure consistency and explain discrepancies over time, so that there is a clearer picture of the progression of cases and outbreak size.

MORTALITY

People receiving aged care – particularly residential care – have a higher risk of adverse outcomes from COVID-19 than the general population. There is rightfully discussion at present, however, about the need to balance the risks of COVID-19 infections against the effects of infection control measures that may isolate residents. For a provider or individual resident to make a reasonable risk-based decision they need to be able to actually understand the level of risk that they are facing.

There have been 499 new deaths reported in January 2022. The number of deaths reported appears to have peaked as of about 27 January and is currently declining. Over the 7 days to 31 January, an average of roughly 35 resident deaths per day have been reported.

The risk of COVID-19 to older people is now dramatically lower thanks to widespread vaccination. However, the level of risk specific to Omicron is unclear, with evidence that Omicron is generally milder offset against evidence that Omicron has a high level of vaccine evasion. Fortunately, early evidence seems to indicate that booster doses restore the level of protection offered by two doses.

To gain insight into the current level of risk, it is useful to look at previous waves. At the end of 2020 (prior to vaccination) the crude Case Fatality Rate (CFR) for residents in aged care was about 33.4 per cent. This is easy to calculate because at the end of 2020 there were no active cases.

Analysis of the initial wave in 2020 showed that many deaths associated with COVID-19 occurred a significant period after the initial infection, with an average period from detection to death of more than 18 days, and some deaths recorded almost 60 days after infection.[6] This raises some questions about the association between COVID-19 and some of the deaths during the initial wave since the risk of death over a 60 day period for a person in residential aged care (if nothing else is known

[6] https://bmcmedresmethodol.biomedcentral.com/articles/10.1186/s12874-021-01314-w

about them) would be about 4-5 per cent regardless of COVID-19. This is not intended to downplay the severity of the disease or its potential to contribute to pre-mature death, it simply emphasises the importance of adjusting for the baseline mortality rate within the relevant population when trying to understand the level of risk.

It is easy to calculate the crude CFR for the 2020 COVID-19 wave, but it is harder to calculate even the crude CFR for the Delta wave because there is no clear end point, and we do not have access to individual unit records. We can say that as of 3 December 2021, when there were perhaps 127 remaining active cases,[7] the crude CFR calculated based on all resolved cases since July 2021 was 14.1 per cent.

If both susceptibility and mortality risk are significantly higher among the unvaccinated then even the 10 per cent of unvaccinated residents could account for a large share of these deaths. Unfortunately, data on vaccinated versus unvaccinated cases and deaths is not published separately for aged care residents.

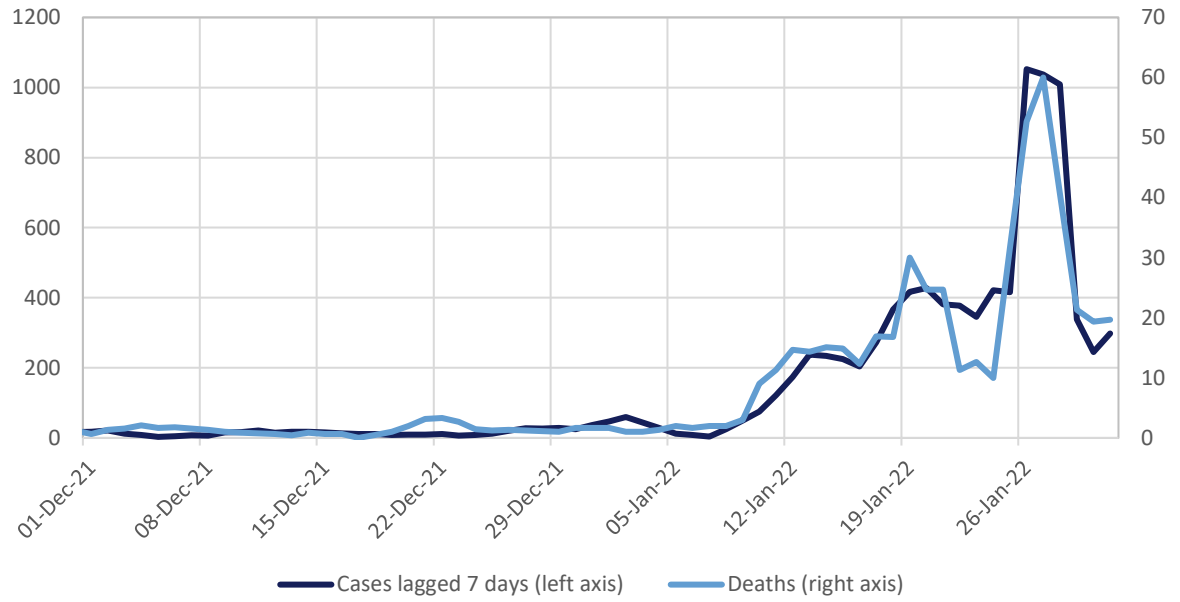
It seems likely that the CFR for unvaccinated residents during the Delta wave would be at least as high as during the initial wave. There is also evidence that the Delta variant is more severe than the ancestral strain. For example, a Canadian study found Delta to be 133 per cent more likely to result in death than the ancestral strain, but this analysis was undertaken on a largely younger cohort.[8] Unvaccinated people would also have been more likely to contract COVID-19, with a US study showing that for the Delta strain vaccination provided 53 per cent protection against symptomatic disease.[9]

If the unvaccinated are twice as likely to be infected they and have the same mortality rate as ancestral COVID-19, the unvaccinated would account for more than half of all deaths. If Delta is significantly more deadly than the ancestral strain, then the unvaccinated could account for the vast majority of deaths during the Delta wave. This in turn would imply a greatly lowered risk for vaccinated residents, which is important to understand when weighing the risks of the disease against the adverse effects of infection prevention and control measures.

It is very difficult to estimate the crude CFR for the Omicron wave without unit data on cases given the current stage of the Omicron outbreak. As noted above, deaths appear to be attributed to COVID-19 significantly after their initial infection is recorded so it is very uncertain what period of time the deaths currently reported should be recorded against.

As the chart below shows, a simple 7-day lag appears to correlate seems to closely align trends in case numbers and deaths. However, this would imply a much more rapid progression of the disease towards death than previous data indicates, so we regard this correlation cautiously.

[7] At least according to the outbreak report, notably the daily data implied 761 active cases
[8] https://www.cmaj.ca/content/cmaj/early/2021/10/04/cmaj.211248.full.pdf
[9] https://www.cdc.gov/mmwr/volumes/70/wr/mm7034e3.htm , noting is likely that this finding was also influenced by waning immunity



For illustrative purposes, looking at deaths from 1 January to 28 January, assuming an average 18 days from detection to death with a standard deviation of 6 and a normal distribution produces a crude CFR of 14.8 per cent (in line with the Delta wave). Whereas assuming an average 10 days from detection to death with a normal distribution and a standard deviation of 4 produces a crude CFR of 7.1 per cent.

Uncertainty about the level of vaccine evasion, and lack of information on booster doses also makes it difficult to estimate the relative susceptibility of the double vaccinated, unvaccinated and boosted. As with the Delta wave, it is likely that the 10 per cent of people who are unvaccinated make up much more than 10 per cent of deaths. This, in turn, pushes down the implied level of risk for those who are vaccinated. Data on cases and deaths by vaccination status would assist in estimating relative risk levels.

Minister Hunt stated at a press conference on 31 January 2021, that 60 per cent of people who had died in aged care were in palliative care and approximately 25 per cent of those to have died were either unvaccinated or partially vaccinated.[10]

Further clarification of these statements is needed. There is currently no official palliative designation for a person in residential aged care. The proposed definition under the the new residential care funding model is person with a prognosis of less than 3 months, a palliative care plan and an Australia-modified Karnofsky Performance Status of less than or equal to 40. As noted above about 4 to 5 per cent mortality would ordinarily be expected over 60-day period within a given aged care cohort, which might equate to perhaps 30 per cent of deaths (depending on the crude CFR). However, it is not clear whether all deaths for a period post infection are included in COVID-19 mortality statistics or whether statistics are based on medical determinations about cause of death.

The share of deaths accounted for by unvaccinated residents quoted by the Minister is less than we would have expected during the Delta wave given higher susceptibility and higher mortality risk. However, it may make more sense in the context of vaccine evasion by Omicron. It is not clear what period of time the statistics quoted by the Minister relate to.

[10] https://www.sbs.com.au/news/scott-morrison-to-announce-cash-handouts-for-workers-in-covid-stricken-aged-care-sector/9a25faf9-0b4a-419f-bbe9-2df91e156a2b

Recommendation 4: Government needs to provide data on mortality rates adjusted for vaccination status, variants and other relevant co-morbidities so that aged care providers, residents and their families can make sensible risk-based decisions about how to live with COVID.

VACCINATION

At this stage, in concert with all other measures, the most reliable protection against COVID-19 is vaccination. This applies to older people, their loved ones, and the staff of aged care services.

Residential care and home care staff are all required to be vaccinated with two doses, unless they have a medical exemption. Current vaccination rates are close to 100 per cent. Boosters for residential aged care staff has also been made mandatory in some jurisdictions.

In residential care the vaccination rate for residents is over 92 per cent as of 31 January 2022. This is lower than desired, despite the efforts of providers and health authorities, though it has risen by several percentage points in the last month.[11]

With widespread COVID-19 cases in an increasing number of communities, getting vaccinated has never been more urgent or important for older people.

The Commonwealth is currently visiting aged care services to conduct booster clinics, to give people third doses. As of 31 January 2022, 2,310 booster clinics had occurred with the remaining clinics to be completed by 4 February. We understand that take-up of boosters in these clinics has been about 80 per cent. We note that there will also be some delay before booster doses take full effect.

We have been advised by the Department of Health that data in the outbreak report on the total number of vaccine doses (provided in the table below) reflects the number of doses reported by aged care providers. This means it fluctuates over time as residents move into and out of care, and vaccination status for new residents are updated. Reporting requirements for third doses have recently been introduced, but with widespread outbreaks and staff shortages, many providers have limited staffing to devote towards this activity. This means comprehensive data on booster levels is not currently available.

		Total doses to residents	Implied doses per day since the previous datapoint
21/01/2022		460,433	1,933
21/01/2022		446,902	1950
14/01/2022		433,251	1140
7/01/2022		425,273	4942
22/12/2021		346,195	2920
17/12/2021		331,594	79
10/12/2021		331,044	-1427
30/11/2021		345,315	3250
25/11/2021		329,064	63
12/11/2021		328,242	-247
2/11/2021		330,710	-1589
29/10/2021		337,066	

[11] https://www.health.gov.au/sites/default/files/documents/2022/01/covid-19-vaccine-rollout-update-31-january-2022.pdf

Recommendation 5.1: Based on the health experts' advice, we support mandatory booster doses for aged care staff, but during the transition phase, providers will need to make risk-based decisions about having staff with only two doses attend work to avoid critical effects on services, just as they are currently doing with potential close contacts. We also seek prioritised pathways for aged care workers to get access to booster shots.

Recommendation 5.2: Inconsistencies in data on the vaccine rollout need to be clarified so that there is a clearer picture of vaccine coverage.

Recommendation 5.3: Advance planning is needed regarding the possibility of a fourth dose, and how this would be best rolled out quickly to aged care recipients.

WORKFORCE SHORTAGES AND MISSED CARE

High levels of community transmission and a historically conservative approach to furloughing have caused extensive loss of staff in both residential aged care and home and community care, mirroring the pressure facing other sectors including the health sector. Loss of staff to infection of close contacts are being reported as ranging from 5 per cent to 50 per cent.

This loss of staff to COVID-19 exposure comes on top of existing workforce shortages, which the sector has been calling for Government to urgently fix.[12]

According to outbreak report data, the Commonwealth surge workforce filled approximately 2,000 shifts in aged care between 23 December 2021 and 7 January 2022, equating to approximately 1,000 shifts per week. This is roughly in line with what the Commonwealth was able to supply during the 2021 Delta wave in October/November. The number of surge workforce shifts was not updated in the 14 January report, and is reported on a different basis for the 20 January report, which makes it impossible to calculate the number of shifts per day that were delivered in the previous two weeks. Looking at the data between 20 January and 28 January, around 1,265 shifts per week were delivered.

The scale of the surge workforce program is clearly insufficient relative to the scale of current workforce shortages, and this seems unlikely to be resolved in the near future.

Based on aged care workforce census data from 2020, we estimate that there are around 565,000 direct care shifts in residential aged care each week. If 25 per cent of shifts are going unfilled (based on provider reports), then the average number of unfilled shifts would be around 141,000 per week.

Government has been working for several weeks on avenues to fill staffing shortages, including volunteers, private hospital staff, and retired and student nurses. We are advised that support from the military has been explored as an option but is not considered viable.

Unfortunately, there is no sign of a surge workforce that might approach the scale needed to address the current crisis. We ask families and clients for their support during this difficult time. Staff and providers are doing absolutely everything they can with the resources they have available.

[12] https://www.careaboutagedcare.org.au/wp-content/uploads/2021/11/AACC_Urgent-Call-for-Action-on-Aged-Care-Workforce.pdf ; https://www.careaboutagedcare.org.au/wp-content/uploads/2021/12/211216-MYEFO-sidesteps-aged-care-workforce-crisis-MR.pdf

An important element of the workforce problem is the need for shift allowances to reflect the additional workload and pressure on staff as they strive to protect residents and clients from infection, and to acknowledge the risk they are exposed to in the event of an outbreak. These payments are needed to retain staff who have been on the frontline in the fight against COVID for the past two years as fatigue and frustration takes its toll. While some funding can be accessed under an outbreak grant funding program, all staff working in aged care during the widescale community transmission should receive additional pay.

Government has made available two additional payments of $400, in line with the retention bonus offered during the first wave of COVID-19. This additional funding is welcome, but is relatively modest compared to shift allowances made available in the Victorian public hospital system. It is also a temporary solution rather than a structural solution that will help address future COVID waves.

A further problem is that many workers are excluded from the retention bonus program, this include reception staff that may be undertaking screening of people entering a care facility, maintenance staff, lifestyle staff and all staff employed the Commonwealth Home Support Program, even though these staff may be delivering the same services as eligible staff employed under the Home Care Package Program.

Recommendation 6: Ongoing discussion is needed about a structural mechanism to appropriately support and reward aged care workers for their contributions during the pandemic.

ACCESS TO RAPID ANTIGEN TESTS

It is now widely acknowledged that the previous testing regime which was reliant on PCR tests is not capable of coping with current levels of demand. There has, therefore, been a national and local shift in some states/territories to reliance on rapid antigen tests. However, this guidance has been issued before a reliable supply chain for these tests has been established.

All aged care homes were to receive RAT kits to test all residents, staff and visitors from early January. However, with widespread omicron infections and limited RAT supplies, the Commonwealth Department of Health has written to all providers to explain these will be distributed only for those who are experiencing outbreaks access.

In practice though we have heard that even Members who are mid outbreak are not being able to source RAT in a timely fashion. A common solution is to seek resources from state health stockpiles that are backfilled by the Commonwealth, but providers are still forced to use RATs on a rationed basis.

Given that RAT is now considered to be a required approach for providers having confidence that they will access to these tools is essential. We understand that Government is working to urgently resolve the current logistical and supply constraints but issues persist.

The table below indicates the number of RATs being delivered from the national medical stockpile to residential care, based on the weekly outbreak reports.

	Total RATs delivered	Implied RATS per day since previous update
28-Jan-22	7,600,000	187,500

20-Jan-22	6,100,000	83,333
14-Jan-22	5,600,000	110,556
21-Dec-21	2,946,655	18,348
16-Dec-21	2,854,915	27,219
08-Dec-21	2,637,160	8,604
01-Dec-21	2,576,935	

Providers need to be able to screen staff, residents and visitors with RATs every 72 hours, and more regularly in cases where an employee may have been exposed to COVID-19, or during an active outbreak.

There are 260,000 aged care workers recorded in immunisation data. Screening each of these workers every 72 hours would require about 87,000 tests per day. Also screening residents would require another 63,000 tests per day, for a total of about 150,000 tests per day. The delivery data suggests that the number of RATs being delivered finally surpassed this level in the 8 days to 28 January 2022.

Unfortunately, 47 per cent of residential care facilities are experiencing active outbreaks means and require more frequent testing (more than offsetting the exclusion of WA and staff currently furloughed). Consequently, we continue to receive reports from Members facing supply difficulties.

There has also been no decision to make RATs available to the home and CHSP workforce. They are in the community now and delivering services. In the absence of a funded support and access to RAT providers have to tackle the open market and these costs are not factored into their pricing schedules.

Government has given permission for providers to recoup the cost of RATs from home care funds, reversing previous advice. However, providers in practice feel that consumers will not be willing to use their funds in this way.

Recommendation 7: Providers in residential care, and home and community care need to be supplied with enough RATs to undertake regular screening of clients, staff and regular visitors.

REVISED TESTING PROTOCOL

A new national testing protocol has been published and states are also preparing their own. However, there is no consistency and in fact these materials can be contradictory. For example, in NSW there is guidance to undertake RAT daily but the Commonwealth recommends testing every 72 hours. Recently AHPPC has published guidance for daily RAT testing, however, with a caveat for less frequent testing of staff in the event of supply constraints. In VIC, the use of RAT tests is a feature of the Pandemic (Visitors to Hospitals and Care Facilities) Order 2022 (No .2) putting a further obligation on providers.

Having a consistent approach is important. In Victoria, new definitions are being introduced which differ to those to which providers are held to account nationally. These also determine the way in which outbreaks are counted. There needs to be urgent and nationally consistent guidance. For example, if a RAT can be evidence for being positive in other settings why not in aged care?

Recommendation 8: National Cabinet needs to agree the recommended frequency of RAT testing for clients, staff, and regular visitors in residential care and home and community care.

PPE ACCESS

Rigorous PPE protocols are vital to effective infection control. However, these rigorous protocols use enormous volumes of PPE. For example, one large QLD provider has reported currently using 25,000 PPE sets a day.

Where possible, providers have established supply arrangements to purchase their own COVID related PPE – despite no funding being allocated for this purpose since early 2021. Government PPE stockpiles are notionally accessible when an outbreak occurs or when a provider is facing an imminent shortage.

However, these arrangements are being challenged due to supply chain disruptions in both the private market and in sourcing deliveries from Commonwealth stockpiles. In many cases, local health authorities are being forced to step in to ensure that PPE is available.

Concerns about imminent PPE shortages are forcing providers to make decisions about how to plan for potential shortages, making it challenge to maximise infection control measures and provide confidence to staff.

The Commonwealth has now asked providers to order PPE from the national stockpile five days in advance. However, we have a number of reports of deliveries taking longer than this, as well as partial deliveries appearing, making it difficult for providers to know how much stock they will have at a given point in time.

We have a report of providers taking matters into their own hands, hiring supply trucks and warehouse space because the usual logistics chain is not functioning. The cost of privately purchased PPE is also immense. And as noted below there is no funding for preventative costs.

Data from outbreak reports suggest that relatively little PPE was delivered from the National Medical Stockpile from 29 November 2021 through to 20 January 2022. The latest data suggests a massive increase in deliveries for masks and goggles/shields. However, there has been relatively little increase in the delivery of gowns and gloves. We have not included sanitiser in this table because we have not heard reports of sanitiser shortages.

The table below shows the change in the number of PPE items delivered since 29 November and the implied rate of delivery per day. While the number of items delivered per day is significant, so too is the volume of PPE being used by services.

	masks	gowns	gloves	googles/ shields
28/01/2022	35,400,000	14,100,000	36,200,000	11,500,000
20/01/2022	27,000,000	13,000,000	34,000,000	10,000,000
29/11/2021	23,000,000	7,000,000	20,000,000	6,000,000
Implied daily deliveries most recent 8 days	1,050,000	137,500	275,000	187,500
Implied daily deliveries from 29 November to 20 January.	76,923	115,385	269,231	76,923

Recommendation 9: To provide greater certainty regarding PPE access, there needs to be transparency about delivery timetables for PPE, support to organise alternative distribution channels where needed, and clarity on availability of PPE for home care. Funding also needs to be made available to fund preventative PPE costs.

COMMONWEALTH AND LOCAL PUBLIC HEALTH UNIT SUPPORT

National and local guidance requires aged care providers to promptly engage with both their local public health unit and the Commonwealth when they experience outbreaks. The local Public Health Unit (PHU) directs the public health response and the Commonwealth case officer is there to support the provider to navigate the outbreak. Providers are experiencing delays in this engagement.

This inhibits for instance the ability to host outbreak management teams with the relevant participants and to close an outbreak, leaving residents in isolation until the PHU agrees or has the capacity to respond.

The Commonwealth Department of Health has advised that it is looking to bring on board additional Commonwealth case officers and is likely to adjust some of the process levers but an indication of timing and detail is required urgently so that providers are aware of expectations. The involvement of the case officer is critical as providers attempt to navigate PPE, RAT supply etcetera. A Member in Queensland has reported that the contact and support from the case officer has been a 'game changer' and therefore greatly appreciated.

The response from states appears to be to adjust the policy levers at the local level as to when PHU involvement is required. However, providers are left accountable to national requirements which has this involvement as a pre-requisite to be compliant.

Recommendation 10: There needs to be a national agreement as to the continuum of involvement of PHUs determined by the risks and degree of infection, including giving providers more support to handle outbreaks based on their own risk assessments.

CASE MANAGERS

Another exacerbating factor in the management of outbreaks has been the shortage of Commonwealth Case Managers. During previous waves these case managers have assisted in coordinating access to essential supports – such as surge workforce, PPE, and testing. However, there have not been enough case managers to support all outbreaks. This has led to increased delays in access to supports.

Recommendation 11: Government must ensure that there are enough case managers to support a large number of outbreaks during widespread community transmission.

SINGLE SITE WORKING

Since the removal of Commonwealth defined 'hotspots', there is now an expectation that staff only work at a single site should an outbreak occur. This is no longer a requirement in whole areas where there is high community transmission.

Those services can access funding to support additional costs associated with single site working through the aged care COVID grant. However, this does not extend to those services who lose the

staff to single site working and may incur additional costs to replace these staff. Nor is it clear whether the funding would allow for the 'no worse off' arrangement for the workforce.

Recommendation 12: Clarity on the role of single site working arrangements, including in outbreak scenarios, is required so that workers and providers are able to plan for workforce appropriately.

PANDEMIC LEAVE FUNDING

Providers are facing increasing numbers of staff who are being forced to be away from work due to exposure. In the past the numbers of staff have been relatively low and there has been access to some funding through hotspot declaration. Now these no longer exist and given the increasing numbers of staff involved, will there be any funding to support staff to appropriately stay away from the workplace until the risk has been addressed?

Recommendation 13: Staff who are forced to take leave because of COVID exposures need to have access to the disaster relief payment.

PREVENTATIVE COSTS

In any crisis there are a number of steps to manage – prevention, preparation, response and recovery. Grant funding has been clarified to allow services to make grant claims for additional COVID-19 related costs from the time a staff member needs to be tested and isolate. However, this does not cover baseline preventative costs, including ongoing IPC leads and PPE use when there are cases in the community but not at the service. Grant applications are also an administratively costly way to pay for costs that will be incurred by almost all aged care providers for the foreseeable future.

Recommendation 14: Government must recognise and fund the costs that aged care providers incur keeping older Australians safe.

OTHER ADMINISTRATIVE REPORTING REQUIREMENTS

Providers have reported they continue to be required to comply with a range of reporting requirements, including for the aged care funding instrument, quality indicator reporting, and a range of other matters.

Given the current workforce crisis it is not possible or responsible for providers to prioritise administrative requirements over immediate care delivery priorities.

Recommendation 15: There needs to be broad relief given to providers in relation to reporting requirements until case numbers recede and the workforce situation normalises.

HOSPITAL SYSTEM SUPPORT

During earlier stages of the pandemic, residents with COVID-19 were often transferred to hospital to reduce the risk of other residents being exposed.

It is important for residents and families to understand that transfer to hospital for residents with COVID-19 is generally no longer possible unless they are exhibiting severe symptoms, given the number of people being hospitalised with COVID-19 with severe illness.

EFFECTS OF ISOLATION

The effects of widespread covid infections are both direct and indirect. Many older Australians at home and in the community are currently isolating to reduce their risk of COVID-19. In the community this may mean not just social isolation but missing out on important care and support.

The effects of isolation increase as the length of the isolation period grows. With the likelihood of ongoing cases in the community, providers and older Australians are being forced to start making risk-based decisions that weigh the risk of exposure to COVID-19 against the risks of isolation.

Everyone is doing their best to make judgements based on the evidence that they have available, but much clearer information on relative risk of transmission and severe disease and death – given vaccination levels, demographics and co-morbidities – would assist in making better decisions – both for providers, staff and older people.

Government is currently working with the sector on revised approaches to lockdown and isolation measures.

Recommendation 16: There need to be nationally consistent and evidence-based guidelines on balancing the risks of COVID-19 and the risks of isolation.

ANTI-VIRALS

On 20 January 2022 the Therapeutic Goods Administration (TGA) provisionally approved two oral antivirals, molnupiravir (sold as Lagevrio) and nirmatrelvir in combination with ritonavir (sold as Paxlovid).

These treatments have the potential to work with vaccination to significantly reduce the risk of COVID-19 to older Australians. Statements made at the time of approval said that doses had been ordered for Australia and would be available within 'weeks'. However, there is no further clarity on when these doses are delivered.

There is also little information on how extensively aged care residents have been able to access Sotrovimab as an existing treatment option.

Recommendation 17: There needs to be a clear plan to urgently provide access to antiviral treatments to people in aged care who contract COVID-19.

PLANNING FOR NEXT TIME

We cannot continue responding to future COVID-19 waves while the outbreak is occurring, we need long-term, durable policy solutions that can provide certainty to both providers, workers and older people.

A transparent and consultative planning process is needed so that everyone is better prepared in future. There needs to be transparency about the capacity constraints of the support programs, and wargaming about how the system would respond to different scenarios. For example, it is possible that as we enter winter, Australia could experience combined waves of COVID and seasonal flu (notwithstanding low rates of flu identified in the community in recent years).

There also needs to be ongoing support for workforce incentives and preventative costs rather than one-off payments where the case needs to be re-prosecuted for every new wave.

Recommendation 18: There need to be a transparent process to plan for future COVID-19 waves, including ensuring that supports are part of ongoing programs, rather than ad-hoc measures, and capacity constraints are tested and understood by all.

LIST OF RECOMMENDATIONS

Recommendation 1: Government should remove home and community care case numbers given the likely inaccuracy of these figures.

Recommendation 2: Government should either not report active case counts, or provide clear caveats about the uncertainty in this data.

Recommendation 3: The Commonwealth should review again data on outbreaks to ensure consistency and explain discrepancies over time, so that there is a clearer picture of the progression of cases and outbreak size.

Recommendation 4: Government needs to provide data on mortality rates adjusted for vaccination status, variants and other relevant co-morbidities so that aged care providers, residents and their families can make sensible risk-based decisions about how to live with COVID.

Recommendation 5.1: Based on the health experts' advice, we support mandatory booster doses for aged care staff, but during the transition phase, providers will need to make risk-based decisions about having staff with only two doses attend work to avoid critical effects on services, just as they are currently doing with potential close contacts. We also seek prioritised pathways for aged care workers to get access to booster shots.

Recommendation 5.2: Inconsistencies in data on the vaccine rollout need to be clarified so that there is a clearer picture of vaccine coverage.

Recommendation 5.3: Advance planning is needed regarding the possibility of a fourth dose, and how this would be best rolled out quickly to aged care recipients.

Recommendation 6: Ongoing discussion is needed about a structural mechanism to appropriately support and reward aged care workers for their contributions during the pandemic.

Recommendation 7: Providers in residential care, and home and community care need to be supplied with enough RATs to undertake regular screening of clients, staff and regular visitors.

Recommendation 8: National Cabinet needs to agree the recommended frequency of RAT testing for clients, staff, and regular visitors in residential care and home and community care.

Recommendation 9: To provide greater certainty regarding PPE access, there needs to be transparency about delivery timetables for PPE, support to organise alternative distribution channels where needed, and clarity on availability of PPE for home care. Funding also needs to be made available to fund preventative PPE costs.

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Recommendation 11: Government must ensure that there are enough case managers to support a large number of outbreaks during widespread community transmission.

Recommendation 12: Clarity on the role of single site working arrangements, including in outbreak scenarios, is required so that workers and providers are able to plan for workforce appropriately.

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