Public Health Workforce Surge Guideline

1. Guiding Principles

During a public health incident/outbreak it is important that the public health workforce has adequate capacity to enact an effective response. This requires a sufficient number of available staff with the necessary skills and expertise to meet rising demands. If the magnitude or nature of a public health emergency exceeds the available capacity of the existing public health workforce, a 'surge' in staff may be necessary.

The WA health system Infectious Disease Emergency Management Plan (IDEMP)[1] describes how the WA health system responds to infectious disease emergencies within Western Australia. Public health emergencies that can be managed within the capacity of existing health services do not warrant activation of the IDEMP.
This document aims to provide guidance for the WA Country Health Service (WACHS) in 'surging' staff in response to a public health incident/outbreak that does not enact the IDEMP but exceeds existing local/regional capacity to respond to the emergency.

Whilst Public Health Workforce Surge Planning is a local/regional activity, it is envisaged that established plans can be easily incorporated into Statewide surge when the IDEMP (or equivalent) is enacted.
The WA health system responds to infectious disease emergencies using a five phase approach:

1. PREVENTION & PREPAREDNESS
2. STANDBY
3. INITIAL ACTION
4. TARGETED ACTION
5. STAND DOWN

This guideline has been adapted from the New South Wales (NSW) Government Public Health Workforce Surge Guidelines.[2]

Appendix 1 provides a quick reference guide of the Public Health Unit Surge Activities for the Region including the triggers and responses to an infectious disease emergency according to these five phases. The quick reference guide contains standard actions in-line with the IDEMP, WACHS COVID-19 Emergency Management Framework[3], and Interim Respiratory Infectious Disease Emergency Response (RIDER) Plan[4], and has the capacity to be adapted to accommodate the triggers and further activities specific to each Region.

2. Guideline

2.1 Prevention & preparedness phase (default phase)

During this phase, the Director of Population Health (DPH) within each WACHS region is responsible for ensuring strategies are in place to enable appropriate local and regional response should a public health emergency arise. To ensure preparedness, DPH is to ensure the following on an annual basis, when planning for public health incidents/outbreaks:

- A sound level of understanding of the regions current public health service model for public health responses e.g. is there a large dependency on primary health care staff?
- The capacity of the existing workforce to respond to incidents/outbreaks and knowledge of the populations that these may effect
- Preparation of a register of prospective WACHS staff in the region with existing skills that could be called upon if required
- Understanding of the principles that underpin the triggers to move between phases
- The additional workload and types of staff that maybe requested depending on disease characteristics and provided as surge capacity
- Business continuity during a period of workforce surge when low priority tasks may need to be transferred or temporarily suspended
- The potential sources of staff that may be available when public health workforce surge is required and the IDEMP has not been activated, and the processes for requesting staff in an escalated manner from within the region, within WACHS
- The training needs and materials for existing and potential surge staff to enable integration of surge staff into existing public health structures quickly, productively and safely
- Undertake an exercise focusing on the principles of emergency management, command, control and communication
- The legal, industrial and practical logistics for engaging surge staff and integrating them into the public health response

2.1.2 Triggers for escalation

The need for surge staff is influenced by the features of the incident/outbreak, the existing resources of the responding public health team, the service model in the region and the potentially affected population. When the public health demand increases or is likely to increase, workforce surge processes should be initiated early and decisions about surge requirements made by the regional DPH in conjunction with Public Health Physician/Consultant and Public Health Manager according to this guideline. Escalation and de-escalation within the INITIAL and TARGETED ACTION stages should be scalable and proportionate to need (see Appendix 1) i.e.:

- Low surge (20% increase above baseline activities)
- Medium surge (100% increase above baseline activities)
- High surge (200% increase above baseline activities)[3]

The following factors may influence the need to initiate then stand-down a public health workforce surge response:

Features of the threat
A public health incident/outbreak requiring surge capacity may occur independently of acute health emergencies and/or in a localised area, and may not require a surge across the whole region.

Features of the incident/outbreak to be considered when determining the response and resourcing include:

- Duration (short vs. long)
- Onset (slow vs. rapid)
- Spread (local/district vs. regional vs. state-wide)
- Severity (mild vs. severe)
- Transmissibility (low vs high)
- Contact exposure (few vs. many)
- Exposure pathways (few vs. many)
- Concurrent events (single vs. multiple)
- Identification of cause (known vs. unknown)

Features of the Public Health Team
The composition and capacity of public health teams across WACHS regions differs and therefore each team has varying levels of reserve capacity to cope with a surge in workforce demands. For example, a typical public health response in a large region is led and implemented by the Public Health Team but public health actions may be executed by Primary Health Care (PHC) located on the ground in affected communities. In this situation, surge may be required in PHC rather than the Public Health Team.

Activation of the TARGETED ACTION phase will be dependent on the available resources, environmental context at the time and be influenced by:

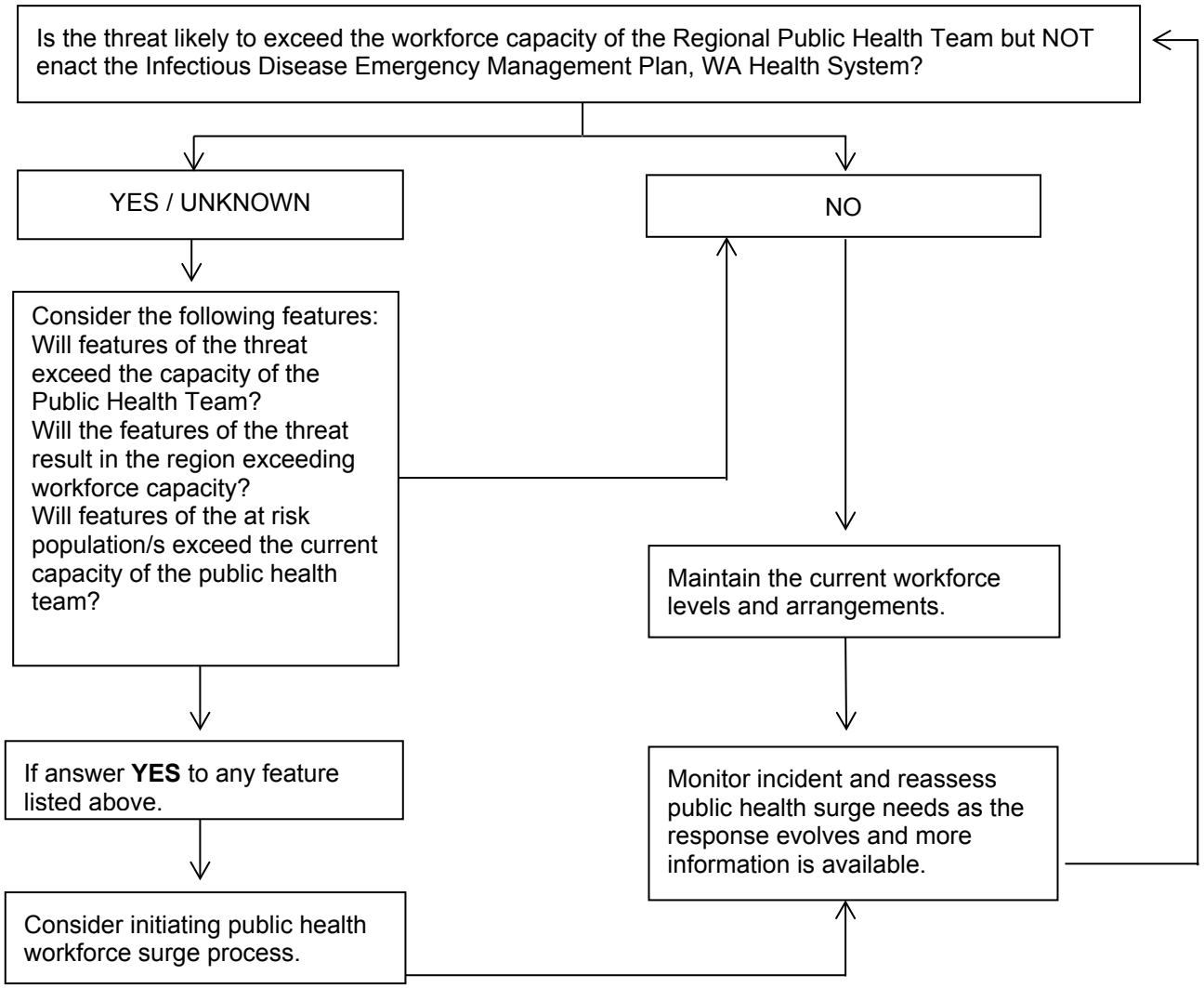
- Existing number/capacity of public health staff and other staff with public health expertise (skills, locations, number, current vacancies)
- Personnel availability (absenteeism may be elevated due to a public health incident or during holiday periods when staffing levels are reduced)
- Infrastructure (physical space and information communication technology capacity)
- Geographical barriers (staff access to affected rural and remote communities)

Features of the potentially affected population
During a public health response the population(s) at risk should be identified with a particular focus on vulnerable groups. Features of the vulnerable population(s) that may influence public health surge requirement include:

- Size (i.e. number of people and proportion of the broader community)
- Demographics and diversity (i.e. age, gender, socioeconomic status, ethnicity)
- Location (i.e. community access and isolation)

A summary diagram for determining the need to move from an INITIAL ACTION to TARGETED ACTION phase when considering the features of the incident/outbreak is shown in Figure 1. below.

Figure 1: Determining the need to move from an INITIAL ACTION to TARGETED ACTION phase



2.1.3 Authority to escalate

Authority to escalate to the phases of these guidelines rests with the regional DPH.

2.2 Targeted action phase

A range of skills may be required during the public health response to manage both the incident/outbreak and maintain other priority 'business as usual' processes e.g. the management of other communicable diseases.

2.2.1 Workload requirements during public health surge response

The activities performed during a surge response may require generic health skills or be highly specific to the incident/outbreak. The regional context and existing capacity at

the local site of the incident/outbreak will also influence workload requirements and the selection of surge staff.
Activities that may need additional support during public health surge include:

- Case finding and contact tracing (e.g. conducting interviews)
- Case and contact management (e.g. supporting those in home isolation/quarantine)
- Infection prevention and control (e.g. advising clinical partners about the pathogen and providing advice about safe interaction with cases, the use of PPE, and environmental cleaning)
- Mass drug administration
- Mass vaccination
- Internal/partner agency communication (e.g. briefings, reports)
- Health risk assessment (e.g. assessing needs and identifying exposure pathways)
- Health risk communication (e.g. fact sheets, letters)
- Information management (e.g. maintaining data system/record entries)
- Pathology liaison) e.g. confirming specimen collection, transport and processing
- Surveillance (e.g. monitoring and analysing disease progression in the community)
- Managing enquiries from within the health system, the public and media
- Logistics (e.g. arranging supplies and managing them in accordance with relevant controls e.g. cold chain, secure storage and accounting for use and loss)
- Document control (e.g. using endorsed processes)
- Development of Structured Administration Supply Arrangements (SASAs) (if required)
- Development of Standard Administrative Processes (SAPs) (if required)
- Development of Standard Operating Procedures (SOPs) (if required)

2.2.2 Business continuity during surge response

Some public health tasks are considered essential to maintain at all times, such as managing other urgent communicable diseases. All population health units should develop a business continuity plan (BCPs) that identifies critical activities that must continue to be delivered during a surge event, and less critical activities that can be temporarily suspended or reallocated to other work areas when resources are stretched during a surge response.
A phased approach to redirecting less urgent work is the first approach to meet increasing demands. Although the context of the incident/outbreak and regional context and capacity will influence workload prioritisation, (Appendix 2) provides some guidance. Public health teams should also assess the minimum staffing levels required to adequately maintain various levels of their own public health service provision as

well as, in conjunction with primary health care team, the levels required in primary health care for public health functions.

2.2.3 Identifying surge staff

Identifying surge staff with relevant skills is a key feature of public health emergency preparedness and will contribute to the efficiency of a surge response.
The release of staff to assist in a surge response will be influenced by the expected duration and pervasiveness of the response.
Staff with various backgrounds may be engaged to provide diverse skills required during a surge response. The Surge Capacity Grid (Appendix 3) provides assistance to identify an appropriate public health surge workforce.
Types of staff that may contribute to public health surge response include:

- Additional public health professionals (e.g. physicians/consultants, managers and nurses)
- Other health professionals from within WACHS (e.g. rural clinical nurses, immunisation providers, community nurses, hospital nurses, medical officers, Aboriginal health workers/liaison officers, environmental health staff and health promotion officers)
- Health managers (e.g. population health directors, program managers, nurse managers)
- Administration support including office and business managers and data entry personnel (personnel with access to data systems)

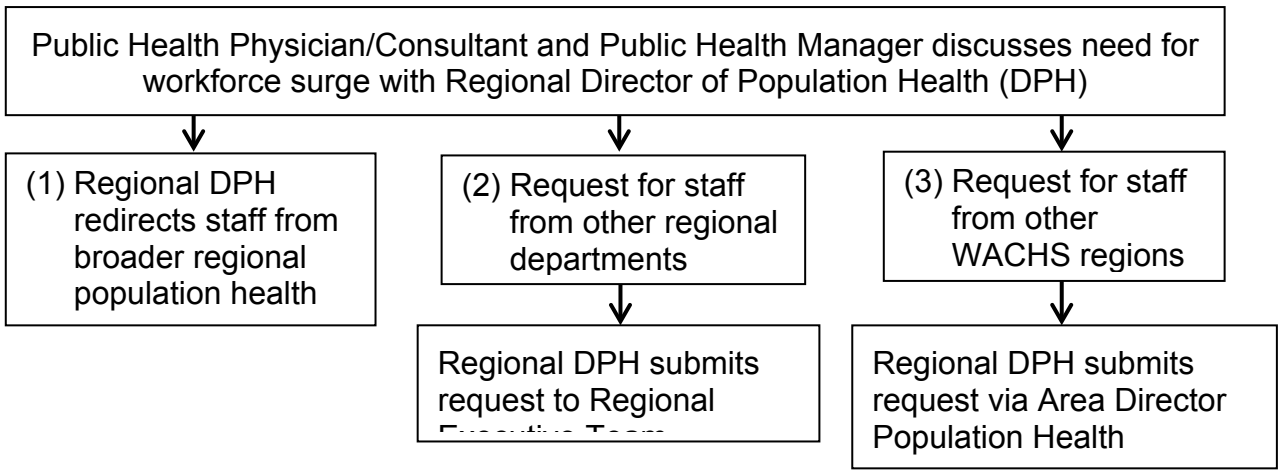
Consideration must be taken to minimise exposure for staff that are at increased risk of adverse events from the underlying incident/outbreak. For example, consideration should be given to staff vaccination status, underlying health conditions and pregnancy/preconception status.
Consideration must also be given to cultural competence and the provision of a culturally responsive workforce.

2.2.4 Process for escalating workforce surge response

When the need for additional resources in public health and/or primary health is identified, the regional DPH is to initially source locally and escalate as required (Figure 2). Depending on the skills required, the suggested order for requesting staff is:

1. Broader regional Population Health Unit
2. Other departments within the region through medical and nursing directors, managers of mental health and aged care, and local agency staff where they are available
3. Other regions through the relevant Regional Director and regional DPH

Figure 2: Process for escalating workforce surge response



2.2.5 Integrating surge staff into the team

Surging staff effectively during a public health response requires the application of adequate orientation and rostering procedures. When staff are temporarily relocated, the relevant provisions of Industrial Awards, requirements in relation to Occupational Health and Safety and Working with Children Checks must be observed. Staff must continue to work within their scope of professional practice.

The regional DPH is to ensure that staff providing the surge capacity are provided with adequate (fast track) orientation and rostering processes are used to reflect hours worked.

2.2.6 Training needs of surge staff

The time available to provide extensive training for staff becomes very limited once a public health surge response has begun. Ideally training of an identified surge workforce should happen prior to a surge. Once staff with applicable skills for a surge are identified (Appendix 3: Surge Capacity Grid) can be used as a guide), any necessary additional training should be undertaken as soon as is practical, and should focus on the specific incident/outbreak and task the staff member is required to undertake.

Training delivered at the time of a surge response will be at the discretion of the Public Health Physician/Consultant and Public Health Manager and may include:

- Orientation to workplace and introductions to staff
- Description of public health threat and anticipated response
- Instruction on the required roles and responsibilities
- Specific ‘at risk’ population requirements and cultural considerations
- Local cultural awareness
- Overview of response-specific communication arrangements
- Relevant information management tasks and systems
- Specific technical skills related to designed tasks
- Education on management of actual and perceived personal risks
- Review of logistical considerations for workforce surge

2.2.7 Logistics of surging a public health workforce

The provision of public health surge staff has logistical implications for the staff and the departments/organisations releasing staff. The regional DPH is to ensure that effective communication occurs with the department/organisation providing the surge staff.
The logistical considerations for effectively integrating surge staff should be agreed among all affected stakeholders early in the surge process and may include:

- Legal requirements (i.e. liability, indemnity, criminal checks)
- Industrial considerations (i.e. awards, leave allowances, overtime)
- Timeframes (i.e. duration of release of surge staff)
- Cost absorption (i.e. responsibility for salaries of the released/engaged staff)
- Travel and accommodation requirements
- Access to clinical applications and information systems
- Workstation (i.e. office, computer, phone)
- Facility access (i.e. swipe cards, security)
- Rostering (i.e. work hours, breaks)

It is advisable that regions set up a blank cost centre to enable the cost of the surge to be tracked and used for further planning/resource allocation. The plan for logistical considerations for the Public Health workforce surge can be documented in Appendix 4.

2.3 Stand down phase

As the public health demand decreases the decision about which public health surge staff to stand-down should be made locally by the regional DPH in consultation with the Public Health Physician/Consultant and Public Health Manager. Surge staff may be retained for a period after the public health threat has subsided to assist with retrospective evaluation and completion of tasks that were temporarily paused during the surge.
It is important that adequate debriefing and support is available during the surge and after stand-down. Evaluation of the overall response should capture feedback from staff involved to facilitate lessons learned and contribute to developing best practice for future public health incidents/outbreaks.

3 Definitions

Public health incident/outbreak	A serious public health risk involving potential harm to public health that is irreversible, of a high impact or on a wide scale. A formal declaration is not required, however, when the Chief Health Officer (CHO) determines a serious public health risk exists, affected stakeholders will be informed.[5] A public health incident/outbreak may arise in the following situations: • A single case of a serious illness with major public health implications (e.g. measles hepatitis A, viral haemorrhagic fever, XDR-TB) where action is necessary to investigate and

	prevent ongoing exposure to the hazardous agent • Two or more linked cases that could indicate the possibility that they may both be caused by the same known or unknown agent or exposure i.e. an outbreak Higher than expected number of cases or geographic clustering of a serious pathogen; a high likelihood of a population being exposed to a hazard (e.g. a chemical or infectious agent) at levels sufficient to cause illness, even though no cases have yet occurred (e.g. contamination of the drinking water supply)
Public health workforce surge	The formal or informal employment of additional personnel to assist and augment the Public Health Team during a Public Health Incident/Outbreak. A workforce surge may be required when the magnitude or nature of a public health incident/disease outbreak exceeds the available capacity of the existing regional public health workforce **but does not enact** the WA Health Infectious Disease Emergency Management Plan.
Emergency Operations Centre (EOC)	A location for the coordination of information and resources to support incident management activities. Such a centre may be a temporary facility, or may be established in a permanent location.[6]
Public Health Emergency Operations Centre (PHEOC)	The PHEOC, is a public health oriented EOC A PHEOC integrates traditional public health services into an emergency management model. It supports and is a component of existing national disaster management authorities or entities.[6]
State Health Incident Coordination Centre (SHICC)	The State-level centre responsible for the strategic coordination of the Health response to an incident.[7]

4 Roles and Responsibilities

The responsibilities below are a guide and may be delegated to a different appropriate role if necessary.

Area Director Population Health (Central Office)
The Area Director Population Health is responsible for assisting the regional DPH in requesting surge staff from other WACHS regions.

Director Population Health (Regional)
The regional DPH is responsible for:

- Ensuring strategies are in place to enable appropriate local and regional response to a public health incident/outbreak
- Arranging backfilling of staff on secondment for surge assistance e.g. Public Health Physician/Public Health Nurses seconded by PHEOC to assist in case management and contact tracing
- Determining the need for a surge in public health workforce in consultation with the regional Public Health Physician/Consultant and Public Health Manager according to this guideline
- Requesting appropriate workforce surge support through appropriate channels as outlined in this guideline
- Leading or delegating to the Public Health Manager and/or Public Health Physician/Consultant, the workforce surge response once initiated including the operational aspects such as rostering, training and communication with surge staff and those departments/organisations releasing staff
- Liaising and communicating with respective WACHS Regional Director and other regional executive staff
- Determining the need to STAND-DOWN in consultation with the regional Public Health Physician/Consultant and Public Health Manager

Public Health Physician/Consultant
The regional Public Health Physician/Consultant is responsible for:

- Working with the regional DPH and the Public Health Manager to determine the need for a surge in public health workforce
- Assisting the regional DPH and Public Health Manager in leading the workforce Surge response once initiated
- Assisting regional DPH and Public Health Manager in determining the need to STAND-DOWN
- Leading the evaluation of surge response after STAND-DOWN

Public Health Manager
Where a Region does not have a Public Health Manager, the DPH will allocate the role to an appropriate person e.g. Clinical Nurse Manager Public Health/Disease Control. The regional Public Health Manager is responsible for:

- *Ensuring strategies are in place to enable appropriate local and regional response to a public health incident/outbreak*
- *Working with the regional DPH and the Public Health Physician/Consultant to determine the need for a surge in public health workforce*
- *Coordinating business continuity during the surge response*
- *If delegated by the regional DPH:*
    - *Leading the workforce surge response once initiated including the operational aspects such as rostering, training and communication with surge staff and those departments/organisations releasing staff*
    - *Determining the need to STAND-DOWN in consultation with regional DPH*
- *Assisting the Public Health Physician/Consultant in the evaluation of surge response after STAND-DOWN*

Public Health Clinical Staff (including Clinical Nurse Manager Public Health/Disease Control)
The Public Health Unit clinical staff are responsible for:

- BAU priorities

- Clinical lead of surge staff
- Training and coordination of surge staff
-

Complex Care Coordinator

If required, the Complex Care Coordinator is responsible for:

- Triage and assessment of Complex Case requirements
- Referral to appropriate Regional services
- Case Coordination (as required)

It is not a requirement for the Complex Care Coordinator to be an independent role, it may be fulfilled by surge staff or existing Public Health staff.

Surge staff

Surge staff are responsible for:

- Participation in any orientation and training required in relation responding to the incident/outbreak; including cultural competence
- Participating in evaluation of surge response after STAND-DOWN

Roles within the surge staff do not have to be completed by separate people. If it is appropriate in each region, multiple roles can be fulfilled by the same person or existing positions.

Surge roles and supporting services may include but are not limited to:

- Aboriginal Health/Community Liaison
- CALD Liaison
- Case & Contact Tracing (e.g. conducting interviews)
- Case & Contact Management (e.g. supporting those in home quarantine)
- Infection Prevention & Control (e.g. advising clinical partners about the pathogen
- Internal/partner agency communication/liaison (e.g. briefing executive teams)
- Risk communication (e.g. to general public to raise awareness of event & ways to minimise illness risk)
- Information Management
- Interpretation and Translation of documents and other communications
- Laboratory liaison (e.g. confirming specimen collection)
- Surveillance (including support for enhanced surveillance as directed by SHICC)
- Support for quarantined persons
- Managing enquiries from the public
- Logistics
- Document control
- Vaccination

5 Compliance

Failure to comply with this policy document may constitute a breach of the WA Health Code of Conduct (Code). The Code is part of the Integrity Policy Framework issued pursuant to section 26 of the *Health Services Act 2016* (WA) and is binding on all WACHS staff which for this purpose includes trainees, students, volunteers, researchers, contractors for service (including all visiting health professionals and agency staff) and persons delivering training or education within WACHS.

WACHS staff are reminded that compliance with all policies is mandatory.

6 Records Management

All records are to be stored in stored in the approved Electronic Documents and Records Management System and in line with the following WACHS policies:
Records Management Policy
Health Record Management Policy

7 Evaluation

The WACHS Population Health Leadership Team is to undertake a review of guideline every three (3) years or sooner if required.
Whenever this guideline is enacted, the relevant region is to undertake an evaluation of the overall response to the incident/outbreak and impact of the workforce surge.

8 Standards

National Safety and Quality Health Service Standards - .1, 1.2, 1.3, 1.5, 1.6, 1.7, 1.10

9 Legislation

Health Services Act 2016 (WA)
Public Health Act 2016 (WA)

10 References

1. Infectious Disease Emergency Management Plan, WA Health System (2017)
2. New South Wales Government Public Health Workforce Surge Guidelines, (2014) accessed 1 March 2018.
3. WACHS COVID-19 Emergency Management Framework (V1.0) (2020)
4. Interim Respiratory Infectious Diseases Emergency Response (RIDER) Plan (2020)
5. Public Health Act 2016 Handbook
6. World Health Organization (WHO) Framework for a Public Health Emergency Operations Centre (2015)
7. SHERP: State Health Emergency Response Plan V1 (2018)

11 Related Policy Documents

WACHS Emergency (Disaster) Management Arrangements Policy

12 Related WA Health System Policies

Infectious Disease Emergency Management Plan, WA Health System (2017)

13 Policy Framework

Public Health
Clinical Services Planning and Programs
Clinical Governance, Safety and Quality

This document can be made available in alternative formats on request for a person with a disability

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Appendix 1: Public Health Unit Surge Activities for the Region

IDEMP / RIDER Stage	Definition	Surge Criteria (Triggers)	Regional Public Health Actions
Prevention & Preparedness	No public health emergency currently exists	N/A	**Maintain Business as Usual (BAU) Public Health services** **Planning and routine disease control programs continue** • Establish pre-agreed arrangements by developing and maintaining plans • Research Infectious disease management strategies • Ensure resources are available and ready for rapid response • Monitor for the emergence of infectious diseases and investigate possible cases and/or contacts if they occur **Further Prevention & Preparedness activities** • _____ • _____ • _____ • _____
Response – Standby	Recognition of the emergence of a serious infectious disease threat overseas or interstate *OR* Sustained community person to person transmission of a serious infectious disease overseas or interstate	N/A	**Initial planning and preparation** • Review and update the Public Health Business Continuity Plan and this Public Health Workforce Surge Plan • Review relevant outbreak management plans e.g. Residential Aged Care Facility Outbreak Plan • Reduce non-essential meetings to enable more time to plan and prepare • Plan and prepare for alternative service delivery modalities • Prepare to commence enhanced arrangements • Prepare targeted and culturally appropriate and relevant communications to at risk people, etc. • Workforce contingency planning for next stages if staff become sick, having home caring roles or need to self-quarantine/isolate • Communicate to raise awareness and confirm governance arrangements • Any further planning/preparation activities relevant to the Region • Familiarise staff with case management and contact tracing **Further Response – Standby activities** • _____ • _____ • _____

IDEMP / RIDER Stage	Definition	Surge Criteria (Triggers)	Regional Public Health Actions
			•

IDEMP / RIDER Stage	Definition	Surge Criteria (Triggers)	Regional Public Health Actions
Response – Initial Actions **Implement initial response actions if definition is met and noting the surge criteria (low surge)**	A serious infectious disease threat is present in WA that has the potential to cause an emergency *OR* Sustained community person to person transmission of a serious infectious disease in interstate jurisdictions *OR* A small number of cases and/or contacts are present in the Region *OR* High Surge has been triggered in another Australian jurisdiction (within WA or interstate) requiring cross-jurisdictional support *OR* PHEOC have requested assistance in contact tracing and case management *AND* Insufficient information about the serious infectious disease presence to move from Standby to Targeted Action.	PHEOC have requested assistance in contact tracing and case management AND/OR *According to the RIDER Plan; Low Surge is 20% increase of requirements above capacity* _____ _____ _____ _____ _____ AND/OR _____ _____ _____ _____ _____ AND/OR _____ _____ _____ _____ _____	**Admin & Management** • Advise WACHS EOC • Reform the LEOC / REOC structure for decision making during the response **Communication** • Communicate internally and externally to advise on current escalation status of Public Health response • Respond to media via WACHS central office **Workforce** • Utilise surge workforce • Separate staff teams for duration of response • Monitor staff health, wellbeing and fatigue • Risk management for staff, including those with increased vulnerabilities **Resources and Equipment** • _____ • _____ • _____ • _____ **Policy and Guidelines** • Public Health Response planning complete for each site including patient flow, staffing, cohorting and service delivery **Monitoring & Evaluation** • Collect and monitor escalation data • Monitor cases and close contacts • Carry out daily situational analysis **Further Response – Initial Action activities** • _____ • _____ • _____ • _____

IDEMP / RIDER Stage	Definition	Surge Criteria (Triggers)	Regional Public Health Actions
Response – Targeted Actions **Implement additional targeted actions in Region if the definition is met but PROPORTIONATE to the numbers of cases, extent of community transmission, and resource requirements noting surge criteria - moderate to high surge.**	Serious infectious disease threat is present in WA that has the potential to cause an emergency *OR* Sustained community person to person transmission in another Australian jurisdiction (within WA or interstate) *OR* Cases and/or contacts are present in the Region *OR* High Surge has been triggered in another Australian jurisdiction (within WA or interstate) requiring cross-jurisdictional support *OR* PHEOC have requested assistance in contact tracing and case management *AND* There is sufficient information about the serious infectious disease presence to implement Targeted Actions	PHEOC have requested assistance in contact tracing and case management AND/OR *According to the RIDER Plan; Moderate Surge is 100% increase of requirements above capacity & High Surge is 200% increase of requirements above capacity* AND/OR AND/OR	**As per initial action stage plus…** • Maintain implementation of the COVID-19 business continuity plan and respond to increasing Public Health requirements **Ongoing communication with staff and external agencies** • Communicate internally and externally to advise on current escalation status of Public Health emergency response • Respond to media via WACHS central office **Workforce strategies** • Utilise surge workforce • Separate staff teams for duration of response • Monitor staff health, wellbeing and fatigue • Risk management for staff, including those with increased vulnerabilities **Monitoring & Evaluation** • Collect and monitor escalation data **Further Response – Targeted Action activities** •

IDEMP / RIDER Stage	Definition	Surge Criteria (Triggers)	Regional Public Health Actions
Stand-down and Recover	The trigger for the response to move into the Stand down stage will occur when advice from Communicable Diseases Network Australia (CDNA) indicates that the outbreak has reached a level where it can be managed under normal healthcare arrangements. This is generally after 2 incubation periods of the disease has passed with no new notifications and/or when a vaccine is readily available.	Minimal to no serious infectious disease cases and/or contacts.	**Start reintroducing Business as Usual (BAU) maternity services and activities** • Review appropriate timing of staged re-introduction of BAU arrangements • Communicate to clients, staff, GPs and external stakeholders the return from emergency response to normal Region Public Health services • Re-introduce non-essential training and team activities, performance monitoring, and business continuity planning **Workforce Strategies** • Acknowledge recovery efforts by all staff and thank all staff at all levels for their work efforts and commitment during the pandemic response • Consider retaining extra staff for a period after the Public Health emergency has subsided to assist with retrospective evaluation and completion of tasks that were temporarily paused during the Public Health emergency • Ensure debriefing and support is available to all staff • Support Public Health staff leave requests where possible • Provide staff training incident/outbreak management, application refresher and other pandemic related training • Ongoing monitoring of Public Health workforce well-being **Response evaluation and lessons learned** • Capture staff feedback to facilitate lessons learned, contribute to future planning and contribute to overall response evaluation • Review pharmacy and equipment stocks and replenish as appropriate • Participate in evaluation of pandemic emergency management systems • Revise this Plan and procedures based on lessons learned **Further Response – Targeted Action activities** • _____ • _____ • _____ • _____

Appendix 2: Public health priorities during a surge response

Priority level	Priorities
High	• Follow-up cases and at-risk contacts for notifiable diseases with public health priority of 'urgent' or 'high' (e.g. measles, invasive meningococcal disease) • Outbreaks of unknown disease with severe complications and/or high transmissibility (e.g. severe respiratory infections, gastroenteritis) • Investigations of significant microbial threats to drinking water supplies (i.e. E. coli) • Assessing public health risks linked to chemical incidents or contamination of food/products (e.g. lead contamination) • Vaccination of high priority groups (including outbreak control) • Ministerial and media responses directly related to the underlying cause of the public health surge or other urgent issues arising • Daily review of WANIDD and data entry for urgent and high priority diseases and outbreaks
Medium	• Follow-up of individual cases and at risk contacts for notifiable infectious disease with public health priority of 'routine' (e.g. influenza, Ross River virus). NOTE: May become 'high priority' if part of a cluster or in a high risk setting (e.g. influenza in an institution, Ross River in a post-flood setting) • Outbreaks of unknown disease with mild symptoms and low/moderate transmissibility. (e.g. minor skin rashes, upper respiratory tract infections) • Teleconference participation in external and internal committees, meetings, consultation processes or working groups that are **not** related to the cause of the public health surge but concerning other diseases of high priority e.g. Rheumatic Heart Disease • Provision of routine and catch-up vaccinations; continue to monitor, analyse and provide advice on potential and actual risks • Management and monitoring of vaccine cold chain • Non-urgent ministerial and media responses that are **not** related to the underlying cause of the public health surge • Time-limited project work **not** related to the cause of the public health surge • Process destitute burials for disposal of bodies (provided storage is not compromised)
Low priority	• All research that is not related to the cause of the public health surge • All work travel that is **not** related to the cause of the public health surge • All travel related to the cause of the public health surge that can be replaced by remote access • All professional development, conferences and work presentations with the exception of training for public health surge staff • Face-to-face participation in external and internal committees, meetings, consultation processes or working groups that are **not** related to the cause of the public health surge • Postpone quarterly and annual reporting responsibilities until resolution of the cause of the public health surge • Project work **not** time-limited and **not** related to the cause of the public health surge • Other public health work not linked to the public health surge (e.g. public policy, planning, health promotion)

NOTE: This list is intended to provide guidance only and is not exhaustive or prescriptive. Each PHU should consider other priorities and/or tasks that may be relevant during a surge response. Significant changes to 'business as usual' priorities and reasons for these changes should be clearly documented by the PHU.

Appendix 3: Surge Capacity Grid

	Name	HE Number	Substantive / Pool	Competencies Rank each skill as either: Expert=5 Advanced = 4 Average = 3 Some experience = 2 Basic Proficiency = 1 No capability/Experience = 0										Comments
				Immunisation	Public Health &/or Community Health	Experience: health assessment	Experience: risk assessment & referral pathways (incl. case coordination)	Ability to function independently in a team	Time management & organisational skills	Computer skills with current software	Experience: computer data entry	Experience working with CALD clients	Other (specify)	
1														
2														
3														
4														
5														
6														
7														
8														
9														
10														
11														
12														
13														
14														
15														

	Name	HE Number	Substantive / Pool	Competencies Rank each skill as either: Expert=5 Advanced = 4 Average = 3 Some experience = 2 Basic Proficiency = 1 No capability/Experience = 0										Comments
				Immunisation	Public Health &/or Community Health	Experience: health assessment	Experience: risk assessment & referral pathways (incl. case coordination)	Ability to function independently in a team	Time management & organisational skills	Computer skills with current software	Experience: computer data entry	Experience working with CALD clients	Other (specify)	
16														
17														
18														
19														
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21														
22														
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Appendix 4: Logistical Considerations Plan

Logistical Consideration	Details	Responsibility *Who is responsible for organising the logistical consideration?*	Plan *Specific details e.g. which building/rooms have been allocated to house surge staff*	Completed
Legal Requirements	Liability, indemnity, criminal checks			
Industrial Considerations	Awards, leave allowances, overtime. Are staff seconded? How are award / EBA requirements fulfilled?			
Timeframes	Duration of release of surge staff e.g. minimum/maximum period, periodic review of requirements			
Cost absorption	Responsibility for salaries of the released/engaged staff			
Travel & accommodation requirements	e.g. if staff are seconded or deployed			
Access to clinical applications & information systems	Which systems/applications will be required?			
Workstation	Phone, office, computer, location			
Facility Access	Swipe cards, security			
Rostering	Work hours, breaks			
Cost Centre	Advisable to set up blank cost centre to enable cost of surge to be tracked			