GL2014_003 - State Preparedness and Response Branch

Summary This guideline provides guidance and supporting tools for surging public health staff in response to health protection events that exceed the existing capacity. It is designed to assist public health staff, Health Service Functional Area Coordinators (HSFACs) and administrators of workforce strategy with the following key issues: determining the need to surge and stand-down; skills needed from public health surge staff; sources of public health surge staff; integrating public health surge staff into existing structures.

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Distributed to Public Health System, Government Medical Officers, NSW Ambulance Service, Ministry of Health, Public Health Units

Audience Health Service Functional Area Coordinators;Public Health Unit;HR and Workforce Planning staff

NSW GOVERNMENT Health

GUIDELINE SUMMARY

PUBLIC HEALTH WORKFORCE SURGE GUIDELINES

PURPOSE

The purpose of this Guideline is to provide guidance and support tools for surging public health staff in response to health protection events that exceed the existing capacity (e.g. infectious disease outbreak, chemical release, contamination incident, natural disaster).

KEY PRINCIPLES

During a public health response it is important that the workforce has adequate capacity to deliver services effectively. This requires a sufficient number of available staff with the necessary skills and expertise to meet the arising demands. If the magnitude or nature of a precipitating event exceeds the available capacity of the existing public health workforce, a "surge" in staffing may be necessary.

It is recommended that all Local Health Districts (LHDs) and their Public Health Units (PHUs) assess their current and reserve public health workforce capacity. The local context and available resources should be considered when establishing:

- the capacity of the existing workforce to respond to various public health threats and the populations that these may affect (Section 2.1 - 2.3)
- the principles that may influence the decision to surge or stand-down staff in response to a public health threat (Section 2.4 - 2.5)
- the additional workload and types of staff that are most likely to be required during a public health surge response (Section 3.1, Section 4.1)
- the procedures for managing and prioritising "business as usual" during a period of workforce surge when low priority tasks may need to be temporarily suspended (Section 3.2, Attachment 1)
- the potential sources of staff that may be available during a surge response and the processes for requesting staff from within the LHD and/or from the statewide health protection network (Section 4.2)
- the long-term training needs of existing staff and the "just-in-time" training materials available if surge staff were rapidly engaged (Section 5.1)
- the legal, industrial and practical logistics for engaging surge staff and integrating them into the existing workforce (Section 5.2)
- the current level of planning and preparedness for public health workforce surge (Attachment 2).

USE OF THE GUIDELINE

This document is designed as a platform to assist public health staff, Health Service Functional Area Coordinators (HSFACs) and administrators of workforce strategy from:

- Local Health Districts (LHDs) – particularly Public Health Units (PHUs)
- Justice Health & Forensic Mental Health Specialty Network (JH&FMHSN)

- Ministry of Health and Health Protection NSW.

The document contains four sections that provide guidance for the target audience. It can be utilised during both planned and unplanned events that require public health workforce surge:

- Determining the need to surge and stand-down (Section 2)
- Functions needed from public health surge staff (Section 3)
- Source of public health surge staff (Section 4)
- Integrating public health surge staff into existing structures (Section 5).

There are also two attachments that provide practical tools to assist the target audience with planning for public health workforce surge and responding appropriately:

- Public health priorities during a surge response (Attachment 1)
- Public health workforce surge planning checklist (Attachment 2).

REVISION HISTORY

Version	Approved by	Amendment notes
February 2014 (GL2013_003)	Deputy Director General, Population and Public Health	New guideline

ATTACHMENTS

1. Public health priorities during a surge response
2. Public health workforce surge planning checklist

Public Health Workforce Surge Guidelines

NSW GOVERNMENT Health
GUIDELINE

Issue date: February-2014

GL2014_003

CONTENTS

1 INTRODUCTION

1.1 Background

During a public health response it is important that the workforce has adequate capacity to deliver services effectively. This requires a sufficient number of available staff with the necessary skills and expertise to meet the arising demands. It is also important that this workforce has been trained to provide appropriate public health services and preparations have been made to incorporate new staff into response teams.

If the magnitude or nature of a precipitating event exceeds the available capacity of the existing public health workforce, a "surge" in staffing may be necessary. Optimising efficiency and minimising duplication of resources is increasingly important as the workforce is stretched during a surge response. These needs may be addressed by pooling and sharing resources across the statewide health protection network (e.g. centralising a particular function at Health Protection NSW or a nominated Public Health Unit). This document addresses planning issues that may arise in these circumstances.

1.2 Purpose

The purpose of this document is to provide guidance and support tools for surging public health staff in response to events that exceed the existing capacity (e.g. infectious disease outbreak, chemical release, contamination incident, natural disaster).

1.3 Scope

The scope of this document is confined to the surge of personnel in response to public health service needs during both planned and unplanned events. Key issues include:

- Determining the need to surge and stand-down;
- Skills needed from public health surge staff;
- Sources of public health surge staff;
- Integrating public health surge staff into existing structures.

1.4 How to use this document

This document is designed as a platform to assist public health staff, Health Service Functional Area Coordinators (HSFACs) and administrators of workforce strategy from:

- Local Health Districts (LHDs) – particularly Public Health Units (PHUs);
- Justice Health & Forensic Mental Health Specialty Network (JH&FMHSN);
- Ministry of Health and Health Protection NSW.

This document often refers to LHD Public Health Controllers and HSFACs. These references equally apply to Justice Health & Forensic Mental Health Speciality Network and its HSFAC and Public Health Controller.

Part two describes the factors that may influence *when* surge personnel are needed and stood-down. Part three identifies *what* tasks may require personnel surge. Part four outlines *who* may be surged and options for *where* they can be sourced. Part five considers *how* to integrate surge staff appropriately into response teams.

2 DETERMINING THE NEED TO SURGE AND STAND-DOWN

Describing “triggers” and specific scenarios for surging staff early and subsequently standing-down will help support a comprehensive public health response. To minimise staff shortages it is also important that the need for additional capacity to meet the ongoing needs of a prolonged response is recognised rather than just “surging to cope” with the immediate threat.

This section describes factors that may influence the need to surge and stand-down a public health response.

2.1 Features of the threat

Threats to public health may occur independently of acute health emergencies. Therefore, events requiring a public health surge will not always require surge across the health system. The PHU director is encouraged to discuss the process for accessing surge staff in these circumstances with his/her manager and LHD HSFAC.

Features of the threat that may influence public health personnel surge needs include:

- Duration (short *vs.* long);
- Onset (slow *vs.* rapid);
- Spread (localised *vs.* statewide);
- 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).

2.2 Features of the Public Health Unit

In keeping with emergency management principles, the public health control and coordination of a response should be managed by the smallest functional unit and with adequate resources to address the underlying threat. In NSW these units are PHUs, which have varying levels of reserve capacity to cope with a surge in workforce demands.

Features of the PHU that may influence public health personnel surge needs include:

- Existing personnel and public health reserve pool (skills, location, number of staff);
- Personnel availability (absenteeism may be elevated due to a public health threat or during holiday periods when staffing levels are reduced);
- Infrastructure (physical space and IT capacity);
- Geographical barriers (staff access to affected urban, rural and remote communities).

2.3 Features of the potentially affected population

During a public health response the populations at risk should be identified with particular reference to any vulnerable groups.

Features of the at-risk population that may influence public health surge needs include:

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

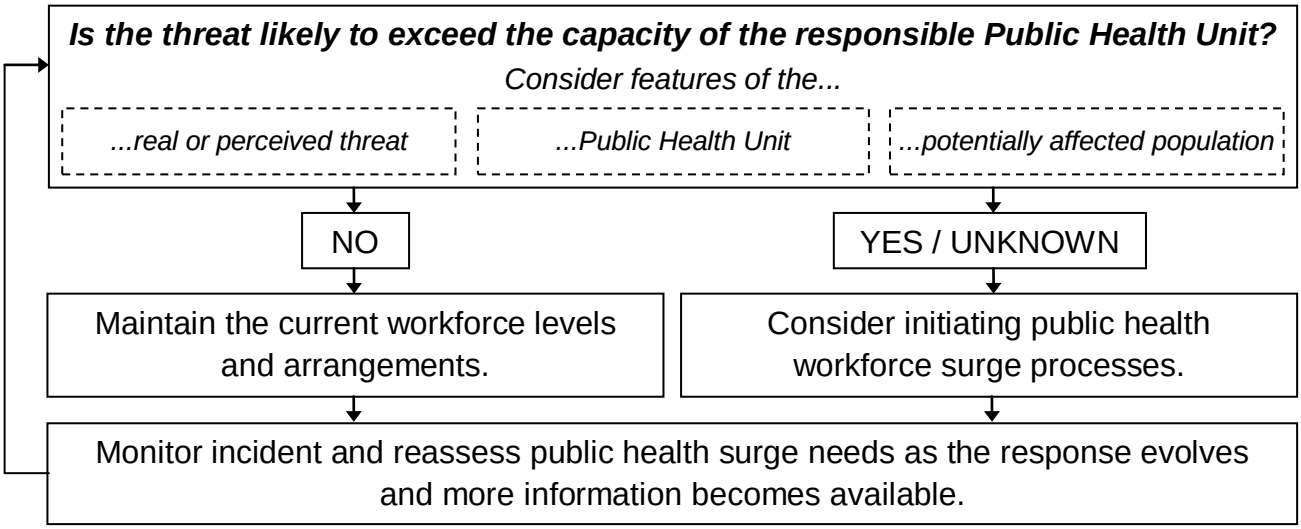
2.4 Principles for deciding to surge staff

The need to surge personnel is influenced by the features of the threat, the existing resources of the responding PHU and the potentially affected population. As the public health demand increases, initial decisions about surge requirements should be made by the LHD Public Health Controller in conjunction with the LHD HSFAC.

Importantly, the perception of the threat and the expectation of the public to reach a rapid resolution may influence the decision to surge independently of the actual public health risk. Responding to perceived risks and satisfying public demands can be resource intensive. Information about these factors may be incomplete at the beginning of a public health response. In this situation workforce surge processes should be initiated early in the response. As details of the threat are subsequently understood the surge personnel can be stood down if and/or when their services are not required.

The principles that influence determining the need to surge public health personnel in response to a threat are summarised in the diagram below (Figure 1).

Figure 1: Summary diagram for determining the need to surge staff



2.5 Principles for deciding to stand-down staff

As the public health demand decreases the decision about which public health surge staff to stand-down should be made locally by the LHD Public Health Controller in conjunction with the LHD HSFAC. Surged personnel should return to normal duties as soon as possible, but may be retained for a period after the public health threat has subsided to assist with retrospective evaluation and the completion of tasks that were temporarily paused during the surge. Formal thank you correspondence should be sent to the surge

staff as well as managers and other existing staff who maintained “business as usual” during the response. It is also important that adequate debriefing and mental health support are available during the surge and after stand-down. The evaluation should capture feedback from all of the staff involved in the surge. This will facilitate the collation of lessons learned and contribute to developing best practice principles for future events.

3 FUNCTIONS NEEDED FROM PUBLIC HEALTH SURGE STAFF

A diverse range of skills may be required during a public health response depending on the underlying threat. Ideally the existing public health workload is maintained throughout a surge response, but in many situations this is not feasible and less urgent services may need to be temporarily paused and work priorities re-assessed.

This section describes the tasks that may be in demand when addressing a public health threat and provides guidance on managing "business as usual" during a surge response.

3.1 Additional workload requirements during a public health surge

The activities performed during a surge response may require generic public health skills or be highly specific to the underlying threat (e.g. infectious disease vs. environmental health skill-sets). The local context and existing capacity at the site of the threat will also influence workload requirements and the surge staff selected. Care must be taken when assigning surge staff duties to minimise exposure for personnel who are at increased risk of adverse affects from the underlying threat.

Activities that may need additional support during a public health surge include:

- Case and contact finding (e.g. developing a case definition, 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);
- Immunisation (e.g. coordinating a mass clinic);
- Internal/partner agency communication (e.g. briefing executive teams);
- Health risk assessment (e.g. assessing needs and identifying exposure pathways);
- Health risk communication (e.g. developing fact sheets);
- Information management (e.g. maintaining NCIMS entries);
- Interpretation and translation (e.g. creating culturally / linguistically diverse resources);
- Laboratory liaison (e.g. confirming specimen collection, transport and processing);
- Surveillance (e.g. analysing disease and rumour surveillance);
- Managing enquiries from the public (e.g. operating telephone contact centres);
- Logistics (e.g. arranging workspaces and supplies for staff);
- Document control (e.g. applying clear endorsement processes).

Statewide public health resources (e.g. job action cards) are available and may provide guidance for incorporating these activities into an Incident Control System (ICS) structure. ICS provides a valuable platform for coordinating an emergency response and PHUs should consider identifying team leaders for each arm of the ICS structure from within their LHD to facilitate rapid allocation of personnel when the need arises. However, it is important to note that an ICS structure is not always required to support a workforce surge.

3.2 Managing the "business as usual" workload during a surge response

Some public health tasks are considered essential to maintain at all times. However, other activities may be temporarily suspended or reallocated to other work units when resources are stretched during a surge response (e.g. other PHUs). A phased approach to provisionally freezing or redirecting less urgent work may be the most effective way to meet increasing demands. Although the context of the public health threat and local

capacity will influence workload prioritisation, the attached table provides some guidance (Attachment 1). As part of emergency planning, PHUs should also assess the minimum staffing levels required to adequately maintain various levels of service provision.

4 SOURCE OF PUBLIC HEALTH SURGE STAFF

Identifying available pools of surge personnel with relevant skills is a key feature of public health emergency preparedness and will contribute to the efficiency of a surge response. Matching existing job descriptions with the skill-sets required may assist with this process. PHUs may also need additional staff at times when the rest of the health service's workforce is also in demand or diminished. This presents challenges that may limit the surge of staff from outside the PHUs. The expected duration and pervasiveness of the response also influences the release of staff, the contribution of Human Resources departments and the capacity for temporary redistribution of work tasks within teams.

This section describes options for who should be engaged from where and under what circumstances during a public health surge response.

4.1 Types of staff

Staff with various backgrounds may be engaged to provide the diverse skills required during a surge in the public health workforce. PHUs should regularly assess and anticipate their needs during periods of increased demand. Engagement of surge staff should be targeted to ensure any gaps identified from this needs analysis are addressed.

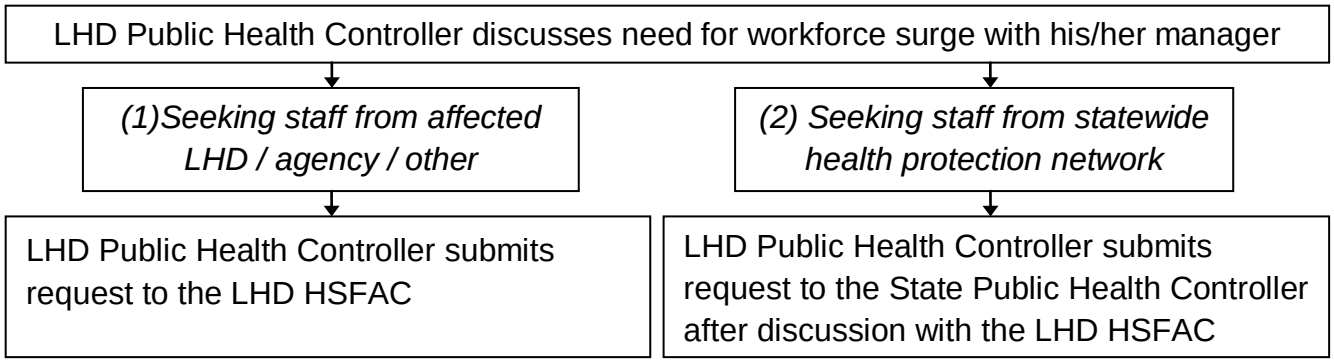
The types of staff who might contribute to a public health surge response include:

- Public health professionals (including students or retirees in extreme circumstances);
- Other health professionals (e.g. clinical doctor/nurse, community health, sexual health);
- Health administrators and human resources experts;
- Office and business managers;
- Data entry and management (e.g. personnel pre-registered to access NCIMs);
- Information systems and data analysis specialists (e.g. existing SAPHaRI users);
- Other staff and volunteers willing to up-skill in areas of need.

4.2 Potential pools of surge staff

During a public health surge response, the LHD Public Health Controller should initially request support from within the affected LHD through his/her LHD HSFAC. If the locally available expertise and resources are not sufficient, Public Health Controllers may rapidly move towards asking the State Public Health Controller for health protection support from outside the LHD in consultation with their HSFAC. The processes for requesting staff from LHD HSFACs and the State Public Health Controller are summarised below (Figure 2).

Figure 2: Processes for requesting surge staff



Personnel should be sourced locally at first (i.e. existing PHU staff), particularly if the initial onset is acute and/or requires a rapid response.[1] This may be even more important during the response to a statewide public health threat because the availability of surge personnel outside the LHD may be limited (e.g. influenza pandemic). Depending on the skills required, the suggested order for requesting staff from within LHDs to assist with public health surge is:

1. Within PHU (e.g. staff who have recently left the PHU, are able to be recalled to duty from leave, can be redeployed from "return to work" plans or are part-time / casual / agency and can work additional hours);
2. Population Health Services (e.g. staff with transferrable skills from sexual health);
3. Remainder of the LHD (e.g. data management and suitably skilled clinical staff).

Following the initial consideration of available local resources, it may be appropriate to request assistance from outside the LHD. This may occur during a more localised response that does not increase statewide demand for public health services (e.g. a point source environmental health incident). Similarly, engagement of surge staff from outside the LHD may be possible if the initial onset of the threat is slow and/or during a prolonged public health response (e.g. measles outbreak). The sources of staff surged from other parts of the NSW Health may include:

- Statewide Health Protection Network (PHUs, Health Protection NSW);
- Ministry of Health (including Public Health Officer and Biostatical trainees).

Surge personnel may also be engaged from outside NSW Health to address needs for specific expertise or when other sources have been depleted. The sources of staff surged from outside of the NSW Health network may include:

- Tertiary education students (e.g. Master of Public Health candidates);
- Other government agencies (e.g. Department of Primary Industries, local council);
- Not-for-profit sector (e.g. charitable organisations);
- Agency staff in addition to those already under LHD contract (e.g. senior nurses);
- Health Protection Services of other states/territories (i.e. coordinated centrally and accessed through the Australian Health Protection Principal Committee in extreme circumstances).

Surge personnel may be engaged from different sources within and outside the affected LHD simultaneously. The composition of the surge staff teams may also be categorised according to the intensity of the required public health response. As a guide, compositions of three public health response levels are described below:

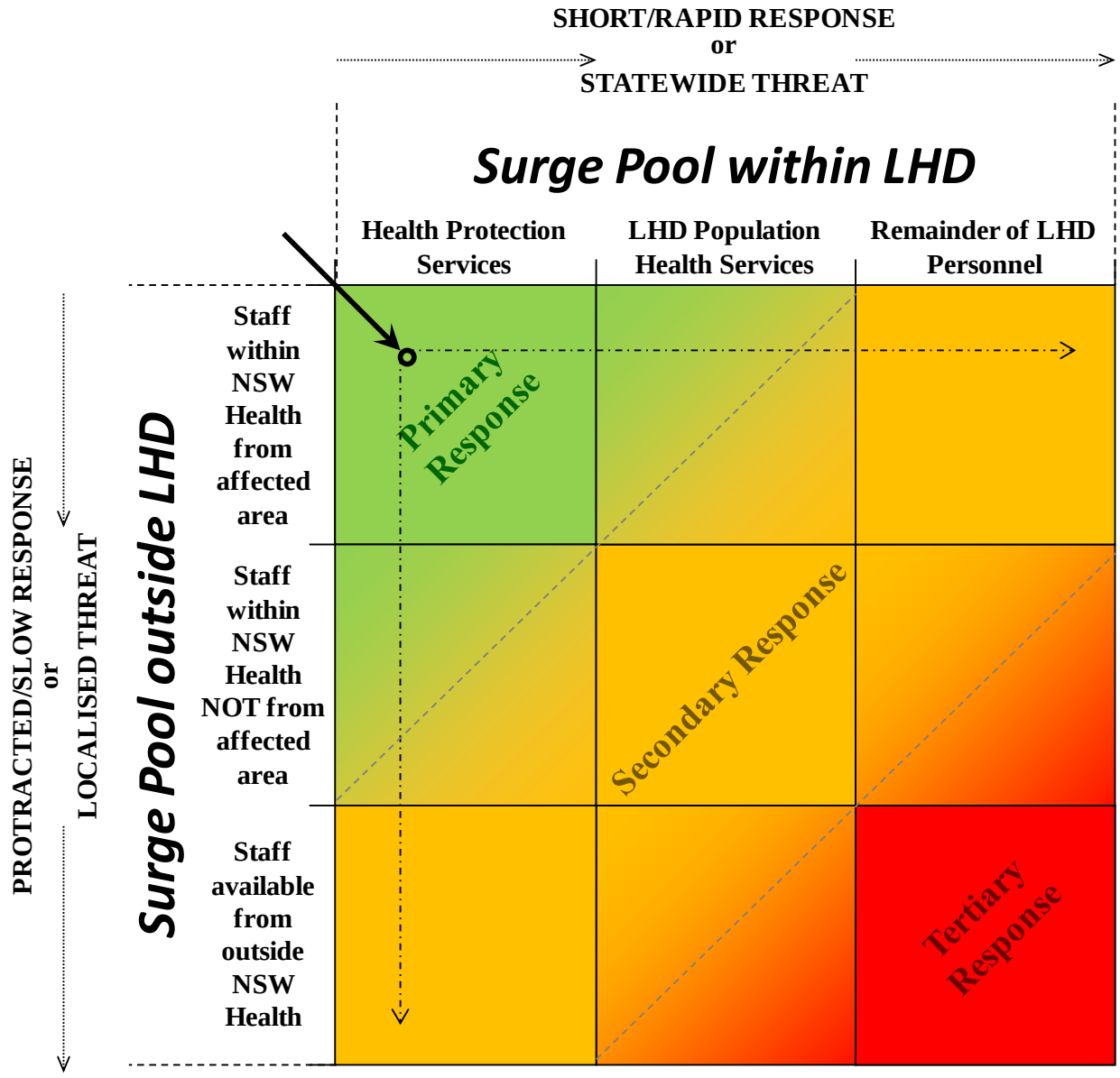
- The primary response typically provides the initial surge in public health services and handles relatively minor threats.
- The secondary response may be activated if the threat is not rapidly resolved, requires very specific public health expertise that is not immediately available or poses a broader demand for an increased number of staff.

[1] *According to the Public Health Emergency Response Preparedness Minimum Standards, LHDs must have the capacity to provide public health response 24hrs/day for two days AND 16hrs/day for five days in exceptional circumstances.*

- The tertiary response is only likely to be activated during a prolonged response to a severe public health threat or if there are other extreme circumstances (e.g. multiple simultaneous events).

The various options for sources of surge staff based on characteristics of the response and its requirements are summarised in the diagram below (Figure 3).

Figure 3: Summary diagram of options for sourcing public health surge personnel



NOTE: This diagram is not to scale and is designed to indicate the intensity of a phased public health response rather than prescribe how to source surge staff. Although surging staff may sometimes follow a continuum of increasing intensity, there are other circumstances when the response may require a "jump" to a higher intensity.

5 INTEGRATING PUBLIC HEALTH SURGE STAFF INTO EXISTING STRUCTURES

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 (e.g. nurse, medical, clerical) and requirements in relation to worker health and safety must also be observed. Prior to commencing work, appropriate criminal and working with children checks should be conducted on any external staff engaged where those checks are usually required.

Work environments that facilitate clear communication and enable staff to raise their concerns are also essential. It is important that every effort is made to explain the current situation to both surge and existing personnel to minimise exposure to potential health risks and ensure staff co-operation. This will facilitate workforce flexibility regarding temporary workplace changes, redeployment arrangements or reallocation of work. Adequately addressing these issues may also improve output quality of the surged workforce and reduce the risk of staff burn-out during the response.

This section describes points for consideration to the transition of personnel into a surged public health workforce.

5.1 Training needs of surge staff

The time available to provide extensive training for staff becomes very limited after a public health surge response has begun. Consequently, the “just-in-time” training should ideally focus on threat or task specific content for personnel who already have a sufficient awareness of emergency management principles. PHUs may consider hosting and/or encouraging participation in annual refresher training sessions for identified surge staff (e.g. school immunisation program nurses). Discussion with HSFACs to ensure any additional surge training complements existing arrangements and addresses identified needs is essential.

The “just-in-time” training delivered at the time of the surge response may include:

- Orientation to the workplace and introduction to other staff;
- Description of the public health threat and the anticipated response;
- Instruction on the required roles and responsibilities;
- Guidance on the application of Incident Control System (ICS);
- Identification of a mentor (other than the designated supervisor);
- Overview of response-specific communication arrangements;
- Tuition in specific information management tasks and systems;
- Coaching for other specific technical skills related to designated tasks;
- Education on actual and perceived personal risk reduction;
- Review of the relevant logistical considerations for workforce surge (see below).

It is important to balance the training requirements of surge staff with the potential length of the surge period. While more experienced staff may be able to ‘hit the ground running’ and provide a valuable contribution in a short time period, the response may benefit from rostering staff requiring more comprehensive ‘just-in-time’ training for a longer period to derive the benefits of the training (i.e. at least a week).

5.2 Logistics of surging the public health workforce

The provision of public health surge personnel has logistical implications for the individuals being surged as well as both the releasing and the receiving organisations. It is important to recognise that during a response the surged public health personnel are working for the LHD Public Health Controller in conjunction with the relevant HSFAC. Although this authority overrides other normal line management processes, some flexibility may be necessary to enable the surge staff to maintain their high priority "business as usual" workload (Attachment 1). Maintaining effective communication pathways and systems is an integral part of supporting these processes and management structures.

Depending on the circumstances, public health surge staff may relocate or be able to undertake the work remotely (e.g. one PHU supporting another with an extensive contact tracing response via phone or online calling system). This may require subsequent surge in the releasing jurisdiction as part of the statewide public health network and it is important that the associated costs are considered. It is also possible that experts in under-resourced areas may need to supervise several staff with different training backgrounds and provide ongoing "on-the-job" training. Facilitating these processes requires careful planning and additional complexities may also apply to surging staff external to NSW Health. The early engagement of the Human Resources department of the affected LHDs is integral to optimise efficiency and ensure all required processes for rapidly hiring temporary staff and redeploying personnel are satisfied.

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, code of conduct);
- Time frames (i.e. duration of release of surge staff may depend on level of expertise);
- Cost absorption (i.e. responsibility for salaries of the released / engaged surge staff);
- Transport (i.e. access to public transport, parking for private vehicles);
- Physical space and equipment (i.e. offices, computers, desks, accommodation);
- Information management systems (i.e. pre-registering staff and informing MOH of staff movement to ensure adequate access to NCIMs);
- Facility access (i.e. swipe cards, passwords, security);
- Workplace health and safety (i.e. appropriate work environments, availability of sufficient quantities of personal protective equipment, information about access to employee assistance programs, confirm vaccination category status of PHU staff);
- Coordination of staff rosters (i.e. work hours, enforced breaks, rest between shifts).

Many of these considerations can be resolved through discussion with LHD colleagues responsible for the relevant portfolios and may need to be reconsidered regularly during the surge period (e.g. HSFAC, human resources, facilities). PHUs and LHDs are also encouraged to initiate and/or revisit these discussions regularly in preparation for future public health threats to ensure formalised local processes are in place to enable rapid engagement of surge staff when the need arises. Several issues that will facilitate LHD logistics planning for public health workforce surge have been identified in a recommendations checklist (Attachment 2).

6 REFERENCES

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7 LIST OF ATTACHMENTS

1. Public health priorities during a surge response
2. Public health workforce surge planning checklist

Attachment 1: Public health priorities during a surge response

High priority	Medium priority	Low priority
Follow-up of cases and at-risk contacts for notifiable infectious diseases with public health priority of 'urgent' or 'high' (e.g. anthrax, Hendra, Murray Valley encephalitis, measles, invasive meningococcal disease, hepatitis A). *NOTE: if the cause of the public health threat is an infectious disease it will be 'high priority'.*	Follow-up of individual cases and at-risk contacts for notifiable infectious diseases with public health priority of 'routine'. (e.g. influenza, Ross River virus, food complaints). *NOTE: may become 'high priority' if part of a cluster or in a high risk setting (e.g. influenza in an institution, Ross River virus in a post-flood setting).*	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.
Outbreaks of unknown disease with severe complications and/or high transmissibility (e.g. severe respiratory infections, foodborne disease, gastroenteritis).	Outbreaks of unknown disease with mild symptoms and low/moderate transmissibility. (e.g. minor skin rashes, upper respiratory tract infections).	All professional development, conferences and work presentations with the exception of training for public health surge personnel.
Investigations of significant microbial threats to drinking water supplies (i.e. E.coli, lead contamination, high fluoride, significant pH differences).	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.	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.
Assessing public health risks linked to chemical incidents or contamination of food/products.		
Vaccination of high-priority groups (including outbreak control); advise MOH on areas of need for targeting resources; communication strategies for providers and the community.	Provision of routine and catch-up vaccinations; continue to monitor, analyse and provide advice on potential and actual risks.	Provision of general immunisations; management and monitoring of vaccine cold chain.
Ministerial and media responses directly related to the underlying cause of the public health surge or other urgent issues arising.	Non-urgent ministerial and media responses that are NOT related to the underlying cause of the public health surge.	Postpone quarterly and annual reporting responsibilities until resolution of the cause of the public health surge.
Daily NCIMs data entry for urgent and high priority diseases and outbreaks.	Time-limited project work NOT related to the cause of the public health surge.	Project work NOT time-limited and NOT related to the cause of the public health surge.
Maintain emergency management protocols for major incidents.	Process destitute burials for disposal of bodies (provided storage is not compromised).	When possible delay the follow-up of tobacco-related complaints.

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.

Attachment 2: Public health workforce surge planning checklist

This checklist is designed to facilitate collaboration between PHUs and HSFACs regarding public health workforce surge and to link with processes that may already be in place.

Service provision and systems

Has the PHU considered:

- □ describing minimum staffing levels required to adequately maintain current services
- □ identifying team leaders for each arm of the Incident Control System (ICS)
- □ preparing orientation resources for surge staff
- □ adapting the "Business as Usual" priority list to the local context (see Attachment 1)
- □ adapting public health statewide resources for local use (e.g. job action cards)
- □ providing adequate physical space, IT support and facility access for surge staff
- □ maintaining communication pathways and systems during a surge response
- □ linking with staff health to review vaccination category status for PHU staff
- □ human resources requirements for rapid hire of surge staff (e.g. liability, CRC, awards)

Existing capacity and training

Has the PHU undertaken:

- □ annual review of internal and surge capacity to identify training and surge needs
- □ recent staff education and training to address these needs
- □ regular training activities promoting public health emergency preparedness for all staff (e.g. desktop exercises including ICS structures and/or public health workforce surge)

Staff sources and categorisation

Has the PHU identified and categorised the skills of a pool of potential surge staff from:

- □ part-time PHU personnel who are available to work additional hours
- □ casual PHU employees who are available to work additional hours
- □ recently retired / redundant / resigned PHU personnel who can be temporarily engaged
- □ displaced PHU personnel or those on "return to work" plans who can be deployed
- □ existing PHU personnel who are prepared to defer annual or long service leave
- □ sources outside the PHU (e.g. clinical / admin / agency) in consultation with the HSFAC

Staff awareness and preparedness

Has the PHU advised all staff that during a surge response:

- □ there is a risk of high absenteeism of existing personnel
- □ the potential need to temporarily work different hours, location and/or capacity
- □ flexibility will be requested with regard to appropriate skill sets and workload

Staff welfare and support

Has the PHU put in place or linked with existing mechanisms for surge staff that:

- □ minimise exposure to and clearly communicate any health risks
- □ ensure rostering is equitable and appropriately manage fatigue
- □ provide adequate opportunity to debrief during and after the response
- □ support any mental health needs that may arise