

**State health emergency response plan  
SHERP Victoria**

**Second edition – 2009**

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State Health Emergency Response Plan (SHERP Victoria) – 2009 (Version 2)

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## Acronyms

<b>AEOC</b>	Ambulance Emergency Operations Centre
<b>AV</b>	Ambulance Victoria
<b>CBR</b>	Chemical, biological or radiological (incident)
<b>CCP</b>	Casualty clearing post
<b>DH</b>	Department of Health
<b>DHS</b>	Department of Human Services
<b>EMMV</b>	Emergency Management Manual Victoria
<b>EMT</b>	Emergency Management Team
<b>EOC</b>	Emergency Operations Centre
<b>FEMO</b>	Field Emergency Medical Officer
<b>FEMC</b>	Field Emergency Medical Coordinator
<b>FPCC</b>	Field Primary Care Clinic
<b>HC</b>	Health Commander
<b>HIMT</b>	Health Incident Management Team
<b>HHS ECC</b>	Health and Human Services Emergency Coordination Centre
<b>ICS</b>	Incident Control System
<b>IMT</b>	Incident Management Team
<b>MEMP</b>	Municipal Emergency Management Plan
<b>MEMPC</b>	Municipal Emergency Management Planning Committee
<b>MERC</b>	Municipal Emergency Response Coordinator
<b>NRIS</b>	National Registration and Inquiry System
<b>OESC</b>	Office of the Emergency Services Commissioner
<b>PPE</b>	Personal protective equipment
<b>SHERP</b>	State Health Emergency Response Plan
<b>SHIC</b>	State Health Incident Coordinator
<b>SH&amp;MC</b>	State Health and Medical Commander (Department of Health position)
<b>SOP</b>	Standard operating procedure
<b>VHEC</b>	Victorian Health Emergency Coordination
<b>VMAT</b>	Victorian Medical Assistance Teams



## Purpose

The State Health Emergency Response Plan (SHERP) is a sub plan of the Victoria State Emergency Response Plan. SHERP is the framework for a coordinated whole-of-health approach to emergencies – mass casualty incidents, complex trauma events, mass gatherings and other incidents that impact the health of Victorians.

SHERP ensures a safe, effective and coordinated health and medical response to emergencies, by:

- establishing an incident management structure for health agencies that interfaces and works with the incident management structure established by the control agency
- coordinating health resources, from the incident site through to affected hospitals
- managing pre-hospital resources and the hospital interface
- coordinating resources to manage the health impacts of an incident.

SHERP adopts an ‘all-hazards’ approach. The principles outlined in this plan will apply in any emergency including mass gatherings and public events and from small complex incidents to major ones requiring a coordination and management framework, such as:

- mass casualty incidents
- complex trauma emergencies
- chemical, biological or radiological incidents
- food and drinking water contamination involving health impacts
- human illness epidemic
- natural disasters
- essential services disruption.

Emergency prevention and response activities may include the following.

Resource deployment:

- saving and protecting life through triage, first aid and resuscitation
- containing the emergency, by limiting its escalation or spread
- sourcing and deploying medical teams to assist at an emergency site
- coordinating transport of the injured to the most appropriate hospital or treatment area
- protecting public health.

Community resilience activities:

- raising community awareness of immediate or emergent health issues through public presence, community information and warnings
- planning for and selectively deploying medical, health or emergency management personnel to public events and mass gatherings.

Organisation and response structures:

- participating in the Emergency Management Team and providing advice to the Incident Controller on both specific and broader health issues and impacts, including impacts on the community
- protecting the health and safety of responding health, medical and emergency management personnel
- evaluating the response and identifying lessons to be learned.

Coordination with other agencies:

- establishing an incident management structure on scene and working with the control agency and other support agencies
- seamlessly interfacing and linking to other health specific plans at local, municipal, regional, state and national levels
- relieving suffering through psychological first aid and links to relief and recovery arrangements.

SHERP incorporates contemporary directions in emergency management, such as counter terrorism and climate change, with health planning and learnings from significant events in Victoria and other jurisdictions, to ensure that it is relevant, responsive and operational in the current environment.

## Authorities and references

SHERP takes its authority from the *Emergency Management Act 1986*, and is accountable to the Minister for Health, with responsibility to the Minister for Police and Emergency Services (as Coordinator in Chief of Emergency Management for the State of Victoria). The Victorian Government – through the Emergency Management Act – has responsibilities in planning for, and managing, the consequences of a health emergency event.

The Emergency Management Manual Victoria (EMMV) defines the role of each contributing organisation. The EMMV may be downloaded or viewed on the Office of the Emergency Services Commissioner (OESC) website. Other agencies' standard operating procedures are available from their respective websites, or by direct request. Part 3 of the EMMV describes the State Emergency Response Plan, of which the SHERP is a sub plan (EMMV Part 3).

Note that emergency contact details are not provided in this document – see the State Emergency Response Plan Contact List, issued quarterly to registered recipients.

The Department of Health (DH) is responsible for coordinating all health and medical emergency responses. It therefore has the responsibility for developing, reviewing and maintaining this plan. This is done by the Health and Human Services Emergency Management Branch.

## Context of SHERP

### A supporting framework

Emergency responses to incidents of a nature and scale that may impact on the health and wellbeing of Victorians will typically involve multiple agencies, and require the coordination of emergency plans into an integrated operation. The control agency will designate an Incident Controller and establish the Incident Management Team (IMT). The control authority will depend on the nature of the incident.

Establishing an Emergency Management Team (EMT) provides expert assistance, advice and support to the Incident Controller. SHERP supports the control agency and incident management structure established by the Incident Controller. SHERP is a framework for coordinating whole-of-health response that operates in support of other emergency management plans of agencies such as Police and Fire.

SHERP is used as a supporting health coordination framework for flood, fire, storm and public health emergencies with likely health impacts. SHERP also supports plans such as the Public Health Emergency Management Arrangements, the State Chemical Biological and Radiological (CBR) Plan, the State Burns Plan and other emergency management plans, including Commonwealth plans.

SHERP describes the means for emergency relief, recognising that provision of basic physical and emotional needs such as water, shelter and psychological first aid can reduce the impact on the health of individuals. *Emergency Relief* is an appendix to the State Emergency Response Plan, but has strong links to recovery and enables the State Emergency Recovery Arrangements to be activated early in the emergency.

SHERP describes the means for providing information to the Emergency Management Team, on both specific and broader health impacts.

SHERP describes the means for delivery of health and medical care in response to emergencies.

How SHERP works to support other plans can be illustrated by the response to bushfire, where the relevant fire service is the 'control agency'.

Where there are impacts from the fire on the health of the community, SHERP is used as a framework for coordinating the health response.

### Standardising management plans

All agencies involved in a health emergency response do so under the authority of legislation and their own individual agency policies and procedures. They must ensure that their health response capacity is consistent with the principles, standards and operational practices contained within this plan. Individuals within these agencies are also required to work within the policies and guidelines set down by their professional organisations or statutory bodies.

### Regional planning

In country Victoria, each of the five DH rural regions is responsible for ensuring local health and medical emergency response planning follows SHERP. A designated officer from each region is responsible for emergency management planning and represents DH interests on regional health and medical emergency management committees. To view the regions and their relationship with local government authorities, see Appendix 5.

### Municipal plans

Under the *Health Act (1958)* each Victorian municipality is responsible for health protection within its boundaries. Health agencies (including Ambulance Victoria, Red Cross, St John Ambulance, environmental health officers, hospitals, divisions of general practice, Department of Health) are responsible for emergency management planning.

As members of Municipal Emergency Management Planning Committees (MEMPC), they contribute to the health aspects of the Municipal Emergency Management Plan (MEMPC) and the Municipal Public Health Plan. Municipalities are strongly encouraged to engage and work with local hospitals and other health agencies to develop a consistent approach to planning, preparedness and resilience, to ultimately support one another in the response phase of an emergency.

### Standard operating procedures

SHERP requires the planning and involvement of many agencies, to ensure that management and governance of the whole-of-health response to mass casualty events is effective and coordinated at the incident level. Key agencies are required to develop standard operating procedures (SOPs) consistent with the principles of SHERP.

Standard operating procedures should be developed in consultation with other partner agencies and plans, to ensure a consistent and integrated approach. Each agency should ensure that procedures are approved, communicated, articulated and clearly documented. Standard operating procedures should be reviewed regularly.

### SHERP linkages to other plans

The plans listed in Figures 1 and 2 and Appendix 1 *Other relevant plans and sub plans*, are linked to SHERP and reflect a coordinated approach to health and medical emergency arrangements.

**Figure 1: SHERP linkages to national plans**

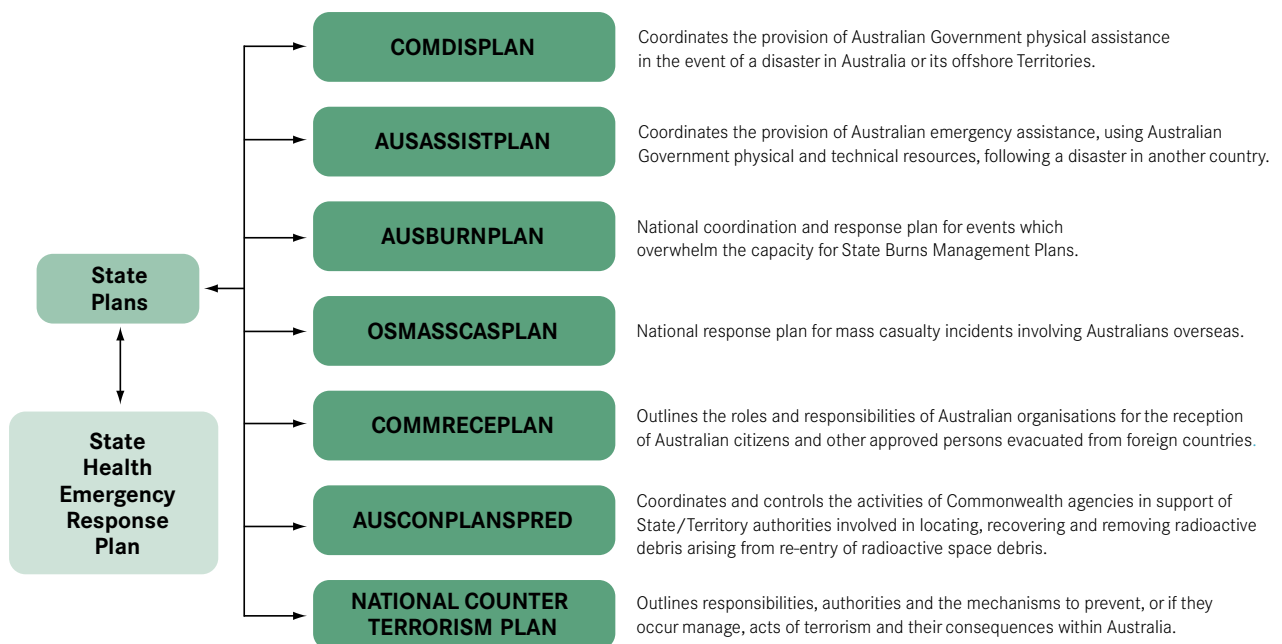
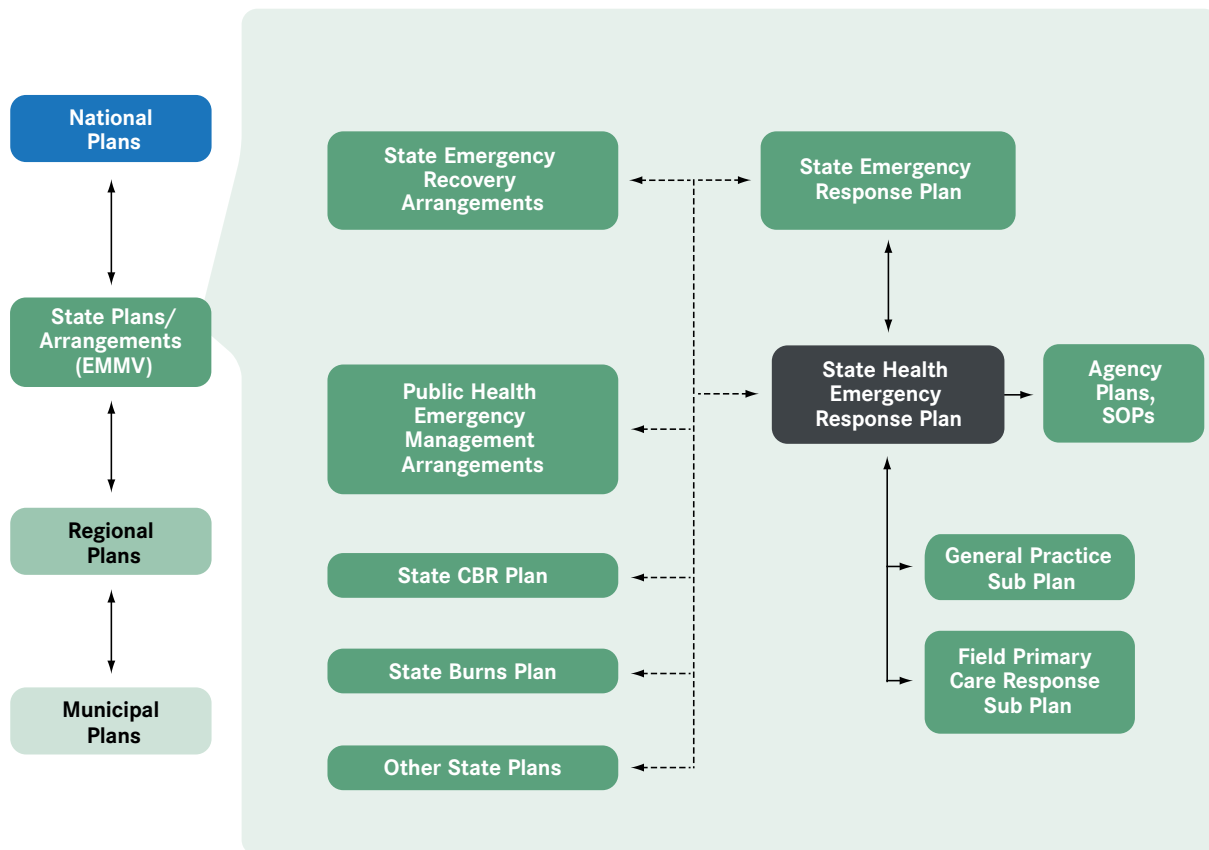


Figure: 2 SHERP linkages to State plans



## SHERP as a planning and preparedness framework

SHERP provides a planning and health management structure for public events and mass gatherings where there is a potential for mass or complex casualties<sup>1</sup>. When planning for public events and mass gatherings, the SHERP methodology will be used as a management framework for response to health emergencies. This allows for the management and coordination any incident, whether small and complex, or major.

<sup>1</sup> See Appendix 2: Public events and mass gatherings

## Concept of operations

### Principles of SHERP

SHERP is underpinned by several principles guiding the application of the plan.

#### **Safety of health responders**

The physical and psychological health and safety of emergency personnel is paramount. Agencies and personnel responding under SHERP have a duty of care to ensure the principles of occupational health and safety extend to the emergency environment and that personnel work in a manner that is not harmful to their own physical and mental health and safety.

#### **Incident management**

SHERP applies the arrangements detailed in Part 3 of the Emergency Management Manual Victoria. In doing so, SHERP uses the Incident Control System (ICS) to enable the seamless integration of activities and resources from multiple agencies and health organisations. The ICS principles (management by objectives, functional management and span of control) will be used in the Incident Management Team, Emergency Management Team and Health Incident Management Team.

#### **Information to communities**

Timely, accurate and consistent evidence based community information on the health impacts of an emergency will help to limit further damage to health and wellbeing. This information must be integrated into the incident strategy and be community focused.

#### **Understanding the consequences of the incident**

Health consequences of the incident must be understood and considered when developing the incident strategy, in order to minimise the impacts on community health and safety.

#### **Influencing strategy**

SHERP ensures that a health strategy and management plan is integrated into the Incident Strategy and Incident Action Plan developed by the control agency. Where there is a health consequence, the Health Commander will inform the Incident Controller, to effect risk mitigation.

#### **Collaborative approach**

The success of the Health Incident Management Team depends upon adopting a collaborative approach, resulting in an understanding of each others' roles and a joint contribution to effective coordination and management.

## Management of an incident

### Incident control

Control involves the overall direction of response activities in an emergency. Authority for control is established in legislation, and carries with it the responsibility for tasking other agencies, according to the needs of the situation.

The control agency is the agency, service, organisation or authority with legislative responsibility for control of the incident, as identified in accordance with Part 7 of the Emergency Management Manual Victoria (EMMV).

The Incident Controller is the individual with overall responsibility for emergency response operations. The Incident Controller is normally appointed by the control agency, but can be appointed by an emergency response co-coordinator in circumstances where s. 16 or 16A of the *Emergency Management Act 1986* apply.

There are three tiers of incident control for emergency response in Victoria:

- state level – strategic leadership for resolution of emergencies across Victoria
- regional / area of operations level – leadership and management within a defined area of operations
- incident level – leadership and management at the incident site.

### Incident Management Team

The Incident Controller may, depending on the complexity and duration of the emergency, decide to form an Incident Management Team (IMT) to manage the delegated responsibilities of planning, operations and logistics relating to overall control of the incident. The Incident Management Team sets the objectives and strategies of the incident as they relate to the type of emergency. It operates whether or not other agencies are involved.

### Emergency Management Team

If an emergency requires a response by more than one agency, the Incident Controller will form an Emergency Management Team (EMT). The Emergency Management Team consists of the Incident Controller, support and recovery functional / agency commanders, Emergency Response Coordinator and other specialist persons as required. The Emergency Management Team provides expert advice, support and identified management strategies for potential consequences of the emergency to the Incident Controller.

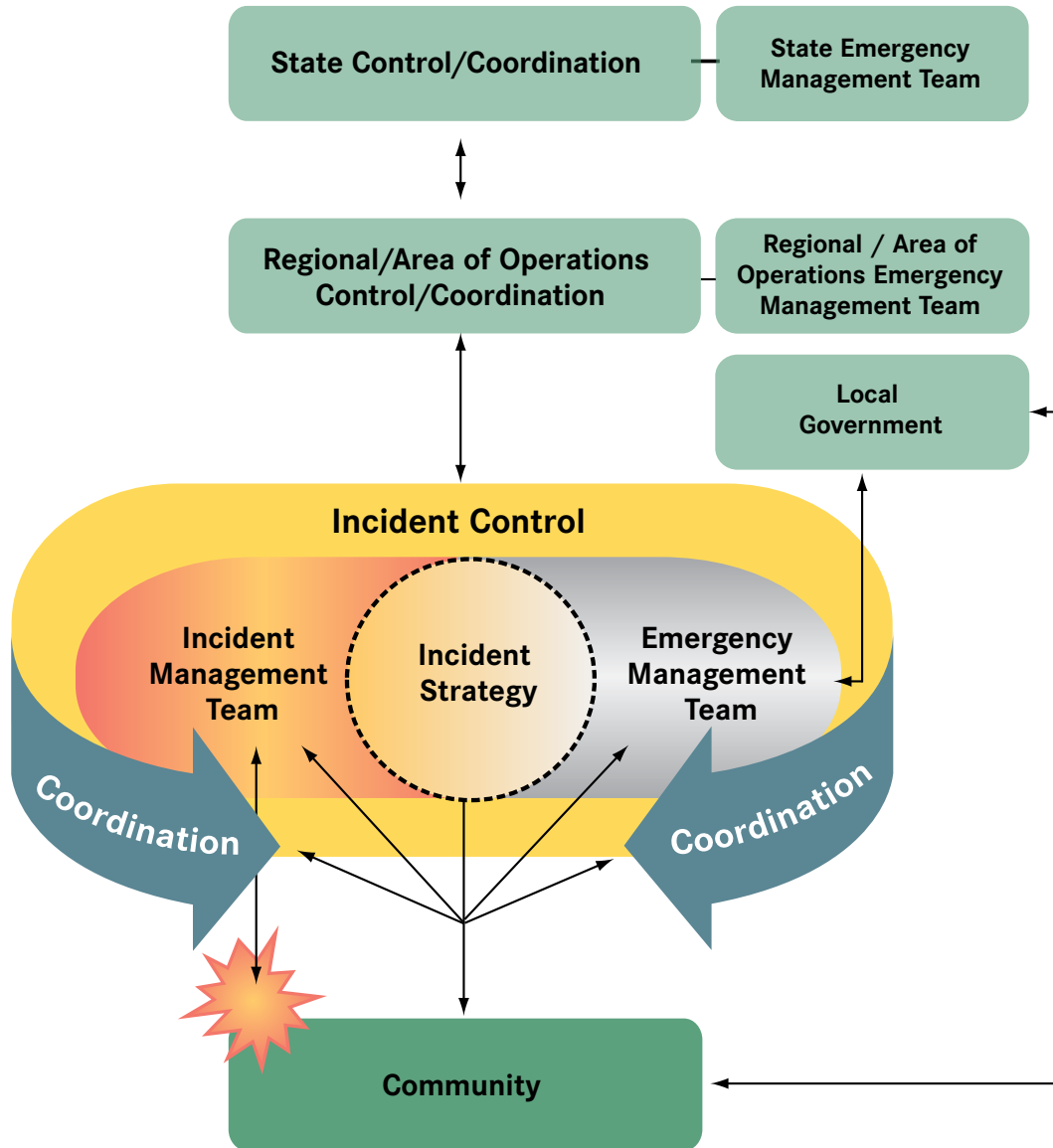
### Incident strategy

This is the overall strategy, which describes the direction of actions based on the conditions prevailing at a given time in the life of the incident. The Incident Controller, the Incident Management Team and the Emergency Management Team collaborate on the Incident Strategy, to ensure a common understanding and a unified approach.

### Functional command

This is the integrated command of associated activities, resources and capabilities that may normally exist across a number of organisations. Where there are agreed, pre-existing arrangements, a functional commander can direct members and resources of a number of agencies in accordance with those arrangements. For example, in a fire emergency which has health impacts, the Health Commander leads the management of health elements/ consequences of the emergency. The Health Commander represents this function within the Emergency Management Team supporting the Incident Controller. This function may require the resources of a number of agencies – including Ambulance Victoria, first aid agencies and field medical support.

Figure 3: Emergency management interdependencies



- Incident Control**  
 Established by legislation, the Incident Controller is the individual with overall responsibility for emergency response operations
- |   |  |
|---|--|
| <p><b>Incident Management Team</b></p> <ul style="list-style-type: none"> <li>• Set objectives and strategies</li> <li>• Consequence Management</li> <li>• Responsible for Control</li> <li>• Completes risk assessments</li> </ul> | <p><b>Emergency Management Team</b></p> <ul style="list-style-type: none"> <li>• Assist Control agency achieve objectives</li> <li>• Provide expert advice and assistance</li> <li>• Broader scope consequence management</li> <li>• Sets interagency understanding of situation, objectives, strategies</li> <li>• Expedites situational awareness</li> </ul> |
| <p><b>Coordination</b></p> <ul style="list-style-type: none"> <li>• Emergency Response Coordinator</li> <li>• Coordination of resources</li> </ul>  |  |

## Agency command

Command relates to agencies and operates vertically within an agency. It involves directing agency members and resources in the performance of that organisation's role and tasks. Authority to command is established in legislation, or by agreement within an agency.

## Health Commander

The Health Commander is a senior ambulance manager (unless otherwise appointed by the State Health Incident Coordinator) who oversees and, where appropriate, directs the operational health response to a major incident within Victoria. The Health Commander is an incident based position, working with the Incident Controller and the Emergency Management Team to develop the health strategy and contribute to the Incident Strategy.

The Health Commander has three key objectives:

- Establish and coordinate a Health Incident Management Team (HIMT) to direct the emergency health response.
- Represent the Health Incident Management Team on the Emergency Management Team.
- Contribute to the Incident Strategy and Incident Action Plan, via the Incident Controller.

## Strategic relationships

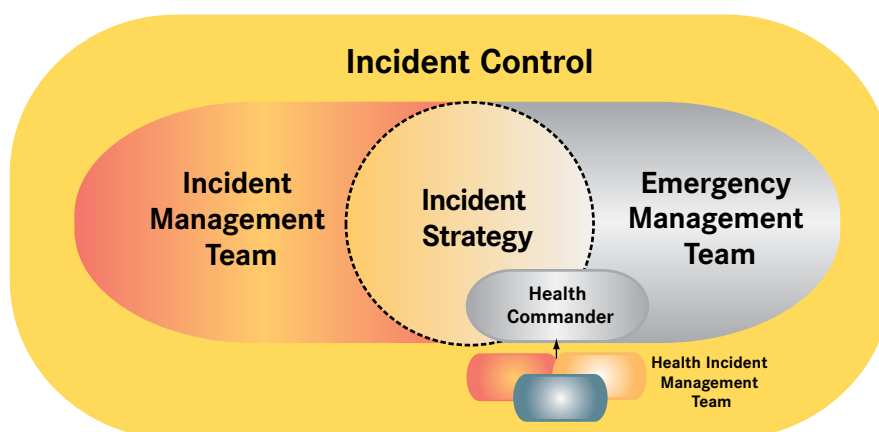
The Emergency Management Team enables the Incident Strategy to be carried out by support agencies (through their own commanders), and assists the Emergency Response Co-ordinator in determining resource needs, and in ensuring a coordinated response to the emergency.

The Health Commander represents all responding health agencies, as a member of the Emergency Management Team supporting the Incident Controller.

There are occasions where either the Incident Management Team or Emergency Management Team are not formed. If this is the case it is vital for the Health Commander to make contact with the Incident Controller.

Figure 4 illustrates the relationship between the Health Incident Management Team, the Emergency Management Team and the Incident Management Team.

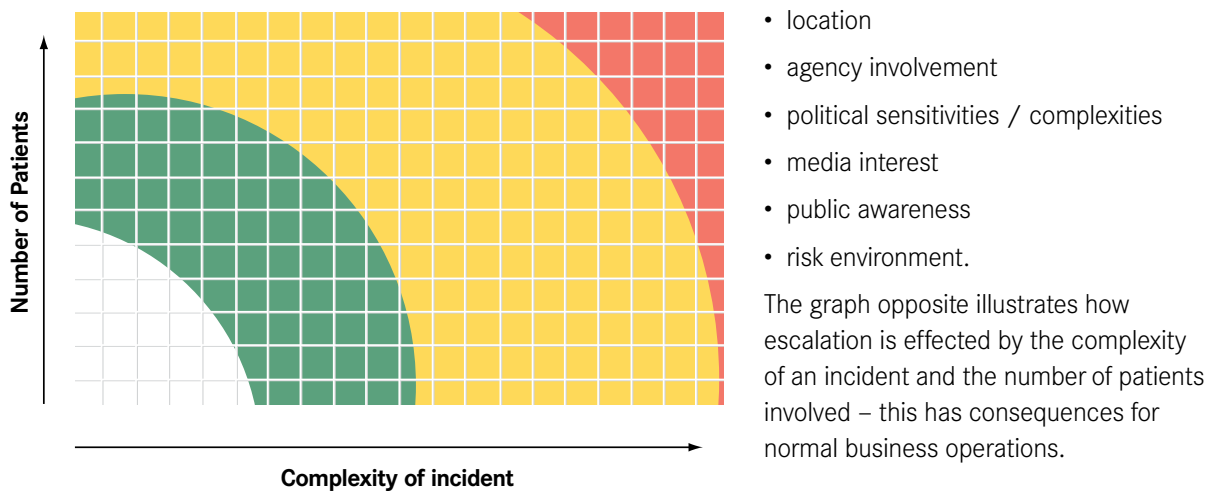
**Figure 4: Strategic relationships**



## Escalation

The complexity and size of the incident will determine which functions of SHERP are activated. It can be influenced by:

**Figure 5: Complexity and escalation (adapted from Ambulance Victoria)**



Normal operations	Level 1	Level 2	Level 3
Low impact on normal operations	Medium impact on normal operations. Resolved through use of local or initial response resources.	Major impact on normal operations. More complex management of emergency response in size, resources or risk.	Severe impact on normal operations – complexities requiring substantial management of response.

The following table also illustrates a range of events and the functions that may be deployed to each incident. It should be noted that while the first two examples would normally be managed as day-to-day business by the ambulance service, the complexities of the incident may require escalation of SHERP.

**Table 1: Examples of types / complexity of incidents**

Incident	Complexities	Casualties	Command	Function(s)
Single vehicle accident – <b>high profile identity</b> – major injuries	Sensitive environment Intense media scrutiny	1 plus	Health Commander	<ul style="list-style-type: none"> <li>• State Critical Incident Manager</li> <li>• State Health Incident Coordinator</li> </ul>
Complex entrapment – major injuries	Complex injuries Extended time at incident Multiple onlookers	1 plus	Health Commander	<ul style="list-style-type: none"> <li>• State Critical Incident Manager</li> <li>• State Health Incident Coordinator</li> <li>• Field Emergency Medical Officer, Victorian Medical Assistance Team</li> <li>• Personal support</li> </ul>
Train crash multiple dead and injured	Complex scene Multiple patient transport to hospitals Media scrutiny Involvement of volunteers	Multiple	Health Commander	<ul style="list-style-type: none"> <li>• State Critical Incident Manager</li> <li>• State Health Incident Coordinator</li> <li>• Field Emergency Medical Officer(s), Victorian Medical Assistance Team(s)</li> <li>• First Aid</li> <li>• Personal Support</li> <li>• HHS Emergency Coordination Centre/ Victorian Health Emergency Coordination (HHS ECC/VHEC)</li> <li>• State Health &amp; Medical Commander</li> </ul>
Evacuation of nursing home/ major hospital	Close monitoring of health issues Complex transport issues Media scrutiny	Not immediate	Health Commander	<ul style="list-style-type: none"> <li>• State Critical Incident Manager</li> <li>• State Health Incident Coordinator</li> <li>• HHS Emergency Coordination Centre/ Victorian Health Emergency Coordination (HHS ECC/VHEC)</li> <li>• State Health and Medical Commander</li> </ul>

### Health Incident Management Team

Based on the incident type and location, a health management structure will be established to enable coordination and management of the health response. The management structure will be lead by the Health Commander and supported by the Health Incident Management Team. The Health Incident Management Team will provide the ICS functions of planning, operations and logistics to support the health response.

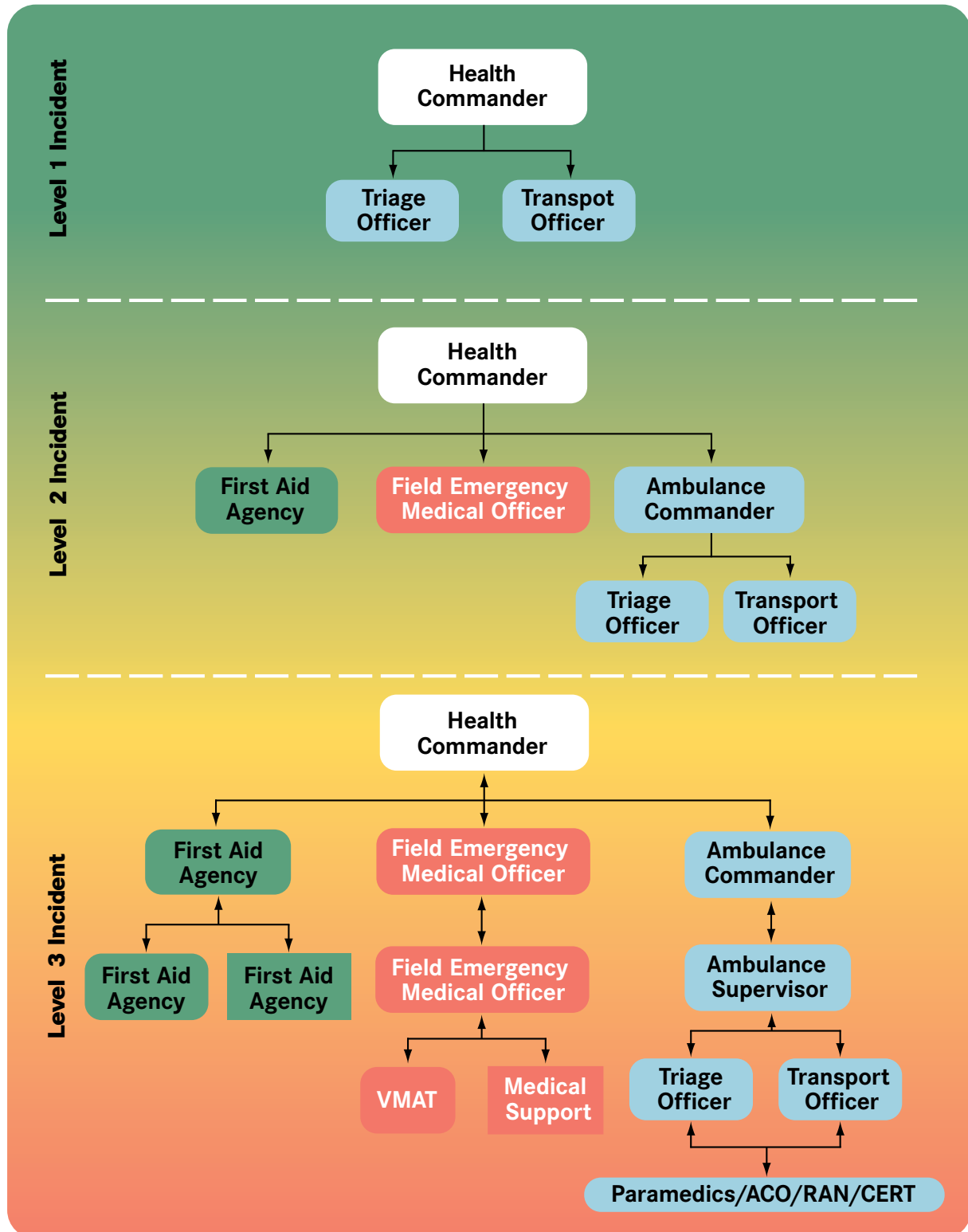
In normal events Ambulance Victoria appoints a Triage Officer who establishes the Casualty Clearing Post (if required) and a Transport Officer who manages the movement of ambulance vehicles at the site.

As incidents increase in size or complexity, management becomes more demanding and the Health Commander is appointed by Ambulance Victoria. At this point, the Health Commander needs to consider delegating responsibility for ICS functions.

For ‘green level’ incidents of medium complexity, the Health Commander, Triage Officer and Transport Officer form the Health Incident Management Team. The ICS functions of operations and logistics are undertaken by the Triage Officer and Transport Officer respectively. The Health Commander will initially take on the planning role.

Orange level incidents have a major impact on operations and are more complex in size, control or risk factors. The deployment of first aid agencies and Field Emergency Medical Officers may be required and will participate in the operations function. Further resources may be required to support the planning and logistics functions undertaken by Health Commander and Transport Officer.

Figure 6: Health Incident Management Teams for different level incidents



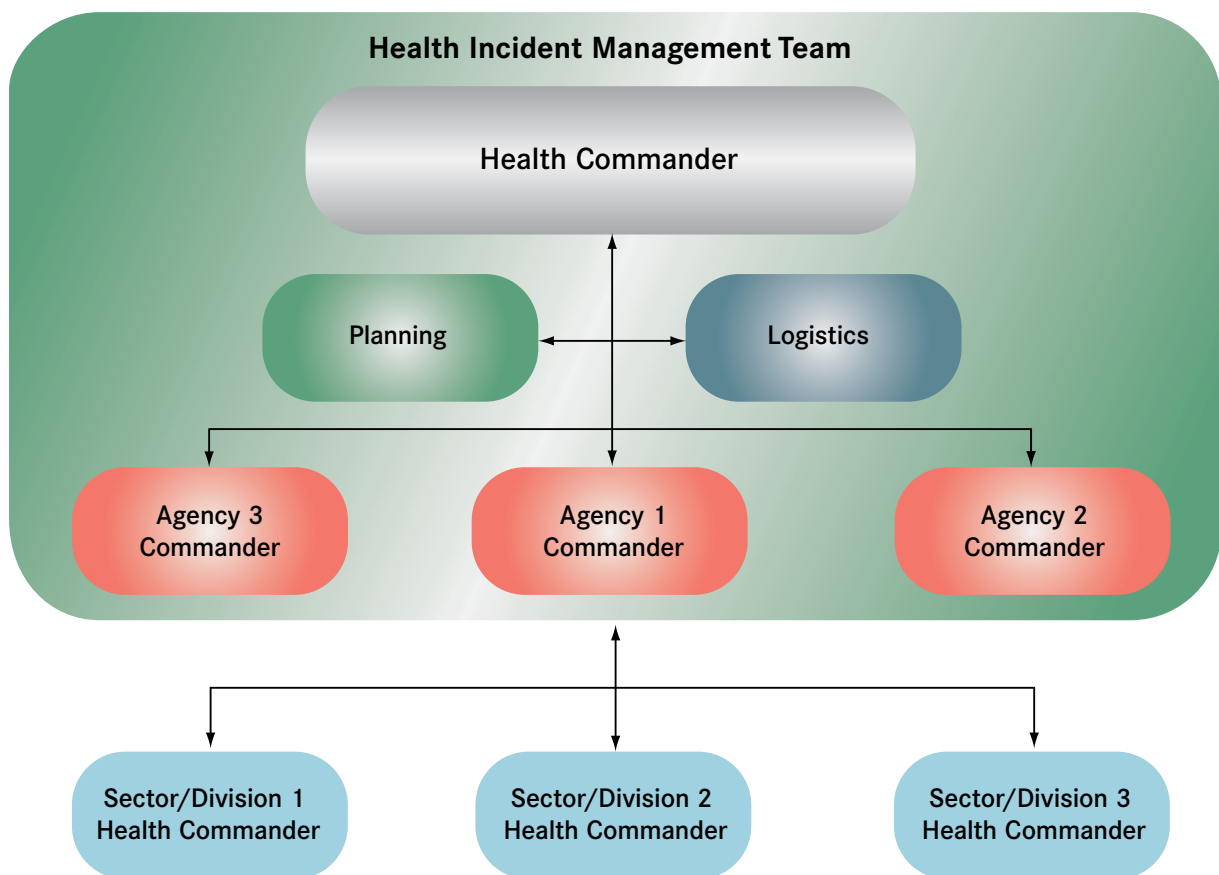
Red Level events have a severe impact on normal operations and are characterised by high levels of complexity in terms of size, risk and control factors. The deployment of further field medical support through Field Emergency Medical Officers or Victorian Medical Assistance Teams may be required. In these very complex events, further functions such as intelligence and information may be added to assist in the management of the health response.

### Multiple sites

In the case of an emergency with a number of sites (such as a complex terrorist attack) or a site spread over a wide area, the Health Commander will remain with or in close contact with the Incident Controller and the Emergency Management Team. The Health Commander will form the Health Incident Management Team and establish an incident structure to effectively manage the incident, but may be required to direct operations via phone or radio.

In this rare occurrence, it may be necessary to appoint Sector or Division Health Commanders for each specific site. Each Sector / Division Health Commander will inform the Health Commander of the specific requirements of the site, to ensure appropriate targeting of health resources. Within the 'operations function' of ICS, consideration must be given to effective span of control over either a single or multiple sites (or zones). 'Span of control' refers to the practical limit of the resources and issues that one person can effectively manage. In a widespread emergency, Sector / Division Health Commanders will be appointed to support the Health Commander.

Figure 7: Health Management Team (Multi Site)



Notes:

- Sites are split into divisions/sectors, with individual resource requirements.
- Specific site requirements will be reported to the Health Commander by the Division/Sector Health Commander (if appointed).

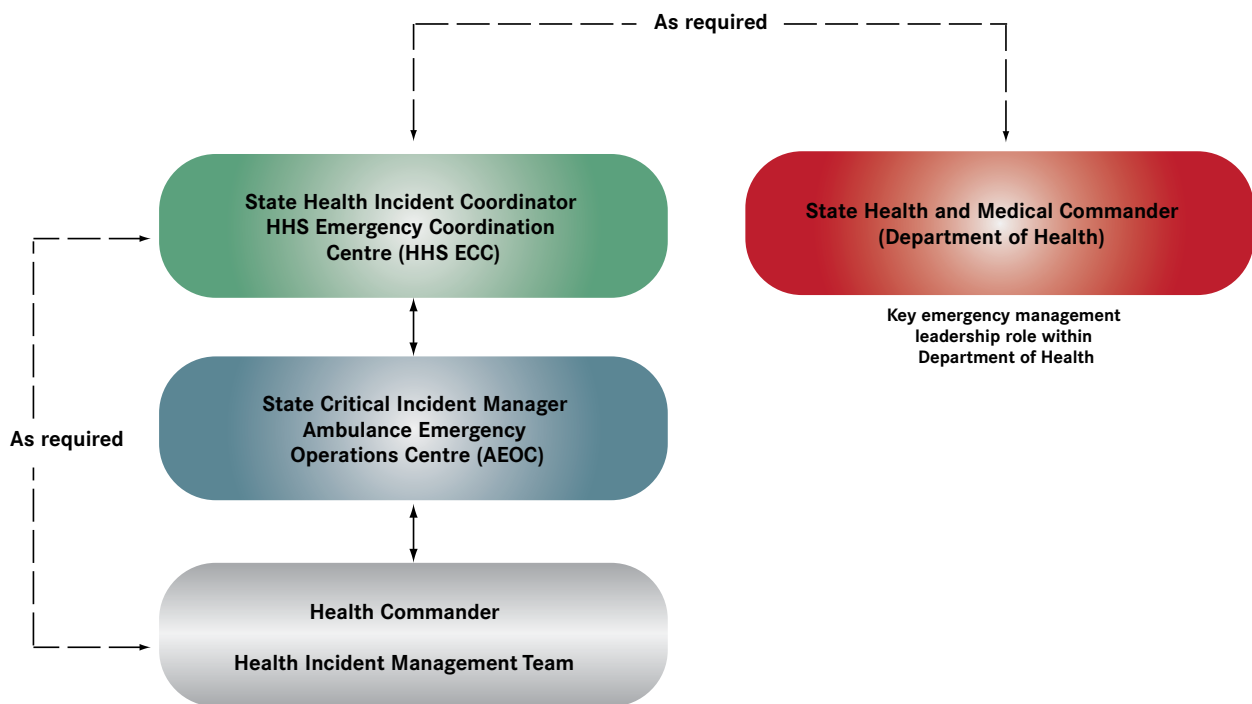
### Reporting relationships

The Health Commander will report to the **State Critical Incident Manager – Ambulance Emergency Operations Centre (AEOC)**.

The AEOC (depending on the complexity and size of the incident – see Escalation) will report to the HHS Emergency Coordination Centre (HHS ECC). The State Health Incident Coordinator (SHIC) is a function of the HHS ECC. If required, the Health Commander will also report to the SHIC.

The SHIC will discuss all key health issues with the State Health and Medical Commander (DH)

**Figure 8: Report relationships**



## Notification and communications

Various methods of formal and informal incident notification are in place and are unchanged by this plan. However, SHERP places a requirement on all officers to formally categorise and notify other agencies of an incident.

### Alert

Information may be received by Ambulance Victoria, DH, DHS, a statutory authority, support agency or hospital advising that an incident has occurred, may potentially occur or is imminent. There is recognition of the requirement for resources to enable increased preparedness. Notification can occur through various channels, including but not limited to:

- '000'
- notification via other emergency services
- State Health Incident Coordinator (SHIC) via VicPol State Emergency Response Coordinator.

### Standby

Following initial notification, an assessment is made to determine the scale of response required. Agencies and organisations, through their standard operating procedures, have objective measures for determining when thresholds are reached. In the event of catastrophic or significant emergencies, initial assessment is not required to escalate the health response. If necessary, immediate activation notification can be made to Ambulance Victoria, DH, DHS (State Health Incident Coordinator – SHIC) and other agencies.

#### Standby

- Ambulance Emergency Operations Centre (AEOC) and/or SHIC are notified if escalation and coordination of resources is required.
- First aid agencies are notified if provision of first aid is likely, or the emergency is known to involve significant patient numbers.
- Field Emergency Medical Coordinator (FEMC) is notified if field medical assistance is required at the scene, or patients are to be distributed to receiving hospitals.

Notification to other agencies depends on the nature of the emergency and resources required.

## Activation and deployment

### Health Commander

The Health Commander assumes the role as necessary, working at incident level and in accordance with standard operating procedures. In the case of multi-site emergencies, the Health Commander will co-locate with the Incident Controller and Emergency Management Team (EMT) and deploy Sector or Division Health Commanders, consistent with the span of control concept.

### Health Incident Management Team

The Health Commander will generally appoint the Health Incident Management Team (HIMT) according to a scene assessment. However, to ensure effective and timely support, some agencies may be pre-deployed according to the initial assessment. The Health Commander will establish a staging area and direct all responding health support resources to this area. Responding health agencies will appoint an Agency Commander and on arrival at the staging area, will report to the Health Commander and deploy as directed.

### Municipal resources

To activate municipal assets and resources, the Health Commander will lodge a request through the Emergency Management Team and/or direct to the Municipality.

### State, interstate and Commonwealth resources

To activate health resources or assistance at State level, the Health Commander will lodge a request through the State Health Incident Coordinator (SHIC). A request for health resources from interstate or Commonwealth sources is lodged through the SHIC, who will then notify the State Emergency Response Coordinator (Victoria Police). The SERC will action this, according to *Part 8 Appendix 4 of the Emergency Management Manual of Victoria*.

## Scene management

### People management

Incident sites can be chaotic, with numbers of dead, injured and uninjured people. Three key groups are evident:

- People with physical injuries (including dead)
- People with little or no physical injuries, but who may be affected by the event
- People electing to leave the scene prior arrival of emergency services or during the triage process. These people may self-present at hospitals or general practitioners' clinics, or simply return to their community.

*Note that the deceased are left in situ for the Coroner (or Victoria Police acting on behalf of the Coroner) to process.*

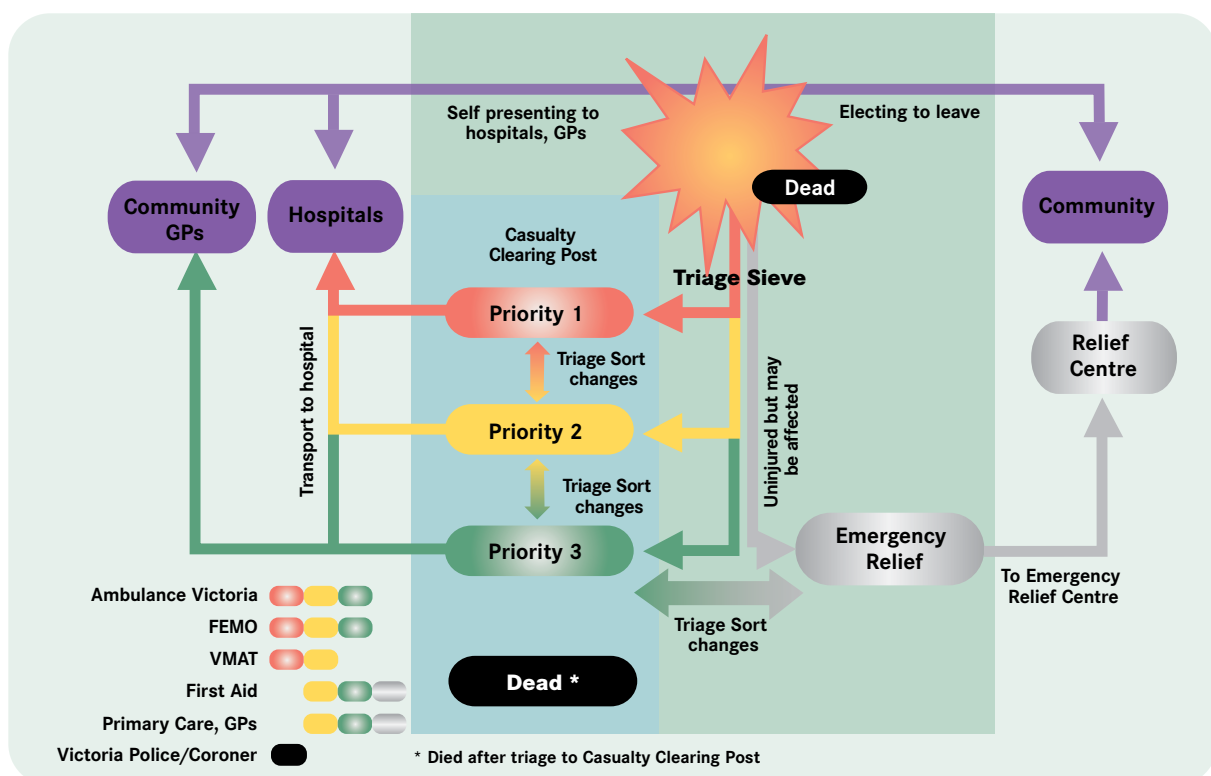
### Triage

Triage ensures that constrained medical resources are directed at achieving the greatest good for the most number of people. It seeks to prioritise patients by severity of injury and optimise outcomes during times of severe resource constraints. Patients may be triaged into a particular category, but may then be re-categorised due to the evolving nature and deterioration of injuries. Triage is used to provide pre-hospital personnel with guidelines for assigning treatment priorities. Initial triage by ambulance and first aid personnel will 'sieve' people with physical injuries into the following streams:

- the casualty clearing post for the injured
- an emergency relief area set aside for people with little or no injuries, where emergency relief can be provided if required.

Following initial triage to the casualty clearing post, secondary triage is undertaken by Ambulance Victoria, or other appropriate agencies designated by the Health Commander to 'sort' patients by priority. Some people may elect to leave the scene prior to triage and it may be difficult to contact them for further follow up, if required. Where possible, agencies should emphasise the importance of the triage and registration process for all people affected by the incident.

Figure 9: Scene management



## People with physical injuries

Establishing a casualty clearing post is the responsibility of an on-site ambulance commander or the Health Commander. Triage and appropriate triage tagging of casualties is an ambulance responsibility, with appropriate liaison with infield medical personnel if present. Following initial triage 'sieve' to the casualty clearing post, secondary triage is undertaken to sort patients by category.

Ongoing casualty care will be managed by health personnel from:

- Ambulance Victoria
- Field Emergency Medical Officers (FEMOs), Victorian Medical Assistance Teams (VMATs) – (see *Field medical support, below*)
- First aid personnel
- spontaneous health volunteers (once credentials are checked by FEMO).

As resources become available, casualties requiring hospital care will be transported from the scene to appropriate hospitals. Where practicable, Ambulance Victoria should advise the hospital of the patient's condition and expected time of arrival. Lightly injured people may be referred to local GPs directly, or through the emergency relief process.

### Ambulance Victoria

Ambulance Victoria will usually be the first health agency responder on the scene and in partnership with the Health Commander (when there is no Field Emergency Medical Officer on-site), will decide where casualties should be taken and provide immediate treatment, transport and coordinate communications between different parts of the health response.

The role of ambulance, as defined in the Emergency Management Manual Victoria and Chemical, Biological and Radiological (CBR) arrangements are:

- provide appropriate skills and equipment for various health emergencies, including mass casualty and complex incidents
- triage casualties and provide first aid and advanced treatment
- provide the most effective transportation for casualties to appropriate medical care
- assist with coordinating medical teams
- provide health support to other agencies, where appropriate
- provide medical support to casualties undergoing decontamination.

Ambulance Victoria performs additional roles under the SHERP:

- when required, deploy a Health Commander to the incident scene
- deploy other key position holders or mobile specialist teams, as required
- notify hospitals
- assist with communications and logistics for additional medical support
- supply/transport of Victorian Medical Assistance Teams to the emergency site.

## Field medical support

The Health Commander will assess the requirement for field medical support and resources. If required, a Field Emergency Medical Officer (FEMO) can be deployed via the Field Emergency Medical Coordinator (FEMC), according to standard operating procedures. The Field Emergency Medical Officer:

- provides advanced medical care to patients
- provides advanced medical and clinical advice to ambulance services
- liaises with the Health Commander and Field Emergency Medical Coordinator to determine the appropriate casualty distribution to receiving hospital(s)
- refers casualties to alternative care options
- checks credentials and manages spontaneous health and medical volunteers.

If further medical support is required, the Field Emergency Medical Officer can assess the need for and activate Victorian Medical Assistance Teams (VMATs) via Field Emergency Medical Coordinator – FEMC. A VMAT is a team of experienced doctors and nurses providing on-site assessment and emergency treatment of casualties, prior to transfer. VMATs can provide extended duration or advanced clinical care.

If there is no Field Emergency Medical Coordinator or VMAT in close proximity, then the Health Commander, in consultation with the State Health Incident Coordinator, may deploy a local general practitioner (GP) to attend the incident scene.

## First aid

The role of first aid agencies under SHERP is to provide trained first aid teams at incident sites, casualty clearing posts, and relief centres – or as otherwise directed by the Health Commander or State Health Incident Coordinator. Services and resources provided may include:

- trained first aid officers able to assist with site triage, initial treatment and resuscitation of casualties and ongoing care
- trained advanced level first aid officers, capable of providing such care as defibrillation, oxygen resuscitation and limited drug therapy
- portable first aid supplies and other patient care equipment that is easily transported in vehicle, trailer and kit form, for establishing first aid posts
- comprehensive radio communications networks, capable of stand-alone operation.

If more than one first aid agency is deployed to the incident scene, the agencies will elect one First Aid Commander to represent all first aid agencies on the Health Incident Management Team. When appointed, the First Aid Commander will report to the Health Commander and work with the First Aid Agency leader.

For further information, refer to Appendix 3.

## Public Health

When Public Health is not the key control agency, early involvement of this support may help protect health and contribute to risk communication strategies for the community. A Public Health liaison officer may attend an incident in support of the SHERP to provide public health expertise to the Health Incident Management Team and Emergency Management Team. Public Health can provide technical advice and community support, without attending the incident and advise on post incident recovery processes.

## Managing spontaneous health and medical volunteers

Spontaneous health and medical volunteers are not part of any agency response and will require registration and credential checking prior to assisting in the health response.

The Field Emergency Medical Officer (FEMO) in conjunction with the Health Commander and Victoria Police, will be responsible for independent volunteer registration, credential checking and task deployment. The FEMO will ensure volunteers are supervised by appropriate personnel.

## Transport

### Patient distribution

Patient distribution to hospital(s) is facilitated through the Ambulance Emergency Operations Centre. In larger scale incidents involving large numbers of patients, distribution is managed in consultation with the Field Emergency Medical Coordinator (FEMC) and HHS Emergency Coordination Centre (HHS ECC). Standard operating procedures exist for patient distribution and contacting appropriate hospitals. The following criteria are taken into account when distributing patients:

- patient numbers, including percentage occupancy of destination hospital
- time to destination
- transport resources
- type of injuries
- special needs patients.

Other State and Commonwealth plans for patients, such as transport plans, burns and CBR plans, link with SHERP and will be used if required. A request for transport assistance from interstate or the Commonwealth is lodged through the State Health Incident Coordinator (SHIC), who will then notify the State Emergency Response Coordinator (Victoria Police). This will be actioned according to *Part 8 Appendix 4 of the Emergency Management Manual Victoria*.

A comprehensive list of State and Commonwealth plans is included in Appendix 1.

### Secondary transfer

Secondary transfer occurs where a patient is admitted to a hospital from the scene, but is then transferred to another hospital. If this situation occurs, the hospital will follow their normal procedures for inter-hospital transfer of patients. In the planning and activation of secondary transfers, ambulance transport resources will be a key element. Where an emergency involves multiple health services and there is more than one patient for inter hospital transfer, the decision making process will be coordinated by HHS Emergency Coordination Centre (HHS ECC).

For further information on secondary transfer of patients, please refer to '*Hospital Resilience – Code Brown Policy Framework*'.

## Hospitals

Health services play a critical role in the Victorian whole-of-health response to an emergency. Once notified of an incident, Code Brown response plans will be activated and the whole health service prepares to manage an influx of patients.

The health service will appoint a hospital commander who will oversee all aspects of the incident, and be the key contact person for all incoming and outgoing communications. Hospital Code Brown plans will interface with the *Hospital Resilience Code Brown Policy Framework* and ultimately the SHERP.

Some private hospitals have formed partnerships with public health services, to assist in such functions as emergency decanting of patients. Additional requests for assistance from the private hospital sector will be coordinated through HHS Emergency Coordination Centre (HHS ECC).

### Self-presenting casualties

Following an emergency, affected people may leave the scene and then self-present at hospitals and general medical practices. Casualty receiving hospitals will be notified of the incident through Ambulance Victoria. However, when hospitals and health services become aware of an event, other than through normal communication channels, they should consider activating Code Brown plans.

General practices should develop internal procedures to manage an influx of self-presenters. In long duration incidents, general practitioners may be requested to assist, as described within local health service arrangements.

## People with no physical injuries

### Emergency relief

People with no obvious physical injuries or contamination should be offered emergency relief, including psychological first aid. Emergency relief recognises basic physical and emotional needs, such as safety and shelter, water, food and psychological first aid. Emergency relief is time critical and health and medical responders must be aware of the need for immediate provision of support at the site of the emergency, not just at relief or evacuation centres which take time to set up.

It should not be assumed that if a person is uninjured, they are unaffected. People triaged to the emergency relief stream (refer Fig. 9 Scene management) should be escorted if possible to a safer area, away from the immediate noise and direct viewing of the incident scene. Where possible, they should not be left alone and as other resources become available, personnel are to be allocated to ensure their safety.

Psychological first aid is an element of emergency relief which addresses the immediate emotional support needs of persons affected by an emergency, and can be instrumental in preventing psychological trauma in the future.

Health and medical personnel at the scene of the emergency should alert the Health Commander immediately if psychological first aid services or other elements of emergency relief are required. The Health Commander will activate field emergency relief services through the Municipal Emergency Response Coordinator (MERC) or the HHS ECC.

Registration of affected individuals may begin at the scene of the emergency and then move to a relief or recovery centre. It remains the responsibility of Victoria Police to register individuals involved in the incident and to manage members of the public on-site. Transport of individuals to an emergency relief centre (if established) is the responsibility of the Emergency Response Coordinator.

### Primary health care access in emergency areas

#### Field Primary Care Clinics (FPCCs)

In major emergencies, communities may have reduced access to primary medical care due to medical infrastructure damage, incapacity of usual general practitioners, increased demand for medical services, loss of personal transport or limited capacity to leave the immediate vicinity.

Where additional primary health care is identified as a need, field primary care clinics (FPCC) can be established and staffed by registered general practitioners, nurses and paramedics.

Management of these Field Primary Care Clinics is the responsibility of Ambulance Victoria and is established under SHERP. The Health Commander will appoint a paramedic to manage the Field Primary Care Clinic.

Emergency medical care (and hospital care, if required) will continue to be the responsibility of emergency paramedics. Clinics will operate within appropriate safety and clinical governance guidelines.

For more details, refer to *Attachment 2: Field Primary Care Response Subplan*.

### **General practitioners**

General practitioners (GPs) play an important support role in Victoria's overall ability to respond to emergencies. Generally GPs will not be required at the scene of the emergency however, if attendance is required this will be managed under the Health Commander, or Field Primary Care Clinics (FPCCs).

- Within clinics / practices GPs:
  - assist hospitals in managing clinical surge demands as a result on an emergency.
  - provide clinical care for self-presenters resulting from an emergency; eg walking wounded and individuals who have no physical injuries, but have psychological trauma or distress)
  - provide primary treatment and care for their local community
  - provide clinical assistance with patients referred from hospital to home base care.

For more details, refer to *Attachment 1: General Practice SubPlan*.

### **Short term clinics**

Additional general practice and nursing services may be provided in affected areas to help support people affected by emergencies. These services are established by the practitioners themselves and are not necessarily linked to the government response efforts.

While such services are valued, general practitioners and nurses are urged to link in with the Health Commander to ensure coordination of appropriate services. Clinics are also advised to link in with coordinating bodies such as Rural Workforce Agency Victoria (RWAV), General Practice Victoria (GPV), the Royal District Nursing Service (RDNS) or the Australian Government Department of Health and Ageing (DoHA), to ensure appropriate services are provided to these communities. This coordinated effort will also form part of discussions between State and Commonwealth Governments in planning appropriate responses.

### **Community information**

Information in the initial phase of an event may be limited. The ambulance service may not be in a position to provide information, due to their priority of responding to the event. Secondary sources of information may be obtained from media outlets (radio, television and the internet).

In some instances where the consequences of the emergency are likely to impact further on the immediate area or local neighbourhood / community, the control agency has the responsibility to manage community information. This information should address:

- what is known and unknown about the emergency
- what is being done
- ongoing threats
- actions required by individuals and the community to prevent further injury, death and damage to property and the environment.

The Health Commander, as the representative on the Emergency Management Team (EMT) of the health response agencies, will advise the Incident Controller of information regarding public health and medical issues.

The State Health Incident Coordinator (SHIC) will assist in providing further information if required, through the HHS Emergency Coordination Centre and the Chief Health Officer.

## Media

Health personnel on-site are advised not to speak to the media or release any information about casualties. Media management at any incident is the responsibility of the Incident Controller.

If the control agency is not equipped, or is otherwise unable to deal directly with the media, the assistance of the State Health Incident Coordinator (SHIC) and the Victoria Police Media Liaison Unit may be requested. Warnings, or release of other public information which the response coordinator deems necessary, must first be cleared by the Incident Controller, (see EMMV parts 3–4). The Health Commander must ensure the Incident Controller is briefed on the health impact and consequences of the incident.

## Stand down

Stand down is the return to normal operations when deployment of resources and personnel to the health incident is no longer required (see EMMV part 3).

Stand down activities include:

- hospital notification of incident site stand down
- hot debrief of all agencies deployed
- peer support
- audits and reports
- review of SHERP and supporting plans and standard operating procedures.

## Debriefing, review and evaluation

To assist future planning and address issues requiring improvement, debriefing is essential after each multi-agency response to a health event. The Control Agency is responsible for conducting a multi-agency debrief with input from participating agencies, who are responsible for conducting their own operational debriefs beforehand. Where a multi-agency debrief does not occur, the Director Emergency Management Branch will be responsible for organising an operation debrief of health agencies involved in the event.

Debriefs and post incident assessments will recognise positive outcomes and identify lessons learned. They should be published and distributed appropriately. Relevant information or outcomes of interstate and overseas health events should be included in the review of health incident management plans.

## Plan development, administration and maintenance

### Training and awareness

Training and awareness of the SHERP is invested in the Department of Health, the Department of Human Services Emergency Management Branch, response agencies and all agencies with a key role to play.

SHERP is a sub plan to the State Emergency Response Plan and is critical to the ‘all hazards, all agencies’ response to emergencies.

Multi-agency training and exercising is essential in preparing all to implement SHERP.

### Governance

SHERP is administered by the Director Emergency Management for the Department of Human Services. SHERP is a sub plan of the Victoria State Emergency Response Plan, described in the Emergency Management Manual Victoria. It is reviewed by the Health and Medical Sub Committee of the State Emergency Response Planning Committee. The department’s Emergency Management Branch is responsible for distributing this document and for managing contact lists. The Health and Medical Sub Committee’s terms of reference is detailed in the DHS *Health and Medical Sub Committee Terms of Reference document*.

### Monitoring and review

This plan (and any relevant sub or specific plans) shall be reviewed:

- *Three yearly*. This review will be the responsibility of the Department of Human Services, through the Director Emergency Management.
- *following any major activation* of this plan or relevant sub or specific plans to any major health event, as deemed required by the Health and Medical Sub Committee.
- *following any new developments* or substantial changes to the health operational context.

Outcomes of any monitoring and review activities will be provided to the State Health and Medical Sub Committee.



## Appendices

**Appendix 1: Other relevant plans and sub plans**

**Appendix 2: Public events and mass gatherings**

**Appendix 3: First aid**

**Appendix 4: Key SHERP function and facility descriptions**

## Appendix 1: Other relevant plans and sub plans

Name	Brief description	Jurisdiction
COMDISPLAN	Coordinates Commonwealth Government physical assistance, following a disaster in Australia or its offshore territories.	Commonwealth
AUSASSISTPLAN	Coordinates Commonwealth Government physical assistance, following a disaster in another country.	Commonwealth
AUSBURNPLAN	National coordination and response plan for events which overwhelm capacity of State Burns Management Plans.	Commonwealth
OSMASSCASPLAN	National response plan for overseas mass casualty incidents involving Australians.	Commonwealth
COMMRECEPLAN	Roles and responsibilities of Australian organisations for reception of Australian citizens (and other approved persons) evacuated from foreign countries.	Commonwealth
AUSCONPLANSPPRED	Coordinates and controls Commonwealth support for State/Territory authorities involved in locating, recovering and removing radioactive material arising from re-entry of space debris.	Commonwealth
Australian Health Management Plan for Pandemic Influenza	A national health sector plan for responding to an influenza pandemic.	Commonwealth
National Counter-Terrorism Plan	Outlines responsibilities, authorities and mechanisms to prevent or manage acts of terrorism and their consequences within Australia.	Commonwealth
State Emergency Response Plan	Organisational arrangements for managing the response to emergencies within (or with the potential to affect) Victoria. Applies to all agencies with emergency roles or responsibilities.	State
State Emergency Recovery Arrangements	Together with the State Emergency Response Arrangements, this is the strategic framework for emergency recovery planning and operations in Victoria.	State
State Burns Plan	A plan for the optimal care of survivors of a mass burn casualty incident in Victoria.	State
State CBR Plan	Arrangements for managing a chemical, biological or radioactive (CBR) incident. Dovetails with other Victorian emergency management plans, including SHERP and the State Counter Terrorism Plan.	State
Public Health Emergency Response Arrangements	Outlines agency roles and responsibilities in response to a public health emergency.	State
Victorian Health Management Plan for Pandemic Influenza	A health response framework to minimise the morbidity and mortality of an influenza pandemic and its impacts on the Victorian community, health care system and economy.	State
Victorian Human Influenza Pandemic Plan	Outlines the responsibilities, authorities, mechanisms and actions to prevent, respond to and recover from an influenza pandemic in Victoria. Describes the relationship between existing public health and emergency management arrangements.	State

## Appendix 2: Public events and mass gatherings

### 1. Introduction

Every day, events conducted throughout Australia attract crowds to all types of venues. The degree of planning and preparation for associated health and safety aspects varies just as greatly.

SHERP provides a planning and management structure for public events and gatherings where there is potential for immediate mass casualties – and possibly increasing numbers of casualties over time. Involving health response agencies in pre-event planning may contribute to a safer, and therefore more successful, event. Planners should ensure that event managers have a basic understanding of the SHERP framework and the role of the Health Commander and Health Incident Management Team (HIMT).

### 2. Aim

To provide a resource and checklist for planners using the SHERP model as a basis for emergency health response coordination in public events and mass gatherings.

### 3. Scope

This information applies to a wide range of mass gatherings and public events within Victoria. In situations such as visits by high-profile political figures or controversial activists, intensive security arrangements are necessary. Such procedures are outside the scope of this appendix, therefore, liaison between emergency services personnel, health professionals and security personnel is required.

### 4. Planning considerations

Take health and safety considerations into account:

- a hazard analysis of the area
- geographic location
- entry and exit for emergency vehicles
- crowd movement
- types of spectators
- time of year and weather conditions
- public health issues
- availability of food and water.

Also consider general health and medical issues:

- level and mix of on-site medical care required, for example; first aiders, paramedics, nurses, doctors, mobile medical teams, psychological first aid
- appropriate skilling for selected personnel
- notification of appropriate persons, such as State Health Incident Coordinator (SHIC)
- special credentialing, to allow medical personnel and/or vehicle access to all parts of the venue and to any restricted areas
- storage and re-supply of medical supplies
- suitable on-site medical facilities, such as first aid room, tent or vehicle, which are clearly identified and easily accessible
- transporting patients within and outside the event
- communications between health and medical staff, off-site medical staff, event organisers, security and other support staff.

## Events requiring special consideration

Certain types of events have inherent management issues:

- water events and power boat races
- car rallies on public roads
- air shows and displays
- fireworks and pyrotechnics, including laser light shows
- events involving pre-teens and early teens
- festivals with potential for heightened emotional states, or consumption of alcohol and drugs.

## Checklist for planners

Health response planners should use this as an *aid memoire* only. Components such as a detailed hazard analysis and communications plan should be attached.

Issue/Item	Y/N	Comment/Document attached
Involvement in event planning committee		
Event requires special consideration. See above.		
Hazard analysis undertaken:		
• hazard identification		
• risk assessment matrix		
• treatment options.		
Level of Ambulance Victoria involvement (staffing load/mix/skill)		
Health agencies, other than Ambulance Victoria		
Medical facilities available		
Roles and responsibilities		
Communications plan		
SHERP notifications required (SHIC, FEMC, hospitals etc)		
Entry/exit security		
Links with MEMP/Regional Plans		

For more information on planning for these types of events, see the Australian Emergency Manuals Series' Safe and Healthy Mass Gatherings, available through [www.ema.gov.au](http://www.ema.gov.au)

## Appendix 3: First aid

### 1. Introduction

This appendix addresses the appropriate provision of first aid support services under SHERP, in the event of a major emergency.

### 2. Role of first aid agencies

The role of first aid agencies under SHERP is to provide trained first aid teams at incident sites, casualty clearing posts, and relief centres – or as otherwise directed by the Health Commander. Services and resources may include:

- trained first aid officers to assist with site triage, initial treatment and resuscitation of casualties and ongoing care
- trained advanced level first aid officers, capable of providing defibrillation, oxygen resuscitation and limited drug therapy
- portable first aid supplies and other patient care equipment, easily transported in vehicle, trailer and kit form, for establishing first aid posts
- comprehensive radio communications networks, capable of stand-alone operation.

### 3. Concept of operations

#### 3.1 Activation

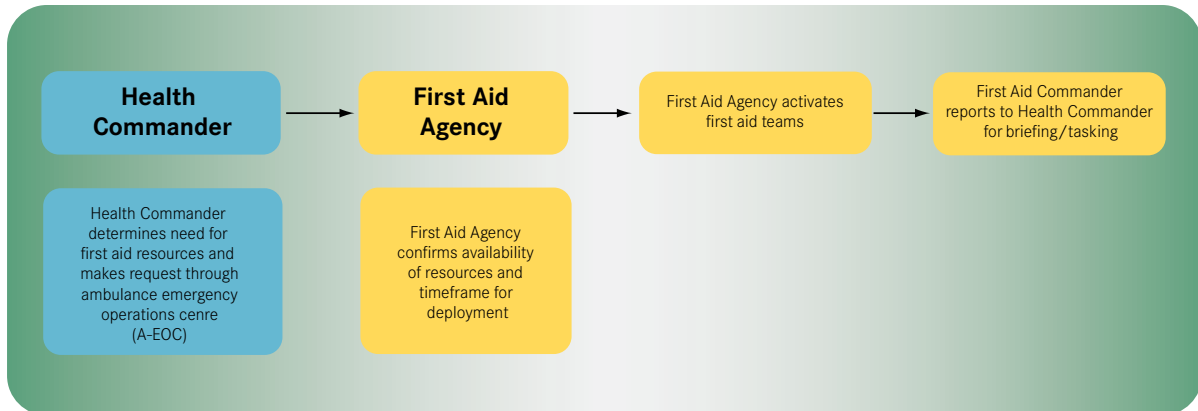
##### 3.1.1 Local activations

- All first aid agencies have local arrangements in place. Any small-scale response will remain as per those local arrangements.
- When activated locally, the first aid agency shall notify Ambulance Victoria.

##### 3.1.2 Regional/State activations

- If an incident progresses to regional/state level, Ambulance Victoria will coordinate first aid responses. The Health Commander will determine the resources required from the relevant first aid organisation, based on the capabilities of each agency, and make requests through appropriate activation contacts.
- The Health Commander will provide the agency with all relevant information and instructions for deployment, using the 'ETHANE' format:
  - **E**xact location
  - **T**ype of incident
  - **H**azards
  - **A**ccess and egress
  - **N**umber of patients
  - **E**mergency services at scene/required.

Figure 10: Flow chart for activation



## 3.2 Response

### 3.2.1 Management structure

- All health management at an incident is based on the Incident Control System (ICS).
- The First Aid Commander will report to the Health Commander and form part of the Health Incident Management Team (HIMT).
- The Health Commander is responsible for tasking the agency commanders within the HIMT.
- Where there are two or more first aid agencies, the Health Commander will appoint a single First Aid Commander to coordinate all first aid teams.
- Each agency is responsible for ensuring that personnel are equipped with appropriate personal protective equipment and that all team leaders and commanders are wearing tabards.
- Each first aid agency involved in an incident will participate in post incident debriefs and provide Incident Reports through normal agency processes.

## Appendix 4: Key SHERP function and facility descriptions

The following pages are single-sheet *aides memoire* summarising key functions and facilities under SHERP. They can be removed for easy reference.

### Key functions

- 4.1 Health Commander
- 4.2 State Health Incident Coordinator (SHIC)
- 4.3 Health Incident Management Team
- 4.4 State Critical Incident Manager (SCIM)
- 4.5 Ambulance Commander, Triage Officer, Transport Officer
- 4.6 Field Emergency Medical Officer (FEMO)
- 4.7 Victorian Medical Assistance Team (VMAT)

### Key facilities

- 4.8 Department of Health and Human Services Emergency Coordination Centre
- 4.9 Ambulance Emergency Operations Centre
- 4.10 Emergency Operations Centre (generic)

## 4.1 Health Commander

Performed by	Ambulance Victoria personnel (normally)
Deputies / Delegates	As nominated by Ambulance Victoria
Reports to:	State Coordinator-Ambulance Emergency Operations Centre (AEOC) State Health Incident Coordinator (SHIC) as required

### Role

The Health Commander is a senior ambulance manager (unless otherwise appointed by the State Health Incident Coordinator) who oversees and, where appropriate, directs the operational health response to a major incident within Victoria. This person has the authority and experience to make decisions on delivering the health incident management objectives.

The Health Commander has two key roles:

- establish and coordinate a Health Incident Management Team (HIMT) to direct the emergency health response
- represent the HIMT on the Emergency Management Team (EMT).

### Responsibilities

The Health Commander will:

1. Operate to support the Incident Controller and participate in the Emergency Management Team (EMT).
2. Assume command of health and medical aspects of the emergency.
3. Provide regular situation reports to AEOC (and SHIC if required).
4. Establish and lead the Health Incident Management Team (HIMT) and the functional structure within the team, to provide tactical direction to health personnel.
5. Represent health agencies within the EMT.
6. Liaise with AEOC to activate health support agencies and ensure all notifications are carried out. This includes:
  - activating FEMO, VMAT and first aid organisations
  - activating specialist assistance or resources beyond the capacity of Victoria's health and medical agencies, such as SES deployment of mass casualty tent, lighting or additional communications, (requested through the EMT)
  - activating ambulance communications and equipment resources
  - activating additional patient, personnel and equipment transport vehicles
  - notifying hospitals
  - notifying the SHIC.
7. In consultation with the HIMT, develop the health component of the overall Incident Action Plan (responsibility of the control agency), evaluating casualty needs and how best to manage them on-site, in both the short and long term. Include casualty transport options and identify receiving hospitals.
8. Monitor practices relating to occupational health and safety of all responding health personnel involved in the emergency.
9. Determine the requirements, quantity and urgency for medical supplies to the incident site.
10. Oversee (with Police assistance) registration and deployment of spontaneous health volunteers.
11. Take all reasonable actions to ensure the activities of health agencies minimise disturbance to the incident site, to assist future investigations. Liaise with Police regarding casualties who have died after removal from their original position.
12. Assess the requirement for emergency relief, including psychological first aid, at the scene and notify Emergency Response Coordinator through the EMT to activate.

## 4.2 State Health Incident Coordinator (SHIC)

Performed by	Director Emergency Management, Department of Human Services
Deputies / Delegates	As nominated by SHIC
Reports to	State Emergency Response Coordinator

### Role and responsibilities

The SHIC will:

- ensure the Health Incident Management Structure is established at incident level
- provide support to the Health Commander as appropriate
- report on a regular basis to:
  - State Health and Medical Commander
  - State Emergency Response Coordinator
  - Departmental heads
  - Ministers
- ensure HHS ECC/VHEC is established and is effectively operating to ensure hospital emergency response to surge is managed
- ensure AEOC is established to ensure Ambulance Victoria, through State Critical Incident Manager, manage an emergency incident
- ensure State planning and predictive information is established and communicated to all levels, as appropriate
- lead the development of the State Health Incident Strategy.

### 4.3 Health Incident Management Team

Performed by	Various health responding agencies
Deputies / Delegates	As nominated by Health Commander
Reports to	Health Commander

#### Role

The Health Commander coordinates the health response by forming and managing a Health Incident Management Team (HIMT).

Based on the incident type and location, a health management structure will be established to coordinate the health response. The HIMT is formed from senior personnel from responding health agencies, for the purpose of coordinating the health and medical response in an emergency.

The HIMT provides the strategic direction for tactical health responses to the incident.

Each health support agency on scene will appoint a commander/team leader. The commander/team leader will represent the support agency in the HIMT. Members of the HIMT **may** include, but are not limited to:

- Ambulance Commander – responsible for all ambulance and first aid activities at the incident
- Field Emergency Medical Officer (FEMO) – responsible for working in close liaison with the Health Commander, especially in managing medical teams and prioritising patient transport
- Public Health Team Leader – when the Department of Health is not the control agency
- Public Health Liaison Officer – when the department is the control agency
- First Aid Commander – one agency commander represents all the first aid organisations on-site.

#### Multiple sites

In the case of an emergency with a number of sites (such as a coordinated terrorist attack), or a site spread over a wide area (such as a train crash), the Health Commander will remain with the Incident Controller and the EMT.

The Health Commander may need to direct operations via phone or radio. It may also be necessary to appoint Health Sector Commanders and Sector HIMTs for each specific site. Each Health Sector Commander will inform the Health Commander of the specific site requirements, to ensure appropriate targeting of health resources.

Within the 'operations function' of ICS, consider the effective span of control over either a single or multiple sites (or zones). In a widespread emergency Health Sector Commanders will be appointed to support each Incident Controller where ever a health issue has been identified or anticipated.

#### 4.4 State Critical Incident Manager (SCIM)

Performed by	Ambulance Victoria
Deputies / Delegates	As required
Reports to	As described below

#### State Critical Incident Manager (State CIM)

- overall responsibility for Ambulance Victoria Emergency Management response
- will be an operational member of the Emergency Management Unit (EMU)
- liaison with Duty Team Managers (DTM)/ Operations Centres and Ambulance Emergency Operations Centre (AEOC)
- responsible for activating the AEOC
- participates in incident coordination, once Emergency Response Plan activated.

## 4.5 Ambulance Commander, Triage Officer and Transport Officer

Performed by	Ambulance Victoria
Deputies / Delegates	As required
Reports to	As described below

### Ambulance Commander

- initially the most senior paramedic at the scene, until a more senior officer arrives
- responsible for managing ambulance resources at the scene
- liaises with Health Commander
- liaises with FEMO
- liaises with DTM/SCO and AEOC
- provides direction for ambulance supervisors, ambulance safety officer and on-site paramedics
- liaises with Ambulance Victoria Media Department and may represent Ambulance Victoria operations in the media
- represents Ambulance Victoria in the Health Incident Management Team.

### Triage Officer

- the most experienced paramedic of the first crew on scene
- takes on role as Ambulance Commander, until the arrival of a manager who will assume the role
- performs triage and assesses the number and type of patients
- allocates the clinical priority for patients
- establishes a casualty clearing post
- liaises with transport officers and (initially) duty team managers
- takes direction from relevant Ambulance Supervisor or Ambulance Commander
- provides direction for on-site paramedics
- additional Triage Officers may be appointed for each incident sector and/or casualty clearing post.

### Transport Officer

- the least experienced paramedic of the first crew on scene
- provides situation reports
- coordinates transport vehicles to ensure appropriate transfer of patients
- liaises with Triage Officer and (initially) duty team manager
- takes direction from the relevant Ambulance Supervisor or Ambulance Commander.

## 4.6 Field Emergency Medical Officer (FEMO)

Performed by	Appropriate FEMO for region
Deputies / Delegates	As nominated by FEMO Program
Reports to	Health Commander

### Role

The FEMO is activated via the Field Emergency Medical Coordinator (FEMC), according to pre-determined triggers by the Ambulance Emergency Operations Centre (AEOC), to provide:

- field medical assistance
- advanced medical advice
- assistance with determining appropriate hospital distribution of casualties
- assessment and management of health and medical volunteers.

### Responsibilities

The FEMO:

- is a member of the Health Incident Management Team (HIMT), reporting to the Health Commander
- provides advanced medical care to patients
- provides advanced medical and clinical advice to ambulance services
- assesses the need for, activates (via FEMC) and manages Victorian Medical Assistance Teams (VMATs)
- liaises with the Health Commander and FEMC to determine the appropriate casualty receiving hospital(s)
- refers casualties to alternative care options
- assesses credentials and manages spontaneous health and medical volunteers.

## 4.7 Victorian Medical Assistance Team (VMAT)

Performed by	Appropriate VMAT team as required
Deputies / Delegates	As nominated by FEMO
Reports to	FEMO or Health Commander (if FEMO not present)

### Role

Where the number of casualties exceeds the capacity of concurrent treatment and transport by ambulance services, a Victorian Medical Assistance Team (VMAT) may be required. VMATs:

- are a team of trained doctors and nurses who provide on-site assessment and emergency treatment of casualties, prior to transfer
- can provide extended duration or advanced clinical care.

Activation of a VMAT is initiated through the FEMO and/or the Health Commander, if a FEMO is not present.

The FEMO or Health Commander will contact the Field Emergency Medical Coordinator via standard operating procedures to organise the appropriate VMAT to the incident site. The FEMO will command VMAT resources once on site.

The FEMO is generally expected to be on the scene before a VMAT arrives. However, the medical teams should be flexible enough to operate as a small team of only two members, deployed through a model that allows multiple teams to work together if a field treatment facility is established.

Ambulance Victoria will provide a liaison officer to each VMAT unit deployed, to assist with communications and logistics.

## 4.8 Health and Human Services Emergency Coordination Centre (HHS ECC) Includes Victorian Health Emergency Coordination (VHEC)

Performed by	State Duty Officer
Deputies / Delegates	As nominated by Director Emergency Management
Reports to	Director Emergency Management

### Role

The HHS ECC links and coordinates DH and DHS interests in an emergency, using its information management and communication systems to enable effective and informed decisions on risk communication and resource management. This includes DH and DHS responsibilities associated with:

- Victoria’s emergency response and recovery arrangements
- a major crisis that impacts the community and human services portfolio interests
- a major surge in demand for health services, requiring coordination of capacity planning and escalation of the response by health services agencies
- a major public health emergency, such as a flu pandemic
- continuity of departmental internal business critical systems and services.

The HHS ECC is managed by the DHS Emergency Management Branch, Service Delivery and Performance Division and is activated in the event of an emergency/incident when DH or DHS involvement is required at state/central level. The HHS ECC has all hours standby arrangements; twenty four hours a day 7 days a week, through the DHS Emergency Management Branch. The all hours contact number is 1300 790 733.

Victorian Health Emergency Coordination (VHEC) is a function of the HHS ECC, with a focus on the incident’s impact within and across Victoria’s health services. From response to recovery, it has a strategic role in coordination, leadership and appropriate support. The department will have an overview of all major incidents and when necessary, will ensure arrangements are made for a well coordinated response.

The department does not have a direct resource procurement role for resource requirements, as there is an expectation that all health services have business continuity plans for essential services and resources. Should a state-wide shortage of resources occur, the department can start the process for rationing state resources and/or seeking Commonwealth assistance.

The VHEC function is on standby at all times and can be activated at short notice (1300 790 733) in response to an emergency incident. It will:

- analyse the scope, status and likely impact of the emergency incident on the Victorian hospital system
- communicate with, and share intelligence amongst key stakeholders; health services, ambulance services in Victoria, the department’s regional and central offices and the Minister for Health
- act as a central hub for information on the availability of resources and facilitate the appropriate allocation of these
- take a command role if an incident is on a scale which threatens to overwhelm the Victorian health services.

## 4.9 Ambulance Emergency Operations Centre (AEOC) Includes Field Emergency Medical Coordinator (FEMC)

Performed by

Ambulance Victoria

### Ambulance Emergency Operations Centre (AEOC)

- located within the Ambulance Victoria (AV) Emergency Management Unit
- activated by State Critical Incident Manager, as per AV Emergency Response Plan
- responsible for communicating incident information to AV personnel, as per the AV Emergency Response Plan
- responsible for coordinating ambulance resources to the incident, as required
- communication with:
  - Health / Ambulance Commander
  - Duty Team Manager
  - Operations managers/ Regional managers
  - key AV personnel
  - key external stakeholders.
- ensures a ‘whole of organisation’ approach to appropriately manage an incident
- liaises with Victoria State Health Emergency Response Plan representatives, Department of Health, Department of Human Services, first aid agencies and other key stakeholders
- location for the Field Emergency Medical Coordinator (if activated)
- possible location for media representatives
- responsible for coordinating the stand down stage, which includes debriefing and reporting processes.

The following function is also based within the AEOC:

### Field Emergency Medical Coordinator

A senior medical officer from the Field Emergency Medical Officer Program provides:

- field medical assistance, if required at the scene of an emergency
- large scale patient distribution to casualty receiving hospitals, facilitated through the FEMC in consultation with the HHS ECC/VHEC and using the following criteria:
  - patient numbers (including percentage occupancy of destination hospital)
  - time to destination
  - resources
  - type of injuries
  - special needs patients.
- based in the Ambulance Emergency Operations Centre (AEOC)
- liaises with the Health Commander, Ambulance Victoria, HHS Emergency Coordination Centre (HHS ECC), Victorian Health Emergency Coordination (VHEC) and Field Emergency Medical Officers (FEMOs).
- Appropriate hospitals will be contacted, according to standard operating procedures.

## 4.10 Emergency Operations Centre (EOC)

Performed by	Responding agencies
Deputies / Delegates	As required
Reports to	As per agency standard operating procedures

### Role

An Emergency Operations Centre (EOC) is the physical location for coordinating response and recovery actions and resources. It is not an incident command post; rather, it is the operations centre for effective and efficient coordination of emergency response efforts.

The EOC uses the Incident Control System (ICS) to provide a management structure for conducting emergency operations. ICS provides the EOC and operational staff with a standardised operational structure and common terminology. It is applicable to small scale daily operational activities, as well as major mobilisations. Because of this, ICS provides a useful and flexible management system that is particularly adaptable to incidents involving multi-jurisdictional or multi-disciplinary responses.

## Appendix 5: Maps and useful links

Type	Link
<b>Maps – Victoria</b> with Department of Human Services Regional Boundaries	<p><a href="http://www.health.vic.gov.au/maps/index.htm">www.health.vic.gov.au/maps/index.htm</a></p> <p>Victorian and metropolitan Melbourne maps can be overlaid with public, private hospitals or day procedure centres, local government areas and Department of Human Services regional boundaries.</p> <p>Shows Victorian public and private hospitals mapped on Google Earth, with basic information on each hospital and access to topographic and street information.</p> <p>Note: To access these maps you will need Flash Player and Google Earth (both downloads are free)</p>
<b>Map – Trauma Services in Regional Victoria</b> (Nov 2005)	<a href="http://www.health.vic.gov.au/trauma/map.pdf">www.health.vic.gov.au/trauma/map.pdf</a>
<b>Melbourne Metropolitan Hospitals and Health Services Locations</b>	<a href="http://www.healthcollect.vic.gov.au/directories/metrohos.htm">www.healthcollect.vic.gov.au/directories/metrohos.htm</a>
<b>Rural Hospitals and Health Services Locations</b>	<a href="http://www.healthcollect.vic.gov.au/directories/ruralhos.htm">www.healthcollect.vic.gov.au/directories/ruralhos.htm</a>
<b>Victorian Public Hospital Websites</b>	<a href="http://www.health.vic.gov.au/hospitals/pubwebs.htm">www.health.vic.gov.au/hospitals/pubwebs.htm</a>
<b>Victorian Private Hospitals Website</b>	<a href="http://www.health.vic.gov.au/privatehospitals/privwebs.htm">www.health.vic.gov.au/privatehospitals/privwebs.htm</a>
<b>DHS Emergency Management Website</b>	<p><a href="http://www.dhs.vic.gov.au/emergency">www.dhs.vic.gov.au/emergency</a></p> <p>Includes links to emergency recovery activities, SHERP, training, reports and publications</p>
<b>DH Emergency Management Health Services and Hospitals Information</b>	<p><a href="http://www.dhs.vic.gov.au/emergency/health-services-and-hospitals">www.dhs.vic.gov.au/emergency/health-services-and-hospitals</a></p> <p>Includes Victorian Hospital Resilience Code Brown Policy Framework</p>
<b>Public Sector Residential Aged Care – List of Facilities</b>	<a href="http://www.health.vic.gov.au/agedcare/downloads/res_aged_care_services_feb09.xls">www.health.vic.gov.au/agedcare/downloads/res_aged_care_services_feb09.xls</a>
<b>Victorian Community Health Centres and Services</b>	<a href="http://www.health.vic.gov.au/communityhealth/downloads/comm_health_centres_services_vic.xls">www.health.vic.gov.au/communityhealth/downloads/comm_health_centres_services_vic.xls</a>
<b>DH Pandemic Influenza Website</b>	<a href="http://www.health.vic.gov.au/pandemicinfluenza/">www.health.vic.gov.au/pandemicinfluenza/</a>

## Appendix 6: Summary of SHERP

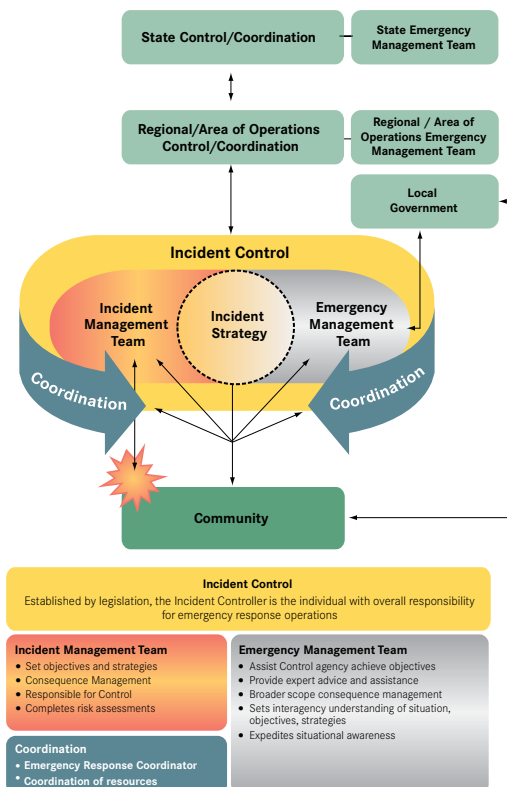
The State Health Emergency Response Plan (SHERP) is a sub plan of the Victoria State Emergency Response Plan. The SHERP provides a framework to ensure a coordinated whole-of-health approach to mass casualty incidents, complex trauma events, mass gatherings and other incidents impacting the health of Victorians.

SHERP adopts an ‘all-hazards’ approach to enable a safe, effective and coordinated health and medical response to emergencies.

This includes:

- coordinating health resources, from the incident site through to affected hospitals
- managing pre-hospital resources and the hospital interface
- resource coordination to support management of public health impacts.

SHERP can be used as a supporting health coordination framework for flood, fire, storm and public health emergencies. SHERP also supports the Public Health Emergency Management Arrangements, the State Chemical Biological and Radiological (CBR) Plan, the State Burns Plan and other emergency management plans, including Commonwealth plans.

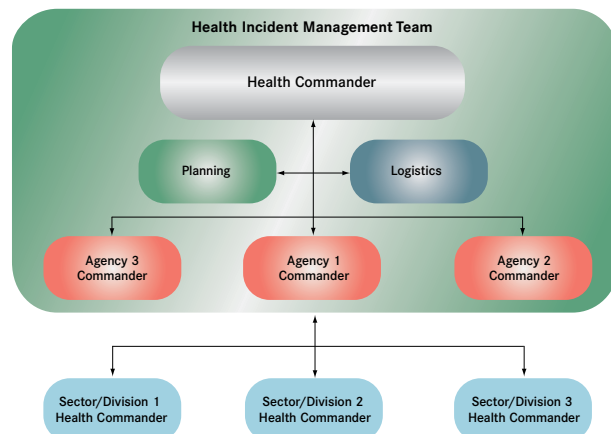


### SHERP as a planning and preparedness framework

SHERP provides a planning and health management framework for public events and mass gatherings where there is a potential for mass or complex health emergencies. This allows for the management and coordination of any incident – small, complex, or major – which may occur as a result.

### Roles and strategic relationships

SHERP describes the key roles of the Health Commander, who represents all responding health agencies on the Emergency Management Team (EMT) and the Health Incident Management Team (HIMT). It models the strategic relationships between the Incident Controller, the IMT and the EMT.

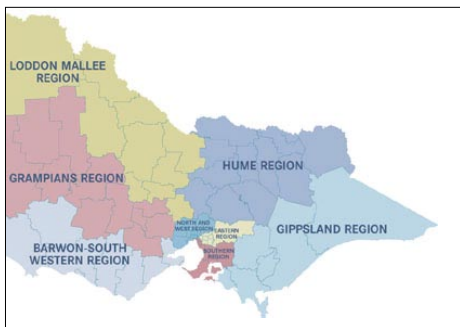


### Scene management

The management of single site and multiple site incidents are illustrated and escalation processes are defined, not just by the size of the emergency and patient numbers, but also by complexity. Notification and communication pathways are described, as are the roles of various supporting agencies.

## Appendices and sub plans

In order to reduce the size of the plan and aid readability, SHERP has included a number of removable appendices and sub plans. Other relevant State and Commonwealth plans which link with SHERP are provided in a table, with a short description of the plan. First aid agencies have an appendix which describes the role of first aid under SHERP and the relationship with the Health Commander. There is also a useful appendix for health agencies involved in planning for mass gatherings and public events. Appendix 4 provides one page lift out role descriptions for key roles under SHERP. This section can be used as an aide memoire for personnel involved in responding under SHERP. Useful maps are described and referenced in a single page table and a comprehensive glossary completes the appendices.



The General Practice (GP) Sub plan describes the role of GPs in communities affected by health impacts from emergencies. The Field Primary Care Sub plan outlines the role of field primary care clinics (FPCC) which can be established and staffed by registered general practitioners, nurses and paramedics in areas where access to primary care has been impacted by emergencies.

## Glossary

<b>Alert</b>	Recognition that resources are required to enable an increased level of preparedness.
<b>'All hazards' approach</b>	An 'all hazards' approach to emergency planning that is adaptable to a wide range of situations.
<b>Ambulance Commander</b>	The senior ambulance manager on-site, with command of all ambulance personnel and resources.
<b>Casualty</b>	An injured person.
<b>Casualty clearing post (CCP)</b>	Established and controlled by Ambulance Victoria; staffed by paramedics, medical teams and support agency workers. A CCP is located at a safe distance from the incident scene (uphill and upwind) and is large enough to cater for expected numbers of casualties. Within the CCP, casualties are managed in groups according to priority (triage category) and receive treatment on-site and transport according to priority. There may be more than one CCP established, based around a geographical location or total number of patients.
<b>Code Brown</b>	Hospital recognised code for an external emergency.
<b>Command</b>	Directing an agency's people and resources in the performance of its role and tasks. Authority is vertical within the agency.
<b>Complex</b>	Long, drawn-out emergency that cannot be ended quickly or simply. An evolving, multi-faceted, multi-system event, which may adversely affect many different areas of the community. Potential economic and infrastructure impacts.
<b>Control</b>	The overall direction of response activities in an emergency situation. Control acts horizontally across agencies, as it carries the responsibility for tasking other agencies.
<b>Control agency</b>	An agency nominated through the authority of the Emergency Management Manual Victoria to control response activities for a specific emergency.
<b>Coordinate/Coordination</b>	Bringing together agencies and elements to ensure an effective response to the emergency. Involves systematic acquisition and application of resources (agencies, personnel and equipment). Police are always the coordinators of an incident response.
<b>Debrief</b>	A meeting held during or at the end of an operation, to assess its conduct or results.
<b>Emergency</b>	<p>Definition from the Emergency Management Act, 1986:</p> <p>An emergency due to the actual or imminent occurrence of an event which in any way endangers or threatens to endanger the safety or health of any person in Victoria or which destroys or damages, or threatens to destroy or damage, any property in Victoria, or endangers or threatens to endanger the environment or an element of the environment in Victoria including, without limiting the generality of the foregoing:</p> <ul style="list-style-type: none"> <li>(a) an earthquake, flood, wind-storm or other natural event; and</li> <li>(b) a fire; and</li> <li>(c) an explosion; and</li> <li>(d) a road accident or any other accident; and</li> <li>(e) a plague or an epidemic; and</li> </ul>

<b>Emergency (cont.)</b>	(f) a warlike act, whether directed at Victoria or part of Victoria or at any other State or Territory of the Commonwealth; and (g) a hi-jack, siege or riot; and (h) a disruption to an essential service.”
<b>Emergency management</b>	Measures taken in response to particular hazards, incidents or disasters. Government, voluntary and private agency resources are organised and directed on the basis of a plan that anticipates needs and coordinates efforts, by assigning tasks to particular responders, organisations or field units.
<b>Emergency Management Team (EMT)</b>	Consists of the Incident Controller, support agency commanders (or their representatives) and the Emergency Response Coordinator (or representative). The EMT should be formed when two or more agencies combine or work cooperatively in response to an emergency.  Once the Incident Controller determines the control strategy (in consultation with support agency commanders), this is implemented through their respective command structures. The Emergency Response Coordinator’s role is to ensure a coordinated multi-agency response, and to provide for systematic acquisition of required resources.
<b>Field Emergency Medical Coordinator (FEMC)</b>	A senior medical officer, based off-site to manage the following tasks: (1) liaise with and identify casualty receiving hospitals; (2) provide additional infield FEMO resources, as determined by the first FEMO on-scene; (3) provide advice and support for infield FEMO personnel; (4) liaise with the Health Commander, Ambulance Victoria and HHS Emergency Coordination Centre; and (5) organise regular relief for infield FEMO(s) and VMAT personnel.
<b>Field Emergency Medical Officer (FEMO)</b>	An infield medical officer who: (1) in consultation with the Health Commander, determines the appropriate casualty receiving hospital; (2) provides advanced medical and clinical advice to ambulance services paramedics; (3) provides advanced medical care to patients as part of a forward medical team function; (4) assesses the need for, and activates, medical assistance team(s); (5) manages and represents medical teams in the Health Incident Management Team; (6) refers casualties to alternative care options (such as their GP) when transport to hospital is not deemed necessary; and (7) manages health and medical volunteers. More than one FEMO may be appointed.
<b>Hazard</b>	A condition or event potentially harmful to the community or environment. <i>Natural hazards</i> are phenomena such as disease, floods, earthquakes, bushfires, severe storms and temperature extremes. <i>Technological hazards</i> include transport accidents, industrial accidents and hazardous material incidents. <i>Conflict hazards</i> include riots, civil unrest, terrorism and war.
<b>Health agency</b>	A health organisation or department contributing to the Victorian emergency management arrangements.
<b>Health Commander (HC)</b>	The person responsible for directing the health emergency operations. In emergencies with an incident site, the Health Commander will be a senior ambulance manager. Otherwise, the appointment is made by the Department of Human Services.

<b>Health Incident Management Team (HIMT)</b>	The health response will be lead by the Health Commander and supported by the Health Incident Management Team (HIMT). The HIMT provides the Incident Control System functions of planning, operations and logistics to support the health response and is made up of the team leaders of attending health response agencies.
<b>Health response</b>	Immediate and ongoing actions to save lives and meet basic human needs.
<b>Incident Action Plan (IAP)</b>	An Incident Action Plan is a consolidated ‘road map’ of action to be taken for the next period of time.
<b>Incident Control System (ICS)</b>	A system promoting effective operational management structure, through common terminology, appropriate communication and a cohesive chain of command. It is based on three principles: <i>management by objectives</i> , <i>functional management</i> (control, planning, operations, logistics) and <i>span of control</i> .
<b>Incident Controller (IC)</b>	The individual with overall responsibility for emergency response operations. Normally appointed by the control agency, but can be appointed by the Emergency Response Coordinator in circumstances where s. 16 or 16A of the <i>Emergency Management Act 1986</i> apply.
<b>National Registration and Inquiry System (NRIS)</b>	The system used to register evacuated and injured persons, in order to inform searching family and friends of their location.
<b>Personal support</b>	Psychological first aid, practical assistance, assessment, access to general and specialist services, and provision of sub-clinical and preventative health services.
<b>Preparedness</b>	Involves both arrangements and measures. Arrangements to ensure that, should an emergency occur, all required resources and services can be efficiently mobilised and deployed. Measures to ensure that, should an emergency occur, communities, resources and services are able to cope.
<b>SITREP</b>	Agency situation report of an event, outlining the background of the situation and the action taken by the agency responding.
<b>Spontaneous health volunteers</b>	Persons volunteering their skills/knowledge who are not members of either an attending emergency service, or a volunteer organisation.
<b>Stand-by</b>	The period normally following an alert, when deployment of resources is imminent. Personnel are ready to respond immediately.
<b>Stand down</b>	That phase where an agency’s response is no longer required, and services are drawn back. Site teams are returned to base, and additional staff released from duty.
<b>State Health Incident Commander (SHIC)</b>	The Director Emergency Management Branch, Department of Human Services, or delegate. Provides high level support and advice to the Health Commander.
<b>Support</b>	The control agency may need assistance from support agencies. Support agencies are either primary (e.g. ambulance service) or secondary (e.g. a first aid organisation activated to support the ambulance service). A primary agency is designated by the EMMV as having a responsibility to provide and/ or manage support tasks.

<b>Transport Officer</b>	Initially, the least experienced paramedic of the first crew on scene; coordinates transport to ensure appropriate transfer of patients and provides situation reports (SITREP).
<b>Triage</b>	The process by which casualties are sorted, prioritised and distributed, according to their need for first aid, resuscitation, emergency transportation and appropriate care.
<b>Triage Officer</b>	The most experienced Ambulance Victoria paramedic of the first crew on scene establishes a Casualty Clearing Post, then triages and assesses the number and type of patients.
<b>Victorian Health Emergency Coordination (VHEC)</b>	Departmental group that supports the health sector during major emergencies. VHEC is structured in line with the recognised industry standard for an Incident Control System.
<b>Victorian Medical Assistance Team (VMAT)</b>	A team of experienced doctors and nurses, usually sent from a hospital, providing on-site assessment and emergency treatment of casualties prior to transfer. VMAT provides extended duration or advanced clinical care, for example, during emergencies where the number of casualties exceed the capacity of concurrent treatment and transport by ambulance services, or there are difficulties accessing a casualty. High casualty numbers alone will not necessarily require a VMAT response. One member of each team is appointed Medical Team Leader.

## Attachment 1: General Practice Sub Plan

### Introduction

General practice and general practitioners (GPs) play an important support role in Victoria's overall ability to respond to emergencies. The General Practice Sub Plan defines the role of general practice in emergency management in Victoria, and describes how general practices interface with Victoria's health and medical emergency management arrangements. This plan will be reviewed as consultation and development of the plan progresses.

### Aim

The aim of the General Practice Sub Plan is to provide:

- an understanding of the role of general practice in planning for, responding to and recovering from emergencies with health and medical impacts on the community
- a clear statement on how general practices interface with Victoria's health and medical emergency management arrangements.

### Principles

#### Planning

- The degree to which general practice and GPs may be involved in emergency management will vary.
- GPs, through their Division of General Practice, are encouraged to develop emergency management relationships / partnerships with local health services, Ambulance Victoria and other local health agencies.
- Knowledge of local and regional emergency management plans and arrangements is encouraged. Divisions need to be aware of these plans and work with general practices, as appropriate.

### Response

Responses that involve general practice should, wherever possible, make use of or build upon the usual care available. This ensures sustainability and continuity of care, once the emergency response has been provided.

- Within clinics / practices, GPs can continue to provide a primary care service and help hospitals maintain effectiveness as an acute response setting, by:
  - providing clinical care for self-presenters (the 'walking wounded' and individuals who have no physical injuries, but have psychological trauma or distress)
  - providing primary treatment and care for their local community
  - providing clinical assistance for patients referred from hospital to home-based care.
- Within local hospitals / health services:
  - assist with clinical management of the surge, according to identified partnership arrangements and hospital Code Brown Plans.
- At the scene of the emergency:
  - generally, GPs will not be required at the scene. If attendance is required, GPs will be managed under the **Health Commander – State Health Emergency Response Plan (SHERP)** in the case of response, or Field Primary Care Clinics (FPCCs – see Field Primary Care Plan) in the case of relief / recovery.

## Recovery

General practitioners:

- are critical to the ongoing health and wellbeing of affected individuals / families following an emergency
- are often the first point of clinical contact to care for affected people with long term physical and emotional recovery needs
- can provide services to prevent escalation of impacts, such as referral, counselling, and advice
- can provide mutual support to other GPs in affected areas of Victoria, through coordination with General Practice Victoria.

## Attachment 2: Field Primary Care Response Subplan

### Introduction

People affected by emergencies may have reduced access to primary medical care, due to medical infrastructure damage, isolation, incapacity of their usual general practitioners, loss of personal transport or limited ability to enter or leave the affected locality.

While some services may still be available following an emergency, they are likely to experience additional demands on their work force and other resources to support the emergency response, and people may have difficulty getting to them.

### Purpose

Field Primary Care Clinics (FPCCs) can provide appropriate and timely access to primary medical care in communities where this care is limited or non-existent, following an emergency. FPCCs, when established, will be located in close proximity to the affected communities. The FPCC will be led by Ambulance Victoria and staffed by general practitioners, registered nurses and paramedics.

The purpose of the FPCC is to:

- ensure appropriate and timely access to additional primary health care support for people affected by emergencies
- provide access to primary health care close to where people are congregating during an emergency
- support existing primary care services that may still be operating in the affected area.

### Role

The role of the FPCC is to:

- provide primary care clinical consultations
- prescribe medication as needed (both continuation of previous and prescription of newly required medication)
- provide immediate care for clinical conditions related to the emergency, such as:
  - minor lacerations, animal bites and other trauma
  - superficial burns requiring dressings
  - respiratory illness caused by smoke inhalation
  - foreign bodies in eyes and eye irritation
  - viral and other infectious illness
  - psychological distress.
- provide limited medical supplies (such as dressings, tetanus vaccination, eye irrigation, etc) and medications
- provide clinical care for existing conditions and newly arising problems unrelated to the emergency, such as:
  - asthma
  - diabetes
  - mental illness
  - viral and other infectious illness.

- provide limited medical record keeping, including appropriate correspondence to enable follow up and/or referral as needed
- liaise with existing health and medical services, to optimise primary health care provision within the affected community
- refer to ambulance, hospital or other services all conditions requiring secondary or tertiary level care.

## **Deployment**

Activation and deployment of FPCCs is the responsibility of the Department of Health, through the State Health and Medical Commander (SH&MC) and the Director Emergency Management. The decision to activate a Field Primary Care response, including the establishment of a FPCC, will be informed by the Health Commander.