

Major Incident Medical Services Supporting Plan

Summary The purpose of the NSW MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN (NSW MEDPLAN) is to enable medical service resources to be varied from business as usual arrangements and effectively and efficiently coordinate the resources in the event of major incidents requiring a significant and coordinated medical response.

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Author branch NSW Health Emergency Management Unit

Branch contact (02) 8396 5014

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Distributed to Divisions of General Practice, Ministry of Health, NSW Ambulance Service, Private Hospitals and Day Procedure Centres, Public Health System

Audience CEs, AHS Functional Area Coordinators, Disaster Coordinators, All staff in emergency management, Directors Critical Care, State Controllers

MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN

PURPOSE

The attached plan is the NSW Health Major Incident Medical Services Supporting Plan supporting the NSW Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) developed pursuant to the State Emergency and Rescue Management Act 1989 (as amended).

The purpose of the NSW MAJOR INCIDENT MEDICAL SERVICES SUPPORTING PLAN (NSW MEDPLAN) is to enable medical service resources to be varied from business as usual arrangements and effectively and efficiently coordinate the resources in the event of major incidents requiring a significant and coordinated medical response.

The NSW MEDPLAN details the arrangements to be adopted by NSW Health in order to coordinate all of the hospitals and medical services resources available in NSW (both government and non-government) to the State HSFAC and State Medical Controller for the response and recovery from the impact and effects of a major incident.

The arrangements in this plan will also provide guidance for the preparation of the Local Health District/Network medical services arrangements and procedures of the LHD HEALTHPLAN.

KEY PRINCIPLES

The following principles underpin the NSW MEDPLAN:

- 1) The Plan shall be read in conjunction with NSW HEALTHPLAN.
- 2) The provisions defined in the NSWHEALTHPLAN (Part 3) for prevention and preparation responsibilities in a health emergency for NSW Medical services apply.
- 3) The provisions of the NSW MEDPLAN should not inhibit the LHD instigating a local response, if required.

The plan assigns responsibility to the State Medical Services Controller for hospitals and medical services once the NSW MEDPLAN has been activated by the State Health Services Functional Area Coordinator (HSFAC) such that:

- a. the management of multiple casualties and potential casualties is centrally coordinated (both government and non-government)
- b. definitive care is provided as rapidly as possible. This may require deployment to the incident, receiving hospitals or other emergency centres.

The plan identifies recommended actions under four phases: Prevention, Preparation, Response and Recovery. Actions under the Prevention and Preparation phases are identified in the NSW HEALTHPLAN and are recommended to be carried out on a continual basis. Actions under the Response and Recovery phases (Parts Three and Four) are recommended to be carried out once the NSW MEDPLAN has been activated by the State Health Services Functional Area Coordinator (State HSFAC).

The primary role for medical services in the response phase will be to manage multiple casualties and potential casualties using central coordination to ensure the provision of definitive care as rapidly as possible.

USE OF THE GUIDELINE

The NSW MEDPLAN:

- a. Covers the governance structure for standby, response and recovery for major incident management [Part Three – Four].
- b. Addresses the coordination of all hospitals and medical services in NSW (both government and non-government) for response to and recovery from major incidents [Annex One].
- c. Assigns responsibility to the State Medical Services Controller for the statewide coordination of hospitals and medical services so that the management of multiple casualties is centrally coordinated. This ensures that definitive care is provided as rapidly as possible.
- d. May require deployment of Scene Medical Commander(s) and Emergency Medical Teams either to assist hospitals overwhelmed by casualties or to the incident.
- e. Represents the first hours of a major incident and not a protracted event.

Responsibilities of key parties are detailed in Part Two of the NSW MEDPLAN. Action Cards for specific position holders are listed in Annex Three with specific actions. Details for the Concept of Operations for LHDs are listed in Annex Four. The plan should be communicated to those with roles and responsibilities under this plan and the HEALTHPLAN.

Reporting and Governance of this Plan and key parties are outlined in Annex One.

REVISION HISTORY

Version	Approved by	Amendment notes
August 2010 (GL2010_011)	Director-General	New guideline issuing the Medical Services Support Plan
June 2018 (GL2018_017)	Deputy Secretary, Population and Public Health	Review and rewrite

ATTACHMENTS

1. Major Incident Medical Services Supporting Plan: Guideline (NSW MEDPLAN)

Major Incident Medical Services Supporting Plan



Issue date: June-2018

GL2018_017

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1 AUTHORISATION

The New South Wales Health Major Incident Medical Services Supporting Plan (NSW MEDPLAN) has been prepared to support the New South Wales Health Services Functional Area Supporting Plan (HEALTHPLAN).

The plan was developed by the Health Emergency Management Unit, Office of the State Health Service Functional Area Coordinator (State HSFAC).

RECOMMENDED Dr Richard Morris

State Medical Services Controller
Dated: 17 May 2018

ENDORSED Dr Gary Tall

State Health Services Functional Area Coordinator
Dated: 17 May 2018

2 AMENDMENTS

Suggested amendments or additions to the contents of this plan are to be forwarded in writing to:

- State Medical Services Controller

All proposed changes to this plan will be subject to the approval and endorsement requirements covered within the Authorisation Statement.

Amendments promulgated are to be certified in the following table when entered.

Version	Amendment Notes
2010 (GL2010_011)	New guideline issuing the Medical Services Supporting Plan
2018 (GL2018_XXX)	Complete rewrite approved by State Medical Services Controller

3 BACKGROUND

3.1 About this document

A Mass Casualty Incident in any community has the potential to quickly exhaust medical resources available for the response.

Mass casualty incidents in recent years generally have an injury profile of approximately:

- 20% (Red) Critical - patients who require immediate treatment.
- 30% (Yellow) Serious - patients who do not have life threatening injury but require definitive treatment within 6 hours.
- 50% (Green) Stable - patients walking and/or with little or no physical injuries.

NSW Health must be prepared to coordinate medical resources to mass casualty incidents.

The NSW Health Major Incident Medical Services Supporting Plan has been prepared as a supporting plan to the NSW Health Services Functional Area Supporting Plan (NSW HEALTHPLAN) to coordinate medical resources for the response and recovery from the impact and effects of a major incident in New South Wales, developed pursuant to the *State Emergency and Rescue Management Act 1989* (NSW) (as amended).

3.2 Key definitions

Major incident can be defined¹ as an incident or event where the location, number, severity or type of live casualties requires extraordinary resources. The consequence for NSW Health is that the service providers (Local Health Districts/Networks) are unable to provide effective support and other areas of NSW Health are known to be affected. For the purposes of this document where reference is made to major incident, any incident that can be defined as significant/major/catastrophic multi or mass casualty incident is to be considered.

Catastrophic incident is any natural disaster, act of terrorism, or other man-made disaster that results in extraordinary levels of mass casualties or damage or disruption severely affecting the population (including mass evacuations), infrastructure, environment, economy, national morale, or government functions in an area. With regard to NSW Health, it represents a State-wide system dysfunction resulting in total shutdown of service delivery or operations.

Significant incident is an incident involving, or having the potential to involve, a finite number of casualties for whom the location, available resources and injury types present significant challenges to responding agencies. These incidents may be adequately managed by local resources but require a greatly enhanced and coordinated response of those resources. Significant incidents are most likely to occur in regional, rural and remote NSW.

¹ Based on the Major Incident Medical Management and Support definition of 'major incident'

In the NSW MEDPLAN, the term 'NSW Health' may be used to describe the Health Administration Corporation, the Ministry of Health and any other body and organisation under the control and direction of the Minister or the Secretary. [Source: *Health Administration Act 1982 (NSW)*]

4 PART 1 – INTRODUCTION

4.1 General

The NSW MEDPLAN details the arrangements to be adopted by NSW Health in order to coordinate all of the medical services resources available to the State HSFAC for the response and recovery from the impact and effects of a major incident where a State response is coordinated under EMPLAN, whilst minimising the impact on normal operations.

Triggers for activation of the NSW MEDPLAN are when the required major incident response involves more than one LHD, or where a single affected LHD requires coordination of statewide assets/resources to optimise management of the response.

The primary responsibility for managing the statewide medical services response to major incidents in NSW lies with the State Medical Controller. This includes responsibility for the overall direction, control and coordination of medical services response and recovery phases of major incidents.

In the event of activation of NSW HEALTHPLAN, the State HSFAC will contact the State Medical Controller to coordinate the medical services health emergency response.

4.2 Principles

The following principles underpin the NSW MEDPLAN:

- 1) The Plan shall be read in conjunction with NSW HEALTHPLAN.
- 2) The provisions defined in the NSW HEALTHPLAN (Part 3) for prevention and preparation responsibilities in a health emergency for NSW Medical services apply.
- 3) The provisions of the NSW MEDPLAN should not inhibit the LHD instigating a local response if required.

4.3 Scope

The NSW MEDPLAN:

- a. Covers the governance structure for standby, response and recovery for major incident management (see Part 3 - 4).
- b. Addresses the coordination of all hospitals and medical services in NSW (both government and non-government) for response to and recovery from major incidents [Annex 1].

- c. Assigns responsibility to the State Medical Services Controller for the statewide coordination of hospitals and medical services so that the management of multiple casualties is centrally coordinated. This ensures that definitive care is provided as rapidly as possible.
- d. May require deployment of Scene Medical Commander(s) and Emergency Medical Teams either to assist hospitals overwhelmed by casualties or to the incident.
- e. Represents the first hours of a major incident and not a protracted event.

NSW Health is the lead combat agency for all human health emergencies within NSW. NSW Health has a number of major contributing health service components which constitute the whole-of-health response. All of these components work together to support a response to a Major Incident. They are:

- a. Medical Services;
- b. Ambulance Services;
- c. Mental Health Services;
- d. Public Health Services;
- e. Health Communications;
- f. Shared Services - HealthShare NSW and eHealth NSW;
- g. NSW Health Pathology;
- h. The Sydney Children's Hospitals Network; and
- i. Justice Health and Forensic Mental Health Network

5 PART 2 – ROLES AND RESPONSIBILITIES OF MEDICAL SERVICES

5.1 State Medical Services Controller

The State Medical Services Controller is responsible under the NSW HEALTHPLAN for management of multiple casualties through the coordination of medical resources and, where necessary, the possible reallocation of medical resources by controlling and coordinating medical services during a major incident. [Refer to Annex 3: Action Card]

The State Medical Services Controller reports to the State HSFAC.

The State Medical Services Controller coordinates statewide medical services when NSW HEALTHPLAN and NSW MEDPLAN are activated, working with the LHD HSFACs, Directors Critical Care and Specialty Networks, NSW Ambulance Aeromedical Control Centre, and the State Ambulance Controller to determine the appropriate treatment and transport of casualties.

5.2 LHD/Network HSFACs/Medical Services Controllers

For the purposes of this plan the LHD/Network (LHD/N) HSFAC is responsible under the NSW HEALTHPLAN for:

- a) Management of multiple casualties in the LHD through the coordination of medical resources and, where necessary, the possible reallocation of medical resources by controlling and coordinating medical services during a mass casualty incident.
[Annex 4]
- b) LHDs having a documented and current plan (LHD Plan) that explains how the LHD will respond to a major incident. The LHD plan will be consistent with NSW HEALTHPLAN and NSW MEDPLAN. The LHD plan will detail the Response and Recovery phases and include (not limited to):
 - i. Notification pathway and activation pathway of the LHD Incident Management Team (IMT)
 - ii. LHD position holder responsibilities within the IMT
 - iii. Location, set up and function of the Health Emergency Operations Centres (LHD EOC/s)
 - iv. Mechanisms to minimise unnecessary services, including but not limited to:
 - Increasing the capacity of the Emergency Department/s (ED) and Intensive Care Unit/s (ICU) to accept major incident casualties by discharging suitable patients to wards or home, advising non-urgent patients of alternate means of accessing medical care in the community
 - Increasing the capacity to provide necessary surgical and anaesthetic services for casualties by finishing surgical cases that have already commenced, cancelling elective surgery, opening extra operating theatres (OT) and recovery areas
 - Increasing the capacity for medical imaging of casualties by cancelling imaging that is not urgent
 - Increasing the capacity for wards to accept casualties by discharging suitable patients to other facilities or home
 - Cancelling or rescheduling elective admissions
 - Limiting or cancelling outpatient clinics if appropriate
 - v. Mechanisms to increase capacity to handle increased activity, including plans to handle initial care for patients that may not fall under the normal role delineation of the facility (paediatrics, burns, major trauma):
 - Increasing staffing numbers in critical areas – including clinical areas, pathology, medical imaging, pharmacy, ancillary services
 - Opening and staffing extra beds – ED, OT, ICU, surge wards
 - Identifying and tracking patients and their medical records
 - Anticipate and effectively manage common bottlenecks for patient care in facilities – transport, medical imaging, prioritisation of patients for surgery, prioritisation of patients for admission to ICU, availability of blood products
 - vi. Communication pathways between the LHD Incident Management Team (IMT) and both LHD Executive and State Health EOC, including
 - Current numbers and types of patients being treated in LHD facilities

- Capacity of facilities to accept further patients
- vii. Mechanisms to coordinate appropriate public health, mental health and health communications responses
- viii. Strategies to sustain the facility response for an appropriate time period.
- c) Developing and maintaining Memorandums of Understanding with other stakeholders including neighbouring LHDs and pre-identified plans for Concept of Operations.

5.3 NSW Ambulance Aeromedical Control Centre (ACC)

The NSW Ambulance Aeromedical Control Centre (ACC) is responsible for state-wide tasking of contracted aeromedical vehicles (helicopters, fixed wing planes) and associated medical retrieval teams.

The ACC will provide an onsite liaison in the State Health Emergency Operations Centre (SHEOC) if requested during a major incident. The liaison may be either a state retrieval consultant (doctor) or ACC supervisor (paramedic).

The ACC will be responsible for effecting requests from the State Medical Controller regarding pre-hospital transport of medical teams and equipment to the scene, aeromedical transport of patients from the scene to hospitals, medical retrieval of patients between hospitals, and maintaining capacity to respond to critically ill patients not involved in the incident.

Major incidents in rural or remote areas will be challenged by the relative scarcity of hospitals with significant critical care capacity, in addition to prolonged times and distances to appropriate care. Additional aviation capacity and capability may be sought from appropriate non-contracted providers in these instances.

5.4 Directors of Critical Care and Specialty Networks

Various critical care and specialty networks play important roles in the response to a major incident. They facilitate statewide use of resources in their area of expertise.

Important clinical areas include but are not limited to Emergency Medicine, Intensive Care, Neonatal Intensive Care, Surgery, Anaesthesia, Trauma, Burns, Paediatrics, Spinal Cord Injuries, Pathology and Medical Imaging.

The State Medical Controller will ensure arrangements are in place for clinical areas to provide expert advice and/or a liaison person to the SHEOC when requested via the State HSFAC.

5.5 Scene Medical Commander

For the purposes of rapid response, the Scene Medical Commander is appointed by the State Medical Controller to supervise clinical aspects of secondary triage, treatment, transport priority and transport destination from the scene. [Refer to Annex 3: Action Card].

Note: On appointment of a Medical Commander the Ambulance Commander assumes the Health Commander role [Refer to Annex 9.2]

5.6 Casualty Clearing Station Medical Supervisor

The Scene Medical Commander may appoint a Casualty Clearing Station (CCS) Medical Supervisor (dependent on the complexity of the incident) to lead the clinical aspects of secondary triage, treatment, transport priority and transport destination in the CCS. [Refer to Annex 3: Action Card]

5.7 Emergency Medical Teams

The provision of Emergency Medical Teams (EMT) to the scene will be determined by the State HSFAC in consultation with the State Medical Controller and the Scene Medical Commander. Scene EMTs may be required where the number of patients will exceed the ability to transport them to suitable facilities within the usual timeframes, or where the type and extent of injuries requires specific or advanced clinical skills unable to be provided by paramedics. They will provide necessary treatment to casualties at the incident site prior to their transport to hospitals for definitive care and/or medical discharge direct from the scene.

EMTs will in the first instance be drawn from the pool of on-duty medical retrieval personnel to enable rapid response to the scene. Additional EMTs may be drawn from medical retrieval personnel and/or LHDs in consultation with State HSFAC and LHD HSFACs. [Annex 3 defines roles, Annex 5 describes qualifications and Annexes 6 and 7 provides details on uniforms and equipment]

6 PART 3 – RESPONSE

6.1 Notification Cascade

The State Medical Services Controller is notified by the State HSFAC of an actual or imminent incident that may require statewide coordination of medical services.

All information regarding the progress of an incident will be coordinated through the State HSFAC and the State Health Emergency Operations Centre (SHEOC). The LHDs/Networks have pre-identified plans in place for receiving casualties prior to receiving accurate information about their number and injuries [Annex 4 – Concept of Operations].

The following describes the sequence of actions for the conduct of response operations. Whilst the entire State may not necessarily be affected by the incident, State level involvement may be required to support an affected locality/region to varying degrees.

6.1.1 Alert Phase

The 'Alert Phase' is activated by the State HSFAC when notified of a possible/imminent situation that may require the coordination of State health services, resources and support.

The State Medical Services Controller will:

- communicate with the LHD/Network HSFACs, relevant State Controllers and Directors of Critical Care and Specialty Networks
- monitor the situation for escalation/improvement
- identify potential impacts on medical resources and possible deployment requirements

6.1.2 Standby Phase

The 'Standby Phase' is activated by the State HSFAC that the situation may require the deployment/utilisation of hospitals and medical resources.

The State Medical Services Controller will communicate with the LHD/Network HSFACs, relevant State Controllers and Directors of Critical Care and Specialty Networks to advise the nature and extent of a possible required response.

6.1.3 Response Phase

The 'Response Phase' is activated by the State HSFAC when information is received that requires the deployment of additional hospital and medical resources. The initial response involves HEALTHPLAN activation and concurrent medical management at both the scene and receiving hospitals.

The State Medical Controller will communicate regularly with LHD HSFACs, relevant State Controllers and Directors of Critical Care and Specialty Networks to advise the actual numbers and injury patterns of current and expected casualties, and to receive feedback regarding how LHD facilities and Networks are coping.

6.1.4 Stand down Phase

The 'Stand down Phase' is announced by the State HSFAC and communicated to LHD/Network HSFACs and relevant State Controllers once the major incident is abated and after consultation with appropriate services. There may be multiple or phased stand down components and the transition to recovery (Scene, Casualty Clearing Station, Transport, and Emergency Departments) to assist with managing the changing surge requirements.

6.2 Command and Control

This Plan will involve incident response and recovery operations using the Incident Control System (ICS) methodology and framework.

6.3 Coordination and Communications

The State Medical Services Controller communicates regularly and directly with the State HSFAC, LHD/N HSFACs, other State Controllers and Directors of Critical Care and Specialty networks.

The geographical boundaries of LHDs do not always correspond with the Emergency Management districts or NSW Ambulance boundaries. Where boundary mismatching occurs it will be necessary for the LHD HSFACs/LHD Medical Controllers to have pre-planned cross-LHD arrangements for medical response in place and these must be formalised in the relevant LHD Plan.

Medical resources do not always correspond to LHD structures. Where there are Supporting Organisations and Participating Organisations including private health facilities as defined in NSW HEALTHPLAN, it will be necessary for the LHD/N HSFACs to have service agreements in place to enable the LHD Medical Controller to call on these medical resources during an incident response.

In general private hospitals are not used as a destination for patients from the scene, but more frequently as a destination to allow larger public hospitals involved in receiving multiple casualties to decant stable admitted patients from their wards and emergency departments to increase capacity at the public facility.

Where necessary and appropriate, LHDs should have formal pre-planned **cross border/interstate arrangements** with other LHDs or interstate facilities to facilitate a coordinated response. The State HSFAC will coordinate the request for medical resources for NSW Health.

During the response and recovery phase all health service media statements will be released by the State Health Communications Controller under the authority of the State HSFAC as defined in NSW HEALTHPLAN. The State HSFAC may nominate a media spokesperson.

7 PART 4 – RECOVERY

Recovery operations should be managed locally where possible. Planning the recovery aspects of the incident needs to commence early in the incident. LHD/N HSFAC/s may request additional health and medical resources via the State HSFAC, who will delegate the State Medical Services Controller to coordinate the provision of same. This may involve the establishment of a recovery committee which will include representation from LHD/Network HSFACs/Medical Controllers.

8 PART 5 – REVIEW, TESTING, EVALUATING AND MAINTAINING THE PLAN

The State Medical Services Controller is responsible for ensuring that the NSW MEDPLAN and its supporting plans and procedures are reviewed, tested, evaluated and maintained. This will include relevant aspects from NSW HEALTHPLAN, Part 3 Prevention and Preparation.

Local Health Districts and Specialty Networks must undertake:

- a) Biennial Health Emergency risk assessments to develop appropriate health treatment or control plans within their facilities.

- b) Annual training exercises (or contribute to planned events) as a method of testing medical resources for emergency management.

8.1 The NSW MEDPLAN

The NSW MEDPLAN will be reviewed and/or updated:

- a) Every five (5) years, or after the occurrence of any of:
- b) An incident in which the health emergency arrangements in this plan were activated; or
- c) Major structural, organisational or legislative changes which affect NSW Health; or
- d) The direction of the State Medical Controller.

8.2 LHD Plans

LHD Plans will be reviewed and/or updated:

- a) Every five (5) years, or after the occurrence of any of the following;
- b) An incident in which the health emergency arrangements in this plan were activated; or
- c) Major structural, organisational or legislative changes which affect the LHD; or
- d) The direction of the LHD HSFAC.

8.3 State Medical Services Controller responsibility

The State Medical Services Controller is to facilitate a state level exercise (field or tabletop) at least biennially to:

- a) Ensure all key participants are familiar with the contents of the plan; and
- b) Test specific aspects of the plan.
- c) Ensure the efficient establishment and function of the State Health Emergency Operations Centre.

Exercises may be undertaken in the following forms:

- a) Exercises internal to Health; and/or
- b) Multi-agency exercises at Local Health District and/or State levels; and/or,
- c) Major planned event.

Following an exercise, a written report is to be submitted by the State Medical Services Controller within three months to the State HSFAC.

8.4 LHD/Network HSFAC responsibility

Each LHD/N HSFAC is to facilitate an LHD/N-level exercise (field or tabletop) at least biennially to:

- a) Ensure all key participants are familiar with the contents of the plan
- b) Test specific aspects of the plan
- c) Ensure the efficient establishment and function of an LHD Emergency Operations Centre.

Exercises may be undertaken in the following forms:

- a) Exercises internal to Health; and/or
- b) Multi-agency exercises at local health facility, LHD and/or State levels, and/or,
- c) Planned event

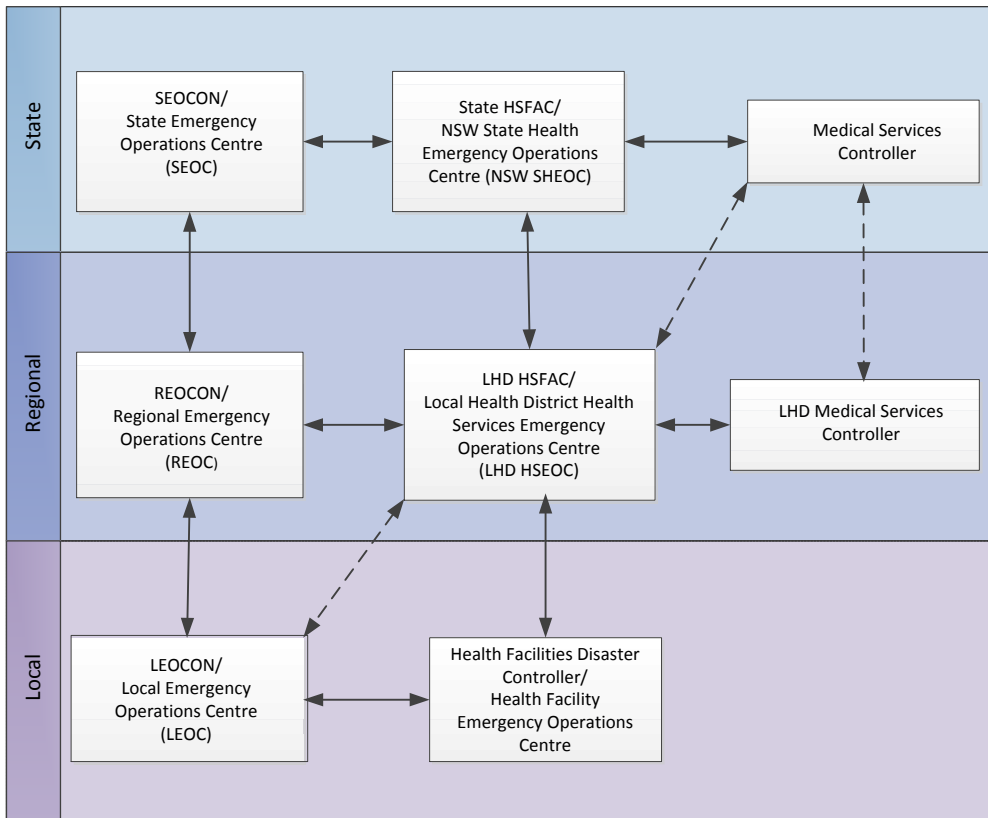
Following an exercise, a written report is to be submitted by the exercise coordinator within three months to the LHD HSFAC.

8.5 State HSFAC responsibility

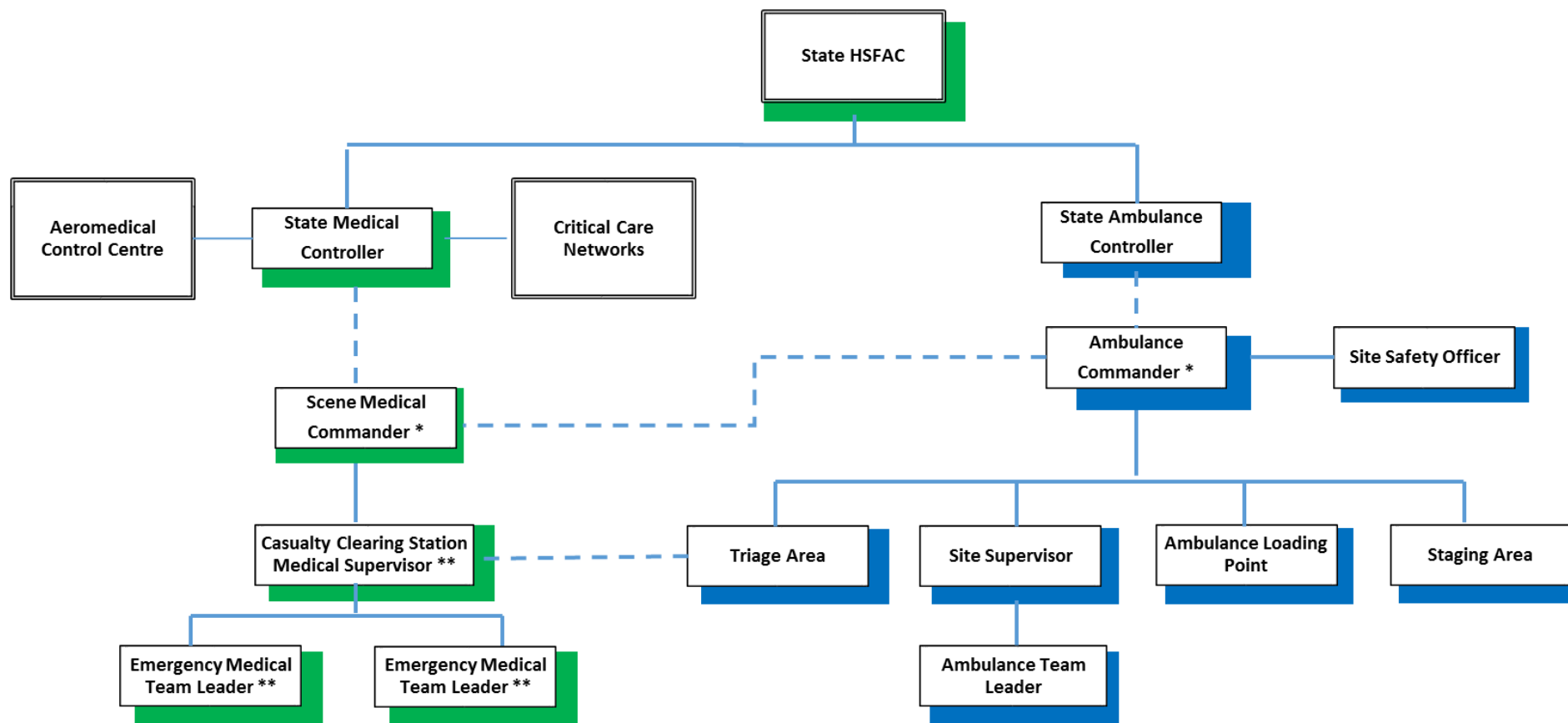
The State HSFAC coordinates the participation of NSW Health at national and international exercises, where appropriate.

9 ANNEXURES

9.1 ANNEX 1 - REPORTING



9.2 ANNEX 2 - SCENE MANAGEMENT STRUCTURE UNDER HEALTHPLAN ACTIVATION



* Ambulance and Medical Commanders work as a team

** The appointment of these position holders and the number of teams is dependent on the complexity of the incident. On appointment of a Medical Commander the Ambulance Commander assumes the Health Commander role

9.3 ANNEX 3 – JOB ACTION CARDS

No	Position Holder
1	State Medical Controller
2	Scene Medical Commander
3	Casualty Clearing Station Medical Supervisor
4	Emergency Medical Team(s)

9.3.1 ACTION CARD – State Medical Services Controller

STATE MEDICAL SERVICES CONTROLLER

The primary role of the State Medical Controller is to coordinate statewide medical services when NSW HEALTHPLAN is activated, working with the LHD HSFACs, Directors Critical Care and Specialty Networks, NSW Ambulance Aeromedical Control Centre, and the State Ambulance Controller to determine the appropriate treatment and transport of casualties.

The State Medical Services Controller will proceed to the SHEOC when notified by the State HSFAC of HEALTHPLAN activation.

- On arrival at the SHEOC:
- Meet with the State HSFAC and Ambulance Controller to obtain a briefing and Incident Action Plan (IAP)
 - Liaise with Aeromedical Control Centre management to delegate responsibilities for the coordination of aeromedical support of operations
 - Appoint a scene Medical Commander to provide expert clinical assessment at the incident site to determine the requirements for medical services
 - Determine the need for Emergency Medical Teams (EMTs) at the scene. EMTs will in the first instance be sourced from duty and on call medical retrieval teams, and supplemented if necessary with LHD/hospital medical teams.

Regularly liaise with the State Ambulance Controller on distribution of casualties to receiving hospitals.

Regularly liaise with LHD HSFACs, other State Health Controllers Directors of Critical Care/Specialty Networks and other specialist medical services to communicate current information on:

- number of casualties LHDs may expect to receive;
- types of injuries and age group of casualties (adults or children); and,
- hospitals to which casualties may be dispatched.

These decisions will be based on the Concept of Operations (CONOPS) document as agreed with LHD HSFACs.

Determine bed status and ongoing capacity of all receiving hospitals from LHD HSFACs.

Liaise with Incident Management Team (IMT) functions within the SHEOC to ensure planning, logistics and operations functions are in place for medical elements. Communicate regularly with the Scene Medical Commander regarding the numbers and types of casualties at the scene, providing advice in regard to appropriate

destination hospitals.

Planning may be required to ensure relief of the Scene Medical Commander and scene EMTs.

Assume responsibility for all secondary referrals of patients, and determine destination hospitals and priorities of secondary transport.

Maintain core medical services in NSW during an emergency:

- Provide technical and clinical management advice on medical issues during an emergency
- Coordinate pharmaceutical support
- Coordinate in conjunction with NSW Pathology State Controller, the provision of blood supplies through the Australian Red Cross Blood Services
- Maintain close liaison and partnership with other emergency management health services including aged care facilities, general practitioners and private health services.

Keep a contemporaneous log of actions and timings during the incident and record in SHEMS; provide reports and communicate with Operations Officer (IMT member); and, submit a written report at the conclusion of the incident as requested by the State HSFAC

9.3.2 ACTION CARD – Scene Medical Commander

SCENE MEDICAL COMMANDER

The role of the Scene Medical Commander is to command all clinical aspects of secondary triage, treatment, transport priority and transport destination from the scene and liaise regularly with the State Medical Controller.

The Scene Medical Commander will:

Proceed to the Scene when notified, establishing communications as soon as possible with the State Medical Controller at State Health Emergency Operations Centre (SHEOC).

On arrival at the Scene :

- Don appropriate PPE and tabard
- Make contact with the Health Commander to obtain a briefing (Ambulance Commander assumes role of Health Commander).
- Confirm the best choice to optimise patient treatment and transport opportunities has been made for:
 - Ambulance Staging Area
 - Loading Point
 - Casualty Clearing Station
- Appoint the CCS Medical Supervisor. This will be the most experienced clinician available. They will be responsible for the clinical coordination of the CCS, including secondary triage, deciding priority and destination of transport, and clinical supervision of treating medical teams
- Review the incident and report regularly (approximately every 30mins) to the State Medical Controller detailing:
 - Number of casualties and respective triage categories (both known and estimated) at the scene
 - Number of casualties and respective triage categories (both known and estimated) transported to hospitals
 - Type of injuries (eg penetrating trauma, blunt trauma, burns)
 - Breakdown of patients between adults and children
 - Requirement for further Medical Teams and/or special equipment
- Liaise regularly with the CCS Medical Supervisor regarding preferred destination hospitals as advised by State Medical Controller.

Keep contemporaneous log of:

- Important decisions made
- Hospital assignments and tracking of patients - information from CCS Medical Supervisor.

Brief and allocate Emergency Medical Teams (EMT) as they arrive on site.

Conduct welfare checks and maintain logs of medical team duration within incident. Liaise with State Medical Controller regarding ongoing medical team shifts for relief of teams within protracted events.

Provide appropriate handover at the end of the shift.

On completion of the incident, advise the State Medical Controller, advise all EMTs and contribute to “Hot” debrief.

9.3.3 ACTION CARD – Casualty Clearing Station Medical Supervisor

CASUALTY CLEARING STATION (CCS) MEDICAL SUPERVISOR

The CCS Medical Supervisor may be deployed to the scene at the request of the State Medical Controller to lead the clinical aspects of secondary triage, treatment, transport priority and transport destination in the CCS.

The CCS Medical Supervisor will:

On arrival at the site, report to the Scene Medical Commander in the Medical Forward Command Post for a briefing.

Briefly review location and internal setup of CCS for best suitability.

Allocate Medical Teams to treatment areas.

Establish liaison with Ambulance Triage (SORT).

Perform (alone or by utilising another doctor) secondary triage (sort) on patients arriving into the CCS.

Document on SMART tag the decision re both

- Triage colour (red, yellow, green) and
- Destination hospital (Major Trauma Services (MTS), Burns MTS, Paediatric MTS, Regional Trauma Service/other).

Communicate clearly (directly or delegate) with the Ambulance Loading Point Officer to determine transport priorities and destination hospitals of individual patients, and keep a log of same.

Note: In a major incident situation, the transfer of patients will not necessarily be influenced by hospital status.

Regularly update (30mins at least) Scene Medical Commander with information re injuries, categories and destinations of patients.

Receive regular updates from Scene Medical Commander re preferred destination hospitals using feedback from the Medical Controller/SHEOC.

Conduct welfare checks and maintain logs of medical team duration within incident. Advise Medical Commander of requirements for further medical teams and/or equipment.

Identify and correct any issues affecting patient triage, treatment and flow.

Provide appropriate handover at the end of the shift.

On Stand Down of Incident attend hot debrief.

9.3.4 ACTION CARD – Emergency Medical Team

EMERGENCY MEDICAL TEAM(s)

Emergency Medical Team(s) (EMTs) may be deployed to the scene at the request of the State Medical Services Controller where they have the necessary resources to function effectively. Team members are responsible when on scene to the Scene Medical Commander or, if appointed, to the CCS Medical Supervisor. They will provide necessary treatment to casualties at the incident site prior to their transport to hospitals for definitive care and/or medical discharge direct from the scene.

Initial deployment of EMTs to an incident scene will generally be from duty aeromedical retrieval personnel. They will be attired in standard medical retrieval uniform and PPE (blue/navy flight suit) with appropriate qualifications, identification and medical equipment.

An LHD EMT if deployed will have the necessary training detailed in Appendix 5, be attired in the uniform as detailed in Annex 6, with appropriate PPE and if required medical equipment as detailed in Annex 7.

If there are multiple teams, an EMT leader will be appointed from within each team.

The Team(s) will:

On arrival at the site, report to the Scene Medical Commander in the Forward Command Post.
Receive a briefing and allocation of tasks from the Scene Medical Commander.
Under supervision provide necessary treatment to casualties at the CCS prior to their transport to hospitals for definitive care or medical discharge direct from the CCS.
The CCS will generally be subdivided by triage category, and EMTs may be assigned to be responsible for one or more categories of patients.
Medical treatment at the scene should not delay transport to definitive care unless absolutely necessary to save life or limb. In general any interventions should be minimised to the simplest Airway/Breathing/Circulation interventions required to maintain oxygenation and perfusion to vital organs during transport to definitive care.
If scene times are prolonged due to transport delays or for other reasons, further interventions may be advisable – the CCS Medical Supervisor and Scene Medical Commander should be involved in these decisions to enable feedback to the SHEOC.
Review all Green patients to determine if injuries can be dealt with at an alternate location to a public hospital.
Maintain up-to-date clinical documentation of triage, vital signs and treatment by updating the SMART Triage tags.
Complete documentation as required, including the Disaster Patient Record Form.

Provide appropriate handover to relieving medical team members at the end of the shift.
On Stand Down of Incident: <ul style="list-style-type: none">• Attend hot debrief• Collect all medical equipment and resources.

The EMT Leader will:

Provide leadership and support to EMT members in medical services provision.
Report to CCS Medical Supervisor.
Ensure all EMT members are appropriately attired.
Ensure accuracy and collection of all documentation.
Conduct welfare checks and maintain logs of medical team duration within incident. Request if required further equipment/consumables for further medical teams.
Provide appropriate handover at the end of the shift.
On Stand Down of Incident attend hot debrief.

9.4 ANNEX 4 – ANNEX 4 HEALTH PLAN ACTIVATION – INITIAL RESPONSE – CONCEPT OF OPERATIONS Major Incident

LHD HSFACs undertook a risk assessment in 2017 of the facilities within the LHD geographic catchment with a focus on capability and capacity to handle increased activity in the event of a Major Incident. The LHDs/Networks identified the scalability and capacity of their resources to prepare to receive casualties, whilst maintaining normal operations. Consideration included the numbers of persons who may not wait for triage or transport and self-present to a hospital.

The following Activation Plan details the LHDs preparedness to receive casualties until accurate information is known about the number and injuries of the casualties in the Sydney region for up to 100 patients.

The arrangements for other regions across NSW will be included in the pre-planned cross-LHD arrangements for medical response as detailed in section 6.3. These arrangements need to ensure flexibility to manage all incidents using the ICS Framework and prioritising the range of responses to fit the scenario that is occurring.

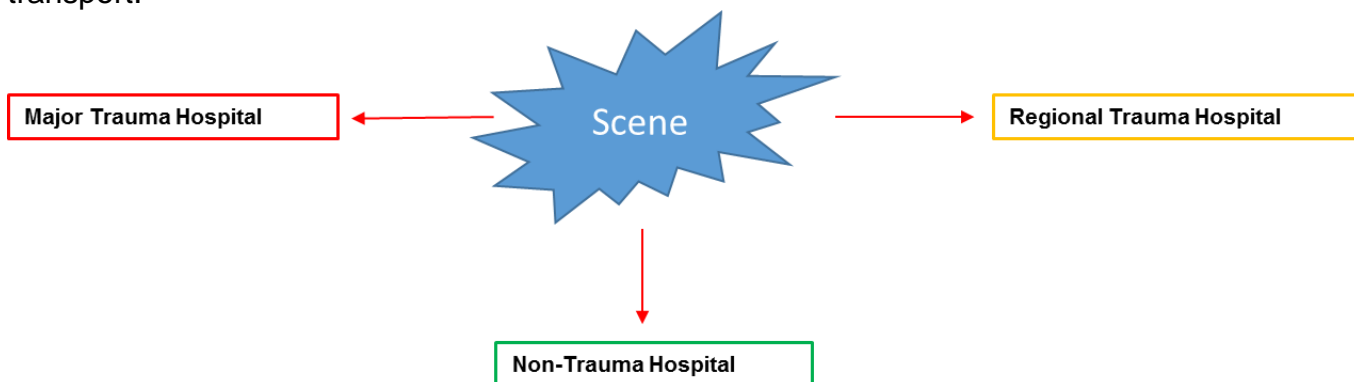
Response options to consider for each specific major incident include:

- The most suitable location for a Casualty Clearing Station – this may include any, or all of a nearby health facility, a more distant health facility or at the scene
- The advisability of deploying:
 - local hospital resources (teams and equipment) to a scene or nearby
 - other LHD resources to support a hospital
 - statewide Emergency Medical Teams to a scene and/or nearby health facility
 - all or parts of the statewide medical cache to a scene or nearby health facility.
- Whether the LHD HSFAC activates the LHD CONOPs
- Whether the State HSFAC activates the NSW HEALTHPLAN and state CONOPs.

Models of patient distribution need to consider the number of hospitals in close proximity to the scene based on need (Major Trauma Services, Regional Trauma Services and Non-Trauma Local Hospitals) and complexity of the incident.

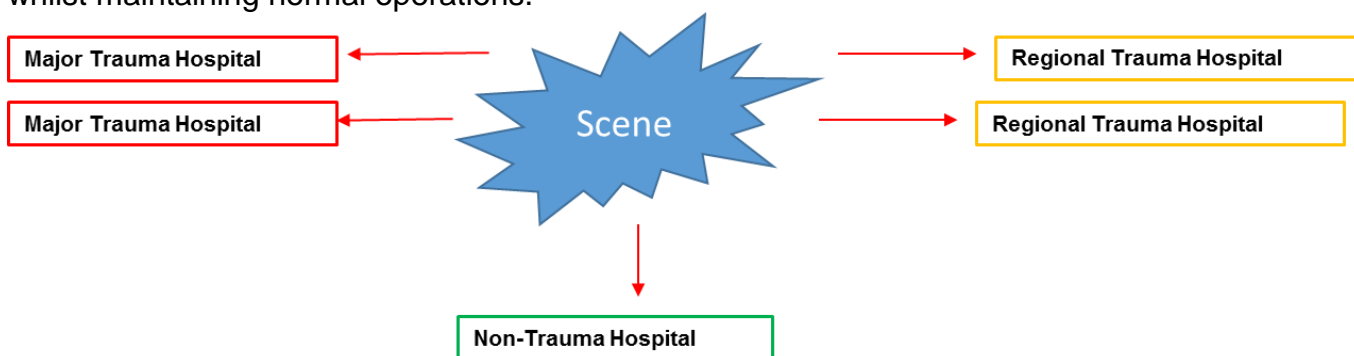
1) Simple Distribution Model:

In a simple model of distribution, patients are distributed to a number of hospitals in close proximity based on need. The focus is on the right patient to the right place by the right transport.



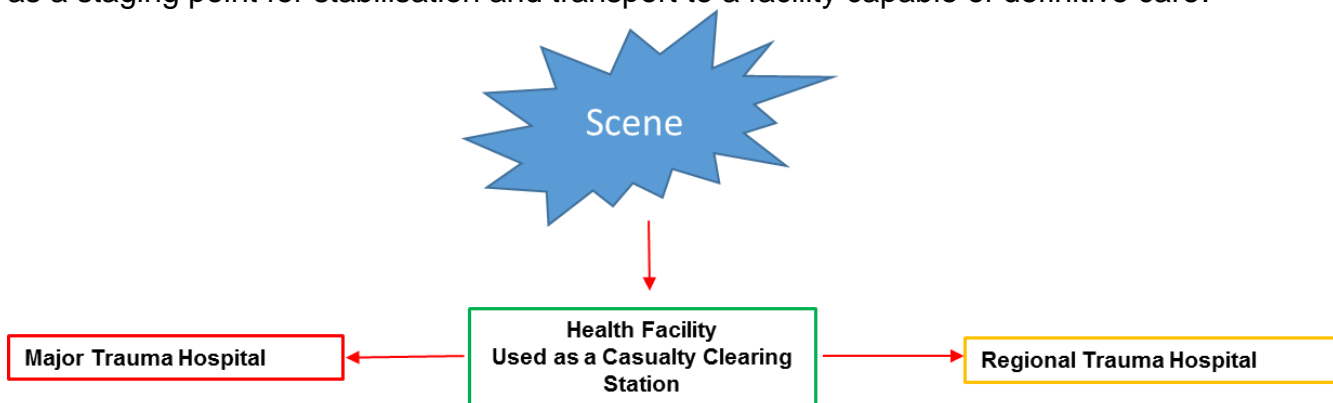
2) Expanded Distribution Model to accommodate scalability and capacity:

Patients are distributed to a number of hospitals in close proximity based on need and expanded to include hospitals further away to accommodate the increase in casualties, whilst maintaining normal operations.



3) Distribution Model where CCS is at a nearby/distant health facility:

This model can also be used where the facility is in a rural or remote area and is utilised as a staging point for stabilisation and transport to a facility capable of definitive care.



9.4.1 Mass Casualty Incident: up to 100 patients - Sydney

<p>Situation <i>Covers general and background information for the mission. It will indicate any special information as to the reason for the mission.</i></p>	<p>A Mass Casualty Incident in the Sydney area involving up to 100 patients has occurred.</p> <p>Accurate information about patient numbers and injury profile is currently unknown.</p>
<p>Mission <i>Provides a clear and concise statement of the task(s) to be accomplished.</i></p>	<p>To prepare to receive casualties until accurate information is known about the number and injuries of casualties.</p>
<p>Execution <i>Explains how the mission is to be carried out in order to accomplish the mission. Sub headings provide three areas of information.</i> <i>General Outline: Gives the concept of the mission and is a broad statement on how it is intended to be carried out.</i> <i>Group Detail: Instructions are given for every role whose presence is necessary to the success of the mission, including tasks, locality and areas of responsibility.</i> <i>Co-ordinating Instructions: Provide the details necessary to co-ordinate the mission, such as boundaries, routes, procedures etc.</i></p> <p>Capacity described: RED/YELLOW = 105 GREEN = 120</p>	<p>Each Sydney area LHD will prepare to receive up to 30 casualties on notification of event only as follows:</p> <p>Up to 15 RED / YELLOW Adult patients each to:</p> <ul style="list-style-type: none"> • Royal Prince Alfred Hospital • St Vincent’s Hospital • St George Hospital • Royal North Shore Hospital • Westmead Hospital • Liverpool Hospital • Nepean Hospital. <p>Following LHD advice UP TO 15 GREEN Adult patients each to:</p> <ul style="list-style-type: none"> • Canterbury Hospital • St Vincent’s Hospital • Royal North Shore Hospital • Auburn Hospital • Bankstown Hospital • Liverpool Hospital • Nepean Hospital • Sutherland Hospital. <p><u>Incidents involving up to 40 RED/YELLOW Paediatric Patients:</u></p> <p>Up to 20 RED / YELLOW paediatric patients to each:</p> <ul style="list-style-type: none"> • Sydney Children’s Hospital (SCH) • Children’s Hospital Westmead. <p>Up to 30 GREEN paediatric patients to each:</p> <ul style="list-style-type: none"> • Sydney Children’s Hospital • Children’s Hospital Westmead. <p>* Incidents approaching or exceeding 40 red/yellow paediatric patients would be managed in consultation with the Paediatric Controller with the principles of:</p> <ul style="list-style-type: none"> • Red/yellow patients 12 years or greater would be managed at major Trauma services initially.

	<ul style="list-style-type: none"> • Subsequent triage of Red/Yellow patients based on age and severity: <ul style="list-style-type: none"> ○ Less than 5 years to SCHN ○ The younger and sicker to SCHN ○ The older and less sick to Major Trauma Service.
<p>Administration & Logistics <i>Includes everything necessary to support the mission and keep it going once it has commenced. It has clearly defined sections. Catering where, when and how issued. Medical back-up arrangements and facility locations. Hours of duty when to commence, location arrival, stand down time, and estimated completion time. Dress PPE and specific requirements.</i></p>	<p>HEALTHPLAN is activated to “Response”</p> <p>The Mass Casualty Incident Action Plan is applicable.</p> <p>A Teleconference of the Health Incident Management Team will be conducted within 90 minutes to manage further response.</p>
<p>Command, control & communication <i>Advises all control arrangement and command personnel. It describes the lines of communication.</i></p> <p><i>For external communication purposes:</i></p> <p><i>RED = Critical</i> <i>YELLOW = Serious</i> <i>GREEN = Minor</i></p>	<p>HEALTHPLAN is activated to “RESPONSE”</p> <p>The SHEOC has been activated to “RESPONSE”.</p> <p>The primary source of information and notification is via SHEMS.</p> <p>The NSW Health IMT is activated and key personnel are responsible for delivering on objectives set out in the Incident Action Plan.</p> <p>All external Health communications are via the Communications Controller</p>

9.4.2 Mass Casualty Incident: Non-metropolitan

The principles of response to a Major Incident in a rural or remote area are:

- 1) Some LHDs have regional base hospitals with the capacity to provide definitive care to some patients from a major incident, and to act as a staging point for stabilisation and transport to a facility capable of definitive care. These regional base hospitals will be used in this capacity during a major incident when they are one of the closest such facilities (including across normal LHD boundaries where necessary).
- 2) For a Major Incident occurring in a remote area where there is no such facility nearby, the nearest LHD health facility, regardless of size and capacity, will likely be used as a Casualty Clearing Station due to availability of some clinical staff, clinical supplies and shelter. Extra senior clinical staff (Retrieval +/- other LHD staff) will be urgently transported to the facility (and Casualty Clearance Station if still active) to assist with both clinical care and Command/Control. Medical transport resources (helicopters, fixed wing aircraft, road ambulances, others as required) and teams will be tasked to begin transportation to definitive care. Close liaison between the medical commanders at the scene and facility will occur with the LHD HSFAC (regional) and the medical controller/State HSFAC.
- 3) For Major Incidents in both regional and remote areas, destinations and priorities for transfer will be guided by liaison between the Scene Medical Commander, State Medical Controller and LHD HSFACs.

9.5 ANNEX 5 – EMERGENCY MEDICAL TEAM QUALIFICATIONS AND TRAINING

Medical retrieval personnel (generally doctors, paramedics, flight nurses) are trained and have experience in scene safety and the clinical and operational aspects of working with critically ill patients in an austere environment.

Doctors will generally be a Consultant or Advanced Trainee in a critical care specialty (Emergency Medicine, Anaesthesia or Intensive Care) with major incident training in MIMMS and possibly AUSMAT and USAR.

Paramedics as part of the medical team will generally be NSW Ambulance Critical Care paramedics with extensive out-of-hospital experience including training and knowledge of NSW Ambulance protocols for major incidents, and possibly MIMMS and USAR.

Flight nurses are registered nurses employed by NSW Ambulance with training and currency in critical care and midwifery.

A single team is usually comprised of one doctor and either one paramedic or one flight nurse.

LHD Emergency Medical Teams are comprised of hospital-based doctors and nurses, usually from critical care disciplines.

Doctors should preferably be Consultants or Advanced Trainees in a critical care discipline (Emergency Medicine, Anaesthesia or Intensive Care).

Nurses should preferably be senior registered nurses with critical care certification and triage experience.

Both doctors and nurses should have training and currency in MIMMS or Hospital MIMMS or AUSMAT.

A single team should generally be comprised of two doctors and four nurses. This team may have members from more than one health facility or LHD in certain circumstances.

9.6 ANNEX 6 – EMERGENCY MEDICAL TEAM UNIFORM REQUIREMENTS

LHD Emergency Medical Teams (LHD EMT) may be mobilised/deployed to provide a range of health and medical support to a major incident under the direction of the State Health Services Functional Coordinator (State HSFAC). In order to clearly identify the team to other emergency management organisations at the site there is a need to wear an appropriate uniform that complies with Australian Standards. The provision and maintenance of appropriate uniforms is to be approved by the relevant LHD HSFAC.

The uniform requirements are required to ensure:

- Statewide consistency
- Meets requirements for external environments
- Comfortable, functional and practical

Additional requirements to the standard uniform will be available from the Non-Allocated Items on the Uniform Catalogue. LHDs are to ensure all members of LHD EMTs comply with the uniform requirement before deployment.

LHDs shall ensure they have a supply of Green Tabards with Identification – Position Holder Labels. The position holder labels are:

- Team Leader
- Doctor
- Nurse
- Triage
- Medical Commander

Medical Retrieval personnel

Due to aviation requirements regarding flammability, medical retrieval teams generally wear a blue or navy fire-retardant flight suit with appropriate identification and reflective markings already familiar to other EMS agencies.

9.7 ANNEX 7 – LHD DISASTER MEDICAL EQUIPMENT KIT

The aim of the LHD Disaster Medical Kit is to enhance resources if the incident overwhelms the first responders' resources. The provision and maintenance of LHD Disaster Medical Equipment kits is the responsibility of the LHD and is compiled following an assessment by the LHD taking into account the geographical constraints (remote v metro) and the potential delay in response to maintaining an appropriate level of supplies. Additionally the LHD needs to consider the capability of responding to the number of patients as laid out in the Concept of Operations for the relevant LHD.

The Kit is required to provide critical care support for up to 4 critical "Red" triage category patients. The exact contents provided to meet this objective will be determined by the LHD.

The content and layout of the kit should be familiar to the staff who will be using it, and rapidly deployable when required.