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Submission to the Department of Health and Human Services Health and Emergency Surge Arrangements

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1. Introduction

The Australasian College for Emergency Medicine (ACEM, the College) welcomes the opportunity to provide comment to the Department of Human and Health Services (DHHS) in response to the Health Emergency Surge Arrangements Discussion Paper (the discussion paper), as part of an ongoing review of health and emergency surge arrangements. ACEM recognises the importance of this work in ensuring adequate capability and capacity to ensure Victoria is equipped to respond to surges in demand during large-scale emergencies that can overwhelm Victoria's usual health responses.

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand.

2. ACEM Position

ACEM welcomes the work being undertaken by DHHS to update its health emergency surge arrangements. These such events challenge transport, communications and health infrastructure and pose a particularly complex challenge for the health system to respond to. Therefore, timely and informed system governance, integrated and effective networks of pre-hospital, hospital, general practice, public health, private, volunteer and military resources as well as an understanding of escalation to national plans and international resources is critical for Victoria to adequately plan for health emergencies.

While most system events in Victoria are related to surface transport incidents, ACEM notes that the risks and frequency of events in Victoria has heightened in recent years. This increased risk is largely due to climate change, increased population size and density, mass gatherings of people and heightened risk of terrorist activity. The work being undertaken to update how Victoria responds to these events is timely and has never been more essential.

ACEM believes that systems and processes should be developed to mitigate day-to-day surges in demand for emergency health services. These pre-existing systems and processes must also be readily upscaled in response to less common disasters or other emergency responses. To achieve the required degree of preparedness, Victoria's system can be improved to be more agile, better integrated, fit-for-purpose and responsive.

3. Recommendations

ACEM believes that health emergency responses must be planned and regularly exercised with all emergency services and health and community organisations. Emergency responses must be agile and appropriate, with clarity of purpose for the responders, and accountability and clear communication to those that lead and those they serve. Processes need to be in place to ensure that disaster response is effective, rapid, only constrained by necessary bureaucracy, and able to be escalated to match system surge with all available resources. Responses need to be of an appropriate size and duration to match the emergency, with articulated plans for transition to recovery and business continuity.

To support the development of effective, accountable and appropriate emergency surge arrangements, ACEM wishes to make several recommendations to DHHS for the consideration of developing updated health emergency and surge arrangements that are current and fit-for-purpose. We have structured our comments and recommendations per the Parts as listed in Appendix A of the discussion paper.

3.1 Deployable advisory health practitioners

ACEM recommends that FEMO be better integrated with VMATs to ensure training, exercising and annual audits of readiness for immediate deployment is undertaken. We also recommend that wider multidisciplinary integration is undertaken to embed expanded VMAT capability within major metropolitan and geographically strategic hospitals, such as Geelong, Bendigo, Ballarat and Frankston. To support more integrated and readily deployable advisory health practitioners, ACEM recommends that public health capability, communications expertise and media training be undertaken so that health practitioners are readily able to manage and coordinate disaster response.

3.2 On-scene treatment capability

ACEM notes that emergency physicians have unique expertise in dealing with emergency patients, particularly in the management of the patient through the complex pre-hospital, hospital and post-hospital systems. Emergency Physicians have experience of both national and international disasters; therefore, sharing of this knowledge and experience is essential to increasing the capability of health practitioners to provide on-scene treatment. ACEM recommends that this experience and knowledge be shared at a local, national and international level by leveraging existing training networks and the FACEM curriculum.

In addition to emergency physicians, VMATs represent a wide range of other members, including nurses, pharmacists, mental health practitioners and allied health. There needs to be future of enhanced multidisciplinary involvement across VMATs to increase flexibility and capability to respond to events, particularly for prolonged events and recovery. Further, specialist VMATs, such as paediatrics, should be retained. ACEM suggests that the use of VMATs can be embedded within existing Code Brown plans of the larger hospitals, ensuring suitable rostering arrangements to enable pre-hospital, hospital and recovery needs are met in emergencies.

To support VMATs in their role of providing on-scene treatment, there needs to be clear governance that outlines the arrangements, credentialing, training and transport/deployment of VMATs. VMATs also need to be adequately funded with clear agreements for their training, preparation and post-deployment recovery. ACEM believes that the hospital network has adequate capacity to provide this service without significant investment in overheads.

3.3 Clinical Reference Group

ACEM is supportive of a clinical reference group being formed to support the implementation of emergency surge arrangements.

ACEM recommends that the membership of the clinical reference group must cover a broad range of expertise and specialisations to ensure integration is embedded at an advisory level, including: trauma, burns, toxicology, infectious diseases, obstetrics, paediatrics, geriatrics, public health, mental health, radiation, occupational medicine, respiratory medicine, primary care, as well as key organisations such as medical colleges and emergency response services. To ensure the clinical reference group is coordinated with the DHHS, the Chief Medical Officer should also be a member or represented on the clinical reference group.

3.4 Enhancing Capability and Capacity of Ambulance Victoria

Managing surges in demand is part of everyday business for Ambulance Victoria (AV). ACEM notes that simply increasing capacity of AV so that there is enough redundancy to manage major disasters and emergencies would be costly, given that increasing capacity means increasing staffing levels and upskilling paramedics when emergency physicians are already available.

Therefore, AV needs the capability to manage and respond to peaks and surges in demand. Enhancing the capability of AV to respond to emergencies in a pre-hospital system is a more viable alternative. To support increased capability of AV, ACEM makes the following recommendations:

- Enhancing the availability of AV's deployable structural capacity, e.g. mobile field units;
- Ensuring AV has readily deployable and maintained equipment, with adequate stock of consumables on-hand always;
- Having agreements in-place between AV, VMATs and other relevant stakeholders to have agreed access and management of deployable resources.

3.5 Deployment of Retrieval Teams

As retrieval services such as ARV and PIPER have a rapid response capability, ACEM recommends that these services be enhanced for use in both normal business and emergencies. Although these retrieval teams have a small capacity to transfer a limited number of patients, their role enables with the most acuity to tertiary care, removing them from the scene and enabling staff on-site to care for the larger number of low-acuity patients.

3.6 Deployment of Victorian-based AUSMAT teams

ACEM notes that there are only a small number of AUSMAT members that are currently deployable in Victoria, being spread throughout the state and comprising of medical and nursing staff from a variety of disciplines including nurses, surgeons, anaesthetists, emergency physicians, logistics staff and administrators. These teams are generally staff selected and trained to work in a surgical field hospital for time periods up to 4 weeks. ACEM recognises that there is a challenge in creating a functional team, especially given the small number of available people, their geographic spread and varied and specialised skill sets.

To help address these barriers, ACEM recommends that calling on the AUSMAT capability should be considered as part of a business continuity plan where infrastructure of hospitals or access had been impacted by an event. ACEM notes that the AUSMAT model of combining a team from a variety of settings and then deploying them requires a preparation and set up time which results in a deployment time of approx. 6-24 hours, compared to the current VMAT which can be very rapidly deployed from on-shift or immediately available staff. However, ACEM notes that the distribution of AUSMAT members across Victoria limits the ability of the members to participate in training exercises, and cautions DHHS to examine ways to address this issue.

3.7 Deployment of Victorian Public Health Services Resources

ACEM notes that business continuity plans should include arrangements for health services to be able to source staff from other jurisdictions and have appropriate legal and credentialing frameworks in place.

ACEM recommends that training should be achieved through current in-hospital and College arrangements.

3.8 Deployment of regional Victorian GPs/specialists

ACEM notes that larger regional hospitals have enough capability to implement health emergency surge arrangements. However, other hospitals would require additional resources.

ACEM recommends that training for doctors in resource-limited settings, such as underserved communities in rural, regional and remote areas would need to be supported, such as through the provision of locum coverage.

3.9 Deployment of Non-Government First-aid Sector

ACEM believes that first aid trained personnel should only be used in areas where their level of training is adequate to meet the anticipated needs and not deployed to areas in order to replace trained clinical staff. First aid staff must only practice within their range of clinical expertise, even in disaster settings.

We note that Ambulance Community Officers and Community Emergency Response Teams are involved in the provision of ambulance services to underserved communities and are integral to any response, however these services also need to be available for normal business.

We recommend that pre-requisites for this capability include the continued development of an accreditation framework and regulatory context for the non-government first-aid sector, training, agreements regarding funding, command/control integration, deployment protocols, and operation of a systemic readiness program should be part of all response groups.

3.10 Leveraging of Other Emergency Service Agencies

ACEM agrees that leveraging other emergency service agencies is desirable, however we note that Fire, Police and the Victorian State Emergency Service are likely to have limited resources available immediately and would also be able to provide long-term support in recovery.

To complement the agencies listed in the Discussion Paper, ACEM recommends that the following groups also be listed in this section:

- Private hospitals, to enable greater capacity in an emergency that overwhelms demand in the public system;

- Military, to tap into military health capacity which would be activated at a federal level to complement civilian resources;
- Private transport operators, e.g. regional bus operators that can link with NCCTRC/AUSMAT to convert buses with simple systems into multiple stretcher capability; and
- Overseas emergency medicine medical teams verified by the WHO EMT Initiative (e.g. NZMAT). We note that credentialing of overseas teams is currently under consideration by Department of Health (Canberra) and Emergency Management Australia.

4. Final Remarks

Thank you again for consulting with the wider sector on health emergency surge arrangements. ACEM appreciates the opportunity to work with the DHHS in building a more integrated, responsive and fit-for-purpose system that better responds to surges in demand for emergency healthcare.

We look forward to further supporting the work being undertaken by DHHS into this review. If you require further information, please do not hesitate to contact ACEM Executive Director Policy and Strategic Partnerships on (03) 9320 0444 or nicola.ballenden@acem.org.au.

Yours sincerely

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