Government of **Western Australia**
Department of **Health**

# WA health system
# Emergency Management Arrangements



Version 2.0

# Foreword

The WA health system has long been at the forefront of addressing complex and large-scale incidents that impact the service delivery of health and underscoring the critical need for a comprehensive and integrated framework for emergency management. This document outlines the WA health system's strategic approach to preventing, preparing for, responding to, and recovering from emergencies and disasters, both within WA and beyond.

Developed to ensure uniformity in structure, nomenclature, and governance – these arrangements align with the all-agencies, all-hazards State Emergency Management Framework. They connect seamlessly with the National Health Emergency Response Arrangements (NatHealth Arrangements), and other national emergency management frameworks.

By adhering to the statutory requirements of the *Emergency Management Act 2005*, these arrangements will enhance the WA health system's preparedness and response capabilities, whilst supporting Health Service Providers in meeting the National Safety and Quality Health Service Standards. It ensures that the WA health system remains resilient and capable of effectively managing emergencies and disasters, whilst safeguarding the health and well-being of the community.

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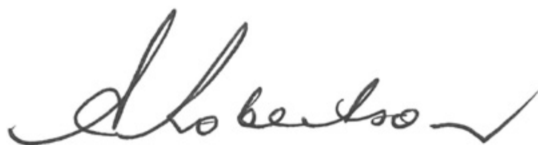
# Authorisation

These arrangements have been endorsed by the Health Emergency Management Committee (HEMC) as a document that describes integration between the State Emergency Management Framework and its application to the WA health system. These arrangements enable the WA health system to fulfill its obligations as detailed in emergency management legislation. The review of these arrangements is to occur on a 3-year term.

Approved 17 July 2025



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# Amendment certificate

Any amendments to this plan are subject to the approval of the WA Health emergency management committee.

| Version No. | Date | Detail of amendment / review | Amended by |
|---|---|---|---|
| 1.0 | September 2017 | Initial release | |
| 1.1 | November 2024 | Draft for consultation | Senior Policy Officer, DPMD |
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# 1. Introduction

The WA health system Emergency Management Arrangements provide information on roles and responsibilities, including plans to support the WA health system across the emergency management continuum. The number, scale, and complexity of emergencies demonstrates the need for the WA health system to have robust and integrated emergency management arrangements in place to prevent, prepare for, respond to, and recover from emergencies, disasters and other disruptive events.

Strategic, tactical and operational responsibilities are outlined throughout the arrangements. These responsibilities may occur through committee level functions, actions of incident management teams at all levels, or as a product of planning and preparation phases. Elements of these arrangements are established as part of normal business, such as committee structures to guide emergency management plans and support emergency management policy. Other elements of the arrangements are activated in times of disaster or emergency, or when the health service or system is experiencing an internal emergency.

## 1.1 Aim and objectives

To provide a common framework to ensure a clear, consistent, and comprehensive approach to emergency management is undertaken across the WA health system. The objectives of these arrangements are to:

- assist Health Service Providers (HSPs) in achieving compliance with the emergency management policy, including the relation to emergencies and other disruptive events
- outline the command-and-control arrangements
- identify key stakeholders, their roles, responsibilities and delegations
- provide a framework for the development of emergency management plans and procedures
- detail alignment between site (i.e. hospital or health business entity), HSP, Hazard Management Agency (HMA) and state emergency management arrangements.

## 1.2 Principles

The WA health system applies the following principles in its approach to emergency management that align with the State Emergency Management Policy:

- **emergency risk management approach –** considers the likely effects of hazardous events on the human population, and controls by which they can be minimised- traditionally the prevention, preparedness, response and recovery approach
- **shared responsibility for resilience –** to minimise the vulnerability, dependence and susceptibility of a community by creating or strengthening social and physical capacity in the human and built environment to cope with, adapt and respond to, and recover from emergencies
- **all hazards approach –** recognises a common framework that applies to all emergency types under which the WA health system's role, function and activities in an emergency are applicable
- **all agencies coordinated and integrated approach –** recognises all relevant organisations, agencies and governments have specific roles that, in any incident, require coordination and inter-operability

- **graduated approach –** ensures that the response efforts match the severity of the incident. A proportional, practical, and scalable approach to emergencies is enabled, for the appropriate use of resources, and the empowerment of decision-making at the lowest appropriate level
- **continuous improvement** through monitoring and review of arrangements, plans, and lessons identified to improve emergency management across the WA health system
- **integrated information management** in the recognition of sharing information enables efficient and effective incident response
- **clear governance structures –** that delineate roles and responsibilities
- **developing capability** through education, training and exercising.

# 2. Governance

## Legislative framework

The *Emergency Management Act 2005* (EM Act) and *Emergency Management Regulations 2006* (EM Regs) define WA's emergency management structure and the obligation of the Department of Health (department) as a public authority responsible for the provision of health services; and management of the adverse effects of an emergency across the prevention, preparedness, response and recovery continuum.

The *Health Services Act 2016* (HS Act), and the *Public Health Act 2016* (PH Act), provide complementary legislative frameworks that govern aspects of health incidents and emergency response activities in WA.

The HS Act primarily establishes the structure and governance of the WA health system. It provides a modern legal framework for clear roles, responsibilities and accountabilities at all levels. It establishes department, led by the chief executive officer (Director General), as the System Manager, responsible for the overall management performance and strategic direction of the WA health system. It also establishes HSP's as separate board governed statutory authorities, legally responsible and accountable for the delivery of health services for their local areas and communities. The devolved model of governance and basis for systemwide coordination enables decision-making and accountability closer to service delivery and patient care.

The PH Act focuses on protecting, promoting and improving public health in WA. It provides a graduated risk-based model for managing public health risks and coordinating responses to both everyday public health issues and emergency responses. The PH Act provides the Chief Health Officer (CHO), and authorised officers with wide scale powers to take action to protect public health.

In an incident or emergency, the HS Act supports the operational and organisational command, control and coordination of health services by the System Manager. The PH Act provides for public health interventions, directions and exercising of emergency powers in relation to public health aspects of any emergency or disaster.

### National standards

This document includes references to National Safety and Quality Health Service Standards (NSQHSS) as a guide to HSPs of hospitals where a standard has relevance to an element of the national, state or department policy, plan, or there is relevance to the State emergency management framework.

## Security of critical infrastructure

The *Security of Critical Infrastructure Act 2018* (SOCI Act) is Commonwealth legislation aimed at safeguarding the nation's critical infrastructure from various threats. These include cyber-attacks, natural disasters, and other emergencies. The SOCI Act establishes a framework for identifying and managing risks to critical infrastructure – ensuring that essential services such as energy, water, communications, and transportation remain secure and resilient. The SOCI Act covers 11 critical infrastructure sectors. This includes communications, data storage or processing, defence industry, energy, financial services and markets, food and grocery, health care and medical, higher education and research, space technology, transport and water and sewerage.

Key aspects of the SOCI Act:

- **Risk Management:** the Act requires owners and operators of critical infrastructure to adopt risk management programs that address potential threats and vulnerabilities.
- **Reporting Obligations:** entities must report any incidents that could significantly impact the operation of critical infrastructure to the relevant authorities.
- **Government Assistance:** the Act provides mechanisms for government intervention and assistance in the event of a significant threat or emergency.
- **Information Sharing:** promotes the sharing of information between the government and critical infrastructure entities to enhance situational awareness and response capabilities.

### Interaction with emergency planning

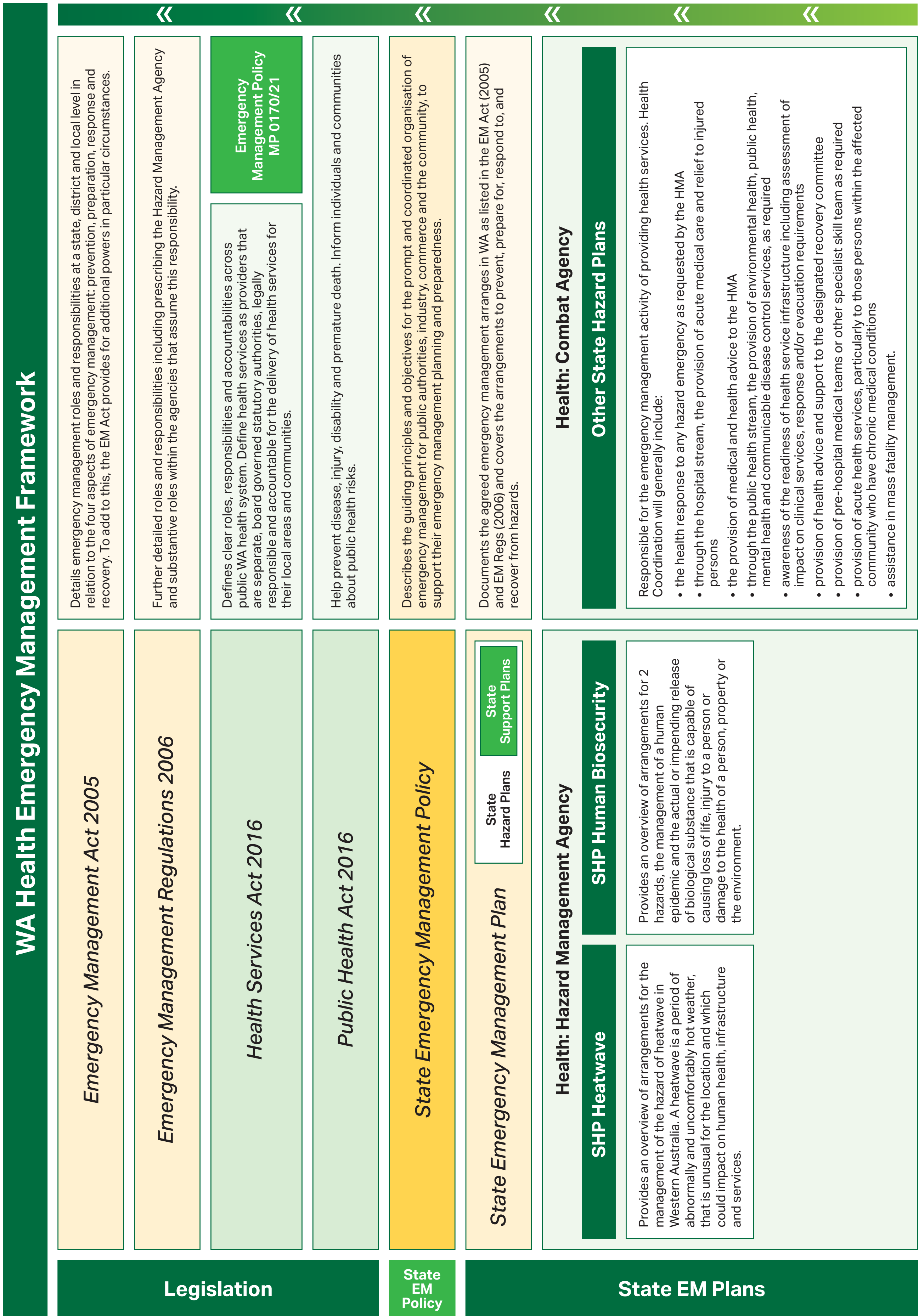
The SOCI Act plays a crucial role in emergency planning by ensuring that critical infrastructure entities are prepared to respond to and recover from emergencies. Some ways it interacts with emergency planning include:

- **Preparedness:** mandates that critical infrastructure entities develop and implement comprehensive emergency plans that address various scenarios, including natural disasters, cyber-attacks, and other threats.
- **Coordination:** it facilitates coordination between different levels of government and private sector entities, ensuring a unified and effective response to emergencies.
- **Resilience:** by requiring risk management and reporting, the Act helps build resilience within critical infrastructure sectors, making them better equipped to withstand and recover from emergencies.
- **Training and Exercises:** encourages regular training and exercises to test and improve emergency response plans and capabilities.

## WA health system emergency management framework

The WA health system emergency management framework details the intersect between legislation, state emergency management framework, strategic documents and the cascade of plans for the WA health system. This includes whole-of-system plans (department and HSP’s) and where these plans plug into other emergency management doctrine. This framework is applicable for disasters, emergencies and other disruptive events.

## WA Health Emergency Management Framework



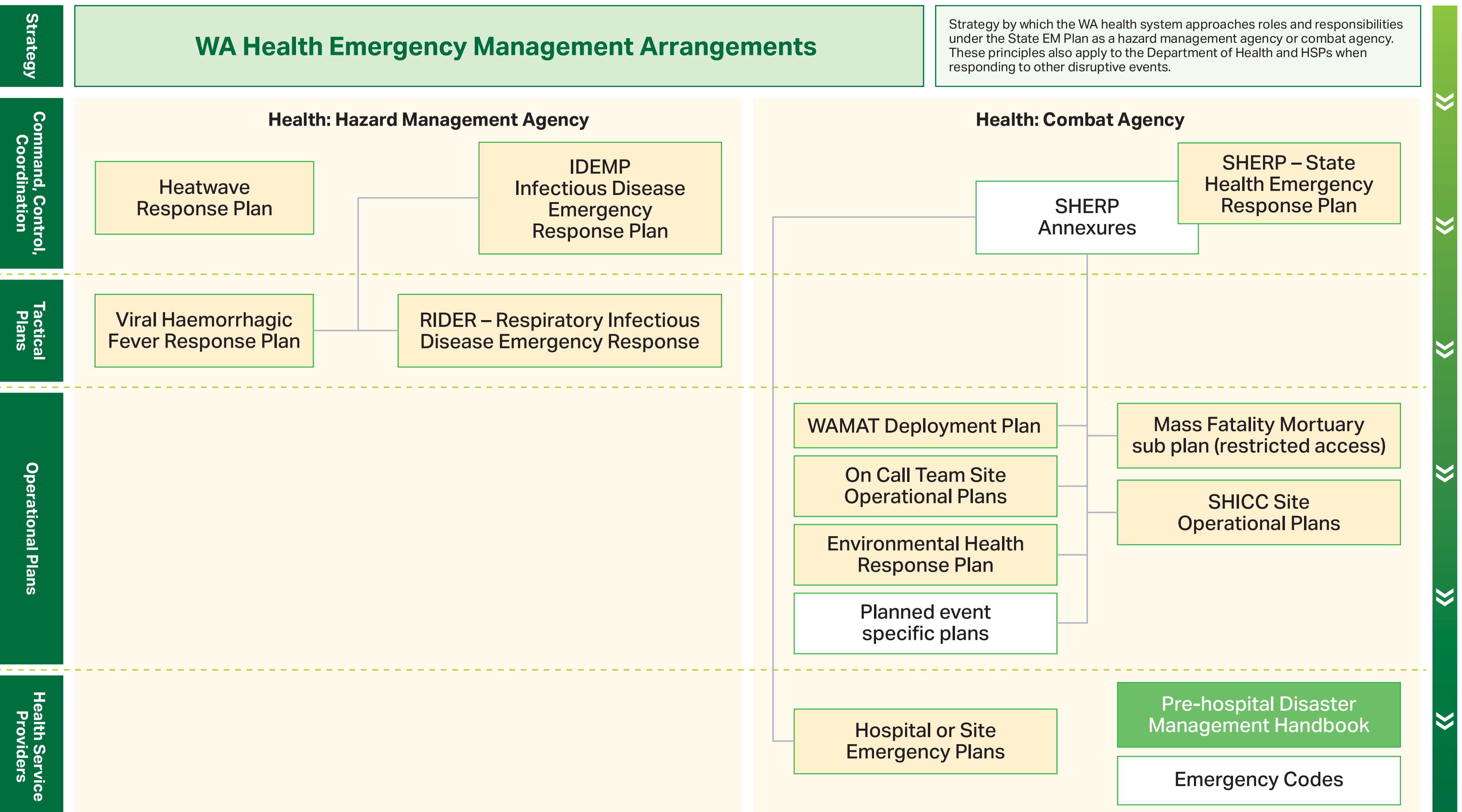



**Figure 1: Interface between State, WA health system and HSP emergency management legislation, policy and plans**

### Combat agency

A combat agency is defined as a public authority in subsection 1 of the EM Act, due to its specialised knowledge, expertise and resources. It is responsible for performing an emergency management activity prescribed by the regulations.

The department is prescribed as a combat agency under section 26 of the EM Regs, with responsibility for the emergency management activity of providing health services. The combat agency responsibility is applied across the spectrum of the 28 prescribed hazards the Regs in line with all hazards approach.

### Hazard management agency

A Hazard Management Agency (HMA) is a public authority or other person prescribed by the regulations because of that agency's functions under any written law, or because of its specialised knowledge, expertise, and resources, to be responsible for the emergency management, or an aspect of emergency management, of a hazard for part or the whole of the state.

The Chief Executive Officer of the Department of Health (Department CEO), known as the Director General of the Department of Health, is the nominated HMA position with responsibilities under section 22 of the regulations.

The Department CEO is the HMA for the following hazards:

- Human epidemic
- Actual or impending spillage, release or escape of a biological substance that is capable of causing loss of life, injury to a person or damage to the health of a person, property or the environment
- Heatwave.

The WA health system supports the Department CEO in their role as the HMA.

### Department of Health

As per the *Health Services Act (HS Act) 2016*, part 1 section 6, the department is the public service assisting the Minister in the administration of the HS Act. The Department CEO is responsible for carrying out the System Manager role and is defined in the HS Act 2016.

## 2.1 WA Health Policy Framework

The Emergency Management Policy (EM policy) has been established under the Public Health Policy Framework. The purpose of this policy is to set minimum standards required to ensure that a clear, consistent, and comprehensive approach to emergency management is undertaken. The policy requires HSPs to have arrangements in place to respond appropriately in an emergency.

HSPs are required to annually complete a self-assessment on compliance to the EM Policy. A summarised report is provided to the WA Health Emergency Management Committee for endorsement.

## 2.2 At risk populations and accessibility

Vulnerability in the context of emergency management can be circumstantial, as a result of the incident or compounded by an underlying risk factor related to a person or group of people. Accessibility to services can be compromised, and providing equality of access can be challenged in disasters or emergencies. The State Emergency Management Plan (State EM Plan), State Hazard Plans and State Support Plans consider and identify individuals and groups who are particularly at risk or vulnerable to the effects of their hazard. Agencies that support the emergency services sector are engaged to provide support to the whole community and have skillsets and capabilities to support at-risk groups or individuals. Spanning across the states hazards, the State Support Plan – Emergency Relief Support outlines organisational responsibilities across the prevention, preparedness, response and recovery spectrum.

## 2.3 Committee structure

To ensure effective oversight and coordination, WA Health operates through emergency management committees. A summary of the local, district, state, and national emergency management governance structures can be found in Appendix A.

### State Emergency Management Committee

The State Emergency Management Committee (SEMC) established under section 13 of the Act, is the peak statutory body for emergency management in WA, reporting to the Minister for Emergency Services. WA Health is represented at the SEMC by the Deputy Director General, Public and Aboriginal Health/Chief Health Officer. The SEMC is attended by state agencies that have a role or responsibly detailed in the regulations.

The SEMC has reporting lines from District Emergency Management Committees (DEMCs) and 5 SEMC subcommittees. WA Health has representation on 5 SEMC subcommittees:

- Climate change
- Community resilience and recovery
- Public safety communications
- Response policy
- Risk and capability.

The SEMC and the subcommittees are not activated for response activities. The SEMC considers strategic issues, makes recommendations to the Minister for Emergency Services and provides oversight and direction to the emergency management sector.

The department as System Manager represents the WA health system on SEMC and the subcommittees.

## WA Health Emergency Management Committee

The WA Health Emergency Management Committee (WA HEMC) is the peak emergency management body for the WA health system. It is chaired by the Deputy Director General, Public and Aboriginal Health/Chief Health Officer and has responsibility for establishing the strategic direction for emergency management across the WA health system.

WA HEMC has representation from the Department's Environmental Health, Communicable Disease Control, and Disaster Preparedness and Management Directorates; and the State Health Operations Centre (SHOC), as well as Chief Executive level representation from all HSPs. The committee can co-opt external representatives. For example, St John's Ambulance WA (SJWA), Royal Flying Doctors Service (RFDS), Private Hospitals Association, Catholic Health Australia, in an advisory capacity in relation to a specific agenda item.

The WA HEMC can be activated in times of response to provide strategic direction for incidents that are systemwide service continuity related.

The WA health system HEMC sub-committee, comprised of emergency management practitioners, provide subject matter expertise, or undertake discrete projects as assigned by the WA HEMC.

## Health Service Provider committees

HSPs are required by the WA Health Emergency Management Policy MP 0170/21 to have adequate governance and policy arrangements in place. This ensures emergency management is implemented appropriately and an emergency management framework is established, maintained, monitored and reviewed. HSP's must have an emergency management committee function, however titled, to provide local oversight and compliance, and ensure alignment with contemporary emergency management approaches.

## Local and district emergency management committees

HSPs have significant roles to play in an emergency or disaster and are key stakeholders in their community's emergency management planning process. HSPs of healthcare facilities are required by policy to provide active representation to local and district emergency management committees (LEMC and DEMC).

Committee representatives may be requested to provide health advice on mitigation, preparedness, response and recovery arrangements for the WA health system's prescribed hazards under the regulations, the local health service's role in the provision of health care, or public health relating to an emergency or disaster. Representation may include provision of advice, involvement in multi-agency exercises, or input into local or district emergency management arrangements and emergency risk management plans.

The mandatory EM Policy MP 0170/21 details HSPs of healthcare facilities must provide adequate representation to the relevant DEMC for their respective health service, and ensure active representation on the LEMC facilitated by their local shire or council.

HSPs provide representation to the following DEMC(s):

| Health Service Provider | District Emergency Management Committee(s) |
|---|---|
| South Metropolitan Health Service | South Metropolitan DEMC |
| North Metropolitan Health Service | North and Central Metropolitan DEMC |
| East Metropolitan Health Service | East Metropolitan DEMC and<br>Central Metropolitan DEMC |
| WACHS – Goldfields | Goldfields-Esperance DEMC |
| WACHS – Great Southern | Great Southern DEMC |
| WACHS – Kimberley | Kimberley DEMC |
| WACHS – Midwest | Midwest-Gascoyne DEMC |
| WACHS – Pilbara | Pilbara DEMC |
| WACHS – South West | South West DEMC |
| WACHS – Wheatbelt | Wheatbelt DEMC |

More information on LEMCs, DEMCs and the SEMC can be found online.

Appendix A refers to a structure of the committee governance structure.

Appendix B provides a map of the health regions and the regional boundaries of emergency management districts.

## 2.4 Key roles, directorates and responsibilities

The NSQHSS, governance, leadership and culture, aligns with 1.01 (e) ensuring that roles and responsibilities are clearly defined for the governing body, management, clinicians and the workforce.

### Department of Health

The Department of Health CEO as System Manager is responsible for the overall management and strategic direction of the WA health system.

Director General (DG) has overarching authority and accountability for the WA health system and is the HMA for the three hazards in accordance with the regs.

#### State Health Coordinator

Pursuant to section 24 of the HS Act 2016, the role of the DG has delegated powers to persons occupying the role of the State Health Coordinator (SHC) to direct any WA health entity to undertake certain functions for the purposes of preventing, preparing for, responding to, and recovering from emergencies, disasters, and other disruptive events. The SHC reports directly to the DG.

Key responsibilities include:

- providing strategic oversight and governance of the WA health system in relation to emergencies, disasters, or other disruptive events
- representing the WA health system at the State Emergency Coordination Group (SECG)
- commanding, controlling and coordinating the WA health system during an emergency, disaster or other disruptive event, mobilising an incident management team, activating the State Health Incident Coordination Centre (SHICC) appointing a SHICC coordinator, and appointing an Incident Controller (IC) for HMA assigned hazards
- activating the WA Health Emergency Management Committee for pre-determined incident types to provide strategic input. (Cyber, significant ICT and service failure)
- acting as the department media spokesperson during emergencies
- allocating the role of Health Commander for any Health Response Team (HRT) deploying within the metropolitan area
- providing advice to the State Recovery Coordinator on WA Health recovery efforts.

#### Incident Controller

The person designated by the relevant Controlling Agency[1], is responsible for the overall management and control of an incident within an incident area and the tasking of agencies in accordance with the needs of the situation . In an epidemic, heatwave, or biological hazard incident, the SHC, as delegate of the HMA, is responsible for appointing an IC. In some cases, the SHC may assume the role as IC. Where the department is the controlling agency and an incident is occurring in a regional area, such as heatwave, the SHC will request the IC is nominated by WA Country Health Service (WACHS) from that locality or region.

1. State Emergency Management Glossary.

The IC is the person designated to be responsible for the overall management and control of an incident, within an incident area, and the tasking of combat agencies and other agencies in accordance with the needs of the situation. Hazard-specific roles of the IC and the multi-agency response arrangements are outlined in the following State Hazard Plan (SHPs):

- Human epidemic and release of a biological hazard: SHP – Human Biosecurity
- Heatwave: SHP – Heatwave.

**Chief Health Officer and Deputy Chief Health Officers:** oversees all emergency management elements relating to public health. The Chief Health Officer (CHO) is a statutory position under the *Public Health Act 2016*.

Key responsibilities include:

- representing the WA health system at the Australian Health Protection Committee (AHPC) and other national bodies
- fulfilling various statutory obligations under various legal instruments
- providing leadership and oversight on public health aspects of any emergency or disaster.

**Director, Disaster Preparedness and Management Directorate:** oversees the disaster and emergency Management aspects of the *Health Services Act 2016*. This position is responsible for ensuring appropriate emergency management policies, frameworks, resourcing and planning are in place to minimise the impacts on the WA health system from emergencies and adverse events.

Key responsibilities include:

- deputy chair of the WA HEMC
- acting as the official deputy and proxy to the Deputy Director General, Public and Aboriginal Health/Chief Health officer at the SEMC
- briefing and advising the Director General and Minister for Health on emergency management matters affecting the WA health system
- ensuring the WA health system can fulfil its roles and responsibilities under various plans and arrangements by providing oversight on the development and approval of strategic emergency management plans and policies
- liaising, engaging, and consulting with key stakeholders on emergency management within the WA health system.

**Disaster Preparedness and Management Directorate:** provides the policy framework, logistical support and operational emergency management capability to the WA health system.

Key roles include:

- developing plans, policies and arrangements affecting emergency management within the WA health system
- staffing a 24-hour On Call service for notification, monitoring and escalation of all emergencies and adverse events
- managing the Western Australian contingent of the Australian Medical Assistance Team (AUSMAT) and WA Medical Assistance Team (WAMAT) capability
- communicating with internal and external stakeholders
- coordinating logistical support to incidents
- managing the State Disaster Contingency Warehouse

- coordinating access to the National Medical Stockpile
- managing the crisis information system, WebEOC
- providing leadership and coordination across the WA health system through managing the State Health Coordinator function and mobilisation of the SHICC
- providing a range of risk management, training, and exercising support services.

**Environmental Health Directorate (EHD):** is the principal environmental health body for the WA health system.

Key roles in all stages of the PPRR continuum include:

- providing advice and assistance in relation to water quality, food safety, human waste, hazardous materials, site contamination, vermin/vector control, non-clinical toxicology and environmental health impact assessment
- providing guidance and assistance to local government environmental health officers and LEMCs to strengthen preparedness for environmental health emergency response and recovery
- developing plans and procedures to prepare for the environmental health impacts of climate change
- deploying specialist health response teams from environmental health as part of emergency response
- providing a 24-hour on-call service for environmental health
- investigate emerging environmental health risks.

**Communicable Disease Control Directorate (CDCD):** provides expert public health advice on communicable diseases and coordinates statewide prevention and control, including assisting in the public health response to an infectious disease emergency.

Key roles include:

- developing statewide plans, policies and arrangements relating to the public health response to communicable diseases.
- conducting notifiable communicable disease surveillance and monitoring statewide trends
- leading and coordinating the public health response to statewide or significant clusters or outbreaks of communicable diseases of public health significance in partnership with the relevant public health units (PHUs)
- providing statewide expert public health advice and information about communicable diseases and immunisation
- providing an after-hours service for urgent public health advice and response in relation to communicable diseases.

**Director, Communicable Disease Control Directorate:** assumes the role of Chief Human Biosecurity Officer for WA under the *Biosecurity Act 2015* (Australian Government).

Key roles include:

- liaising with the CHO and federal agencies, including the Communicable Disease Network Australia (CDNA), Australian Government Department of Health, Disability and Ageing's Director of Human Biosecurity, and the Australian Centre for Disease Control in relation to any threatened or actual communicable disease emergency
- coordinating the operations of the Public Health Emergency Operations Centre (PHEOC) during communicable disease emergencies.

**Public Health Regulation:** administers the *Radiation Safety Act 1975* and associated subsidiary regulations on behalf of the Radiological Council of WA:

- Licenses and Registrations (radiation users, equipment, sources and premises)
- Incident surveillance program
- Radiation safety education, monitoring and support
- Radiation Emergency Response
- Compliance and testing programs.

### State Health Operations Centre

The state-level operations centre that facilitates patient flow and a suite of virtual care services.

## Health Service Providers

Health Service Providers (HSP's) are legally responsible and accountable for the delivery of health services for their local communities.

**Chief Executives:** provide oversight to emergency management within their respective health services.

Key roles include:

- ensuring the emergency management arrangements are in place and adequately resourced to minimise the negative impacts from emergencies
- providing the System Manager with assurance the Health Service is adequately prepared for emergencies affecting its health service
- ensuring all entities within the health service are compliant with the requirements of the mandatory Emergency Management Policy MP 01790/21
- attend the WA Health Emergency Management Committee (HEMC) as required during state level critical incidents managed by the SHICC
- ensuring health service representation to WA HEMC and respective DEMCs (Health Emergency Management Policy)
- providing support, media assistance and resourcing to hospitals
- providing additional resources at the request of the SHC or IC.

**Health Service Provider Lead** (incident type specific and activated as needed): facilitates coordination between the SHICC and relevant HSP during an incident.

Key roles include:

- acting as the single point of contact for the SHICC during major incidents by representing and providing information regarding HSP hospitals and any other HSP level concerns
- enabling the HSP Chief Executive to execute their obligations within the State emergency Management framework and representing the HSP Chief Executive in discussions with the SHICC as required
- mobilise an incident management team for the health service wide Emergency Operations Centre
- providing direction to hospital sites as appropriate to the level of authority designated by the HSP Chief Executive.

**Regional Executive Directors and Regional Health Disaster Coordinators** (WACHS Regions): the roles and responsibilities of Regional Directors and Regional Health Disaster Coordinators (RHDCs) are detailed in the WACHS Emergency (Disaster) Management Arrangements Policy.

**Public/Population Health Units (PHU):** Public health management of cases, contacts, clusters and outbreaks of infectious diseases within the boundaries of the health region and in conjunction with the CDCD.

Key roles include:

- performing local notifiable infectious disease monitoring and surveillance in accordance with state and national requirements
- providing expert public health advice and information about infectious diseases and immunisation to the region
- following up local cases and contacts of notifiable infectious diseases
- investigating, monitoring and reporting of infectious disease clusters and outbreaks of public health significance affecting the region
- providing surge capacity staff and authorisation to implement an appropriate public health response to a significant infectious disease cluster or outbreak affecting the region
- establishing and maintaining a metropolitan or regional Emergency Operations Centres (see State Hazard Plan – Human Biosecurity and IDEMP for more information).

## Health facilities

**Executives:** govern and resource the hospital emergency management arrangements, undertaking a leadership role during emergencies.

Key roles include:

- overseeing the development, maintenance and approval of local health service emergency management plans
- providing resources to ensure emergency management activities are undertaken in compliance with relevant policies and procedures
- ensuring appropriate representation to DEMCs and LEMCs
- ensuring appropriate representation to HSP emergency management committees
- appointing a Hospital Incident Commander (HIC) to oversee emergency response coordination at a site level
- escalating emergencies or incidents that may overwhelm the health facility and require a higher level of response coordination and support.

**Hospital Incident Commander:** coordinate the emergency management activities at local hospitals and health service entities.

Key roles include:

- developing, maintaining and testing of emergency management plans
- leading the local Health service/hospital response to emergency
- notifying and liaising with the RHDC (WACHS) or SHICC via the On Call Duty Officer
- where requested, participating in a local multi-agency Incident Support Groups (ISG)
- where requested by the RHDC/SHC, deploying assets and personnel in response to an emergency
- leading internal recovery activities.

## Stakeholder responsibilities matrix (RACI model)

To support command, control and coordination functions across the WA health system, these arrangements incorporate a stakeholder responsibilities matrix (RACI model). The matrix defines key stakeholders and outlines their respective responsibilities, accountabilities, consultation and information obligations across the emergency management continuum. It applies across the Prevention, Preparedness, Response and Recovery phases, and is aligned to the legislative and policy frameworks outlined in these arrangements.

The RACI matrix serves as a reference tool to assist agencies, directorates and health service providers in understanding their roles, interdependencies, escalation pathways and decision-making responsibilities during emergencies and disasters. It is intended to enhance consistency, interoperability and accountability within the WA health system and between the system and external partners.

DPMD will maintain the matrix and ensure it aligns with contemporary policy and legislative requirements. The matrix will be reviewed in conjunction with the review of these arrangements and updated following any significant organisational or legislative changes, or after lessons identified from exercises or real events.

For reference, the RACI matrix is provided at Appendix E.

# 3. **Prevention** (including mitigation)

Prevention includes strategies, measures and interventions taken prior to the occurrence of an emergency. It aims to eliminate, or reduce the negative societal, environmental, economic, human health and critical infrastructure consequences of the emergency. Preventative measures can include physical or engineered solutions, legislative instruments, and/or public health initiatives such as immunisation programs.

## 3.1 Risk management

The WA health system has a legal obligation to implement risk management practices in accordance with Treasurer's Instruction (TI 4) Risk Management and Internal Control, Requirement 2: Risk Management. The specific requirements for HSP's for risk management are outlined in the Risk Management Policy MP0006/16. Complementing the risk management consideration, mandatory Emergency Management Policy requirement 3.4 states, HSPs must use a continuous risk-based approach to inform emergency management arrangements. A risk-based approach involves the identification, assessment and control of hazards, including the potential likelihood and consequence, to support the development and maintenance of relevant emergency management plans, procedures, compliance activities and testing frequency.

In the emergency management context, prevention and mitigation is heavily associated with risk management; the systematic process that deals with the effect of uncertainty on the objectives of an organisation. Emergency risk management involves identifying, assessing, and treating risks to minimise the likelihood of an adverse event occurring and/or mitigating the impacts of events when they occur. Risks such as heatwaves and cyclones cannot be prevented, therefore the focus shifts to impact mitigation.

Systemic risk in emergency management refers to the potential for a disruption in one part of a system to cause cascading failures throughout the entire system. This type of risk is characterised by its complexity and interconnection, meaning that a single event can trigger a chain reaction of adverse effects across multiple sectors and regions.  For example, a heatwave and power outage occur at the same time, or a cyclone or flood resulting in prolonged road closures affecting critical supply chains.

### Risk-based approach to emergency management

Emergency risk management follows ISO 31000:2018 – Risk Management Guidelines and adopts a capability-based approach to mitigate the impacts of hazards. Risk management includes assessing the likelihood and consequence of all foreseeable risks and hazards, and the development of appropriate control strategies. Control strategies are to be developed for all foreseeable risks and should focus on reducing the likelihood of an event occurring and/or mitigating the consequences. Control strategies should be developed for all foreseeable risks and additional treatment strategies to improve controls to comply with the risk tolerance for the organisation (i.e. HSP or Department of Health).

For example:

A hospital in the northwest of WA is exposed to tropical cyclones. As part of its risk assessment, the hospital seeks advice from the Bureau of Meteorology, Department of Fire and Emergency Services and local government. The hospital determines a cyclone would likely affect its facility at least once every one to 3 years, ranking the likelihood as 'likely' and is attributed a rating of 4. The hospital assesses a cyclone would likely lead to a medium term suspension of work, ranking the impact as moderate 3. The overall risk of cyclones on the facility is ranked as 4 x 3 = 12 (High).

As cyclones cannot be prevented, the risk treatment focuses on mitigating the impact of a cyclone.

Control strategies for risks may include:

- Infrastructure resilience
- Ensure facilities comply with relevant building codes and regulations to withstand the predicted severity of cyclones
- Develop procedures for rapidly securing and preparing buildings before a cyclone impact
- Supply chain security
- Establish protocols to maintain adequate stock of essential supplies, including linen and critical consumables, particularly during high-risk seasons
- Ensure sufficient portable medical gases and a reliable backup power and water supply
- Develop business continuity plan (BCP) and service resilience to prioritise the resumption of critical services following a disruption
- Implement strategies to sustain operations and ensure continued access to essential medical resources
- Cybersecurity and critical infrastructure protection
- Safeguard critical health information and infrastructure in compliance with the SOCI Act
- Implement robust cybersecurity measures to protect against data breaches and system failures.

Emergency management risk assessments must account for rare, but high-impact events. These events can be underestimated in risk matrices due to their low frequency ratings. WA state hazard plans define a capability baseline that details a credible scenario applied to the respective hazards.

### NSQHSS Patient Safety and Quality Systems

Policies and Procedures 1.07 The health service organisation uses a risk management approach to:

a. set out, review, and maintain the currency and effectiveness of policies, procedures and protocols.
b. Review compliance with legislation, regulation and jurisdictional requirements.

Risk Management 1.10 The health service organisation:

a. identifies and documents organisational risks.
b. uses clinical and other data collections to support risk assessments.
c. acts to reduce risks.
d. regularly reviews and acts to improve the effectiveness of the risk management system.
e. reports on risks to the workforce and consumers.
f. plans for, and manages, internal and external emergencies and disasters.

Incident management systems and open disclosure:

1.11 The health service organisation has organisation-wide incident management and investigation systems:

f. incorporates risks identified in the analysis of incidents into the risk management system.

# 4. Preparedness

Preparedness refers to the activities that are undertaken in preparation for an emergency. Activities include:

- planning
- stakeholder engagement
- education
- training and exercising
- resource management.

## 4.1 Planning

To provide a coordinated and integrated response to an emergency, the WA health system must ensure adequate and contemporaneous planning has been afforded. This planning should be risk-based and align with appropriate local, district, state and Australian requirements.

- **National:** NatHealth Arrangements, Australian Health Protection Committee guidelines
- **State:** State Emergency Management Plan, WA Health Emergency Response Plans, WA Health Emergency Management Arrangements
- **State Health Emergency Response Plan (SHERP):** establishes WA Health's operational framework.
- **Infectious Disease Emergency Management Plan (IDEMP):** guides pandemic and outbreak response
- Respiratory Infectious Disease Emergency Response Plan
- **Heatwave Response Plan:** defines coordinated actions for extreme heat events
- **Local:** site-specific, hospital, facility emergency plans and hazard-specific planning documents.

Planning should be based upon:

- best practice principles
- technical and scientific knowledge
- an evidence-based approach
- local knowledge and experience.

Health service planning requirements are reinforced by National Safety and Quality Health Service Standards and Australian Standards, including:

- AS ISO 31000-2018 – Risk Management – Guidelines
- AS 4083-2010 – Planning for emergencies – Health care facilities
- AS 3745-2010 – Planning for emergencies in facilities
- AS ISO 22301-2020 – Societal security – Business continuity management systems – Requirements
- SA TS ISO 22317:2022 Security and resilience – Business continuity management systems – Guidelines for business impact analysis.

## WA health system emergency planning framework and national integration

The WA health system, through the Director General as System Manager, maintains formal mechanisms for integration with national health emergency arrangements. These mechanisms support seamless coordination with the Australian Government, Department of Health and Aged Care, the Australian Health Protection Principal Committee, the Communicable Diseases Network Australia, the National Critical Care and Trauma Response Centre, and other Commonwealth or jurisdictional agencies as appropriate. Plans and procedures must ensure interoperability with national response frameworks, including the National Health Emergency Response Arrangements (NatHealth Arrangements) and other relevant national plans, to facilitate cross-border assistance, deployment of national resources and cooperation during overseas deployments where WA health resources are engaged.

| WA Health Emergency Planning Framework | | |
|---|---|---|
| | Enablers | Plans |
| **National** | | |
| Health-specific | Australian Health Protection Committee (AHPC)<br>National Health Emergency Management Standing Committee<br>National Critical Care Trauma Response Centre (NCCTRC) | • National Health Emergency Response Arrangements (NatHealth Arrangements) 2011<br>• Australia's Domestic Health Response Plan for All-Hazards Incidents of National Significance (AUSHEALTHRESPLAN) 2021<br>• Domestic Health Response Plan for Chemical, Biological, Radiological or Nuclear Incidents of National Significance (CBRN Plan) 2018<br>• Emergency Response Plan for Communicable Diseases of National Significance (CD Plan) 2016<br>• Australian Health Management Plan for Pandemic Influenza (AHMPPI) 2019 |
| All agencies | National Emergency Management Australia | • Australian Government Disaster Response Plan (COMDISPLAN)<br>• National Response Plan for Mass Casualty Incidents Involving Australians Overseas (OSMASCASPLAN)<br>• Australian Government Overseas Disaster Assistance Plan (AUSASSISTPLAN)<br>• Australian Government Plan for the Reception of Australian Citizens and Approved Foreign Nationals Evacuated from Overseas (AUSRECEPLAN) |

| WA Health Emergency Planning Framework | | |
|---|---|---|
| | Enablers | Plans |
| **State** | | |
| Health-specific | WA Health Emergency Management Committee (WA HEMC) | • WA health system emergency management arrangements (this document)<br>• State Health Emergency Response Plan (SHERP)<br>• Infectious Disease Emergency Management Plan (IDEMP) |
| All agencies | State Emergency Management Committee (SEMC) | • State EM Plan<br>• State Hazard Plans |
| **Regional (District)** | | |
| Health-specific | Health Service Emergency Management Committee | • Regional Health Emergency Response Plan (WACHS only)<br>• Business Continuity Plan<br>• Infectious Disease Emergency Management Plan |
| All agencies | District Emergency Management Committee (DEMC) | • District Emergency Management Arrangements |
| **Local** | | |
| Health-specific | Health service entity emergency management committee | • Emergency Management Plan<br>• Infectious Disease Emergency Management Plan<br>• Business Continuity Plan<br>• Other plans (as based on local risk assessment) |
| All agencies | Local Emergency Management Committee (LEMC) | • Local Emergency Management Arrangements |

## State Plans

### State Emergency Management Plan

The State Emergency Management (EM) Plan is the over-arching, multi-agency plan that outlines the arrangements for preventing, preparing for, responding to and recovering from the prescribed hazards within WA. The State EM Plan is supported by hazard-specific plans (State Hazard Plans).

## State Health Plans

### State Health Emergency Response Plan

The State Health Emergency Response Plan (SHERP) is an all hazards response plan that outlines how WA Health, as a system, fulfils its role as a HMA or combat agency in responding to an emergency or disaster, including dealing with other disruptive events The WA health system should ensure their emergency management plans and arrangements align with the strategies outlined in the SHERP.

By default, the SHERP remains in a standby phase and may be escalated to the response phase by the SHC. The SHERP provides a single response mechanism that is supported by several functional annexes, each outlining a specific response capability:

a. Pre-hospital incident site coordination
b. Health Liaison Officers
c. Health Response Teams
d. Mass casualty aeromedical transport
e. WA Medical Assistance Team (WAMAT) response
f. Surge management
g. Trauma response
h. Burn response
i. Hostile act
j. CBRN/HAZMAT hospital response
k. Environmental health response
l. Management of the deceased
m. Mental health response
n. Media and public information
o. Other Health response considerations
p. WA Blood Supply Contingency Plan
q. Cyber incident.

### Infectious Disease Emergency Management Plan

The Infectious Disease Emergency Management Plan (IDEMP) is an agency-specific plan that outlines how the WA health system prepares for, and will respond to, a declared infectious disease emergency. The IDEMP may be activated in conjunction with, or isolation from, the State Hazard Plan – Human Biosecurity.

Two subplans provide specific considerations in support to the IDEMP, the Respiratory and Infectious Diseases Emergency Response (RIDER) and the Viral Haemorrhagic Fever sub-plan. All HSPs and the DoH should ensure their infectious disease emergency management plans align with the strategies detailed in the IDEMP.

### Regional Health Emergency Management Plan

The WA Country Health Service (WACHS) has articulated roles and responsibilities for developing, documenting and maintaining plans and procedures for emergency management in the WACHS Emergency (Disaster) Management Arrangements Policy.

## Hospital/health service plans

All hospitals (HSPs) and health service entities are required by policy and accreditation bodies to develop, monitor, maintain and test a suite of site-specific plans that detail how the entity manages emergencies. These plans should include:

- an emergency management plan (as based on the appropriate national standards and accreditation guidelines)
- infectious disease emergency management plan
- business continuity plan
- other plans, based on local risk assessment and responsibilities (such as deployment of the health response team)
- escalation triggers and pathways.

### NHSQHHS Risk Management 1.10

The health service organisation:

a. identifies and documents organisational risks
b. uses clinical and other data collections to support risk assessments
c. acts to reduce risks
d. regularly reviews and acts to improve the effectiveness of the risk management system
e. reports on risks to the workforce and consumers
f. plans for, and manages, internal and external emergencies and disasters.

Integrating clinical governance.

The health service organisation 3.02 (g) Plans for public health and pandemic risks

While most plans will address a specific hazard, HSPs must consider the effects of hazards, secondary effects, and protracted durations.

### Emergency management plans

Emergency management plans should be developed, documented, tested and evaluated based on an all-hazards approach. The plan should detail how the health service responds to, and recovers from an emergency.

Hospitals and health care facilities utilise a nationally recognised set of codes to respond to emergencies. These codes are based upon *AS 4083-2010 – Planning for emergencies – Health care facilities* and *AS 3745-2010 – Planning for emergencies in facilities*.

### Business Continuity Plans

A suite of Australian and international standards informs of best practice for emergency management. HSPs in their alignment of National Health Standards to Australian standards should include identification of critical business activities through a business impact assessment (BIA), identification of continuity strategies and resources, development of the BCP, and on-going training, exercising and maintenance of the BCP.

BCPs are to be tested and reviewed. The BIA for each business area, including the DoH, should be reviewed on a regular basis or after any substantial organisational change or restructure. Reference of standards:

- AS/NZS HB 292:2006 A Practitioners Guide to Business Continuity Management
- AS ISO 22301:2020 Security and resilience – Business continuity management systems – Requirements
- AS/NZS ISO 22313:2020 Security and resilience – Business continuity management systems – Guidance on the use of ISO 22301
- SA TS ISO 22331:2022 Security and resilience – Business continuity management systems – Guidelines for business continuity strategy
- SA TS ISO 22332:2022 Security and resilience – Business continuity management systems – Guidelines for developing business continuity plans and procedures.

Appendix C details a checklist to support emergency operations and business continuity plans.

### Hospital Infectious Disease Emergency Management Plans

HSPs are required by policy to ensure infectious disease emergency management plans are developed, documented, reviewed and tested. The plans should align with the IDEMP and focus on the operational aspects of maintaining essential services, preventing nosocomial transmission, and if applicable, responding to a potential surge in demand for services.

The Respiratory Infectious Disease Emergency Response (RIDER) plan supports the IDEMP. The RIDER outlines the approaches that the health system should implement to respond to a respiratory infectious disease emergency event. HSPs should use the IDEMP and RIDER to base their internal infectious disease management plans.

**NHSQHHS 3.14**

The health service organisation has processes to evaluate and respond to infection risks for:

e. novel infections, and risks identified as part of a public health response or pandemic planning.

### Other hazard-specific plans

Using the same risk-based approach, HSPs should develop hazard-specific emergency management plans to prevent or mitigate against foreseen risks. For example, hospitals in cyclone or bushfire prone areas should develop cyclone and bushfire specific emergency management plans.

### Heatwave Response Plan

The Heatwave Response Plan is an internal WA Health plan on how the WA health system will enact its responsibilities as HMA for heatwave. The WA health system should use this plan to develop their operational plan to be enacted during a heatwave.

Emergency management planning and response often requires additional consideration for vulnerable populations, also referred to as high-risk groups.

NSQHSS Diversity and High-Risk Groups

1.15 The health service organisation

b. Identifies groups of patients using its services who are at higher risk of harm.

## 4.2 Stakeholder engagement

The WA health system recognises that all its partner agencies, such as those detailed in SHPs, or agencies that support District/Local Emergency Management Committees, play an integral role in an emergency. HSPs must identify and document key private and community sector partners relevant to their services or regions. HSPs must ensure appropriate representation of these partners in local emergency management planning activities and establish formal protocols for coordination, information sharing and mutual support. These arrangements are to be reflected in local emergency management plans, tested through exercises and reviewed as part of the continuous improvement process. Stakeholders influence plans, policies and procedures. It should be engaged across the entire emergency management continuum to ensure the WA health system can better prevent, prepare for, respond to and recover from an emergency or disaster. Plans for the WA health system are developed through a detailed and relevant consultation process, while state based plans undergo consultation conducted by the State Emergency Management Committee.

## 4.3 Education and training

A targeted and comprehensive emergency management education and training program can provide health staff and allied emergency services with the skills and knowledge to better prepare for and respond to the health consequences of a disaster.

The provision of a statewide education and training program for both metropolitan and regional areas is a shared responsibility between the individual health services and the department.

## Hospitals

Individual health services should develop training programs that:

- identify local training needs based on identified risks in the area of emergency management. For example – chemical decontamination
- facilitate induction and general awareness training to staff
- validate and practice local emergency response plans at an appropriate frequency
- train members of the Incident Management Team and other relevant positions.

## Disaster Preparedness and Management Directorate

Disaster Preparedness and Management Directorate (DPMD) provides the following training and educational services:

- identifies state-level health training needs based on identified risks in the area of emergency management
- conducts state-level exercises that align with the SEMC's State exercising framework (section 4.8 in the State Emergency Management Policy)
- delivers a range of consistent emergency management training for all-of health that cannot be suitably implemented at an individual health service.

For example:

- Major Incident Medical Management and Support (MIMMS) training in the pre-hospital environment (for HRTs – both health commanders and team members).
- Hospital MIMMS (for hospital staff responsible for planning, training and managing aspects of a major incident from a hospital perspective).
- Disaster and executive training, including incident management team (IMT) training.
- Emergo-Train System Instructor Training (useful for staff responsible for facilitating collective training).
- Western Australian Medical Assistance Team (WAMAT) training.
- facilitating specialised 'one-off' training courses, including courses on Chemical, Biological and Radiological courses; emergency radio training; Bombs, Blasts and Bullets.

Additional guidance can be found in the Managing Exercises Handbook.

Further training information can be found at the DPMD website:

For the mobilisation of Health Response Teams (as per Annex C of the SHERP), the following training requirements are recommended:

- Health Commanders of HRT
  - a current MIMMS Advanced Qualification.
- Senior Doctors and Senior Nurses
  - minimum: a current MIMMS Team Qualification
  - preferable: a MIMMS Advanced Qualification.

## 4.4 Disaster equipment and maintenance requirements

Hospitals and health services may be issued with specialised equipment to fulfil their combat agency obligations. This may include, but is not limited to:

- disaster response kits
- communication equipment, including radios and satellite telephones
- personal protective equipment, including HRT uniforms and CBRN/HAZMAT protective suits and respirators
- disaster surge equipment, medical consumables and pharmaceuticals.

Hospitals and health services are required by policy to ensure all disaster response equipment is maintained and in a functional state of readiness at all times.

Equipment owned by the System Manager is to be maintained and in a functional state of readiness at all times and in accordance to applicable standards or product guidelines.

## 4.5 Exercising of emergency management plans

The testing and/or exercising of emergency management plans is critical to ensure the plans are valid, fit-for-purpose, and integrate with the WA health system emergency management arrangements. Exercising of plans is a training opportunity for key stakeholders. Exercising is to consider the emergency management, clinical response elements and business continuity of a disaster. The testing of emergency management plans is required under State Emergency Management Policy, which is issued under the auspices of the EM Act, HSPs and the department are required by policy to regularly exercise their EM arrangements.

Exercises are a critical component of preparedness and assist in a number of facets, including:

- validation of emergency plans and procedures
- exploring issues
- building, enhancing and demonstrating capability
- testing assumptions
- continuous improvement
- promoting awareness
- assessing competence
- identifying gaps
- evaluating equipment, techniques and processes.

In addition to testing emergency management plans, it is essential to assess the clinical management of patients during emergency scenarios. Clinical exercises should evaluate the effectiveness of patient triage, stabilisation, treatment pathways, and transfer protocols under surge conditions. This ensures that healthcare staff can provide timely and appropriate care while operating within the constraints of an emergency response. Such exercises also help to identify gaps in clinical protocols, refine decision-making processes, and test coordination between emergency response teams and health facilities. Regular testing of clinical management approaches supports improved patient outcomes and ensures that the healthcare system is prepared to manage mass casualty incidents, infectious disease outbreaks, and other complex emergencies.

## Types of exercises

Exercises should be conducted on a regular basis with exercise frequency determined on a risk-based approach. For state-level exercises, the Lessons Management and Exercising Reference Group, a SEMC working group, provide oversight of the state's lessons and exercise activities, including the identification of lessons and reporting on the implementation of resultant actions across the emergency management sector.

Exercise styles:

- **Discussion exercise –** a discussion exercise (discex) is a cost effective and efficient exercise method that utilises participant discussion to actively explore issues, assess ideas and build confidence in the use of plans and procedures.
- **Emergency operations centre exercise –** an emergency operations centre (EOC) exercise involves testing the governance structure, communications and decision-making of the Incident Management Team that has overall responsibility for managing an incident at a health service facility.
- **Field exercise –** a field exercise involves the deployment of resources and personnel to a simulated incident or emergency. Teams involved in a field exercise may be required to respond to a pre-determined sequence of events that occur in real time and in collaboration with other partner agencies. Field exercises are resource-intensive and require extensive planning.
- **Drill or simulation –** a drill or simulation involves participants performing their duties using a realistic hypothetical scenario or simulation, such as an Emergo-Train System exercise.
- **Real event –** situation in which the emergency management plan is activated and EOC mobilised due to an actual emergency.

## Post-exercise debriefing and reporting

Following an exercise, debriefing helps to capture lessons learned and identify any opportunities and required changes to plans, procedures and structures. For more information on debriefing, refer to section 6.1. The capture of lessons learned should be shared with HSPs, and DoH via the HEMC and relevant agencies.

A post exercise report provides a synopsis of a hospital or health service's response to an exercise and should be developed using the outputs from the debrief. It is a policy requirement for post-exercise reports to be tabled at the appropriate emergency management committee.

Additional guidance can be found in the Lessons Management Handbook.

# 5. Response

As a provider of an essential service, the WA health system is required to provide the capability and surge to respond to any event that causes or threatens to cause death, injury, destruction or damage to property, or disruption to critical services.

All staff must be competent with the process for notifying the appropriate authorities of an actual or potential emergency and their roles and responsibilities when responding to an emergency.

At the state level, the response to an incident will be assessed based on which type of event the incident is. The types of incident types for response purposes are:

- major incident involving casualties
- business continuity incident following a code yellow that will affect the ability of the HSP(s) to fulfil their obligations
- incident response as per hazard management responsibilities
- public health incident impacting the population/community.

For all types of events, the activation, escalation, notification and incident communication will remain consistent. For business continuity following a Code Yellow, incident management procedures will have additional considerations – see section 5.4.

## 5.1 Activation and escalation of an incident/disruptive event

Emergency response plans should clearly identify who has the responsibility and authority for activating the suite of plans, how and when to activate them, and escalation procedures where appropriate.

Escalation should occur from:

- the HIC to the RHDC when an incident affecting a single WACHS health service or facility is beyond the capacity of that facility and requires assistance and coordination across the region. RHDC then notifies the On Call Duty Officer (OCDO)
- the HIC to the OCDO when an incident affecting a metropolitan hospital or health service entity is beyond the capacity of that facility and requires assistance and coordination across multiple health services
- for other statewide shared services where the incident is beyond the capacity of the region or entity and requires assistance and coordination across the WA health system
- OCDO to SHC.

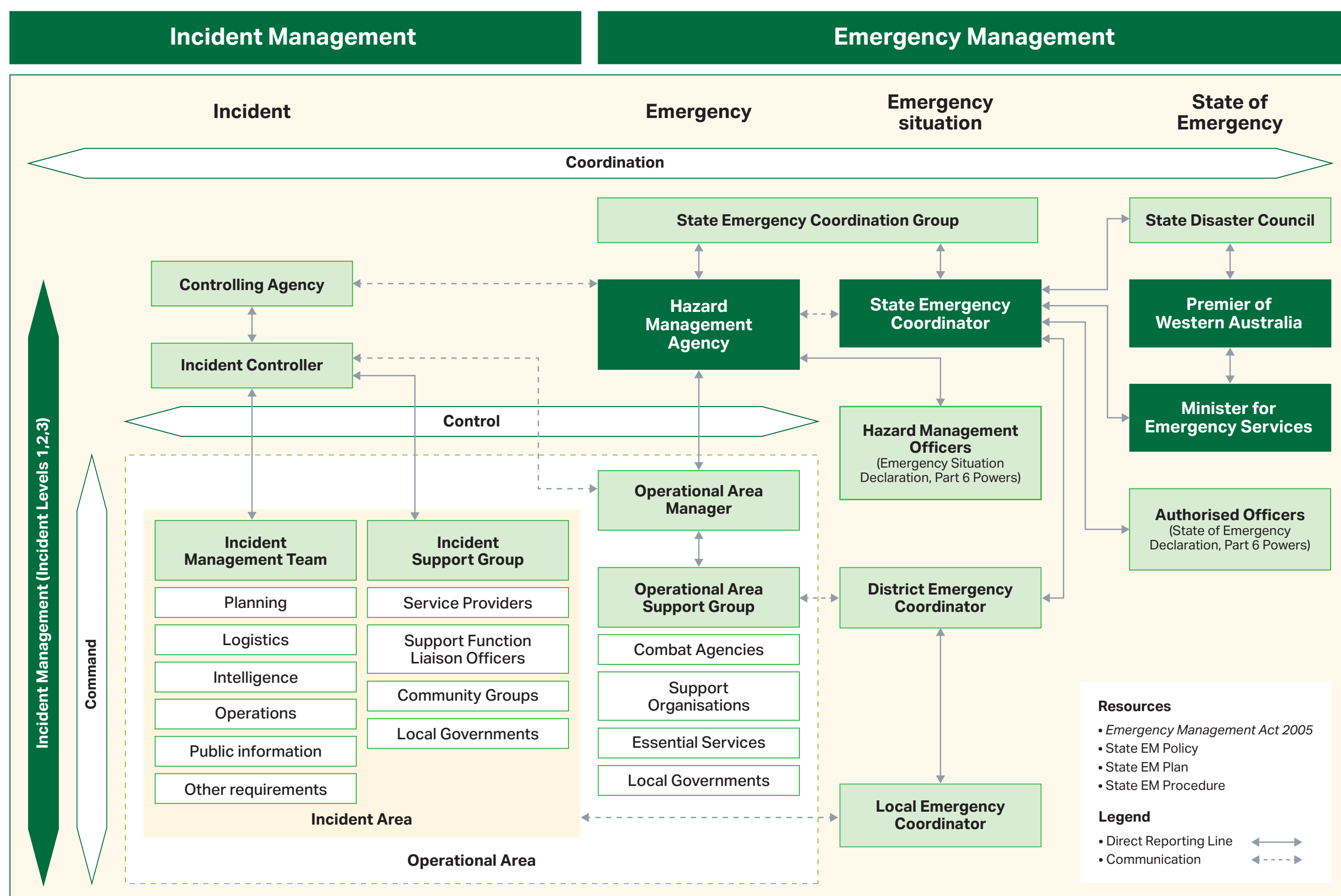
Local plans should involve the notification of the OCDO via free call, 1800 434 122 for incidents that have the potential to deteriorate as a means of working under a ‘no surprises’ and ‘no regrets’ concept. Any significant planned works that would reduce a site’s capacity to respond to a potential incident should be notified prior. The OCDO will work with the affected site and negotiate the best communication plan.

In a large-scale disaster where the capacity of the entire WA health system is exhausted or overwhelmed, the SHC may request assistance from the Australian Government through the appropriate channels.

### External emergencies and state arrangements

For emergencies or incidents that are defined as one of the States 28 prescribed Hazards, the State Emergency Management Plan and the relevant SHP details the roles, responsibilities and incident command structure. Related to hazard specific plans are State Support Plans that could be activated across the hazards, refer to Figure 1 (page 12): Interface between State, WA health system and HSP emergency management legislation, policy and plans.

Importantly and of relevance to the WA Health System EM Arrangements is the response section's detailing of the HMA's Incident Management Structure. Figure 2 details a large-scale emergency for a State of Emergency level declaration. Lower level incident management systems are further described in the State Emergency Plan (section 5 – Response).




### Figure 2: State of Emergency incident management structure

Interfacing with the HMA, the WA health system discharges its role of providing a coordinated health response. Hospitals and relevant DoH Directorates perform their functions through the ISG. HSPs have a functional role that relates at the Operational Area Support Group (OASG) level, noting WACHS would look to aligning their regional representation through the RHDC for the incident. The WA health system coordination is provided under the authority of the SHC and functions to support the HMA. The System Manager will represent the WA health system when state-level coordination or representation is required at All Hazard Liaison Group, State Emergency Coordination Group or State Disaster Council mechanisms.

## 5.2 Notification

### Department of Health

The DPMD – On Call Duty Officer, is the primary point of notification for incidents or as an escalation point. Hospital emergency 'Code' escalation points are to refer to the On Call Duty Officer, where their capacity is exceeded. DoH directorates with an emergency response capability. For example, EHD, CDCD, and SHOC should have plans and processes in place to notify the OCDO of an incident or emergency that may impact or overwhelm the WA health system. Internal processes will ensure communication is escalated and emergency response measures are activated across the WA health system.

The WA health system is often notified of an incident by an external agency, such as St John Ambulance WA. In these circumstances, the person receiving notification should assess the incident and escalate or cascade the issue as necessary using the mentioned processes above.

In an emergency, the primary notification method is any combination of telephone, SMS and email (see section Broadcast messaging system). Once notification has been established, ongoing communication will be established through information and communication technology (ICT) platforms including WebEOC and email, or contingency measures where technology solutions are unavailable. The DPMD on call team, or SHICC incident management processes will undertake the broadcast.

Notification will follow the ETHANE communication to assist in providing a quick synopsis of the emergency or disaster:

- **E** – Exact location of incident
- **T** – Type of hazard
- **H** – Hazards present
- **A** – Access to incident site
- **N** – Number and type of casualties
- **E** – Emergency services present and required.

### State Health Coordinator

The State Health Coordinator (SHC) is to be formally notified of any actual or potential incident or emergency by telephoning 1800 434 122 (On Call Duty Officer – 24 hours).

### Hospital

#### Internal notification

Hospitals should have internal processes in place to notify key personnel of an incident or disaster. These processes should have adequate redundancies, be tested and updated regularly. Such redundancies should include alternative network service providers for phone services.

### External notification

All hospitals are required to have a principal telephone number that can be utilised by the SHICC or RHDC (WACHS) for urgent notification during an incident or disaster. The principal number should:

- be staffed at all times by personnel trained to respond to incident notification calls
- not be changed once the hospital's EOC is activated

Metropolitan hospitals with Emergency Departments (ED) should provide ED priority numbers to the SHICC. This number is used by SHICC to advise of the onset of a critical incident and/or request the preparation for deployment of a HRT to an incident site.

Department of Health (DoH) services with emergency response capability should provide priority numbers to the SHICC to be used by the SHICC to advise of the onset of a critical incident and/or request for response.

## WACHS regions

WACHS regions must have a centralised emergency notification system in place for urgent and emergency notification during an incident or disaster. The number should be staffed at all hours.

## Maintenance

Any changes to emergency notification numbers are to be immediately conveyed to DPMD.

## 5.3 Incident communication

Rapid notification and efficient communication systems within the WA health system are vital to a successful and timely incident response.

### Broadcast messaging system

The department utilises a proprietary messaging system for internal notification purposes. A SMS via mobile phone is often the quickest and most efficient method to distribute early notification of an actual or impending incident. It is also likely to function even if the voice telephony has been compromised. A broadcast message may be sent via email or SMS to pre-designated stakeholders to provide urgent notification of an event. Hospitals and HSPs are strongly encouraged to ensure, at a minimum, the 24-hour contact has a mobile number registered with DPMD. Most HSPs and hospital providers have registered their executive on call along with HIC roles which have proven successful in past incident responses. Communication redundancies should include alternative network service providers for phone services.

The broadcast message will contain a brief message about the incident and a request to join a teleconference, virtual meeting or prompt to log into WebEOC for further information. Hospitals and HSPs are responsible for pro-actively maintaining the currency of their broadcast contacts list with DPMD.

### Notification of the nearest hospital to the incident site

If an incident occurs near a hospital, SHICC may contact the hospital/HSP directly so that incident details can be relayed immediately. This call may precede, but not necessarily replace, the initial broadcast notification.

### Requesting a Health Response Team (HRT)

The SHICC may directly contact a metropolitan hospital emergency department and request they undertake preparation for deployment of a HRT to an incident site. This request may precede, but not necessarily replace, the initial broadcast notification. Once deployed, HRTs report directly to the SHC through the SHICC and not to their hospital of origin.

Regional requests for a HRT will be redirected to the RHDC where the decision maker will follow WACHS decision pathways.

Refer to the SHERP Annex C: Health Response Teams.

### WebEOC

WebEOC is the WA health system's Crisis Information Management System. WebEOC provides secure real-time information sharing during an incident, enabling staff within an EOC to improve coordination of a response. WebEOC is the records management system for disasters and emergencies. The mandatory MP0170/21 Emergency Management Policy prescribes *Where a WebEOC incident has been created, Health Service Providers must ensure that all incident-related information and decisions are entered into the System Manager WebEOC application*. Ideally, real-time updates or as soon as feasible should be maintained.

### Situation reports

The SHC or RHDC (WACHS) may disseminate situation reports (sitreps) via email to relevant stakeholders to inform them of an internal or external incident impact, mitigation strategies in place, taskings and actions to occur. Sitreps may be disseminated directly from the SHC or RHDC or indirectly via the SHICC.

Sitreps contain a summary of the incident with appropriate updates and actions required. Hospital staff requesting to be added to sitrep distribution lists will be directed to the appropriate hospital or regional distribution list owners.

## 5.4 WA Health Emergency Management Committee (response)

The HEMC supports the SHC during business continuity disruptions. The WA HEMC provides strategic advice and direction in concert with the SHC and where required, subject matter experts. For example, Health Support Services (HSS) for Information Technology based incidents.

The WA HEMC would be activated in the following circumstances:

- a failed infrastructure or service at one or more HSP with a prolonged rectification period and that has a significant impact on the WA health system, i.e. following a Code Yellow
- force majeure event from key contracted services
- prolonged and unplanned essential service disruption
- large scale industrial action
- cyber security incident.

When the WA HEMC has been activated, the incident management team in SHICC will plan and operationalise the agreed service recovery strategies.

## 5.5 Incident management

Incident management is the process of commanding and controlling the incident and coordinating resources. The concepts of command, control, and coordination are essential in managing emergencies.

In alignment with the graduated approach as detailed in the State EM policy:

- Decisions should be made at the lowest appropriate level (subsidiarity); however, existing command, control and coordination arrangements apply
- Where emergency management activities extend beyond the capability of the local community, support may be obtained from the district, state, interstate, national or international levels as appropriate.

These concepts apply over the incident and internally within the WA health system.

### Delegation and transition of Incident Controller role

Where the Department of Health is the Hazard Management Agency or Controlling Agency, the appointment of an IC will follow a risk-based approach consistent with the principles of subsidiarity and proportionality. The SHC will assume or delegate the IC function when an incident:

- spans multiple operational areas or health service provider boundaries
- requires significant cross-agency coordination at the state level
- has been declared, or is likely to escalate to, a State of Emergency.

In regional incidents, the SHC may delegate the IC function to the relevant WA Country Health Service Regional Health Disaster Coordinator, ensuring that local knowledge informs operational command. The transition of IC responsibility from regional to system-level command will occur where the scale, complexity or consequence of the incident exceeds regional capacity, or as determined by the SHC in consultation with the Regional Executive Director. Transition arrangements will be documented in the Incident Action Plan and communicated through established command and coordination structures.

The WA health system utilises the principles of the Australasian Inter-service Incident Management System (AIIMS). These principles align with other emergency service providers in WA and training concepts such as Hospital/Major Incident Medical Management. The AIIMS principles are agnostic of the hazard and can readily be applied to human epidemic, heatwave, cybersecurity incidents, disruptive events; or when the WA health system is fulfilling Combat Agency functions.

## Command

Command refers to the vertical line of authority within each agency or organisation. It is exercised by a Commander who has complete authority over resources.

The WA health system's command structure is scalable, proportionate and varies depending upon whether the incident is affecting a local, regional or metropolitan area, or the entire state.

At the local (hospital) level, an appointed HIC has overall command of health resources for the hospital(s) they command.

In WACHS regions, the RHDC has overall command of health resources within their respective region. All HICs report directly to the RHDC. RHDC's report to SHC through SHICC.

Within the metropolitan area, hospitals will liaise with the appointed Health Service Provider (HSP) lead who will act as a conduit to the SHC via the SHICC.

Deployment of resources, including HRTs, can only be authorised by the RHDCs in regional areas, whereas metropolitan HRTs can only be authorised by the SHC.

Specialist skills teams such as Environmental Health will work under a taskforce lead.

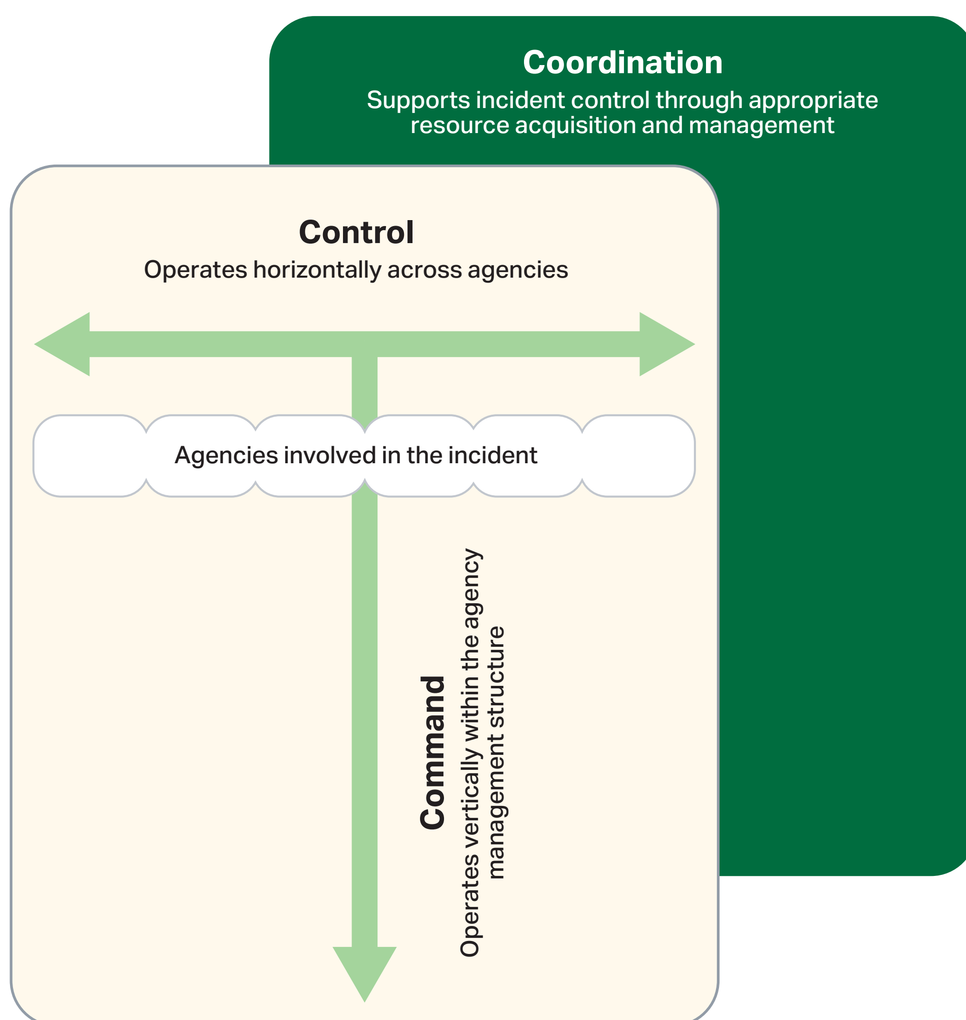
The SHC provides the state-level command of all WA health system resources.

## Control

Control refers to the overall direction of emergency management activities during an emergency. Control operates horizontally across agencies to ensure the overall activities of responding agencies are appropriate to the needs of the incident. In WA, control is supported by legislation where the nature of the hazard dictates which agency has overall control of the incident. This agency is referred to as the CA, and an IC would be appointed to manage and assume overall control of the incident within an incident area and the tasking of agencies in accordance with the needs of the situation.

## Coordination

Coordination refers to bringing together of responding agencies, referred to as combat agencies in the Act, to ensure systematic acquisition and application of resources is achieved. (Figure 3)




(Sourced from Australasian Inter-Service Incident Management System 4th Edition, Australasian Fire and Emergency Services Council 2013).

**Figure 3: Command and Control for an incident**

## 5.6 Incident management system

When responding to an emergency, a scalable incident management system is to be used to provide coordination and control to manage and respond to any emergency. The IMT is the group mobilised in response to an incident. IMT roles are assigned according to specialised skillset requirements. Leadership roles are to be assigned to staff that have completed IMT training. The IMT is responsible for resolving the incident.

An incident management structure is based on the following principles:

- Flexibility
- Unity of command
- Span of control
- Management by objectives
- Functional management.

### Flexibility

Flexibility refers to the ability of an IMT to be applicable to a range of mitigation strategies and respond to changes that evolve during an incident, including the ability to scale up and down.

### Unity of command

Unity of command refers to the need to have a clearly defined set of common objectives and clear lines of command. It recognises that each subordinate should have only one reporting line.

### Span of control

Span of control recognises the size and structure of the IMT should be reflective of the size and complexity of the incident. It also takes into consideration the number of people that can be successfully supervised by one person. The SHICC structure reflects the optimal span of control. EOCs at all levels are to align to this principle.

### Management by objectives

Management by objectives recognises the SHC/HIC/Lead Role, in consultation with the IMT, determines the desired outcomes of the incident. The planning cell within IMTs develops the objectives for the incident.

### Functional management

Functional management is the recognition that a combination of tasks can be grouped together as functions under one cell which can be scaled up or down, depending upon the nature and size of the incident. For small scale incidents, one staff member may be able to perform several functional roles, or some activities may be shared across several cells. Additional IMT functions can be established where there is a requirement to provide a dedicated function for the effective management of the incident.

The IMT structure includes several mandatory, core and additional cellular functions.

### Mandatory functions

- Command.

### Core functions

- Operations
- Planning
- Logistics.

### Additional functions

- Safety
- Intelligence
- Public Information
- Investigation
- Finance
- Liaison Officers.

## Mandatory incident function

### Command

**Role:** has overall responsibility for managing the health service entity and its resources during an incident.

**Responsible for:**
- taking charge and exercising leadership
- setting the incident objectives
- approving the incident action plan.

## Core incident functions

### Planning

**Role:** develops the objectives, strategies and plans for resolution of the incident.

**Responsible for:**
- preparing incident action plans and strategies
- maintaining awareness of all the resources that have been impacted or deployed to the incident
- managing intelligence and public information functions, (unless established as their own separate functional cells).

### Operations

**Role:** implements the incident action plan and managing the operational response at the health site.

**Responsible for:**
- reducing the immediate hazard
- saving lives and property
- establishing situational command
- restoring normal business processes.

### Logistics

**Role:** provide and acquire the human and physical resources required to achieve the incident objectives.

**Responsible for:**
- managing activities and resources necessary to provide local support to the incident.

## Additional incident functions

### Intelligence

**Role:** collects and analyses information or data which is disseminated to support decision-making.

### Public information

**Role:** provides oversight for the development and distribution of public and media information.

**Responsible for:**
- responding to media requests
- social media monitoring and response
- engaging with affected stakeholders
- internal communications to staff.

### Safety

**Role:** supports the incident commander with advice on safety and operational risks.

### Investigation

**Role:** determines the cause of the incident and/or factors that led contributed to the impact of the incident.

### Finance

**Role:** consolidating and tracking costs and expenditure on supplies, equipment and resources that have been utilised for responding to the incident.

This role may also include administrative functions.

### Liaison

**Role:** provide expert advice, commit resources, and enhance communications between services and organisations.

## 5.7 State Health Incident Coordination Centre

An Emergency Operations Centre (EOC) is a capability where the IMT work from to coordinate and manage the incident or disruptive event, be it for a public health emergency, environmental health emergency or HSP disruption. The personnel within the IMT are a combination of emergency management practitioners, subject matter experts and if required, liaison officers from HSPs, DoH staff, specialist skills areas or external agencies. The WA health system EOC is the State Health Incident Coordination Centre (SHICC) and is configured with resources and redundancies that enable the IMT to have systemwide visibility over the incident and to support the gathering of incident and health-related intelligence, command of staff, and resources and liaison with higher levels of command both internal externally to health. Dependant on the hazard, the IMT in the SHICC is led by the SHC, IC or SHICC coordinator.

When the SHICC is activated and there is a patient transfer or capacity objective, the SHOC forms one element of the IMT and provides a centralised platform for the coordination of patient flow, critical care capacity, retrievals and virtual health services during emergencies. SHOC functions as an integral component of the Operations Cell within the SHICC, ensuring that clinical service delivery objectives align with incident management strategies. In addition to its core functions, SHOC coordinates the management of surge capacity, inter-hospital and interstate patient transfers, and supports mass casualty, large-scale public health and cross-jurisdictional incident responses. SHICC also facilitates liaison with Commonwealth counterparts in matters requiring national assistance.

In some circumstances the SHICC is activated for large, planned events.

## 5.8 Emergency Operations Centres

The HSP or hospital EOC is the coordinating hub where the IMT assembles to undertake localised management of the incident. The EOC should be configured to support the gathering of incident and health-related intelligence, command of staff and resources, and liaison with higher levels of WA Health command through the SHICC.

The EOC is to have a direct line of communication with higher and lower levels of command. In regional areas, a Regional Emergency Operations Centre (REOC) may be established to provide regional coordination. Where metropolitan or state-level coordination is required, either the SHICC or Public Health Emergency Operations Centre (PHEOC) is activated, depending on the incident. All hospitals, health care facilities and regions should have a nominated EOC. HSPs may also elect to have a service-wide EOC.

The functional requirements for an EOC should be guided by the following concepts:

- be large enough to accommodate workstations for the required EOC staff
- have redundancy for power, communications (voice and data)
- ready access to refreshment areas and bathroom facilities in the event of a protracted event
- access to monitoring systems that provide intelligence to a planning cell. Examples may include CCTV, site lockdown and access, wireless data access, access to internal paging, integration into existing public address systems
- data projectors/display screens for monitoring key systems and WebEOC
- an alternate location to operate from if the primary location is compromised.

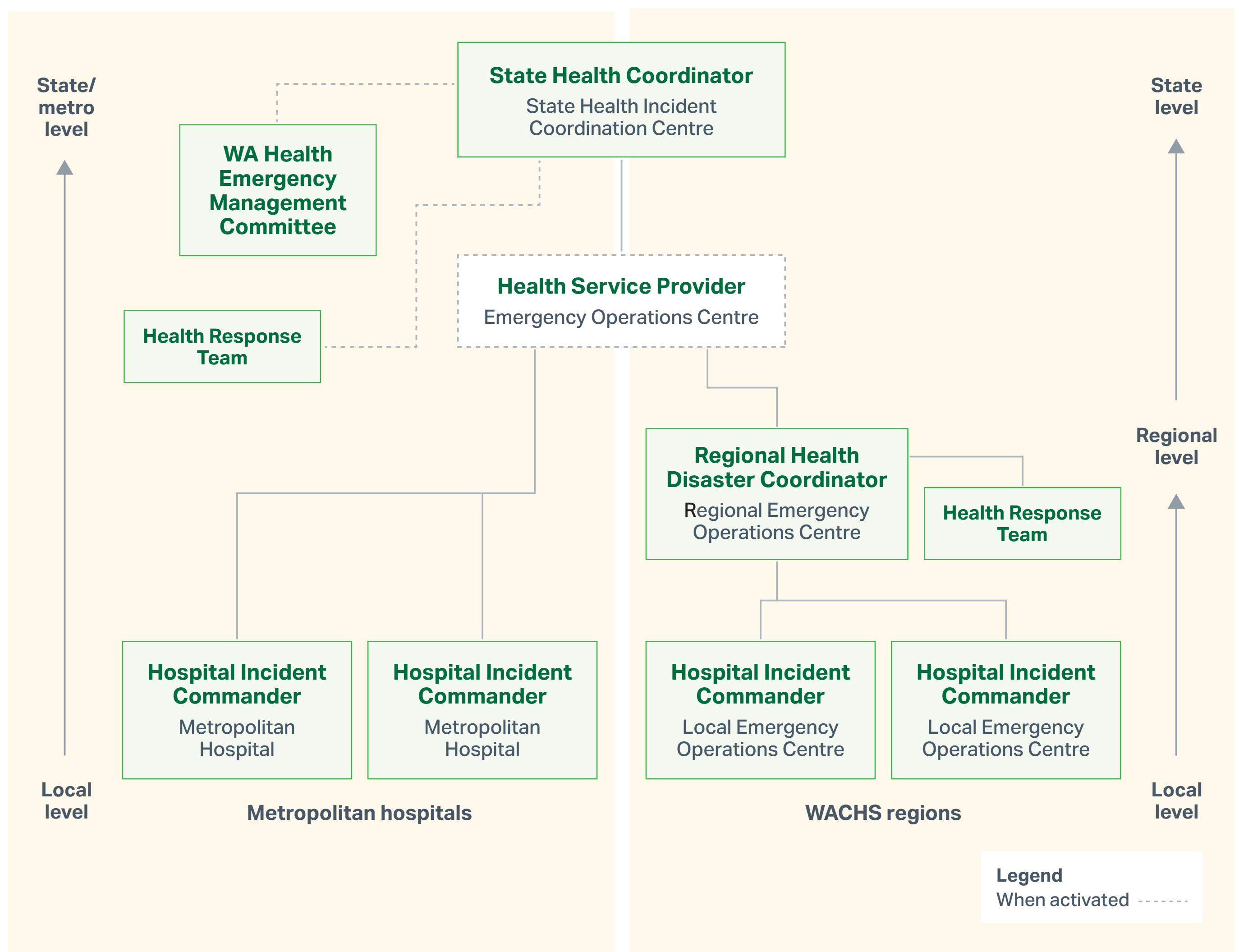



Figure 4: WA HSP emergency management response structure

## 5.9 Incident documentation

### Incident Action Plan

An Incident Action Plan (IAP) should be developed for every emergency. Where an IMT is mobilised, a formal IAP should be documented, developed and communicated to all IMT members and relevant stakeholders. The IAP is iterative and may be revised during an incident to reflect developments and changes in circumstances.

The SMEAC model can be used when developing an IAP:

- **S** – **Situation** – what is the general situation/nature of the incident?
- **M** – **Mission** – what are our objectives?
- **E** – **Execution** – how will we achieve our objectives?
- **A** – **Admin and Logistics** – what logistical and administrative support is required?
- **C** – **Command, Control and Communication** – who is in charge? who reports to who? how and who do we communicate to? when do we escalate?

### Incident log

An incident log should be established at the earliest opportunity. The log is a record of all decisions made, actions taken and communications with appropriate stakeholders when responding to an emergency. The incident log provides a running commentary of the incident and helps to maintain continuity of situational awareness and decision-making. The incident log should be appropriately filed in compliance with the *State Records Act 2000*.

Each log should contain:

- time/date of activity or communication
- person(s) involved
- method of communication (in person, telephone, email)
- detail of decision, action or communication.

WebEOC facilitates an electronic logging of records and a WebEOC incident will be created by the SHICC IMT. Upon creation of a WebEOC incident, all subsequent commentary should be entered and shared appropriately in the Activity Communications Log in the WebEOC system. The use of WebEOC fulfils the compliance with the *State Records Act 2000*.

## 5.10 Financial management

All HSPs and responding department services are to track expenditure and costs incurred relating to an incident. Expenditure should include expenses such as overtime payments, consumables and contractor expenses that are not covered under normal operating budgets. The tracking of incident related expenditure will assist in preparing a case for cost pressures. HMAs may request information on agency expenditure to inform reporting requirements.

In some circumstances, Disaster Recovery Funding Arrangements (DRFA) may be accessed for financial assistance.

## 5.11 Safety and welfare

Responsibility for the safety and welfare of all personnel involved incidents follows normal work practices. Many incidents have the potential for prolonged activations and the area leads should consider fatigue management issues, shift length, access to amenities, ensuring a suitable and safe work environment, and catering.

## 5.12 Media and public information

Intense media and public interest can be anticipated following the impact of an emergency or disaster.

Media coordination during state-level incidents is undertaken by the Public Information Cell within the IMT and staffed by the Department of Health Communications Directorate. Less complex or site-specific incidents should be managed by HSP media coordinators.

## Responsibility

The overall responsibility for responding to media requests and issuing media statements lies with the SHC or the IC. The coordination of media inquiries during an emergency is performed by the Public Information Cell Officer. This cell will specifically coordinate activities at a state level, including:

- providing up-to-date information to media outlets
- responding to media enquiries
- coordinating social media messages
- providing media management and communication assistance to senior staff involved in an emergency
- coordinating community announcements to be disseminated via media outlets
- liaising with public relations staff across the WA health system
- liaising with the minister for health and department of premier and cabinet media offices
- liaising with media and public relations staff from other government and non-government agencies involved in any emergency event (e.g. WA Police Force (WAPOL), Department of Fire and Emergency Services (DFES), St John Ambulance WA (SJWA), Royal Flying Doctor Service (RFDS) Western Operations (WO) etc.)
- ensuring close communication is maintained with key stakeholders throughout the emergency, including via the Public Information Reference Group.

## Media process during an emergency

The SHC is responsible for the provision of emergency public information for the WA health system.

Preparation of media statements, including social media, and coordination of media inquiries during an emergency lies with the Department of Health's Media Manager or nominated delegate.

All media responses and spokespeople must be approved by the SHC or IC.

## Hospital, health service and regional public relations

All official contact, queries with, and comments to the media during a major health crisis is to be directed to the Department of Health media query line and will be managed by the Department of Health's Communications Directorate.

It may be appropriate for selected hospital or health staff to speak to the media, but this should be done in consultation with the Communications Directorate and with the approval of the SHC or IC.

Patient condition reports can be given to the media as per current protocols.

## State Emergency Public Information Management

The SHC/IC, with advice from the Public Information Cell, may request assistance from the State Emergency Public Information Coordinator (SEPIC) to provide additional media relations support for the health emergency management functions if required. This ensures a coordinated messaging strategy is maintained for an incident.

# 6. Recovery

The focus of recovery is to return to a normal state of operations as soon as possible whilst taking into consideration lessons learned from the incident and opportunities to improve plans, procedures and structures.

Following a stand-down of the incident response, the following post-incident and recovery activities should be undertaken:

- Debriefing and post-incident reporting
- Post-incident support
- Recovery of deployed staff and assets
- Replenishment of stock and consumables
- Financial reconciliation and accountability.

The recovery objectives as stated in the State Emergency Management Plan are to:

- assist recovery at a social, built, economic and natural environment level
- ensure that recovery activities are community-led
- ensure that available government and non-government support to affected communities is targeted
- assist communities to rebuild in a way that enhances social, economic and environmental values where possible
- improve resilience of the relevant communities
- ensure that lessons learnt through the recovery process are captured and available to managers of future recovery processes.

Recovery is best undertaken at a local level and may require support and/or representation from the WA health system on recovery committees accordingly. For large or significant incidents, the HMA will require reporting from combat agencies on impacts, observations and actions being undertaken to support recovery activities.

## 6.1 Debriefing and post incident reporting

### Debriefing

Debriefing involves analysing the health system's response to an incident to capture lessons learned and identify any opportunities and changes required to plans, procedures and structures. The lessons identified should be shared widely with other hospitals and health services as a means of best practice. Debriefing also provides an opportunity to advise which staff can access post-incident support if required – See section 6.2.

There are 2 main types of debriefs:

1. **Hot debrief** – a short informal debrief immediately following the incident to capture any feedback, outcomes and actions requiring urgent action. The hot debrief should have a strong focus on the personal welfare of those involved in the response.
2. **Operational debrief** – a formal process that is scheduled no more than three weeks following an incident. The operational debrief should be facilitated by the HIC and include all those involved in the incident plus any other appropriate stakeholder. Where an incident affects more than one health service, the SHC or nominated officer may facilitate the debrief.

An operational debrief should be conducted for all significant and complex incidents. The operational debrief should include the following items:

- Overview of incident
- Timelines of events
- Analysis of what activities worked well, and those that didn't work well. The analysis should address the following elements of capability:
  - people – roles, responsibilities, accountabilities, skills
  - processes – plans, policies, procedures, processes
  - organisation – IMT structure
  - support – infrastructure, facilities, maintenance
  - technology – equipment, systems, standards, security, inter-operability
  - training – capability, qualifications/skill levels, training requirements.
- Identification of lessons learned (lessons may need to be risk-assessed to determine the priority for action)
- Identification of actions required.

The outputs from the operational debrief should be incorporated into a post-incident report.

### Post-incident reporting

The post-incident report provides a synopsis of a hospital, health services or system manager's response to an emergency. It should be developed using the outputs from the operational debrief. The post-incident report should be tabled at the emergency management committee (however titled) for the hospital or health service and via the appropriate representative to the WA HEMC. Learnings and lessons shared across the health sector will ensure resilience is enhanced for future hazards.

## 6.2 Impact statement

Level 2 incidents as prescribed by the HMA will require the completion of an Impact Statement – a requirement that supports the recovery process and post-incident reporting. The State Emergency Management Procedure provides direction on completion of Impact Statements. Agencies are requested to submit a single impact statement. The HSPs and System Manager co-author the impact statement with final submission endorsed by the SHC.

## 6.3 Post-incident support

The department and HSPs recognise that following or during an incident or disaster, employees may encounter extraordinary situations that can have an adverse effect on their health and wellbeing.

The department and HSPs offer Employee Assistance Programs (EAPs) that allow free access to independent and confidential counselling services.

More information on EAPs can be obtained from the appropriate human resources department and through Healthpoint – Employee Assistance Program (internal site).

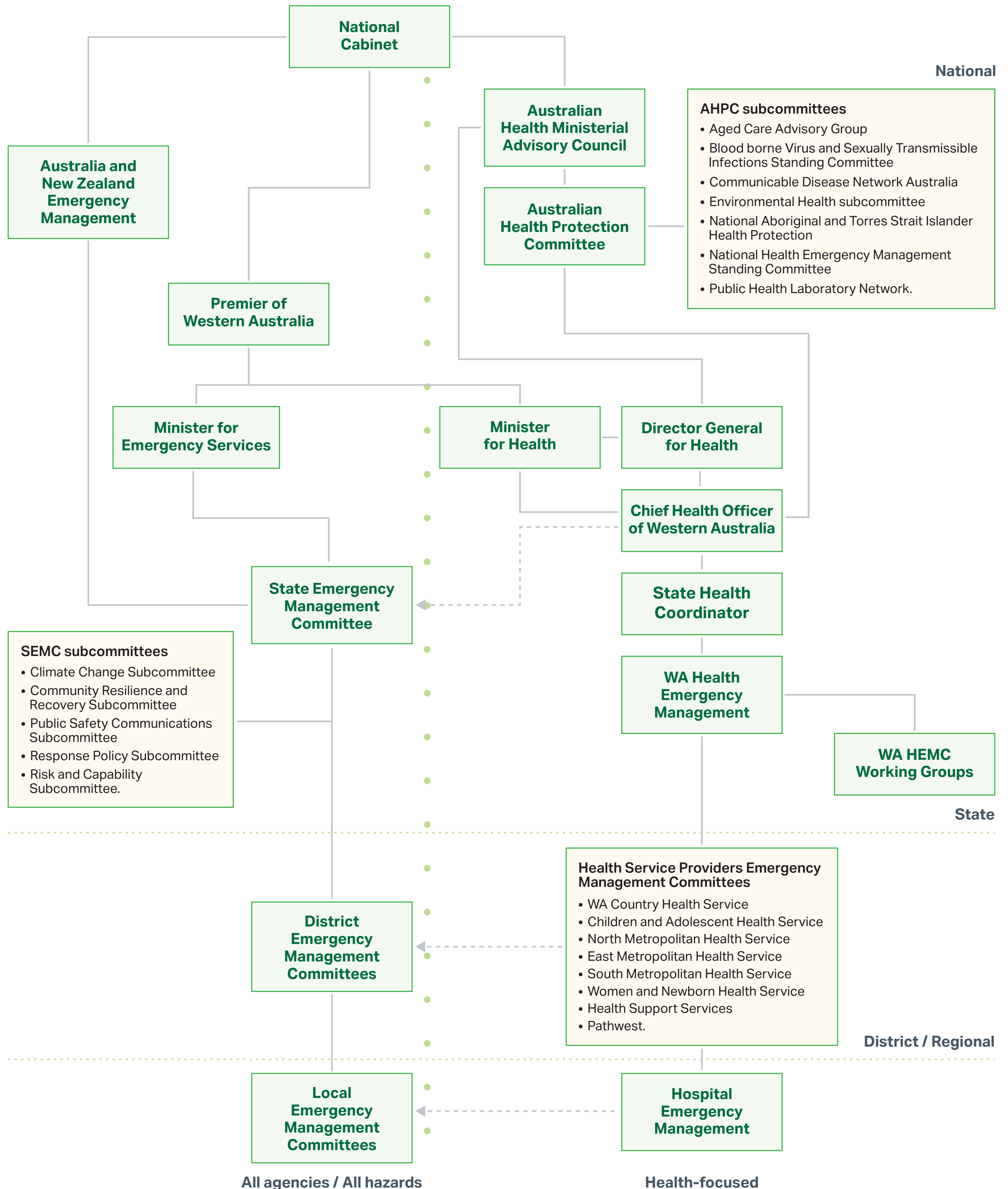
## 6.4 Financial reconciliation and accountability

Depending upon the nature of the incident, some expenses incurred from responding to an incident (not including normal operational costs), may qualify for disaster relief and recovery funding. To qualify for funding, detailed records of expenditure must be maintained.

Entities should not assume that all costs will be reimbursed and may need to include these costs as a cost pressure with their finance managers.

# Appendix A:

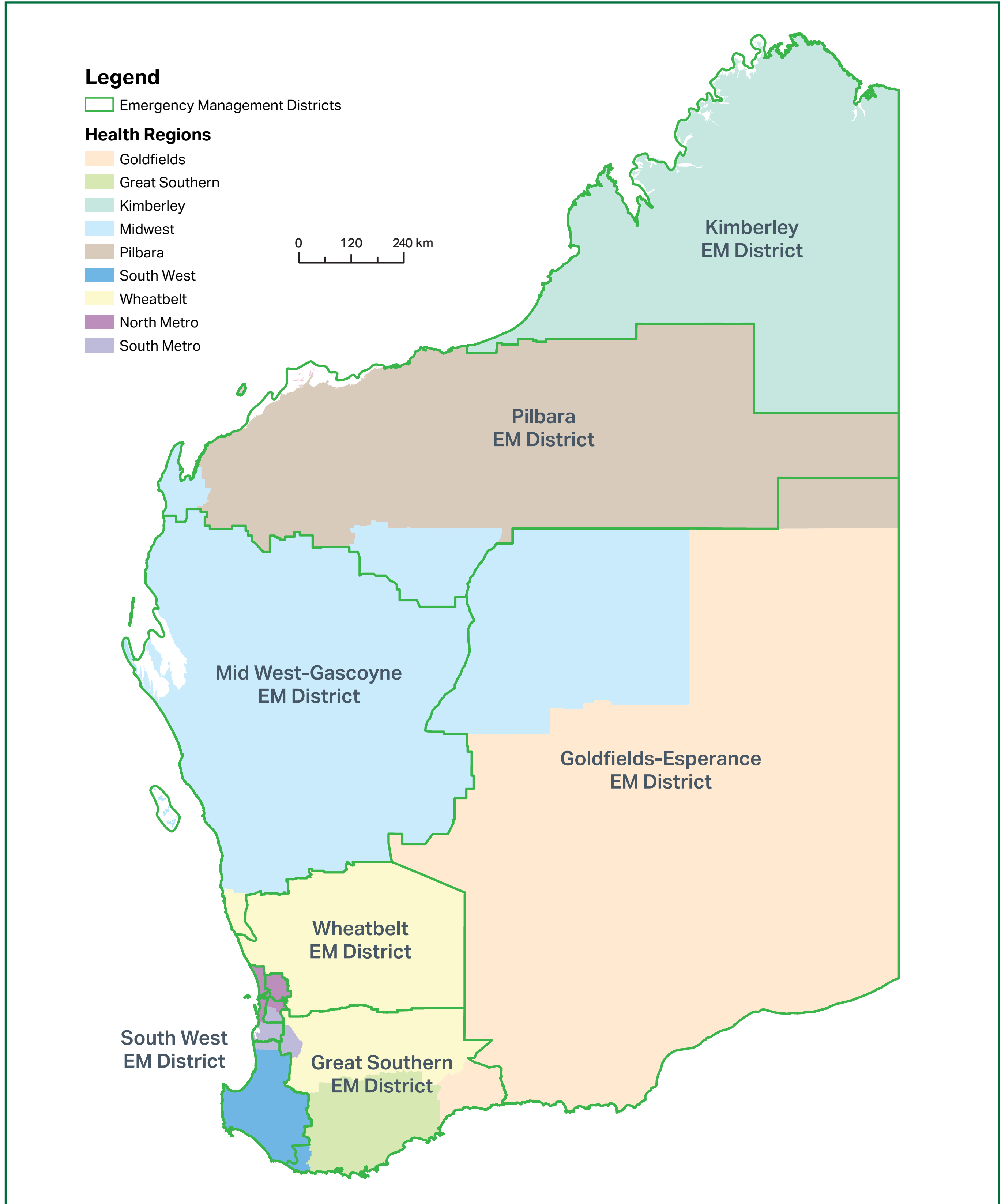
## Local, district, state, and national emergency management governance structures



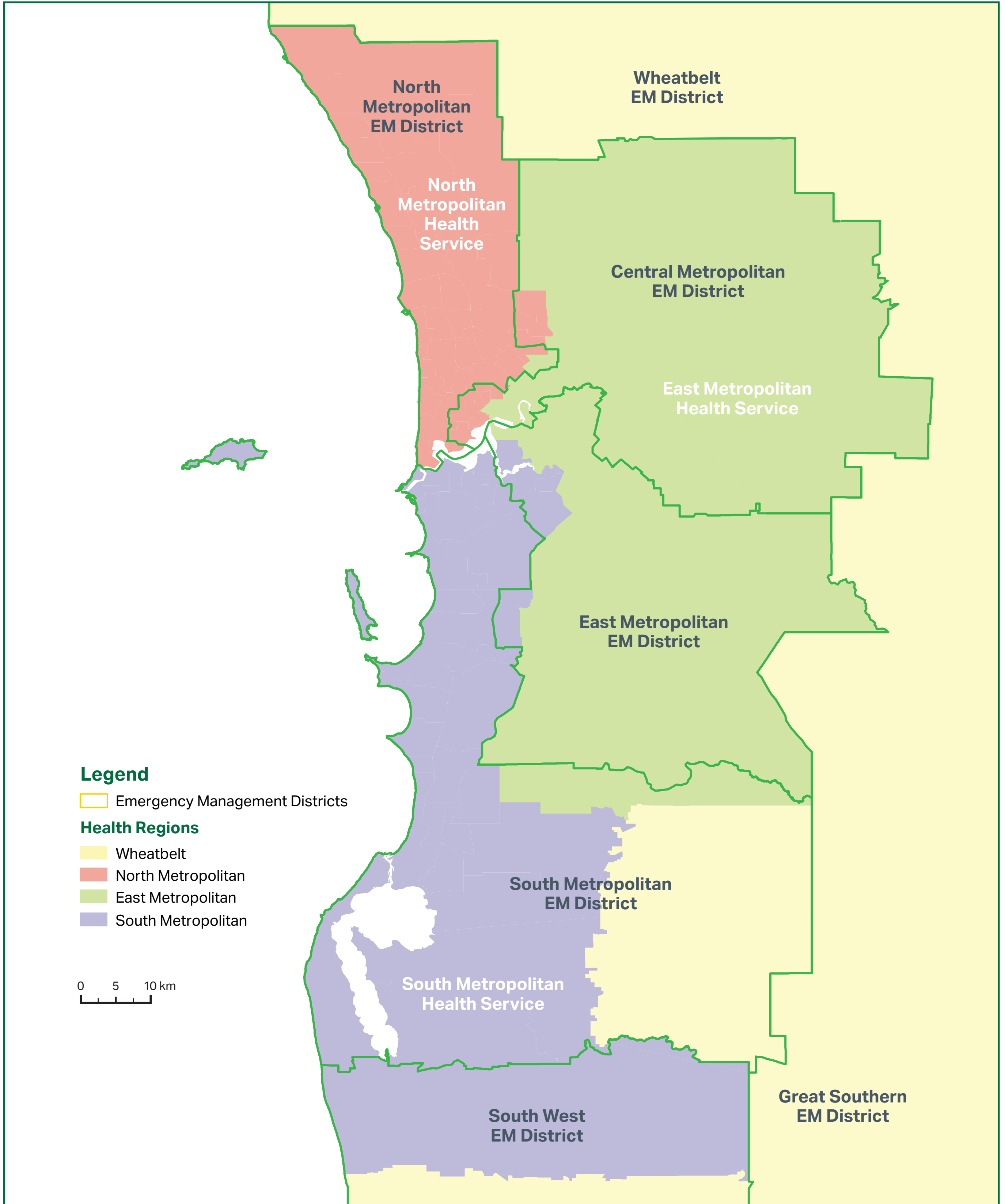
# Appendix B:

## DEMC boundaries and representation

### WACHS health regions with district emergency management boundaries overlaid



## Metropolitan health regions with district emergency management boundaries overlaid



# Appendix C:

## Checklist to support development of emergency operations and business continuity plans

- ☐ Hazard and threat analysis summary
- ☐ Concept of operations
- ☐ Organisation and assignment of responsibilities (key functions)
- ☐ Command, control, and coordination
- ☐ Information collection, analysis and dissemination
- ☐ Communications
- ☐ Administration, record keeping and finance
- ☐ Logistics
- ☐ Plan development and maintenance
- ☐ Authorities and references.

**Functional annexes** (not an exhaustive list):

- ☐ Communications
- ☐ Continuity
- ☐ Direction, control, coordination
- ☐ Energy and power
- ☐ Financial management
- ☐ Firefighting
- ☐ HAZMAT
- ☐ Law enforcement, public safety and security
- ☐ Logistics and resource management
- ☐ Mutual aid, memoranda of understanding, across boundaries coordination
- ☐ Private sector coordination
- ☐ Protective actions during hospital evacuation
- ☐ Public alert and warnings
- ☐ Public health and medical services (adults, children, other vulnerable categories)
- ☐ Management of the deceased
- ☐ Mass casualty incidents
- ☐ Public information
- ☐ Public works and engineering / infrastructure restoration
- ☐ Recovery
- ☐ Search and rescue
- ☐ Transportation
- ☐ Volunteer and donations management
- ☐ Work health and safety.

# Appendix D:

## Glossary

The following table provides a list of terminology, acronyms (abbreviations) and definitions.

| Name | Acronym | Definition |
|---|---|---|
| **Australian Medical Assistance Team** | AUSMAT | An official Australian Government multidisciplinary healthcare team deployed in response to national or international disasters where assistance is requested by the impacted government. |
| **Business Continuity Plan** | BCP | A plan that outlines the actions to be taken and resources to be used before, during and after a disruptive event to ensure the timely resumption of critical business activities and long term recovery of the organisation. |
| The Department of Health as a **Controlling Agency** | – | An agency nominated to control the response activities to a specified type of emergency. The responsibility for being a Controlling Agency stems from the EM Act. |
| **Disaster** | – | A serious disruption to community life which threatens or causes death or injury in that community and damage to property which is beyond the day-to-day capacity of the prescribed statutory authorities, and which requires special mobilisation and organisation or resources other than those normally available to those authorities. |
| **Emergency** | – | An event, actual or imminent, which endangers or threatens to endanger life, property or the environment, and which requires a significant and coordinated response. |
| **Emergency Operations Centre** | EOC | A facility established to control and coordinate the response and support to an incident or emergency. Also see Local Emergency Operations Centre (LEOC). |
| **Emergency Response Team** | ERT | A team deployed in the initial stages of an incident to assess, coordinate, and where necessary, escalate the incident to the Incident Management Team. |
| **Health Response Team** | HRT | A deployable team that can be sent to an incident site to augment the pre-hospital response or to provide specialist procedures and advice. |
| **Hospital Incident Commander** | HIC | A senior staff member that has authority for the coordination of all hospital staff and resources during an incident or emergency. (Within WACHS, the HIC was formerly known as the Local Health Disaster Coordinator or LHDC). |
| **Health Service Provider** | HSP | A statutory body, as defined under section 32 of the *Health Services Act 2016*. |

| Name | Acronym | Definition |
|---|---|---|
| **Incident Action Plan** | IAP | A statement of objectives and strategies to be taken to control an incident, and approved by the Hospital Incident Commander. |
| **Incident Management** | – | The process of controlling the incident and coordinating resources. |
| **Incident Management Team** | IMT | A scalable and flexible team of personnel, commanded by the Hospital Incident Commander that makes decisions and coordinates actions to resolve an emergency or incident. |
| **Liaison Officer** | – | An individual allocated to an incident from an assisting agency, or HSP and who has been delegated full authority to make decisions on all matters affecting that agency's/ HSP participation at the incident. |
| **Operational Area Support Group** | OASG | A group of agency / organisation liaison officers convened by the operational area manager/HMA. The HMA may activate an OASG to provide strategic support to the emergency response, when multiple agencies need to be coordinated at a district (regional) level or multiple incidents are occurring simultaneously within one operational area. |
| **Public Health Emergency Operations Centre** | PHEOC | The State-level operations centre that coordinates the public health response to an infectious disease emergency. |
| **Regional Emergency Operations Centre** | REOC | A regional level facility established to provide coordination across a WA Country Health Service region during an incident or emergency. |
| **Regional Health Disaster Coordinator** | RHDC | A designated senior staff member who has the authority to command and coordinate the use of all resources with a WA Country Health Service region during an incident. |
| **State Emergency Coordinator** | SEC | A statutory position under section 10 of the *Emergency Management Act 2005*. The Commissioner of Police is the State Emergency Coordinator and is responsible for coordinating the response to an emergency during a state of emergency. |
| **State Emergency Coordination Group** | SECG | A strategic multi-agency group chaired by the State Emergency Coordinator that provides strategic advice and direction on emergency management to the public, emergency management agencies and the Minister for Emergency Services. |
| **State Emergency Management Committee** | SEMC | The peak multi-agency emergency management committee in Western Australia, established under section 13 of the *Emergency Management Act 2005*. |

| Name | Acronym | Definition |
|---|---|---|
| **State Emergency Management Plan** | State EM Plan | An overarching multi-agency plan prepared under Section 18 of the *Emergency Management Act 2005* to outline the State arrangements for the emergency management of hazards and support functions. |
| **State Health Emergency Response Plan** | SHERP | The state-level plan that outlines how the WA health system provides a scalable, proportionate whole-of-agency response, with appropriate and timely interventions and allocation of resources, to minimise the health consequences of a disaster or emergency. |
| **State Health Coordinator** | SHC | Pursuant to section 24 of the HS Act 2016, the role of the Director General (DG) has delegated powers to persons occupying the role of the State Health Coordinator to direct any WA health entity to undertake certain functions for the purposes of preventing, preparing for, responding to and recovering from emergencies, disasters, and other disruptive events. The SHC reports directly to the DG. |
| **State Health Incident Coordination Centre** | SHICC | The state-level emergency operations centre that facilitates command, control and coordination as required across the entire WA health system during an incident or emergency. |
| **State Health Operations Centre** | SHOC | The state-level operations centre that facilitates patient flow and a suite of virtual care services. |
| **Situation Report** | Sitrep | A brief report that is published and updated periodically during an emergency which outlines the details of the emergency, the needs generated and the responses undertaken as they become known. |
| **System Manager** | – | Under Section 19 of the HS Act, the System Manager is defined as having the role of:<br>• Managing the WA health system to the extent necessary to provide stewardship, strategic leadership and direction, and to allocate resources for the provision of public health services in the State. |
| **WA Health Emergency Management Committee** | WA HEMC | The peak emergency management body for the WA health system, which is chaired by the Assistant Director General Public and Aboriginal Health Division/Chief Health Officer. |
| **WA health system** | – | Western Australia's public health care system which comprises of:<br>• The Department of Health (the system manager)<br>• Health Service Providers (HS Act)<br>• Contracted health entities. |
| **Western Australian Medical Assistance Teams** | WAMAT | State-based medical assistance team with self-sustaining field deployment capabilities, that can be deployed in response to incidents across Western Australia. |

# Appendix E:

## Responsible, Accountable, Consulted, Informed (RACI) matrix

| Function/Activity | Responsible (R) | Accountable (A) | Consulted (C) | Informed (I) |
|---|---|---|---|---|
| **System-level governance of health EM arrangements** | WA Health Emergency Management Committee (HEMC) | Director General (System Manager) | Assistant Director General Public and Aboriginal Health / CHO; HSP Chief Executives; DPMD | SEMC; Minister for Health |
| **Development of system-wide EM policy and frameworks** | Disaster Preparedness and Management Directorate (DPMD) | Director General (System Manager) | HSPs; EHD; CDCD; SHOC; Health Support Services; private sector partners | HEMC; SEMC subcommittees |
| **Incident Control (HMA hazards)** | Incident Controller (IC) appointed by SHC | SHC | HSPs; relevant Directorates (DPMD, CDCD, EHD) | DoH executives; SECG; Minister for Health |
| **Activation of SHICC** | SHC / SHICC Coordinator | SHC | IC; HSP Lead; DPMD | SEMC (via SECG); HSPs |
| **Activation of HSP or facility EOC** | Hospital Incident Commander (HIC) / HSP Lead | HSP Chief Executive | SHC / SHICC; Regional Health Disaster Coordinator (WACHS) | Facility executives; SHICC |
| **Development of HSP emergency plans** | HSP Emergency Management Committee / HSP Lead | HSP Chief Executive | DPMD; local DEMC; LEMC; private providers | SHC; HEMC |
| **Operational response to local incidents** | Hospital Incident Commander (HIC) / Regional Health Disaster Coordinator (WACHS) | HSP Chief Executive | SHC / SHICC; local ISG / OASG | HSP Board; community stakeholders |

| Function/Activity | Responsible (R) | Accountable (A) | Consulted (C) | Informed (I) |
|---|---|---|---|---|
| **Public health response (e.g. epidemic control)** | CDCD; Public Health Units (PHU) | CHO | SHC; SHICC; HSPs; national agencies (for example, CDNA) | HEMC; SECG |
| **Environmental health emergency response** | EHD | CHO | SHC; SHICC; local government EHOs; LEMC | HEMC; SECG |
| **Patient flow coordination during emergencies** | SHOC | SHC | HSP Lead; DPMD; retrieval services | SHICC; SECG |
| **Risk assessments and mitigation planning** | HSP Emergency Management Committees | HSP Chief Executive | DPMD; local DEMC; relevant DoH Directorates | SHC; HEMC |
| **Training and exercising** | DPMD (state level); HSPs (local level) | Director General (System Manager) / HSP Chief Executive | HEMC; SEMC exercising groups; other agencies | All WA health staff; external partners where relevant |
| **Communication with public / media during emergencies** | DoH Communications Directorate / Public Information Cell | SHC / IC | Minister for Health Office; HSP media leads | All stakeholders; community |

Further definitions are available in the State Emergency Management Glossary.

This document can be made available in alternative formats on request.

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