Policy Directive

NSW Health Incident Coordination Framework

Summary This Policy Directive sets forth a strategic framework of the governance arrangements used by NSW Health to coordinate responses to a range of hazards. It also explains how these arrangements and their associated plans align. Incidents may be coordinated locally or at a state level, and the Policy Directive describes the circumstances according to which each may be considered. Section 8 identifies key responsibilities of local health districts, specialty networks and other Health organisations to support incident response.

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Corporate Administration - Communications, Governance
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Applies to Ministry of Health, Public Health Units, Local Health Districts, Board Governed Statutory Health Corporations, Chief Executive Governed Statutory Health Corporations, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, NSW Health Pathology, Public Health System Support Division, Cancer Institute, NSW Ambulance Service

Distributed to Ministry of Health, Public Health System, NSW Ambulance Service

Audience Chief Executive;Executive and Administration;Emergency Departments and all staff involved in Health Emergency Management

NSW Health Incident Coordination Framework

PURPOSE

The purpose of this Policy Directive is to:

- Provide an overview of governance arrangements used to coordinate responses to a range of hazards (sections 3 and 6)

- Demonstrate how these arrangements and their associated plans align (sections 3 and 6)

- Identify key strategic responsibilities of local health districts, speciality networks and other relevant Health organisations to support incident response (section 8)

- Identify the purpose of central coordination (section 9)

- Set forth criteria for determining whether a response is best managed locally or at a state level (section 9)

This document presents a strategic framework, and complements existing related policy directives, such as *NSW HEALTHPLAN* or the *NSW Health Influenza Pandemic Plan.*

MANDATORY REQUIREMENTS

Chief Executives are accountable for incident prevention (where possible), preparedness, response and recovery for their services.

Section 8 outlines incident management responsibilities of Chief Executives of local health districts, specialty networks and other Health organisations (as defined in the Policy Directive). Appendix 1 contains a preparedness checklist to support Health services self-assess compliance with these requirements.

IMPLEMENTATION

Chief Executives of local health districts, specialty networks and other Health organisations are responsible for implementing the requirements identified in section 8.

Health services will report on compliance with these requirements as requested by the Ministry.

REVISION HISTORY

Version	Approved by	Amendment notes
June 2019 (PD2019_023)	Secretary, NSW Health	New policy directive

ATTACHMENTS

1. NSW Health Incident Coordination Framework: Procedures.

NSW Health Incident Coordination Framework

NSW Health
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CONTENTS

1   INTRODUCTION

Many hazard types can impact adversely on public health or health system performance.

These include but are not limited to:
- Natural disaster
- Mass casualty (eg: major transport accidents, explosions)
- Major infrastructure disruption
- Terrorist incident (resulting hazard types may include mass casualty, major health protection incident etc.)
- Pandemic, or other major emerging/re-emerging respiratory illness (eg: Sudden Acute Respiratory Syndrome, or SARS)
- Acute medicine shortage/contamination or medical device issue with potential patient safety impact
- Critical information, communication and technology (ICT) failure
- Other major health protection incident (eg: cases of viral haemorrhagic fever, environmental health hazards such as an industrial chemical incident affecting a nearby community or contamination of a drinking water supply)

NSW Health coordinates preparation for and response to incidents and emergencies arising from these hazards through a range of governance channels.

The intentional use of multiple channels occurs for two main reasons:

1) We build on our model of resilience through strengthening business-as-usual practices, such as improved NSW Health services' self-reliance and leveraging existing arrangements with partner agencies (eg: Therapeutic Goods Administration during a major medical device incident or Sydney Catchment Authority during a drinking water incident); and

2) Risk is prepared for and informed by those with specific expertise (eg: hospital incident response, information technology, infectious disease).

2 PURPOSE

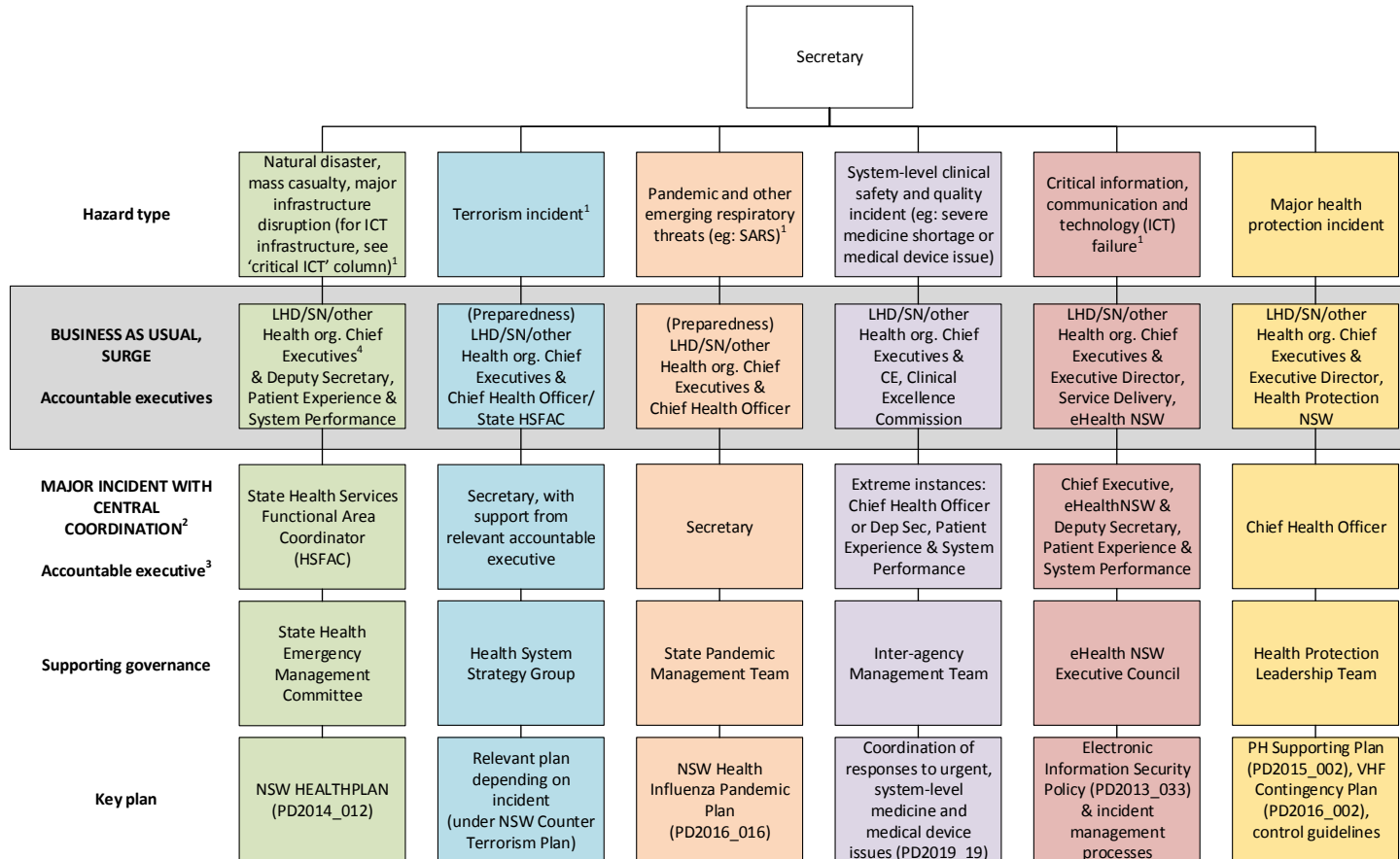The purpose of this Policy Directive is to:

- Provide an overview of governance arrangements used to coordinate responses to a range of hazards (sections 3 and 6)

- Demonstrate how these arrangements and their associated plans align (sections 3 and 6)

- Identify key strategic responsibilities of local health districts (LHDs), speciality networks (SNs) and other relevant Health organisations[1] to support incident[2] response (section 8)

- Identify the purpose of central coordination (section 9)

- Set forth criteria for determining whether a response is best managed locally or at a state level (section 9)

This document presents a strategic framework, and complements existing related Policy Directives, such as *NSW HEALTHPLAN* or the *NSW Health Influenza Pandemic Plan*.

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[1] Other Health organisations: St Vincent's Health Network, NSW Health Pathology, eHealth NSW, NSW Ambulance and HealthShare NSW
[2] Note: in this Policy Directive, the term 'incident' is used generally and indicates an occurrence beyond business-as-usual that requires either a local or centrally coordinated response.

3   FRAMEWORK FOR COORDINATED INCIDENT RESPONSE

Secretary

	Natural disaster, mass casualty, major infrastructure disruption (for ICT infrastructure, see 'critical ICT' column)[1]	Terrorism incident[1]	Pandemic and other emerging respiratory threats (eg: SARS)[1]	System-level clinical safety and quality incident (eg: severe medicine shortage or medical device issue)	Critical information, communication and technology (ICT) failure[1]	Major health protection incident
Hazard type						
BUSINESS AS USUAL, SURGE **Accountable executives**	LHD/SN/other Health org. Chief Executives[4] & Deputy Secretary, Patient Experience & System Performance	(Preparedness) LHD/SN/other Health org. Chief Executives & Chief Health Officer/ State HSFAC	(Preparedness) LHD/SN/other Health org. Chief Executives & Chief Health Officer	LHD/SN/other Health org. Chief Executives & CE, Clinical Excellence Commission	LHD/SN/other Health org. Chief Executives & Executive Director, Service Delivery, eHealth NSW	LHD/SN/other Health org. Chief Executives & Executive Director, Health Protection NSW
MAJOR INCIDENT WITH CENTRAL COORDINATION[2] **Accountable executive[3]**	State Health Services Functional Area Coordinator (HSFAC)	Secretary, with support from relevant accountable executive	Secretary	Extreme instances: Chief Health Officer or Dep Sec, Patient Experience & System Performance	Chief Executive, eHealthNSW & Deputy Secretary, Patient Experience & System Performance	Chief Health Officer
Supporting governance	State Health Emergency Management Committee	Health System Strategy Group	State Pandemic Management Team	Inter-agency Management Team	eHealth NSW Executive Council	Health Protection Leadership Team
Key plan	NSW HEALTHPLAN (PD2014_012)	Relevant plan depending on incident (under NSW Counter Terrorism Plan)	NSW Health Influenza Pandemic Plan (PD2016_016)	Coordination of responses to urgent, system-level medicine and medical device issues (PD2019_19)	Electronic Information Security Policy (PD2013_033) & incident management processes	PH Supporting Plan (PD2015_002), VHF Contingency Plan (PD2016_002), control guidelines

[1] Incidents of these sorts are likely to require statewide whole-of-government coordination. This is possible, but less likely, for other identified hazards.
[2] See section 9 for a description of factors that may trigger central coordination.
[3] Regardless of whether or not central coordination is implemented, Chief Executives remain responsible for service delivery within their service.
[4] Local health district, specialty network and other Health organisation Chief Executives

4   NOTIFICATION AND ESCALATION

Incidents occur on a spectrum ranging from those that can be managed with 'business-as-usual' processes to those requiring a fully coordinated response, either locally or centrally (ie: at the state level).

Movement along this spectrum may not be linear and incidents may progress up and down the spectrum as dictated by changing circumstances and risk assessments. There will be appropriate exceptions to what is summarised by the below figure.

Understanding the phases of a response and where the control and coordination resides at any point in time is critical to the successful management of any type of incident, for both locally and centrally coordinated responses.

A transition to central coordination may occur at any point beyond normal business operations. This transition must involve a very clear handover to ensure a shared understanding of who is leading the response.

It is important to recognise that situations where neither business continuity nor emergency management arrangements are required (for instance, state-level coordination of a severe medicine shortage or a widespread measles outbreak) may still be transitioned to central coordination. Section 9 describes the factors leading to a response being coordinated centrally.

	Normal business operations	**Surge** **(provide more of)**	**Business continuity plan activation** **(focus on essential services)**	**Emergency management (disaster)** **(alternative ways of providing essential services)**
Objective	Provide normal services	Provide normal services	Provide essential services	Use alternate ways of providing essential services
Likely coordination level (indication only)	Local	Local or central	Local or central	Local or central

Increasing coordination/centralisation of decision-making as incident progresses along the spectrum

For the purposes of this document,

'Local' refers to:
- Local health districts

- Specialty networks (Sydney Children's Hospitals Network, Justice Health and Forensic Mental Health Network)
- Affiliated health organisations (St Vincent's Health Network)
- Services provided by NSW Health Pathology and HealthShare NSW

'Central' (ie: state) refers to:
- Ministry of Health
- State Health Services Functional Area Coordinator

To the greatest extent practicable, the expectations set forth in this document apply to all local health districts/speciality networks/other Health organisations. In some instances, reasonable adjustment (eg: different thresholds for escalation) by rural Health services may be necessary to ensure the most effective response.

The responsibilities outlined in section 8 apply to all local health districts, specialty networks and other Health organisations.

5   LOCALLY COORDINATED INCIDENTS

The majority of incidents will be coordinated locally through usual operational channels.

Surge, business continuity and emergency management plans may be activated as needed for incidents which require local or central coordination.

Some incidents, despite being locally coordinated, will also require frequent reporting via the Ministry to the Minister's Office due to their high profile or sensitive nature (see section 9). Following a rapid assessment, the Ministry will provide clear guidance on what information is required, and how frequently.

6   STATE-LEVEL COORDINATION ARRANGEMENTS

Overall accountability for incident preparedness and response rests with the Health Secretary.

In most instances, the Secretary delegates this responsibility to a corresponding accountable executive.

Two notable exceptions would be during the acute response phase of a terrorist incident or a pandemic. In these scenarios, the Secretary maintains the key response leadership role.

The Health System Strategy Group (Secretary, Deputy Secretaries and Chief Executives of pillar organisations, NSW Ambulance and eHealth NSW) will conduct an annual discussion exercise to test knowledge and functionality of governance arrangements for a pandemic or terrorist incident.

Incidents may be of such seriousness as to require a significant and centrally coordinated response across different government agencies under the *State Emergency and Rescue Management Act* and the *NSW Emergency Management Plan* (*EMPLAN*). When this occurs, Health's default position would be coordination through the State HSFAC (noting pandemic and terrorism response are examples of exceptions).

6.1   Natural disaster, mass casualties and major infrastructure disruptions

The State Health Services Functional Area Coordinator (HSFAC) is the accountable executive for Health's response to incidents which require central coordination and result from natural disasters, mass casualties and major infrastructure disruptions[3].

Notes:
- see page 8 for commentary on critical NSW Health ICT incidents (which may accompany one of these hazards), and the importance of clear leadership and effective clinical risk assessment during these incidents
- see page 13 for commentary on how these incidents are escalated to central coordination

Coordination arrangements for these responses are set forth in the *NSW Health Services Functional Area Supporting Plan* (*HEALTHPLAN*).

The State Health Emergency Management Committee (SHEMC) provides supporting governance.

Depending on the scale of the event, responses to these types of hazards are likely to require engagement with *EMPLAN* arrangements.

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[3] Major infrastructure disruptions, for example: disruptions to electricity, water and gas services

6.2   Terrorism incident

From a health system perspective, responding to a terrorism incident (suspected or confirmed) is primarily an act of consequence management. There would also be close and constant engagement between agencies at the highest levels of government. The Secretary would lead this engagement for NSW Health.

The response to an act of terror would be immediately escalated to central coordination, regardless of the severity of its impact on the Health system.

The consequences of a terrorism incident would fall into various hazard categories (eg: mass casualty incident, infectious disease outbreak, critical disruption to or failure of ICT or other infrastructure). The Secretary, while maintaining overarching leadership, would be supported by the relevant accountable executive and plan (in support of the overarching arrangements described in the *NSW Counter Terrorism Plan*).

For example, the response to a terrorism incident resulting in mass casualties would be coordinated under *HEALTHPLAN*, while a deliberate release into the community of a highly pathogenic respiratory illness would be coordinated under the arrangements of the *NSW Health Influenza Pandemic Plan* (PD2016_016).

The Secretary, in consultation with the State HSFAC and other relevant accountable executives (eg: Chief Health Officer), will confirm the coordination arrangements, and communicate this to Chief Executives.

6.3   Pandemic

During the acute phase of a pandemic (including any subsequent pandemic waves which may heavily impact NSW), the Secretary leads the health system response, and is supported by the State Pandemic Management Team, as set forth in the *NSW Health Influenza Pandemic Plan* (PD2016_016).

The Chief Health Officer represents NSW on the Australian Health Protection Principal Committee. This committee coordinates the national health sector response to a pandemic, technical aspects of which are adopted by NSW for national consistency.

The Secretary, the Chief Health Officer and the State HSFAC represent NSW Health on the Senior Officials' Group[4], which coordinates the management of the NSW Government response to a pandemic, and puts forth recommendations on significant policy decisions to the Crisis Policy Committee as needed.

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[4] Membership includes NSW Government Secretaries, Chief Health Officer, State Health Services Functional Area Coordinator, State Emergency Operations Controller, State Recovery Controller and others as required

In recognition of the all-encompassing nature of a pandemic, all Health executives are responsible for ensuring their service's preparedness for a pandemic, primarily through implementing and testing robust business continuity and surge arrangements.

These arrangements would also apply to other major emerging or re-emerging respiratory illness threats, such as Sudden Acute Respiratory Syndrome (SARS).

6.4 System-level clinical safety or quality incident (eg: acute medicine shortage/contamination and medical device issues with potential patient safety impact)

The vast majority of these issues and incidents (eg: routine recalls for medicines/medical devices) will be coordinated locally, as part of normal operations. Only a very small proportion will have public health or critical patient safety implications that require a centralised, coordinated health system response.

The Chief Executive, Clinical Excellence Commission (CEC), supported by the Chief Health Officer or delegate, leads the response to acute medicine shortages, medicine contamination incidents, or medical device issues with potential patient safety impacts that require a centrally coordinated response (eg: a significant or complex recall of a crucial product without readily available alternatives).

During a centrally coordinated response, the Chief Executive, CEC, is supported by the Inter-agency Management Team (core agencies: CEC, HealthShare NSW and Ministry of Health). These arrangements are set forth in the Policy Directive *Coordination of Responses to Urgent System-level Medicine or Medical Device Issues* (PD2019_19).

Leadership of these responses will transfer to the Chief Health Officer (or Deputy Secretary, Patient Experience and System Performance) in instances of critical public health or patient safety risk, or major operational impact.

6.5 Critical information, communication and technology failure

A critical information, communication and technology (ICT) failure[5] could occur as the result of a range of incidents, such as a cyber security incident, leading to a data breach. These incidents may be internal to NSW Health, and also external, with a wider impact across NSW Government and beyond.

The Chief Executive, eHealth NSW, is the executive accountable for a critical ICT incident.

Note: ICT failures involving infrastructure or applications not supported by eHealth NSW would be coordinated by the impacted Health service. Where a local system is

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[5] Including voice platforms

dependent on eHealth NSW services, or connects with other government agencies' ICT services, the impacted Health service should consider a coordinated response.

ICT failures or disruptions may directly impact on clinical service delivery. It is also possible that temporary fixes or solutions may have unintended consequences or flow-on effects (eg: a vulnerable group may be inadvertently disproportionately affected) which could further disrupt clinical service delivery if not appropriately mitigated.

For this reason, the impact on clinical services of any current or potential disruption needs to be rapidly and comprehensively risk assessed by those directly involved with managing these services.

The overarching response to critical ICT incidents which have significant operational impact on system performance will be coordinated by the Deputy Secretary, Patient Experience and System Performance, with the Chief Executive, eHealth NSW, continuing to coordinate the ICT components.

The Chief Executive, eHealth NSW, is a member of the Cyber Security Senior Officers' Group, a state-wide, whole-of-government coordination group that oversees prevention, preparedness, response and recovery for significant cyber security incidents.

Within NSW Health, the eHealth Executive Council oversees preparedness for ICT failures or disruptions.

The *Electronic Information Security Policy* (PD2013_033) covers security requirements for NSW Health information; LHD/SNs must report on their compliance with this Policy Directive to the Secretary annually. EHealth NSW also maintains a range of incident management processes and standard operating procedures that are designed to guide the NSW Health response to incidents of this nature*.*

6.6 Major health protection incident

The Chief Health Officer is responsible for state-level preparation for and response to health protection incidents (eg: cases of a viral haemorrhagic fever, or a major environmental hazard; see section 6.3 for pandemics). The Health Protection Leadership Team and hazard-specific panels provide expert input.

There are a number of national plans that set forth coordination arrangements for major health protection incidents. These arrangements are supported by hazard-specific and disease control guidelines. Public health emergency management arrangements are explained in the *Public Health Services Supporting Plan* to *HEALTHPLAN* (PD2015_002).

7   CONCURRENT UNRELATED INCIDENTS

Responses to more than one unrelated incident may occur concurrently.

An example of this would be a mass casualty incident occurring during a prolonged pandemic response.

In this scenario, it is likely that the two incidents would be managed largely separately, as delegated by the Secretary, with coordination as needed between the State HSFAC and the State Pandemic Management Team (noting the State HSFAC is also a member of the State Pandemic Management Team).

As the most appropriate approach to the control and coordination arrangements for concurrent unrelated incidents will depend on a risk assessment undertaken at the time, discussion between all relevant parties (eg: the Secretary and Ministry executive team, State HSFAC, impacted Chief Executive etc.) will be essential.

It is crucial that there is a shared understanding as to whether concurrent incidents are being managed as one, or separately, and by who.

8 LOCAL HEALTH DISTRICT, SPECIALTY NETWORK AND OTHER HEALTH ORGANISATION[6] RESPONSIBILITIES

Chief Executives are accountable for incident prevention (where possible), preparedness, response and recovery for their services.[7]

Chief Executives must:

- Identify an executive (with appropriate skills, seniority and experience) with delegated authority for each hazard type – for example, the Chief Executive may delegate preparedness for and response to a major medicine shortage to an executive with responsibility for clinical operations, or a health protection incident to an executive with responsibility for public health. The same person may be responsible for more than one hazard type. It is at the discretion of the Chief Executive, who maintains overall accountability, how this delegated authority aligns with designation of the LHD/SN HSFAC function (as defined in HEALTHPLAN).

- Identify overarching incident preparedness and response governance – for example, the Chief Executive should include hazard identification and risk assessment as routine agenda items at senior executive leadership team meetings to inform preparedness and response

- Ensure documented coordination arrangements for each hazard type - for example, local pandemic plans should include an equivalent of the State Pandemic Management Team (eg: LHD executive team)

- Nominate an executive contact point to meet the Ministry's requests for information during incidents

- Ensure business continuity and surge plans are in place for all business and clinical units – these plans must be widely understood, easily accessible, able to be applied and routinely tested, and updated according to changing circumstances

- Ensure capability and capacity (including through liaison with partner agencies) in hazard identification, and health risk assessment and management

- Ensure a training/exercise program is in place to test the above requirements

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[6] Other Health organisations: St Vincent's Health Network, NSW Health Pathology, eHealth NSW, NSW Ambulance and HealthShare NSW

[7] Attachment 1 contains a preparedness checklist to support Health services self-assess compliance with these requirements.

9   CENTRAL COORDINATION

Incidents are managed as locally as practicable. LHD/SN/other Health organisations have increasing experience and capability to manage relatively complex incidents.

Chief Executives are responsible for monitoring any response within their Health service. They may request central coordination of a response, and must provide early notification to the state-level accountable executive of the potential to escalate to central coordination or the potential for an incident to impact additional NSW Health services.

On occasion, the state-level accountable executive or Secretary will determine that central coordination is necessary. This will be formally communicated to the impacted Health service(s).

Hazard type[8]	State-level accountable executive
Natural disaster, mass casualty, major infrastructure disruption (for ICT disruption see below)	Major infrastructure disruptions: Impacted Health service initially notifies the Deputy Secretary, Patient Experience and System Performance, who escalates to the State HSFAC for central coordination as necessary Natural disasters and mass casualty incidents: Impacted Health service notifies the Deputy Secretary, Patient Experience and System Performance and the State HSFAC concurrently, who together determine the appropriate course of action**
System-level safety and quality incident	Impacted Health service initially notifies the CE, CEC, who then escalates to CHO or delegate as necessary
Critical ICT failure	Impacted Health service initially notifies the Executive Director, Service Delivery, eHealth NSW, who escalates to CE, eHealth NSW (and Deputy Secretary, Patient Experience and System Performance if widespread clinical risk/system impact)
Major health protection incident	Impacted Health service initially notifies Executive Director, Health Protection NSW, who escalates to the CHO as necessary
Note: a terrorism incident and pandemic (or other emerging major infectious threat) will be immediately centrally coordinated	

**The State HSFAC and Deputy Secretary, Patient Experience and System Performance, will rapidly assess any major incident that may escalate to central coordination under the State HSFAC's leadership according to the factors identified in section 9.2.

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[8] Note: NSW Health's involvement in significant and centrally coordinated responses across different government agencies under the *State Emergency and Rescue Management Act* and the *NSW Emergency Management Plan* will, by default, be coordinated by the State HSFAC (noting pandemic and terrorism responses are examples of exceptions, refer to section 6).

Regardless of this determination, the Ministry will require frequent briefings and information from the impacted Health service's nominated contact point to support the Minister's Office and Secretary.

This may also apply for responses that are managed locally by the impacted Health service but due to their high profile or sensitive nature still require notification and regular reporting to the Ministry. The Ministry will provide clear guidance at the time on what information is required and how frequently.

Some incidents may be immediately escalated to central coordination. Examples could include:
- Act of terrorism or other mass casualty event
- Pandemic, or other major emerging/re-emerging infectious disease (eg: Ebola/SARS)
- Widespread cyber security threat or risk (eg: new global cyber-attack)
- Widespread medicine contamination or other medicine/device issue with critical patient safety implications

The decision may be made to centrally coordinate an incident even if its operational impacts do not necessitate business continuity plan activation or a full emergency management response.

Regardless of whether or not central coordination is implemented, Chief Executives remain responsible for service delivery within their service.

9.1   Purpose of central coordination

Central coordination aligns with the contemporary approach of emergency preparedness through building resilience in normal business operations (eg: major health protection issues managed by state health protection teams, technical components of critical ICT failures managed by state ICT teams). It also increases state-wide accountability for incident preparedness and response.

The purpose of centrally coordinated preparedness and response is to:
- proactively mitigate risk
- ensure that no LHD/SN/other Health organisation is disproportionately affected
- support cross coordination (including with partner agencies) and leverage off the strengths and expertise of HealthShare NSW, eHealth NSW, NSW Health Pathology and other pillar agencies
- promote a consistent approach
- facilitate mobilisation of total Health resources as required
- mitigate the challenges of extended supply chains during times of rapid medicine or equipment re-procurement (eg: rural/remote areas)
- reduce duplication of effort across the system

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- enable better state-level visibility of the phase of response (eg: normal operations, surge, emergency management etc.), thus facilitating graded control, coordination and support

9.2 Factors that influence the decision to centrally coordinate a response

The decision to escalate a response from local to central coordination depends on a range of factors, including whether the incident:

- has critical patient safety or widespread public health implications
- has the potential for widespread impact on system performance
- could benefit from leveraging HealthShare NSW's purchasing power on behalf of the system (eg: a coordinated purchase of a medicine in very short supply)
- is being nationally coordinated
- has significant security implications or is very sensitive/high-profile for other reasons and involves close links with central agencies or Ministers' offices
- results in an inability to maintain essential services
- results in a prolonged reduction of essential services as a consequence of the incident or as a requirement to manage the incident
- involves reallocating resources or moving patients between LHD/SN/other Health services (noting that in some rural services, this would occur also as part of normal operations)

Generally, the state-level accountable executive will make the decision to escalate to a centrally coordinated response, in consultation with the Chief Executive(s) of the affected LHD/SN/other Health service(s).

Likewise, as these factors subside, the state-level accountable executive and Chief Executive will determine the timing for transition back to local coordination.

ATTACHMENT 1: IMPLEMENTATION CHECKLIST

LHD/SN/other Health organisation	
Assessed by:	**Date of Assessment:**

IMPLEMENTATION REQUIREMENTS	Not commenced	Partial compliance	Full compliance
1. Identify an executive (with the appropriate skills, seniority and experience) with delegated authority for each hazard type	❑	❑	❑
	Notes:		
2. Identify overarching incident preparedness and response governance	❑	❑	❑
	Notes:		
3. Ensure documented coordination arrangements for each hazard type	❑	❑	❑
	Notes:		
4. Nominate an executive contact point to meet the Ministry's requests for information during incidents	❑	❑	❑
	Notes:		
5. Ensure business continuity and surge plans are in place for all business and clinical units	❑	❑	❑
	Notes:		
6. Ensure capability and capacity (including through liaison with partner agencies) in hazard identification, and health risk assessment and management	❑	❑	❑
	Notes:		
7. Ensure a training/exercise program is in place to test the above requirements	❑	❑	❑
	Notes:		