Public Health England

Protecting and improving the nation's health

Report on Exercise Pica
NHS primary care preparedness and response to pandemic influenza

05 September 2018

[Images removed under Section 40 of the FOI Act]

About Public Health England

Public Health England exists to protect and improve the nation's health and wellbeing, and reduce health inequalities. We do this through world-leading science, knowledge and intelligence, advocacy, partnerships and the delivery of specialist public health services. We are an executive agency of the Department of Health and Social Care, and a distinct delivery organisation with operational autonomy. We provide government, local government, the NHS, Parliament, industry and the public with evidence-based professional, scientific and delivery expertise and support.

For more details please go to http://www.gov.uk/phe

About the Emergency Response Department

Public Health England's Emergency Response Department works with national and international partners to ensure that healthcare professionals are able to respond to emergencies, including the deliberate or accidental release of chemical, biological, radiological or nuclear substances. Emergency preparedness specialists throughout PHE play an important role in training and exercising the healthcare community.

On behalf of the Department of Health and Social Care, training courses and exercises are delivered every year throughout England to develop resilience across healthcare organisations. In addition, the Emergency Response Department works with the European Commission, the European Centre for Disease Prevention and Control, the World Health Organisation and other major international public health partners.

Skills for Health Quality Mark
Awarded for face to face delivery of education and training to the health sector

Public Health England Emergency Response Department's Training and Exercises Team has achieved the 'gold standard benchmark' for training and exercises delivery providers by the Skills for Health and the National Skills Academy provider.
For more details please go to [redacted]

The Report on Exercise Pica

Exercise Pica was delivered on 05 September 2018, supported by NHS England and Public Health England. The exercise was sponsored by NHS England as part of the Public Health England funded programme directed by the Emergency Preparedness, Resilience and Response Partnership Group, chaired by the Department of Health and Social Care.

Pandemic influenza is one of the most severe natural phenomena to affect the UK[1] and the most severe civil emergency risk[2]. As such pandemic influenza remains at the top of the UK Government National Risk Register. Although primary care was out of scope for Exercise Cygnus in 2016, the Department of Health and Social Care sponsored Tier 1 national level pandemic influenza command post exercise[3], one of the lessons identified concerned the NHS's ability to scale-up its services during a pandemic, including primary care which would play a key role in providing health care and reassuring the public.

Exercise Pica reviewed and assessed pandemic influenza preparedness and response within primary care by providing an opportunity to review and explore the existing processes and arrangements.

[redacted]
Head of Emergency Response Department
Director Emergency Preparedness Resilience and Response
Health Protection and Medical Directorate
Public Health England

December 2018

[1] Cabinet Office, Department of Health and Social Care, Home Office, Ministry of Justice, and Ministry of Housing, Communities and Local Government. Emergencies: preparation, response and recovery. https://www.gov.uk/guidance/pandemic-flu
[2] Cabinet Office. National Risk Register for Emergencies 2017 edition.
[3] Public Health England, Exercise Cygnus Final Report dated 13 July 2017 OFFICIAL -SENSITIVE

Contents

Executive summary

Exercise Pica was held on 05 September 2018, in London to review and explore existing NHS primary care arrangements and processes within the context of an influenza pandemic.

Its purpose was to identify lessons for the NHS primary care response to pandemic influenza over three key stages: Detect and Assess phase (first days/weeks), Treat and Escalate phase (peak of pandemic at 6/7 weeks) and the Recovery phase (months later).

Participants in the exercise represented the breadth of primary care professions across representative bodies, associations, providers and commissioners, royal colleges, and regulators.

Participants completed evaluation forms and feedback indicated that the exercise was *"Really good to have a wide range of healthcare professionals in one room to discuss such an important issue".*[4]

Twenty six lessons were identified through the three sessions of the exercise. The report gives prominence to several significant areas for consideration which were identified by the participants. The main lessons are as follows:

- **Coordinated communications to the profession and public**
  Communication to the profession needs to be co-ordinated with aligned consistent messaging. Similar consideration should also be given to the means to communicate with the public.
- **Collaboration between regulators**
  Further guidance and clarity from regulatory expectations of services and temporary locations during an extreme event such as pandemic would be helpful.
- **Upscaling surge capacity**
  Further consideration is needed on recruitment and management of staff to assist in the response, including at what point assistance is required given the surge capacity tipping point varies across primary care services.
- **Pharmacy Sector vulnerabilities**
  The wider impact of a pandemic on the pharmacy sector needs further consideration.

A full list of the lessons identified is included at **Appendix A.**

In many ways Exercise Pica has proved to be reassuring. It confirmed understanding of the current situation and identified potential new solutions for some challenges. The exercise identified 27 lessons; many of which are aspects that are already in progress. NHS England is developing an action plan to develop these, which will be shared with exercise participants and others in due course.

[4] Where appropriate, the direct comments from the participants have been include as quotes and are annotated by "italics". All quotes are anonymised.

1. Introduction

This report describes the design, delivery and outcomes of Exercise Pica, a discussion based exercise designed to explore the challenges faced by the NHS primary care organisations during an influenza pandemic.

2. Aim and objectives

2.1 Aim

To explore the preparedness and response arrangements for NHS primary care organisations to an influenza pandemic outbreak.

2.2 Objectives

The objectives for the exercise were:

1. To explore how primary care capacities will maintain 'business as usual' in response to a 'rising tide' of a worsening situation from winter pressures, to seasonal influenza to a pandemic outbreak.

2. To consider how primary care pandemic influenza response will vary from urban to rural communities.

3. To explore how different aspects of primary care will respond in a severe pandemic and support the wider system.

4. To explore how primary care services will return to the 'new Business As Usual'.

5. To review the current draft of the "Primary Care Potential Roles and Responsibilities during an Influenza Pandemic" guidance document

3. Scenario

This fictional scenario was based on the progression of an influenza pandemic in the UK (that had no known vaccine) over and focussed on three distinct phases: Phase 1 – first few days and weeks, Phase 2 – peak of the pandemic 6/7 weeks, Phase 3 – the recovery phase.

The scenario initiated with a new influenza virus from birds (A/H2N2) that had been causing cases of severe respiratory illness across Eastern Europe over the last six months, with cases reported in South East Asia, the Pacific and pockets recorded in Hong Kong and Australia. To date in the scenario, the World Health Organization (WHO) had reported that there were 47 cases and 9 fatalities with evidence of some person to person spread. So far this virus had not been detected in the UK and it was not known if or when the virus would reach the UK.

The WHO declared the emergence of the outbreak as a Public Health Emergency of International Concern (PHEIC). There was no vaccine and no immunity in the population.

There are UK national stockpiles of personal protective equipment for health and social care workers (e.g. face masks, gloves, FFP3 respirators, aprons), antivirals (to treat 50% of the population), antibiotics (to treat secondary complications of influenza) and some other relevant healthcare consumables (e.g. for delivery of vaccine – needles, syringes, sharps bins; oxygen)

4. Exercise format

4.1 Exercise style

Exercise Pica was designed as a one-day discussion based exercise which was delivered by PHE Emergency Response Department's (ERD) Exercises Team in [redacted]

The exercise provided an opportunity for participants to discuss and consider their own organisational planning to assess gaps and areas of improvement required.

Each group had a Chair, to guide the group's discussion through the challenges raised by the exercise questions, and a note taker to capture the key points, actions and recommended solutions for the challenges that the exercise highlighted.

4.2 Outline of the day

The exercise was opened by NHS England, who provided background and context for the exercise as well as establishing the need for the exercise. This was reinforced by presentations by [redacted] - Public Health England and [redacted] - NHS England which helped to focus the minds of the participants and set the scene for the day. After a scene setting simulated news broadcast and comprehensive exercise briefing, the day was divided into three phased discussion sessions.

Each session was followed by discussions to cover the key challenges, and a final plenary session where participants were given the opportunity to consider the entire day's discussions, reflect on the key issues raised and discuss. In the final session, the lead facilitator ([redacted] – NHS England) guided the exercise participants through shared feedback and prompted and guided participants to cover key areas.

The scenario and questions enabled participants to consider their understanding of current procedures, roles and responsibilities, capabilities to share information, highlight potential areas of vulnerability and areas for development. Participants were encouraged to refer to reference material including extant guidance and plans that were available on the day, and were sent to participants prior to the exercise as part of their joining instructions.

4.3 Participants

Representatives from the following organisations participated in the exercise:

- British Dental Association
- British Medical Association GP Committee
- College of Optometrists
- Care Quality Commission (CQC)
- Federation of Ophthalmic and Dispensing Opticians (FODO)
- General Dental Council
- General Medical Council
- General Pharmaceutical Council (GPhC)
- Health and Care Professions Council (HCPC)
- Local Optical Committees Support Unit (LOCSU)
- NHS Digital
- NHS Employers
- NHS England
- NHS Gloucestershire Clinical Commissioning Group
- NHS Improvement
- NHS Leeds Clinical Commissioning Group
- NHS Business Services Authority (NHSBSA)
- Nursing and Midwifery Council
- Pharmaceutical Services Negotiating Committee
- Public Health England
- Association of Dental Groups represented by Portman Dental Care
- Royal College of General Practitioners
- Royal College of Nursing
- Royal Pharmaceutical Society
- West London GP federation

A list of participants and organisations is at **Appendix C**.

5. Exercise evaluation and lessons identified

5.1 Session One – Detect and Assess Phase (First days / weeks)

There were discussions around the impact of increased numbers of worried well in primary care locations. Communication to the public and reminders of public health measures are key to ensuring an appropriate response. These communications could be pushed out to the public and professionals through primary care routes.

Participants discussed the need for all primary care providers to have access to NHS.net, otherwise this could affect the ability to communicate effectively during a pandemic.

Pharmacists have shared access to NHSmail and participants encouraged a need to ensure they use it. This could present IT issues during the Pandemic.

Participants discussed the issue around communications on all levels including the need to communicate with the public with a clear and simple message, the need to communicate with health care professionals and what is expected of them, and the need to communicate with the wider NHS.

Lesson identified 1: Communication to the profession needs to be co-ordinated between ALBs with aligned consistent messaging. Similar consideration should also be given to the means to communicate with the public to inform them of what to do and where to go.

Participants noted that at the early stage in the pandemic they would review their business continuity arrangements and ensure that they were ready when further information was released.

Participants discussed the issue of employing additional people, including retired medical professionals and final year medical and nursing students, to support tasks. It was suggested that there is also potential for dentists to give injections as a method of supporting requests for mutual aid. Concerns over the capacity to manage these extra staff was raised, consideration would need to be given to induction, training and supervision, as well as access to practice clinical systems in line with information governance restrictions. The surge capacity tipping point was also discussed, and that this would vary across different primary care services.

Lesson identified 2: Further consideration is needed on recruitment and management of staff to assist in the response, including at what point assistance is required given the surge capacity tipping point varies across primary care services.

Participants discussed the need for a common clinical lexicon that could be used for case management with definitions for possible, probable and confirmed cases of influenza across health care during an influenza pandemic.

Lesson identified 3: A common clinical lexicon for health care that could be used for case management with definitions for possible, probable and confirmed cases of influenza during an influenza pandemic would be beneficial.

Pandemic influenza plans are currently separated across primary care organisations, and these need to be joined up in order to provide a more efficient response in primary care.

Lesson identified 4: Joining-up primary care pandemic influenza plans at local level would help deliver a more efficient response.

It was noted that during Ebola, NHS England led a multi-agency stakeholder group that worked well, this could be beneficial for pandemic influenza.

Lesson identified 5: A national multiagency stakeholder group convened at the time of a pandemic would be beneficial in a pandemic influenza response.

It was suggested that the Regulators need to re-interpret existing standards within the context of pandemic influenza, to give clarity on what are acceptable standards of care. Regulators are working together to prepare a joint statement for pandemic influenza.

Lesson identified 6: Existing standards need to be re-interpreted within the context of pandemic influenza to give clarity on acceptable standards of care in such a scenario.

Participants stated that primary care staff must be able to work more flexibly, and that this should consider remote working and providing staff with sufficient IT kit which they are trained to use.

Lesson identified 7: Remote working by primary care staff as part of normal practice, would contribute to a more effective primary care provision during a pandemic.

It was proposed that patients could use smart phone applications from their home, to alleviate pressure on primary care services. Reference was made to recently launched PHE-a self-diagnosis heart-age tool, and it was suggested that a similar app could be developed for pandemic influenza.

Lesson identified 8: A pandemic influenza self-diagnosis app could reduce pressure on primary care services.

The importance of capabilities working together and of the General Medical Council talking to Local Resilience Forums and Local Health Resilience Partnerships was discussed.

Lesson identified 9: Engagement across local systems would support a joined up response to the benefit of professionals and patients

There were discussions around the process for using and accessing key data management systems in general practice. General practices use different clinical systems across the country to access patient medical records, (such as EMIS training or ‘System 1’). During a pandemic this could create an IT challenge for staff re-deployed

who would need access to such systems, but which may need to be constrained in keeping with information governance.

Lesson identified 10: General Practice across the country use different IT systems; this could hinder a flexible approach to responding to an influenza pandemic.

The 2017 'wannacry' cyber-attack which affected the NHS demonstrated the dependence on IT services and the impact on patient care if these services are disrupted. NHS Digital co-ordinate communications with NHS providers working with NHS England and with Ministers through DHSC. While there is a specific role for NHS Digital in a cyber-attack this is less clear in an influenza pandemic.

The response in the initial phase of a pandemic would be improved if there was a suite of documents (i.e. preparedness plans, patient temporary health service facilities, pharmacies) that were 'ready to use' and could be rapidly updated to provide appropriate and timely details. The preferred provision of strategic actions, options, and principles rather than operational detail was highlighted recognising the detail would change over time.

Lesson identified 11: A suite of documents (i.e. preparedness plans, patient temporary health service facilities, pharmacies) that are 'ready to use' and can be rapidly updated to provide timely detail would facilitate an improved pandemic response.

5.2 Session Two – Treat and Escalate Phase (week 6 or 7, peak of the pandemic)

Participants discussed the issues that staff absence and fuel shortages would have on the primary care sector, and it was noted that primary care providers are not currently identified among professions/ organisations that are eligible for fuel vouchers during a crisis. Maintaining the supply chain of medicines deliveries by wholesalers and oxygen suppliers would also be a key element of pandemic response and it was highlighted these organisations were also believed to be excluded from the fuel access list.

Lesson identified 12: Fuel and staff shortages during a pandemic influenza could impact NHS staff travel and delivery of care through disrupted medicines/ oxygen availability. Primary care providers are not currently identified among professions/ organisations that are eligible for fuel vouchers during a crisis

Discussions continued regarding recruiting staff from other areas in support, including retired GPs and medical/nursing students continued to raise the concern over ensuring staff are in a supported governance framework with reference to indemnities. This will be crucial during the recruitment phase, and needs to be in place before the outbreak so that there is no delay. Funding may also be needed to support the increase in demand on primary care services and resources in the event of a pandemic.

Some regulators have powers to add additional Registrants (recently retired registered professionals) to register with a license to practise but there is an issue of whether Registrants would want to return to practice and the mechanics needed to support this (indemnity) and whether local providers / employers have capacity to do local checks that are fit for purpose to do the intended role.

Lesson identified 13: Further consideration is needed for surge capacity such as Registrants, professional standards, indemnities, pay, terms and conditions and funding.

It was recognised that the pharmacy sector is particularly vulnerable to pressures in a pandemic as force majeure does not apply in the sector.

Lesson identified 14: National guidance is needed on expectations of checks and inductions for recently retired clinical staff and students who are willing to assist in the response to pandemic influenza.

Some participants raised concerns over potential IT challenges given the potential impact of staff absences. Reversion to paper-based systems were discussed if IT systems were not functioning, however there were concerns raised as to whether pharmacies could revert to paper prescriptions (particularly around stocks of paper prescriptions), and the implications of this in terms of payments for pharmacies.

Lesson identified 15: Reversion to paper prescriptions may not be easily implemented in pharmacies in the event of IT challenges; legislative changes might be required to allow other prescription templates to be used, and payments/ reimbursements could be impacted.

Current rules and expectations pertaining to death certification and cremation was discussed. Increased demand on completing death certificates could put a strain on GPs' time and availability during a pandemic and affect staff capacity to treat the living.

Lesson identified 16: Current death certification legislation could impede primary care of the living in a pandemic.

The NHS supply chain could be disrupted owing to illness/absence within the supply system network. This could affect pharmacy ability to supply patients with prescriptions (for treatment of long term conditions, routine repeat prescriptions and oxygen). It was suggested that pharmacies could potentially run out of some stock items within two days if demand was high and supply disrupted.

Lesson identified 17: The business continuity arrangements of NHS Supply Chain, wholesalers and other suppliers to the NHS is not well known, and if this failed there could be a significant impact to pharmacy's ability to support patients.

Discussion occurred on CQC rules on temporary additional healthcare facilities premises and registration requirements of NHS facilities e.g. access to resuscitation and oxygen equipment. It is understood whilst certain rules could be related, other rules would be non-negotiable e.g. safeguarding.

Lesson identified 18: Further guidance and clarity from regulatory expectations of services and temporary locations during a pandemic would be helpful.

Primary Care Support England (PCSE) currently provides a number of key services to support primary care, these services could be impacted during a pandemic.

Lesson identified 19: Further exploration with PCSE on business continuity plans and contingencies.

The clear communications role for Directors of Public Health in local authorities to help and support a system wide response to pandemic influenza, particularly with hard to reach groups, was mentioned, however this is not well understood.

Lesson identified 20: The role of Directors of Public Health in supporting the local response to pandemic influenza would benefit from further clarification.

5.3 Session Three – Recovery Phase.

Discussions were held in relation to the short term, with concerns over staff morale being low, particularly due to the uncertainty over a potential second pandemic wave. In addition to an increase in demand to support patients with mental health issues stemming from the impact of the pandemic, mental health support would also be required for staff. It was unclear where and how staff support could be sourced and if community mental health services could deal with the additional demand from patient needs.

Lesson identified 21: Mental health care demand from Psychosocial is expected to increase during/ after a pandemic, but it was unclear how this would be met.

A risk was identified that retired / student staff recruited to support the response could become integral to post-pandemic primary care functioning. Discussions were held on the impact of medical/nursing students being unable to complete their training, resulting in a limited new workforce in a year or so after the pandemic. Consideration might be

needed for the five to six year horizon (e.g. university recruitment and training) which would assist in the recovery phase and with the possible impact on staffing levels.

Lesson identified 22: The potential impact to long term workforce planning due to recruiting students to support that pandemic and disrupting their education was unclear.

Participants highlighted that the public will probably have an expectation of a fast recovery from the pandemic. Clarity will be required on financial positions / viability or even bail out which will affect professional disciplines differently and without which, there is a risk that inconsistent approaches will be taken by contractors submitting claims for payment.

It was discussed that during the initial recovery period it could be beneficial to focus on restocking/ resourcing core pharmacy and general practice centres, rather than all at once, and it was recognised that this will require CCGs in such decision-making.

Lesson identified 23: Strategically supporting core centres during the initial recovery period (with finance, stock and staffing) could be more beneficial than trying to return the whole system to service at the same time.

Recovery needs to be measured and planned; returning the whole system to Business As Usual will take some considerable time, and will be affected by the impact of the pandemic. It was also recognised that the new Business as Usual may be different to the pre-pandemic landscape.

There will undoubtedly be delays in IT updates, clinical codes, and a potential build-up of technical debt (security updates etc.) The group also anticipated that there could be a flurry of complaints, including from patients and the public about GP decisions and/ or failures.

Discussions raised the need for assurances that staff, wholesalers and suppliers, would continue to be paid during the recovery phase as well as during the response.

Lesson identified 24: The recovery period presents unknown challenges (including 2nd and 3rd waves) and further consideration is needed to identify potential key issues and how they could be mitigated.

The group discussed how pandemic specific vaccinations will be recorded during the pandemic, and what system will be utilised to track and record the number of patients who have been vaccinated. Use of the ‘spine’ IT record system (summary care records for all patients) was recommended as being a universal system, however it was noted that not all primary health care professionals have access to the spine.

There also needs to be focus on the anticipated 'second wave' vaccination programme, with members of the public potentially showing signs of lethargy or non-compliance during the second wave which could reduce uptake.

Lesson identified 25: Public health messaging for the pandemic specific vaccination campaign, particularly in light of a second wave, or additional waves of the pandemic, will be key to ensure maximum uptake.

The group discussed the impact on the pharmacy sector during a pandemic is likely to be significant. There could be major impact on the NHS supply chain during a pandemic and stock of medicinal supplies.

It was thought that Pharmacies might be at particular risk during a pandemic as many are small to medium enterprises and are reliant on a few key members of staff.

Lesson identified 26: The wider impact of a pandemic on the pharmacy sector needs further consideration.

6. Conclusions

The NHS is undergoing a significant process of continued change, with the development of primary care networks, sustainability and transformation partnerships, integrated care systems, and the alignment of NHS England and NHS Improvement. This presents both challenges and opportunities.

In many ways Exercise Pica has proved to be reassuring. It confirmed understanding of the current situation and identified potential new solutions for some challenges. The exercise identified 27 lessons; many of which are aspects that are already in progress. NHS England is developing an action plan to develop these, which will be shared with exercise participants and others in due course.

The main challenge identified was that clear communication to staff and the public during a pandemic is essential to provide clarity and reassurance. To achieve this, steps need to be taken to ensure plans and processes are aligned and that primary care stakeholders are clear on their roles during a pandemic. There was a strong desire for a follow on exercise, to focus on communication in order to address these issues.

Exercise Pica was well received by the participants who were fully engaged throughout the exercise. Feedback indicated that the participants in the exercise considered that the event was worthwhile *“I thought it was a helpful and valuable exercise. Bringing key professional bodies together in an open environment and giving everyone the opportunity to feed in to the process* and *“really good to have a wide range of healthcare professionals in one room to discuss such an important issue”.*

Appendix A – Lessons Identified

Lesson	Description of lesson identified
Session 1 – Detect and Assess Phase (first days/weeks)	
1	Communication to the profession needs to be co-ordinated between ALBs with aligned consistent messaging. Similar consideration should also be given to the means to communicate with the public to inform them of what to do and where to go.
2	Further consideration is needed on recruitment and management of staff to assist in the response, including at what point assistance is required given the surge capacity tipping point varies across primary care services.
3	A common clinical lexicon for health care that could be used for case management with definitions for possible, probable and confirmed cases of influenza during an influenza pandemic would be beneficial
4	Joining-up primary care pandemic influenza plans at local level would help deliver a more efficient response
5	A national multiagency stakeholder group convened at the time of a pandemic would be beneficial in a pandemic influenza response.
6	Existing standards need to be re-interpreted within the context of pandemic influenza to give clarity on acceptable standards of care in such a scenario.
7	Remote working by primary care staff as part of normal practice, would contribute to a more effective primary care provision during a pandemic.
8	A pandemic influenza self-diagnosis app could reduce pressure on primary care services.
9	Engagement across local systems would support a joined up response to the benefit of professionals and patients
10	General Practice across the country use different IT systems; this could hinder a flexible approach to responding to an influenza pandemic
11	A suite of documents that are 'ready to use' and can be rapidly updated to provide timely detail would facilitate an improved pandemic response.
Session 2 – Treat and Escalate Phase (Peak of pandemic 6/7 week)	
12	Fuel and staff shortages during a pandemic influenza could impact NHS staff travel and delivery of care through disrupted medicines/ oxygen availability. Primary care providers are not currently identified among professions/ organisations that are eligible for fuel vouchers during a crisis
13	Further consideration is needed for surge capacity such as Registrants, professional standards, indemnities, pay, terms and conditions and funding.
14	National guidance is needed on expectations of checks and inductions for recently retired clinical staff and students who are willing to assist in the response to pandemic influenza.
15	Reversion to paper prescriptions may not be easily implemented in pharmacies in the event of IT challenges, legislative changes might be required to allow other templates to be used, and payments/ reimbursements could be impacted.
16	Current death certification legislation could impede care of the living in a pandemic.
17	The business continuity arrangements of NHS Supply Chain, wholesalers and other suppliers to the NHS is not well known, and if this failed there could be a

Lesson	Description of lesson identified
	significant impact to pharmacy's ability to support patients.
18	Further guidance and clarity from regulatory expectations of services and temporary locations during an extreme event such as pandemic would be helpful.
19	Further exploration with PCSE on business continuity plans and contingencies.
20	The role of Directors of Public Health in supporting the local response to pandemic influenza would benefit from further clarification.
Session 3 - Recovery Phase	
21	Mental health care demand from Psychosocial is expected to increase during/ after a pandemic, but it was unclear how this would be met.
22	The potential impact to long term workforce planning due to recruiting students to support that pandemic and disrupting their education was unclear.
23	Strategically supporting core centres during the initial recovery period (with finance, stock and staffing) could be more beneficial than trying to return the whole system to service at the same time.
24	The recovery period presents unknown challenges (including 2nd and 3rd waves) and further consideration is needed to identify potential key issues and how they could be mitigated.
25	Public health messaging for the pandemic specific vaccination campaign, particularly in light of a second wave or additional waves of the pandemic, will be key to ensure maximum uptake.
26	The wider impact of a pandemic on the pharmacy sector needs further consideration.

Appendix B Scenario

Phase 1 - The new virus reached the UK, and within weeks there were dozens of cases being reported in rural farming and nursing homes in North Yorkshire, and in primary/ secondary schools in urban west London.

The first cases in England were identified in an agricultural student in a rural farming community in North Yorkshire, with hot spots subsequently emerging in a nursing home in Scarborough (also in North Yorkshire), and in West London (affecting universities/ schools and infant nurseries). The first case in England received care in Scarborough Hospital.

Early indications showed a particular susceptibility in the frail elderly, infants and the young adult population.

Phase 2 - It was two months later and the situation in the UK had escalated significantly. There had been thousands of reported deaths across the country with highest mortality in young adults, children and the frail elderly.

The National Pandemic Flu Service (NPFS) was active and Antiviral Collection Points (ACPs) were operational. All NHS beds in the acute and community sectors were full and nursing home / residential homes were at capacity, having difficulty in maintaining safe staffing levels and were closed to admission. There were high staffing absences and disruptions to essential supplies and services. Universities/schools and nurseries were closed.

The majority of public transport was disrupted with only an ‘emergency’ essential skeleton service running.

With hospitals and community care settings under extraordinary strain the provision of care within NHS Care settings as we currently know it was no longer possible. Patients were being cared for either in their home and/or other make-shift temporary environments.

All non-urgent routine and elective care was suspended, and all primary care providers were asked to re-task services to address the peak of the pandemic.

Members of the public who were not ill or showing immunity were asked to volunteer support and health services in the community.

In some areas, food supplies were starting to run short as many shops and supermarkets closed due to staffing absences, national food conserving and rationing advice was given by the media in anticipation of the situation potentially worsening.

Phase 3 - It was a further two months later (four months from the first case in North Yorkshire). The number of new cases was reducing in the UK and the health services were reducing pandemic response activities. However it was not known whether there could be another wave before the pandemic was declared over. There was potential for severe pressures across the country in the coming winter.

Appendix C List of Participants

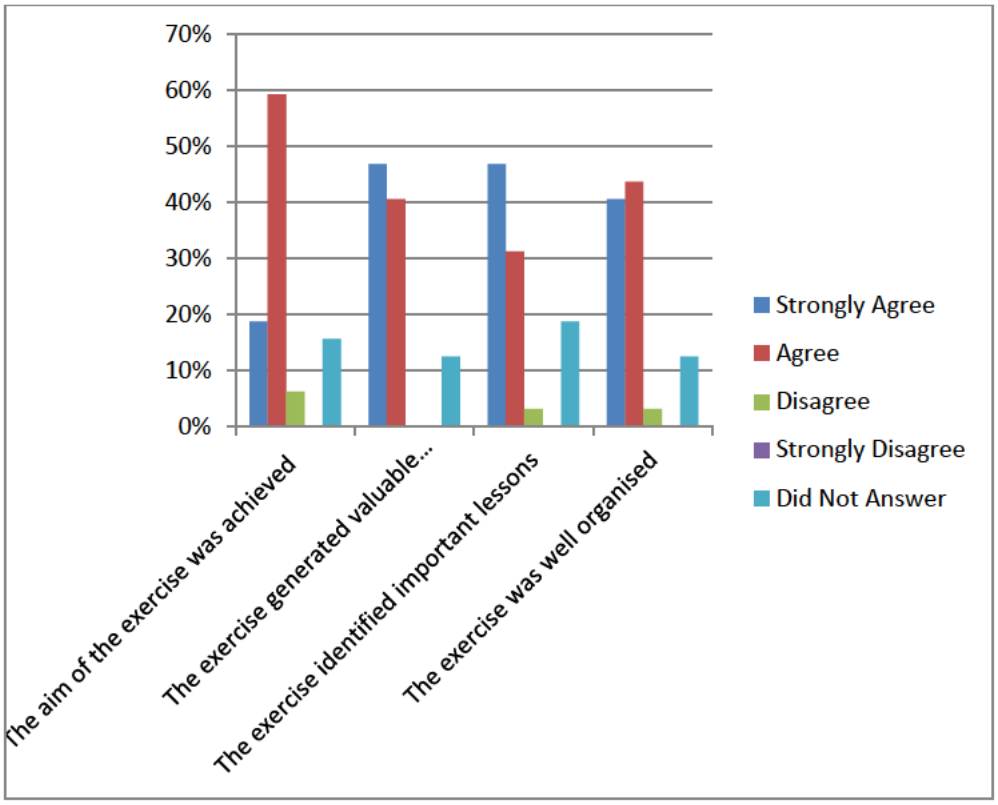
Appendix D Participant feedback

The effective evaluation of exercises is key in identifying areas for improvement and the information for the evaluation provided in this report is drawn from the following sources:

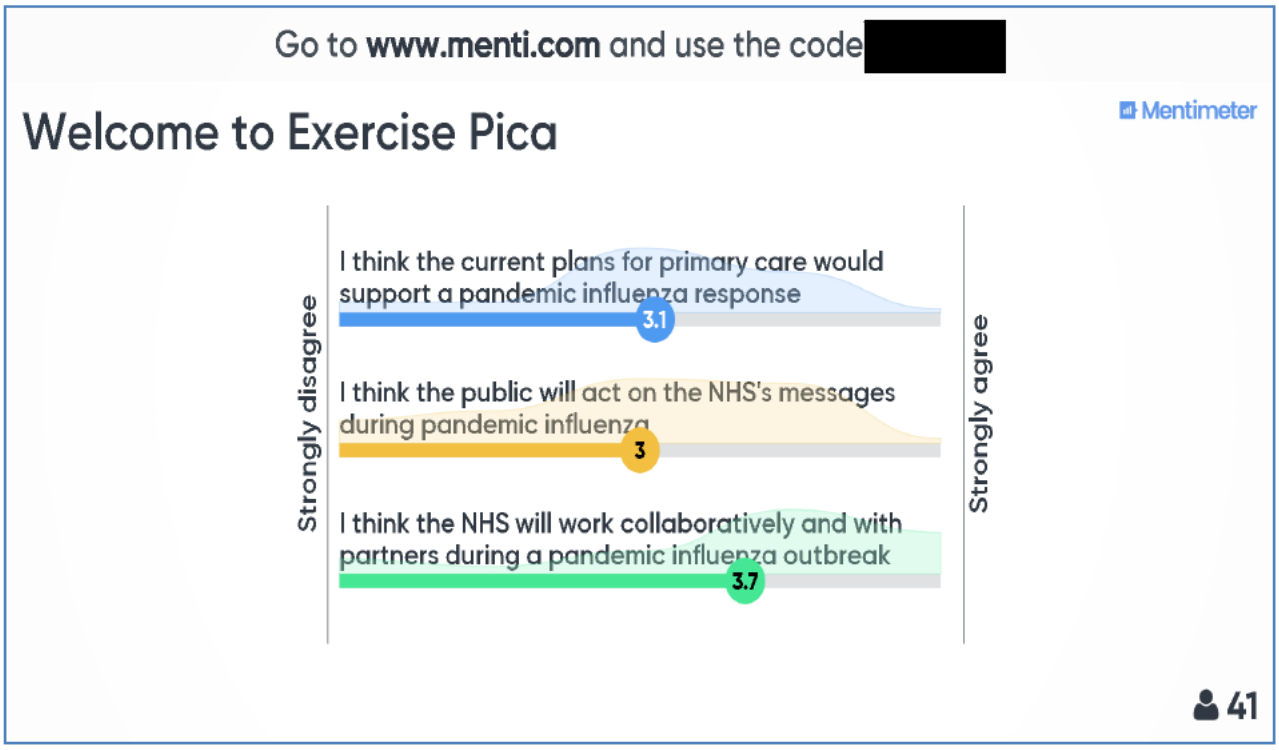
- participant feedback provided during the exercise;
- participant discussion during the plenary sessions;
- feedback and evaluation provided by the exercise controllers and planning team;
- post-exercise evaluation forms
- mentimeter

There were 47 attendees at the exercise, including 38 participants, 4 subject matter experts and 5 members of exercise control. Thirty-two completed and returned participant evaluation forms (82% return). From these, 78% of responses strongly agreed or agreed that the aim of the exercise was achieved 6% disagreed (due to not having enough time to discuss all the issues, and feeling that they didn't really get an opportunity to "red pen" the guidance document) and 88% thought the session's generated important issues and lessons identified (12% did not answer).

	Strongly Agree	Agree	Disagree	Strongly Disagree	Did Not Answer
The aim of the exercise was achieved	19%	59%	6%	0%	16%
The exercise generated valuable discussions and actions	47%	41%	0%	0%	12%
The exercise identified important lessons	47%	31%	3%	0%	19%
The exercise was well organised	41%	44%	3%	0%	12%

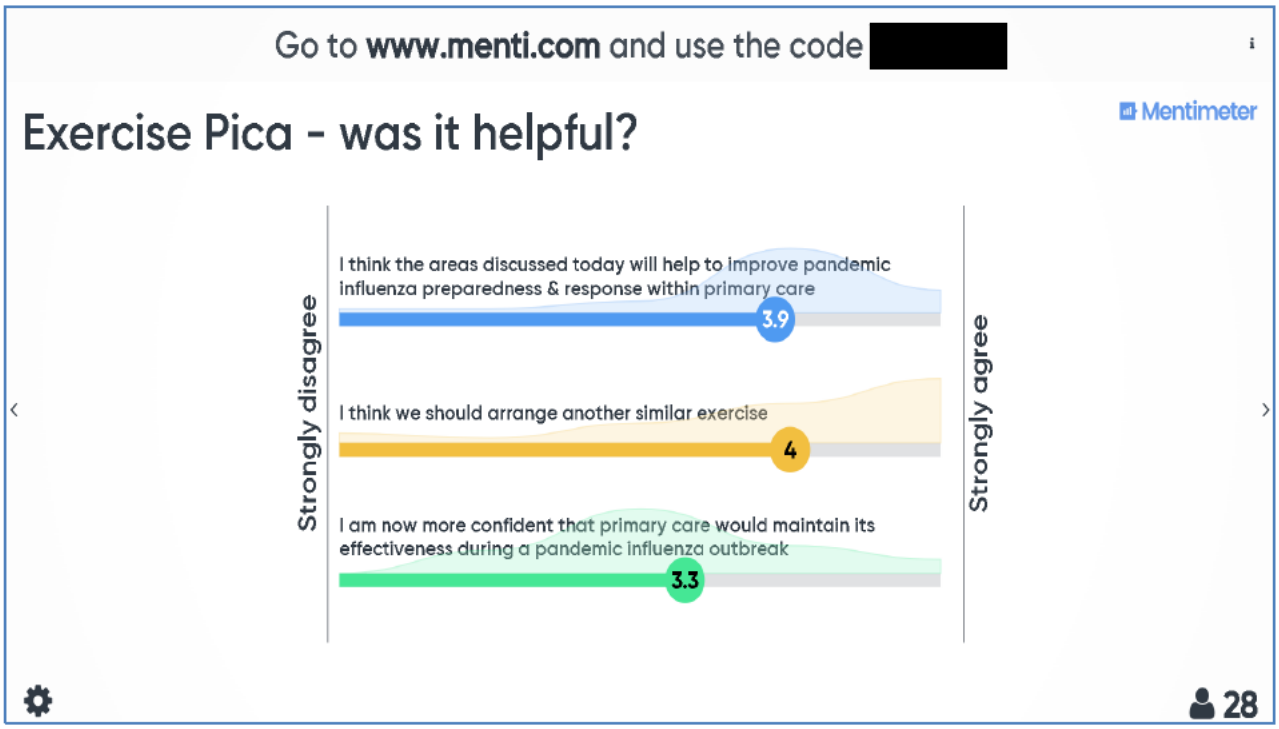


Before the exercise started, participants had the opportunity to give their opinion on the subject matter utilising an evaluation tool called mentimeter. Participants were asked before the exercise started whether they agreed or disagreed on three statements, the responses are shown below, with 41 responses.

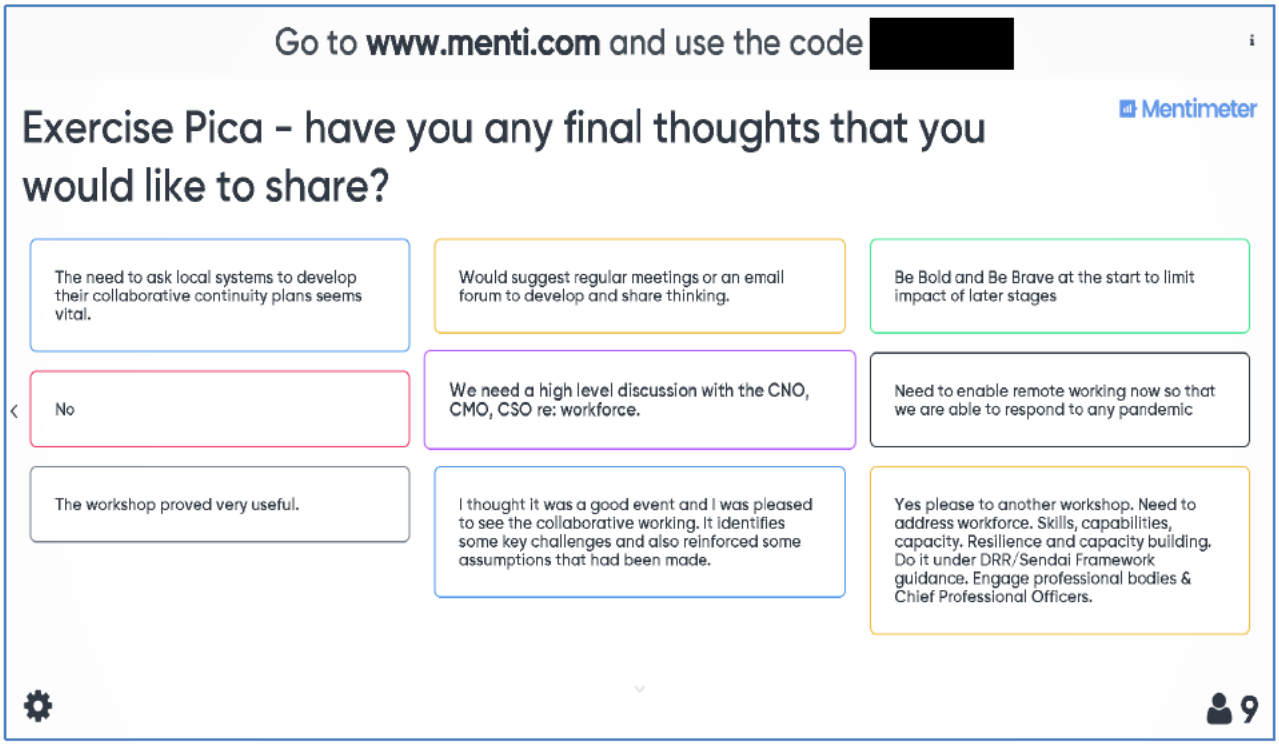


Following the exercise, participants were asked whether they agreed or disagreed with an additional three questions; the responses are shown below, with 28 responses.

Final Exercise Report: Exercise Pica



Finally participants were asked for final thoughts using the mentimeter system.



Appendix E - Glossary

BAU	Business As Usual
CCG	Clinical Commissioning Group
CCU	Civil Contingencies Unit
DHSC	Department for Health and Social Care
EPRR	Emergency Preparedness, Resilience and Response
ERD	Emergency Response Department
FODO	Federation of Ophthalmic and Dispensing Opticians
GMC	General Medical Council
GPhC	General Pharmaceutical Council
LOCSU	Local Optical Committees Support Unit
LRF	Local Resilience Forum
NFPS	National Pandemic Flu Service
NHS	National Health Service
NHSBSA	NHS Business Services Authority
PHE	Public Health England

Acknowledgements

Many people contributed to the planning, delivery and evaluation of this exercise. The exercise planning group would like to thank them for their time and efforts, with particular thanks to the participants.

It should be noted that following the exercise, comments were received on the current draft guidance "Primary Care potential roles and responsibilities" from [redacted] who was a participant at the exercise, these comprehensive comments have been gratefully acknowledged and forwarded to the author of the guidance for assistance in the review of this DRAFT document.

Distribution

[redacted]

Disclaimer

The exercise scenarios are entirely fictitious and are intended for training and exercise purposes only. The exercise report is provided by Public Health England and is subject to

This report has been compiled from the comments made by the participants during the exercise and the observations of facilitators and note takers. The report's author has tried to assimilate this information in an impartial and unbiased manner to draw out the key themes and lessons: the report is not a verbatim account of the exercise. The report is then quality checked by the senior management within PHE's Emergency Response Department before it is released to the sponsor organisation.

The lessons identified in the report are not therefore necessarily PHE's corporate position; they are evidenced on the information gathered at the exercise and interpreted in the context of ERD's experience and judgement. It is suggested that the lessons identified are reviewed by the appropriate organisations to assess if any further action is required.

Public Health England
Emergency Response Department
[redacted]

Tel: [redacted]

Follow us on Twitter @phe_uk