Resilience and Flood Risk

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Exercise PROMETHEUS
Control-Post Exercise 26th - 27th March 2015
Post-Exercise Report

29th June 2015

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Revision History

Version	Date	Amendments	Issued to
Draft v1	20th May 2015		Noel Sykes, FSA
Draft v2	29th May 2015	Minor amendments following review by FSA	Noel Sykes, FSA
Draft v3	5th June 2015	Minor amendments following comments from FSA Social Media Team	Noel Sykes, FSA
Final	29th June 2015	Minor comments from project manager to finalise	Noel Sykes, FSA

Quality Control

Action	Signature	Date
Prepared	Ray Pickering, RAB Consultants and Susan Escott, Escott Hunt	29th June 2015
Checked	Russell Burton, RAB Consultants and Kaarin Goodburn MBE, Acumentia Consulting	29th June 2015
Approved	Russell Burton, RAB Consultants	29th June 2015

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Executive Summary

Introduction

Exercise PROMETHEUS was a programme of three exercises in 2014/15 designed to test the Food Standards Agency's (FSA) new Incident Management Plan and improve the overall response to food incidents in the future working with staff and key partners from government and industry. This report summarises the observations and debrief undertaken during and after Exercise PROMETHEUS multi-agency control-post exercise which was delivered on 26th and 27th March 2015.

The aim of the control-post exercise:

> *To design, plan and deliver a UK-wide multi-agency test of the Food Standards Agency's new Incident Management Plan through a two-day control-post exercise by March 2015.*

A scenario was designed that escalated the incident to 'Major' in accordance with the Incident Management Plan, requiring cross-government response coordinated at Cabinet Office Briefing Room level. The food incident scenario included mycotoxin contamination of grain imported to the United Kingdom and an outbreak of *E.coli* O157 in Northern Ireland. The exercise commenced with impacts on human and animal health already being reported to the FSA by Public Health England and the Animal and Plant Health Agency

The exercise was deemed a success by the players with 86% agreeing or strongly agreeing that the exercise had met its aim.

Throughout the two-day exercise, facilitators observed a professional response and enthusiasm from all players in the exercise. A significant amount of good team work was observed at all three FSA offices plus positive feedback from external meetings such as Scientific Advisory Group for Emergencies and Cabinet Office Briefing Room. The participation of external partners added to the realism of the exercise. Key lessons have been identified and a number of recommendations formulated in partnership with FSA staff and external partners from government and industry.

A key challenge was the fact that the 'incident' had notionally been ongoing for some time which made it difficult for participants to move from a reactive to proactive stance in the early phase. This may have impacted on the prompt dissemination of information initially.

Summary of Lessons and Recommendations

Below is a summary of key lessons and recommendations to improve the FSA's incident response capability.

Organisational Command and Control

The FSA operates a three-tier command and control structure from Operational to Tactical and Strategic. Tactical and Strategic Incident Management Teams meetings' were convened by FSA staff during the exercise. Strategic meetings worked well and were effective in agreeing strategic objectives and response. Tactical meetings went over much of the same ground with many of the same personnel at both meetings. The Tactical Incident Management Team currently operates as a meeting but its role and function needs to be reviewed. The tactical response would be better delivered if the Tactical Incident Management Team operated as a multi-disciplinary tactical response cell responsible for implementing the strategic objectives from a formal incident room.

To ensure differentiation between the Tactical and Strategic Incident Management Teams, the Strategic Standard Operating Procedure should be strengthened to ensure only strategic areas of responsibility are included:

- Define, review and share strategic objectives.
- Ensure the communications strategy is appropriate for the incident and that it is implemented at the tactical level.
- Ensure the Tactical Team have the technical resources and support to respond effectively at the pace and scale of the incident.
- Political and reputation management.

The response structure should be able to initiate and respond 24 hours a day for 365 days per year.

Communication and Information

Communication and sharing of information within the devolved administrations was observed to be very good, in particular FSA Northern Ireland was very proactive at communicating with external agencies involved in the response and FSA Wales very good at sharing information around the responding team.

The impact of having so many key FSA staff tied up in meetings resulted in a lack of situational awareness at times across the wider organisation as it was a challenge to disseminate and share information coming out of the meetings. This, in turn impacted on the ability of the Briefing Cell to communicate and share information to partner organisations and to the communications teams, which had a knock on effect on the effectiveness of communications with the media.

At the strategic level, there is a need to clarify cross-government lines of liaison, communication and responsibilities of FSA Directorates with other government departments and ministers.

The consistency of media information across the FSA in London, Wales and Northern Ireland was impressive. However, at times, an information vacuum was created while FSA identified the likely cause of the food poisoning outbreak and also in part due to the challenge of ensuring situational awareness across the organisation. The following should be considered:

- While the use of social media as an intelligence-gathering tool was impressive, it could have been used more proactively to communicate advice and information.
- FSA spokespeople demonstrated a strong public face and clear leadership. Their deployment during an incident requires a more strategic approach to make best use of media interviews. Improved situational awareness across the organisation will enable spokespeople to provide more up to data and informative information.
- The meeting schedule required to fulfil the battle rhythm meant that the Communications team could not access the right people to get answers to journalists' questions and respond in a timely manner, an issue that could be resolved by improving the command and control, particularly at the tactical level.

Plans and Procedures

A number of recommendations are put forward to help strengthen the Incident Management Plan. These include:

- Identifying cross-government lines of communication at the strategic level.

- Strengthening the communication links between the devolved administrations and identifying the role of each.
- Improving the strategic risk assessment process.
- How FSA engages with the Scientific Advisory Group for Emergencies.
- Producing and using a register of staff capability/expertise to ensure the most effective use of technical expertise at any time during an incident.
- Setting out how FSA engages with the Four Nations' meeting.
- Reviewing the technical detail in the Standard Operating Procedures that support the Incident Management Plan.

Personnel

Feedback from exercise players suggests that a better understanding of roles and responsibilities in responding to non-routine incidents is needed amongst staff. To aid the understanding of roles and responsibilities both within the FSA and of other external partners, it is recommended that capability frameworks are developed that set out the knowledge, skills and responsibilities of individual roles required to help and support the FSA response to non-routine incidents.

Training

Future training and exercising should be linked to the incident management capability frameworks and include a programme of more frequent smaller scale training and drills and a programme of exercises to test, embed and then maintain revised arrangements.

Training should focus on roles, incident management structure and incident management skills and capabilities that are different from the day job including the use of the Incident Management Plan and Standard Operating Procedures.

Conclusion and Recommendations

The FSA developed a new Incident Management Plan following the June 2013 Professor Troop Review of the FSA's response to the contamination of beef with horse and pork meat. Exercise PROMETHEUS tested the Incident Management Plan in a simulated major food incident scenario that required cross-government response coordinated at Cabinet Office Briefing Room level. The exercise proved that the FSA are able to conduct an effective response to a major food incident in accordance with the Incident Management Plan and supporting procedures. However, the exercise also highlighted a number of lessons to strengthen and improve the overall response to future food incidents. Of significant importance is how the FSA responds at the tactical level, and how the organisation can improve its situational awareness to ensure proactive dissemination and sharing of incident information internally and to external partners, public and the media.

A total of 22 recommendations are presented within this report.

The following is a full list of the recommendations that are presented throughout the report.

Recommendation No.	Recommendation Detail
Organisational Command and Control	
RECOMMENDATION 1	How the command and control structure operates within the FSA should be examined to optimise its effectiveness during non-routine incidents and improve situational awareness across the organisation. Of particular importance is the role and strategic functioning of SIMT compared with the TIMT. TIMT should operate more effectively as a multi-disciplinary tactical response cell.
RECOMMENDATION 2	Administration of key meetings (SIMT/TIMT/Bird-Table etc.) should be improved to ensure invites and agendas are issued to all attendees ahead of time and that actions from the meeting are communicated rapidly to the rest of the organisation.
Communication and Information	
RECOMMENDATION 3	The FSA needs to have better systems in place that will improve situational awareness during incidents to provide a common view of the incident. The sharing of this information across the FSA, other government departments and partners needs also to be examined. In particular: (a) How to improve the activation and functioning of the Briefing Cell that considers: routes of communications in and out of the FSA (including to devolved administrations); membership of the Cell; roles and responsibilities; prompt communications; procedures to initiate, manage and stand down the Cell; and holding statement/lines to take at various stages of an incident. (b) A review of the logs recorded in FSA incident database to determine whether key decisions and actions were appropriately logged would serve to identify if improvements are needed in incident logging. (c) The IMP or a SOP could include tips on best practice logging.
RECOMMENDATION 4	The FSA should look at how it liaises with government partners and other stakeholders during an incident and consider in particular: early and proactive communications with partners and the structure, focus and function of the Bird-Table and stakeholder liaison meetings.
Infrastructure (Equipment and Resources)	
RECOMMENDATION 5	The use of telephone and videoconference equipment should be reviewed to check that it meets the needs of the FSA in managing non-routine incidents. Improvements to the technology and the protocols for its use should be implemented to ensure effective sharing of information and an efficient use of time.
RECOMMENDATION 6	The FSA should examine the use of service level agreements with sampling and testing contractors to ensure speed and capacity of response in major incidents.

Recommendation No.	Recommendation Detail
RECOMMENDATION 7	FSA should investigate the benefits of having dedicated incident rooms or co-locating key elements of the Tactical team during non-routine incidents.
RECOMMENDATION 8	Consider 24/7 operation and training of back-up staff within the FSA to fulfil defined non-routine incident response roles. Consider the potential resources available to the FSA from external partners, in particular from local authorities. Create a call-out list of partners who may be able to provide additional resource in major incidents potentially through other government departments or enforcement partner organisations. The arrangements would need to be included within the IMP or stakeholder management plans.
Plans and Procedures	
RECOMMENDATION 9	Provide a register identifying the capability/expertise of internal staff and teams to help define membership of TIMT in terms of the required technical and policy expertise
RECOMMENDATION 10	Through the use of the above register, ensure that all relevant expertise is commissioned at the appropriate time within an incident and that each person has access to the most up to date information available.
RECOMMENDATION 11	The IMP should clearly identify cross-government lines of liaison at the strategic level and emphasise the importance of a co-ordinated consistent approach to the briefing of ministers across the FSA and other government departments.
RECOMMENDATION 12	The roles and responsibilities set out in the IMP covering England, Wales and Northern Ireland should be re-visited to make sure they are fit for purpose during non-routine incidents and facilitate strong communications with each other; particularly where one administration is managing a different incident to the rest of the country.
RECOMMENDATION 13	A review of the strategic risk assessment process should be undertaken to simplify the process and make it fit better with the IMP requirements for escalation and incident command and control structure.
RECOMMENDATION 14	As part of the IMP, the role and function of SAGE should be set out in in terms of how the FSA is most likely to engage with it. The FSA, through a possible competency framework, should identify in advance who would be most likely to represent the FSA at SAGE and identify independent food and feed experts before incidents occur, to allow for pre-engagement. The FSA should focus on participating in cross-government exercises where SAGE is played to get a broader / better understanding of the FSA's role.
RECOMMENDATION 15	The role and function of the Four Nations' meeting and how the FSA is expected to engage with it should be set out in the IMP.
RECOMMENDATION 16	The SOPs that support the IMP should be reviewed to ensure that the right level of technical and operational detail is included. Staff should be regularly drilled in the use of both the SOPs and IMP.

Recommendation No.	Recommendation Detail
Personnel	
RECOMMENDATION 17	Incident response roles should be underpinned by capability frameworks that set out the knowledge, skills and responsibilities that are required to help and support the FSA response to non-routine incidents. The framework should be embedded into the organisation through training to allow staff to develop over time.
Training	
RECOMMENDATION 18	Future training and exercising should include a programme of more frequent smaller scale training and drills and a programme of exercises to test, embed and then maintain revised arrangements including use of the IMP and SOPs. Training should focus on roles, incident management structure and incident management specific skills and capabilities. These include but are not limited to: - Incident Logging - Leadership - Situational Awareness - Roles and Responsibilities (internally and externally) - Communication - Strategic Objectives - Tactical Objectives - Decision Making - Information Management - Health, Safety and Welfare - Incident room set up and management - Use of IT in incident management - IMP and SOPs - Best practice in effective chairing and management of meetings and tele/video conferences
Media and Social Media	
RECOMMENDATION 19	The FSA needs to consider how it can be more proactive in providing information to the media/social media to fill the information void whilst an incident is being investigated. Explanation of what is being done and on what basis key decisions are being made and some standard holding lines to take would be beneficial.
RECOMMENDATION 20	The role of a lead government department should be to ensure that all other agencies involved are speaking with one voice and that messages are consistent and complement each other.
RECOMMENDATION 21	FSA has strong spokespeople. A more strategic approach needs to be taken to their deployment so that the media interviews can be used to best effect, coupled with the ability of the organisation to improve situational awareness that enables more up to date and informative information to be provided.

Recommendation No.	Recommendation Detail
RECOMMENDATION 22	The systems are in place at the FSA for the effective use of social media to provide advice, guidance and regular updates on what the FSA is doing. However, the exercise threw up the need for people involved in an incident, and specifically a properly resourced Briefing Cell, to be digitally aware and suitably responsive to external communication during the course of an incident. There should be an internal awareness campaign to help develop these skills.

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Contents

Abbreviations

Abbreviation	Definition
ACTSO	Association of Chief Trading Standards Officers
APHA	Animal and Plant Health Agency
BHA	British Hospitality Association
BRC	British Retail Consortium
CIEH	Chartered Institute of Environmental Health
CO	Cabinet Office
COBR	Cabinet Office Briefing Room
CONOPS	Cabinet Office Concept of Operations
CPX	Control Post Exercise
DARD	Department of Agriculture and Rural Development
DCLG	Department for Communities and Local Government
DEFRA	Department for Environment, Food & Rural Affairs
DHSSPS	Department of Health, Social Services and Public Safety
DOH	Department of Health
EFSA	European Food Safety Authority
EHO	Environmental Health Officer
EU	European Union
FDF	Food and Drink Federation
FSA	Food Standards Agency
FSAI	Food Safety Authority Republic of Ireland
FSANI	Food Standards Agency in Northern Ireland
FSAS	Food Standards Agency in Scotland
FSAW	Food Standards Agency in Wales
ExMS	Exercise Messaging System
Go-Science	Government Office for Science
IMP	Incident Management Plan
NI	Northern Ireland
PHE	Public Health England
RAB	RAB Consultants Ltd
ROI	Republic of Ireland
SAGE	Scientific Advisory Group for Emergencies
SOP	Standard Operating Procedure

1.0 Introduction

The Food Standards Agency's (FSA) exercise programme was designed to test the new Incident Management Plan (IMP) and improve the overall response to food incidents in the future working with key partners. RAB Consultants was engaged to aid the planning and delivery of the programme. The exercise was codenamed PROMETHEUS.

Exercise PROMETHEUS was a three-exercise programme that ran a continuous food incident scenario. The first exercise, Table-top 1, was an internal FSA exercise that focussed on the new IMP, in particular the activation and escalation procedures. Table-top 2 was a high-level government and industry partners' workshop to introduce the exercise scenario and agree participation in the multi-agency control-post exercise (CPX). The CPX was held on 26-27th March 2015 with control posts at FSA Offices in London, FSA Wales (FSAW) in Cardiff and FSA Northern Ireland (FSANI) in Belfast. A hot debrief immediately followed the exercise and a post-exercise debrief workshop was held with FSA and partners on 20th April 2015 to capture the multi-agency lessons. All players were invited to evaluate the delivery and management of the exercise, the results of which are summarised in Chapter 5.0.

The aim and objectives of Exercise PROMETHEUS were as follows:

1.1 Aim

To design, plan and deliver a UK-wide multi-agency test of the FSA's new Incident Management Plan through a two-day control-post exercise by March 2015.

1.2 Objectives

1. To deliver a two-day control post exercise involving a major food incident to test the new IMP arrangements, including embedded procedures and roles.
2. To scope and agree a food incident scenario that presents a potential risk to the public; requires risk assessment, tests the triggers for and escalation; and tests the resilience of staff resources.
3. To identify and gain buy-in from partners that will be involved in the exercise programme and help shape the detailed scenarios.
4. To test the interaction of cross-nation working with devolved administrations.
5. To identify lessons from the exercises and make recommendations that will further improve the FSA response to food incidents.

1.3 Purpose of this Document

This report outlines how the exercise was planned and implemented. It identifies issues and lessons arising from the CPX and considers improvements for the future. This is achieved by drawing upon observations, comments and notes made by directing staff and players during the exercise, as well as views obtained during the hot debriefs, post-exercise debrief and exercise evaluation.

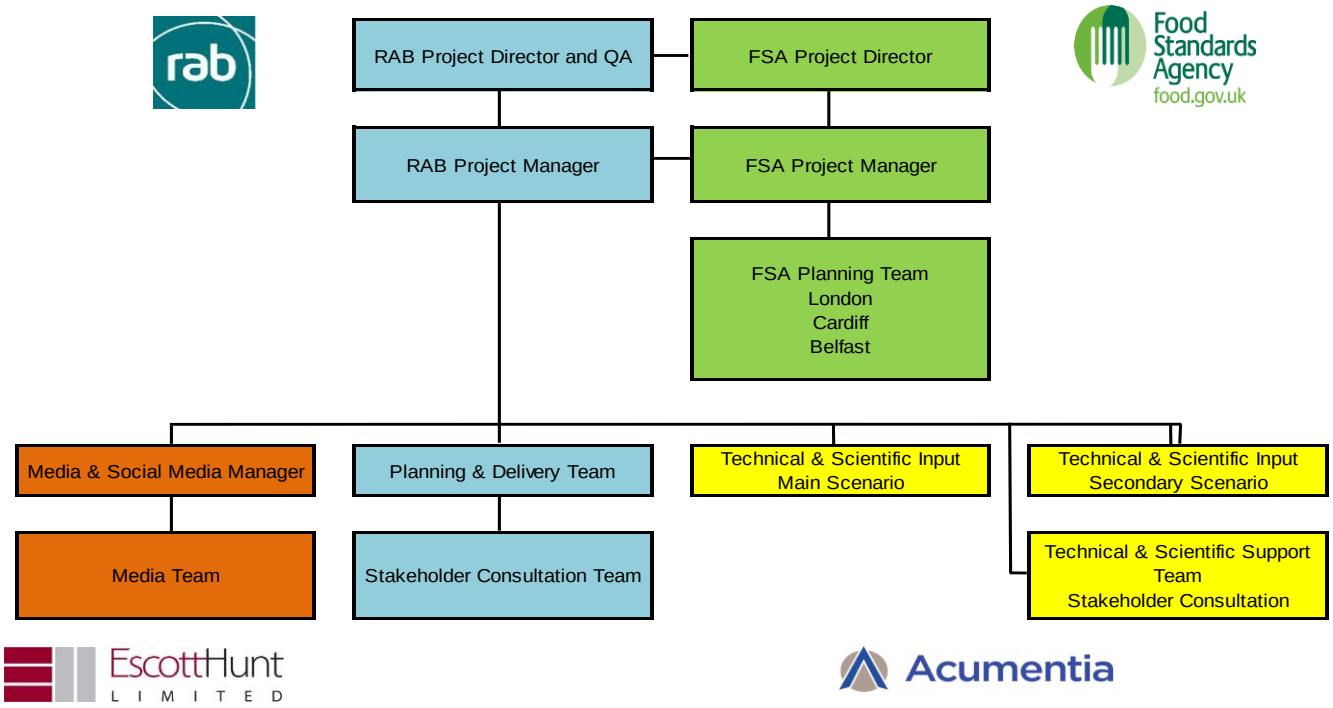
This report does not seek to criticise or comment on individual performance, but to highlight possible good practice and limitations with the current systems and processes in place to respond to and manage a major food incident in the UK.

2.0 Exercise Planning and Organisation

2.1 Exercise Planning Group

RAB Consultants partnered with FSA officers to form the Exercise Planning Group to ensure the exercise met the specific requirements. Technical and scientific support was sub-contracted to Acumentia Consulting, a group of highly qualified and experienced consultants who provide services to the food & drink and pharmaceutical & healthcare industries; Escott Hunt, one of the largest providers of exercise media in the UK was sub-contracted to provide media play throughout the programme.

Figure 1 – Exercise Planning Group Structure



The role of the Exercise Planning Group was to act as subject matter experts and review and approve the exercise proposals and documents during development.

The Planning Group met frequently to discuss the exercise and set actions for each member to deliver. Regular focussed teleconferences allowed detailed issues to be discussed and ironed out.

The planning process was a significant undertaking to ensure there were sufficient and realistic injects throughout the exercise period, and that pre-exercise injects were carefully designed. At times, specialists from the FSA were brought in, as and when required, to review the technical and scientific elements of the scenarios.

2.2 Exercise Scenarios

Two food incident scenarios were designed. The FSA required that the main scenario should have a significant impact such that it would trigger health impacts that would meet the criteria for a 'Major' incident under the IMP and escalate to Cabinet Office Briefing Room (COBR). The secondary scenario was required to have impacts in Northern Ireland that were not linked to the main scenario and would provide an opportunity to test cross border communications with the Republic of Ireland albeit in a simulated environment.

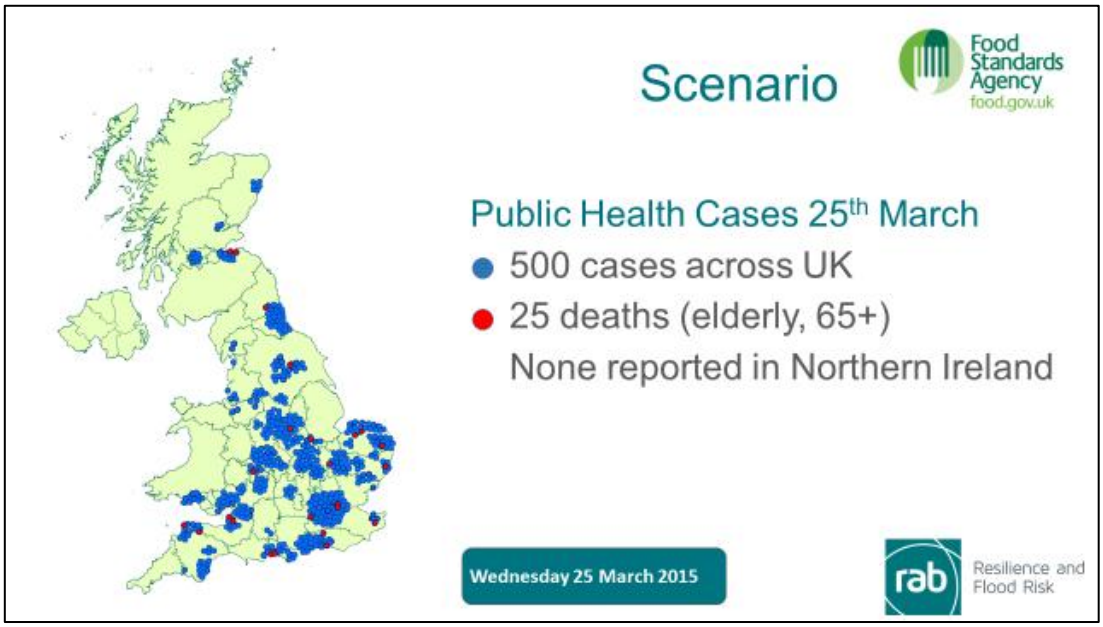
> **Major** incidents are of such severe significance that they cannot be co-ordinated or dealt with solely by the FSA and require a cross government response coordinated at COBR level. Depending on the nature of the incident, the FSA may assume various responsibilities including acting as the Lead Government Department.
>
> FSA Incident Management Plan V2

All players were given advance notice of the impacts of the scenarios leading up to start of the CPX on Day 1 (26th March 2015) via players packs issued in advance. This information was also provided at the exercise briefing on the morning of Day 1.

Main Scenario: Contamination of Grain Imported to the UK

The main scenario was mycotoxin contamination of grain that affected both human and animal health. This resulted in significant numbers of illness in the human population, including multiple deaths in vulnerable consumers and a substantial number of cattle herds being impacted, again resulting in illness and death. At the start of the exercise, the following impacts were reported by Public Health England (PHE).

Figure 2 – Slide Presented at Start of Exercise to Highlight Human Impact



Secondary Scenario: *E.coli* O157 Outbreak in Meat Products Sold in Northern Ireland

This scenario was based around a farm shop in Northern Ireland near the border with the Republic of Ireland. The farm shop is a producer of meat and meat products and distributes direct to the public through the shop and via internet sales. It also sells to other businesses through a distributor working in both Northern Ireland and in the Republic of Ireland, to retailers, care homes, schools and hospitals. Contamination of the production environment by *E.coli* O157 arises affecting raw lamb, cooked beef and hot-smoked duck.

The impacts were first noted by the Food Safety Authority of Ireland (FSAI) in the Republic of Ireland six days before the start of the exercise on 20th March 2015. The exercise briefing included early simulated communication from FSAI to FSANI to advise of a developing incident in the Republic of Ireland.

2.3 Communications Objectives

The aim was to provide a comprehensive test of the FSA's media and social media strategy with a view to ensuring that information released was accurate, easily understood, consistent and timely.

This aim was broken down into eight communications objectives and feedback is provided against each of these.

It was decided that the focus should be on examining the quality of information provided and that this exercise would not test capacity. In the event, all communications teams faced significant pressures throughout the two days but worked hard to deal with them, while continuing to manage their real-world operations.

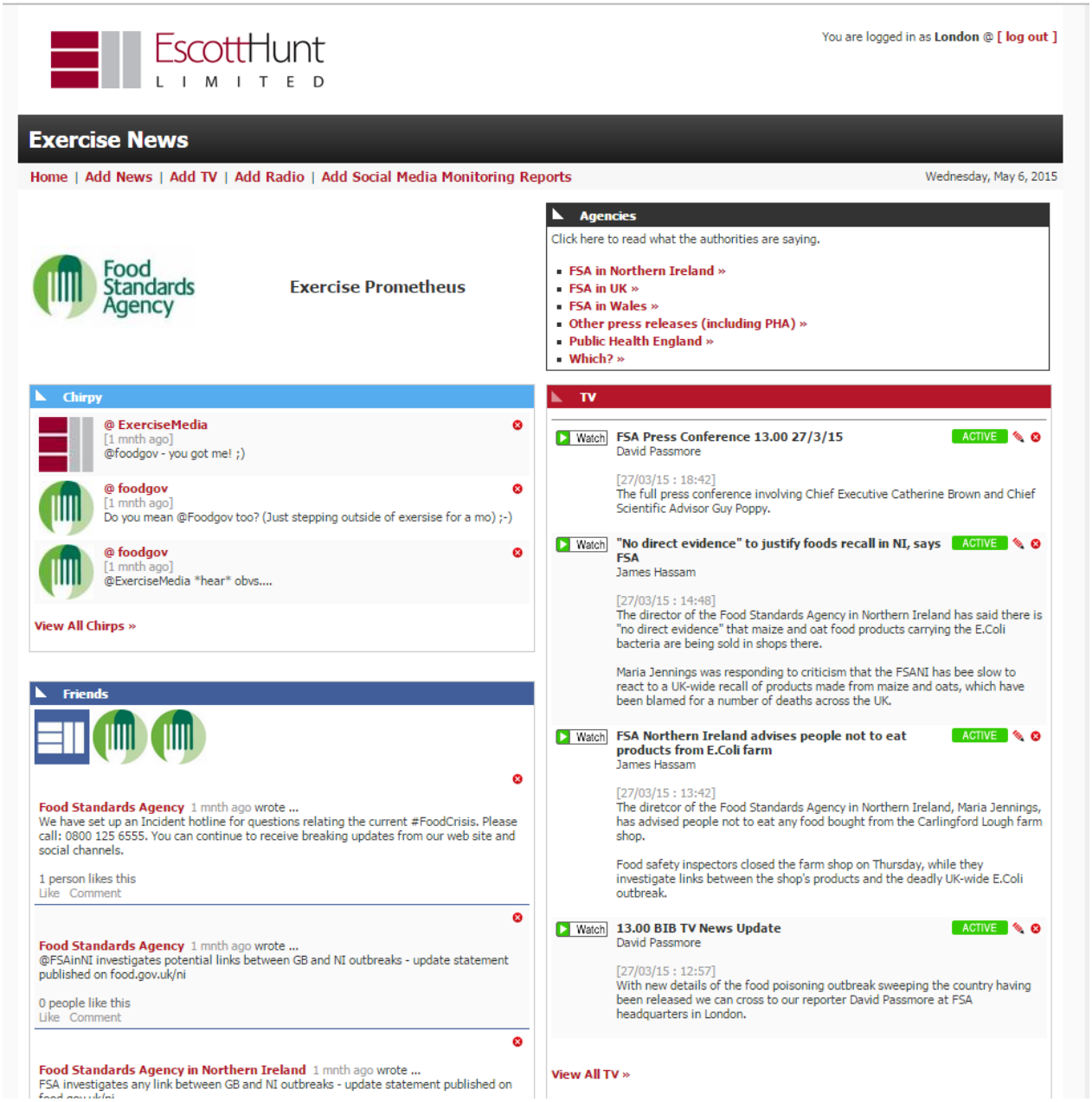
The eight communications objectives were:

1. To ensure the timeliness of information.
2. To demonstrate consistency of information in a UK-wide response (excluding Scotland).
3. To explore any potential tensions between different responding agencies.
4. To rehearse FSA's ability to prepare spokespeople for in-depth interviews.
5. To ensure that there is a strong public face and clear leadership.
6. To demonstrate the proactive use of social media and the ability to react appropriately, particularly to stories that would have significant impact.
7. Effective media/social media monitoring.
8. To test ability to prioritise multiple tasks.

An exercise media contingent produced TV, radio and online news reports during the exercise. The coverage was accessed via a password-protected website (see Figure 3). Mock versions of Twitter ('Chirpy') and Facebook ('Friends') was also simulated and all players could access these and contribute. Players were also able to read the latest press releases and other information issued by key responding agencies.

Feedback on how well the communications objectives were met can be found in Chapter 4.0.

Figure 3 – Exercise PROMETHEUS Media and Social Media Website



2.4 Stakeholder Engagement

A key part of the exercise planning was to engage with stakeholders on both exercise planning and exercise participation. The key stakeholders were identified by the FSA Exercise Planning Group and included:

- Government departments:
  - Animal and Plant Health Agency (APHA);
  - Cabinet Office (CO);
  - Department for Communities and Local Government (DCLG);
  - Department for Environment Food and Rural Affairs (DEFRA);
  - Department of Health (DH);

- Government Office of Science (Go-Science); and
- Public Health England (PHE).
- Food Industry Bodies and Trade Associations:
- Association of Chief Trading Standards Officers (ACTSO);
- British Hospitality Association (BHA);
- British Retail Consortium (BRC);
- Chartered Institute of Environmental Health (CIEH);
- Food and Drink Federation (FDF); and
- Which?

A series of stakeholder liaison meetings were held throughout February and early March 2015 as part of the scenario planning stage. At each meeting the general scenario was presented to each stakeholder giving them a chance to ask questions and confirm understanding. The meetings were also an opportunity to agree and plan how each stakeholder could be represented by exercise injects and how each stakeholder would 'play' on each day of the exercise.

These meetings were key in gaining engagement with each stakeholder and enabled effective scenario planning to make the exercise as close to reality as possible.

2.5 Exercise Control

Exercise Control was located across three FSA offices: FSA in London, FSAW in Cardiff and FSANI in Belfast. Whilst, the then, FSA Scotland (FSAS) was not playing, a member of the FSAS team was available to receive exercise communications that would otherwise have been made to the organisation.

All aspects of the exercise were managed from Exercise Control including the exercise injects and timing.

2.6 Exercise Players

FSA Players

Over 60 FSA staff from a wide range of departments in London, FSAW and FSANI took part in the exercise.

The following FSA teams participated in the exercise:

- FSA England
  - Private Office
  - Consumer Protection Division - Incidents & Resilience
  - Science - Microbiology
  - Science – Chemical Risk Assessment Unit
  - Policy – Agriculture, Process & Environmental Contaminants
  - Communications
  - Regulatory and Legal Strategy
  - Finance
  - Human Resources
- FSA Wales
  - Enforcement Strategy, Audit and Incidents

    - Communications
- FSA Northern Ireland
    - Consumer Protection Unit
    - Communications

FSA players were expected to respond in accordance with the IMP and Standard Operating Procedure (SOPs), and to proactively engage with partners throughout the exercise to effectively manage the response to the major food incident.

Partner Players

A total of 25 external players from government and industry also played in the exercise from the following organisations, a number of which also contributed to the planning of the exercise.

- Association of Chief Trading Standards Officers (ACTSO)
- Animal and Plant Health Agency (APHA)
- British Hospitality Association (BHA)
- British Retail Consortium (BRC)
- Cabinet Office (CO)
- Chartered Institute of Environmental Health (CIEH)
- Department for Communities and Local Government (DCLG)
- Department for Environment, Food & Rural Affairs (DEFRA)
- Department of Health (DH)
- Food and Drink Federation (FDF)
- Government Office for Science
- Public Health England (PHE)
- WHICH?

2.7 Exercise Battle Rhythm

During the planning for the exercise, the Exercise Planning Team proposed a battle rhythm for the exercise, with the expectation of a simulated Ministerial COBR meeting at the end of Days 1 and 2. The battle rhythm identified key meetings such as COBR Officials, simulated Ministerial COBR and Scientific Advisory Group for Emergencies (SAGE) and tentatively identified when internal Strategic Incident Management Team (SIMT) and Tactical Incident Management Team (TIMT) meetings might take place to meet the requirements of COBR and the escalating incident.

Figure 4 and Figure 5 below show the final battle rhythm that was played out during the exercise.

Figure 4 – Day 1 Battle Rhythm

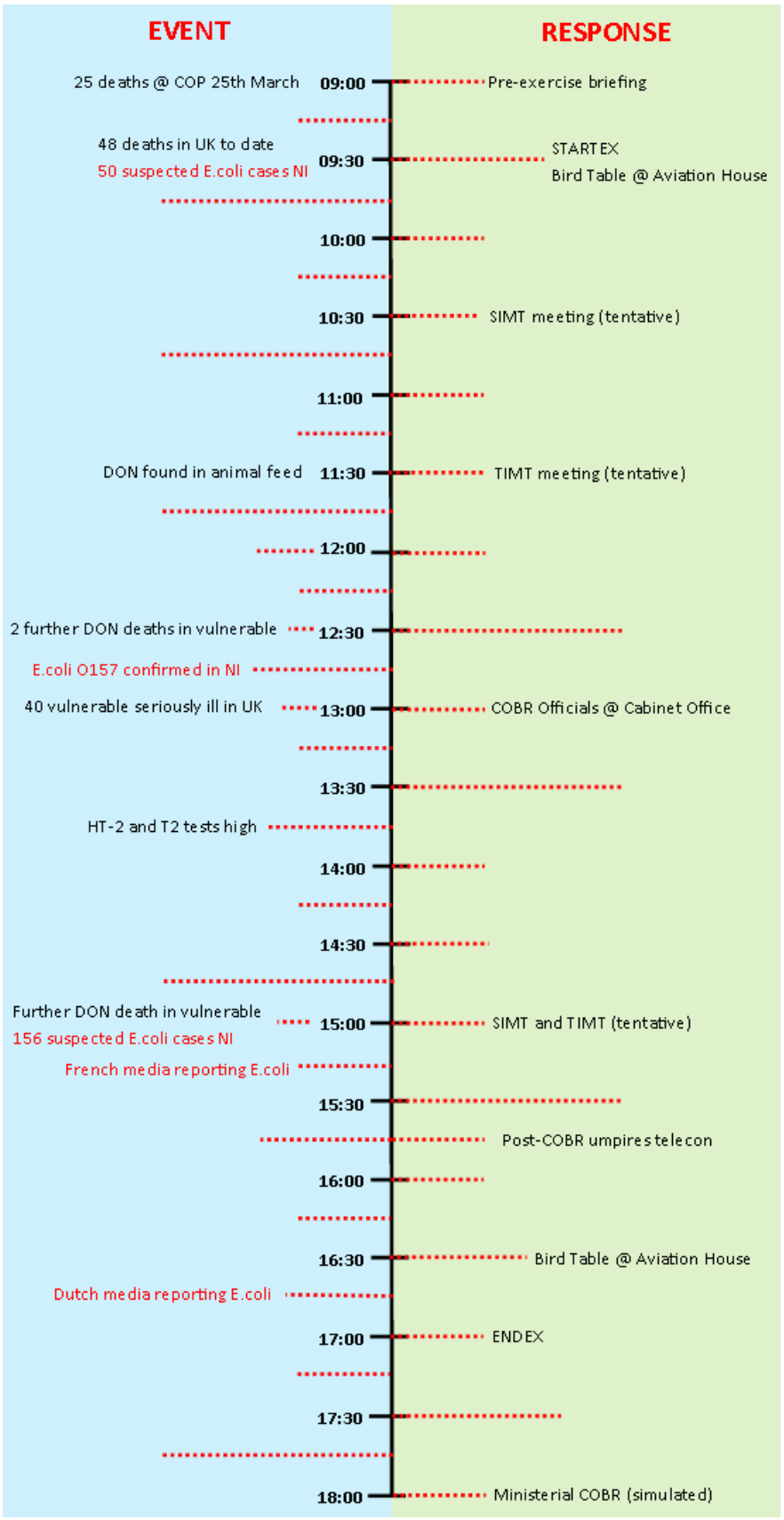
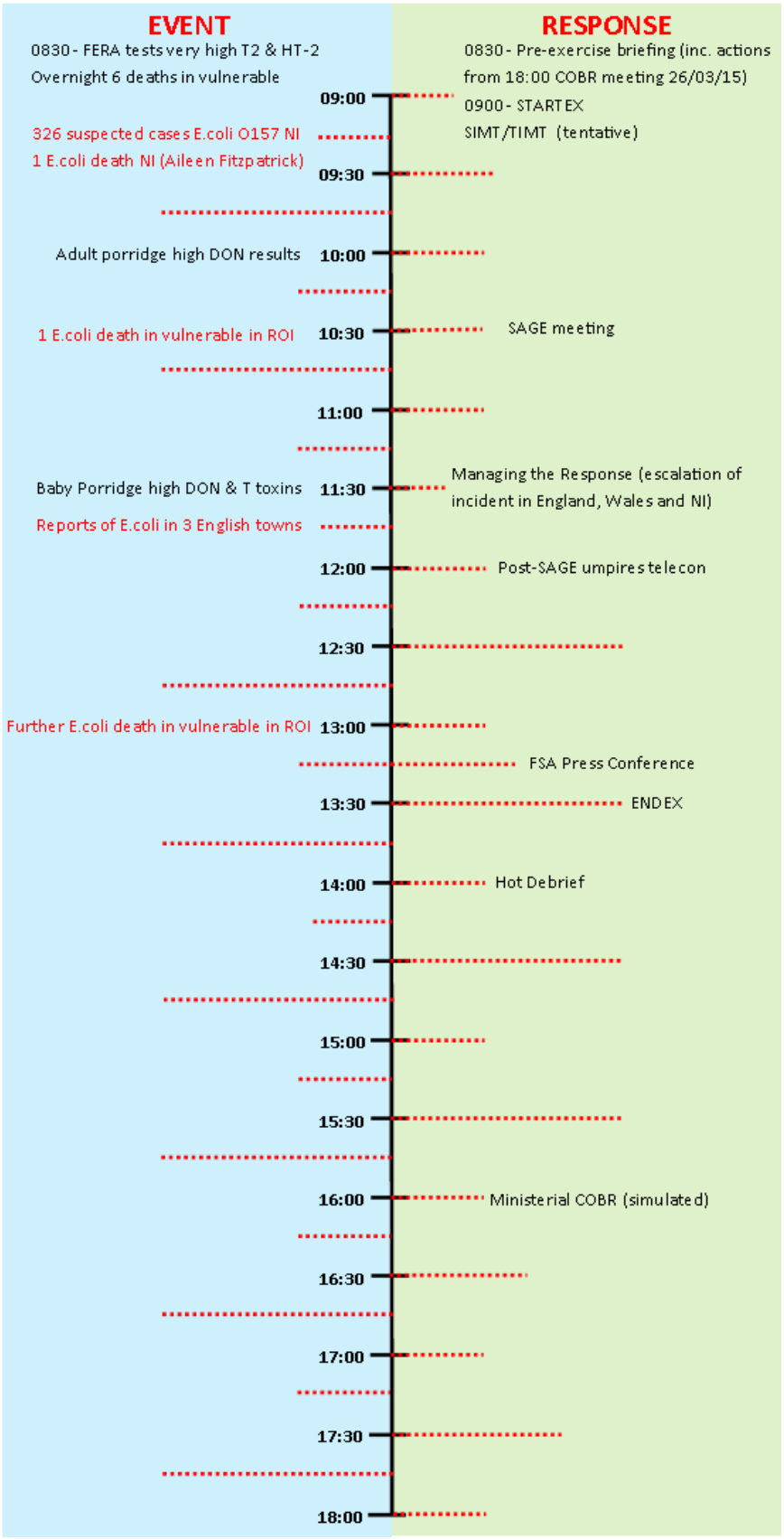


Figure 5 – Day 2 Battle Rhythm



2.8 Day 1 and 2 Agenda

The agenda issued to players for each day of the CPX is shown below.

Table 1 – Day 1 Exercise Agenda

Time	Activity
08:30 - 08:45	Arrive and Register
09:00 – 09:30	STARTEX Briefing issued to all players at each control post. • FSA London: Conference Room A and B • FSAW: Conference Room 1 and 2 • FSANI: Conference Room 1
09:30	Bird-Table Meeting
09:30 – 17:00	Exercise play
17:00	ENDEX

Table 2 – Day 2 Exercise Agenda

Time	Activity
08:30 - 08:45	Arrive and Register
09:00 – 09:30	Briefing issued to players via email
09:30	STARTEX
09:30 – 15:00	Exercise play
15:00	ENDEX
15:15 – 16:00	Hot debrief for FSA players
16:00	Close

2.9 Exercise Messaging System (ExMS)

During the exercise ExMS was used for:

- ensuring that all pre-prepared email injects were delivered on time and in accordance with the PROMETHEUS Main Events List;
- delivering email communication from non-participating organisations to FSA players;

- delivering pre-planned emails from participating organisations to the FSA;
- delivering FSA Helpline referrals to the Investigations Team from simulated public and other partner phone calls; and
- delivering pre-prepared lab test results.

2.10 Debriefing and Evaluation

To capture the lessons from the exercise the debrief process was two-fold:

1. A 'hot' debrief to capture immediate lessons following the exercise; and
2. A post-exercise debrief workshop to bring together the multi-agency partners with FSA staff.

An overview of each is provided below.

Hot Debrief

A hot debrief led by RAB Consultants took place at the end of Day 2 in FSA London, FSAW and FSANI. For those players that could not attend the hot debrief in person, an online version was created that mirrored the questions posed. The hot debrief had the following aims:

- For players to reflect on their experience of using the new FSA Incident Management Plan in response to exercise PROMETHEUS.
- These views to be shared and discussed to identify lessons from the exercise and make recommendations that will further improve the FSA response to food incidents.

The hot debrief allowed participants to answer three simple questions to help identify lessons from the exercise:

Initial Prompt

- For me, the least effective element of our response during the Exercise was…
- For me, the most effective element of our response during the Exercise was…

Final prompt

- My suggestion of how we can improve our joint response in the future is…

A visual was presented that represents the IMP arrangements tested during the exercise:

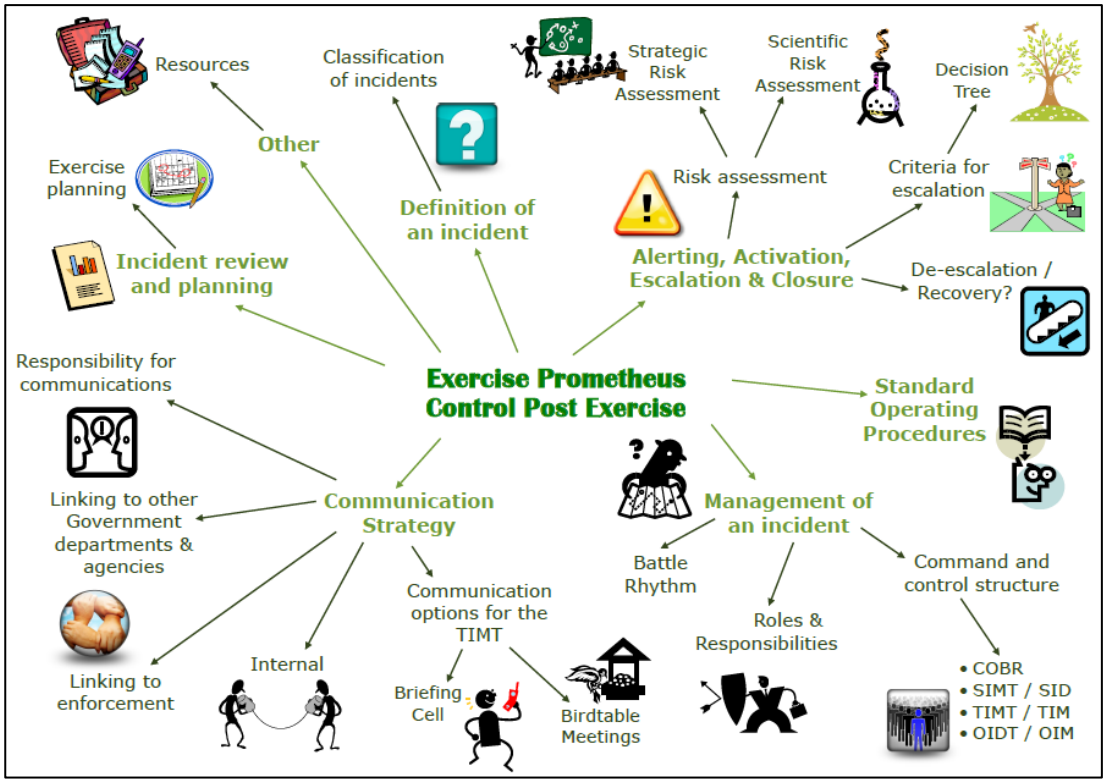


Figure 6 – Hot Debrief Visual Aid

The lessons from the hot debrief and observations of the exercise are discussed in Chapter 3.0.

Post-exercise Debrief Workshop

A debrief workshop led by RAB Consultants took place on 20th April 2015 at FSA offices in London. The aim of the workshop was to identify lessons from the exercise and make recommendations that will further improve the FSA response to food incidents.

The workshop had three objectives to support its aim:

- FSA staff from London, FSANI, FSAW and FSAS to share experiences in order to identify lessons from the exercise.
- All partner organisations who played in the exercise to share experiences in order to capture the wider multi-agency lessons from the exercise.
- To identify recommendations to improve the FSA IMP and to improve incident response with government departments and food industry and consumer stakeholders.

The workshop commenced with a presentation of the lessons identified from the analysis of the hot debrief and the observations made during the exercise. An opportunity was provided to discuss the lessons and identify any that had not been highlighted during the presentation. Participants were then split into three groups and tasked with identifying recommendations to address to the key lessons. The groups and questions and summarised below:

- Group 1 – FSA Staff: “My top 2 recommendations to improve our incident response are…”

- Group 2 – COBR and SAGE: “My top 2 recommendations to improve the COBR, SAGE and Bird-Table meetings in response to food related incidents are…”
- Group 3 – Stakeholders and Communications: “My top 2 recommendations to improve communications with media and stakeholders in response to food related incidents are…”

Lessons from the debrief workshop have been analysed and captured in Chapter 3.0.

Exercise Evaluation

Exercise evaluation was via an online survey. This provided participants with the opportunity to express their thoughts on the running and structure of the exercise and to assess whether they thought the objectives of the exercise had been met.

The summary of feedback received from the evaluation forms is discussed in Chapter 5.0.

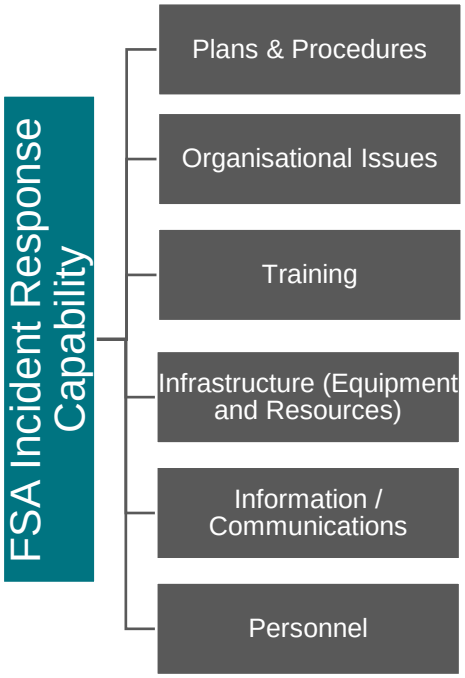
3.0 Lessons Identified During Exercise PROMETHEUS

3.1 Introduction

The key lessons are captured below and contribute towards meeting Objective 5 of the exercise which is about learning lessons to further improve the FSA response to food incidents.

Lessons identified as a result of the exercise have been collated using a military capability development concept called TEPID OIL. This is where lessons to improve capability are categorised under common key topics (Training, Equipment, Personnel, Information, Doctrine, Organisation, Infrastructure and Logistics).

For the purposes for the Exercise PROMETHEUS these have been streamlined into the following topics and these all link into improving the FSA incident response capability.



Throughout the two-day exercise, the facilitators observed a professional response and enthusiasm from all players who participated in the exercise. A significant amount of good team work was observed at all three FSA offices plus positive feedback from external meetings such as SAGE and COBR. The participation of external partners added to the realism of the exercise. The observations below do not seek to criticise any individuals, rather highlight issues that should be addressed.

3.2 Information and Communication

Communication and sharing of information within the devolved administrations was observed to be very good. In FSANI there was proactive and effective sharing of information with FSAI (simulated) on the developing incident in Northern Ireland and regarding the potential link with E.coli outbreaks in Paris and Amsterdam. FSANI staff were observed asking detailed and challenging questions of partners with prompt and proactive liaison with public and external partners (EHOs, FSAI, DARD,

DHSSPS). In FSAW, there was good communication observed internally between the responding staff including post SIMT/TIMT briefings to the team.

From observations and debrief comments, there was a feeling that situational awareness was an issue across some areas of the FSA. The Chemical Risk Assessment Unit stated that they, at times, felt out of the loop. There was also concern that not all of the right technical staff were engaged early in the exercise. Other debrief comments relate to the late receipt of situation reports (SITREPs).

There were also issues with communications from TIMT and SIMT to the wider organisation. There is a need to have a structure that allows all parts of the organisation to be situationally aware.

SIMT was effective at developing appropriate strategy and advice based on the information presented to them. However, there should have been hand over to TIMT to take on the tactical response. Battle rhythm and resource constraints sometimes delayed the flow of vital information to SIMT to inform policy discussion. The same constraints also hampered the dissemination of policy advice from SIMT, therefore communications teams found it difficult to share a proactive "line to take".

The role of a strategic team in managing incidents should fall within the following areas:

- Define, review and share strategic and policy objectives.
- Ensure the communications strategy is appropriate for the incident and that it is implemented at the tactical level.
- Ensure the tactical team have the technical resources and support to respond effectively at the pace and scale of the incident.
- Political and reputation management.

RECOMMENDATION 1 How the command and control structure operates within the FSA should be examined to optimise its effectiveness during non-routine incidents and improve situational awareness across the organisation. Of particular importance is the role and strategic functioning of SIMT compared with the TIMT. TIMT should operate more effectively as a multi-disciplinary tactical response cell.

RECOMMENDATION 2 Administration of key meetings (SIMT/TIMT/Bird-Table etc.) should be improved to ensure invites and agendas are issued to all attendees ahead of time and that actions from the meeting are communicated rapidly to the rest of the organisation.

The FSA Briefing Cell is key to the co-ordination of communications from the FSA and supports the tactical response. The Cell in this exercise was subject to the same situational awareness constraints suffered by other areas of the FSA. This had a knock-on effect to the Communication teams and external partners.

Logging key information, decisions that are made and actions that are taken helps to deliver a professional response and provide accurate evidence of the management of an incident. Logged decisions are defensible. The FSA uses an incidents database to capture incident logs. Observations as to whether the logs kept were appropriate were inconclusive. It would be worthwhile examining the logs made during the exercise to review whether decisions and actions are appropriately logged.

RECOMMENDATION 3 The FSA needs to have better systems in place that will improve situational awareness during incidents to provide a common view of the incident. The sharing of this information across the FSA, other government departments and partners needs also to be examined. In particular:

(a) How to improve the activation and functioning of the Briefing Cell that considers: routes of communications in and out of the FSA (including to devolved administrations); membership of the Cell; roles and responsibilities; prompt communications; procedures to initiate, manage and stand down the Cell; and holding statement/lines to take at various stages of an incident.

(b) A review of the logs recorded in FSA incident database to determine whether key decisions and actions were appropriately logged would serve to identify if improvements are needed in incident logging.

(c) The IMP or a SOP could include tips on best practice logging.

Bird-Table meetings were effective at sharing knowledge and understanding with stakeholders and industry, but external industry partners felt that there is still a need to engage with them separately and at the earliest opportunity by means of a dedicated meeting. Feedback suggests that the role and structure of Bird-Table Meetings could be clearer and some thought there was a need to separate government partners and industry stakeholders where potentially sensitive information is being discussed.

RECOMMENDATION 4 The FSA should look at how it liaises with government partners and other stakeholders during an incident and consider in particular: early and proactive communications with partners and the structure, focus and function of the Bird-Table and stakeholder liaison meetings.

3.3 Infrastructure (Equipment and Resources)

Extensive use of the FSA's teleconferencing and videoconferencing facilities was made throughout the exercise. That said, the management of conference calls and the quality of audio was poor at times and hampered the effectiveness of communicating incident information. This was particularly true on Day 1 and identified as an issue and so the use of the conferencing equipment was made more effective on Day 2.

RECOMMENDATION 5 The use of telephone and videoconference equipment should be reviewed to check that it meets the needs of the FSA in managing non-routine incidents. Improvements to the technology and the protocols for its use should be implemented to ensure effective sharing of information and an efficient use of time.

During the debrief, it was suggested that service level agreements in place with sampling testing contractors could be used to strengthen the FSA response in major incidents. Whilst this wasn't tested in the exercise, it is an area that the FSA could examine to ensure that the capacity is available.

RECOMMENDATION 6 The FSA should examine the use of service level agreements with sampling and testing contractors to ensure speed and capacity of response in major incidents.

In observing all three control posts, exercise facilitators noted that FSA staff managing the incident operated from their desks rather than dedicated incident rooms. Incident rooms can provide staff with a more effective incident response in that: internal communications are made simpler; they facilitate closer working relationships with Tactical Managers and the response team; they make capturing and sharing of key incident information more efficient and effective; and increase situational awareness. It is possible to operate effectively without an incident room, however, as recommended in Chapter 3.2 above improved structures and systems must be in place to improve situational awareness of the organisation.

RECOMMENDATION 7 FSA should investigate the benefits of having dedicated incident rooms or co-locating key elements of the Tactical team during non-routine incidents.

3.4 Organisational Issues

As discussed in Chapter 3.2 above, issues with the command and control structure and meetings schedule had an impact on this area of the response. The initial SIMT was effective in setting the FSA strategy, but from then on there was little differentiation between its role and that of the TIMT. The need for subsequent meetings was questionable considering how resource intensive the groups are. Feedback from players suggests that the command and control structure within the FSA is not fully understood. RECOMMENDATION 1 above will help to address this.

The exercise scenario resulted in a 'Major' food incident, requiring the response of a significant pool of FSA staff across the organisation. Observations from facilitators suggest that there was limited planning of resources for the coming days. This raised the question - would the FSA be able to maintain a 24/7 response for an incident of this scale? Feedback from FSA staff suggests this would be difficult with the resources available to them. During the multi-agency debrief it was suggested that FSA make better use of external support from local authorities.

RECOMMENDATION 8 Consider 24/7 operation and training of back-up staff within the FSA to fulfil defined non-routine incident response roles. Consider the potential resources available to the FSA from external partners, in particular from local authorities. Create a call-out list of partners who may be able to provide additional resource in major incidents potentially through other government departments or enforcement partner organisations. The arrangements would need to be included within the IMP or stakeholder management plans.

3.5 Plans and Procedures

During the exercise the risk assessment process was hampered by an onerous meeting schedule and the way in which critical information was transferred and shared.

RECOMMENDATION 1 and RECOMMENDATION 3 will improve the time and information available for the risk assessment process. Additionally, a register identifying the capability/expertise of internal staff and teams would help to ensure the right technical specialists are consulted.

RECOMMENDATION 9 Provide a register identifying the capability/expertise of internal staff and teams to help define membership of TIMT in terms of the required technical and policy expertise.

RECOMMENDATION 10 Through the use of the above register, ensure that all relevant expertise is commissioned at the appropriate time within an incident and that each person has access to the most up to date information available.

Feedback suggests that at the strategic level, there is a need to clarify cross-government lines of liaison, communication and responsibilities of FSA with other government departments and ministers across the UK.

RECOMMENDATION 11 The IMP should clearly identify cross-government lines of liaison at the strategic level and emphasise the importance of a co-ordinated consistent approach to the briefing of ministers across the FSA and other government departments.

As observed during the exercise, the role of the devolved administrations is critical to the management and response of local and national incidents. The response and in particular stakeholder communications observed in FSAW and FSANI was proactive and effective. However, their roles, responsibilities and communication links with the devolved administrations is not reflected in the IMP and feedback suggests that there is some lack of understanding of the role of the devolved FSA offices.

RECOMMENDATION 12 The roles and responsibilities set out in the IMP covering England, Wales and Northern Ireland should be re-visited to make sure they are fit for purpose during non-routine incidents and facilitate strong communications with each other; particularly where one administration is managing a different incident to the rest of the country.

Feedback suggests that there was good support from FSA Policy teams during the risk assessment process but that it was difficult to document the process within the time constraints of the exercise.

During Table-top Exercise 1, the risk assessment matrix, which is normally used by operational staff to decide when to inform the Operational Manager that an incident was in need of escalation, was used to try and classify the incident. Feedback from this process confirms the need for work already being undertaken by the FSA, to provide operational staff with a simple and quick assessment that meets the demands of an incident early on.

RECOMMENDATION 13 A review of the strategic risk assessment process should be undertaken to simplify the process and make it fit better with the IMP requirements for escalation and incident command and control structure.

The SAGE meeting worked well as a forum for sharing scientific evidence and understanding. There is however a general lack of understanding of SAGE protocols, membership and purpose which should be addressed.

RECOMMENDATION 14 As part of the IMP, the role and function of SAGE should be set out in in terms of how the FSA is most likely to engage with it. The FSA, through a possible competency framework, should identify in advance who would be most likely to represent the FSA at SAGE and identify independent food and feed experts before incidents occur, to allow for pre-engagement. The FSA should focus on participating in cross-government exercises where SAGE is played to get a broader / better understanding of the FSA's role.

COBR Officials meeting worked well during the exercise and quickly escalated to Prime Ministerial level.

One element of cross-departmental and cross-nation working that was not tested as part of the exercise was that of how the FSA would interface with the Four Nations' meeting. The Four Nations' meeting is not documented in the Cabinet Office Concept of Operations (CONOPS) but is likely to be a key element of effectively communicating across the UK for public health related major incidents ahead of COBR.

RECOMMENDATION 15 The role and function of the Four Nations' meeting and how the FSA is expected to engage with it should be set out in the IMP.

Players' feedback during the hot debrief and the post-exercise workshop suggests that the SOPs that support the IMP are not widely used and that the level of operational detail could be improved.

RECOMMENDATION 16 The SOPs that support the IMP should be reviewed to ensure that the right level of technical and operational detail is included. Staff should be regularly drilled in the use of both the SOPs and IMP.

3.6 Personnel

The hot debrief and post-exercise workshop highlighted a large number of comments that suggested that the understanding of roles and responsibilities in managing non-routine incidents requires improvement in some parts of the FSA. In FSANI the FSA players were observed to be well drilled in their roles and delivered a professional response.

To aid the understanding of roles and responsibilities both within the FSA and of other external partners, capability frameworks should be developed that set out the knowledge, skills and responsibilities of individual roles required to respond to non-routine incidents.

RECOMMENDATION 17 Incident response roles should be underpinned by capability frameworks that set out the knowledge, skills and responsibilities that are required to help and support the FSA response to non-routine incidents. The framework should be embedded into the organisation through training to allow staff to develop over time.

3.7 Training

The exercise has identified a number of learning points and training needs, backed up by feedback from some of the players, including:

- a need to embed the SOPs with the FSA teams who need to use them;
- any SAGE protocols need to be drilled practically to further increase understanding;
- provision of training, exercises and regular drills for all staff to maintain a state of readiness; and
- better understanding of incident management roles, responsibilities skills, capabilities and knowledge.

RECOMMENDATION 18 Future training and exercising should include a programme of more frequent smaller scale training and drills and a programme of exercises to test, embed and then maintain revised arrangements including use of the IMP and SOPs. Training should focus on roles, incident management structure and incident management specific skills and capabilities. These include but are not limited to:

- Incident Logging
- Leadership
- Situational Awareness
- Roles and Responsibilities (internally and externally)
- Communication
- Strategic Objectives
- Tactical Objectives
- Decision Making
- Information Management
- Health, Safety and Welfare
- Incident room set up and management
- Use of IT in incident management
- IMP and SOPs
- Best practice in effective chairing and management of meetings and tele/video conferences

4.0 Media & Social Media

4.1 Introduction

Communications professionals from Escott Hunt located in Exercise Control at FSA London, FSAW and FSANI monitored the media and social media response of the FSA against the communications objectives. The observations and recommendations are given below.

4.2 Observations and Recommendations

Every single member of the communications teams who were engaged in the exercise (e.g. through social media) was positive, professional and committed. The exercise news website (Figure 3) was well received by players.

The consistency of media information across the FSA in London, FSAW and FSANI was impressive. However, at times an information vacuum was created while FSA identifies the likely cause of the food poisoning outbreak. The following should be considered:

- While the use of social media as an intelligence-gathering was impressive, it could have been used more proactively to communicate advice and information.
- FSA spokespeople demonstrated a strong public face and clear leadership and should take early opportunities to provide reassurance that everything possible was being done to deal with the incident, including some background information.
- The meeting schedule required to fulfil the battle rhythm meant that the Communications team could not access the right people to get answers to journalists' questions and respond in a timely manner, an issue that could be resolved by improving the command and control, particularly at the tactical level.

A key challenge was the fact that the 'incident' had notionally been ongoing for some time which made it difficult for them to move from a reactive to proactive stance in the early phase. This may have impacted on the timeliness of information initially.

Objective 1: To ensure the timeliness of information

The exercise facilitators simulated injects from the public and other agencies via social media and placed requests for information and interviews from simulated media channels. The first substantive information from FSA Communications was issued in a statement at 13:45 on Day 1. It provided a useful update with two strands of information covering a testing and tracing programme around cereals and dairy products, and separately about animal feed. More detail on this during the afternoon would have helped to fill a void. If the statement could have been released an hour or so earlier it could have made the lunchtime news bulletins.

It is appreciated that it will take time to identify the cause of a suspected food poisoning outbreak. However, an information vacuum is created, during which time speculation will be rife and everyone will be looking to criticise the authorities.

As highlighted above in Chapter 3.2, issues with the command and control structure and meetings schedule had an impact on this area of the response. The implementation of RECOMMENDATION 1 and RECOMMENDATION 3 would help improve situational awareness and in turn, the timeliness of information from the FSA to other organisations including the media and public.

Specific public guidance was issued at 16:28 on Day 1 although it appeared that the guidance was issued in response to public/media pressure rather than as a part of a systematic, structured response. It wasn't until 11:45 on Day 2 that it was confirmed that the advice applied to Northern Ireland as well and it wasn't until 12 noon on Day 2 that a spokesperson from FSANI was put up for interview to reinforce that advice.

When the decision was made to extend the precautionary advice to cover everyone, the subsequent press conference provided the valuable background information that journalists and the public needed to understand why this guidance had been issued.

Exercise journalists in all three nations suggested that the usefulness of information provided to specific questions could be improved. A lack of information from 'official' sources led the journalists to seek external specialists to speculate as to what might be happening. The journalists were careful to make this reasoned for the exercise but some of it might have been more extreme in a real major incident. Many questions were never answered and this in part was due to the issues raised with respect to the Briefing Cell in Chapter 3.2.

There were some very good initiatives but each one could have been put out earlier:

- The minute-long message from the Chief Operating Officer at 15:00 on Day 1.
- The precautionary advice to vulnerable people was issued in a press statement at 1628 on Day 1. It would have been beneficial to update social media at the same time.
- The very strong statement from FSANI at 11:58 on Day 2 (FSA investigates any link between GP and NI outbreaks).
- The press conference at 13:15 on Day 2. Whilst the information on the suspected sources of the food poisoning may not have been available any earlier, the powerful, reassuring message from the Chief Executive and the authoritative background information supplied by the Chief Scientific Advisor would have given people confidence in the authorities' commitment to tackle this.

The media response to the suspected *E.coli* outbreak in Northern Ireland did appear to be more proactive and the two spokespeople put forward for interview were effective.

RECOMMENDATION 19 The FSA needs to consider how it can be more proactive in providing information to the media/social media to fill the information void whilst an incident is being investigated. Explanation of what is being done and on what basis key decisions are being made and some standard holding lines to take would be beneficial.

Objective 2: To demonstrate consistency of information in a UK-wide response (excluding Scotland)

There appeared to be good co-ordination between FSA's press offices in London, FSAW and FSANI. This was tested on numerous occasions over the two days in respect to responses to media inquiries and social media postings and was found to be consistent throughout.

Objective 3: To explore any potential tensions between different responding agencies

There was meaningful communications play between FSA and Public Health England (PHE). PHE was a key player in the exercise due to the impact on human health caused by the incident scenario and the significant pressures the incident placed on the NHS.

Due to exercise artificiality, there was a view that FSA was declared the lead agency too quickly – before there was absolute confidence that the incident was food-related.

The main concern from a communications perspective is that, as the lead agency, FSA made clear to PHE that they should not release any information proactively or put up spokespeople for interview. A PHE statement was agreed for use on a reactive basis only.

It is acknowledged that information that would have been issued by PHE (the number of deaths and cases of gastroenteritis) was included in the first FSA press statement issued at 13:45 on Day 1. Whilst further updates were available on Day 2 in this regard from PHE to FSA, it was not made public.

RECOMMENDATION 20 The role of a lead government department should be to ensure that all other agencies involved are speaking with one voice and that messages are consistent and complement each other.

Objective 4: To rehearse FSA's ability to prepare spokespeople for in-depth interviews

Objective 5: To ensure that there is a strong public face and clear leadership

Note: These two objectives are linked.

The following observations are made in respect to spokespeople:

- It was agreed in advance that some specific styles of in-depth interview to be exercised in London (Newsnight, in-depth broadsheet, Today programme). Although bids were made, a combination of real-world pressures and the pressure of the battle rhythm meetings meant that these interviews did not go ahead.
- The Chief Executive and Chief Operating Officer both demonstrated authority in their style of delivery despite gaps in available information.
- The Chief Scientific Advisor might have been a good person to complement the Chief Executive and Chief Operating Officer on Day 1 (it is appreciated that in the real world we would only have seen one of them and that is right). They could have briefed the media on the work being undertaken to identify the cause.
- The Chief Operating Officer's minute-long message issued at just after 15:00 on Day 1 was effective.
- The press conference on Day 2 was impressive and conveyed key messages with confidence. However, it is assumed that due to the pressures of the battle rhythm and the lack of situational awareness there was a lack of spokespeople available on Day 1 when the precautionary advice was issued and throughout the morning of Day 2.
- In FSAW no spokespeople were put up for interview, despite repeated requests.
- In FSANI on Day 1 of the suspected *E.coli* outbreak, the Head of Food Safety and Operations was put up for interview with some strict controls around what they could and couldn't be

asked. The statement selected for broadcast showed that they were able to demonstrate a strong public face and clear leadership. The FSANI Director was put up at lunchtime on Day 2 and was effective.

- In FSANI, when the Communications team couldn't answer a specific question, they did use journalists' calls to reassure them that everything possible was being done to deal with the situation (particularly around the suspected *E.coli* outbreak). This is good practice.

To summarise, the FSA can demonstrate a strong public face and clear leadership in delivering messages to the public via the media. It is considered that the ability of the FSA to share situational awareness and the challenging battle rhythm hampered the organisation to front spokespeople to do this at an early stage of the incident and at more frequent intervals.

RECOMMENDATION 21 FSA has strong spokespeople. A more strategic approach needs to be taken to their deployment so that the media interviews can be used to best effect, coupled with the ability of the organisation to improve situational awareness that enables more up to date and informative information to be provided.

Objective 6: To demonstrate the proactive use of social media and the ability to react appropriately, particularly to stories that would have significant impact

Objective 7: Effective media/social media monitoring.

Note: These two objectives are linked.

From FSA documentation, the FSA's social media policy is clearly defined and appropriate. It was well implemented in practice.

Intelligence gathering could not be faulted. Through multiple mechanisms the incident responders were provided with timely information from the social media team, picking up on the full range of issues. They missed nothing.

However, due to issues previously stated related to the challenge of organisational situation awareness, at times the social media team was not in possession of key information that would allow them to respond to specific Tweets and Facebook postings. They were not always updated on the latest statements. For example the release of the precautionary advice to vulnerable people at 1628 on Day 1 was not posted on social media until more than half an hour later. Exercise artifice also played a part in some delays in that the communications teams were using different systems during the exercise than they would normally use for monitoring social media.

Reaction to posts was usually prompt. More general points were picked up and responded to immediately. When a specific response was requested, it was at times met with a generic answer or holding statement, e.g. 'We understand it must be confusing and we're checking with policy teams for you. Back with more info ASAP.' At times, other direct questions went unanswered, e.g. 'Is it safe to give children milk?' Again, this may be partly due to the challenge of ensuring that there is good situational awareness across the organisation, but a holding statement may be appropriate whilst informed response are sought.

It was observed that at times there were gaps of 1-1½ hours between Tweets from the FSA. Filling a gap with generic guidance is a good way of keeping consumers interest and shows a more proactive response. As discussed previously, due to challenges of sharing situational awareness, the social

media team was not always in possession of key information at times to enable an informed quick response.

In this exercise social media was not used proactively to encourage people to provide intelligence. This would be good practice during an incident to help identify a common cause. Feedback suggests that the social media team would routinely monitor for intelligence but only proactively encourage social media users to provide intelligence if the response strategy required it.

A few other points observed on Twitter use:

- Sending messages as 1 of 2 isn't good practice as Twitter users are likely only to see half the message (in one case, message 2 was sent 3 minutes after the first). It is understood that under normal circumstances the FSA's own systems would avoid this.
- Pitching the tone of the Tweet appropriately is an effective way of engaging with the audience – highlighting in one case when the FSA tweeted a response that the member of the public had a good point.
- Responses to tweets could include thank you messages and how the information might be shared or used in response to the incident. Whilst on occasion, the FSA tweeted responses that the information provided will be passed to investigations teams, no individual was thanked personally for providing information. A general "thank you" was given to all.

There was strong evidence that FSANI was media monitoring – they promptly contacted a journalist about a report containing out of date information. They also thanked them when it was corrected.

FSA social media monitoring was good, however, there was no evidence of broader media monitoring in FSAW and FSA London. There were significant deliberate inaccuracies broadcast by the exercise media team in at least one TV news report and this was not picked up which may have been due to issues already identified around situational awareness (see Chapter 3.2). It was noted however, that the Communications Team had a limited number of players in the exercise, one of which was in regular attendance at TIMT meetings, and this potentially impacted the resources available to effectively monitor media. Feedback suggests that exercise artifice also contributed to lack of media monitoring, and in a real incident, systems are in place to effectively monitor media.

RECOMMENDATION 22 The systems are in place at the FSA for the effective use of social media to provide advice, guidance and regular updates on what the FSA is doing. However, the exercise threw up the need for people involved in an incident, and specifically a properly resourced Briefing Cell, to be digitally aware and suitably responsive to external communication during the course of an incident. There should be an internal awareness campaign to help develop these skills.

The implementation of RECOMMENDATION 1 and RECOMMENDATION 3 would also improve the availability of resources to monitor all media by restructuring of TIMT and through improvements to the functioning of the Briefing Cell.

Objective 8: To test ability to prioritise multiple tasks

The intensity of the battle rhythm and meeting required to facilitate this coupled with the challenge of ensuring the FSA was situationally aware impacted the ability of the FSA to proactively disseminate information externally. Multi-tasking was therefore a challenge. This is addressed in RECOMMENDATION 19 above.

5.0 Exercise Evaluation

5.1 Summary of Players Evaluation

An important part of any exercise is to evaluate how well the players felt the exercise was run and if they felt that the aim and objectives have been met. The evaluation is therefore a means of validating the exercise and giving weight to the findings and recommendations.

A record of the exercise evaluation is provided and summarised below. The majority of questions were answered by all respondents. Where a response was not given then this has not been included within the results. Appendix A includes a full analysis of the evaluation results.

In summary the exercise was deemed a success. A total of 29 players responded to all of the evaluation questions. 25 (86%) respondents agreed or strongly agreed that the Exercise met its aim. One respondent did not think that the aim was met, whilst three remained neutral.

A comment from the evaluation form states:

It was a well-run exercise that gave an insight as to the processes that take place when dealing with an urgent incident.

22 (69%) respondents agreed or strongly agreed the objectives of the Exercise were met and seven remained neutral. A quote from one player supports this as:

The scenario had obviously been crafted with great care and stood as a good test against which to assess the processes.

16 out of 29 (55%) respondents agreed or strongly agreed that the Exercise was a success. One respondent disagreed whilst ten remained neutral. One player commented that:

It was a success in that it highlighted where the weaker areas are and also identified which things worked well.

Whilst another commented on timeliness of information and restrictions on injects that could be played, which is primarily down to the exercise design:

From an industry perspective I felt that information was not timely, we were restricted in the injects we could phone in.

5.2 Meeting the Exercise Objectives

In assessing whether the exercise objectives have been met, the table below lists each of the objectives and summarises how each was met.

Table 3 – Exercise Objectives Successes

Exercise Objectives	Met	Supporting Evidence
1. To deliver a two-day control post exercise involving a major food incident to test the new IMP arrangements, including embedded procedures and roles.	✓	Exercise PROMETHEUS was successfully delivered across England, Wales and Northern Ireland on the 26th and 27th March 2015. The exercise evaluation data demonstrates that the exercise met the overall aim and objectives.
2. To scope and agree a food incident scenario that presents a potential risk to the public; requires risk assessment, tests the triggers for and escalation; and tests the resilience of staff resources.	✓	The exercise planning team designed and agreed a food incident scenario that was able to stress test the incident management procedures and communication chains between England, Wales and Northern Ireland. This is supported by the evaluation feedback of this report on the exercise aim and objectives being met and positive comments on the scenario used for Exercise PROMETHEUS.
3. To identify and gain buy-in from partners that will be involved in the exercise programme and help shape the detailed scenarios.	✓	Liaison with the following organisations was undertaken in the form of workshops, meetings and telecoms to ensure the exercise scenario was pertinent and realistic: • Government Departments – APHA, Cabinet Office, DCLG, DEFRA, Government Office for Science, Department of Health and Public Health England • Food Industry Bodies and Trade Associations – ACTSO, British Hospitality Association, British Retail Consortium, Food and Drink Federation, CIEH and Which?
4. To test the interaction of cross-nation working with devolved administrations.	✓	The exercise successfully tested the interaction of cross-nation working via: • Live SIMT and TIMT meetings • Activated Briefing Cell • Testing the IT infrastructure for cross-nation working when responding to incidents • Via the Exercise Messaging system used by the exercise approx. 100 emails • 20 live telephone calls • Live pressure from media role play
5. To identify lessons from the exercises and make recommendations that will further improve the FSA response to food incidents	✓	Lessons identified and recommendations raised as a result of Exercise PROMETHEUS and the debriefs are presented in this report.

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Appendix A – Exercise Evaluation Analysis

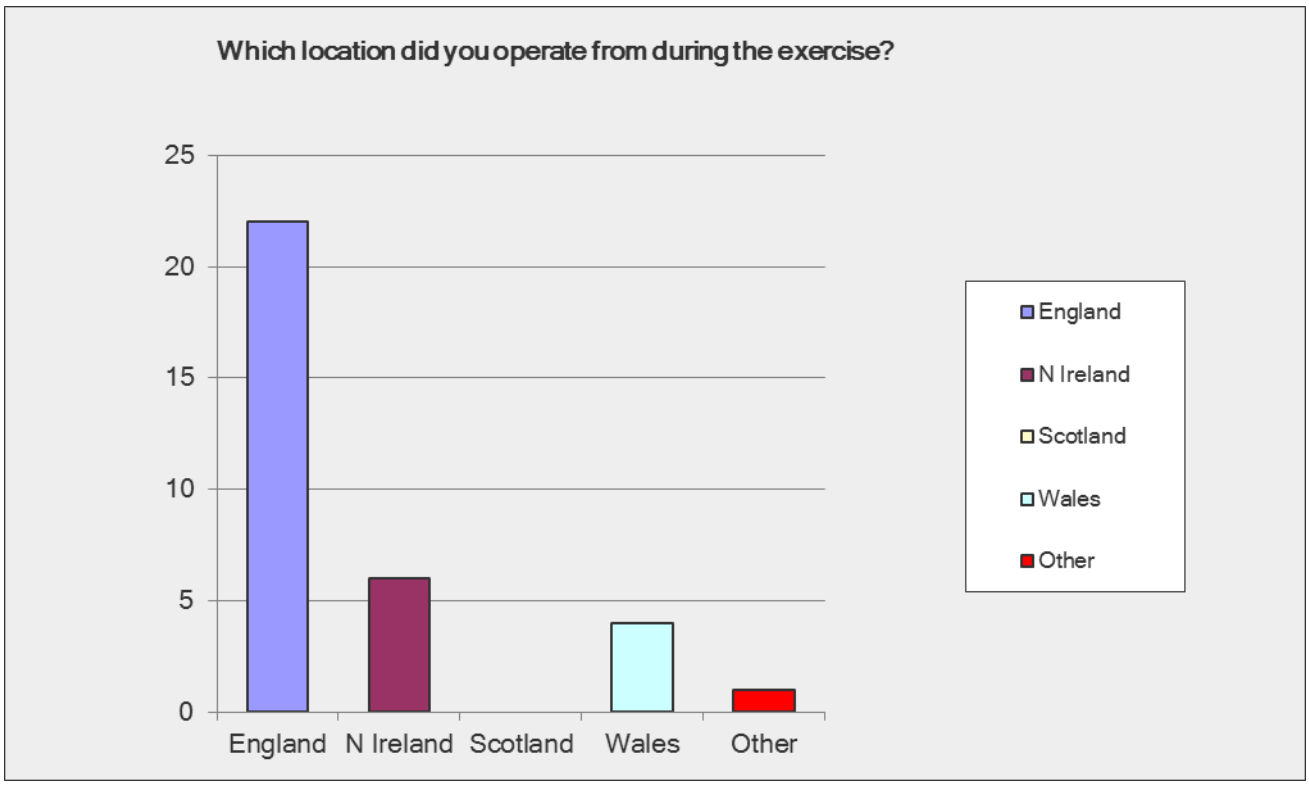
Results for each evaluation category have been assessed using the total number of all scores given by participants.

The attached spreadsheets include the raw data captured during the evaluation.

Location of Players

As shown in Figure 7, 22 of the respondents to the evaluation operated from England, six from Northern Ireland and 4 from Wales.

Figure 7 – Location of Players during the Exercise



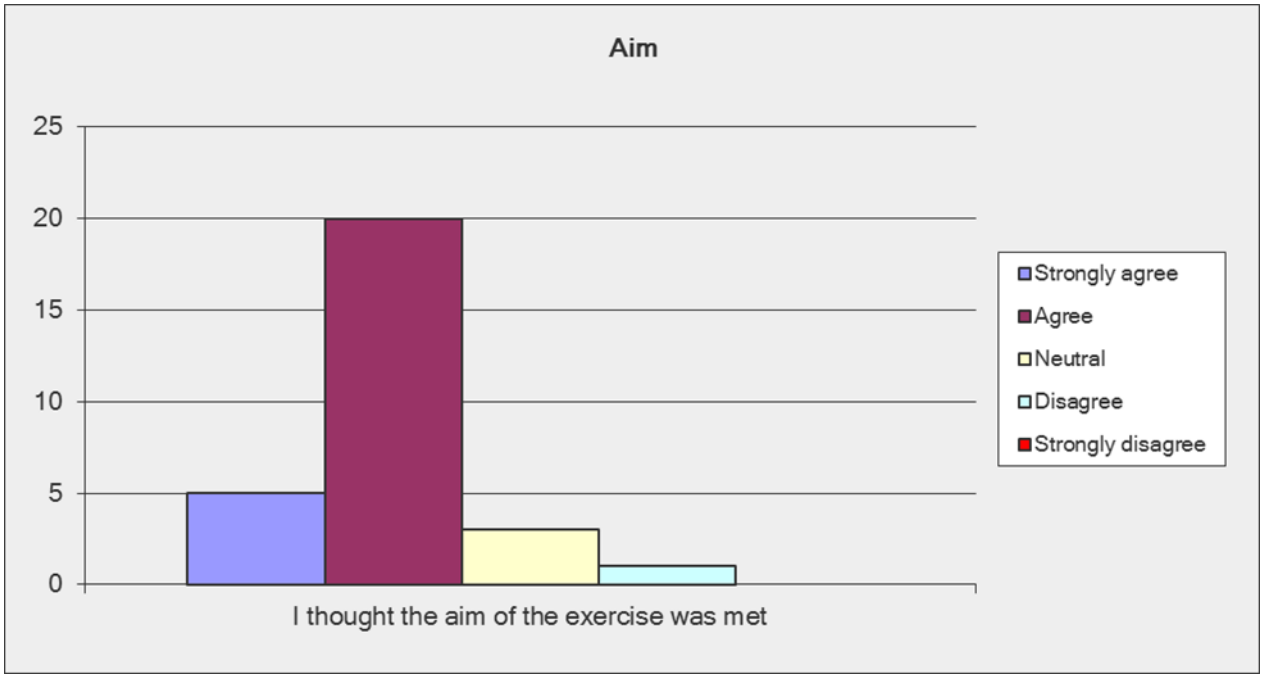
Was the Aim of the Exercise Met?

Figure 8 shows that of 29 respondents, 25 (86%) agreed or strongly agreed that the Exercise met its aim. One respondent did not think that the aim was met, whilst three remained neutral.

A comment from the evaluation form states:

It was a well-run exercise that gave an insight as to the processes that take place when dealing with an urgent incident.

Figure 8 – Players Evaluation of the Exercise Meeting its Aim



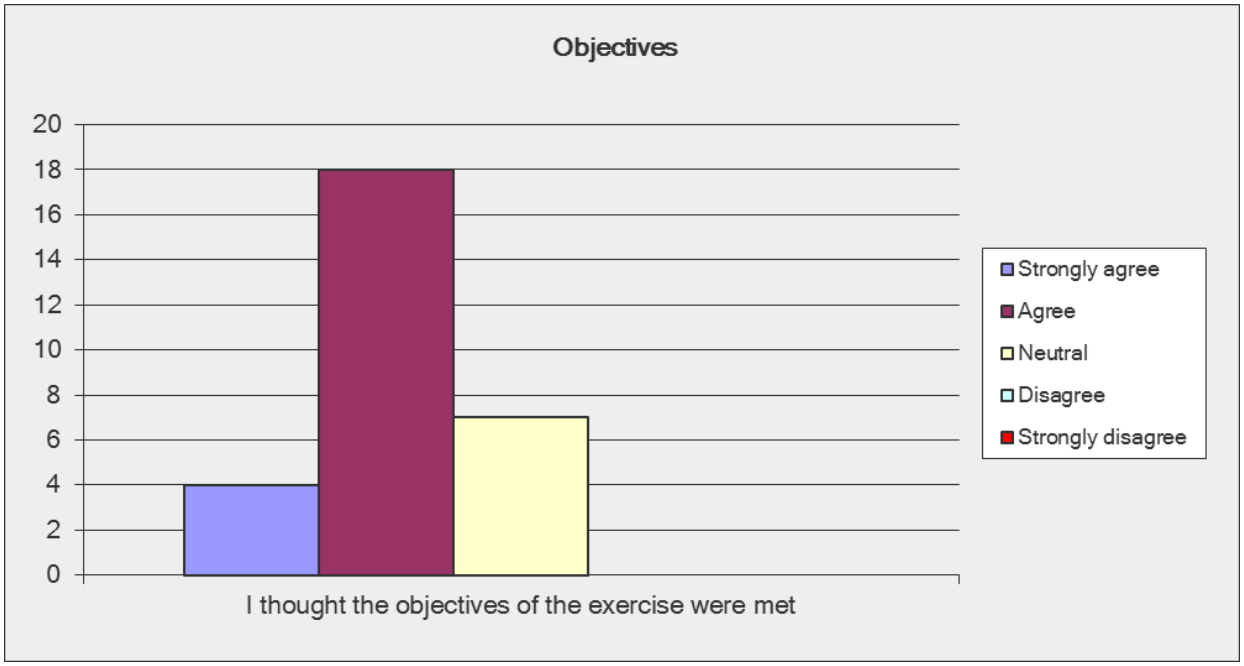
Were the Objectives of the Exercise Met?

Figure 9 shows that of 29 respondents 22 (69%) agreed or strongly agreed the objectives of the Exercise were met. A quote from one player supports this as:

> *The scenario had obviously been crafted with great care and stood as a good test against which to assess the processes.*

The remaining seven respondents gave a neutral response.

Figure 9 – Players Evaluation of the Exercise Meeting its Objectives



Was the Players Pack Clear and Accurate?

Figure 10 below shows that 25 out of 29 (86%) respondents agreed or strongly agreed that the Exercise Players Pack was clear and accurate. A response from a player during the exercise said:

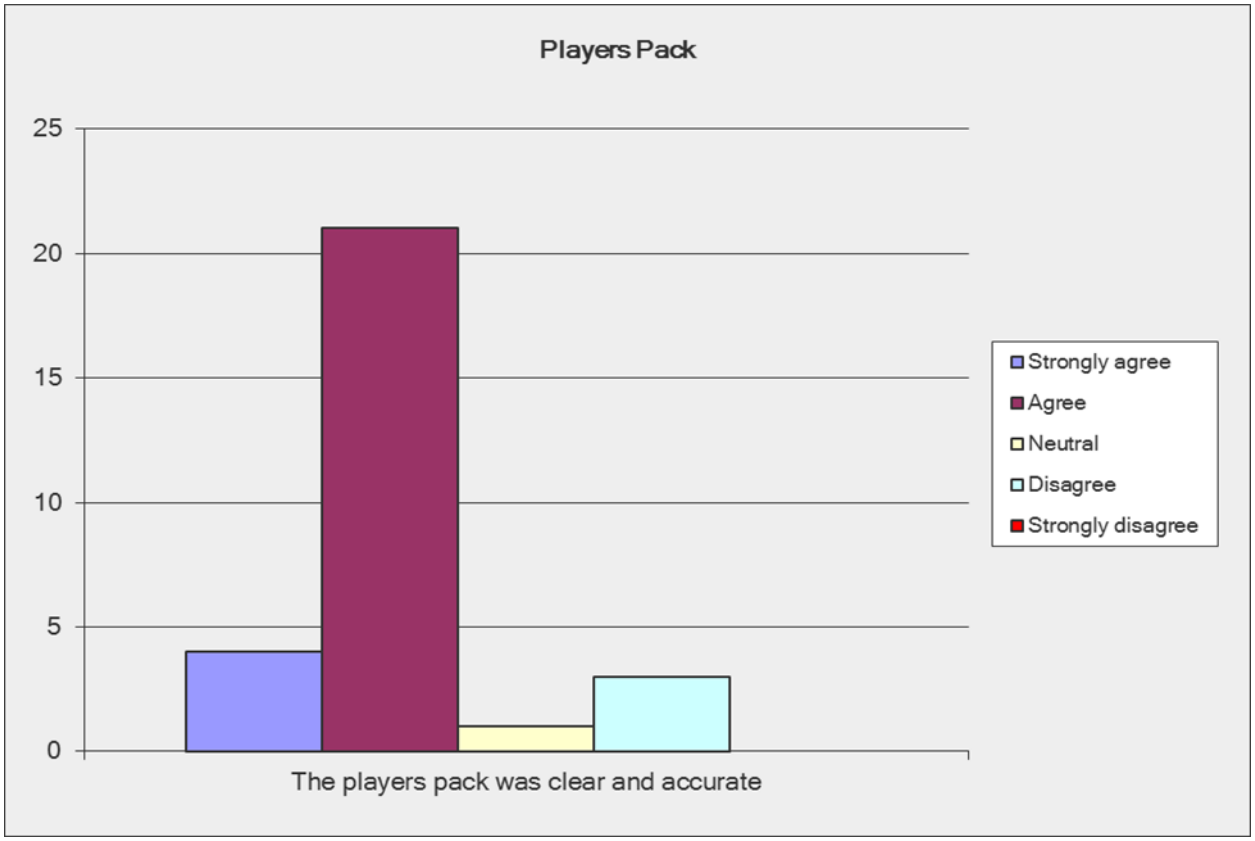
> *I thought the players pack was clear and accurate and served the necessary purpose.*

Three players disagreed with this, one comment stating:

> *The players pack was clear but I did not receive the MEL which I believe would have given me a timetable for my injects and an overview of other discussions. I chased the timetable with the consultant. More background would have been appreciated to understand what background discussions were taking place before discussion with industry.*

It is noted however, that a number of the comments given in relation to the Players Pack are directed at the IMP and associated SOPs.

Figure 10 – Players Evaluation of the Players Pack



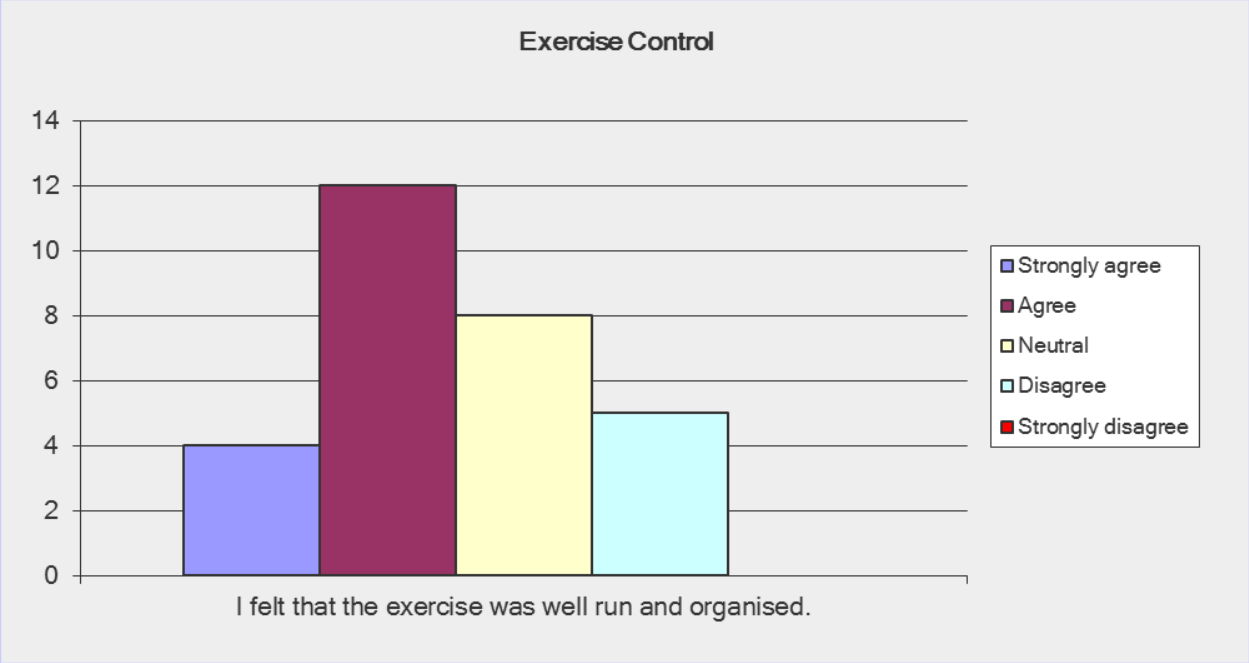
I felt that the exercise was well run and organised

Figure 11 below shows that 16 out of 29 (55%) of respondents agreed or strongly agreed that the Exercise was well run and organised. Five respondents disagreed whilst eight remained neutral.

Some common themes from the comments relating to this are:

- The pace was faster than in a real incident.
- Updates were required to the Exercise Contacts Directory during play.
- Not all relevant stakeholders playing.
- Problems with FSA IT (Teleconference and videoconferencing kit, emails going to junk).

Figure 11 – Players Evaluation of Exercise Control



Overall Impression of the Exercise

Figure 12 below shows that 16 out of 29 (55%) respondents agreed or strongly agreed that the Exercise was a success. One respondent disagreed whilst ten remained neutral. One player commented that:

It was a success in that it highlighted where the weaker areas are and also identified which things worked well.

Whilst another commented on timeliness of information and restrictions on injects that could be played, which is primarily down to the exercise design:

From an industry perspective I felt that information was not timely, we were restricted in the injects we could phone in.

The majority of the respondents' comments are in relation to weaknesses in the response rather than the success of the exercise and this may have an influence on the scoring of this question.

Some common themes from the comments relating to this are:

- Membership of TIMT.
- Limited number of players.
- Communications with external stakeholders and to consumers.

Figure 12 – Players Overall Impression of the Exercise