IN THE MATTER OF THE INQUIRIES ACT 2005
AND IN THE MATTER OF THE INQUIRY RULES 2006

UK COVID-19 INQUIRY

FIRST WITNESS STATEMENT OF EMMA REED

I, Emma Reed, Director of Emergency Preparedness and Health Protection, 39 Victoria Street, London SW1H 0EU, will say as follows:

1. This statement is a response to the personal Rule 9 request from the UK COVID-19 Inquiry ("the Inquiry") dated 15 May 2023, related to Module 1, preparedness for the COVID-19 pandemic. In this request the Inquiry has asked about my role in relation to the Pandemic Flu Readiness Board ("PFRB"). The material is true to the best of my knowledge; the Department of Health and Social Care's ("the Department") corporate statements best set out the material and approach of the Department over this time period by reference to its records.

ROLE AND BACKGROUND

2. My current role is Director of Emergency Preparedness and Health Protection in the Department. I have been in post since February 2018.

3. I have been a civil servant since April 2003. Prior to my current role, I have held a number of posts in the Department, the Cabinet Office and the Government Equalities Office. I was appointed to the Senior Civil Service in April 2013.

4. From November 2014 until June 2015, I was one of two Deputy Directors ("DD") within the Department leading on the response to the Ebola outbreak. I led the policy and operational aspects of the NHS and clinical elements of the response, including treatment protocols and Medevac while my colleague, Dr Tim Baxter, led the public health implications of Ebola, which included border measures and contact tracing.

5. From June 2015 until July 2017, I led the Department's Childhood Obesity programme, before moving, in July 2017, to lead the Cybersecurity function in the Department. Here I was responsible for ensuring the cyber resilience of the health and social care system following the Wannacry cyber attack on the NHS.

EMERGENCY PREPARDNESS AND HEALTH PROTECTION

6. Since February 2018, I have held the post of Director for Emergency Preparedness and Health Protection. I oversee a Directorate structured into three branches, Health Protection, Health Security, and the Operational Response Centre ("ORC").

7. My responsibilities include pandemic preparedness, emergency resilience and response ("EPRR"), the ORC, the oversight of the routine vaccination programme, antimicrobial resistance policy, counter-terrorism and national security policy for the health sector. My role also previously included contingency planning for the event of a no-deal Brexit (through the Operation Yellowhammer).

EMERGENCY RESPONSE

8. Under the emergency preparedness element of my role, I lead in the planning for, and response to, all incidents where there is a potential risk to the public's health.

9. It is my EPRR function that delivers the Secretary of State's responsibilities as a Category 1 responder under the Civil Contingencies Act 2004 ("CCA"). This includes assessing the risk of threats and hazards and then using this risk assessment to shape and implement contingency planning. This threats and hazards assessment is informed by the Cabinet Office's National Risk Register ("NRR") and National Strategic Risk Register ("NSRA").

10. I provide the Departmental Board with assurance that it has appropriate contingency and response plans in place. Similarly, the Department seeks assurance from its delivery partners, including UK Health Security Agency ("UKSHA") (formerly Public Health England ("PHE")), NHS England, the other Arm's Length Bodies that they have appropriate contingency and response plans in place. It is the responsibility of the individual delivery partners to assure themselves of the contingency plans within their own organisations. Therefore, it would be for NHS England to be assured that Trusts

within the NHS have adequate plans in place to respond to emergency incidents, including pandemics.

11. Since my appointment, I have led the Department's response to over 20 major incidents including the Novichok poisoning in Salisbury in 2018, the fuel crisis in 2021, the heat wave in 2022, the repatriation from Ukraine in 2022, the outbreak of Monkeypox in 2019, and 2022.

12. The Department's EPRR function maintains an on-call system which ensures 24-hour, 7 day a week emergency cover. During periods of incident response, staff in these teams pivot to work in incident response mode. Once an incident is stood down, these staff revert to contingency planning and mitigation, or return to their roles within the Department.

13. In 2018 the Department established the ORC within this Directorate to lead the health and social care systems readiness for a no-deal Brexit (known as Operation Yellowhammer). In 2019 the EPRR team were incorporated within the ORC.

PANDEMIC PREPAREDNESS

14. The other part of my Directorate's portfolio is focused on health protection and health security policies and programmes such as pandemic preparedness, routine immunisation, climate and environmental hazards, antimicrobial resistance, infectious and endemic diseases.

15. Across these areas, these teams lead on a range of policy and work with key partners, such as NHS England and UKHSA, to support and assure the delivery of various programmes. For example, in respect of routine vaccinations, the Immunisation Team lead on the development of the national vaccine policy. UKHSA provide the clinical advice and lead on procurement of the vaccines and NHS England lead on the delivery of the national vaccine programme.

16. The Department is the lead Government Department for pandemic preparedness, response and recovery. As the lead Government Department, one of the permanent teams within this Directorate is the Pandemic Preparedness team, which sits as part of the Health Protection Branch. This team works with delivery partners to assess and understand the risks of pandemics, considers the capabilities required to address

these and assures the health and social care systems readiness to manage a potential outbreak.

17. The pandemic preparedness programme reports to two boards: the Pandemic Influenza Preparedness Programme ("PIPP"), chaired by Clara Swinson, the Director General for Global Health, and the Pandemic Disease Capabilities Board ("PDCB") which is jointly chaired by myself and the Cabinet Office Resilience Director. The PDCB replaced the Pandemic Flu Readiness Board ("PFRB") in March 2022.

18. The PIPP oversees the preparedness across the health and social care system for any potential influenza pandemic across England. The PIPP Board overseas the tripartite work led by the Department, UKHSA and NHS England. The PIPP Board was established in 2007. The terms of reference for this board are exhibited at INQ000022804.

19. The PIPP was informed by and responded to the Reasonable Worse Case Scenarios set out in the NRR and the 2019 NSRA risk assessment, which stated that an influenza-type pandemic remains the highest assessed natural hazards scenario in the NSRA with potentially catastrophic impacts across a wide range of sectors.

20. At the time of my appointment the PIPP Board and the PFRB were both well established boards, underpinned by defined programmes of work.

PANDEMIC FLU READINESS BOARD

21. The PFRB was established in March 2017, following Exercise Cygnus in 2016, to oversee the delivery of a cross Government and UK wide programme to address the Exercise report's recommendations. The PFRB was co-chaired by the Cabinet Office and the Department. On my appointment to my role in 2018, I assumed the co-chair for PFRB alongside Katharine Hammond who was, at that point, Director of the Civil Contingencies Secretariat within the Cabinet Office.

22. The PFRB had the following responsibilities:

    a. Oversee the delivery of the PFRB work programme and the delivery of associated outcome and products;
    b. Provide an interdepartmental forum to challenge and question progress against milestones;

c. Coordinate the work programme of constituent departments and, as appropriate, the Devolved Administrations ("DAs"), provide a forum for clarifying boundaries of departmental responsibility and manage any interdependencies between departments; agreed arrangements for maintaining and assuring the capability to manage the non-clinical aspects of pandemic influenza; and
d. Where policy areas are devolved, provide a forum for exchanging best practice among the four UK administrations with a view to developing common approaches where appropriate with the UK overall constitutional arrangements.

23. The Terms of Reference for the Board are exhibited at INQ000022743.

24. The programme was divided into five workstreams, with the lead responsibilities identified across Cabinet Office, the Department and NHS England. The workstreams were:

a. Workstream 1: Healthcare – led by NHS England
b. Workstream 2: Community/Adult Social Care – led by the Department
c. Workstream 3: Excess Death – led by Cabinet Office
d. Workstream 4: Sector Resilience – led by Cabinet Office
e. Workstream 5: Cross cutting issues (Legislation, Communications, Moral and ethical) – led by the Department and Cabinet Office

25. Katherine Hammond, as the Director for the Civil Contingencies Secretariat, had responsibility for the cross-Government preparedness for a range of threats and hazards. With respect to pandemic preparedness her role as the co-chair of PFRB was to seek assurance from other Government Department's on their plans and readiness to respond to a pandemic flu risk.

26. As the other co-chair, I represented the Lead Government Department for the Pandemic Flu Risk. My role was to ensure the widespread understanding of the risk, to update the Board on contingency planning within the health and social care system, to lead on the workstreams listed above and to support the Cabinet Office in securing the delivery of the Pandemic Flu readiness programme across Government.

27. Working together as co-chairs, Katharine and I would agree the focus of the meetings to ensure the right level of challenge required to maintain the progress in delivering the

programme. In meetings, Katherine and I would alternate the chair to ensure there was appropriate challenge on areas we led on respectively. I would, therefore, lead the discussion on cross Government delivery, while Katherine would lead the discussion on health and social care delivery.

28. I attended six PFRB meetings (21 February 2018, 5 April 2018, 22 May 2018, 26 July 2018, 27 November 2019 and 22 March 2022). Meetings of PFRB were held on 14 November 2018 and 23 January 2020, but I was unable to attend: my first absence was because I was leading the response to a non-pandemic incident and the second was because I was engaged with the emerging COVID-19 outbreak. It was agreed to pause PFRB meetings between 14 November 2018 and 27 November 2019 due to the increased focus on Operation Yellowhammer. It was also agreed that we would pause PFRB between 23 January 2020 and 22 March 2022 due to the COVID-19 outbreak. The last meeting of PFRB was held on 22 March 2022, where it was agreed that PFRB would be replaced with the PDCB. The terms of reference for PDCB are exhibited at INQ000057649.

DEVOLVED ADMINISTRATIONS

29. From the outset, the PFRB included representatives from the DAs. While health is a devolved matter, close working relationships with our DA counterparts was essential in ensuring a cohesive UK response. To this end, I visited my counterparts and the Chief Medical Officers in the Welsh Government (14 June 2018 and 30 July 2019), the Scottish Government (27 March 2018 and 6 August 2019) and the Northern Irish Government (7 August 2019) to discuss their progress in meeting the commitments in the Pandemic Flu Programme and their wider EPRR programme.

STRENGTHS AND WEAKNESSES

30. It is my view that the PFRB approach delivered several outcomes which were essential to the COVID-19 response, both in relation to the capabilities it developed and the relationships and collaboration it fostered. There were some areas which could have been better developed as well as challenges which impacted on our ability to drive and deliver our pandemic planning as effectively as we would have wished.

31. Membership of the PFRB was drawn from across Government departments and, in most cases, these representatives were also their Departmental lead for EPRR. For

example, the PFRB member for what was then the Ministry of Housing Communities and Local Government was also the Director of Resilience and Emergencies Department (RED). Similarly, both Katherine and I were also responsible for EPRR within our Departments. This provided several benefits to pandemic flu preparedness. Firstly, the EPRR methodology is routed in continuous learning and following any incident, lessons learned processes are run and wider learning captured and embedded into practice. This means, therefore, that the learning from the response to the Salisbury poisoning or the monkeypox outbreaks were applied to the management of other infectious disease outbreaks, including pandemic flu. This ensured that the Pandemic Flu Programme benefited from continuous learning, based on practical experiences, and was able to reflect and refine as it developed. This included the work to prepare for the potential of a no-deal Brexit, where many of the capabilities developed across Government and within the Department were applied during the COVID-19 pandemic.

32. Secondly, the members of PFRB enhanced the established network of officials who had practical experience of working collaboratively on major incidents. The cohesion of this group was highly beneficial, particularly in the early stages of the COVID-19 pandemic, where rapid decisions were required. The PFRB provided an important forum for the exchange of best practice among the four UK nations. The strength of these relationships allowed us to pull together effectively when the need arose.

33. The workstreams, identified through Exercise Cygnus and then embedded into the PFRB programme, included the development of capabilities essential to the initial response. This included the development of draft legislation (the Draft Pandemic Flu Bill) which provided a significant framework for the subsequent Coronavirus Act 2020. The programme also delivered planning assumptions for sector wide workforce shortages, a UK wide health-focused communications strategy, the establishment of a Moral and Ethical Advisory Group (MEAG), refreshed guidance for local responders in the management of excess deaths and improved surge plans for the health sector during a pandemic. Overall, it is my view that the programme focused on many of the right capabilities needed for the COVID-19 pandemic.

34. On reflection, however, there were three main areas where the Department and PFRB could have either operated differently, or where we should develop our approach in the future.

35. The first is in the readiness of the Adult Social Care ("ASC") sector. Exercise Cygnus considered the impact of a pandemic flu on the Adult Social Care Sector and made a number of recommendations for mitigating actions. These actions focused on capacity and surge planning, provision of PPE, data and reporting, and guidance to the sector. In early 2018, MHCLG, in partnership with other government Departments and Local Resilience Forums ("LRFs"), ran four pandemic workshops, the outcomes of which were used to inform national pandemic planning and ongoing engagement with LRFs. The Department also commissioned from the Association of Directors of Adult Social Services ("ADASS") to produce advice and guidance on planning for a pandemic. This was completed and circulated in the spring of 2018.

36. However, the ASC sector was facing a number of challenges before the pandemic, which reduced the resilience of the sector to external shocks. Prior to the pandemic, the ASC Sector was under considerable financial pressure, which was demonstrated by the failure of one major provider in 2019. Further, the ASC sector was only just beginning to make the required adjustments needed on workforce planning and supply management following Brexit. In addition, the sector was highly devolved, with the statutory duties for the provision of ASC sitting with local authorities. The limited direct engagement with the providers in the sector, together with the lack of access to timely operational data, restricted our ability to influence planning for a pandemic. Since the pandemic, changes have been made to data flows, funding and guidance which will better strengthen the resilience of the sector to a wider range of threats, including any future pandemics. However, at the point the pandemic struck, the ASC sector was not adequately prepared or sufficiently resilient.

37. Secondly, under workstream 4, we considered the impact of a pandemic flu outbreak on critical sectors including education, transport, prisons and finance. This predominantly focused on the impact of workforce reductions on the continuation of public services. On reflection, I think PFRB could have pressed the relevant Departments for more detailed contingency planning which should have drawn out wider impacts and how a sustained pandemic would affect the continuity of key public services. A number of Government Departments, most notably the Department for Education, flagged that they were not able to adequately prioritise the work needed to complete key elements of the Pandemic Flu Preparedness Programme, for example on the Pan Flu Bill.

38. Finally, with the benefit of hindsight, I can see that our response would have been strengthened had we focused on wider pandemic diseases readiness as opposed to the narrow pandemic influenza. Pandemic influenza was and remains the highest risk on the NRR, and it is right that this demands a specific focus and the development of relevant capabilities. Our new approach to pandemic preparedness reflects the potential risks from a wider range of pathogens with pandemic potential (including through all five routes of infectious disease transmission: respiratory (including droplet/aerosol), vector-borne (mosquitoes, ticks, sandflies, etc.), contact (touch), oral (food/water), and sexual/blood (HIV, etc.)).

STATEMENT OF TRUTH

I believe that the facts stated in this witness statement are true. I understand that proceedings may be brought against anyone who makes, or causes to be made, a false statement in a document verified by a statement of truth without an honest belief of its truth.

Name: Emma Reed
Date: 26 May 2023

Signature: Personal Data