Module 1

Witness Statement of: Sir Frank Atherton

No. of Statement: 1

Exhibits: 54

Date of Statement: 20 April 2023

IN THE UK COVID-19 PUBLIC INQUIRY

Before the Right Honourable Baroness Hallett D.B.E

WITNESS STATEMENT OF SIR FRANK ATHERTON

I, SIR FRANK ATHERTON, WILL SAY AS FOLLOWS:

1. I give this statement on behalf of the Welsh Government to assist the work of the UK Covid-19 Public Inquiry ("the Inquiry"). My statement is provided in response to the Inquiry's Rule 9 request dated 10 February 2023 - M01-ATHERTON-01. I have provided a personal statement for Module 2B but this is my first statement for the Module 1 investigation.

2. I first set out some brief information as my role as Chief Medical Officer for Wales, I then set out in some detail my part in preparedness and pandemic planning from 2016 (when I took up my post) until January 2020. This is followed by some reflections on preparedness and emergency health planning as requested. Attached is an index to this statement.

Introduction – role as Chief Medical Officer for Wales

3. I was appointed as the Chief Medical Officer for Wales ("CMO(W)") on 1 August 2016 and I remain in that post.

4. I studied medicine at Leeds University following which I worked in a broad range of medical areas, but in particular paediatrics. I then completed my training in General Practice. After training as a General Practitioner ("GP"), I joined the Voluntary Service Overseas as a District

Medical Officer in Malawi between 1 August 1988 and 1 May 1990 where I formed a keen interest in public health. I undertook specialist training and then practised in public health, working in a wide range of different countries including former Yugoslavia, Tanzania, and Bangladesh. I worked as a Director of Public Health in Lancashire and Cumbria between 1 August 2002 and 1 May 2012 and I served a term as President of the Association of Directors of Public Health ("ADPH") between 1 August 2008 and 1 May 2012. My last job before moving to Cardiff to take up the post as CMO(W) was as the deputy Chief Medical Officer for Health in Nova Scotia between 1 May 2012 and 1 August 2016.

5. The CMO(W) is a member of staff of the Welsh Government designated by the Welsh Ministers as the 'Chief Medical Officer for Wales'. Section 52 of the Government of Wales Act 2006 provides that the Welsh Ministers may appoint persons to be members of the staff of the Welsh Government and service as a member of staff of the Welsh Government is service in the civil service of the State. As such, the CMO(W) is bound by the Civil Service Code like any other member of the civil service in Wales. There is a difference, however, between the generally understood position of a civil servant and the role of CMO. The CMO must retain a high degree of independence and separation from the concerns of the government. Although this is not set out in statute or in the job description it is well established by custom and practice. I am free to provide advice without regard to government policy or direction. The best example of how this independence manifests itself is the writing of the CMO annual reports. In these reports I set out my concerns for the health of the nation and encourage the Welsh Government to respond and the people of Wales to take heed. These annual reports are not subject to vetting by special advisors or clearance by Ministers. In my experience, Ministers have understood and respected the role that I, as an independent medical advisor, serve and they translate my independent advice, along with advice from others, into decisions which affect the people of Wales. This remained the case during the pandemic.

6. The CMO post in Wales is a Director-level post. I report to the Director General of the Health and Social Services Group ("HSSG") who in turn reports to the Permanent Secretary. Sir Derek Jones was Permanent Secretary when I became the CMO, succeeded by Dame Shan Morgan in January 2017. For the duration of my role as CMO(W) from August 2016 to 21 January 2020 (the relevant period for Module 1), Dr Andrew Goodall was Director General of the HSSG/NHS Chief Executive.

7. I consider my role as CMO(W) as threefold. First, as advisor to the Welsh Ministers and the Welsh Government, bringing a public health perspective to decisions that are made, not just on the narrow subject of health, but also more generally. Secondly, I am the Medical Director of the NHS, so I work closely with the local health board medical directors to support the delivery of high-quality clinical service. Thirdly, I have a public health role as an advocate for better health for the people of Wales.

8. As well as my CMO(W) role, during the relevant period, I was also the Director of the Health Policy Directorate up to 2018 with responsibilities for primary care, healthcare quality, major health conditions, public health and research and development. In 2018, the directorate was re-structured and re-named as Population Health with responsibility for public health, population healthcare and population research and development. This aspect of my role gave the post oversight of the Health Emergency Planning Unit ("HEPU"), which included pandemic preparedness and civil contingency planning within HSSG that sat within the public health division including the budget and resource allocated for pandemic preparedness with HSSG.

9. Although HEPU sat within the population health directorate, it provided a corporate service to HSSG in providing support and oversight on emergency preparedness to the NHS bodies in Wales. I was not involved in day-to-day running of the unit but met frequently with the Head of HEPU who kept me informed of significant developments.

Pandemic preparedness

10. My first introduction to pandemic preparedness in my role as CMO(W) was through my involvement in Exercise Cygnus in October 2016. As CMO(W) I was a key contact between Ministers and officials for the purpose of the exercise. I attended the COBR Ministerial and COBR Officials meetings [**EXHIBIT - FAM01ATHERTON01/001 – INQ000180395**]. My main recollection of the exercise was the issue of triaging access to intensive care services at the point in a pandemic where they might become overloaded. A suggestion that, in this eventuality, ventilatory support would need to be withdrawn from some patients was a source of concern to me and I subsequently discussed the issue with other CMOs. A later email that I was sent by the Head of the HEPU on 18 September 2018 made reference to this – "*you had strong views on population triage*" [**EXHIBIT - FAM01ATHERTON01/002 - INQ000180430**]. In the same email he informed me that pandemic flu would be on the agenda for the next four nations CMO meeting.

11. Following a UK CMO meeting in June 2017, the UK CMO shared a briefing paper on Exercise Cygnus with me and the other CMOs from the devolved governments. I shared it with members of the public health division [**EXHIBIT - FAM01ATHERTON01/003 - INQ000180418**].

12. I was also copied in on the work that was being undertaken post Cygnus (in July 2017) to update the pandemic flu plans. I was made aware that the Cabinet Office and Department of Health had established a UK Pan Flu Readiness Board and the Welsh Government was involved in the five workstreams that were identified [**EXHIBIT – FAM01ATHERTON01/004 – INQ000180420**]. I was listed as a Welsh Government contact and invited to these meetings, but representation was delegated to staff working in the specialist area of emergency planning who then shared the information with me [**EXHIBIT – FAM01ATHERTON01/005 – INQ000180430**, **EXHIBIT – FAM01ATHERTON01/006 – INQ000180427**].

13. I was sent a copy of the final report on Exercise Cygnus on 17 July 2017 [**EXHIBIT – FAM01ATHERTON01/007 – INQ000180421**].

14. The Exercise Cygnus report published by Public Health England made a set of recommendations many of which were of relevance to future CMO discussions [**EXHIBIT – FAM01ATHERTON01/008 – INQ000177328**]. One of the issues that we certainly discussed was population triage and the moral and ethical questions this raised.

15. I am aware that following these discussions, the Moral and Ethical Advisory Group ("MEAG") was set up in October 2019 and the Welsh Government was represented on the group by Heather Payne [**EXHIBIT – FAM01ATHERTON01/009 – INQ000180621**]. Heather Payne subsequently set up the Cymru MEAG ("CMEAG") in June 2020.

16. I was kept informed about how the Welsh Government was contributing to the UK Pandemic Influenza Review [**EXHIBIT – FAM01ATHERTON01/010 – INQ000180432**]; about information that was emerging from the review [**EXHIBIT – FAM01ATHERTON01/011 – INQ000180477**]; and about discussions around the drafting of the Pandemic Influenza (Emergency) Bill [**EXHIBIT – FAM01ATHERTON01/012 – INQ000180472; EXHIBIT – FAM01ATHERTON01/013 – INQ000180474, EXHIBIT – FAM01ATHERTON01/014 – INQ000177329; EXHIBIT – FAM01ATHERTON01/015 – INQ000180479].**

17. In January 2018, the joint chairs of the UK Pandemic Influenza Review Board suggested a meeting with me and Reg Kilpatrick, Director for Local Government, to discuss preparedness for pandemic influenza [**EXHIBIT – FAM01ATHERTON01/016 – INQ000180471].** This took place on 14 March 2018 [**EXHIBIT – FAM01ATHERTON01/017 – INQ000180478].**

18. There was a further Pandemic Influenza Preparedness Senior Officials meeting between the Welsh Government, the UK Department for Health and Social Care ("DHSC") and the Cabinet Office in Cardiff on 14 June 2018 which I also attended [**EXHIBIT – FAM01ATHERTON01/018 – INQ000180482; EXHIBIT – FAM01ATHERTON01/019 – INQ000177334].** I asked how the surge and triage and moral and ethical considerations would inform the holistic communications strategy. Katherine Hammond, Director, Civil Contingencies Secretariat, said that advice would be going to Ministers shortly on taking forward the moral and ethical strand and Ministers would be given a choice about whether something should be done proactively ahead of a pandemic.

19. After the meeting there were some internal discussions about the extent to which we were sufficiently involved in the review process. I noted that there was still considerable outstanding work and we needed to deepen our liaison with the Local Resilience Forum ("LRF") structures, but I was assured that we had a good engagement with the UK Department of Health on that issue [**EXHIBIT – FAM01ATHERTON01/020 – INQ000180484].** I was copied in on the Ministerial Advice about the draft Pandemic Influenza (Emergency) Bill in October 2019 [**EXHIBIT – FAM01ATHERTON01/021 – INQ000180551].**

20. I was asked to speak to the Executive Directors Team meeting and the NHS Executive Board meeting in November 2018 about pandemic flu and health resilience/ business continuity. An update on Pandemic Planning and Business Continuity was provided to the board (although I was unable to attend) [**EXHIBIT – FAM01ATHERTON01/022 – INQ000180687,** of which the original had three embedded documents which are presented as **EXHIBIT - FAM01ATHERTON01/023 - INQ000180756, EXHIBIT - FAM01ATHERTON01/023-A - INQ000180758 and EXHIBIT - FAM01ATHERTON01/023-B - INQ000180757].**

21. In June 2019, the UK Director of Emergency Preparedness and Health Protection (based in the DHSC) asked to visit Wales to discuss emergency preparedness, resilience and response and I was copied in on the correspondence and considered whether Public Health Wales ("PHW") should be involved [**EXHIBIT - FAM01ATHERTON01/023-C - INQ000180510].** I was

also copied in on an email that the health Emergency Planning Adviser sent to the Minister for Health and Social Services updating him on pandemic flu preparedness including the Pandemic Influenza (Emergency) Bill at around the same time [**EXHIBIT - FAM01ATHERTON01/024 - INQ000180511;** and later a further update to ministers on the Bill **EXHIBIT - FAM01ATHERTON01/025 - INQ000180553].**

22. In July 2019, I added an update on the Ebola outbreak to my CMO Update. The Executive Director of Public Health Services at PHW also asked me to remind local health board medical directors about the importance of adequate provision of isolation rooms and he attached a paper which I sent as a link after the meeting [**EXHIBIT - FAM01ATHERTON01/026 - INQ000180544].** I asked whether there had been any progress on ensuring there were a sufficient number of isolation rooms and whether additional facilities had been identified [**EXHIBIT - FAM01ATHERTON01/027 - INQ000180549].** I also asked whether a new hospital being built was compliant with the requirements [**EXHIBIT - FAM01ATHERTON01/028 - INQ000180550].**

23. Emergency planning sat alongside many competing public health priorities such as smoking, health inequalities, sexual health, obesity, air pollution and gambling. The resource available within the Welsh civil service made it impossible to respond to every request or initiative.

Outbreak Management in Wales

24. A key health protection function in Wales has always been to identify, respond to, and learn from outbreaks of infectious disease. The way in which outbreaks should be managed is described in the Welsh Outbreak Management Plan [**EXHIBIT - FAM01ATHERTON01/029 - INQ000116459]**. The plan was useful to local health protection staff throughout the pandemic during which it was kept under review and updated. As CMO I approved the adoption of revised versions of the Plan.

Health Protection Advisory Group ("HPAG")

25. In May 2018, I re-established a Health Protection Advisory Committee ("HPAG") with representatives from the Welsh Government, local health boards, Welsh local authorities, the Food Standards Agency, PHW, National Resources Wales and the Health and Safety Executive [**EXHIBIT - FAM01ATHERTON01/030 – INQ000180630].** Its aim was to secure wide integration and effective implementation of health protection policies, maintain an

overview of the work of health protection and drive forward the health protection agenda in Wales. I chaired the meetings.

26. One of the objectives was to act "*to prevent problems from occurring or getting worse by considering the learning outcomes from outbreaks and incidents in order to support the promulgation of best practice guidance*" (see Terms of Reference document exhibited in paragraph 25 above).

27. Two sub-groups reported to HPAG: the outbreaks and incidents sub-group and the Welsh Immunisation Group. The following existing subgroups/committees also highlighted key issues and informed the discussions of HPAG: Wales Sexual Health Advisory Board, Healthcare Acquired Infection/Antimicrobial resistance Strategic Group and the Welsh Screening Committee.

28. I set out below some of the issues which we discussed and which touch on the issue of disease outbreaks and emergency health planning. However, as is clear from a reading of the full minutes, the focus of HPAG extended beyond pandemic planning and civil contingencies. It had a wide public protection remit: there were discussions on vaccination, sexual health, Brexit planning, air pollution, food safety and many other topics. What follows should be read in that context: the issues identified from the HPAG minutes exhibited, below were a small part of a much larger health protection discussion and debate.

29. The inaugural meeting was held in Cardiff on 2 May 2018 [**EXHIBIT - FAM01ATHERTON01/031 – INQ000177344**]. That meeting included a consideration of lessons that could be learned from the cold winter and the priorities for the next winter.

30. The next meeting was held on 19 July 2018 [**EXHIBIT - FAM01ATHERTON01/032 - INQ000180486**]. The meeting was given an update on Brexit preparedness. We put winter preparedness on the agenda for the next meeting in October 2018. At around the same time, Andrew Jones from PHW shared a presentation with me and other colleagues in the Welsh government on the more detailed aspects of High Consequence Infectious Diseases ("HCID") which he said was intended to inform a more detailed conversation on this specific aspect of service delivery going forward [**EXHIBIT - FAM01ATHERTON01/033 - INQ000180483**].

31. At the next meeting on 18 October 2018, we considered a Winter preparedness update paper and recommendations from the Wales Immunisation Group [**EXHIBIT -**

FAM01ATHERTON01/034 - INQ000180490]. Dr Marion Lyons (Senior Medical Officer) presented a PowerPoint on current infectious disease threats and **Name Redacted** (civil servant in the Public Health Division) noted that there had been capacity issues at UK centres for infectious diseases during the recent monkeypox incident. We put as a future agenda item "Emergency preparedness – (Salisbury incident scenario within Wales)".

32. On 22 January 2019, the meeting focussed on environmental health issues and I suggested that a broader agenda should be pursued at the next meeting **[EXHIBIT - FAM01ATHERTON01/035 - INQ000180533]**. We were also given the Exercise Melyn report **[EXHIBIT - FAM01ATHERTON01/036 - INQ000180524]** in which four deliberate chemical release exercises had been held across Wales in 2018. One of the recommendations was for there to be further clarity about the role of a Scientific and Technical Advice Cell ("STAC") in the event of an emergency (see recommendations 3 and 4). This follow up work was to be done by the Wales Resilience Partnership Team ("WRPT") and by PHW.

33. At the 8 July 2019 meeting Dr Marion Lyons presented a paper on the preparations underway for the forthcoming flu season. It was agreed that the Chief Nursing Officer and I would issue a joint letter to all key professional bodies/unions emphasising that flu vaccination should be viewed as a professional responsibility for health and social care staff **[EXHIBIT – FAM01ATHERTON01/037 – INQ000180587]**. In the event, the joint letter was not sent, but both the Chief Nursing Officer and I sent out communications to make this point.

34. Dr Lyons also presented a paper on the need for a strengthened National Health Protection Service ("NHPS") **[EXHIBIT - FAM01ATHERTON01/038 - INQ000177362]**. The Chief Nursing Officer (Jean White) and I had hosted a workshop on 17 May 2019 with representatives from the health boards and trust to discuss the proposed model. The rationale for the request for increased funding for the NHPS was that the current microbiology/infection services in Wales were fragile and were struggling to deliver on a day-to-day basis the prevention, early diagnosis and frontline support that professionals and the public required. We agreed that whilst strengthening microbiology was important, it was not the sole focus of the proposal for a strengthened NHPS.

35. The aim was to continue to deliver strong immunisation and public health programmes driven by a consistent national framework. That included the need to promote a better understanding of health, infection and environmental hazards. Further to this aim, I led on a paper in 2019

which recommended prioritising the strengthening of the NHPS. This paper was presented to the HSSG Executive Director Team who were asked to support the recommendation and advise the MHSS to prioritise investment in the NHPS [**EXHIBIT - FAM01ATHERTON01/039 - INQ000180543]**.

36. HPAG updated the proposal to strengthen the NHPS at the meeting on 17 December 2019 **[EXHIBIT - FAM01ATHERTON01/040 - INQ000177380].** Additional funding was to be provided and ringfenced for the NHPS, and the PHW funding allocation would include funding for the Pathogen Genomics Unit [**EXHIBIT - FAM01ATHERTON01/041 - INQ000180588]**. This investment provided additional capacity and capability in the system which would later be utilised during Covid-19 pandemic.

37. During the HPAG December meeting, Dr Lyons confirmed that flu was circulating in Wales and that although it had begun earlier than usual, it was within expected parameters and early indications were that the vaccine was a good match. I expressed concerns around the preparedness of care homes and, in particular, the arrangements for antivirals. Dr Lyons confirmed that the agreement remained in place for GPs to prescribe antivirals in care homes and that care homes had received guidance from PHW.

38. Dr Lyons also gave a presentation on High Consequence Infectious Diseases ("HCID") **[EXHIBIT - FAM01ATHERTON01/042 - INQ000180755]** setting out the actions necessary and the initial learning from the recent case of Monkeypox and Lassa fever. I acknowledged that there were significant questions around the preparedness of NHS Wales to deal with HCIDs and it was agreed that whilst a key work stream of strengthening the NHPS would look at an all-Wales system for dealing with HCIDs more urgent action was necessary to provide reassurance. We agreed that we would arrange a meeting of key partners in early January to deal with the immediate needs for responding to HCIDs, such as training needed for new PPE guidance. I also undertook to write to the Health Boards, PHW and WAST requesting their plan/pathway for dealing with HCIDs. The deadline for a response was 31 March 2020.

39. The meeting agreed that 'risks in the system' should be considered at the next meeting of HPAG.

40. On 31 December 2019, I wrote to the core team saying the minutes were good, but there were lots of actions to get on with and asking if we could regroup early in the new year to track progress [**EXHIBIT - FAM01ATHERTON01/043 - INQ000180589].**

41. Name (Health Protection Policy and Legislation Branch) forwarded the minutes and my comments to the Health Emergency Planning Advisor and the policy lead for health emergency preparedness setting out that we were not 'adequately prepared' for a HCID outbreak and some urgent work needed to be done early in the new year **[EXHIBIT - FAM01ATHERTON01/044 - INQ000177379].**

42. On 13 January 2020 I received an email from Name Redacted Health Protection Policy and Legislation Branch, informing me that the 'Wuhan Novel coronavirus' was now classified as an airborne High Consequence Infectious Disease **[EXHIBIT - FAM01ATHERTON01/045 - INQ000180591].**

43. On 15 January 2020 at 5.34pm, Dr Marion Lyons, informed me of a suspected novel coronavirus case, with a link to Wuhan, affecting a North Wales resident **[EXHIBIT - FAM01ATHERTON01/046 - INQ000180594].** I did not see the email until the next morning and wrote back saying that I would expect to be called about this sort of issue and asking for an informal briefing for the Minister that morning **[EXHIBIT - FAM01ATHERTON01/047 - INQ000180595].** The informal briefing was provided by Name Redacted **[EXHIBIT - FAM01ATHERTON01/048 - INQ000180596].** There was a follow-up briefing on 17 January 2020 which set out the position as we knew it at that point; the risk assessment remained low **[EXHIBIT - FAM01ATHERTON01/049 - INQ000180597].** It was also confirmed on 17 January 2020 that the test results for the resident from North Wales were negative for all coronaviruses **[EXHIBIT - FAM01ATHERTON01/050 - INQ000180615].**

44. From around this point onwards, my team and I received a huge number of queries about the novel coronavirus and the need to respond and issue communications to the public and the NHS.

Annual reports: my reflections on public health and pandemics

45. I have published annual reports during my time as CMO(W), including:

    a. Gambling with Our Health – 2016/2017 **[EXHIBIT - FAM01ATHERTON01/051 – INQ00001194]**;

    b. Valuing our Health – 2018/2019 **[EXHIBIT - FAM01ATHERTON01/052 – INQ00001195];**

c. Protecting our Health – 2019/2020 [**EXHIBIT - FAM01ATHERTON01/053 – INQ00001196];** and

d. Restoring our Health 2021/2022 [**EXHIBIT - FAM01ATHERTON01/054 – INQ00001034].**

46. These reports set out my thinking over time about health protection and the need to work to eradicate health inequalities. They also refer to the key policies that were emerging in Wales to support a healthier population which would be more resilient to the threats of the modern world.

47. Chapter 3 of the 2016/2017 report looked at the risk to the health of the Welsh population from infectious diseases, environmental issues and major incidents and an overview of the work that was being done in Wales to manage these risks. I touched on international infectious diseases and recommended that health professionals should remain alert for imported disease and ensure that training and appropriate PPE was available. This chapter also considered health inequalities and recommended that PHW should consider the scope of environmental health surveillance in Wales to target environmental health inequalities.

48. In my 2018/2019 report (published on 7 May 2019) I noted in the introduction that obesity levels in the population were at a worrying level with childhood obesity being a particular concern; I was developing a healthy weight plan for Wales. I also referred to the Welsh Government's new long-term health strategy – "A Healthier Wales" and the urgent need to look carefully at the services we provide and the way they are delivered. The report concluded by considering some of the challenges in the area of health protection arising from infections and environmental threats. I stated that "*we live in an inter-connected world and recent events, such as the rise of measles across Europe, new and importable diseases such as Ebola and Monkeypox, and the use of chemical agents all serve to remind us that we ignore health protection concerns at our peril. I will be looking further at ways in which we need to strengthen this aspect of our public health system*".

49. The work done to increase the funding for the health protection system in general and the isolation beds in particular (as described above) was done following this report.

50. My 2019/2020 report was published on 30 January 2021 when we had been dealing with the pandemic for almost a year. I took the opportunity to focus on health inequalities and examine

the effect of the pandemic on different groups of people in Wales. I noted that it was "*a sad fact that the pandemic has exacerbated the situation for many people who are already the most disadvantaged or potentially neglected in our society, worsening pre-existing inequities*". I considered that the pandemic had provided us with a sharper focus to address these inequities.

51. Chapter 3 focused on Covid-19 and its effects on health inequities in Wales and the UK. There is a great deal of detailed information in the chapter which I will not repeat here but it considers many forms of health inequities, including the disproportionate impact of Covid-19 on people from ethnic minority communities and the steps taken by the Welsh government to try and address this fact. I set out 10 key messages in this report as follows:

    i. Responding to the coronavirus crisis has meant major changes to the lives of all across Wales and has meant making difficult decisions in order to save lives and protect our NHS.

    ii. We will continue to face significant challenges as we deal with changes in the number of cases and demand on healthcare services, as well as balancing the direct and indirect harms from COVID-19.

    iii. Maintaining and strengthening our Test, Trace and Protect ("TTP") programme is an essential part of protecting the people of Wales.

    iv. We are continuing to learn about the disease and to understand its transmission and risk factors, as well as understanding the wider harms associated with the crisis.

    v. We should prepare for future pandemics alongside other hazards which have the potential to have a negative impact on the people of Wales.

    vi. Preventing the next pandemic will need us to work closer than ever before across human, animal and environmental disciplines.

    vii. Wales has a unique opportunity to bring different sectors and disciplines together to face emerging challenges through the Well-being of Future Generations (Wales) Act 2015.

viii. Even before the COVID-19 pandemic, we knew there were health inequities in our society.

ix. The COVID-19 pandemic has exacerbated many existing health inequities in the Welsh population, with direct and indirect effects having a disproportionate impact on some groups more than others.

x. The reduction of health inequities should be a central part of every action that we take in re-stabilising our society and protecting our population from the impacts of COVID-19.

52. I set out eight recommendations intended to address some of these key issues.

53. My 2021/2022 report was published in June 2022 and had four chapters focusing on:

a. the effect of climate change on public health;
b. our aging population;
c. the effects of the pandemic on the most deprived areas' mortality rates and life expectancy; and
d. the effect of the pandemic on our health and social care system, lessons learned and new ways of working.

54. I included new recommendations and provided an update on recommendations from my previous report.

The future

55. As an overarching point, I consider that the pandemic plans and arrangements for outbreak/incident management that were in place were generally robust and proved themselves invaluable in our Covid-19 response but that they were predicated on a short, sharp shock; something that would disrupt the normal functioning of society for days or weeks. The plans were inadequate for a two, or three, year shock to the system and that should be factored into any future pandemic planning.

56. In terms of the detail of how we strengthen public health protection in the future, my annual reports set out many of my thoughts on what needs to happen to prepare Wales for new threats and a future pandemic. It is difficult to summarise the detail of those reports succinctly but in brief I consider that we must work on improving health outcomes and reducing inequities

to ensure that our population is as healthy as possible; we need to maintain monitoring and surveillance systems so we can track the health of our population and identify new threats; we also need to focus on environmental issues and inequities. It will be important in the coming years that we continue to invest in our health protection system and to test the resilience of our plans against a wide range of potential threats.

General Reflections on Pandemic Preparedness

57. I have also contributed to a document aimed at the CMOs, Government Chief Scientific Advisers (GCSA / CSAs), National Medical Directors and public health leaders of the future should they find themselves faced with a new pandemic or major epidemic. I believe it is a useful tool with lessons from the pandemic. It was published on the UK government website on 1 December 2022[1]. It covers some technical aspects of interest primarily to our scientific, public health and clinical successors. Any future pandemic will present its own unique challenges, but the document sets out what the four UK CMOs and our colleagues learned from this pandemic.

58. Having continued to reflect on the management of the pandemic I also consider that we need to have an 'all hazards' response to threats with a suite of detailed national documents to help structure the response in the early days. There is a risk that having dealt with a novel virus, we focus all our energies on responding to a similar threat (in the way that the majority of the pandemic planning pre 2020 focused on influenza) and fail to look more broadly at chemical, radiological, biological, environmental or nuclear threats.

59. The pandemic has shown us the importance of both behavioural science and modelling and we need to recognise that importance and continue to invest in these. The Welsh Government was reliant on a team at Swansea University for modelling information which was specific to Wales and reliant on PHW for information on the attitudes and behaviours of the Welsh population. The close relationships in Wales facilitated this work but I think that we need to consider whether there would be benefits to codifying the arrangements for provision of these valuable services.

[1] Technical report on the COVID-19 pandemic in the UK: A technical report for future UK Chief Medical Officers, Government Chief Scientific Advisers, National Medical Directors and public health leaders in a pandemic.

60. There is a longstanding dilemma and tension around pandemic preparedness which relates to the amount of redundancy that can be justified when NHS resources in particular and system capacity more generally are significantly constrained. This tension relates to the planning function but is also relevant to issues of NHS bed capacity, ITU provision, laboratory capacity, the public health workforce, stores of consumables, etc. Throughout my career in public health, I have seen additional investments and capacity allocated in the immediate aftermath of significant events and incidents only for this to gradually leach away in times of relative calm as other system pressures make competing demands on scarce resources. Given the impact and scale of the Covid-19 pandemic I would hope that our institutional memory is sufficiently extended so that the UK remains ready to face future shocks. Some degree of redundancy should be seen as a necessary protection against an uncertain future rather than an inefficiency to be ruthlessly eradicated.

61. Finally, I have touched on health inequities elsewhere, but I would like to finish on this point as the effort to promote better health across populations has been a feature of my whole career. We cannot predict the exact nature of future threats, but we can focus on building the health of our nation so that we limit their adverse impacts.

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.

Personal Data

Signed:

Date: 20/04/2023