Module 1
Statement of Dr Ruth Hussey
1st statement
May 2023

IN THE UK COVID-19 INQUIRY

Before the Right Honourable Baroness Hallett D.B.E

WITNESS STATEMENT OF DR RUTH HUSSEY

I, Ruth Hussey, will say as follows: -

1. I was born in North Wales and lived there until I studied medicine at the University of Liverpool School of Medicine. I trained as a GP and subsequently entered training for Public Health Medicine. After a period in academic public health at the University of Liverpool, I was director of public health for Liverpool Health Authority from 1991-2002; then Medical Director at Cheshire and Merseyside Strategic Health Authority 2002-2006; Regional Director of Public Health and senior medical director at NHS North West 2006-2012. During 2011-12, I was seconded to the Public Health Transition Team in the Department of Health, Whitehall to support the establishment of Public Health England and the transfer of the Public Health function to Local Government in England. I was appointed to the post of Chief Medical Officer for Wales (CMOW) and Medical Director NHS Wales in Sept 2012 and stepped down from that post in March 2016. I chaired a parliamentary review of health and social care in Wales which was published in 2018. I undertook a short project on Local Resilience Forums (LRFs) for the Ministry of Housing, Communities and Local Government (MHCLG) in March 2020; worked as a senior civil servant in the emergency response team for MHCLG in April and May 2020; and undertook a rapid review of future requirements for the Public Health Agency in Northern Ireland, completed in December 2020.

2. At present, I am Deputy Chair of the Food Standards Agency, Deputy Chair of The Health Foundation and a trustee of The Reader charity. I chair or have contributed to a number of policy and research advisory boards and independent commissions in

England and Wales. I chair the Care Inspectorate Wales Advisory Board. Currently, I am a member of the Commission on the use of Public Health Law in Emergencies.

3. The Inquiry has asked me questions about the period September 2012 – March 2016 when I was the CMOW. I am also asked to give evidence about the 2020 Battle and Hussey Review which I conducted for the Department for Levelling Up, Housing and Communities, previously known as MHCLG. I include evidence in respect of that review in this statement although, as the Inquiry is aware, it post-dates my time as CMOW and was undertaken in March 2020, outside the time frame for this module of the inquiry.

4. The pandemic led to substantial numbers of deaths and harm to individuals and families. It has left many with chronic health problems. The disease and control measures affected the lives of people of all ages and from all parts of society. It disproportionately affected those who were most disadvantaged. It has had devasting consequences on health and social care, both on patients and staff. I offer my deepest and heartfelt sympathies to everyone who has been affected. The pandemic is not over and the Inquiry provides an opportunity to learn and improve plans and responses to ongoing and future threats.

The r. 9 request

5. I understand that a number of requests for information, under r. 9 of the Inquiries Rules 2006, have been made by the Inquiry in relation to Module 1. I also understand that the substance of the Welsh Government's preparedness arrangements has been set out in statements, provided by senior officials, in response to those requests.

6. The request asks ten questions which I shall answer in turn. In some cases, I am unable to answer the question asked. Where this is the case, I have set out why I am unable to answer and in some cases I have attempted to provide information which I hope will be useful.

What are your general views on the systems, processes and structures for pandemic preparedness in Wales? To what extent, and how, was it integrated with the UK's systems, processes and structures for pandemic preparedness? How, in your view, could they be improved?

7. As CMOW I was a member of the Welsh Resilience Forum and attended the Civil Contingency Group meetings. The Welsh Resilience Forum was updated on infectious disease threats by myself and the lead from Public Health Wales (PHW) who provided information, informed by work at UK level and through Welsh specific data **[Exhibit RHM01/01-INQ000144780]**.

8. I considered that the basic systems, processes and structures in place were sound during the period 2012 – 2016. They dealt adequately with the outbreaks of Ebola and MERS during that time.

9. The systems were also used as a basis to plan for the NATO summit held in South Wales which necessitated comprehensive preparations by all agencies. Health emergency planning was co-ordinated by staff in my directorate, namely the Health Emergency Planning Adviser, **Name Redacted** Dr Andrew Riley was appointed as a clinical lead for health protection. Both attended Wales and UK level emergency planning and infection control meetings on my behalf, where relevant. PHW collaborated with other UK Public Health Agencies.

10. Throughout my time as CMOW, the 4 UK Chief Medical Officers (CMOs) met approximately quarterly. We covered a wide variety of issues including infectious diseases and other threats to the public's health. In that period, we collaborated on producing guidelines, such as on alcohol and physical activity. In September 2014, we discussed 4 nation collaboration for Exercise Cygnus **[Exhibit RHM01/02-INQ000184202]**. When the UK Civil Contingencies response was active, such as during the response to Ebola, the UK CMO shared information with the Devolved Government CMOs **[Exhibit RHM01/03-INQ000184206]**. We undertook a four-nation exercise in December 2014 to ensure effective communication and collaboration.

[Exhibit RHM01/04-INQ000177199]. Welsh Government provided funding in support of the UK wide role provided by Public Health England (PHE).

11. Areas that could have been enhanced with clearer responsibilities are the arrangements for scientific advice and a strengthening of information systems. Wales, when I was CMOW, was guided by UK wide science **[Exhibit RHM01/05-INQ000184183]** and used UK advice to inform plans. Whilst most of the evidence was relevant across the UK, there was a need to understand the Welsh context. PHW undertook that role as far as was practicable.

12. During planning for Exercise Cygnus, it appears there was an assumption by PHE that Wales would produce its own modelling, but Wales' expectation was that this would be done at a UK wide level **[Exhibit RHM01/06-INQ000184179].** Likewise, Wales worked from a UK level pandemic communications strategy **[Exhibit RHM01/07-INQ 000184175, Exhibit RHM01/08-INQ 000184306 and Exhibit RHM01/09-INQ000184305]**. The Civil Contingency response at the time I was CMOW was led by the UK Government. However, as devolution has progressed there is an opportunity to clarify what is undertaken at UK-wide and Country specific level including information gathering, scientific advice and frameworks for Ministerial decision making. New four-nation frameworks have been developed in other aspects of UK-wide working and may inform emergency planning arrangements.

What are your general views on the Pan Wales Response Plan?

13. The Pan Wales Response Plan provided a clear framework and set out respective responsibilities for mounting and maintaining an emergency response. No incident is the same and the generic Pan Wales Response Plan provided a sound basis for initial co-ordination and communication. Difficulties arose when it was used in real time because personnel change, skills fade over time, and there is a need to ensure sufficient trained cadre of people to operate the plan over a prolonged period.

Maintaining effective Wales-wide and UK- wide relationships is necessary so that individuals are known to each other before an incident occurs.

14. In terms of improvements to the arrangements, whilst the plan covers communication and public information, the context has changed, with substantially more information readily available now through social media. The plan should consider the way in which information now flows and the need for responses to counter mis-information. The other aspect which could be reviewed is the engagement of civil society, through communities and voluntary organisations. Involving communities would enable better planning and understanding of the requirements of different sectors of society and what role civil society can offer when the plan is in action.

15. This could well have been done in later iterations of the plan.

Which key policies, in respect of public health and science, had a material effect on Wales' pandemic readiness? What effect did they have?

16. As CMOW I advised Ministers on public health and medical matters, but I was not responsible for policy decision-making. My CMO reports documented the general health and ageing demographic of the population and recommended actions to improve and protect health, including reducing health inequality. Life expectancy in Wales was improving but a third of the population was living with chronic illness or disability. At the time, healthy life expectancy was around 63 years for men and women. Action was also recommended on lifestyle factors which were highlighted as a concern with consequent health issues such as obesity, diabetes, heart, cancer and liver disease.

17. During my time in the role, Welsh Government passed legislation such as the Active Travel (Wales) Act 2013, the Well-being of Future Generations (Wales) Act 2015, and the Social Services and Well-being (Wales) Act 2014 all of which contributed to improvements in public services. Welsh Government also pursued legislation to address public health matters such as smoking, implemented policies to reduce health

inequalities (Tackling Poverty Action Plan 2012-2016) and invested in enhanced scientific capability through the Chief Scientific Adviser for Wales. Funding was broadly maintained for the Health and Social Care Research function. New policies were developed on aspects of specific disease prevention and treatment such as diabetes and heart disease. An obesity pathway was in place from 2010, healthy eating in school regulations were introduced in 2013 and the Healthy Child programme was reviewed. The school curriculum was revised to include health and wellbeing. A public health outcomes framework was published in March 2016 to monitor progress.

What effect did policies that were implemented, in particular, on the funding and structure of health and social care have on the preparedness and resilience of Wales?

18. My time as CMOW coincided with austere public finance policies pursued by the UK Government which affected Welsh Government funding. In this context, I recall that I was asked to make a 5% budget cut to departmental staff in 2013. By 2015/16 the NHS in Wales overspent its budget by £50m which was offset by savings in the central Health and Social Care Department.

19. The structure of the Welsh health service was relatively stable during my tenure though clarity on responsibilities was continuing to develop. Seven Local Health Boards had been formed in 2009 as well as three NHS Trusts, one of which was PHW. Local Health Boards (LHBs) were encouraged and expected to work as a collective across Wales with variable success. Regional working arrangements were established to bring 22 Local Authorities (responsible for Social Care) and 7 LHBs closer together. The accountability relationship between PHW and LHBs was clarified as far as possible, where PHW provided a service to LHBs and where LHBs had a responsibility to PHW for service delivery eg vaccination and screening services. The role of the Director of Public Health in LHBs and the relationship with PHW was part of the consideration.

What, do you consider, has been done correctly in relation to pandemic planning, preparedness and resilience during your tenure in office?

20. There were three main areas where there was effective preparedness work during my time in office: (i) updating relevant plans (ii) participation in exercises and planning at UK–wide level and (iii) responding to incidents, namely Ebola and MERS. We also pursued improvements in the NHS' ability to respond.

21. Specifically, the following plans were updated:

    a. Wales Framework for Management of major infectious diseases, **[Exhibit RHM01/10-INQ000184289]**,

    b. Wales outbreak plan **[Exhibit RHM01/11-INQ000116459]**,

    c. Wales Health and Social Care pandemic preparedness and response **[Exhibit RHM01/12-INQ000184295]**.

22. The standing Health Protection Committee provided ongoing advice on a wide range of threats to the public's health **[Exhibit RHM01/13-INQ000184185].**

23. As an example of exercising, during the emergence of H7N9 in 2013, I suggested that all relevant staff re-familiarise themselves with the systems in place for managing a pandemic and arranged a live run-through of the relevant plans and procedures. **[Exhibit RHM01/14-INQ000184178].**

24. With regard to the Welsh NHS examples of relevant improvements, these included improved vaccination uptake, reducing Health Care Acquired infection, and enhancing Critical Care capacity. Work was also undertaken by PHW to secure improved laboratory services and genomic testing capability.

25. I took a particular interest in promoting uptake of seasonal flu vaccine to reduce the impact of flu and to create a better understanding and acceptance of the value of flu vaccination in the population and amongst staff. Uptake of influenza vaccination in those 65 years and over improved from 59.5% in 2008-9 to 68% in 2014-5. For staff this increased from 11% in 2009-10 to 44% in 2014-5. **[Exhibit RHM01/15-INQ000184309** and **Exhibit RHM01/16-INQ000184308]**. Vaccination was also promoted during the Measles outbreak in 2014.

26. The following example illustrates learning from the experience of the Ebola incident. The Chair of the Welsh Intensive Care Society (Dr Paul Morgan) wrote to me on 5th November 2014 in relation to Ebola **[Exhibit RHM01/17-INQ000184218].** He also wrote the same letter to the Deputy CMO, the Chief Nurse and the Health Minister. In the letter he noted that guidance on the use of PPE had been issued by PHW and that PPE had been purchased. However, he raised concerns that frontline staff needed training and easy access to the equipment. He requested that there should be an all-Wales training programme rather than at Health Board level. He also described the impact of a recent possible case on the running of the ICU at his hospital. The matter was followed up by Dr Marion Lyons, Consultant in Health Protection, Public Health Wales and a formal reply issued on 10th November 2014 which describes the actions taken to address the concerns **[Exhibit RHM01/18-INQ000184293].**

Based upon your experience, what changes could be made to the specialist structures, systems and processes in Wales to better prepare it for a pandemic?

27. Although not in the CMOW post during the pandemic, based on my general experience, a review of the funding, capacity and capability of the public health system in Wales would ensure that sufficient attention is given to developing and maintaining the range of skills required to prepare for and respond to a future pandemic or other health threats. This would include laboratory capacity, surveillance, data science, modelling, as well as supporting capacity such as Environmental Health, and resources such as PPE, medicines etc. It should include a clear statement of minimum standards to be

maintained in key areas. In particular, the relationship, roles and accountability between Directors of Public Health in LHBs, PHW and the Office of the CMO should be clarified. Directors of Public Health (DsPH) are employed in the NHS by LHBs. I recommended in 2015 that DsPH should be joint appointments with Local Authorities (LAs) to strengthen the public health system at local level. This would include emergency preparedness. An obstacle, though not insurmountable, to joint appointments is the mismatch in number of LAs compared to the LHBs.

28. In response to the 10 recommendations of the parliamentary review of health and social care in Wales, published in 2018, the Welsh Government published 'A Healthier Wales.' This strategy should be implemented with urgency as it sets the basis for a health and care system better suited to the needs of the population.

29. The parliamentary review of health and social care recognised that the NHS and social care are funded and organised in different ways but recommended that there should be 'One system of seamless health and care in Wales' with attention paid to greater individual and community involvement in prevention and care as well as improving staff wellbeing and development. It also commits to reducing health inequalities. These are important aspects of the pandemic response. Evidently, the NHS and Social Care will need to review capacity to recover from the current pandemic but also ensure sufficient capacity for future events. Areas to strengthen include primary care systems and ensuring sufficient access to highly specialised services such as Critical Care, extracorporeal membrane oxygenation (ECMO) and isolation facilities.

30. Emergency preparedness and response in the Social Care sector will require resources. This should cover resilience of Care Homes and Community Services that support people in their homes. The current system is understaffed and will require sustained effort to improve the situation. Carers also need to be considered in plans when pandemic control measures lead to a reduction in support. Collaboration between the NHS and Social care is vital to ensure 'One Seamless system' and this should be prioritised.

31. It is also vital that the NHS maintains a cadre of staff who are able to collaborate in a multiagency setting in planning and response.

32. Further enhancement of laboratory, data and surveillance capacity and capability is needed to maintain skills acquired during the pandemic and to stay abreast of future developments. Wales should ensure it has self-sufficiency in these services.

Which lessons had been learned from past simulation exercises, in particular Winter Willow and Cygnus, and potential pandemic events which made Wales ready for the Covid-19 pandemic? Which lessons had not been learned from these events?

33. I was not in the CMO post when the Winter Willow exercise was carried out (2007) and I had left post before the UK-wide Cygnus exercise was conducted in 2016. I was in post when the following exercises were carried out:

    a. The Cygnus exercise in 2014 (part UK level, part Wales only);

    b. The 4 nations Ebola exercise in 2014;

    c. Exercise Alice in 2016.

Exercise Cygnus 2014

34. In late 2013 I was copied in on correspondence about the Pandemic Influenza Exercise Cygnus that was to take place at UK level in May 2014 **[Exhibit RHM01/06-INQ 000184179** and **Exhibit RHM01/19-INQ000184181]**.

35. On 16 April 2014 I sent a letter to colleagues inviting them to participate in Phase 1 of Exercise Cygnus which was to take place on 14 May 2014. In that letter I set out the

importance of conducting exercises as follows: "I regard exercises as extremely important for testing and validating our responses to major public health risks. They provide opportunities to test plans and procedures and help foster integrated responses across both health and Government" **[Exhibit RHM01/20-INQ000184307]**. This letter was sent with other briefing documents to those participating in the Welsh government **[Exhibit RHM01/21-INQ000144658].**

36. I was sent the scenario on 1 May 2014 **[Exhibit RHM01/22-INQ000184195].** I was responsible for chairing the senior officials meeting on the afternoon on 14 May 2014 **[Exhibit RHM01/23-INQ000144662].** The meeting provided a useful opportunity to explore the types of issues that would arise and the interface with the UK Government.

37. I was sent an invite to the next part of the exercise which was due to take place in October 2014 **[Exhibit RHM01/24-INQ000184201].** The SAGE papers were circulated on 8 October 2014 **[Exhibit RHM01/25-INQ000184195].** Due to the Ebola outbreak, the UK government pulled out of the October exercise on 9 October 2014 **[Exhibit RHM01/26-INQ000144754]** but in Wales we continued with the exercise in respect of our Local Resilience Forums workshops **[Exhibit RHM01/27-INQ000144756].**

38. I recall that the exercise was useful in identifying a number of issues for further discussion. These covered regulations, communication, data requests, activation of the national flu service, needs of vulnerable people in social care and arrangements for managing excess deaths. Work was also underway to update the HR plan to enable staff to be redeployed across organisational boundaries. I commented that IT connectivity should be considered so that staff could access test results across organisations in Wales. **[Exhibit RHM01/28-INQ000184273].**

39. The issues raised were reported to the Wales Resilience Forum in November 2014. **[Exhibit RHM01/29-INQ000184291].** Recommendations from Exercise Cygnus was discussed at the Emergency Planning Advisors Group (EPAG). The group identified who would take on the follow up work **[Exhibit RHM01/30-INQ000184280].**

The 4 nations Ebola exercise (2014)

40. On 4 December 2014 I was sent the draft exercise brief for the 4 Nations Ebola exercise which was due to take place on 10 December 2014 **[Exhibit RHM01/31 - INQ000184219].**

41. The briefing document from PHE set out that the aim of the exercise was to develop and coordinate a consistent response strategy across the four nations in the event of an Ebola case in the UK **[Exhibit RHM01/32-INQ000184220].**

42. Further information was sent on the 9 December 2014 and on the morning of the exercise on 10 December 2014 **[Exhibit RHM01/33-INQ000184222, Exhibit RHM01/34-INQ000184236** and **Exhibit RHM01/35-INQ000184251].**

43. A second phase took place on 11 December 2014; I also participated in this phase. I note from the briefing for this phase that PHE was due to prepare a report with concise lessons from the exercise **[Exhibit RHM01/36-INQ000128982].**

44. In January 2015 the Health Emergency Planning Adviser shared the PHE Plan for Response to High Probability and Confirmed Cases of Ebola. The covering email noted that PHE had created and shared a common lexicon to describe cases which was one of the recommendations to come out of the four nations exercise **[Exhibit RHM01/37-INQ000184281].**

Exercise Alice (2016)

45. The Health Emergency Planning Adviser was invited to observe this exercise on MERS-Covid. The exercise took place in February 2016 and my post as CMOW ended in March 2016, so I do not recall seeing the final report or any lessons learned.

What are the principal developments in public health and epidemiology that the Welsh Government should now be taking into account when preparing for a pandemic?

46. Assessment of the underlying health of the nation should underpin an understanding of the necessary response to a pandemic, paying particular attention to social circumstances and barriers facing parts of the population so that necessary support systems are planned for and are available. There is a growing body of knowledge about behavioural science that can inform effective approaches to public information and engagement and this capability could be strengthened. Policies to reduce health inequality and to enhance inclusion are important; there is a substantial body of science to inform action. There should be an emphasis on improving the health and wellbeing of the population and recovering and transforming the NHS and social care systems.

47. Research and Development was used to good effect to inform treatment options during the pandemic. Wales already has a well-established health and social care research function. This could be enhanced to include a rapid research capability for future incidents in Wales. There should be continued strengthening of four nation and international links, in partnership with academia, to improve horizon scanning, and anticipation of new threats. Wales should have direct access to all international systems and relationships to inform its own system development.

48. An area that has grown substantially is in the field of health informatics. New data systems were used in the Covid pandemic. This area should be strengthened further to develop data analytical capability and data linkage on an ongoing basis. Artificial Intelligence may play a key part in the medium term.

49. Surveillance systems should be reviewed to ensure the devolved nations have access to international data sets and collaborations.

50. The ability to activate mass testing should be maintained.

51. Genomics research and analysis as well as population surveillance have been improved in recent years, but it is essential that Wales keeps up to date on these aspects.

52. Some aspects of a pandemic response are not devolved such as vaccine development and approval. Wales should play a full role in future plans to maintain a standing vaccine development capacity.

53. Public engagement and transparency of scientific evidence has become more important. Consideration should be given to how scientific evidence is produced and shared; how Wales participates in UK scientific advisory systems and what capacity it develops at country level. Evidence should include impacts of the disease and the interventions used to control the disease.

54. The role of public health law in emergencies is relevant to review, especially with the increase of devolved powers.

The Inquiry also wishes to draw on your experience from the 2020 Battle and Hussey Review for the Department for Levelling Up Housing and Communities. What issues did you identify in LRFs' ability to plan and respond effectively to civil emergencies such as pandemics? What recommendations did you make?

55. I do not have access to final reports and emails held by the Department of Levelling Up Housing and Communities. I emailed the Department on 29 March 2023 and on 14 April to request materials. The review was a rapid assessment of the situation in the LRFs in England. My involvement was over a period of 3 weeks from 9 March 2020 when I joined Andy Battle, who had already commenced. The assignment was charged with raising local awareness of the likely scale, severity and duration of the pandemic and to understand what stage the LRFs were at in terms of planning and activating the response.

56. The work was informed by a rapid planning survey and self-assessment by LRFs. Analysis of returns by officials showed that, overall, most LRFs reported good levels of preparedness planning and multi-agency engagement.

57. This was followed up by meetings, attendance at LRF planning events, table-top exercises and attending live Strategic Co-ordinating Groups either in person or virtually. In total contact was made with 14 of the 38 LRFs in England.

58. Short weekly summaries were provided to MHCLG to provide 'live feedback' from local systems. We highlighted the key issues that were being raised by LRFs. These included Adult Social Care, business continuity and organisational resilience, excess deaths planning, availability of central guidance, PPE, links between NHS and LRFs, communication and information flows and volunteer co-ordination. We also advised ways in which national co-ordination could be enhanced to support local areas.

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.

Signed: **Personal Data**

Dated: 4th May 2023