Department of Health & Social Care

From the Private Secretary

39 Victoria Street
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I&S

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Dear NR

The tri-lateral (CDL, CX, SoS DHSC) agreed in-principle the *Living with COVID* strategy must retain of a critical surveillance system, including genomic sequencing; provide the ability to rapidly reinstate testing through a stockpile of LFDs and a surge in laboratory capacity when needed; and provide preventative symptomatic and asymptomatic testing to protect high-risk settings. As we remove defences, we need to be confident we can scale up our response to manage a highly-likely COVID resurgence, particularly from variants of concern. Failing to maintain the necessary COVID response or contingency infrastructure makes it more likely we will need to rely on societal restrictions, at far greater costs, to manage resurgences.

My SoS has again challenged officials to determine the minimum response credible from a public health perspective. This would provide:

- **Continued protections in vulnerable settings and for clinically higher risk individuals as we transition to living with COVID, with asymptomatic testing expected to reduce when prevalence and risk decreases, costing £1,355m**:
    - Development of a targeted approach for deployment of antivirals for the PANORAMIC trial (£200m), possibly through a GP led pathway.
    - Provision of both symptomatic and asymptomatic testing in the NHS, for patients and staff, as part of necessary routine clinical care (£535m). This has been rationalised to recognise expected changes in prevalence, but must be agreed with the NHS.
    - Provision of both symptomatic and asymptomatic testing in the social care settings for residents and staff, as part of necessary routine clinical care (£620m). This will taper down over the course of the year and includes the removal of visitor testing.

- **Robust surveillance and sequencing systems to ensure we can monitor the virus, rapidly detect and respond to variants of concern detected both domestically and internationally, and sequencing critical to meet our global 100-day commitment on vaccine development, costing £601m for 22/23 covering both programme and testing costs, including:**
    - Reduced ONS CIS costing c.£303m, excluding testing (saving £233m on 2021/22 spend), noting the loss of granularity that will significantly delay the identification of VUI/VOCs arising in the UK. (Sample size could be stood back up if a VoC meant we needed more specific intelligence.) Surveillance studies would also be supported with requisite PCR Testing (~£50m).
    - Continued COVID surveillance in high-risk vulnerable groups such as healthcare workers (c.£8m for SIREN) and in care homes (c.£2.8m for Vivaldi).
    - Reduced wastewater surveillance research at a cost of £22.3m (saving £30.1m on initial proposal).

- Continued primary care surveillance via Royal College of GPs. This surveillance detected the first case of community SARS-CoV-2 in the last week of February 2020 (£3m).
- Borders surveillance of 5% of incoming travellers (£111m).
- Genomics capacity (£100m)

- **Retaining a flexible capability to respond to a resurgence of COVID-19 and other health threats requiring:**
  - Retain a stockpile of approximately 119m LFDs. This would enable asymptomatic testing for a priority cohort, for 6 weeks whilst a wider response is developed alongside a rationalised outbreak testing response to offer local support (£288m).
  - Maintain a general PCR lab network at a reduced scale of 180k per day. This network should consist of the Rosalind Franklin Laboratory ("RFL," 150k capacity) alongside a small laboratory presence in the devolved administrations (30k capacity altogether).
  - Retain trace platforms developed for COVID-19 at low cost (£31m in 2022/23). This would retain digital platforms developed for COVID-19.

- In order to scale down our testing and trace network to this reduced infrastructure and continue to run effectively requires decommissioning and running costs of £541m.

- Securing a sustainable three-year settlement for UKHSA core is essential to underpin the ongoing resilience and contingency capabilities set out above, as well as securing on an enduring basis the innovations and opportunities from COVID-19. With reduced ambition for Centre for Pandemic Preparedness and Global Health security the cost can be brought down to £773m.

The overall estimated cost of this proposed package in financial year 2022/23 is therefore £4,323m above baseline (ex-PHE) spend – £2,755m above what is available through the Spending Review envelope. A further £50M would provide for continued use of proven therapeutics, and £252M for expansion of the flu programme to reduce the impact of concurrent COVID and flu waves.

Reprioritising DHSC Group spending

My SoS agrees with the need to control public spending and identify tough choices, and has again challenged officials to reprioritise DHSC Group spending to meet the costs of the COVID response. It is important to recognise that we negotiated an extremely taut settlement at the Spending Review which baked in the more feasible options across the board, building on the extensive engagement and scrutiny of our budgets over the last eight months. We had already been asked to reprioritise nearly £2bn of spending to cover both vaccine procurement and increased costs resulting from our response to Omicron – all while managing a £350m overcommitment just against the currently available funding for COVID.

We have engaged in this exercise in good faith, however all options are unpalatable and would require the Government to make extremely challenging choices in relation to manifesto commitments and those more recently announced in the Autumn (both the Spending Review and Build Back Better). Where possible, we have tried to protect these but our scope to do so is limited. **To live within the settlement we would have the implementation of adult social care reform by six months, row back on all the prevention commitments made at the SR, break the manifesto commitment on car**

parking, and it's not clear we could fully deliver the commitments on 50,000 additional nurses or 50m additional appointments in general practice. Reprioritising spending in this way would put our NHS reform agenda and broader public health objectives at risk, including on childhood obesity which has been particularly exacerbated over the pandemic. Areas targeted for Levelling Up that will be hit disproportionately by these measures.

NHS funding represents the single largest element of our budgets, with nearly three quarters of this flowing to systems for the delivery of front-line care. As part of the settlement, we secured a doubling of the aggregate efficiency ask of NHS systems to 2.2%, alongside setting ambitious productivity assumptions to support the recovery of elective care. This is over double the average for the last decade (0.9%). Pay for NHS staff is our single largest element of spend so to live within the envelope, we would have to revisit the spending review assumption – reducing to 2% to release c.£750m compared to our current plans. There would be significant consequences for doing so, both in the short and longer-term with a high likelihood of industrial action and risks to recruitment and retention. We are due to publish our recommendations to the Pay Review Board on Wednesday so this would require immediate action.

My SoS agreed a further tough savings to other budgets including freezing the growth in transformation budgets in 24/25 – which would have been worth £700m in the final year of the period; challenging savings in primary care – worth over £300m by 24/25; and halving the rate of growth is specialised commissioning budgets which provide treatment to rare and complex cases. However, we would need to go further, freezing growth in the System Development Fund next year, which would require us cut mental health services, breaching the mental health investment standard. Alongside this we would have to freeze growth in NHS contributions to the Better Care Fund, effectively creating a pressure for local government and potentially impacting pace of discharge from acute settings.

DHSC faces a series of pressures on our workforce budgets associated with growing a number of students already in the system thanks to the Governments success in growing domestic training pipeline to begin to meet acute staffing shortage. To meet this ask we would need to scale back all discretionary elements of our plans to deliver 50,000 additional nurses and 50m additional appointments in General Practice; and end our transfer to Department for Education for the additional 1500 medical school places announced in 2017.

Our remaining areas of non-NHS spend are dominated by either ringfenced (public health grant) or demand-led spend such as reciprocal health care. Correspondingly we would also need to revisit the public health grant, reissuing allocations with a 10% reduction, generating £320m. The CMO notes that this would directly diminish our ability to prevent and respond to future Covid outbreaks particularly in the most disadvantaged areas~~This proposal however would be strongly opposed by the CMO, who notes that this would directly diminish our ability to prevent and respond to future COVID outbreaks, particularly in the most disadvantaged areas~~. It is likely we would face a very high risk of legal challenge. We would also need to delay the implementation of social care reforms by six months with corresponding implications for the delivery of our commitments and profile in future years.

My SoS has also considered the options in our capital budgets. A large proportion of our capital budget for 22-23 is already contractually committed and includes major projects that are already in construction. Equally, we are planning to spend £2.3bn in 22-23 on projects to directly drive elective recovery. This makes it difficult to identify things that could be slowed down in 22-23 so the options for reprioritisation are spread thinly.

My SoS does not believe that it is feasible or desirable to reduce the operational capital which the NHS uses for managing critical infrastructure risks, operational maintenance and replacement equipment, prioritised at a health system level, as this would affect service delivery in all parts of the NHS and compound pressures on individual hospital trusts and physical infrastructure.

The largest feasible options are: frontline digitisation tech (where we could release a maximum of £150m by marginally slowing down rollout of electronic patient records to new sites and halt other aspects of frontline digitisation, but doing so is likely to be less cost effective in the long-term by compromising delivery of the productivity targets in Build Back Better and LTP targets for overall digitisation); the new hospital programme and hospital upgrades (where we could delay up to £150m of spend, including to future SRs – but this would mean that we would be unable to meet major manifesto commitments including those specifically announced by the Prime Minister, and would further compound known pressures and the number of announced upgrade schemes that would need to be cancelled); and R&D (where we could delay up to £100m of research spend but risk progress against the Life Sciences Vision and making the UK a science superpower). All of these options would delay spend and increasing the total costs of the projects, as well as weakening confidence in the construction industry in some cases.

We could also introduce a further limited delay to the Science Hub programme but options are constrained by the low overall spend 22/23 (so the maximum saving would be £40m allowing for contractual commitments), and the need to maintain the overall timeline so we do not compromise the delivery of containment laboratory provision given the finite life of the current facilities at Porton. Again, cost inflation will mean the overall programme costs increasing.

A modest saving to Disabled Facilities Grant (maximum £50m) is feasible without affecting our statutory duty but may represent a false economy, in that delays in adaptations to homes can prevent timely hospital discharge and compound hospital occupancy pressures. Similarly, delaying spend on Care and Support Specialised Housing for older people and adults with disabilities or mental health problems will reduce their ability to live independently, and put additional pressure on the NHS.

These options total £3127.8m, against a total cost of £3,057m for UKHSA and further funding required, with £70.8m flexibility. We also need to consider vaccine consumption which we've also agreed to find via reprioritisation.

The level of cover required is extremely uncertain given we do not yet have JCVI advice on Covid vaccination cohorts in 22/23. However we know it will be less than the £1,473bn originally forecast as this included a booster for all adults in autumn/winter and a further booster for cohorts 1-9 in spring – and JCVI has already recommended less than this for the spring booster. While we won't be able to establish a more accurate forecast until later in the year, this would be the first call on the flexibility detailed above.

This also assumes that other government departments cover some limited costs appropriate to their remits including funding testing within their estate to follow infection prevention and control advice, including DfE (SEND schools, children's care homes), HO (immigration removal centres) and MoJ (prisons). If DLUHC wish to ensure there is further funding for local authorities to transition from COVID and maintain local response, this should be provided from their budgets. In total these costs stand at £296m in 2022/23 (Annex C).

***Living with COVID* strategy**

My SoS' position is that it is not possible to publish a comprehensive *Living with COVID* strategy without reprioritisation of our committed and announced spending, or further funding. Where funding is not yet agreed we cannot make public commitments in the Living with COVID strategy. If the PM wishes to decide upon the savings we have described above, and announce them alongside the strategy, my Secretary of State agrees that a comprehensive *Living with COVID* strategy can be published on the basis of that funding. Our narrative would set out that living with COVID has short-term costs which mean reprioritisation is necessary to maintain our pharmaceutical defences and preserve hard-won freedoms.

If these decisions are not made, we could announce a limited package, excluding testing and contingencies, under the *Living with COVID* strategy. This must remove the unfunded elements and commit to follow up with a further COVID resilience strategy setting out our approach to testing and contingencies before 31st March whilst we agree further funding or reprioritisation. This would of course be difficult in presentation terms and create system uncertainty.

I am copying this note to Private Secretaries to the Chancellor of the Exchequer, and the Chancellor of the Duchy of Lancaster.

Annex A – Additional Funding Potentially Required

Additional Funding (all pre-Barnett, £ms)	***22/23***	***Comment***
Proven therapeutics	*50*	*Required to continue use of proven therapeutics.*
Flu programme expansion	*252*	*This includes £93.41m recurrent funding for children's and c.£45m for call/recall both are being sought by separate business cases.*
UKHSA minimum bid		***Additional to £1.6bn SR allocation.***
UKHSA Core (above PHE baseline)	*224*	*Detail set out above.*
UKHSA Enhanced	*70*	^
UKHSA (T&T) decommissioning	*131*	^
NHS Testing	*198*	^
Vulnerable testing	*476*	^
Surge management LFDs	*288*	^
Genomics	*100*	^
Covid transition	*36*	^
Surveillance	*501*	^
Testing operating costs	*453*	^
Corporate operating costs	*56*	^
Crown dependencies LFDs	*0*	^
UKHSA Core CDEL	*222*	^
Total Additional Funding	***3057***	
Plus vaccine consumption	*1473*	*Highly uncertain that these doses would all be consumed in 22/23.*

Annex B – Reprioritisation Options

Reprioritisation Options (£ms)	***22/23***	***Comment***
RDEL		
of which - Non-NHS Prevention & ASC		
10% cut to Public Health Grant	*426*	*Most of non-NHS spend (excluding workforce are dominated by either ringfenced (public health grant) or demand-led spend such as reciprocal health care. Correspondingly we'd need to consider reductions to the PH Grant and recent policy announcements:*
Halve DHSC Adult Social Care Reform investment	*237*	
Cut weight management funding	*100*	*- PH Grant: committed to flat real at the SR. Early Years and Drugs funding packages also rely on PHG spend continuing at current levels. Already confirmed 22/23 allocations - high legal risk.*
Cut Early Years funding	*37*	
Cut drugs strategy funding	*175*	*- ASC reform: goes directly against the Build Back Better commitment and the stated objectives of the Health and Social Care Levy.*
		- SR announcements on weight management (rejected at SR), early years and drugs strategy (rejected at SR) – very challenging to row back on those commitments.
of which - Non-NHS Workforce		

Don't transfer DfE for 1500 medical places	*40*	*Committed in 2017.*
Scrap international recruitment grants	*35*	*Increases delivery risk to 50k nurses manifesto commitment.*
of which - other Non-NHS		
Retrench on free car parking manifesto commitment	*76*	*Breaks manifesto commitment.*
IHS Forecast Changes	*100*	*Increases risk against non-NHS settlement and ability to manage emerging pressures.*
Scrap UK Research & Innovation Fund	*17*	*No.10-driven fund for public health initiative. Not bid for by DHSC at SR21.*
School Games and Sport	*45*	*Offered at SR21 but rejected by HMT.*
of which - NHS		
Pay restraint	*750*	*We already have a stretching ask for NHS systems - doubling the existing efficiency ask to 2.2%. Correspondingly we need to look at a range of other options including:*
Flat cash System Development Funding	*300*	*- Pay restraint: Holding pay down to 2% in 22/23. Clearly immensely challenging with high risk of industrial relations and impacts on retention.*
Better Care Fund Growth at flat cash	*225*	*- This would likely remove any optionality to accelerate "off-track" ambitions at the LTP update – and you may have accept further slippage too. Would entail at least one of: breaching Mental Health Investment Standard due to a cut to services; Deferring Diagnostics Strategy and Elective Tech Investments; and reopening GP Contract. Would also entail reneging on published planning guidance for 22/23.*
		- Counter to HMT settlement condition letter. Would shunt costs into ASC Budgets and/or Local Gov. May have knock on impact on pace of discharge into non-Acute Settings.
CDEL		
Tech (NHSX)	*150*	*Delaying spend on frontline digitisation and rollout of electronic patient records could release c£150m in 22-23 but would mean missing the 2023 and 2025 targets and hinder the NHS's ability to make the productivity gains needed to deliver elective recovery trajectory.*
New hospitals programme	*100*	*This reduction would delay projects already in construction and impact progress made on 40 new hospitals during this Parliament; increase overall costs due to inflation and damage construction industry confidence in this major programme.*
Hospital upgrades	*100*	*Reducing this budget in 22-23 would risk delivery of the manifesto commitment to delivering the PM's 20 hospital upgrades. Even if those projects had their funding protected, this would delay delivery of other upgrade projects that have been publicly committed to and many of these are in active construction. Delaying spend would also increase overall costs due to inflation.*

Research and Development	*100*	*This would de-scope commitments made publicly at SR21 to make the UK a science superpower, specifically by not investing in Genomics newborn screening and making a cut to clinical trial funding.*
Disabled Facilities Grant (DFG)	*50*	*Local Authorities have a statutory duty to provide adaptations to people who are assessed as needing them (and who meet means testing criteria). Reductions to the DFG budget could put this at risk, or delay delivery of adaptations and create significant backlogs. We would not advise reducing this budget to lower than £520m in 22-23 (i.e. c£50m saving).*
Health protection (UKHSA)	*45*	*Further one year delay to the Science Hub programme, which is building new high containment labs and co-locating health protection capabilities at Harlow. Costs will increase overall (due to cost inflation) and also puts containment lab timeline at risk.*
Care and Support Specialised Housing (CASSH)	*20*	*Reducing spend on specialised housing for older people and adults with disabilities or mental health problems would reduce their ability to live independently, and so put additional pressure on the NHS. Any reduction greater than this that would risk long-term viability of this programme as it would seriously damage confidence of commercial delivery partners (which has been a challenge for this programme in the past).*
Total	***3128***	
of which NHS RDEL	*1275.0*	
of which Non-NHS RDEL	*1287.8*	
of which CDEL	*565.0*	

Annex C – Costs Covered by Other Government Departments

UKHSA Cost for OGDs (RDEL, £ms)	***22/23***	***Comment***
Crown dependency LFDs	*19*	*Relies on Crown Dependency Authorities/MoJ picking up cost.*
SEND	*12.5*	*Relies on DfE picking up cost.*
Education Outbreak Management	*15.2*	*Relies on DfE picking up cost.*
Asylum Seeker Accommodation	*0.06*	*Relies on HO picking up cost.*
Immigration Detention	*0.07*	*Relies on HO picking up cost.*
Independent Healthcare Providers	*12.3*	*Relies on IHPs picking up cost.*
Surge Outbreak Testing	*127*	*Relies on LAs/DLUHC picking up cost.*
COVID Transition Fund	*100*	*Relies on LAs/DLUHC picking up cost.*
Prisons Testing	*9.9*	*Relies on MoJ picking up cost.*
Total	***296.03***	