Witness Name: Sir Christopher Stephen Wormald
Statement No.: 10
Exhibits: CW10/1-CW10/58
Dated: 27 October 2023

UK COVID-19 INQUIRY

TENTH WITNESS STATEMENT OF SIR CHRISTOPHER STEPHEN WORMALD

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1. I, Sir Christopher Stephen Wormald, of the Department of Health and Social Care, 39 Victoria Street, London SW1H 0EU, will say as follows: -

2. I am employed by the Department of Health and Social Care (the Department) as Permanent Secretary, a post I have held since May 2016.

3. Before joining the Department, I was the Permanent Secretary of the Department for Education (DfE) between 2012 and 2016, and a Director General (DG) within the Cabinet Office (CO) between 2009 and 2012.

4. I make this statement in response to the request from the UK COVID-19 Public Inquiry (the Inquiry) dated 16 March 2023, under Rule 9 of The Inquiry Rules 2006 (SI 2006/1838), requiring the Department to provide the Inquiry with a witness statement in respect of specified matters relating to Module 3. In particular, this statement will address questions 1 and 2 as set out in the Inquiry's request, which ask, in broad terms, for details of the Department's organisational structure, key decision-makers and the structures and processes within which they operate, together with an overview of the Department's responsibilities in relation to the publicly-funded healthcare system in England, the healthcare system's response to

the COVID-19 pandemic and the resources and levels of funding for the healthcare system in the event of pandemics, including COVID-19.

5. As this is a corporate statement on behalf of the Department, it necessarily covers matters that are not within my personal knowledge or recollection. As a corporate statement involving many different areas of policy within the Department, information has been gathered from a number of sources. This statement is to the best of my knowledge and belief accurate and complete at the time of signing, in line with responding as far as possible within the Inquiry's deadlines. Notwithstanding this, it is the case that the Department continues to prepare for its involvement in the Inquiry. As part of these preparations, it is possible that additional material will be discovered. In this eventuality, the additional material will of course be provided to the Inquiry and a supplementary statement will be made if need be.

Overview of the organisational structure of the Department

6. I turn first to setting out the organisational structure of the Department and how the structure changed during the period, 1 March 2020 to 28 June 2022 (the relevant period).

Overview of the role of the Department

7. In broad terms, the Department's role is to support and advise the Government's health and social care ministers by shaping policy, assisting in the setting of the strategic direction for the health and care system and implementing agreed policy. The Department supports the Secretary of State in the discharge of his duties. The Department secures funds for the NHS and remains accountable for this funding, which is allocated to the most appropriate local level.

8. Decision-making on strategy, policy and implementation in the Department is, as it is across Government, largely carried out through submissions to the Secretary of State and other Department ministers which set out an issue and recommendation and give information to note. The relevant ministers take decisions based on this advice, and sometimes will call meetings to discuss the advice before making a

decision. Urgent decisions are sometimes taken in meetings or in other discussions. All Government decisions should be recorded by the minister's private office. Decisions that require cross-department input or alignment are made through the well-established approaches to collective agreement. These are led by the Cabinet Office and agreement is sought and received either meeting in person or in writing, through Cabinet Committees, or Cabinet itself.

Summary of key statutory duties and responsibilities

9. The Secretary of State has a wide range of powers and duties as a result of various Acts of Parliament and secondary legislation and is accountable to Parliament for his responsibilities. This witness statement does not set out a comprehensive list of all those responsibilities but includes those most related to the issues raised by the pandemic in relation to this module.

NHS Act 2006

10. The central statutory responsibilities of the Secretary of State as enshrined in the National Health Service Act 2006 (the NHS Act) include the statutory duty to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and in the prevention, diagnosis, and treatment of physical and mental illness: s.1(1) of the NHS Act. Whilst the Secretary of State maintains ministerial responsibility to Parliament for the provision of the health service (s.1(3) of the NHS Act), NHS England (NHSE) is also subject to the duty to promote a comprehensive health service in England under s.1(1) concurrently with the Secretary of State, except in relation to the part of the health service that is provided in pursuance of the public health functions of the Secretary of State or local authorities. To discharge this duty NHSE has responsibility for arranging the provision of services for the purposes of the health service in England (see s.1H of the NHS Act).

11. Under s.1A of the NHS Act, the Secretary of State has a duty to exercise his functions in relation to the health service with a view to securing continuous improvement in the quality of services provided to an individual in respect of the prevention, diagnosis or treatment of illness or the protection and improvement of

public health. These involve continuous improvement in the outcomes (s.1A(2)), which include, in particular, the effectiveness, safety and quality of the services provided. Under s.247D of the NHS Act, the Secretary of State must publish an annual report about the performance of the health service in England, which includes his assessment of the effectiveness of the discharge of duties under s1A and 1C of the NHS Act by the bodies used by the Secretary of State to provide services and support to the NHS (including NHSE, the Care Quality Commission (CQC), and the National Institute for Health and Care Excellence (NICE)). In practice, this document is included as part of the Department's annual report and accounts (**CW10/1 - INQ000235008; CW10/2 - INQ000257323)**, for 2020-21 and 2021-22).

12. Under s.1B of the NHS Act, the Secretary of State must have regard to the NHS Constitution (**CW10/3 - INQ000327532**) when exercising functions related to the health service (the NHS constitution having been enshrined in legislation under the Health Act 2009).

13. S.1C of the NHS Act imposes a duty on the Secretary of State to exercise his functions so as to have regard to the need to reduce inequalities between the people of England with respect to the benefits that they can obtain from the health service. The Secretary of State is also bound by the public sector equality duty under s.149 of the Equality Act 2010.

14. S.1D of the NHS Act (subsequently revoked by the Health and Care Act 2022) imposed a duty on the Secretary of State when exercising his functions to have regard to the desirability of securing the autonomy of NHS bodies and providers when exercising their functions, and that unnecessary burdens are not placed upon them. Where the Secretary of State considers there would be a conflict between the duty to secure autonomy and the discharge of the duty to promote a comprehensive health service and secure that services are provided (s.1 of the NHS Act) the Secretary of State must give priority to the duties in s.1.

15. Under s.1E of the NHS Act, when exercising functions in relation to the health service, the Secretary of State must promote research on matters relevant to the NHS and the use of evidence obtained from research.

16. Under s.1F of the NHS Act, the Secretary of State must exercise his functions so as to secure that there is an effective system for the planning and delivery of education and training to persons who are employed, or who are considering becoming employed in an activity which involves or is connected with the provision of services as part of the health service in England.

17. The Secretary of State also has a statutory duty under s.2A of the NHS Act to take such steps he considers appropriate to protect public health in England and a power under s.2B to support public health improvement. The principal route for the discharge of these responsibilities was previously through Public Health England (PHE), with both the Department and PHE having responsibilities for planning for and managing the response to emergencies and health protection incidents and outbreaks, in an extended team working across Government. In October 2021, PHE was replaced by the UK Health Security Agency (UKHSA) and the Office for Health Improvement and Disparities (OHID) **(CW10/4 - INQ000257090)**.

18. There are many other specific duties under the NHS Act. For example, s.251 of the NHS Act provides a wide power for the Secretary of State to make regulations about the extent to which NHS bodies can use patient data, including without obtaining consent if it is necessary for medical research, or the provision of care and treatment.

19. The Secretary of State has a number of general powers over certain NHS bodies allowing the Secretary of State to delegate his functions to the bodies, or to direct them in the exercise of their functions. Under s.7 of the NHS Act, the Secretary of State can direct a Special Health Authority to exercise any of his functions, or any health service functions of another person. There are currently four Special Health Authorities. These are NHS Blood and Transplant; the NHS Business Services Authority; the NHS Litigation Authority (known as NHS Resolution); and the NHS Counter Fraud Authority. During the relevant period, there was also a fifth, the NHS Trust Development Authority (NHS TDA), which was part of NHS Improvement. The Secretary of State can also delegate certain functions relating to the provision of primary medical, dental and ophthalmic services and NHS pharmaceutical services to NHSE (ss.98A, 114A, 125A and 168A of the NHS Act), and he can delegate his public health functions by direction under s.7B of the NHS Act or by arrangement

under s.7A of the NHS Act. The Secretary of State has a general power under s.8 of the NHS Act to issue directions to NHS Trusts (but not NHS Foundation Trusts) and special health authorities about the exercise of their functions. Prior to the Health and Care Act 2022, there was no general power for the Secretary of State to issue directions to NHSE about the exercise of its functions other than in an emergency scenario where such directions can be issued under s.253 of the NHS Act. The Health and Care Act 2022 introduced a general power to direct NHSE in the exercise of its functions (s13ZC of the NHS Act) though subject to explicit exemptions (s13ZD of the NHS Act).

20. The Secretary of State also has powers to make directions to certain NHS bodies about specified matters. These include, for example, the ability to make directions which define the payments made to GP practices working under General Medical Services contracts (s.87(1) of the NHS Act); or to set the remuneration paid to pharmacists for the provision of certain drugs (s.127(3) of the NHS Act). The Secretary of State also, for example, has powers to issue directions in relation to establishing information systems under the Health and Social Care Act 2012. These directions were previously in respect of NHS Digital but are now given to NHSE following NHS Digital's merger into NHSE on 1 February 2023.

21. Under s.2 of the NHS Act, the Secretary of State can do "anything which is calculated to facilitate, or is conductive or incidental to, the discharge of any function conferred on that person by this Act". That includes the issuing of guidance (R(Rogers) v Swindon NHS Trust [2006] EWHC 171 (Admin) at paragraph 52 of the judgement).

22. The Secretary of State has a series of ancillary powers and duties under Schedule 1 to the NHS Act, which includes, under paragraph 13 of Schedule 1, the power to commission or assist the conduct of research into any matters relating to the causation, prevention, diagnosis or treatment of illness or any other matters connected with services provided under the NHS Act, and analyse data, seek expert advice or provide monies or services to those undertaking research.

23. Under s.253 of the NHS Act, the Secretary of State has wide powers he can use where there is an emergency, to give directions about the exercise of functions or

provision of services to NHS bodies, NICE, or anyone else providing services to the NHS. The Secretary of State also has the power under this section to give directions to NHSE to exercise these powers.

Civil Contingencies Act 2004

24. Under s.2 of the Civil Contingencies Act 2004 (CCA), the Secretary of State has a duty to assess, plan and advise in respect of emergencies. The duties of the Department and other Category 1 responders under the CCA are fulfilled through the Department's emergency preparedness, resilience and response function for the health and social care sector.

The Health and Social Care Act 2012

25. The Health and Social Care Act 2012, which came substantively into force on 1 April 2013, made significant amendments to the NHS Act. It gave effect to a wide range of structural changes to the NHS, with the abolition of PCTs and Strategic Health Authorities, and responsibility for NHS commissioning passing to the newly created NHSE and CCGs. It also underpinned the creation of PHE and took forward measures to reform health public bodies.

26. The Act sought to consolidate and extend developments in policy that had been put in place over the 2000s. The legislation aimed to strengthen the role of commissioning within the system to, with a greater role for competition and the use of alternative providers of services (including NHS, VCSE and independent sector providers). This was supported by reforms of the regulatory structure, payment mechanisms and included the establishment of an NHS Commissioning Board (later renamed NHS England) at arms-length from Government.

27. The changes were predominantly to establish a more clearly 'rules-based' system, with individual NHS bodies' day-to-day operations being more clearly separated from the strategic role of ministers. To formalise this relationship, a system of assurance and assessment of NHS bodies was also introduced. This included the Secretary of State retaining a duty to set strategic direction for the NHS through a statutory mandate setting objectives for NHSE as well as its capital and revenue

resource spending limits, which was replaced annually. The content of the mandate is subject to collective government agreement and the objectives in the mandate are reflected in NHSE's operational guidance. From 2019, the mandate was addressed to both NHSE and NHSI, and their joint operational guidance was addressed to both CCGs and NHS providers.

28. Part 1 of the Health and Social Care Act 2012 made changes to the NHS Act in relation to the organisational structure of the health service in England, and the relative duties of the Secretary of State and how these were discharged, with the support of the Department. A new duty was conferred upon the Secretary of State (under new s.1G NHS Act) to keep the performance of the health service under review and to report annually to Parliament on its findings. The core duty to promote a comprehensive health service (s.1 NHS Act), dating back to the founding of the NHS Act of 1946, remained in place but with the introduction of a new subsection 3, clarifying that the Secretary of State retained ministerial responsibility to Parliament for the provision of the health service. Further amendments to this core duty were also made to reflect the change in the role of the Secretary of State in relation to the health service.

29. Subsection 2 (s.1 NHS Act) of the Secretary of State's core duty was amended to reflect the fact that the functions of commissioning services and the provision of services were no longer to be delegated by the Secretary of State, but instead directly conferred on the organisations responsible for providing them. NHSE and CCGs would be responsible for arranging services (that is for their commissioning and not for their provision).

30. A new s.7A was introduced to the NHS Act, granting the Secretary of State the power to delegate the delivery of various national public health programmes, for which he has statutory responsibility, to NHSE. This power has been used for such programmes as cancer and non-cancer screening, vaccination, including for COVID-19, seasonal flu and routine childhood immunisation. The vehicle for delegating these functions to NHSE is an annual public health functions agreement which is published on the GOV.UK website **(CW10/5 - INQ000104750 CW10/6 - INQ000327511; CW10/7 - INQ000327512; CW10/8 - INQ000327518; CW10/9 -**

INQ000327520; CW10/10 - INQ000327519; CW10/11 - INQ000327527, **CW10/12 - INQ000327524; CW10/13 - INQ000327526**, **CW10/14 - INQ000327525)**. The agreements set out how NHSE is accountable for the delivery of such public health services and gives details of arrangements for expert support. The service specifications provide details of the public health evidence and advice needed to support effective commissioning. The Health and Care Act 2022 updated s.7A of the NHS Act and introduced a new s.7B which created a power for the Secretary of State to direct NHSE or an ICB to discharge any of his public health functions.

31. The legal framework established in the NHS Act, as amended, also provided the Secretary of State with certain powers to intervene in NHS decision making by issuing statutory directions. Outside of emergency situations, the powers to issue directions to NHSE were very limited, largely to issuing directions on financial matters and in circumstances where the Secretary of State considered that it was, or was at risk of, failing or not acting in the interest of patients, and that failure was or was likely to be significant. The power to issue directions in the case of failure was never used.

32. As a result of the Health and Social Care Act 2012, the Secretary of State's role changed to ensuring the functions of commissioning services and the provision of services were being carried out effectively, through his powers to set objectives for NHSE (through the mandate to NHSE under the new s.13A NHS Act, as I have already mentioned), by overseeing the effective operation of the health service and through his power to intervene in the event of significant failure (under the new s.13Z2 NHS Act).

33. The Health and Social Care Act 2012 (through the new s.1I NHS Act) also established 211 CCGs to replace the 152 PCTs, which were responsible for the planning and commissioning of health services in local areas. CCGs commissioned most NHS services and were supported by and accountable to NHSE. CCGs were clinically led groups made up of GP practices and other clinicians within defined geographical boundaries, covering the whole of England. CCGs were the appropriate commissioners under the NHS Act, unless there was a specific duty on NHSE to commission that service. CCGs were subject to a number of duties more

clearly set out in legislation than had been the case for PCTs. The new s.3(1F) NHS Act conferred a duty to act consistently with the duty of the Secretary of State, and NHSE, under s.1 NHS Act to promote a comprehensive health service.

34. Through the Health and Social Care Act 2012 (new s.1H NHS Act), the NHS Commissioning Board (operating under the name NHSE) was established. This was a statutory body, holding a large number of functions and duties in its own right, and as a result having considerable effective autonomy.

35. To discharge its s.1(1) Act duty to promote a comprehensive health service, NHSE had two specific functions (as set out in s.1H(3) NHS Act):

    a. To commission services in accordance with the NHS Act (as described in new s.3B NHS Act), including services which could be more effectively commissioned at national level, or which it would be inappropriate or impractical for CCGs to commission. This could include child and adolescent inpatient mental health services, some dental services, prison health services and health services for the armed forces; and
    b. When exercising functions in relation to CCGs (when issuing commissioning guidance under new s.14Z8, for example), to do so in a way as to ensure services are provided for those purposes in accordance with the NHS Act.

36. Under the new s.13A NHS Act, the Secretary of State was under a duty to publish and lay before Parliament the mandate to NHSE before the start of each financial year. The mandate would set out what the Government expected from NHSE on behalf of the public, comprising a series of objectives that NHSE should set to achieve in that financial year and subsequent years as the Secretary of State considered appropriate. The Secretary of State was also to specify within the mandate the limits on capital and revenue resource use (s.13A(3) NHS Act). The aim of the mandate was to provide NHSE with a single annual set of objectives to provide stability and clarity and allow NHSE to develop effective planning solutions. A mandate continued to be issued annually until 2022 when further legislative changes contained in the Health and Care Act 2022 provided new flexibility for the

Secretary of State to decide when the mandate should be updated. The 2022 changes also removed the duty from the Secretary of State to specify NHSE's annual capital and revenue resource limits in the mandate, instead setting these limits through financial directions which continue to be issued on an annual basis and, in light of the 2022 changes, are now laid before Parliament.

37. Part 2 of the Health and Social Care Act 2012 made changes to the NHS Act in relation to the public health and subsequent duties of the Secretary of State. This included the introduction of a duty on the Secretary of State for Health to take such steps as the Secretary of State considers appropriate to protect the public in England from disease or other dangers to health (s.2A NHS Act), and a duty for unitary and upper-tier local authorities to take such steps as each considers appropriate for improving the health of the people in its area (s.2B NHS Act). Section 2B also gave the Secretary of State power to take such steps as the Secretary of State might consider appropriate for improving the health of the people of England.

38. Functions of the HPA, which was abolished, were transferred to the Secretary of State. To support the exercise of these new functions, PHE was established as an Executive Agency of the Department of Health. PHE was the principal route for discharge of the Secretary of State's public health protection duty (s.2A NHS Act) and it also acted under the Secretary of State's public health improvement power (s.2B NHS Act).

The Care Act 2014

39. The Department does not have the same legal duties and responsibilities in respect of social care. The Department does not directly fund or deliver adult social care and much of the funding for adult social care is raised locally through council tax and other forms of funding. The Care Act 2014 places the duty to plan and secure adult social care services on 152 local authorities in England who commission services through a predominantly outsourced market of approximately 14,000 provider organisations. The Department is responsible for setting national policy and the legal framework, while the Department for Levelling Up, Housing and Communities (DLUHC) oversees local government funding and the financial framework.

Arms-Length Bodies

40. In addition to the work that the Department carries out directly, it also works through a number of arms-length bodies (ALBs) to deliver its strategic objectives. Each ALB has a Senior Sponsor in the Department, with a small supporting team.

41. ALBs are accountable to Parliament, either directly or via the Secretary of State. The Secretary of State, or the Department on his behalf, sets their strategic direction and holds them to account for delivery of a range of agreed objectives. The ALBs perform a range of diverse functions to support the Department in delivering its objectives.

42. There are different categories of ALBs – Executive Agencies, Special Health Authorities, Executive Non-Departmental Public Bodies and Advisory Non-Departmental Public Bodies – which I set out below for clarity in order of legal proximity to the Department. Within the list below, it may be helpful to note that there are certain ALBs whose functions are of greater relevance to the core issues in Module 3, such as: NHSE; NHSI (which was operationally merged with NHSE throughout the relevant period); UKHSA; NICE; and the CQC.

Executive Agencies

43. The Executive Agencies may be considered as the 'shortest arm' of the Department. Unlike other ALBs, they are not legally separate from the Department (i.e., they do not have a separate legal identity) but are operationally independent whilst remaining accountable to it. There are two Executive Agencies within the Department:

PHE/UK Health Security Agency

44. From 2013 to 2021 PHE was an executive agency of the Department. It was a distinct delivery organisation with operational autonomy that existed to protect and improve the nation's health and wellbeing, reduce inequalities and prepare for public health emergencies. It provided government, local government, the NHS, Parliament, industry, public health professionals and the public with evidence-based

professional, scientific and delivery expertise and support, and carried out some statutory functions of the Secretary of State. PHE had responsibility for four critical functions:

a. Fulfil the Secretary of State's duty to protect the public's health;
b. Secure improvements to the public's health, including supporting the system to reduce health inequalities;
c. Improve population health supporting sustainable health and care services; and
d. Ensure the public health system maintains the capability and capacity to tackle today's (and future) public health challenges.

45. On 1 April 2021 UKHSA was established as a new executive agency of the Department. As part of a wider restructuring of national public health bodies in England, it took on the majority of the functions of PHE, NHS Test and Trace, and the Joint Biosecurity Centre (JBC) in planning for and responding to infectious diseases, chemical, biological and nuclear incidents and other health threats. To protect operational continuity and provide for necessary staff consultations and stakeholder engagement, these responsibilities were transitioned to UKHSA over a six-month period, with UKHSA becoming operational from 1 October 2021. UKHSA is our permanent standing capacity to prepare for, prevent and respond to threats to health.

46. Since its establishment in 2021 Dr Jenny Harries (previously DCMO) has been the CEO of UKHSA and Ian Peters has chaired its Advisory Board. PHE was chaired by Professor Dame Julia Goodfellow from 2018 until it ceased to exist, with Duncan Selbie as its CEO until August 2020, then Michael Brodie as its interim CEO until it ceased to exist. DGs of the JBC were Tom Hurd (from May 2020 to June 2020) and then Clare Gardiner. Baroness Dido Harding was the Chief Executive Officer (CEO) of NHS Test and Trace from its establishment until it ceased to exist.

47. UKHSA's responsibilities are primarily for England, across the UK on reserved health matters such as responding to radiation, and in partnership with lead agencies in Scotland, Wales and Northern Ireland on devolved issues where

relevant. It provides clinical, scientific and operational leadership for the public health system at a national and local level on health security and health protection, and a cohesive response across public health functions.

The Medicines & Healthcare products Regulatory Agency

48. The Medicines & Healthcare products Regulatory Agency (MHRA) regulates medicines, medical devices and blood components for transfusion in the UK. During the relevant period it was chaired by Michael Rawlins (until September 2020) and then Stephen Lightfoot, who stood down in July 2023. Dame June Raine has been its CEO since September 2019.

49. MHRA is responsible for:

    a. Ensuring that medicines, medical devices and blood components for transfusion meet applicable standards of safety, quality and efficacy;
    b. Securing a safe supply chain for medicines, medical devices and blood components;
    c. Promoting international standardisation and harmonisation to assure the effectiveness and safety of biological medicines;
    d. Educating the public and healthcare professionals about the risks and benefits of medicines, medical devices and blood components, leading to safer and more effective use;
    e. Enabling innovation and research and development that is beneficial to public health;
    f. Collaborating with partners in the UK and internationally to support its mission to enable the earliest access to safe medicines and medical devices and to protect public health.

50. In relation to medicines and vaccines, MHRA decides whether manufacturers should be granted licences to make, assemble or import them and whether licences can be varied as information about the medicines and vaccines develop. The decisions are based on safety, quality, and effectiveness data. The Department makes decisions on which medicines should be purchased for the UK, and NICE decides whether

medicines should be made available on the NHS. These organisations are able to consider wider factors in their decision-making, including the need for the medicine in the UK given the circumstances at the time.

51. MHRA also carries out a number of regulatory activities such as inspecting facilities and carrying out safety tests; approving and inspecting clinical trials; monitoring the safety of medicines while on the market; regulating the importation of licensed medicines; and helping to set and enforce advertising regulations for medicines. MHRA has powers of enforcement under the Consumer Protection Act 1987, the Medical Devices Regulations 2002, and the General Product Safety Regulations 2005. These powers include issuing compliance, prohibition, restriction, and suspension notices, with further non-compliance resulting in prosecution.

Special Health Authorities

52. Special Health Authorities are separate legal entities that are created by secondary legislation to carry out the functions of the Secretary of State. They therefore have more independence from the Department than Executive Agencies, being further removed from direct ministerial oversight, though are subject to ministerial direction.

53. The Department's Special Health Authorities are as follows:

NHS Business Services Authority

54. The NHS Business Services Authority (NHSBSA) provides a range of critical business support services to NHS organisations, NHS contractors, patients, and the public. During the relevant period it was chaired by Silla Maizey (until April 2022) and then Sue Douthwaite, with Michael Brodie as its CEO.

55. NHSBSA maintains an Electronic Staff Record system, which is the platform on which NHS organisations record essential workforce, skills and training information and make accurate and timely payments to their staff. NHSBSA supports primary care in the NHS by helping commissioners to manage their contractual arrangements with NHS providers. It supports essential providers of services to the

NHS, including in respect of pharmacy. NHSBSA manages NHS Prescription Services, which calculates the remuneration and reimbursement due to dispensing contractors (pharmacists) across England. NHSBSA also delivers the NHS Pension Scheme.

56. During the pandemic, NHSBSA's services included, amongst other things, management of the NHS and Social Care Coronavirus Life Assurance Scheme. This provided compensation for families of NHS staff who died of COVID-19 contracted during the course of their NHS work. NHSBSA also played a central role in facilitating shielding arrangements and was responsible for developing an SMS text messaging service which allowed it to contact at-risk patients quickly and safely.

NHS Blood & Transplant

57. NHS Blood & Transplant (NHSBT) is responsible for the supply of blood, organs, tissues and stem cells. It collects and supplies blood to hospitals in England and is the organ donation organisation for the UK. During the relevant period, it was chaired by Millie Bannerjee (until August 2021) and then Peter Wyman, with Betsy Bassis as the CEO.

Other

58. The Department's other Special Health Authorities are NHS Resolution, which manages negligence claims against the NHS in England, and the NHS Counter Fraud Authority, which identifies and prevents fraud and other economic crime within the NHS and the wider health group. During the relevant period, the NHS TDA, which was a Special Health Authority, exercised functions in relation to NHS trusts.

Executive Non-Departmental Public Bodies

59. Executive Non-Departmental Public Bodies are separate legal entities that are set up in primary legislation and have a greater degree of independence from the Department than Special Health Authorities or Executive Agencies.

60. These Bodies carry out administrative, commercial, executive or regulatory functions. They are not under day-to-day ministerial control, although a minister will be responsible to Parliament for their performance and effectiveness. The Department's Executive Non-Departmental Public Bodies are described below.

NHS England and NHS Improvement

61. The NHS Commissioning Board was established as a non-departmental body, with its own statutory Board, on 1 April 2013, and leads and oversees the NHS in England. During the relevant period the Board was chaired by Lord David Prior (until March 2022) and then by Richard Meddings. The CEOs were Sir Simon Stevens (until July 2021) and then Amanda Pritchard. Ms Pritchard had previously been the Board's Chief Operating Officer as well as the CEO of NHS Improvement (NHSI). Other Board members included Julian Kelly (Chief Financial Officer), Professor Stephen Powis (National Medical Director), Ian Dodge (National Director for Strategy and Innovation), Emily Lawson (the National Director for Transformation and then the Chief Commercial Officer until July 2021), and Ruth May (Chief Nursing Officer). Ms May has held the Chief Nursing Officer post since 2019, providing clinical and nursing workforce advice to government as well as to the NHSE Board, and previously also to the NHSI Board.

62. The Health and Care Act 2022 renamed the NHS Commissioning Board 'NHS England' (section 1 of the 2022 Act) and abolished and transferred the functions of NHSI (which encompassed the NHS Trust Development Authority and Monitor) to NHS England (sections 33-39 of the 2022 Act).

63. Whilst the Secretary of State maintains ministerial responsibility to Parliament for the provision of the health service (s.1(3) of the NHS Act), NHSE is subject to the duty to promote a comprehensive health service in England under s.1(1) concurrently with the Secretary of State, except in relation to the part of the health service that is provided in pursuance of the public health functions of the Secretary of State or local authorities. To discharge this duty, NHSE has responsibility for arranging the provision of services for the purposes of the health service in England (s.1H of the NHS Act).

64. NHSE has a series of statutory duties set out in the NHS Act (introduced through amendments made by the Health and Social Care Act 2012 and the Health and Care Act 2022). A number of the duties under the NHS Act relate to the way that it exercises its functions, for example: to exercise functions effectively, efficiently and economically (s.13D); to seek to secure continuous improvement in the quality of services (s.13E); to promote patient involvement in decisions relating to the prevention or diagnosis of illness in the patient, or their care or treatment (s.13H); to seek to enable patients to exercise choice (s.13I); to obtain appropriate advice about the prevention, diagnosis and treatment of illness or the protection or improvement of public health from those who have a broad range of professional expertise (s.13J); to promote research (s.13L); to promote education and training (s.13M); to promote integration of services where this would improve the quality of those services or reduce inequalities in terms of access to services or the outcomes achieved in the provision of services, including integration of health and health-related or social care services (s.13N); to collect and analyse patient safety data (s.13R); and to have regard to the impact on health services to persons who reside in areas that are close to the border with England (s.13O).

65. There is a specific duty on NHSE to, in the exercise of its functions, have regard to the need to reduce inequalities between patients in respect of their ability to access health services, and to reduce inequalities in the outcomes achieved for them by the provision of health services (s.13G). This is supported by guidance to ICBs and those acting within NHSE, titled 'Guidance for NHS Commissioners on equality and health inequality duties' **(CW10/15 - INQ000327509)**.

66. There are also duties to secure consultation of patients in the planning of commissioning arrangements, the development of changes in commissioning arrangements and other matters (s.13Q of the NHS Act).

67. There are also a series of duties in respect of financial management, establishment of pooled funds, grant making powers and an ability for NHSE to discharge its functions alongside other health bodies under various subsections of s.13 of the NHS Act. The funding of NHSE is set out in statute under s223B– F of the NHS Act.

68. NHSE has an oversight role with regards to local commissioning organisations and NHS providers, such as hospitals and trusts. Prior to 1 July 2022, it previously held various powers to issue guidance (s.14Z8 of the NHS Act), conduct an assessment on an annual basis of the performance of each CCG (s.14Z16 of the NHS Act). It has tightly prescribed powers to give directions to ICBs and, previously, CCGs where it is failing to discharge its functions, or there is a significant risk that it may do so (s.14Z21 of the NHS Act is now repealed; s. 14Z61 is in force and applies to ICBs). During the relevant period, the local commissioning organisations held to account by NHSE were CCGs. CCGs were replaced with ICBs under the Health and Care Act 2022 from 1 July 2022. ICBs are statutory NHS organisations responsible for developing a plan to meet the health needs of the population, managing the NHS budget and arranging for the provision of health services in their Integrated Care System area. They are also responsible for commissioning the majority of NHS services, including primary care and some specialised services (which were previously commissioned by NHSE).

69. In 2018, NHSE operationally merged with NHSI (jointly referred to as NHSEI, however for the purposes of this statement we refer to them by their separate titles). NHSI was the operational name for the two legal bodies, the TDA and Monitor (the sector regulator for health services in England) and was the body responsible for overseeing NHS Foundation Trusts and NHS Trusts, as well as independent providers that provide NHS-funded care. During the relevant period, it retained its own statutory Board, chaired by Baroness Dido Harding until October 2021, and then by Andrew Morris until June 2022. As already mentioned, Amanda Pritchard was its CEO until July 2021, and this role was then held on an interim basis by Professor Stephen Powis until June 2022.

70. NHSI's aim was to ensure that providers give patients consistently safe, high quality and compassionate care within local health systems that are financially stable. Following the operational merger in 2018, and throughout the relevant period, NHSE and NHSI functioned as one integrated organisation, albeit retaining their individual legal and financial responsibilities. Though their Boards continued to meet separately on a quarterly basis, they also met quarterly as a joint Board. Following

the merger on 1 July 2022, NHSE's and NHSI's legal functions (including those of TDA and Monitor) were joined under NHSE and NHSI was abolished.

71. The operationally merged NHSE and NHSI held a number of regulatory, oversight and management functions over providers including: the NHS Oversight Framework, ensuring the alignment of priorities across the NHS; identifying where NHS commissioners and/or NHS providers may benefit from, or require, support; and providing an objective basis for decisions about when and how NHSE and NHSI would intervene. They also held oversight functions in respect of Trusts, Foundation Trusts and other providers of NHS services, including: the Special Measures Programme; licensing; the NHS tariff; and intervention in case of failure. NHSE also set the NHS Standard Contract for use by commissioners for all contracts for healthcare services other than primary care. NHSE was responsible for commissioning primary care and all specialised services throughout the relevant period (delegating commissioning of primary medical care to CCGs for some time prior to the establishment of ICBs).

72. Consistent with their statutory duties, NHSE and NHSI provided operational leadership to the NHS throughout the pandemic. This included:

    a. Making arrangements for NHS providers to deliver certain health services to patients;
    b. Allocating funds to CCGs, so they could arrange with providers for the remainder and the majority of NHS services to be provided to patients;
    c. Ensuring that both they and CCGs were properly prepared for dealing with emergencies (including a pandemic);
    d. Monitoring NHS providers' compliance with the arrangements imposed upon them to ensure that they were properly prepared for emergencies.

73. NHSE previously hosted the Healthcare Safety Investigation Branch (HSIB) which was established in 2016 and became operational in 2017. HSIB's role was to carry out independent investigations into patient safety issues arising in NHS funded care. In the context of the pandemic, HSIB carried out 13 investigations relevant to the care of patients with COVID-19 and users of non-COVID-19 services, 9 of which

were published. These included, for example, an investigation into safety issues raised in respect of NHS 111's handling of calls from patients with COVID-19 symptoms following the deaths of four such patients.

74. The HSIB recently went through an organisational transformation to become the Health Services Safety Investigations Body (HSSIB), an Executive Non-Departmental Public Body that was established in October 2023. HSSIB has powers and independence to conduct investigations into incidents that occur during the provision of healthcare provided in NHS services and by the independent sector which have or may have implications for the safety of patients. Investigation reports will make recommendations and require organisations to publicly respond to these within a specified timescale.

Health Education England

75. Health Education England (HEE), initially established as a Special Health Authority in 2012 and then established as an Executive Non-Departmental Body in 2015 under provisions of the Care Act 2014, existed to support the delivery of healthcare and health improvement by planning, recruiting, educating and training the health workforce. During the pandemic, HEE was involved in a number of activities to increase the number of health professionals available to the NHS During the relevant period, it was chaired by Sir David Behan, and its CEOs were Professor Wendy Reid (interim, until October 2020) and then Dr Navina Evans.

76. HEE merged with NHSE in April 2023.

NHS Digital

77. NHS Digital (NHSD) (the operational name for the Health and Social Care Information Centre), was initially established as a Special Health Authority in 2005 and was converted to an Executive Non-Departmental Public Body under provisions in the Health and Social Care Act 2012. During the relevant period it was chaired by Noel Gordon (until September 2020) and then by Laura Wade-Gery. CEOs were Sarah Wilkinson (until June 2021) and then Simon Bolton (interim) until NHSD ceased to exist following incorporation into NHSE.

78. NHSD designed, developed and operated national IT and data services for the NHS and social care and its responsibilities included:

a. Collecting, analysing and publishing health and care data;
b. Making submitting data as easy as possible for health and care staff;
c. Providing national technology for health and care services;
d. Producing information standards;
e. Improving the quality of health and care information and data;
f. Publishing national indicators for health and care, to measure quality of care and progress against policy initiatives;
g. Giving advice and support to health and care organisations on information and cyber security.

79. During the pandemic, NHSD's responsibilities included establishing and managing the shielded patients list. It worked closely with NHSX, which was a joint unit run by the Department and NHSE responsible for setting the strategy for digital transformation in the NHS (the 'X' standing for user experience). During the pandemic, NHSX provided a leadership role in the roll out of technology to support the health and care pandemic response, for example by enabling remote working arrangements, digital appointments, and monitoring of patients outside of hospital. NHSX was incorporated into NHSE from February 2022.

80. NHSD operationally merged with NHSE in 2022, and legally merged with NHSE on 1 February 2023.

Care Quality Commission

81. The CQC is the independent regulator of health and social care in England, responsible for registering health and adult social care providers, monitoring, inspecting and rating their services to see whether they are safe, effective, caring, responsive and well-led, and with legal powers to take action where it identifies poor care. CQC publishes its findings, including quality ratings, and also publishes its independent views on major quality issues in health and social care, encouraging

improvement by highlighting good practice. . During the relevant period, it was chaired by Peter Wyman (until March 2022) and then Ian Dilks. The CEO is Ian Trenholm.

82. In the context of the pandemic, the CQC published a number of COVID-19 reports examining the impact of the pandemic on various services.

National Institute for Health and Care Excellence

83. NICE drives best practice in the health and care system through the development of authoritative, evidence-based recommendations and guidance, including on the use of medicines. During the pandemic, NICE's work included the provision of guidance on clinical pathways for patients with COVID-19 **(CW10/16 - INQ000327535; CW10/17 - INQ000327515; CW10/18 - INQ000327513; CW10/19; - INQ000327516; CW10/20 - INQ000327514)**. During the relevant period it was chaired by Sharmila Nebhrajani, and the CEOs were Professor Gillian Leng (until February 2022) and then Dr Sam Roberts.

Health Research Authority

84. The Health Research Authority (HRA) regulates research in health and social care.

Human Tissue Authority

85. The Human Tissue Authority regulates organisations that remove, store and use human tissue.

Human Fertilisation and Embryology Authority

86. The Human Fertilisation and Embryology Authority regulates treatment using gametes and embryos and embryo research and ensures that fertility clinics and research centres comply with the law.

Advisory Non-Departmental Public Bodies

87. Advisory Non-Departmental Public Bodies include a range of committees and boards which provide independent expert advice to ministers. They consist of external experts who operate in a personal capacity.

88. The Department's Advisory Non-Departmental Public Bodies include the Commission on Human Medicines, which advises ministers on the safety, efficacy and quality of medicinal products; the NHS Pay Review Body, which advises on the pay of NHS staff; the Advisory Committee on Clinical Excellence Awards, which advises ministers on the presentation of clinical excellence awards to consultants working in the NHS; the British Pharmacopoeia Commission, which advises on the quality standards of medicines and healthcare products; the Committee on Mutagenicity of Chemicals in Food Consumer Products and the Environment, which assesses and advises on mutagenic risks to humans; the Independent Reconfiguration Panel which advises ministers on proposed NHS reconfigurations or significant service change in England; and the Review Body on Doctor's and Dentists' Remuneration, which advises on rates of pay for doctors and dentists.

DHSC key decision makers and advisers

89. Ministers, Special Advisors and Senior Civil Servants in relation to matters within the Provisional Outline of Scope for Module 3, including names, dates in post and descriptions of their roles are exhibited at **(CW10/21 - INQ000327533)**. The data provided is to the best of the Department's knowledge, based on records the Department has been able to access. More information on senior roles and responsibilities are set out below.

Ministers and Special Advisers

90. Ministers in role from 1 March 2020 to 28 June 2022 including names and dates in roles are also exhibited in **CW10/21 - INQ000327533**, along with Special Advisers. Responsibilities have not been included for Special Advisers due to the changing nature of their roles and shared ownership of portfolios.

Permanent Secretary

91. As Permanent Secretary, I am responsible for:
    a. Ensuring ministers receive advice on strategy and objectives for the health and social care system;
    b. Acting as the Department's CEO, setting standards and managing risk and assurance; and
    c. Acting as the Department's Accounting Officer, reporting to Parliament. Beyond this, I am also the Principal Accounting Officer for the Departmental Group. The group consists of the Department, its executive agencies and its sponsored non-departmental and other specific ALBs as designated by order made under the Government Resources and Accounts Act 2000. The CEO of each of the ALBs acts as that ALB's Accounting Officer and is responsible to me as the Principal Accounting Officer.

92. The Permanent Secretary is the most senior civil servant in a department. Each supports the government minister who is the head of the department, who is accountable to the Prime Minister, Cabinet, Parliament, and the public for the department's performance.

93. As set out above, I have been Permanent Secretary of the Department since May 2016.

Second Permanent Secretary

94. The role of the Second Permanent Secretary in the Department was created in response to the COVID-19 pandemic. Initially the role was held by David Williams, who commenced in the role in March 2020, having previously served as DG for Finance and Group Operations at the Department since March 2015. In his role as Second Permanent Secretary, Mr Williams led on Finance (including COVID-19 Finance), Group Operations and business as usual. Increasingly, as COVID-19 become the majority of the Department's work, Mr Williams acted as an additional accounting officer on all departmental matters and my deputy across the board. He continued to serve as Second Permanent Secretary until April 2021.

95. Shona Dunn became Second Permanent Secretary in April 2021. She is similarly an additional accounting officer on all departmental matters and acts as my deputy across the board. She has direct responsibility for Finance and Group Operations.

Chief Medical Officer for England

96. The Chief Medical Officer (CMO) for England is the UK Government's chief medical adviser, and the professional head of all directors of public health (DPH) in local government and the medical profession in government. The CMO provides public health and clinical advice to ministers in the Department and across government on both communicable and non-communicable diseases.

97. The CMO is an independent position at Permanent Secretary level. The current post holder is Professor Sir Chris Whitty, who took office in October 2019.

98. The CMO is assisted by Deputy Chief Medical Officers (DCMOs), one of whom is specifically responsible for health protection, which includes infectious threats. Professor Sir Jonathan van Tam held this role between 2017 and March 2022, and it is now held by Dr Thomas Waite (previously interim DCMO for COVID-19 from July 2021). The second DCMO normally covers health improvement (non-communicable diseases), but in an emergency could be expected also to cover health protection issues. Professor Dame Jenny Harries was the DCMO for health improvement from July 2019 to March 2021 but due to the pandemic spent much of her time on health protection issues related to COVID-19. The current DCMO for health improvement is Dr Jeanelle Louise de Gruchy, who took up post in October 2021 is also the co-lead of OHID.

99. In addition, Dr Aidan Fowler, whose main role is as the National Director of Patient Safety in NHSE, was also a DCMO covering some relevant areas on COVID-19, including some of the work on testing, for a part of the relevant period.

100. Scotland, Wales, and Northern Ireland also have CMOs and DCMOs for devolved health issues. The UK CMOs meet regularly, dependent on the external situation.

They met more than 270 times, and multiple times a week, during the relevant period.

Chief Scientific Adviser

101. The Department has a Chief Scientific Adviser (CSA) with overall responsibility for the Department's research and development, including the National Institute for Health Research (NIHR), and who advises on scientific aspects of health. The current CSA, Professor Lucy Chappell, has held the post since August 2021. Her predecessor was Professor Sir Chris Whitty who held the post between 2016 and 2021.

Director General for Global Health and Health Protection

102. Clara Swinson was DG for Global and Public Health from 2016 to 2018 and since 2018 has been DG for Global Health and Health Protection. In this role she has been responsible for leading teams handling emergency preparedness and health protection, international policy and EU Exit.

103. Clara Swinson was the DG level Senior Responsible Officer (SRO) for the COVID-19 Battle Plan in the Department, which I discuss further below. In 2020 and throughout the relevant Period, Ms Swinson's responsibility expanded to include COVID-19-specific directorates on social distancing strategy, the COVID-19 programme (and Battle Plan), COVID-19 vaccines deployment and the Therapeutics and Antivirals Taskforces.

Director General for Acute Care and Workforce and NHS Policy and Performance Group

104. Lee McDonough was the DG for Acute Care and Workforce from November 2016 to November 2020. She was responsible for policies on acute care and quality, NHS workforce, and NHS efficiency and productivity. Ms McDonough then became DG for the NHS Policy and Performance Group from 2020 until June 2021, responsible for policies on provider performance, care quality, patient safety and investigations,

NHS workforce mental health and disabilities, and primary and community health care. She was also the senior departmental sponsor for NHSE and NHSI. I provided oversight of the Group's work until her successor started in post.

105. The current DG for NHS Policy and Performance Group is Matthew Style, who took up this post in November 2021. In addition to the above responsibilities carried out by his predecessor, Mr Style took on responsibility for medicines and medical technology policy in October 2022. Mr Style was previously the Deputy Chief Financial Officer for NHSE.

Chief Commercial officer and Director General for Commercial and Life Sciences

106. Steve Oldfield was the Chief Commercial Officer and DG for Commercial and Life Sciences from October 2017 to October 2022. He was responsible for the Department's commercial strategy, as well as strategy and engagement with the life sciences sector and for supply continuity, including during the pandemic. Since Mr Oldfield's departure, his responsibilities have been shared by Mr Style (medicines and medical technology), Ms Swinson (supply resilience), Ms Dunn (commercial), and the CSA (life sciences).

Director General for the Office for Health Improvement and Disparities

107. Since 1 October 2021, Jonathan Marron has served as the DG for OHID. He is responsible for a group which includes public health, prevention, the Work and Health Unit and the delivery of two major Government programmes (Start for Life and Drug Strategy Treatment). He also has responsibility for joint work with the Department for Work and Pensions (DWP) on health and inclusive employment.

108. Between May 2020 and September 2021, Mr Marron served as the DG for Public Health and PPE, responsible for policies on public health reform, population health and PPE.

109. Between June 2017 and April 2020, Mr Marron served as the DG for Prevention, Community and Social Care, responsible for policies on primary care (including medicines and pharmacy), mental health, dementia and disabilities, adult social care

and transformation, health and inclusive employment and sponsorship of Public Health England.

Director General for Adult Social Care

110. In April 2020 a new DG post was established to cover adult social care. From April 2020 to July 2020, Rosamond Roughton was the DG with responsibility for adult social care. She was succeeded by Michelle Dyson initially on an interim basis from September 2020 and then permanently from May 2021.

Director General for NHSX

111. Matthew Gould was DG for NHSX from its establishment in 2019 until it was incorporated into NHSE in February 2022. He was responsible for driving digital transformation of health and care.

Director General for Finance

112. Since April 2021, Andy Brittain has served as the DG for Finance, responsible for ensuring financial accountability of the health and social care system. The post was previously held by David Williams, as I have already mentioned.

Non-Executive Directors

113. Non-Executive Directors (NEDs) are appointed primarily to support, advise, and provide an external source of challenge to the Department. They also make a significant contribution to Departmental business by working through Committees and with senior officials. NEDs, whose details are included in the Accountability Report section of DHSC's annual report and accounts **(CW10/1 - INQ000235008; CW10/2 - INQ000257323** for 2020-21 and 2021-22) are appointed for a fixed term of three years.

The Department's Structures

114. The structures that are most relevant to departmental governance are the following:

Departmental Board

115. The Departmental Board is chaired by the Secretary of State. The Departmental Board is an advisory board made up of members of the Department's leadership team, ministers and NEDs. It meets quarterly to discuss how the Department is performing against its objectives; to identify potential threats, emerging issues and opportunities that could have an impact on policy; and to provide oversight of delivery partners – namely, the ALBs. The Board's work is at the discretion of the Secretary of State, with whom the powers and responsibilities ultimately lie.

116. The Audit and Risk Committee (ARC), a sub-committee of the Board, advises the Departmental Board and the Department's accounting officer on risk management, corporate governance and assurance arrangements for the Department and its subsidiary bodies and reviews the comprehensiveness of assurances and the integrity of financial statements.

Executive Committee

117. I chair the Executive Committee (ExCo) which oversees the management of the Department. Issues it considers include strategy, finance, performance, and core departmental business including the Secretary of State and other ministers' priorities; system wide finance; matching resources to priorities; and departmental pay policy decisions. ExCo meets monthly, except in August, and ad hoc when the Department's business needs require. Its current membership includes the Second Permanent Secretary, CMO, CSA, DGs and Directors of Human Resources (HR) and Ministers, Accountability and Strategy.

118. ExCo does not create departmental policy. Its role is to set standards and procedures in the Department.

119. Membership of ExCo from January 2020 to July 2022 is exhibited at **(CW10/22 - INQ000327534)**.

The Department and the publicly funded healthcare system in England

120. I turn next to set out the Department's role, function, responsibilities, and accountability in relation to the publicly funded healthcare system in England. But firstly, I would like to set out more detail about the way in which the Department works with NHSE (and during the pandemic worked with NHSE and NHSI jointly), as the leadership body for the NHS in England.

The Department's relationship with NHSE

121. The Department's relationship with NHSE is managed within the context of the departmental structures and processes that I have already described, as well as the legal duties placed on each organisation which are explained throughout this statement. The Department sets strategic direction for NHSE through a statutory mandate (**CW10/23 - INQ000327536; CW10/24 - INQ000327522; CW10/25 - INQ000327521**), which during the pandemic was addressed jointly to both NHSE and NHSI. This document, which is both published and laid in Parliament, is a statutory document in which the Secretary of State sets strategic direction for NHSE in the form of objectives that it must seek to meet. Throughout the relevant period, the mandate was also the vehicle for giving statutory effect to NHSE's annual capital and revenue resource limits, which determined the funding envelope that the CEO had to work within in delivering objectives in the mandate as well as NHSE's many statutory functions.

122. The relationship with NHSE exists on both a formal and statutory level, and also a more informal one. On a formal level, the Secretary of State has a duty to keep NHSE's progress in delivering its mandate under review, and to lay in Parliament and publish an annual assessment of its performance (which must be informed by NHSE's own annual report). This process is managed by the NHSE sponsor team within the Department; but the relationship between the Department and NHSE goes far beyond these formal processes. Ministers and senior civil servants meet NHSE leadership very frequently - often many times a week – to discuss progress on

delivery of key government commitments for health and care and to resolve associated challenges. This continued to be the case throughout the relevant period.

123. Individual policy teams across the Department also maintain regular contact with their counterparts in NHSE to underpin this ministerial and senior level engagement, as well as to collaborate on shared challenges (such as the challenge of recovering performance on elective care following prioritisation of the NHS response to the pandemic). There was regular engagement at official level as well as ministerial level on aspects of the NHS response to the pandemic that the Department and wider government could support it in delivering, and on resulting challenges for maintaining delivery of non-COVID services. This included, for example, engagement on increasing hospital capacity through funding and directions to establish Nightingale hospitals and a national contract with independent sector hospitals, legislative changes to enable health professionals who had recently left the NHS to return to practice, or to support more flexibility in the roles that existing staff could play, as well as on rollout of the COVID-19 vaccination programme which was critical both to protect those at risk and to reduce pressures on NHS services and frontline staff.

124. NHSE established a National Incident Response Board chaired by its CEO to respond to COVID-19. This was a subgroup of the main NHSE Board as set out in the Board's terms of reference (**CW10/26 - INQ000327537**). The Department was invited to attend and in practice a Director attended Board meetings as the matters under discussion required. NIRB was disbanded in August 2021 and replaced by a new Operational Response and Delivery Group, which had a wider operational delivery remit **(CW10/27 - INQ000327517)**. It was then re-established in December 2021 **(CW10/28 - INQ000327538)**.

125. At Ministerial and senior official level, there are – and were throughout the relevant period – a variety of meetings and forums, both routine and ad-hoc, which were deployed flexibly in responses to the issues at hand and in line with the preferences of relevant Ministers, officials and NHSE leadership. A regular weekly conversation between the NHSE CEO and the Secretary of State on key issues is often the central discussion and escalation point and has taken different forms, with some

Secretaries of State convening wider board-style meetings and others a smaller group. These meetings and forums do not replace either the Department's standard processes for decision making which I have previously mentioned and which centre on formal engagement with Ministers through policy submissions, or NHSE's processes for seeking Board approval for its decisions. I would note that often both the Department's submission process and NHSE's equivalent process worked in parallel, with teams in the Department and in NHSE working together to resolve differences, agree priorities to recommend, and to identify any further work needed – often joint work – to address specific questions that needed to be answered in order to provide sound policy and delivery recommendations for Ministers and the NHSE Board to consider.

126. There was throughout the pandemic, therefore, a strong culture of joint working between the Department and NHSE. Many of the Department's policy teams liaised with parallel NHSE teams on a daily basis. The Department's teams would lead on handling issues that required engagement with ministers, across government or across sectors, and NHSE would lead both on providing expert advice to the Department on the practicalities of operational delivery, as well as in operational implementation of agreed decisions within the NHS.

127. There was also regular discussion between the CMO, DCMOs and senior clinical colleagues in NHSE throughout the pandemic, both bilaterally and as part of wider discussions. CMO, NHSE, and PHE clinicians met frequently from early 2020, writing out to the system as a collective regularly. The Senior Clinicians Group was also a forum for clinicians to share information rather than a decision-making forum. Professor Stephen Powis (NHSE's National Medical Director) and Professor Dame Ruth May (CNO) attended as did clinicians across the four UK nations.

The Department's role in the healthcare system

128. Now I will turn to the Department's role in relation to the healthcare system, which is the context for its relationship with NHSE as well as with its other ALBs. As set out above, the Secretary of State and NHSE have a concurrent statutory duty to continue the promotion in England of a comprehensive health service designed to secure improvement in the physical and mental health of the people of England and

in the prevention, diagnosis and treatment of physical and mental illness: s.1 of the NHS Act. The Department supports the Secretary of State in the discharge of that duty. The Department's responsibilities in relation to, and its relationship with, NHS bodies largely reflect the legal framework provided by the NHS Act as amended by the Health and Social Care Act 2012. The intention was to establish a clear set of interlocking responsibilities for the relationship between the Department and NHS bodies. Though outside the relevant period, I would note that the Health and Care Act 2022 further updated this legislative framework with a focus on integration. This again changed NHS commissioning structures, including through the introduction of new statutory Integrated Care Boards taking on many of the functions previously held by Clinical Commissioning Groups, and the relationship between the Secretary of State and NHSE.

129. Prior to 2022, the three main statutory bodies for leadership, service commissioning and service improvement in the NHS were the NHS Commissioning Board (NHSE), Monitor, and the NHS TDA. In 2016 the TDA was directed by the Secretary of State to work collaboratively with Monitor under a single leadership and operating model, known as NHSI which in turn was operationally merged with NHSE in 2018 and legally merged by the Health and Care Act 2022.

130. The Secretary of State has a statutory duty under s.2A of the NHS Act to take such steps as he considers appropriate for the purpose of protecting the public in England from disease or other dangers to health and a power under s.2B to take such steps as he considers appropriate for improving the health of the people of England. The principal route for the discharge of these responsibilities was previously through PHE, with both the Department and PHE having responsibilities for planning for and managing the response to emergencies and health protection incidents and outbreaks in an extended team working across Government. On 1 October 2021 as previously mentioned, PHE was replaced by UKHSA and OHID as part of a wider government restructuring of national public health bodies in England. The health improvement responsibilities of PHE formally moved to OHID and some PHE functions relating to the NHS were transferred to NHSE. The majority of the remaining functions of PHE, NHS Test and Trace and the JBC transferred to UKHSA.

131. OHID is jointly led by the DG for OHID and the DCMO, under the professional leadership of the CMO. OHID's mission is to improve people's health and reduce health disparities. It brings together expert advice, analysis, and evidence, helps develop and implement policy and drives the prevention agenda across government. OHID is part of the Department, unlike UKHSA which is an Executive Agency sponsored by the Department.

132. Both PHE and the Department had responsibilities in planning for and managing the response to emergencies and health protection incidents and outbreaks in an extended team that worked across government.

133. PHE and the Department worked together to provide assurance that PHE's responsibilities were being discharged. PHE and the Department (with other bodies) developed a protocol to ensure the statutory duty under the CCA to prepare for and respond to emergencies was met. The relevant Minister issued an annual remit letter setting out PHE's priorities for the year, and there were quarterly meetings between the departmental senior sponsor and the chief executive to consider the objectives and deliverables and to review performance against these.

134. PHE drew together functions from a number of pre-existing bodies which had performed health improvement functions, including the HPA. Core health protection functions of PHE included: hosting national expertise and research capability; operation of high containment laboratories and other nationally important scientific facilities; and managing local health protection teams which provided specialist advice and support to local government, the NHS and other agencies. PHE's health protection brief encompassed infectious diseases and other hazards to health, such as chemical, radiation and environmental risks.

135. PHE's Regional Directors (RDs) provided regional leadership for both health protection and health improvement activities in PHE and were professionally and managerially accountable within the organisation. The number, configuration and reporting arrangements for these regional roles evolved in the years following PHE's establishment, with a seven-region model in place by 2019. During 2019, PHE and

NHSE were working together to establish joint RD roles spanning their respective public health remits, with RDs remaining PHE employees accountable to the organisation's Medical Director but also operating as part of NHSE's regional leadership structures.

136. PHE's primary remit was for England, but it worked closely with other UK public health agencies, including to co-ordinate knowledge and action on protecting the public's health, and was active internationally in countering global health protection threats such as specific disease outbreaks overseas.

137. The Department supported discharge of the Secretary of State's functions in respect of policy development and implementation both for the protection and improvement of the public's health. This included holding PHE and NHSE to account for the performance of their functions.

The Department's role in the healthcare system's planning for and response to COVID-19

The Secretary of State's responsibilities as Category 1 responder

138. The Secretary of State is designated as a Category 1 responder under the CCA and therefore has a responsibility to deliver the full set of civil protection duties including:

    a. Assessing the risk of emergencies occurring and using this to inform contingency planning;
    b. Putting in place emergency plans and business continuity arrangements;
    c. Putting in place arrangements to make information available to the public about civil protection matters and maintain arrangements to warn, inform and advise the public in the event of an emergency; and
    d. Sharing information and cooperating witPRRh local responders to enhance emergency response coordination and efficiency.

139. The Secretary of State's responsibilities as a Category 1 responder apply to emergencies as defined under CCA s.1(1)(a). These are events or situations which threaten serious damage to human welfare in a place in the United Kingdom which

causes or may cause loss of human life, human illness or injury or disruption of health and social care sectors, including the public health system, the functioning of the NHS, or adult social care.

140. The Secretary of State discharges these duties through policy and emergency preparedness teams throughout the Department. As such, the Department has maintained a dedicated Director-led Emergency Preparedness, Resilience and Response (EPRR) function since before 2009. The Department's Operational Response Centre (ORC) has responsibility for this EPRR function and leads on the planning for and response to incidents where there is a potential serious risk to the public's human welfare and disruption to services relating to health. This approach applied to COVID-19 as well and also applies to broader operational risks such as fuel shortages and medicine supply disruption, environmental threats such as adverse weather, deliberate threats such as terrorism, infectious disease outbreaks such as Mpox and Ebola, and the potential impact of a pandemic.

141. NHSE plays a lead role in NHS emergency planning. As previously mentioned, in relation to pandemic preparedness NHSE's relevant responsibilities included:

    a. Making arrangements for NHS providers to deliver certain health services to patients;
    b. Allocating funds to NHS CCGs, so they can arrange with providers for the remainder, and the majority of NHS services to be provided to patients;
    c. Ensuring that both itself and NHS CCGs are properly prepared for dealing with emergencies (including a pandemic);
    d. Monitoring NHS providers' compliance with the arrangements imposed upon them to ensure that they are properly prepared for emergencies.

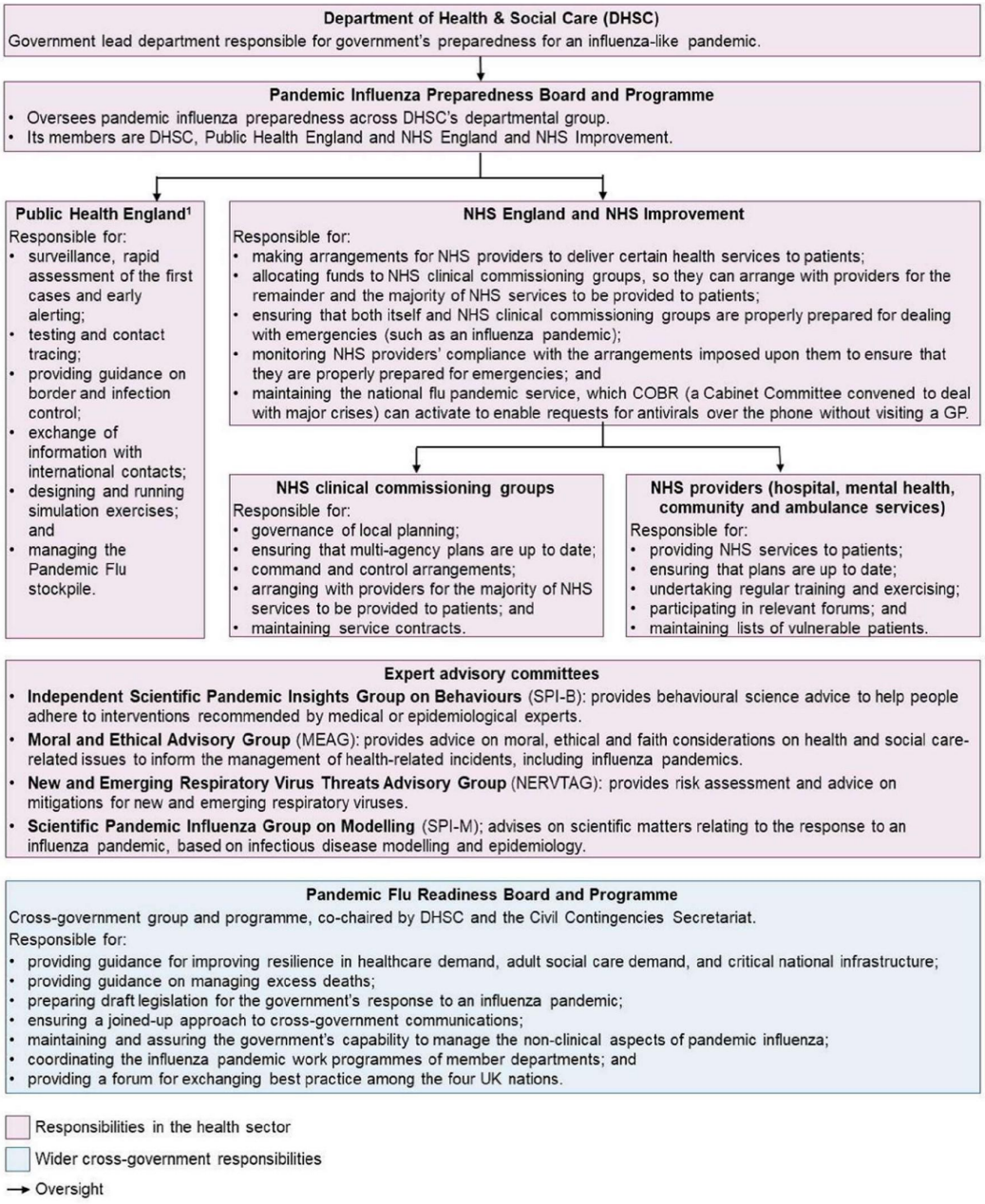
142. In addition to responding to emergency incidents as they occur, the EPRR function also leads on policy and planning for specific risks, including both known and anticipated risks as set out in the National Risk Register (NRR). Included as one of the risks the Department has been preparing for over several years is an influenza pandemic. This is because it has been the most significant natural hazard risk on the NRR and the underlying National Risk Assessment (NRA) or National Security

Risk Assessment (NSRA) since 2008. The Department is the LGD for mitigating the pandemic risk as described in the NRR and the NSRA.

143. Other organisations who have Category 1 responsibilities include NHSE, ambulance services, NHS Hospital Trusts and UKHSA.

The Department's role in relation to pandemics

144. The main roles and responsibilities for pandemics were covered in the National Audit Office (NAO) report, 'The government's preparedness for the COVID-19 pandemic: lessons learnt for government on risk management' (November 2021) **(CW10/29 - INQ000023128)**. This is demonstrated in the figure below, taken from the report.



145. The Department is the LGD for pandemic preparedness, response and recovery working with others in areas of their responsibility. The Pandemic Influenza Preparedness Programme (PIPP) was the central department-led programme of activity for managing pandemic preparedness. The Pandemic Flu Readiness Board

(PFRB) was the cross-government group on management of pandemic preparedness activity.

Emergency planning governance

146. From September 2018, the Operational Response Board (ORB) maintained oversight of 'no deal' preparedness plans for EU Exit, working with the EU Exit Assurance Board which had been established to oversee all EU Exit activity.

147. The Department brought its existing EPRR function into its Operational Response Centre (ORC) in January 2019. The ORC covered all emergency responses across the Department's responsibilities, including 'no deal' EU Exit, and infectious disease responses. It included enhanced capabilities such as a system of shift working on a rota basis.

148. The Concurrent Risks And their Mitigations (CRAM) Board was established in June 2020 and its Terms of Reference are exhibited at **CW10/30 - INQ000287609**. Its meetings aimed to facilitate robust, coordinated and holistic approaches to managing concurrent risks and their mitigations as well as the actions to take when mitigations fail.

149. The Strategic Emergency Preparedness Board (SEP) was established in January 2021 as an evolution of the EPRR Partnership Group and ORB. It is a senior level group, whose core membership consists of the Department and all relevant ALBs or Delivery Partners. The purpose of the SEP is to provide assurance on emergency planning, resilience and response across the health and care system.

150. The SEP Delivery Group (SEP-DG) is a working level group that reports to the SEP Board. The purpose of the group is to provide a forum for regular check-ins to ensure SEP objectives and actions are achieved. The group shares its purpose with SEP in providing a forum for assurance and emergency planning.

The Department's response to COVID-19

151. In the paragraphs that follow, I summarise the Department's response to COVID-19 specifically as context for its role in relation to the healthcare response.

COVID Incident Management Team

152. On 19 January 2020, DHSC established COVID Incident Management Team (the ORC COVID IMT).

153. The ORC COVID IMT established and chaired Daily National Sector calls from 21 January until summer 2020. NHSE and NHSI attended these meetings alongside Department officials, PHE and Devolved Governments. The agenda covered the current reported cases and testing, repatriation, case definitions, port health measures, clinical management, the picture across all four nations, and policy and operational decisions. The calls were informed by the Daily Situation Report (SitRep) from the previous evening and were used to address key live issues and to inform the subsequent SitRep. Sitreps (**CW10/31 - INQ000106052**, **CW10/32 - INQ000106112**, **CW10/33 - INQ000106209**, **CW10/34 - INQ000106309**, **CW10/35 - INQ000106352**, **CW10/36 - INQ000106432**, **CW10/37 - INQ000106512**) were produced daily by the Department with input from NHSE, NHSI and PHE. They set out the current situation on COVID-19 in the UK and internationally to inform policy decisions. The content evolved and expanded as the pandemic developed. SitReps were disseminated to the Government and Ministers to aid decision making.

154. Shift working was introduced for ORC staff in February 2020 to meet the work demands, with 07:00-22:00 covered seven days a week and designated on call officers covering night shifts. The ORC had the ability to stand up to 24/7 shift working if required. The ORC COVID IMT also provided a dedicated response function to identify and resolve issues.

155. Staff were deployed from the Department's VERT in support. At its height in April 2020, the ORC had over 150 staff drawn from across the Department as well as on loan from other government departments (OGDs) and ALBs.

156. Staff from NHSE, NHSI, OGDs and ALBs were embedded in the Department to facilitate communication and reporting across government. Department, NHSE and NHSI staff were also embedded in the FCO to assist with the repatriation efforts and communication between the organisations.

157. Throughout the pandemic, the ORC staff facilitated the flow of information from the NHSE, NHSI and the wider health and social care system into the CO. This included reporting on death management within the NHS and provided assurance on NHS mortuary capacity and the effective management of COVID-19 related excess deaths. The ORC's emergency response function remained agile and was designed to respond and react to emerging information, informing wider departmental knowledge.

Phases of the Department's response

158. As the Department's understanding of COVID-19 developed, so did its response. The Department transitioned between three phases of operation:

    a. Phase 1: the ORC solely managing the national incident response on behalf of the Department where there were a small number of COVID-19 cases in the UK but increasing numbers worldwide;
    b. Phase 2: the ORC providing coordination across a number of workstreams operating across the Department as case rates increased in the UK and Europe; and
    c. Phase 3: a whole departmental response to address significant UK cases and pressures on the health and social care system.

159. The Department's ExCo met on 6 February 2020 and discussed these three phases for managing the response **(CW10/38 - INQ000106136)**. ExCo noted that the first phase applied and that it was anticipated that the Department might move to the second phase within two to three months. In practice, this happened at a faster pace. The Department moved to the second phase in mid-February 2020 and to the third phase on 4 March 2020.

160. On 10 February 2020, a new policy directorate, the Reasonable Worst Case Scenario (RWCS) Team was established within the Global and Public Health Group to develop COVID-19 policy in conjunction with others in the Department, its ALBs, CO and OGDs.

161. On 4 March 2020, the RWCS Oversight Board, chaired by Clara Swinson, was set up to co-ordinate and assure the Department's COVID-19 response, supporting and aligning where possible with cross-government response and assurance. This continued, renamed after the first wave as the Covid Oversight Board, throughout the relevant period. It maintained a focus on the Battleplan and the system response as covered from paragraphs 168 below.

Whole government approach

162. The Department maintained its role as LGD until 2 March 2020 when the Prime Minister began to chair the COBR meetings, which had been chaired by the Secretary of State since 24 January 2020, in response to the pandemic. At this stage, it became clear that the response to the pandemic required a whole government approach. Therefore, whilst it was confirmed in the Coronavirus (COVID-19) Action Plan published on 3 March 2020 (the Action Plan) **(CW10/39 - INQ000057508**; **CW10/40 - INQ000106145**) that the Department remained the LGD, the issue became a cross-government one, with key decisions and overall policy responsibility being taken over by the CO/No.10.

Coronavirus (COVID-19) Action Plan, published 3 March 2020

163. The Action Plan was developed under the leadership of the Department, following a request from the Secretary of State recorded on 10 February 2020 (**CW10/41 - INQ000106107**). The decision-making structures in the Action Plan relied on the CO/No.10 structures, including ministerial Cabinet meetings. The Action Plan was jointly agreed between the UK Government and the Devolved Governments.

164. The Action Plan set out:

a. What the Government knew about the virus and the disease it caused;
b. How the Government had planned for an infectious disease outbreak such as that caused by COVID-19;
c. The actions that the Government had taken in response to the COVID-19 outbreak so far;
d. What the Government was planning to do next, depending on the course of the outbreak; and
e. The role of the public in supporting the Government's response, both in the immediate term and the future.

COVID-19 Battle Plan

165. Whilst the Action Plan represented the outward-facing information provided to the public, internally the Department prepared a 'Battle Plan'. The initial three-month Battle Plan was commissioned by the Prime Minister at a meeting on 20 March 2020 (**CW10/42 - INQ000049742**; **CW10/43 - INQ000049743**) and was intended to organise the work of the Department (to lead the health and care response to COVID-19. This drew on work already underway in the Department to identify and organise key workstreams. The Battle Plan was scrutinised by the Health Ministerial Implementation Group (HMIG) and the Prime Minister and agreed on 22 March 2020 **(CW10/44 - INQ000106279)**.

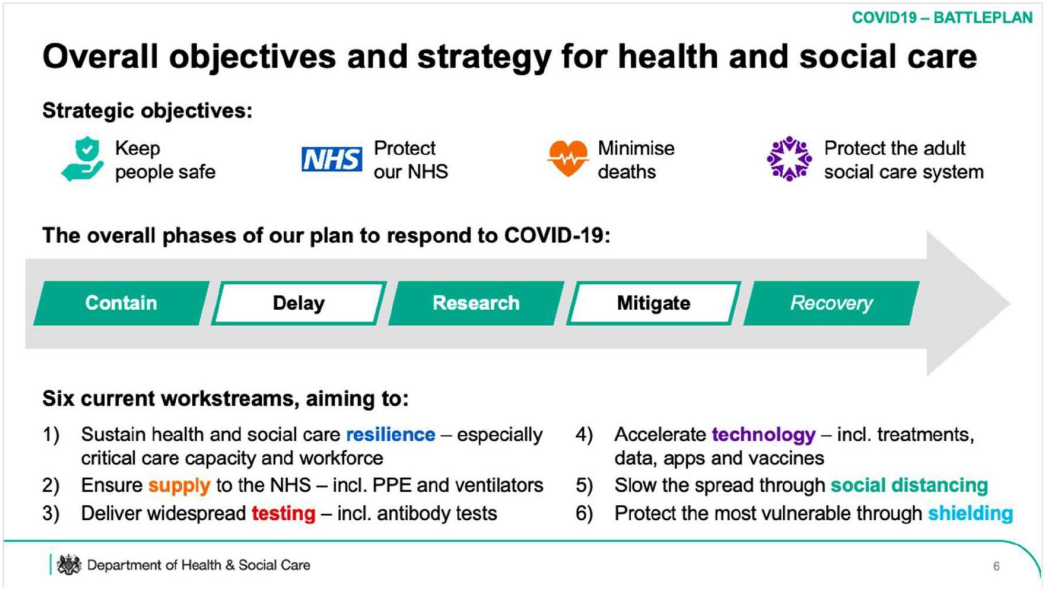
166. Work under the Battle Plan was initially split into six workstreams. Under each workstream a number of key performance indicators were identified, and an SRO was assigned to each workstream. The SROs were drawn variously from the Department ALBs and MHCLG, reflecting their organisations' respective responsibilities, and the Department worked closely with all of them to ensure a coherent approach to delivery of the Battle Plan. Initial workstreams and SROs were as follows:

Workstreams	**SROs**
(1) resilience for the NHS and adult social care;	Lee McDonough & Jonathan Marron (DHSC)

(2) supply of key products and equipment;	Steve Oldfield (DHSC) Emily Lawson (NHSE/I)
(3) testing widespread across the population;	Kathy Hall (NHSX)
(4) technology accelerating new interventions;	Jonathan Van Tam (DHSC) & Matthew Gould (NHSX)
(5) social distancing to slow the rate of transmission; and	Clara Swinson (DHSC)
(6) shielding to protect the most vulnerable.	Jonathan Marron (DHSC) & Catherine Frances (MHCLG)

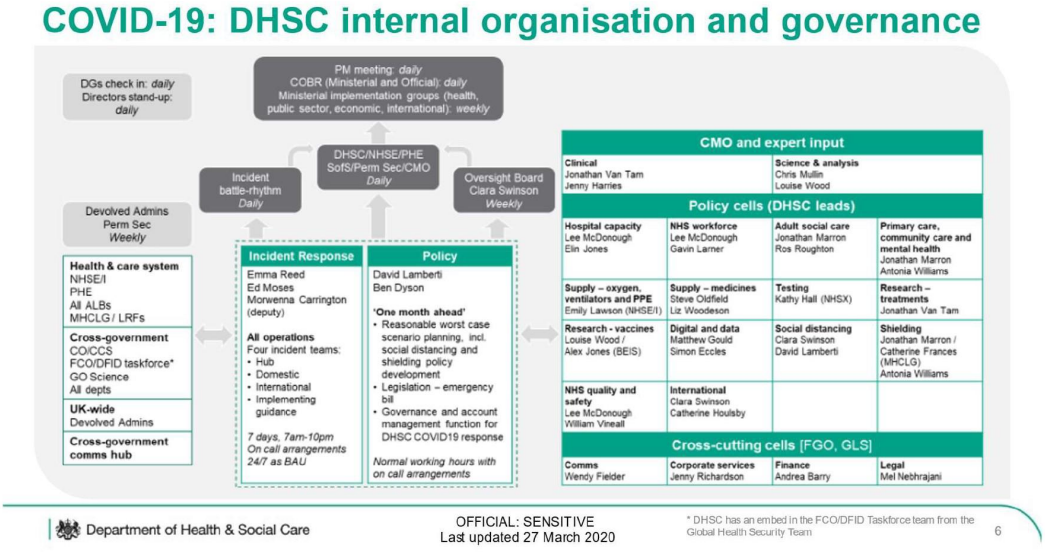
167. Progress on the workstreams was reported to the Department's Oversight Board by SROs or their deputies, on a weekly basis. The Oversight Board was later renamed the COVID-19 Oversight Board and met weekly until the end of June 2021, after which the frequency of meetings was agreed by the Board to reflect the level of assurance needed during particular phases of the pandemic. The Oversight Board's Terms of Reference were updated in October 2020, but its purpose was fundamentally unchanged **(CW10/45 - INQ000106149)**.

168. As set out in the diagram below, the Battle Plan also set out the broad phases of the proposed response to COVID-19, reflecdeting those in the Action Plan: (1) Contain, (2) Delay, (3) Research, (4) Mitigate and (5) Recovery **(CW10/46 - INQ000056110 CW10/47 - INQ000106295, CW10/49 - INQ000106297, CW10/50 - INQ000106298**

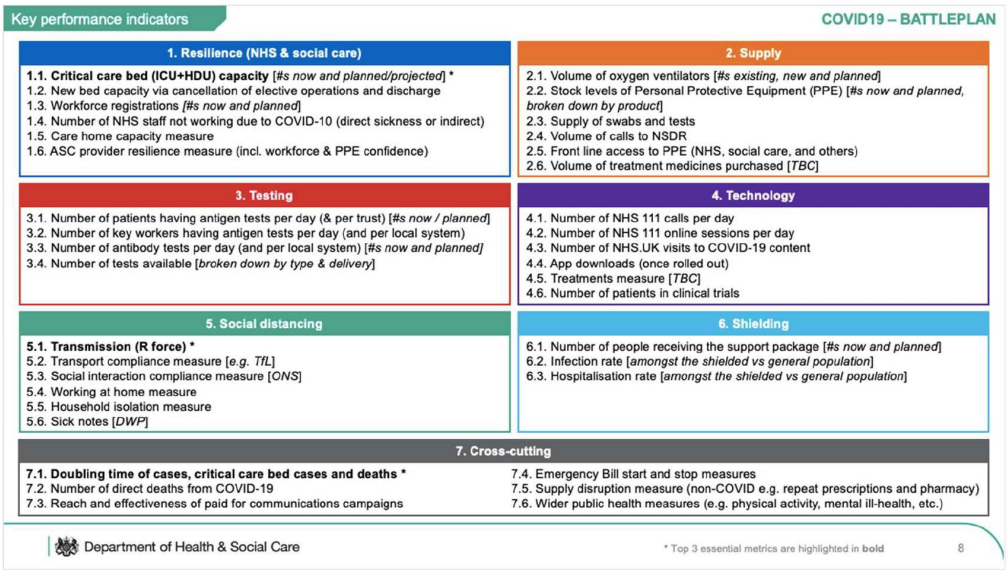


(Battle Plan, v.1.1)

169. Organisation and governance arrangements for the workstreams, and the wider cross-cutting workstreams that supported them, are set out in the image below:



170. A number of key performance indicators (KPIs) were developed for each workstream to accompany the Battle Plan, which are set out in the image below:



171. The Battle Plan continued to be developed in terms of number of workstreams and detailed priorities and KPIs for each, but it remained broadly consistent, covering similar areas and encompassing work by the Department's policy teams and some of the ALBs, particularly NHSEI and PHE.

The Department's role in resourcing and funding of the healthcare system in the context of emergencies and COVID-19

172. I turn now to consider the Department's role in resourcing and levels of funding for the healthcare system in the context of emergencies, including COVID-19.

Managing Public Money

173. The Department's responsibilities and accountability for resourcing and funding the healthcare system stem from Managing Public Money which sets out the principles for dealing with public resources. It is updated periodically to reflect any minor technical clarifications or changes to annexes and templates. As at the date of

signing this statement, the latest version is dated May 2023 **(CW10/51 - INQ000279942)**.

174. Managing Public Money provides guidance on sound financial management in public sector organisations and on the specific rules and conventions that have been put in place to ensure that public funding will be used for the purpose intended. The document applies to Ministers and Central Government and to other public sector organisations including ALBs. Accountability for compliance with Managing Public Money lies with the designated Accounting Officers.

175. As set out above, as Permanent Secretary of the Department, I am the Principal Accounting Officer for the Departmental Group, consisting of the Department and its sponsored non-Departmental and other ALBs, designated by order made under the Government Resources and Accounts Act 2000. As I have already explained, the CEOs of each ALB acts as that ALB's Accounting Officer and is in turn responsible to me, as the Principal Accounting Officer for the Departmental Group.

176. Accounting Officers are responsible for ensuring that funding is spent in a way that is regular, proper, value for money and feasible. In the event that these four AO standards cannot be met, a ministerial direction may be sought. This in fact happened during the pandemic, as set out in paragraph 186.

Budgeting

177. The May 2023 edition of Managing Public Money sets out in Section 5.1 the general principle that most public expenditure is financed from centrally agreed multi-year budgets administered by HMT. It is HMT which oversees each Government department's use of their budget allocations. In the main, departments have considerable discretion about how they distribute these budget allocations, which are expressed net of relevant income. HMT issue departments with delegated authorities, with issues outside of delegated limits requiring HMT approval. In settling departmental funding or providing spending approvals, HMT can issue conditions which departments are expected to meet.

178. Whilst, as already stated, a department's expenditure is determined through multi-year budgets (Spending Reviews) or other fiscal events, there is in practice scope to adjust funding through the annual budget process.

Financial allocations for healthcare

179. Overall funding for the NHS, the Department and its ALBs is agreed in regular Spending Review processes between the Department and HMT, as is the case for the rest of government. Depending on the level of spend and its features, areas are either within Departmental delegation or require further agreement with HMT or CO. The Department implements the policy and financial decisions accordingly.

180. The Department is responsible for the Spending Review negotiation for adult social care, including any social care funding that is within the DHSC expenditure limit. DLUHC (formerly MHCLG) remains accountable for the allocation of majority of central government funding set by the Spending Review to local authorities. It is local government that is responsible for the overall level of social care funding as that includes funding raised through council tax and business rates as well as central government funding.

181. Prior to the pandemic, the NHS was part way through a five-year funding settlement that was agreed to support the delivery of the NHS long term plan between 2019/20 and 2023/24. This was announced by the Prime Minister in June 2018 and reconfirmed in the 2019 Spending Round. It planned to increase NHS funding by £33.9bn per year by 2023/24 compared to the 2018/19 budget of £114.6bn.

Funding during the COVID-19 pandemic

182. There are no specific arrangements in place for an amended funding regime in relation to the funding of healthcare during pandemics in general or during COVID-19 in particular. The existing five-year funding settlement therefore remained in place. As the scale of the pandemic became clear, this settlement was supplemented by very significant additional funding for specific capabilities and response.

183. There is a process that HMT has put in place that allows departments to make Reserve claims from HMT in unforeseen circumstances. HMT publishes annual budgeting guidance, the most recent edition of which is dated March 2023 and covers the period 2023 – 2024 **(CW10/52 - INQ000327528)**. The guidance explains that Departments are, in general, expected to manage their budgets so as to stay within them. It provides (at paragraph 2.38), however that "*Exceptionally, a department may seek support from the Reserve*". As to the circumstances in which the Reserve can be drawn upon, the guidance provides (at paragraph 2.39) as follows: "*The Reserve can only be used for genuinely unforeseen, unaffordable and unavoidable pressures, or certain special cases of expenditure that would otherwise be difficult to manage, as agreed with the Chief Secretary*".

184. HMT's annual budgeting guidance over the course of the relevant period contained analogous provisions (**CW10/53 - INQ000187590**; **CW10/54 - INQ000068418** **CW10/55 - INQ000327529**).

185. This Reserve claim process was used to agree additional funding for the Department, the NHS and its ALBs, over and above the budget agreed at the 2019 Spending Review. Via the Supply Estimates in 2020/21 total Covid Reserve claim funding for 2020-21 agreed with HMT was c£58.6bn. The 2020 Spending Review then revised Departmental Budgets for 2021-22, with further Supply Estimate Reserve claims for that year, together creating additional budgets of £38.6bn. Whilst health is a devolved matter and the majority of the DHSC budget routinely funds healthcare services in England only, in certain circumstances the Department led on a UK-wide Covid response such as for NHS testing, vaccines purchasing and PPE, which were funded directly from DHSC Reserve claims. Those elements of the Reserve claims were then excluded from the Barnett Formula related adjustments to Covid funding for the Devolved Administrations. Against these revised budgets, the department reported underspends in both financial years. The table below provides a breakdown of the main budgets and underspends:

	2020-21 (£m)			2021-22 (£m)		
	Budget	Outturn	*Under / (Over) spend*	Budget	Outturn	*Under / (Over) spend*
NHS non-Covid BAU	129,459	125,946	*3,513*	134,315	133,670	*645*
Non-NHS Business as usual activities	10,788	10,396	*392*	11,812	10,323	*1,489*
NHS Covid-19	17,995	15,749	*2,246*	13,698	13,329	*369*
NHS Test & Trace	20,369	11,070	*9,300*	16,045	15,154	*891*
Personal Protective Equipment	14,705	13,039	*1,666*	2,361	1,918	*443*
Vaccines deployment	3,045	860	*2,185*	5,036	4,629	*407*
Other Covid-19	2,804	1,945	*859*	2,048	1,772	*276*
Total RDEL Non-RF (exc Depreciation)	**199,166**	**179,006**	***20,161***	**185,315**	**180,795**	***4,520***
Depreciation Ring-Fence	1,589	1,194	*395*	1,580	2,753	*(1,173)*
Total RDEL	**200,755**	**180,199**	***20,556***	**186,895**	**183,548**	***3,347***

Note - figuress above represent spending across NHS and non-NHS budget boundaries. NHS RDEL budget, as per the published Financial Directions, for 2020-21 was £150bn and for 2021-22 was £151bn. With the remaining held in DHSC and other ALBs' budgets.

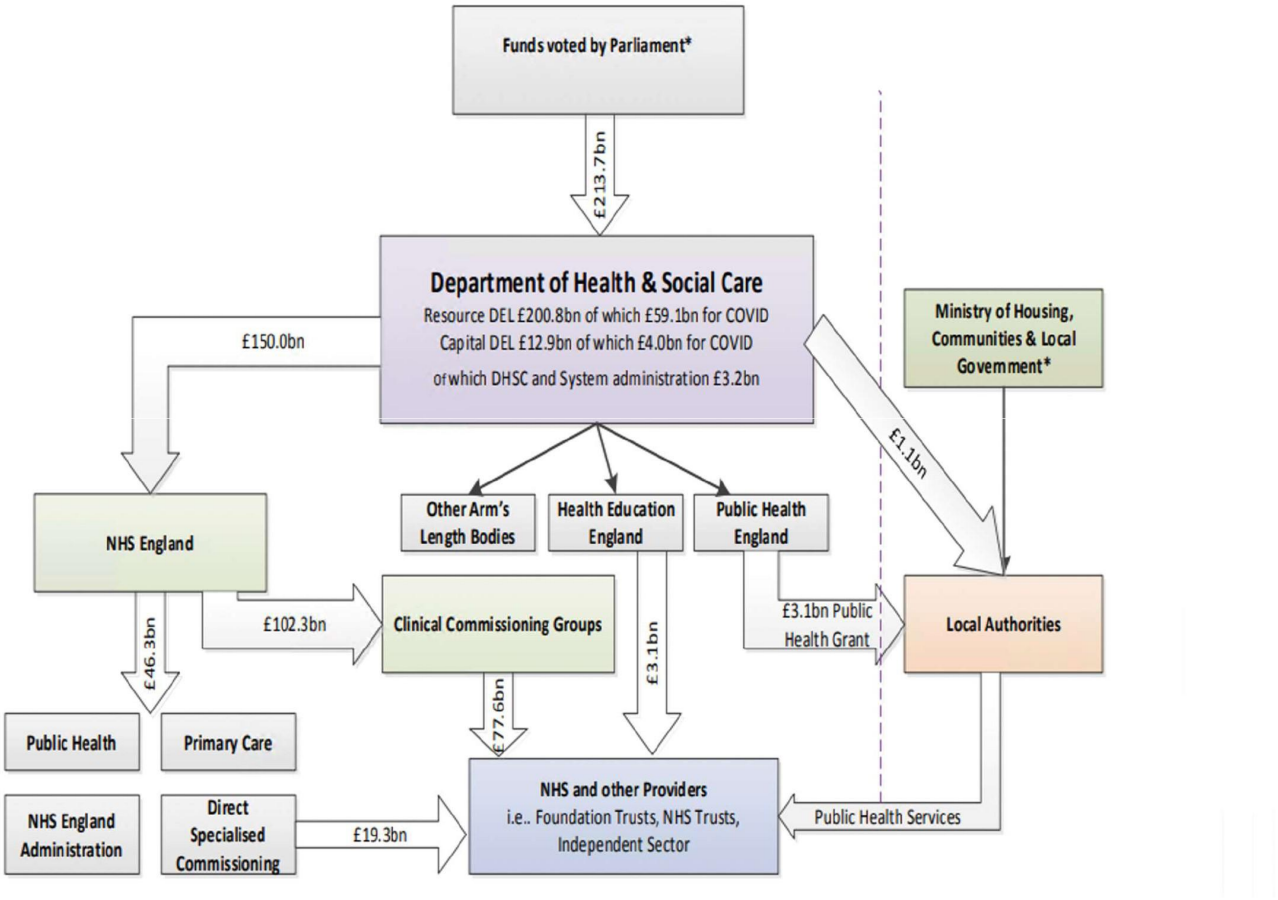
Source: Table 5, page 35, DHSC Annual Report and Accounts 2020-21; and Table 10, page 68, DHSC Annual Report and Accounts 2021-22.

186. Paragraph 176 set out how, in certain circumstance, a ministerial direction can be sought in order to spend in excess of the limits authorized by Parliament. On 29 March 2020 the Secretary of State directed the NHSE CEO and myself to continue to authorise and spend money on urgent COVID-19 issues even if this would mean that spending was in excess of the formal Departmental Expenditure Limits authorised by Parliament for 2019-20 (**CW10/56 - INQ000279920**). I understand that corresponding arrangements were also made by NHS England to ensure that NHS organisations had confidence that the additional costs they incurred as a result of the pandemic would be met centrally. The Secretary of State directed the NHS CEO

in January 2022 to agree contracts with independent sector providers to ensure that additional bed capacity in independent hospitals would be available to the NHS if needed **(CW10/57 - INQ000279941)**.

Funding flows within the healthcare system

187. The diagram below, which has been extracted from the Department's 2020 – 2021 Annual Report and Accounts (covering the period ending 31 March 2021) **(CW10/1 - INQ000235008)**, illustrates the way in which funds flowed to the various levels of the health and social care system during 2020-21, i.e., before the establishment of Integrated Care Boards in July 2022.



*This includes funding from National Insurance Contributions that are not included in the parliamentary vote on DHSC budget. This funding is received directly from HMRC via the National Insurance Fund which is provided for in legislation.
Budgeted figures are used in this presentation with actual figures used by exception where allocations are not included in budgets.
Dashed line indicates boundary of consolidation for DHSC and shows Local Authority funding to Health. MHCLG is now referred to as the Department for Levelling Up, Housing and Communities.

188. During the 2020 – 2021 financial year, the Department had a revenue expenditure limit of £200.8 billion (of which £150bn was for NHS England) and invested a further £12.9 billion in capital funding such as new hospitals and equipment. Further detail on funding in each financial year during the relevant period is included in Annual Reports and Accounts, including additional funding for COVID 19. The NAO has

also published a detailed COVID 19 cost tracker setting out COVID 19 costs incurred across government **(CW10/58 - INQ000327523)**.

189. As set out in the Department's 2021 – 2022 Annual Report and Accounts (covering the period ending 31 March 2022) **CW10/2 - INQ000257323)**, during the 2021 – 2022 financial year, the Department had a revenue expenditure limit of £186.9 billion (of which £151bn was for NHS England) and invested a further £10.4 billion to fund capital items such as new hospitals and equipment

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: _____

Dated: ___27 October 2023_____

1 |dhsc004:06659401|INQ000235008|HC 1053- Department of Health and Social Care Annual Report and Accounts 2020-21
2 |dhsc001:09578037|INQ000257323|Department of Health
3 |dhsc001:09578289|INQ000327532|The NHS Constitution for England.pdf
4 |dhsc001:01246686|INQ000257090|210927 – MB_JM – PHE Functions.pdf
5 |dhsc001:09578283| **[INQ000104750]** |NHS Public Health Functions Agreement 2020-21 - letter from Jonathan Marron to Amanda Pritchard
6 |dhsc001:09578291|INQ000327511|NHS Public Health Functions Agreement 2020-21 - response from Amanda Pritchard to Jonathan Marron
7 |dhsc001:09578284|INQ000327512|Annex - public health functions (section 7A) agreement 2020 to 2021 – services to be provided.pdf
8 |dhsc002:07958922|INQ000327518|NHS public health functions (section 7A) agreement 2021 to 2022 letter from DHSC to NHSE.pdf
9 |dhsc002:07958926|INQ000327520|Annex A - public health functions (section 7A) agreement 2021 to 2022 – services to be provided.pdf
10 |dhsc002:07958924|INQ000327519|NHS public health functions (section 7A) agreement 2021 to 2022 response from NHSE to DHSC.pdf
11 |dhsc002:07958925|INQ000327527|NHS public health functions agreement 2022 to 2023.pdf
12 |dhsc002:07958920|INQ000327524|Annex A - services to be provided 2022 to 2023.pdf
13 |dhsc002:07958923|INQ000327526|Annex B - performance indicators and key deliverables.pdf
14 |dhsc002:07958921|INQ000327525|Annex C - additional functions from 1 October 2021.pdf
15 |dhsc001:09578295|INQ000327509|Guidance for NHS commissioners on equality and health inequalities legal duties.pdf
16 |dhsc001:09578293|INQ000327535|COVID 19 rapid guideline - haematopoietic stem cell transplantation.pdf
17 |dhsc001:09578286|INQ000327515|COVID-19 rapid guideline - managing COVID-19.pdf
18 |dhsc001:09578285|INQ000327513|COVID-19 rapid guideline - vitamin D.pdf
19 |dhsc001:09578287|INQ000327516|COVID-19 rapid guideline - vaccine-induced immune thrombocytopenia and thrombosis (VITT).pdf
20 |dhsc001:09578292|INQ000327514|COVID-19 rapid guideline - managing the long-term effects of COVID-19.pdf
21 |dhsc002:07958928|INQ000327533|Module 3 Ministers Special Advisors and SCS.pdf
22 |dhsc002:07958927|INQ000327534|ExCo membership.docx
23 |dhsc001:09578288|INQ000327536|Revised 2020 to 2021 mandate to NHSEI
24 |dhsc001:09578290|INQ000327522|The government's revised 2021 to 2022 mandate to NHS England and NHS Improvement
25 |dhsc001:09578294|INQ000327521|The government's 2022 to 2023 mandate to NHS England
26 |dhsc002:00956752|INQ000327537|For information_2020414 COVID-19 NIRB ToR
27 |dhsc002:02244298|INQ000327517|FW: NIRB disbandment end July