Witness Name: Catherine Little
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THE UK COVID-19 INQUIRY

MODULE 3 WITNESS STATEMENT OF HIS MAJESTY'S TREASURY

WITNESS STATEMENT OF CATHERINE LITTLE

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1. I, Catherine Little, make this statement on behalf of His Majesty's Treasury ("HM Treasury", "the Treasury", "HMT" or "the Department"). My work address is HM Treasury, 1 Horse Guards Road, London, SW1 2HQ and my date of birth can be supplied to the Inquiry upon request.

2. I am providing this statement in response to the Inquiry's draft Rule 9 request dated 31 March 2023 ("the Rule 9 request") on behalf of the Department.

3. I joined the Civil Service in 2013 in the Legal Aid Agency following a career in professional services. I have also worked in senior leadership and strategic finance roles in the Ministry of Justice and the Ministry of Defence. In 2020 I joined HM Treasury as Director General Public Spending. I have been HM Treasury's Second Permanent Secretary since October 2022. In this role, I oversee public spending, international finance and national security policy. I am also the head of the Government Finance Function.

4. Whilst I have some personal recollection of some of the events or processes described in this witness statement, I have also co-ordinated and liaised with colleagues who have the relevant knowledge and experience across the Department. Their contributions have been used to respond to the questions in the Rule 9 request. My statement therefore relies upon those

contributions to form the responses in this statement. I have also relied on document archive searches conducted by colleagues.

5. My statement should be read subject to the caveats above. I have done my best to assist the Inquiry on behalf of the Department. If further material is made available to me, I would be happy to add to or clarify this statement to take it into account.

6. In line with the Rule 9 request, this statement covers the period between 1 March 2020 and 28 June 2022.

Introduction

7. HM Treasury is the government's economic and finance ministry, maintaining control over public spending, setting the direction of the UK's economic policy, and working to achieve strong and sustainable economic growth. The Chancellor of the Exchequer, the government's chief financial and economic minister, has overall responsibility for the work of the Treasury. (In the period covered by this statement, this office was held by the Rt Hon Rishi Sunak MP. For a full list of HM Treasury Ministers in the relevant period, see Annex 1).

8. The Covid-19 pandemic posed a huge and immediate challenge to health and care systems in England and the devolved administrations. While health and care policy and health and care response to civil emergencies are not lead responsibilities of HM Treasury, the response to the pandemic (and, in particular, the scale of the funding requirements arising from it) engaged core Treasury roles, functions and interests, including:

   a. HM Treasury's role in supporting the delivery of high-quality public services, including delivering the best possible outcomes for patients, care users and public health.

   b. HM Treasury's role in setting budgets and applying spending controls for government departments, associated bodies and the devolved administrations.

   c. HM Treasury's role in maintaining value for money for taxpayers.

   d. HM Treasury's responsibility for supporting and sustaining economic growth and stability across the UK.

   e. HM Treasury's role in supporting Accounting Officers to ensure that government spending operates with regularity and propriety at all times.

   f. HM Treasury's broad interests in supporting effective response to civil emergencies with risks to the economy and public finances.

9. HM Treasury's role with respect to health and care systems in the pandemic was heavily centred on its public spending role and on providing a framework within which Ministers could take decisions, balancing proportionately the needs of health and care systems with the interests of taxpayers and the economy. This statement will cover HM Treasury's involvement in health and care spending and policy prior to the outbreak of Covid-19, how HM Treasury approached decision-making in these areas as the Covid-19 pandemic emerged, and how HM Treasury's approach over the course of the pandemic evolved.

10. As this statement will set out, although changes were made during the pandemic to health-specific budgets and funding frameworks (e.g. suspension of the NHS financial framework), the principles underpinning how HM Treasury approached public spending policy did not fundamentally change from established practice. HM Treasury sought at all times to deliver its responsibilities to Parliament, Ministers and taxpayers within the established overarching framework for public spending, though it applied that framework flexibly to respond rapidly to acute public health need, while enabling Ministers to assess the value for money of individual spending decisions and the wider fiscal policy context.

11. This statement is structured as follows:

    a. Firstly, it will set out HM Treasury's role, function and responsibilities under the established public spending framework and how this applied to health and care systems in England and the devolved administrations in the period prior to the pandemic.

    b. Secondly, it will discuss the flexibilities in the public spending framework which exist for responding to civil emergencies, how these were applied during the pandemic, and how HM Treasury sought to balance different considerations in health and care spending decisions over the course of the pandemic.

    c. Thirdly, it will set out a thematic chronology of the decision making in core areas of health and social care in the relevant period.

    d. Finally, it considers the lessons that have been learned, and the changes and proactive improvements to relevant processes (in particular spending processes) made during the response to the pandemic, including changes and improvements HM Treasury has driven across government.

The role, function, and responsibilities of HM Treasury with respect to health and care systems within England and the Devolved Administrations

HM Treasury's constitutional role and the Accounting Officer system

12. HM Treasury has a constitutional role and is responsible to Parliament for creating and maintaining a framework to manage public resources, which applies across the whole of government. This framework is codified in the document Managing Public Money ("MPM") exhibited as CL3/001 **INQ000279942**. Parliament looks to HM Treasury to make sure that departments only use their powers as intended, and that revenue is raised and resources are spent within agreed limits.

13. HM Treasury performs this role in three ways: by designing the Budgeting Framework (set out in an annual Consolidated Budgeting Guidance document, exhibited as [CL3/002 **INQ000068418** setting departmental budgets through the Spending Review and Estimates processes; and controlling departmental spending on an ongoing basis so that they stay within budgets and achieve value for money. HM Treasury's role ensures that Parliament's requirements are met and the delivery of government objectives are supported.

14. HM Treasury also appoints a Principal Accounting Officer ("AO") in each central government department who is always the Permanent Secretary or Chief Executive. That Principal AO appoints the heads of any arms-length bodies (ALBs) within their departmental group as AOs. The Principal AO may also appoint AOs for specific areas of Departmental expenditure. AOs are responsible to Parliament for the stewardship of the relevant departmental or ALB's resources.

15. As of March 2020, DHSC appointed a Second Permanently Secretary as an additional AO to address the operational pressures that arose due to the Department's role in responding to the pandemic. This appointment did not detract from the Permanent Secretary's overall responsibility as Principal AO for the department. The Principal AO for DHSC appoints the Chief Executive for NHSE to act as AO for the NHS.

16. A key requirement for AOs is to ensure that spending in their department conforms to the principles of regularity, propriety, value for money and feasibility as set out in Managing Public Money. Broadly, this means that AOs are responsible for ensuring that their department and any ALBs it sponsors operate effectively and to a high standard of probity, for managing risks in their organisation, for ensuring that spending has HM Treasury Ministers' approval and is compliant

with the law and MPM guidance, and for ensuring that policies represent value for the taxpayer and are deliverable.

17. During the pandemic, the basis on which AOs made decisions about expenditure in their departments did not change.At all times they needed to be satisfied that spending decisions met the usual AO standards of regularity, propriety, value for money and feasibility. HM Treasury reiterated the primacy of this responsibility to AOs and Ministers across spending departments at multiple points throughout the pandemic and provided support to department AOs throughout. The following exhibits are relevant; [CL3/003 INQ000399236; CL3/004 INQ000408779; CL3/005 INQ000399234; CL3/006 INQ000408780; CL3/007 INQ000408781].

Overview of the budget setting process

18. HM Treasury sets departmental resource and capital 'Departmental Expenditure Limit' (DEL) budgets through the Spending Review ("SR") process. The process for SRs is not defined in law and the scope and length of an SR can vary. Resource DEL ("RDEL") is used on day-to-day expenditure, including pay and procurement, while capital DEL ("CDEL") is used for investment (e.g. in rail or roads) and financial transactions. SR processes are led by the Chancellor, but typically involve bilateral negotiations with departments and collective decision making to set the budgets for government priorities.

19. The SR sets departmental budgets for any particular year. The Secretary of State of each department, on the advice of their officials, is responsible for decisions on allocations within their budget. This will be guided by, amongst other things, their existing commitments, priorities and risks. Each department sets out to Parliament how it has funded its activities and used its resources during the financial year in its Annual Report and Accounts.

20. The government can also use the annual Budget process to announce new policies. However, baseline spend per department is not updated at this point. To fund these new policies, a department's budget may need to be adjusted in-year.

21. SRs are the internal process the Government uses to develop budgets. Supply Estimates are the process through which the government seeks Parliament's authority for its spending plans. Supply Estimates are based on the principle of 'annuality', meaning that provision voted by Parliament and authorised under the relevant Supply and Appropriation Act can only be applied to the financial years (running from 1 April to 31 March) specified in that Act. HM Treasury collates the Estimates from departments and lays them in Parliament. These Estimates set departmental budgets in RDEL and CDEL are referred to informally as control totals. Spending

in excess of these control totals is breach of regularity and requires Parliament to approve that spending through an excess vote.

22. There are two annual Supply Estimates: Main Estimates, which set budgets at the beginning of the financial year, and Supplementary Estimates, which adjust for any variation to provide the most taut and realistic estimate for the end of the financial year.

23. HM Treasury delegates authority to departments to enter into commitments and to spend within predefined limits ("Delegated Authority Limit", "delegated limit" or "delegation"), without specific prior approval from HM Treasury. Delegated authorities strike a balance between HM Treasury's need to control spending to fulfil its responsibilities to Parliament and the department's freedom to manage within its agreed budget limits and Parliamentary provision. Delegated authorities can be set with a high degree of flexibility, e.g., they can apply as a broad spending limit on all individual projects within a department's remit, or they can be set as a spending limit for a specific policy or programme. Delegations are usually recorded in a bespoke delegated authority letter for each department, but this process can be departed from.

24. Before any expenditure outside the delegated authorities is submitted by the department to HM Treasury for formal approval, it should already have passed the highest level of scrutiny within the department. Expenditure submitted to HM Treasury for approval should also have been signed off by the relevant departmental minister (excepting cases related to special payments).

25. HM Treasury also delegates a number of spending controls to the Cabinet Office on particular areas of spending, for example commercial and digital spending. This means that departments must seek approval from Cabinet Office ministers for spending that falls in these categories, as well as seeking any necessary approvals from HM Treasury ministers. At the time the pandemic started, all commercial spending greater in value than £10 million was subject to CO commercial control.

The work of HM Treasury Spending Teams

26. HM Treasury has specific teams ("spending teams") responsible for overseeing the spending policy for specific departments, for instance advising HM Treasury ministers on departmental allocations at fiscal events and in-year approvals. Spending teams consist of officials up to Deputy Director level (SCS1). HM Treasury has a specific team (the Health & Social Care team, "HSC", sitting i2n Public Services Group) responsible for health and care spending and policy. Alongside HSC, a separate dedicated team was established for spending and policy advice related to Covid-19 vaccines and Covid-19 medicines between March 2020 and March 2021. Where necessary, other spending teams might also advise on aspects of health policy, for

example the DLUHC spending team where funding is delivered by local government. There is also a central spending coordination team called General Expenditure Policy ("GEP").

27. Regular meetings take place between HM Treasury spending teams and spending departments to discuss the department's key financial and policy issues and financial management information (including financial outturn and forecast data) and agree next steps. Directors and Directors General also frequently interact with senior counterparts in departments, including the departmental AO.

28. There is also significant engagement with departments in advance of an SR. Departments submit 'bids' to HM Treasury, which are then assessed by spending teams, and worked through between ministers in bilateral negotiations. This process considers the priority outcomes each department is responsible for delivering and the funding required to deliver those outcomes, taking into account the potential for efficiency and savings within each department.

29. In addition to the engagement described above, departments provide reporting on their overall financial position to HM Treasury. HM Treasury's spending teams monitor this data throughout the year, engaging with departments on any areas of concern. Where the team consider that action is needed to ensure that a department can operate within its budget, advice is provided to HM Treasury ministers on any options requiring their decision.

30. In line with Parliamentary expectations as set out in the principles and rules in Consolidated Budgeting Guidance, exhibited as [CL3/002 **INQ000068418**], departments must bring spending proposals to HM Treasury for approval where they exceed Delegated Authority Limits or are 'novel, contentious, or repercussive'.

31. As health is primarily a devolved matter,[1] HM Treasury's role in directly setting health budgets and approving spending and policy is principally focused on its interaction with and budget setting for DHSC and is normally England-only in scope. Social care is also a devolved matter. However, HM Treasury does indirectly fund health and care activity via funding settlements for devolved administrations ("DAs") and local government (and approves some local authority health spending).

Health and care funding arrangements in Scotland, Wales and Northern Ireland

[1] There are a limited number of areas where health-related spending occurs on a UK-wide basis. At the beginning of the 2020-21 financial year, only European Economic Area medical costs and the Medicines and Healthcare Products Regulatory Agency (MHRA) were operated UK-wide by DHSC, representing around 0.3% of DHSC's non-Covid-19 expenditure at the time.

32. The funding arrangements for DAs are set out in the Statement of Funding Policy, which was first published in March 1999 and has been updated eight times with the most recent edition published alongside the 2021 Spending Review. The Statement of Funding Policy sets out how HM Treasury will fund the DAs as well as the sources of self-funding (and financial flexibilities) available to the DAs. For more information on the Statement of Funding Policy, see Annex 2.

33. Similar to departments, DAs receive multi-year funding settlements at SRs, with in-year changes in funding determined through annual Parliamentary Estimates processes. The quantum of funding provided to the devolved administrations is largely determined through the longstanding Barnett formula, with further adjustments to funding in relation to specific policy areas (notably agreed tax and welfare Block Grant Adjustments). The DAs also have their own agreed tax and borrowing powers.

34. HM Treasury does not approve DA health and care spending as DAs take their own decisions and are accountable to their respective legislatures. DA finance departments set delegated authority limits for their policy/delivery departments.

35. Agreements are generally reached bilaterally, reflecting the asymmetric devolution settlements, though discussions about cross-cutting issues take place in the Finance Inter-ministerial Standing Committee ("FISC") and its predecessor forum the Finance Ministers' Quadrilateral ("FMQ").

Local government health and care funding

36. Two areas of health and care spending are delivered through local authority spending: local authorities provide or commission social care services and deliver public health activity under the Public Health Grant.

37. HM Treasury agrees the local government DEL budget which is the main source of local government funding through its normal budget processes. However, in general it does not approve local government spending because local authorities are democratically accountable to their local communities. Central government sets the overall level of funding for local government in England through the annual Local Government Finance Settlement, which is set out by DLUHC and approved by Parliament.

38. Adult social care spending by local authorities is funded primarily from local government revenue, including national level grants and revenue raised locally. Additional relevant funding sources include the Better Care Fund, which supports integrated working across health and care.

39. The Public Health Grant is allocated to local authorities from DHSC to fund certain activity (such as sexual health services, local health authority health protection functions and children's aged 0-5 services). HM Treasury approves these grants, in accordance with section 31 of the Local Government Act 2003. These are approved either by officials or Ministers alongside other aspects of spending control as set out in MPM. The Public Health Grant can also be used for unprescribed functions and was used for some public health spending relating to Covid-19, for example outbreak planning and Test & Trace, during the pandemic.

The Public Sector Equality Duty and public spending

40. The general duty imposed by the Public Sector Equality Duty (PSED) requires HM Treasury Ministers and other senior decision makers to pay 'due regard' to equalities implications in the exercise of its functions and to do so with an open mind (including the scope for mitigating options when differentiated negative impacts have been identified).

41. For policy areas owned by HM Treasury, there are internal procedural requirements and support in place for ensuring that such considerations inform decisions taken, including at fiscal events such as a Budget or Spring Statement, or during exercises such as a Spending Review. Ministers must be informed on a timely basis of the impacts of policies to ensure they pay due regard to those impacts during early deliberations on the likely direction of a particular policy proposal, through to the actual point of a final decision to proceed. Usually, ministers would be informed via submissions on the policy, including in the final piece of advice provided. Additional overarching advice for Ministers on their obligations under the PSED and a summary of the equalities impacts of the package are provided where helpful.

42. Where a policy area is not owned by HM Treasury, as is the case for health and social care, the relevant department is responsible for conducting equalities impact assessments pursuant to the PSED general duty. HM Treasury expects departments to meet their PSED requirements through their own internal processes. When HM Treasury Ministers take decisions, they have due regard to their responsibilities under the PSED, and HM Treasury can seek specific information from other Government departments to support HM Treasury decision making – for example, for the SR20 process, exhibited as [CL3/009 INQ000399232] departments were requested to set out in their funding submissions:

    a. how the current pattern of spending affects groups with protected characteristics, i.e., the equalities profile of the main areas of departmental spend;

b. any significant impacts for any of the protected groups of new spending proposals, including relevant opportunities for the positive promotion of equality or for the mitigation of potential negative impacts; and

c. high level assessments of the quality of the data sources underpinning the assessments, as well as the scope to improve data quality and detail plans to do so.

43. Departmental returns are used to inform HM Treasury's discussions with departments regarding their settlements.

44. The PSED also imposes specific duties, designed to support delivery of the general duty, which requires organisations such as HM Treasury to publish equalities objectives and information concerning their PSED compliance. Information on the HM Treasury specific duties can be found on HM Treasury's gov.uk page, which is exhibited as [CL3/010 INQ000408782].

The funding position for health and care pre-pandemic

45. HM Treasury is responsible for agreeing and setting overall funding envelopes for departments, including for DHSC and therefore also the NHS. The two key decision-making points which governed the level of funding for health and care systems in the years prior to the pandemic were the 2015 Spending Review, which set departmental resource and capital budgets for five years (for financial years 2016/17 to 2020/21) for the whole of government, and the 2018 NHS 5-Year funding settlement, which was a revised RDEL funding settlement, agreed separately from a Spending Review process and only covering NHS budgets. Following the announcement of the 2018 funding settlement, the NHS 'Long-Term Plan' was published in 2019, which set out the objectives to be delivered using the additional funding and how these objectives would be monitored. In both cases the DAs received overall allocations through the Barnett formula in the usual way and were free to set their own health and care budgets within their own overall envelope (the total amount of funding they receive).

2015 Spending Review

46. The 2015 Spending Review, which is set out in the letter exhibited as [CL3/011 INQ000412039], agreed an increase in real terms to health budgets, including an increase in real terms of over £10bn per annum to NHSE[2] budgets by 2020/21 from a 2014/15 baseline, and £24bn of capital investment over the SR period for key priorities such as new hospitals. This settlement included provision for RDEL grants from DH (as then named) to local government for commissioning

[2] NHSE refers to activity of NHS England, including NHS organisations that may have previously been separate from NHSE, such as NHS England Improvement (NHSEI), which became part of NHSE in July 2022.

public health services (£3,384m, £3,300m, £3,215, £3,130m, £3,130 from 2016/17 to 2020/21), ring-fenced for public health in 2016/17 and 2017/18.

TABLE 1: Department of Health settlement Spending Review 2015

(£m)	2015-16 baseline	2016-17	2017-18	2018-19	2019-20	2020-21	Cumulative real growth rate (15-16 to 19-20)	Cumulative real growth 15-16 to 20-21 (%)
RDEL ex*	111,600	115,600	118,700	121,300	124,100	128,200	3.3%	4.4%
o/w admin	2,700	2,600	2,500	2,400	2,400	2,400	-19.2%	-21.0%
CDEL	4,800	4,800	4,800	4,800	4,800	4,800	-7.2%	-9.2%
TDEL	116,400	120,400	123,500	126,100	128,900	133,100	2.8%	3.9%
o/w NHSE TDEL	101,300	106,800	110,200	112,700	115,800	119,900	6.1%	7.5%

*Excluding depreciation

47. The local government settlement at SR15 also included a new 'social care precept', enabling local authorities with adult social care responsibilities to increase council tax by 2% above the existing threshold. This would give local authorities the opportunity to raise nearly £2 billion a year for social care by 2019/20. SR15 also made available new social care grant funds for local government from April 2017, rising to £1.5 billion a year by 19/20, to be included in the Better Care Fund and allocated to local authorities in reflection of social care need. In aggregate this meant that local authorities could access £3.5bn a year of extra funding for social care by 2019/20.

48. The DAs received overall settlements in the usual way and were free to set their own health and care budgets within that.

2018 Funding Settlement and 2019 NHS Long Term Plan

49. On 18 June 2018, the Prime Minister announced a five-year funding settlement for the NHS, after meetings at official and Ministerial level between HM Treasury, DHSC and NHS England. This was announced outside of the SR process; a table of the revised NHS budgets was published at that point. That settlement allowed for average annual real-terms growth of 3.4% per year over the period, based on the OBR's March 2018 economic forecasts. At the Autumn Budget in 2018, the OBR's forecasts were revised such that the budgets (agreed in nominal terms) represented lower real-terms growth, and the settlement was revised upwards in cash terms to ensure it kept pace with inflation.

50. Following the 2019 election, the government enshrined the settlement in law through the NHS Funding Act 2020. The 2018 settlement and the revised settlement, legislated for in 2020, are as follows:

TABLE 2: 2018 settlement and revised settlement by year:

NHS England RDEL, nominal terms	**2018-19**	**2019-20**	**2020-21**	**2021-22**	**2022-23**	**2023-24**
As announced in 2018	+114.60bn	+120.55bn	+126.91bn	+133.15bn	+139.83bn	+147.76bn
As legislated for in 2020			+127.01bn	+133.28bn	+139.99bn	+148.47bn

51. The NHS Long-Term Plan was published by NHS England in 2019 and set out their plans to improve services and outcomes using the funding provided. HM Treasury's primary involvement was in agreeing 5 'Financial Tests' with the NHS, which were designed to ensure that taxpayers' money is used as effectively as possible. These are set out in Chapter 6 of the Long-Term Plan, and are:
    a. Test 1: The NHS (including providers) will return to financial balance;
    b. Test 2: The NHS will achieve cash-releasing productivity growth of at least 1.1% per year;
    c. Test 3: The NHS will reduce the growth in demand for care through better integration and prevention;
    d. Test 4: The NHS will reduce unjustified variation in performance; and
    e. Test 5: The NHS will make better use of capital investment and its existing assets to drive transformation.

52. This settlement determined the overall budget for the NHS over the period and through the Long-Term Plan priority areas of focus for the NHS were agreed with the Government. It remained the responsibility of NHS senior leaders how they chose to allocate their budgets across services and priorities, in line with their responsibilities as set out in the Health and Social Care Act 2012, and in the annual NHS mandate. This includes their responsibility for pandemic preparedness. As such, no specific budget for pandemic preparedness and resilience

was included in the 2018 NHS settlement. It nevertheless was, and is, a responsibility of the NHS to assess risks and ensure it has robust mitigation and contingency plans in place which includes pandemic planning.

53. The 2018 agreement covered only NHS England's budgets and therefore also did not cover the pandemic preparedness responsibilities of Public Health England (the primary responsible agency) or the Department of Health and Social Care. Both organisations are similarly responsible for their own internal budget allocations.

54. The DAs received funding uplifts through the Barnett formula in the usual way and remained free to allocate those (to health or to other areas of spending) as they wished.

HM Treasury's role in funding civil emergencies and its spending approach on health and care systems during Covid-19

Framework for provision of funding in civil emergencies

55. SRs generally cover only expenditure which can reasonably be planned in advance. Where unexpected pressures arise, in the first instance, Consolidated Budgeting Guidance sets out HM Treasury's expectation that all departments identify 5% of their allocated DEL that could be reprioritised to fund these. This can be made up of either having a list of contingency plans for how the department could reprioritise resources should it be necessary, by a Departmental Unallocated Provision ("DUP"), or a combination of the two.

56. As part of every SR, HM Treasury sets aside contingency for genuinely unforeseen, unabsorbable and unavoidable pressures. HM Treasury controls how this contingency – called the Reserve – is allocated. There is one Reserve for Resource DEL ("RDEL") and one for Capital DEL ("CDEL"). Access to the Reserve must be agreed by the Chief Secretary to the Treasury ("CST"), while the Reserve can also be augmented at subsequent fiscal events.

57. Consolidated Budgeting Guidance sets out the process that departments should follow if they wish to make a call on the Reserve. As well as proposing and discussing any alternative courses of action with their HM Treasury spending team as early as possible, departmental proposals for Reserve access must set out:

    a. The size of the pressure;

    b. The cause and why it is unforeseen;

    c. Any offsetting actions to manage down the pressure – including cutting costs, cutting inefficiencies, cutting unnecessary programmes and cutting lower priority budgets;

    d. The residual pressure; and

    e. Corrective actions they mean to take if Reserve access is granted.

58. If discussions conclude with no other alternative course of action identified, departments must submit a formal Ministerial letter to the CST with the support of their HM Treasury spending team. The drawdown of funding from the Reserve is then subject to an assessment of need, realism, and affordability at the time at which funds are released. Where the CST agrees to

provide support to a department from the Reserve, the amount may be repayable the following year by means of a reduction in the department's budget.

59. Though departments should always follow the Reserve process set out in CBG where possible, there are occasions where a department's request for access to the Reserve may need to be approved to a much shorter timescale. In such circumstances, HM Treasury can agree to allow the department to access the Reserve in principle without following the standard approval process. These requests will still need Ministerial approval during the Estimates process and funding will only be provided based on the need, realism, and affordability of the claim. HM Treasury relied heavily on this approach during the early stages of the Covid-19 pandemic.

60. Budgets and any associated cash allocated through the Reserve still require voting in Parliament at either Main or Supplementary Estimates for departments to receive access to this additional funding. If departments need to incur urgent expenditure ahead of it being voted in Parliament (and receiving Royal Assent), they can apply for a Contingencies Fund Advance ("CFA"). A CFA enables HM Treasury to make repayable cash advances to departments for urgent services, in anticipation of provision for those services by Parliament. HM Treasury may authorise issues out of the Fund subject to the limit set on the capital of the Fund by the Contingencies Fund Act 1974. The limit is fixed at 2 percent of the total of authorised Supply expenditure (i.e. the total of all authorised departmental net cash requirements) in the preceding financial year.

61. There are no special arrangements in place with Cabinet Office for funding civil emergencies, beyond the usual arrangements in place for all urgent and unexpected expenditure through application to the Reserve.

62. In the context of the Covid-19 pandemic, as funding requirements became apparent from early 2020 onward, HM Treasury examined in the first instance how resources might be reprioritised to meet the funding need and applied this principle throughout the pandemic, while also providing very significant amounts of additional funding to departments. This was primarily delivered by applying additional scrutiny to overall budget positions and identifying areas where the pandemic could reasonably be expected to create underspends (for example where the delivery of a project had had to be slowed and it would no longer spend its full budget for that year as a result). This approach protected the taxpayer by only increasing funding where needed, while ensuring HM Government's overall response at the height of the pandemic could flex rapidly to meet the needs of the moment. DHSC and NHSE received significant budgetary uplifts in this period, as detailed from paragraph 94 onwards.

63. The level of the Contingencies Fund was increased using primary legislation amending the Contingencies Fund Act 1974 in both 2020-21 and 2021-22 to ensure that departments could access cash advances for urgent services in a timely manner, ahead of formal voting in Parliament at Main or Supplementary Estimates. For 2020-21 the Contingencies Fund Act 2020 increased the percentage to 50% from the usual 2% (from approximately £11bn to £266bn). For 2021-22, the Contingencies Fund Act 2021 increased the percentage to 12% (from approximately £17.5bn to £105bn). In 2022-23 the Contingencies Fund returned to the usual 2% (approximately £15.1bn).

64. For DA funding in civil emergencies, Chapter 8 of the Statement of Funding Policy sets out the arrangements for the DAs to access the UK Reserve. In summary, access will be considered by HM Treasury ministers in exceptional circumstances where either:

    a. A UK Government department is granted access to the Reserve and a DA is facing similar pressures,

    b. A DA faces specific costs that cannot reasonably be managed without a major dislocation of existing services.

65. DAs must send a ministerial letter to the CST setting out their case. Access is judged on largely the same criteria as claims by UK Government departments but also considering the additional tools and powers available to DAs.

66. In 2020-21, the DAs were provided with an in-year funding guarantee of £16.8 billion. This meant that DAs could plan their response to the pandemic without having to wait for changes to UK Government departments' budgets to be confirmed and without them having to make a claim on the Reserve. This guarantee was initially set at £12.7 billion on 24 July 2020, exhibited as [CL3/012 INQ000399208, CL3/013 INQ000399210 and CL3/014 INQ000408783] and subsequently uplifted to £14bn on 9 October 2020, exhibited as [CL3/015 INQ000408784 and CL3/016 INQ000399212], £16bn on 5 November 2020, exhibited as [CL3/017 INQ000408785 and CL3/018 INQ000399214] and finally £16.8bn on 24 December 2020 exhibited as [CL3/019 INQ000408786 and CL3/020 INQ000399219]. For 2021-22 onwards, Covid-19 was largely taken into account through Spending Review settlements, so a further funding guarantee was not required.

67. Policy on health and care continued to operate as a devolved matter during the pandemic (for example, policy on eligibility for free testing was set by DAs). However a number of significant health spending programmes (e.g. vaccine procurement, testing) were delivered on a UK-wide basis in collaboration with DAs, and UK-wide budgets were set for lead HM Government

departments. Lead HM Government departments either conducted procurement and allocated inventory/capacity to DAs in lieu of Barnett formula funding (e.g. vaccines inventory, testing capacity), or made financial transfers to DAs, in line with the Barnett formula. This meant that in some areas of health spending during the pandemic, value-for-money and commercial judgements were in practice exercised at the HMG-level rather than being devolved. This was usually in areas where there were significant practical, speed or efficiency advantages from a UK-wide approach.

HM Treasury's approach to health and care spending during the pandemic

68. Covid-19 represented an unprecedented civil emergency affecting health and care systems, and necessitated a response by government also unprecedented in speed and scale. HM Treasury had to support decision making on significant expenditure and novel interventions for health and care systems at unusual pace and in a more uncertain environment than usual. This was due to the speed at which the pandemic unfolded, the pace at which global markets for health supplies moved, and uncertainty over the course and endpoint of the pandemic (including uncertainty over when pandemic-controlling pharmaceutical interventions would be available, and the impacts of virus variants).

69. HM Treasury continued to apply the principles of effective and efficient public spending in a consistent fashion throughout the pandemic, in line with its responsibility to deliver value for money for the taxpayer. That being said, there was a need to apply the spending framework in a more flexible way than would otherwise have been the case, in order to meet the spending requirements of the health response at the necessary pace. In March 2020 the HM Treasury Permanent Secretary wrote to all departments [CL3/003 INQ000399236] reminding them of the need to consider AO duties, the process for Ministerial Directions if control totals were likely to be breached and confirmation that spending teams would respond to requests for spending approvals related to the pandemic response with urgency and understanding. A Ministerial Direction is the formal process by which a minister may instruct a department's Accounting Officer to proceed with an activity or policy which, in the AO's judgement, does not comply with their duties as AO to ensure the Regularity, Propriety, Value for Money and Feasibility of all expenditure. Details of the AO's duties and the direction process are published in Chapter 3 of Managing Public Money.

70. In exercising its control of health and social care spending through the pandemic, HM Treasury broadly sought to balance four principles:

    a. Maintaining value for money for taxpayers, avoiding waste and driving efficiency;

b. Delivering the best possible outcomes for patients, care users and public health, in line with proposals from NHSE, UKHSA (and its predecessor organisations) and the social care sector;

c. Supporting AOs to ensure that government spending operated with regularity and propriety at all times; and,

d. Accounting for considerations on the health of the economy.

71. The key elements of this flexibility shown in applying these principles included:

a. Delegating more control to AOs in individual departments. As set out in paragraph 16, AOs still had to be satisfied at all times that spending decisions in their departments met the tests of value for money, regularity, propriety and feasibility set out in MPM. However, in the case of PPE and vaccines, increased delegation of control to the judgement of individual AOs allowed departments to act more quickly in response to emergency spending needs than would otherwise have been the case.

b. Providing more generous spending envelopes and delegated authorities than would normally be the case, specifically in relation to PPE and vaccines in relation to the pandemic period, again supporting more rapid decision making.

c. Reacting very quickly to spending requests where necessary, often within hours.

72. The relative weight of HM Treasury's considerations across the four principles driving decision-making shifted across the pandemic. At its most high-level, this shift can be characterised into three distinct but overlapping phases.

73. **Phase 1: March 2020 – May 2020.** At the start of the pandemic, outcomes for patients, care users and public health were the government's overriding priority, with the Chancellor committing to give the NHS 'whatever it need[ed]' to tackle Covid. Dimension b) therefore weighed heavily in HM Treasury's decision-making, although the 4 key tests of Managing Public Money – value for money, regularity, propriety and feasibility – remained fundamental. In this phase, spending decisions were often required at extreme pace, hence structures to facilitate these were relatively informal and collaborative across HMT/DHSC/NHSE. In this early phase it was therefore inevitable that the risk appetite of government was inherently higher with many of the decisions made involving HM Treasury requiring us to balance a proportionate level of risk to the taxpayer against risks to health outcomes. These spending decisions are outlined from

paragraph 94 onwards. Information and data from DHSC during this time was limited but the view of Ministers was that approvals for such spending measures should not be rejected on the grounds of an absence of data, due to the urgency of supporting health and care systems in responding to Covid-19.

74. **Phase 2: May 2020 – April 2021.** As incidence slowed, and overall costs increased, there was greater opportunity and need to ensure a balance between the interests of taxpayers and service users/public health. This was reflected in HM Treasury's approach to health and care spending, where we sought to put frameworks, improved data collection, formal governance and further controls around areas of major spending risk. This phase was also characterised by learning and adaptation. As time-limited approvals came to an end, we sought to improve scheme design, for example through contractual changes, refocussing resource and amending conditions. At this point, we also began to weigh economic considerations more heavily in decision making, for example where health and care spending could facilitate the reopening of business or education settings, and put increasing focus on longer-term system resilience, including the elective care backlog (paragraphs 122, 130, 143-4) and mental health (paragraphs 130, 189-202).

75. **Phase 3: April 2021 – October 2022.** Subsequent waves were characterised by an increasingly refined 'playbook' of spending responses, building on the learning outlined above. In peaks, patient and public health outcomes remained paramount, although the impact of newer mitigations such as testing and vaccines meant trade-offs between taxpayer and patient interests were less acute than at the start of the pandemic. Between peaks, increasing focus was put on preparing systems to return to pre-Covid spending arrangements and considering the most effective and efficient ways to rebuild system resilience, including the development of the Health and Social Care Levy to provide additional long-term funding.

76. Maintaining a flexible approach underpinned by fixed principles was not without its challenges. The chronological sections that follow will expand on these challenges in further detail but three challenges particularly increased the levels of risk involved in health and care spending decisions across the board. The judgement to accept this risk, given the 'emergency' context, was one taken by Ministers based on the best evidence and analysis available at the time.

77. Firstly, pace: this was particularly true of the first phase of our response when, for example, a competitive global market meant that hours mattered to ventilator/PPE contracting, or decisions to increase NHS bed capacity/workforce needed to come onstream before the projected peak. As a result, HM Treasury relied more heavily on AO judgements and conditions on spending approvals to reduce taxpayer exposure than would usually be the case, whilst still prioritising patient, public health and value for money outcomes.

78. Secondly, uncertainty: again, this was particularly the case in the first phase although, given the novel nature of many of our interventions, it persisted to an extent throughout. Recognising the need to accept a proportionate level of uncertainty in plans or evidence – albeit more than we would outside a crisis – was critical to spending decisions. To mitigate this, HM Treasury sought external evidence and forecasts wherever possible, and in later phases made these core parts of governance structures and funding conditions.

79. Thirdly, and in part a corollary to the above, incomplete information: HM Treasury will always be further from the frontline than delivery departments and organisations, and these stakeholders will typically advocate for spending on their priorities over other fiscal pressures. At times, this asymmetry, alongside the uncertainty explored above, meant that the level of information on which we would normally base spending decisions was not available. Delegating responsibility to AOs who were closer to the spend was a core mitigation here, as was information sharing. For example, at the start of the pandemic we held a call between senior officials in HM Treasury, DHSC and NHSE every weekday, which over time transitioned into more formal governance structures, better forecasting and live access to data tools such as the NHS Palantir database.

80. HM Treasury's response to these challenges therefore evolved across the pandemic. A number of lessons emerge in more detail over the coming sections but, at their most fundamental, support the conclusion that the significant flexibility facilitated by MPM allowed government to be highly responsive in its approach to health and care spending and system delivery in an 'emergency' context, whilst adhering to MPM principles. Whilst balancing the interests of taxpayers and public services is ultimately a judgement for Ministers, HM Treasury's structures allowed our response to meet demands and shift in line with wider government priorities across the pandemic. It enabled departments to take decisions rapidly in the best interests of patients, care users and public health, whilst safeguarding the fundamental need to deliver value for money and efficiency of spending.

Thematic account of decisions on health and care spending and policy

81. This section sets out HM Treasury's involvement in decision making during the pandemic on key areas of health and care. It is structured thematically, starting with a short overview of the epidemiological and policy context, and how this evolved over the pandemic. It then addresses headline spending decisions on overall DHSC and NHS budgets, followed by accounts of decision making on: electives and use of the independent sector, workforce, mental health, pharmacies, GPs, and enhanced discharge.

Epidemiological and policy context

82. In the run up to the Prime Minister's announcement of the first social distancing measures on **16 March 2020**, HM Treasury Ministers and officials' main contributions to cross-government decision-making on public health measures was via analysis of the possible economic impacts – in particular the potential supply shock to the UK economy of proposed health restriction measures – and involvement in initial isolation measures.

83. During April to June 2020, it became clear that the response to Covid-19 would be prolonged, NPIs would be in place longer than initially expected and continued support for the health and care system would be required. HM Treasury supported measures addressing the immediate needs of the health and care system as the UK experienced its first peak of infections, which are described from paragraph 116 of this statement.

84. Restrictions eased on **4 July 2020**. **Across July to November 2020**, HM Treasury officials contributed to work led by the Covid Taskforce on the strategic approach for managing the pandemic during autumn and winter. HM Treasury officials advised the Chancellor on a NHS Winter 2020/21 capacity package. This broad package included use of the independent sector and Nightingale hospitals, as well as extending the enhanced discharge policy to end of March 2021, introducing a 6-week cap on the NHS paying for care costs from September 2020.

85. In **December 2020** the vaccination campaign began. The main rollout of first and second doses to adults in England and the DAs took place over **spring and early summer 2021**.

86. Alongside responding to high prevalence, HM Treasury worked with the Covid-19 Taskforce **during summer 2021** to pull together a plan to help respond to potential challenges over the course of the autumn and winter, in what would become the "Autumn and Winter Plan for Covid" (delivering on the government commitment in July to assess preparedness for autumn and winter). The Autumn and Winter Plan was split into Plan A and Plan B, designed to manage

uncertainty around the path of the virus and pressures on the NHS. Plan A focused on vaccines and therapeutics, continued testing, and communications to encourage responsible behaviours. Plan B was created for a scenario in which the epidemiological picture had begun to deteriorate, where additional interventions necessary to reduce transmission. Plan B focused on introducing "lower cost" NPIs such as increased communications, the mandating of facemasks in some settings, mandatory certification in some settings and the return to working from home guidance if the epidemiological situation demanded it.

87. Over **summer 2021**, HM Treasury also worked with DHSC and No10 on a new tax to increase funding for health and social care over the next three years. The Health and Social Care Levy, based on National Insurance Contributions, was announced by the Prime Minister on **7 September 2021.**

88. On **14 September 2021** the Prime Minister announced the government's Autumn and Winter Plan for Covid, which was explicit in focusing on pharmaceutical interventions (vaccination, testing and therapeutics), only expecting NPIs (social and economic restrictions) to be used if data suggested further measures were necessary to protect the NHS.

89. On **16 September 2021** the NHS began the autumn booster vaccination campaign for vulnerable groups.

90. Following the publication of the Autumn and Winter Plan for Covid, HM Treasury ministers and officials continued to work on ongoing domestic Covid-19 policy response and winter preparedness. In **October 2021** cases began rising significantly and there was concern in government over whether vaccine protection may be starting to wane.

91. In parallel, work continued to optimise pharmaceutical interventions, such as daily contact testing, with the aim of shortening self-isolation periods.

92. During this time period, there were concerns over NHS Winter capacity due to the Omicron variant and the number of hospitalisations increasing over the time period. HM Treasury supported DHSC and NHSE with capacity management including use of the independent care sector and how it would be used under 'surge scenarios'. Work also continued to plan to tackle issues relating to the elective treatment backlog and how workforce measures could be used to support this.

93. In **November 2021** it was recognised that the Omicron variant was spreading rapidly in the UK, and the booster programme was accelerated and expanded.

94. In **February 2022**, the government published the 'Living with COVID-19 Strategy', which set out how England would move into a new phase of managing Covid-19, using vaccination as the key ongoing intervention, and establishing a trajectory towards managing Covid-19 in the same way as other respiratory infectious diseases.

Overarching spending policy

95. This section sets out the key decisions on overarching funding envelopes for health and care spending, key decisions on the underlying financial frameworks for DHSC/NHSE funding during the pandemic, and the collaboration and decision-making structures that enabled them.

96. HM Treasury's approach to these decisions was consistent with the principles and phases outlined in paragraphs 67-79.

97. Starting on 16 March 2020 there were calls every weekday evening between HM Treasury (the Health and Social Care Spending Team), DHSC, and NHS England. These meetings would run through the day's 'live' issues and provide an opportunity to work through where issues needed resolving between the three organisations. During the early days of the pandemic, they were a crucial forum for information-sharing and unblocking problems as needed. As the urgency of the initial response reduced after the first few months, the meetings became less frequent.

98. There were also regular Ministerial group meetings on a range of topics, including a 'Healthcare Ministerial Implementation Group' which served as a decision-making forum on key issues. CST attended those meetings on behalf of HM Treasury, with briefings provided by the Health spending team. Initially, those meetings were almost daily, providing a regular drumbeat of decision-making.

NHS Financial Framework

99. The 'NHS Financial Framework' is the term generally used to describe the set of rules and processes governing how money is distributed across the NHS, and how local areas are required to spend and account for it. For the relevant period covered by this module, the Financial Framework incorporated the NHS National Tariff, a set of prices and rules used by providers and commissioners of NHS care.

100. Senior HM Treasury officials met with DHSC and NHSE colleagues on the morning of 16 March 2020 – a note of which is attached as exhibited as **CL3/003** INQ000399236] – to discuss revised guidance planned by NHSE - moving to a system of block contracts (instead of activity-based payment), in order to simplify financial arrangements and provide certainty for

Trusts and Clinical Commissioning Groups (CCGs). This would support NHS trusts to make critical prioritisation decisions without concern for the impact that changing the types of activity they were delivering would have on their finances.

101. HM Treasury officials recognised the value of the approach, but had concerns about how NHSE proposed to implement it in practice. In particular:

a. The proposed commitment to cover 'reasonable costs' was very broad, with no clarity as to how it would be defined and assessed in practice;

b. The move to block contracting was open-ended, with no built-in stage at which to review the arrangements.

102. The proposals also removed the elements of the financial framework which underpinned efficiency and productivity improvements; as such, they could be expected to generate significant long-run additional costs.

103. Following further discussion NHSE colleagues agreed to:

a. Clarify the checks and balances that would be put around the commitment to reimburse additional costs;

b. Set an initial end-date for the guidance of July, at which point it would be reviewed.

104. DHSC and NHSE planned to proceed with issuing the guidance that evening – on that basis, a 'for information' note setting out NHSE's plans and their potential fiscal implications was drafted by the Health Spending Team and sent to the CST [see exhibit CL3/021 INQ000399236]. The guidance was subsequently published by NHSE; formal approval from HM Treasury for the changes was not sought.

Funding Commitments and Main Estimates 2020

105. As part of the Spring Budget on 11 March 2020, HM Government announced a £5bn fund to support public services response to Covid-19. This included provision for the NHS as set out in [CL3/022 INQ000412011]. When the Chancellor delivered his Spring Budget speech, exhibited as [CL3/023 **INQ000236913**]o the House of Commons on 11 March 2020, he committed to provide the additional resource needed for the NHS to respond to Covid-19. On 28 March 2020 DHSC sought a Ministerial Direction authorising spend in excess of control totals. Despite this, DHSC did not breach its control totals for FY 19/20, reporting a £444m RDEL underspend. On

13 April 2020, HMG announced that the NHS would be receiving £6.6bn for its response to Covid, exhibited as [CL3/024 INQ000408788].

106. To help manage cashflow issues in advance of the relevant Supply Estimates, a Contingencies Fund Advance of £25 billion was paid to DHSC on 29 June 2020, exhibited as CL3/025 INQ000408789. A further Contingencies Fund Advance of £34 billion was paid to DHSC on 18 December 2020 see exhibit ([CL3/026 INQ000412017.])

107. Although commitments had been made to give DHSC significant amounts of funding to support the pandemic response, exhibited as [CL3/027 INQ000412027], the numbers included in Main Estimates were relatively small. This was at the request of DHSC, in light of the fact that the commitments were largely open-ended, and the timelines for approving Main Estimates did not allow for the numbers to be worked through in sufficient detail.

108. As such, it was agreed that the necessary transfers of funding, with a few small exceptions where numbers were known and fixed, would be transferred at Supplementary Estimates.

109. There was a significant increase in capital funding (c £1.2bn) added to the DHSC total at Main Estimates in line with an agreement made with DHSC in September 2019 – exhibited as [CL3/028 INQ000412048] - to provide additional funding over multiple years for diagnostics and delivery of new hospital infrastructure. Smaller increases were made for R&D, small Covid-19 measures and car parking. NHS Operational Capital budgets were also uplifted to ensure budgets remained at the same level as 2019/20 where a £1bn increase was allocated in-year.

110. The additional capital funding was provided on condition of reforms to the capital regime agreed at the end of the previous year.

NHS Mandate

111. The NHS Mandate is an annual document setting out HM Government's priorities for the NHS to deliver. It has statutory weight and has to be published before the start of each financial year.

112. In March 2020, DHSC approached HM Treasury with a proposal to significantly slim down the NHS Mandate [CL3/029 INQ000412010] that was due to be published shortly, on the basis that it would no longer be realistic to expect the NHS to deliver all the commitments it would otherwise have been asked to.

113. It was envisaged that this would be an 'interim' mandate, with an updated version to follow later in the year once the implications of Covid-19 were clearer and the NHS could be set a more realistic set of objectives.

114. HM Treasury's primary concern was that the proposal included removing all reference to the 'Five Financial Tests' which had been agreed as part of the NHS Long-Term Plan and were designed to ensure that the five-year funding settlement agreed in 2018 was spent wisely (see paragraph 50 for detail on the tests). There was a clear need in this scenario to provide some level of protection for taxpayers in the context of huge uncertainty about potential outlays of public funds.

115. While it was recognised that the tests would be difficult to deliver during the immediate response to the pandemic, HM Treasury officials had significant concerns about removing all reference to them entirely. HM Treasury Ministers agreed to clear the publication of the document only on the condition that a reference to the five financial tests be included, as set out in exhibit [CL3/030 INQ000399197].

116. The mandate was therefore updated to be clear that HM Government remained committed to the tests, and that reporting against them would resume once the immediate pressures from the pandemic had passed. The Mandate was published on 25 March 2020 in the document exhibited as [CL3/031 INQ000399198].

Subsequent negotiations on the financial framework

117. In line with the approach agreed in March, HM Treasury officials worked with NHSE and DHSC officials during the Spring and Summer of 2020 to agree revised guidance for July to September. At the same time, we agreed both the amount that needed to be reimbursed for the previous 3 months, and a forward-looking budget. Advice provided to HM Treasury Ministers on 22 May 2020, exhibited as [CL3/032 INQ000327536] set out a range of expected asks from the NHS, including on overall funding and surge capacity. The advice set out the key spending decisions that were expected to come up over the subsequent six months and the potential costs, and provided HM Treasury's best estimates on what was being spent by the NHS above their baseline on acute and community capacity (c.£4bn a month).

118. After discussions between DHSC, No10 and HM Treasury over plans for additional NHS capacity, the Chancellor wrote to the PM on 19 June 2020. He reiterated HM Treasury's commitment that the health service would 'get whatever it needs to respond to Covid' but explained how HM Treasury had concerns about the NHS £15bn bid in which several assumptions lacked sufficient evidence. On the question of demand, the Chancellor pointed out

that during April's peak little more than half the beds in hospitals were occupied and the Nightingales only saw a few hundred patients. HM Treasury also had concerns that the NHS plan would be undeliverable, for example, it would require the recruitment of at least 33,000 new staff. The Chancellor proposed an alternative proposal which included extending the Nightingales in case of a surge in Covid cases and agreeing new contracts with the Independent Sector for beds.

119. The PM subsequently commissioned DHSC and HM Treasury to work together to agree specific measures and investments to manage NHS capacity for the upcoming winter. The Chancellor approved the new plan to deliver the capacity that the NHS required, and the CST was advised by HM Treasury officials to approve the associated costs of up to £3.6bn including £526m for the extension of Nightingale contracts and up to £1.9bn for the continuation of Independent Sector contracts exhibited as [CL3/033 INQ000412015].

120. NHS England then provided proposals, exhibited in the financial framework at exhibit CL3/034 INQ000412028 for how much money they thought was needed in total, at that stage estimating a funding gap of £22.5bn. These incorporated both summaries of the money spent to date (with projections for what that meant for future spending) and assessments of the loss of both productivity gains and external income which would push up the financial burden on NHS trusts.

121. A series of meetings between HM Treasury, DHSC and NHSE were held over a number of weeks, focused primarily on refining the estimated costs and testing the assumptions behind them. Discussion points included the extent to which funding had been freed up by the need to pause broader NHS programmes (for example transformation programmes) as a result of the pandemic, and could therefore offset some of the additional expenditure needed, and whether there were elements of duplication in the proposals shared by NHSE, for example whether PPE costs that had been incurred directly by the NHS in some areas were already captured in the budgets set for PPE more broadly. HM Treasury's primary interest in these discussions was ensuring value for money for taxpayers in the use of public money.

122. Discussions also focused on the extent to which the NHS could increase activity in non-emergency care, including elective care, to limit the increases to care backlogs which were of increasing concern, and the best financial mechanisms for supporting systems to do so. This would ensure the delivery of the best outcomes for patients and care users.

123. Similar discussions were held in the Autumn of 2020 and it was ultimately agreed that the NHS would be provided with a further £19bn at Supplementary Estimates.

124. Following the 2020 Spending Review, negotiations were held in the Spring of 2021 on how much additional funding the NHS might need for the Covid-19 response above the SR settlement, and additional funding of £6.6bn for the NHS was announced on 18 March 2021 to cover the first half of 2021.

125. In the Summer of 2021, discussions on funding for the second half of the financial year were held, alongside negotiations on the Health and Social Care Levy.

126. On 6 September 2021, the Government announced the agreed settlement for the second half of 2021-22 totalling £5.4bn, broken down as:

a. £2.8 billion for COVID-19 costs including infection control measures
b. £600 million for day-to-day costs
c. £478 million for enhanced hospital discharge
d. £1.5 billion for elective recovery, including £500 million capital funding.

127. The introduction of Integrated Care Systems and other changes under the Health and Social Care Act 2020 from July 2022 meant that there was never a full move back to the pre-pandemic system.

Spending Review 2020

128. The Spending Review in 2020 was initially planned on the basis that it would allocate multi-year settlements to departments. Evidence notes were submitted by DHSC during the week commencing 24 September 2020, summarised in the letter at [CL3/035 **INQ000087455** on that basis, covering spending plans up until 2023/24. However, given the uncertainty created by the pandemic the decision was taken in October that the SR would instead only set budgets for one year.

129. Given that the NHS's core RDEL budgets had been set in 2018, the focus of RDEL discussions between HM Treasury and DHSC was on what additional funding would be required in response to the pandemic, looking ahead to what the main pressures might be over the next year, while recognising the inherent uncertainty. HM Treasury's focus was on balancing ensuring sufficient funding certainty with the need to avoid costs spiralling beyond what would be affordable for the public purse.

130. The RDEL settlement, exhibited at [CL3/036 INQ000399223] allocated £20.3 billion to DHSC for Covid-19 spending, comprised of:

a. £15 billion for NHS Test and Trace,

b. £2.1 billion for PPE,
c. Around £1.5 billion for pandemic-related NHS pressures,
d. £1 billion to begin tackling the NHS elective backlog,
e. Around £500 million to target the backlog in clinical mental health services and to separately support the wellbeing of the NHS workforce, and
f. £163 million for Covid-19 medicines and therapeutics.

131. Whilst the one-year settlement would apply across all RDEL and most CDEL budgets, the agreement on multi-year funding for the New Hospitals Programme (£3.7bn from 2021/22 to 2024/25) was to be protected as an exception and allocated as a multi-year settlement as previously agreed.

132. For capital funding the 4-year settlement for the New Hospital Programme announced by the Prime Minister at the start of October was confirmed and an additional multi-year settlement totalling £1.7bn was given for investment in NHS hospital upgrades.

133. Other capital budgets were uplifted for NHS maintenance, tech and digital, R&D and diagnostics whilst £165m was allocated for the eradication of mental health dormitory accommodation across the NHS estate following a pledge to spend over £400m in the next four years, backed by an initial £165m for 2020/21 at the SEU.

134. Funding was rolled over for primary care, the disabled facilities grant, health improvement, UKHSA maintenance, and a 1-year settlement of £129m was given to make progress on the Science Hub conditional on DHSC carrying out a value for money review of a delivery options at Porton Down.

135. The settlement represented the largest real terms budget for health capital since 2010, but major decisions on Covid-19 funding were deferred.

Supplementary Estimates 2020

136. As set out above, very little of the additional Covid-19 funding agreed for DHSC had been transferred at Main Estimates, which, combined with the high volume of additional spending requests agreed in the intervening period, meant that Supplementary Estimates was the point at which the amounts spent up to that point and likely to be spent over the remainder of the financial year needed to be formally agreed.

137. HM Treasury's focus through this process was on ensuring that DHSC had the money they needed to deliver an effective response, whilst applying sufficient scrutiny to avoid money being

allocated unnecessarily and ultimately wasted. There were therefore extensive discussions on the assumptions underpinning DHSC's requests for additional funding to make sure they represented central estimates and took into account areas of potentially offsetting slippage across the Department.

138. DHSC were ultimately allocated an additional £55.9bn of RDEL at the Supplementary Estimate, as set out in exhibit [CL3/037 INQ000418977].

139. As well as confirming capital funding awarded as part of the Supplementary Estimates process, additional capital funding which had been agreed through the year, primarily for the response to Covid-19 was confirmed. Covid-19 funding covered NHS investment in IT (c£600m), ventilators and critical care equipment (c£450m), Covid-19 testing capacity (c£2.7bn), and R&D related investment (c£130m). In addition, DHSC surrendered c£700m CDEL which they had underspent, primarily on NHS budgets through the year, meaning in total DHSC were allocated £4.7bn CDEL at Supplementary Estimates bringing their total allocation to £12.9bn.

140. Through the process of agreeing the Estimate, it became clear that DHSC had, in a small number of areas, incurred spend without having sought or received the necessary approvals from HM Treasury at the time. DHSC were therefore seeking retrospective approval for that spending, as well as the additional funding needed to cover it. Whilst recognising that decisions had been taken at pace in a challenging environment, HM Treasury ultimately took the view that retrospective approval should not be provided, as we could not confidently say that approval would have been recommended had it been sought prospectively. This resulted in around £1bn of spending being classed as 'irregular' (i.e. not having the necessary approvals in place), which contributed to the qualification of DHSC's 2020-21 accounts by the National Audit Office. This reasoning for this decision was set out in a letter from CST to DHSC SoS in January 2021, exhibited as [CL3/038 INQ000412030]. Here, the CST expressed concern that Treasury controls had been ignored in a number of cases, including but not limited to: the funding for community pharmacy (which is covered separately below), enhanced discharge, and dental charges. The letter emphasised that these were the most recent and significant examples, but that CST had also been disappointed over the past year by: (i) the lack of timely data or evidence to support proposals (ii) the Department's approach to meeting conditions, and (iii) the repeated announcements of new spending before HM Treasury approval has even informally been sought.

Health and Social Care Levy

141. In the Summer of 2021, HM Treasury worked with DHSC on the development of the Health and Social Care Levy, which was part of a long-term solution to fund health and social care in

the UK. It was to be funded initially by a temporary 1.25% increase in National Insurance contributions (NICs) until 2023. From April 2023 onwards, the NIC rates were to decrease back to 2021-2022 tax year levels and would be replaced by a new 1.25% Health and Social Care Levy, where the revenue would be ringfenced to support UK health and social care bodies.

142. This process effectively brought forward discussions which would normally be had at a Spending Review, as decisions on the amount of funding to be raised from the Levy needed to be informed by a robust assessment of how much funding would be needed.

143. Negotiations took place involving HM Treasury, No.10, DHSC, and NHS England, with a particular focus on what progress could be made on the elective backlog. This is set out in the letter exhibited as [CL3/039 **INQ000270097**

144. The Levy and the accompanying funding settlement were announced on 7 September 2021 in the statement exhibited as [CL3/040 INQ000257025], with a commitment to spend more than £8 billion on tackling the elective backlog in the three years from 2022-23 to 2024-25, enabling the NHS in England to deliver around 30 per cent more elective activity by 2024-25 than it was before the pandemic, after accounting for the impact of an improved care offer through system transformation, and advice and guidance.

145. The Levy settlement also made provision of £9.6bn over 3 years (before Barnett) for ongoing Covid-19 spending such as vaccines procurement and deployment, testing, some UKHSA 'core' funding, and PPE storage and disposal costs (in late 2021, further provision was made for vaccine procurement and antiviral drugs in the SR period, to be funded from the Reserve).

146. Whilst the Levy was subsequently repealed in 2022, the accompanying funding agreement for the NHS and for DHSC was maintained.

Spending Review 2021

147. The agreements reached as part of the Health and Social Care Levy meant that the RDEL funding settlement for the SR had effectively been pre-agreed, though the envelope increased slightly as a result of new forecasts for the revenue from the Levy.

148. As set out in DHSC's funding settlement letter from CST on 2 March 2022, exhibited as [CL3/041 INQ000412036], multi-year settlements for New Hospitals and Hospital Upgrades that had previously been agreed were reconfirmed and funding for NHS estate maintenance was maintained, alongside a large new front-loaded package of £5.9bn over three years for NHS capital to aid the elective recovery. This package covered diagnostics (£2.3bn), NHS tech

(£2.1bn) and investment specifically in projects to aid the elective recovery such as new surgical hubs and hospital reconfigurations (£1.5bn).

149. The R&D budget for health was given a significant backloading uplift to reach £2bn in 2024/25 whilst other budgets for social care grants and UKHSA maintenance were maintained at a flat level.

Living With COVID-19 Strategy 2022

150. In early 2022, HM Treasury officials worked with DHSC, the CO Covid-19 Taskforce and No10 to agree the 'Living with COVID-19 Strategy', which was published on 21 February 2022. This strategy marked a significant milestone in the government response to Covid-19 and set out a plan for eventually managing Covid-19 in the same way as other respiratory infectious diseases, underpinned by the ongoing use of pharmaceutical interventions (principally vaccines). It was the collective judgement of Ministers at the time that the balance between health need and taxpayer considerations had shifted significantly from the previous period, due to the changed epidemiological and hospital capacity picture following the vaccination campaign, which had included managing the Omicron wave largely through vaccination. The strategy acknowledged the very significant cost to the taxpayer of Covid-19 health programmes such as the testing programme, and it was accordingly announced that government spending on Covid-19 would reduce significantly.

151. In the process of agreeing the strategy, HM Treasury Ministers agreed in February 2022 – as exhibited at [CL3/042 INQ000399233] - that £941m would be added to UKHSA's SR21 allocation for 2022/23, funded from within existing DHSC 2022/23 control totals. In March 2022, it was agreed that a further £120m could be added to UKHSA's 2022/23 settlement: this represented final ring-fenced settlement of £2,629m for UKHSA in 2022/23. This is exhibited as [CL3/043 INQ000412037].

Electives and independent care sector

152. Given the capacity pressures on the NHS during Covid, DHSC's approach was to increase usage of the Independent Sector ("IS") as an additional capacity resource to provide urgent, non-Covid care and to support elective activity where possible. Independent Sector beds are generally more expensive but allowed for increased capacity at a time where we did not know what the eventual pressures would be.

153. Following advice from officials on 20 March 2020, exhibited as [CL3/044 INQ000412012], HM Treasury approved an NHSE plan to access circa 8,000 beds in the independent sector for

patients with COVID-19. Estimated costs were at c. £345m per month – a contract length of 3 months was suggested, at a projected cost of over £1bn.

154. On 27 May 2020 CST received advice, exhibited as CL3/045 INQ000412016 from senior officials to roll over existing contracts for IS capacity, in response to acute concerns over bed capacity across the NHS system. Since March 2020, HM Treasury officials had consistently been requesting increased access to data from NHSE including on unit costs and activity data for utilisation of the IS, to ensure strong value for money. CST expressed concerns that the low occupancy (c 20%) in the IS did not justify the contract, and recommended obtaining views from the Chancellor on this decision.

155. The Chancellor's office asked HM Treasury officials to judge the consequences if the Independent Sector Provider ("ISP") contracts were not rolled over. HM Treasury seniors provided a risk assessment of contract termination which would see c.6000 beds lapse at the end of June 2020. The Chancellor was advised that there was a risk of having to support more expensive options as a substitute to the ISP contract.

156. Following this assessment, the Chancellor decided that the independent sector providers' contracts should be rolled over but that feedback should be given to DHSC around the information required to steer decisions to enable better understanding of how taxpayers' money is being used. On this basis CST agreed to the three-week roll over (26 June – 17 July) to consider more fully the capacity requirements for the system over the coming months. HM Treasury officials also wrote to NHSE and DHSC, exhibited as [CL3/046 INQ000412056], to communicate that the Chancellor and CST were disappointed not to have a better understanding of how taxpayers' money is being used. At each stage thus far, and subsequently, HM Treasury attached stringent conditions to funding to ensure ministers were given advice on any new contracts and the chance to scrutinise data on use of the IS, to ensure value for money.

157. On 17 June 2020 the CST was briefed regarding IS capacity – namely, that NHSE had failed to share critical data for decision making on funding for the IS. The briefing is exhibited as [CL3/047 INQ000412038]. CST was advised that some capacity was being used under the ISP contract but that occupancy was still low overall. HM Treasury had received some data on IS usage, but obtaining comprehensive data from NHSE was still proving difficult. CST was also informed that No10 had indicated that they had seen data showing that IS bed usage in the week prior was 17.4%, with occupancy of chemotherapy, diagnostic and day case capacity at 35%.

158. HM Treasury officials therefore recommended a daily roll over to give the Prime Minister more time to consider a way forward on NHS capacity. A daily rollover would cost £7.4m per day (excluding DAs) based on NHS costings of £230m for July. This approach was accepted by CST on 23 June 2020.

159. On 11 August 2020, in response to pressing from HM Treasury for greater value for money, there was communication from NHSE to HM Treasury which evidenced more effective ISP contracts. The aim was to achieve better value for money by amending contracts to move from 'block booking' arrangements to a cost and volume contract with a few specific providers to allow flexibility in areas of lower demand and for local negotiations in areas of high cost (primarily central London). Contracts with twelve providers were terminated with a one month notice period to enable transition back to local commissioning arrangements. This document is exhibited as [CL3/048 INQ000412018].

160. In September 2020, new national arrangements were negotiated to secure independent sector capacity until December 2020 to continue to support elective recovery. HM Treasury officials scrutinised changes to IS contracts at each stage and discussed any changes in length to ensure robust contracts were in place to meet the objectives of the contract.

161. In order to ensure ongoing accountability for independent sector spending, and better value for money, HM Treasury officials continued to request data from NHSE and NHSI regarding activity and costing in the independent sector. For example, spreadsheets were shared with DHSC and HM Treasury on 22 September 2020, exhibited as [CL3/049 INQ000412020]. This showed the cost of each Independent Sector Provider on month-by-month basis to be c.£241m in April 2020, c.£207m in May 2020, c.£199m in June 2020 and c.£177m in July 2020 with activity data showing c. 1,086,441 patients treated during this period.

162. Between April to October 2020, KPMG, on behalf of NHSE, communicated with HMRC on issues of VAT payments on health services contracted to the independent sector providers. These conversations and negotiations had no impact on the delivery of health services as the negotiations were conducted in parallel.

IS contract next steps

163. On 8 December 2020, NHSE requested an interim extension to the existing national IS contract, to ensure additional capacity during Winter. Officials advised that they had significant concerns about the value for money being achieved due to the under-usage of contracts. However, on balance they recommended that the potential patient safety risks of repatriating during a second wave meant that the contracts should be extended, exhibited as [CL3/050

INQ000412024], CST indicated a preference for a one-month extension, [CL3/051 INQ000412025], but was concerned that the procurement framework was not yet in place and that NHSEI had not included DHSC in discussions.

164. Following advice from officials at the end of January 2021, exhibited as [CL3/052 INQ000412031], HM Treasury approved an additional £115.5m at Supplementary Estimates – exhibited as [CL3/053 INQ000412063] - for ISPs, with conditions on sharing data around weekly bed occupancy and planned vs. actual performance, as well as details of the steps NHSE/I were taking to increase usage, alongside lessons learned.

165. From April 2021 there was a return to local contracts rather than national guaranteed capacity. DHSC shared NHSE's "NHS-IS COVID Response Lessons Learnt Review", exhibited as [CL3/054 INQ000412033], which was specifically prepared for HM Treasury following extensive reflections and interviews including seventy stakeholders.

166. This review identified six key learning themes to enable future NHS-IS collaboration should support be required from the sector. Recommendations included focus on developing and maintaining strong working relationships at all levels, inclusive leadership (for example, system level leads, national NHS clinical lead for elective recovery programme), opportunities to increase productivity, understanding the capacity and capability of whole health economy, data driven insights, and effective surge management.

167. Following advice on 7 January 2022, exhibited as [CL3/055 INQ000412035], HM Treasury approved NHSE's proposed national contract with the Independent Sector to increase NHS capacity over winter. This is exhibited as [CL3/056 INQ000412074]. The surge contract had two elements to underpin good value for money under both 'non-surge' and 'surge' scenarios, with a minimum income guarantee to independent sector providers alongside incentives for NHS activity depending on whether 'surge' or 'non-surge' scenarios materialised. The DHSC Secretary of State issued a Direction for this contract, which is exhibited as [CL3/057 **INQ000270153** – given the uncertainty regarding whether this capacity was needed and the risk of nugatory (e.g. unnecessary) spending a direction was sought on value for money grounds.

168. On 30 March 2022, HM Treasury received confirmation from DHSC, exhibited as **CL3/056** INQ000412074], that the national arrangements with 10 IS providers ended after 31 March and that contracting would revert to local commissioning, as was the case prior to the pandemic.

Nightingale Hospitals

169. The proposal to build a temporary hospital in the Excel Centre in London was first mentioned to HM Treasury in late March 2020, and discussed briefly in the daily call between HM Treasury, DHSC and the NHS on 24 March 2020. A note of this call is exhibited as [CL3/059 INQ000412044].

170. On 26 March 2020, NHSE indicated on the daily call that they were looking at putting in place between 5 and 10 field hospitals. At that stage, DHSC were working on what the costs would be, including on the basis that some of the work would be done by the military. On 30 March 2020, NHSE communicated that they had signed contracts for three sites, and were looking to put in place a further two that day. This is exhibited as [CL3/060 INQ000399202].

171. The hospitals were set up without HM Treasury approval for the spending, or formal agreement to proceed. This did not have any practical implication for the building of these hospitals but did mean that DHSC were spending at risk and had to return to HM Treasury for retrospective approval.

172. A paragraph updating the Chief Secretary on the initial costings that had just been received from DHSC was sent on 9 April 2020 (exhibited as [CL3/061 INQ000412047]) – at that stage, costings of c£230m for set-up and £70m per month running costs, not including staff. However, DHSC were highly uncertain of these figures. Updates and further information continued to be provided throughout April, as set out in the figures at exhibit [CL3/062 INQ000399203]. HM Treasury did not receive firm costings for the Nightingale Hospitals until late April, as exhibited at [CL3/063 INQ000399204].

173. On 5 May 2020 a further update was sent to the CST and Chancellor, setting out that we still had yet to receive sufficient detail on the costs and operation of the Nightingale Hospitals to be able to provide HM Treasury clearance. That advice set out that, while we accepted the in-principle case for the hospitals, further detail would be needed before we could provide retrospective approval for the spend incurred. The advice is attached as exhibit [CL3/064 INQ000412013].

174. A request for retrospective approval of the funding costs was received on 13 May 2020. This is exhibited as [CL3/065 INQ000412058]. HM Treasury approval for the set-up and initial running costs of the Nightingale Hospitals was provided retrospectively in July 2020. This document is exhibited as [CL3/033 INQ000412015].

175. Over the winter of 2020-21, various Nightingale Hospitals were re-opened or placed on standby at various points – these decisions came to HM Treasury for approval in advance. The CST stated that he would be content to approve the reopening of Nightingales if the NHS were

able to provide sufficient evidence of genuine need. While he approved the reopening and extensions of the Exeter, Manchester and London sites, he opted to not to approve the reopening of Birmingham because data at the time was showing a reduction in infections in the Midlands and therefore it was unclear whether capacity would be required.

Workforce

176. In March 2020, in response to Covid-19, DHSC introduced a number of measures which were intended to increase the supply of the NHS workforce, as well as support current NHS staff.

177. The measures that were announced included offering re-registration to nurses, midwives and nursing associates whose registration had lapsed in the last three years; offering nursing students employment as Healthcare Support Workers; and, options to accelerate the registration of student doctors. These measures were supported by HM Treasury, which approved the associated costs on 20 March 2020. The relevant advice is set out as exhibit [CL3/066 INQ000412068].

178. As these measures included a number of retired workers returning to the workforce, there were proposed changes to the NHS Pension Scheme (and a number of other public sector pension schemes), which included waivers of abatement rules. CST published a Written Ministerial Statement to Parliament – exhibited as [CL3/067 INQ000399196] - setting out these changes on 22 March 2020.

179. HM Treasury also approved spending for measures designed to support current NHS staff, relating to the terms and conditions of their employment. These included removing the disparity between pay terms for those on sick leave and those self-isolating; removing the pre-authorisation for overtime; and, providing support to outsourced staff such as facilities and waste management who were required to self-isolate. The cost of these measures, estimated to be c.£130-230m per month, was approved by HM Treasury.

180. In response to staff unions raising a number of issues around Covid-related absences, with CST's agreement, HM Treasury asked DHSC to ensure that they were supporting NHS staff to stay at work wherever possible and that messaging to NHS Trusts was consistent with the government's wider approach on the management of school closures. This document is exhibited as [CL3/068 INQ000408791].

181. In April 2020, the CST agreed to the temporary voluntary transfer of Department for Work and Pensions ("DWP") contracted clinicians to support the NHS as part of the Covid-19

response. This is exhibited as **CL3/067** INQ000399196]. Normally, this group of registered health professionals provide health assessments to determine the entitlement of welfare claimants with health conditions to different levels of benefit. However, in April 2020, the majority of DWP's health assessment activity was cancelled due to DWP's inability to conduct face-to-face health assessments. As a result many clinicians had no role to perform, whilst also being paid and so it represented good value-for-money for them to be seconded to the NHS.

182. Following the successful deployment of this group in April 2020, in February 2021, DHSC requested the redeployment of around 60 DWP contracted clinicians to the NHS for 3 months to help address significant workforce capacity issues. HM Treasury officials expressed concerns about the proposal, given that the installation of a new telephone-based system for DWP health assessments meant there was excess demand for clinicians to work through the backlog of health assessments. DWP officials estimated that losing 60 clinicians for three months would have led to a reduced capacity of 4,300 health assessments per month, with an attached cost to the Exchequer of c.£12m across a 5-year period.

183. HM Treasury officials' view was that this cost impact was disproportionately high for relatively few clinicians and did not represent value for money. Seconding these staff would also have undermined DWP's ability to tackle their assessment backlog, which was a major delivery risk for the department at the time. Following advice from officials to Ministers on 4 February 2021, exhibited as [CL3/070 INQ000412045], HM Treasury rejected the request. The refusal is exhibited as [CL3/071 INQ000412066].

184. In January 2021, DHSC requested approval for funding of £113m to deploy final year student nurses in England as part of the Covid-19 response. These were paid placements for a period of 12 weeks. During the first wave in 2020, around 70% of eligible students took up the roles. The assessment by DHSC's officials was that by deploying student nurses, capacity could be reduced quickly as necessary, within 3-4 weeks. Other proposals and options, such as hiring more healthcare assistants, were also considered but they would have taken longer and would have resulted in longer-term pay implications. On 19 January 2021, HM Treasury officials sent advice to the Chief Secretary – advice exhibited as CL3/072 INQ000412067 - who approved funding subject to a number of conditions, including that roles are limited to 12 weeks and that DHSC provided periodic updates as to how many student nurses had signed up. The approval is attached as [CL3/073 INQ000412064].

185. In April 2021, DHSC and Health Education England (HEE) requested additional funding for 2021/22, and approval to spend in the region of £140-£380m RDEL, with a central estimate of

£290m RDEL, and £11.3m CDEL, for missed clinical placements as part of medical, clinical and dental training in England.

186. Clinical placement training had been disrupted as a result of Covid-19 – placements in England were cancelled and some trainees redeployed to support the response. Additional placements and postings needed to be made available in order to avoid losing any of the future workforce.

187. On 21 April 2021, HM Treasury officials sent advice to CST recommending approval for spend only, setting out that DHSC must manage costs within existing budgets, and make wider efficiencies and reforms to ensure this was affordable. This advice was based on consideration of the costs being uncertain, the wider context of DHSC and NHS' 2020/21 budget underspends, and because DHSC spending priorities should be agreed during the Spending Review process. CST agreed with this advice, which is exhibited as [CL3/074 INQ000412065].

188. On 30 April 2021, DHSC announced a temporary pause on the travel of nurses from India to England for one month, with a review at the end of May 2021. The intention behind this decision was to minimise the spread of Covid-19 due to outbreaks in the region at the time. DHSC requested approval to spend c£400k RDEL as one-off ex-gratia payments of £400 to compensate each nurse affected by the pause. At the time, the NHS recruited around 1,000 nurses from India each month.

189. It was proposed that this funding would come from the international recruitment part of the budget for the 50,000 additional nurses manifesto commitment, a budget that was already facing pressures. Following advice from officials on 14 May 2021, exhibited as [CL3/075 INQ000412070], HM Treasury approved this request. From 12 June 2021, the travel ban in respect of recruiting nurses to the NHS was lifted.

Mental Health

190. Mental health was an important element of the health system's response to Covid-19 – both in terms of mental health challenges faced by the general population, and those faced by the health and care workforce. As in other areas, in considering spending requests, HM Treasury looked to be flexible in its approach to funding while maintaining the principle of delivering value for money for the taxpayer.

191. In March 2020, DHSC sought HM Treasury permission for an imminent announcement to provide the mental health charity MIND with a £5m grant to expand one-to-one support for

people experiencing mental health problems, and enable the mental health charity sector to scale up its short-term Covid-19 support. This included bolstering helplines, online peer-to-peer support, and sharing of information on social media platforms.

192. MIND was selected by DHSC on account of the leading role the charity had played coordinating a response to Covid-19 across the mental health sector. It was agreed that £260k would go to MIND for administering the grant scheme, and the rest would be distributed across the sector. The grant was for one year, and was subject to conditions set by DHSC, with the department responsible for monitoring and scrutinising the spending decisions.

193. On 28 March 2020, HM Treasury approved this funding, on the condition that, if any further funding was needed for mental health charities, it should be explored through wider support for the voluntary sector. The approval is exhibited as [CL3/076 INQ000412071].

194. On 23 November 2020, DHSC sought HM Treasury approval for a range of policies in the Mental Health Winter Plan, exhibited as [CL3/077 INQ000399201]. These policies included enhanced discharge for mental health and outreach to increase flu vaccine uptake for those with serious mental illness, at a combined estimated cost of £54.45 million. DHSC wanted to announce the plan in 3 days' time.

195. DHSC proposed funding these policies from underspends, despite the department's substantial claim in the supplementary estimates process at the time. Further, DHSC and NHSE had not included these requests in their wider proposals on winter capacity where HM Treasury had agreed an additional £205m in the previous days.

196. On 20 November, HM Treasury confirmed that it was not content to approve this, as the request should have been made within the wider NHS capacity bid, where HM Treasury was not made aware of any underspends within DHSC's budget. HM Treasury's view was that in the first instance, underspends should be used to offset the significant pressures elsewhere in DHSC's budget. The relevant documents are exhibited as [CL3/078 INQ000372799] and [CL3/079 INQ000412023].

197. Following further conversations between DHSC and HM Treasury Ministers, on 23 November 2020 HM Treasury agreed to provide an additional £25m for mental health, on the condition that the £25m was match-funded by NHSE. The approval is exhibited as [CL3/081 INQ000399215].

Mental health recovery package 2021/22

198. At SR20, the Chancellor announced £3bn to support NHS recovery from the impacts of Covid-19 in 2021/22. Around £500 million of this funding would be used to target the mental health backlog and to support the well-being of the workforce. This funding proposal originated in HM Treasury, as Ministers were concerned about the likely impact of the pandemic on the delivery of mental health services and the prevalence of mental health conditions across the population. This led to an ambitious package to support overall service recovery and specifically for those groups which had been most impacted by the pandemic, including those with severe mental illness, young people, and frontline staff. Details of the package are exhibited as CL3/082 INQ000412076.

199. Following advice from officials on 1 March 2021, exhibited as CL3/083 INQ000399225, on 4 March 2021 HM Treasury approved £79m of a DHSC spending request that covered £289m of the £500m pot. A condition of this approval was that the funding should be used to fund mental health enhanced discharge. HM Treasury also requested that DHSC send a revised proposal covering the entire £500m package. The approval is exhibited as [CL3/084 INQ000399224].

200. On request from DHSC, on 16 March 2021 HM Treasury approved a further £87m of the £500m recovery package to continue mental health enhanced discharge for 9 months in 2021/22. The approval is exhibited as [CL3/085 INQ000399226].

201. DHSC proceeded to seek HM Treasury approval for proposals for the remaining £334m of the funding pot. Following advice from officials on 19 March 2021, exhibited as [CL3/086 INQ000399227], on 22 March 2021 HM Treasury approved the use of £110m to take forward the expansion of adult community and crisis services, Increasing Access to Psychological Therapies (IAPT), and suicide prevention. Alongside this, HM Treasury approved £111m from the package to grow the NHS mental health workforce. The approval is exhibited as [CL3/087 INQ000399228].

202. DHSC were requested to submit a revised proposal, including proposals on workforce wellbeing, for the remaining £113m of funding by May 2021.

203. On 25 March 2021 DHSC put forward a revised proposal for the £113m that included £10m for workforce wellbeing. HM Treasury approved this proposal the same day, subject to agreement that DHSC manage any further pressures for workforce wellbeing from existing budgets. The approval is exhibited as [CL3/088 INQ000399199].

Pharmacies and GPs

204. Pharmacies and GPs were heavily impacted during the pandemic, both directly in the provision of services and vaccines, and indirectly in, for example, increased rates of sickness. In its decisions HM Treasury considered the critical role that pharmacies and GP practices played during the pandemic in delivering essential health services, the data and evidence provided by DHSC/NHS on the additional costs incurred during Covid-19 to evidence the funding requests put to HM Treasury, the overall funding position across DHSC budgets and the MPM principles and rules.

Community Pharmacy Support

205. Community Pharmacies were eligible for the Bank Holiday funding (April 2020 onwards) and Medicines Delivery funding from 19 March 2020 onwards (both explained below). Community Pharmacies were also eligible for wider HM Treasury scheme support such as business rates relief, Covid-19 statutory sick pay arrangements, Business Interruption Loans and Bounce Back Loans should they meet the associated criteria.

206. On 23rd March 2020 a proposal from the Pharmaceutical Services Negotiating Committee ("PSNC") was provided to HM Treasury, consisting of two main elements:

- Cash flow – increasing the January payment at end March by 75% (based on both product reimbursement and service fees) worth £570m;
- Extra funds for FY 2020/21 of £350m (so total = £2.943bn for 2020/21) to cover extra Covid-19 related costs.

207. On 25 March 2020 DHSC superseded PSNC's cash flow request of £570m with a £300m cash advance proposal to support all models of pharmacy through Covid-19, all of which would be recovered within the 2020/21 Financial Year. Following further discussion with DHSC on 25 March, it was agreed that the NHS Business Services Authority (NHSBSA – the body that would provide the advance funding to pharmacies) had sufficient existing cash reserves to deliver the £300m advance. This is exhibited as [CL3/089 INQ000399200].

208. In relation to the second funding request, on 27 March 2020 HM Treasury Ministers agreed to a £300m advance payment to support pharmacy cash-flow on the condition that the funding was recouped in 2020/21, and DHSC committed to not return for any further funding on this issue. The relevant document is exhibited as [CL3/090 INQ000399205].

209. In June 2020, DHSC requested £332.6m to support community pharmacies for the costs incurred from March 2020 to May 2020 due to the impact of Covid-19. Following advice to HM Treasury Ministers on 9 June 2020, exhibited as [CL3/091 INQ000399207], and 17 June 2020,

HM Treasury approved a £120m support package on 19 June 2020. This decision was based on reduced assumptions on demand surge and closures against DHSC's estimates, and the discounting of business support provided through other schemes. Funding was subject to a claims-based process for pharmacies claims, to be managed by NHSBSA. The approval is exhibited as **CL3/091** NQ000399207].

210. Health Minister Jo Churchill MP wrote to CST on 3rd December 2020 requesting up to £575m to offset £372m of costs for March-October 2020 against the £370m loan given to the sector, and distribute £203m between November 2020 and March 2021 based on evidenced claims. This letter is exhibited as [CL3/093 INQ000059164].

211. Following advice to Ministers on 8 December 2020, exhibited as [CL3/094 INQ000412062] HM Treasury responded on 15 December 2020 stating that no new funding would be provided beyond the £120m previously approved, on the basis that:

a. DHSC had not met a pre-agreed condition of the initial funding, namely the repayment of the £370m cash advance in this financial year.
b. The purpose of the £370m cash advance was to mitigate a temporary cash flow problem facing pharmacies, and was not intended to be a grant to the sector for Covid-19 pressures.
c. The evidence was limited that additional Covid-19 costs were equivalent to £370m. Further, several conditions were placed on the June package to mitigate the risk of overpayment and ensure support was only paid out where genuine cost pressures were identified. Offsetting the loans would not allow funding to be distributed based on evidenced claims. This response is exhibited as [CL3/095 INQ000399218].

212. During the Supplementary Estimates process in January 2021 – relevant documents exhibited as [CL3/096 INQ000399220] and [CL3/097 INQ000399222] - HM Treasury agreed to fund the £370m pressure created by DHSC being unable to recover the advance payments made to the sector, but recognised it as irregular spend as it had not been subject to HM Treasury approval before being spent.

213. DHSC proposed that the £120m funding approval (which had not been accepted by the sector) should be netted off the £370m that needed to be recovered. HM Treasury accepted this as it did not materially impact the amount to be recovered, on the condition this was done on a claims-based basis with individual pharmacies evidencing each of their claims.

214. DHSC proposed that the remaining claims made by the sector would be recovered from the sector in 2021/22 instead of the 2020/21 financial year. After advice from officials, exhibited as

[CL3/098 INQ000399229], HM Treasury agreed on 19 April 2021 that an uncapped claims-based process could be run to decide on reimbursements. Up to September 2021, £266m was claimed by the sector. Following advice to Ministers on 21 September 2021, exhibited as [CL3/099 INQ000412072], HM Treasury approved a request from DHSC to meet this pressure through £146m of FY 2020/21 underspends, alongside the £120m provided for this use. HM Treasury noted it was content that the claims-based system and verification process was operating in line with expectations.

Bank holiday opening

215. On 6 April 2020 DHSC officials advised HM Treasury that NHSE had instructed GPs and community pharmacies to remain open on Good Friday and Easter Monday, which would incur additional costs for HMG. The policy to remain open was to ensure continued access for patients thus supporting the management of overall demand, particularly for hospital services. Following advice to Ministers on 7 April 2020, exhibited as [CL3/100 INQ000412049], HM Treasury approved an upper limit of £56.45m to fund GPs (£39.2m) and community pharmacies (£17.25m).

216. Following advice to Ministers on 30 April 2020, HM Treasury approved an additional £8.5m for Community Pharmacies and £24.2m for general practice, to support opening on Early May Bank Holiday (Friday 8 May), in line with high demand related to Covid-19. The approval is exhibited as **CL3/100** INQ000412049].

217. DHSC confirmed on 21 May 2020 that no further funding was required to direct the opening of 2,000 pharmacies (of around 11,500 nationwide) for the late May Bank Holiday (25 May 2020), as the cost could be covered from previous budget requests. Any underspends would be returned to HM Treasury. The confirmation is exhibited as [CL3/102 INQ000412055].

Remote working support for staff

218. In March 2020, DHSC and NHS requested funding of up to £100m CDEL for laptops (a minimum of 75,000 units) to increase remote working and virtual appointments across primary and secondary care in response to Covid-19 pressures.

219. On 3 April 2020, following advice from HM Treasury officials, exhibited as [CL3/103 INQ000412046], CST was not content to approve this without the further detail from DHSC on the aim of this proposal, unit price for laptops and wider process of distribution that would enable HM Treasury to ensure value for money was being delivered. Following further advice addressing CST's questions, on 8 April 2020 HM Treasury approved the request.

General Practice support

220. In April 2020 DHSC sought HM Treasury approval of a bid from NHSE/I and DHSC for up to £320m (of which £109m had already been agreed for GPs to stay open on Bank Holidays and provide support in Care Homes), in addition to £60m for the DAs to support the General Practice Covid-19 response. HM Treasury Ministers requested further information from DHSC before considering approval of any additional funding, specifically data on additional demand for General Practice and staff absences (exhibited as [CL3/104 INQ000412051]).

221. On 19 May 2020 officials provided further advice to HM Treasury Ministers, exhibited as [CL3/105 INQ000412053], setting out that NHSE announced without HM Treasury clearance the introduction of 'a reimbursement mechanism for general practice to help practices meet the additional costs of Covid-19 related activity which cannot be met from existing practice resources'.

222. Following this announcement DHSC sent a revised bid to HM Treasury for approval. The British Medical Association (BMA) also wrote to CST to ask him to release the funding requested by NHSE for GPs. This letter is exhibited as CL3/106 **INQ000097904** On 20 May 2020 CST confirmed that he was content to fund the £109m previously agreed for bank holidays and care homes, with the remaining £210m to be funded from existing DHSC/NHSE budgets. Regarding the latter, CST felt that more information was required before agreeing to this spend and wanted a model where we funded based on actual expenditure. This is exhibited as [CL3/107 INQ000412054].

223. NHSE surveyed a sample of 68 practices across England to collect data on additional costs in general practices (incurred between end of March 2020 and end of May 2020) and provided a further revised request to HM Treasury in June 2020 for an additional c.£191m for 4 months (compared to c£212m for 3 months previously).

224. Following advice from officials on 30 June 2020, exhibited as [CL3/108 INQ000399211], on 3 July 2020 CST agreed to fund a further £88.5m (plus £16.7m for DAs) for all staff absence cover from April-June. CST rejected bids for additional capacity (£52.5m), consumables (£25.5m) and travel costs (£4.5m). The agreement is exhibited as [CL3/109 INQ000412060]. The bid for additional capacity was rejected on the basis that appointments data suggested that demand had decreased over the previous three months.

225. In summary, together with the funding CST had already agreed, a total of £197.5m (plus £37.3m Barnett) additional HM Treasury funding was given for general practice support during Covid. This represented the upper limit of costs and NHSE used a claims-based process to ensure practices only received funding for genuinely additional Covid-19 costs.

GP support for care homes

226. In April 2020, DHSC requested HM Treasury approval for £45-60m of additional funding for GPs until the end of September 2020, to ensure that care homes had 24-hour access to a lead clinician through digital consultations, telephone advice and face to face work.

227. On 2 May 2020, after advice from officials recommending approval, HM Treasury approved £53.5m (£45m + £8.5 Barnett consequential) and requested that DHSC provide a detailed breakdown of costings as soon as possible. The approval is exhibited as [CL3/110 INQ000412050].

Medicines delivery

228. Following advice to Ministers on 19 March 2020, HM Treasury approved an upper limit of £307m for the PM's announcement of a medicines delivery service on 20 March 2020, to support people subject to shielding measures. This funding consisted of a £21m flat fee for all pharmacies could be spent, followed by a £5 fee per delivery made. HM Treasury would recover any unspent funding. The approval is exhibited as [CL3/111 INQ000399195]. Funding, later reduced to £293m following new cost estimates (exhibited as [CL3/112 INQ000412022]), which was provided to DHSC at Main Estimates FY 2020-21.

229. Later in the year shielding was reduced following the conclusion of lockdowns; as such, this scheme was temporarily paused. On 20 August 2020, HM Treasury agreed that DHSC could continue to draw down funding from an existing reserve claim for the Medicines Delivery Service where shielding guidance was reinstated, either locally or nationally. The approval is exhibited as [CL3/113 INQ000412019].

230. On 2 November 2020, officials provided a written update to the CST, exhibited as [CL3/114 INQ000399213] confirming the reinstatement of the service nationwide following new national lockdown measures, within the existing funding envelope. From April to September the spend to

date had been £35.5m of the £293m pot, suggesting sufficient funding would be available for the rest of the financial year.

231. During Supplementary Estimates in November the process commenced to agree how much of the £293m was still required for medicines delivery and how much could be returned to the Exchequer. In November, DHSC initially bid to reduce their initial £293m allocation by £193m to £100m total spend. This is exhibited as [CL3/115 INQ000412026]. However, before the process concluded across Supplementary Estimates, on 20 December the bid required revision to account for the imposition of Tier 4 and the expansion of shielding in response to the Omicron variant. The revised bid is exhibited as [CL3/116 INQ000412029].

232. By 5 January 2021 shielding was reintroduced as part of the national lockdown, and the medicines delivery service was again implemented nationally. On 7 January 2021 DHSC provided updated estimates setting out: the new expected costs of £83m for the financial year up to 21 February 2021 (pending any further shielding requirements from February to April). The estimate is exhibited as **CL3/116** INQ000412029].

233. HM Treasury challenged that DHSC's estimates were now assuming 100% uptake of the service by shielding individuals for the rest of the financial year, where previously uptake had been stable at 40%. On 13 January 2021 DHSC provided a revised estimate of £129 million of total funding need for FY 2020/21 (£52m for prior to 5January 2021 and £77m for the rest of the financial year). The estimate is exhibited as **CL3/116** INQ000412029].

234. HM Treasury approved this estimate on 21 January 2021, reducing the Main Estimates agreement of £293m by £164m. The approval is exhibited as [CL3/119 INQ000399221]. £72.2m of this funding was spent by the end of the financial year, as summarised in the document at [CL3/120 INQ000399230].

Enhanced Discharge

235. HM Government introduced 'Enhanced Discharge' in March 2020 to free up beds in hospitals, in response to projections of a significant increase in demand for beds. This involved initially suspending the means test for social care for people leaving hospital. HM Treasury considered enhanced discharge in the context of the range of policies NHSE and DHSC were pursuing to ensure there was sufficient capacity, alongside for example independent sector capacity. DHSC and the NHS were responsible for the implementation and operation of Enhanced Discharge. HM Treasury's role was to approve the spending required.

236. On 17 March 2020 HM Treasury approved two urgent requests from DHSC and the Ministry for Housing, Communities and Local Government (MHCLG): firstly, to speed up discharges from the NHS into adult social care by disapplying the means test for these patients for six months; Secondly allocating £2.9bn to address expected cost pressures in local government, including in adult social care, children's social care and other services. This is exhibited as [CL3/121 INQ000412057].

237. Through March to July 2020, HM Treasury made repeated requests to DHSC to provide data on how the funding agreed in March was spent, including on numbers of discharges as well as evidence to judge risks such as contagion in care. This is exhibited as [CL3/122 INQ000412014].

238. Across June and July 2020, consideration was given across HM Government to the future of the Enhanced Discharge policy, which did not have an agreed sunsetting (e.g. end) date ([exhibit CL3/123 INQ000399206]). HM Treasury's position was that while approval could be granted to extend the enhanced discharge policy to the end of March 2021, with a six week cap on the NHS paying for care costs introduced from September 2020, the policy should have a clear time limit, with data sharing effectively across HM Government to ensure the policy was having the desired effects. The data shared to date with HM Treasury provided some evidence that the policy had helped to free up beds within acute settings. This document is exhibited as [CL3/124 INQ000399209 CL3/124 (1) **INQ000088088**

239. In February 2021 HM Treasury responded to a request from DHSC and NHSE to extend the scheme to the end of June 2021, agreeing that that there was a case for continuing (and data sharing had now improved, providing the necessary evidence). However, HM Treasury agreed to a short extension to end-March 2021, subject to a number of conditions, to allow consideration of a longer extension at a later date alongside other NHS Covid-19 costs. This is exhibited as [CL3/125 INQ000412032].

240. On 9 March 2021 officials advised the Chancellor and CST on remaining outstanding NHS Covid-19 costs for 2021/22. This included a bid from NHSE to continue the enhanced discharge programme. The advice noted that evidence indicated that the enhanced discharge programme was the best value for money option of the capacity interventions used in 2020/21, but that there were choices – for example reducing the payment for six weeks of care to four weeks, either immediately or in the second quarter of 2021/22. This submission is exhibited as [CL3/126 INQ000412069].

241. Enhanced discharge was included in the DHSC and NHS bid for Covid-19 costs for the second half of FY 2021/22, submitted in August 2021. While HM Treasury accepted there was a case for continuing funding to avoid a sudden end to funding in September, as well as to protect NHS elective capacity, HM Treasury was clear that this would be the last separate payment for enhanced discharge. This is exhibited as [CL3/127 INQ000412034].

242. On 17 December 2021, HM Treasury approved up to £80m to improve discharge from acute hospitals. This approval was on the condition that it was to be monitored closely, with frequent data sharing and updates of the work of the Discharge Taskforce, as well as the undertaking of an evaluation of the enhanced discharge policy. This approval is exhibited as [CL3/128 INQ000412073].

Lessons learned

243. As set out above, the principles underpinning HM Treasury's approach to spending did not fundamentally change during the pandemic. The established framework in which AOs are responsible for expenditure in their departments remained in place throughout, as did the requirement that AOs must ensure spending takes place in line with the principles of regularity, propriety, value for money and feasibility. In advising on value for money, HM Treasury's general considerations when advising Ministers also remained the same (albeit different considerations were weighted differently - and proportionately - according to the circumstances at the time during different phases of the pandemic).

244. Within that framework, HM Treasury was able to act flexibly thus allowing DHSC (and HMG more broadly) to be responsive in its approach despite the key challenges posed by the pandemic, predominantly pace and uncertainty. HM Treasury worked to ensure DHSC could act rapidly when necessary, while establishing upfront scrutiny and risk management which, while varying from normal practice, were proportionate to the circumstances. HM Treasury was also able to strengthen risk mitigation and assurance with bespoke processes after decision-making took place and was able to act quickly and responsively when necessary.

245. In practice therefore, the public spending framework proved to be a flexible framework within which Ministers and departments could take rapid decisions, balancing urgent public health need with value for money for the taxpayer. The framework also proved to be adaptable over time, and was able to accommodate evolution in the weighting of spending considerations over the course of the pandemic.

246. That being said, the Covid-19 pandemic was an unprecedented challenge for the health system and the management of public money in support of public service delivery in a crisis. HM Treasury has worked to embed lessons from the pandemic in our own practices and to share lessons on best practice more broadly across government. A number of elements of this work have been delivered through the Government Finance Function ("GFF").

247. I, as Head of the GFF, convene a Finance Leadership Group ("FLG"), which meets every month outside August. The agendas include a HM Treasury update in which the latest information on fiscal events and other HM Treasury activity with departments is shared. The agendas also include items that require the attention of all government departments and which allow departments to share best practice and common issues and concerns.

248. Previous sessions have covered the following topics:

a. Forecasting - this has led to the creation of an FLG forecasting sub-group tasked with working to improve forecasting accuracy. The group has discussed the impact of Covid-19 on departmental forecasting has set expectations around forecasting best practice for finance professionals and budget holders through the development of a new forecasting framework – exhibited as [CL3/129 INQ000408792] - which has been published and shared with departments. This sets out forecasting expectations and incentivises departments to share robust forecasts that enable HM Treasury to monitor public spending effectively and thereby minimise the risk to public finances. The sub-group is now exploring capital specific forecasting issues.

b. Risk Management - several updates on risk management activities have been shared with and discussed at the FLG including the development, approval and publication of the Risk Control Framework as Part II of the Orange Book, exhibited as [CL3/130 INQ000412040] and [CL3/131 INQ000412081].

c. Financial Reporting - a joint session was held in November 2021 with FLG and the National Audit Office on timeliness and quality of reporting in Annual Report and Accounts ("ARA") for 2021-22. The relevant documents are exhibited as [CL3/132 INQ000412077] and [CL3/133 INQ000412079]. HM Treasury is currently undertaking a review to identify and resolve issues that may hinder more timely reporting for ARAs going forward and will cascade relevant updates as needed. On the content of ARAs for 2020-21 and 2021-22, HM Treasury has introduced new mandatory requirements for reports on the impact of the pandemic on departmental goals, strategic objectives and priority outcomes, and a fraud and error analysis of Covid-19 support schemes.

d. Audit and Assurance – The GIAA attended a session in December 2021 on cross-government insights from the 2020-21 assurance work, in particular those related to the Covid-19 response. FLG looked at the outcomes from the cross-government Risk Management review and discussed the impact of Covid on risk tolerance levels. The relevant documents are exhibited as [CL3/134 INQ000412078] and [CL3/135 INQ000412080].

249. The GFF remains committed to ensuring that the finance community across government has access to adequate guidance and best practice. The GFF maintain a Covid-19 hub on the OneFinance platform, accessible to all government finance staff, that provides the latest advice and guidance in a single place online, including updates that cover AO flexibilities, response and recovery risk management, and changes to payment and debt processes.

250. HM Treasury has also reflected on the way the spending control framework operated during Covid-19, flexibilities that were agreed with departments, and the process of procuring specific products, including PPE, Test and Trace, and Covid-19 vaccines. The conclusions, including lessons learned for future crises, were set out in a letter from the CST to the Chair of the Treasury Select Committee in April 2021 [CL3/008 INQ000068427]. HM Treasury applied learnings between key health programmes during the pandemic, for example, applying lessons from the PPE programme in designing the assurance for the vaccine deployment programme. This is exhibited as [CL3/136 INQ000399216].

251. One key lesson identified in the CST's April 2021 letter was the importance of high-quality data and data sharing in managing spending risks in crisis contexts. In some cases, DHSC had to act on the basis of the best available, but imperfect, information, and this resulted in decision-making that in hindsight was not optimal. HM Treasury put in place mechanisms during the pandemic to assure the quality of demand modelling and sharing of management information, and the quality of these improved over time. Demand modelling has also subsequently been examined by the Finance Leadership Group (see below).

252. The second key learning identified by the CST was the importance of commercial capability to decision-making, both embedded in programmes to provide advice at an early stage in decision-making, and in an external scrutiny role. Commercial expertise in programmes was particularly important because during the pandemic government relied more heavily than usual on the 'first line of defence' in assuring spending decisions, so there was a premium on strengthening commercial capability in programmes.

253. The third key reflection in the CST's letter was the benefit of embedding HM Treasury and Cabinet Office officials into internal processes in spending departments in order to facilitate earlier scrutiny of key data that would influence funding allocations.

254. Following the recommendations of the Boardman Review of Government Covid-19 Procurement in May 2021, exhibited as [CL3/137 INQ000055876], pages 5-7, HM Treasury undertook an internal exercise to record the flexibilities utilised within the spending framework during the pandemic and set out lessons learned, with the aim of informing the department's approach to future crisis scenarios. This is exhibited as [CL3/138 INQ000399235].

255. Further, HM Treasury has separately considered lessons relevant to the AO assessment process. In winter 2021, HM Treasury facilitated a review for the Civil Service Board of the application of the AO processes during the initial phases of Covid-19. A letter setting out details

of the review is exhibited as [CL3/005 INQ000399234]. This review identified the following lessons:

a. AO assessments are a valuable tool in undertaking a systematic appraisal of specific significant projects or proposals;

b. Detailed arrangements for producing AO advice should be tailored to the wider structures of each organisation. However, the Finance Function within each body provides an important second line of defence and should, therefore, sign off an AO assessment before it is put to the AO for final clearance; and

c. AOs and those who support them would benefit from enhanced training and support, as well as more detailed central guidance in specific areas, including the circumstances that merit departments assuming a greater level of risk appetite than they would in usual conditions.

256. Following the publication of the Living with COVID-19 Strategy in February 2022, HM Treasury:

a. published updated Accounting Officer Assessment guidance [CL/038 INQ000107246] that details better ways of joint working and advice on how to approach accounting officer duties in circumstances of uncertainty. We have also more explicitly linked business cases and accounting officer assessments and strengthened the role of the Finance Function in the authoring of assessments by requiring that such assessments should have Finance director sign off; and

b. published an updated version of Managing Public Money with additions on combating fraud and communication with Parliament regarding Ministerial directions and contingent liabilities.

Response of health and care systems to any future pandemic

257. As set out above, health protection, pandemic preparedness and pandemic response are not lead responsibilities of HM Treasury; DHSC has responsibility for these areas under the 'lead department' model.

258. HM Treasury considers risk management to be a critical component of planning for health and care systems' response to any future pandemic. The pandemic reinforced the need for continuing improvement in the way the government manages risk. Effectiveness and efficiency improvements being made relate to the design and performance of frameworks and toolkits as well as the individual and collective capabilities of those using them.

259. HM Treasury and CO have been updating the Public Accounts Committee on risk management improvements relating to:

a. Strengthening leadership and enhancing credibility,

b. Collaborating across boundaries,

c. Enhancing capabilities and driving professionalism.

260. As many of our improvements relate to the consideration of riskiness and risk management effectiveness when important decisions are being shaped and taken, the improvements need to be adapted to the governance structures already in place across government. This means addressing challenges associated with cross-department decisions and responsibilities.

261. Additionally, in May 2022 the government has updated the PAC on the evolution of specific capabilities addressing civil contingency risk (exhibited as [CL3/140 INQ000408794]):

a. The National Security Risk Assessment (classified)

b. The National Risk Register (public overview based on the NSRA)

c. The National Situation Centre ("SitCen")

262. In addition to its role driving improved risk management across government, HM Treasury's role in planning for response in future pandemics centres on its role in agreeing health protection and health resilience spending. HM Treasury will consider spending proposals for the next SR period at the next Spending Review.

263. HM Treasury officials also attend the CO-DHSC chaired Pandemic Diseases Capabilities Board. This has replaced the pre-Covid cross-Whitehall Pandemic Flu Readiness Board, with focus on transitioning Covid-19 response capabilities into their long-term states, identifying capability requirements for future pandemics and managing impacts of future pandemics.

Statement of Truth

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

Signed

ANNEX 1

HM Treasury's organisation and structure

1a. Organisation of HM Treasury Senior Officials relevant to module

264. HM Treasury have completed the below organogram of senior officials (Director and above) relevant to the decisions set out in this statement, based on the historical organisational records (the Annual Reports and Accounts) from the period 2020-2022. Individual role holders, where known, have been included in chronological order.

265. It should be noted that the structure and roles of HM Treasury senior officials have changed over the time period covered in this organogram. Where job titles have changed but the job content remained broadly the same, we have included in the same row.

Job Title and Grade	Name (in post for the duration of pandemic unless stated)	Job/Team Function
Permanent Secretary	Thomas Scholar	Responsible for decision making, Coordination and Management of the Department and Communications with media and the public.
Second Permanent Secretary	Charles Roxburgh	Responsible for growth policy, financial services and infrastructure.
Director General, Chief Economic Adviser to the Treasury	Clare Lombardelli	Responsible for economic and fiscal policy advice, analysis and surveillance. Also head of Government Economic service - leadership of the economic profession across government, working closely with other heads of profession, in particular for social research.
Director – Economics	Vanessa MacDougall (until Nov 2020)	Responsible for UK Economic analysis, surveillance, and professionalism

	James Benford (Nov 2020 – Feb 2023)	
Director, Fiscal Policy	Tom Josephs	Responsible for Fiscal Policy Framework and Statistics and Debt, Cash, and Reserves Management
Director General, Tax and Welfare	Beth Russell	Responsible for Tax and Welfare.
Director, Strategy Planning and Budget	Daniel York-Smith	Responsible for defining forward strategy, work programme, the budget, tax strategy and short-term priority policy projects
Director General, Public Spending	James Bowler (until March 2020) Catherine Little (March 2020 – Oct 2022)	Responsible for the Treasury's work on public services with overall responsibility for managing public spending, strengthening financial discipline across central government, helping to ensure the delivery of more cost effective public services, and contributing to creating the conditions for sustainable growth whilst supporting development in infrastructure and a low carbon economy.
Director, Public Spending	Conrad Smewing	Responsible for Spending Control, Pay and Pensions.
Director, Public Services	William Garton Jean-Christophe Gray (until Dec 2020) Philippa Davies (from Dec 2020)	Responsible for Oversight of Major Public Service Expenditure.

1b. Organisational structure of HM Treasury at Ministerial level

Ministerial Post	Individual in post	Date Started in Department	Date left post/department	Responsibilities
Chancellor to the Exchequer				
Chancellor of the Exchequer	Rishi Sunak MP	13/02/2020	05/07/2022	The Chancellor of the Exchequer is the government's chief economic and financial minister and as such is responsible for raising revenue through taxation or borrowing, for controlling public spending, and for delivering economic growth and stability. He has overall responsibility for the work of the Treasury. The Chancellor's responsibilities cover:

				• fiscal policy (including the presenting of the annual Budget) • monetary policy, setting inflation targets • ministerial arrangements (in his role as Second Lord of the Treasury) overall responsibility for the Treasury's response to COVID-19
	Sajid Javid MP	24/07/2019	13/02/2020	
CST				
	Simon Clarke MP	15/09/2021	06/09/2022	The Chief Secretary (CST) is responsible for public expenditure, including: • spending reviews and strategic planning • in-year spending control • public sector pay and pensions • Annually Managed Expenditure (AME) and welfare reform • efficiency and value for money in public service • procurement • capital investment • infrastructure spending • housing and planning • spending issues related to trade • transport policy, including HS2, Crossrail 2, Roads, Network Rail, Oxford/Cambridge corridor • Treasury interest in devolution to Scotland, Wales and Northern Ireland • women in the economy • skills, labour market policy and childcare policy, including tax free childcare • tax credits policy • housing and planning • legislative strategy • state pensions/ pensioner benefits freeports – with support from EST on customs aspects .

	Steve Barclay MP	13/02/2020	15/09/2021	
	Rishi Sunak MP	24/07/2019	13/02/2020	
FST				

	Lucy Frazer MP	16/09/2021	07/09/2022	The Financial Secretary to the Treasury (FST) is responsible for:
				• The UK tax system including:
				  • Direct, indirect, business, property, and personal taxation (except for taxes covered by EST and XST)
				  • European and other international tax issues
				  • Customs and VAT at the border
				  • The Finance Bill and the National Insurance Bill
				• Trade policy: goods, including tariffs
				• Departmental Minister for HM Revenue and Customs (HMRC), the Valuation Office Agency, and the Government's Actuary's Department
				• Tax administration policy
				• Input to Investment Zones and Freeports focussing on tax and customs elements
				Overall responsibility for retained EU Law and Brexit opportunities

	Jesse Norman MP	23/05/2019	16/09/2021	
EST				

	John Glen MP	09/01/2018	06/07/2022	The Economic Secretary to the Treasury is the City Minister and is responsible for financial services.
				• Financial services policy, reform and regulation including:
				  • Financial conduct, including relationship with the FCA
				  • Financial stability, including relationship with the PRA

				• Competitiveness and growth of the financial services sector • Capital markets and listings • Financial inclusion (overall government lead, working with DWP) • Islamic finance, Fintech, and Crypto assets, including Central Bank Digital Currency • International financial services (excluding input to DIT FTAs) including regulatory cooperation, the Swiss Mutual Recognition Agreement, EU issues • Sponsorship of UKGI and State-owned financial assets, including NatWest shareholding • Cash and Payments including Royal Mint • Financial services tax, including bank levy, bank corporation tax surcharge, Insurance Premium Tax • Personal savings tax and pensions tax policy • Foreign exchange reserves and debt management policy (including green gilt), National Savings and Investment, Debt Management Office • Public Works Loan Board • UK Infrastructure Bank, British Business Bank and British Patient Capital • Parliamentary deputy on economy issues Supporting the Chancellor with his overall responsibility for appointments
XST				
	Helen Whately MP	16/09/2021	08/07/2022	The Exchequer Secretary (XST) is responsible for: • Growth and productivity, including skills, migration, infrastructure (physical & digital), digital economy, economic regulation, business regulation, competition, corporate governance, foreign direct investment (non-FS), and the Levelling Up White Paper living standards mission.

				• Energy, environment and climate policy and taxes (including transport taxes)
				• The following indirect taxes, including stakeholder engagement:
				  • Excise duties (alcohol, tobacco, gambling, and SDIL), including excise fraud and law enforcement
				  • Charities, the voluntary sector, and gift aid
				• Departmental minister for HM Treasury Group (including responsibility for the Darlington campus)
				• Crown Estate and the Royal Household
				Energy Profits Levy

	Kemi Badenoch MP	13/02/2020	16/09/2021	
	Simon Clarke MP	27/09/2019	13/02/2020	
Treasury Lords Minister				
Treasury Lords Minister	Baroness Penn	30/10/2022	Incumbent	The Treasury Lords Minister is responsible for: • Economic security • Financial sanctions (including OFSI) • Countering economic crime and illicit finance • Russia/Ukraine conflict • Trade policy (input to DIT FTAs): services, including financial services • International climate and nature finance • ESG in financial services, including Green Finance • Women in Finance • Overseas territories and Crown Dependencies
[as Minister of State for Efficiency and	Lord Agnew of Oulton	14/02/2020	24/01/2022	

Transformation]				

1c. Organisational structure of HM Treasury Special Advisers

Name of Special Advisor	Date started in post	Date left post/department	Responsibilities
Liam Booth-Smith	13/02/20	05/07/22	Chancellor's Chief of Staff
Name Redacted	01/09/20	05/07/22	Chancellor's Spad
Name Redacted	13/02/20	05/07/22	Chancellor's Spad
Name Redacted	06/01/21	05/07/22	Chancellor's Spad
Name Redacted	23/03/20	06/06/22	Chancellor's Spad
Name Redacted	24/02/20	05/07/22	Chancellor's Media spad
Name Redacted	13/02/20	05/07/22	Chancellor's Media spad
Olivia Oates	15/09/21	06/09/22	CST's special adviser
Rupert Yorke	03/03/20	05/07/22	Chancellor's Spad
Allegra Stratton	28/04/20	25/10/20	Chancellor's Media spad
Name Redacted	14/04/20	14/09/21	CST's special adviser

266. The Statement of Funding Policy [CL3/141, INQ000102912] is a HM Treasury policy document that is subject to consultation with the devolved administrations, though much of the document now reflects agreements reached with the devolved administrations about their funding arrangements. In particular:

a. **Scottish Government:** The Statement of Funding Policy reflects the jointly agreed Scottish Government Fiscal Framework [CL3/142, INQ000102914] which sets out the funding arrangements that underpin the latest Scottish devolution settlement (Scotland Act 2016). In particular, the UK and Scottish Governments agreed through the Joint Exchequer Committee (Scotland) that: the Barnett formula will continue to determine changes to Scottish Government block grant funding in relation to departmental spending (Departmental Expenditure Limits); this Barnett-based block grant funding will be adjusted in relation to tax and welfare devolution through an agreed Block Grant Adjustment methodology; the Scottish Government can borrow up to £3bn for capital purposes and up to £1.75bn for certain resource purposes (notably tax/welfare forecast error); and the Scottish Government can operate a £700m Scotland Reserve. Following a review of the Fiscal Framework concluded in August 2023, the capital and resource borrowing limits and Reserve limits will all be increased from 2023-24 onwards using the GDP deflator.

b. **Welsh Government:** The Statement of Funding Policy reflects the jointly agreed Welsh Government Fiscal Framework [CL3/143, INQ000068435], which sets out the funding arrangements that underpin the latest Welsh devolution settlement (Wales Act 2017). In particular, the UK and Welsh Governments agreed through the Joint Exchequer Committee (Wales) that: a needs-based factor (initially 5%) will be added into the Barnett formula to uplift changes to Welsh Government block grant funding in relation to departmental spending (Departmental Expenditure Limits); this Barnett-based block grant funding will be adjusted in relation to tax devolution through an agreed Block Grant Adjustment methodology; the Welsh Government can borrow up to £1bn for capital purposes and up to £500m for certain resource purposes (notably tax forecast error); and the Welsh Government can operate a £350m Wales Reserve.

c. **Northern Ireland Executive:** There is no Fiscal Framework agreement between the UK Government and Northern Ireland Executive, though nor have there been as significant changes in the Northern Ireland devolution settlement as in Scotland and Wales. However, the Statement of Funding Policy still reflects specific agreements reached between the UK Government and Northern Ireland Executive. In particular, it includes the Northern Ireland

Executive's £3bn capital borrowing under the Reinvestment and Reform Initiative ("RRI") and the agreed mechanism for adjusting Barnett-based block grant funding in relation to the devolution of long-haul Air Passenger Duty.

267. The below identifies and describes the key roles of those in the devolved administrations who cooperated with HM Treasury in relation to setting funding and controlling spending:

a. **Scottish Government:** The Scottish Government's organisational structures have evolved over the past decade to reflect its significant increase in tax, borrowing and welfare powers. The key roles now sit within the remit of the Director General Scottish Exchequer (with the Budget and Public Spending Directorate responsible for operating the Scottish Government's Fiscal Framework and setting the annual Scottish budget and medium-term financial strategy) and the Director General Corporate (as the Financial Management Directorate is responsible for in-year spending control).

b. **Welsh Government:** The Welsh Government's organisational structures have also evolved over the past decade to reflect its additional tax and borrowing powers. HM Treasury now works most closely with the Director General Economy, Treasury and Constitution (which includes working with the Welsh Treasury to set funding, under the Director of the Welsh Treasury) and the Chief Operating Officer's Group (which leads on in-year spending control under the Director of Finance).

c. **Northern Ireland Executive:** HM Treasury's main relationship is with the Department of Finance, which was the Department of Finance and Personnel until May 2016. Within the department the key engagement is with the Central Expenditure Division, which sits within the Public Spending Directorate.