People's Covid Inquiry February-June 2021

Expert witness statement

John Lister

Session 1 24 February 2021
COVID-19: HOW PREPARED WAS THE NHS?

STATEMENT

I (name) John Lister

Job title/ role/ occupation Academic researcher, Journalist, Health Campaigner

will say as follows:

1. I make this statement for the purposes of the People's Covid Inquiry, which is to be held on 24 February.

2. I am able/unable to attend and give evidence. If unable to attend, I agree to my statement being considered by the Inquiry.

3. What is your job/ role/ occupation – how long doing this for/ brief summary of background/ experience - if possible, attach CV to statement

4. What is your connection/ interest/ background/ experience relevant to the pandemic in England?

5. How are you able to assist the Inquiry – what is you expertise/ knowledge/ specialism?

6. What in your view were the original vision and principles underpinning the NHS?

Please briefly outline your testimony below or attach or reference an article which will provide the panel with relevant information.

Before the pandemic – an NHS on its knees

After the December 2019 election warnings began ringing out from doctors' leaders and from NHS Providers on the state of the NHS. The Queen's Speech made a big gesture of enshrining the promised extra money for the NHS in law: but this also meant that there was no immediate prospect of increasing the funding above the level set out in the manifesto – despite all of the evidence that the NHS pre-Covid was drastically under-funded and failing to deliver performance targets after almost a decade of austerity-driven real-terms cuts.

NHS Providers Chief Executive Chris Hopson pointed out that if NHS spending had increased in line with the previous average prior to 2010, the Department of Health and Social Care budget would have been £35 billion higher.

The Johnson government promised in the election to increase spending by "£34 billion in cash terms" over five years – but as campaigners warned, even the government's own figures show than taking inflation and cost pressures into account that will only be worth £20.5 billion in real terms.

In other words unless the law is changed, real NHS budgets in 2024 will still be miles short of the level needed to deal with today's increased population, the substantially increased older population, and nine years of decline. Before the pandemic the BMA had conservatively estimated the shortfall as a £6.2 billion annual "black hole", in addition to existing deficits: but trusts had run up deficits to the tune of £14 billion.

Missing performance targets

Weighed down by financial constraints hospitals were struggling – and often failing – to deliver A&E performance targets, waiting list targets, cancer treatment targets.

The manifesto commitment to the target to see and treat or discharge 95% of A&E patients within 4 hours was clearly not linked to any commitment to meet it: only TWO of the 119 major A&E departments that submitted information for September 2019 met the 4-hour target.

The 95% target has not been met in England for over five years.

64,921 patients who needed to be admitted spent over 4 hours on trolleys in September 2019 waiting for a bed – 46% higher than the same month in 2018.

This followed the staggering increase of 1,400% in the numbers of so-called "trolley waits" from August 2010 to August 2019.

What was alarming is that these incredibly high levels of pressure were continuing right through what used to be relatively quiet summer months.

455 patients waited over 12 hours on a trolley in September, THREE TIMES the number last year. The increased delays flow from a combination of rising use of A&E (and limited availability of alternative support) with a hefty reduction in front-line beds and a lack of services outside hospital.

Numbers of the most serious “Type 1” emergency patients attending A&E in August have increased by 21% since 2010, while the population is only estimated to have increased by around 6.6%.

NHS figures withheld on election day, and published on December 13, showed a further rise on demand for emergency care coupled with a fall in performance. They showed there were 2.1 million attendances at A&E departments in November – a 5.2% rise from the same point last year, while 94.9% of front-line general and acute beds were occupied – meaning they were already as full as they were for nearly every week of last winter.

Total emergency admissions to hospital, which include urgent referrals by GPs, had risen by 28%, since 2010, rising faster than general attendances at A&E.

The Manifesto commitment to speedy cancer treatment was grimly ironic given that the 62-day target to start cancer treatment had only been met once in five years, and more than one patient in five waited more than two months for their first treatment.

The Manifesto commitment to the 18-week target for elective treatment was no more convincing, given that the proportion of the 4.5 million waiting list who had waited more than 18 weeks had risen to 15% -- the highest since 2008.

The diagnostic waiting time target had not been met since November 2013.

Reduced capacity

One of the reasons the targets were being missed was (and remains) the heavy reduction in numbers of front line staff.

In 2010 when David Cameron won the General Election there were 144,500 beds in England’s NHS: nine years later almost 16,000 of these had closed – leaving a total of 128,649.

The pace of closure had also been rapid in the “general and acute” beds which treat emergency admissions, waiting list cases and also include any remaining beds for older patients. In 2010 there were 110,568 of these: nine years later there were just 101,790, a loss of close to 9,000 front-line beds, while the population has increased. During the pandemic thousands more beds closed or had to be left empty in order to ensure social distancing or because staff were off sick or had been transferred elsewhere.

The reduction had been even more spectacular in mental health, where numbers had been slashed from 23,500 in 2010 to just 18,271, a reduction of 5,245 (22%). This explains widespread problems finding mental health beds, despite the rhetoric of parity of esteem for mental health needs.

The biggest cut of all had been in Learning Disabilities, where 61% of the already reduced 2010 NHS provision of beds had been axed, with responsibility transferred to hard-pressed and under-funded social care – leaving many patients with health needs unable to access specialist support, and dependent on general NHS services.

Empty promises on GP services

Delays and shortages were also impacting on GP services and community services. After the election and Queen’s Speech a letter to Boris Johnson from the Doctors’ Association UK (DAUK), signed by over 2,000

doctors - including 654 GPs and 312 GP trainees – highlighted the devastating, but utterly predictable impact that years of underfunding had had on the NHS, and warned that the NHS was "on its knees".

The promise of 6,000 extra "doctors in general practice" was not included in the legally binding proposals – for good reason. Since the initial promise of 5,000 extra GPs was made by Jeremy Hunt back in 2015, (and reiterated no fewer than FIVE times by Hunt and Matt Hancock, the numbers had actually gone down by over 1,000: and during 2019 alone the numbers fell by another 340.

The vanishing 50,000 extra nurses

Staff shortages of course are another major factor, and ministers repeatedly tied themselves in knots trying to explain what happened to their promise of an "extra" 50,000 nurses. It had become clear that the plan was for an increase over TEN years, not five. And it also hinged on trying to retain over 18,000 nurses who were **already working for the NHS**: in other words at most only 32,000 "extra" nurses would be added. To make matters worse, while talking about extra "nurses", ministers also relied on using thousands of less qualified nursing assistants to cover for qualified staff.

Immigration restrictions

The plan for extra nurses also relied heavily on further recruitment from overseas: it's still not clear if many of those who supported Brexit as a way to reduce immigration were aware of the extent to which the entire NHS depends on migrant workers.

The Queen's Speech states that "a new visa will ensure qualified doctors, nurses and health professionals have fast-track entry to the United Kingdom." But recruitment from the EU has fallen massively since the Brexit vote, and the new £400 visa plus the immigration health surcharge, which ministers have recently pledged to increase to £625 per person, mean that after Brexit EU nationals will face a new £1000-plus up-front cost in coming here – in addition to paying the same taxes that we do: how this is supposed to attract extra recruits is a mystery, especially given the increased incidence of racism towards overseas and BME staff.

Parking charges

Doctors' organisations and NHS Providers had tried in vain to push the Johnson government into taking its own promises to improve the NHS more seriously. Instead the double talk of the Conservative Manifesto was repeated in the Queen's Speech.

Even the minimal Conservative manifesto pledge to scrap some hospital car parking charges, turned out to be deceptively phrased in the Queen's Speech as scrapping charges "for those in greatest need," even though devolved governments in Wales and Scotland had abolished these charges years ago.

After Johnson's minimal changes a large majority of people using hospital car parks – outpatients, visitors and day-shift staff – would still have to fork out hefty sums to park, while the continued centralisation of services and loss of local access in many areas, combined with poor or non-existent public transport, ensured that many would have no choice but to travel by car

Social care – a problem deferred

The much bigger problem of social care had also again been kicked into the long grass, after vague proposals to seek a "cross party" consensus having failed to make any headway in the past 9 years, while the yawning gaps in services had left **over a million vulnerable people without any care at all**.

Much of the privately-run care home sector was lurching from one financial crisis to another, with only the larger chains siphoning out hefty profits through inflated "rent" and other payments, while the bulk of smaller care home operators struggled to balance the books and recruit sufficient staff on minimum wage. Domiciliary care, also almost entirely privatised, delivered by oppressed staff on zero hours contracts and minimum wage, was in no shape to take on any extra demand.

This was shown when in December 2020 NHS Providers recognised the need not only to bang the drum for more money for hospitals: instead the demands were for improvements elsewhere in the system:

- "a sustainable solution to the current social care crisis …
- "a reversal of the cuts to public health spending," with investment in prevention services, and
- "a move away from the hospital-centric focus," to invest in mental health, boost primary care and community services.

Long term plan

Reduced to a mere heading in the Queen's Speech, with no further explanation was the proposal for an "NHS Long Term Plan Bill" – to implement a 10-year plan that lacks adequate revenue or capital funding, a coherent workforce plan, or any details on how some of its ideas are to be translated into reality. The Plan also embodied deeply worrying plans to strip away the last vestiges of local accountability and implement so-called "integrated care provider" contracts that carve the NHS up into 42 separate health services, with fears that this could open the way to larger-scale private sector involvement.

Capital shortfall – and misleading claims

On capital investment, it was quite clear that only six of the promised "40 new hospitals" could even get beyond the drawing board before 2024, while 21 other trusts had been fobbed off with a share of £100m "seed funding" to draw up plans which the next government would have to finance.

NHS Providers, which represents NHS and foundation trusts, had been running a campaign for a big increase in capital spending. Its chief executive Chris Hopson argued that while £2.7bn had been allocated to the six new hospital projects where "need rebuilding and already have full business cases", averaging of £400-500m per hospital, the government had not said how much capital was to be allocated to the NHS after 2021.

The government was already facing stiff questions from the Office for Statistics Regulation over what turned out to be misleading claims by ministers that £1.8 billion of capital funding announced by ministers back in August was genuinely new money, when most of it was simply the release of money already in trusts' accounts.

Even if the £13 billion turned out to be real money for real hospital schemes, the other obvious question being widely asked was what were the plans to deal with the other NHS capital needs (e.g. mental health, community, ambulance, digital, and the £6 billion backlog maintenance?

20 more trusts were to get a capital sum for long-awaited upgrades and maintenance but over 100 trusts were left with hefty and rising backlog maintenance bills knowing they would be getting no help to repair and upgrade crumbling buildings or replace clapped out equipment unless the new government did an abrupt u-turn in the budget.

The Health Foundation has argued that the UK now spends only half as much on health service capital each year as comparable economies. If capital funding from 2010 had kept pace with growth in revenue funding it would have grown by more than £2bn over the same period – enough to build the equivalent of four new hospitals a year. Instead the bill for backlog maintenance was growing, so issues like leaking roofs and broken boilers, ligature points in mental health facilities and outdated technology could not be fully addressed, let alone any investment made in new buildings and services.

July 2019 saw fire chiefs threaten to close down parts of four hospitals as they were so rundown they had become a hazard to patients and staff. The hospital trusts were required to make improvements or face legal action. An NHS Providers briefing document in August warned: "The NHS' annual capital budget is now less than the NHS' entire backlog maintenance bill (which is growing by 10% a year).

The Health Foundation estimated £3bn each year was needed for the next 5 years to upgrade crumbling buildings and replace outdated equipment: but there was no significant money for backlog maintenance - and only £200m to bring scanner numbers up to EU average, compared with the £1.5bn the Health Foundation argued was needed. Joshua Kraindler, economics analyst at the Health Foundation, warned that: "The capital budget is, in real terms, the same as it was in 2010-11 and as a result, capital investment per NHS worker continues to fall."

Mental health neglected

And while £13 billion was allegedly coming eventually for shiny new **acute** hospitals, mental health services had been left to struggle on with no new investment. The bonanza of cash hand-outs before the autumn Conservative Party conference included promises of a measly £70m for 12 mental health 'pilot areas', where the NHS was expected to seek help from charities and local councils. And after thousands of mental health nursing posts had been lost, ministers vaguely promised to recruit "about 1,000 extra specialist staff" to the pilot areas, while other areas within serious problems got nothing.

Revenue and deficits

On revenue spending the picture was just as bleak: NHS trusts up and down the country had racked up massive cumulative deficits in the form of loans from the Department of Health and Social Care which they were in no position ever to repay.

Many had no plan or hopes of returning even to a recurrent break-even position, and were relying on continued rounds of "cash funding loan finance" to stave off bankruptcy. On many trust annual reports, auditors stated "a material uncertainty that may cast significant doubt on the Trust's ability to continue as a going concern."

The Health Service Journal estimated that "trusts' combined debts to the department reached £14 billion by the end of 2018-19." Loans from the DHSC were half as much again as the £9 billion still outstanding in payments on 100+ PFI hospital projects: some of the trusts in deepest trouble were running both a loan and a PFI contract. Four of the ten trusts with the largest relative loans compared to income had major PFI contracts.

The Nuffield Trust and the Institute for Fiscal Studies both damned the claim of £33.9 billion increased funding (£20.5 billion in real terms) over 5 years with faint praise, arguing that the money would merely "help stem further decline in the health service".

They also pointed out that increases of at least 4% a year on average are needed in order to meet the NHS's needs and see any improvement in its services. Anita Charlesworth of the Health Foundation echoed the same view:

"Healthcare funding has grown by an average of 2 per cent a year since 2010…. less than the overall rise in public spending, and below the estimated increases needed to address the lack of investment in staff and public health over recent years."

The £20.5bn increase also only applies to the part of the health budget controlled by NHS England. So parts of the Department of Health and Social Care budget – including the education and training of doctors, nurses and health professionals and the public health grant income to councils for sexual health and children's services – were to get nothing and FALL in real terms. Far from generous, the allocation threatened to bring more damaging cuts.

By claiming it was '£33.9 billion extra' ministers were exaggerating its real value … by 65%.

Why NHS funding needs to rise each year

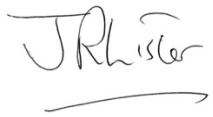
According to the Institute for Government demand for hospital services has been rising rapidly as a result of demographic change. The population of England rose by 6.6% between 2009 and 2017, but the number of people aged over 65 increased almost three times as fast – 19.4% in the same period. In 2016/17 the over 65s made up 18% of England's population, but accounted for more than 40% of hospital treatment.

Spending on medicines in hospitals doubled in cash terms between 2010 and 2017 ("a real terms increase of 80%"), and this helped to keep health inflation higher than general inflation. National average costs per episode of hospital care increased by 7% for emergency short stays, 20% for emergency long stays, and 27% for elective inpatient care, with A&E care increasing in cost by 22.1% between 2012 and 2017.

Numbers of admissions via A&E increased by almost 31% from 2009 to 2018, while elective admissions rose by almost 20% over the same period, outpatients increased by 42% and diagnostic tests by over 50%.

All this underlines why NHS spending has to increase each year to keep pace with these pressures – and rise faster to ensure services can be improved.

I confirm that the opinions I have expressed represent my true and complete professional opinions on the matters to which they refer.



John Lister **23 February 2021**

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SIGNED **DATE**

Please return to Inquiry@keepournhspublic.com

Thank you
Olivia O'Sullivan
Secretary to the panel
The People's Covid Inquiry

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I, ……., confirm that this statement is true to the best of my knowledge and belief:

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SIGNED **DATE**