AGENDA

Meeting: Health Committee

Date: Wednesday 2 March 2022

Time: 2.00 pm

Place: G02 – G03 – G04, LFB Headquarters, 169 Union Street, London, SE1 0LL

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Members of the Committee

Caroline Russell AM (Chair)

Emma Best AM (Deputy Chairman)

Andrew Boff AM

Krupesh Hirani AM

Dr Onkar Sahota AM

A meeting of the Committee has been called by the Chair of the Committee to deal with the business listed below.

Proper Officer: Mary Harpley, Chief Officer
Tuesday 22 February 2022

Further Information

If you have questions, would like further information about the meeting or require special facilities please contact: Diane Richards, Committee Officer; Telephone: 07925 353478; Email: diane.richards@london.gov.uk.

For media enquiries please contact: Emma Bowden, External Communications Officer; Telephone: 07849 308897; Email: emma.bowden@london.gov.uk. If you have any questions about individual items please contact the author whose details are at the end of the report.

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Agenda
Health Committee
Wednesday 2 March 2022

1 Apologies for Absence and Chair's Announcements

To receive any apologies for absence and any announcements from the Chair.

2 Declarations of Interests (Pages 1 - 4)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk, 07925 353478

The Committee is recommended to:

(a) Note the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, as disclosable pecuniary interests;

(b) Note the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s); and

(c) Note the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at Agenda Item 2) and to note any necessary action taken by the Member(s) following such declaration(s).

3 Minutes (Pages 5 - 52)

The Committee is recommended to confirm the minutes of the meeting of the Health Committee held on 13 January 2022 to be signed by the Chair as a correct record.

4 Summary List of Actions (Pages 53 - 66)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk, 07925 353478

The Committee is recommended to note the completed and ongoing actions arising from its previous meetings.

5 Responses to The Toilet Paper Report (Pages 67 - 78)

Report of the Executive Director of Assembly Secretariat

Contact: Diane Richards, diane.richards@london.gov.uk, 07925 353478

The Committee is recommended to note the responses from the Mayor of London and the Secretary of State for Levelling Up, Housing and Communities to the Committee's *The Toilet Paper* report, as attached at Appendices 1 and 2.

6 Health Inequalities Strategy Implementation Plan 2021-2024 (Pages 79 - 82)

Report of the Executive Director of Assembly Secretariat

Contact: Dan Tattersall, daniel.tattersall@london.gov.uk; 07783 805825

The Committee is recommended to:

a) Note the report as background to putting questions to invited guests and note the subsequent discussion; and

b) Delegate authority to the Chair, in consultation with party Group Lead Members, to agree any outputs from the discussion.

7 Date of Next Meeting

The next meeting of the Committee will be confirmed at the London Assembly's Annual Meeting on 6 May 2022.

8 Any Other Business the Chair Considers Urgent

Subject: Declarations of Interests

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**2 March 2022**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report sets out details of offices held by Assembly Members for noting as disclosable pecuniary interests and requires additional relevant declarations relating to disclosable pecuniary interests, and gifts and hospitality to be made.

2. Recommendations

2.1 **That the list of offices held by Assembly Members, as set out in the table below, be noted as disclosable pecuniary interests;**

2.2 **That the declaration by any Member(s) of any disclosable pecuniary interests in specific items listed on the agenda and the necessary action taken by the Member(s) regarding withdrawal following such declaration(s) be noted; and**

2.3 **That the declaration by any Member(s) of any other interests deemed to be relevant (including any interests arising from gifts and hospitality received which are not at the time of the meeting reflected on the Authority's register of gifts and hospitality, and noting also the advice from the GLA's Monitoring Officer set out at below) and any necessary action taken by the Member(s) following such declaration(s) be noted.**

3. Issues for Consideration

3.1 The Monitoring Officer advises that: Paragraph 10 of the Code of Conduct will only preclude a Member from participating in any matter to be considered or being considered at, for example, a meeting of the Assembly, where the Member has a direct Disclosable Pecuniary Interest in that particular matter. The effect of this is that the 'matter to be considered, or being considered' must be about the Member's interest. So, by way of example, if an Assembly Member is also a councillor of London Borough X, that Assembly Member will be precluded from participating in an Assembly

meeting where the Assembly is to consider a matter about the Member's role / employment as a councillor of London Borough X; the Member will not be precluded from participating in a meeting where the Assembly is to consider a matter about an activity or decision of London Borough X.

3.2 Relevant offices held by Assembly Members are listed in the table below:

Assembly Member Interests

Member	**Interest**
Marina Ahmad AM	
Shaun Bailey AM	
Elly Baker AM	
Siân Berry AM	Member, London Borough of Camden
Emma Best AM	Member, London Borough of Waltham Forest
Andrew Boff AM	Congress of Local and Regional Authorities (Council of Europe)
Hina Bokhari AM	Member, London Borough of Merton
Anne Clarke AM	Member, London Borough of Barnet
Léonie Cooper AM	Member, London Borough of Wandsworth
Unmesh Desai AM	
Tony Devenish AM	Member, City of Westminster
Len Duvall AM	
Peter Fortune AM	Member, London Borough of Bromley
Neil Garratt AM	Member, London Borough of Sutton
Susan Hall AM	Member, London Borough of Harrow
Krupesh Hirani AM	Member, London Borough of Brent
Joanne McCartney AM	Deputy Mayor
Sem Moema AM	Member, London Borough of Hackney
Caroline Pidgeon MBE AM	
Zack Polanski AM	
Keith Prince AM	
Nicholas Rogers AM	
Caroline Russell AM	Member, London Borough of Islington
Dr Onkar Sahota AM	
Sakina Sheikh AM	Member, London Borough of Lewisham

3.4 Paragraph 10 of the GLA's Code of Conduct, which reflects the relevant provisions of the Localism Act 2011, provides that:

- where an Assembly Member has a Disclosable Pecuniary Interest in any matter to be considered or being considered or at

  (i) a meeting of the Assembly and any of its committees or sub-committees; or

  (ii) any formal meeting held by the Mayor in connection with the exercise of the Authority's functions

- they must disclose that interest to the meeting (or, if it is a sensitive interest, disclose the fact that they have a sensitive interest to the meeting); and

- must not (i) participate, or participate any further, in any discussion of the matter at the meeting; or (ii) participate in any vote, or further vote, taken on the matter at the meeting

UNLESS

- they have obtained a dispensation from the GLA's Monitoring Officer (in accordance with section 2 of the Procedure for registration and declarations of interests, gifts and hospitality – Appendix 5 to the Code).

3.5 Failure to comply with the above requirements, without reasonable excuse, is a criminal offence; as is knowingly or recklessly providing information about your interests that is false or misleading.

3.6 In addition, the Monitoring Officer has advised Assembly Members to continue to apply the test that was previously applied to help determine whether a pecuniary / prejudicial interest was arising - namely, that Members rely on a reasonable estimation of whether a member of the public, with knowledge of the relevant facts, could, with justification, regard the matter as so significant that it would be likely to prejudice the Member's judgement of the public interest.

3.7 Members should then exercise their judgement as to whether or not, in view of their interests and the interests of others close to them, they should participate in any given discussions and/or decisions business of within and by the GLA. It remains the responsibility of individual Members to make further declarations about their actual or apparent interests at formal meetings noting also that a Member's failure to disclose relevant interest(s) has become a potential criminal offence.

3.8 Members are also required, where considering a matter which relates to or is likely to affect a person from whom they have received a gift or hospitality with an estimated value of at least £50 within the previous three years or from the date of election to the London Assembly, whichever is the later, to disclose the existence and nature of that interest at any meeting of the Authority which they attend at which that business is considered.

3.9 The obligation to declare any gift or hospitality at a meeting is discharged, subject to the proviso set out below, by registering gifts and hospitality received on the Authority's on-line database. The gifts and hospitality database may be viewed online.

3.10 If any gift or hospitality received by a Member is not set out on the online database at the time of the meeting, and under consideration is a matter which relates to or is likely to affect a person from whom a Member has received a gift or hospitality with an estimated value of at least £50, Members are asked to disclose these at the meeting, either at the declarations of interest agenda item or when the interest becomes apparent.

3.11 It is for Members to decide, in light of the particular circumstances, whether their receipt of a gift or hospitality, could, on a reasonable estimation of a member of the public with knowledge of the relevant facts, with justification, be regarded as so significant that it would be likely to prejudice the Member's judgement of the public interest. Where receipt of a gift or hospitality could be so regarded, the Member must exercise their judgement as to whether or not, they should participate in any given discussions and/or decisions business of within and by the GLA.

4. Legal Implications

4.1 The legal implications are as set out in the body of this report.

5. Financial Implications

5.1 There are no financial implications arising directly from this report.

List of appendices to this report:

None

Local Government (Access to Information) Act 1985

List of Background Papers: None

Contact Information

Contact Officer:	Diane Richards, Committee Officer
Telephone:	07925 353478
E-mail:	diane.richards@london.gov.uk

MINUTES

Meeting: Health Committee

Date: Thursday 13 January 2022

Time: 10.00 am

Place: G02 – G03 – G04, LFB Headquarters, 169 Union Street, London, SE1 0LL

Copies of the minutes may be found at:

www.london.gov.uk/about-us/london-assembly/london-assembly-committees

Present:

Caroline Russell AM (Chair)

Emma Best AM (Deputy Chairman)

Andrew Boff AM

Dr Onkar Sahota AM

1 Apologies for Absence and Chair's Announcements (Item 1)

1.1 There were no apologies for absence. In accordance with Standing Order 2.4, Krupesh Hirani AM participated in the meeting remotely, with the permission of the Chair.

1.2 The Chair extended the Committee's congratulations to Professor Kevin Fenton on his Commander of the Order of the British Empire (CBE) award in the New Year Honours List for service to Public Health.

2 Declarations of Interests (Item 2)

2.1 The Committee received the report of the Executive Director of Assembly Secretariat.

2.2 **Resolved:**

That the list of offices held by Assembly Members, as set out in the table at Agenda Item 2, be noted as disclosable pecuniary interests.

3 Minutes (Item 3)

3.1 **Resolved:**

That the minutes of the meeting held on 25 November 2021 be signed by the Chair as a correct record.

4 Summary List of Actions (Item 4)

4.1 The Committee received the report of the Executive Director of Assembly Secretariat.

4.2 **Resolved:**

That the completed, ongoing and closed actions arising from previous meetings of the Health Committee be noted.

5 Action Taken Under Delegated Authority (Item 5)

5.1 The Committee received the report of the Executive Director of Assembly Secretariat.

5.2 **Resolved**

That the recent action taken by the Chair under delegated authority, following consultation with party Group Lead Members, namely to agree *The Toilet Paper* report, as attached at Appendix 1, be noted.

6 COVID-19: The Current Situation in London and the Indirect Effects of the Pandemic (Item 6)

6.1 The Committee received the report of the Executive Director of Assembly Secretariat as background to putting questions to the following invited guests:

Session 1: COVID-19: The Current Situation in London

- Professor Kevin Fenton CBE, Regional Director for London, Office of Health Improvement and Disparities;
- Martin Machray, Executive Director of Performance and Covid-19 Incident Director, NHS England and NHS Improvement- London; and
- Daniel Elkeles, Chief Executive, London Ambulance Service.

Session 2: The Indirect Effects of the Pandemic

- Martin Machray, Executive Director of Performance and Covid-19 Incident Director, NHS England and NHS Improvement;
- Siva Anandaciva, Chief Analyst, The King's Fund;
- Emma Tingley, Head of Partnerships- London & South East Regions, Macmillan Cancer Support; and
- Dr Chaand Nagpaul, Chair of Council, British Medical Association.

6.2 Transcripts of the two sessions are attached at **Appendices 1 and 2**.

6.3 During the course of the first panel discussion, the Executive Director of Performance and Covid-19 Incident Director, NHS England and NHS Improvement- London, agreed to:

- Provide data regarding the numbers of children who are being admitted to hospital and to intensive care due to COVID-19/Omicron; and
- Share details of the plan to improve recruitment and retention of NHS nursing staff.

6.4 During the second panel discussion, the Chair of Council, British Medical Association, agreed to send the plan detailing a different model to deliver care that brings primary and secondary care together.

6.5 The Head of Partnerships, London and South East Regions, Macmillan Cancer Support agreed to circulate the MacMillan *Cancer Nursing on the Line* report.

6.6 **Resolved:**

(a) That the report and subsequent discussion be noted.

(b) That authority be delegated to the Chair, in consultation with the party Group Lead Members, to agree any output arising from the discussion.

7 Health Committee Work Programme (Item 7)

7.1 The Committee received the report of the Executive Director of Assembly Secretariat.

7.2 **Resolved:**

That its work programme be noted.

8 Date of Next Meeting (Item 8)

8.1 The next meeting of the Committee was scheduled for 2 March 2022 at 2.00 pm in the Chamber, City Hall.

9 Any Other Business the Chair Considers Urgent (Item 9)

9.1 There were no items of business that the Chair considered to be urgent.

10 Close of Meeting

10.1 The meeting ended at 13.09pm.

Chair Date

Contact Officer: Diane Richards, Committee Officer; Telephone: 07925 353478;
Email: diane.richards@london.gov.uk

London Assembly Health Committee - Thursday 13 January 2022

Transcript of Agenda Item 6 Panel 1 – COVID-19: The Current Situation in London

Caroline Russell AM (Chair): That brings us to today's main item. I would like to extend a warm welcome to our first panel of guests, joining us virtually to discuss the current COVID-19 situation in London. We have Professor Kevin Fenton CBE, Regional Director for London, the Office of Health Improvement and Disparities, Martin Machray, Executive Director of Performance and COVID-19 Incident Director for the NHS England and NHS Improvement – London, and Daniel Elkeles, Chief Executive of the London Ambulance Service. Thank you, all three of you, for giving us your time at what is an incredibly busy time for everyone working in health as we come through this Omicron wave, which seems to be having a huge impact on sickness levels as well as the numbers of people who are needing help in our hospitals.

That brings me to our first question. Kevin, what is your assessment of the current risk that is posed by COVID-19 to London and Londoners? What do you expect the next month to look like in terms of case numbers, reinfections, and sadly, deaths?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Thank you very much, Chair. Good morning, everyone. May I begin by just saying thank you to the Assembly Members for the congratulations at the beginning. This is really a time to thank and acknowledge the tremendous work of our public health staff across the city as well as wider health and care staff that have been working on the pandemic over the past two years. As we are navigating the Omicron wave and preparing for the end of this wave, and living with COVID as we move forward, the work of all of the public health and health and care staff will continue to be critical.

To reflect initially on where we are with the Omicron wave, colleagues will remember that the variant was first described in November of last year. Very soon after its discovery we identified cases in London. As an infectious disease epidemiologist, I must say this is the most infectious agent I have ever seen in my practice or have had the privilege of working on. At the beginning of the emergence of Omicron it was clear that we were seeing phenomenal doubling times within the city. Numbers of cases of Omicron were increasing every 1.7 to 2 days initially. We have seen significant increases throughout the Christmas holidays and into the new year.

This wave peaked at rates in excess of 2,000 per 100,000. That is more than five times what we were seeing at the beginning of November. The peak itself is thought to have occurred just before the new year, consistent with what we saw in last year's peak over the winter period. Since the new year, we have been seeing gradual declines in case rates. Initially in all ages, and then more recently we have begun to see a downturn in cases rates in those aged over 60.

Although there is a temptation to say that the worst is behind us, that may be true in terms of the peak, however I would like to draw the Committee's attention to the fact that our rates are still phenomenally high. They are in excess now of 1,500 per 100,000. That is more than four times higher than where we were before the wave started. We still see very high rates of infection across the city. People are still getting unwell. Sickness absence rates are still significant in both health and care as well as the wider workforce. This means that everything that we can do to help to drive those rates down will be critical. This includes adherence to the Plan B measures.

Finally, Chair, you asked me to reflect on a forward look as to what we might expect to see in the coming weeks. There are three things that I will be concerned about as we progress through this month and into [February]. The first is that we continue to see sustained declines in case rates, both in all ages, as well as in those aged over 60. Those declines - especially when combined with reductions in Office for National Statistics (ONS) community prevalence estimates - will give us the assurance that we are truly past the wave and that we are now seeing true declines in the spread of the infection across the city. We have to have that assurance of community prevalence reductions because of the changes that have recently been introduced in the testing policy and regime nationally. That is the first thing.

The second will be a concomitant reduction in the pressures both on National Health Service (NHS) admissions but also in the prevalence of infection among those who are most vulnerable in our communities. Here I am thinking about the case positivity and prevalence in our care home residents and staff. If we see reductions there, that will augur well for reductions in the pressures on the NHS.

The third thing I will be looking forward to monitoring really carefully with our NHS partners is what is happening with our vaccine rates and vaccine coverage in the city. Vaccination remains the most effective tool that we have to control the pandemic in the region. Our rates are lower generally than are other regions nationally. The combination of increasing booster coverage plus exposure to the virus over the course of the pandemic will continue to give and ensure that London has a strong vaccine wall and immunity wall, which is what will be necessary for resilience as we exit the Omicron wave.

Chair, I am going to pause there in terms of where we are with the Omicron wave, and things that we will be looking closely at in the weeks ahead. Thank you.

Caroline Russell AM (Chair): Thank you, Kevin, that was incredibly clear. That figure, 2,000 per 100,000 in terms of the case rates, I remember back in the first wave when we started to get very concerned when the case rates went to above 20 per 100,000. It just shows how much work the vaccines must be doing to help prevent very high levels of hospital admissions and sickness.

What we have heard here is that you talked about a temptation to think that the worst is behind us, and you have given us three things that we need to be thinking about to be sure that the worst is behind us. That is the sustained declines in case rates in all ages and shown through the ONS community prevalence data as well as the testing data because of the changes. You have talked about seeing a sustained reduction in NHS admissions and particularly in case positivity rates for the most vulnerable. You have also talked about checking how our vaccination rates are going. Those are the three things that you want London to be thinking about. Is that before we can begin to think about any change from our Plan B measures?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Decisions on Plan B measures will be taken by Government and that will be a Government policy decision. Our role in London, and certainly as the public health director for London, is to provide assurance that London is ready as and when decisions are being taken on removal of those restrictions. Also, to ensure we do everything to reduce levels of transmission within the city and to ensure we are as resilient as possible. A key part of this, in addition to the three things I have mentioned, is our work collectively to ensure we continue to reinforce the Plan B measures.

In the absence of a more stringent non-pharmaceutical intervention (NPI), for example a national lockdown or further restrictions, we are relying on all Londoners to continue to get vaccinated, to test regularly, to work from home, and to ensure that we are doing everything we can to reduce transmission. That is the other thing

that would be necessary that we continue to work with Londoners and alongside Londoners to help reduce rates of transmission in order to prepare for Government's decision on Plan B.

Caroline Russell AM (Chair): Thank you very much. All that mention of vaccination brings us to our second question, which is going to be taken by Emma Best [AM].

Emma Best AM (Deputy Chairman): Thanks, Caroline. Good morning, guests. Firstly, sticking with you, Kevin, and congratulations on the CBE. I feel like every time I have turned on the news channel recently, I have seen you. Well done on all those broadcasts and putting the points across so well for London recently. I do not need to rehash how poorly we are doing for vaccinations, or I should say how poorly our rates are compared to the rest of the country; we all know that here and on the panel. My question is, how well is the vaccination rollout progressing, including the uptake of boosters, and what action is being taken to bring us more closely in line with the rest of the country?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): I always begin, when reflecting on vaccination, to say that as a large densely-populated urban population, even before the pandemic, we have always had challenges with uptake of both our vaccination and screening programmes within the city. This is consistent with other global cities, other urban centres within the United Kingdom. The COVID vaccine and our journey with the vaccine has been, in a sense, no different. However, I do want to acknowledge that, having recognised London's unique challenges with vaccines, we have been working hand in glove across the NHS, public health and local government, and community partners, even before the first COVID vaccine was available, to both address hesitancy and to ensure we had a vaccination programme that was fit for purpose in London. I am sure my colleague Martin Machray will highlight some of the tremendous progress that we have made.

In the city we are making progress with the uptake of the vaccine and delivery of the booster programme. While our overall rates of uptake will be somewhat lower than those of other regions, do bear in mind that for the most vulnerable, those aged over 60, the difference between other regions and London is significantly less. In other words, for the most vulnerable in the city, we have made excellent progress in ensuring that there is very high coverage of the vaccine as well as the booster programme. That has in part helped us to mitigate the impact of the Omicron wave.

Where we see perhaps more challenge is in the younger people within London, both in the completion of the full three-dose course, the first and second dose and the booster. That reflects a number of factors. It reflects the fact that many younger Londoners may have become infected with the virus through waves one and two. Therefore, there is a natural hesitancy or reluctance or reticence in getting the vaccine because they felt that they have already acquired COVID and therefore the impetus for getting the vaccine may be less.

A second reason of course is the issues of trust and confidence in the vaccine, some misinformation. We have been doing a lot of work across the city to engage communities, using vaccine ambassadors, doing our outreach, to engage with communities to address that.

The third area that we see are people who are not able or confident in navigating the system. There is something about confidence in being able to go in, register through your general practitioner (GP), get your vaccine, or go to one of the mass-vaccination sites. Again, we tackle that by working again with the NHS and local government in our hyper-local approach to vaccine delivery and ensuring that we are getting the vaccine to where people are to reduce the barriers to access.

Then finally there is a lot of narrative and a lot of media interest in antivaxxers, but I want to reassure colleagues that we feel that this is a relatively small proportion of the people in London who have not yet had their vaccines. We are highly focused on trust, information, access, and confidence, as a key strategy for getting our rates up in London.

I will pause there, colleagues, as I have described the overall picture in London and the context for vaccination programmes, as well as some of the work we are doing to tackle some of the hesitancy that we are seeing.

Emma Best AM (Deputy Chairman): Thanks, Kevin. If I could just come back on a couple of points for perhaps some more information. You have outlined a few groups there that have been reluctant to get the vaccine and gave some anecdotal evidence. Could you go into more detail about how you have had those conversations and how you have come to those conclusions about those groups? For example, you said that there are a lot of younger people who think they got COVID in the first wave or know they got COVID in the first wave and were then reluctant to get a booster in the second because of that. Could you detail a bit more about how you came to those conclusions and how you have managed to speak to those groups and understand those concerns and hesitancies?

I know you spoke briefly about going out into communities and some of the hyperlocal ways in which we have done this. The second question was: could you perhaps outline in some greater detail some of those really good examples which I know exist, where that has happened? Perhaps maybe if we could understand if any of them are scalable to do on a larger scale to recommend they are taken across London.

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Great. The insights on what communities want and need to get their vaccines come from a variety of sources. Throughout the course of the vaccination programme, we work with behavioural insights colleagues in the Cabinet Office, who are continually doing market research, and we rely on polling data, which are done by the Greater London Authority (GLA). We also get insights from a number of our London academic partners, who are also looking at the data and canvassing Londoners. Of course, our own public health teams are doing continual review of the evidence and the published literature on the factors which are influencing vaccination uptake, specifically for COVID. We have had an active data analysis and insights programme which has informed the vaccine equity work that we have done in the city.

As the programme is being rolled out, we will have more information on vaccine uptake by different demographic characteristics and a key part of the monitoring that is being done by the NHS allows us to look at the data in many ways. We can look at the intersection, for example, between race, ethnicity and age and area of residence. We can see, for example, within and across boroughs in the city, what vaccine uptake rates are for Afro-Caribbean men of a particular age group. These data are invaluable for our local authority partners. Again, the Office of Health Improvement and Disparities' (OHID) data analysis team works with the NHS to provide cuts of the data to each Director of Public Health in the city to say, "Here are the vaccine uptake rates by key demographic characteristic, including socioeconomic status". Directors of Public Health teams are then able to understand the levels of coverage, where coverage is low and where to target their hyperlocal efforts and that information is available at the ward level. If programmes are needed to do outreach in a particular area, the Directors of Public Health have insight in where to target those. That work is done collaboratively with our integrated care systems (ICSs), NHS, local authority colleagues and local communities in using the data. In summary, we use a range of sources, including polling data, scientific research, as well as programme delivery data to understand both attitudes towards vaccination and how they are changing over time, but also the performance data as well.

You asked a specific question on some of our hyperlocal approaches and I know that Martin will also reflect on this because this is one of the unique things that we have done in London and have done really well. The principle of the hyperlocal approach is that in order to get the vaccines to those communities that need it most, you must rely on a deeper partnership between local communities, the local authority and the NHS locally, supported by great data. You need to have a variety of channels that will speak to the needs of different communities, supported by hyperlocal communications and outreach approaches. If we take a typical model that we have across the city, it will involve in a particular area looking at a range of tools, including the use of community pharmacies. Some boroughs such as [the London Borough of] Brent in the northeast, some of the northeast boroughs and many of our boroughs are now using vaccine buses to deliver the vaccines. That can be complemented by and with outreach workers, who will be knocking on doors doing outreach and spot conversations with members of the public, guiding them where to get their vaccines, combined with culturally appropriate communications materials such as pamphlets/leaflets in different languages and using diverse images as well.

We also use techniques such as town hall events and engagement events, which can be either online or in person, to bring community members together to talk about the vaccine, tackle any myths and misinformation and then to promote the vaccine. That has been also highly effective as well. Then a final strategy that has been used is literally going and knocking on doors and engaging with members of the public. Especially when you have data that says a particular area, sub region or neighbourhood has a very low uptake rate, then using the door knocking engagement has been really helpful. We have used that for testing and getting test kits out. We also use it for promoting vaccines as well, and all of this is supported by our COVID Community Champions and Vaccine Champions.

That gives a sense of the protocols aspect for a hyperlocal approach that we have really developed here in London and has been a key element of our vaccine programme.

Emma Best AM (Deputy Chairman): Thanks, Kevin. That is really, really helpful. I remember I did some of that door knocking myself when I was excited that we were getting the vaccine rollout and, going to door knock when I knew the vaccine centre had spares for the day. That was the first time I realised just quite how much reluctance there was and that was an eye-opening experience. Thank you for all the work you are doing in that.

Turning to Martin. Is there anything you either wanted to add or reiterate from that?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Thank you very much, Assembly Member Best. I can only amplify what Kevin says in many ways. He put it so beautifully and so comprehensively, and I would add a couple of things. In terms of how we understand what is needed and motivations about convenience or motivations about confidence or about complacency, the key in all of this is not just the data, not just the insights we get from the academic institutions and the Cabinet Office but listening to communities. What we have learnt to do much better than probably in the NHS we have ever done before is to listen to our local communities and listen to why they are doing what they are doing. That is whether they are taking up the vaccine, whether they are not taking up the vaccine, and trying to put in solutions that communities suggest or need. When people are not coming to our vaccination centres, why are they not? Would they rather it was in a local pharmacy? Would they rather that we did it door knocking? You can only do that at a hyperlocal level.

It is really important that the NHS works alongside Directors of Public Health, alongside local voluntary and third sector organisations to really provide a service for communities rather than to communities, and that is

why we have been so successful. Although the numbers are not where we would like them to be, I have never known such a successful public health vaccination or screening programme in London in my entire career. This is phenomenally successful and if you compare us with other diverse cities within the country or, indeed, across the globe, London has done brilliantly well. We will come on to it, but that probably plays out in what that means in terms of illness, serious illness and death from COVID-19, which has been much reduced because of the success of the vaccine programme in London. It is not as good as we want it to be, and it never will be. We are perfectionists and idealists, and we want to get this right, but we have done really well.

There are a couple of examples that you may know already about how you do that local delivery and I have a couple to add to that along with the ones that Kevin gave you. We have done some work with particular faith groups, who have had particular sets of questions. We have set up vaccine centres, purely within churches, synagogues and temples and so on, to really drive confidence in communities that this vaccine is good for them. We have worked very closely with faith leaders and, in fact, Kevin, [Dr] Debbie Weekes-Bernard, the Deputy Mayor [for Social Integration, Social Mobility and Community Engagement], and I are having monthly sessions with community leaders where we talk about the vaccine very frequently and listen to what their concerns are.

Another example is in what we term as exclusion health groups, those groups who are not as well served by the NHS and public sector services as we would like them to be, the homeless, the traveller community and similar groups. We have been doing work with the third sector, who are much better linked into those groups than we are as statutory bodies, and we have been working with them. We have worked with all sorts of groups that in the past we probably have not even known about, but now we are successfully delivering vaccine programmes to specific groups. That only is born out of listening to people and listening to what they want from us, rather than saying what is best for them, which is probably how I was trained 30-odd years ago.

Emma Best AM (Deputy Chairman): Thank you, Martin. Coming on to testing, do you have any thoughts on how London has fared, especially through the Omicron wave, in accessing lateral flow tests and polymerase chain reaction (PCR) tests? Has there been any struggle with that and what has the impact been?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Yes, I can talk about access for health and care staff, but I am not sure I can talk about the access to testing overall.

Clearly, everyone who is going to deliver personal care to Londoners needs to make sure that they are both vaccinated and that they test regularly. There has been a programme in place since testing began of making sure that health and care workers get access to lateral flow tests and rapid PCR tests if that is necessary. That has gone on very well. There has been the odd glitch with delivery sometimes and there has been for the past few months a requirement that NHS staff like me access the same stocks of lateral flow tests as everyone else. I have to go online and order my box of seven or go to my local pharmacist, and we have experienced some of the same issues that the general public have felt over the past couple of months when demand for lateral flow tests has shot through the roof because of the Omicron wave. We have had some tricky moments but nothing that has got in the way of care and nothing that has stopped care being delivered across London. I am sure there will be a member of my profession, a nurse, who will be going, "No, that's not true. I couldn't get hold of a vaccine yesterday and it will stop me getting in to work". Overall, our Trusts are reporting that access remains good if sometimes it has been a bit tricky on a day-to-day basis.

Emma Best AM (Deputy Chairman): Brilliant and that is reassuring to hear, Martin. Just quickly before I go to Kevin, is there anything else that you would like to see from the GLA or the Mayor to support you and your work with vaccines and testing?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Well, just to acknowledge the strong leadership of the Mayor and the GLA over the course of, again, the pandemic.

Emma Best AM (Deputy Chairman): Sorry, Kevin. That was just to Martin quickly.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): OK, can I start where I should have started? I will apologise. I should have started by thanking Assembly Members for their support because the Assembly has been brilliant. I have met with group leaders on a regular basis, and I hope those meetings have been fed out to other Assembly Members. That is massively supportive because we also get to hear from your constituents about what their concerns are, and we have been able to address them directly. The Mayor equally has been fantastically supportive, both in his ability to convene groups, as I mentioned about the community network, but also in the way that the communications from the GLA and the Mayor have really supported London. The ones we need to thank most of all for the success of the programme are Londoners themselves. Londoners have come forward in their millions to be vaccinated and today we are in a place because Londoners have looked after London and for that I am eternally grateful.

Emma Best AM (Deputy Chairman): Thank you, Martin. It is a point really well made and it cannot be made enough, I do not think, over the course of this meeting. Kevin, to you just on testing, was there anything that you wanted to add?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Yes, very briefly, that as we were going through the peak of the pandemic we did see constraints on testing capacity, especially as other regions began to take off with their Omicron waves, and that put a huge demand on the system nationally. At the beginning of January [2022] for the first week or so, we did see testing capacity constraints across the city and our testing rates fell initially. Over the past week, I am really pleased to say that we have seen significant increases in PCR capacity for the city, and we have increased the numbers of mobile testing units, which are available, as well as the lateral flow device availability has increased significantly. We are now looking at in excess of a one million test kit ordering capacity nationally, and there is a lot more capacity which is now available, and Londoners are taking full advantage of the tests. From our activity data, we can see that while we are no longer reaching the maximum capacity for the city, we are still maintaining very high rates of testing and that is important because we do want to encourage Londoners to continue to test. We also want to encourage Londoners when they do a lateral flow device test to please register the results, whether it is a positive or a negative, so that we can get a good handle on what is happening with levels of infection in the city.

Caroline Russell AM (Chair): Thank you, Emma. That brings us to Andrew Boff [AM], who is going to lead the next section of questions.

Andrew Boff AM: Thank you. To Mr Machray, what impact is COVID-19 having on hospital capacity, in particular intensive care units (ICUs)?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): You will recall when I previously gave evidence to this Committee after the second wave, we had experienced really high levels of hospital admissions due to COVID, and we had had particularly challenging high levels of admission into intensive care. That was pre the impact of the vaccine programme and it was a different variant. This time, when we saw the figures that Kevin described shoot beyond to those astronomical levels, our planning was really going to be focused on experiencing something similar, if not far worse. That has, thankfully, proved not to be the case and I will give you the detail as I talk it through.

We have seen a significant increase in admissions into hospital with respiratory disease because of the virus and, to give you an example, our admissions for COVID in a month's period from early December [2021] to early January [2022] trebled. It is not published data yet; that gets published later, as you know. The operational data I see on a day-to-day basis shows that we saw a rise from about 1,000 cases of COVID in our hospitals to over 3,000 within a month, which is a significant rise. However, we did not see the consequential rise in admissions into intensive care, and we did not see it as severe disease at the levels that we saw last time. It is not to say we did not see it at all, and we have about 200/220 patients in our intensive therapy units (ITUs) now with COVID. The vast majority of them have not got a completed vaccine record - so no vaccine or only a first dose - and the few others that are in there usually are immunocompromised and have other serious illnesses linked with their COVID status. I am pleased to report that the impact on serious illness is not what it was. For some individuals though, it is still very significant and we are still seeing deaths from COVID and from this variant of COVID.

Andrew Boff AM: If I can be clear, we have seen a trebling of admissions to hospitals --

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Yes.

Andrew Boff AM: -- but not concomitant carry-through on admissions to ICU?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Not at the same levels, no. What we call the gearing ratio, the percentage of patients who go on to ITU, is much greater, so far fewer patients into ITU.

Andrew Boff AM: But there are still, however, 220 in ICUs?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): At last night's figures, yes.

Andrew Boff AM: Thank you. What is the current state of play with the new Nightingale surge hub at St George's Hospital and how will that be staffed?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): As we were seeing on those figures in December [2021], we were asked to create extra capacity to be used *in extremis* and hence the Nightingale facility that is being built in the carparks at St George's [Hospital] at Tooting. That would be staffed if it was necessary by stretching our existing staff and bringing in non-clinical staff under supervision to look after the least sickly of our patients who are inpatients. There is no plan at present to use that facility and, as Kevin has described, the current wave of community infection is falling and so are our admissions now, thankfully, for COVID. We have no

expectation under this wave that that would be needed to be staffed or used, but it was there in preparation for that worst case scenario. It would have been staffed in a far less clinically rich staff mix that you have on a normal ward, but that is not our plan at present.

Andrew Boff AM: We saw an example during the first wave of where Nightingale hospitals or units were set up and just not used and then mothballed. How long do you think this arrangement is going to continue for these facilities? Are they going to continue in the long term? Are they going to be there for months or are we going to pack them up as soon as the infections or admissions reduce?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): The history we have got is of three waves now of that sort of pressure where we have looked at extra capacity, the first few times at the ExCel for London and, as you said, the use of that was thankfully very little in both cases. This third time because of the lessons learnt in many ways - trying to staff a facility like that outside the normal healthcare arena was very difficult - we work with our local Trusts to choose an area where it is next to an existing large healthcare facility, which would have made staffing easier. Hopefully, we will never need them again. We have grown our permanent ITU bed base across London over the past two years so that we will not need more ITU beds in subsequent waves. We need to get to a place where we have sufficient beds for future waves, general beds rather than ITU beds, but the last three waves have proved that London has got sufficient beds to deal with that. We will come on to it in a subsequent part of this meeting, but even that puts challenges on other parts of our system.

Andrew Boff AM: Thank you. Anyone who has encountered the army during the vaccination programme and during the assistance has got to have been incredibly impressed by the professionalism that they have. What impact is army support having for London's hospitals?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): It is military in total, and I would hate to think that we forgot about our other services, who have also been great. There are three impacts if you will allow me. We have worked with the military now since February 2020 in different ways, and they have been absolutely brilliant at providing extra staffing capacity at times when we have needed it most. Even in this wave, although the demand on health services has not been as great as it might have been, you will also know that our staffing levels because of COVID absences have been very challenged, as every other employer has been very challenged by that. The military coming in and providing support when we need them because of the staffing level has been fabulous.

The second impact though is on the morale that brings to our services as well. I was talking to one of our Trusts only last night, who had just been in receipt of 20 military personnel this week. They were saying the smiles on the faces of the staff nurses and the doctors in the accident and emergency (A&E) departments in which they came to work, could not be measured with the rulers they had in the department. It really brings a sense of support. People are heard and that is really important. That is the second impact.

The third impact is the long-term learning we have got from the military, particularly around their planning and logistics and their ability to mobilise things. I am sure Daniel [Elkeles] from the London Ambulance [Service] may want to comment on this as well, but we have learnt an awful lot from working alongside the military in the skill sets that they bring that we do not normally think we have in the NHS.

Andrew Boff AM: How are we communicating with the army? Is that something that is a central direction or are local agencies able to call for help? How are we managing that relationship?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): There is a formal process within the NHS, as there is for other public sector organisations, where we have a process that is called, shorthand, MACA. That stands for Military Aid to the Civil Authorities and there is a formal process where we do that. If one of our Trusts thought that it needed military aid, they would come to me as the emergency officer for the city and put their case, and my team would then draw up the MACA request that would go both through military lines to the Ministry of Defence for armed forces, and up to the Secretary of State for Health. That is the formal communication, but of course, as you know, organisations run best on relationships, not formal communications. We have really good relationships with London Division and, in fact, my boss is currently meeting with Major General [Christopher] Ghika of London Division as one of his regular catch-ups today and they meet on a regular basis. I have a Military Liaison Officer based in the building here with me and we speak on a daily basis. We have those relationships, working all the way through those formal communication lines that you would expect, and that then plays out into the local. When troops are deployed into a Trust or into the vaccination programme, they are tasked by the local Health Service Manager, but they do that in conjunction with the commanding officer of that troop or group of soldiers and that works really well.

Andrew Boff AM: Thank you. Mr Elkeles, what has been your experience of the involvement with the army with regard to the London Ambulance Service (LAS)?

Daniel Elkeles (Chief Executive, London Ambulance Service): We have not been part of the MACA process, but there is another process where you can ask for support for things, and to give you advice. We have had one of the military team based in how we are running the incident essentially we have been running for the last few weeks and they are providing loads of support to help us do that. Then, as Martin mentioned, the army is really good at logistics. Clearly, the LAS is a big logistics operation about delivering ambulances to people when they are in need, and we have been using their support to work out how we do that even better than we have been doing it in the past. We have been using them for advice and specialist skills so far.

Andrew Boff AM: Moving on slightly to another subject, have issues with hospital capacity had any knock-on effects for the LAS, such as ambulances waiting for bed spaces before transferring patients into hospitals?

Daniel Elkeles (Chief Executive, London Ambulance Service): The short answer to that question is "Yes". Ambulance handover delays, which there has been a huge amount about in the news, are really quite long, and they are the longest they have been in London for quite a long period of time. However, relative to the rest of the country, they have been good. The teamwork has been really impressive that has gone on in London across my service, all of the hospitals, the five ICSs and the London region about how we manage flow to ensure that ambulances go to the hospital that has the least wait. The teamwork has been really good between my teams and the A&E teams about how we ensure that when there are waits, they are as short as they can be and that patients are treated well. We have got some good examples of new facilities and some of the hospital staff jointly between my team and the hospital team share the load so that we provide better care and get ambulances back on the road more quickly. One of them is at Queen's [Hospital] in Romford, and we can demonstrate thousands of paramedic hours released by the good joint working between our teams to get ambulances back out into the community more quickly.

The December [2021] national performance data came out today, and it is not great reading for the whole ambulance service across the country, but on all of the measures London has done better than the average for the nation, whether that is in answering the phone or responding to category 1, 2, 3 or 4 calls. The thing I would mostly say is an absolute thank you to all our staff and volunteers who have delivered extraordinary care in really difficult circumstances in the last few weeks.

Andrew Boff AM: Thank you. Have there been any other unforeseen issues for the LAS as a result of the Omicron spread?

Daniel Elkeles (Chief Executive, London Ambulance Service): We have had the issues that Martin and Kevin were talking about in terms of staff absence, and they were much higher than we had originally planned in our winter plan. The thing that I am really proud about is we did do a really detailed plan for what we thought could happen in the few weeks in December [2021] and early January [2022] and more or less we delivered the plan. Actually, nothing massively untoward has happened. Essentially, we had a plan, it had some scenarios in it, we have been playing through the scenarios and it has been really helpful that we did really good planning before we got into it.

Caroline Russell AM (Chair): Thank you, Andrew. I would like to bring in Assembly Member Hirani.

Krupesh Hirani AM: Thank you, Chair, and thank you to all the guests for your hard work, not just over the pandemic period but throughout. Firstly, to Professor Kevin Fenton, sticking to hospitalisation, roughly what proportion of COVID-19 patients in London who are hospitalised with COVID-19 are unvaccinated?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): The estimates that we have to date, especially as we went through the peak of pandemic, suggested that three in five patients who were admitted to hospital were unvaccinated. When you include people who were incompletely vaccinated - they may have received only one dose, two doses or just recently received their booster - then that number goes up. That proportion increases to more than 80%. We see a further concentration of that figure when you look at people who are admitted to ICUs, and you see a much larger proportion of people who are unvaccinated or incompletely vaccinated. That confirms the power of the vaccines in preventing severe disease and death.

Krupesh Hirani AM: It also shows the importance of continuing that message on vaccination to the wider public. I have a question on case numbers. While cases have started to decline overall in London, it appears that they are increasing in prevalence in older age groups. Are you concerned that this is already translating into more hospitalisations in the weeks ahead as well as deaths? I have just had this morning a look at the death rates and yesterday's figure was 398, which is quite concerning really, with the number of deaths going up at the level they are going up. 20 May [2021] was in the news quite a lot yesterday for understandable reasons, but I just looked at the rate on that date and it was 328. Deaths yesterday were higher than they were on that infamous date last year, which has been all over the news recently. Are we concerned at how things are going as we stand today, looking at the figures that came out this morning, or are we still confident the vaccine is effectively doing its job and will not lead to further increases in death rates?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): The encouraging data from this week suggests that we are beginning to turn a corner with our case rates, especially in those aged over 60. What we had seen right to the beginning of the week was a plateauing of those rates, and it had been staying relatively stable for a few days and now we are beginning to see some consistent declines in those overall case rates in those aged over 60, who are the most vulnerable. I am also more reassured and confident in that figure because when we look at the positivity of COVID in care home residents and workers, we are no longer seeing the steep increases that we saw. In fact, in both of those groups the prevalence of infection and the positivity of infection are beginning to either plateau or decline. We have an objective measure of the overall population case rates, but if you look at the most vulnerable sector in care home staff and residents, things are beginning to come down.

Remember that the death rates are going to be delayed. There is a lag between reductions in population or community case rates and then a lag after hospitalisation rates begin to decline, before you begin to see the declines in your death rates. The numbers of deaths that we are seeing, although tragic at this time, are going to reflect people who were infected nearly four to six weeks previously, significantly earlier. Although our rates are now beginning to decline in the city, especially in the most vulnerable groups, I would not expect to see significant declines in death rates just yet. There will be a lag before beginning to see that but, thankfully, we are not anticipating that the numbers of deaths that we are seeing will be anywhere near what we saw in waves 1 and 2, again because of the power of the vaccines.

Caroline Russell AM (Chair): Can I pick up on that? There is another aspect of hospitalisation that I have seen a few people commenting on, which is the numbers of children who are being admitted to hospital and to intensive care, I believe. That seems to be unusual for Omicron compared to previous variants.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): I have not got that data with me and I can see if I can provide that to Members afterwards. Operationally, what we are seeing is a small uptick in the number of children being admitted with respiratory conditions, which is not unusual at this time of year. In fact, in some ways it is unusual in that the numbers are not as great as they normally would be. There is a condition, not COVID, known as respiratory syncytial virus (RSV), which is a respiratory condition that affects children and can lead to spikes in the winter of admission into hospital and serious illness into intensive care. Although we have seen a small rise in that, we have not seen it like previous years, and we did not see it at all last year. We are seeing that. We are not seeing significant numbers of children being admitted with COVID. The ones we are most worried about are those who have other vulnerabilities, clinically extremely vulnerable children who have immunosuppression or other long-term chronic conditions or cancer and we have been very worried about them. Making sure that they are vaccinated is really important to protect them and that vaccine seems to be working in supporting that. In fact, we are about to roll out that vaccine programme to even the younger cohorts, who are extremely clinically vulnerable, and 5 to 11-year-olds will get that protection, too. It will not help the general younger population at present, but it will help that group.

Caroline Russell AM (Chair): Thank you. I am going to move on to the final question in this section before we move on to look at the impact on the NHS workforce, which is a question for Kevin. I am trying to tease out the different way that this wave has been handled. We have not had a big lockdown. We did see, certainly anecdotally, people on the Tube and on buses wearing masks more once the Omicron wave started and the Plan B measures were brought in. Do you have any comments on whether people are isolating when they are required to, and how well the self-isolation support measures are supporting people to do this? How do you think Londoners are dealing with two years into living with waves of pandemic? Are people a bit exhausted with it all? What is your opinion on how things are going here?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Yes, this is exactly the question. I meet with all the Directors of Public Health in the city every Friday, and of course we have a variety of pan-London co-ordination meetings as we have been working through this wave of the pandemic. We are always getting that pulse check from our local partners on what they are seeing and feeling from local communities and there are four key things that are absolutely apparent.

The first is pandemic fatigue. Although people were initially wary about another wave and the uncertainties about Omicron, Londoners acted - and as Martin and others have said - and have been really good in coming forward for their vaccines and for their boosters. In fact, we saw some of our highest daily uptake rates just

before the Christmas period. From a community perspective, we saw people being engaged, people stepping forward for their vaccines and we were able to complement that with some key messages over the Christmas holidays regarding mixing, reducing risk and testing.

Second, we can also look at people's engagement in testing. Throughout the course of the wave, our messages to Londoners about testing before going out socially, testing before the holidays and ensuring that people are isolating landed well. We could see from the data the demand on testing and that was good.

There are two other areas though that we have been tracking really carefully and they provide us with a sense of where we might enhance our messaging further. The first is around, as you mentioned, the support that people have in this wave to both isolate and to mitigate the economic impacts of COVID. It was clear in waves 1 and 2 where there were really strong packages for isolation support, furloughing and so forth. Somehow, those messages perhaps were not as clear and robust to Londoners. Thankfully, Omicron was less clinically severe for people who are vaccinated, so many people were able to manage their infections and the new guidance on the isolation time periods really made a difference to resilience and returning to work. That certainly was a different feel for this wave of the pandemic.

The second different feel for the pandemic is just the degree to which our businesses were able to fully engage with the advice and guidance. Many of our businesses were able to support the working from home mandate and that is really, really critical. There is the degree to which our communities had the support to do some of the COVID security measures, which are now required as part of Plan B, which includes provision of hand sanitisers, ensuring that vaccination status may be checked for some venues, and of course promoting indoor use of mask wearing. We could probably see from being around the city that perhaps some of those measures could be strengthened as we go through the rest of the season.

It is a mixed picture, Chair. We have robust evidence of how people have engaged in testing as well as in vaccination, and we need to pick that up now as we come out of the New Year period. Then there are some areas where perhaps there have been less stringent measures from Government in terms of the package of support, as well as some of the business activities and enforcement of those that we are seeing now.

Caroline Russell AM (Chair): Yes, we have not seen those community wardens going around my local shopping parade, things like that. Londoners know what to do to stay safe now because we have been through this all before but, yes, from this wave it has been less obvious out on the street. Are there any things, key messages, that Assembly Members should be getting out that we can do - as well as the Mayor actually - about this whole area of sticking to measures and wearing our masks? Is there anything extra that we are not saying at the moment that would be helpful if we were to be sharing?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Yes, there are three key things, Chair. Number 1, we are still in the midst of this wave of the pandemic, we need to work together to drive rates down further and that really requires us to use the tools that we have available to us, which are the Plan B measures. Encouraging all Londoners to continue wearing masks on the Tubes and in indoor venues, as stipulated by the guidelines. We still have work to do on the vaccination rates and we really need everybody. Even if you have been infected over the Christmas holidays with Omicron, please, it is 28 days from the end of your infection to getting your vaccine and that is a key message that we can push out. Of course, working with businesses to encourage all their patrons to observe the COVID secure rules. Those are some of the core messages, that this is not yet over, and those measures are still important for us as a city. Your support in reinforcing those messages will be key.

Caroline Russell AM (Chair): Thank you. That is really helpful and very clear.

Andrew Boff AM: You talked about possibly some mixed messaging earlier. To what extent is mask-wearing important on public transport? The reason I ask this is I got on a bus yesterday and six drivers from the local bus company got on. These were drivers who should have been trained, only two of whom were wearing masks. It looks like people are just not taking mask-wearing seriously, and I wonder if more effort needs to be put into that or whether we have done with masks. What should we be doing?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Masks are important, and they are particularly important because the prevalence is so high at the moment and Omicron is so transmissible at the moment. The combination of the two means that whatever we can do to both reduce the risk of transmitting infection asymptomatically, which is what masks are really good at, and so if I am infected and I wear a mask the probability of me spreading it to others is significantly reduced, but if I am wearing a mask it also helps to reduce the likelihood of me becoming infected by aerosol transmission from others. Masks definitely have a role to play.

However, they only do so if three conditions are met. Number one: that they are worn consistently and correctly. We know of the phenomenon of people wearing the mask on the chin or on the neck and forgetting to bring it up. We see that consistently. That is the first thing: if you are wearing it, wear it consistently and correctly.

Number two: it really requires high coverage of the public wearing masks together to have the population health impact. If only 30% of people are wearing masks, then it will have limited impact on transmission, but if 80% or 90% of people are wearing masks it becomes an even more powerful tool.

Then the third thing is the quality of the masks that people are wearing, especially at this time with a more infectious variant. The single layer of fabric handkerchief covering the nose will not cut it because it is not an effective barrier, which is why we encourage people not to use medical grade masks because that is not what we want, but to ensure that you have a good mask, a good fit and good quality, especially in public transportation and areas where you cannot socially distance.

Masks still remain a key element of the work that we do to reduce rates and I would really encourage everybody in the city, as we are going through this wave, to get back and to continue wearing their masks.

Andrew Boff AM: Just finally, this says many people are hopeful that the Plan B restrictions will ease in two weeks. Do you share this view at the moment?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): It will depend on what happens in other regions of the country. The Government is committed to not having a region-by-region or sub-regional approach to moving from one level of restriction to another. I suspect that the Government will look carefully at the rates of decline of the pandemic in other regions. It will have a close look at NHS pressures and resilience, and then make a decision on what measures would be necessary at that point.

Then there is also going to need to be consideration of what additional measures we need to continue after Plan B measures are released. In other words, it is unlikely that we are going to see rates decline to where they were, for example, in the summer of 2020, below 50 per 100,000, and so we will have some endemic

transmission of the virus for some time. We need to think about what everyday measures we want to put in place as we live with COVID.

Caroline Russell AM (Chair): Thank you very much. I am now going to bring in Dr Onkar Sahota, who is on the front line, actually, of these workforce pressures. Onkar, over to you.

Dr Onkar Sahota AM: Thank you, Chair. First of all, let me just echo the comments by my colleagues of congratulating and thanking all the frontline staff in the NHS and in public health for all the work you have done and to congratulate you, Professor Fenton, on your CBE. It is very well deserved, and I am sure it is a reflection of all the teamwork that supports you.

I will start off my questions with you, Professor Fenton, about masks. Are all masks the same or are there differences in the masks that are available? For example, as a member of the public I might get away with wearing a mask that I can buy off the shelf but, if I work in the NHS, should I be wearing the same mask or should I be wearing a filtering facepiece (FFP) 2 there?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): I am sure Martin will be happy to speak to the NHS's guidelines and regulations on mask wearing, but for the public what we are really getting people to do is just to get an appropriate mask and wearing it correctly, as this is going to be key. For most Londoners, the masks that are available in community pharmacies, the blue basic medical masks are sufficient if worn correctly. For people who are keen to have somewhat greater protection, people are using the N95 masks or FFP2 masks, which are available from a number of online retailers as well as in pharmacies.

What I am really keen to avoid is people using makeshift face coverings at this stage of the pandemic and because Omicron is so infectious. Wherever possible, just upgrade the facial covering that you are using and ensure that it meets the standards of having multiple layers, it is a good fit, and you are wearing it correctly. That is the sort of message I would like to get out to Londoners now.

Dr Onkar Sahota AM: Great. Thank you, Professor. Martin, we are going to talk about the impact on the NHS workforce of this pandemic. Can you tell me what impact increased staff absence rates caused by both by the sickness and self-isolation requirements are having on the primary and secondary workforce in London?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): I was just about to say, because of your role in another life, can I just take the opportunity to thank all of primary care for the work that they have done over the past 24 months? They have been absolutely fabulous and they have had a bad press, which is completely undeserved. I just wanted to say that on record.

Dr Onkar Sahota AM: Thank you.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): In terms of staff absence, the picture is very similar in terms of overall numbers whether it is in primary care - general practices (GPs), pharmacies or dental practices - or indeed in hospitals, but the impact is slightly different.

I will explain. What we have seen since the Omicron wave took its grip in London in December [2021] is that because of the sheer rates of community infection and the rules about self-isolation if you are positive or if

you were in close contact, that had an enormous effect on staff absence rates. Normally we run at this time of year at about 5%, if it is a bad winter, of absences among staff because of sickness. That has gone up a notch in the overall picture in London and the data that is published now on a weekly basis would show that it has gone up and peaked at around 6.5%.

If you think of 6.5% of a workforce of over the quarter of a million people who are working in London's NHS, you can imagine that is not insignificant. That makes a massive difference. If you are a hospital with thousands of staff and you have that rate of absenteeism, it is really difficult, but you can mutually aid. When I used to run a medical ward and I was a member of staff down, I might borrow a member of staff from another ward to make sure that we were safe. That is possible when you have thousands of staff. If you are in a small organisation or indeed a small team, that is more difficult. With the nature of Omicron being so transmissible, it means that if you are in a small team working together - a surgical group, for example, that operates in a specialty or a GP practice where you work within a building together - and you have a very transmissible disease and therefore some of you go off, my overall aggregate figure for London is meaningless because that means the surgery cannot operate, the surgeons cannot do their jobs and that sort of thing.

We have seen that play out over the past five to six weeks. Thankfully, those increases are getting less and there has been brilliant mutual aid between GP practices and primary care to make sure that Londoners get access to their primary care, but it has had a really significant impact. I know that that impact has been felt in all the NHS. Daniel will speak about LAS but it is true with mental health services and hospitals, primary care, and community teams, but it is also felt in our social care services and we are so much part of that team, as you will know as a GP. Our domiciliary care teams and our nursing homes all experience that as well. That then plays back to a question previously asked by an Assembly Member about hospital capacity and the health service capacity. It stops what we would describe as the flow through the system when teams are affected by staff absence. It has been significant, but it is impact on service.

The other thing I would like to say is about the ongoing impact that this pandemic has had on our staff overall, on their wellbeing, their mental health and their mental wellbeing. It has been huge. We cannot underplay the impact that my 270,000 colleagues in the NHS have experienced delivering frontline services. It affects family life in all sorts of ways. It affects personal wellbeing and that has played out over the past few weeks as well. It is not just being absent because of a contact of COVID but also because of the secondary impact that COVID has on people's lives.

Dr Onkar Sahota AM: Thank you, Martin, for describing it very well. Of course, we entered the pandemic not in a good place in the NHS. At that time, we had a vacancy rate of 9,000. Beds were being occupied 97% of the time. Despite some people arguing that there should be cuts in beds in London, we actually needed 1,600 more beds across the country, according to The King's Fund. We did not start off in a good place.

The staff were told they would get a respite between the first wave and the second wave. That has not happened and so the morale of the staff is pretty low. What is the impact of this low morale on our staffing levels?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): I recognise the picture you describe, though I am amazed by people's morale. I am not dismissing the point you are making, but our colleagues' resilience has been phenomenal and so that balances it a little bit. We have made sure that staff are being as well looked after as they can be and lots of work has gone into making sure that staff get time away.

However, as you know and I know, we do not run a service that we can switch off for a couple of weeks just to give people some respite. I wish that we could. I always remember as a ward manager when I got that job as a charge nurse, my job description said, "You have 24-hour responsibility for your patients". You have that 365 days a year to your list as a GP.

Dr Onkar Sahota AM: Yes.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): You cannot turn off. It is very difficult then to manage how you get people rest and recuperation. It is really important that staff get their holidays, and they get their time off. We ask them to do extra shifts, but we also need to make sure that we are not asking them to fill their off-duty [time] just working more and more because, in the end, there are diminishing returns on that. We need to make sure that we provide support to those staff. It is really difficult after 23 months of a pandemic, but we must continue to work at it.

Dr Onkar Sahota AM: Of course, look, waiting lists have gone up. Access to health services, which are already stretched, are even more stretched. The public are frustrated, and they are taking their anger out on frontline staff, on your nurses, on your doctors. The headline in the *Metro* on 24 December was, "Nurses are afraid of going to work". On 4,000 occasions the police have been called to hospitals in London over the last two years because of attacks on members of staff.

How is this impacting on morale? The public are taking it out on the frontline staff, who are the wrong people to be taking it out on.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Yes. Your point is so well made. When I started training as a nurse, I remember looking after patients who were in their 60s, 70s and 80s, showing me respect as a 21-year-old that I had not earned and did not deserve, but they were hugely respectful for my profession. The vast majority of the public still are. Let us be honest: 99.999% - I am sure a statistician will tell me I am wrong - the vast majority absolutely trust and respect frontline staff, but there has been an increase in the amount of violence and abuse that frontline staff have received, particularly over the last two years. It has an enormous effect on individuals and on teams.

I did not think I would ever work in a health service where we need security guards at our accident and emergency (A&E) departments. I did not think we would need to call the police, who have been brilliant, to help us to resolve issues where people have become violent and aggressive with our staff, who are there to serve them. It is completely unfair.

If there is a message from me today that you could help spread is that that is unacceptable behaviour. People come to work to care and love those who need it most, to look after them when they are ill and to help them to a comfortable death when that time comes. Being abused, being hit, and being physically attacked is completely unacceptable and you can imagine what that does to individuals' lives.

Dr Onkar Sahota AM: Martin, I agree with you entirely. Over the years I have myself seen, when I was a junior doctor, the respect I had from the public and how I wanted to do more for them. Now we have been converted into sometimes the recipients of aggression. My inbox is full of these people and colleagues' too. I am privileged in a way that I can come here and raise their concerns with you and with the leaders of the NHS and give a voice to those people who are serving the communities and are getting abuse for political

judgments being made, for which neither you are responsible nor I am responsible. Maybe I am more responsible in some ways than others, but I just want to echo that comment.

One more thing that we are concerned about is that it has been decided that every member of the NHS should be vaccinated by 31 March [2022]. They have to have their first dose by 3 February. Do you have some measure of how many members of your NHS staff will be affected, people who are resistant to vaccination?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Yes, we have a measure of where we are at with that at present. There are a couple of unknowns, though, and I will explain those as well. Currently, of the health staff who will be affected by the legislation that is going to be enacted - as you say, you must have that first dose by 3 February if you are to have had the second dose in time for the legislation kicking in eight weeks later - we know that over 90% of our staff have now had that vaccination.

We also know from our experience when this legislation was applied in care homes early last year that there were staff who really did not want it but recognised that they wanted to continue to be employed as a healthcare professional or supporting in healthcare. That number will change over the next two to three weeks when people come forward when they know that they have to have it. What we do not know is the scale in that and how much of that delta between over 90% and 100% that would have been.

The other thing we do not know is how many of that remaining just under 10% are genuinely never going to have it because they have an exemption because of their personal circumstances, which is absolutely right. That 10% does not represent 10% of people who are antivaxxers or who are against having the vaccine themselves, a lot of those staff will be people who cannot have that vaccine and we need to put in place mitigations to support them continuing to work and that will be fine. It may be about half of that or it may be more, but we need to see that as it comes through.

There will be a small group of people who currently work in the health service and who will not be able to work at all in health if they do not become vaccinated and are not medically exempt. That is a great loss to the profession, but our job as healthcare professionals is to care for our patients and our public. If being vaccinated helps us prevent disease, and if it protects our most vulnerable, then we should be vaccinated, and we will follow that Government policy. Personally, I think it is my duty to be vaccinated but that is a personal choice I make, but there will be a group of staff who will not be able to work in any Care Quality Commission (CQC) regulated environments - that is care homes, GPs, hospitals and so on - if they are not vaccinated. That will be a loss.

I would really encourage them. It is not too late. There is plenty of capacity to vaccinate you between now and 3 February. We will make sure you are vaccinated if that is what you want to do because we really value your skills.

Dr Onkar Sahota AM: I again echo that, Martin. I am also a person who went for the vaccination on the first day it came out and I was lining up for the booster. Hopefully, some of our colleagues who have a reservation can be persuaded. I agree that they will be a great loss to the profession if we cannot square that one up.

Caroline Russell AM (Chair): Dr Sahota, we are getting lots of messages that we are getting a bit behind on time and so, if I can ask you to just pick up the pace a bit, that would be really helpful.

Dr Onkar Sahota AM: Chair, this is a thing I really am passionate about. I really care about the NHS staff and I am really concerned about these issues. I am raising these issues not only on behalf of myself but on behalf of some of the professionals who have contacted me. I hope that you will allow me the discretion to raise these issues, which are very important.

Caroline Russell AM (Chair): Yes.

Dr Onkar Sahota AM: Thank you. Daniel, what is the current state of affairs in the LAS and how have your staff been responding to the Omicron variant?

Daniel Elkeles (Chief Executive, London Ambulance Service): The current state of affairs is we are extremely busy. The statistic that I heard earlier in the week, which is just phenomenal, is 2.1 million people phoned 999 in London last year. That is 15% more than it was the year before. That is a huge increase in activity. Have our staff responded really well to that huge increase in activity? Yes, they have. Has it been really stressful? Yes. Martin used the word 'resilience'. The resilience of NHS staff is absolutely extraordinary in the face of quite so much demand.

Where we are today, though, is, as Kevin was reporting, is the incidence of Omicron has begun to come down and so the amount of activity is much more like a normal January now than it was a few weeks ago. Our performance has become much better. We are quicker answering the phone and we are getting much quicker at getting to people in the community when they have phoned for us. Sickness levels have come down, too. When they were at a peak, 1,000 people were off sick a few weeks ago. It has now come down several percentage points and so it is much easier to provide a service. Things are challenging and hard, but performance is getting better. That would be my summary.

Dr Onkar Sahota AM: Thank you. Daniel, the LAS has done a tremendous amount of good work. They are not anymore just the conveyers of patients from homes to hospitals, but they do a lot of treatment in people's homes. I want to recognise their contribution and how important they have been in the pandemic.

Are you being supported by the military also and also by the [London] Fire Brigade (LFB)? Is the Ambulance Service relying upon these people also?

Daniel Elkeles (Chief Executive, London Ambulance Service): On the first point about how we do a lot more than just take people to hospital, that is completely true. We have hundreds of really highly trained paramedics who have access to all sorts of services other than taking people to hospital. Less than half the people we see end up being conveyed to hospital. The other half are either treated in their own homes by us or are referred to another part of the NHS. Also, a lot of the response that we have does not actually involve an ambulance. We have lots of solo paramedics and we make use of other kinds of vehicles other than ambulances. There are lots of different treatment options. Now I have forgotten the second part of your question, sorry.

Dr Onkar Sahota AM: How much reliance is there by the LAS on the firefighters and on the military?

Daniel Elkeles (Chief Executive, London Ambulance Service): We currently do not have the support of either the Metropolitan Police [Service] (MPS) or the LFB that we had in the first two waves of COVID. That is in part because they have had the same resourcing challenges as we have had.

As I reported earlier, our performance relative to other ambulance services has remained better. When London was assessing the need and where it should be asking for army support in the Military Aid to the Civil Authorities (MACA) process, as Martin said, the priority for the hospital was greater than the priority for the Ambulance Service. We have used the army, as I said before, to help us in improving how we run ourselves during the incident and in some of the logistical things that we do, but we have not had the same need that other parts of the NHS have had for the direct frontline support from military personnel. Our performance has remained generally better than the rest of the ambulance services.

Dr Onkar Sahota AM: Thank you, Daniel. I just want to come back to you, Martin, for one last question to end this section. We have discussed the problems we have, but we need to improve our recruitment and retention of our nursing staff. The vacancy rate now in London is the highest in the country at 13.1%. Do we have a plan for how to get this workforce crisis resolved?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Yes. Again, I will get the exact details to you if the Committee needs them. That vacancy rate hides a success story over the past two years. The actual number of nurses working in London has grown by thousands in the last two years. From memory, it is approximately 3,500 to 4,000 extra nurses. That is not just new nurses. That is in total. In sum, the number of nurses working in the NHS today has grown in the last two years.

That also reflects the amount of demand and therefore the vacancy rates, of course. We need to grow the staff even further to meet the demand that we are facing. It is not just true in nursing, but it is true in all health professional roles, allied health professional roles and the support staff [roles] that are so vital to making our healthcare services work.

There is a real opportunity in recovery here. As London thinks about recovering from this and growing, the health services and other organisations can help give people hope and opportunity in terms of employment and jobs. If I leave you with a message as a nurse to a doctor and to the Assembly, it would be: if you are thinking about a career in the health service, come forward. There are brilliant opportunities. Be a paramedic. Be a nurse. Be a doctor. It would be great. They are brilliant jobs and they save lives and they make a difference to our city.

Dr Onkar Sahota AM: Great. As I said, we did talk about the problem and I agree with you that this is a wonderful profession and I hope that people are encouraged to come back into it. Thank you very much.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Hear, hear. Thank you.

Caroline Russell AM (Chair): Thank you. Dr Sahota. I am next going to bring in very briefly Emma Best AM, but we are really up against the clock.

Emma Best AM (Deputy Chairman): Yes. I am going to do this in about 30 seconds. It would be remiss not to mention that the major incident was brought in in December [2021] due to NHS vacancies. As we are light on time, could I just get a confirmation from Kevin, Martin, and Daniel, that you were all consulted on the decision to take that? Were you all consulted by the Mayor on the decision? Daniel?

Daniel Elkeles (Chief Executive, London Ambulance Service): Martin asked me, but I am not a consultee. The NHS comes from NHS England in Martin.

Emma Best AM (Deputy Chairman): OK. Kevin and Martin were consulted but not Daniel from London Ambulance.

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Yes.

Emma Best AM (Deputy Chairman): Just to check, were you all happy with the decision to declare a major incident?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): Yes.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Yes. Absolutely.

Emma Best AM (Deputy Chairman): Brilliant. It was important we got that.

Caroline Russell AM (Chair): Thank you very much, everyone. That is all very clear. Our final section is on London's future resilience and I am bringing in Krupesh, who is leading on those questions.

Krupesh Hirani AM: Thank you, Chair. Firstly, what can we learn from the Omicron wave to improve London's resilience to new and emerging strains of COVID-19? We all know that this is not going to be the only wave or variant that we have of COVID. What can we learn from it and for other respiratory illnesses? One of the things that has come out of the pandemic is the importance of lung health and clean air in general. Notwithstanding COVID, there are other illnesses that could benefit from some of the lessons from COVID-19 and the Omicron wave.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Can I kick that off? I have responsibility in the NHS for emergency planning, preparedness and resilience. As the title suggests, I should know that one.

There are three big lessons that we can learn. One I have already mentioned is that we listen to the people we serve and we work with communities, not to communities. That is absolutely vital. The reason why we have done so well on the vaccine programme is because we stopped being paternal and started being part of communities. That is lesson one.

The second lesson is that no single statutory organisation can protect London from subsequent waves. The only way we will do that well is by working in close operational partnership with each other. That requires trust and it requires ongoing dialogue. What we must not do is go, "All right, we are over this one. We will wait till the next one before we talk to each other". We have to keep working in partnership and that is at every level, not just at the London level but at a borough level and at a place-based community level. If you think about my mental health community teams or the community district nursing teams and so on, it has to happen at all those levels.

The third thing I would say we have learned - and this is an NHS organisational reflection - is that we can do things well and rapidly, when before we thought we did things only slowly and badly. That was the narrative about the public sector and certainly about the NHS: it takes forever to change anything. It does not. We can

change and we can respond to the unique circumstances of anything that comes in front of us quickly and well, but only if we learned the two lessons before that I mentioned.

Krupesh Hirani AM: Thank you. Turning to Professor Kevin Fenton, what we have seen in the last couple of years is - probably adding to maybe Martin's answer as well - the importance of local Government and public health delivery locally. As well in the last couple of years, while we have seen funding to the NHS increase, and we have seen more money going in at the acute end, sadly, at the prevention end we have seen the NHS treated very differently, quite starkly.

In my previous life I was the cabinet member for public health in the London Borough of Brent. Just going back to when public health was integrated into local government, it came in with spending cuts that were forced upon local areas mid-budget. Do you feel that we could maybe see a turning point following the crisis on how public health is viewed and invested in, not only by the NHS but by the Treasury as well?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): We can hope that as we emerge from certainly this wave of the pandemic and we begin the process of recovery and addressing the worsened inequalities that have emerged throughout the course of the pandemic, plus the social and economic challenges that we will have in the wake of the pandemic, the role of investment in public health and the role of investment in local Government and local communities will be part and parcel of the Government's thinking moving forward.

The good news for the next financial year is that the public health settlement sees the public health grant increasing with inflationary pressures, and we are not going to see the cuts *per se* that we have experienced for the past five years. I was a director of public health in Southwark before doing my regional director role and so I know first-hand the impact of those cuts on what we are able to do locally.

We are going to have to work as systems, though, to use the resources that we have available differently and more effectively moving forward. For London, it means perhaps looking at more collaborative working across local authorities so that we do for London once what we can, and we use our scarce public health resources effectively. We do that for mental health, and we do it for sexual health and human immunodeficiency virus (HIV). Might there be other opportunities for us to work at a pan-London level to do that?

Secondly, it may be an opportunity for us to use and to work in the sub-regional footprints with the ICSs so that we are leveraging more resources across the NHS, local government and public health to tackle issues and to improve population health. That partnership in the ICSs will be better.

Then third, as we exit the pandemic, we need to ensure that we are working with the Treasury so that the investments and the COVID response are not withdrawn too quickly because we will need that infrastructure for continued vaccine equity work and continued work on the testing infrastructure and capacity. We are going to need mitigations in schools and other settings to reduce transmission, as well as ensuring that we are protecting the most vulnerable. In the next year as we go through this, it is about more efficient use of resources but also maintaining some of that COVID pandemic response infrastructure as well.

Krupesh Hirani AM: Thinking about other sectors in the public sector, I was always struck by Duncan Selbie [Chief Executive Officer, Public Health England] and what he said about prevention in general in terms of looking at the best way to prevent ill health. One of the things that he said is it is about people's wider lifestyles and what they have, the means that they have, income, housing, having a secure roof over their head.

Also, one of the things that we have seen in the pandemic is that areas that experience poor air quality had some of the highest death rates. We have seen the Mayor of London looking at air quality and it has always been an area that he has championed across London, but what confidence do we have that we have the buy-in of other sides of the public sector so that going forward and looking at London's future resilience, we can have a better public health outcome for all residents in London?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): That certainly is our ambition. I am really pleased that as a London system, when we look at other regions in the country, our geographic cohesion and the political - both regional and local - coterminosity means that we can work differently in London. The pandemic has brought us together. I am hopeful and encouraged because we have major pan-London strategies that bring together different constituencies to focus on what London needs emerging from this.

Recently the Mayor has published the revised London Health Inequalities Strategy. That was published in December of last year [2021], just four weeks ago, and that really began to think about how we work across sectors to promote healthier communities and healthier lifestyles to address inequalities, as you say, looking beyond the health and care sector to wider sectors.

Similarly, we are currently refreshing the health and care London Vision, which identifies the 10 priority areas across the city where we need to work together across boundaries to achieve greater impact. Then that is layered onto the grand challenges in the London missions, which also bring diverse stakeholders and constituencies together to tackle the big issues that London is faced with.

At least as a region we have a phenomenal strategic framework and partners around the table who are focused on achieving more than the sum of our parts. That provides the leadership, engagement, and confidence that we need to tackle those wider determinants and to really accelerate our efforts moving forward.

Krupesh Hirani AM: Going back to hospital admissions and Plan B, what would we need to see in terms of case rates and hospital admissions to begin exiting Plan B? What do we need to do to get us to that situation?

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): The Government has not provided any hard case rate thresholds in order to make its decisions on Plan B. Very similar to moving into Plan B, it was more a combination of the trajectory of increases, the pressures on hospital systems and the resilience of the staffing cadre that really informed the decisions. I would anticipate that that qualitative view on a range of indicators will inform the exit.

From my perspective as a public health director, what will help that decision is our adherence to the Plan B measures, as I mentioned before, because in a sense that is the only tool that we have at the moment to help to drive rates down. That includes increasing our vaccination rates, ensuring we have high testing rates, people isolating at home if unwell and of course working from home wherever you can. Those are the key measures that we have. The stronger that we implement them, especially between now and the end of January [2022], the more likely we are to be in a good position to be considered for exiting from Plan B measures.

Krupesh Hirani AM: Martin, do you want to come into that?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): We are asked to provide a position to the Government about the

pressures the NHS is under. You have heard that reported over the past hour of the meeting that they are starting to, in COVID terms, ease. It is then a political judgement about how that plays out across the country and of course it is not just the London region that decision makers will have to take into consideration.

Krupesh Hirani AM: Thank you. I have a final question from me to all the panellists. What is your assessment of the key challenges that London faces in relation to COVID-19 in the next six to 12 months?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): I will take it from an NHS-wide perspective, and we are going to come on to it in a moment. It is making sure that the NHS in London remains able to do what we were set up to do, which is to provide care, free at the point of need, at the time of need. We need to be able to do that whatever your condition, not just COVID. Of course, COVID has taken its toll; we have discussed that. Our priority is making sure that London continues to provide all the care that Londoners need

I would leave you with the ask to Londoners that if they need healthcare, do not think, "I will not do it because of Omicron. I will not do it because of the pandemic". Come forward. We are here to serve you and we do not want you holding onto your symptoms for longer than you need. That is the priority: to get Londoners to use us, and to make sure we continue to be there when Londoners need us.

Professor Kevin Fenton CBE (Regional Director for London, Office of Health Improvement and Disparities): From a prevention perspective, the three challenges will be complacency, clarity, and confidence. We need to tackle complacency over the next few months as people feel that Omicron is behind us. Do we still need to get vaccinated? Do we still need to adhere to measures? We need to be absolutely clear that these measures are still important, and we follow the guidelines as we are exiting Plan B.

We will need to provide clarity because the messaging and the policies for COVID are changing rapidly, the isolation and testing policy and what to do in terms of measures. Cutting through and providing that clarity to Londoners will be important.

Then finally, it is building confidence that as we exit this wave and we begin to live with COVID that we reassure Londoners that we have the tools that we need to manage infection, to keep rates down and to reopen our community and society economically and socially, which will be important for mental and physical health as well.

Daniel Elkeles (Chief Executive, London Ambulance Service): It is hard to know what to say next after that. I will focus on staff. Please respect our staff. They work really hard for you. Also, say the NHS and the care system have the most fantastic careers and so please come and join us because that will really help us provide the best care.

Caroline Russell AM (Chair): Thank you. That has been a really brilliant meeting. Thank you for all of your input, your thoughts and your very clear messages to Londoners and to health service staff. There is an awful lot for us to take away and to think about.

I just want to give you an opportunity, the three of you who are in this part of the meeting, if there is anything that you feel that you have not had a chance to say, speak now. Put your hand up. If not, I am going to draw this part of the meeting to a close with huge thanks to all three of you. Martin, I believe you are staying on for the second part of the meeting, just for the beginning of it, but to Daniel and Kevin, thank you very much. You are free to press the leave button.

London Assembly Health Committee - Thursday 13 January 2022

Transcript of Agenda Item 6 Panel 2 – The Indirect Effects of the Pandemic in London

Caroline Russell AM (Chair): Welcome to part two of the London Assembly Health Committee. We have Martin Machray [Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London] still with us, whom you have all been introduced to already, but I am also welcoming Dr Chaand Nagpaul, Chair of the Council of the British Medical Association (BMA); Siva Anandaciva, Chief Analyst, The King's Fund; and Emma Tingley, Head of Partnerships at Macmillan Cancer Support. Welcome to all our new guests.

In this part of the meeting, we are looking at the indirect health effects of the pandemic and in particular the impact on waiting times for elective and outpatient treatment. I am going to start with Martin Machray, who is, I believe, going to be leaving the meeting after he has given his input to this part. Martin, what is the scale of the problem in relation to diagnostic waiting times for cancer services and waiting times for treatment across London, and are there any specialisms or conditions that are particularly affected?

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): Thank you, Chair, and forgive me that I do have to leave at 12 pm but I thought it would be helpful to give you some data and context for the rest of the meeting.

As you quite rightly point out, there is a huge impact of the pandemic on those parts of the service that are not directly related to treating people with COVID-19. Just to make that in personal terms, what that means is the anaesthetist who has given their all in waves one, two and three in intensive therapy units (ITUs), looking after people who are severely ill or dying is then expected to be providing the anaesthetic support to major surgery at the same time. Of course, staff cannot do all things at all times. That is repeated at every level of the NHS, clinically with the general practitioners who make those referrals in the first place, right through to our porter staff and our catering staff who make our hospitals work. There is a massive impact.

The published data shows for London that our waiting list overall, which includes diagnostics, outpatients and waiting for surgery, has grown over the past 23 months disproportionately to the way it would normally grow seasonally. For London that meant that in the last published data, which was November [2021], there were just about 950,000 people waiting for one of those things in London. Some of those people had been waiting an inordinately long time.

Therefore, the thing we want to focus on most, is making sure that people who need urgent and life-saving surgery or treatment or diagnosis get that no matter where we are in the pandemic. I gave evidence previously to this Committee about how we failed after wave one and two of that. Now we see that the position in London has stabilised in some ways. Although the numbers are still very large for people waiting, we have continued to provide that urgent and emergency care for everyone who has needed it. If you are focusing particularly on elective care, that is people waiting for cancer surgery, for neurosurgery, for those things that save lives or stop lives being completely ruined, they have been continued.

We have been able to do that thanks to our staff, thanks to their resilience and their commitment to their patients but also because of the way we have reorganised some of our services to keep things COVID-free or

COVID-safe in some of those elective pathways, making sure that some surgical services are protected from the potential of cross-infection with COVID, and keeping what we call 'green pathways' clear. That is not always easy and in the last waves that has been increasingly stretched but we have been able to do that, which means that Londoners who needed that immediate care have had it.

It means that also people who are waiting for care that is not lifesaving have waited longer than they would normally, and those numbers are significant. People waiting over a year for an outpatient diagnostic or their surgery has grown now, and the last published data was just over 30,000 people in London who have waited over a year. The majority of those are not waiting for surgery. Given that scale of the numbers, that is still a significant number of people who are waiting for lifechanging treatment.

You can be very dismissive of some surgery and say that it is only varicose veins or only a bunion or whatever it might be, but that is lifechanging. If I cannot pick up my granddaughter because I have not had my surgery, it impacts not only on my life but on the lives of my family. I say that now as a grandfather who was a grandfather in wave one. I want to be able to look after my grandchild and if I cannot because I am waiting for surgery that is a massive impact on my life, but it is not lifesaving.

There are also a number of people waiting even longer and some of this is over two years now. Those numbers are very much smaller and the good news for Londoners is that those numbers, even though we have been in Omicron and this wave of the pandemic, have continued to come down. London as a region is starting to reduce those people waiting for an inordinately long time but that is not to dismiss the impact that has on people's lives.

Outpatients, again, has the same picture but the scale is larger, as you would imagine, and there is lots of work being done to change the way we do outpatients, but it is not black and white and either we will do it all virtually or we will not. This is horses for courses. One of the questions you asked, Chair, was around whether there are any specialties we are worried about. You have to take this specialty by specialty and person by person about what the right approach to caring for people is, particularly in outpatients. Some of our outpatient waiting times do not lend themselves to virtual consultations. They need physical consultations to do a diagnosis, to touch the patient, to listen to them and to actually see their expression on their face. It is so important. In other specialties, we have made great grounds in using digital technology to really speed up those processes.

The area that I am most concerned about is those people - and you may come on to it later - with the lumps, bumps and strange things that are happening to them that they really should get checked out that could become something lifechanging to the point of death. Those cancer symptoms do not hold back and, again, the message I gave in the previous session was that Londoners should not stop coming forward if they are concerned about their health. We are here to help them.

However, there is an enormous backlog we are dealing with. The good news is that London is dealing with it, not as quickly as I would like, but we are dealing with it now. I hope that is helpful, Chair.

Caroline Russell AM (Chair): Thank you. That is incredibly helpful and gives a context from an NHS perspective to frame our conversation. Martin, I am assuming that you are going to leave the meeting now. Thank you so much for your time this morning. It has been incredibly helpful.

Martin Machray (Executive Director of Performance and COVID-19 Incident Director, NHS England and NHS Improvement - London): As always, thank you and stay safe. Thank you for your support.

Caroline Russell AM (Chair): And you. Thank you. I am going to move on now with a question both for Siva and for Emma. Both the direct and the indirect effects of the pandemic have not played out equally for all groups of the population. How have these inequalities shown themselves in terms of access to services and delays in diagnosis and treatment? Is this something that the Mayor could highlight given his remit to address health inequalities in London? Emma, would you like to start?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Yes, thank you, Chair. Just to give some of the context around the cancer numbers in terms of what that backlog is looking like for London, we know that there are about 4,500 fewer people who started cancer treatment between March 2020 and October 2021, which is a really significant number. Pre-pandemic somebody in London was diagnosed with cancer roughly every 15 minutes and we have around 230,000 people in the capital living with a diagnosis of cancer.

In terms of the numbers of people, around 70,000 fewer people than expected are seeing a specialist with a suspected cancer diagnosis. We know that not all of those people will go on to get a confirmed cancer diagnosis, but that is down by about 13%. Again, in terms of performance and that delay, we have around 84% of cancer patients seeing their first consultant appointment within two weeks of an urgent referral, which is down on where it was previously for London. We were hitting the national target of 93% in 2019.

In terms of the inequalities that we are seeing, in all of those measures, we know that people who are living in the most deprived areas see a larger drop-off across the board, in two-week wait referrals for suspected cancer, in new diagnoses and in first treatments. That is compared to the people who are living in the least deprived areas.

We do not have the full data at Macmillan Cancer Support just yet, but our early indications certainly show lots of different variations between different patient groups as well by tumour type. We are seeing more lung cancers and colorectal cancers and also some differences in gender and deprivation. We do not have the full data yet but that is what our early indicators are telling us.

Caroline Russell AM (Chair): Thank you. Siva, would you like to come in on that question as well?

Siva Anandaciva (Chief Analyst, The King's Fund): Thank you, Chair. The first thing I would say, at the risk of sounding obvious, is that different people have had different experiences of the pandemic. My simple message is that waiting lists are worse in more deprived parts of the country. By 'worse', I mean that waiting lists are growing faster in more deprived parts of the country, and that once you are on a waiting list you wait longer in more deprived parts of the country.

Colleagues at The King's Fund did some analysis of planned elective care against deprivation of local areas, and what they found looking at how waits had grown over the course of the pandemic was that waiting lists grew everywhere for the most part. Even in less deprived areas waiting lists were up by a third. When you look at the most deprived areas, waiting lists have gone up by 55%. These are not small numbers we are talking about. If you look at extremely long waits, waits that are over a year for planned elective care, again, people are waiting in less deprived parts of the country. Some 4% of people waiting for treatment have been waiting over a year in less deprived parts of the country. That rises to over 7% when you are in the more deprived parts of the country. It is a real problem that the Assembly has identified.

The second thing I would say is there are some bright spots and causes for hope. The first is that when we looked at the analysis there were some anomalies. There were some organisations in more deprived parts of the country that were demonstrating good performance on waiting lists. When you picked at why that was happening, you heard good stories about making every contact count. You had staff from the NHS going to foodbanks to reinforce that message, "We are open for business. What are your health needs? Please come and see us." You also saw them putting in more capacity targeted at communities and more communication targeted at communities who were not using services in the way or as much as we would have hoped.

The second bright spot is that I can honestly say [in] my policy career I have never seen as strong a national focus within the NHS on understanding the different experiences and health inequalities of people on waiting lists. It is something that I had seen done in pockets but never with this strong national focus on really understanding what your waiting list looks like in terms of deprivation.

The third and final thing I will say in answer to the second part of your question over whether there is something that the Mayor and the Assembly can do, absolutely, not just in a generic sense of more focus on the issue being a good thing. When you look at some of the wider determinants of health, some of the things that make us healthier, it goes beyond access to services. When you look at some of the barriers that prevent people accessing services, it is more than choice of appointment. It is whether you can have childcare arrangements, whether you can have support, whether you are allowed to leave your employment to attend an appointment during office hours. Having the Mayor and the Assembly focus on the wider population and the things that matter to people will be absolutely essential because this is not something that the NHS can do by itself if it is going to successfully tackle health inequalities.

Caroline Russell AM (Chair): That is very powerful. You say that there is making every contact count, which is a different approach to thinking about, if you are working in healthcare, how you are engaging with people so that there is more chance that you are going to pick up issues that people need to get help with. Is that what you mean by making every contact count?

Siva Anandaciva (Chief Analyst, The King's Fund): Yes, Chair. Part of the issue is absolutely making sure you have the supply and capacity available so that services are operating when people need them, but that is just not going far enough. In a lot of the places, we have spoken to both within this country and internationally, the sense I get is of proactivity. The best phrase I heard was from someone who works in the Bronx in New York. He said, if you really want to serve your most deprived and most needy populations, you have to go out and find them. There is much more focus on going into communities and understanding their needs rather than saying, "We are open for business. Come and use us if you need to."

Caroline Russell AM (Chair): That is a bit like what the NHS has been doing around the vaccine rollout and the tackling vaccine hesitancy. Martin was talking, in the first section of our meeting, about being in and of the community to try to get the messages across rather than having a paternalistic, top-down healthcare approach. That is very helpful.

Is there anything else that either of you two want to say before I move on to Emma [Best AM], who is taking on the next question, in particular about the inequality side and either good things that have come out of the pandemic approach, or challenges that have come through that particularly relate to inequalities? Emma?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Certainly, in personalised cancer care and how we meet people's needs not just beyond diagnosis, there has been a really positive focus on inequalities over the last 12 months. It is the first time since I have been in this

role over the last four years that we have had a pan-London personalised care cancer inequalities board really focusing in on this. There are some definite positives that are happening, yes.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): On this issue, I just wanted to say that a lot of effort has been made but we still are suffering huge inequalities when you look at the data around intensive care. You still have such a stark disparity with three times more likelihood of being in intensive care if you are from a deprived social class 5 compared to social class 1. That is recent data. Similarly, in terms of ethnicity, you have all been aware how much the pandemic shook us all when we saw the disproportionate impact on ill health and death. In intensive care now, again, you carry on seeing that disparity of disproportionate numbers of ethnic minorities in intensive care, especially those of a black background. That of course also then leads into the other debate around vaccination and the levels of uptake among some communities. I know this is about waiting lists, but all of this does impact on the health service. On those inequalities we are making a lot of effort, but we really do need to do better collectively.

Caroline Russell AM (Chair): Thank you. Siva?

Siva Anandaciva (Chief Analyst, The King's Fund): I have two final brief points from me. The first is there is a lot of changes going on to how health and care is delivered in this country. In the near term, having an eye on how those changes are impacting different people across the health and equality spectrum will be incredibly important.

To pick two examples, a lot more care is being delivered digitally rather than face-to-face, and there are plans to change how outpatient care is accessed as well. Rather than a routine follow-up appointment, there is more choice for the patient over how and when they access services. Both of those can be absolutely key innovations and help the NHS. Both of those also need to have appropriate safety-netting and monitoring to make sure we are not losing people out of the system, particularly people from lower-income or more deprived populations.

The second thing is, hand on heart, genuinely, there has been more focus on understanding waiting lists and the relationship with deprivation than at any other point in my career but, at the same time, it is still in that mode of trying to understand what is going on and what the relationship is. We are not yet at the point where the rubber has hit the road and how are we going to use that information to change how we deliver services. There are some really knotty issues that will be coming up in the future. For example, where you have two patients of equal clinical need and they come from different backgrounds, could deprivation be used as prioritisation criteria? That is a huge topic to unpack. We have a near-term need to focus on changes to how health and care is delivered but there are some longer-term, almost medical-ethical issues to consider as well, both of which the Assembly can bring a helpful focus to.

Caroline Russell AM (Chair): The medical-ethical challenges of that are flashing through my mind, but I wanted to pick up on the digital point that you just made. I have found it really convenient having my GP now working much more digitally and sending me text messages with appointments and a link to click to be able to change the appointment. That makes communication with my healthcare provider much easier. I have a smartphone. I can click the link. I can change my appointment. I have older constituents who do not have smartphones or who have very basic phones that can receive text messages from the NHS but do not connect to the internet. The challenge of a digital exclusion, which also relates to deprivation, is clearly something that needs to be kept at the forefront because, if we end up with everything being digital, then there is a huge number of people who fall out at the bottom.

I am going to bring in Assembly Member Best here, who is going to be asking the next question.

Emma Best AM (Deputy Chairman): Thanks, Chair. It is incredibly depressing with the highlighting of those cancer figures and those misdiagnoses and late treatments. The NHS and charities such as Macmillan are world-leading really in our support in the UK for cancer sufferers. I know everybody will have a case that is close to them or even more personal where the NHS and Macmillan have been there. We have a long way to come back from where we now are.

My question is for Dr Nagpaul. What is your assessment of NHS staff resilience to deal with this growing backlog for treatment and diagnosis, and what measures should or have been put in place that you have seen to deal with this and cope?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Thank you. I am also a GP and I represent doctors across the United Kingdom (UK). I am a GP in London and so I have a London perspective.

It is just important to remind ourselves - and I am not trying to sound negative - that when we went into the pandemic in January 2020, we actually at that time had record waits in the NHS. We had actually the longest waits for cancer treatment. We had problems prior to the pandemic that have just been exacerbated during the pandemic.

In fact, when we talk about waiting lists, the scale of wait is much higher than the figures suggest. We talk about 6 million patients nationally waiting for treatment, in London 870,000, but in actual fact, that is only for elective planned care. Our own estimates have shown that 26.8 million fewer outpatient appointments took place during the pandemic from March 2020 to October 2021. All of those patients are also waiting. They may not be waiting for an operation, but they are waiting to see a specialist with regards to an abdominal problem, a specialist regarding a neurological issue and so forth. In fact, the burden of waiting and illness that is not being dealt with is much bigger than simply looking at crude figures around operation waits.

That is actually quite a challenge for us in the health service for those of us who provide care because our own surveys show that there is a sense of wondering if there is going to be an end in sight and that we hope we are getting over a pandemic and we have this huge, accumulated backlog that we have never faced before. What that has meant for the workforce is that many are planning to leave, and in fact our stats show about a third of doctors are saying that they want to retire in the next three years. Many have limited the amount of work they are doing already to try to protect themselves.

There is something called moral injury that we are describing in the BMA (British Medical Association), which is when doctors - and this applies to all healthcare workers - cannot do their best for patients and feel quite morally injured that they are not able to do the right thing for patients. This applies both in general practice but also in hospital services. We are seeing patients waiting now at record levels for more than 12 hours being unable to admit them or being a doctor or a healthcare professional knowing that there is an ambulance outside unable to admit the patient and the patient may be deteriorating or knowing that patients are now waiting 40 minutes for category 2 ambulances - and that is a London statistic - when they have a suspected stroke. There is this moral injury, this fatigue and also the very real fact that we have been working for nearly 23 months. Of course, we have worked throughout lockdowns, we have not stayed at home and it has been a very gruelling time for the profession.

That sounds really challenging. What needs to be done? First of all, it is really important to start with the workforce because the NHS really is nothing without its workforce. At the moment we know how important

the workforce is with the absence figure of around 10,000 staff absent in London on a daily basis due to Omicron. We know that staffing is vital. What we need to do first and foremost is make sure that the workforce is looked after, that it is valued and that in fact when people go to work there are simple things like making sure they have adequate rest breaks and that they can have food. Those little things cannot be taken for granted. There is no hot food provision for thousands of doctors and healthcare workers when they are doing overnight shifts, for example. Valuing your workforce and making sure that they are looked after is important.

The second is making sure that they are protected. We are still in an environment of a highly infectious virus and we know that spread occurs in healthcare settings. We are calling for much better levels of infection control. You will need that if you want the workforce to be able to deliver care. There are no clear specifications on ventilation in hospitals. There is no routine carbon dioxide (CO_2) monitoring. That sort of thing should be done. In terms of masks, it does not make sense that we are using masks that do not filtrate viruses for large numbers of healthcare workers when they are seeing people who are infected. We do not know whether they are getting infected as a result of their work. Those sorts of things need to happen.

We need to also - and this was said previously when I caught the tail end of the previous discussion - make sure that we are efficient. At the moment, there is a huge amount of bureaucratic work that is going on because when patients are on waiting lists they are actually coming to their GP and asking them questions around, "When will I be seen? Can you expedite my appointment? I have not heard. I tried calling but I do not know. I was told I would be treated in three months. It is now four months. I still have not heard". All of those are taking up GP appointments and that really should be avoided. We should have some sort of helpline, so people know where they are in the queue. It should not be wasting clinical time because that is reducing access for other people.

Other measures around the interface between hospitals and general practice could be much more efficient such as reducing the number of patients who need to see a GP to get a prescription. That should be electronically possible through an outpatient appointment where the patient can go to collect the prescription at their local pharmacy. Similarly, for diagnostics, too many appointments are being wasted and of course that means that patients themselves also are inconvenienced in going to see two healthcare professionals when all of this could be done in one visit.

The role of technology is important. I really would urge that we do not get into a binary debate around whether face-to-face is better than remote. They both have a place and, in fact, the more efficiently you use both, the better your access will be. Also, we should not be too simplistic around which categories of people may not be able to use digital technology. I have been very surprised at some people. Many of our older population have been amazing at using technology. Some of it is also about resourcing people to have the right technology. It should not be an excuse that you do not have a smartphone. There should be investment in that.

We have also learned a lot in the pandemic around how we can make better use of healthcare staff time through self-empowerment. Things like, for example, patients routinely now being able to measure their blood pressures and sending information to their GP practice has reduced not just GP time, but it has empowered patients. There is something to be looked at in that regard.

Ultimately, as a GP, I would want to reiterate that anyone who needs to be seen face-to-face - and that is when we feel they need to be seen face-to-face as well - should be seen face to face but we need to do this in a much more intelligent manner as well.

Finally, of course, we know that vaccinations will protect staff and so that also needs to happen. I hope that has given you a picture.

Sorry, just one more thing about diagnostics, which you mentioned earlier. People forget that the waits for diagnostics also result in delays in cancer treatment or other diagnoses. In fact, at the moment 26.1% of patients wait more than six weeks for a diagnostic test. The national target is 1%. Before the pandemic, 3.8% of people waited more than six weeks for a diagnostic test. We now have huge delays in diagnostic waits, which also impact on diagnosis of serious illness.

Emma Best AM (Deputy Chairman): Thanks so much. You mentioned there the morale of staff quite heavily. One of the issues I have found talking to nurses and frontline staff is their issue in actually getting to work. We have known for some time the difficulty with parking at hospitals and that sort of thing but now there is the added stress with the Night Tube still not running for shift workers. Do you think there is a push here really from the NHS that the sooner we can get the Night Tube up and running in full, it will help with our staff who need to get to and from work?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Yes. This goes back to valuing your workforce. What needs to be happening much more amongst managers and in fact in terms of those who are responsible for running our health services, is to always think from the perspective of those who provide care. What are their obstacles and what are the issues that affect them? That is how you will have a workforce that will feel valued. Getting to work is critically an important part of that. If they cannot, then there are other ways to get to work that should be supported.

A small thing that we have mentioned for a long time as the BMA, is that it seems a little perverse when a member of staff has to come into work and pay more for carparking charges in their hospital than perhaps the charge on the road outside. There is that sense of feeling devalued and that you are not even being given the provision to come to work and park your car. It would be a small investment to give people the ability to park without feeling perhaps ripped off in that charge. I mention again about when you come into work making sure you have the right facilities to feel supported and rested and looked after.

Emma Best AM (Deputy Chairman): Thank you. I absolutely could not agree more with that point as well.

Finally, one of the big resilience issues is going to be the vacancies that we see. The Mayor launched the Mayor's Academies Programme, which allowed people to make bids to help people get into good work. One of the areas that focused on was health and social care. I wondered whether you or perhaps any member of the panel had interacted with that fund at all.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): I have not personally interacted or known about it directly in my line of work, but I would be very interested to know what others may say. It seems a very good idea.

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): I just wanted to build on a couple of points that have been made there, particularly around the impact on the workforce.

One of the things that the backlog is presenting in cancer and what we are seeing is that people when they get to the diagnosis point are coming in with a much more advanced and complex disease and are entering the

pathway at different points. Many more people may be diagnosed and then go straight into a palliative care or end-of-life care pathway, sadly. That is having an impact on the cancer nursing workforce and the cancer workforce in general. There is lots about resilience but, even pre-pandemic, the workforce was quite fragile and did not have much of that bandwidth for dealing with all this additional work that is coming in.

What we are calling for at Macmillan is really a fully funded workforce strategy. We know we are across the UK at least 3,000 cancer nurses short. Also, what we are doing is looking at the skills mix that is needed to work for people with cancer. We heard from Dr Nagpaul around a lot of people phoning their GPs for some of those administrative questions. One of the things we are doing in cancer is putting in navigator roles and support worker roles because we realise that when you get a cancer diagnosis, it sometimes can become a full-time job just navigating through the system with all the different appointments that you are getting. Cancer – just like many health conditions – is not just a medical diagnosis. It has an impact on your finances, on your mental health, on your wellbeing, on your ability to work. Taking a much more holistic approach and having a skills mix in the team that really addresses that is one of the things I wanted to talk about.

Also, how are we developing our workforce and within London what does that look like? I know there is work going on with Health Education England and our lead cancer nurses. We have a group of lead cancer nurses from across all of the London Trusts working together on what a career pathway looks like for cancer. We are leaking people out of one end, and we are not having that succession planning or the succession of people coming into those roles. Cancer nursing is a very specialist role. It needs investment. It needs development. We need to have a much more long-term view on this, not just short-term answers now. Those are some of the things that we are supporting, and we are working on. Thank you.

Emma Best AM (Deputy Chairman): Just very briefly – and it is more a point for our Committee – is that the Mayor's Academies Programme, by the way it is set up or it is suggested it is set up, could look to tackle a lot of the issues that both Emma [Tingley] and Dr Nagpaul have mentioned and so I would really appreciate if we could delve into that outside of this meeting and get some more information on how that is helping build those good standards of work.

Caroline Russell AM (Chair): Yes, that sounds very sensible. Siva, you wanted to come in on this.

Siva Anandaciva (Chief Analyst, The King's Fund): Thanks, Chair, if that is all right. I would also like to hear more about the academy. I do not know. I have not heard of it before, but it did make me think.

It is quite clear that the NHS nationally and in London does not have the number of staff it needs to deliver the volume and quality of care it wants to. There are nationally 100,000 staffing vacancies that need to be filled. Part of the solution is absolutely recruiting more staff and getting those pipelines in of new people, but someone who knows a lot about staffing issues once said to me that there is no point building that pipeline if it leads people to a place they just do not want to work and you are losing people, the leaky bucket syndrome. There needs to be as much of a focus on how to create the right environment that will retain staff as well.

For me, there are three things. The first is absolutely what Dr Nagpaul was saying. Are you doing what I would call the no-brainers? Do you have the break rooms? Do you provide the hot meals? Do you do what you would expect a good employer to do? Local employers and local organisations in the NHS have the agency to do that. That does not need a national strategy.

The second thing is also probably for local agency, which is responding to changing patterns of work. Certainly, the junior doctors I speak to have a different approach. They want much more of a portfolio career and greater flexibility over how they work. How as an employer are you responding to that agenda?

The third bit, to just re-emphasise what Emma [Tingley] said, we do not have a national workforce strategy that is fully funded in this country. Given how long it takes to train a nurse, given how long it takes to train a doctor, the single biggest thing we can do if we want to retain more staff is have enough people working in the health and care system to give you a shot at feeling like you have a reasonable job and that you can deliver the quality of care you want to. The continued absence of the national workforce plan is a huge blind spot, and we can see the playing out of that day in and day out in the pressure on NHS services. That is the point I wanted to make.

Caroline Russell AM (Chair): Thank you and that is very helpful. I also just wanted to come back myself on one of the points about carparking. We also need decent public transport options for people. Not everyone can afford to run a car. While I absolutely take the carparking point, if we had a really reliable and affordable public transport option for everyone to access the hospitals, it would also help staff a lot as well as the parking point. Dr Sahota?

Dr Onkar Sahota AM: Thank you. First of all, I want to put on record the hard work of the NHS doctors and nurses and frontline staff and, Dr Nagpaul, to you particularly for how much you have been working hard both in your job in the BMA but also as a frontline GP. I also want to acknowledge the tremendous amount of work the nurses are doing in supporting our cancer patients. Let me put this on record and how much of an important contribution you have made to the NHS, particularly during the pandemic.

Let me come to the question. Look, we know that the whole system is really stressed. We went into the pandemic with a stressed NHS system and the pandemic has merely exaggerated and impacted more adversely on those inequalities that already existed. We have talked about workforce planning and I did not think I would ever say this, but I am going to say this. I was very impressed that Jeremy Hunt [MP], Chair of the Health [and Social Care Select] Committee in the House of Commons, wanted a national workforce order taking place independent of the Government, but the Government has refused that. What are your views on that, Dr Nagpaul?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Thank you, Onkar. As you know, there is a Health Bill at the moment going through the [House of] Lords. One of the key elements that we at the BMA have been pushing for alongside other organisations is exactly what you describe, for it to be embedded in the Health Bill for there to be a workforce plan where there is an independent analysis of what is needed for the service, and then to put in place the measures to achieve that. Now, we are starting at the moment in an NHS where we do not have even an understanding of what the workforce needs are. That would be a basic thing that you would do in even a small employment arrangement. You would know what staff you need to deliver your service.

Just so you know, our own figures show - these are facts - that the UK has around 50,000 fewer doctors across the population, in comparative terms, than France, Germany or Organisation for Economic Co-operation and Development (OECD) averages. That is a huge number of fewer doctors and that has an impact. That applies also for nurses and others.

We need to have a workforce strategy that is open and honest about our starting position, open and honest about where we need to get to in order to provide a service, and then put in place a plan. Without doing that

you will never have a plan because you are starting with no information. That is why we believe that should absolutely be something that should happen, and it should happen independent of Government because it needs to be an honest, independent analysis that is ongoing, with clear recommendations, and have a workforce strategy to deliver. That is our position, a very clear position.

Dr Onkar Sahota AM: Thank you. Of course, you will know that once upon a time there was a link between GPs and the population in any given area. That link was broken and now we have no correlation between patient sizes, practice sizes and the number of doctors in there. Getting an independent audit would be very helpful and I hope the Committee will take this on board, Chair. This is a very important recommendation if we can make this, and it will be a shift changer.

The other thing I want to talk about is that it is very good to have more recruitment and more people entering the profession, but the best advocates of the profession are the people who are already working in the profession, and if they themselves are complaining about their lot then they are not going to be a very good advocates for new entrants coming in. Retention is also very important. How do you judge the morale of the workforce? I know the answer, or I think I know the answer because I have been a frontline GP, but I want to get this on the record. How do you judge the morale of the profession, of the nurses and of the doctors on the front line?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): What we have been doing at the BMA throughout the pandemic is running some tracker surveys so that we have an understanding of the realities facing doctors, and we have had thousands of responses.

The most recent survey has reiterated what we have seen throughout, that morale is low. In fact, 51% of doctors are telling us that they are suffering with some sort of mental ailment or stress disorder. What they are also saying is that about 50% are considering reducing their hours, and I suspect by the time I am saying this a lot have. I know many doctors who have reduced their hours in order to cope, and if you reduce hours you may still be retained but in fact the capacity of care being provided has reduced.

The second is that we know that people are retiring early. About one third of doctors are saying they intend to retire before completing their tenure. That will have a huge impact.

There is a specific issue for doctors - and for some other workers as well - around pensions because we have a very perverse pension and taxation system where, for many doctors, if they work additional hours or they carry on working, they in some instances end up paying more than they are earning. There is a huge disincentive that needs to be tackled.

There is no doubt our figures are showing that significant numbers are reducing their hours and wishing to retire early, and a certain proportion, about 20%, are saying they want to leave the NHS altogether. These are people who want to be in the NHS, they have become doctors because they want to care, but they are feeling that those external pressures are so great that they have little option but to make these career decisions to protect themselves.

Dr Onkar Sahota AM: Thank you. Dr Nagpaul, just one more thing. I know we have an increased waiting list and of course the whole system is under stress. I know that work that used to be done in the hospitals is now coming out into primary care. The journey of the patients is now much more complicated. I have to run through hurdles. When I started general practice 30 years ago, I could get an investigation for my patient, get them referred and get them seen, but now I have to run hurdles behind the scenes to get an X-ray or

ultrasound done because the hospital is using these things as a way of controlling their workflows. For example, if one of my patients sees a respiratory physician and they need to see, say, a gynaecologist, they cannot do a direct transfer. They have to come through to me. If they miss one appointment, they get discharged by the hospital system and I have to go make a re-referral. This is all adding to the work of general practice. Should not this now be the Government, if the Government really wants to resolve this?

Also, we heard earlier on that every contact should count and that patients should not have to go through hurdles, through the GP, to reach their care. They should be looking at the patient pathway to make sure that the patient gets the right treatment, right time, right person, every time, and every contact does count. Can you put some suggestions of what we can do to make the journey easier and life easier for the professionals also?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): I could not agree with you more. The interface between general practice and hospitals is one where there is a completely unhelpful divide, which is meaning that thousands of patients every day are suffering the results. In fact, our own BMA surveys have shown that the majority of GPs think that the divide between hospital and general practice is harming patient care, and 75%, as you say, think it is increasing administration. The more time we spend on bureaucratic tasks, the less time we have to look after patients. The hours that you and others are spending - and myself - in trying to get people to respond to queries, getting them to be referred and trying to jump through hurdles, is time that we should be being doctors, treating patients.

I think the solution, ultimately, is about changing the current system, which is very siloed. It is a system where you have separate budgets to hospitals, separate budgets to general practice/community, and you have vested interests that work against each other. We need to have pathways where patients are seen, and their care concluded as quickly as possible with the fewest number of interactions.

Specific recommendations we have made as the BMA and I have made are: first, that patients should have access to a central or local helpline with regards to information about their wait; they should not be coming to a GP practice. The second I have made is that there should be a system where prescriptions in hospitals should be electronically enabled to allow the patient to collect them from their local pharmacy. That is something we can do as GPs, but what is happening every single day is that GP practices are being inundated by patients who have been told to come to their GP simply to get a prescription that has been initiated by a hospital doctor. The third is investigations. Investigations that are requested in hospitals, where the patient is told, "Have an X-ray in four weeks", inevitably result in a GP consultation and the GP having to then make that referral again.

These are things that need to end so that there is not that inconvenience for patients and to reduce the bureaucracy for general practice. That needs a pathway care. We do not currently have that system. I have some ideas, which I can send to the Assembly later on, about a different model of the way in which we deliver care that brings primary and secondary care together. That, I believe, has been long overdue but is even more important now with this huge backlog of care.

Dr Onkar Sahota AM: Dr Nagpaul, thank you very much. For the sake of saving time - I know that the Chair is very keen to continue - if you would kindly write with that plan to the Committee. I would be very interested if you could send it to me also, please. Thank you.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): I will do that. Thank you.

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): I would like to just quickly build on those points that have been made around how we measure morale. One of the ways we see the impact of staff morale is on the patient experience. There are good measures in cancer care. There is the National Cancer Patient Experience Survey where we can pick up some of those issues. Particularly around that integration between what happens in a hospital and what happens outside of hospital in primary care, it is really important that we look at that, are challenged by that and think very differently, think out of the box around how we are providing care and the different models of care that we can bring.

Macmillan published a report called *Cancer Nursing on the Line* which I can share with the Assembly afterwards. There is some data in there that a third of Londoners with cancer in the last five years said that the healthcare professionals working on their care had unmanageable workloads. A quarter of those people felt a lack of support because of that. How do we respond to that? How do we make sure we get the right skills mix in, the right professionals seeing the people at the right time, really focusing clinical skills where they are needed as well as some of those other skills around how we navigate people through a system and support those holistic needs? They need to come together and work better together.

Dr Onkar Sahota AM: Emma, it would be very helpful if you would share that. I just want to make a point that all these people who go into the healthcare profession, when they went for their interviews, would say, "We want to go there to help other people. We want to help the sick. We want to help the suffering". They worked very hard, they worked long hours, they worked harder than their other colleagues, and then something happens to them in the system that demoralises them, and we need to address those issues. I would be very grateful if you could share the feedback you have had. Thank you very much.

Caroline Russell AM (Chair): Thank you. Siva, if you wanted to come in.

Siva Anandaciva (Chief Analyst, The King's Fund): Yes, thank you, Chair. A few points on this topic of morale and retention.

The first is that you should not take vocation for granted. There is a generalised assumption that people who work in health and care services have a strong sense of vocation. They do still reach a breaking point. If you are a clinical professional trained in the UK, you are gold dust. You have internationally deployable skills and there is a worldwide shortage of healthcare professionals. You absolutely have opportunities to go elsewhere if we do not appropriately value our staff.

The second thing is that there are absolutely issues of the moment that have contributed to poor morale, including the management of staffing pressures during COVID, as well as the longer-term issues of staff shortages that we have already talked about. The main point I wanted to make is about culture. Even before the pandemic, if you look at the NHS Staff Survey, it does tell a worrying and variable story. Other 20% of staff were experiencing bullying and harassment. There are separate figures from the Workforce Race Equality Standard about the different experience of ethnic minority staff in the workforce. There are issues of how much control you have over your professional life. Alongside the issues of the moment, there are some deep-rooted underlying cultural issues about the NHS as an employer that also have to be tackled if we are going to support good morale and good recruitment of health and care staff. Thank you.

Dr Onkar Sahota AM: Thank you for that, Siva, and also thank you for all the work the King's Fund does in highlighting those issues.

Caroline Russell AM (Chair): I am now going to bring in Krupesh.

Krupesh Hirani AM: Thank you, Chair, and thank you to all the guests for their contributions so far and the wider work that you do as well. First is a question to all, really. What action is required to meet the needs of those whose access to healthcare has been reduced because of the pandemic, both in the short term and in the longer term as well? We will start with Siva.

Siva Anandaciva (Chief Analyst, The King's Fund): Thank you, Assembly Member. I would say four things.

The first is: understand their needs. Work is already underway in the NHS through the national initiative Core20PLUS5. Basically, understand the profile of your waiting list, including the needs of the most deprived populations.

The second thing is, at the risk of sounding reductive, to do more. Where staff capacity allows it, put on extra surgical lists and weekend lists, expand community diagnostic capacity; all the things that are being done to provide more healthcare.

The third is: do differently. Again, in health and care services there is a lot of work going on to separate out where planned elective care happens from more-hot emergency care. Make greater use of things like social prescribing to meet the wider needs of people where the core root is not a medical issue, it is a social issue. Do things differently.

The fourth thing is: communicate more effectively. The reality is that tackling the waiting list is not going to be a two to three-year job. It is a five to seven-year job. There is a lot of work going on over how you can make waiting for your care a more active process, whether that is through better information, more interaction outside of the waystation of coming in for an outpatient appointment, or more options for self-care. The phrase that keeps coming into my head is, "Make waiting a more active process", which is the advice someone gave me. We absolutely have to do that if we are going to manage the waiting list rather than just view the waiting list as a set of numbers that ticks up and down over the next five to seven years.

Krupesh Hirani AM: Just very quickly, what role do you feel the private healthcare sector can play in that?

Siva Anandaciva (Chief Analyst, The King's Fund): With the caveat that private healthcare is a wide market so includes things like mental healthcare and community care, particularly for the planned elective backlog, it has two functions. One is extra capacity during periods of surge, which we are seeing at the moment is needed. Then the second is, as during the New Labour period, playing a more stable role in delivering, particularly, planned, routine knee and hip operations, that type of work. I honestly cannot see a way that we are going to tackle this 6 million waiting list backlog without the independent sector playing a strong role.

As always, the thing that we have to be very conscious of is that any time you poll the public, the concept of an NHS that is free at the point of use, comprehensive and universally accessible is close to their hearts and they absolutely will fight for it. When you have this sort of pressure of an unprecedented level, you have to be constantly monitoring the risk of a two-tier system developing. There are some constraints in the way healthcare works in our country that make that less likely, the principal one being that it is largely the same clinical staff who work in private and NHS hospitals. You do not have a hermetically sealed private sector that can take on loads of work with a few paying clients because it will be limited by the pressures on the NHS.

It absolutely will have a role in tackling the backlog. As always, we need to monitor that we are not developing, either consciously or unconsciously, a two-tier healthcare system in the UK.

Krupesh Hirani AM: Thank you for that. To Emma [Tingley], the same question but if you could reflect, maybe, on how the voluntary sector can also play a part in this as well.

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Yes, thank you. That would be my build on the four really clear points that we have just heard from Siva. Absolutely, the third sector/charity sector has a role to play as partners in healthcare. We have seen it at Macmillan Cancer Support in terms of the increase of people coming to our support line and the increase in people accessing our welfare benefit support. That is the same across all of the charities. How do we work, as a charity sector, better in partnership with the NHS? There is definitely more work to do that, but we want to be part of the solution.

Sometimes we have the agility to think differently and try things differently. We have some examples across London where we have put funding into different ways of working. There is a great programme in Hammersmith and Fulham that we have done in partnership with the primary care network there, led by the GP federation, looking at how we integrate services across acute settings and primary care settings using social prescribing. We have been a core partner and a funder in that. Sometimes our role is to facilitate what that might look like to start with, so that we get the data, and we can work out what the sustainability plan might look like. That is something about the way that we work across the sector. Yes, the third sector has a definite partnership role to play.

Krupesh Hirani AM: Dr Nagpaul, if you could also just go into what you would like to see in a Department of Health and Social Care's forthcoming elective recovery plan as well.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): Sure. Thank you. We must not forget that at the moment, one of the reasons why we cannot clear the waiting list as quickly as we should be able to is because of continued levels of Omicron or COVID. I know it is not as bad as in previous waves, but we still have 20,000 people in hospital at the moment compared to about 7,500 a month ago. It is still having a real impact. It has an impact on the workforce with staff absence. Those things must not be forgotten as a precursor to what I am going to say.

In terms of the recovery plan, that is one of the things that we have been really concerned that we have not seen. We should have seen, in my view, months ago a clear plan of how you tackle the backlog. As Siva said, waiting should be an active process, not just, "We have a waiting list. We must somehow now clear it".

One of the things is prioritisation. Within those 6 million waiting for operations - remember there are probably more than that number who are waiting for outpatient appointments and they also are people who are waiting for medical care - there should be a process of making sure that those for whom further waits could be dangerous for their health - and some conditions deteriorate as a result of waiting - should be prioritised. You need to have a system where you may have to prioritise those who may be towards the later stage in their lives, where every year of an extra wait may reduce their quality of life considerably. At the moment we do not have any systematic approach to clearing the backlog or even assessing what that backlog is, who is waiting and who needs to be prioritised.

We have a retired doctor workforce. There are, I think, about 30,000 who volunteered in the pandemic to come back to support the NHS, and it has been a shambles. They have not been able to come to work because

of lots of bureaucracy. However, if they could, for example, be contacting patients, trying to find out how they are, explaining to them the backlog and checking to see which would need to be prioritised, that would make a huge difference. It would also reduce, as I said earlier, the impact on us as GPs - and, for that matter, I am sure, hospital services - in just those queries that keep coming and taking up a lot of our time.

The recovery plan is vital. Part of that recovery plan should include improving access to diagnostic equipment. We still have much lower levels of magnetic resonance imaging (MRI) scanners and computed tomography (CT) scanners than other European nations. It should also include what Onkar had asked for earlier, making sure we are efficient in the use of our clinical staff so that we reduce the bureaucracy that wastes a lot of outpatient appointments and wastes a lot of doctor time.

Krupesh Hirani AM: Thank you. Emma, anything to add on the elective recovery plan?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Not specifically. We just really need one, and to make sure we are thinking about where we are deploying the staff because it is not just about getting people in to diagnosis, but what happens beyond. We are really interested and keen to support that and input into that.

Krupesh Hirani AM: Thank you. Siva, anything to add? There were some interesting things I picked up in some of the answers around the plan, which should have come a few months ago. I know waiting lists were growing worryingly before the pandemic as well, so there is an argument that maybe, in any case, we would have needed some sort of immediate or urgent action on waiting lists and an elective recovery plan. Now that has been exacerbated exponentially. Is there anything from your perspective to add to that?

Siva Anandaciva (Chief Analyst, The King's Fund): Yes, I agree with that. Three things for me.

One is the workforce component. We need some detail on what level of care you want to deliver, what workforce you will need, and what your plan is for getting them. That is the first one.

The second one is the signal over what happens after the next three years. I understand the political cycle and, nationally, I understand that three years' worth of funding has been given, but if this a longer than three-year job, what are you signalling about what happens after that period?

The third thing is: what are your expectations over performance? We have a very broad target for increase in activity over the next three years, and we have a very short-term target of reducing the number of people waiting over two years for care. What is in between? I know it sounds quite technocratic to have a target, but it is remarkable how quickly poor care can become normalised. What is the plan to get us back to a level where 92% of people are being seen in 18 weeks? I think the public will understand, if COVID comes back in several waves, if that plan goes off-track, but you need the plan in the first place.

Those are my three things, Assembly Member.

Krupesh Hirani AM: Thank you, that is the end of my questioning.

Dr Chaand Nagpaul (Chair of Council, British Medical Association): A very small point about the use of the private sector. The real limitation is workforce. We saw this with the Nightingale hospitals. You built the hospitals, but the staff could not be in two places at once. That is the limitation, the workforce.

Caroline Russell AM (Chair): Thank you. Andrew, our final two questions, and if you can keep the pace up that would be brilliant.

Andrew Boff AM: Yes. Very quick replies to this if you can. What could the Mayor do to raise the profile of this issue? Do you think he has a role in this?

Siva Anandaciva (Chief Analyst, The King's Fund): Alongside the tackling of the elective backlog, the single biggest thing the Mayor could do is raise the profile of the wider things that contribute to our health because the NHS is balancing -- sorry, I know you wanted to be quick. I will be quicker. The NHS is trying to do two huge strategic things: tackle the biggest backlog in recent history for care, and also transform how it delivers services and the role it plays so that it moves from being a world-class treatment service to a world-class treatment service and a service that supports the things that keep us healthy. One of my big concerns is that there will be a relentless focus on tackling backlogs, getting people in and out of hospital and GP surgeries quickly, and the focus on the wider things that keep us healthy will be lost. The office of the Mayor is one of the most powerful agencies to say, "In the longer term, over the next 10 to 15 years, we do not want to look back and say we missed a chance to reduce health inequalities and improve the health of the population". A focus on the two aspects of what the NHS is trying to do would be very welcome.

Andrew Boff AM: Do I take that as being increasing the priority of public health and the Mayor's role in public health?

Siva Anandaciva (Chief Analyst, The King's Fund): Yes.

Andrew Boff AM: Thanks. Very good, very economical. Anybody else want to contribute before I move on to the next question?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): From my end - and the Mayor has been doing this - we are still not only in a pandemic with Omicron rates affecting the capital to a very significant degree, but there may be new viruses and new variants coming along the way. The Mayor has a role and has taken decisions such as mask-wearing on public transport that preceded national policy of late. There is still, I cannot emphasise enough, a need to bring down COVID rates in order for the NHS to be able to be free to carry on doing its elective work to a greater capacity.

The other issue is, as we heard earlier, the disparities in health are disproportionately impacting on the health service and on individuals. Those should be tackled through public health measures. London is a very diverse capital, and those disparities are pretty glaring within London itself. Much more, I believe, should be done. This comes under the Mayor's portfolio and I know that he is very dedicated to that but that should be very much up front.

The third is what we discussed earlier. I do think there are ways in which the hospital sector, community, general practice, social care, and the public themselves can work in a much more holistic manner. Even if national policy does not allow us to make those changes, in London we should just get on and try to create a model that really does integrate, in the best possible terms, the way in which both public, patients and those who work in the service can work in a seamless way.

Andrew Boff AM: Sorry to interrupt but the Mayor's role in that should be to promote that, is that right?

Dr Chaand Nagpaul (Chair of Council, British Medical Association): He should promote that because it is in the interests of those who live in London to have a better experience of the health service, improving their health as a result.

Andrew Boff AM: My final question is, Mr Anandaciva, how do we monitor the effect on health outcomes of the delayed diagnoses and treatment due to the pandemic so that we can assess measures to rectify the backlog in care? You are the data man.

Siva Anandaciva (Chief Analyst, The King's Fund): I am the data man. It is a great data question. I would say, first of all, develop a framework or a structured way for how you are going to look at it. For me that would include one component, which is looking at the different aspects of quality: measuring experience, safety, clinical effectiveness, and outcomes. All four are important. Again, going back to that earlier point, I do worry that we will focus on access and getting people in and out quickly without looking at balancing measures of clinical effectiveness like, "Did the person re-attend within 31 days or seven days because they got fast care but not good care?"

I would say looking at all four of those and, realistically, looking at how long some of these outcomes will take to manifest, bearing in mind this will take ten to 15 years. There will be some leading indicators like experience that you can look at and see decreasing rapidly. There will others, like mortality and morbidity, that may take some time to show up.

Just a final point. We did some work looking at how other countries had responded to disasters, not necessarily the pandemic but things like earthquakes, floods, and typhoons, and pretty consistently they said, "The one thing we wish we had done more to measure, in hindsight, was the mental health and wellbeing of children". They said, "That was the one indicator we probably didn't pay enough attention to". When you look back over such a shock to a country's system, that is the thing that can sometimes fall between the cracks. Alongside that framework I would pick particular groups, and from that previous work I am particularly concerned about the mental health and wellbeing of children and adolescents.

Andrew Boff AM: It is funny -- it is not funny at all, actually, but it does seem that on almost every health issue that we discuss there is this obvious question. The health of the children is a pretty strong indicator of the health of the adult, and yet we are still trying to make that point. I just find it ironic, after years and years of that being established. Ms Tingley, could you perhaps come back on that as well, about how we can retain this information or this experience?

Emma Tingley (Head of Partnerships - London & South East Regions, Macmillan Cancer Support): Absolutely. There are some measures that are already being used and have been for years. Certainly, that Cancer Patient Experience Survey that I talked about previously is a key area of information, looking at the ongoing impact with people.

More recently, Macmillan Cancer Support and NHS England have worked on quality-of-life measures and that is now a live tool that we are using. We are looking at somebody's quality of life with cancer 18 months after diagnosis. London's a bit lower in the uptake of that survey so we are doing some work on why that is, and we are looking at that in the Inequalities Group as well.

However, I am not sure if it will tell us the whole story, particularly bearing in mind the point that I made earlier around delays to diagnosis, perhaps because somebody has been too frightened to enter the healthcare system although we have been clearly saying, "We are open for business, please come and tell us if you have signs and

symptoms". A number of people are coming in with much more complex and advanced disease and we are sadly seeing them entering that end-of-life care pathway much sooner, so we may not be capturing all of the data. We do need to think a bit more around what it is that we are using to look at this in the long term.

The backlog is a huge ongoing challenge. Ten to 15 years was mentioned previously. We would love to be able to come back to you and talk more about that and the third sector response to it at some point, please.

Andrew Boff AM: Thank you very much. Thank you, Chair.

Caroline Russell AM (Chair): Thank you, and thank you, everybody. Clearly, we have just scratched the surface of all of this, but it has been really helpful to have so much input. We have this big backlog, we have the impact of the pandemic and this latest Omicron wave which has really put health service staff under huge pressure, partly from just the staff sickness levels, but the thing I have particularly taken is the importance of thinking carefully about how we focus on getting through the backlog so that we do not have unintended consequences that potentially worsen people's health. I have written pages of closely written notes, there is going to be a transcript, we will be looking at all the evidence you have given us and coming to some conclusions, but for now I would just like to thank you for your contributions to our session today.

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GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Summary List of Actions

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**2 March 2022**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report updates the Committee on the progress made on actions arising from previous meetings of the Health Committee.

2. Recommendation

2.1 **That the Committee notes the completed and ongoing actions arising from its previous meetings.**

3. Summary List of Actions

Actions Arising from the Meeting Held on 13 January 2022

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	COVID-19: The Current Situation in London and the Indirect Effects of the Pandemic	Executive Director of Performance and Covid-19 Incident Director, NHS England and NHS Improvement-London	• To share details of the plan to improve recruitment and retention of NHS nursing staff; and • To provide data regarding the numbers of children who are being admitted to hospital and to intensive care due to COVID-19/ Omicron.	Completed. See **Appendix 1**.

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	COVID-19: The Current Situation in London and the Indirect Effects of the Pandemic	Chair of Council, British Medical Association	To send the plan detailing a different model to deliver care that brings primary and secondary care together.	Completed. See **Appendix 2**.
6.	COVID-19: The Current Situation in London and the Indirect Effects of the Pandemic	Head of Partnerships, London and South East Regions, Macmillan Cancer Support	To circulate the MacMillan *Cancer Nursing on the Line* report.	Completed. Circulated to Members separately.
6.	COVID-19: The Current Situation in London and the Indirect Effects of the Pandemic	Senior Policy Advisor	That authority be delegated to the Chair, in consultation with the party Group Lead Members, to agree any output arising from the discussion.	In progress.

Actions Arising from the Meeting Held on 25 November 2021

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Trans Access to Healthcare	Founder, cliniQ	• Provide further details on the HIV and AIDS inclusive data collection and reporting system, comparing the issues of living with HIV for trans and nonbinary people with cis people living with HIV; and • Provide information about clinQ's two-stage data collection and the Public Health England data collection guidance.	Ongoing. Followed up on 9 February 2022.
6.	Trans Access to Healthcare	Director, TransActual UK	Provide details of the pilot programme(s) at Chelsea and Westminster Hospitals.	Ongoing. Followed up on 9 February 2022.
6.	Trans Access to Healthcare	Pride in Practice Manager, LGBT Foundation	Provide their list of signposting to LGBTQ charities and services.	Completed. See **Appendix 3**.

Item No:	Item Title	Responsible Person	Action(s)	Status
6.	Trans Access to Healthcare	Senior Policy Advisor	That authority be delegated to the Chair, in consultation with the party Group Lead Members, to agree any output arising from the discussion.	In progress.

Actions Arising from the Meeting Held on 18 October 2021

Item No:	Item Title	Responsible Person	Action(s)	Status
5.	Reducing Drug Deaths in London	Senior Policy Advisor	That authority be delegated to the Chair, in consultation with the party Group Lead Members, to agree any output arising from the discussion.	In progress.

4. Legal Implications

4.1 The Committee has the power to do what is recommended in this report.

5. Financial Implications

5.1 There are no financial implications arising from this report.

List of appendices to this report:

Appendix 1 – Response from Executive Director of Performance, NHS England and Improvement, London Region, 11 February 2022

Appendix 2 – Response from the Chair of Council, British Medical Association, 14 February 2022

Appendix 3 – The Pride in Practice London Social Prescribing Directory

Local Government (Access to Information) Act 1985

List of Background Papers:

None

Contact Information

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Via Email: Caroline.Russell@london.gov.uk

Martin Machray
Executive Director of Performance

Wellington House
133-155 Waterloo Road
London
SE1 8UG

11th February 2022

Dear Caroline,

Thank you for your letter following my most recent appearance before the London Assembly Health Committee and thank you too for including details of the two information requests from members.

Taking each in turn, I hope that the following answers are useful but please come back to me if I can be of further help.

1. Data regarding the numbers of children who are being admitted to hospital and to intensive care due to COVID-19/Omicron

Unfortunately, I am unable to share the data for admissions because it is not yet been verified and made publicly-available. In the committee I was referring to operational data which shows the numbers of children being admitted to intensive care who are SARS-CoV-2 positive in London are low. The numbers have gone up nationally as a result of the spread of the Omicron variant, but the data shows that the overall numbers are still small given that we will have a few hundred admissions to PICU nationally each week.

This data is not broken down by region because the numbers are too small, so we do not have a specific regional breakdown.

2. Details of the plan to improve recruitment and retention of NHS nursing staff.

The following information details the support available for recruiting nurses and healthcare workers in London.

- Between November 2020 and November 2021, London's substantive nursing and midwifery workforce grew by 1,340 WTEs (2.2%).
- During the same period, use of agency staff grew, indicating the ongoing need to fill vacant posts.
- Recruiting to vacant posts is prioritised across all NHS organisations, with support from national and regional teams. A number of initiatives are in place:

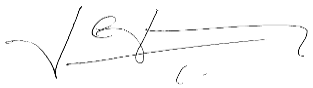
- There is support to recruit healthcare support workers who are an important part of our nursing teams and pipeline; many go on to become registered nurses. This includes support with recruitment campaigns, sifting applications, and funding pastoral roles for those recruited. There are currently 612 HCSWs in the recruitment pipeline. This will reduce vacancy rates by 20%.

- There are currently 11,745 student nurses in London universities at various stages of their pre-registration studies. London trusts have agreed to offer every London student a post on qualifying and have a well-established preceptorship offer. This supports the transition from being a student to a registered nurse over the course of a year.

- From January 2021 to December 2021, 3,141 nurses recruited from abroad joined teams in London's NHS. Trusts were and will continue to be supported with funding of some of the recruitment costs and a dedicated regional team is in place.

- To retain our nurses in London, we continue to offer nurses excellent professional and educational development in numerous specialities at every point in their career.

Yours sincerely



Martin Machray
Executive Director of Performance
NHS England & Improvement - London Region

Response to follow up request for information from the 13 January 2022 meeting of the Health Committee

Request for information:
During the course of the discussion, Members requested that the Chair of Council, British Medical Association, provide the plan detailing a different model to deliver care that brings primary and secondary care together.
Response:
Dear Chairman, These two papers published should be helpful on this topic. Supporting effective collaboration between primary, secondary and community care in England in the wake of Covid-19 Caring, Supportive, Collaborative / Further information Best wishes, Stephen **Stephen Hall** (he/him) Special Advisor (On behalf of Dr Chaand Nagpaul) **British Medical Association**
Sent by email on 14 February 2022

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PRIDE IN PRACTICE

SOCIAL PRESCRIBING DIRECTORY

LONDON

LGBT foundation

WE'RE HERE IF YOU NEED US

lgbt.foundation
0345 3 30 30 30

LGBT Foundation

What

LGBT Foundation's **Helpline Service** has been running for 35 years and provides thousands of hours of **advice and support** to thousands of people every year on a huge range of issues. The Helpline is staffed by a team of dedicated staff and volunteer operators, all of whom receive extensive training and support.

How

Call: 0345 3 30 30 30 Monday to Friday between 10am and 6pm
Email: helpline@lgbt.foundation and receive a reply within 10 working days

If you aren't completely sure where the best place to go is LGBT Foundation helpline is always a good first port of call as they can offer further signposting and detailed initial support and advice

ANTIDOTE

What

Antidote is a free, LGBT run and targeted **drug and alcohol support service** delivered by highly trained staff and volunteers. Antidote see over 8000 LGBT people in London each year & offer one-to-one key working, referral to detox clinics and prescribing centres, drop-ins to discuss drug and alcohol issues, sexual health, chemsex, and steroid use issues, intensive structured weekend programmes (SWAP), an advice helpline, referrals to in-house counselling, and more.

How

Call: 020 7833 1674 (10am-6pm, Monday to Friday) and ask for one of the Antidote Team.
Drop-in: Clinics at 6 different locations in London across the week, see link below for details.
londonfriend.org.uk/get-support/drugsandalcohol/antidote-accessing-our-services

CLINIQ

What

CliniQ are a **holistic sexual health and well-being service** for all trans people, partners and friends. CliniQ are a trans-led team who offer a safe, confidential space for those who may not feel comfortable accessing mainstream services. They also perform cervical screening.

How

Visit: By appointment or drop in at King's College Hospital every Tuesday 4 - 7pm at the Caldecot Clinic
Online: cliniq.org.uk

56 DEAN STREET

What

Dean Street is a large sexual health clinic in central Soho with a focus on serving the LGBT community. Alongside drop in hours and appointments, Dean Street have a trans specific clinic *'56T'* offering sexual health and screening services. The clinic also offer support for people wishing to purchase PrEP.

How

Visit during drop in hours or book appointments online for 56 Dean Street, every day. See www.Dean.st for details of specific clinics.

GI (Gendered Intelligence)

What

GI work with the trans community and those who impact on trans lives; they particularly specialise in **supporting young trans people under the age of 21**. GI deliver trans youth programmes, resources, **support for parents and carers**, and educational workshops for schools, colleges, universities and other educational settings. GI also have a **youth group specifically for black and minority ethnic young people** who are trans or questioning their gender.

How

GI have youth groups across the city, see their website for more information: genderedintelligence.co.uk

London Friend

What

London Friend **supports the health and mental well-being of the LGBT** community in and around London. They offer **counselling and support** around issues such as same-sex relationships, sexual and gender identity and promoting personal growth and self-confidence. They're also home to Antidote drug and alcohol service, and a range of social and support groups.

How

To find out more about the service you're interested in, visit: londonfriend.org.uk/get-support

MERMAIDS

What

Mermaids also focus on **supporting and informing gender diverse children and young people**, and their families, Mermaids have a particular focus on younger children who may be questioning their gender or who identify as trans.

How

Mermaids have online forums, a helpline, and host meet ups across the UK. Find out more at mermaidsuk.org.uk

METRO

What

A service that works in a number of areas across London, and offers **a variety of LGBT-specific services including sexual health, mental health, and youth groups**.

How

Different services operate in different parts of London, you can see what's available in your borough by visiting the Metro Website: metrocharity.org.uk

MOSAIC

What

Mosaic **LGBT Youth Centre** supports, educates and inspires young lesbian, gay, bisexual and trans community of London **age thirteen to nineteen** through a variety of youth clubs, outings, retreats and events.

How

The youth club takes place every Wednesday from 6.30PM – 9.00PM in Euston. Contact Mosaic to get details of the venue.

Opening Doors

What

Opening Doors London is here to **support LGBT people over 50** to live full, vibrant and respected lives free from isolation, loneliness, discrimination and prejudice.

How

Opening Doors offer 40+ **groups and one-off activities each month**. From singing to creative writing to walks, we aim to provide a range of opportunities that allow LGBT+ people over 50 from across London to meet each other, have fun, and feel confident to be themselves.
Call: 020 7239 0400
Visit: www.openingdoorslondon.org.uk

Stonewall Housing

What

Housing advice and support for LGBT people, including those at risk of or experiencing homelessness, family breakdown, harassment, domestic abuse, eviction. Stonewall also provide supported accommodation for young people in some London boroughs and are a partner in The Outside Project - the UK's first **LGBT crisis/homeless shelter and community centre**.

How

Call: advice line on 020 7359 5767 for confidential advice (weekdays 10.00 -1.00 pm)
Online: complete a self-referral or see LGBT and trans specific drop-in times at the link below
Drop In: several drop-ins across London, including trans specific drop-ins at CliniQ
stonewallhousing.org/services/advice

Naz

What

Naz is a **sexual health** service directed specifically at **people of colour (or BAME people).** They offer outreach and testing services, and provide support for LGBT people from a range of communities, working with **immigration and asylum** issues, and people living or newly diagnosed with **HIV**.

How

Call: 02087411879 | Email: naz@naz.org.uk | Website: naz.org.uk

Your Local LGBT Forum

What

Many London boroughs have an LGBT Forum that will have specific information about what's happening locally and what the community are experiencing.

How

You can search for your local forum or contact the London LGBT Forums Network at LondonLGBTnetwork@gmail.com.

FindOut.org

What

An interactive map of LGBT services in the city.

How

Search online at **FindOut.Outlife.org.uk**

GREATERLONDONAUTHORITY LONDONASSEMBLY

Subject: Responses to *The Toilet Paper* Report

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**2 March 2022**
Public Access:	**This report will be considered in public**

1. Summary

1.1 The Committee is asked to note the responses to its report on public toilet provision across London.

2. Recommendation

2.1 **That the Committee notes the responses from the Mayor of London and the Secretary of State for Levelling Up, Housing and Communities to the Committee's *The Toilet Paper* report, as attached at Appendices 1 and 2.**

3. Background

3.1 At its meeting on 14 September 2021, the Health Committee discussed the issue of access to public toilets in London with invited guests. Following the meeting, the Committee sent the report to the Mayor and to the Secretary of State for Levelling Up, Housing and Communities with its recommendations as follows:

- The government should make the provision of public toilets a statutory duty for local authorities, and the Mayor should be leading on this issue for London, lobbying with London Councils for the provision of ringfenced funding to enable this to be achieved.
- The Mayor and London Councils should provide an opportunity for local authorities to share best practice on their community toilet schemes, including how to run them successfully and how to ensure that information and directions about such schemes are clear, consistent and accessible.
- The Mayor should engage with large businesses and retail chains on the high street, to encourage them to open their toilets to the public and advertise that they are doing so.

- To make current public toilets more financially viable, and to stimulate provision of new public toilets, the Mayor should convene local authorities and prospective commercial partners to explore innovative practice with regards to advertising and broader commercial opportunities in public toilets.

- Transport for London (TfL) should share, in a public forum, the results of their current review of toilet provision across the network and any actions that will be taken as a result of the findings.

- TfL should create an action plan for how they will enable the wider public, not just paying passengers, to access toilets situated behind the barrier in stations.

- The Mayor, local authorities and TfL should all improve the quantity and quality of information on how to find the types of publicly accessible toilets that Londoners require, with the information provided in a range of formats that suit the diverse needs of Londoners.

- TfL should add an easy-to-find toilet map on their TfL Go app, ensure it is available in accessible formats and contains accurate data on facilities and opening times.

- TfL should meet with disability charities including Crohn's and Colitis UK, and Changing Places, to review their provision for people with disabilities and people with long-term health conditions and join the "not every disability is visible" campaign.

- Each local authority should produce a toilet strategy based on population need and current provision.

- Using the principles of the Health Inequalities Strategy, the Mayor should review the health inequalities implications of current public toilet provision in London, and use that analysis to help drive improvements in provision with partner organisations.

- The Mayor and London Councils should work with local authorities to review the quality of accessible toilets to ensure they are genuinely accessible for Londoners with all disabilities.

4. Issues for Consideration

4.1 The Mayor of London wrote to the Chair responding to the recommendations in the Committee's *The Toilet Paper* report on 17 January 2022, attached at **Appendix 1**.

4.2 The Department for Levelling Up, Housing and Communities responded to the report on 15 February 2022, attached at **Appendix 2**.

4.3 The Committee is asked to note the responses.

5. Legal Implications

5.1 The Committee has the power to do what is recommended in the report.

6. Financial Implications

6.1 There are no financial implications arising from this report

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List of appendices to this report:

Appendix 1 – Response from the Mayor to Health Committee, 17 January 2022

Appendix 2 – Response from the Department for Levelling Up, Housing and Communities, 15 February 2022

Local Government (Access to Information) Act 1985

List of Background Papers:

None

Contact Information

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MAYOR OF LONDON

Caroline Russell AM
Chair
London Assembly Health Committee
C/o Daniel.Tattersall@london.gov.uk

Our ref: MGLA191121-8263

Date: 17 January 2022

Dear Caroline,

Thank you very much for sharing the London Assembly Health Committee's recently published report into public toilet provision across London. I welcome the work that the Committee has done in this area. I have responded to each of the report recommendations in the annex attached, and please accept my apologies for the delay.

Public toilets are a vital facility for everyone, giving Londoners and visitors to our city the confidence to move around and spend time in public spaces. A lack of easy access to suitable toilet facilities is more than just an inconvenience – it can have serious implications for health and can limit people's ability to go about their daily lives as they would choose. No one should be worried about whether or not they can find a toilet that meets their needs when they are out and about in London.

I will continue to promote the provision of free, publicly accessible toilets in our city, and I would like to reassure the Committee of my commitment to doing everything within my power to support this.

Yours sincerely,

Sadiq Khan
Mayor of London

City Hall, Kamal Chunchie Way, London E16 1ZE
mayor@london.gov.uk ◆ london.gov.uk ◆ 020 7983 4000

Annex

Mayor of London's response to the recommendations of the London Assembly Health Committee's report on improving public toilet provision in London

Recommendation 1
The government should make the provision of public toilets a statutory duty for local authorities, and the Mayor should be leading on this issue for London, lobbying with London Councils for the provision of ringfenced funding to enable this to be achieved.

Any decision about imposing a statutory duty is a matter for the Government. The Mayor will ask his officers to initiate discussions with colleagues in London Councils, to explore how local authorities could be best supported in their efforts to enhance public toilet provision.

Recommendation 2
The Mayor and London Councils should provide an opportunity for local authorities to share best practice on their community toilet schemes, including how to run them successfully and how to ensure that information and directions about such schemes are clear, consistent and accessible.

The Mayor supports the principle of enabling local authorities to share best practice in this area. The Mayor will ask his officers to discuss with colleagues at London Councils as to how this might be best facilitated.

Recommendation 3
The Mayor should engage with large businesses and retail chains on the high street, to encourage them to open their toilets to the public and advertise that they are doing so.

The Mayor's Good Growth investment is creating or refurbishing more than 250 toilet units, including more than 180 that are fully accessible, across London; and Transport for London (TfL) is also improving its toilet provision.

The London Plan Policy S6 requires large-scale developments that are open to the public – such as shopping centres or large community spaces – and those where new, large-scale public realm is created, to provide free, publicly accessible toilets suitable for a range of users.

In respect of high street access, the Mayor supports borough community toilet schemes that promote access to toilets on commercial and retail premises by members of the public; and will continue to work with boroughs, TfL and businesses to provide inclusive and accessible toilet services in London.

Recommendation 4
To make current public toilets more financially viable, and to stimulate provision of new public toilets, the Mayor should convene local authorities and prospective commercial partners to explore innovative practice with regards to advertising and broader commercial opportunities in public toilets.

The Mayor will ask his officers to explore what support they can offer in facilitating such discussions between local authorities and commercial partners.

Recommendation 5

TfL should share, in a public forum, the results of their current review of toilet provision across the network and any actions that will be taken as a result of the findings.

TfL is currently in the process of compiling the findings of its audit of London Underground facilities, which included assessing the general condition of toilets and any restricted opening hours that were in place. Some of this information, such as opening hours and precise locations within stations, will be incorporated into TfL's published customer information, although a timescale for this is yet to be agreed. My officers will keep the Committee informed of progress.

As a result of the findings, TfL has already identified low-cost improvements to the general presentation of some toilets – for example, redecoration. These improvements will enhance the experience of customers using these facilities. TfL's ability to progress this work is contingent on the availability of future funding.

Recommendation 6

TfL should create an action plan for how they will enable the wider public, not just paying passengers, to access toilets situated behind the barrier in stations.

TfL will continue to expect its staff to allow people through the barrier to use toilets wherever possible. In some circumstances this might not be possible, such as if they are the only staff member in the station and the toilet is remote from the ticket barrier. In this case, TfL expects staff to offer useful information to customers about where the nearest alternative toilets can be found.

TfL will be undertaking engagement with operational colleagues about supporting customers who need toilet facilities when they are travelling. TfL is also providing staff with information on more general actions they can take to support people who may need to access station toilets. This includes ensuring toilets are operating as they are meant to, allowing customers access on request at times when toilets are locked, and, when requested, allowing people through the barrier to use toilets even if they are not travelling. Staff are also being asked to stay informed regarding the facilities that might be available locally.

It should be noted that TfL's current guidance for new facilities is that they should be located in the ticket hall after the barrier, as it means staff are better able to monitor toilets. In turn, this helps to ensure facilities remain in a better condition for all users. Technology-based solutions to permit access to toilets for the wider public (i.e. non-customers) are cost-prohibitive.

Recommendation 7

The Mayor, local authorities and TfL should all improve the quantity and quality of information on how to find the types of publicly accessible toilets that Londoners require, with the information provided in a range of formats that suit the diverse needs of Londoners.

TfL is investigating options for improving toilet signage to make it more prominent and obvious to customers looking for facilities. This includes the use of bolder pictograms and including messaging about hidden disabilities where appropriate. TfL is also developing a set of more detailed principles for toilet signage, which will ensure that customers are more easily able to locate toilets within stations.

Once the information obtained through TfL's audit of London Underground toilets is finalised, the intention is to publish more comprehensive information about the location of toilets within stations, as well as opening hours at stations where these are not available throughout the full traffic day. This will allow customers to plan their journeys more effectively.

Information about toilets is currently available in several formats, including within the TfL Go app and in the printable online toilet map. Information about the locations of accessible toilets is also published in the Step-free Tube Guide, which is available both online and as a printed map. TfL is also exploring options for enhanced customer information about toilets, including incorporating additional detail into TfL Go.

Some local authorities provide open data regarding existing public toilets and community toilet schemes. The Mayor would encourage all local authorities to make this kind of information publicly available. There is also a range of existing online resources (for example, the Great British Toilet Map, AccessAble; Flushed; Toilet Finder; Open Lavs and Loocations.com (formerly Lockdown Loos), which are useful sources of information for the public.

Recommendation 8

TfL should add an easy-to-find toilet map on their TfL Go app, ensure it is available in accessible formats and contains accurate data on facilities and opening times.

TfL's toilet map data is already integrated in TfL Go. The app currently provides information at the station level for: whether there are toilets and baby changing facilities present; the gender for the toilets, if applicable; whether toilets are located inside or outside the ticket gate line, and whether facilities are managed by TfL or not.

As mentioned previously, TfL is investigating options for enhanced customer information about toilets, including incorporating additional opening hours detail into TfL Go. However, timescales for this are not yet agreed.

Recommendation 9

TfL should meet with disability charities including Crohn's and Colitis UK, and Changing Places, to review their provision for people with disabilities and people with long-term health conditions and join the "not every disability is visible" campaign.

TfL is always open to opportunities to collaborate with external organisations. Officers have had recent meetings with Crohn's and Colitis UK, who are positive about TfL's initiatives to improve access to toilets across the network. TfL also supported their recent awareness week (1-7 December 2021) by publishing a blogpost for staff, which highlighted the experiences of a customer with these conditions using the network.

TfL has developed new signage for customers that includes the message that not all disabilities are visible. This has already been installed at Nine Elms and Battersea Power Station, which opened as part of the Northern line extension. All TfL's information for staff highlights that there may be a number of reasons why customers require quick access to toilets when out and about and that many of these disabilities may not be visible or obvious.

TfL has been working with Changing Places to develop proposals for a facility at Colindale station when construction of the proposed new ticket hall is complete. A Changing Places toilet is also opening at Ealing Broadway station.

London Underground has rewritten its requirements for projects to provide a much stronger instruction around toilet provision when new station infrastructure is constructed. This will include considering the provision of Changing Places toilets. TfL is also working to develop a variation on a Changing Places toilet that will also be suitable for other users.

Recommendation 10
Each local authority should produce a toilet strategy based on population need and current provision.

The decision as to whether to produce a local toilet strategy is a matter for each local authority. The Mayor will ask his officers to raise this issue with colleagues at London Councils, as part of their wider discussions on this topic.

Recommendation 11
Using the principles of the Health Inequalities Strategy, the Mayor should review the health inequalities implications of current public toilet provision in London, and use that analysis to help drive improvements in provision with partner organisations.

Londoners have diverse needs when it comes to toilet provision. Improving the availability of suitable and accessible toilet facilities plays a role in addressing inequalities, while being of benefit to all.

As above, the London Plan Policy S6 requires large-scale developments that are open to the public to provide and secure the future management of free, publicly accessible toilets suitable for a range of users. This and other health and wellbeing provisions from the London Plan have been included in the newly published Health Inequalities Strategy Implementation Plan, reflecting the Mayor's commitment to using every power at his disposal to tackle health inequalities.

The Mayor will ask his officers to speak to colleagues in the Office for Health Improvement and Disparities to find out what data exists about public toilet provision and its impact on health inequalities, and to explore how such data might be used to support local decision making around public toilet provision.

Recommendation 12
The Mayor and London Councils should work with local authorities to review the quality of accessible toilets to ensure they are genuinely accessible for Londoners with all disabilities

The Mayor's Good Growth investment is creating or refurbishing more than 180 fully accessible toilets across London, which will contribute towards improving the quality and availability of accessible public toilets across the city.

The Mayor will ask his officers to raise this issue with colleagues at London Councils as part of their wider discussions.

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Department for Levelling Up,
Housing & Communities

Department for Levelling up, Housing and Communities
Technical Policy Division
Building Safety Programme
Fry Building
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London SW1P 4DF

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www.gov.uk/dluhc

Daniel Tattersall
Senior Policy Adviser (Health & Economy)
Scrutiny and Investigations
LondonAssembly
City Hall, Kamal Chunchie Way,
London E16 1ZE
daniel.tattersall@london.gov.uk

Our Ref:14306208
Your Ref: Public toilet provision

Date:**15 February 2022**

Dear Daniel Tattersall,

Thank you for writing to our Secretary of State, the Rt Hon Michael Gove MP, about public toilet provision, I have been asked to reply and am sorry for the delay.

Public lavatories are valuable community amenities. People's ability to work, shop and enjoy their leisure time depends on good access to toilet facilities. Good lavatory provision contributes to public health and helps maintain a high level of public hygiene, this is key as we emerge from the pandemic and as more and more people make use of our public spaces across the country.

The Government encourages local authorities to keep public lavatories open and many local authorities already operate local community toilets schemes to encourage cafés and other businesses to open their toilets to the public. It is for local authorities to decide what facilities to provide in their area. Nevertheless, the Government would encourage all local authorities to consider whether such a scheme would be beneficial in their area.

At Budget 2018, the Government committed to introduce a 100% mandatory relief for public lavatories. The Non-Domestic Rating (Public Lavatories) Bill 2019-21 has received royal ascent and will provide support where removing the additional costs of business rates could help to keep facilities open. The Act delivers on this commitment and will mean that properties that consist wholly or mainly of public lavatories in England and Wales will receive a 100% relief from business rates. The relief is to be granted to properties that are assessed by the Valuation Office Agency for rating purposes as public toilets. This relief could take around 3,500 facilities in England out of rates, many of which are run by town and parish councils.

Access to public toilets, both in municipal and private sector locations, is an important facility for all members of the public. Building owners, including local authorities, have the role to open, maintain and oversee their toilets. The Covid 19 pandemic has highlighted a need for toilets and changed how existing toilets are managed. To help everyone maintain good hygiene, consideration should be given to configuration of toilet facilities to ensure they are kept clean, with social distancing achieved as far as possible and with best practice handwashing followed.

We are working to ensure buildings are safe through clearer standards and guidance. We have a programme of work to upgrade statutory guidance supporting the Building Regulations. Government has committed to review statutory guidance given in Document M (Access to and use of buildings). This includes a review of guidance on new accessible toilets and of wider inclusive design for new buildings. This guidance describes a range of toilets suiting different needs and the review will look to refresh evidence underpinning regulation and its links to best practice standards.

Government has also recently worked to make relevant change to building regulations in England to help add larger accessible toilets, known as Changing Places toilets, to more than 150 buildings a year and has launched a grant of £30 million to install Changing Places toilets into existing premises.

Government also launched and since closed a call for evidence in October 2020 for a technical review on the provision of toilets.

Statutory guidance does, however, point to independent best practice standards on toilet provision in the external environment. Such as BS 8300-1:2018: Design of an accessible and inclusive built environment. External environment. This best practice recommends that public toilets should be provided at locations where people meet, wait or spend time, such as arrival points, car parks, public transport interchanges, retail areas and cafés. It also recommends that a variety of facilities should be provided to ensure that toilets are available for the anticipated range of users (e.g. accessible toilets, Changing Places toilets, family toilets).

Government is working on legalisation, on improving statutory guidance, on a technical review on the provision of toilets and with grant funding for new Changing Places toilets, but there are no plans to make the provision of public toilets a statutory duty for local authorities, backed by ring fenced funding.

With thanks again for writing on this important matter.

Yours sincerely

Luke Turner

Luke Turner
Principal Architect - Approved Documents M and Q
Technical Policy Division, Building Safety Programme

Subject: Health Inequalities Strategy Implementation Plan 2021-2024

Report to:	**Health Committee**
Report of:	**Executive Director of Assembly Secretariat**
Date:	**2 March 2022**
Public Access:	**This report will be considered in public**

1. Summary

1.1 This report provides background for the Health Committee meeting focusing on the Health Inequalities Strategy Implementation Plan for 2021-2024.

2. Recommendations

2.1 **That the Committee notes the report as background to putting questions to invited guests and notes the subsequent discussion.**

2.2 **That the Committee delegates authority to the Chair, in consultation with party Group Lead Members, to agree any outputs from the discussion.**

3. Background

3.1 The Health Inequalities Strategy (HIS) Implementation Plan for 2021-2024 was published in December 2021. The plan details the actions the Mayor and partners will take to tackle health inequalities over the next few years. The five themes of the HIS remain the core framework, but the plan also reflects priorities that have emerged from the COVID-19 pandemic, including those highlighted through the London Recovery Programme.

3.2 The Health Committee is responsible for leading scrutiny of the HIS. The Committee will look in detail at each of the six key commitments, to understand how they were agreed and how they will be delivered.

4. Issues for Consideration

4.1 This investigation will scrutinise the Health Inequalities Implementation Plan and how it delivers the HIS. The session will consider:

- How the key commitments were identified;
- What progress has been made to-date;
- What funding has been allocated to achieve each commitment;
- Who the key partners are;
- What problems, if any, could potentially affect the achievement of these commitments;
- How these commitments will help to deliver the HIS; and
- How progress against these key commitments will translate into improvements in health inequalities and how this will be measured.

4.2 The following guests have been invited to attend the meeting and participate in the discussion:

- Vicky Hobart, Head of Health, GLA Health Team and Deputy Statutory Health Adviser;
- Dr Tom Coffey OBE, Mayoral Health Advisor;
- Professor Kevin Fenton CBE, Regional Director for London, Office of Health Improvement and Disparities; and
- Jazz Bhogal, GLA Assistant Director of Health, Education and Youth.

5. Legal Implications

5.1 The Committee has the power to do what is recommended in the report.

6. Financial Implications

6.1 There are no direct financial implications to the GLA arising from this report.

List of appendices to this report:

None.

Local Government (Access to Information) Act 1985

List of Background Papers:

None.

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