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.