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without too much extra costs. The Mayor of London, for example, has a legal obligation to take health into account. Others *want* or are willing to listen to a health perspective, whether because they are designing an Olympic bid with a focus on social inclusion and regeneration, or whether because they are servants of a government that has an interest, however weak sometimes, in mainstreaming health and reducing health inequalities.

In other words, because of its powerful backing, consistent profile, inclusive membership and fixed staff the LHC has been able to become a credible representative of parts of the London health policy network and an important factor in specialist debates about London health issues such as workforce or smoking. We found much less evidence, though, that it is successful in influencing big organisations such as the London NHS or boroughs- its efforts to diffuse good practice, while still recent and therefore too early to evaluate, are competing with other networks.

The research

This report is the culmination of a research project funded by the King's Fund, as part of its *Putting Health First* programme. The research was carried out between January and September 2004. The information presented here is based on an analysis of websites and documents, attendance at various LHC events, and a range of semi-structured interviews. These started with interviews with the 9 members of the LHC executive. A 'snowball' technique was then used to identify further interviewees: the executive members were asked for names of actors who should be interviewed and these were followed up. Most actors identified in this way were individuals from non-health organizations: for instance, environment, voluntary, black and minority ethnic group representatives. Unattributed quotes from interviewees are used in this report.

We adopted an approach of respectful scepticism to the data obtained from respondents. In our experience, actors within governance networks have a tendency to mix optimism with a positive evaluation of progress so far. We are not suggesting that any of our respondents were insincere or aimed to mislead; positive thinking results from networking with 'like minds' and is a vital and understated ingredient in keeping networks alive. Given this, however, to obtain a more objective assessment of the progress of a network, it is necessary to analyse the standpoints of sources and complement interviews with desk-based research (Yin 2002, Strauss 1998).

London's health

Greater London is a complex world city, with a diverse, mobile, and rapidly changing

> of its population. It is hard to feel confident that this good fortune will continue." (388-89).

Between the abolition of the Greater London Council in 1986 and the arrival of the Greater London Authority in 2000, there was no tier of government covering the territory of Greater London. The 32 boroughs and the City of London ran all local government services alongside a range of joint boards and central government-controlled agencies. These included bodies such as the Metropolitan Police and London Transport, which were later to become part of the GLA 'family' (see below), and agencies such as the Housing Corporation and London Arts Board, which did not.

In the run-up to the 1997 general election, the Labour Party had a long-standing commitment to restore London-wide government, though this was not particularly well argued or thought through (Travers 2004:46-47). Rather vague arguments were made about the need for London to

examining the potential role for the Mayor and a 'strategic' government in the area of public health. This research looked at the roles played by other mayoral authorities in Europe and North America.

The GLA was created with a separately-constituted executive Mayor and a scrutinising Assembly. The Mayor of London holds all the executive powers in the GLA, but most of them are carried out at one remove through four 'functional bodies', which are essentially quangos. These are: Transport for London (TfL), the London Development Agency, the Metropolitan Police Authority and London Fire and Emergency Planning Authority. The Assembly, meanwhile, has a limited scrutiny and budget-approving role which has little influence on the day-to-day work of the Mayor.

The GLA has 'responsibility' for matters such as culture and arts, the environment, and health, but it was not to run public services in those policy fields. It is obliged to write a number of strategy documents on matters such as ambient noise, air quality, biodiversity and waste (see Table 1), though it would have few powers and sanctions to ensure that they were implemented (consider the problems of improving air quality and reducing noise pollution in London without being able to touch Heathrow). The Mayor therefore relies upon goodwill, partnership and his electoral mandate to take them forward.

Table 1: Mayoral powers and strategies

Executive powers	**Strategy documents**
Metropolitan Police Authority	
Transport for London	Transport
London Fire and Emergency Planning Authority	
London Development Agency	Economic Development
	Air Quality Ambient Noise Biodiversity Waste Management
	Culture
Planning	London Plan

London's health and public health structures

strategic health authorities, each responsible for co-ordination and performance management in its patch. Their heads meet and are sometimes known as the “London NHS Cabinet.”

Below the SHAs are Primary Care Trusts responsible for providing or commissioning care for a

and safety, and employment, for example - promote health rather than obstructing it.

The London Health Commission represents a bottom-up attempt to engage health advocates with Mayoral policy. It predates the establishment of the GLA and the election of the Mayor, and hence has an independent existence from the Mayor. At the same time, it is dependent upon Mayoral and Kings Fund largesse for most of its effectiveness – providing office space and some funding, and the opportunity to network. Conversely, the LHC is not the Mayor's only 'health policy'. He set up the Greater London Alcohol and Drug Alliance (GLADA) in early 2001, with a membership including the ALG, probation, the London NHS, the prison service, the Metropolitan Police and the Social Services Inspectorate. The high-level aims of this group resemble those of the LHC. They include being "a voice for London" and "providing a mechanism for tackling Londonwide problems" (GLA website). An eight-point plan of action was produced for the first year, which included producing a 'policy for London' on alcohol, research, involvement of users, and impact on Mayoral strategies. Besides this, a campaign entitled "Saving Londoners' Lives" was run jointly with the London NHS and a range of voluntary organizations (including the British Heart Foundation, the Red Cross, St John Ambulance and Under Pressure). This was an advertising campaign publicising ways to recognise when a heart attack is happening, in order to increase the likelihood of help being called from emergency services. A wide-ranging survey of disabled people's experience was undertaken through 2003 and the results launched at a conference in December 2003 (the Disability Capit.3(ed)8.5(rv)(gn)3(e)7r1.2rondoe

The LHC: a brief history

Formation and influence on the GLA Act

The LHC itself first appeared in 1999, when a group of self-appointed 'concerned organizations' came together informally, and produced to produce a *London Health Strategy* in March 2000 (LHC 2001). The strategy was the descendent of what one interviewee then involved some "fairly crude" work produced by the NHS public health team in the early 1990s, and subsequently developed to a much more sophisticated level. It identified health-related targets based factors known to contribute to morbidity, rather than on health outcomes, noted areas in which London performed poorly, and suggested some mechanisms to overcome them.

The LHC at this point had only an informal structure, and little in the way of stable funding (and no staff, being run out of the King's Fund's offices). It was, however, able to gain commitments from all of the mayoral candidates for the first elections in 2000 to include health concerns in their manifestos. Ken Livingstone, after his election victory, appointed Dr Sue Atkinson as his health advisor. As noted above, Atkinson was and is a serving civil servant (as Regional Director of Public Health) and one of the founding members of the LHC. This formalises important lines of communication.

Neither boroughs nor the Department of Health had been positive about a GLA role in health, while leading pro- GLA politicians (including Ken Livingstone) were prone to suggest that they thought the GLA should control the London NHS - a stance that was unlikely to win friends in the DH or London NHS organizations. Two interviewees who had been involved in this entire period both suggested that the breakthrough was to divert the GLA from this (probably hopeless) goal and to identify an attractive and important set of health issues that would sidestep conflict while giving Greater London a health role. Interviewees reflected on how politically-charged innovations such as the LHC were at this period:

> "There was a lot of politics- it seems amazing [now] that people got so worried about their prerogatives." [LHC official]
>
> "People were so nervous then- everybody was safeguarding their positions" [Member of a 'GLA family' organisation].
>
> "The boroughs worried that the GLA would take over health policy, so they got interested… even though nobody was sure it was the right way to go" [Member of the LHC steering committee]

Expansion, 2000 - 2003

Following the 2000 election, a number of organizations contributed money towards the establishment of a secretarial function in City Hall. These were the GLA, the King's Fund, Government Office for London, Association of London Government, the Social Services

Inspectorate, the NHS Executive London, the Metropolitan Police Authority and the London

therefore formally appoint its chair, in practice this is what happened. Indeed, GLA literature sometimes claims that the Mayor set the LHC up (GLA website). Whatever the exact details, Len Duvall was a high-profile chair who could raise the profile of the LHC, both with the Mayor's office and with the public (he was replaced by Jennette Arnold, a fellow Labour assembly member, in December 2004).

Other LHC members, and newly interested groups, now contribute to three 'priority groups' on black and minority ethnic communities, children and young people, and disabled Londoners. The first has been established for 12 months, and is building towards 25-30 regular members. The second group is in its infancy, and the third has yet to be established. Each group is chaired - or will be chaired - by a member of the Executive, to enable the groups' opinions to move directly into the Executive. These networks, it is expected, should extend further the reach of the LHC by serving as connections to groups interested in particular topics.

The LHC has approximately three permanent members of staff: a secondee from the Health Development Agency (via the public health team in the Government Office), a staffer paid for by the Kings Fund to work on London Works for Better Health (see below), and two administrators (one temporary), supported by the GLA and DH. They operate from a bank of desks within City Hall, the GLA building, and therefore have access to GLA staff and to the news and information facilities of the GLA. Close relationships have been built with the Mayor's own (separate) health policy team.

Funding for the Commission currently comes from a range of sources (see table 2, which is consolidated from LHC documents and gives an indication of its range of support). The GLA also provides in-kind support (through housing the staff team), as does the London Health Observatory.

Table 2: LHC funding streams

Sources	**£000**	**Destination**
Department of Health / Health Development Agency	90 *20* *45* ***155***	LHC Co-ordinator post and Assistant post Communications post HDA 'programme support'
GLA	25 25 **50**	Health In London Report General funding
Kings Fund	100 *20* ***120***	'London Works for Better Health; Communications post

Reserves	***20***	
Total	**396**	

Interestingly, although the total funding available for 2004-05 is £396,000, the LHC set a budget of £581,000. This indicates the range of work it would like to pursue. Some of the un-funded programmes included in LHC documents include a review of race equality schemes, promoting National black and minority ethnic mental health strategy, supporting the ALG Fair Funding London Campaign, promoting the Disability Discrimination Act, and Developing tracking of implementation of Mayoral strategies. Health inequalities stand out as a recurring theme in this list.

What does the LHC do?

The LHC's website describes it as "an independent, high level, strategic partnership that seeks to improve the well-being of all Londoners and reduce inequalities in health." It claims to do so by

identified health-related targets based on known factors contributing to morbidity, rather than health outcomes; of the ten indicators only three are specifically about health. The rest were about risk factors that contribute to poor health[9]. It noted particular areas in which London performed poorly, and suggested some mechanisms to overcome them

The LHC also publishes updates on health indicators in the form of the *Health in London* reports. These show progress on its chosen indicators and give London a regional data bank with visibility. The London Health Observatory, one of a network of regional health data producers established by the Department of Health, helps produce the data, but the LHC does much of the commissioning and editorial work on the document.

There is no equivalent series of publications for any other part of England. The result is that thanks to the LHC it is possible to understand the challenges facing London- and think coherently about its health and heath problems. It also probably therefore contributes to wider understanding of the broad nature of London's distinctiveness in health. Judging by interviews, it is the most appreciated and widely used LHC output.

Advice and Assessment

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Assembly's Environment Committee.[10]

An assessment of the HIA process itself was carried out by Opinion Leader Research in 2003, commissioned by the GLA.[11] The assessment found that a wide range of stakeholders had been engaged in the HIA process, which had had the effect of raising awareness of HIA. But it also identified "limitations" including "a lack of agreed methods, time-scales and gaps in the evidence base for health impacts" (p6). A number of our respondents also suggested that the HIAs had been too reliant on the opinion of seminar participants, rather than on research and analysis and they questioned how much difference the process had made on the ground, although the OLR report quotes GLA officers who claimed they had taken the HIAs into account when finalising strategies (Opinion Leader Research 2003:43).

Through 2004 the LHC contributed to London's Olympic bid. There are two reasons to "drop everything and focus on the Games," as one interviewee in GOL put it. First, such a bid can unleash strategically directed public action (to regenerate areas or improve transport, for example) that might be harnessed to healthy ends. Second, it presented opportunities to convince payers and the International Olympic Committee that the Games will have a social impact beyond entertainment and sports facilities. London's bid, for example, intends to use the games to change the face of the area around Stratford and Hackney; it was designed to produce beneficial regeneration.

An interviewee on the LHC executive said the LHC had been "the obvious way to speak about health" and influence the bid "both because it could coordinate, and because it could speak for all the different stakeholders". In other words, the LHC's role in the bid is an example of it representing upwards; using its relatively comprehensive membership and information to speak for the health sector in a situation in which a health input was called for.

Diffusing ideas

basic skills such as literacy.[12] The LHC's response has been a series of "learning events" that try to bring together the different skills and employment agencies to "raise awareness of the health issues" and good practice. The second is keeping people in work and finding ways to stop people leaving work for incapacity benefit. The third is work at the community level, focusing, above all on the role of the NHS. This means diffusing, for example, the lessons from Barts and the

exists, even if all that leads to is a seminar tied to a press release (Kingdon 1995; Baumgartner and Jones 1993).

Another way to get them to focus on a given issue, and one that policymakers are more likely to appreciate, is to identify how a policy or approach can help with problems that they have already. There is not just a dearth of time, money, and attention in politics: very often there is also a

Networks and advocacy coalitions: the location of the LHC in policy theory

Most of the public sector bodies which have responsibility for health or health related matters within London are represented on the LHC. The LHC seeks to influence or direct public policy, and it is physically located within the GLA. But it is not a conventional form of government. It is a membership organization; it aims to deliver its desired outcomes through other organizations. Being a new and unconventional form of government, what it should or can try to achieve is not self-evident. On a theoretical level, the LHC can be viewed in two complementary ways. Firstly, it is an example of a policy network. Secondly, it is an innovative solution to a specific policy

serve to link between tiers of government and to link across policy areas at a single fragmented tier of government. Forums and networks normally lack institutional permanence, but their influence comes through the activities they pursue, not through their status in the hierarchy of

of vertical interdependence, in that, although it does not rely on the GLA for its existence, its work would be severely compromised without its support. Also, having obtained GLA support in kind and a relatively stable set of funding streams, it can no longer be described as 'unstable'. Further, the LHC has a formalised membership structure in that, although members do not pay to join, it restricts membership to individuals representative of 'relevant' health and related bodies. It also has a small staff team, which makes a substantial difference between a mere network of interested individuals and a more organised and sustained discussion forum.

The LHC, then, represents a form of 'network governance' as described by Rhodes (1997) and Marsh (1998). It differs, however, from their descriptions of national policy networks, which have direct links to central government. The LHC is a self-established, semi-formalised network developed as a political strategy and tool in itself. It has been able to seek influence with the main political players within a particular territory through its manipulation of the constant

priorities. This is because there are a number of organisations that for one reason or another want to incorporate health, or at least fend off challenges that they are ignoring health. Working with the LHC suits their interests as well as those of the LHC; it can supply a credible idea and connections to other important backers, while its credibility and coherence make it difficult to challenge work with it. The result is that it is able to have some influence over debates in which health must participate but in which it has traditionally been ignored.

The LHC "model"

If we were to write a description of the London Health Commission, to make it transferable to other regions or cities, what would be its chief characteristics? The LHC is not simply an issue network but a *semi-formalised issue network*. It is an intentional effort to create a form of sustainable network governance. The LHC, in other words, is a new development in policy networks, occasioned by the introduction of strategic government in London.

The LHC's structure as a semi-formalised issue network cannot be understood apart from the institutional context in which it exists – that of London under the GLA. The GLA is a unique form of government in the UK, in that its entire approach depends, for any effectiveness, on engagement with outside interests: stakeholders, officers of other tiers of government, private organisations. The Commission model is an efficient quasi-institutional response to this new form of governance. It engages stakeholders; it is engaged with, but not dependent on, political structures; and it has its own institutional presence, which enables it to set and pursue agendas and not merely follow those of other actors.

We have identified six[14] characteristics that differentiate the LHC from the *ad hoc* partnerships

form it takes, since they pay for it and staff the core steering group. They also give it a sense of importance (because they are all important) and permanence.

The UK is “full of partnerships that last as long as the grant application they came together to write” according to one interviewee in local government. The relative permanence and resources of the founding organisations means the LHC can do some medium-term planning in security. However, because a coalition of these organisations sustains the LHC, it is not seen as the creature of any one.

A*n underlying network of known individuals:*

It should be clear from the short history and description of the LHC that it is in many ways an extension and formalization of pre-existing networks based on specific individuals with a given worldview. This should be no surprise. If there is anything consistent about public health working at the local and regional level in the UK, it is the importance of personal trust-based networks. London, in common with other areas of the UK (Wales, the North West of England, Greater Glasgow), has had a relatively stable group of local actors for many years who exchange information and act together.

Overcoming problems of organisational integration - of establishing enough trust to deviate from organisational mandates and accountabilities – takes trust in other members of the network (Behn 2001). It is this trust, formed in a stable issue network that was fundamental in forming the LHC into the ‘commission model’. But it goes beyond ordinary organisations- in the same way other partnerships could and have done- by being public enough, and coherent enough over time, to be joinable. It pools their credibility and is a formal vehicle for adding credible newcomers, whether from neighbourhood groups or big organisations.

A *measure of autonomy from politics*

surprising. The LHC's flexibility - its fundamental opportunism - does not lead to particularly consistent agendas. Influencing organisations must take at least part of their cue from the opportunities to influence.

The activities of the LHC can be discussed from the perspective of its level of organization. The LHC is a *regional* organization. It operates on a level between Whitehall and the boroughs. It is closer to Whitehall than the boroughs, and it is closer to the boroughs than Whitehall. That means, we argue, that it engages in all directions- up, down, and sideways. Its greatest successes, and its greatest use of its semi-formal nature, appear to date to have been in representing upwards.

Representing upwards

The LHC has a claim to be the best representative of London in public health. It has the support of the key public health organisations, the key local governments, articulate policy analysts, and (more nebulously) groups focused on local upstream policies. The London SHAs and trust chief executives, without a NHS London region, band together to speak for health services and the NHS in London; the LHC can speak for broader public health. This reflects the fact that almost all of the levers of power needed to influence public health remain, in the last instance, with central government. Regional networking will often run up against legislation, programmes that cannot be modified without the consent of Whitehall, or lack of money. Influencing, and maintaining a good relationship with central government, are vital tools if those impediments are to be removed. Examples of its attempts to influence upwards include its response to the government's 2004 consultation on public health or its efforts to supply ideas for making the Olympics healthy.

Discussing sideways

London, thanks to the presence of the GLA, has a much stronger regional level than the rest of England. The GLA's creation prompted the creation of the LHC in its current form. The presence of the GLA also gave the LHC its first real role, as producer of HIAs. There is a confluence of interests: the GLA needs some sort of health policy (and shows no reluctance to have one) and the organisations in the LHC want to use any opportunity to influence policy. Structurally, "the GLA needs some way to develop its interest in health and the LHC does much of that" (interview data, LHC executive member).

A notable feature of our research was the lack of engagement revealed between the LHC and the London Assembly's Health Scrutiny Committee (merged since June 2004 into the Health and Public Services Committee). The LHC and the scrutiny secretariat share the same open-plan office and the (former) chair of the HSC, Elizabeth Howlett, sits on the LHC, but we found no evidence of actual joint working between the two. Interviewees agreed that LHC relationships are stronger with the 'Mayoral side' of the GLA staff.[16] One LHC respondent expressed surprise that the committee had never tried to scrutinise the LHC, though another stated that this would

[16] Reflecting the divide between the executive Mayor and the scrutinising Assembly, there is quite a sharp divide within the GLA between executive staff and the scrutiny secretariat.

be inappropriate.

A majority of core, repeat participants in the LHC appear to be from non-health organisations (based on the attendance lists from the various events held by the LHC during 2004) and very few are from the high-profile power centres of the London NHS. While a few senior staff from PCTs, hospital trusts, and GP practices do attend LHC events, they are in the minority. Indeed, in the course of this research we came across some PCT directors of public health who had no

Lessons for the rest of the UK

The problems of integration in London after the demise of the GLC, and the new networks and opportunities they created, may appear unique, but were shared to some extent by all the former Metropolitan counties. Policy makers in Strathclyde, Greater Manchester, South Yorkshire and the West Midlands felt the need to reassign some regional services and replace others with networks. Indeed, such networks have grown up with greater or lesser success and permanence around the UK; even in the most poisonous local government politics there are overwhelming reasons to work together on some issues. Therefore, it may appear that the LHC has a lot to offer other areas, and that its key characteristics should be studied by them. We believe there are some reasons to be sceptical about this.

First, the LHC was lucky to have, from the outset, players with a local commitment and significant resources - not just money, but premises and a reputation for neutrality in intergovernmental relations. In particular, the King's Fund's ability to provide sufficient resources to enable London networks to start to look institutionalised, to provide information, and to run events that promoted London-wide thinking were vital in building some of the capacity that led to the establishment of the LHC in the first place. Some London universities also took an interest in the city's governance, including the Greater London Group at the LSE. Their contribution in resources was less, but they could both contribute to thinking about London as a meaningful shared space for policy and

Other regions in England have been putting in place structures that slightly resemble anaemic forms of the Commission. For example, there is a North-East Forum for Health and Regeneration, which operates from the North-East Assembly (i.e. the voluntary, un-elected regional chamber – see Sandford 2002). It has a wide-ranging membership, including the Government office, the Regional Development Agency, Health Development Agency, Public Health Observatory, SHAs, PCTs and local government. It is chaired by the Health representative on the Assembly, and holds an annual Health Summit, at which a wide range of stakeholders discuss public health issues. In the South-East, the Regional Assembly runs a Healthy Region forum which meets three times per year. This is supplemented by an annual Health Summit, where presentations on matters of importance to health in the region are given.

These represent valiant efforts from fragmented regional authorities, but they are not on the same scale as the LHC. Though small amounts of office space, officer time and cash are available, there is far less of these things in the un-elected Regional Chambers. These have 30-50 staff members and total budgets of £2m per annum, overwhelmingly programme-related. By contrast, the GLA has some 675 staff and costs £73 million per annum, a sum raised through precepting powers on London's boroughs. It is unlikely that Regional Chambers could have the time or resources to animate regional networks to the same extent. They also lack access to political

Conclusion

Networks are a fact of life in government. They are the way policymaking happens in almost any system. The London Health Commission has its roots in such networks - the governments developed by organisations and individuals interested in the wider determinants of health and population health in London. But the LHC is distinctive above and beyond those networks. It is an effort to consciously use and give a formal label to networks- to develop networks that will enable not just coherent governance but also to pursue complex policy ideas such as employment policy that contributes to health. It has been most successful in representing the broader public health of London to national government and in talking on behalf of London about health issues in debates that are primarily about other topics (such as the Olympics). It has also carved out a role with London policy makers, for example through its Health Impact Assessment of mayoral strategies and the Big Smoke debate. As a regional organization, it seems to work most often and most effectively on the regional level.

Like other regional actors in the UK, it has had more difficulty in influencing downward, although we have argued that it has the potential to have a downward impact, for example by identifying and connecting examples of good practice from around London. Its highest profile programme, London Works for Better Health, already collects examples of NHS staff recruitment and retention schemes that both expand local employment and help solve the nightmarish staffing difficulties of London's acute trusts.

The LHC is not just a policy network. Its *organizational* distinctiveness, and distinct advantages, are to do with the characteristics described above that distinguish it from the networks maintained by any good Regional Director of Public Health. They are: a stable core of organisations; good personal networks, at least at start; some autonomy from politics; some political support; staff; and an identity. These features, presumably, allow it to solve other people's problems in ways that also improve health. Their virtues largely amount to a high, consistent, status- a good position for an influencing organization. The combination of relative neutrality with a Greater London remit and political backing (in the small p sense, including actors like GOL) gives it an aura of importance. The combination of an identity, staff, consistent support and ancillary resources such as the website gives it an appearance of seriousness and, over time, a record of activity while the presence of staff means that it can target and promote a few ideas that would otherwise be ignored for lack of dedicated budget lines.

It is not surprising to find that other regions of the country, facing similar 'wicked problems', and the need to find solutions that can be applied in an era of fragmenting public services, are trying to establish their own networks along similar lines. However, our study of the LHC raises questions about how successful these are likely to be, outside the unique political, organisational and academic community of London. If the commission model is to work in other regions (or other cities), it needs the support of substantial funding. It also needs the political clout of an organization that is central to regional administration – this might be a Regional Chamber, or a regional development agency or Government Office for the Region.

A further effect of the LHC has been the expansion of London-oriented territorial policy networks (see Keating and Loughlin 2002). As the capital of the UK, London has always been a major location of national policy networks, but those relating to the territorial governance of London have been underdeveloped by comparison. Such a development might contribute to the embedding of the concept of Greater London as a region of England. The LHC indisputably has created something of a network beyond the initial group of a few activists. Its precarious status means that it has to keep doing something to attract the support of organisations that have more than enough other demands on their time and resources. It is a regional organization and that is where it almost seems, judging by its work, to have found its own added value. There is no other organization that can address the GLA, London policymakers, or Whitehall with such a base and such a claim to representation.[17] The LHC partially creates and partially represents a technically skilled, representative group of London health policy players. Its coherence and credibility- and ability to expand- mean that it can speak for London's health in a relatively consensual, technically competent way and propose solutions that ideas that will solve policymakers' problems as well as advancing ideas.

The commission model is therefore a representation of one of the ways in which the new 'strategic' government can work. Using minimal hard resources (cash and executive powers) and

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Appendix 1: London's health situation in the UK

London Borough (+City)	**SMR**	**Local authority**	**SMR**
Camden	91	Newcastle-upon-Tyne	110
City of London	60	Manchester	127
Hammersmith and Fulham	95	Liverpool	126
Kensington and Chelsea	80	Sedgefield	121
Wandsworth	97	Middlesbrough	103
Westminster	71	Derbyshire Dales	90
Hackney	102	Burnley	117
Haringey	94	Leeds	98
Islington	100	Doncaster	111
Lambeth	96	Nottingham	107
Lewisham	108	Rutland	81
Newham	116	Norwich	88
Southwark	100	Birmingham	105
Tower Hamlets	106	Wolverhampton	109
Barking and Dagenham	114	City of Bristol	85
Bexley	93	East Dorset	75
Enfield	95	Merthyr Tydfil	125
Greenwich	103	Blaenau Gwent	115
Havering	97	Cardiff	100
Redbridge	89	Swansea	98
Waltham Forest	106	Glasgow City	144
Bromley	88	Scottish Borders	99
Croydon	96	West Lothian	136
Kingston upon Thames	93	Falkirk	123
Merton	93	Belfast	104
Sutton	95	Derry	111
Barnet	86	Cookstown	85
Brent	95	**UK**	100
Ealing	97	England	98
Harrow	86	Northern Ireland	100
Hillingdon	90	Scotland	118
Hounslow	95	Wales	104
Richmond-upon-Thames	79	London	95

Source: *Regional Trends* 36 (2001)

Appendix 2 : Chronology of Events 1999 – 2004

	inequalities	
30 December		First contracts signed for London Underground PPP
2003 18 January	Trevor Phillips also relinquishes LHC role	Trevor Phillips, first chair of London Assembly, resigns to become head of the Commission for Racial Equality
5 February		Mayor agrees terms of transfer of London Underground with UK Government
17 February	Culture Strategy HIA workshop	Congestion charging introduced
12 March	Submission of Culture Strategy HIA	
15 May		Government agrees to back a London bid for the 2012 Olympics
18 July	Children & Young People strategy HIA seminar	
2004 6 January		Ken Livingstone rejoins the Labour Party
February	Scoping event for "London Works for Better Health"	
29 April	Crack cocaine strategy launched with GLADA	
10 June		Ken Livingstone re-elected as mayor

The New LHC Executive, established autumn 2003:

Dr Sue Atkinson	Regional Public Health Group
Mark Brangwyn	Association of London Government
Anna Coote	King's Fund
Helen Davies	Greater London Authority
Len Duvall	Greater London Authority (Labour Assembly Member)
Gail Findlay	London Health Commission
Judith Hunt	London Health Observatory
Marion Kerr	Government Office for London
Melba Wilson	PCT chair

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