London Assembly Health Committee - Wednesday 02 March 2022

Transcript of Agenda Item 6 – Health Inequalities Strategy Implementation Plan 2021-2024

Caroline Russell AM (Chair): That brings us to today's main item. I would like to extend a warm welcome to our guests today joining us to discuss the Health Inequalities Strategy Implementation Plan 2021-24. We have Jazz Bhogal, Assistant Director of Health, Education and Youth, Greater London Authority (GLA), and Professor Kevin Fenton CBE, Regional Director for London, the Office of Health Improvement and Disparities. Welcome to both of you. We are also expecting Dr Tom Coffey OBE, Mayoral Health Adviser, who will be joining us at approximately 3pm.

That brings us to our questions. Our first section of questions is looking overall at the Health [Inequalities Strategy] (HIS) Implementation Plan.

Kevin, there are around 200 commitments in the latest HIS Implementation Plan. We would like to know what mechanisms and metrics are in place to track the progress against all of those, and to understand whether you think it is realistic to deliver against such a large number of commitments.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I would like to begin by framing the importance of the HIS for London as we exit from and emerge from this phase of the COVID-19 pandemic. Throughout the pandemic, the light that has been shone on inequalities is undeniable, and the pervasive nature of these inequalities and the fact that many of them have been exacerbated is also quite clear to all of us working across the London system.

The HIS is bold and comprehensive and, by virtue of covering quite a number of key priority areas, it necessarily means that we have identified a number of performance indicators as well as key indicators to monitor progress moving forward.

I would also like to remind the Committee that the activities and the commitments within the Plan not only reflect the commitments of the GLA but also wider partners across the London landscape, whether working on healthy children, healthy minds, healthy places, healthy communities or healthy living, the range of partners including local government, the Office for Health Improvement and Disparities, the United Kingdom Health Security Agency (UKSHA), the National Health Service (NHS) and the GLA are all contributing a range of activities on the Plan. That results, therefore, in a number of core indicators that are being committed to.

To prioritise and focus our efforts on what really matters to ensure we are moving in the right direction, each of the core themes within the HIS has articulated a single ambition and has identified a key commitment that will galvanise partners and will keep the focus overall in terms of the range of activities on what we think are the most important things that need to be measured to demonstrate forward movement and progress.

As an example, for our Healthy Children theme, we know that the ambition there is to ensure that London's children eat better and families find it easier to eat healthy food. Our commitment is around the initial ambition of up to 50 School Superzones supported by 2025, and that gives us a sense of a totemic commitment that will galvanise the system but supported by a range of other performance measures as well.

I will pause there, Chair, to give a sense of both the complexity of the HIS and also the importance of using a range of indicators for different stakeholders but galvanised by an overarching commitment in the Strategy.

Caroline Russell AM (Chair): Thank you. You have given a good sense of the key commitment and the decision about what the most important thing to measure is. I am still slightly wondering how you are managing the scale of this because there are so many different partners and people that you are working with. I wonder if there is anything extra you can say on that.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Absolutely. One of the great things about the HIS and as the Public Health Director I was very keen that we not only have concrete performance indicators and commitments but we have the governance in place to oversee and to track both the commitments as well as the indicators.

Very briefly, just to highlight the governance that we have in place, at the most proximal level is the Health Equity Group, which is a subgroup of the London Health Board. It is chaired by me and Will Tuckley, who is the Chief Executive of Tower Hamlets Council. The Health Equity Group has the overarching responsibility for overseeing the development of the HIS and is taking an active role in the implementation of the HIS and ensuring that there is forward progress on all of the core commitments as well as the major themes. In the Health Equity Group, we have been working closely to ensure that the agendas are formatted so that we are reflecting on and tracking the progress in the various sections of the HIS.

In addition to the Health Equity Group, we also have the Health Equity Delivery Group, which is chaired by the NHS and by colleagues in the Association of Directors of Public Health (ADPH). That provides oversight into the NHS health equity commitments, which are articulated in the Plan, as well as a range of other equity priorities for the NHS. That group oversees and tracks the progress against those commitments in the NHS.

Finally, other governance bodies which we report into that also have an active interest in our progress include the London Health Board. We have an ongoing regular update to the Health Board which provides progress on all of the core themes as well as the recovery missions and the Recovery Board, which provides the other governance framework for this.

In addition to the key performance indicators (KPIs) and the overall commitments, we now have robust governance in place to drive and to assure ourselves of process in these domains.

Caroline Russell AM (Chair): That is really helpful to understand that. That is much clearer certainly. The GLA Health and Wellbeing team has been allocated £739,000 to deliver the Health Inequalities Programme between 2021 and 2024. How much funding is being made available across the wider GLA group to deliver the HIS and all the commitments in the Implementation Plan? That is outside of the £739,000.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): You have correctly identified and it is really important that we view the funding for the HIS as not only residing in the Health and Wellbeing group but, by virtue of the GLA's commitment to health in all policies, there are commitments from across the GLA and the group towards health inequalities.

The figures that I have here are just as a top-line indication and I would be very happy to follow up with more detail to the Committee. Most of the Health team's work currently is in fact focused on health inequalities

and, in 2022/23, the budget was £4.5 million. This included nearly £1 million on Superzones and £420,000 on HIS implementation work with stakeholders.

I will defer to Jazz to see if she would like to add any more detail to that, but we would be happy to follow up with the Committee on budgetary detail.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): To add to Kevin's point, it is important to note that tackling health inequalities and the objectives of the HIS do not just live within the part of the team that is called the 'HIS team'. Tackling health inequalities is a foundational objective of pretty much everything we are doing and not just across health. It is important to note also other resources that will be in relation to other programmes of work that actually are seen as good examples, some active travel work that Transport for London (TfL) colleagues will be doing or work that the Mayor's Office for Policing and Crime (MOPAC) is doing to tackle violent crime. These are all objectives that will contribute to the global delivery of these HIS objectives and most of these KPIs. The resource that we have allocated here is actually about us being able to mobilise that wider resource and take that health-in-all-policies approach much more broadly.

In addition to that, what we are going to be doing is to look at creating a new public health function that would go groupwide. I know that is something that you would like to ask questions on later and so we can come on to that later if that is helpful. This is really about mobilising the breadth of work that can be done, taking a health-in-all policies approach across the GLA to really look at how we can maximise that much bigger impact that we could be making.

Caroline Russell AM (Chair): That £739,000 is like a mobilising fund to make sure that the other parts of the GLA are doing the work that is required to deliver?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Yes, to some degree, and partners so not just the GLA group. For example, some of the work that we have previously funded and we would want to continue looking at how we support might be around social prescribing. This is a way in which we can work with the NHS to look at how it can get much broader support for their patients where their patients need help beyond medical and healthcare services and might need access, for example, to support in the voluntary sector and so on. This is an example of where we have the opportunity to really try to create that capacity in the system and how we are working with partners to jointly fund or to create the new ideas for what we could be doing.

This money, yes, in some ways, is about mobilising what we can be doing with others' budgets across the GLA group but also looking at how we can be more creative and push the boundaries on what we potentially can be doing, working a lot with some of our wider partners and most of those - all of them, in fact, and more - being representative on the Health Equity Group. We are certainly working with some world experts, not just UK experts - for example, the team that [Professor Sir] Michael Marmot leads at University College London and others - who are giving us phenomenal advice on that. Some of the other work that we will do is about bringing some of those partners together in workshops and looking at how we are able to create the communities of practice that we are going to need that are enabling some of that work to happen at the ground. The big focus for us is about how we mobilise action at a community level in the places where people live and, in tackling and targeting those areas, where the inequalities are greatest.

Caroline Russell AM (Chair): That is very clear. My next question is a very brief question. This Implementation Plan is 2021 to 2024. Is that the financial year and so to April 2024 or is to the very end of 2024?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): I suppose a practical response is the mayoral term.

Caroline Russell AM (Chair): That is May [2024].

Emma Best AM (Deputy Chairman): That last answer clarifies a question that I just wanted to ask. Are all of the 200 commitments to be achieved by the end of the mayoral term?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): We will certainly be working towards achieving as many as we can. We recognise that a number of them are complex and, as we are emerging from the pandemic, that we are going to be faced with a range of challenges with both many of our delivery partners in terms of the funding environment and new priorities that may emerge and of course the ways in which we are going to be engaging with Londoners and communities as well as part of this journey. This is why we have a robust governance infrastructure in place to keep track. We will be looking at annual reporting so that annual reports are provided and publicly available to track and reflect on our progress. We will be looking at keeping that resolute focus on some of the top-level commitments that I mentioned earlier.

Emma Best AM (Deputy Chairman): How many commitments would you consider it a success to achieve if you are looking back in May 2024?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I do not want to be held to a numerical target. What I would be keen to see are three things: first, definite forward movement in as many of our core indicators as we can; second, a deeper mobilisation of our partners as a result of participating in the HIS implementation programme and a broader engagement of a range of partners so that they are acting together; and then third, looking at our community mobilisation in this space as well. Yes, we will be looking at forward progress in our commitments, especially in our overarching commitments and targets, but it is almost a deeper engagement that we are wanting to see over the next three years.

I am mindful as well, Assembly Member, that for many public health targets, as you know, the changes that we are expecting to see often take some time as well and so we will be looking at some short-term gains but really laying the foundation for longer-term progress as well.

Emma Best AM (Deputy Chairman): On the other end of that, some of the key targets in the 2018 to 2020 Plan were met very early. Are you happy that all these targets are ambitious enough?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Having pored over them and worked with the team, I think they are. They represent a mixture of challenging targets and also some that we think are not low-hanging fruit but are certainly indicators that can enable us to mobilise action across our partners and to demonstrate forward motion.

One of the things that we are grappling with in tackling health inequalities is that we are doing so within a highly complex environment. There is, as you know, no one single driver of health inequalities. It does require action on multiple fronts by multiple partners acting in an aligned format and in an aligned way. That is what the HIS is enabling us to do. That is the ethos behind this work and why the partnership work that we have mentioned is so important.

Emma Best AM (Deputy Chairman): Coming back to that first bit about some of those key commitments, they specified deadlines beyond the Implementation Plan's lifespan. Where that is the case and where those targets will not be met before May 2024, what are the interim targets or how will you be measuring and monitoring progress and success? Again, how will you measure the success up to that point and then how will you measure the success beyond that point?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): A number of our targets go beyond the 2024/25 period but if we look, for example, at the air quality Healthy Places target, which really has a bold ambition for London being a net zero carbon city by 2030 and to have the cleanest air of any major world city by 2050, those are targets that go beyond the three-year period.

What we will be looking at are some of the core indicators on air quality to demonstrate forward movement and year-on-year progress. At the end of the three-year period of this Strategy, we will be working - I presume with the new administration or with the next administration - to ensure that the statutory responsibility for developing the HIS remains in place and, as the Statutory Health Advisor, to work with the administration to develop that Strategy and ensure we have bold interim targets in place to get us to our 2025 and 2050 targets.

Again, what we are laying here are both the overarching direction of travel and annual targets through our performance indicators that we will be measuring and monitoring. That is an example from Healthy Places but it pertains to all of the other themes as well.

Emma Best AM (Deputy Chairman): Where those interim targets will be in place, will those be shared widely?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): As I mentioned, we will be doing an annual report and that will provide key progress updates on how we are getting on with all of the core themes and a number of our core indicators. Those indicators have been chosen because they are robust, are available using public datasets and can be reported on annually. It is our commitment to provide the annual report. You will be able to see how we are progressing with those core indicators and that will be a chance for us to reflect on what is working, what is not working and what we may need to enhance in terms of our focus.

Emma Best AM (Deputy Chairman): Great, thanks. Chair, I may wish to come in if Onkar's [Sahota AM] questions do not answer a question I have, if that is OK.

Dr Onkar Sahota AM: One of the things of course is, when this HIS was written up, it was pre-pandemic and none of us knew what was going to happen. How adaptable is the HIS and the Implementation Plan so that they can respond to the changes in London's health priorities? How responsive is the HIS to that?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): The work on this HIS actually began in the summer of last year after the mayoral election. It really enabled us therefore to build into the development of the Strategy the learning from the first year and a half of the pandemic, some of the deep understanding that we now have in terms of the pervasive nature of the inequalities, the importance of community-centred approaches to tackling the pandemic, the importance of the vaccination programme and

the NHS's role in addressing inequalities, and also the comprehensive nature of all partners being aligned in thinking about and committing to tackling health inequalities.

Finally, one of the key lessons from the pandemic has certainly been the importance of tackling structural and systemic inequalities and discrimination. I am really pleased that this HIS has such a strong and visible focus on structural racism and the role that all partners in the health and care system and broader London partners can and should be doing in terms of tackling those structural issues that drive inequality. I am really pleased that by virtue of having developed the Strategy in the past nine months we have been able to be agile and to build in the lessons of the pandemic into this.

Dr Onkar Sahota AM: That is very reassuring. How does the Mayor address the areas of inequalities that are not included in the HIS, for example, trans health?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): One of the things about all strategies is that we try to be comprehensive but there are going to be new issues that emerge and new priorities and imperatives that we need to integrate and to reflect on. I know that this Committee has taken a very strong interest - and rightly so - on trans health issues. As one of the co-chairs of the Mayor's Fast-Track Cities initiative for human immunodeficiency virus (HIV) prevention in London, I am very much aware of the importance of trans health as well as the importance of dealing with the health and wellbeing of all key populations.

Specifically, we would be very happy to work with the Committee to understand how some of the core principles of the HIS may be applied to address some of the pervasive health inequalities challenges faced by trans people. I am very happy to look at the recent results of your investigation into this to see how we may support the implementation of those recommendations.

Dr Onkar Sahota AM: Thank you. How do you see the Implementation Plan working alongside the Government's *Levelling Up White Paper* and its mission to increase life expectancy by five years by 2030?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I am very excited about the alignment between the HIS and levelling up. One of the benefits I have working as not only the Mayor's Statutory Health Advisor but as the Regional Director of the new Office for Health Improvement and Disparities (OHID) in the Department for Health and Social Care is that I get to interface with my regional public health director colleagues from across the country. London's leadership, governance and commitment to health inequalities really stands apart from what other regions have been able to accomplish so far.

This puts us in a very good place to think about some of the intersections with the *Levelling Up White Paper*, to think of what we do as part of the HIS in terms of supporting communities and how we leverage new investments through the *Levelling Up White Paper* and new initiatives, to think about how that may help some of our community-centred approaches and also align those investments along some of the core themes that we have in the HIS.

It is also bidirectional, because we are learning lots of lessons in our implementation of the HIS and how we have designed it. We have been able to inform our colleagues in the Department for Levelling Up, Housing and Communities (DLUHC) and the Department of Health in how we address inequalities. I am hoping that as we are now poised to begin reflecting on the implementation of the *Levelling Up White Paper*, that our

experience here in London on addressing inequalities will be able to put our city in a very good place for implementation.

Dr Onkar Sahota AM: Of course, London is not a homogenous city. It is a city of great variation. For example, at the top of the scale, the life expectancy of a woman living in Westminster is 87 years and the lowest point of life expectancy of a woman living in Barking and Dagenham is 78. Yet the Government's funding for Barking and Dagenham will be £3.93 per head from the first round of the Government's Levelling Up Fund while the wealthier Bromsgrove with a higher male life expectancy of 81 years will receive £148 per head. How do you see this Government policy helping us deliver in London the levelling up?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I cannot comment on Government policy and how funding formulas result in allocations to regions, but what I can say is the importance of, whatever allocations we have, being able to use those allocations as effectively as possible. What we have in the HIS, as I mentioned earlier, is an alignment of what we as partners working across the city feel are the most important things we need to invest in to help to reduce the inequalities, which have widened over the course of the pandemic, and to ensure that we put our region on a stronger footing moving forwards.

While the advocacy for resources will sit necessarily within the political domain, as a person who is charged with policy development and programme implementation it is my responsibility, working with partners in the GLA, with directors of public health and local authorities, to make the best use of those resources. On the initiatives here that we have in this Strategy, we worked with partners. We worked so closely with our local authority partners and the NHS to really articulate the things that are most important and to check these with our communities to ensure we are on the right track. I am hoping that as the resources from the *Levelling Up White Paper* become available to this city we can move faster and move towards greater implementation with those resources.

That is my reflection on where we are with this. It is about being poised to act cohesively for impact. Our HIS allows us to do that.

Dr Onkar Sahota AM: One of the concerns that I do have - and I speak as a practising doctor who has been in the NHS for 30 years - that there are inequalities of funding that comes from the Government in different parts of London. For example, I work in the London Borough of Ealing, which does not do very well compared with [the City of] Westminster and [the London Borough of] Richmond [upon Thames]. There are inequalities of funding and somehow we do need to raise those concerns. If you want to level up those people with the most inequalities, you need more resources put into them. Unless that voice is raised, maybe that is a voice I should be raising but I need help from people like you, Professor Fenton, to make that voice be heard. Those inequalities need to be addressed.

The other thing I want to pick up on is how the new GLA public health function will deliver the Implementation Plan?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I would like to put my initial reflections on that and then I would like to ask my colleague Jazz [Bhogal] to respond as well.

As you know, as the Mayor's Statutory Health Advisor, I have a very close link with the Health team in the GLA. Since starting my role, the value-add of the Health team has proven itself repeatedly as we have gone through the course of the pandemic, in its ability to brief all parts of the GLA and the Mayor, to really focus

the GLA on the most important health inequalities, health equity and health priorities for Londoners, and to be a strong systems partner in the city, working with the NHS, previously Public Health England but now UKSHA, OHID and other key partners.

Emerging from the pandemic, we now have a chance to strengthen that Health function in a number of ways: first, ensuring that we have more public health capacity in terms of technical capacity available to provide more support and to provide stronger partnership with the different departments within the GLA and different groups within the GLA; second, ensuring that we are strengthening the support that we have to deliver on the HIS, the various missions that are health-related and of course the London Vision for the London health and care partnership, as well as the core health functions, which are articulated in our plans; then third, working closely with OHID and the NHS and really operating in systems leadership for public health in the city to ensure that the scarce public health resource that we have operates more effectively.

The final thing that I am really excited about for the new public health collaboration is the strong focus that we now have on health in all policies for the GLA and the group. What this does is that it formalises the somewhat informal relationships and partnerships that we had previously, which were effective, but we are now ensuring that these are right-sized, resourced and prioritised in terms of prioritised action to go even further. Through all four of those functions - from partnership, systems, leadership, programme delivery and health in all policies - the new public health function is extremely exciting.

Jazz, I am going to invite you to say a little bit more about the collaboration.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): It is important to remember that Section 4 of the GLA Act is where the role of health sits and, since the Act was first inspired, it did include the creation of a Statutory Health Advisor and a deputy to the Statutory Health Advisor to cover the remit of the GLA group, not just the GLA itself as an agency, including you as the Assembly. That realisation of taking that broader view was very much in the aspiration. Certainly when I joined the GLA in July 2019, it was already a conversation that was beginning to be remembered and thought of. That is worth saying.

That health-in-all-policies approach, realising that health in all policies has to be across the breadth of what the Mayor is delivering, and the wider impacts are really clear to see. A good example, of course, is air quality. Through planning, we know that we can make massive strides in improving health outcomes. We already have seen that now with TfL and with the recent publication of the evaluation of that with the **a**dvertising ban. These are agencies that will benefit, by the way, from having technical public health expertise but done on an ad hoc basis and done without the organisation and structure that the public health collaboration work can now start delivering. The creation of a public health group function based within the GLA - it needs to be anchored somewhere - but actually making sure that that is a function that is built on public health technical expertise that can really drive and make those changes systematically.

It is important to say that the design work that is already underway in the creation and the design of the team is very much alongside and aligns with the chapters in the HIS. The new public health function will be designed around the delivery of the HIS and the HIS will be the guiding strategic objective, if you like, of the team, bearing in mind that much of the HIS will be delivered through the group as well as that wider partnership.

The alignment, then, with the core Health and Wellbeing team that is based and remains within the GLA is something that we are really looking forward to. It is going to be a really good opportunity to get that clarity

of work across the GLA group and then that more focused work on delivery of those wider programmes of work that will happen within the GLA core team.

It is probably also worth saying that the ambition here is to extend -- what we have seen in the last two years, having public health expertise and growing the public health capacity within the GLA has enabled us to be far more responsive within the pandemic. The role that Vicky [Hobart, Head of Health, GLA] and the other public health consultants have played in supporting the GLA, the Mayor and that wider system to understand its contribution and the role it should take through the biggest health protection emergency we have seen for a generation has given us a much stronger reason, in addition, for having that broader HIS delivery function.

Dr Onkar Sahota AM: Thank you. I welcome this initiative for all the reasons you allude to.

Emma Best AM (Deputy Chairman): I will try to be brief but just to make one point. It is always worth reflecting when we are talking about levelling-up funding that London does get the highest per-head spending of any English region and actually has over £2,000 more per head than people in Bromsgrove. It is always worth bearing that in mind before we make comments like the previous Assembly Member.

I wanted to ask really quickly. You covered in that question how, when the Health Committee brings something up that might not be in the Implementation Plan, you might work with us to do that, but how about when the Mayor goes in a separate direction to what is in the Implementation Plan? Specifically here, for example, the Drugs Commission has a massive impact on health and is one of the biggest conversations in London for health. That is not necessarily covered in the Implementation Plan but actually has a massive impact on health inequalities. If that becomes a main plank of what the Mayor wants to achieve, then how does that get brought into the work of the Implementation Plan?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): May I just clarify, Assembly Member? Are you speaking about alcohol and drugs as a programme of work in terms of drug treatment, therapy and rehabilitation services?

Emma Best AM (Deputy Chairman): I do not know because the Drugs Commission has not been -- we know it is coming but we do not know the outcomes it will reach. However, the outcomes it does reach, I should imagine, would have some big impacts on health and health inequalities. It would make sense, therefore, that those outcomes were laced into the HIS Implementation Plan.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I would like to get back to you on this. I know that the London Drugs Commission will involve independent experts looking at the effectiveness of drug laws. It will not look at the classification of class A drugs. I am still waiting to see further detail on the Commission's terms of reference and of course its areas of focus. I would rather get back to you on this, if I may.

Emma Best AM (Deputy Chairman): Sorry, the idea was not to catch you out on the specifics of that. It is just an example of where the Mayor may decide there is a big health issue he now wants to tackle that is pivotal to his administration. How does that then feed into this so that we can then monitor? Sorry. An example is meant to be helpful, not misleading.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): No, thank you for

clarifying. In that case, I can respond to that. Absolutely, as I said, the HIS is not meant to be set in concrete. It has to be agile because we cannot say what some of the new challenges are that may come in the short and medium term. A really good example of this - as well as the Drugs Commission - is what is happening now in Ukraine and what may be the impact on London's health and care system as we prepare to receive asylum seekers and refugees from that part of the world. The HIS provides us with a framework through which we can look at new policies, new approaches and new programmes and say, "If you are going to do this well and minimise inequalities, then here are some principles that you need to do look at. How do you think about your policies through the prism of Healthy Places and Healthy Communities and the things that you need to do to support some of the structural drivers of inequalities?" That is how the HIS will be able to be agile.

As I mentioned earlier with the trans health issues, as and when we have new directions or new ambitions for the city, I am really keen that we work with the Health team to support them as well.

Caroline Russell AM (Chair): Thank you. I will now bring in Assembly Member Hirani, who is going to take us into our next section, which is the first set of Healthy Places questions.

Krupesh Hirani AM: Firstly just focusing on the air quality side and to Professor Kevin Fenton to start , how will the impact of improved air quality on health inequalities be measured and evidenced and what metrics will be used to measure the impact of improved air quality on Londoners' health?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I am going to ask my colleagues in the GLA to start off on this one, only because of their proximity to the programmatic indicators, and then I would be happy to reflect on some of the measurements and the ways in which we are going to be doing that.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): To answer your questions you ask about the key indicators that will be used to measure air quality, these are the ones that we currently use, the World Health Organization (WHO) targets. Really, we would be looking at the interim target. You have to forgive me. I am not *au fait* with the technicalities of the indicators. The line is that by 2030 the aim is for London to be a net zero carbon city.

The measures for that will be the ones around the WHO's interim target of particulate matter (PM), less than 2.5 microns in diameter (PM2.5) in 2030 by that time. The wider actions that we are looking to take and so the reasons why -- we know that London's air pollution contributes to over 4,000 premature deaths a year. That is 61,000 years of life lost. Those figures are in themselves really hard to hear. In a city like London that is the powerhouse of the country, it really needs to be very different.

We are making huge improvements. Between 2016 and 2019 we saw a 22% reduction in nitrogen dioxide (NO_2) levels. What we have seen is particulates are still a problem. PM is still quite tough to change. We have seen a bigger effect in the inner London areas than in the outer London areas for that change and that is something that we are really looking at understanding more.

There is £150,000 that is being put together into a joint programme of work with health and care partners to dedicate a programme of work that will be supporting the wider work, which is the Green New Deal. The Green New Deal is the recovery mission that is funded to £54 million that will be looking at a whole range of programmes that will contribute to this. Then the progress really is using that NO_2 level and the PM2.5 metric to understand where we are against that delivery.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Thank you very much for that. The two core indicators are PM2.5 and NO_2 and these are going to be KPIs that we will track on an annual basis. We have fairly high-quality data and quite granular data on these indicators and so we will be able to look at them not only at the regional level but at the borough level and of course at hyperlocal levels. As Jazz has mentioned, it really allows us to look at where we see persistent and pervasive exceedances for these indicators across the city. A key approach to tackling air pollution is the combination of both universal approaches, which allow us to manage particulate matter pollution through the Ultra Low Emission Zone (ULEZ), for example, which are universal measures, but also combining that with more targeted and local measures that can be used to reduce PM and NO_2 in particular high-risk areas. Those are the two key indicators and how we intend to use them moving forward.

Krupesh Hirani AM: It is interesting you mentioned the ULEZ because I know, Jazz, in one of your previous answers you talked about health in all policies. That is an example of transport policies having a positive impact on air quality, lung health and Londoners as well.

Just in terms of the TfL situation, there is the funding that you are providing through this section, but actually TfL's lack of capital and revenue funding going forward, particularly over the pandemic, means that certain investments in policies like the ULEZ may be slow in coming forward or may not be coming at all. How much of a danger do you see in that in terms of improving London's air quality in general? Who do you feel are the other delivery partners in making sure that this strand of the HIS is successful?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): As you know, we are waiting for the final settlement from the Government for TfL. As we await that settlement, it will have an impact on our ability to plan for, as you mentioned, the expansion of the ULEZ, the ability to go further and faster with the greening of the bus fleet and making other investments into the infrastructure required to accelerate our progress on tackling air pollution.

It may also have an impact on our ability to fund and support some of the active travel programmes. I know that a key part of what we are trying to do, not only in tackling air quality but to ensure that Londoners are healthy and more physically active, is in fact looking at our active travel plans. TfL is also awaiting the settlement to determine the nature, scale and impact of that plan as well.

As we wait, there are things that we can continue to do with partners. Last week the Mayor held an air quality and health summit, which brought not only partners from across London but also national and international partners like the WHO to really raise the call on the importance of air quality and health, and align health and community partners on what more needs to be done. That is a great example of actions that can be taken with partners in the here and now while we are waiting for the settlement.

In addition, at today's London Health Board we had an excellent session on air quality, which again highlighted the importance of partners such as the NHS and local government in not only accelerating their plans on tackling air pollution and doing what they can in place, but also working together as partnerships and as networks to think about the health impacts of air quality. There are a number of things that we can do while we are waiting for the TfL settlement. Again, the HIS, its ambition, the KPIs that we have identified and the core actions allow us to keep momentum on this while we are waiting.

Krupesh Hirani AM: The next question is for Jazz. What progress does the Mayor hope to achieve by the end of the Implementation Plan's lifecycle in 2024 so that it is possible to assess whether London is actually on track to meet the 2030 zero-carbon and zero-pollution targets?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): There is a range of objectives here and there are things that he will be responsible for, his own actions and the way he is going to be pulling some of his resources together, but nothing is going to be done without the partnerships and the work with, for examples, local authorities, with schools and with the places where people live. Also, thinking about this on a global scale, air quality is not something that contains in one place. The Mayor's role as Chair of C40 is an important one here and being able to really learn and keep agile. The point that was made here earlier about the HIS is that it is not a static thing and we are able to move things on. While he has the agenda here, this is something that we need to get to a point by 2030 but the job will not be done in terms of having really good air quality even then.

Just to talk about then the actual targets themselves and using those metrics that Kevin set out earlier and understanding where we are against those on a regular basis and knowing where action needs to be taken, those metrics allow us, as Kevin said, the opportunity to really target where some of that action needs to be focused; for example, recognising in a local authority area where we know air quality to be particularly poor because the data tells us and the data can tell us quite quickly, really, and action can be taken. The Mayor's role here will not just be about doing the big population-level London-wide agenda such as ULEZ. It will also need to be about how he is able to provide leadership and support to those areas and enable the sharing of good practice and information around how we take some of those actions forward.

What 'good' will look like in the future will be both a combination of whether we have managed to hit those targets and how close we are to them and also how more capable the system is in doing what it needs to do - and by that I mean at a local level all the way through to a national level - and being able to manage and improve air quality in its own way. There is a delivering targets piece and there is a piece around enabling him in his role as a system leader to ensure that he is able to encourage and move partners along with us.

Krupesh Hirani AM: Are you also tracking the financial benefits to the NHS in this as well? I recall when the ULEZ rollout was announced, a figure of something like £5 billion over the next 30 years will be saved to the NHS as a result of that specific policy. Sadly, we focus on the money but actually, if you look at the figures in terms of human lives impacted, that will lead on track to one million fewer hospital admissions, which is a real impact and a demonstrable impact on people's lives. Are you tracking also the impact on the health service and on individuals and on Londoners from a wider health system perspective as well?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Yes, we are tracking. What it is we are tracking is really thinking about the ways in which we are reducing the exposure gap between the most and the least deprived areas in London. At the moment, we know that we have been able to reduce the exposure gap between the most and least deprived areas in London by 71% by 2030. That is the target. We know already that in the inner London area we are closing that gap and moving towards that target. There will be other areas around London, the outer London areas in particular, where we know we are further away from that target and so we have not made as much progress. On some of those, we will be using that data to track the progress towards the delivery of the target.

Krupesh Hirani AM: Is there any work underway to futureproof meeting that 2030 target? I am just mindful that this is tied up with politicians and elections as well and, in the future, you may get a Mayor who might decide to, for example, scrap the ULEZ or delay it. Certainly at the last elections we had some of the candidates saying they would delay the implementation of extending it as well. Is there anything that you are

doing to make that case to show the importance of how these measures are improving the air quality in London and Londoners' lives?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Some of the best ways of futureproofing public health interventions is ensuring that you deliver on your commitments and you can show the positive impacts and positive progress with your interventions. The second is of course having robust evaluation that looks at the effectiveness, cost-effectiveness and impact of your intervention to build that confidence of politicians in supporting the future investment into the programme. For both of those, that is exactly what we will be doing. While we are waiting for, as I mentioned earlier, the TfL settlement, there is a range of activities going on in places across the city to continue that forward motion.

One of the benefits of the air quality work that we do in London is that we have fantastic academic partners who are able to help us both evaluate the impact of the interventions and of course do the economic analysis as well. As we move forward in the years ahead, we will continue to build those relationships with academic partners as well. It is hard to get things in concrete, but certainly what we will commit to doing is ensuring that the evidence is there and that we have a positive track record of forward motion in these areas.

Krupesh Hirani AM: How much funding has been allocated to achieve this commitment?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Within the Health and Wellbeing team or across the GLA's work or globally across London?

Krupesh Hirani AM: As part of this HIS on the Healthy Places commitment.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I am really delighted to report that through our London Health and Care Partnership we have identified £150,000 to establish a dedicated team that will focus on air quality and health. We also have additional resources coming in from the Green New Deal of about £54 million as well as building improvement programmes of £221 million of Government schemes and a further £90 million in Green Bonds that will unlock another £500 million into this agenda. You see that there are substantial investments that we are anticipating or are in the progress of unlocking.

Again, this comes back to a recurring theme here. There is not going to be any one agency that is going to be able to drive the progress that we need to see on some of these complex issues. That is where the funding from multiple sources involving multiple partners is exactly the way to go in helping to address this issue.

Caroline Russell AM (Chair): That is great. Now I would just like to welcome our third guest, Dr Tom Coffey OBE, the Mayoral Health Advisor, who has just joined us. Welcome to the meeting. Before we move on to our next section of questions, I know that Assembly Member Boff, who is joining the meeting remotely, wanted to come in with a follow-up from that previous section.

Andrew Boff AM: We know that the ULEZ with all its good intentions is going to reduce the ability of many disabled people to get around London. How are we monitoring the effects on the mental health of disabled people who have had their mobility reduced?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): We will take that away to

provide you with a more detailed response, but I would like to just reassure you that evaluation of the ULEZ expansion has been part and parcel of the programme. The impacts of the ULEZ expansion were evaluated, for example, at one month and a further is planned for six and 12 months following operation. The commitment to evaluating the impacts is built into the programme.

I will specifically take back your question, Assembly Member, on those wider impacts on mental health and disability to the team as well.

Andrew Boff AM: Can you undertake to talk to disabled organisations in informing your response?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I am happy to discuss that with the team, yes. I am getting nods here. Yes, we would be happy to do that.

Andrew Boff AM: My second question, is that of course pretty soon we are going to be expecting many thousands more vehicles being sucked into a part of London that already has poor air quality - I am referring to the approaches to the new Silvertown Tunnel - and so what particular measures are being taken to measure the impacts of air quality both from the construction traffic, which is never known to be clean, and also from the ongoing increase of many thousands of extra vehicles that will be sucked into this part of London?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): This is a project that I have taken an active interest in and I have been briefed recently on it. For all major infrastructure projects, both within the city and elsewhere, we will always have key concerns about environmental impact and impact on health, wellbeing and other core outcomes.

For the Silvertown Tunnel, my understanding is that there will be and there are plans in place to evaluate the impacts, both intended and unintended, of the project as it progresses. This includes looking at factors such as traffic congestion and burden both during the construction process and of course afterwards. The project itself has been designed to ensure that should some of the intended benefits not be accrued, there are mechanisms in place to evaluate what more can be done to ensure that those are delivered.

This raises a broader issue of major infrastructure projects and managing the costs and benefits. Clearly, there are going to be opportunities for improving air quality by virtue of improving access to sustainable public transportation and a reduction in congestion, and also in concert with other interventions that are taking place across the city, the movement towards more green public transportation, the ULEZ and so on, to ensure that the Silvertown Tunnel delivers on its ambitions.

In summary, evaluation points are being built into the project. We will be able to look at both the intended and the unintended consequences. This is something that is going to be under close scrutiny as well.

Andrew Boff AM: It is a fair point that we all want better air quality but it should not be, as far as I am concerned, at the expense of people in one particular part of London. Can you let me know whether or not you have been involved in any decisions about the construction traffic and whether or not that construction traffic will be using low-emission fuel? There are remedies. There are fuels that mitigate emissions. I wondered if the Health team had relayed that to the project for the Silvertown Tunnel.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I can confirm that I have

not been involved in providing any advice on the planning of the Silvertown Tunnel, but I will also take away to the Health team your specific request as well.

Andrew Boff AM: You personally have not been. Has the Health team at all been involved in the planning and implementation of the Silvertown Tunnel?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I would like to get back to you on that to confirm our answer on that one.

Andrew Boff AM: I am surprised that you do not know. Yes, I would appreciate that. Bearing in mind that you do not know, I would rather hope that you could forward on to me what communication has taken place from the Health team to the project for the Silvertown Tunnel. I would appreciate that.

Caroline Russell AM (Chair): If that could come through the Committee, that would be great. Assembly Member Sahota?

Dr Onkar Sahota AM: I am not talking specifically about Silvertown but generally where there has been development taking place in London. I was involved in my constituency for the Southall Gas Works site, which was a contaminated site that was being developed, and air quality issues were raised with me by the residents. When I tried to approach them, they said that no one wanted to touch it with a bargepole. The Environment Agency was saying, "It is not our job to monitor air quality". Public health was saying, "It is not our job".

Let us look at the case of the Silvertown Tunnel. Whose responsibility will it be to monitor the air quality and whose job will it be to comment on any violations that take place? Who will be taking responsibility for it?

Caroline Russell AM (Chair): That sounds like a slightly rhetorical question.

Dr Onkar Sahota AM: It is a question that I want information on. When I posed this question, Chair, last time, I did not know who was responsible. It is very important with any big project we know who is going to do the work.

Caroline Russell AM (Chair): If our guests have a response to that, then that is great. If not, if we can add it to the written response we get afterwards. Kevin, it looks like your mic is ready to go.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): No, Chair, I was going to thank you for that intervention and to say that that would be the best thing for this specific question. I am mindful that the Health team has a particular domain of expertise and responsibility and I would not want to stray further from that in this Committee at this time. I would like to come back to the Committee on this.

Caroline Russell AM (Chair): Thank you. These big infrastructure projects, as Assembly Member Boff and Assembly Member Sahota have raised, do have impacts on communities, they have impacts on health, and also, yes, huge numbers of people locally in Newham have contacted me about the dust from the construction traffic from the Silvertown Tunnel. In central London, lorries get hosed down and washed before they go out on the public highway and that does not seem to be happening out there in east London. It may be that there are some things where the Health team can intervene with TfL and suggest a bit of improvement in terms of the way that the construction process is being managed, on top of the questions about the air pollution.

I am going to move us on to our next section, which is on Healthy Living. This is looking at active travel, something very dear to my heart. TfL and the Mayor, in the Mayor's Transport Strategy, have done a huge amount of work over the last five years on taking a public health approach to Healthy Streets and to walking and cycling. It seems to me to be a very good example of where a public health approach to policy has been rippled through a policy document of the Mayor, and I would like to commend the Transport Strategy as a really good example of that. My first question is: how will the impact of increased active travel on health inequalities be measured and evidenced, and what progress does the Mayor hope to achieve against this commitment by the end of the Implementation Plan's life cycle given that we have the commitment of having 80% of journeys to be made by active travel by 2041?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Like yourself, this is an area which I am particularly passionate about. I have spoken eloquently and repeatedly about the importance of physical activity both for improving physical and mental health and wellbeing. The core indicators that we will be tracking will be ensuring that all Londoners are active 20 minutes per day of active travel, in order to stay healthy. The target date for that is 2041.

We know that the impact of the pandemic in the last two years has had a negative impact on the proportion of Londoners who are able to meet this target. In fact, we have seen a relative stabilisation in this target over the past couple of years, in part because of the impacts of the various lockdowns but also in part because of changing patterns of work and the nature of active travel in the city as a result of the pandemic. Now, with the reopening, the lifting of restrictions and the return to work we would expect to see some movement in this, but I would agree with you, Chair, that the degree of progress that we would need to see to achieve the target by 2041 would mean that we would need to see a significant step up in the annual change in the proportion of Londoners who are being physically active in this way.

This, therefore, really highlights the importance of three key things. First, the importance of us really developing the Active Travel Plan. We have earlier reflected on TfL's plan, which is being developed, and we are waiting for the settlement for TfL to look at the overall strategy for this.

Second, for us to be working very closely with our partners in local government or directors of public health who are committed to increasing physical activity and active travel. That certainly is a key part of the work that we do in OHID with GLA colleagues and our director of public health colleagues in local government.

Third, ensuring that we continue to mobilise all of our communities, especially engaging some of the communities which we know are less likely to be practicing active travel – for example, our Black, Asian and minority ethnic communities; we also see lower levels of active travel in older age groups – and ensuring that we are mobilising, incentivising and nudging through behavioural insights and communication messaging around active travel. This is an area where we will need a whole system approach and, as you said earlier, it does lend itself very much to a public health approach to increasing active travel.

Caroline Russell AM (Chair): Yes, it is getting physical activity into those daily journeys – walking to the shops, getting off the bus one stop earlier than you might otherwise – and just building activity into everyday life, rather than sending people to the gym. A lot of public health messaging historically has been about getting people to sign up for an exercise class rather than thinking about how to get people building activity into those daily journeys, just how you are getting from A to B. Tom, have you turned your mic on because you want to come in at this point?

Dr Tom Coffey OBE (Mayoral Health Advisor): First, I apologise for being late. I had a meeting I could not get out of, I apologise, but thank you for allowing us to attend. I just wanted to build on what you said anecdotally and give you something that we are doing as well. As a general practitioner (GP), if I have a patient in front of me I no longer say, "Go to the gym", I just say, "Tell me where you go every day". Usually they either get a bus or a train or a car, and I say, "Can you get off one Tube stop early? Can you get off four bus stops early and just walk the last bit there, and walk the last bit back?" That usually is enough to do the 20 minutes of active travel per day.

I am sure you will have heard my colleagues previously talk about health in all policies. I remember when the Transport Strategy came out, I said, "This is not about buses and Tubes, it is about walking and cycling". It is a health improvement approach. You will see many other things we do, such as making sure people have access to green spaces. You are more likely to be active if you are near a green space and can walk to that green space. Also, the School Superzones, building the daily mile into schools. It is no silver bullet, it is no one magic wand to give everyone membership of a gym; it is changing their lives and adapting their infrastructure to allow that 20 minutes of active travel to be easy, convenient, hassle-free, and feel healthy. I would like to say, echoing your point, that it is about changing your life and changing the environment.

Caroline Russell AM (Chair): Do you feel that you have health partners on board with the idea of getting more people walking and cycling and building that activity into their daily lives? I have been campaigning on this stuff for over 20 years and in the past it has been quite frustrating because it has felt like some of the medical or doctor messaging has not been up and along with the ideas around active travel. I am just wondering. Do you feel that you are cutting through and that you have the support of medical teams in all parts of healthcare across London with this?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I am happy to reflect on this. It certainly has been a journey. Prior to doing this role as regional director I was National Director for Health and Wellbeing and so one of my roles was to develop a national strategy for physical activity, which was built upon the principle of 'everybody active every day', looking at how we activated professionals and got professionals to encourage people they were in contact with to promote physical activity, promote active communities and promote active travel, for example.

In the health and care system we have made great progress with social prescribing for physical activity, working with social prescribers and primary care practitioners around the importance of physical activity. We have also invested in primary care physical activity champions, who have done a great job in working with their peers to promote the benefits of physical activity and to link practitioners to community assets to promote physical activity. The national Government has launched a number of campaigns on physical activity which we amplify regionally and locally, working in partnership with local authorities so that message around the importance of physical activity is both reinforced and supported as well.

Again, as we emerge from the pandemic, do remember that, as part of the London health and care vision, promoting physical activity and active travel are going to be key parts of our commitments as a health and care system. I would say that yes, the focus has been on COVID over the past couple of years, but I am keen to ensure that we get back on target with our promotion of physical activity and active travel.

Dr Tom Coffey OBE (Mayoral Health Advisor): Just to add to that, every single NHS trust in London by the end of March [2022] has to publish its Green Plan. As part of that, at most hospitals you might say, "How do I cycle safely to my hospital? How do I walk safely to my hospital?" It will be saying, "Do we really need to provide enormous carparks? We want to make it safe for people who can walk and cycle to the hospital". The

NHS perhaps five years ago were not as on board. Now it is a movement about air quality, which is very linked to this as well, and active travel. It is not just about obesity, it is about arthritis, diabetes and heart disease. The benefits are phenomenal.

Caroline Russell AM (Chair): Yes, the number of health conditions that can be improved by a bit of regular daily physical activity is incredibly broad. You have mentioned several partners who are working together on all of this. Has any funding been that mobilisation-type funding that we were talking about earlier? Has any funding been allocated to help coordinate all of this, pull all the threads together and make it happen?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): As we mentioned earlier, the budget will be agreed following the final TfL settlement from Government. I would hasten to say that the funding for physical activity not only rests within the GLA but certainly rests in the public health grant in local authorities. As you have mentioned, we work with the NHS and the NHS's commitment to active travel and a greener new deal within the NHS moving forward. This is an area where we have funds and pots of money for physical activity in many places, and once we have the TfL settlement that really gives us a chance to see how we provide that value-add and additional impact to amazing work that is being done across the city in this area.

Caroline Russell AM (Chair): Thank you. I am going to move us on to the next section, which is Healthy Communities, and I am going to bring in Dr Sahota [AM].

Dr Onkar Sahota AM: Professor Fenton, can you provide an update on the London Recovery Board's structural inequalities work, please?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Yes, I am really pleased that we had the Recovery Board meeting yesterday and the final deliberations and report from the Structural Inequalities Subgroup was presented at the Board at that time. What is exciting about the paper is that it focused on four key areas for action across the city and across our partners, and these included action on labour market inequality, tackling financial hardship and living standards, tackling equity in public service, and a focus on civil society strengthening.

Key elements within all of these are a number of key actions that were articulated by the subgroup and ratified by the London Recovery Board yesterday, which focused on tangible actions on each of these four themes. Key among those were ensuring that we were able to look at how London creates the governance and the partnerships which are required for action in all of these areas, as well as key commitments from this group that then could be informed by, and be tracked in, a HIS.

One of the things I am particularly pleased about in the work of the group is its work on tackling structural racism and the importance of really working to think through what London partners should be doing in this area, especially because this has been a key request from our communities arising from the COVID-19 pandemic. I will pause there, Assembly Member, in terms of the initial report from that subgroup.

Dr Onkar Sahota AM: When do you think you will be publishing this report, and when will the commitments be finalised and in the public domain?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I believe the Recovery

Board papers are publicly available but I am pleased to report that there will be a major launch of the report later on in the spring. That will enable a range of London partners and communities to be engaged in both celebrating the progress that has been made, but also reinforcing commitments on implementation.

Dr Onkar Sahota AM: I take it that means before 30 June [2022]?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Yes, definitely before 30 June.

Dr Onkar Sahota AM: Thank you. The other thing is that funding for the Implementation Plan had already been allocated before the key commitments had been defined. What funding, if any, has been earmarked to help take those commitments forward?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I will need to get back to you on that question specifically. I do not have a funding figure here in front of me at this time.

Dr Onkar Sahota AM: That is all right. If you can write to the Chair, that would be fine.

Dr Onkar Sahota AM: You spoke earlier about structural inequalities and the importance of them. When you look at the Government's [*White*] *Paper on Levelling Up*, do you think there is too much focus there on geographical inequalities and neglect of the inequalities based upon race, disability, gender and sexual orientation, or do I have a wrong reading of it?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): From my reading of the *Levelling Up White Paper* the focus has primarily been on some of the geographic disparities, but the door has clearly been opened to understanding the impact of other inequalities and how partners at every level should be working to address those. I know that there are other Government White Papers that are planned which will have deeper reflections on disparities, for example, and other inequalities, and that may well provide us with an opportunity to tackle some of those other issues which you have mentioned.

Key among all of this, though, is using all of the opportunities that are coming up with new Government White Papers to see how they align with the work we are doing in London and how we may take full advantage of any new funding opportunities or policy opportunities which may present themselves. The Health team, working with partners in the NHS, OHID and UKHSA, will be actively tracking those opportunities for us.

Dr Onkar Sahota AM: Good. Thank you.

Caroline Russell AM (Chair): We are now moving on to the next section, which is the second healthy places section. We are looking at the Living Wage commitment, which is a commitment that the Mayor will lead the campaign to make London a Living Wage city, targeting accreditation of an additional 1,600 employers, lifting at least 48,000 people on to the real Living Wage and putting £635 million in Londoners' pay. This is a new key commitment. My question is: how does the London Living Wage commitment help to deliver the HIS and reduce health inequalities in London, and how will the impact on health inequalities achieved by this commitment be measured and evidenced?

Dr Tom Coffey OBE (Mayoral Health Advisor): The impact of inequalities is probably quite stark. The level of poverty in London is significant, whereby 74% of adults in poverty are working. If we can raise their working wage, we can reduce that poverty. Another indicator which I find useful is that for every £1,000 extra per year you pay someone, that gives them an extra 0.5 years of healthy life. Third, when we ask people to assess their health and wellbeing, if you are poor, 34% of people say their ill health is significant. If you are in the highest bracket, it is only 11%. Those three facts show that addressing poverty inequality will affect health inequality. The second question was?

Caroline Russell AM (Chair): The second question was: how will the impact on health inequalities achieved by this commitment be measured and evidenced?

Dr Tom Coffey OBE (Mayoral Health Advisor): There is a national survey which looks at people rating their health. That is one which I just quoted from for the highest and lowest bracket. That one will be monitored regularly to see, are we getting more people describing themselves as in good health? Secondly, we are going to be looking at people who are in work and are classified as living in poverty. That has gone up in the last few years from 62% to 74%. We will be monitoring that to see if that goes down.

Caroline Russell AM (Chair): Thank you very much. Then the actual campaign that the Mayor is going to lead to make London a Living Wage city, what is that campaign going to look like, what are the key elements of it and how is it going to be structured so that employers are keen to sign up?

Dr Tom Coffey OBE (Mayoral Health Advisor): The campaign is very much a partnership. Sadiq [Khan, Mayor of London] will be one of the co-chairs of the London Living Wage City Work Steering Group. The structure there will be involving health and care settings, microbusinesses, the night-time economy and the voluntary sector. That will be very much a partnership group who cover the majority of the employers in London. We will be doing it using the Living Wage Foundation and Citizens UK. They are leading this campaign. They are the ones who are forming the targets and who will be monitoring the targets. They are funded by Trust for London at £4.8 million. They will be funding the campaign, which will be a partnership campaign publicly to work with employers to move them on to the Living Wage.

We also have something called the Good Work Standard. That will be another avenue that we will be using, to ask employers to sign up to the Good Work Standard. Again, I will be saying this until you are sick in the teeth: health in all policies. We have a Deputy Mayor for Business and he will be a key partner in working with the business community and his contacts to ensure we move people on to the London Living Wage.

One thing which I was quite pleased to see as well was research by both Cardiff University and Queen Mary University that looked at the impact of the London Living Wage proposals on recruitment and retention. This is at a time when most industries have a big workforce crisis. They found that if you pay people more and take them up and above the London Living Wage, you will increase your retention and you will increase your recruitment. That will be the message we will be taking, via the Deputy Mayor for Business, to our London businesses. When you have a healthy workplace you are more likely to retain your staff, which at the moment we are very much aware of. A workforce crisis can really undermine how a business in London works.

Caroline Russell AM (Chair): Thank you. This is another area where basically it is about the Mayor partnering with other bodies outside of the GLA to help to deliver these good outcomes for Londoners.

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes. When people say, "What does the Mayor do?" I say that the Mayor can do and commission things, but often as powerful are the soft powers of convening, advocating and shining a spotlight. He will be doing all three in this area: convening that steering group,

shining a spotlight on it and advocating on behalf of Londoners to employers to raise everyone on to the London Living Wage.

Caroline Russell AM (Chair): The commitment aims to lift 48,000 people on to the real Living Wage. How many of these are estimated to be Londoners, given that presumably some of the employees of the 1,600 employers that are being targeted will be commuting from outside of London?

Dr Tom Coffey OBE (Mayoral Health Advisor): I do not have the exact figures but what you say is a reality because many Londoners work outside London and many people from Surrey and the shire counties work in London. That will be being monitored by the Living Wage Foundation and Citizens UK so I can get you those figures but, to be honest, only as we do it will we know what those figures are. The majority, I would reckon, will be in London and Londoners.

Just one area that I was quite surprised about recently is that the NHS now is really moving on board with this. I often talk about challenging and championing the NHS but since the COVID pandemic we in City Hall have learnt to collaborate with the NHS as well. We now have eight NHS trusts signed up to become London Living Wage employers, and last week I meet with the London Ambulance Service (LAS) Chair and Chief Executive, who said they are bringing all their cleaning staff back in from an outside provider and they are moving them all on to the London Living Wage. The NHS are real, living partners to this process.

Caroline Russell AM (Chair): That is very good to hear. The commitment talks about an additional 1,600 employers. Are you expecting these to be 1,600 new employers or are you expecting to make the total number of employers 1,600?

Dr Tom Coffey OBE (Mayoral Health Advisor): No, it is 1,600 new, additional employers signing up for the London Living Wage.

Caroline Russell AM (Chair): Great, thank you very much. What was the process that was used to identify and agree this commitment? Presumably there were discussions with various partners. Who was involved and how were those decisions reached?

Dr Tom Coffey OBE (Mayoral Health Advisor): It was very much a collective process. I can remember a few years ago when we were just launching the Child Obesity Taskforce Action Plan and one of their key commitments was, "London should address poverty", because poverty causes childhood obesity. OK, we will try to. That is a key idea. Then we looked at all other causes of poor health. Poor mental health: again, it was poverty and income inequality. Then we received some reports nationally from Professor Sir Michael Marmot [Epidemiology and Health Inequalities, University College London], the Marmot report, again clearly saying that health inequalities are intrinsically linked to income inequality and poverty. Then we look at some of the work that has been done by David Buck [Senior Fellow, Public Health and Inequalities] at the King's Fund, focusing on using a city as a body to improve the health of those Londoners. It is not about necessarily just a borough or about the health service; it is about the powers of the city, be it Andy Street [Mayor of the West Midlands], Andy Burnham [Mayor of Greater Manchester], or our own Mayor, Sadiq Khan.

We got all that information from our advisors, from external research. Then the Health Equity Group, which Kevin [Fenton] chairs, has those wider partners: the local authority, the NHS, the voluntary sector, citizens. They, together, decided that the links between income inequality and health inequality are so stark that this is something that has to be on a health agenda. I do not make any apology for the fact that this is not about diabetes or health disease because this is what will make a difference.

Caroline Russell AM (Chair): My final question is a practical one. How much funding has been allocated by the Mayor to deliver the campaign that he is going to lead to make London a Living Wage city?

Dr Tom Coffey OBE (Mayoral Health Advisor): The funding is multi-layered. He will be using the resource of the people he employs to support the campaign and the secretariat because the majority of the funding, the £4.8 million, is coming from Trust for London. Secondly, as a procurer and as an employer we will make sure that our procurement contracts have built into them that people who wish to succeed in those contracts will have to be paying the London Living Wage. That comes at a cost. Then, over time, we may see some of those costs of procurement increase. That is a cost that the GLA and the Mayor wish to bear to take those Londoners out of poverty. There is no set fund which is set aside, but the added-on costs of the human resources support are there. We do have the Good Work Standard, which has its own funding stream, which will assist the process because you cannot sign up to the Good Work Standard unless you are a Living Wage employer. Again, it is another cost. If you want, I can add them all up and get back to you. This is not four project workers; this is convene, advocate, spotlight and do. All those come with costs but well worth spending.

Caroline Russell AM (Chair): If there are some numbers that could be shared with us, that would be really helpful.

Dr Tom Coffey OBE (Mayoral Health Advisor): I will do that.

Caroline Russell AM (Chair): We do understand that what you are doing here is bringing people together to deliver better to reduce health disparities in our city, but we do also have a job, which is to scrutinise what is going on. As a result of the way this is structured and set up, which is clearly creative, it is getting good partnerships going and that is always good, but it also makes it very complicated for us to be able to see what is actually happening and what is being delivered with what.

I am now going to bring in Assembly Member Best, who has a follow-up on one of my earlier questions in this section, and then will take us into the following section, which is Healthy Children.

Emma Best AM (Deputy Chairman): Following up on Assembly Member Russell's previous question on who was involved in the decision-making, was the Deputy Mayor for Business involved in this commitment?

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes.

Emma Best AM (Deputy Chairman): Perfect, thank you. The other question I had was: the Economy Committee previously called on the Mayor to implement an action plan to boost the uptake of his Good Work Standard. Is that something that our health representatives here would also endorse happening?

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, we are very much involved in that as well. You would have remembered that we had what is called a Healthy Workplace Award, and so what has happened over the last few years is we have transformed that and integrated it into the Good Work Standard. We were giving out awards throughout London to make sure that we had a healthy workplace. This is about good mental health, good physical health, and good work policies. Rather than having a Good Work Standard and a Healthy Workplace Award, we thought we would put them together. We have been very involved in it. All the aspects of the Healthy Workplace Award have been integrated into the Good Work Standard and we have been very involved.

Emma Best AM (Deputy Chairman): Would you endorse the Mayor delivering an action plan to boost the numbers of those signed up to the Good Work Standard?

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, I would endorse anything which improves uptake of the Good Work Standard.

Emma Best AM (Deputy Chairman): Perfect. Kevin or Jazz, I do not know if you think there should be an action plan to try to boost uptake.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): There kind of is an action plan in the sense that it is a running programme, it is just --

Emma Best AM (Deputy Chairman): Not on the programme. An action plan to boost the numbers, because the uptake has been less than great in certain areas. An action plan to boost the number signing up to the Good Work Standard and, as a result, of course, sign up to the London Living Wage.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): A specific dedicated programme for the Good Work Standard set apart from the wider work, I would not recommend. I would suggest that the core work here should be done through the partnership and the Steering Group that the Mayor is co-chairing, working with partners on. That is where we would want to see the Good Work Standard contributing to. Rather than a dedicated separate work strand, the wider work strand is the one the Good Work Standard would be best placed to contribute to.

Emma Best AM (Deputy Chairman): I am not quite sure that answers the question, but that is fine. The other question I had around the London Living Wage -- obviously, Tom, you spoke earlier about the massive impact a good wage has on health and life expectancy, and my colleague Andrew Boff [AM] talked earlier about evaluating the impact of the expanded ULEZ on disabled Londoners. Could you also undertake to look at the expansion on small businesses?

Dr Tom Coffey OBE (Mayoral Health Advisor): It would be wrong of me to give an undertaking that I do not have the power to do, but I can advocate on your behalf if that is what you would like me to do. I am happy to do that, but I cannot give an undertaking which is not in my gift, which would be unfair, I am sorry.

Emma Best AM (Deputy Chairman): Thank you. What we need is to understand the impact on disabled Londoners and small businesses for the reasons we are looking at today, and to make sure, in further evaluations of the success of the ULEZ, we look at how we are ensuring those people are not left behind.

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, it is a fair point. I would take the message you have given me and pass it on. What I do not want to do is undertake something I do not have the power to do so, but I can definitely communicate concerns that you have, as we all would have, about the wellbeing of disabled Londoners and how they live their lives. I would say that disabled Londoners also need to breathe good quality air, and it is really important that that does happen. I will take that message back to the team and make sure that is clearly made.

Emma Best AM (Deputy Chairman): Thank you.

Krupesh Hirani AM: I am not sure what is being asked. Are we asking the Health team to look at the impact on businesses of ULEZ? Are we asking the Health team to do that?

Emma Best AM (Deputy Chairman): We are talking here about the London Living Wage, as you will see from the section.

Krupesh Hirani AM: You mentioned ULEZ.

Emma Best AM (Deputy Chairman): Sorry, can I finish speaking? Thank you. We are talking here about the London Living Wage. Of course, you will understand that paying the ULEZ charge affects small businesses in the same way that a London Living Wage does, so if we are to put economy into health and health in all policies, we therefore need to evaluate the effect that the ULEZ has had on small businesses as well as on disabled Londoners. As those are two things that we have talked about today, it would be good for the Health team to advocate, as health in all policies, how we do not leave behind those on low incomes as well as disabled Londoners. As Tom [Coffey] rightly articulated, poverty and poor health outcomes are intrinsically linked. What we are doing today is making sure that we evaluate everything in a "health in all policies" approach, and that is what you will see in your paper before you.

Krupesh Hirani AM: Sorry, Chair, I was just clarifying, because it felt like what was said was that they were being asked to look at the impact of ULEZ on businesses.

Caroline Russell AM (Chair): If we are talking about health disparities, we do need to evaluate the impact of all policies on all disparities. It is an interesting line of questioning. If the Mayor is putting health in all policies, then we do have to think about the impact of all policies on, as Assembly Member Best said, disabled people and also on businesses, and in particular on those small business' ability to pay the Living Wage, because that all impacts on Londoners' health.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I believe the action is for the Health team to advocate on these issues with colleagues who are responsible for the evaluations, so that the evaluation takes into consideration some of these wider indicators or wider issues as well, which we would be happy to do with colleagues who are charged with the evaluation of the ULEZ.

Emma Best AM (Deputy Chairman): Thank you. I am just going to move now on to Healthy Children.

Dr Onkar Sahota AM: Before you move on, still on the last section, the quality of air in London is important to everyone, regardless of whether you are disabled or you are a small business person. No one can risk the air quality being detrimental to anyone's health, and that is the overriding fact. Coming specifically to the question about work standards, do you think that the low pay is a particular issue amongst young Londoners, and do you agree that Government should help tackle the health inequalities by allowing all over-18s to access the highest level of National Living Wage?

Dr Tom Coffey OBE (Mayoral Health Advisor): The number of people in London who are earning below the London Living Wage is definitely higher in young people. We know there is a cost-of-living crisis at the moment regarding rents and fuel bills, so it would seem sensible to make sure all adults get access to a wage which moves them out of poverty. What this Government and previous Governments have done when they have looked at minimum wage is they have adjusted it for age - because often the younger adults are in training and education, they are often living with their parents - to mitigate the impact on the economy of an increase in their income. However, I would definitely be supportive of maximising the number of people who work and get the London Living Wage.

Dr Onkar Sahota AM: Also, another impact, Dr Coffey, is the fact that the statutory sick pay does not match the London Living Wage. Do you think there is a case for raising the statutory sick pay so that people --

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes.

Dr Onkar Sahota AM: That is a very clear answer, thank you very much. One more thing, to come back to you, Jazz, is the programme to increase the uptake of the Good Work Standard programme. I know that the big employers are adopting it and it is easy for them, but how are we targeting the small and medium enterprises (SMEs) to adopt the Good Work Standard? Are we focusing on that sector?

Dr Tom Coffey OBE (Mayoral Health Advisor): There is a new workstream and you are right that the very large employers often find it much easier to have a human resources (HR) department, a training department, an occupational health department and employment assistance teams. It is much more difficult if you are in a small business. In fact, on the London Living Wage Committee Steering Group there is a particular workstream on what they call "microbusinesses", small businesses which need the extra support to move to the Good Work Standard and the London Living Wage. I would say very clearly that all businesses are finding it hard to recruit and retain; therefore, I would hope that as everyone around you becomes a London Living Wage employer, that raises everyone's standard. I do recognise the need for the smaller businesses to get extra dedicated support, and that is happening.

Dr Onkar Sahota AM: Thank you.

Caroline Russell AM (Chair): We are going to have to keep up the pace, everyone. Assembly Member Boff wanted to come in on this point. If you could be as succinct as possible, that would be super helpful.

Andrew Boff AM: I shall try my best. Mr Coffey, do you think it is important that any measures that the Mayor adopts in order to improve air quality and resolve poverty should not disproportionately fall on those people who are least able to pay?

Dr Tom Coffey OBE (Mayoral Health Advisor): A consistent theme that Sadiq [Khan, Mayor of London] will say is it is not just health in all policies, it is health inequalities in all policies. I am going to equate people having more difficulty to pay, ie it should not unfairly fall on those who have lower income. Yes, that is why I agree.

Andrew Boff AM: When people are unable, for example, to change their vehicle due to not having the funds and there being an inadequate scrappage scheme, those costs of the ULEZ policy surely do fall disproportionately on those people.

Dr Tom Coffey OBE (Mayoral Health Advisor): When I have looked at a policy in the round, the people who drive cars in London are the people on the higher incomes; the people who live in the poorest air quality are on the lowest incomes.

Andrew Boff AM: I am not talking about in the round, I am talking specifically for those people who are unable to pay the costs of everybody else's clean air.

Dr Tom Coffey OBE (Mayoral Health Advisor): What I am trying to work out is, when one makes a policy, you have to balance the impact on everybody. I would definitely be supporting the Government funding a more generous scrappage system to help make this happen.

Andrew Boff AM: That is down to the Mayor, is it not? The Mayor can fund his own scrappage system.

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, if the Government's TfL settlement is very generous, that is something we definitely would want to consider, but at the moment those negotiations are very tight and what we are trying to do is do policies which maximise the benefit for the most people. The air quality policy in London will have that maximum benefit. I am very sympathetic to those Londoners who will find it very difficult to be able to do those car changes, but overall, the impact on their health is so significant. Poor air quality causes 6.4% of premature deaths in London. This is the highest percentage in the country. We need to act now.

Andrew Boff AM: That is agreed, yes. Your utilitarian argument there does argue the fact that if some people suffer, it does not matter as long as the rest are OK.

Dr Tom Coffey OBE (Mayoral Health Advisor): No, I am just trying to make and support a policy that has maximum benefit for Londoners.

Andrew Boff AM: Even poorer Londoners who cannot afford your policies? You made a point.

Dr Tom Coffey OBE (Mayoral Health Advisor): What you will find is that the poorest Londoners will be the greatest beneficiaries of improving air quality, because, as I have said before, the poorest Londoners live in the area with the poorest quality air.

Andrew Boff AM: Some poorest Londoners --

Caroline Russell AM (Chair): I am going to call a halt to this one now and bring in Assembly Member Best, otherwise we are going to be in this room forever.

Emma Best AM (Deputy Chairman): We will talk about School Superzones, but I do think, Tom, when you are making that point you are forgetting the vital difference between outer London and inner London. For example, in an area where I live, the poorest Londoners are driving because we do not have any public transport. If you are talking about inner London, that is a different case.

On to the School Superzones. How will School Superzones help deliver the HIS and help reduce inequalities in London, and how will the impact of School Superzones on health inequalities be measured and evidenced?

Dr Tom Coffey OBE (Mayoral Health Advisor): When we developed some of our polices, we have to make sure we target them. For the School Superzones, they were evaluated by the University of Manchester looking at how they create around the school areas of better air quality, safer streets, more active travel, Water Only Schools, the Daily Mile, and schools which have Mental Health First Aid. Therefore, the benefits that were shown by evaluation were significant.

As we roll out for 50 more Superzones around schools in London, we will be targeting those at the boroughs with the most deprivation. Therefore, what we want to make sure of is that this is not a universal approach, I have to say, at the outset. We are going to deliberately target our resources on the poorest Londoners, so the health benefits from the School Superzones will therefore fall on the poorest Londoners.

The evaluation thereafter: we have evaluation funds built into the project and, in fact, four days ago they had their first meeting to decide how they are going to partner with local authorities, because this is one of those areas whereby - and I have said the same with London Living Wage - this is a partnership approach. The real

delivery people for this are the schools, the parent teacher organisations and the local authorities, and we are providing very much the seed funding and the model, and almost the curriculum. There will be an evaluation and there is funding set aside for that to occur, but we are trying to work out whether we do it across London, or do evaluations almost borough by borough and allow our borough partners to have a lead in that process.

Emma Best AM (Deputy Chairman): Yes. Having looked at the pilots, the outcomes are very different and the proposals are very different, so having a 'one size fits all' monitoring system is probably going to be difficult to work. It would perhaps have to be line by line.

Dr Tom Coffey OBE (Mayoral Health Advisor): You are right.

Emma Best AM (Deputy Chairman): Given that, how easy is it going to be to monitor what the most effective policy is when it is going to be so different in every borough? It could be the culmination of polices, it could be one separate one, but given the difference in areas and difference of combinations, how are you going to pinpoint that?

Dr Tom Coffey OBE (Mayoral Health Advisor): You are right. There are two principles attached here. One is about flexibility. The School Superzone is not one of those prescriptive programmes to say, "If you are going to follow a School Superzone, you must do these four things in this fashion in this way". We are not doing that. We are saying that there are many parts of a School Superzone, and the local authority, that school and the parents will decide what is important. The flexibility inherently means it is much harder to evaluate, because you are not having everyone doing the same thing. That is why we are looking at each borough doing its own evaluation and us supporting it, as well as a London-wide evaluation.

What we will probably find is, and I can give you examples here, you may get 20 of the 50 Superzones focusing on safer streets, 25 of 50 focusing on air quality, another on a healthy food environment, so we might have to match them together. We are going to have what we call a matrix evaluation; otherwise, we have to remove that flexibility that we have given schools. Schools have always said to us and local authorities, "We want to work with you, but do not tell us what to do. Give us the tools to do the School Superzone project". In our evaluation of the first host of Superzones, it was a flexibility which allowed local people to really design it, and that is a core principle of our School Superzone project.

Emma Best AM (Deputy Chairman): Thank you, I certainly agree with that flexibility element. The concern I have around a lot of the School Superzone travelling projects is how it helps people who are time-poor. There is a way to do that but I could not see it in any of the pilots, and I wonder if it is something that you have been looking at helping, as an option, with this funding. That is breakfast clubs and making sure that every school involved has an early morning breakfast club, which not only allows the schools to provide a good meal for the start of the day for the children, but also allows those parents who perhaps are doing multiple drop-offs to nurseries, schools and then work, to have that extra time and flexibility which may allow them to have that active travel.

Dr Tom Coffey OBE (Mayoral Health Advisor): First of all, I should have said at the beginning, I know your role is to scrutinise and evaluate us, but I would really appreciate your feedback to us. A lot of these projects are in a formative phase. I will actually feed that back because when you talk about active travel - and it is something which the Chair said at the outset - you have to remove barriers. If you talk to people, people say, "No, I do not want to be actively travelling", and they do, but you have to make it easy and remove barriers. That is the idea about making you feel it is safe, making you feel that the air quality is good. To be honest, trying to do the kids' breakfast and then getting them to school when they have a ten-minute extra journey because they have to walk -- if you can say, "But when you get to school the breakfast is there", that

removes a barrier and it promotes active travel. If you do not mind, I will steal the idea and bring it back to the group.

Emma Best AM (Deputy Chairman): Thank you. Jazz?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): What is really exciting in how I have understood it and how the team have taught me about it is that the Superzone is the space around the school; Healthy Schools London (HSL) is the programme in the school. What is really important is how those two schemes work really hand-in-glove to understand, exactly as you are saying, the potential here for the choices families might make. "Actually, am I going to be able to spend ten minutes on walking the kids to school or do I have that ten minutes to feed them?" Those sorts of questions become much more manageable when we are understanding the lives of the people that we are trying to support. That is a really good example, isn't it, about our engagement with communities? The value of Superzones and local authorities being in the driving seat of them, with the relationships with the schools that they would like to Superzone around, is going to be that real place-based opportunity for getting the model right for that local place and that local community. It becomes really important.

The other ideas that we are seeing come out beyond the evaluation, in some of the conversations that we know are being had in local areas, are about, "How more creatively can we use the wider assets in the community as part of the Superzone?" We are already hearing where, for example, primary care networks and GP surgeries are keen to be involved in some of those relationships going forward because they want to do far more outreach with those communities. It feels to me it has the potential to be a really positive Christmas tree on which lots of really positive baubles could be added. There is some mileage to go before we get there, but it is exciting people locally, which is really interesting.

Emma Best AM (Deputy Chairman): We have covered this quite a bit, but I wondered if there was anything you wanted to add. What process what used to identify and agree School Superzones as the Healthy Children key commitment for 2021 to 2024, who was involved and how were those decisions made?

Dr Tom Coffey OBE (Mayoral Health Advisor): I will probably ask Kevin [Fenton] to get involved as well because he chairs the Health Equity Group and that was the final decision-making process.

You will see, hopefully, a theme in how we are approaching our Healthy Children, and it is building around the school. We have Mental Health First Aid in school, we have Healthy Early Years, we have Healthy Schools, we have a Daily Mile at school, we have a Water Only school. What we wanted to do was build it a bit further. It is the environment around that school, especially for primary schools. Most people who go to primary school in London live within 400 metres of that school, and you tend to walk or you drive there, depending. It naturally fitted into the idea of using the building block of the school as a way of promoting good health, and it also had that health in all policies theme. It was not just about childhood obesity or air quality, it was all of those. Therefore, that is where the idea came from.

We tested it out in our various Big Conversation networks, we do surveying, and eventually the decision-making process was via Kevin's group, the Health Equity Group, who looked at it and said -- because we could have just carried on with the Healthy Early Years, but that is just so successful it would have been too easy. We thought we would get 1,300 in the first three or four years; we got over 2,000. As a result of judgment, the curriculum of the Healthy Early Years matches the Office for Standards in Education, Children's Services and Skills (Ofsted) curriculum for you to say you are a healthy place of education. Many Healthy Early Years places just took it up, so we took the braver decision not to do something which we knew was already working, but to add to it; hence the reason we chose Superzones.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): If I could just add here in terms of the partners that have been involved, this is another great example of us working across a range of stakeholders: the ADPH, which represents our local councils, Public Health England and now my team in OHID, the Town and Country Planning Association, and, of course - as we have mentioned, the Health Equity Group, which also has a wider range of partners sitting around the table.

What is really beautiful about the School Superzone and why it is an important KPI is that it is a combination intervention. What you are doing is using the school as the unit of intervention, but you are looking at a range of activities that can help to improve the wellbeing of our children. That is why it has the strong support of public health directors across the city.

Emma Best AM (Deputy Chairman): In January [2022], the Mayor confirmed £1.8 million of funding for the GLA to establish 50 Superzones. How will that be allocated?

Dr Tom Coffey OBE (Mayoral Health Advisor): That funding is over a couple of years and we are going to do it in phases. In year 2022/23 there will be the first tranche of funding, and then in year 2023/24 the second tranche. The overall total of funding is £1.8 million. How it will work is that each School Superzone - and we will work with our local authority colleagues - will be allocated £30,000 of seed funding which allows them to do some of the structural work. When you create a Healthy Street, you have to buy those yellow elastic things which are going to close off your streets and maybe do things to adjust to improve the air quality around your school.

When we did the pilot previously, the local authorities welcomed that extra funding. It is not all that is needed because the local authority will have to put money in. What I am hoping to create is a jealousy-level movement - "My school is a School Superzone", "Why is my school not a School Superzone?" - whereby we get other partners' funding to match what we are doing, and other local authorities also see this as a real project which can benefit the children in their school. Fifty School Superzones in London, on top of the ones we already have, are not sufficient to transform all of London, but it is starting a process which I believe parents and teachers will want for their school and for their children.

Emma Best AM (Deputy Chairman): On that jealousy point, one of my next questions is to ask: of those 50 Superzones, I know that they are going to be targeted by deprivation and obesity levels, but will you make sure that there is one in at least every borough?

Dr Tom Coffey OBE (Mayoral Health Advisor): Definitely. That is one of the principles. It is about targeted universalism. Every borough gets one, some will get more, but they will be targeted probably - because there are health inequalities - at the poorest areas of those boroughs.

Emma Best AM (Deputy Chairman): Perfect, thanks. How will the GLA work with local authorities to deliver the commitment?

Dr Tom Coffey OBE (Mayoral Health Advisor): I am going to bring Jazz in on this one, but the ADPH's network is the vital thing and we are going to be using principally Directors of Public Health from each area and Directors of Children's Services. Therefore, we are providing this infrastructure and some of the seed funding; the delivery is the boroughs' responsibility.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): I would add that the target of 50 Superzones is the key deliverable of the Healthy Place Healthy Weight mission, which as part of the Recovery Programme is part of the shared programme of work that we do with the Local Government Association (LGA). The LGA and the Mayor jointly lead that work. Local government is from a strategic, decision-making point of view all the way through to the funding being directly to local authorities and the relationship is via the ADHP. Also, increasingly, we know Directors of Children's Services and Directors of Planning and Environment are becoming far more interested in this Programme. There is a bigger swell in local government, potentially, of interest than we might have even anticipated in the very beginning and that definitely feels the way forward.

The other opportunity is also to think about where there are some wider agendas across local government that could also influence some of this. For example, there is the work that MOPAC colleagues are doing through the Violence Reduction Unit (VRU). That is looking at how Safe Schools and safe school environments is a real driver of work that it is taking forward to support young people, who are at risk of violence and crime after school, that after-school time. This is an additional layer of work that supports some of that wider work.

The many layers of work give a much stronger potential for those areas. The deprived areas we will be thinking about for Superzones are likely to be similar areas where other programmes of work are also targeting effort. These are all useful and very thoughtfully defined choices that have been made around how we target those areas and ensure that we are double counting deliberately, I suppose. There is the layering of the investment and support given to those areas.

Emma Best AM (Deputy Chairman): Thank you. I have a lot more questions on School Superzones, but we do not have time. I do want to quickly tackle the junk food ad ban, which is something that will come into play as part of School Superzones, and we know it has already been in operation in the TfL network. How successful has that been at preventing or lowering childhood obesity in London?

Dr Tom Coffey OBE (Mayoral Health Advisor): I am just looking for the latest evaluation, which was only published a few weeks ago. As we know, childhood obesity is a problem in London because London has the most obese children in the country and the poorest children are the most obese in London. That is why it is quite important that we do everything we can. There is no silver bullet to manage in a single way a reduction in childhood obesity and we have to use every single part of our armoury.

We chose to use the ad ban because we had looked at some lessons in Amsterdam and wanted to see whether we can replicate them in London. Therefore, when we did it, we did commit very clearly to evaluation because I practise evidence-based medicine and, as a policymaker, I want to practise evidence-based policy. We committed to the London School of Hygiene & Tropical Medicine to do our evaluation and then to see whether it would have an impact. The impact we looked at was calorie intake in Londoners over a week because we know that has an impact on childhood obesity. I would not believe that an ad ban, which you do on the beginning of a year, in a year and a half is going to have a massive impact on childhood obesity. That is going to take years and years. What we do have to do is take what we call proxy measures of success or failure, and a proxy measure of success would be "Are Londoners consuming fewer calories as a result of the ad ban?" The evaluation said, "Yes".

Emma Best AM (Deputy Chairman): Do you think that evaluation is accurate, despite it not including any fast food, food-on-the-go or food in restaurants, which I would imagine are the main foods that the ad ban was targeting?

Dr Tom Coffey OBE (Mayoral Health Advisor): The importance of having peer reviewed research is that you are giving a degree of independence and the need for scrutiny of the evaluation you are doing. First of all, the evaluation was done by an independent organisation, a credible one, the London School of Hygiene & Tropical Medicine. Then it put the evaluation it conducted forward to a peer review journal and it was the conclusion of that peer review journal that the evaluation showed the significant impact. Therefore, all I can take from that is the science, and the science says to me the calorie reduction on average for the average shopper was 1,008 calories per week. Did it go into whether it was a hamburger or whether it was a different type of food? What it looked at in essence was a comparison to what would have happened if there was not an ad ban and that is what the peer reviewed, independent research showed.

Emma Best AM (Deputy Chairman): We will have to agree to disagree then perhaps, especially on whether something excluding fast food, food-on-the-go and food in restaurants could accurately show what a family is consuming in a week. The main point for asking this is that with a food ban being put into the School Superzones --

Krupesh Hirani AM: Chair --

Emma Best AM (Deputy Chairman): -- there is --

Krupesh Hirani AM: -- Chair, when someone has come back with empirical facts, we should not really try to put baseless comments --

Emma Best AM (Deputy Chairman): I can say what I like.

Caroline Russell AM (Chair): The Member can ask --

Emma Best AM (Deputy Chairman): Yes --

Krupesh Hirani AM: We are entering Donald Trump world here.

Emma Best AM (Deputy Chairman): It is not empirical facts. By the way, I have a science degree as well and so you will understand that research and studies is not fact.

Krupesh Hirani AM: I would love to see your peer review journal into this then.

Emma Best AM (Deputy Chairman): It is not fact.

Krupesh Hirani AM: I would love to see your --

Emma Best AM (Deputy Chairman): It is not necessarily just fact --

Caroline Russell AM (Chair): Assembly Member Hirani --

Krupesh Hirani AM: It is dangerous ground to go on to make comments that basically rubbish --

Caroline Russell AM (Chair): Can we let --

Krupesh Hirani AM: -- peer reviewed --

Caroline Russell AM (Chair): -- Assembly Member Best just finish her question --

Krupesh Hirani AM: OK.

Caroline Russell AM (Chair): -- quickly because we are getting very short on time? I will then bring you in for your question that you have on the list to ask if you can be quick as well, please.

Emma Best AM (Deputy Chairman): I will do, and God forbid you ever go to a uni and see that you actually can fake research and studies. It is not fact.

Caroline Russell AM (Chair): Can you just ask your question, please?

Emma Best AM (Deputy Chairman): I will do. With all due respect, Chair, it was not me that was holding up my question asking. Briefly, there is not a clear-cut definition yet on the ads that should be banned and we have seen this throw up anomalies throughout the year on TfL. How are we going to straighten that out for the School Superzones to make sure, if that is part of what is being used, that there is a clear understanding of how you do not have the likes of KFC and McDonald's still advertising?

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, first of all what I would like to say is that McDonald's and KFC are able to advertise healthy food. I have never said we should not have any companies not advertising, and I want to see the advertising of healthy food. One of the benefits of the ad ban, which I was so surprised about - because my fear was that companies that you just mentioned might pull out of their advertising, but they did not - is they started advertising their healthy food products. That was a win-win situation. I am going to bring in my colleague, Professor Fenton, in a second. What we have done is very much use public health advice to define what is high fat, sugar and salt. There are some quite good national guidelines because, again, I tend to defer to people who know more than me, which is quite a lot of people. I am going to ask Kevin, who perhaps might say about how the public health look at this proposal and we will be using that kind of advice.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Thanks and I will be very brief, just to say that we worked very closely with Public Health England at the time with the definitions of high-fat, salt, sugar products. I was the Director of Public Health in [the London Borough of] Southwark, which was one of the pilot sites for the School Zones Programme and we also used the standards for high-fat, salt and sugar programmes to help us with restricting advertising in the borough as well. We worked with Public Health England, which set the standards, and those standards are reviewed, based on the evidence that it is looking at on a regular basis. This has been part of the Childhood Obesity Strategy nationally as well and we use a standard which is not just for London, but which is used nationally, too.

Caroline Russell AM (Chair): Thank you. Assembly Member Hirani?

Krupesh Hirani AM: This is an issue I have also worked on in my borough for years as well and I want to pick on something with the School Superzones and this 400 metre definition as well. One of the problems I have with it is sometimes you get areas where you might have a bus interchange where you have pupils from a school and parents travelling to an area, which is outside that 400 metres, but it might be the only place where you have maybe six or seven bus routes convening in one place. Is there scope to widen that definition to look at town centres that might be just outside that 400-metre strict definition?

Dr Tom Coffey OBE (Mayoral Health Advisor): In my answer to Assembly Member Best, I was very clear about flexibility, and I do not want to say they definitely will because it is their decision. Imagine if you had a school, which is right up against a railway line. Not every school has a neat 400-metre circle around a school as its catchment area. A school like that might have 800 metres that way and 2 metres that way. Of course, we have to really, I would say, consider the catchment area when you are looking at the School Superzone and they have to have some sort of coherence. Otherwise - what you are saying - we would have to ignore, which would be pointless. I would support the idea that the catchment area of the school should be taken into consideration when you are doing the School Superzone distance. Now it might be the case that it goes too far away or crosses local authority boundaries, or you are not able to do certain things because of structural issues. However, that flexibility to try to make the School Superzone match the catchment area of that school, especially in primary schools where the catchment area is very small, is something that I would definitely support.

Krupesh Hirani AM: That is helpful and maybe if that is encouraged to local authorities as well because in their minds they will be thinking 400 metres and that is it. That is the definition, but if that could be widely encouraged to local areas as well, that would be great.

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, it is a fair point.

Krupesh Hirani AM: Also, back when I was looking at policies on restrictions around, let us say, fast food outlets around schools and planning policies, one of my bugbears was that you had to go to the Secretary of State to get approval for your local plans. Is that still the case with this?

Dr Tom Coffey OBE (Mayoral Health Advisor): No. My understanding is that the London Plan has now been accepted and the restriction of 400 metres from a school of any new fast food outlet is now part of the London Plan. I am not aware - but I will stand to be corrected - that each individual one would have to go to the Secretary of State. My understanding now is that there is the ability to restrict that accordingly. That is my understanding; that the London Plan is now accepted. I am looking to my left to make sure I have said that correctly. Yes.

Krupesh Hirani AM: Jazz? Yes.

Dr Tom Coffey OBE (Mayoral Health Advisor): Again, that is one of the triggers for the School Superzone 400-metre distance because we knew that was already in people's minds about we are going to restrict the opening of new fast food outlets in that 400-metre area. The flexibility you suggest to match catchment areas is sensible.

Krupesh Hirani AM: Thank you. One of the issues that we always came up against locally in the [London] Borough of Brent, which is where I was the public health lead, was that we did often have resistance as well. When we submitted some of the policies through that had to go through the rigorous processes, we even had at one stage KFC's head office come and argue against some of the restrictions around fast food especially. We have already heard at this Committee - and even when the TfL ad ban was proposed and came forward at a time when TfL is under pressure - all the scare stories about why we are stopping them from making money. Some things are more valuable than money as well. In terms of resistance, what resistance have you faced with some of these policies around School Superzones?

Dr Tom Coffey OBE (Mayoral Health Advisor): I have to say very little resistance. When you are working in a local area, the majority have the headquarters of a fast food outlet in their base and you will make travel changes. When you close off a school and you do a Healthy Street around a school, that will restrict people's

ability to travel past that school at school opening hours and school hours, and that does cause some concern because people have to change their journeys. However, all in all, in fact we have found minimal resistance and I expect that the biggest drivers for the School Superzones in the future will not be the teachers or the local authorities. It will be the parents, parents saying, "I want my school to be part of a School Superzone to benefit my child". Therefore, we have had very little resistance.

I will echo that point again about the larger firms, who have previously had very high-fat, high-salt, high-sugar food. I expect them to change, just as you now go into a food outlet and you have vegan options, which you would not have had 10 years ago. For a person who has a child who is milk-allergic, that is just fantastic. We will get the same. Those companies need to have a business model, which makes money and if Londoners are choosing to take the healthy options, they will alter their menu, alter their advertising and alter their business model. We have to be brave and use models like this to promote that.

Krupesh Hirani AM: I have a couple of comments on that. I agree on that final point and companies will change, and are changing. To the Government's credit as well, some of the changes that it has made on the sugar tax have helped to alter some recipe changes and more sugar-free options in drinks as well. It is a combination of things that come forward to help put that point forward and that is very helpful, putting it into context, as well.

Dr Tom Coffey OBE (Mayoral Health Advisor): Thank you.

Caroline Russell AM (Chair): We are now on to the final round of questions, which is going to be led by Assembly Member Boff. This is looking at Healthy Minds and the key commitment that by 2025 London will have a quarter of a million Wellbeing Champions, supporting Londoners where they live, work and play.

Andrew Boff AM: I am going to roll back a little bit before I launch on to Healthy Minds because so much of the last discussion piqued my interest. Do we know how many young people were surveyed by Kantar?

Dr Tom Coffey OBE (Mayoral Health Advisor): I do not know the information, but I can get the information for you.

Andrew Boff AM: Thank you very much. Was there a specific reason that the survey did not include those foods which the junk food ban was specifically designed to prevent us eating?

Dr Tom Coffey OBE (Mayoral Health Advisor): You are going to a level of detail, which I apologise for, that I am not able to answer, but I can get that information for you. I was not --

Andrew Boff AM: At the moment in terms of the junk food ban, it is a survey that does not talk about the junk food ban. It goes on about domestic cooking arrangements, stuff that you would cook at home. It is difficult to see how that can be a justification for the junk food ban. I know I am almost repeating the question Assembly Member Best put to you earlier, but I really did not understand the answer.

Dr Tom Coffey OBE (Mayoral Health Advisor): OK. Do you want me to repeat the answer or --

Andrew Boff AM: No. No, but if you want to provide me some data, that would be --

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes, I will do it and --

Andrew Boff AM: Just for your information, Dr Coffey, I am a vegan and a McPlant is just as bad for you as a Big Mac. It is not just that --

Dr Tom Coffey OBE (Mayoral Health Advisor): It definitely can be, yes.

Andrew Boff AM: It definitely can, and I have eaten so many that I absolutely know that to be the case.

Can we just now move on to Healthy Minds then? Ms Bhogal, could you explain what a Wellbeing Champion is, how they are trained, how they are supported and managed and what support the Champions will provide and give us an idea of how they will operate on a day-to-day basis?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): A Wellbeing Champion is broadly defined and I know it is important to say that there are lots of routes in, potentially, but effectively we are working with our partners. We have a steering group and a working group that supports the work of the development of this mission and it is taking forward. They have defined the concept, the definition if you like, of who is a Wellbeing Champion as a person who helps another person, group, community or organisation to influence or inspire a simple change to support the mental health and wellbeing of others.

That is quite a broad definition but necessarily so, and there are many reasons for that. One of the reasons will be there will be people that will be engaging and entering into being a Champion in many different ways. We already have a large number of people that have had specific training for various schemes such as suicide awareness campaigns or through mental health first aid or through a whole range of other different means that they have had. However, the majority of these people are not connected. They are not linked into something. They have often had the training, but they are not necessarily utilising it, there are plenty of other people who do want to access some sort of training and there is a broad spectrum of what that training could be.

What we want to do is two things. One is to increase the number of people who have had some skills development, who have that ability and inclination to want to be able to support people in various different communities in the way that I defined earlier. Also, it is to better connect them up together and to the opportunities where they can support people, communities and organisations. That is the real crux of it. What we found during the pandemic, for example, is that lots of people who wanted to take part in something or wanted to be able to volunteer were not able to access those opportunities.

Then there is another element to this, which is around very often a lot of the training that is provided to support individuals to support others is contained in the place where they have received that training. For example, we deliver a really broad programme of work to young people, who want to be mental health first aiders. Often, their perception once they are trained is that they only have licence to use that training in that context. What we want to be able to do is to ensure that people feel those are lifelong skills that then can be supported - they can be topped up and they can be refreshed over time - and that they feel that they are a community champion, that that is part of themselves and they are able to take that forward.

The other element to this is they will come from different routes, very often through building community coalitions, community champions, the ways in which we are working with communities on a number of other elements. For example, what we saw as a good parallel, I would say, is the vaccine programme. We had a huge army of hundreds and thousands of people that took part in volunteering for that and that came from somewhere. How do we harness a similar passion in people to be able to enter and become a Wellbeing Champion?

Then really it is working at that local level with local authorities and with neighbourhoods to look at how they are able to engage in activities locally. We know that there is a lot of mobilisation of some of the community partnerships that exist to look at how they can work in the places most effectively to reach the people that need that sort of support. At a local level, they were looking at 11 dimensions of wellbeing that include income and wealth, work and job quality and security, housing, health itself, knowledge and skills, environment quality, subjective wellbeing, safety and work/life balance. There is a whole range of different dimensions where we want to encourage the role of those community champions and how they can engage in that.

A really good example is we know some local areas are looking at how they can have people trained up as Wellbeing Champions, who would then go and do some volunteering in Job Centres. We know now there is an enormous swathe of people who are, for the first time, becoming unemployed or needing to claim benefits. Being able to go to those places where people are struggling most is going to be part of the plan.

Andrew Boff AM: How many are there?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): The target is 250,000 Wellbeing Champions and that is 250,000 people who are connected, who are part of a Programme, who have an engagement, connectively and together. Right now, for example, we probably have more than 200,000 Londoners who have completed suicide awareness training in the last two years. What we do not have is a clear understanding of how well connected they are into some of the local opportunities to utilise that training.

Andrew Boff AM: Yes, I am aware of the target of 250,000, but how many are there now?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Right now, let me try to --

Dr Tom Coffey OBE (Mayoral Health Advisor): We are collecting the data. At the moment, we think we have 65,000, but we want to clarify that data. That might include someone who has done a mental health first aid course, a suicide prevention course and a bereavement training course, all of which we help fund. We do not want to count that person three times. At the moment, we have 65,000 people that we think match that definition, but I am going to clarify that data and refine it. The figure will be lower than 65,000 because there will be some people who have done more than one of those courses that would make them, as Jazz's definition, a Mental Wellbeing Champion.

Andrew Boff AM: Do they know they are Mental Wellbeing Champions?

Dr Tom Coffey OBE (Mayoral Health Advisor): I would expect they do. Would they define it just the way Jazz defined it? Probably not, but they would know; they have done a training course. Also, the additionality which we are also trying to bring to it is two things. One is a hub of engagement, which is a way where people can access information and resource. An example is I am a Mental Wellbeing Champion, I am working with a neighbour/a work colleague/someone at the school gates and they are depressed or anxious. What do I do next? They go on to the Thrive [LDN] website and the hub of engagement. There is there the Good Thinking website, which allows you to access anxiety management and depression management.

One thing we are doing as well, which is going to be spectacular, is what is known as Improving Access to Psychological Therapies (IAPT) in general practice. [Dr] Onkar [Sahota AM] knows it. At the moment, if you want to access talking therapies in London you have to find a phone number and you must even know what you are looking for. We are going to use this process now of having a single place in London where you put in

your postcode and your NHS resource for talking therapies comes up of how you contact them and how you get help. We are going to make sure that all our Wellbeing Champions are aware of that so when they are doing the work that they do they will have the tools, not just to listen and to support, but to actually do something about giving additional access to mental health services that some of these Londoners will need.

Andrew Boff AM: Help me understand the 65,000. We are not talking about people who have been recruited? They are people who have done various training courses and as a result of that we have called them Wellbeing Champions?

Dr Tom Coffey OBE (Mayoral Health Advisor): They are the ones who are likely to fit the definition, but what I do not want to do is over-promise and under-achieve. That figure might be much lower, but I believe we will get our 250,000 Wellbeing Champions by our date. I think it is May 2024.

Andrew Boff AM: It is 2025, actually --

Dr Tom Coffey OBE (Mayoral Health Advisor): OK, thank you for that.

Andrew Boff AM: -- being generous to you. We will be able to measure the progress, will we --

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Yes.

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes.

Andrew Boff AM: -- of that towards 250,000?

Dr Tom Coffey OBE (Mayoral Health Advisor): Definitely.

Andrew Boff AM: How will we do that?

Dr Tom Coffey OBE (Mayoral Health Advisor): We will have a definition and we will then be able to assess how people are meeting the definition and they will be added on to our target. Again, the Health Equity Group, which Kevin chairs, has oversight of the whole process, but this is part of one of our recovery missions and that has a Recovery Mission Group, which is looking at that. We will make sure that we are calculating the data very carefully, making sure that the definition is shared and is agreed upon and that people qualify for it and we can prove it. What one does not want is us making spurious claims, without being able to demonstrate to you real improvement.

Andrew Boff AM: OK. The idea of Wellbeing Champions is very important, and there are a few locally around here who take it on themselves to help people, who are obviously under some mental pressure. We are just trying to understand how this works. Is there a danger that if you centralise this it all falls to pieces?

Dr Tom Coffey OBE (Mayoral Health Advisor): That is why it is being led by Thrive [LDN]. One of the criticisms of Thrive when it first started was it was too dispersed, it was just embedded in the community and it did not have a core programme office. In fact, that was also the beauty of Thrive because it was based in people's communities, in people's boroughs and in people's neighbourhoods. That is why we are using Thrive to be the key vehicle that we are going to use to develop this programme of work, just so it does not do what your fear is.

Andrew Boff AM: Yes, it is a genuine fear. I have seen --

Dr Tom Coffey OBE (Mayoral Health Advisor): Yes you are quite right.

Andrew Boff AM: -- many London-wide schemes --

Dr Tom Coffey OBE (Mayoral Health Advisor): Quite right.

Andrew Boff AM: The previous Mayor had a very good intention on child mentoring, but it did not quite get to where he wanted it to be because I believe the model was over-centralised, but that is my opinion.

Dr Tom Coffey OBE (Mayoral Health Advisor): One thing which we have learnt about the vaccine community champions and the COVID community champions is what you have just said. If you build these champions into your community - and Kevin talks about the hyperlocal approach - only then do you get the thousand flowers that bloom. If you try, as we have done in the past, to push centrally things like vaccine programmes, it does not always work and it does not reach the people you want it to reach.

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): Yes, and it has been a lesson from the COVID champions and the COVID vaccine ambassadors. It is actually building the asset within communities and learning from those lessons, but using your regional resource to facilitate learning and sharing of best and promising practice and also to stimulate innovation. That is what we do at the regional level, but really the actions should be as local as possible.

Andrew Boff AM: You have explained well what the objective of the Wellbeing Champions is, but will there be any particular disadvantaged groups that it is hoped the Wellbeing Champions will support?

Dr Tom Coffey OBE (Mayoral Health Advisor): This is part of our HIS. Therefore, we will make sure it focuses where possible, on those who face the most inequalities. In mental health terms, it is very much about disabled people, our lesbian, gay, bisexual, transgender, queer (LGBTQ) community, our black and minority ethic community, and often our recently arrived migrants and those who are rough sleepers. Therefore, I would want to make sure that when we are focusing this work, it does what it is meant to do: address health inequalities. We do know that those communities who suffer the poorest mental health are more likely to kill themselves. Therefore, this project has to address those two outcomes, poor mental health and suicide.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): There are two key programmes within the approach. Right to Thrive is an element of the Programme that is really going to focus in on intersectional, marginalised communities and provide a small grant scheme that will support community organisations who work in that sort of space with those communities. Complementary to that is a programme around resilience to look at how, through the Thrive LDN champions, the mental health sector partners' work. It is looking at how through their peer support - it is a peer support scheme - particularly mental health champions/Wellbeing Champions who are from those communities can be better buddied up, have a bit more of a peer support that will enable their offer as Champions to be far more impactful in communities. Those are two very specific things.

Then there is the wider work around tackling groups with greater risk of mental illness, including those communities that we have talked about, but we know, for example, men's mental health has greater challenges. Some of the Men's Health Week work and some of the wider programmes that we are delivering slightly beyond the specific deliverables for the Champions Programme but still constitute part of our agreement, and work through Thrive LDN will also be supportive to that objective.

Then there is work that other partners are doing that will also contribute to almost the ballast that sits underneath and behind the objective around the Champions work. OHID's work, Kevin's team, doing the work around prevention and promotion of the fund for better mental health, will support 11 London boroughs to develop prevention-focused approaches to improving mental health in their communities. The work that the integrated care systems (ICSs) will be doing on mental health trusts is to look at how there are greater relationships directly with mental health trusts. That is particularly, for example, where Champions might identify people where actually their problem is they are not getting the right access to services. It is enabling some of that bridging of some of those sorts of challenges and looking at how we can get better access and better utility of the NHS datasets on mental health and mental illness. Then it is looking at how, working with them and extending and continuing some of the work that we had funded through the pandemic. During the pandemic, we funded Good Thinking, which is a digital access tool to provide specific access for young people. It was a model that was provided more generically, and we asked for that work to be funded to focus in on supporting younger Londoners.

Then through the London Borough of Culture's work, we are doing some work directly with [the London Borough of] Lewisham and next year with [the London Borough of] Croydon to look at how they would have a bit of a theme around wellbeing and utilise the Champions that are created in those communities to tie in to some of those works.

We have an opportunity here to have greater support of the Wellbeing Champions and the Champions having a much broader role across some of that wider, more strategic way of working in those local places.

Andrew Boff AM: You will be pleased to know this is my last question. Last week, we approved the Mayor's Budget and that actually more than halved the amount available to the Health and Wellbeing mission's budget. How is that going to affect the rollout of the Mayor's ambition?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): There are three health budgets for the GLA that sit within the overall budget for the Mental Health and Wellbeing block. The Mental Health and Wellbeing block previously included quite a lot of activity that was not directly related specifically to the Mental Health and Wellbeing, not just the mission but that broader description that I have given you. What we needed to do was to recalibrate how budget had been allocated across all three blocks. For example, that included funding for some other areas of work, delivery of other aspects of the HIS, or work that we would be doing through focussing our policy work on health and care partnerships or even funding staff. What we have done is recalibrate the budget. It already was not quite right, and now the budget as it currently stands is correct for what we will be delivering across what I have described.

Andrew Boff AM: Is that about £700,000?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Yes.

Andrew Boff AM: Will there be any external funding?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Yes. The point is the budget that we have allocated is our contribution to a partnership approach to delivering the mission and so the --

Andrew Boff AM: Who are the partners and how much are they paying?

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): We will come back to you on that. That is part of a broader approach. There is some specific work that will fund the support of the creation, the networking and the hubs for the Wellbeing Champions. That money is contained here, £450,000, and that is what that will be per year, specifically for the programmes of work that will create and support the Champions. That is what we have calculated, and that is the money that we think we need to invest in that Programme. Additional money from partners will be in support of that. The way I described it is there is a wider opportunity to make sure that we are providing that ballast of wider support and then where those Champions can more broadly work. That is where some of that wider money will come --

Andrew Boff AM: You must have somebody in mind as to who the partners are going to be.

Jazz Bhogal (Assistant Director of Health, Education and Youth, Greater London Authority): Yes, the other partners will be local authorities, the voluntary sector itself and the NHS, and we are also looking at the wider business sector. For example, we have already had conversations with colleagues who are leading on the High Streets mission, who are really keen to look at how we can place some of these and support them to be in places on high streets where they know that there are opportunities to support wellbeing. Yes, there is lots of creative thinking.

Dr Tom Coffey OBE (Mayoral Health Advisor): Andrew, to give an example, many businesses now see the benefit of doing mental health first aid training for their employees. They realise that you are much more likely to not go to work because you have poor mental health rather than poor physical health. They themselves are investing in putting their employees on mental health first aid training and that is an investment which will go to creating these Wellbeing Champions.

Secondly, the King's Fund looked for us at the health service in London and it gave us a report, which came out last year. The key message it came to said that the NHS has now adopted City Hall's approach where health inequality is integral to all they deliver. Now the new five ICSs have as one of their top priorities, addressing health inequalities and doing our work that we have described to you today with their money.

Andrew Boff AM: Professor Fenton, is the NHS going to come up with some support for this scheme?

Professor Kevin Fenton CBE (Regional Director for London, Office for Health Improvement and Disparities, and Statutory Health Advisor to the Greater London Authority): I cannot speak for the NHS as I am not with the NHS, but I would certainly be advocating for as many of our health and care partners to be investing in supporting this important initiative, absolutely.

Andrew Boff AM: Great, thank you very much.

Caroline Russell AM (Chair): Thank you to all three of our guests, for a really illuminating afternoon. It is a hugely ambitious programme, to put health in all policies, and it has been really helpful for us to have the opportunity to ask some of our very basic questions, trying to really understand exactly how this new way of working is going to work. All the stuff about learning the lessons from the pandemic and the ways that we found to work differently during that, working with the model of the vaccine volunteers, has been a very inspiring thing to see and witness as we have gone through these last two years. It has also exposed that there are bits that are still unclear about exactly how they are going to work and we will want to keep in close contact as all of those details become more scoped out and more defined, but we do have a much clearer idea of what we are trying to track and watch as this work progresses. Thank you very much, all of you, for your time.