King's Fund

Mapping Primary Care Groups in London

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Publishing
11–13 Cavendish Square
London W1M 0AN

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Published by
King's Fund Publishing
11–13 Cavendish Square
London W1M 0AN

First published 1999

ISBN 1 85717 236 1

A CIP catalogue record for this book is available from the British Library

Available from:

King's Fund Bookshop
11–13 Cavendish Square
London W1M 0AN
Tel: 0171 307 2591
Fax: 0171 307 2801

This report has been produced to disseminate research findings and promote good practice in health and social care. It has not been professionally copy-edited or proofread.

Printed and bound in Great Britain

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Acknowledgements

We would like to thank the following people:

- the Health Authority managers who took part in the survey
- Paul Haigh at Kensington & Chelsea and Westminster Health Authority for his help in piloting the questionnaire
- Vince McCabe, Neil Francis and Gail Pascoe at the North and South Thames NHSE Regional Offices for their help throughout the project
- Dominique Florin, Angela Coulter, Martin Horwood and Liz Kendall for their comments on earlier drafts of this report.

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Executive Summary

1 Introduction

1.1 Background

The White Paper, *The new NHS*, set out the Government's health policy for the next ten years. All general practices in England are to belong to a Primary Care Group (PCG), whose core functions will be to:

- Improve the health of their community and reduce inequalities
- Commission a range of services to meet their patients' needs
- Develop primary care and community services

The PCG model is consistent with earlier policies aimed at promoting a primary-care led NHS. General practitioners (GPs) will take on increasing responsibility for shaping local services. About 500 PCGs will replace the 4,000 or so GP fundholding practices, with the aim of removing the 'two-tierism' that this earlier model of GP purchasing created.

In April 1998, the NHS Executive issued guidance to Health Authorities setting out the criteria and timescale for the formation of PCGs. Health Authorities had to submit proposals on configuration to their Regional Office by the end of July, having consulted with all their local stakeholders.

1.2 Purpose of this paper

The structure of PCGs, and the relationships they have with their Health Authority and other organisations will affect their ability to meet their objectives. This report provides an overview of the 'birth' of PCGs in the 16 London Health Authorities. It describes both the outcome and configuration process and discusses implications for future functioning.

2 Methods

A questionnaire was sent to the lead Commissioning or Primary Care Manager in each of the London Health Authorities in August 1998. Health Authorities were also asked to supply relevant documents such as consultation papers. The two Regional Offices provided data they had obtained on PCGs.

3 Key findings

All 16 Health Authorities responded to the questionnaire. Three Health Authorities were asked to reconsider their initial proposals for PCG configuration by their Regional Office because they did not adequately meet the national criteria. Final configurations were established by October 1998.

3.1 Health Authority Profiles

London Health Authorities cover populations ranging from 250,000 to 730,000. Nearly 40% contract with three or more main acute hospitals, and more than two-thirds cover two or more London boroughs. 14 Health Authorities had pre-existing locality structures (smaller geographical patches

within the Health Authority). Five were able to exactly match these boundaries in creating their PCGs. These PCGs may start to function more quickly because they have faced relatively little disruption.

3.2 Overview of PCG profiles

There are 66 PCGs in London with populations ranging from 57,000 to 234,000 (median 105,000). There are between 13 and 68 general practices in each PCG, and the number of PCGs per Health Authority ranges from two to nine.

3.3 Characteristics of general practices in PCGs

We used the proportion of GP fundholders (GPFH) in each PCG as an indicator of primary care commissioning experience. The proportion of GPFHs in PCGs varies from none to 93%.

Single-handed practitioners may be less able to participate in their PCG because they may find it harder to spend time away from their practice. PCGs with a high proportion of single-handed practices might need extra support from their Health Authority to fulfil their functions. In a quarter of London's PCGs, more than 50% of practices are single-handed.

3.4 Fate of other primary care organisations

A total of 35 primary care organisations such as multifunds, GP Commissioning Groups, Total Purchasing Pilots and Personal Medical Services Pilots were identified by the 16 Health Authorities. Only one of these has become a stand-alone PCG. 18 have merged with other practices to become part of a bigger PCG, and 16 have been disaggregated and spread across several PCGs. There may be a risk of losing the skills and experience that the champions of these earlier organisations have developed, since these GPs may have become disaffected and choose not to participate fully in their PCG.

3.5 Demographic characteristics of PCGs

The proportion of a practice's population that is eligible for high deprivation payments is an indication of health need. Four Health Authorities provided information on the proportion of their PCGs' population eligible for high deprivation payments. There was marked variation between PCGs within three of these Health Authorities, the most extreme being from 0.3% to 24% in one Health Authority. In the fourth Health Authority, there were no high deprivation payments for any of the PCGs.

3.6 Provider relationships

About three quarters of PCGs contract with only one main acute hospital so, from a PCG perspective, contracting for acute services may be relatively simple. Trusts have raised concerns about the number of PCGs they will have to contract with, and the impact on cost-effective management arrangements.

3.7 Local Authority relationships

In 13 Health Authorities, PCG boundaries either exactly matched Local Authority ones or lay completely within them. This should facilitate joint working, although other cultural problems and financial barriers have hindered this in the past.

3.8 Initial level of PCG responsibility

Ten Health Authorities had tentative views on the initial level of commissioning responsibility that their PCGs might take on. Three thought all their PCGs would start at level one (advising the health Authority on commissioning decisions), and five thought that they would start at level two (managing the budget to purchase hospital and community health care services). In two Health Authorities, only those PCGs with a high proportion of GPFHs would start at level two, the others at level one. Level two PCGs may be keen to race ahead to levels three and four once legislation has been passed. However, population-based commissioning requires different skills from GPFH and these PCG members may have to spend time 'unlearning' old skills and replacing them with new ones.

3.9 Configuring PCGs

Although the configuration process was clearly intensive and time-consuming, the lack of appeals from stakeholders against proposed configurations suggests that this was generally well managed. The four criteria that Health Authorities identified as most important to meet were PCG size; primary care development (and networks to facilitate this); partnership with local authorities; and "natural communities" (as defined in the April guidance). Health Authorities found it difficult to implement the latter criterion because of the diversity of London's population.

Community Health Councils were involved in the configuration process as a minimum attempt to involve the public. However, raising public awareness proved difficult at this early stage.

4 Implications of findings

4.1 Context

The diversity of health needs in London's population is well documented. The Turnberg review outlined service delivery issues, emphasising the continuing need for primary care development, the complexities of administrative boundaries and the difficulties in rationalising acute health care. These are particular challenges that PCGs in London must respond to in fulfilling their functions.

4.2 From form to function

Organisational Development

Health Authorities were keen to pay attention to GPs' views, recognising that their enthusiasm would be a key factor in the development and success of PCGs. In order to maintain motivation, however, PCG members will need to feel that there are tangible benefits for themselves and their patients. At present there is little to reassure PCGs that this will be the case, although the autumn guidance does acknowledge the need for incentives.

There is a trade-off in deciding the size of a PCG. Smaller PCGs may "come together" more quickly, and might also be better forums for developing primary care, as the organisation may be less bureaucratic and allow greater participation by its member practices. However, larger organisations have more purchasing power, and are likely to be more sustainable in terms of efficient use of capped management costs.

Public Health Functions

Issues such as tackling health inequalities and contributing to the Health Improvement Programme are likely to be low on PCGs' current list of priorities, secondary to issues which have more direct relevance to everyday clinical practice such as managing the prescribing budget or developing practice premises and staff.

Our study shows the considerable variation in health needs of PCG populations, and suggests that different PCGs will have different capacities to meet these needs. Health Authorities may have to provide different levels of support for PCGs if the inverse care law is not to apply at this level.

Commissioning function

An advantage that PCGs could have over Health Authorities is the ability to commission services that are more locally responsive to patients' needs. However, given their smaller size, several PCGs will have to work together to achieve more strategic change, and Health Authorities will have an important role to play in facilitating this. Where several PCGs purchase from the same hospital, the development of lead purchasing arrangements would help to ensure consistency of approach and share the commissioning workload between PCGs.

Primary care development

Primary care development is the challenge that PCGs are likely to take up most naturally. The PCG structure could reduce the isolation of single-handed practices and promote clinical governance by sharing good practice and providing peer support. PCGs may, however, struggle to address poor performance, since the independent contractor status of general practitioners remains intact, and the levers for change are therefore limited.

5 Conclusions

The success of PCGs in carrying out the tasks they have been set will depend on the ability of their members to work together, their experience and skills, good leadership and the nature of their relationships with other organisations, particularly their Health Authority.

The emerging map already suggests considerable heterogeneity and some PCGs are likely to progress more rapidly than others. The challenge for Health Authorities and for those in primary care will be to prevent such variations becoming entrenched in PCGs. Otherwise there is a real risk of perpetuating inequities in health and health care.

1 Introduction

1.1 Background

The White Paper, *'The new NHS'*, set out the main strands of the Government's health policy for the next ten years[1]. All general practices in England are to belong to a Primary Care Group (PCG). Their core functions will be to:

- Improve the health of their community and reduce inequalities
- Commission a range of services to meet their patients' needs
- Develop primary care and community services

This is a considerably wider remit than that of their predecessors such as Total Purchasing Pilots and GP Commissioning Groups (TPPs and GPCGs). PCGs are an attempt both to build on the strengths of these models and to address their limitations. They are to begin as sub-committees of their Health Authorities, but eventually become free-standing bodies, finally evolving into Primary Care Trusts with responsibility both for providing all community and primary care and for commissioning services. Links between primary care and Local Authorities are to be strengthened by the presence of Social Services officers on PCG boards.

The PCG model is consistent with earlier policies aimed at promoting a primary-care led NHS, as GPs will take on increasing responsibility for shaping and negotiating local health services. In keeping with the spirit of a truly national health service, about 500 PCGs will replace the 4,000 or so GP fundholding practices scattered throughout the country, forming a universal set of apparently more homogenous organisations, and removing the 'two-tierism' that this earlier model of GP purchasing created [2 3].

Health Service Circular 065, issued in April 1998, set out a range of criteria that needed to be "considered fully" by Health Authorities as they established PCGs[4].

Figure 1: Criteria for assessment set out in Health Service Circular 065

Criteria for Assessment

Based on the presumption that Primary Care Groups will be based on natural communities (typically with a population of around 100,000). The following questions will need to be considered locally in reviewing a proposed Primary Care Group configuration:

- *does the configuration allow the wider public health needs of the local community and the continued development of primary care to be addressed, in addition to the commissioning of health care?*
- *does the configuration allow the Primary Care Group to contribute to the development of the Health Improvement Programme, to contribute to the effective delivery of health gain as defined in the HImP and form appropriate alliances with other agencies?*
- *does the configuration allow meaningful consultation of local populations (ie covering a population base that makes sense to them) about decisions to spend NHS money on primary and secondary services?)*
- *does the configuration embrace natural communities that make sense to the local populations and allow inequalities to be addressed (ie reflect transport links, consumer habits, language, culture etc) as well as meeting the needs of the mobile (homeless, travellers and refugee) population?*
- *does the configuration allow specific localised health problems to be tackled coherently?*
- *is the configuration geographically congruent with the distribution of any minority group which would be advantaged by a relationship with one Primary Care Group?*
- *has the configuration proposed been discussed by all key stakeholders (GPs, LMCs, Local Authority, community nurses, community and acute NHS Trusts, other health professionals, health Authority and public etc.) and does it command their support?*
- *does the configuration provide a basis for effective working relationships within primary care and with social service professionals and does it have the active support of the social services department?*
- *does the configuration allow cost-effective and meaningful discussions with secondary care providers? (ie do the GPs in the group have unacceptably disparate interests because of their relationship with different secondary care providers)*
- *do the arrangements include all practices within the boundary of the Primary Care Group?*
- *does the configuration represent effective use of available management resources and avoid logistical difficulties for effective operation of the group?*
- *does the configuration form part of a coherent structure of Primary Care Groups within the Health Authority area as a whole?*

The guidance also defined the timescale. PCG proposals were to be submitted to Regional Offices of the NHS Executive by the end of July. Discussions on PCG configuration had already begun in many places before April but, given the extent of consultation required, it was still a formidable task.

Regional Offices were able to ask Health Authorities to re-consider their proposals if they felt that the configuration proposed did not meet the criteria adequately. There was no formal arbitration system, although Health Authorities were expected to demonstrate that all stakeholders' views had been taken into account.

1.2 Purpose of this paper

PCG structures, the relationships they have with their Health Authority and other organisations will undoubtedly affect their ability to meet the challenging tasks that they have been set. Arguably, total purchasing is the model most similar to PCGs. The Total Purchasing Pilot Evaluation highlighted the variable success of TPPs in achieving their objectives [5]. Barriers to success included organisational issues such as size, ambitions and relationship with the parent Health Authority. PCGs differ from TPPs in terms of their core functions, their universality and compulsory nature, but some of the lessons learnt from the systematic evaluation of the latter are relevant to these new primary care organisations.

This report provides an overview of the 'birth' of PCGs in the 16 London Health Authorities. Both the configuration process and outcome are described, and some implications for future functioning discussed as the PCG map in London begins to take shape.

Figure 2: The London Health Authority boundaries and Local Authorities

Source: The Health of Londoners Report

2 Methods

In August 1998 we sent a questionnaire to the lead Commissioning or Primary Care managers in each of the London Health Authorities (HAs). These lead managers were identified by the HA Chief Executives. The questionnaire was piloted with one Health Authority and discussed with the lead Primary Care managers at North Thames and South Thames Regional Offices.

Information was requested on each Health Authority's proposed PCG configuration, the process undertaken to achieve this and certain PCG characteristics. Health Authorities were asked to comment on the role of the Regional Office and their Local Medical Committees (LMC).

Health Authorities were also asked to supply any relevant documents such as consultation papers and responses from stakeholders. Content analysis of these was used to supplement information from the questionnaire on the nature of the configuration process.

The questionnaires were followed up with telephone interviews to ensure that the information was as complete as possible. The two Regional Offices provided information they had obtained, which helped to supplement any missing data.

3 Results

All 16 Health Authorities responded to the questionnaire. Summaries for each of the Health Authorities are in the Appendix. The rest of this section provides an overview of emerging PCGs and the process that led to their configuration in London.

13 Health Authorities established PCG configurations that their Regional Office approved by the end of August. Three Health Authorities were asked by their Regional Offices to re-consider their initial proposals. For two of these this was because they had proposed PCGs which were considered too small (less than 45,000) or too large (more than 250,000). For the third this was because one PCG was geographically divided by another. All of these original proposals had been strongly supported by local GPs. The three Health Authorities underwent further local consultation, and by October all had achieved both consensus amongst local stakeholders (including the GPs) and Regional Office approval for revised proposals.

3.1 Health Authority Profiles

The Health Authorities cover populations ranging from 250,000 to 730,000 (mid-1996 population estimates). Many of the Health Authorities contract with several main acute hospitals, community and mental health Trusts. More than two-thirds cover two or more London Boroughs (*Table 1*).

Table 1: Relationships between Health Authorities (HAs), Local Authorities and health services providers in London (n=16)

	Number of Health Authorities (%)
HA covers more than one Local Authority	11 (69%)
HA contracts with more than two main acute providers	6 (38%)
HA contracts with two or more community/mental health Trusts	9 (56%)

14 Health Authorities had pre-existing locality structures, dividing up the district into smaller geographical patches, to improve local sensitivity. Often, GPs in each patch would have met regularly, for example to discuss their Health Authority's commissioning strategies, and already built up a sense of identity with each other. Health Authorities might have also undertaken population profiles for their localities. In five Health Authorities (36%), PCG structures almost exactly match the locality boundaries. Of the others, four (29%) formed PCGs by merging whole localities.

3.2 Overview of PCG Profiles

There are 66 PCGs in London, with populations ranging from 57,000 to 234,000. Eight PCGs (12%) cover populations of less than 75,000 people, and three (5%) have populations of more than 200,000. Table 2 provides an overview of London's PCGs, compared with available national data.

Table 2: Key Characteristics of PCGs in London (n=66)

	London	England
Range (and median number) of PCGs per Health Authority	2 – 9 (3)	1 – 12
Range (and median) population per PCG	57,000 – 234,000 (105,000)	46 – 257,000
Range (and median number) of practices per PCG	13 – 68 (25)	N/A

Most Health Authorities used registered practice populations as a basis for estimating PCG size. Two Health Authorities used census-based resident population estimates, and two referred to both measures. In these latter cases, registered populations were almost always larger than the census estimates. Using practice registers may over-estimate the PCG population because of the problem of list inflation (patients may remain on GPs' lists after they have moved or died). Projections from the 1991 Census will become increasingly inaccurate over time, and tend to under-estimate the population in a given area.

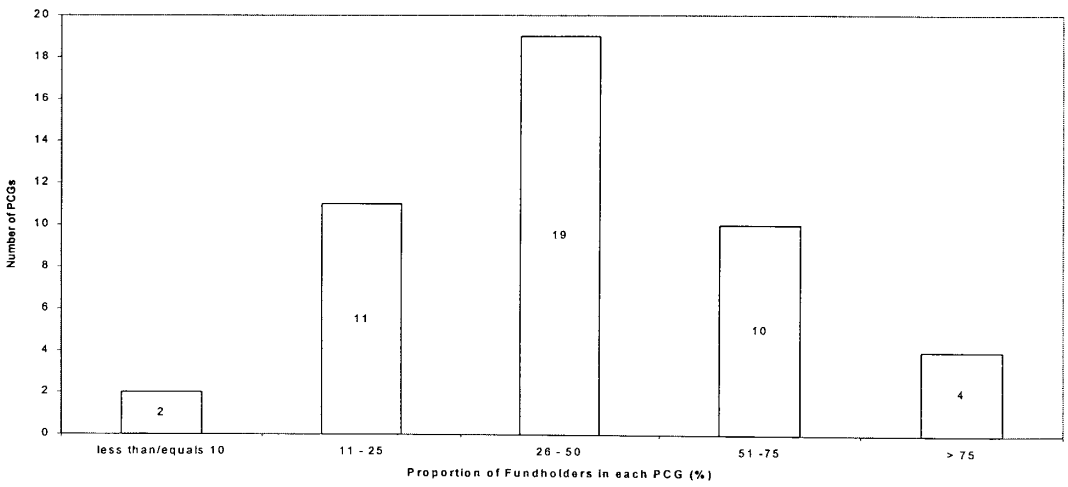
3.3 Characteristics of General Practices in PCGs

Information was requested on two particular practice characteristics. The proportion of GP fundholders (GPFHs) in each PCG was used as a measure of the extent to which PCG members had some experience of purchasing health care, and so might be more confident about fulfilling this particular PCG function. Information on the proportion of single-handed practices in each PCG was also sought. Single-handed GPs may be less able to participate in the work of their PCG because they may not have the same capacity to spend time away from their practice. PCGs with a high proportion of single-handed practitioners could therefore require more support to fulfil their functions. Single–handed practices also tend to predominate in more deprived areas, where the need for health care is greatest[6].

3.3.1 GP-Fundholding practices

Eleven Health Authorities, covering 46 PCGs, provided information on the proportion of GP fundholding practices (GPFHs) in each of their PCGs. This ranges from 0% to 93% (*Figure 3*).

Figure 3: Proportion of GPFHs in each PCG (n=46)



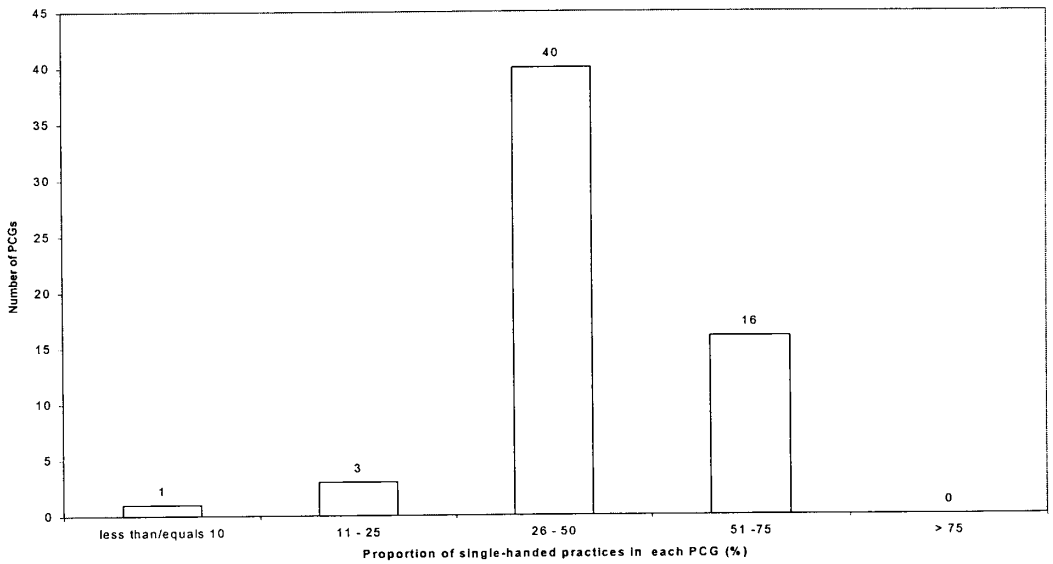
There is also wide variation within some Health Authorities. In four, the PCGs with the most fundholding practices have more than twice the proportion of those with the

least. The most extreme example is Merton, Sutton and Wandsworth, where the range of GPFHs in different PCGs is 11 – 84%. By contrast, in two Health Authorities proportions of GPFHs are relatively even (within 15% of each other) across all of their PCGs.

3.3.2 Single-handed practices

A similarly varied picture is seen in the distribution of single-handed practices by PCG and Health Authority. A quarter of London's PCGs have more than 50% of practices as single-handed practices (*Figure 4*).

Figure 4: Proportion of single-handed practices by PCG (n=60)



The variation within any given Health Authority is similar to that found in GPFH practices. The most extreme variation is again in Merton, Sutton and Wandsworth where the proportion of single-handed practices in PCGs ranges from 5% to 52%. Ealing, Hammersmith and Hounslow Health Authority also has wide variation,with a range of 31 – 72%.

3.4 Fate of other primary care organisations in London

Across the 16 Health Authorities 35 primary care organisations such as multifunds, GP Commissioning Groups, Total Purchasing Pilots and Personal Medical Services pilots were identified. Only one of all these organisations has become a stand-alone PCG, as shown in Table 3.

Table 3: The fate of pre-existing GP organisations (n=35)

Pre-existing GP organisation	Exists as stand-alone PCG	All practices remain together, but merged with other practices to form a PCG	GP organisation dis-aggregated & spread across more than one PCG
Multi-fund (n=8)	1	1	6
GP Commissioning Pilot (n=8)		4	4
Total Purchasing Pilot (n=8)		5	3
Personal Medical Services Pilot (n=11)		8	3
TOTAL	*1*	*18*	*16*

To avoid being split across two PCGs, one Personal Medical Services pilot decided to form a single partnership by merging practices.

3.5 Demographic characteristics of PCGs

Deprivation payments to practices, based on ward Jarman deprivation scores, are used as proxy measures of health need in primary care. At this early stage in the development of PCGs, only four Health Authorities were able to provide information on the numbers of patients in each PCG entitling practices to high deprivation

payments (*Table 4*). The striking feature is the variation between PCG populations within most Health Authorities.

Table 4 : Range of high deprivation payments between PCGs in four Health Authorities

Health Authority	Number of PCGs	High deprivation payments per 10,000 population in least deprived PCG	High deprivation payments per 10,000 population in most deprived PCG
Bexley & Greenwich	2	3	240
Hillingdon	3	0	0
Kensington & Chelsea and Westminster	3	1	33
Redbridge & Waltham Forest	3	2	18

Enfield and Haringey Health Authority provided information on the proportion of patients entitling practices to any deprivation payment (high, medium and low) which ranged from 3% of the practice population in one PCG to 82% in another.

Two other Health Authorities used indices such as ethnicity and standardised mortality ratios to describe differences in their PCG populations. East London and the City Health Authority also highlighted the proportion of poor premises, which ranged from 48% to 74% of practices in its different PCGs.

3.6 Provider relationships

15 Health Authorities, covering 60 PCGs, provided information about relationships between their PCGs and main providers of acute services. Of the 60 PCGs, 46 (77%) will contract with only one main acute hospital. Only one PCG contracts with three main acute hospitals. Whilst this means that from a PCG perspective acute services contracting may be relatively simple, some Trusts raised concerns about having to contract with several PCGs :

> ***"...from the view of Trusts and Local Authorities in particular, fewer PCGs would make for more cost-effective management arrangements"***
>
> *Source: Ealing Hammersmith & Hounslow Proposal for PCG Configuration*

For one Health Authority, the potentially close relationship that a PCG might develop with a single Trust might turn out to be a double-edged sword:

> ***"The natural loyalty such a PCG may have to individual NHS providers could lead to protectionism. Strategic change, for example the provider re-configuration, may therefore be more difficult to achieve"***
>
> *Source: Kingston & Richmond Discussion Paper on PCGs*

3.7 Local Authority relationships

In 13 Health Authorities, all PCGs were either co-terminous (matched exactly) with their Local Authorities, or lay completely within them. In the other three Health Authorities the PCGs straddled Local Authority boundaries. The reasons given by Health Authorities for approving these configurations were:

- GPs had a history of working together in different configurations, and secondary provider patient flows did not fit with Local Authority boundaries
- relationships with Community Trust catchment areas were given priority (these crossed Local Authority boundaries)
- geographical natural communities existed that did not match Local Authority boundaries and were favoured by GPs.

In general, Local Authorities were keen to encourage completely co-terminous PCGs:

> ***"Lambeth Council have strongly reiterated their support for one PCG in Lambeth, co-terminous with the borough"***
>
> *Source: Lambeth Southwark and Lewisham Health Authority Paper on PCGs.*

Health Authorities often recognised the potential benefits of such a configuration, but had to take into account the large size of the PCGs this might have created, and the views of other stakeholders, particularly in primary care, who tended to favour smaller organisations:

> ***"Borough based PCGs would be more than twice the size of PCGs set out in the White Paper and Department of Health guidance. The Authority ...would [only] support one PCG in each borough if there was overwhelming support from all parties, including primary care."***
>
> *Source: Lambeth Southwark and Lewisham Health Authority Paper on PCGs*

3.8 Initial level of PCG responsibility

Ten Health Authorities had tentative views on the initial level of responsibility for their PCGs.

Figure 5: Levels of responsibility for PCGs

LEVEL ONE – Support the Health Authority in commissioning care for its population, acting in an advisory capacity

LEVEL TWO – Devolved responsibility for managing a budget for health care in their area, acting as part of the Health Authority

LEVEL THREE – Free-standing body accountable to the Health Authority (legislation required first)

LEVEL FOUR – Primary Care Trust. Responsibilities as for level three plus responsibility for the provision of community services for their population (legislation required first)

Source: The new NHS

Three Health Authorities, Camden & Islington, Redbridge & Waltham Forest and Bromley, intend all PCGs to start at level one. In Hillingdon and in Merton, Sutton and Wandsworth most PCGs would also start at level one but one PCG in each which was predominantly fundholding would start at level two. In five other Health Authorities it was anticipated that all PCGs would start at level two, irrespective of the proportion of GPFHs in different PCGs. A concept of 'level one plus' was also beginning to emerge in Lambeth Southwark and Lewisham Health Authority, with the

possibility of PCGs co-commissioning with their Health Authority, but this was as yet undecided.

3.9 Configuring PCGs

3.9.1 Nature of the process

The process of agreeing configurations was time-consuming and intensive for those involved:

> ***"Over 100 meetings have been held since January 1998"***
>
> *Source: Lambeth Southwark & Lewisham HA*

> ***"intensive but well-run...Community Health Councils praised the process"***
>
> *Source: Camden & Islington HA*

Several Health Authorities set up specific steering groups to oversee the configuration process, whereas others used pre-existing forums for this purpose. The Local Medical Committees played a key role in canvassing GP opinion using ballots and by participating in steering groups. In some Health Authorities they were more integral to the process, being the main conduit between the Health Authority and GP opinion:

> ***"the LMC's Primary Care sub-group [with widened membership] was chosen as the forum in which the formation of PCGs in Barnet would be debated"***
>
> *Source: Barnet Health Authority PCG Proposal Paper.*

Health Authorities did acknowledge that there were issues and stakeholders to consider as well as GP opinion:

> ***"Ministers have made it clear that it is not acceptable to base the boundaries of PCGs solely on the preference of like-minded GPs to work together"***
>
> *Source: Merton Sutton & Wandsworth PCG proposal document*

But GP opinion was given high priority:

> ***" It is clear that where GPs feel comfortable working with their peer group the task of improving primary care...will be simplified. Therefore the preferences of GPs must be carefully considered"***
>
> *Source: Kensington & Chelsea and Westminster HA Paper on PCGs*

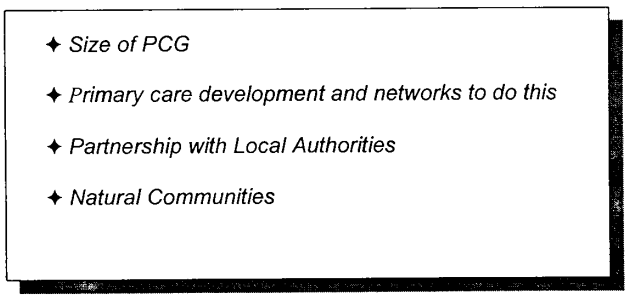
3.9.2 Use of criteria

All Health Authorities made some reference to the criteria set out in HSC 065 as required by the Regional Offices. One Health Authority, Bromley, developed other explicit local criteria, such as smooth transition from current arrangements and encouragement of innovation.

In other Health Authorities, consultation documents suggest more implicit consideration of local factors and criteria.

Health Authority managers were asked to identify which national criteria they thought to be most important (*Figure 6*).

Figure 6: Criteria most frequently identified as important by Health Authorities



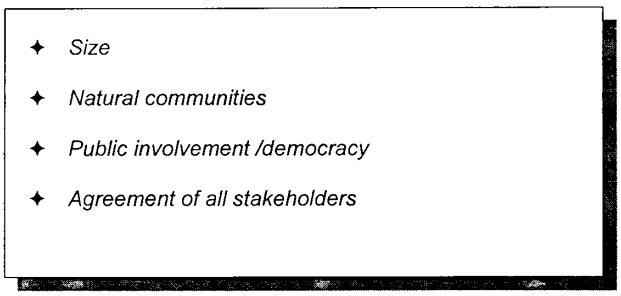
Size was felt to be particularly important because of the trade-off between small PCGs which would favour good inter-practice communication and local sensitivity, and larger groups which would be more viable in terms of meaningful epidemiological analysis, risk management and more efficient use of capped management costs. In those Health Authorities where PCGs are relatively large, such as Bexley and Greenwich and East London and the City, a sub-PCG locality structure is envisaged. In those with smaller PCGs such as Ealing Hammersmith and Hounslow and Bromley, structures allowing collaboration between PCGs will be encouraged, particularly to ensure coherent purchasing policies across the district, and to share the work between PCGs if this is felt to be appropriate.

For a few Health Authorities, some criteria were difficult to reconcile with others:

> ***"It has become clear that no one set of options can meet all the guidance criteria ... the question is what degree of compromise should exist"***
>
> *Source: Kensington & Chelsea and Westminster Health Authority PCG consultation paper*

Health Authorities were asked to identify which criteria they found particularly difficult to meet (*Figure 7*). For two, PCG size was a problem. Kensington & Chelsea and Westminster Health Authority's initial proposal contained a PCG of less than 45,000 people, while Bromley proposed a PCG of about 300,000 population.

Figure 7: Criteria that Health Authorities found difficult to implement



Seven out of the 14 who commented on this aspect noted the difficulty of creating PCGs that were natural communities:

> ***"What are natural geographical communities in the inner city context? One respondent has identified 15 in Camden alone after seven years' work".***
>
> *Source: Comment from Camden & Islington PCG questionnaire*

Three Health Authorities (Barking & Havering, Hillingdon and Enfield & Haringey) opted for parliamentary constituencies as natural boundaries that would also favour local accountability arrangements.

Six out of 14 Health Authorities failed to gain complete agreement from all their stakeholders, although the dissatisfied stakeholders ranged from a few general practitioners to organisations such as Local Authorities and Trusts. Only two GPs

were known to have appealed to Regional Offices. Larger organisations tended to indicate that they would go along with a configuration that was not necessarily their first choice, but would expect the Health Authority and PCGs to address their concerns in future.

> ***"It is important to acknowledge that Barking, Havering & Brentwood Community Trust favours option 3...However subsequent discussions have indicated that they would work with option 4 should it be the considered outcome."***
>
> *Source: Barking and Havering Health Authority PCG proposal paper*

3.9.3 Public involvement

As a minimum level of public consultation, Community Health Councils were involved in discussions over PCG configuration. Some Health Authorities went to greater lengths to try to involve the public, and the mechanisms used are listed below *(Figure 8)*.

Figure 8: Mechanisms used to involve the public

- *wide distribution of consultation document (500 – 2,500 copies circulated)*
- *open meetings and attendance at public meetings*
- *advertisements in local newspapers*
- *exhibitions at the Health Authority and local library*

However, even those Health Authorities that tried to ensure high public awareness encountered difficulties:

> ***"Concerns have been expressed by the Health and Community Care Forum on Race that the views of black and minority ethnic people are not being properly heard in the configuration process. It would be helpful if the GPs most involved...would ensure local debate with minority ethnic members of their community"***
>
> *Source: Kensington & Chelsea and Westminster Health Authority consultation document*

> ***"The views of the local voluntary organisations have not been represented as strongly as we would have liked. Attempts to involve voluntary sector 'umbrella' organisations at several stages did not meet with success, and contact by telephone with local groups indicated that there would be greater interest in developing the way PCGs will operate"***
>
> *Source: Redbridge and Waltham Forest Health Authority paper on PCGs*

Redbridge and Waltham Forest was the only Health Authority that specifically mentioned the difficulty of engaging the public and ensuring local democracy, but there is no reason to suppose that this was any easier elsewhere. It is possible, as their paper suggests, that involving the public will have more salience as PCGs begin to take decisions that more directly influence their local communities' health and health services.

4 Discussion – implications of findings

4.1 PCG configuration in the capital : context

The diversity of health needs in London's population and the complexity of health care services are well-known. For example, London contains some of the most deprived boroughs in the country, but the picture is complex, with pockets of great affluence juxtaposed against those of extreme[7]. And while about 45% of the country's minority ethnic population live in the city, this label covers a wealth of cultures and different generations, often in small pockets throughout London[8]. Issues such as the health of refugees and street homeless also pose public health challenges particularly in inner London[8].

The Turnberg Review highlighted the complexity of London's administrative boundaries, and the continuing need to rationalise acute health care, with service planning at pan-London, sector and local levels[9]. And whilst considerable progress has been made in developing the primary care infra-structure through the London Initiative Zone programme, there is still more to be done to ensure that even the most basic primary care structures and services are in place throughout London[10]. For example, London still contains a higher proportion of single handed practices (20%) than the rest of England (8.6%), and 52% of practices are still located in poor premises[9].

Although there are a number of primary care organisations such as multifunds, GP Commissioning and Total Purchasing pilots throughout London, the uptake of fundholding has been lower than elsewhere, with a few notable exceptions such as Kingston and Richmond Health Authority[11 12].

The success of an organisation in meeting its aims and objectives is influenced by more than just its structure. But the configuration process and outcome will have some impact on the speed of development and the capacity of PCGs to carry out their core functions and to respond to the particular challenges in London.

4.2 PCG Configurations: from form to function

4.2.1 Organisational development

The findings presented in this report show that the configuration process was time-consuming and complex in many parts of London. Attention to getting this right is important if these new organisations are to function both internally and externally. The relatively few appeals to Regional Offices suggest that the process was well-managed by Health Authorities and that the outcome has caused less conflict than expected given the diverse range of stakeholders involved, many of whom have no history of working together. However, it is important to remember that there was no formal right of appeal or arbitration procedure available during this time, and our survey found that six Health Authorities failed to achieve complete agreement from all their stakeholders. Whilst these stakeholders have generally accepted the PCG configuration, the degree to which their original concerns are met will affect their motivation and support for their PCGs.

Health Authorities were keen to take into account GPs' views in particular, perhaps partly in recognition that their enthusiasm must be maintained if PCGs are to work. There are examples of GPs working well together, such as in out of hours co-operatives, but in such circumstances membership is voluntary and the benefits not only to patients but to primary care staff are clear. Many GPs still remain unsure as to whether PCGs are likely to yield any tangible benefits[13], although the NHSE autumn guidance acknowledges the need for real incentives[14].

That a number of Health Authorities were able to make use of pre-existing locality structures suggests a state of evolution rather than revolution, and these PCGs may be able to achieve their tasks more quickly because they have faced less disruption. Such smooth transition, however, was not always going to be feasible. Almost all of the multifunds and nearly half of the GP Commissioning and Total Purchasing Pilots have been disaggregated and spread across several PCGs. Theoretically this could lead to wider dissemination of the skills and experience these organisations nurtured. However, disaffected GPs who had championed these pre-existing organisations may choose not to participate in PCGs, and merely be passive members in the new system.

Arguably, a "new style of leadership" is needed for the new primary care organisations[15]. But it will be important not to lose the input of those with relevant experience and skills.

The size of an organisation influences its development. Smaller Total Purchasing Pilots were more likely to achieve their objectives in the short term than larger ones, but not necessarily in the longer term[5]. Whilst the speed of organisational development and primary care development are two factors which seem to favour smaller organisations, there are several pressures to establish fewer larger PCGs. These are likely to be more efficient in terms of management costs, (which are to be capped) and are also likely to be better able to manage financial risk because of their larger commissioning budgets. The case for large purchasers in achieving effective strategic change has been made, but size is not the only thing that matters; good information, and sophisticated management processes including provider accountability are also necessary[16].

London's PCGs are within the range of population size nationally, but given the higher proportion of single-handed practices in London, there are likely to be more practices per PCG in London than elsewhere. Initially this may slow organisational development in some PCGs. They may take longer than expected to acquire some of the other characteristics necessary for effective purchasing[16 17], and to establish communication networks and support systems to promote primary care development.

As PCG boards are appointed, they will debate their organisational structures and processes. A number of Health Authorities are anticipating the development of an additional tier – either an umbrella structure to co-ordinate smaller PCGs, or sub-PCG structures to ensure local democracy within larger PCGs. This could certainly facilitate communication, but at the cost of some PCG board members spending more time in meetings at the expense of their clinical commitments. This could be a strong dis-incentive for single-handed practitioners to become PCG board members, because of their reliance on locum cover. PCGs could be innovative in addressing this by employing a pool of salaried GPs to provide regular cover[18], but this will stretch the management allowance budget of about £3 per head of population which has already been criticised as being too low[5].

4.2.2 Public health functions

PCGs' contributions to the local Health Improvement Programme (HImP) will be one way in which they can influence the health of their populations.

The PCG contribution should reflect the needs of their local population[19]. The diverse range of natural communities within each PCG was a recurring theme in London so techniques for carrying out needs assessments at sub-PCG level should be developed to ensure sufficient sensitivity to local needs. There is a growing body of literature on needs assessment in primary care[20 21], but PCG members may not wish to undertake formal needs assessment, nor have the time or skills to do so. Given the number the tasks they face, it is easy to see this slipping down their list of priorities, secondary to issues which appear to have more direct relevance to everyday clinical practice such as managing the prescribing budget or developing practice premises and staff.

Contributions to the HImP could therefore be 'back of an envelope' exercises based entirely on GPs' perceptions of their patients' needs. But leaving GPs to identify need based on those who attend theirsurgeries will mean that people with decreased access to health care services such as minority ethnic groups, refugees or the street-homeless become even more dis-enfranchised. The roles of Health Authorities in assessing the needs of their entire population and in acting as advocates for vulnerable groups will still be crucial.

Once needs have been identified, PCGs will need to develop an explicit and transparent framework for prioritising action to meet those needs. To some extent their priorities will be shaped by national guidance[22], but PCGs will need such mechanisms to manage conflict that could arise as they try to decide which local issues to target.

Our study shows that in London there are likely to be considerable variations in need between different PCG populations within the same Health Authority. Different PCGs also show variations in primary care (for example, proportions of poor premises or single-handed practitioners) which may affect their capacity to address these

inequalities effectively. Whilst the PCG structure and its inclusiveness may have removed the two-tierism of fundholding, Health Authorities will need to address inequities between PCGs if the inverse care law (those with the greatest need for health care have least access to it) is not to apply at this level. Tackling inequalities is a national priority[23]. Health Authorities may have to provide differential levels of resource and support for their PCGs if they are to make an impact on this. It may prove difficult to negotiate this if some PCGs feel that they are net losers of resources as a result.

If PCGs really are to influence the health of their populations, their members will need to work with organisations outside the health sector such as the Local Authority. Most PCGs lie within one Local Authority or are completely co-terminous with it, which partly reflects the importance given to this in the Turnberg Review[9] as well as the guidance from the NHS Executive. But it will take more than matching up borders to break down fundamental barriers such as the different cultures, languages and financial pressures that have impeded joint working between primary health and the social sector[24]. Social services members of PCG boards will need to show strong leadership. They need to be senior members of their organisations with autonomy to take decisions as required at PCG board meetings. Many Local Authorities are linked to several PCGs, so their senior/middle managers will be thinly spread. Therefore their ability to influence PCGs may be limited, and will depend on the extent to which issues outside primary care demand their attention.

4.2.3 Commissioning function

When PCGs covering populations of 100,000 were first proposed, concerns were expressed about the appropriateness of this size for commissioning purposes. There is no ideal size that is appropriate for commissioning all services[25 17], but PCGs could suffer by falling between two stools, having neither the bite of fundholders, nor the leverage of Health Authorities to implement more strategic change[26]. The London Health Authorities have shown 'relative weakness....in this environment when faced with the negotiating power of the London teaching hospitals'[9], so this will be a major challenge. If PCGs are able to capitalise on their ability to be locally responsive they

could achieve less ambitious, but tangible improvements in the quality of health care for patients. Where major strategic change in acute services is a desired objective, several PCGs will need to work together to achieve this.

Where a number of smaller PCGs are commissioning services from the same Trust, there will need to be mechanisms for co-operation and perhaps delegation of purchasing to 'lead' PCGs if Trust concerns about inefficient contracting are to be allayed. Communication and collaboration between PCGs provides an opportunity to learn from and support each other. Health Authorities will have a key role in developing these communication networks in the first place. As PCGs develop, the role of Health Authorities should change from a directive, controlling one to a facilitatory and influencing one. This will be new territory for Health Authority staff who have their own training and development needs in the new NHS[27].

Some PCGs will be more enthusiastic than others to develop their commissioning role and manage their own budget (level two). Arguably "one GP with a cheque book is worth 100 GPs on a committee"[28] and experience from TPPs suggests that ownership of the budget is a motivating factor[5]. Of ten Health Authorities, five anticipated that all of their PCGs would start at level two. In two other Health Authorities, only those with a substantial amount of fundholding or purchasing experience were likely to become level two PCGs. The tendency for GPs who already have experience of managing a budget to be more ambitious is unsurprising, and these PCGs could be expected to move quickly towards level three. But population-based commissioning is different from fundholding and they may have to spend some time 'un-learning' or 're-learning' skills appropriate for this level of commissioning. There is also the danger that these PCGs concentrate almost entirely on the commissioning role and neglect their other functions. The extent to which their Health Authority holds them accountable for overall performance will be an important check on this.

Finally, if primary-care led commissioning is to be truly responsive to the needs of the local population, PCGs will need to develop effective mechanisms to ensure public involvement in decisions that affect their health and health care services. Engaging the public has proved a hard challenge for Health Authorities. The presence of a lay member on the PCG board and the requirement to hold open meetings may ensure a

minimum level of public engagement by PCGs to begin with, but other mechanisms will need to be developed if this is not be seen as mere tokenism.

4.2.4 Primary care development and service integration

Primary care development is the challenge that PCGs are most likely to take up. Certainly TPPs were able to demonstrate changes in primary care more easily than in the secondary sector where they had much less direct control. Admittedly these changes often involved recruitment of extra staff such as Community Psychiatric Nurses, but most would argue that primary care development needs to be broader than this. One model defines four dimensions of personal, professional, practice and service development, progress in all of these being important (*Professor Patrick Pietroni – personal communication*).

Health Authorities also see the emergence of PCGs as an opportunity for primary care development and frequently identified this as an important criterion influencing PCG configuration. Health Authorities tended to cite this as one of their main reasons for having small PCGs, as it was felt that good primary care networks would be easier to develop in smaller organisations. Good communication between members requires an appropriate infra-structure and processes. The challenges of implementing the Information Management and Technology Strategy[29] so that, for example, all practices can have 'on-line' access to the latest clinical evidence, are still considerable in London. Many practices are in poor premises and may lack computers, or the training to use them.

For those Health Authorities with a large number of single-handed practices, the PCG structure does provide a means of addressing the isolation of such practitioners, should they want to engage with the new organisation. The PCG could raise standards by providing "an environment in which excellence in clinical care will flourish"[30] through peer support, sharing good practice and training for its members. Whether those responsible for clinical governance in PCGs will be able to tackle the thorny issue of poor performance at a practice level remains to be seen, since the independent contractor status of GPs remains intact and the levers for changing behaviour are still limited[31]. The effectiveness of PCGs in addressing variations in the quality of clinical care may prove to be the ultimate test for professional self-regulation.

5 Conclusion

In London some specific issues make the environment in which PCGs and Health Authorities function a complicated one:

- the diversity of the population, with scattered small pockets of natural communities
- the number and diversity of general practices
- complex acute provider relationships
- the lack of 'neat' boundaries in a densely-populated city.

Now that PCG boards have formed, and further guidance on the function of PCGs has been issued, the debate has begun to move away from the 'what' and the 'who' towards the 'how' and 'who with'. The first major tasks confronting these fledgling organisations will be to contribute to the development of the Health Improvement Programme, to participate in the forthcoming contracting rounds, to develop Primary Care Investment Plans and Clinical Governance action plans. The capacity of PCGs to address these will depend on the ability of their members to work together, the experience and skills they bring, good leadership and the links they develop with other organisations. The relationship between Health Authorities and their PCGs is of vital importance if these organisations are to establish themselves and meet their objectives in the first live year. Early successes will be important to maintain enthusiasm, and to demonstrate that the upheaval of the past few months has had some benefit for patients.

The emerging map already suggests considerable heterogeneity, with some PCGs more developed and stronger than others. For example, one PCG in Enfield and Haringey is working on its outline business plan and likely to register its intention to become a Primary Care Trust, whilst another is still trying to elect its Chair[32]. The challenge for Health Authorities and for those in primary care will be to prevent such variation becoming entrenched in PCGs. If they fail to do so, could people start choosing where to live not only on the basis of school catchment areas but also on PCG boundaries?

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APPENDIX

SUMMARY OF HEALTH AUTHORITY AND PRIMARY CARE GROUP PROFILES IN LONDON

Summary of Health Authority and Primary Care Group profiles in London

	HEALTH AUTHORITY POPULATION (USING PRACTICE POPULATION)	NO. OF LOCAL AUTHORITIES	NO. OF MAIN ACUTE HOSPITALS	NO. OF COMMUNITY TRUSTS	NO. OF MENTAL HEALTH TRUSTS	NO. OF PCGs	RANGE OF PCG POPULATIONS SIZE IN 000'S	RANGE IN NUMBER OF PRACTICES PER PCG	RANGE IN PROPORTION OF GPFH PRACTICES PER PCG (%)	RANGE IN PROPORTION OF SINGLE – HANDED PRACTICES PER PCG (%)	ANTICIPATED LEVEL OF RESPONSIBILITY
Barking & Havering	403,000	2	2	1	Provided by community Trust	5	72 – 89	16 -26	43 - 75%	35 – 74%	Not yet known
Barnet	362,000	1	3	1	Provided by community Trust	3	104 – 144	23 - 32	26 - 48%	30 - 52%	Not yet known
Bexley & Greenwich	452,500	2	2	1	Provided by community Trust	2	219 – 234	40 - 51	33 – 40%	42 – 45%	2
Brent & Harrow	455,400*	2	2	2	2	5	93 - 147	20 - 30	N/A	30 – 50%	Not yet known
Bromley	300,000	1	1	1	1	3	88 – 122	16 -25	20 – 38%	25 – 39%	1
Camden & Islington	469,600	2	3	1	Provided by community Trust	4	79 – 140	14 - 32	0 –13%	29 – 56%	1
Croydon	342,000	1	1	1	1	3	72– 142	15 –29	13 – 28%	22 – 60%	2
Ealing, Hammer-smith & Hounslow	808,300	3	3	2	2	9	64 – 129	13 – 27	N/A	31 – 72%	Level 2 likely

* Based on Census projection, not practice population

	HEALTH AUTHORITY POPULATION (USING PRACTICE POPULATION)	NO. OF LOCAL AUTHORITIES	NO. OF MAIN ACUTE HOSPITALS	NO. OF COMMUNITY TRUSTS	NO. OF MENTAL HEALTH TRUSTS	NO. OF PCGS	RANGE OF PCG POPULATION SIZE IN 000'S	RANGE IN NUMBER OF PRACTICES PER PCG	RANGE IN PROPORTION OF GPFH PRACTICES PER PCG (%)	RANGE IN PROPORTION OF SINGLE – HANDED PRACTICES PER PCG (%)	ANTICIPATED LEVEL OF RESPONSIBILITY
East London, the City & Hackney	604,500*	4	3	3	Provided by community Trust	3	177 – 229	43 - 68	14 – 63%	41 – 58%	2
Enfield & Haringey	582,900	2	2	2	Provided by community Trust	5	89 – 161	17 - 31	26 – 47%	29 – 51%	Not yet known
Hillingdon	248,000	1	2	1	Provided by community Trust	3	69 – 94	17 - 19	29 – 57%	31 – 59%	1 (level 2 for PCG with high % of GPFHs)
Kensington, Chelsea & Westminster	423,000	2	2	2	2	3	104 - 167	28 - 41	24 – 61%	53 – 61%	2
Kingston & Richmond	352,000	2	3	2	Provided by community Trust	3	74 - 161	15 - 29	76 – 93%	27 – 33%	Not yet known
Lambeth, Southwark & Lewisham	874,926	2	3	2	2	6	126 – 185	24 - 33	N/A	N/A	Not yet known (Possibly level 1+)
Merton, Sutton & Wandsworth	670,165	3	2	3	2	6	62 – 154	14 - 34	11 – 84%	5 – 52%	1 (level 2 for PCG with high % of GPFHs)
Redbridge & Waltham Forest	476,200	2	2	2	Provided by community Trust	3	128 – 177	31 - 50	48 – 56%	42 – 54%	Level 1 likely

*Based on Census projection, not practice populations

ISBN 1-85717-236-1

King's Fund Primary Care series