

doctors enabling a more precise diagnosis and more accurate titration of treatment in the long term follow up of hypertension.

George Stergiou *assistant professor of medicine*

Hypertension Center, Third University Department of Medicine, Sotiria Hospital, 152 Mesogion Avenue, Athens 11527 Greece

Thomas Mengden *assistant medical director, head of division*

Division of Hypertension and Vascular Medicine, Medizinische Poliklinik, University Clinic Bonn, Wilhelmstrasse 35, D-53111 Bonn, Germany

Paul L Padfield *consultant physician*

Department of Medical Sciences, Western General Hospital, Edinburgh EH4 2HU

Gianfranco Parati *associate professor of medicine*

University of Milano-Bicocca, Cardiology II, S. Luca Hospital, via Spagnoleto, 3, 20149-Milan, Italy

Eoin O'Brien *professor of cardiovascular pharmacology*

On behalf of the working group on blood pressure monitoring of the European Society of Hypertension

ADAPT Centre and Blood Pressure Unit, Beaumont Hospital and Department of Clinical Pharmacology, Royal College of Surgeons in Ireland, Dublin 9, Ireland (eobrien@iol.ie)

Competing interests: Various device manufacturing companies for blood pressure measuring devices, including devices for self measurement, have funded the costs of validation studies done by EOB over the past 10 years; the results of all such research have been published in peer reviewed journals.

- 2003 European Society of Hypertension-European Society of Cardiology guidelines for the management of arterial hypertension. Guidelines committee. *J Hypertens* 2003;21:1011-53.
- Seventh report of the Joint National Committee on prevention, detection, evaluation, and treatment of high blood pressure. *Hypertension* 2003;42:1206-52.
- Williams B, Poulter N, Brown M, Davis M, McInnes GT, Potter JF, et al. The BHS guidelines working party, for the British Hypertension Society. British Hypertension Society guidelines for hypertension management 2004 (BHS-IV): summary. *BMJ* 2004;328:634-40.
- O'Brien E, Asmar R, Belin L, Imai Y, Mancia G, Mengden T, et al. on behalf of the European Society of Hypertension working group on blood pressure monitoring. European Society of Hypertension recommendations for conventional, ambulatory and home blood pressure measurement. *J Hypertens* 2003;21:821-48.
- Thijs L, Staessen JA, Celis H, Fagard R, De Cort P, De Gaudemaris R, et al. The international database of self-recorded blood pressure in normotensive and hypertensive subjects. *Blood Press Monit* 1999;4:77-86.
- Tsuji I, Imai Y, Nagai K, Ohkubo T, Watanabe N, Minami N, et al. Proposal of reference values for home blood pressure measurement: prognostic criteria based on a prospective observation of the general population in Ohasama, Japan. *Am J Hypertens* 1997;10:409-18.
- Ohkubo T, Imai Y, Tsuji I, Nagai K, Sakuma M, Watanabe N, et al. Home blood pressure measurement has a stronger predictive power for mortality than does screening blood pressure measurement: a population-based observation in Ohasama, Japan. *J Hypertens* 1998;16:971-5.
- Bobrie G, Chatellier G, Genes N, Clerson P, Vaur L, Vaise B, et al. Cardiovascular prognosis of "masked hypertension" detected by blood pressure self-measurement in elderly treated hypertensive patients. *JAMA* 2004;291:1342-9.
- Cappuccio FP, Kerry SM, Forbes L, Donald A. Blood pressure control by home monitoring: meta-analysis of randomised trials. *BMJ* 2004;329:145.
- Pickering TG. Self-monitoring of blood pressure. In: *Ambulatory monitoring and blood pressure variability (part 1)*. Science Press: London, 1990:8.5.
- Parati G, Stergiou G. Self measured and ambulatory blood pressure in assessing the white coat phenomenon. *J Hypertens* 2003;21:677-82.
- Verdecchia P, O'Brien E, Pickering T, Staessen JA, Parati G, Myers M, et al. on behalf of the European Society of Hypertension working group on blood pressure monitoring. Statement from the working group on blood pressure monitoring of the European Society of Hypertension. When can the practicing physician suspect white coat hypertension? *Am J Hypertens* 2003;16:87-91.

Primary care trusts

Premature reorganisation, with mergers, may be harmful

Just over two years ago, in a reorganisation of the NHS in England, 303 primary care trusts were created, each with responsibility for providing primary health care, improving health, and commissioning secondary care services for a population of around 180 000. With about 80% of NHS funding flowing directly to primary care trusts on a capitation based formula, hopes were high that these new organisations would be powerful agents for change in a more devolved, clinically driven, and locally responsive NHS.¹

Some in the NHS, however, believe that primary care trusts have failed to fulfil these expectations. There is a growing belief that many trusts are perhaps ineffective organisations—too weak to stand up to providers of acute care in tough negotiations on commissioning and too small to fulfil their public health responsibilities. Some would argue that they have so far been unable to establish strong and credible management teams.²

The unsurprising solution being mooted is a further reorganisation, in which widespread mergers of primary care trusts would reduce their number to 100-150 across England.³ Coincidentally, that is roughly how many health authorities existed before they were abolished and primary care trusts were created to take on many of their responsibilities.

Although a moratorium of sorts on wholesale organisational restructuring has been in place for the past two years in the Department of Health, some primary care trusts have already been merged in all but name. Strategic health authorities have organised them into "clusters" and appointed joint management teams.⁴ In 2005—after the next election—we expect an epidemic of mergers of primary care trusts.

So what would these mergers achieve? We have no good evidence to show that a structural reorganisation of primary care trusts would bring benefit to patients. It would lead to a distraction from the real tasks at hand such as developing clinical governance and new forms of management for chronic disease; implementing new incentive structures, such as practice based commissioning, to improve coordination of services and deal with poor morale; and using new policies such as payment by results and choice for patients as a lever for developing services that are more responsive to local people.⁵ Primary care trusts have so far made some progress, but they have important problems to tackle.^{6,7} The growing and somewhat self fulfilling beliefs that they are not fit for their purpose in the longer term and that structural reorganisation would bring improvement deserve to be challenged.

Firstly, primary care organisations do not have one right size and configuration. The advantages of being big for managing risk and exploiting economies of scale in management clash with the advantages of being small, close to primary care, and adaptable to local needs.⁸ However, many primary care trusts already struggle to secure clinical engagement and support among general practitioners because of their size and the number of practices they cover. Larger primary care trusts would seem more remote and bureaucratic to clinicians. Securing clinical involvement and leadership are crucial to the success of primary care organisations as providers and commissioners and to developing practice based commissioning.^{9 10}

Secondly, although primary care trusts have not yet had time to become effective negotiators in their commissioning relations with acute care providers or to develop their planning and purchasing capacity, we have no evidence to show that the old health authorities that were larger than current primary care trusts were any better at commissioning.¹¹ We know that flexible arrangements are needed to let commissioning take place at different population levels, depending on the nature of the service.¹²

Thirdly, although management teams of primary care trusts are still immature and inexperienced, this will resolve over time. The rush to reorganise and merge fails to recognise that many primary care trusts are already developing creative and flexible arrangements for the sharing of expertise and functions with neighbouring trusts.¹³ Countywide or citywide networks for public health, commissioning arrangements, shared senior executive posts, and agencies to provide support services are examples of such innovation. These are happening in response to local need—not prescribed from above by strategic health authorities or the Department of Health.

Reorganisations are a clumsy reform tool, and research shows that they seldom deliver the promised benefits. Every reorganisation produces a transient drop in performance,¹⁴ and it takes a new organisation at least two to three years to become established and start to perform as well as its predecessor. Yet the NHS is reorganised every two years or so, which probably means it sees all the costs of each reorganisation and few of the benefits. In a truly devolved NHS that is clinically driven and locally responsive, top down reorganisations should become outdated. To propose making major structural changes to primary care trusts is premature. What they need instead is the space to work on implementing current policy initiatives and seeing their effects, building relations in local healthcare communities, and securing much needed clinical engagement and improvement in

service. The Department of Health and NHS managers should resist the temptation to reach for the old panacea of reorganisation.

Kieran Walshe *professor of health policy and management*

University of Manchester, Manchester M13 9PL
(kieran.walshe@man.ac.uk)

Judith Smith *senior lecturer*

University of Birmingham, Birmingham B15 2RT

Jennifer Dixon *director of health policy*

King's Fund, London W1G 0AN

Nigel Edwards *director of policy*

NHS Confederation, 1 Warwick Row, London SW1E 5ER

David J Hunter *professor of health policy and management*

Wolfson Research Institute, University of Durham, Queen's Campus, Thornaby, Stockton on Tees TS17 6BH

Nicholas Mays *professor of health policy*

London School of Hygiene and Tropical Medicine, London WC1E 7HT

Charles Normand *Edward Kennedy professor of health policy and management*

Trinity College Dublin, 3-4 Foster Place, Dublin 2

Ray Robinson *professor of health policy*

London School of Economics and Political Science, London WC2A 2AE

Competing interests: All authors have been involved in health policy development and evaluation as researchers, analysts, or managers over recent years—including undertaking work with and for the Department of Health and NHS organisations, on the development of primary care policy and primary care organisations.

- 1 Department of Health. *Shifting the balance of power within the NHS: securing delivery*. London: DoH, 2001.
- 2 Gould M. Merger pressures on primary care trusts threaten to blur local focus. *Health Serv J* 2004;114:10-1.
- 3 Walshe K. Foundation hospitals: a new direction for NHS reform? *J R Soc Med* 2003;96:106-10.
- 4 Clews G. Primary care trusts chiefs lose jobs in merger programme. *Health Serv J* 2004;114:6-7.
- 5 Smith J, Walshe K, Hunter D. The reorganisation of the NHS. *BMJ* 2001;323:1262-3.
- 6 NHS Confederation. *Making a difference: how primary care trusts are transforming the NHS*. London: NHS Confederation, 2004.
- 7 Commission for Health Improvement. *What CHI has found in primary care trusts: sector report*. London: CHI, 2004.
- 8 Bjork C, Gravelle H, Wilkin D. Is bigger better for primary care groups and trusts? *BMJ* 2001;322:599-602.
- 9 Smith J, Walshe K. Big business: lessons from the corporatisation of primary care in the United Kingdom and the United States. *Public Money Manage* 2004;24:87-96.
- 10 Lewis R. *Practice-led commissioning: harnessing the power of the primary care frontline*. London: King's Fund, 2004.
- 11 Robinson R, Le Grand J. *Evaluating the NHS reforms*. London: King's Fund, 1994.
- 12 Smith JA and Goodwin N. *Developing effective commissioning by primary care trusts: lessons from the research evidence*. Birmingham: Health Services Management Centre, University of Birmingham, 2002.
- 13 Edwards N, Woodford C. *Meeting the challenge: primary care trusts and integrated management models*. London: NHS Confederation, 2004.
- 14 Lamont BT, Williams RJ, Hoffman JJ. Performance during "M-form" reorganisation and recovery time: the effects of prior strategy and implementation speed. *Acad Manage J* 1994;37:153-66.