



WHO OWNS THE STRATEGY... THE MANAGERS OR THE CLINICIANS?

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During a discussion about World Class Commissioning, a GP Chairman of a well developed practice based commissioning group (PbC) was reflecting on the continued gulf between those in the know (the Board and senior managers in the PCT), and the clinical community and public at large. PCTs have worked hard to produce good Strategies for improving the health of the local population, but the contents seem to be mainly owned by the top of the organisation and have failed to excite, or even be seen as relevant to the people who will implement the changes. Even the PEC and the PbC Chairs are not always consulted about the priorities. My colleague was asking if flatter structures and increasing guidance from the top (the DH and SHAs) is making local leadership obsolete.

There is evidence, popularized by James Surowiecki in his book *The Wisdom of Crowds*, that a lot more people have useful insights and ideas than just the few at the top. In fact, the 'crowd' (in the case of the NHS, clinicians and users of services) may collectively have significantly more ideas and wiser judgments than experts

alone. So what does that say about the legitimacy of the Board and also who should own the Strategy if it is to be implemented and not just sit on a shelf? As I recall, the opening anecdote in the book talks about how a crowd at a county show did a better job of accurately estimating the weight of a cow than did the proverbial panel of experts. This knowledgeable and interested crowd's individual guesses, when averaged, came in very close to the beast's true weight. Closer to the actual weight, in fact, than were any of the individual opinions of the cattle "experts" on hand.

This says a lot about the wisdom of the collective, but the outcome should come as no surprise to anyone trying to make progress with health commissioning. Occasionally involving large numbers of people and inputs can go wrong (when a majority is misled by a bad leader, self interest, poor information or fear of change), but it is still the best way to make decisions. When everyone is focused on the right outcome, especially if there is good use of evidence and clinicians, managers and patients all have an opportunity to input into the process, it is hard to beat.

This country fair example, however, also says something significant about the need for leadership from the top, even when the crowd is wise and fully engaged. Think about it ... somebody had to decide to run the process and pick the cow. Somebody had to gather and organize the crowd, set up the 'rules of engagement', and establish the structure that juxtaposed those cattle experts with the crowd. That organisation came from the leader and their team. This does not by any means make illegitimate the crowd, the individuals in it and what they bring to the table. Clearly, they need to have their knowledge plumbed and voices heard. However, at a certain point, somebody had to shape the agenda and circumstances within which the others were acting, and maybe even moderate the most extreme views.

The answer therefore is that to have a good NHS strategic direction we need both leadership and experts engaged in the process. Clear clinical and managerial leadership in the PCT and primary care needs to work together with the public whose behaviours will ultimately dictate whether any changes occur. The Board should set the parameters and create the conditions within which the wider health system will apply its wisdom, knowledge and efforts. The communications between the two groups needs to be open and fluid so that information, ideas, and insights can flow -- so that one can inform the other.

Good NHS strategic direction needs both leadership and experts engaged

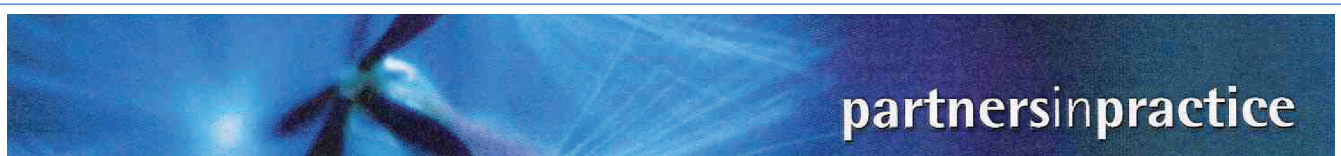
I don't think we will ever evolve to the point where there is no need for top level leadership in the NHS, as this would be a time when no further changes to health were needed or envisaged. We have, however, matured to a stage where decisions are supported by good information technology, but leaders still need to vigorously seek out and hear the views of the people they lead and the users of the services they commission for. Good strategy development is both a science and an art and most PCTs are getting quite good at the technical stuff but still need a lot of support with engaging with and exercising influence over how, where and when to

implement change. Where there is ownership of the strategy and plans and patients have confidence in the new services, we have seen real cost benefits and improved access to services. Unfortunately, where change has been top down, costs often escalate, as new services are underutilised and patients continue to be referred as before.

Many top performing PCTs and PbC consortia have invested in support from a good management consultancy, such as Partners in Practice (www.partnerinpractice.co.uk) to take them through a structured process of engagement leading to the

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