Conversation Piece – The Chairman of a Health Board

Mr R.B. Weatherstone was, until recently, Chairman of the Lothian Health Board, 11 Drumsheugh Gardens, Edinburgh EH3 7QQ. This conversation took place before the conclusion of his term of office.

DR P.D. WELSBY: Mr Weatherstone, you were appointed Chairman of the Lothian Health Board for 4 years after a successful career as a Director of Christian Salvesen. Who appoints the Chairmen of Health Boards and what general criteria are used in their appointment? MR R.B. WEATHERSTONE: The Chairmanship of a Scottish Health Board is termed 'a part-time paid appointment'. The Honorarium paid is based on the assumption that we devote one-third of our time to the appointment but in practice we, inevitably and quite happily, get drawn into much more than that. Changes will occur both in remuneration and commitment by 1991.

The Chairman is appointed by the Secretary of State for Scotland to chair the Board. The Board acts as the agent of the Secretary of State and carries out his duties for the provision of health services within its area.

Criteria for these appointments are not published, but from a reading of agreed 'Functions and Responsibilities of Chairmen' I would say that the following requirements are likely: developed and proven powers of leadership and chairmanship; a true understanding of the word 'care'; sufficient numeracy to understand financial policies and monitoring; capacity to adapt to the much larger scale of Health Service finance, employment and problems; an understanding of people and human nature; a capacity to command the respect of, and successfully lead, a very mixed workforce – from cleaner to consultant; and of course considerable stamina.

These are but a few – and one more I would personally add – 'the ability to exercise the self-discipline necessary to allow the Board's chief executive and his team to manage' – a chairman must remember he is non-executive.

PDW: In what ways does a Health Board differ from a 'big business' concern?

RBW: Since the introduction of the principle of General Management there has been a gradual move by the service towards structures and philosophies adopted by the business sector. With the introduction of a Chief Executive for the Health Service in Scotland I would expect to see greater impetus given to this movement. I hope to see more emphasis placed on 'retrospective' rather than 'prospective' accountability. The former will encourage managers to work out 'how' to achieve 'what matters' having regard to certain 'guidelines' bearing in mind their local circumstances and not forgetting the 'rewards' and 'penalties' of success or failure. The latter was the practice of the civil service or colonial service of the past in which managers were told what the objective was, how to achieve it, what part each would play and by when it should be achieved.

The move to 'capital accounting' contained in the White Paper *Working for Patients* will itself bring the service more in line with business accounting and financial practices.

The things we have in common with 'big business' are numerous. One important factor relates to manpower planning and personnel policies where both sectors must

make supreme efforts to cope with the demographic problems of the future. Another similarity is the commitment to making the 'customer king' or, in the Health Service world 'putting patients first', and quality assurance issues generally are high priorities in both spheres.

There are of course fundamental differences between running a business and running a Health Board. For example, the purpose of the NHS is not to generate profit: it is subject to greater political and public pressures than businesses and has less overall autonomy.

PDW: Are doctors difficult to manage? If so in what ways?

RBW: Your question suggests that somehow doctors are 'difficult' and therefore more difficult to manage than 'others'. I would agree that you can be a bunch of 'prima donnas' – but that does not make you difficult to manage. It does, however, mean that managers must adapt their skills to suit the particular group for whom they are responsible. Quite naturally you develop an application of your sapiential skills that depends for its success upon a very personal, confidential relationship with your patient. This in turn encourages the development of a very strong feeling of independence – or rather individualism.

It was a challenge to me – and those charged with the introduction of general management – to discuss with you – in groups and individually – the difference between professional responsibility and line management responsibility. We seem to have achieved a fair degree of success when we see the extent to which you are participating in general management today.

Yes, you are different – but please don't change – the strength of the service depends to a very great extent upon what you are. It is up to the managers to make the adaptation.

PDW: Doctors by and large have security of tenure whereas non-medical managers are on term contracts. Do you think that this makes doctors more liable to be outspoken than perhaps they should be – and the managers less outspoken than they should be?

RBW: Your statement with regard to security of tenure is factually correct – but I would hate to think that this factor featured highly in the influencing of individuals when confronted with problems to resolve. Successful progression in management depends a lot upon leadership in the exercise of which initiative plays a large part. If a manager fails to 'speak his mind' he is unlikely to attract the attention of his superiors – it is rather the quality of what he says that matters than the way in which it is said. It may be that some adjustments to contracts will come in the future – but I do hope that those will have no influence on the exercise of initiative or on the 'outspokenness' of both doctors and managers.

PDW: Consensus management after the gathering of reams of written advice, mostly contradictory I suspect, has been the style of health service management in the past. Do you think that this era is coming to a close?

RBW: Briefly yes (I think I have covered this in reply to your second question).

PDW: Are Board decisions independent or are opinions of 'external bodies' communicated behind the scenes? Obviously the discussions at Board meetings should be

confidential but in the real world decisions made are often known to the media soon after meetings (a problem that also faces the government!). Does this not make your role rather difficult?

RBW: The first part of your question relates to the confidentiality of Board meetings. We in Lothian have examined the conduct and agenda of our Planning and Resources Committee, our General Purposes Committee and our Board – all of which were held on different dates, the Board being the only one open to the press and public. Our first step was to hold all three meetings on the same day which we now have now successfully been doing for a year. We are trying to increase the number of items that can be placed on the Board (public) agenda and reduce to a minimum those that *must* remain private. We might subsequently be able to re-organize the committee structure to reduce the number of items requiring total confidentiality and reduce the possibility of security leaks.

The second part of your question relates to the *accurate* communication throughout the Board of its important decisions as quickly as possible following a Board meeting. With the system of Team Briefing recently introduced this should be capable of achievement within 7 days – right round the whole Board area and covering every one of our 20,000 or more employees.

PDW: Chairmen of Health Boards are not known for criticizing government policy publicly (whereas some doctors seem to do nothing else). Why is this?

RBW: Let the doctors answer for themselves – the recent comments of some doctors have not always been in the best interests of you all.

In view of the relationship existing between the Chairmen and the Secretary of State which I described previously it would be quite wrong for us to indulge in such public criticism.

PDW: No doctor of any intelligence would deny that there has been inefficiency in the past. Obviously vast savings have been made without (as far as the public experiences it) cuts in service: were we monumentally inefficient?

RBW: Clearly there is room for greater efficiency in the NHS and it is vital that every penny that could be spent on direct patient care *is* spent on this. This is why we have a duty to ensure to continue to examine our organization and working practices critically to ensure that public money is being well spent. I do not think it would be fair to say that the NHS has been monumentally inefficient but I do think we needed, and still need, to bring our work practices up to date and to continue to root out inefficiencies, waste and duplication of effort. In the

Lothian Health Board alone, competitive tendering exercises for a variety of ancillary services have freed over £3.3 million a year so far: this is a lot of extra money for direct patient care activities.

PDW: The Health services seem to undergo a reorganization every 5 to 10 years or so. Doctors are often cynical about such exercises. Do you think that such reorganizations are in fact essential to avoid stagnation?

RBW: Health services in Britain have developed and changed enormously since 1940, as has society itself, and local and national government. It is vital to the success of an organization that it can change and adapt in response to changing circumstances or where there is a clear need for restructuring. Changes of this sort are naturally unsettling for those working within an organization and cynicism or fear of what the future may hold may well arise. My own view is that a healthy, dynamic organization must be able to examine the way it works and make changes where necessary.

The changes in the NHS over the last 15 years or so have seen the unification of health services, the streamlining of the organizational structure, and the introduction of general management. I believe that these changes have generally been desirable and vital to the development of the service.

We are now on the brink of further changes which will lead us forward into the next century and will enable the NHS to provide the customer-orientated services the population demands.

PDW: The costs of medical technological developments and treatments is obviously going to increase at rates far above that of inflation. Obviously no government could pass on the bill directly to voters and get re-elected. Do you think this is the reason why the government is attempting to get the doctors to control the spending by giving them control of budgets by (and this is important) limiting the budgets?

RBW: I do not believe that the idea of giving doctors control over budgets was prompted by a desire to limit spending covertly.

If you want to ensure that patient care money is spent as wisely and efficiently as possible you must evolve budgetary control to those working 'at the coal face', i.e. those who make the crucial decisions which directly affect expenditure. The NHS has always worked within a fixed annual budget and choices have always had to be made between competing demands for resources. Doctors must be fully involved in the decision-making process if the right choices are to be made. That is why giving doctors control over their budgets is so vital.