

GOING PUBLIC IN PERSONNEL – IS THERE A DIFFERENCE?

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“People are our most important asset” is now a cliché in most corporate statements. In many organisations, however, people are viewed as an operating cost and not a major corporate resource or investment. But in the NHS, more than in any other sector in which I have worked, these words about people as the most important asset really are appropriate to the way in which patients’ demands are met. Joining the NHS for the first time in February 1992 from “outside”, I was invited to set out some initial thoughts on my perception of the differences and similarities from a Personnel point of view.

One immediate difference is that the public sector has not, up to now, had to cope with the pace of contraction which has been such a hallmark of the industrial environment in recent times. In many respects, the NHS has been sheltered from such harsh realities; security and a “job for life” has been expected. Unfortunately, growing competitive pressures in the NHS market place and Treasury constraints are unlikely to preserve that distinction in the longer term. The Tomlinson report may become only one of a number! Increasingly in the private sector, people expect to move on; many do deliberately to enhance their experience and hence their “marketability”. But this does not apply in the NHS which currently seems to institutionalise the long service stay. Career structure secondments outside the chosen professional area are not readily available. In fact, one remarkable NHS feature is that despite major technological and organisational change, little has happened to the number and boundaries of the health care professions. Its framework of hierarchical, professional lines does offer a sense of compartmentalised interests rather than a corporate view.

Another major difference to my mind lies in the calibre of information systems, particularly those allied to costing and control. (Working for GEC might have given me a skewed perspective; here, key ratio analysis was a cornerstone of business activity). It strikes me that financial controls are still very broad. In industry, particularly on a production line, cost saving on materials, processes, logistics and labour has become second nature. In the NHS, this philosophy of operation is not at the core of its activity. Yet anecdotal and audit evidence suggest that it is in “pockets” that much of the inefficiencies are to be found; their identification and known size is the key to releasing their resources for use elsewhere.

Public accountability is, of course, another area of stark contrast between the two sectors. Politics and public relations are not so apparent in mainstream industry. Government intervention and the influence of such as Pay Review Bodies is less. Greater autonomy is evident even in large organisations. There will never be enough money it seems in the NHS to meet all needs; as a result, choices have to be made, promoted and defended. The “national” nature of the Health Service, too, even under Trust status suggests a

homogeneity of activity; there are, for example, a number of nationally prescribed initiatives. Externally, business is shaped by the markets it serves.

Activity, too, seems very much driven by the 12 month budget cycle. True, the private sector environment is similarly a hostage to year-end results and the “beauty contest” for shareholders. Opportunities for strategic thinking in the NHS, however, appear limited. Investment monies are not readily available, far more time is spent talking about funding (or should I say about the lack of it) than I experienced in the private sector.

Marketing of services is a concept only now gaining a hold in NHS thinking, demand driven as it has been for many years. Research of customer requirements and tailoring of activity to match these was only effectively triggered by the recent NHS reforms. In most of the private sector, it is the way of life. It must be acknowledged, however, that opportunities to increase market share are limited in the NHS.

Stephen Bevan in some recent work on staff turnover and retention described the concept of inner marketing; an “emotional bonding” to the organisation¹. Communication, unsurprisingly, is perceived as the key. In the last decade, driven by the vagaries of the labour market, perhaps, major businesses have put a lot of time and effort into regular company-wide briefings and information exchange; “top teams” talking to the “shop floor” about levels of sales, company achievements, difficulties and business plans. The Japanese management model has exerted a pervasive influence here in recent times, allied as it is to the whole focus on quality. This approach could be introduced in the NHS but so far it has not become integral to day to day activity.

Other communication symptoms spring to mind. Committees and meetings seem to flourish in the public sector; decision taking tends to slow up as a consequence. Performance monitoring and feedback is not as yet an embedded concept, restricted largely to a small senior group. Staff training and development hold very much a Cinderella status; resources to match the demands of a multi-million pound people-led service provision are meagre by any standard. The profile of Health and Safety is also low and it is not well supported.

I could not end any description of differences without a mention of merit awards for consultants. The intention is not to offer any value judgement on the merit award concept. Present merit award practice is, to put it simply, a truly alien concept to the private sector. I do not know of any major corporation head handing many millions of operating turnover to one discrete employee group without exercising

full control over its final allocation and the yardstick used to determine the allocation.

Most of the above issues revolve around differences in organisational structure and cultural background. It is not surprising to find that many of the mainstream personnel issues are identical in both sectors. Development of people skills continually demands attention. Appraisal discussion, selection, communication, team-building, leadership, negotiation, delegation, discipline and grievance-handling are all part of each manager's duties. A sense of "commercial awareness" in senior and middle management groups in whatever discipline is essential. There must also be a clear commitment to quality. Performance must be linked to organisational objectives and needs; strategic thinking should offer a route map with a clear destination in mind, the occasional detour permitting.

Trusts have limited experience, as yet, of manpower planning, local reward strategy development and pay negotiations. But this also applied in industry when a number of large corporations chose to decentralise bargaining to plant level in order to increase flexibility and to focus on local concerns. It is essential that fair and reasonable treatment of people remains a common aim. Trades Unions and staff representatives will continue to influence the industrial relations environment in the UK in this regard.

Without doubt, the NHS has tremendous strengths. The plan must be how to take on board some of the private sector attributes without impairing those strengths.

A potential model is offered by Drucker² who sees the typical large business 20 years from now styled on a hospital-based structure; largely composed of specialists who direct their own performance through organised feedback from customers, colleagues and headquarters. His perception is one of a shift from the command-and-control organisation; the organisation of departments and divisions to the information based set-up; the organisation of knowledge specialists. Certainly, the focus seems to be moving very much to the development of a "site-based" culture, a particularly fashionable concept since it was legitimised through "In Search of Excellence"³. The "Trust movement" within the NHS seems to fit with this concept quite neatly.

Issues associated with the NHS reforms and the skills to succeed in the new "marketplace" have parallels with the organisational and culture restructuring which went ahead in the financial sector, prompted by deregulation. Figure 1, borrowed from David Smith's article, maps out the transition from the "old" to the "new"⁴. The accent is on wide-ranging business skills; effective management for both the present and future climate; better techniques for diagnosing and tailoring training and development needs exposed as a result of the change.

However unpalatable the NHS must break away from past traditional practices where these are no longer appropriate, if it is going to attract and keep the right blend of skills and capability. The "boom" years in recent times sandwiched between two recessions has altered the contractual relationship. A lifetime career promise is no longer available in most private sector organisations; indeed there is far more emphasis now upon employees managing their own careers, involving increased mobility and, perhaps, two to three careers paths. Commercial vagaries have spawned new attitudes about who should stay in an organisation, when they should leave and for what reasons.

ASPECTS OF MANAGEMENT IN BUILDING SOCIETIES	"OLD" SYSTEMS (APPROPRIATE FOR STABLE CONTROLLED ENVIRONMENT)	"NEW" SYSTEMS (APPROPRIATE FOR DYNAMIC COMPETITIVE ENVIRONMENT)
(1) Objectives	Social	Commercial
(2) Key tasks	Administration	Business Development
(3) Promotion and power	Seniority, general skills and experience Internal promotion	Expertise, specialisation and training. More external recruitment
(4) Structure	Centralised and bureaucratic	Decentralised and flexible
(5) Planning	Short-term, based on tradition	Long-term, based on research
(6) Decision Making	Rules and regulations	Greater personal initiative
(7) Relationships	Status and individual roles	Job content and teamwork
(8) Appraisal systems	Based on effort, loyalty and criticism of mistakes	Based on performance, results and praise
(9) Staff attitudes	Loyal and proud of the Society	Hopefully the same
(10) Employment	Secure, well paid, successful and caring	Striving for achievement to ensure success, whilst still caring

Figure 1 - Changes in Organisation Culture and Design

There is an expectancy that things will now be different in the NHS; there is a task to be done to convince cynics that this is the case. Changes in the external competitive environment do demand professionalism in outlook and practice throughout. Central prescription of payment systems, pay levels, job descriptions and allied constraints is being devolved and has to be absorbed locally. "Fresh blood" should be introduced to ferment the change.

The personnel agenda in the NHS is immense. In a number of respects, it has some catching up to do with initiatives which have been around "outside" for some time. Fundamentally, though, all organisations depend on the calibre of their employees and in this respect the NHS is well placed to succeed.

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