Making change happen in land that time forgot

James Quinn, managing director of Meridian Productivity, talks to Carol Harris about the company's work with NHS trusts and the criticisms and controversy it has generated

When you're going into an NHS trust, what are you aiming to do?

Our first aim is to identify what opportunity there is; we're the only measure of real activity and costs. Generally, we spend three weeks analysing right down to the daily level – activity and utilisation and, ultimately, value for money.

Primarily, we focus on patient activity – on the kind of level of service given in terms of volume and also, to a certain extent, in terms of quality to the client. We analyse whether the organisation has the right service; and the right service for us is measured in terms of quality, quantity and costs.

From that, we look at whether we can put together a programme to help the organisation give their patients and clients a better service; at how we can improve the patient contact; at how can we improve the local health economy; and at how can we improve the value for the money that the organisations are spending.

What qualifications do your staff have?

Our people come from a huge variety of backgrounds. We have a number of accountants, a couple of scientists and a medical microbiologist; we also have a number of engineers, while in the past we had an ex-dentist and a couple of former nurses.

The one thing that all of our people have in common is the ability to work at all levels, with many different kinds of people. I think nearly everyone in the organisation is a graduate.

Have many of your staff ever worked in the NHS?

Not many, no. We see our opportunity and our business as making providers as fit for purpose as possible – not in a theoretical 'fit for purpose, let's tick some boxes on process'way – but to make them as effective as possible at delivering the most appropriate patient service for the most appropriate cost, which at the moment is just not happening.

Community services, he believes have often been overlooked. 'The investment in IT, infrastructure and the tools to help people deliver the service at the frontline have all been sadly neglected.'

We look at demand, activity and utilisation of resources. We're saying that there's an opportunity to increase the patient focus by taking staff away from other things that are diverting them from patient time.

Now, if there was huge demand and shortages everywhere, we would have people being readmitted to hospital constantly because of waiting times for treatment. But the fact of the matter is, there isn't. We're actually coping with the demand, and we're coping with the demand with very, very low efficiency and very low utilisations.

So what's your solution?

To give the frontline managers the tools to manage the cases, to look at what's coming in, to assess patient need, and to turn that around and assign tasks in a practical way to the most appropriate people with the most appropriate skill mix; the teams should also be of the right size.

This goes back to having the right people, in the right place, at the right time. Fundamentally, the clinical expertise comes in from the clinical experts. We do not set the benchmarks and we don't set the standards. We do all of our work through what we call project improvement teams.

We take people within the organisations, from health care assistant level right up to community nursing band 8 level. And we work through the processes of analysing information and data, and setting the categories, the times, the standards and the clinical outcomes.

I have to comment, that previous articles in the press have been disingenuous to the hundreds of health visitors and district nurses who have worked through this programme, who have set these agendas and tasks, and set these absolute clinical related and planning episodes for their trust colleagues.

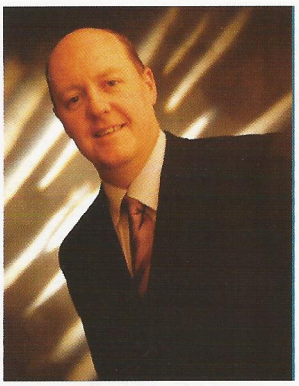
So is it about time and motion?

We couldn't say, actually, that a certain task will take you 12 minutes, and everyone's going to be measured against 12 minutes. That would be nonsense. The one thing we can't ask, and the one thing that is a leap of faith for everyone, is: what

is the unmet need? Nobody yet has come up with a magic formula to measure unmet need.

How do you measure protection, and how do you measure value for money? That is a difficult issue. Ultimately, if your district nurses set targets for getting back to patient facing activity at say 75% of their time, well as a matter of course, health visiting would be about 10% lower at 65%.

Now, in a private industry, 65% pro activity would not be very acceptable. But we're seeing some situations of 50% or 40% client contact. So if you move those up to the 65%, that still gives a huge leeway for the unscheduled, unplannable, unforeseen issues that will come up.



We don't make recommendations; we look at the process, the right resources and the right place to develop in the right sense.

The outcome of our work is to give clinical management the tools and the processes to enable them to put their hand on their heart and say that they can plan and schedule a proper service.

What we're saying, in terms of any new evolution within primary care in the community, is that we're giving and hopefully working with the teams to allow them to say, right, we need a specialist team here; it will be of this size, it will be of this skill mix, it will be of this quality – and then allow them to set that up.

How do you, as a team leader, get Mrs Smith, who on average has done two visits a day for the past five years, to look at her work differently, and to spend more time in practice?

So, all around, it is the best value. It is actually about the best treatment and the best care that we can give to the patients. It's not about the stash in the bank!

You say a lot of healthcare professionals that you've worked with are very happy with the work you have done with them. So why are so many others unhappy?

People don't like change, and people don't like being inspected, and people don't like practices being reviewed. It's about how, to a certain extent, and let's be honest about it, things suit them. We're looking at increasing activity because everything we do is based on increased activity; it's not based on reducing activity.

Our work is based on giving clients and patients more facing time with the clinical specialists – whether it be a nurse, a podiatrist or a therapist – and that's what it's about.

We are trying to look at the process of change and that puts people out of their comfort zone as this process is always difficult. That's what we're here to help the trusts do, which is why we don't just write a report and throw it across the table.

We're implementing change in giving the trusts and frontline management support – and that's where the costs come from, no question.

Our work is about developing the processes with the frontline people. We spend an enormous amount of time with team leaders and managers, helping them through that process, dealing with confrontation skills.

For example, how do you, as a team leader, get Mrs Smith, who on average has done two visits a day for the past five years, to look at her work differently, and to spend more time in practice?

Are you really saying that anyone who disagrees with you is wrong?

We're saying that there is a lot of gossip and hearsay, and what we deal with is statistics, which are real, so we deal with fact. I'm not saying that people are wrong.

I'm saying that people have a perception of what makes them busy and what makes them not busy. But also, the thing you've got to remember is that there's a huge inequity in workload, and this is why working with staff side is so important.

And there are some people, I would think, who are working in an unsafe environment.

Sir Derek Wanless has recently said that organisations like yours have been getting the extra money given to the NHS, instead of it going towards direct patient services. How do you respond to that?

Wanless is absolutely right; billions of pounds have been spent on lots of theoretical modelling. But we will spend up to £35,000 on a study at our cost, to see what opportunity is there, and if we can't find the opportunity (to maximise patient contact) we walk away from it.

We have occasionally walked away – in the case of three of the 37 trusts we have worked with, one of which was Gwent.

We reasoned that the opportunity was probably too difficult to capture and that it would cause too much upheaval.

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We're not talking about innovation and we're not talking about revolution; we're talking about basic fundamental good practice, and that's what makes us angry.

If you look at the Wanless report, I honestly think that a lot of money spent on innovation has been wasted. For example, community services is, to a certain extent, the land that time forgot. The investment in IT, infrastructure and the tools to help people deliver the service at the frontline have all been sadly neglected.

Every single thing we recommend is about how can we optimise the client interface, and I know that I sound like a great evangelist, but that's what our business is about. The core to it is about increasing the contact. Spend an extra few pounds and you'll get a better utilisation and a better service for your clients. It's not rocket science but then nothing we do is rocket science. It's fundamental management practice.

We would be interested to hear about members' experiences with, and views on Meridian Productivity, be they positive, negative or otherwise. Contact carol.harris@tenalpspublishing.com