

# **The Productive Ward:** *Releasing time to care™* *Learning and Impact Review*

Final report

June 2009



# Acknowledgements

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We would particularly like to thank NHS staff working at the five case study sites that participated in the review for sharing their experiences of The Productive Ward: *Releasing time to care*<sup>TM</sup>.

## Research partnership

**T**he NHS Institute supports the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and world class leadership. **Helen Bevan** at the NHS Institute commissioned the review presented here. **Lizzie Cunningham** and **Lynn Callard** provided data about the uptake of The Productive Ward programme and supported liaison with NHS staff.

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The review team liaised with researchers who were undertaking a review of The Productive Ward programme for NHS London at the same time as the present review, and researchers working on The Productive Ward benchmarking study at the NHS Institute to share learning about impact metrics.

The review did not involve the collection of any personal or sensitive information, either from staff or patients. All participants gave their time voluntarily and were free to decline or withdraw at anytime. Each person was asked for permission for their views to be recorded, transcribed and selected quotations to be used in this report. Some participants preferred to remain anonymous and we have respected this request in this report by only using participant's job titles or a reference code. We sought the opinion of the National Research Ethics Service who classified the work as service evaluation and, therefore, not requiring further scrutiny.

### Contact address for further information:

National Nursing Research Unit  
King's College London  
James Clerk Maxwell Building  
57 Waterloo Road  
London SE1 8WA  
nnru@kcl.ac.uk

NHS Institute for Innovation and Improvement  
Coventry House  
University Road  
University of Warwick Campus  
Coventry CV4 7AL  
Tel: 024 7647 5800

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# Foreword

from Dame Christine Beasley

**I** recognised at an early stage in The Productive Ward programme's development that it was going to have a significant impact on the nursing profession and the direct care that nurses give to patients. I was, therefore, delighted to be asked to personally launch the programme at the Royal College of Nursing conference in 2007.

Subsequently, I have met with many ward teams implementing The Productive Ward and have seen first hand the transformation of their working lives and the increase in the quality of care delivered. This report highlights many of the successes achieved that have improved the patient experience and safety of care, whilst putting frontline staff in control of improving their working practices.

The Productive Ward has demonstrated it is a programme that improves the leadership skills of clinical staff at a time when enhancing their skills and competencies will be critical in helping us drive quality improvement at scale across the NHS. The work that the NHS Institute for Innovation and Improvement is doing focusing on developing a Return on Investment model is critical as organisations are looking to improve their productivity whilst increasing efficiency. I would encourage all ward staff to implement The Productive Ward as a way of helping them engage with this important national agenda.

**Dame Christine Beasley**

Chief nursing officer for England



# Introduction by Helen Bevan

## What does this research tell us and what are we doing about it?

I am delighted to introduce *The Productive Ward: Releasing time to care™ Learning and Impact Review* which was commissioned by the NHS Institute for Innovation and Improvement (NHS Institute) from the National Nursing Research Unit (NNRU), Kings College London.

The report goes right back to the beginning - how the idea of The Productive Ward came about, through development, testing and piloting to today, when The Productive Ward is helping to improve care in hundreds of inpatient wards across the NHS. The NHS Institute is immensely proud of this flagship programme and the difference it is making for patients and staff. This report indicates that we are right to feel that way. The report is also immensely helpful in the challenges that it presents. The Productive Ward has the potential to act as a catalyst for improvements in quality and use of resources in all 40,000 inpatient wards across the NHS. However, in order for this to happen some key issues need to be addressed. It is important that you know how this is happening and so this is the core topic for my introduction to the research report.

This report is being published at a time when the NHS is being challenged as never before to deliver improvements at scale in quality and productivity. Research on large-scale change shows us that if cost and quality outcomes are to improve dramatically, it will be through the engaged improvement efforts of frontline clinical teams that do the work, effectively supported by their leaders. Cost and quality improvement needs to be "hard-wired" into the day-to-day practice of our staff, the only people who really know where the problems are in the services they provide and who, with support and encouragement, can deliver dramatic results.

This is the power of The Productive Ward, a programme that puts frontline clinical staff back in control of the care that they give to their patients, encouraging them to question how they work and giving them simple tools and skills development to support them, on the job. Findings from the report indicate that The Productive Ward appeals to the intrinsic values of frontline staff, harnessing a social movement approach and mobilising their personal

energies and drivers for change.

The Productive Ward is a way that you can engage your frontline staff to learn and directly apply improvement techniques to their day-to-day work. The NHS Institute is actively working with over 60% of NHS organisations, helping them to implement The Productive Ward. This report shows that in these organisations there is a minority but significant proportion of wards that are well on their way towards implementation. Even though the numbers are small, they are growing and a conservative estimate of the number of clinicians actively using techniques within the programme is 50,000. Imagine that, 50,000 frontline staff, trained in evidence based improvement techniques and actively working to improve the care they give to their patients every day! In some hospital systems, over 50% of wards have now adopted the programme. We anticipate that several NHS Trusts will achieve 100% coverage during 2010.

This report also tells us that the single most important factor for the success of The Productive Ward is that clinicians need to be supported and encouraged by the senior leaders in their organisations. This is critical learning as we seek to embed radical change throughout the NHS at a time of challenge and opportunity. The findings also show that having a full-time or substantive time improvement facilitator, with the skills and resources to support frontline clinical teams to make change, is also crucial. You need to be thinking about who these people are in your organisation. You will need to be growing and developing them now if you want to meet the challenges that lie ahead.

This report recognises that whilst there are many perceived benefits of The Productive Ward, there are currently limitations to being able to demonstrate measurable impact. This is a challenge to the NHS Institute and one that we are actively addressing. The Productive Ward is a strategic imperative for an organisation, not a short term change programme. Consequently, some of the high level impact



measures currently being collected may not show significant positive change until the programme has had the opportunity to be fully embedded.

In addition, in the early days of The Productive Ward, the focus was very much about increasing patient facing time, hence – *Releasing time to care*<sup>TM</sup>.

In the current economic era, The Productive Ward is being rightly challenged to demonstrate a Return on Investment and the opportunity to make tangible savings. Since February 2009, the NHS Institute has been working with the original Productive Ward whole organisation test sites to develop a mechanism to collect module level impact measures. The aim is to support sites in their efforts to show the Return on Investment of The Productive Ward implementation. The main objective of this work is to provide staff with real tangible evidence of positive change for their everyday improvement efforts from implementing each module.

The model being developed and tested measures the impact of each Productive Ward module on a number of different levels. The objective of the model is to cumulatively calculate benefits from the information that is already being collected, both quantitative and qualitative. Organisations will be able to demonstrate not only time saved, but also quantify the savings into a return on investment. A further impact area that we are continuing to develop is training and staff development benefits, linking skill development to the NHS Knowledge and Skills Framework. Finally, the model will allow staff to capture their stories of improvement in areas of safety, quality, improved patient and staff satisfaction, to provide powerful qualitative evidence to sit alongside the quantified outcome measures.

I have a very positive view of this development.

My sense, having spoken to many leaders across the country who are implementing The Productive Ward is that the problem is not that the programme is failing to achieve cumulative benefits but rather that we have lacked the means to measure them on a systematic basis. The new model will provide senior leaders with the confidence that The Productive Ward makes a positive return on investment. The outputs from this work will be available to the NHS by the beginning of 2010.

Whilst the support provided by the NHS Institute was found to be valued by many of those interviewed, this report recommends that we consider increasing implementation support and ensure that all the support offered is delivered in a more systematic way. The NHS Institute accepts these findings and we have

recently re-designed our service delivery unit in order to respond more effectively to the requests for support. In addition, we have developed a number of new approaches to accelerating the adoption of The Productive Ward. This has been done in response to demand from some organisations who have managed to implement The Productive Ward in many of their wards but now want to spread in to areas such as the maternity unit and emergency department. The NHS Institute is also providing additional training in some aspects of tools and techniques for The Productive Ward, such as managing demand and capacity and running accelerated improvement events.

This research found that the most typical stage of development reported by organisations implementing The Productive Ward was to have the programme active on six wards with a further ten planned in the next roll out. Whilst starting on a few showcase wards is seen as important for the successful embedding of the programme within an organisation, the challenge to us all will be how we speed up the pace of implementation to meet the requirement to drastically improve productivity. I believe that the implementation approaches described above will help to achieve this challenge.

Findings indicate that not all organisations are actively working with the NHS Institute to support them in their implementation. Our own figures show that whilst there are a small number of organisations who have not yet engaged with The Productive Ward, there are some who have managed successful implementation without any external support. These are organisations with a strong history of improving services and a well developed service improvement culture.

This report demonstrates that The Productive Ward is a programme you cannot afford to overlook if you are serious about embedding improvement capability into everyday work, harnessing the support of senior leaders whilst driving change from the frontline. We look forward to continuing to work with the majority of NHS organisations with wards to help to make it happen and to deliver the proven benefits to many more hundreds of thousands of patients.

**Helen Bevan**

Chief of Service Transformation  
NHS Institute for Innovation and Improvement

# Executive Summary

**T**he NHS Institute for Innovation and Improvement's (NHS Institute) The Productive Ward: *Releasing time to care*<sup>TM</sup> programme aims to empower ward teams to identify areas for improvement by giving staff the information, skills and time they need to regain control of their ward and the care they provide.

This review (undertaken February-June 2009) set out to establish the overall learning from and impact of The Productive Ward programme since its conception in 2005, and to suggest how this can be spread and sustained. The review applies an evidence-based Diffusion of Innovation framework<sup>1</sup> to The Productive Ward programme to examine multi-level perspectives (national, regional, local) of learning and impact. The findings are informed by in-depth interviews with national and regional stakeholders, a national web-survey of frontline staff, and case studies of implementation within five NHS acute Trusts.

## Developing The Productive Ward – views of national stakeholders

- The Productive Ward programme draws on principles of 'Lean thinking' (Lean) to help tackle previously neglected everyday issues facing frontline NHS staff. Lean aims to reduce activities that do not add value. In the case of health care this could mean releasing more staff time for work that actually meets patient needs. The programme is distinctive in that it provides tools specifically created to engage frontline staff in the initiation and implementation of service improvement at ward level.
- The programme originated through partnership working between the NHS Institute, national nurse leaders, and industry partners. It was further developed through a planned design process that included drawing on social movement theory to work with NHS test sites and Learning Partners, before wider rollout to the NHS.
- The explicit promise of 'The Productive Ward: *Releasing time to care*<sup>TM</sup>' is framed to appeal both to service managers and ward staff: it suggests that there is room for efficiencies in

organisational systems and that staff can take a lead in improving the delivery of patient care.

- The common opinion amongst senior stakeholders (Strategic Health Authority leads) is that the programme appeals to the intrinsic values of frontline (particularly nursing) staff and has had a positive impact. Key benefits were: equipping staff with new skills, more time for better care, improved patient experiences, cost savings, and higher staff satisfaction and retention. In terms of its overall potential reach across the NHS The Productive Ward is still in its early stages of roll-out and the full-impact may not yet have been felt, or fully understood, even at a ward or organisational level.
- The extent to which the programme enables patient-focused service improvement and supports local approaches to leadership development are important emerging questions. The early successes of The Productive Ward programme raise questions about the type of incentives and mandates that should be put in place to encourage still wider adoption. Spreading the programme needs a careful balance between both dissemination (formal and planned through Strategic Health Authorities (SHAs) and diffusion (informal and unplanned) through social networks and opinion leaders).



## Formal dissemination – SHA support for local adoption and implementation

- Different SHAs have used different approaches to implement and support The Productive Ward programme. For example, comparing across the 10 SHAs, there is a large variation in terms of whether Trusts have purchased either of the NHS Institute's Accelerated or Standard support packages, or purchased neither. As of February 2009, in three of the SHAs over 20 Trusts have purchased one of the packages (in some cases

<sup>1</sup> Greenhalgh, T., Robert, G., Bate, P., Macfarlane, F. and Kyriakidou, O. (2005) Diffusion of Innovations in Health Service Organisations. A systematic literature review. Oxford: Blackwell Publishing.



directly supported by their SHA) whereas in three other SHAs less than five trusts have done so (and in one of these SHAs none at all).

- Applying a narrow measure of a 'decision to adopt' (the percentage of trusts that have purchased a support package) shows that since its official launch in May 2008, 140 acute trusts, 40% of all those in England, have adopted the programme (up to March 2009). Using a much broader measure of 'adoption' (that includes all Trusts that have just downloaded Productive Ward materials from the website) shows uptake of The Productive Ward programme by NHS trusts has been very high: 87% in the acute sector and 92% in the mental health sector.
- SHA leads highlighted the importance of supporting vision, planning and learning in order to engage staff at all levels. Working with trust-leads to align the programme with organisational targets was also seen as a key success factor. Several potential barriers to formal dissemination were identified, including the challenges of winning the hearts and minds of all staff, accessing training and support, rolling the programme out in a planned and measurable way, keeping the programme 'live', and linking it with the transformation of services, existing programmes and evidence of best practice.
- Key areas of impact that SHA leads identified were: improvements in staff skills, more time for better care, improved patient experiences, cost savings, and greater staff satisfaction and retention.

### Informal diffusion and perceived impact across the NHS - national web-based survey of frontline staff

- A web-survey was developed and distributed nationally through NHS Institute email contacts and the professional press to target those with experience of The Productive Ward programme. Data from 150 respondents shows that the majority of staff heard about The Productive Ward programme through the professional press or in meetings at work (20.8% for both). In most organisations, (60% of participants) The Productive Ward programme was running on up to six wards. The most common number of wards for the next phase of roll-out was ten. Staff reported that over half (59%) of implementing wards are Medical, Surgical or Care of the elderly.

- *External resources and support:* The majority of respondents said that within their organisations specific funding has been made available to help implement The Productive Ward (78%, 89 of 114 respondents). Respondents also gained support through visiting other trusts, steering groups or web-networks and learning from colleagues.
- *Internal trust context:* Nearly all respondents agree that 'The Productive Ward fits well with what we want to do in this organisation' (92.3%, 102 of 114 respondents) and that '*Releasing time to care*<sup>TM</sup> is a cause that I strongly identify with' (96.5%, 109 of 113 respondents). The majority of respondents said that staff in their organisation are familiar with working to improve services and can apply these skills to new projects like The Productive Ward. In the main, respondents (more than two-thirds) agreed that leadership and support from senior staff in their trust was generally good. Relatively fewer respondents (just over a half) felt that middle management relationships and communication were generally good in their trust.
- *Internal resources and support:* The majority of respondent's organisations have a clear champion for Productive Ward and there is a strong clinical leader backing the programme. The majority of respondents (70 or more per cent in each case) agreed that inter-organisational learning, communications and project management of Productive Ward in their organisations is good. Relatively fewer respondents (37.7%) felt that there was good patient and carer involvement in the implementation of the programme in their trust.
- *Facilitators and barriers:* By far the most commonly reported facilitating factor for The Productive Ward implementation is having dedicated project leadership (identified by 47 of 150 respondents). Strong support and enthusiasm from senior staff is also important. The most common barrier to Productive Ward implementation was staffing pressures (n=55), as well as generating enthusiasm, finding time and resources, and inter-departmental relationships.
- *Usage and impact of modules and tools:* The Productive Ward foundation modules were most commonly used and this was reflected in the high impact perceived to be associated with these modules (Well Organised Ward, Knowing How we are Doing, Patient Status at a Glance). Several of the process modules had been used by only a

minority of respondents (Admissions and Planned Discharge, Ward Round, Nursing Procedures and Patient Hygiene) but this may reflect the early stage of implementation of the programme and the majority of those who had used the modules found them effective. The most commonly used tools were Activity Follow, Your vision, Meetings, Photographs and 5S Game. Activity Follow and Photographs were rated as having the highest impact. Again, several of the tools had only been used by a relatively small number of respondents (Cost Benefit Analysis and Time Benefit Quantification).

- *Perceived impact and trust-level*

*outcomes:* Although a few respondents said it was too soon to comment about the impact of The Productive Ward the majority (64%) agree 'There have been measurable improvements as a direct result of Productive Ward'. Respondents said The Productive Ward had given staff more time to provide direct care to patients, it had led to better teamworking, well-organised and calmer working environments and that staff felt less stressed. The most tangible outcomes for staff were time savings (more efficient practices) and time investment (increase in direct care time). Other common outcomes were improved physical environment and organisation of wards, reduction in patient falls, reduction in staff sickness absence, cost savings, and an increase in staff morale/job satisfaction.



### Local stories of implementation and impact - case studies in five NHS acute trusts

- Five case study sites (NHS acute trusts) were selected on the basis of timing of adoption of the programme, willingness to participate in the review, size and type (Foundation/non-Foundation Trust) of organisation, and approach to implementation of The Productive Ward programme (Learning partner/standard and accelerated NHS Institute support package/whole hospital site). Overall the case studies showed that key drivers for adoption are specific to each organisation and its strategic goals. For example, The Productive

Ward can be seen as a mechanism for organisational change, an opportunity to build leadership capacity, or a way of demonstrating commitment to improving patient care.

- Trusts have devised their own approaches to implementation of The Productive Ward programme. Some trusts have focused implementation on selected wards, some have devised an overall organisational plan for implementation and have rolled-out the programme in stages or phases, and others have undertaken immediate whole-organisation implementation.
- Resourcing of the programme has been managed in different ways. Original Learning Partner trusts received support from the NHS Institute. Some organisations have set up a dedicated Productive Ward team or made use of the skills of existing service development teams with support from lead executives and clinical staff leads.
- Key organisational factors that influenced success at the case study sites were:
  - *Staff having a 'felt need' for change:* seeing The Productive Ward as a simple practical solution to real problems.
  - *Role of NHS Institute:* valuing the NHS Institute and The Productive Ward modules and resources.
  - *Going where the energy is:* selecting initial wards on the basis of their desire to work on The Productive Ward.
  - *Local ownership and real empowerment:* emphasising local ownership of the programme and empowerment of ward staff, rather than using a directive approach.
  - *Supportive organisational context and resources:* providing sufficient resources and support, in particular allocated budgets for backfill of staff time.

- While there are many perceived benefits of The Productive Ward there are currently limitations in being able to demonstrate measurable impact. 'High end' measures (for example number of full-time equivalent staffing hours saved) are not always obvious or of interest to those immersed in The Productive Ward work. Detailed assessment of locally available data at our case study sites shows that often only routine clinical or administrative measures are available. Potential comparable data across the five sites included: falls incidence, MRSA rates,

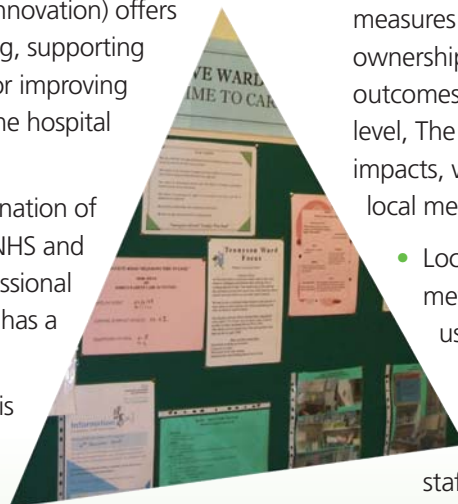
pressure sore incidence, staff satisfaction surveys and staff sickness/absence.

- Typically, data was collated over a relatively short period of time, and only from the start of implementation of The Productive Ward, and so it is not possible to show longer-term trends such as changes in clinical indicators or staff outcomes. Comparative statistical analysis between wards and trusts is problematic because data is not collected frequently or consistently enough. However, for some wards there is longitudinal evidence on some metrics of improvements.
- Staff express a strong conviction that, unlike many other service improvement initiatives, The Productive Ward can be sustained. However, two areas of concern are how to show evidence of the promised greater efficiencies, and that the measures are insensitive to improvements being observed at ward-level.

### Applying the Diffusion of Innovation framework to The Productive Ward

By applying key aspects of the Diffusion of Innovation framework to The Productive Ward programme it is possible to identify important interactions that have contributed to the rapid diffusion of The Productive Ward programme in NHS acute trusts.

- The Productive Ward (the innovation) offers a powerful way of engaging, supporting and acknowledging staff for improving the services they provide (the hospital context).
- A carefully balanced combination of programme 'push' (wider NHS and societal context) with professional 'pull' (the hospital context) has a powerful effect.
- External support (linkages) is crucial in some trusts (hospital context) at different phases of the adoption and implementation process; other trusts are a more receptive context for this particular innovation and require little external support.
- The Productive Ward has huge potential impact - but the range and extent of measurable outcomes remain unclear.



### Conclusions and recommendations

- Overall, this review finds that The Productive Ward programme has been successfully framed and communicated in a way that connects with frontline NHS staffs' need and will for change, and that it thrives where local leadership and ownership are strong. The review suggests 15 'top tips', that comprise of key lessons from the programme to date that will assist trusts in local implementation in the future.
- The Productive Ward programme has a huge perceived value and local impact including improvements in staff skills (in particular ward-level leadership), more time for better care, improved patient experiences, cost savings, and higher staff satisfaction and retention. The programme itself facilitates dialogue 'ward' to 'board' by giving a shared language and focal point where the interests and values of these different staff groups can converge.
- There is considerable potential for the ongoing spread and impact of The Productive Ward programme throughout the NHS. Further research and nationally consistent measures are required to monitor service-wide improvements and to examine longer-term effects of programme diffusion. Current practice in using metrics is not sufficient to support this. However, pushing for consistency in selection and use of measures runs the risk of undermining local ownership and failing to capture the full range of outcomes that are observed. At a more general level, The Productive Ward has a range of impacts, which may or may not be derived from local measures.
- Locally determined and standardised metrics should be recognised as serving useful purposes in their own right. Guidance on deploying routinely collected data (already being collected from all hospital wards, for example staffing, sickness/absence and emerging national metrics such as pressure sore rates) that does not make an additional burden on wards that are running The Productive Ward can provide a way forward for resolving this dilemma.

# 1. Introduction

## Background

The National Health Service is a labour intensive service organisation employing some 1.3 million staff. Approximately a third of total NHS expenditure is spent on delivering ward-based care in hospitals – estimated at £17 billion annually (DH 2003). The ward is the basic work unit of the inpatient system and where patients interact most intensively with staff and where the patient experience of NHS care is largely shaped. It is a place where consistent, reliable and safe care is expected and ought to occur. It is not always the case.

Patient satisfaction and experience of hospital wards is known to vary greatly across the NHS (Maben and Griffiths 2008; Healthcare Commission 2006). Staff experiences of work environments also vary, with potential knock-on effects for staff motivation, satisfaction and ultimately patient experiences of care (Maben 2007). Often hospitals have wards providing outstanding patient care right next to wards that struggle to cope.

*The Next Stage Review* clearly emphasises that change in the NHS should be for the benefit of patients and staff and that it should be locally- and clinically-led (DH 2008a). It supports the view that people working in the NHS have considerable knowledge and understanding of their service and of what constitutes good practice. *Real Involvement* (DH 2008b) sets out how, where necessary, the NHS can change through the leadership of clinicians and the support of patients and the communities in which they live. In addressing these issues The Productive Ward programme, designed by the NHS Institute for Innovation and Improvement (hereafter NHS Institute) in collaboration with the NHS, sets out a practical way for clinicians and other ward-based staff to take the lead in improving services for patients.

The Productive Ward: *Releasing time to care*<sup>™</sup> programme is a self-directed programme comprising 13 modules, Executive and Project Leader's Guide and has the option of additional support for implementation from the NHS

Institute. A summary of the module content is provided as an appendix to this report (Appendix 1). The programme is based on the principles of 'Lean thinking' (lean), which has its origins in the car manufacturer Toyota's approach to production. The Productive Ward draws on these principles to improve patient care and experiences by identifying and eradicating different types of waste (Crump 2008). Lean aims to reduce activities that do not add value. In the case of health care this could mean releasing more staff time for work that actually meets patient needs.

In recent years articles in the health service and nursing press have promoted the programme (Shepherd 2009; Toriessen 2009; O'Dowd 2007), explained the rationale behind it (Crump 2008; Taylor 2006), provided accounts of local implementation (Redgrave and Beel 2009; Anthony 2008; Easton 2008; Parish 2008; Taylor 2007; Hunt 2007; Clarke-Jones 2007) and lessons gained (Wilson 2009; Bevan 2009; Shepherd 2009; HSJ 2008; HSJ 2007). Although The Productive Ward programme often focuses on simple ideas, such as altering patient handover time, reorganising storage facilities or making better use of patient data, it promises a systematic and inclusive approach to improving the reliability, safety and efficiency of the care delivered in a ward setting.

The Productive Ward programme aims to empower ward teams to identify areas for improvement by giving staff the information, skills and time they need to regain control of their ward and the care they provide. Specifically it aims to:

- increase the proportion of time nurses spend in direct patient care,
- improve experience for staff and patients, and
- to make structural changes to the use of ward spaces to improve efficiency in terms of time, effort and money.

In light of these aims, the review presented here set out to tell the story of The Productive Ward: *Releasing time to care*<sup>™</sup>, in terms of how the programme was devised and developed and its spread and impact on the NHS. The purpose of



The model is intended to help in making sense of the multiple aspects that influence diffusion, and their many interactions, in a complex setting such as the NHS. In this review the aim was to describe and analyse these interactions to help explain the 'story' of The Productive Ward. The framework was used to identify and assess the various components of the programme and how they are exerting their effects (on for example, efficiency and safety) and the key facilitators and barriers to the adoption, implementation and assimilation of The Productive Ward programme into day-to-day routines.

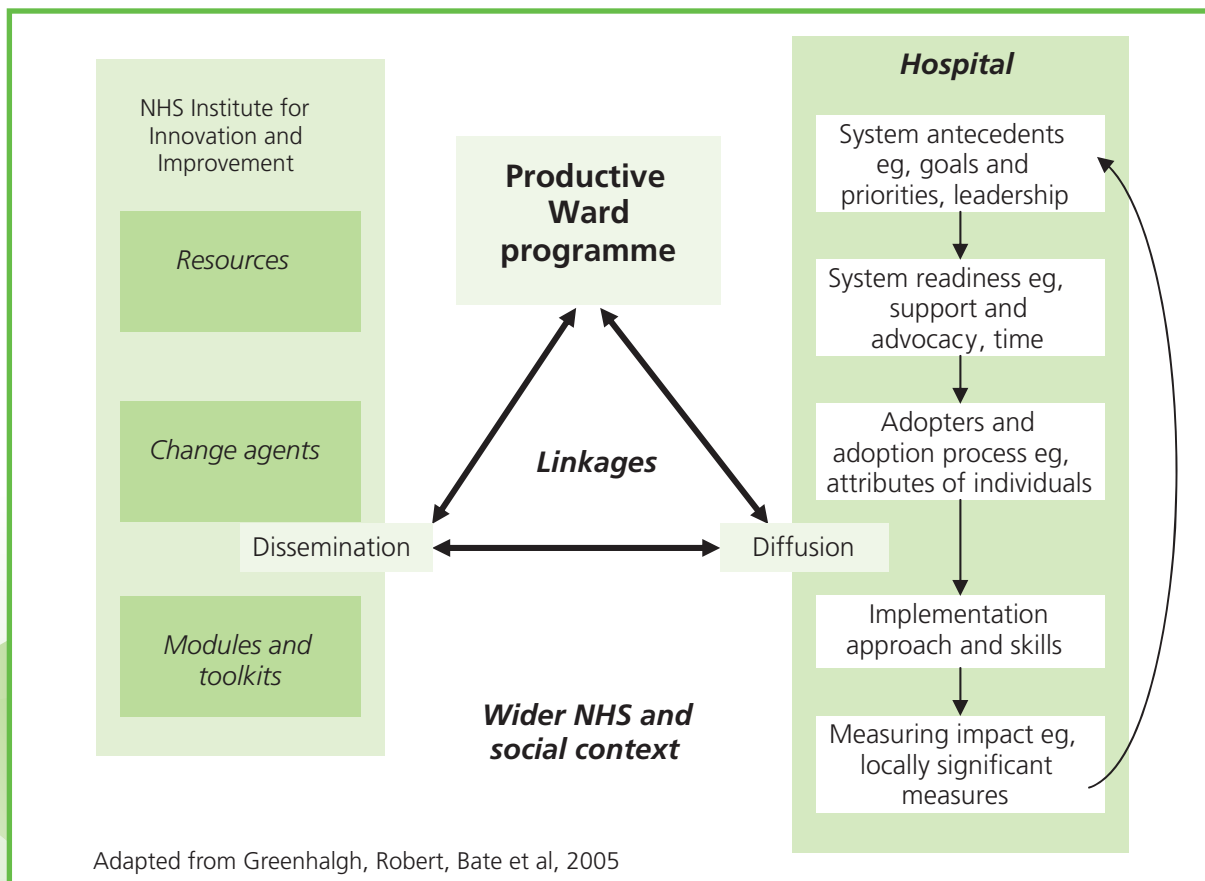
Four key aspects of the Diffusion of Innovation framework guided this review:

- **The Productive Ward programme itself (the innovation):** There is extensive research evidence to show that people considering adopting an innovation are influenced by their preconceptions about it. The review examined the perceptions of a range of stakeholders about the key attributes of The Productive Ward programme and looked at associated variations in the rate of adoption.
- **Linkages:** The nature and quality of any relationship ('linkage') between a formal change

agency - like the NHS Institute for Innovation and Improvement - and an intended adopting organisation will influence the likelihood of uptake and the success of implementation.

- **Hospital context:** Different hospitals provide widely differing contexts for the adoption of service innovations. A number of features of hospitals, both structural and cultural, have been shown to influence the likelihood that an innovation like The Productive Ward programme will be adopted, implemented and successfully assimilated into routine practice. A key question is therefore what factors within an organisation help to support the adoption of The Productive Ward programme.
- **Wider NHS/societal context:** The decision by a hospital to adopt an innovation like The Productive Ward programme, and the success of its efforts to implement and sustain it, is influenced by ideas and information external to the organisation. The review aimed to capture the views of NHS staff about the influence of mutual sense-making between hospitals and the wider NHS with regard to the programme.

**Figure 1.1: Framework for examining diffusion of The Productive Ward programme**



The review engaged with a range of stakeholder groups to help explore and capture issues at different levels of the NHS and across different areas of professional working:

- leaders and frontline staff in local NHS organisations
- the team at the NHS Institute
- SHA leads for The Productive Ward programme
- other key stakeholder in the RCN and Department of Health.

The review made use of multiple quantitative and qualitative methods, where the latter facilitated the interpretation of findings from the former, thereby combining a review for judgment with a review for learning. There were two main phases to the review. These were as follows.

### Phase 1: The national 'story' of The Productive Ward

#### *Interviews with national and regional stakeholders*

The aim of this phase was to capture the story from the NHS Institute's perspective and from policymakers using face-to-face and telephone semi-structured interviews (see appendix 2). An interview topic guide (see appendix 3) was designed which began with an open invitation to 'tell the story' with specific questions focussing on factors relating to the diffusion of The Productive Ward programme, including aspects of the wider NHS and social context that shaped its early adoption. Participants were asked about key success factors. Interviews were conducted between March and May 2009. Most were by telephone and lasted about 30 minutes. They were audio-recorded and transcribed. Key quotes and issues were identified using the principles of framework analysis (Ritchie and Spencer 1994): familiarisation with the data as a whole, identification of striking issues and statements, drawing out potential themes, key issues and concepts, coding and categorisation of the data, mapping and interpretation).

#### *Web-survey*

A second element of Phase 1 was a web-based survey. This was targeted primarily at staff in NHS acute trusts which had implemented or were considering implementing The Productive Ward programme. The aim was to explore perceptions

of The Productive Ward programme in terms of key aspects of the diffusion of innovation model as perceived by those with some exposure to it, as well as assessing the local adoption and implementation of particular modules and the availability and accessibility of local impact data (see appendix 4).

After extensive piloting, including a consultation with SHA lead nurses and leads for The Productive Ward, the web-survey was launched on the National Nursing Research Unit website on 23 February 2009. A web-link was created from the NHS Institute's web-site. Distribution was supported by the NHS Institute who directly notified organisations that had procured a Productive Ward package and organisations known to be working on the programme independently. Release of the survey was publicised through a news piece in the Nursing Times, through national email networks and the RCN Research and Development Network Bulletin e-newsletter, with a follow-up reminder two weeks later. The web-survey closed after eight weeks, on 17 April. 150 responses were received (detailed in Chapter 5). Analysis of the survey data was conducted using a framework approach (Ritchie and Spencer 1994) drawing directly on the diffusion of innovation model.

It was problematic to identify non-adopting trusts and who exactly to approach to elicit information about decisions not-to adopt, however it was possible to gain some insights into these issues through analysis of NHS Institute data and the stakeholder interviews. Hence, taken alone, the results of the web-survey reveal little about decisions not to adopt the programme.

### Phase 2: Local implementation, assimilation and evidence of impact

#### *Case studies*

Phase 2 focused on issues of local implementation of The Productive Ward programme. The aim was to capture detailed views from NHS staff about their experiences and the perceived impact of The Productive Ward programme. It included analysis of key factors within the hospital context that have influenced success.

Selection of five case study sites (NHS acute trusts) was undertaken on the basis of the following criteria and was informed by the activities undertaken in Phase 1:

- timing of adoption of the programme
- willingness to participate in the review
- size and type (Foundation/non-Foundation Trust) of organisation
- approach to implementation of The Productive Ward programme (Learning partner/standard and accelerated NHS Institute support package/whole hospital site).

Further details for each case study site are provided in Chapter 5 (see Table 5.1).

Interviews at the case study sites focused on aspects of local context, perceptions of success and aspects of why the innovation was adopted locally, including the extent to which The Productive Ward was perceived in terms of the known factors leading to the successful adoption and assimilation of innovations in service delivery. Interviewees were selected to represent a

broad range of staff at all levels in the organisation that might be involved with The Productive Ward (Appendix 2). As in Phase 1, interviews were audio-recorded and transcribed for analysis. Data from the interviews is presented in Chapter 5 of this report.

In each case study we assessed locally available data, including audits and clinical measures which might show impact of The Productive Ward before and after implementation, with a view to undertaking further analysis of data from across the five sites if feasible (discussed towards the end of Chapter 5 under the heading Measuring Impact).





## 2. Developing The Productive Ward – Views of national stakeholders

### SUMMARY

- The Productive Ward programme draws on principles of ‘Lean thinking’ (lean) to help tackle previously neglected everyday issues facing frontline NHS staff. The programme is distinctive in that it provides tools specifically created to engage frontline staff in the initiation and implementation of change at ward level.
- The explicit promise of ‘The Productive Ward: *Releasing time to care*<sup>™</sup>’ is framed to appeal both to service managers and ward staff: it suggests that there is room for efficiencies in organisational systems and that staff can take a lead in improving the delivery of patient care.
- The programme originated through partnership working between the NHS Institute, national nurse leaders, and industry partners and was further developed through a planned design process that included working with NHS test sites and Learning Partners.
- The common opinion amongst senior stakeholders is that the programme appeals to the intrinsic values of frontline (particularly nursing) staff and has had a positive impact (key themes were: equipping staff with new skills, more time for better care, improved patient experiences, cost savings, and higher staff satisfaction and retention. However, in terms of its overall potential reach across the NHS The Productive Ward is still in its early stages of roll-out and the full-impact may not yet have been felt, or fully understood, even at a ward or organisational level.
- The extent to which the programme (a) enables patient-focused service improvement and (b) that it can support local approaches to leadership development are emerging questions.
- The early successes of The Productive Ward programme provoke questions about what incentives and mandates should be put in place to encourage still wider adoption. Spreading the programme needs a careful balance between both dissemination (formal and planned through Strategic Health Authorities) and diffusion (informal and unplanned through social networks and opinion leaders).

### Introduction

The following account of development of The Productive Ward programme is based on in-depth interviews with key stakeholders from the original concept phase to the present date (June 2009). The story is a synthesis of the experiences of many individuals, principally those who have or currently work at the NHS Institute and others in national nurse leadership roles, but also informed by the accounts of regional leads for implementation of the programme (Chapter 3).

These different stakeholder perspectives are used selectively here to convey an approximate chronological story of how ideas were formulated, how a quality improvement intervention was developed and how it has been, in the main, eagerly taken up by NHS staff. These stakeholders felt strongly that The Productive Ward differs from other service development initiatives in the way it

has been developed and how it has subsequently been received by NHS staff.

### Concept and testing

The work that developed into The Productive Ward programme was triggered by a series of events and initiatives coming together. Consultations undertaken as part of the establishment of the NHS Institute engaged senior executives at the Department of Health, and SHAs in discussions on what the priorities for the NHS Institute should be. At that time Christine Beasley, Chief Nurse of England, expressed a strong view that initiatives were required to support better direct care processes – the actual interactions between care givers and the patient. In a sense this went against the remit of the NHS Institute to tackle ‘big challenges’ and to achieve high impact solutions across the whole healthcare system.

Some strategic priority areas for the NHS Institute had already been identified and included improving quality, value and productivity (with specific objectives of reducing length of in-patient stay, reducing delays and healthcare associated infection). The tension between focusing on direct care processes whilst achieving whole system improvements was a first spark in the story of The Productive Ward.

At the same time there was a drive towards improved efficiency in the NHS and a renewed interest in applying principles from industry to healthcare systems. Interesting work was going on at the US-based Institute for Health Improvement through a specific project called 'Transformation Care at the Bedside'. Elsewhere at Luton and Dunstable NHS Foundation Trust, an initiative under the title 'Exemplar ward' aimed to combine different approaches to quality and service improvement to deliver ideal patient care. The work primarily focused on 'flow', through the application of lean principles, as well as safety and reliability. Early experiences promised a range of positive benefits for the organisation proved that such improvements could be sustained (Nursing Times 2007).

*"All these kind of things came together and the exact moment when we came up with the scheme the [NHS Institute] Service Transformation Team were having a strategy day (...) there were about five of us (...) [including] a lean specialist that had just come from the steel industry (...) and our Innovation Specialist, and we came up with the idea that maybe we should do this"*

**(Helen Bevan, NHS Institute)**

In early 2006, drawing on these initial ideas and promising results, staff at the NHS Institute began to work with industry partners to explore how ideas and concepts from lean thinking might benefit the wider NHS.

*"It was applying lean methodology and principles to the processes on the ward with the explicit aim of making the nurses' day easier, the environment better. So that they can actually deliver the care that they know they want to deliver"*

**(Kate Jones, NHS Institute)**

*"It's all about shaving time off processes, process mapping, lean exercise... I was pleased to see that somebody was doing something structured, that it was deliberately facing towards a very important part of the workforce"*

**(Tim Curry, Royal College of Nursing)**

In the early days, there was uncertainty about whether the strong emphasis placed on productivity by lean might align with the goals of delivering a high quality health services to patients with diverse needs.

*"The first day that I actually realised what it was about was when I had three gentlemen from Toyota, walk into my organisation and say to me – never been in a hospital before – 'Where are the wastes in your system?' And I remember thinking, 'Where shall we start?!'*

*... – and they were talking about system improvement, they were talking about flow, they were talking about Toyota, so they were talking about cars ... pointing out waste in the system and actually pointing that out to me ... it took me two weeks to realise, what they were talking about... I can just remember being so excited about it, thinking, 'These are the frustrations I've had as a ward manager for so long and ... you're actually telling me there's something we can do about it?'"*

**(Liz Ward, NHS Institute)**

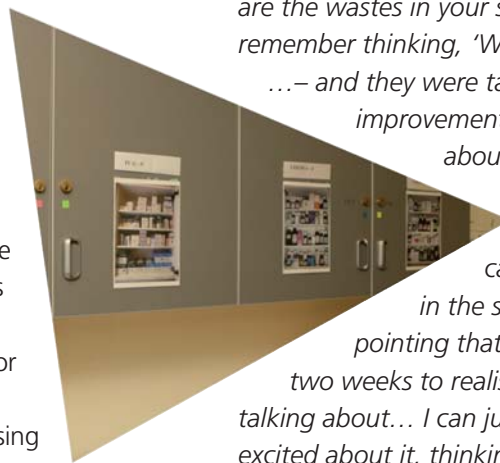
There was also the challenge of securing resources to develop, pilot and roll-out an idea that had emerged outside the NHS Institute's formal business plan:

*"I think there's an interesting lesson here - it's great to business plan, it great to strategise and determine things ahead, but in an innovational improvement environment, you've got to leave room for emergence as well"*

**(Helen Bevan, NHS Institute)**

The issue of what to call the programme was also on the minds of NHS Institute staff:

*"There was a lot of discussion and argument about the name because I was always adamant that it was going to be called The Productive Ward. And a lot of people didn't like that because they didn't like the 'productive' label. But, I did say that if this is going to be really aimed at the leadership community then it's got*



*to have that name. And then the great thing, it was actually the RCN that gave us the other title – what I really like about it is you've got the 'Productive Ward' which is kind of the senior leader framing, and 'Releasing Time to Care' which is the frontline framing"*

**(Helen Bevan, NHS Institute)**

*"(We thought) 'Let's get a by-line that resonates with nurses.' and what resonates is not productivity, what resonates is, 'I want to take care of my patients.' So it's, 'Release time to care,' and that's where that came from. And that was huge"*

**(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

Thus, those developing the programme quickly realised that it needed to be framed in terms of goals that would resonate with both NHS leaders and frontline staff – and therefore tap into both directed and self-motivated energies for change.

*"There are very different kind of models of change around how do you go for wholesale productivity improvement? There's the kind of 'directed' school, versus the 'inspiration' school. And a lot of the people in the direct school will push it straight down and tell people what to do. Well actually, I think the key to so much of our productivity gain is around really engaging the workforce. People, if they're engaged in the right kind of way, and they kind of get a sense of conviction and understanding, people will buy the product"* **(Helen Bevan, NHS Institute)**

The promise of 'The Productive Ward: *Releasing time to care*<sup>TM</sup>' was framed to appeal both to service managers and ward staff: it is an idea that suggests that there is room for efficiencies in organisational systems and the possibility that staff can take a lead on improving the delivery of care:

*"My big anxiety was (...) that this was basically a Trojan Horse for savings ... unless they convinced me otherwise, it was a tool employers could use to save on nursing workforce etc. And literally, the words that reassured me were, 'Releasing time to care"* **(Anon, RCN member)**

### Original test sites

By 2006 a prototype package had been developed and four hospital sites (see Figure 2.1) had agreed to pilot and test the programme. The main goal of

The Productive Ward was still to enable frontline staff to focus and improve the core functions of their ward:

*"It's an opportunity to look in detail at the core things that we do (...) looking at ways of doing them a little bit smarter or finding out what the blocks are and what the enablers are, and making it just a little bit easier, make it a little more pleasurable and maybe save some money along the way as well"*

**(Tim Curry, Royal College of Nursing)**

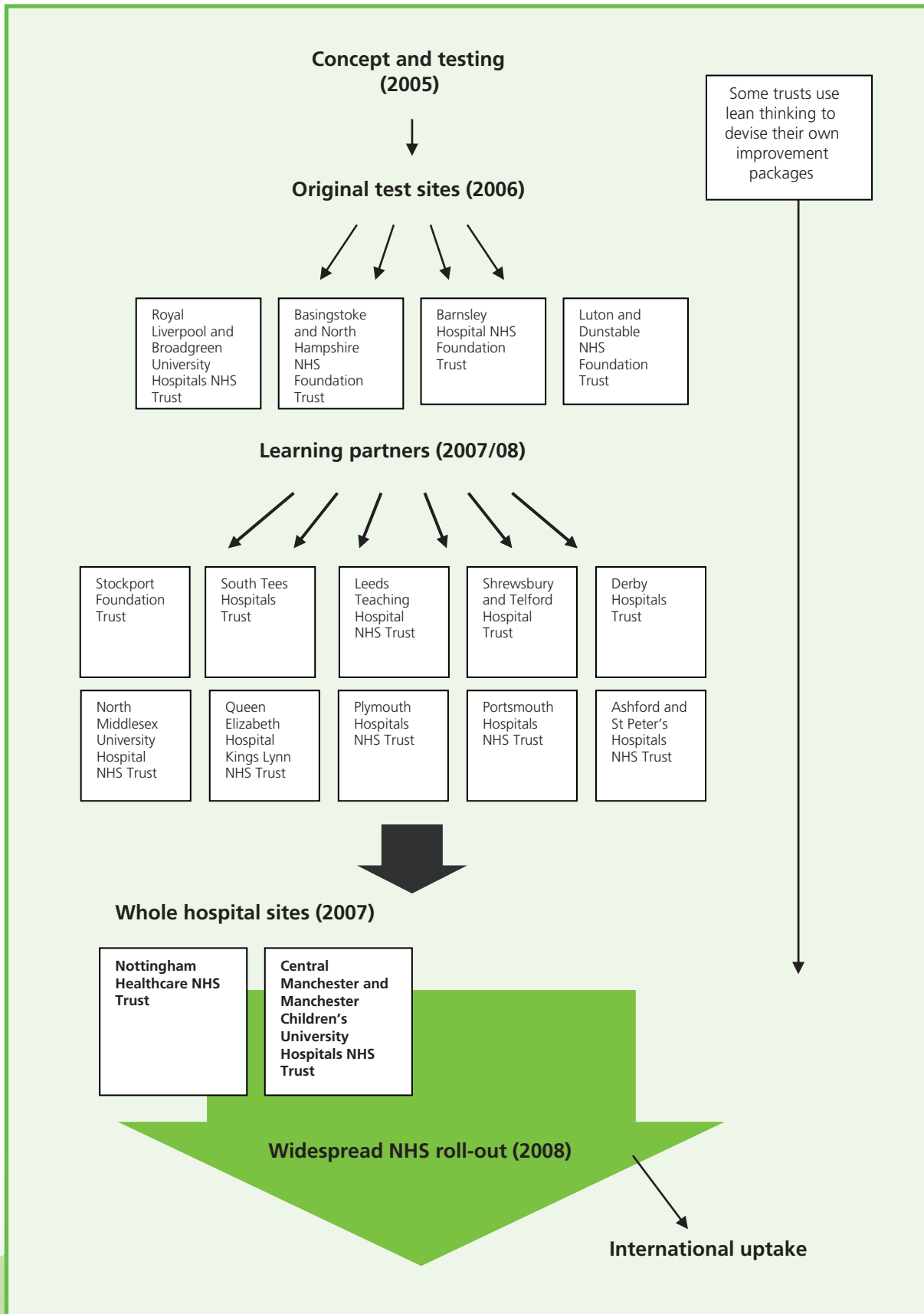
In practical terms, signing up as a test site gave ward staff dedicated time and incentive to look at how things could be done differently.

*"We became one of the original test sites, testing out the concept and very, very quickly after the work started it became very obvious to me that this was going to work really well (...) nurses were being expected to undertake more and more and more on the wards and yet there was very little leadership or service development training or support. You're on this sort of hamster wheel of delivering the care and never getting time out, and becoming continually exhausted by that, to the point that anybody who had any motivation and enthusiasm or creativity to look at how things could be done differently, it was being thwarted"* **(Lizzie Cunningham, NHS Institute)**

The NHS Institute employed a consultant with a background in designing modular learning courses to help devise a resource that nursing staff in particular would feel was created specifically for them. The design of each module deliberately comprised two elements: one strategic, for example, focusing on the role of the chief executive and the other practical, for example 'How do I apply it?

*"In a sense the tools have always got to be behind the scenes, even though they're incredibly powerful, and anything we did around lean, or other methods, that we had to frame it in terms of the type of outcome we wanted"* **(Helen Bevan, NHS Institute)**

Figure 2.1: Development phases of The Productive Ward programme



The consistency of language with nurses' ways of working was a crucial issue for how The Productive Ward was adopted and implemented by nurses in practice. As other NHS Institute funded research (Bibby et al. 2009) has shown more generally, framing innovations in a way that the intended audience recognise as according with their own values and priorities was essential to the success of The Productive Ward.

*"So it's not in the language of service improvement, it's in nurse language (...) we created it in the way they work, in a language they already knew. So they didn't have to learn a new language or a new way to work with it"*

**(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

Early feedback from the four test sites indicated that The Productive Ward was compatible with the needs and values of nursing staff in particular: to feel more fulfilled at work and better able to deliver care in an environment that worked for, rather than against, them.

However, NHS Institute staff quickly recognised that although the modules and tools were well received, successful implementation also required leadership and support at all levels in an organisation.

*"We recognised right from the beginning that you need to get the right leadership to support this at every level. We've got places where there have been really outstanding ward managers and they haven't had the executive leadership, and they can only go so far"*

**(Helen Bevan, NHS Institute)**

The Productive Ward also needed to equip ward leaders with the tools to communicate with organisational leaders and secure their support. One tool is the Visit Pyramid which can be used to stimulate interactions between ward staff and managers/executive staff. The usage and perceived impact of this and other tools by NHS staff is described in Chapter 4 (see Table 4.4).

### Learning partners

Following modification and development based on this pilot work the package was tested further with ten 'Learning Partner' organisations (see Figure 2.1), one from each SHA region.

*"We created these very rough modules that we tested with the ten sites. So we had this prototype idea and that's what the ten sites*

*helped us to refine (...) we watched how they used it, and realised, yes that's a winner. And then from that came the final modules"*

**(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

A further key factor of development was that The Productive Ward was promoted as being inclusive of everyone:

*"The spirit of it is that everyone involved in the ward, whether you're the healthcare assistant, the cleaner, the ward clerk, the sister, the staff nurse, has an involvement in it...you're part of something, whereas where things are not working well, is where people feel that they've got no ownership, they haven't got a stake in it"* **(Peter Carter, Royal College of Nursing).**

In 2007 The Productive Ward: *Releasing time to care™* was launched by the chief nursing officer, Christine Beasley. The launch stimulated the conduct of a survey of more than 2,100 acute trust nurses, managers and therapists by the Health Services Journal (HSJ) and sister publication the Nursing Times. The survey showed that 73 per cent of nurses and 76 per cent of therapists felt they did not spend enough time on direct patient care. More than four in five of those staff said this had an adverse impact on the care of patients.

*"The big launch we did before we had the products... We sent invitations out to all nurse directors and said 'bring one person with you.' The HSJ picked it up and did a survey that said, 'Tell me nurses, do you spend enough time with your patients, how much time do you think you spend with your patients?' 'Oh gee there's a surprise, not enough time, you're spending so much time on paperwork and numerous things.' So they published this... it was almost the classic, 'Let's demonstrate there's a problem.' Okay there's a problem, and oh to the rescue comes The Productive Ward"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

The Productive Ward programme seemed to meet pent-up demands in the system and it gained the backing of high profile nurse leaders:

*"It just kind of caught the imagination of the nursing leadership community, Ann Keen MP was really important in this, who was the kind of sponsoring minister, who was a nurse herself (...) It didn't quite come from nowhere, because what had been happening over a*

*period of time was more and more nurse leaders were getting excited about this incredible peer-to-peer spread around it, and very, very strong ministerial support"*

**(Helen Bevan, NHS Institute)**

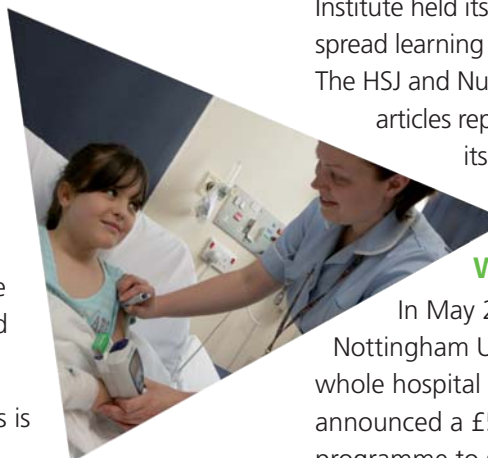
In appealing to nurse's desires to have more patient contact time and therefore more time for holistic individualised care (Maben 2006) The Productive Ward programme generated much interest and a strong 'pull' factor.

*"We started to think, 'this is big, this isn't a nice little service improvement project, this is really big"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

Another NHS-wide key driver was the need - given changing workforce patterns - to ensure a safe, effective, consistent and efficient approach to care provided by teams of care staff:

*"one of the challenges we've got in today's acute hospital, which we didn't have when I was a nurse, is the fact that there are a lot of people who don't have the full time commitment. You remember the days when you worked five days a week, 12 hour shifts didn't exist...people spent more time, full time, in a hospital. Patients were there much longer... today, you have temporary people come in and works two days a week.... so Productive Ward or 'Releasing time to care' gives you a consistent, reliable environment to work in. Things are kept in a place I can find information about patients, it is in a location that makes sense to me..."* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

In 2007 two trusts were invited to work with the NHS Institute to roll out The Productive Ward across their whole hospital. The two sites were Central Manchester and Manchester Children's University Hospitals NHS Trust and Nottingham University Hospitals NHS Trust. These pilots gave specific insights into how to successfully implement The Productive Ward across a whole organisation, which further helped the NHS Institute to develop and frame the approach for maximum appeal and utility.



Throughout 2007 the NHS Institute worked with the ten learning partner organisations, whole hospital sites and SHAs, and collaborated with key champions including members of the RCN, the chief nurse Christine Beasley and her team. The NHS Institute held its first Productive Ward conference to spread learning and engage a wider NHS audience. The HSJ and Nursing Times published a series of articles reporting on The Productive Ward and its development (listed in appendix 1).

### Widespread NHS roll-out

In May 2008, shortly after visiting Nottingham University Hospital (one of the two whole hospital sites), the Rt Hon Alan Johnson announced a £50 million investment in the programme to support the dissemination of The Productive Ward across the country. This degree of central investment was provided on the basis of evidence from the early test sites, widespread commitment from nursing leaders, and the promise of what The Productive Ward might help to achieve across the NHS.

*"I appreciate how frustrating it must be, when nurses feel they are being diverted from direct care for patients by unnecessary bureaucracy. You know how best to run your wards. Indeed, there is clear evidence that where managers and leaders empower nurses to make changes in how wards are run, there are dramatic improvements in patient care. In a recent visit to Nottingham, I was hugely impressed by The Productive Ward's pilot, where ward-based nurses, led by the ward sister, are given time to examine how their ward is organised, and to make changes that allow them to spend more time with patients"*

**Rt Hon Alan Johnson (DH 2008)**

Central funding for The Productive Ward initiatives was made available through SHAs. This meant the NHS Institute needed to begin to work more closely with SHA leads to communicate the aims and objectives of the programme and to support regional decision-making about the use of resources and the nature of support that might be provided.

*"SHAs became then the gatekeeper because they had to choose one organisation, one acute hospital in their patch to be in our secondary wave of test sites. Which meant (..) then they are very involved with the pressure it's building*

*behind other people who want to belong. We didn't do the selection. They did the selection, we didn't hold back the dam of interest, they did. (...) So the frontline pull for this thing, helped to generate a tremendous amount of interest on the part of SHAs"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

As discussed further in the following chapter, some SHA regions put out tenders for Productive Ward funding which appears to have increased appeal for the programme and stimulated organisations to develop plans for implementation. Where SHAs selected particular hospitals for implementation this appeared to create a 'pull' from staff. Those who had not yet been selected heard about it from colleagues and requested copies of The Productive Ward materials:

*"because SHAs chose organisations, and there were others that wanted to do it, they got photocopies of the prototype stuff from the representative from that SHA. So you could have been, say, in the West Midlands and Hospital A is coming to all the workshops with us, learning, testing our products. They're actually photocopying all that stuff and they're giving it to the sister hospital down the road. (...) So we created this little pull, so people wanted it, they felt that it was valuable and they wanted a piece of it. And they wanted to get it somehow"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

The SHAs also partnered with the NHS Institute to share learning which contributed to the spread and sustainability strategy. These partnerships helped in establishing shared meaning and vision and communicating knowledge about The Productive Ward programme and how to implement its principles within health service contexts.

*"We had a lead person in each SHA that worked with the NHS Institute. We tapped into that group, 'Okay what are you doing? What are you doing for Productive Ward?' So they started to share best practice. So they're holding back this dam of activity and also partnering with us. So it was actually a brilliant strategy"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

Many stakeholders feel The Productive Ward is such a successful programme that it should be mainstreamed throughout the NHS:

*"I was relatively speaking, a convert quite early on. But I've been more and more impressed. I mean my wish is that this should be a kind of stock in trade right throughout the NHS and the private sector, I'm quite a fan. (...) I would hope if we were having this conversation in, I don't know, a year from now, it would be encrypted into the way that, healthcare facilities should operate' (...) I think there should be some times when there really is a top-down approach and people say, 'Look this is what you're going to do, and we expect you all to get on board with it'".* **(Peter Carter, Royal College of Nursing)**

However, some stakeholders caution against overly directing the programme, suggesting the self-motivated 'pull' and enthusiasm from frontline staff is a natural force that will gather momentum as staff see for themselves the benefits of the programme:

*"At one point, the department picked it up and wanted to put it in the Operating Framework ....the minute we put this into legislation or regulation or a mandate, it will not work.' (...) it won't work if someone is mandating it. I think that will prove itself if you look around organisations who have mandated it and it hasn't worked"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

Recently the NHS Institute has taken learning from The Productive Ward programme to develop comprehensive programmes for different clinical contexts, including: Productive Community Services, The Productive Operating Theatre, and The Productive Mental Health Ward. Looking to the future, the NHS Institute is also exploring other contexts and countries where this learning can be taken.

*"I do think there are certain areas that we need to look at to support that maybe don't have explicit examples (...) maybe a one-off module or something to show people how they can adapt this for use within maternity, how they can adapt this for use within prison health"* **(Lizzie Cunningham, NHS Institute)**

*"It's not only linking with the universities and nurse education, but it's also linking in with*



*things like hospital build, because what we're finding is the design of sluices and wards etc is not conducive to the processes that those areas are used for. And so Productive Ward could influence how hospitals are designed in the future. And I think also, how we perhaps employ and recruit people in the future"* **(Lizzie Cunningham, NHS Institute)**

### How The Productive Ward differs from other service improvement approaches

Historically, service improvement initiatives have not been targeted at the problems of organising 'every day' care at a ward-level. Although Essence of Care (DH 2001) drew attention to the need for essential aspects of patient care to be improved, such as dignity, nutrition and hygiene, there has been an unaddressed need to support ward teams to tackle problems and issues that are specific to the ward environments they were working in.

*"The majority of care is undertaken on the ward and the ward environment is somewhere that in service improvement sort of initiatives, has actually been largely ignored, because they've gone down pathways, they've gone down specific improvements in terms of clinical issues ... but never looking at the mundane processes that make up the activities that go in a ward, that really hugely impact on, directly on the patient care and the patient experience"* **(Lizzie Cunningham, NHS Institute)**

In accordance with this, those developing the programme felt the will and energy for change was already present amongst NHS staff.

*"Nurses especially are very innovative in that they will find ways to try and improve things. But because there was no structure before, they'd end up a lot of the time getting quite frustrated because they were trying to get to the best they could be. There was no real back up, no resource and no help for them to do that, whereas, Productive Ward gives them that structure"* **(Kirsty Marshall, Ealing PCT)**

The notions of providing some 'slack' and 'time' for frontline staff to reflect on their routines and established ways of working is clearly important to the programme but so is the sense that staff have 'permission' to make changes that accord with their existing values and commitments.

*"The motivation is there, it just gives you the right environment, it gives you the skills and it gives you the time, and it gives you the space to be able to do what you want to do, and equally, that motivates people to do it... it's not a motivational tool and it's not a gimmick and it's not a Public Relations exercise. I think people think it is that, but when people are actually truly using it, that's when they recognise that actually the system is really powerful"* **(Liz Ward, NHS Institute)**

*"It is about delivering the highest quality care that is possible to the patient, using tools and ideas that are out there, that we know are working, but also using your workforce as a creative energy to be able to develop the service"* **(Lizzie Cunningham, NHS Institute)**

A fundamental factor contributing to stresses within the NHS is the historical low status of nursing. In particular, dissatisfaction amongst nurses about not feeling heard or involved in organisational decision-making. The Productive Ward programme is perceived as helping nurses to reassert their role in the organisation of care.

*"I think there was quite a high degree of stress and demoralisation in a lot of people. So, you know, they, they weren't happy with their lot and they knew next week was going to be a bit like this week. So they were in a position where they were ready for it. I think on organisational levels, there's been much more pressure in the system lately about being far more efficient"* **(Sean Manning, NHS Institute)**

*"So, in a Trust, with a strong clinical leadership, where nursing hasn't been depressed through a more general management model, it became a very powerful tool of change. Where there wasn't that high level of engagement and leadership, they probably didn't really fundamentally change the environment"* **(Tim Curry, Royal College of Nursing)**





Across the NHS there has been a general shift in thinking about organisational decision-making and awareness that practices have tended to be based on tradition and long-established routines. Staff are increasingly more interested in knowing what the basis of decisions are, and what evidence there is to support policy and practice. Hence notions of staff empowerment and engagement through The Productive Ward were central to designing a programme that would enable ownership of change.

*"Nurses don't do jargon, they don't do management speak, they do communicate in a different way to managers and medical staff. They tend to talk in a narrative and tell stories as opposed to being very factually based with their information. And that's part of the caring nature of that role... Productive Ward now is able to put a bit of science behind that, so they're able to more succinctly raise their point and give, articulate better evidence"* **(Lizzie Cunningham, NHS Institute)**

*"A lot of people in the NHS are making gut feeling decisions, and one of the things we help people here do is get some objective information about what's happening. So they make an informed decision. It's about speedy decision making by front line staff who are the people who understand the situation the best"* **(Sean Manning, NHS Institute)**

The Productive Ward appears to tap into this need – to enable nurses to express their knowledge of problems within service systems – in a way that perhaps other improvement initiatives have previously not.

*"Releasing Time to Care has helped nurses themselves shine a light on their practice. Not just on where they think there is a problem but also where they think they are doing well"* **(Christine Beasley, Chief Nurse England)**

*"It's empowering frontline staff to take control of their environment, take control of how they spend their time, and particularly for nurses, doctors and care givers, to maximise their face time with patients"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

Importantly The Productive Ward also presents an opportunity to recognise and acknowledge efforts made by frontline staff (an issue that is explored in more depth in our organisational case studies, Chapter 5). In this vein, many frontline staff who

have been closely involved in The Productive Ward appear to have developed strong leadership qualities, which some stakeholders claimed was an important unexpected outcome of The Productive Ward:

*"When this has been implemented and let's say it's the ward manager or the lead sister or whoever it is that's leading it. By the time they've finished implementing it, they have developed leadership qualities that they never had before. (...) We kind of saw this early on with the four test sites. Four people outgrew their jobs because they've become leaders. They've had to manage difficult conflict and change, share a vision, create a vision, all this kind of thing (...) So if you want to create generations of strong nurse leaders, well the people to start with are ones that have worked their way through the system: it's really, really compelling"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**



One outstanding issue is that it will take time for the full potential of The Productive Ward to be realised within organisations and for the full impact across the NHS to be understood.

*"It took a long time for this model to be developed. It's not going to change the NHS overnight. For organisations, it's how high they put it up on their agenda. I think from a clinical facilitator role, I've gone into lots of different organisations and the ones who have it quite high on their agenda and have got a project team in place and they've shown really good upper management support, do exceptionally well"* **(Kirsty Marshall, Ealing PCT)**

*"The nurses are so empowered, that they're challenging all other kinds of things that had nothing to do with The Productive Ward and started to get a flavour that there was a lot of innovation happening off the back of this. And I don't know that we fully know how big that is actually"* **(Liz Thiebe, formerly at NHS Institute now at King's Fund)**

A further issue, which is examined in Chapter 6, is how The Productive Ward enables linkages between improved patient experiences and ward staff-led service change. Certainly in aspiration at least the programme is a mechanism for patient-focused service improvement.

*"The customer focus fits with the lean philosophy, but the way it's got brought into Productive Ward, I think it has a wider agenda and role - the patient is a much bigger thing, and I think that's been missing in the NHS*

*previously, whereas lean puts it very much at the heart of every improvement that you look at. It looks very much at using our patient experience as an improvement resource"*

**(Kirsty Marshall, Ealing PCT)**

The next chapter focuses on diffusion of the programme and in particular different approaches to implementation at the SHA level. It includes the perspective of SHA leads for The Productive Ward and their experiences of providing support and uptake from NHS trusts in their localities.



## 3. Formal dissemination – SHA support for local adoption and implementation

### SUMMARY

- Different SHAs have used different approaches to implement and support The Productive Ward programme. For example, comparing across the 10 SHAs, there is a large variation in terms of whether trusts have purchased either of the NHS Institute's Accelerated or Standard support packages, or purchased neither. In three of the SHAs over 20 trusts have purchased one of the packages (in some cases directly supported by their SHA) whereas in three other SHAs less than five trusts have done so (and in one of these SHAs none at all).
- Applying a narrow measure of a 'decision to adopt' (ie, the per cent of Trusts that have purchased a support package) shows that 140 acute trusts (40% of all those in England) have adopted the programme to March 2009. Using a much broader measure of 'adoption' (that includes all trusts that have just downloaded materials from the website) shows uptake of The Productive Ward programme by NHS trusts has been very high: 87% in the acute, 92% in the mental health, and 82% in the primary care sectors, respectively.
- SHA leads highlighted the importance of supporting vision, planning and learning in order to engage staff at all levels. Working with trust leads to align the programme with organisational targets was also seen as a key success factor. Several potential barriers to formal dissemination were identified, including the challenges of: winning the hearts and minds of all staff, accessing training and support, rolling the programme out in a planned and measurable way, keeping the programme 'live', and linking it with the transformation of services, existing programmes and evidence of best practice.
- Key areas of impact that SHA leads identified were: improvements in staff skills, more time for better care, improved patient experiences, cost savings, and greater staff satisfaction and retention.

### Introduction

This chapter presents information about the different regional approaches to implementation and support of The Productive Ward programme. It also presents the views of SHA leads about the importance of vision, planning and learning, engaging staff at all levels, barriers to formal dissemination and early indicators of impact.

### Approaches to implementation and support

SHAs have supported the dissemination and local implementation of The Productive Ward in a range of ways, including providing funding, networking opportunities and advice. The following examples show some of the approaches to providing support that have been used.



### **NHS East of England SHA**

The SHA recommended that all trusts in the region make use of an NHS Institute support package. The SHA has initiated sharing events, one to launch the programme, another as a progress event and one forthcoming event to share learning. The chair of the SHA is very involved with the programme and developments have been shared widely at chair/chief executive and other regional director's events.

### **NHS East Midlands SHA**

The SHA established a network across the region. Some trusts have been part of the learning partner teams and whole hospital site projects; others have lean methodology experts in-house and are implementing The Productive Ward without external support.

### **NHS Southwest SHA**

The SHA has encouraged trusts to use NHS Institute support and have a mix of both Standard and Accelerated support packages. Other support is provided by facilitated regional sessions, both with and without support from the NHS Institute. A facilitator is employed by the SHA who visits trusts and teams regularly to both provide advice and share good practice. Some Trusts have also bought in 'lean' support from external consultants.

### **NHS South East Coast SHA**

The SHA has purchased the accelerated support packages for trusts to use and seconded a deputy director of nursing to support the collaborative roll-out of The Productive Ward across the region. The SHA has used their director of nursing network as a dissemination channel and have a lead/director of nursing sponsor who chairs The Productive Ward programme board.

### **NHS London SHA**

The SHA asked trusts to bid for resources they required including: training techniques, an employed project lead for organisation, backfill for one day per week for ward managers for each of the wards/teams participating (in some places this was one to two wards), allowance per ward for equipment and audit time. Trusts could put in a secondary bid for a lead in maternity services. Community and mental health trusts were also encouraged to bid. All trusts that bid (69%, n=49) received funding.

Specific issues influencing the decision to adopt an innovation such as The Productive Ward programme are subtle and complex. 'Adoption' itself comprises different phases, such as first finding out about an innovation, deciding to invest time or resources in it, and then deciding to begin a planned set of activities to implement the innovation. Furthermore, healthcare organisations are made up of individual staff and teams that may be working independently of each other. It is possible for there to be several very different perspectives as to when an 'organisation' decides to adopt an innovation.

In the specific case of The Productive Ward, the decision to adopt could be taken as the point at which a Productive Ward package was first requested (downloaded from the NHS Institute website). However, this is a relatively weak indicator of 'adoption' as it is difficult to

determine whether any action was taken as a consequence (or whether the download was simply initiated by an individual staff member acting outside any formal organisational decision-making process). A more robust measure is the date of purchase of a Productive Ward support package (standard or accelerated). However, a complicating factor is that not all trusts that have adopted and implemented the programme purchased a package.

Statistics from the NHS Institute show that from its national launch in 2008 uptake of The Productive Ward has been high across all regions of the UK. Across the regions between 100% and 75% of all NHS trusts have expressed interest in The Productive Ward programme either through downloading packages from the NHS Institute website or formally purchasing a support package.

**Table 3.1: Total number of trusts purchasing package or downloaded by SHA**

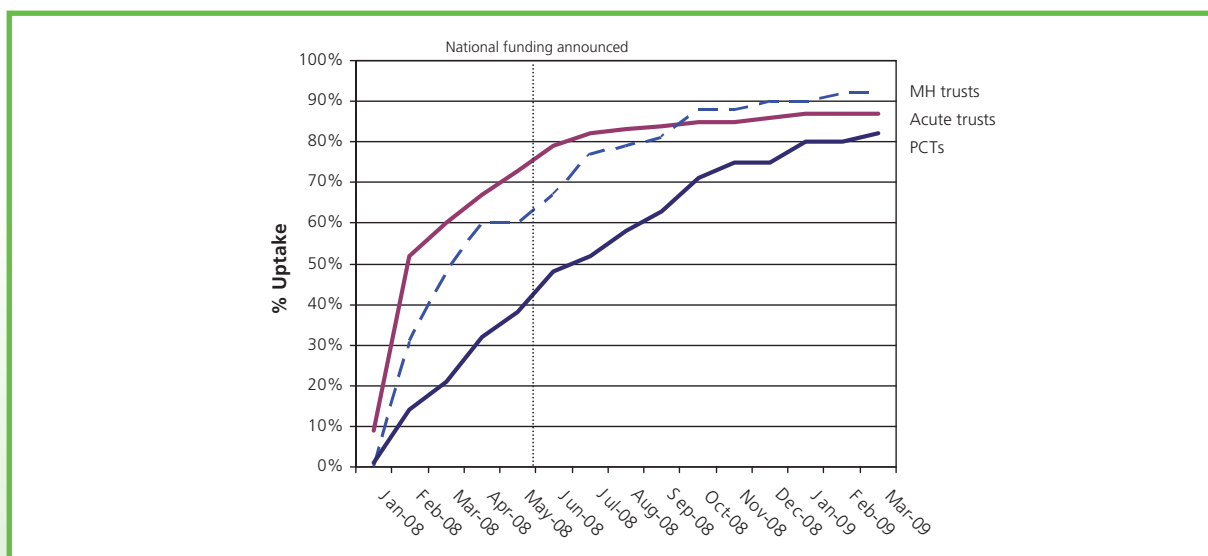
SHA	Total no. NHS trusts and PCTs	Purchased package or downloaded	Adoption (%)
East Midlands	23	23	100
South Central	23	23	100
South West	39	36	92.3
West Midlands	38	35	92.1
South East Coast	28	25	89.3
East of England	40	34	85
Yorkshire and The Humber	37	31	83.8
North West	63	52	82.5
London	75	61	81.3
North East	23	17	73.9

The following figure (Figure 3.1) illustrates the rate of adoption of The Productive Ward nationally using all three of the measures outlined above, ie, the 'decision to adopt' is taken as the date an organisation first downloaded a Productive Ward package or purchased one of the two Productive Ward support packages - whichever date was earliest. The figure, therefore, includes trusts that 'adopted' The Productive Ward programme (by download from NHS Institute website) but did not elect to procure standard or accelerated support packages offered by the NHS Institute.

Using this very broad measure of 'adoption', to date uptake of The Productive Ward by NHS trusts has been high: acute 87%, mental health 92%,

and primary care 82%. As the figure illustrates, by the time central funding was announced in May 2008 momentum had already grown and The Productive Ward had been taken up across the NHS at a rapid rate.

In relation to PCTs, the figures include the first instance of a person within the PCT downloading materials (most likely a PCT board member/clinical lead). The PCT itself may or may not have gone on to procure a Productive Ward support package. The figure does not include any information about downloads or procurement of Productive Community Services or The Productivity Community Hospital programme.

**Figure 3.1: Diffusion curve by organisation type (mental health, acute and primary care trusts)**

### Purchase of support packages and module downloads

The Productive Ward modules and toolkit are freely available to NHS organisations via the NHS Institute website. Trusts also have the option of purchasing standard or accelerated support packages from the NHS Institute.

- Standard package includes: three staff places at Module Implementation Training (MIT), web access, online WebEx clinics and five places at The Productive Ward conference.
- Accelerated package includes: ten staff places at MIT, two staff places at Project Support Training (PST), executive briefing, web access and online WebEx clinics plus five places at The Productive Ward conference.
- Download from website includes: access to all The Productive Ward modules and toolkit via NHS Institute web-site.

The following table (Table 3.2) and figure (Figure 3.2) illustrate variations in purchasing between SHA regions (January 2008-March 2009). Clear differences can be seen between the levels of support purchased, with some regions purchasing the accelerated support package on behalf of all trusts in their region. Taking purchase of the accelerated or standard packages as a narrower (and more formal) measure of 'adoption' than that used in the previous figure, the percentage of NHS acute Trusts that have adopted The Productive Ward programme is 40% (n=140) up to March 2009. It is noticeable how few Trusts have purchased the 'standard' package in relation to the 'accelerated' package, raising questions for the NHS Institute in terms of the 'value-added' of having a 'standard' package at all (only 8% of all NHS acute Trusts have taken this option).

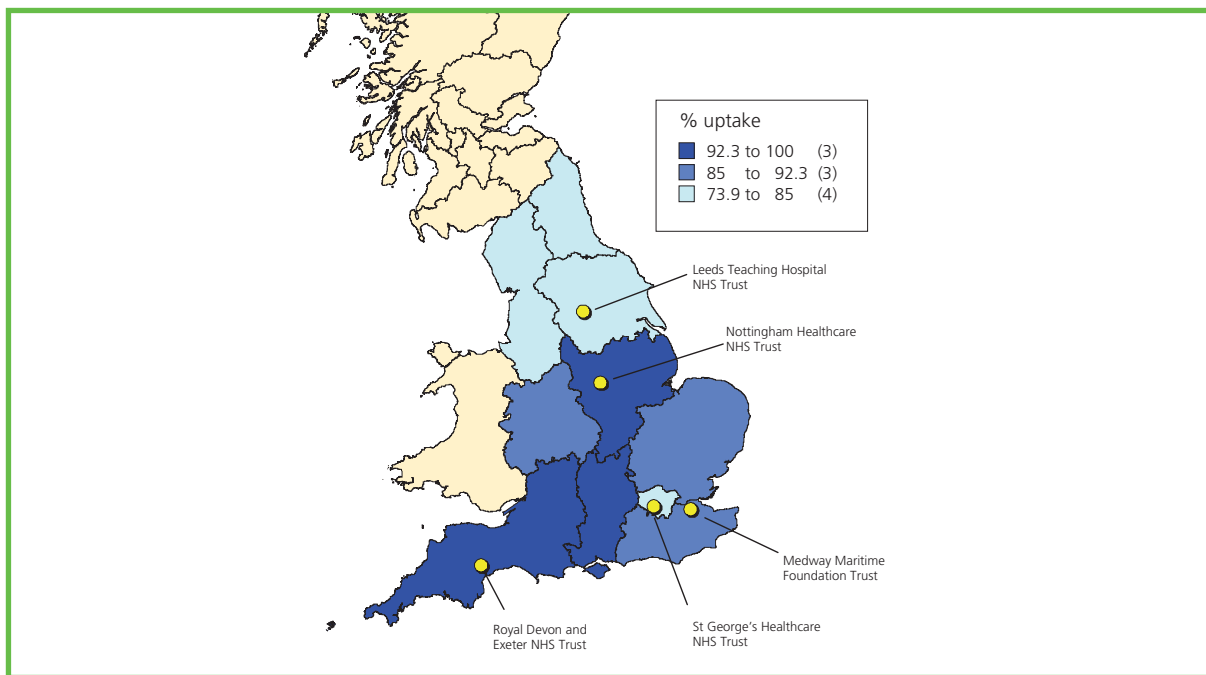
**Table 3.2: Number and percentage of NHS acute Trusts purchasing accelerated or standard support packages by SHA, and number only downloading materials**

SHA	Accelerated (no. and % of all adopters in SHA)	Standard (no. and % of all adopters in SHA)	Download (no. and % of all adopters in SHA)	Total Trusts in SHA (100%)
East Midlands	2 (9%)	0 (0%)	21 (91%)	23
South Central	19 (83%)	2 (9%)	2 (9%)	23
South West	13 (33%)	13 (33%)	10 (26%)	39
West Midlands	2 (5%)	3 (8%)	30 (75%)	38
South East Coast	19 (68%)	0 (0%)	6 (21%)	28
East Of England	27 (68%)	0 (0%)	7 (17.5%)	40
Yorkshire and The Humber	2 (5%)	10 (27%)	19 (51%)	37
North West	8 (13%)	3 (5%)	41 (65%)	63
London	17 (23%)	0 (0%)	44 (59%)	75
North East	0 (0%)	0 (0%)	17 (74%)	23
Total	109	31	197	389

It is clear from the table (Figure 3.2) that different SHAs have used different approaches to implementation and support for The Productive Ward programme. For example, comparing across the ten SHAs, there is a large variation in terms of whether Trusts have purchased either of the NHS Institute's accelerated or standard support packages, or purchased neither.

In three of the SHAs (South Central, South West and East of England) over 20 Trusts have purchased one of the packages (in some cases directly supported by their SHA), whereas in three other SHAs (East Midlands, West Midlands and North East) less than 5 Trusts have done so (and in one of these SHAs – North East - none at all).

**Figure 3.2: Broad measure of 'adoption' of The Productive Ward package by trusts according to SHA region (with case study sites highlighted, discussed in Chapter 5)**



The next part of this chapter presents data from in-depth interviews with SHA leads (n=6). Four main themes were identified using framework analysis (see methods section, Chapter 1). These were:

- support for vision, planning and learning
- engaging staff at all levels
- barriers to formal dissemination
- indicators of impact.

### Support for vision, planning and learning

SHA leads for The Productive Ward described factors that had acted as facilitators to implementation of The Productive Ward in their region. These were felt to include:

- having available external funding
- trusts being involved from the beginning, for example as a pilot site

- executive and senior management support at SHA and trust level
- engagement of all trusts within the region
- clinical leadership in trusts
- access to advice and information.

Overall, SHA leads felt that it was important to explain the vision of The Productive Ward to local staff as a programme seeking to improve both the productivity and quality of services. In this respect, SHA leads played an important role in helping to communicate the explicit intention of the programme to 'release time' to re-invest in quality care.

### Explaining vision

"I was talking to one of the non-execs about Productive Ward, and explaining it. And he said, 'Oh does that mean we can have less nurses then?' He was an accountant by background. And that was good to sort of have somebody actually air that, because it is almost in some ways, the 'elephant on the table' that people don't talk about. And so I said, 'Well actually that's not what it's all about. It's actually so that nurses are doing what they're trained and educated to do in terms of delivery of care'" (deputy director of nursing for SHA)

"Well I think the cost saving is an underlying value in terms of, because this is about productivity. And I know that people don't like that word, but it actually is about maximising nursing contribution to be doing what they should be doing" (SHA lead nurse)

"I made that very clear to the chief exec meeting, that, this was not a way that finance directors could remove...nursing staff because the ward had become more productive. You know, the whole ethos of this is to make sure there's more time to spend on direct care with patients and by that, should become more efficient, because you should, in fact, reduce length of stay because you've got more time to plan somebody's discharge, reducing medication errors, so, you know, that stopped kind of people having to stay in hospital because they were sicker than what they should be, those kind of efficiencies really" (chief nurse for SHA)

SHA leads saw their contribution to facilitating implementation as encouraging ownership, involvement and sharing learning across the region. In terms of our Diffusion of Innovation framework (Figure 1.1), this corresponds with the knowledge transfer role played by change agents.

SHA leads suggested it was important to implement The Productive Ward within

organisations in a planned and measured way, yet at the same time Trusts should promote inclusivity and whole organisation ownership.

There was a sense that it was advisable to show the relative advantage of the programme by implementing it on a few wards at a time and then rolling-out across organisations at a later date.

### Promoting inclusivity

"I think one of the key issues is involvement. It's not done by one person it's done by a group of people, a team of people. And it's also not prescribed, although you've got prescribed modules, you can actually adapt it to local need" (associate director of nursing for SHA)

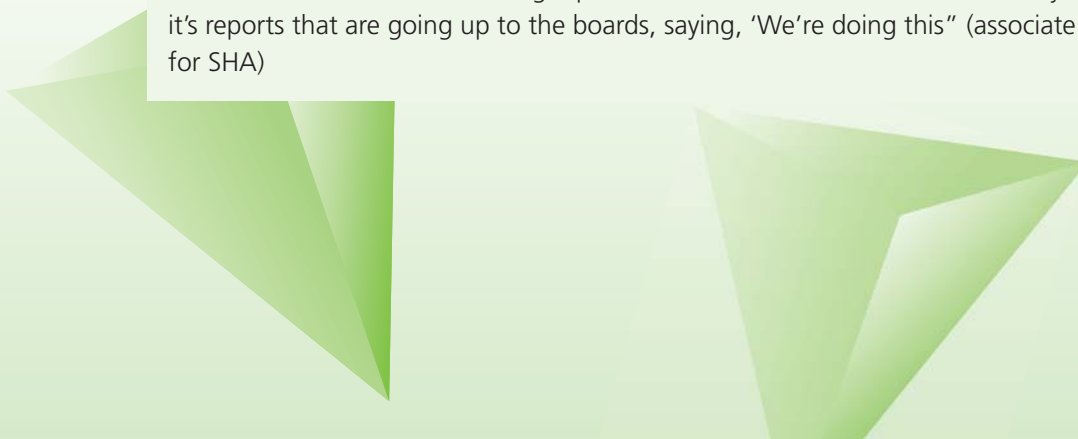
"It's simple and it's based on common sense. And it's something that everybody can get involved with. So I think that's why the take up for it has been so positive" (chief nurse for SHA)

### Sharing learning

"My role within the SHA, it's about learning the lessons and sharing best practice, and being able to sort of facilitate networking to obviously allow those to benefit from that sharing and learnt lessons along the way" (regional lead for clinical standards and patients' experience)

### Whole organisation ownership

"Having looked at it across the patch, what you find is that people actually take pride in it, because it's theirs. And rather than having reports that come down from the boards saying, 'We're doing this,' it's reports that are going up to the boards, saying, 'We're doing this'" (associate director of nursing for SHA)





### Engaging staff at all levels

Although some people suggest The Productive Ward accords more closely with user-led and participative approaches to organisational change, rather than top-down directive approaches, regional leads described the implementation of

The Productive Ward as a ‘top-down-bottom-up’ activity (rather than an ‘either/or’ approach) requiring interest and engagement from all levels of NHS staff. The Productive Ward was also seen as a way of supporting communication between staff.

### Getting ward staff on board

“It tends to be, ‘Oh well we’re too busy to do it, we’ve done it all before, haven’t we?’ and all the rest of it. And I think what we find is that when you actually say to people, ‘Well okay, if you’ve done it all before, that’s great, but let’s start.’ And actually, once you start doing some of the modules, people really can see for themselves” (deputy director of nursing for SHA)

### Leadership and support

“If you don’t get the top table, supporting this you could have your grass roots level, kind of ward sisters, busily doing wonderful things, but if they’re not supported by their Board, it won’t get rolled out real quickly” (assistant chief nurse for SHA)

“Some executives would say they felt this programme would be supportive to nurses and they felt they had to do something for nursing and this ticked the box. Other trusts wanted to improve the patient perspective. Others wanted staff engagement and empowerment” (assistant chief nurse for SHA)

### Communication ‘ward to board’

“Executives in teams where it is flourishing have suggested it is a good tool for ward to board engagement. It gives them the language for engagement” (chief nurse for SHA)

“...if you can get non execs and executives (...) an excuse, if you like, to go and visit a clinical area, bearing in mind... there’s quite a number of them who don’t have a clinical background and I think sometimes people who don’t have a clinical background, find it difficult to walk into a clinical area and know what to talk about. (...) if you’ve got *Releasing time to care*<sup>TM</sup>, which has got a very clear framework, you know, they can logistically go in to clinical areas and talk, you know, in a, in a way, because they understand what the process is and have a very good conversation and therefore are able to support that process. So I think it’s a very clever way of enabling non executives and executives to, you know, get out and about and talk to frontline clinical staff, you know, using *Releasing time to care*<sup>TM</sup> as a bit of a catalyst to do so” (SHA chief nurse)



### Barriers to formal dissemination

SHA leads also described several barriers to the formal dissemination of The Productive Ward across their regions. These were felt to include:

- winning the hearts and minds of all staff
- accessing training and support
- rolling the programme out in a planned and measurable way
- keeping the programme 'live'
- linking it with the transformation of services existing programmes and evidence of best practice.

For SHA leads themselves, challenges included only having limited resources and influence over trusts. A specific challenge was linking The Productive Ward with other organisational initiatives. Stimulating enthusiasm was important to SHA leads but so was evaluating quality improvement and ensuring it remains a high priority for trusts.

### Managing demand

"It is something that clinical staff are hungry for, and everybody seems to know about it. Everybody seems to want to do it" (SHA lead for clinical standards and patients' experience)

### Continued promotion

"We need to ensure it remains forefront in people's minds, but using tools like The Productive Ward, actually do deliver on improving the quality of care, they do deliver on better patient satisfaction survey scores, they do deliver on improved clinical effectiveness from the patient perspective" (associate director of nursing for SHA)

### Commissioning

"In terms of sustainability, the ideal would be that commissioners would be saying, 'Well we only want to commission some Productive services, whether it's Productive Community Series, or Productive Theatres, etc. and actually looking for those quality gains'" (deputy director of nursing for SHA)

### Embedding The Productive Ward into everyday practice

"It's about making sure that the changes that staff are making and seeing, is a change for life and not a change just while the project team are there, that it is about embedding this into everyday practice and it becomes the norm of the working, working life, rather than something that we're doing at the minute" (lead for clinical standards and patients' experience for SHA)



### Indicators of impact

SHA leads identified types of impact of The Productive Ward, summarised in Table 3.3. There is considerable overlap between these themes when compared to those of NHS staff respondents. In particular, views about the impact of more time to provide better care (see Chapter 4, Table 4.5, and Chapter 5 section titled Measuring Impact).

Notably SHA leads reported that staff skills development emerged as a strong and tangible 'unforeseen' outcome for trusts. Indeed a number

of senior stakeholders identified and described The Productive Ward programme as effectively providing a practical leadership programme that had potential to meet the acknowledged deficits in ward level clinical leadership.

*"...they don't realise that in fact, by implementing this in their clinical areas, they in fact go on a leadership programme – and I don't think they realise it until they've finished implementing the Releasing Time To Care™ for their area"* **(SHA chief nurse)**

**Table 3.3: Key themes of impact that regional leads identified included:**

Impact themes	Key outcomes
Staff skills	<ul style="list-style-type: none"> <li>• Practical support for clinical staff to improve working environments</li> <li>• Skills to enhance efficiency of core ward function and therefore provide more direct time to care</li> </ul>
More time for better care	<ul style="list-style-type: none"> <li>• Extra time freed-up because of improved working practices and organisation of wards</li> </ul>
Patient experiences	<ul style="list-style-type: none"> <li>• Visible outcomes and results in real time that are noticeable to patients and visitors eg, well organised wards, patient information boards</li> </ul>
Cost savings	<ul style="list-style-type: none"> <li>• Staff hours saved</li> <li>• Ward resources being used more efficiently</li> <li>• Investment potential of released time</li> </ul>
Staff satisfaction and retention	<ul style="list-style-type: none"> <li>• Improved staff morale</li> <li>• Reduction in sickness absence and staff turnover</li> </ul>
Fit with organisational targets	<ul style="list-style-type: none"> <li>• Framework to achieve organisational targets such as infection control, hygiene, auditing of supplies etc.</li> </ul>

Although regional leads agreed that there are very visible and demonstrable benefits on wards within adopting trusts, they were less certain about the quantifiable impact across organisations and regions as a whole. Some regions are collating baseline data and monthly information in order to identify improvements in a range of quality domains such as reduction in medication errors, increased direct patient care, and reduction in costs for equipment and medicines and improvements in staff morale.

Above all, SHA leads felt that it was important that the impact of The Productive Ward: *Releasing time to care*™ should be measured in meaningful ways that take into consideration the complexity of care, how 'released time' is being better spent, and patient's perspectives of impact.



## 4. Diffusion and impact across the NHS – National web-based survey

### SUMMARY

- Web-survey data from 150 respondents shows that the majority of staff tend to find out about The Productive Ward programme through the professional press or in meetings at work. In most organisations The Productive Ward programme was running on up to six wards. The most common number of wards for the next phase of roll-out was ten. Over half (59%) of implementing wards are Medical, Surgical or Care of the elderly.
- *External resources and support:* The majority of respondents (78%) said that within their organisations specific funding has been made available to help implement The Productive Ward. Respondents accessed further support through visiting other trusts, steering groups, web-networks and learning from colleagues.
- *Internal trust context:* Nearly all respondents agree that 'The Productive Ward fits well with what we want to do in this organisation' (92.3%, 102 of 114 respondents) and that '*Releasing time to care*<sup>TM</sup> is a cause that I strongly identify with' (96.5%, 109 of 113 respondents). The majority of respondents said that staff in their organisation are familiar with working to improve services and can apply these skills to new projects like The Productive Ward. In the main, respondents (more than two-thirds) agreed that leadership and support from senior staff in their trust was generally good. Relatively fewer respondents (just over a half) felt that middle management relationships and communication were generally good in their trust.
- *Internal resources and support:* The majority of respondent's organisations have a clear champion for The Productive Ward and there is a strong clinical leader backing the programme. The majority of respondents (70 or more per cent in each case) agreed that inter-organisational learning, communications and project management of The Productive Ward in their organisations is good. Relatively fewer respondents (37.7%) felt that there was good patient and carer involvement in the implementation of the programme in their trust.
- *Facilitators and barriers:* By far the most commonly reported facilitating factor for The Productive Ward implementation is having dedicated project leadership. Strong support and enthusiasm from senior staff is also important. The greatest barrier to The Productive Ward implementation was staffing pressures. Generating enthusiasm, finding time and resources, and inter-departmental relationships were also potential barriers.
- *Usage and impact of modules and tools:* The Productive Ward foundation modules were most commonly used and this was reflected in the high impact perceived to be associated with these modules. Several of the modules had been used by only a minority of respondents (Admissions and Planned Discharge, Ward Round, Nursing Procedures and Patient Hygiene). The most commonly used tools were activity follow, your vision, meetings, photographs and 5S game. Activity follow and photographs were rated as having the highest impact. Again, several of the tools had only been used by a relatively small number of respondents (cost benefit analysis and time benefit quantification).
- *Perceived impact and Trust-level outcomes:* Although a few respondents said it was too soon to comment about the impact of The Productive Ward the majority (64%) agree 'There have been measurable improvements as a direct result of The Productive Ward'. Respondents said The Productive Ward had given staff more time to provide direct care to patients, it had led to better team working, well-organised and calmer working environments and that staff felt less stressed. The most tangible outcomes for staff were time savings (more efficient practices) and time investment (increase in direct care time). Other common outcomes were improved physical environment and organisation of ward, reduction in patient falls, reduction in staff sickness absence, cost savings, and an increase in staff morale/job satisfaction.

## Introduction

This chapter presents the findings of a national web-based survey about The Productive Ward programme. The chapter examines how staff engage with The Productive Ward programme, their views about external resources and support, internal trust context, resources and support. It also provides detail of usage and perceived impact of specific modules and tools, as well as overall impact of The Productive Ward programme for trusts.

Details of the web-survey questions and respondent profile are provided as an appendix to this report (Appendix 4). Of the 150 individuals who completed the survey the majority of respondents are employed in hospital settings. Other places of work included: community hospitals, SHA, general practice, rehabilitation services, intermediate care hospital and hospice. The largest group of respondents by job role was nursing staff (detail provided in Appendix 4).

## How staff engage with The Productive Ward programme

Nearly half of those who responded to this question in the survey (46%, 67 of 145 respondents) said that they had heard about The Productive Ward before their organisation became involved. Whilst more than two-thirds of respondent's organisations had been engaged in the programme for up to six months, on average a third of the respondents had been involved for six months or more.

As the following table (Table 4.1) shows the professional press and organisational meetings have been important communication channels for finding out about The Productive Ward.

**Table 4.1: Dissemination channels for The Productive Ward**

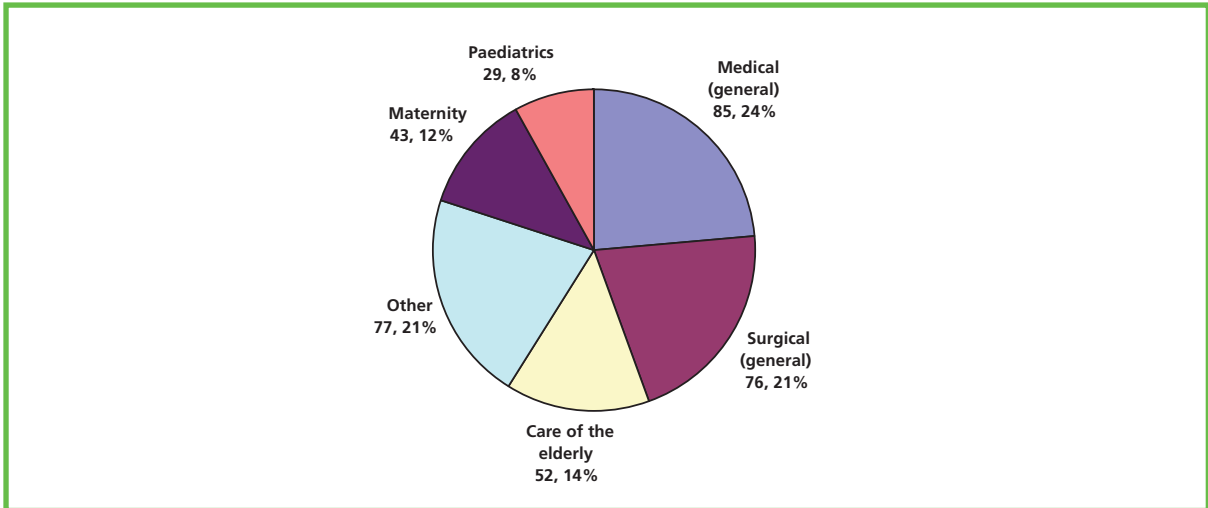
Where first heard about Productive Ward	No.	%
• Read about it in nursing press	31	20.8
• In a formal meeting at work	31	20.8
• Informally from a someone at my place of work	22	14.8
• At a conference or presentation at my work place	17	11.4
• At a conference outside my workplace	14	9.4
• In an email alert or newsletter internal to my place of work	10	6.7
<i>Answered question</i>	149	
<i>No response</i>	1	

To find out about the profile of current implementations of the programme we asked respondents to the web survey what types of wards The Productive Ward was being implemented on in their organisation. Over half of

wards were medical, surgical or care of the elderly. Other types of wards were maternity, paediatrics (and other wards where the programme had been implemented the latter including) critical care and accident and emergency.

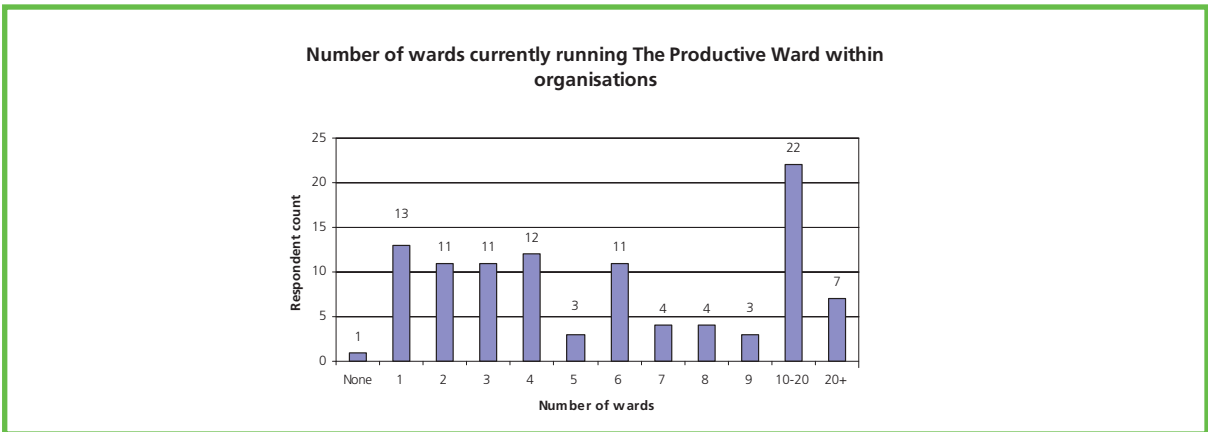


**Figure 4.1: Types of wards The Productive Ward is being implemented on (362 responses in total from 132 respondents)**



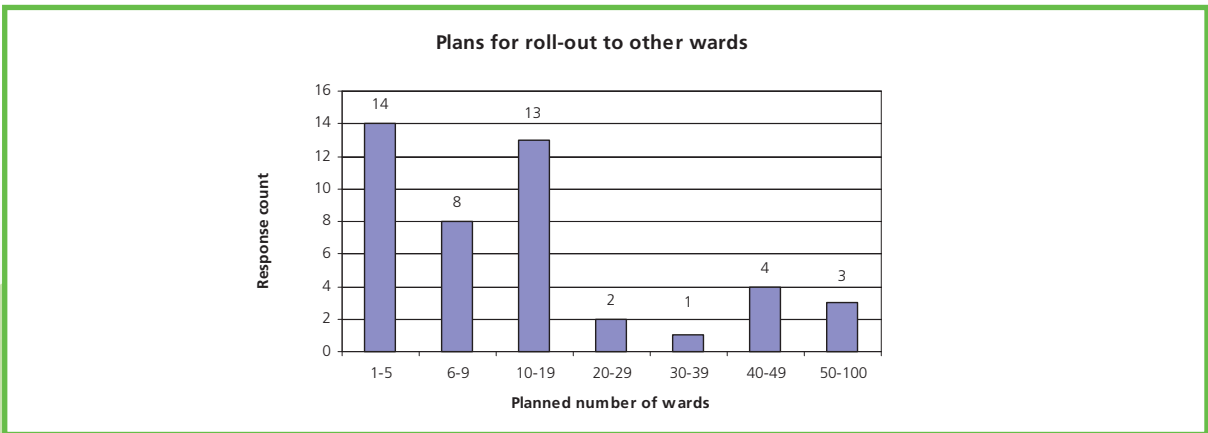
In 62 trusts (of 104) The Productive Ward programme was being implemented on up to six wards. Five respondents said that in their organisation more than 30 wards were taking part in the programme.

**Figure 4.2**



The most popular number of wards for the next phase of roll-out was ten, but ten respondents said that their organisation was planning to roll-out to twenty or more wards.

**Figure 4.3**



### External resources and support

Although some respondents said that their organisation had not received any external funding or resources to implement The Productive Ward, **78.1% of respondents agreed that 'Specific funding has been made available to help implement The Productive Ward in this organisation'**. Acute trusts that had received SHA funding to support implementation of The Productive Ward had invested these resources in project management, facilitation or to provide

cover for staff initiating the programme. In some trusts SHA funding had also helped to begin roll-out of the programme.

Having a dedicated Productive Ward budget was felt to be important both for purchasing equipment to support implementation of the programme and to fund any identified necessary changes within service settings. It appears that for some trusts The Productive Ward is a useful banner under which resources can be drawn together and invested directly at ward level.

### SHA/PCT support

"We have used funding from the SHA to make allocations for enabling works, backfill and facilitation. As well as being useful, it provides a powerful message to ward teams, to say the organisation is funding this" (practice development nurse, general hospital South East Coast region)

"SHA funding for the roll-out of this programme has been invaluable. It has enabled us to have the essential resource of a full-time facilitator, employ a part time handyman and allocate a small amount of funding to each ward to use on backfilling staff and equipment" (Productive Ward facilitator, general hospital South East Coast region)

"The project has its own budget from the PCT, which has greatly eased the problems of obtaining materials like new storage equipment, video/photographic tools, etc." (ward manager, intermediate care hospital South East Coast region)

### Resource allocation within trusts

"The trust has funded the Programme Manager. We have received funding from the Department of Health through the SHA. This has been imperative to taking things forward and has meant we have been able to practically support wards through admin support, equipment (each ward has their digital camera and access to a video and laptop and projector), we have been able to fund some small but significant changes in the wards who have come on board" (ward manager, general hospital South East Coast region)

"Our organisation has successfully introduced all ward leaders and matrons to undertake an NVQ level 3 in Business Improvement Techniques that is based on the 5'S' ethos that underpins the project. We also have a partnership with the lean Healthcare Academy and all staff can access e-learning packages on 5 S's, Process mapping, Standard Operating procedures. All the above serves to consolidate the methods of the project" (deputy ward manager, NHS Foundation Trust South East Coast region)



Facilitation provided by NHS Institute clinical facilitators was generally felt to be useful for providing guidance and encouraging progress.

Study days and conferences were generally felt to be good for sharing learning and ideas about The Productive Ward implementation. Mixed views were expressed about NHS Institute Project

Support Training and Module Implementation Training, principally because of the challenges of releasing staff to attend and the difficulty of providing tailored and timely courses to Trust. In these cases Trusts had sought tailored on-site support from independent organisations, or established full-time organisational Productive Ward facilitator posts.

### NHS Institute facilitation

“We had an Executive Briefing which was helpful. However, I would like to see the NHS Institute return to discuss progress with the Board. That way, interest and engagement at a senior level is kept high on the agenda” (lead nurse for *Releasing time to care*<sup>TM</sup>, NHS Foundation Trust South Central region)

“We had some facilitation from the NHS Institute on areas we were struggling with. It has been useful to have an external perspective” (facilitator, general hospital London region)

“The external facilitator from the NHS Institute has been extremely helpful and we will have a full time facilitator from the beginning of April which will enhance the project markedly!” (matron, specialist hospital West Midlands region)

### NHS Institute study days

“We received three study days facilitated by the NHS Institute. The representatives were very encouraging about what we had done so far and this gave us impetus to carry on and continue to achieve” (ward manager, NHS Foundation trust South East Coast region)

“Initial study days were provided by the NHS Institute however releasing staff to attend was a problem. The study days helped in understanding the toolkit much better than just reading it” (matron, general hospital West Midlands region)

### Tailored support

“We used an external consultant to help develop our own training package. This helped me better understand the delivery structure required” (Productive Ward lead, general hospital South West region)

“We have support from an independent advisor who has been a big influence for me to understand my role. Also how I can support and drive forwards the programme” (Productive Ward facilitator, general hospital South East Coast region)





Whilst some respondents said they were unaware of any external support their organisation had received or how they could access it, others explained the importance of engagement and support from SHAs and primary care trusts. Some respondents (mostly Productive Ward trust leads) were actively engaged in developing and making

use of peer-support networks. Although some respondents commended the support they had received for The Productive Ward through the NHS Institute web-site, a minority suggested that information on the site could be up-dated, ordered more logically and made more accessible.

### Support from SHA leads

“SHA lead meetings have been really useful” (Project Manager, general hospital South West region)

“Support from NHS London has been excellent. Support through the NHS Institute has been essential. Training provided met our needs, together with weekly WebEx sessions and access to an external facilitator has benefited local facilitators and ward leaders” (deputy director of nursing, general hospital London region)

### Self-support networks

“The project management meetings organised by the NHS Institute were helpful, and the WebEx element has real value. However, most support comes from a self-formed group of other facilitators, both met locally and through NHS Institute-arranged events; we meet informally on a regular basis, singly and collectively” (ward manager, intermediate care hospital South East region)

“We receive support from the Strategy and System Reform team NHS Yorkshire and The Humber. This has helped tremendously and the opportunity to network with colleagues around the country has been invaluable” (project manager service development, NHS Foundation Trust Yorkshire and The Humber region)

“Networking meetings allow us to see how others are getting on and to bounce ideas around. It also helps to overcome problems that we may encounter” (staff nurse, community hospital North East region)

### Web-based support

“I use the web site a lot and find this very helpful” (matron, NHS Foundation Trust North East region)

“Web site is limited and hard to find what you need at times” (deputy manager and therapy lead, community hospital North West region)



### Internal trust context

**96.5% of respondents agree that 'Releasing time to care is a cause that I strongly identify with'**

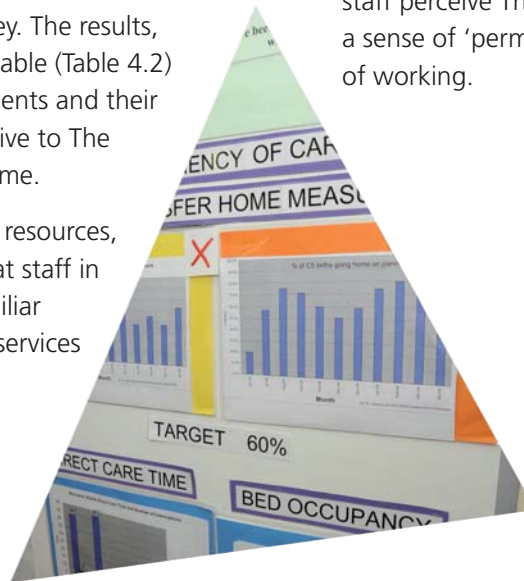
**92.3% of respondents agree 'The Productive Ward fits well with what we want to do in this organisation'**

The original systematic review which informs the Diffusion of Innovation framework (Greenhalgh et al, 2005) identified 11 characteristics of an organisation likely to successfully assimilate a service innovation. We explored these 11 characteristics in our survey. The results, detailed in the following table (Table 4.2) show that overall respondents and their organisations were receptive to The Productive Ward programme.

In terms of organisational resources, most respondents said that staff in their organisation are familiar with working to improve services

and can apply these skills to new projects like The Productive Ward. The majority of respondents (more than two-thirds) agreed that support from senior staff was good in terms of encouraging and facilitating the sharing of knowledge and ideas, and providing leadership and vision. Relatively fewer respondents (just over a half) felt that middle management relationships and communication were good.

Only a third of respondents (34%) agreed that staff in their organisation are rewarded not punished for taking risks. This could explain why staff perceive The Productive Ward as giving them a sense of 'permission' to try new ideas and ways of working.



**Table 4.2: Respondents views about hospital context**

	Strongly agree	Agree	Neither agree/disagree	Disagree	Strongly disagree	Don't know	Response Count
This organisation has a clear division of labour between departments and units, with each concentrating on its own strengths and not meddling too much in the work of others	4.6 (5)	37.0 (40)	34.3 (37)	16.7 (18)	1.9 (2)	5.6 (6)	<b>108</b>
This organisation allows departments and units to make their own decisions	6.5 (7)	53.7 (58)	20.4 (22)	14.8 (16)	1.9 (2)	2.8 (3)	<b>108</b>
Lots of staff in this organisation are familiar with working to improve services and can apply these skills to new projects like The Productive Ward	6.5 (7)	45.4 (49)	29.6 (32)	18.5 (20)	- -	- -	<b>108</b>
This organisation makes adequate resources (money, staff time) available to help us implement new initiatives like The Productive Ward	6.5 (7)	40.7 (44)	26.9 (29)	19.4 (21)	6.5 (7)	- -	<b>108</b>
Staff in this organisation are good at identifying new ways of improving services	13.0 (14)	55.6 (60)	26.9 (29)	4.6 (5)	- -	- -	<b>108</b>
Senior staff in this organisation encourage and facilitate the sharing of knowledge and ideas	15.7 (17)	55.6 (60)	25.0 (27)	3.7 (4)	- -	- -	<b>108</b>
Senior staff in this organisation provides strong and competent leadership and vision	18.7 (20)	45.8 (49)	23.4 (25)	11.2 (12)	0.9 (1)	-	<b>107</b>
Middle management relationships and communication are good in this organisation	4.6 (55)	50.9 (34)	31.5 (13)	12.0 (1)	0.9	-	<b>108</b>
In this organisation staff are rewarded not punished for taking risks	5.7 (6)	28.3 (30)	47.2 (50)	12.3 (13)	1.9 (2)	4.7 (5)	<b>106</b>
Goals and priorities are clearly articulated in this organisation	12.0 (13)	50.0 (54)	6.9 (29)	11.1 (12)	- -	- -	<b>108</b>
In this organisation there are good information and data systems to give timely feedback on the impact of initiatives like The Productive Ward	10.3 (11)	48.6 (52)	27.1 (29)	13.1 (14)	0.9 (1)	- -	<b>107</b>

### Internal support and engagement

**86% of respondents agreed 'There is a clear champion for The Productive Ward in this organisation'**

**84% of respondents agreed 'There is a strong clinical leader, respected by his/her colleagues, who supports The Productive Ward in this organisation'**

The following table (Table 4.3) provides detail of respondent's views about support and engagement specifically in relation to The Productive Ward programme. Overall, the majority of these implementing organisations have a clear champion for The Productive Ward in their organisation and

there is a strong clinical leader backing them.

On the whole these organisations have received, or allocated, specific funding to help implement The Productive Ward and the initiative fits well with professional's desire to spend more time on direct patient care and organisational goals. The majority of respondents (70 or more per cent in each case) agreed that inter-organisational learning, communications and project management of The Productive Ward in their organisations is good.

Relatively fewer respondents (37.7%) felt that there was good patient and carer involvement in the implementation of the programme in their organisation.

Table 4.3: Respondents views about support and engagement

	Strongly agree	Agree	Neither agree/ disagree	Disagree	Strongly disagree	Don't know	Response Count
There is a clear 'champion' for The Productive Ward in this organisation	50.9 (58)	35.1 (40)	11.4 (13)	1.8 (2)	- -	0.9 (1)	114
There is a strong clinical leader, respected by his/her colleagues, who supports The Productive Ward in this organisation	42 (47)	42 (47)	10.7 (12)	1.8 (2)	2.7 (3)	0.9 (1)	112
Specific funding has been made available to help implement The Productive Ward in this organisation	43.9 (50)	34.2 (39)	8.8 (10)	11.4 (13)	0.9 (1)	0.9 (1)	114
There is an experienced and skilled 'change team' in this organisation that facilitates and supports the implementation of The Productive Ward	20.5 (23)	46.4 (52)	18.8 (21)	8.9 (10)	3.6 (4)	1.8 (2)	112
There is strong patient and carer involvement in the implementation of The Productive Ward in this organisation	10.5 (12)	27.2 (31)	36.8 (42)	18.4 (21)	4.4 (5)	2.6 (3)	114
The Productive Ward fits well with what we want to do in this organisation	44.7 (51)	47.4 (51)	7.9 (9)	- -	- -	- -	114
'Releasing time to care™' is a cause that I strongly identify with	73.5 (83)	23 (26)	3.5 (4)	- -	- -	- -	113
This organisation is sharing ideas and knowledge with other hospitals implementing The Productive Ward so that we all benefit from each other's learning	45.1 (51)	37.2 (42)	10.6 (12)	2.7 (3)	- -	4.4 (5)	113
The general communications and information about The Productive Ward are useful	30.7 (35)	52.6 (60)	13.2 (15)	2.6 (3)	0.9 (1)	- -	114
The overall project management associated with the implementation of The Productive Ward is good	27.4 (31)	53.1 (60)	13.3 (15)	4.4 (5)	0.9 (1)	0.9 (1)	113
<i>Answered question</i>						114	
<i>Skipped question</i>						36	



### Facilitators and barriers

Many respondents (n=88 of 150) provided additional comments about the main factors in their organisation that had facilitated the implementation of The Productive Ward.

***By far the most commonly reported facilitating factor was having dedicated project leadership (n=47). Strong support and enthusiasm from senior staff was also commonly felt to be important (n=43).***

Additional factors included enthusiasm and talent of ward managers and staff (n=36), time for staff cover (n=20), funding for implementation and budgets for work and equipment (n=16), the support of skilled facilitators (n=13), good communication (committees/team meetings/Intranet/newsletters) (n=12), good relationships and communication between organisational departments (estates, facilities teams and clerical support) (n=12), seeing and sharing successes (staff and patient feedback) (n=9). Less commonly cited factors were having good Productive Ward information (support package/study days/advice from showcase wards/other trusts) (n=8), Working towards a common goal/vision (ethos of quality improvement, culture of positivity) (n=7), Steering group/project board (n=4), Promotion (launch events, videos) (n=4) and Working at a realistic pace/staged roll-out (n=2).

Respondents were divided in their opinion about whether there were any barriers associated with implementing The Productive Ward. Of 102 respondents just under half said there were, 41% said there weren't any and 14% said they didn't know.

***By far the most commonly cited barrier to Productive Ward implementation was staffing pressures (n=55).***

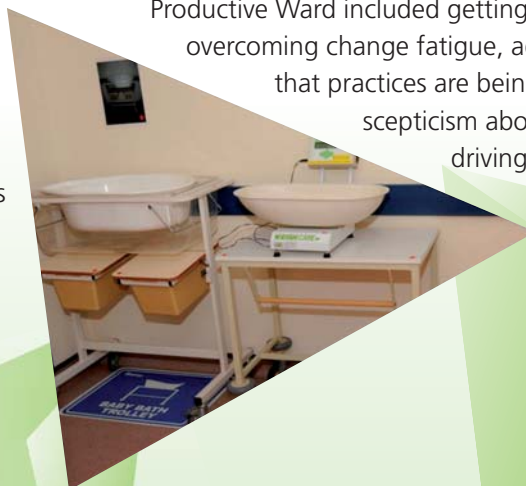
Managing clinical workload, bed pressures, high staff turnover, high sickness rates, winter pressures, infection outbreak, shortage of bank staff were barriers to working on The Productive Ward.

Generating and maintaining staff enthusiasm (including dealing with initiative overload, resistance to change, perceived as a ward-staff initiative, winning hearts and minds of matrons/medical staff/junior staff) was also a common barrier (n=35). As was having time to get everyone involved and to dedicate enough time to Productive Ward work (n=34).

Further barriers included the following:

- Funding (lack of dedicated budget, no backfill funding, hold-up in financing implementation, no investment in training) (n=21).
- Support department issues: poor understanding about The Productive Ward, delays getting purchasing/estates/supplies work done (n=22).
- Lack of dedicated The Productive Ward lead/delay in recruitment/part-time role (n=12). Lack of support/disengagement at Directorate/Senior management level (n=11).
- Gaining access to The Productive Ward training/poor understanding of facilitators about specific ward contexts (n=8).
- Size of organisation/working across multiple sites/organisational change (n=7).
- Difficulty of sustaining improvements/ability to influence change (n=7).
- Planning issues (overly ambitious plans, selection of wards, getting agreement about priorities/who will do what, plans not followed, ward managers not involved) (n=7).
- Lack of organisational data/not able to show impact (n=5).
- Information Technology restrictions/poor I.T skills (n=3).

Specific challenges for staff implementing The Productive Ward included getting staff on-board, overcoming change fatigue, addressing fears that practices are being standardised or scepticism about the motives driving The Productive Ward.



A distinct issue perceived as a barrier was the need to mediate staff expectations about the programme and the impact of The Productive Ward activities. Time was seen as a drawback in terms of finding time for staff on busy wards to participate and having enough time to complete

Productive Ward activities satisfactorily. There was a perceived need to make sure longer-term advances are monitored and evidenced in ways that are meaningful to both ward level staff and at board level.

### Managing staff expectations

“It can be seen as a 'magic bullet' when it is actually a long term programme of cultural change” (assistant director for service improvement, general hospital London region)

“Some staff feel that it's just a way of making the same number of people do more work, rather than increasing staffing” (ward manager, NHS Foundation Trust Yorkshire and The Humber region)

“Expectations may be raised to an unrealistic degree, so that real progress is not properly noted” (ward manager, intermediate care hospital South East Coast region)

### Managing change

“Staff keep going through change - but in this one it is very easy for them to see positive effects very quickly” (Productive Ward facilitator, PCT South Central region)

“Equipping front line staff with service improvement skills and expectations, which middle managers can be challenged by” (service improvement facilitator, general hospital East Midlands region)

“Difficult to begin to convey changes to some members of the management team until results can be seen” (senior nurse workforce projects, general hospital South East Coast region)

### Allocating time

“Time has to be available for the ward staff to spend on it. The time of year it is implemented is also important - rolling it out over the winter period was difficult with all the added winter pressures” (trainee project manager, community hospital South East Coast region)

“It takes time to create the culture for sustainable change in a very 'fast' health care system - with focus on results and outcomes” (matron, NHS Foundation Trust West Midlands region)

“Organisation of baseline measurements - very important but can be time consuming” (service manager, community hospital South East Coast region)



A few respondents (3) felt that there were managerial or organisational expectations that they should work even harder to give time to The Productive Ward activities. These respondents said that unrealistic expectations had led to a decline

in staff motivation and poor uptake or a loss of interest in the programme. For one other respondent, The Productive Ward did not seem to fit with the fast turnover of a day-care environment.

### Difficulties of including all staff

“Does take time and can be difficult if it is not protected. I do have concerns regarding sustainability when backfill money is not available” (clinical director, community hospital South East Coast region)

“Difficult to involve whole team” (trainee project manager, community hospital South East Coast region)

“Always resources are an issue in getting clinical based staff together at the same time to review processes and environment” (project manager service development, general hospital Yorkshire and The Humber region)

### Organisational support and commitment

“Does not work without a good programme lead and organisational commitment” (clinical practitioner educator, general hospital South East Coast region)

“Ongoing support is needed to sustain changes, as if the wards are not assessed and prepared for Productive Ward then it is harder to get going” (Productive Ward facilitator, NHS Foundation Trust South East Coast region)

“It can be difficult for some teams to maintain the momentum and sustain the changes on occasion, this can perpetuate to reduced morale if not dealt with when it starts” (Productive Ward project facilitator, general hospital South West region)

### Balance with clinical responsibilities

“During the initial implementation, it often felt that managers viewed The Productive Ward as more important than meeting the needs of the patients on the ward at the time. Nurses found themselves being asked to clean equipment etc. When the patients they were responsible for that day hadn't even been washed yet. This reduced morale for some time” (staff nurse, NHS Foundation Trust Yorkshire and The Humber region)

“Careful balance not to increase staff pressure to a level that they are unhappy or stressed” (deputy manager and therapy lead, community hospital North West region)



**82.3% of respondents agree 'This organisation is sharing ideas and knowledge with other hospitals implementing The Productive Ward so that we all benefit from each other's learning'**

Several respondents said that visiting or connecting with staff at other trusts that had already implemented The Productive Ward provided useful learning. Networking with people who are working elsewhere in similar types of settings or job roles was useful for mutual

support. Attending organised networking events, steering groups and action learning sets. In some regions trust are beginning to link together making use of web-based networks to share information.

Within organisations much learning about The Productive Ward takes place between colleagues through face-to-face meetings or being informed of progress by receiving copies of meeting minutes or Trust magazines or Intranet web-pages.

### Visiting other sites

"It was really useful to visit other sites further along the 'journey'. It helps to see it in action - this can then be passed onto staff implementing the project" (Productive Ward facilitator, PCT South Central region)

### Steering groups

"Steering group meetings, facilitators communication via face-to-face meetings and email, networking within other trusts and organisations to share knowledge and experience" (Productive Ward facilitator, community hospital South East Coast region)

"As team we attend networking sessions with other trusts undertaking the project within our region to discuss how the implementation is going, what has worked well etc" (Productive Ward facilitator, general hospital West Midlands region)

### Web networks

"South East Coast has a collaborative network which was set up by the directors of nursing and is funded through the SHA. The SHA have provided administrative support to the network and we have links to the improvement lead within the SHA. We have a programme of linking The Productive Ward measures through a web-enabled programme which will allow us to share data and information across the network when this becomes better populated" (executive board member, NHS Foundation Trust South East Coast region)

### Learning from colleagues

"Our ward piloted The Productive Ward for the trust. Since commencing The Productive Ward it has spread to the rest of the hospital. We regularly receive visitors from staff and managers from other wards to see how it functions in practice. We also have a team of nurses whose sole job is to assist other wards in developing The Productive Ward" (staff nurse, NHS Foundation trust Yorkshire and The Humber region)





## Usage and impact of modules and tools

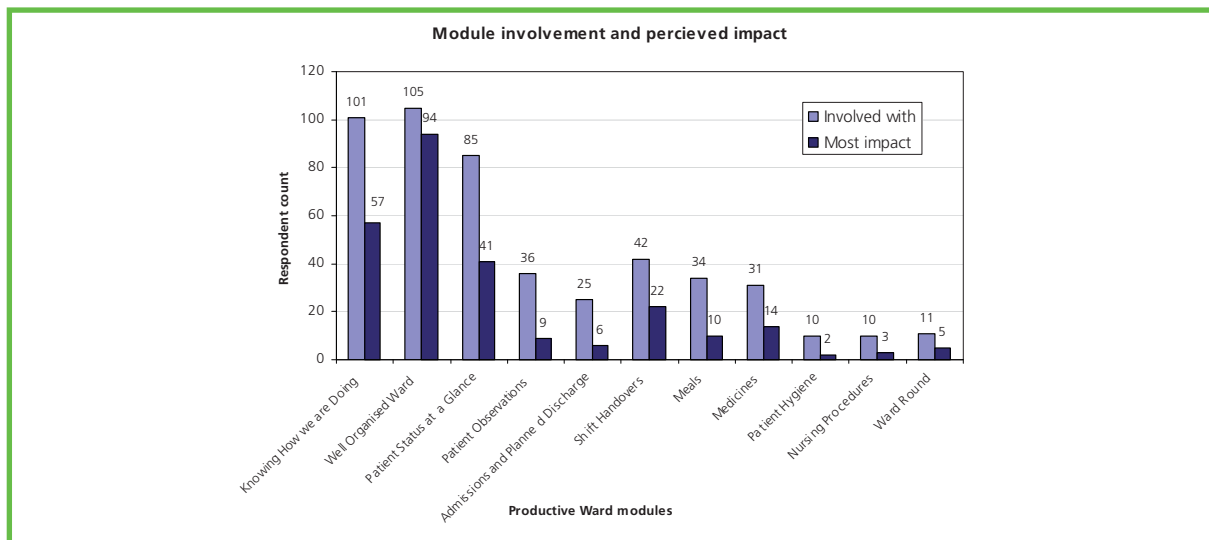
Respondents had most commonly been involved with the foundation modules (Knowing How we are Doing, Well Organised Ward and Patient Status at a Glance). This was reflected in the high impact perceived to be associated with these modules (Figure 4.4). A summary of the contents of the modules and toolkit is provided as an appendix to this report (Appendix 1).

Although fewer respondents reported being involved in other modules (in particular

Admissions and Planned Discharge, Ward Round, Nursing Procedures and Patient Hygiene) this could reflect the fact that many organisations were in the early stages (six months or less) of implementation and had not yet moved on from the foundation modules.

Respondents explained why The Productive Ward foundation modules, in particular, were useful and the impact they have had.

**Figure 4.4: Usage and perceived impact of The Productive Ward modules<sup>1</sup>**



Rank order of effectiveness according to those who have used modules is:

Well Organised Ward 89% (n=93), Knowing How we are Doing 56% (n=57), Shift Handovers 55% (n=23), Patient Status at a Glance 49% (n=42),

Medicines 48% (n=15), Ward Round 45% (n=5), Nursing Procedures 40% (n=4), Meals 32% (n=11), Patient Hygiene 30% (n=3),

Admissions and Planned Discharge 28% (n=7), Patient Observations 28% (n=10).

<sup>1</sup> Figures on usage are derived from multiple response question (n=490 responses in total from 120 respondents). Figures on perceived impact are based on multiple response question (n=263 responses from 113 respondents) where respondents were asked "in their opinion which modules have been most effective".

### Knowing How we are Doing

"It is useful to know how you are doing so you can improve where you need to and if you are receiving praise it motivates you" (ward manager, NHS Foundation Trust London region)

"Collection of baseline data improves ward cohesion, refocuses on patient centred, safe, quality care and allows sharing of knowledge/skills/ways of working" (lead nurse patient safety and quality, hospice South East Coast region)

### Well Organised Ward

"As a team we have been able to look at our area and decide collectively what we want to change and what we can do to improve our process" (Productive Ward facilitator, general hospital South East Coast region)

"The module has allowed staff to take the time to step back from everyday duties and really look at their environment. It has empowered them to make changes that are of real lasting benefit to the whole team and the patients in their care" (deputy director of nursing, general hospital London region)

"Staff can visually see the improvements and get experience working in an organised workplace. As they do this work themselves they have ownership and a vested interest in keeping the improvement" (deputy director of nursing, NHS Foundation trust South East region)

### Patient Status at a Glance

"By redesigning the board, the nurses are interrupted less and the patients journey runs smoothly with no delays" (deputy manager and therapy lead, community hospital North West region)

"Patient status has had a huge impact on discharge progress and every one knows where that patient is on their journey. It stops you being asked the same questions more than once in a shift" (ward manager, general hospital South West region)



**Figure 4.4: Usage and perceived impact of The Productive Ward modules<sup>1</sup>**

Tool	Used		Effective		Used and effective	
	(n)	%	(n)	%	(n)	%
Activity Follow	91	80.5	76	71	76	78
Your vision	87	77	49	45.8	48	55
Meetings	85	75.2	52	48.6	48	56
Photographs	85	75.2	67	62.6	65	76
5S Game	78	69	48	44.9	47	60
Video Waste Walk	61	54	42	39.3	41	67
Timing Processes	58	51.3	26	24.3	26	45
Process Mapping	57	50.4	23	21.5	21	37
Video	54	47.8	29	27.1	27	50
Spaghetti Diagrams	52	46	30	28	30	58
Module Action Planner	38	33.6	11	10.3	11	29
Visit Pyramid	32	28.3	8	7.5	8	25
Audit Planning	31	27.4	9	8.4	7	23
Interviews	30	26.5	15	14	14	47
5-Why Analysis	28	24.8	8	7.5	8	29
Calculating Related Incidents	25	22.1	7	6.5	7	28
Cost/Benefit Analysis	19	16.8	11	10.3	9	47
Time Benefit Quantification	17	15	11	10.3	11	65
Answered question	113		107		(107)	
Total number of responses	928		522		504	
Skipped question	37		43		(43)	

Figures on usage are derived from multiple response question (n=928 responses in total from 113 respondents). Figures on perceived impact are based on multiple response question (n=522 responses from 107 respondents) where respondents were asked "in their opinion which elements of the toolkit have been most effective".

Rank order of effectiveness according to those who have used the tool is:

activity follow (78%), photographs (76%), video waste walk (67%), time benefit quantification (65%), 5S game (60%), spaghetti diagrams (58%), meetings (56%), your vision (55%), with other tools perceived as effective by half or fewer respondents who have used them.



Respondents explained why particular tools ('activity follow', 'photographs' 'meetings') were useful and the impact they had helped to have. It seems that these tools are effective in the early phases of implementation to communicate vision

and identify areas for The Productive Ward work. It is possible that other tools will become more widely used as organisations move through the programme.

### Activity Follow

"The activity follows are a good indication to show how much time is actually wasted through the shift, walking, looking, getting interrupted and how much time is actually spent on direct care. Staff are interested in these and amazed at the results it brings" (healthcare assistant, general hospital West Midlands region)

### Photographs

"Photographs identified areas needing re-organising that on a day-to-day basis you walk past without a second glance" (matron, general hospital West Midlands region)

### Meetings

"Meetings are really important. It gives the participating wards to have a catch up on their progress and share achievements and problems" (Productive Ward facilitator, general hospital South East Coast region)

### Your vision

"Your vision encourages the team to think about what they want to get out of the project" (ward manager, general hospital East Midlands region)

### 5S Game

"It has allowed us to see what we are doing when and why. It has shown us that we have the power to change things for ourselves to make our time more effective" (service manager, specialist hospital North West region)



## Perceived impact and trust-level outcomes

### **64% of respondents agree 'There have been measurable improvements as a direct result of The Productive Ward'**

Although a few respondents said it was too soon to comment about the impact of The Productive Ward programme most perceived it to have given staff more time to provide direct care to patients.

In a few cases time savings had been measured and were expressed in terms of staff hours saved on a ward as a result of better organising sluices, re-positioning ward equipment and drug storage and by improving the efficiency of drug rounds, meal times and shift handovers – however there were not sufficient comparable activities/measures employed to generalise from these examples.

### Time for direct care

"We have already been able to demonstrate increases in direct care time in all of the cohorts to implement the project. Almost all wards have decreased the amount of motion and have also seen significant reductions in interruptions to staff. Many wards have also made one-off cash savings for returning of excess stock and pharmacy" (anonymous, general hospital West Midlands region)

"Due to cutting down on the time spent on shift handovers, the staff have more time to spend with patients. On the afternoon shift this has given the staff time to carry out activities with the patients - this can be anything from chatting to them, playing games such as cards, dominoes etc or taking them for a walk. The patients have seemed happier and less bored and a better rapport has been built between staff and patients" (anonymous, community hospital East Midlands region)

### Evidence to inform purchase/use of equipment

"By rigorously logging the time the ward clerk spent off the ward photocopying drug charts for ordering purposes, and the increased interruption rate, we had the evidence necessary to get a photocopier moved nearer to the ward, reducing a return journey of 382 steps to 130 and get the top-up system reviewed by pharmacy" (ward manager, intermediate care hospital South East Coast region)

"Staff have released time to care for patients through simple changes to stores, moving of cupboards, stock review. Photographs of the before and after have been motivational and are shared with patients, carers and visitors on the notice board. The process has been motivational for our staff" (clinical director, community hospital South East Coast region)

### Less complaints and errors

"When we started the project we had complaints from relatives, high number of falls, high incidence of errors, the nurses were worn out and demoralised, and the patients felt the domestics looked after them. Now the ward team are motivated we have not had a complaint for 7 months the number of falls has decreased and there are no longer errors" (matron, NHS Foundation Trust North East region)



***Many respondents commented that The Productive Ward had led to well-organised and calmer working environments and that staff felt less stressed.***

Anecdotal evidence suggests that The Productive Ward improves staff morale because individuals feel more engaged and empowered to make suggestions for change. In some cases The

Productive Ward also instilled a greater sense of team working and ownership of improvement activities at ward level through staff working together to making change happen. All of these benefits can be a source of motivation for staff to carry on making improvements and to encourage other people to become involved.

### **Staff feel less stressed**

“Simple measures like assessing where equipment is kept and knowing it is there when you are busy reduces frustration and improves efficiency” (matron, general hospital South East Coast region)

“Calm atmosphere. Reduced stress from nurses. Happier team. Staff retention” (Productive Ward facilitator, general hospital South East Coast region)

### **Permission to try changes**

“Staff and patient satisfaction have all increased since starting The Productive Ward. Wards are less cluttered and storage space has been found that we didn't think was there before. Ward staff are putting forward ideas that are being acted upon and tried out” (Productive Ward facilitator, general hospital South East Coast region)

“It has greatly helped ALL grades within the teams to share freely their ideas and value each and every idea as equal. It has improved staff morale in parts but shortage of staff has continued to be a problem” (Productive Ward facilitator, community hospital South East Coast Region)

### **Team working**

“It encourages the team to work together for a common goal. The project is owned by everyone on the ward not just the senior members” (ward manager, specialist hospital London)

“Staff previously disinterested in service improvement are now taking the lead in changes at ward level. They are empowered to challenge and feel supported to keep going until actions are resolved” (project manager, general hospital London region)

### **Commitment to improvement**

“I am a staff nurse and have remained so for 24 years ... Even in the short time we have been implementing The Productive Ward I have seen how much more time I have had to spend with the patients, and it has made my job even more satisfying and rewarding. I am really looking forward to continuing to implement this as I feel it is really beneficial to both staff and patients” (staff nurse, community hospital East Midlands region)



An interesting finding from the survey was that respondents perceived the programme to have greatest (relative) impact on behavioural (team working) and experiential outcomes (staff experience). This is a broader range of outcomes,

than those defined by the aims of the programme (see chapter 1).

It is unclear whether these outcomes are a planned and deliberate aim of The Productive Ward programme or whether they are an unexpected benefit.

**Table 4.5: Respondents ranking of types of impact of The Productive Ward**

Types of impact perceived by staff	High	Medium	Low-none	Response count
Team working	86.3% (88)	12.8 (13)	1% (1)	102
Staff experience	82.2% (83)	17.8% (18)	- -	101
Efficiency	80.4% (82)	19.6% (20)	- -	102
Patient experience	76% (76)	22% (22)	2% (2)	100
Safety	75.2% (76)	21.8% (23)	2% (2)	101
Clinical effectiveness	62.4% (63)	36.7% (37)	1% (1)	101

**By far the most tangible outcomes for staff are time savings (more efficient practices) and time investment (increase in direct care time) (n=25).** This is supported by the views of senior stakeholders (see Chapter 3, Table 3.3) and findings from the case study data presented in chapter 5 (section titled Measuring Impact).

Other outcomes that respondents cited were:

- improved appearance and organisation of ward (n=9)
- reduction in patient falls (n=6)
- reduction in staff sickness absence (n=5)
- stock/cost savings (n=4)
- increase in staff morale/job satisfaction (n=4)
- reduction in medication errors (n=3)
- improved team working (n=3)
- improved patient observations/patient safety (n=3)
- increase in patient satisfaction (n=3)
- reduction in interruptions to staff (n=2)
- reduction in MRSA rate (n=2)
- improved communication and problem solving (n=2)

- reduction in patient complaints (n=2)
- staff more aware of their impact within hospital (n=2).

Patient experience featured fairly low in the responses, possibly because staff did not feel able to comment on behalf of patients about their experiences. It could also be that staff perceive these outcomes (additional time investment in direct care, better appearance of the ward, and better patient safety) to automatically lead to, and be indicative of, better patient care experiences.

Other individual respondents said that the impact of The Productive Ward could be measured by: improvements in quality indicators, reduction in clostridium difficile rate, reduction in pressure sores, reduction in length of stay, improved staff retention, standardisation of documentation, improved cleanliness of ward, improved infection control practices, improved shift handovers, increase in patient and relative involvement, and increase in patients discharged on planned date.

## 5. Local stories of implementation and impact - Case studies of five NHS acute trusts

### SUMMARY

- Case studies in five acute Trusts that have implemented The Productive Ward programme showed that key drivers for adoption are specific to each organisation and its strategic goals. For example, The Productive Ward can be seen as a mechanism for organisational change, an opportunity to build leadership capacity, or a way of demonstrating commitment to improving patient care.
- Trusts have devised their own approaches to implementation of The Productive Ward programme. Some trusts have focused implementation on selected wards, some have devised an overall organisational plan for implementation and have rolled-out the programme in stages or phases, whilst others have undertaken immediate whole-organisation implementation.
- Resourcing of the programme has been managed in different ways. Original learning partner trusts received support from the NHS Institute. Some organisations have set up a dedicated Productive Ward team or made use of the skills of existing service development teams with support from lead executives and clinical staff leads.
- Key organisational factors that influenced success at the case study sites were as follows.
  - Staff having a 'felt need' for change: seeing The Productive Ward as a simple practical solution to real problems.
  - Role of the NHS Institute: valuing the NHS Institute and The Productive Ward modules and resources.
  - Going where the energy is: selecting initial wards on the basis of their desire to work on The Productive Ward.
  - Local ownership and real empowerment: emphasising local ownership of the programme and empowerment of ward staff, rather than using a directive approach.
  - Supportive organisational context and resources: providing sufficient resources and support, in particular allocated budgets for backfill of staff time.
- While there are many perceived benefits of The Productive Ward there are currently limitations in being able to demonstrate measurable impact. 'High end' measures (for example number of full-time equivalent staffing hours saved) are not always obvious or of interest to those immersed in Productive Ward work. Detailed assessment of locally available data at our case study sites shows that often only routine clinical or administrative measures are available. Potential comparable data across the five sites included: falls incidence, MRSA rates, pressure sore incidence, staff satisfaction surveys and staff sickness/absence.
- Typically, data was collated over a relatively short period of time, and only from the start of implementation of The Productive Ward, and so it is not possible to show longer-term trends such as changes in clinical indicators or staff outcomes. Comparative statistical analysis between wards and trusts is problematic because data is not collected frequently or consistently enough. However, for some wards there is longitudinal evidence on some metrics of improvements.
- Staff express a strong conviction that, unlike many other service improvement initiatives, The Productive Ward can be sustained. However, two major areas of concern are how to show evidence of the promised greater efficiencies, and that the measures are insensitive to improvements being observed at ward-level.



## Introduction

This chapter presents findings from five case studies of The Productive Ward implementation in NHS acute trusts. It looks at:

- key drivers of uptake
- approaches to implementation
- organisational factors that influence success
- measuring impact
- sustaining improvement.

The case studies involved face-to-face semi-structured interviews with a range of staff, but mostly clinical teams working at ward level (see appendix 5). Evidence from the case studies is used in this chapter to identify five key factors or characteristics within NHS trusts that have led to successful adoption and implementation of The Productive Ward programme (also see chapter 7 'top tips').

1. **Staff 'felt need' for change:** The Productive Ward is perceived as offering a relatively simple practical solution to real problems that are compatible with professional's desire for improvement and tangible results.
2. **Role of the NHS Institute:** Within successful Trusts, the NHS Institute holds credibility with staff, and The Productive Ward resources are well received by those who are directly working on the programme.
3. **Going where the energy is:** A key feature of successful implementation is the principle of

selecting wards on the basis of their desire to work on The Productive Ward, rather than being directed to do so. Working with enthusiastic staff rather than mandating implementation was seen as key to securing staff ownership.

4. **Local ownership and real empowerment:** The Productive Ward programme was perceived as being different from 'top down' change initiatives because of its emphasis on local ownership and empowerment; successful organisations enabled rather than directed staff. Staff share with colleagues stories about the activities undertaken and observed improvements in ways that are meaningful to them.
5. **Supportive organisational context and resources:** Success of The Productive Ward requires sufficient resources and the provision of support and 'headroom' for development, in particular allocated budgets for backfill of staff time and equipment to support implementation of The Productive Ward modules.

### Key drivers for adoption

In all of the case study sites a combination of factors were the driving forces behind the decision to adopt and implement The Productive Ward. At each site these factors were specific to the organisation and strategic goals. For example, for some organisations showing their commitment to the programme was a way of demonstrating commitment to improving the quality of care for patients.

### Box 5.1

**Leeds Teaching Hospital NHS Trust** – The SHA introduced the idea and suggested becoming one of 10 learning partners. This suited the culture and aims of organisation at that time.

**Nottingham Healthcare NHS Trust** – The newly formed trust was created by a merger of two existing hospitals. The Productive Ward was employed as a way of uniting two hospital cultures with one vision.

**Royal Devon and Exeter NHS Trust** – Although the organisation was ready for change in the early days of Productive Ward the trust was not selected to be an early pilot because of investment from other improvement initiatives. However the trust was already resourced with the necessary skills for change so initiated and funded the programme itself.

**St George's Healthcare NHS Trust** – A suggestion and offer of funding by SHA stimulated uptake. The Productive Ward was also seen as an opportunity to build capacity for nursing leadership and efficiency improvement.

**Medway Maritime NHS Trust** – The trust became aware of The Productive Ward as an improvement methodology and felt it could have benefits. The trust expressed interest to work with the NHS Institute and the SHA then agreed to provide funding.

### Approaches to implementation

The following pages (Table 5.1) present a summary of the key characteristics of these five case study sites and their approaches to implementation of The Productive Ward programme.

Table 5. 1: Summary of case study sites

	Leeds Teaching Hospitals NHS Trust	Nottingham Healthcare NHS Trust	Royal Devon and Exeter NHS Foundation Trust	St George's Healthcare NHS Trust	Medway Maritime NHS Trust
<b>Region</b>	Yorkshire and Humber	East Midlands	South West	London	South East Coast
<b>Date of initiation</b>	August 2007	(Mid)-2007	October 2007	March 2008	February 2008
<b>NHSI support package</b>	Learning partner	Accelerated	No support package	Accelerated	Accelerated
<b>Foundation status</b>	Non foundation trust	Non foundation trust	Foundation trust	Non foundation trust	Foundation trust
<b>Internal programme title</b>	"Releasing time to care™"	Productive Ward	Productive Ward	Productive Ward	Productive Ward
<b>Strategy</b>	Overall organisational plan for implementation but rolled out in stages; wards undergo selection process to join	Whole-organisation implementation (one of first two whole-hospital pilots)	Phased whole hospital implementation; initially launched using previous service improvement experience rather than the NHS Institute package; subsequent phases using package	Focused implementation with selected wards supported by dedicated Productive Ward facilitator	Planned and organised strategy for implementation
<b>Resourcing</b>	As an original learning partner received support from the NHS Institute. Have dedicated Productive Ward team skilled in change management	Dedicated service development team with extensive clinical experience	Key executives and staff previously experienced in improvement methodologies; in-house service improvement team, but no dedicated Productive Ward facilitators at launch; June 08 two dedicated facilitators in place	Dedicated project lead and facilitator, both clinically qualified; new resource which will expand as needed	Dedicated Productive Ward implementation team including service improvement and clinical specialists

Table 5.1: (continued)

	Leeds Teaching Hospitals NHS Trust	Nottingham Healthcare NHS Trust	Royal Devon and Exeter NHS Foundation Trust	St George's Healthcare NHS Trust	Medway Maritime NHS Trust
<b>Priorities/goals</b>	Whole hospital rollout	Whole hospital transformation with new culture uniting the two merged hospitals; driving improvements in quality of care; eventual goal is total 'Productive Trust'	Full Productive Hospital; raising standards in quality of care	Spreading learning and improvements across the whole organisation.  Eventual whole hospital rollout. Achieving improvements in efficiency and patient's experience; "Turnaround to transformation"	Achieving service improvement in terms of both efficiency and quality. Capturing learning so far and showing impact of change  Eventual aim: Productive Hospital; all-ward Productive Ward roll out to be phased over two year period
<b>Key features of implementation:</b>	Allowing staff to learn by doing, adapting The Productive Ward to the contexts they are working within  Adapting and developing metrics to their priorities, eg, developing module-level indicators to monitor modules implemented so far  Developing tailored leadership programme to support staff to implement The Productive Ward programme	Networking event for each new cohort approx four weeks before joining; each ward to define their 'vision' for trust-wide communications and networking opportunities a for participants; ward communication review currently in progress  Ongoing action learning sets, extensive training sessions and time out days for each cohort; now also introducing 'Leading a Module' day for registered nurses	Launched programme on three wards without Institute support. Re-launched in Jan 2008 with the NHS Institute Productive programme  Preferred title reflects practical approach characteristic of this site  Extensive experiential learning at all levels, of necessity as The Productive Ward still in development when project initiated here	Supporting and facilitating staff to make The Productive Ward their own project  Wards selected for participation according to the NHS Institute guidelines  Practical/empirical and flexible approach to development of best practise  Full cross-functional team involvement; chief executive and director of estates involved in monthly Productive Ward project board meetings with staff	Supporting and facilitating staff to make The Productive Ward their own project  Wards selected for participation by project manager and team  Regular and extensive communications with teams; networking opportunities at all levels, through public 'The Productive Ward: <i>Releasing time to care</i> <sup>TM</sup> ' status board, weekly ward / monthly steering group meetings etc.; constant contact with chief executive

Table 5.1: (continued)

Leeds Teaching Hospitals NHS Trust	Nottingham Healthcare NHS Trust	Royal Devon and Exeter NHS Foundation Trust	St George's Healthcare NHS Trust	Medway Maritime NHS Trust
<p>Focus on staff empowerment to encourage participation and innovation; ward teams themselves, rather than their matrons, lead applications to join</p> <p>Communication and sharing of learning encouraged, both within and between ward teams; wards within particular specialisations recruited as cohorts together to facilitate shared learning; also organisation's own 'Releasing time to care™' newsletter published</p>	<p>Regular 'ward to board' Productive Ward steering group meetings headed by chief executive</p> <p>All departments involved, including facilities and Estates, which has a dedicated matron focused on The Productive Ward implementation</p> <p>Patient representative assigned to The Productive Ward steering group. Also devising template for patient-observed activity follows to monitor quality of care from patient's point of view</p> <p>Recognition of need to identify and resolve any implementation problems in order to promote sustainability. System of coding wards' progress on modules red, amber or green, to help identify obstacles in implementation</p>	<p>Effectiveness through recognition of value of identifying and implementing small step change; accessible and manageable by all</p> <p>Developed solutions in all areas including leadership approach, methodologies, and synergy of The Productive Ward with other performance tools and initiatives; executives equally hands-on in their involvement with The Productive Ward</p> <p>Pilot site for The Productive Operating Theatre</p>	<p>Special emphasis on managing resources</p> <p>In-house DVD produced to promote Productive Ward ideals and approaches</p> <p>Also participating in The Productive Operating Theatre development</p>	<p>Efficient solution to collecting metrics via well established, award-winning Nursing and Midwifery accounting system</p> <p>Full use of other available training programmes synergistic with and supportive of aims of The Productive Ward</p> <p>Full cross-functional team involvement; involved all directorate nursing heads in Institute induction days from outset; estates, supplies and catering representatives on Productive Ward team</p> <p>In-house DVD produced to promote The Productive Ward ideals and approaches</p> <p>Also participating in The Productive Operating Theatre development</p>

## Organisational factors at case study sites that influenced success

### 1. Staff 'felt need' for change

While the driving force for implementing The Productive Ward varies between case study sites there appeared to be a general readiness and appetite for change and improvements in the way wards are run and nursing care is delivered.

*"It's the ward where the care for patients is given – and actually that's the bit that needs to be the swan sailing serenely on top of the water with the rest of the hospital paddling like mad to keep that swan going along nice and smoothly. But it's not that way round, it's upside down. The wards fill in gaps elsewhere"* **(Productive Ward Facilitator)**

*"Our context was absolutely ripe for it in the sense that we had largely worked our way through establishing the trust on a more substantial financial footing, and we were very keen to move to a post-recovery renaissance phase for the organisation. The Productive Ward is perfect for that"* **(Executive/Board member)**

*"It felt like the right time – and actually it's always a good indicator that staff are asking you to move forward, rather than you telling them we're going to move forward"* **(Productive Ward Lead)**

The Productive Ward is seen as attractive because it aims to improve the quality of care patients receive, which could secure public trust and reflect well on the reputation of the organisation.

*"So it's trying to get the public confidence, and it's going to take a long time to get that faith put back. People aren't reassured about coming in to hospital. So if The Productive Ward could give more nursing time to patients, and reassure patients, I think that's a winner"* **(Productive Ward Lead)**

For staff working at all levels in the case study sites, the notion of focusing on 'core values' and the emphasis on tangible change are central to

the appeal of The Productive Ward.

*"It supports staff to use their experience, draw on the experience of patients and their relatives, and work out how we can do a better job"* **(executive/board member)**

*"Actually giving people ownership and giving the wards or outpatients or wherever, ownership, as well to the patients and to the carers"* **(patient representative)**

*"Raising the profile of nurses and giving them permission to make some changes, and I think one of the values of The Productive Ward is it's the small step changes that actually make a difference"* **(Productive Ward lead)**

The Productive Ward has appeal because it is focussed and simple to understand yet is potentially a means of effecting sustainable organisation-wide improvement. Crucially it was seen as different from other change initiatives:

*"I was really quite excited about it because what I read and saw about it, that it really was something where teams of people who were delivering direct patient care could actually change things for themselves"* **(Productive Ward facilitator)**

*"It makes sense. It's sort of a no brainer in a way (...) We constantly go round in circles in the NHS but we're looking at how we can just do things better and a lot of what we're doing is making things make sense more"* **(Productive Ward trainer)**

*"Surprisingly, some of the people I thought I'd have to work hard with, came on board really quickly. My older nurses, who you'd think had seen it all before and had been cynical about some other projects, they could see through to what they thought was going back to basics"* **(ward sister)**

Initial understanding of the programme varied between organisations, as did the relative appeal of the two-part programme title. In some cases trusts avoided the use of the title 'The Productive Ward' referring to the programme exclusively by the name "Releasing time to care™". This clearly shows that the dual title provided organisations with a choice about how they would pitch the programme to staff.



*"Nursing staff like to call it Releasing time to care™. That's what matters to them, and that's what it's about"* **(Productive Ward facilitator)**

*"Releasing time to care™ is the way I stressed it and I keep saying, 'It's to give you more time to spend with your patients,' which is what we want to do"* **(ward sister)**

*"If we called it The Productive Ward, some people might think that we were trying to make them more productive, and that certainly wasn't the case"* **(Productive Ward trainer)**

Working on The Productive Ward programme appears to tap into a pent up demand for change. A view expressed by nursing staff in particular, is that there has been a long-standing need for change and that The Productive Ward gives permission to suggest ideas and initiate innovation:

*"It was the frustrations you have had for a long time, and stopped thinking about, because they haven't changed. The Productive Ward was actually a project that was saying, 'Well let's stop, let's look at those again now, and actually spend some time trying to fix them'"* **(Productive Ward facilitator)**

## 2. Role of the NHS Institute

In terms of diffusion of innovation, linkages between organisations are important to the uptake of The Productive Ward programme. One factor influencing uptake and the likely success of an innovation is the nature and quality of relationships between a formal change agency, like the NHS Institute, and an intended adopting organisation. The case studies show that the NHS Institute appears to have credibility with front line staff.

*"I think it feels more grounded [than other previous improvement initiatives] and whether that's because the Institute are involved with it ... But it does feel as if it's different, quite definitely. And I do think it might be having the Institute behind it"* **(Productive Ward trainer)**

Staff working to implement The Productive Ward generally said that the programme was relevant to

their goals and provided useful ideas and tools. All teams appreciated the published materials and the web resources, and as they discussed their experiences and individual successes, it was evident that the more they engage with the materials, the better the result. Early adopters of the programme felt they had been at a relative disadvantage compared to organisations that now had The Productive Ward materials available to them which they could adapt to their contexts.

*"I think it's a fantastic package and I think every organisation has done something slightly different with it"* **(Productive Ward facilitator)**

Individuals expressed a range of positive experiences and specific outcomes from the various modules they had completed, and many detailed stories about these were heard. But without question, the greatest impact to date, and of universal relevance, was that of the Well Organised Ward reflecting findings from the web-survey (Figure 4.4). This was already leading to, at the very least, an impression of more time already or soon to be released to care for patients, and some were in the process of monitoring and assessing direct care time.

An important element of the success of The Productive Ward was felt to be the way it encourages personal and team efforts in improvement and innovation, and there was much pride in achievements. The 'Knowing How We are Doing' module is particularly popular among respondents. The ward performance board created as a part of this module was felt to be not just a display of good results, but a working tool to help identify further opportunities for improvement. And, as such, many teams would now have their regular meetings around the board.

*"That's what The Productive Ward does. It shines a mirror and reflects back to them their attitude, behaviours, all sorts of things – one through data, also through videoing each other, through certain activities of meals, meds or obs, or whatever, through all of that"* **(Productive Ward lead)**

The ability to see and share results has also been helpful for sharing successes, particularly for ward leaders, who often acknowledged that previously publication of performance data has tended to be viewed with suspicion by many nursing staff.



The most popular parts of the tool kit for these respondents were those which use visual evidence, such as photos, videos of waste walks and activity follows, as well as other visual activities such as spaghetti diagrams and the 5S game (see Appendix 1 for details). Videos provide opportunities for ward teams to observe and critically reflect on everyday practices.

*"I loved the ideas of filming and using cameras, videos, because I just think that is one of the most powerful things that we can allow people to do, which is to see themselves as others see them, and not how they experience it"*

**(Productive Ward trainer)**

*"It's like you don't realise the chaos that you work in because you do it every day, it becomes normal. And it's only when you actually see it and think, 'Do we actually do that? That's just ridiculous"* **(ward sister)**

However, it must also be emphasised that there has been some initial anxiety among some wards about being filmed and around the notion that they were being 'spied on' by management – and overcoming such fears and thus developing the confidence to challenge the existing status has contributed to the progress they have made towards devising and implementing improvements.

### 3. Going where the energy is

Another key feature of successful implementation is the principle of selecting wards on the basis of their desire to work on The Productive Ward, rather than being nominated. Supporting enthusiastic staff to make changes that help them to do their job, rather than mandating implementation, was seen as culturally important and a contributor to staff ownership.

*"I think if you come from management and say, 'Right we want you to do this one,' it isn't their decision at the end of the day, and you want them to be on board with it, so I've gone down that way of managing it to be honest with you and I think it works"* **(matron)**

*"There is a lot at the moment around the infection prevention work that's going on. It's 'thou shalt do this' and 'thou shalt do the other.' So this is more about 'look at your ward and see yourself where it needs to change"* **(Productive Ward trainer)**

These views about The Productive Ward's potential to tap into self-motivated change align with the views of national stakeholders (previously discussed in chapter 2) who also suggest that to mandate the initiative would jeopardise the 'professional pull' for the project. However, there were also views (supporting the position of Peter Carter at the RCN) that there should be stronger top-down encouragement for less willing wards because of the potential benefits for staff and patients.

*"A few of them have said they don't like change, it's not nice, and we have likened it... to sort of dragging a couple of toddlers out somewhere saying 'You'll like it when you get there!' And that's what they're actually saying now, a couple of them are saying that they never like change and it's horrible, and it's not for them, but it works. And they're going along with it, reluctantly and they're tagging on the end, but they are going along with everybody else, because they can see the benefits"* **(ward sister)**

Many participants said they only fully understood the ethos of the programme by experiencing it. It was not until they were immersed in The Productive Ward work that they really started to see its value. In terms of self-motivated change, communicating vision therefore becomes vital if ward staff are to develop their own plans for change at a pace that suits them. It is also important that staff feel they are permitted to introduce new ways of working.

*"There's this kind of culture, and I think it's very prevalent in nursing, where it has always been very hierarchical. You can't do anything without having asked sister and sister has to ask matron and matron has to ask somebody else. People lose the will to live and they think 'oh I just won't bother"* **(Productive Ward trainer)**

*"You're taking this back, you're taking control. And how good is that? Because it's your patient, you're making the difference to your patient"* **(Productive Ward trainer)**

Many staff said that The Productive Ward programme focuses on the essentials of care, helping nurses and those working with them to address what's really important and in particular to take more responsibility for decisions about basic care.

*"The thing that really appeals to me is because it actually does focus on what nurses do for patients, and how we can improve that, and it*

*focuses on all the essentials of care. I think it empowers ward sisters and ward teams to be able to take control of their environment, and their ward and make it the best"* **(director of nursing)**

Many respondents identified the importance of seeing early results in establishing and maintaining engagement:

*"I think the nurses on the ward were a bit overwhelmed initially by it all. They didn't realise there was all this to do and the thing they were saying to me was, 'Is there going to be some benefits at the end of it? Are we doing all this, and what's going to change at the end of it?' And I think that's how we would have felt at the beginning, but the more you got on down the road of your modules, you could see the benefits that were coming"* **(matron)**

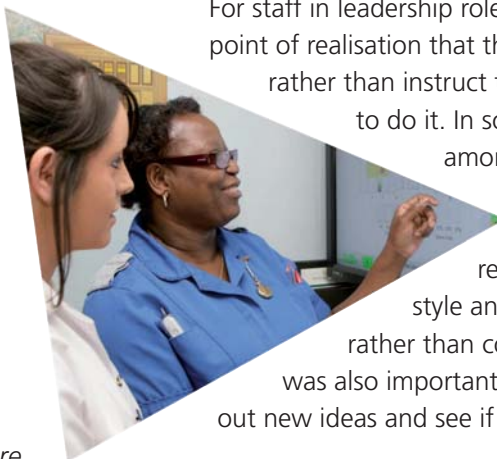
#### 4. Local ownership and real empowerment

The Productive Ward programme was perceived as being different from 'top down' change initiatives because of its emphasis on local ownership and empowerment reflecting the views of SHA leads (Chapter 3). A key aspect of engagement was that staff share stories about the activities undertaken and observed improvements.

*"When we had our cohort meetings, especially at the beginning, when you'd got all your problems, and it was such hard work, we'd get together. I'd never laid eyes on these people before, but we really got very close, because it was, 'Oh I'm so glad you're having that problem too,' whether it was a paediatric ward, a ladies' orthopaedic ward or a male medical ward. Our problems were just the same"* **(ward sister)**

Leadership style was an important factor for overcoming any initial resistance among staff and inspiring staff to find ways to improve practice. The importance of senior leadership in fostering cultural change was recognised by ward-level staff.

*"I think a lot of it is changing, cultural changes, ritualistic practises, how they've always done things and 'oh we can't do it like that, we've done it,' but once they've got into new ways of working, I don't think there's a problem"* **(matron)**



For staff in leadership roles there was often a point of realisation that they needed to guide staff rather than instruct them what to do or how to do it. In some cases, particularly among some experienced ward managers, this meant having to reassess their leadership style and work as a co-ordinator rather than commanding officer. It was also important to encourage staff to try out new ideas and see if they work.

*"I keep going round and saying to people, 'If what you're doing isn't working, stop it and do something different, anything, just try something different and see what happens"* **(Productive Ward trainer)**

*"With a project of this size, it's probably something you have to make your mistakes, learn from them and move on"* **(Productive Ward lead)**

The inherent flexibility is perceived as a key element of success:

*"I think it's that free rein and people being able to develop the modules as they want ... that's helped people to move on as far as they have done ...because they're the people that really know, and the minute you start to put too much of a structure in there, people think that, 'Now we do this, this is the way meals have to run"* **(Productive Ward facilitator)**

#### 5. Supportive organisational context and resources

Across all case study sites implementation and realisation of The Productive Ward ambition required a supportive organisational culture. Fundamental to providing support was the ability to provide 'timeout' from existing work pressures. In many cases even well-established and successful teams found their progress on The Productive Ward had slowed at particular times. The degree of time required of staff also appears to be high and there was a sense that senior management might not always recognise the resources and personal commitment required.

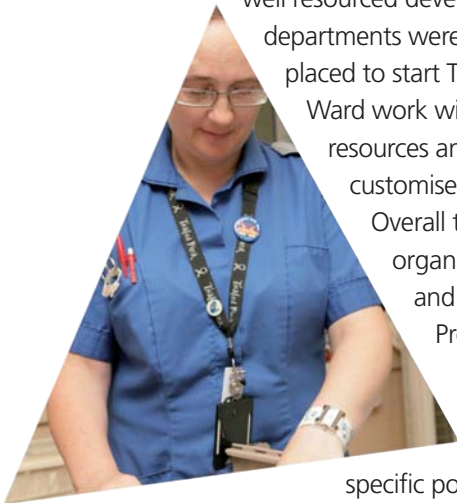
*"We had a brilliant first year. We flew. Everybody was 100% on board, our first two, three modules, flew, and we were doing wonderfully. And then January, all of a sudden we had a very big staff crisis. We were seven whole time*



equivalents short on the ward, and that changed everything. We'd tried to give people time, on the off duty, to do their Productive Ward work. Well all of a sudden that completely stopped. We couldn't cover our off duty, never mind be giving time" **(ward sister)**

"To expect somebody to take on this new initiative or to continue to sustain it with poor staffing, that's just management not really understanding what The Productive Ward is about, I think, because there is a lot of work, it's hard work, and you want to do it properly" **(ward sister)**

Case study sites that had the benefit of well resourced development departments were particularly well placed to start The Productive Ward work with existing resources and to devise customised solutions. Overall this enabled organisations to adopt and implement The Productive Ward more rapidly. Several sites had created specific posts for Productive



Ward facilitators or leads to support implementation. The volume of work involved now meant that all sites were working to expand towards Productive Ward teams with substantive posts and dedicated functions.

It was felt to be important to celebrate these achievements by publicising them to a wider audience so that others get to hear of successful solutions to issues they may face and so the individuals who originate the solutions gain personal recognition and esteem from the experience and become even more strongly loyal and committed to The Productive Ward programme.

"The staff ... take a pride in it, and because it's gone so well, people will come and say, 'May we have a look round?' and they take great pride in the fact that somebody's coming to look round their ward" **(ward sister)**

There were clear examples of how The Productive Ward has given participants opportunities for career development, and its ability to allow this is another factor which is liked by workforce and leaders alike. Furthermore The Productive Ward appeared to provide a practical training in

leadership skills.

"Traditionally in nursing we've not been fantastic at giving all managers leadership training before they go in to post. And this is giving them a real clear focus about how to lead" **(Productive Ward facilitator)**

Some team leaders also explained how publicising individuals achievements further stimulates the 'pull' phenomenon, as initially reluctant team members realise that they too could share in these successes and begin to look for opportunities for getting more involved and making a difference.

"The ward sister asked one of her health carers if she would come and present at the nursing conference, because she had had huge involvement in the programme and she was able to say what a difference it had made to her working day. She was extremely nervous, but she came and she spoke at conference, and then she was asked to take part in some filming, which she did. By this time, she's getting all these accolades and suddenly the other healthcare assistants who weren't interested at all were all on board wanting to do various things, because they thought, we want a bit of that as well" **(Productive Ward trainer)**

The success in unleashing the talent of staff is widely perceived and at all levels of organisations

"It's enabled them to use an established structure and process to harvest the good ideas many staff have had on their minds for years, and we've never actually been able to harvest them" **(Executive/Board member)**



**Photo 5.1: Removal of nurse's station at ward entrance creates more space for ward traffic and more welcoming impression to visitors (Royal Devon and Exeter NHS Foundation Trust)**

One striking observation was that The Productive Ward was seen as an initiative which is democratic in the sense that ownership can be achieved locally and by staff at any level in management positions. Staff described The Productive Ward as providing easier and more effective ways of improving productivity, staff motivation, a better patient experience and financial benefits. In one organisation in particular it was felt that a hospital successfully achieving a Productive Ward culture and systems will be better equipped to deal with any downturn in public spending which may lie ahead.

Many nursing staff said that the programme had enabled them to introduce ward-level initiatives and actions which had produced direct benefits for themselves and their patients. Nursing staff said that The Productive Ward had helped to create a more satisfying and rewarding working environment. A student nurse even commented on arriving on a ward where everything was so neatly organised and labelled she didn't need to ask anyone, and clearly felt more confident in this environment.



**Photo 5.2: Well organised wards mean faster and more accurate access to equipment – easier for staff whether they are familiar or unfamiliar with the ward, and releasing more time for direct care (Nottingham Healthcare NHS Trust)**

Participants at all levels of organisations described 'unexpected' benefits, mainly around improved organisation and efficiency in day-to-day work on the wards, momentum to achieve upgrading of facilities on wards, and greater staff morale and confidence as a result of these. Some clinical staff also commented on a better sense of team building that the programme had achieved, and even that they had met people in similar roles that they might not have done so without it. Regular communications and networking within and outside the organisation had a key part to play.



**Photo 5.3: Service improvements have positive impact on patients (St George's Healthcare NHS Trust)**

## Measuring impact

While there are many visible benefits of The Productive Ward and respondents could identify numerous examples it is clear that there are problematic aspects of perceiving and demonstrating impact. While change may be relatively fast and dramatic to outsiders, measurable impact is not always obvious or of interest to those immersed in The Productive Ward.

*"It was an enormous challenge for us all to get a graph on a ward and getting some of them to understand it. Because to us, as nurses, it's nothing that really turns us on. It's not interesting to us, it's like saying 'Now we'll do some data analysis,' you can almost see most nurses' eyes sort of shut!"* **(Productive Ward facilitator)**

Particular 'high-end' measures that are advocated through The Productive Ward can be perceived as potentially distant and not sensitive enough to detect changes at ward-level.

*"Some of the sort of softer issues, were they being picked up? So, I'm still interested in, when we are monitoring nurses giving direct care time to a patient, actually what is that time spent doing, and how does the patient feel that that time is doing? ... looking at the patients to say, 'What did you get from that interaction with the nurse? Increasing direct patient care is a good thing, but it's then what you do with it'"* **(director of nursing)**

The suggested measures can be perceived to be high level and designed to track programme-wide or organisation-wide changes. Ownership and understanding of metrics by frontline staff was seen as a challenge.

*"I think the set of metrics that come with The Productive Ward, which are the very high level ones, are useful from the perspective of engaging ward sisters and charge nurses, different stakeholders within the organisations, and therefore have a value in themselves, because they show a direction of travel of improvement of change"* **(Productive Ward lead)**

Specifically, there was some concern that given growing financial pressures, a focus on productivity measures (time or cost savings) could threaten the covenant or implied promise to reinvest savings into direct care. Support from frontline staff could diminish if their personal investments begin to be perceived as a mechanism for making direct cost

savings in terms of jobs. More positively, however, The Productive Ward was seen by some participants as a way of coping with such financial pressures.

*"We've been advised that by 2011/2012, that's when the credit crunch will really take effect within the health service. Many Trusts will find themselves in enormous difficulty. And we have to find better ways of staff delivering care that is high quality but also more efficient and this methodology is perfect for that"* **(executive/board member)**

There was also some concern that currently employed Productive Ward measures were not adequately robust or consistently applied:

*"Frankly we were a bit disturbed by the relative paucity of the measurements and the methods used in terms of capturing releasing time to care. I'm sure, whilst they're as good as they can be recorded across the different Trusts doing this, they use significantly different methods. So in terms of how one measures it, I think part of it is getting a methodology that is easy to use, but is reasonably valid and making sure that it's consistently used"* **(executive/board member)**

We also found some evidence of scepticism about some large-scale claims and projections being made about time savings on the basis of such measures:

*"I've observed a number of these national programmes falling into, where the savings are bigged up. They have much pressure from the Treasury and others placed upon organisations to deliver huge savings and so on"* **(executive/board member)**

In this study we undertook a detailed assessment of locally available data in each case study site. Local leads were asked to complete a profile indicating what data was available for their Productive Wards and for comparison wards that had not been part of The Productive Ward programme. Generally only routine clinical or administrative measures were identified as potentially available across all trusts (see table 5.2). Potential comparable data included: falls incidence, MRSA rates, pressure sore incidence, staff satisfaction surveys, and staff sickness/absence. However these had not generally been compiled in order to properly demonstrate change over time, although it might be possible to obtain data on these metrics from trust's administrative systems or other routine returns. However, issues about frequency and consistency of reporting currently make it difficult

to analyse findings and assess impacts across whole organisations. Furthermore, because The Productive Ward is a relatively new initiative it will take time to show impact in clinical indicators and staff outcomes. The NHS Institute are presently undertaking other evaluative work specifically focussing on these issues.

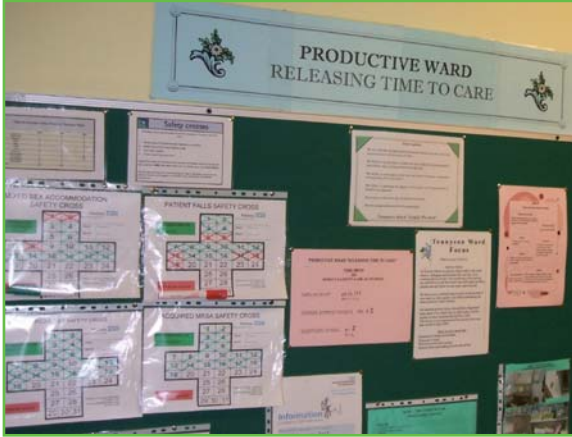
Another evaluation study, commissioned by NHS London SHA and going on at the time of this review, suggests nurses spend an average of 13 per cent more time on direct patient care in 'Productive' Wards because of streamlined ways of working, increasing patient satisfaction by 8 per cent (Snow and Harrison, 2009).

**Table 5.2: Metrics available pre and post Productive Ward implementation**

Case study sites	Royal Devon and Exeter	Nottingham	Leeds	St George's	Medway
<b>Falls Incidence</b>	Pre + Post	Pre + Post	Pre + Post	Pre + Post	Pre + Post
Medication errors	Pre + Post	Pre	-	Pre + Post	Pre + Post
<b>MRSA Rates</b>	Pre + Post	Pre + Post	Pre + Post	Pre + Post	Pre + Post
Patient complaints	Pre + Post	Pre	Pre + Post	Post	Pre
Patient Tracker Data	-	-	Pre + Post	-	Pre + Post
Patient satisfaction surveys	Pre + Post	Pre + Post	Pre + Post	-	Pre + Post
<b>Pressure sore incidence</b>	Pre + Post	Pre + Post	Pre + Post	Pre + Post	Pre + Post
<b>Staff satisfaction surveys</b>	Pre + Post	Pre + Post	Pre + Post	Pre + Post	Pre + Post
<b>Staff sickness/absence</b>	Pre + Post	Pre + Post	Pre + Post	Pre + Post	Pre + Post
Use of bank/agency staff	Pre + Post	Pre + Post	Pre + Post	-	Pre + Post
Patient Observations	-	Post	Pre + Post	-	Pre + Post
C. diff rates	-	Pre + Post	Pre + Post	-	Pre + Post
Ward costs	-	-	Pre + Post	-	Pre + Post
Non-pay expenditure	-	-	Pre + Post	-	Pre + Post
Length of stay	-	Pre + Post	Pre + Post	-	Pre + Post
Patient satisfaction	-	-	Pre + Post	-	Pre + Post
Direct care time	-	-	Pre + Post	-	Pre + Post

## Sustaining improvement

A notable feature of these case studies is the strong conviction among participants that, unlike many other service improvement initiatives, The Productive Ward can be sustained. However, participants described two major areas of concern about the ongoing success and sustainability. As was noted earlier it is important for staff to quickly see the promised greater efficiencies and to feel if more time is available to spend with patients.



**Photo 5.4: Communication about The Productive Ward is essential to ongoing engagement and sustainability (Medway Maritime NHS Trust)**

The difficulty of quantifying time savings to date, due to current lack of agreement on appropriate and reliable metrics, is a challenge for trusts. While current outcome measures for Productive Ward may be perceived by ward staff as distant and insensitive to improvements being observed at ward-level, there is some concern amongst service managers that evidence of impact is not sufficiently robust to assess return on investment and to underpin long term support.

*“We’re a very performance driven NHS at the moment, so there is something about being able to demonstrate some improvement in results because that’s one of the few things that actually drive resource and finance and support, is actually being able to show that it has a tangible benefit. And at the moment it wouldn’t be sufficient for me to say ‘well it feels good.’ So I do need to be able to demonstrate some tangible results” (director of nursing)*

In the medium and longer term The Productive Ward metrics will be invaluable in adjusting policies and processes and targeting investment to develop and improve the programme. Participants also expressed a strong view that improvements at ward-level must be connected with and supported by whole-organisation cultural change.

*“Early on we came to the conclusion that actually we couldn’t have The Productive Ward without having The Productive Trust. The ward is an organism within an organisation” (executive/board member)*



# 6: Applying the Diffusion of Innovation framework to The Productive Ward

## SUMMARY

By applying key aspects of the Diffusion of Innovation framework to The Productive Ward programme it is possible to identify important interactions that have contributed to the rapid diffusion of the programme in NHS acute Trusts.

- The Productive Ward (the innovation) offers a powerful way of engaging, supporting and acknowledging staff for improving the services they provide (the hospital context).
- A carefully balanced combination of programme 'push' (wider NHS and societal context) with professional 'pull' (the hospital context) has a powerful effect.
- External support (linkages) is crucial in some trusts (hospital context) at different phases of the adoption and implementation process; other trusts are a more receptive context for this particular innovation and require little external support.
- The Productive Ward has huge potential impact - but the range and extent of measurable outcomes remain unclear.

## Introduction

As highlighted in the introduction to this report the original Diffusion of Innovation model which has informed the design and analysis of our data collection recognises that the available literature on the issue of diffusion of innovations in healthcare is large, diverse and complex, and highlights the problem of multiple and often unpredictable interactions arising in particular contexts and settings that determine the success or failure of implementing changes (Greenhalgh, Robert, Bate et al, 2005). That systematic review grouped its findings from 213 empirical primary studies under six broad themes:

- the innovation itself
- the adoption process
- communication and influence (including social networks, opinion leadership, and change agents)
- the inner (organisational) context
- the outer (inter-organisational) context
- the implementation/sustainability process.

These themes have previously been applied retrospectively to four case studies on the spread and sustainability of particular innovations in health service delivery and organisations (Greenhalgh, Robert, Bate et al, 2005). It was found that the model provides a helpful framework for explaining the spread and sustainability of the innovations in

the historical case studies and for constructing hypotheses about the success of future innovations that might be in the early stages of dissemination and implementation.

In this review of The Productive Ward programme we have grouped the six themes above into four key aspects of diffusion:

- **The innovation itself**
- **Linkages** (which incorporates themes of communication and influence, for example social networks, opinion leadership and change agents)
- **Hospital context** (which incorporates themes of inner organisational context, adoption, and implementation/sustainability processes)
- **Wider NHS/societal context** (which incorporates themes of outer and inter-organisational context)

Taking each aspect one-by-one we return to one of the stated aims of this review to explain the rapid spread of The Productive Ward programme.

In the table that follows, we apply the Diffusion of Innovation framework to The Productive Ward programme on two levels: we describe the four key aspects (outlined above) as they relate to the programme; and then we highlight probable interactions that have contributed to the diffusion of The Productive Ward programme.

## Applying key aspects of the Diffusion of Innovation to The Productive Ward programme

Table 6.1

1. The innovation itself	The Productive Ward Programme
Key attributes of the innovation as perceived by intended user:	
(a) relative advantage	NHS managers perceive relative advantage as high but only if ward staff engage and improvements on the ground can be demonstrated.
(b) compatibility	The Productive Ward has been framed successfully for multiple audiences, eg, compatible with managerial values (innovative, efficiency) and clinical staff commitment to separating patient-focused work from 'administration'.
(c) complexity	Relatively simple ideas and tools to use (although complexity often over-estimated when The Productive Ward vision is poorly communicated).
(d) trialability	High potential to trial selected modules and tools within the overall Productive Ward framework.
(e) observability	Highly visible and tangible outcomes.
(f) re-invention	High potential for re-invention; organisations likely to selectively adopt component parts (modules and tools) that have already worked well for them in their specific contexts.
<b>Key operational attributes</b>	
(a) task relevance	Generally relevant, useful and feasible but each of these attributes somewhat dependent on selection and application of The Productive Ward component parts (modules and tools) in a specific ward context.
(b) task usefulness	
(c) feasibility	
(d) implementation complexity	May be complex initially due to formulating vision and planning organisation and ward-specific implementation, and aligning with other ongoing Quality Improvement (QI)/Service Improvement (SI) initiatives.
(e) divisibility	Highly divisible, though requires planning and leadership.
(f) nature of knowledge needed	Some knowledge of QI/SI concepts and language needed by those leading implementation – requires willingness to 'take in' new information from frontline staff.

## 2. Linkages

What is the nature of the networks through which influence about the innovation is likely to spread?

Two main mechanisms for spread: formally through SHA to NHS trust networks and informally through interpersonal interest and influence.

Who are the main agents of social influence and what are they doing?

Professional press and organisational meetings are key dissemination routes for finding out about PW. Thereafter impact stories between staff have high degree of resonance and influence.

### The role of external agencies

Are the developers linked with potential users of the innovation at the development stage, and do they share value systems, language and meanings?

Yes: initially expert opinion leaders – mainly academics and quality improvement experts – conveyed principles to a range of local champions and reframed in terms of shared values and language.

What is the capacity and role of the external change agency (if any) to help organisations with operational aspects of assimilation?

Demand from NHS organisations for the involvement of external change agents (the NHS Institute and management consultancies) initially high; subsequently internal trust Productive Ward teams taken-on more of change agency role.

Who are the main external change agents and do they show:

- (a) homophily
- (b) positive relationships and client-centeredness
- (c) shared language and meaning?

Prominent central change agency (NHS Institute) has offered standard support (training courses/web based information) and organisation specific support (clinical facilitation). Spread is also encouraged by using professional networks and organisational Productive Ward champions (increasing homophily and encouraging shared language and meanings).

Does the dissemination programme follow social marketing principles?

- (a) audience segmentation
- (b) assessment of target group needs and perspective
- (c) appropriate message and marketing channels
- (d) good programme management
- (e) process evaluation

The initial bidding process spread The Productive Ward through local interest groups and led to early adoption by individual NHS trusts.

As The Productive Ward has become a centrally financed initiative the main vehicle for spread is now formal vertical channels (eg, SHA leadership, Executive/board sign-up).

Formal promotion activities of the NHS Institute eg, The Productive Ward conferences/website remain channel for dissemination of concept and learning.

What is the nature and quality of any linkage relationship between the change agency and the intended adopter organisations?

The main change agency was the NHS Institute who benefited from national organisational profile and pre-existing links with SHAs and NHS trusts. There have been variable adoption patterns of purchased packages between SHAs.



### 3. The hospital context

#### Inner context

What are the key structural features of the organisation?

- Size/maturity
- Complexity/differentiation
- Decentralisation
- Slack resources

NHS organisations, variable in size, scope and culture. Foundation/Non-foundation status.

Some organisations have established service improvement teams and history of improvement work which lend support to The Productive Ward implementation. Ward staff perceive advantage of The Productive Ward as having time and permission to make changes that enable them to deliver better patient care.

What is the organisation's absorptive capacity for this type of knowledge?

- Skill mix
- Knowledge base
- Transferable know-how
- Ability to evaluate the innovation

Organisational knowledge bases variable. Transferable knowledge from service improvement teams and leadership experience of organisational change supports The Productive Ward implementation.

Ability to capture and evaluate impact of The Productive Ward is supported by strong internal systems for Information Technology, communication and auditing.

What is the organisation's receptive context for this type of change?

- Leadership and vision
- Values and goals
- Risk-taking climate
- Internal and external networks?

Varies but sponsorship at executive level and clear vision of The Productive Ward as quality improvement process seen as key.

The Productive Ward successes more likely in service improvement/quality focused organisations.

Risk-taking climate best illustrated by willingness to become pilot site for The Productive Ward /whole hospital site, willingness to allow staff to try out ideas within the overall Productive Ward plan.

Visits to other organisations, impact stories have horizontal dissemination influence between peers.

What is the organisation's readiness for this specific innovation?

- Organisational fit
- Assessment of implications
- Dedicated time/resources
- Broad based support

Varies but key features include clear, shared targets, strategic goals – also influenced by any staffing issues/levels of motivation and morale.

Ability to appoint The Productive Ward leads/dedicated posts.

Dependent on organisational promotion and communication of The Productive Ward (ie, publicly identified as a priority by senior leadership).

#### Adopters and adoption

Who are the adopters and what are their characteristics and needs?

Motivated trusts/selection criteria, willingness to engage with the NHS Institute and The Productive Ward programme. Perceived value and impact of The Productive Ward work.

What is the meaning of the innovation to intended adopters?

Dual title offers joint appeal to managers and clinical staff for goals of 'productivity' and 'time to care'.

What is the nature of the adoption decision?

Phases include (1) awareness, (2) committing resources to procure The Productive Ward package or downloading materials, (3) local vision/plan devised and then begun to be implemented.

What are adopters concerns at:	Insufficient staff time. Access to support and training, staff resistance to organisational change.
(a) pre-adoption stage?	
(b) early use stage?	Fit of work with organisational goals, capacity to undertake work, willingness of staff to engage. Additional burden of added work.
(c) experienced user stage, and to what extent are they met?	Roll out, sustainability, assessing and demonstrating impact across trust. Engagement of non-ward based clinical staff and reluctant wards.

### Implementation and sustainability

What are the features of the implementation process in terms of:	The Productive Ward Lead, time for backfill of ward staff.
(a) human resources	Executive/board sponsor, support of service improvement teams, engagement of directorate and service managers (estates/communications/IT etc).
(b) involvement of key staff	
(c) project management.	The Productive Ward lead, steering group, allocated budget, flexible work plan.
What measures are in place to capture and respond to the consequences of the innovation (eg, audit and feedback)?	Institutional audits, specific Productive Ward measures.
What measures enable organisations to develop, adapt and re-invent the innovation (eg, inter-organisational networks and collaboratives)?	The Productive Ward networks and interest groups – regionally variable. Ward and organisation-level data collection differs in purpose and quality. Planning stage – modules tend to be selected and applied rather than adapted. Some trusts devise own packages from concept stage. Application of Productive Ward tools rather than creating new tools.

### 4. Wider NHS and societal context

What is the nature and influence of the socio-political climate?	Staffing pressures, multiple organisational targets, patient expectations and quality standards.
Are there any external incentives and mandates?	SHA recommendations and funding allocation.
What are the prevailing norms from other comparable ('opinion leader') organisations?	Implementing organisations generally seen as leading the way or innovative trusts with commitment to quality improvement.

## Interactions between aspects that have contributed to rapid diffusion of The Productive Ward programme

### ***The Productive Ward (the innovation) offers a powerful way of engaging, supporting and acknowledging staff for improving the services they provide (the hospital context)***

The Productive Ward programme aims to empower ward teams to identify areas for improvement by giving staff the information, skills and time they need to regain control of their ward and the care they provide. A strong message throughout this review is that the motivation for change has always been with staff, but what has previously been lacking has been the sense of permission for them to make the changes they feel should happen. The Productive Ward tools support staff to visualise, bring about and monitor observable improvements in the way services are delivered.

The NHS Institute has worked hard to devise and deliver The Productive Ward programme to the NHS in an appropriate way. Staff who have experience of the programme consistently say that the strengths of the modules and toolkit are that it is useable, adaptable to the contexts they are working in and has the potential to achieve improvements in real ward environments.

The framing of the message seems to have been hugely successful in appealing to different audiences within the NHS. While the 'Productive Ward' title speaks to the values and priorities of senior executives charged with delivering services within budget, the sub-title '*Releasing time to care*<sup>TM</sup>' appeals directly to the values and concerns of professionals. Implicit within the phrase '*Releasing time to care*<sup>TM</sup>' is the promise to reinvest the time and resources that are currently spent on non productive activities. While lean processes and the goal of 'productivity' can be equated with immediate cost savings '*Releasing time to care*<sup>TM</sup>' assures nursing staff that it is not a way of getting more work from fewer staff. At the same time the emphasis on 'productivity' provides assurance to executives and board members that investment in the programme will be returned and that benefits will be tangible.

More than simply appealing to different audiences though, the dual title and the programme itself appear to act as a bridge between the two communities 'board' and 'ward'. It facilitates dialogue by giving a shared language and focal

point where the interests and values of these different staff groups, which are often perceived as diametrically opposed, can converge. It legitimates the language of productivity and cost savings at ward level, making it a constructive and enabling force. Ward-based staff in the case study interviews said that The Productive Ward has given them the language to communicate improvements to managers and board members, and the evidence to argue for change. At the same time Productive Ward work provides a catalyst for board members and executives to communicate more directly with ward based staff.

### ***A carefully balanced combination of programme 'push' (wider NHS and societal context) with professional 'pull' (the hospital context) has powerful effect***

The dual title of 'The Productive Ward: *Releasing time to care*<sup>TM</sup>' encapsulates the combined power of a push for programme development and dissemination with professional pull for the time and tools for quality improvement. Combining the strengths of strategic and self-motivated drivers is a key step towards improved healthcare services on a large-scale.

While this dual framing is a major success of adoption of the programme, and future financial pressures on the NHS may provide further impetus for the diffusion of The Productive Ward; this framing needs to be managed carefully if the ethos of the programme is not to be undermined. As more than one senior stakeholder explicitly said (see Chapter 3) there is a significant danger of a break down in the covenant or implied promise to reinvest savings into direct care.

On the basis of the data captured here, mandating The Productive Ward across the NHS is not the right thing to do. It runs the risk of quashing the bottom-up desire for change that has a direct and visible impact on the day-to-day work of NHS staff. Changes brought about by The Productive Ward programme are ones that staff have often wanted to see happen for many years. The Productive Ward promotes team working and self-directed change by tapping into the values and belief systems of frontline staff; mandating such changes would run counter to many of the key factors relating to the programme's success to date.

This is not to say that central commitment to The Productive Ward is not essential to its success. National resourcing and regional support have

undoubtedly boosted the spread and implementation of the programme. Key facilitators of uptake of the programme itself include distribution of financial resources and leadership support from Strategic Health Authorities, as well as the development of regional networks for sharing learning and expertise.

The majority of our data have been gleaned from people and organisations who have engaged with implementing The Productive Ward to a greater or lesser extent. While this has given considerable insight into perceptions of push and pull factors, further insight might be gleaned from those who have been exposed to the ideas but have not proceeded any further.

***External support (linkages) is crucial in some trusts (hospital context) at different phases of the adoption and implementation process; other trusts are a more receptive context for this particular innovation and require little external support.***

Trusts which already have good internal relationships and communication, adequate staffing/cover and enthusiastic and talented ward managers and staff are more likely to be receptive to implementing The Productive Ward programme. Organisational readiness for implementation is associated with a combination of factors, including having strong support from directorate and executive staff, having a dedicated Productive Ward team or lead in place, as well as dedicated funding for implementation.

Uptake is more likely to be successful if an organisation has the capacity to make use of The Productive Ward information, undertake networking activities, communicate a clear common vision of quality improvement and promote 'The Productive Ward: *Releasing time to care™*' as a way of achieving this vision. It is important, for the NHS Institute in particular, to communicate clear vision, meanings and values; particularly in the early stages of adoption when perceptions and expectations about the programme may be divided or uncertain.

For other trusts, there are a range of stumbling blocks and challenges to implementation to be aware of. Trusts are working in the context of staffing pressures, multiple organisational targets,



patient expectations and quality standards – these factors need to be acknowledged and built into dissemination strategies. For example, SHA recommendations and funding allocation for The Productive Ward activities are important drivers but they may not be taken up by pressurised trusts. Some organisations seem to be better at actively seeking support networks than others, and have existing informal support networks through which to share their experiences of what works

and what doesn't. One strategy may be to draw further on the skills and abilities of early adopting organisations to support wider uptake. Implementing organisations have generally been seen as leading the way or as being innovative trusts with commitment to quality improvement – their skills and learning could be spread by setting up collaborative peer-partnerships between trusts.

The Productive Ward programme is often described as an opportunity for personal development. The Productive Ward leadership training could be one way of supporting staff who have engaged with the programme to move onwards and upwards in their careers and to spread the programme through the NHS. Indeed a number of respondents identified and described The Productive Ward programme as effectively providing a practical leadership programme that had potential to meet the acknowledged deficits in ward-level clinical leadership. There seems to be considerable potential for explicitly linking The Productive Ward modules and principles with initiatives focussing on clinical leadership at this level, for example the RCN's current campaign on the role of the ward sister, and developments in undergraduate nursing curricula where there is an increasing demand for leadership preparation to fulfil the projected future role of the nurse as 'practitioner, partner, leader' (Maben and Griffiths 2008).

Organisations can maintain momentum by embedding the principles of The Productive Ward into institutional ways of working. In the first instance there are key 'change agents' in the dissemination, adoption, implementation and assimilation of the programme. In particular, within organisations factors such as having a realistic and flexible plan, support from a steering group, clinical facilitation and communication about The Productive Ward help to maintain momentum of the work itself. Sharing of tools and resources; and external networking and collaboration

between organisations proved to be essential for organisations when developing plans for implementation. Furthermore, human resources and training and education departments can support ward leaders in being able to sustain The Productive Ward principles, for example through creating audit tools that align with The Productive Ward work or making The Productive Ward experience a desirable criteria in job role specifications.

***The Productive Ward has huge potential impact - but the range and extent of measurable outcomes remain unclear.***

Specific aims of The Productive Ward programme are to:

- increase the proportion of time nurses spend in direct patient care,
- improve experience for staff and patients, and
- to make structural changes to the use of ward spaces to improve efficiency in terms of time, effort and money.

This review finds that the promise of 'The Productive Ward: *Releasing time to care™*' appeals both to service managers and ward staff. For many ward staff and service managers, their vision of The Productive Ward is to drive up quality by improving organisation on the ward, team working and staff morale. Efficiency of staff time spent on the ward is only one part of their vision and the outcomes they have observed.

Participants in this review were all keen to find ways of seeing and sharing successes. At a ward level, visual improvements, time savings, and staff and patient stories provide very powerful examples of impact. However, there is also the wider issue that to sustain financial, political and organisational commitment to initiatives such as The Productive Ward it is important to have reliable evidence that shows it is working. Understanding impact on a bigger scale - across whole organisations and systems - requires being able to draw together data selectively and combine different sources.

One way of doing this, which participants in this review were generally in favour of, is to identify metrics that can provide a good indication of impact. The key issue from the perspective of all stakeholder groups was that metrics align with the vision of what The Productive Ward programme aims to achieve. However, participants from all levels of the NHS felt that metrics should help to achieve vision rather than create false goals or additional

burden on ward staff. Yet, participants also expressed strong views that outcome measures that were useful at ward level differed from those that might be useful at board level.

On one hand there is enthusiasm to develop more robust metrics for The Productive Ward (see case studies, Chapter 5 section on Measuring Impact) at the same time there is some scepticism about large-scale claims and projections being made (for example the extrapolations made on the basis of the recent NHS London evaluation (Snow and Harrison, 2009). If the pressure builds for immediate demonstrable benefits the current enthusiasm and willingness to invest in the programme by boards may be undermined and the support from frontline staff diminish if their personal investments begin to be perceived as a mechanism for making direct cost savings in terms of jobs.

Other types of outcomes, such as improvements in service delivery and staff well-being, can not be effectively measured simply in terms of time or cost savings. Indeed, as many participants in this review said, The Productive Ward programme requires additional time investment from staff and organisations to identify what needs to change, to work out plans, to implement changes and assess impact.

It is important not to overlook the potential impact of The Productive Ward on patient outcomes across whole organisations. This could best be achieved by analysing pre and post implementation data on patient safety and quality indicators at ward level. The case study data in this review shows there are some consistent measures which are employed across the NHS which could usefully inform The Productive Ward Programme (see Chapter 5: Measuring impact). In this review it was not possible to examine patient perspectives of the issues and this is an obvious area where future work could be undertaken.

The increasing use of metric systems for nursing care, and in particular outcomes, provides an opportunity for measurement of wider impacts using data that is already collected routinely in hospitals and, if standardised, more opportunity for local benchmarking (Griffiths et al 2008). The key to making most of this opportunity is to align Productive Ward metrics with such wider metrics for nursing care.

# 7. Conclusions and Recommendations

## 1. The Productive Ward has been successfully framed and communicated in a way that connects with NHS staff's need and will for change

This review examined the perceptions of a range of stakeholders about the key attributes of The Productive Ward: *Releasing time to care*<sup>TM</sup> programme. It looked at the innovation itself and found that it has been rapidly taken up and implemented because:

- it connects with staff goals and values,
- it is useful for achieving ward-level improvements, and
- with adequate support it is feasible to implement.

NHS staff are self-motivated to improve the way their wards are organised and the way direct care is provided – The Productive Ward programme provides a framework for staff to put change into action and to demonstrate what has been achieved. Thus, the programme itself can act as a bridge between the two communities 'board' and 'ward'. It facilitates dialogue by giving a shared language and focal point where the interests and values of these different staff groups can converge.

## 2. The Productive Ward thrives where local communication and leadership are strong

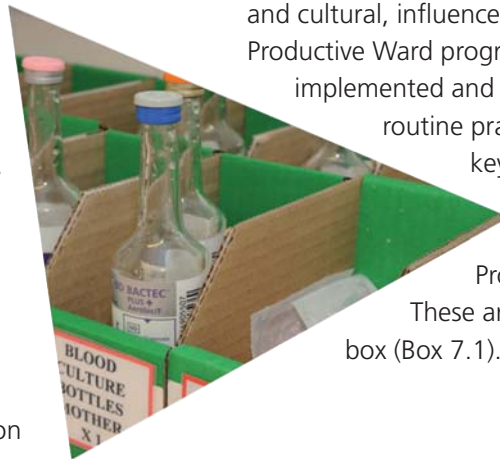
In organisations where a clear vision of quality improvement is communicated and guided by senior staff, ward staff take ownership of The Productive

Ward programme. Trusts that have a culture of service improvement and dedicated teams in place tend to proactively work with the NHS Institute for Innovation and Improvement to support uptake of The Productive Ward programme and achieve successful implementation.

Trusts that do not have these resources in place may require more dedicated time to assimilate what has already been learnt and become ready to implement The Productive Ward. Specifically, organisations need to develop the capacity to make use of The Productive Ward information, undertake networking activities, communicate a clear common vision of quality improvement and promote 'The Productive Ward: *Releasing time to care*<sup>TM</sup>' as a way of achieving this vision.

## 3. Trusts can achieve The Productive Ward successes by following 'top tips' from other organisations

A number of features of hospitals, both structural and cultural, influence the likelihood that The Productive Ward programme will be adopted, implemented and successfully assimilated into routine practice. This review found 16 key success factors for organisations implementing The Productive Ward programme. These are shown in the following box (Box 7.1).



### Box 7.1: Trusts can achieve Productive Ward successes by following 'top tips'

1. **Before launching The Productive Ward** - spend a period of time in a trust where The Productive Ward has been implemented to get a good understanding of what is required. Start to create a buzz in your organisation. Get everyone involved and signed up even if their involvement is minimal.
2. **When planning to implement The Productive Ward** - start with a few wards that want to complete the project then scale-up when appropriate. Invite wards to compete for "showcase" status.
3. **You need strong support from your executive team** - your organisation needs to make it a high priority in practice, not just in principle. Get your managers behind you. Set up a steering group - you may need board-level interventions to get things done.
4. **Secure dedicated resources** - negotiate with senior management clear actions for release and cover of staff to do the work. Release backfill money for certain roles. Set up accounting systems for expenditure. Know what resources are required and put them in place long before starting.
5. **Have a clear leader who is going to actively take charge** and who knows what they are doing so that they can communicate this to other members of the team. Have a dedicated Productive Ward team who will be given time to take this project forward and who are trained on how to develop it.
6. **Make the most of available support** - be open and ask for help, don't be afraid to draw support and advice from the NHS Institute, study days, networks and colleagues, and The Productive Ward literature.
7. **Train key people** in the principles of The Productive Ward and techniques in order to get better staff involvement and engagement.
8. **Set a realistic time scale** - take time and don't rush. Take small steps and complete them before moving on to the next. The project plan should take in to consideration school holidays and busy clinical times.
9. **Concentrate on delivering the core modules first** these will give a foundation for improvement. Ensure you do 'Knowing How We Are Doing' first and get as much baseline data as possible before making any improvement. Take the time to capture evidence and data of where you are now and think about what tools you are going to use to measure improvement and to ensure sustainability.
10. **Ward staff involvement and motivation is imperative** to the success of the programme. Ensure each module is lead by a different member of staff and include non-qualified staff in leading activities. Involve junior staff from the outset.
11. **Allow staff on the ward to make suggestions** - they work in the clinical area and can evaluate if changes are effective, don't impose ideas on them. Choose some projects that produce quick wins. Link activities to your everyday work. Be willing to discuss everyone's ideas and work as a team.



13. **Communicate widely and regularly** – gain ongoing senior management support by starting the visit pyramid and set dates for ward visits. Persist with weekly meetings, type up notes and present results.
14. **Adjust your expectations to match the situation** - don't be frustrated if progress isn't as quick as you would expect. Set clear goals, but don't be afraid to move deadlines as long as there is still a flow of activity and things being achieved.
15. **Identify champions of The Productive Ward area** - ask individuals who are able to motivate others and are willing to explain each stage and key information in simple terms.
16. **Acknowledge ownership and celebrate successes** - share learning across wards and departments, track improvements in patient experience, use staff and patient stories as powerful tools, make use of multi-disciplinary teams and other existing staff groups to spread the learning.

#### 4. There is considerable potential for the ongoing spread and impact of The Productive Ward programme throughout the NHS – consistent measures are required to monitor service-wide improvements

Although it is difficult to predict future uptake of The Productive Ward programme, key influencing factors will be continuation of national resourcing and regional support, plus external support for trusts that do not presently show indicators of readiness (summarised in Table 6.1). It is important to be mindful that the experience of later adopters may differ from early adopting organisations both because of organisational characteristics which led them to adopt late and because they do not gain such benefit from the general enthusiasm associated with the high profile and novelty of the programme.

The Productive Ward programme has a huge perceived value and it is easy to identify local evidence of impact. Senior stakeholders identify benefits including: staff skills, more time for better care, patient experiences, cost savings, staff satisfaction and retention, fit with organisational targets. The potential of the programme to grow leadership skills at ward level is also significant. NHS staff participants reported common outcomes as including: time savings (more efficient practices) and time investment (increase in direct care time) as well as improved appearance and organisation of ward, reduction in patient falls, reduction in staff sickness absence, stock/cost savings, increase in staff morale/job satisfaction, reduction in medication errors, improved team working, improved patient observations/patient safety, increase in patient satisfaction.

These tangible benefits have helped to promote the programme and recognise the achievements of staff who have worked on The Productive Ward activities.

NHS staff and strategic leads are working hard to develop peer-networks between trusts, and there is great potential for The Productive Ward learning to spread further across the NHS and into related sectors. For example, the principles of Productive Ward could provide a very practical component of leadership training programmes for NHS managers and nursing staff.

There is good rationale and data available for further research to undertake in-depth cross-case analysis of impact. However, key issues about The Productive Ward metrics currently being collected are that:

- Locally valued and designed metrics focus on activities that are identified and owned by ward teams. These are valuable but distinctly different in purpose and nature to impact metrics that are useful at an organisational level and across the NHS.
- The NHS Institute template from the 'Knowing How we are Doing' module is good for wards managing data but it is not well set up for whole organisation statistical analysis. Even with use of the template, there is inconsistent reporting between trusts with a considerable amount of missing data.
- Any rigorous assessment of impact of The Productive Ward programme at trust-level requires a minimum of six-month pre and six-month post implementation data, and consistent collection. It is therefore important that the NHS Institute are undertaking new work on wider outcome metrics, possibly as part of measurement toolkits, so that where a particular metric is chosen it is defined and measured in a consistent manner over time and between organisations.



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## Appendix 1: The Productive Ward bibliography

### The Productive Ward - *Releasing time to care™* (box set)

**The Productive Ward -  
*Releasing Time to Care™*.**

**Module Boxed Set.**  
(2008) NHS Institute for Innovation and Improvement. Modules and toolkit. Version 3. ISBN: 978-1-906535-26-1

A boxed set of modular books and supporting information including: Executive Leader's Guide, Project Leader's Guide and Ward Leader's Guide. Module books include: *Knowing How we are Doing, Well Organised Ward, Patient Status at a Glance, Patient Observations, Admissions and Planned Discharge, Shift Handovers, Meals, Medicines, Patient Hygiene, Nursing Procedures, Ward Round. The toolkit involves guided activities: your vision, meetings, activity follow, video waste walk, interviews, photographs, video, timing processes, calculating related incidents, process mapping, cost/benefit analysis, module action planner, 5-why analysis, spaghetti diagrams, audit planning, visit pyramid, 5S game, time benefit quantification.*

(Further detail provided below)

**The Productive Ward -  
*Releasing Time to Care™*.**

**Executive Leader's Guide.** (2008) NHS Institute for Innovation and Improvement. Version 2. ISBN: 978-1-906535-22-3

A guide for Executive Leaders to help design successful outcomes, to outline likely opportunities and challenges and common questions. Sections of the guide include: *Context:* Why focus on direct care has financially beneficial outcome. *Module Structure:* Structure of pack, aim and structure of modules, module summaries, module's status. *Guidance for the Executive Sponsor:* Support, standards, timing, and capitalising on results, training and commitment from line managers, attitudes and approaches to ensure best results. *Getting Started:* Creating goals and strategies, forming recommended teams and roles with commitment and support at all levels, showcase wards, measuring The Productive Ward progress, communications. *Sustain:* Pre-planning awareness, ongoing support and involvement at all levels. *Spread:* Methods for all levels to ensure The Productive Ward is implemented on all wards. Includes a recommended reading list.

**The Productive Ward -  
*Releasing Time to Care™*.**

**Project Leader's Guide.** (2008) NHS Institute for Innovation and Improvement. Version 2. ISBN: 978-1-906535-21-6

A guide for Project Leaders to help construct a workable Productive Ward implementation plan. Sections of the guide include: *Context:* Outline of PW and individual modules, role description and management suggestions, reading list. *Project Start Up:* Preparation and planning at all levels, goals and strategy advice, expected role requirement changes over time, project planning, showcase ward. *Sustain:* Methods to ensure sustainability. *Spread (moving from showcase wards):* Development of 'start small and expand rapidly' and start medium and expand in a linear fashion' shown in Executive's Guide, resources, communication, engagement, reflection and skill building for sustainable and successful 'spread'.

**The Productive Ward -  
*Releasing Time to Care™*.**

**Ward Leader's Guide.** (2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-20-9.

A guide for Ward Leaders to help implement The Productive Ward. Sections of the guide include: *Productive Ward Modules:* Introduction to PW, aims, applicability to the Ward Leader, module summaries. *You:* Various aspects of role of the Ward Leader within The Productive Ward, planning and preparation, implementing, supporting, sustaining, likely barriers, advice and suggestions. *Ward Start-Up:* Outline of team set up in organisation, areas to monitor, alter, prepare and implement prior to starting, suggested implementation and communication methods. *Sustain:* Ward visits, 10 point check list, measurement, key dimensions of care, audits and staff support. *Keep Moving – Spread:* New staff orientation to PW standards, ongoing improvements, building PW into roles, sharing information.

**The Productive Ward -  
*Releasing Time to Care™*.**

**Knowing How we are Doing.** (2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-17-9.

Module book content:

Introduction and rationale. Learning Objectives. Creating module baseline and tracking progress. Explains steps through six-phase process. *Prepare:* Module Roles and Responsibilities. Local Management Role. Gathering Ward Data. Turning ward data into process and outcome measures. *Assess:* five key questions to plan response to the data. Two key questions to ensure the data will lead to change. How to deal with unexpected occurrences. *Diagnose:* four examples of successful methods of displaying processes and outcome measures. *Plan:* Displaying the board. Making it easy to use. Identifying aims and goals using SMART. Ward meetings; good habits, reviewing, communication, preparing staff, are staff ready? Creating the 'Standard Operating

Procedure'. *Treat*: Identifying what to test. Prepare for testing. During the test. *Evaluate*: Agreed changes – checklist. Assessing the impact of the display board and regular reviews. *Appendices*: *How can I make it stick?* Four points to consider incorporating monitoring and audits, leadership, continued improvement, maintaining standards. *Hints and tips – General*: suggestions looking at maintaining enthusiasm, communication, celebrating success, utilising support systems. *Hints and tips – Problem Solving*: Combating five possible problematic areas. *The Productive Ward Measures quick reference table*: Fold out chart. Patient Satisfaction: 5-6 questions to evaluate measures that have been changed – can be analysed quicker than longer more detailed form. *Ward measures self-assessment*: Short questionnaire for Ward Manager to assess changes and see if they are successful/identifiable etc. *Review Meeting Guidelines*. *Weekly Review Meeting Checklist*: Have learning objectives been met? 5 questions to help ascertain this. 10 (11!) point check list.

**The Productive Ward -  
Releasing Time to Care™.  
Well Organised Ward.**  
(2008) NHS Institute for  
Innovation and  
Improvement. Version 3.  
ISBN: 978-1-906535-18-6.

Module book content:

Introduction to the module and purpose of 5S (Sort, Set, Shine, Standardise, Sustain) looks at HOW areas can change, not WHAT to change. *Learning objectives*: How to apply the module, use of toolkit. *Prepare*: Inform ward staff, patients, other necessary internal hospital staff about plans; team is decided and in agreement to participate. *Assess*: Follow the 5S guide to assess the area chosen for intended changes. *Diagnose*: Examples of changes that have worked, suggested audits. *Plan*: Organising the ward using 'Sort, Set, Shine' from 5S model, use of spaghetti diagrams, visual aids, team working to logically reorganise ward. *Treat*: Test changes/difference via feedback, audits, meetings, 'after' videos and, outside senior leadership viewing and auditing. *Evaluate*: Review 'Treat' stages, investigate any further necessary changes, use inventory sheets, communicate findings. Use 'Standardise and Sustain' from 5S model. *Standardise*: definition, aim, process, examples. *Sustain*: aim and process, use of frequent auditing. *How can I make it stick?:* Have in constant process audits and monitoring, leadership in action, continued improvements. Use and revisit learning objectives. 10 point check list.

**The Productive Ward -  
Releasing Time to Care™.  
Patient Status at a  
Glance.** (2008) NHS  
Institute for Innovation and  
Improvement. Version 3.  
ISBN: 978-1906535-19-3

Module book content:

Introduction and rationale for PSAG. *What is Patient Status at a Glance?:* learning objectives, 3 second rule. *What tools will I need?:* Identifies tools and structure cycle. *Prepare*: identify team/staff/ward/policies/governance, information board. *Assess*: Key questions, using Activity Follow analysis, board use analysis. *Diagnose*: six examples of successful ideas. *Plan*: Board considerations, pilot, communication and team involvement. *Treat*: Audit with clear guidelines re: why, for what purposes, use of audit information and people to be involved in the process. *Evaluate*: Use of audit results, verbal communication, trial and error. *How can I make it stick?:* Monitor, audit, leadership in action, continued improvement. Use and revisit learning objectives. Close look at interruptions and surrounding issues. 10 (11!) point check list.

**The Productive Ward -  
Releasing Time to Care™.  
Patient Observations.**  
(2008) NHS Institute for  
Innovation and  
Improvement. Version 3.  
ISBN: 978-1906535-12-4

Module book content:

Introduction and rationale for POBS. *What is the Patient Observations module?:* learning objectives, baseline and progress tracking. *What tools will I need?:* Guide to necessary tools, six-phase process. *Prepare*: nine preparatory steps. *Assess*: nine assessment steps, reliability/alternative audits, using audits to help assessments, five key assessment questions. *Diagnose*: four examples of successful ideas to better organise observation rounds. *Plan*: five key questions, using the toolkit to create and implement the plan, creating a 'standard', equipment organisation. *Treat*: three checklist areas to ensure the plan is successful. *Evaluate*: two steps – collect information, analyse information. How can I make it stick? four consideration points, assessing learning objectives, 10 point checklist.

**The Productive Ward -***Releasing Time to Care™.***Admissions and Planned Discharges.**

(2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-13-1

Module book content:

Introduction and rationale for APD. *What is the Admissions and Planned Discharge module?:* learning objectives, baseline and tracking. *Prepare (Admissions):* preparatory steps for gathering appropriate information about admissions. *Assess (Admissions):* assessment steps of information gathered – serves to give foundation in diagnosis stage of areas in need of change. *Prepare (Discharge):* ten preparatory steps, very similar to admission steps, gathering relevant data. *Assess (Discharge)* –assessment/review steps. *Diagnose:* five examples of successful ideas which improved APD process – intention is to help with ‘Plan’ stage. *Plan:* Design changes/improvements based on areas highlighted by previous steps, involvement of all necessary stakeholders to agree changes, planning how to implement – use of ‘standard operating procedure’. *Treat:* How to test and assess various ideas and outcomes prior to implementation as new structure. *Evaluate:* Builds on ‘Treat’ phase but focuses on bigger picture using three steps looking at data collection, analysis and communication. *How can I make it stick?:* five consideration points, assessing learning objectives, 10 point checklist.

**The Productive Ward -***Releasing Time to Care™.***Shift Handovers.**

(2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-14-8

Module book content:

Introduction and rationale. *What is the Shift Handover module?:* learning objectives. *What tools will I need?:* List of necessary tools, creating and tracking baseline and progress. *Prepare:* preparatory steps using toolkit approach, identify all relevant information pertaining to handovers. *Assess:* Uses: processing located information; accident and errors, patient experience; staff experience and five key questions to enable assessment of current handover state. *Diagnose:* ten examples of successful ideas to help with ‘Plan’ stage. *Plan:* Team approach, plan new design, how it will be implemented, use of ‘standard operating procedure’ so handover is consistent. *Treat:* Identify what is being tested, preparing and assessing testing. *Evaluate:* four steps of information collection, analysis, development and communicating success. *How can I make it stick?:* three consideration points, assessing learning objectives, 10 point checklist.

**The Productive Ward -***Releasing Time to Care™.***Meals.**

(2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-15-5.

Module book content:

Introduction and rationale. *What is the Meals module?:* Further introduction, learning objectives. *What tools will I need?:* List of necessary tools to work through six phase process. *Prepare:* preparatory steps to collate information on current situation, staff and patient input, best practice. *Assess:* the information gathered, accident and errors, patient and staff experiences. *Assess* as closed and open team (ward and non-ward). *Diagnose:* examples of successful ideas in altering meal times to help with planning your own improvements. *Plan:* Using previously gathered information to create a ‘Standard operating procedure’, example from test site. *Treat:* Identify points to test, preparing and undertaking test. *Evaluate:* 3 steps collecting, analysing and locating further areas for improvement in meal time routine. *How can I make it stick?:* three consideration points, assessing learning objectives, 10 point check list.

**The Productive Ward -***Releasing Time to Care™.***Medicines.**

(2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-16-2.

Module book content:

Introduction and rationale. *What is the Medicine Round module?:* learning objectives. *What tools will I need?:* List of necessary tools to work through six phase process. *Prepare:* preparatory steps forming the process and collating relevant information. *Assess:* the information gathered to this point with a focus on the process, accident and errors, staff experience, patient experience, policy. 5 key questions. *Diagnose:* six examples of successful ideas from wards who have improved their medicine rounds. *Plan:* five ‘thought starter’ questions, creating a new design and a ‘standard operating procedure’. *Treat:* Identify what needs to be tested, preparing and undertaking test, keep all staff up to date, included and informed with regular assessment. *Evaluate:* collecting, analysing and locating further areas for improving medicine rounds. *How can I make it stick?:* three consideration points, auditing highly recommended, assess if learning objectives have been met, 10 point checklist.

<p><b>The Productive Ward - Releasing Time to Care™. Patient Hygiene.</b> (2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-09-4.</p>	<p>Module book content:  Introduction and rationale. <i>What is the Patient Hygiene module?</i> Learning objectives, creating and tracking baseline progress, six phase process. <i>Prepare:</i> preparatory steps gather information to give a clear picture of the current patient hygiene routines. <i>Assess:</i> Gathering and understanding information using toolkit. Identify which area/s of PH you want to work on. <i>Diagnose – Featuring ideas that have worked!:</i> ten working examples. <i>Plan:</i> creating new design, agreeing changes, plan and implementing new process, creating a ‘standard operating procedure’. <i>Treat:</i> Identifying appropriate tests, planning the tests. <i>Evaluate:</i> Collating appropriate information, communicating success in measurable ways to ensure sustainability. <i>How can I make it stick?:</i> five consideration points, assessing learning objective, 10 point checklist</p>
<p><b>The Productive Ward - Releasing Time to Care™. Nursing Procedures.</b> (2008) NHS Institute for Innovation and Improvement. Version 3. ISBN:978-1-906535-10-0.</p>	<p>Module book content:  Introduction and rationale. <i>What is the Nursing Procedures module?:</i> learning objectives, creating a baseline and progress tracking. <i>What tools will I need?:</i> necessary tools and the six phase process. <i>Prepare:</i> preparatory steps. Step 3 contains 6 stages of identifying ‘target procedure’. Entire process gathers data to allow for accurate assessment. <i>Assess:</i> Analyse feedback from patients and staff. Identify error rate from incident report forms. Policy explanation. Data analysis and five key questions to help create a clear picture of current situation. <i>Diagnose:</i> nine successfully implemented ideas. <i>Plan:</i> Creating a new NP design; three steps compiling; creating a plan, implanting plan, agreeing changes. Next step is to create a ‘standard’ for all staff to follow. <i>Treat:</i> Test stage; prepare staff/ward/environment for test, necessary undertakings to occur during test phase. <i>Evaluate:</i> two steps; gathering updated data and staff communication and evaluating the data. <i>How can I make it stick?:</i> three consideration points. <i>Spread (to other nursing procedures):</i> How to replicate outcome without repeating unnecessary stages; ‘wide, narrow, wide’. Assess if met learning objectives, three consideration points, 10 point checklist.</p>
<p><b>The Productive Ward - Releasing Time to Care™. Ward Round.</b> (2008) NHS Institute for Innovation and Improvement. Version 3. ISBN: 978-1-906535-11-7.</p>	<p>Module book content:  Introduction and rationale. <i>What is the Ward Round module?:</i> module baseline, tracking progress, guide to tools needed from toolkit and six phase process. <i>Prepare:</i> preparatory steps to gather suitable data for analysis of; communication, team organisation, locating areas for data collection. <i>Assess:</i> Introduction to section, steps of reviewing data, includes input of all ward staff and relevant stake holders. <i>Diagnose:</i> three successful ideas to help with team decision making. <i>Plan:</i> three steps to create new ‘design’ for ward round process, agreeing the changes (consulting various members of the MDT), planning the implementation processes. Next step = create a ‘standard operating procedure’. <i>Treat:</i> Testing the small preliminary changes; considering types of tests, preparing for testing, plan what needs to occur during testing. <i>Evaluate:</i> Build on results from ‘treat’ stage. Three steps; collecting information, analysing it, communicating successes. <i>How can I make it stick:</i> suggestions for ensuring sustainability. Assess if learning objectives met, four consideration points, 10 (13!) point checklist.</p>



**The Productive Ward -***Releasing Time to Care™.*

Toolkit. (2008) NHS

Institute for Innovation and  
Improvement. Version 3.

ISBN: 978-1-906535-08-7

Module book content:

Introduction and explanation of toolkit as reference manual.

*Your vision:* definition, purpose, process, using it for change.*Meetings:* Rationale and purpose, 12 tips, 4 P's – Plan, Prepare, Participate, Pursue.

Agenda design. Role of chairperson.

*Activity follow:* Rationale and purpose, activity follow sheet, 7 preparatory steps, conducting the AF, calculating % of direct care, analysing and interpreting the AF, 'totalising' results to find overall % of direct care.*Video waste walk:* Rationale and purpose, 11 point process in undertaking VWW, 7 types of waste, example of WW sheet, close links to 'video' tool. Interviews: Rationale and purpose, top tips, use of 'open' questions.*Photographs:* Rationale and purpose, top tips, consent.*Video:* Rationale and purpose, top tips, watching video back, advanced tips.*Timing processes:* Rationale and purpose, process.*Calculating related incidents:* Rationale and purpose, method.*Process mapping:* Rationale and purpose, technique, 8 step example, summary.*Cost/benefit analysis:* Rationale and purpose, process.*Module action planner:* Rationale and purpose, using cost/benefit analysis results to design module planner sheet, 9 top tips, detailed MAP and how to fill in the MAP sheet.

5-why analysis: Rationale and purpose, 5-why characteristics, Statement of

problem. Spaghetti diagrams: Rationale and purpose, gathering information, example.

Audit planning: Rationale, examples, reviewing.

*Visit pyramid:* Rationale, examples, guidance, 10 Ward Master.*5S game:* Preparation, playing the game.

Time benefit quantification: Rationale and example



## Literature on The Productive Ward : *Releasing time to care™*

NHS Institute for Innovation and Improvement website.

**The Productive Ward - *Releasing Time to Care™*.**  
[http://www.institute.nhs.uk/quality\\_and\\_value/productivity\\_series/the\\_productive\\_series.html](http://www.institute.nhs.uk/quality_and_value/productivity_series/the_productive_series.html) [accessed Jan 2009]

- *The Productive Ward*; Profiles and comments/Latest news/Video documentaries/Photo galleries/'Contact us'/Module structure overview/Health check survey (unable to access)/Resource guide (for modules).
- *The Productive Community Hospital*; Focus on inpatients, day hospital and minor injuries units. Requires log in password to access. Follows structure of productive ward.
- *The Productive Mental Health Ward*; Requires log in password to access. As above.
- *The Productive Operating Theatre*; Released September 2009 – will be trialled at Heart of England Foundation Trust, Royal Devon and Exeter Foundation Trust and West Middlesex University Hospitals.
- *The Productive Leader*; Improves leadership skills. Teaches how to free time for important work and remove time wasting activities. Uses LEAN thinking and Six Sigma.
- *Quality and Value*; Outlines key areas NHS is concentrating on in order to resolve current problems. Links; Better care, better value indicators/Experience Based Design/Helen Bevan on: (9 topics)/High Volume Care Series 1/High Volume Care Series 2/Rapid Improvement Programme/LEAN/Privacy and Dignity/Ambulatory Emergency Care/Productivity and Efficiency/Quality Improvement/Rapid Improvement Events.

More Time to Care at Ashford and St Peter's. (2008) (Available from NHS Institute)

Feedback from female surgical ward (Kingfisher) which piloted the scheme. Utilised modules: Shift Handovers, Well Organised Ward, (Medicine Rounds, Patient Observations, Meals and Patient Hygiene – still in progress). Utilised tools: Meetings, Activity Follow, Waste Walks, Interviews (with patients and staff), Photographs (of waste from walks), Video (of medicine and observation rounds), Timing Processes, Process Mapping. Feedback from a Staff Nurse, Deputy Sister, Sister, Matron for Surgery and Associate Director of Nursing. Improvements noted in: de-cluttering of ward and reduction in waste, team communication and, timing of activities such as midday. Staff Nurse observed it took hard work and continuity but results have been encouraging. Programme now implemented on orthopaedic and medical wards and programme manager employed.

NHS Institute for Innovation and Improvement (2008) - Case Study 2: Empowering nurses to redesign processes to deliver safer, more dignified care.  
**The Productive Ward - *Releasing Time to Care™*.**

Nine main points underpinning The Productive Ward with short explanations of each. Summarised in '3 key lessons':

- 1) The Productive Ward gives framework and tools to enable frontline staff to examine general shifts from a different perspective. Greatest impact from tools shown when staff demand them over management enforcement.
- 2) Open communication is vital for successful implementation with both positives and negatives shown to gain institute trust.
- 3) Toolkit must be developed both with and for users to give direction but also freedom for interpretation.

Taylor (2006) Stand by your bed. Health Service Journal: 116 (6029) 26-7

Introduction and explanation of rationale behind The Productive Ward programme. Intentions for pilot schemes and when to be trialled. Queries regarding medical/surgical ward differences to be considered with The Productive Ward programme. Intention to make audit data readily available.

**The Productive Ward -  
Releasing Time to Care™.**  
Nursing Times.

O'Dowd (2007) Making Time for your Patients. Nursing Times: 103 (16) 3-5.

Overview of background to The Productive Ward and sites The Productive Ward was launched in. Quote from director at NHS Institute and views from various 'heads' in nursing profession with positive and negative perspectives put forward. 'Point' comparison of positive and negative aspects of nursing today. Case study: Redressing the balance of care.

**The Productive Ward -  
Releasing Time to Care™.**  
Nursing Times. Evans (2007) Survey Results. Nursing Times: 103 (16) 6-9.

Account of survey involving more than 1,300 nursing staff, 330 manager and almost 500 therapists. Questions and areas investigated;

- rating productivity and effectiveness of wards
- nursing role breakdown
- rating ward care delivery
- types of wards
- estimation of time spend on direct patient care
- how much time should be spent?
- times on a shift leaving ward for equipment and supplies
- availability of 24hr pharmacy
- patient dignity
- single word description of feelings toward ward and ability to do your best
- what is working against efficient practice
- availability of equipment
- ease of ordering basic supplies
- naming three most important processes for improvement (manager opinion)
- nursing staff carrying out porter's role.

Key findings include:

- 73% of staff nurses say they don't spend enough time on direct care
- 89% say lack of time spent on patients has adverse impact on patient care
- 43% say temporary staff does not improve efficiency
- 93% say lack of time spent on patients has negative impact on job satisfaction.

**The Productive Ward -  
Releasing Time to Care™.**  
Nursing Times. Taylor (2007) Food for Thought. Nursing Times: 103 (16) 12-14.

Report of Barnsley Hospital (one of original test sites), Ward 22, Elderly Care. Work involved videoing ward to identify patients at risk. Activity round – members of MDT did one hour activity follow of different member of staff, recording each activity undertaken, time spent, use of pedometer. In seven and a half hour shift 30-40% time on direct patient care, 60-70% on paperwork, motion, other non-specified activities. Meal times chosen as priority area for improvement. Catering staff were involved to observe meal round. Watched back with nursing staff and project team – all identified same problems. Identified and agreed required changes. Key to project success was high level of staff involvement and ownership of solutions. Meal round was cut from 40 minutes to 17-25 minutes. A remaining problem is there is not always time to prepare as agreed. Ward 22 is now implementing The Productive Ward into shift handovers.



<p><b>The Productive Ward - <i>Releasing Time to Care™</i>.</b> Nursing Times. Hunt (2007) Transforming the Drug Round. Nursing Times: 103 (16) 15-17.</p>	<p>Luton and Dunstable Hospital (one of original test sites) Ward 23 Orthopaedic – chosen as had previous experience of ward changes work. Drug round chosen as no structure except normal policy, ward having multi-tasks occurring between 8-11am. Ward was videoed and made use of activity following, spaghetti diagrams. The data was analysed by staff and changes were made to structure for drug rounds and activities occurring at the same time. The drug round takes on average 30 minutes less since changes made, knock on effect is that length of stay has reduced. Problems staff voiced included concerns, released more time with patients but also quality of care is better. The project seemed daunting to some staff in the context of a busy ward, more work was not a joyful thought, funding not given for backfill staff so staff on light duties, bank project work or off duty staff used, funding given eventually for bank staff. The Productive Ward requires proving it is sustainable and has various outcomes that will encourage all levels of the organisation. Useful to have improvement facilitator. Communication with all involved regularly is vital. The Productive Ward used to organise sluice, handovers and observations.</p>
<p><b>The Productive Ward - <i>Releasing Time to Care™</i>.</b> Nursing Times. Clarke-Jones (2007) Releasing Time to Care The Way Forward. Nursing Times 103 (16) 18-19</p>	<p>Overview of findings from the original test sites. Quotes from various members of staff. Table of top 10 solutions to inefficient ward working.</p>
<p>Health Service Journal: Productive Ward Supplement (2007)</p>	<p>Overview of findings from the original test sites. Quotes from various members of staff. Table of top 10 solutions to inefficient ward working.</p>
<p>Health Service Journal: Productive Series. Time and Motion. A Programme for Efficiency in the NHS. (2008) (accessible via <a href="http://www.hsj.co.uk">www.hsj.co.uk</a>)</p>	<p>Note from Bernard Crump, NHS Institute. Outline of aims and effects with quote from NHS Institute staff. Forward by Christine Beasley. Brief note of impact of The Productive Ward at Clayponds Hospital (Ealing). Helen Bevan lists six key lessons to implementing The Productive Ward.</p>
<p>Health Service Journal: Productive Series. Time and Motion. A Programme for Efficiency in the NHS. Taylor (2008) Efficient Working Making Time Fly. (accessible via <a href="http://www.hsj.co.uk">www.hsj.co.uk</a>)</p>	<p>Overview of The Productive Leader programme, including module outlines and process. Meetings are largest area of time lost, for example executives spend up to 70% of time weekly in meetings. Benefits, experience of the NHS Institute who used it for better time keeping and management, meeting structure improvement and shortened.</p>
<p>Health Service Journal: Productive Series. Time and Motion. A Programme for Efficiency in the NHS. Taylor (2008) Surgical Solutions Smooth Operations. (accessible via <a href="http://www.hsj.co.uk">www.hsj.co.uk</a>)</p>	<p>Overview of The Productive Operating Theatre, latest in The Productive Series, aimed at surgeons and anaesthetists. Launch September 2009 following test sites. Four dimensions defined – safety and reliability of care, team working and leadership, patient flow, logistics and resources, patient experience and outcomes. Outline of programme, based on global best practice, concerns eliminating errors, communication systems, learning from experience/near misses. Discussion of standardisation of care and sustainable results.</p>

<p>Health Service Journal: The Productive Series. Time and Motion. A Programme for Efficiency in the NHS. Shepherd (2008) Whole Lotta Shake-Up. (accessible via <a href="http://www.hsj.co.uk">www.hsj.co.uk</a>)</p>	<p>Discussion of progress one year into the 'whole hospital' test sites – Nottingham and Manchester. 'The Nottingham Story'; began on two pilot wards, whole hospital roll out. Eight new teams join approx. ever 10 weeks. To date Productive Ward is implemented in 34 wards and A and E. The two year aim is for Productive Ward on 74 wards out of over 90. The most advanced wards completed foundation modules and are onto 5th process module. Kerry Bloodworth – Assistant director of nursing and The Productive Ward project lead. Peter Homa – Trust Chief Executive – chairs Productive Ward monthly steering group. Impact The Productive Ward is having includes: MRSA rates &lt; by 68%, C-diff &lt;54%. Anecdotal evidence from implementing Well Organised Ward module suggests savings of £5,000 - £10,000 made by return of excess stock to stores. % of direct care gone from 38%-52%.</p> <p>'The Manchester Story': Plan to complete by 2010 using 12-week roll-out bringing six to eight new areas at a time. Activity-follow used every quarter shows direct care risen by 8% = 57 extra minutes across 12 hour shift. One ward = average of 12 falls/month now = 3-4. Improved identification of pts at nutritional risk, also demonstrated quantifiable reduction in food waste. Data is on public display (as with Nottingham).</p>
<p>Health Service Journal: The Productive Series. Time and Motion. A Programme for Efficiency in the NHS. Torjesen (2008) Beyond Secondary Care Far and Wide. (accessible via <a href="http://www.hsj.co.uk">www.hsj.co.uk</a>)</p>	<p>Introduction to The Productive Community Hospital and The Productive Mental Health Ward. The Productive Community Hospital – 13 modules, test sites – Chippenham Community Hospital (Wiltshire PCT), Farnham Hospital and Centre for Health (Surrey PCT), Queen Mary's Hospital, Roehampton (Wandsworth PCT) and Grindon Lane Primary Care Centre and St Benedict's Day Hospital (Sunderland PCT).</p> <p>Selection of results = patient handover time cut with improved quality; greater number of professionals per patient case in day hospital by 20% = more direct patient care; referrals more efficient; greater patient and staff satisfaction. Madelyn Griffiths, clinical improvement services manager at Wiltshire CS. Use of LEAN techniques. Minor injuries unit seen increase in patient throughput &gt; to 97% in 2 hours (the government target is 70%). Mental Health sites – North Staffordshire Combined Healthcare Trust and Oakwell Centre, Kendray Hospital (Barnsley PCT). Selection of Results – direct patient care increased, handover cut by 75%, quality improvements. Rob Grant – programme lead for The Productive Ward at North Staff.</p>
<p>Health Service Journal: Productive Series. Time and Motion. A Programme for Efficiency in the NHS. Hopps (2008) Launch Roll Out, Roll Out. (accessible via <a href="http://www.hsj.co.uk">www.hsj.co.uk</a>)</p>	<p>October 2009 is launch of Productive Community Services. This article describes the challenges – this programme is seen as biggest challenge in itself so far. It requires completely new approach but still making use of the clear, accessible presentation as The Productive Ward, evidence-based tools and techniques. Co-production with NHS involves 13 unlisted learning partner provider organisations signed up. Lists ideas for modules looking at; the Productive Communities team; Leadership development; Well organised pathways. Three 'high volume' pathways of care to start programme – wound care; stroke care; continence services. No evidence as yet that increased contact time leads to better clinical outcomes and enhanced patient experience. Testing of a 'care bundle' (small group of clinical actions shown to improve outcomes, are achievable, measurable yet not yet currently performed for most parts. Principle is benefit to patient of the whole care bundle is greater than sum of parts.)</p>
<p>Health Service Journal: Productive Series. Time and Motion. A Programme for Efficiency in the NHS. NHSI (2008) Next steps Winds of Change.</p>	<p>This article explains developments in the NHS Institute due to the success of The Productive Series. Three directions are being taken – stronger links between The Productive Ward approach and use of commissioners; focus on improvement skills NHS organisations need to deliver all potential benefits to patients and staff; create more Productive products for specific settings.</p>

<p>NHS South East Cost web page</p> <p><a href="http://www.southeastcost.nhs.uk/publications/ASPH.asp">http://www.southeastcost.nhs.uk/publications/ASPH.asp</a> [accessed 04/02/09]</p>	<p>This website provides an update of work at Ashford and St Peter's Hospitals NHS Trust The Productive Ward implementation. Wards put into cohorts – 23 in all – full implementation intended by Mar/Apr 2010. Executive champions – director of nursing and governance/ medical director/director of finance. Wards supported by programme team with programme lead, manager and administer. Patient and staff involvement encouraged. A patient questionnaire is available.</p>
<p>Anthony S (2008) The 'Productive Ward' comes to maternity services. <i>Midwives</i> 11 (6) 34-5</p>	<p>Information about The Productive Ward implementation at a maternity unit at Nottingham NHS Trust. Help was received from the NHS Institute and trust project leads. Use of performance board, patient questionnaires and selection of toolkit. 'Well Organised Ward' module named specifically. Findings; direct patient care 33% of time – increase seen to 49%. Interruptions in 12hr shift – 202 = 1 every 4 mins. Movement average = 4 miles per shift. Improvements seen.</p>
<p>Eason S (2008) Releasing Time to Care. <i>Primary Health Care</i> 18 (9) 18-9</p>	<p>Background to the Productive Community Services programme. Outline of intention and who it will effect. Describes how this will need restructuring from The Productive Ward to fit, and the intention to keep frontline staff as leading changes. Important to use existing resources before bringing in new ones. Programme modules – several ones specially designed to fit community needs. 13 Learning Partners from primary care trusts to work with the NHS Institute. To start early 2009 and complete summer 2009.</p>
<p>Gray J (2008) Nurses' ideas get results'. <i>Nursing Standard</i> 22 (36) 1</p>	<p>Editorial which outlines previous improvement scheme flaws. Mention of 'Can Gerry Robinson fix the NHS?' (BBC programme) found that ward staff's ideas were ignored. The Productive Ward in Nottingham impressed the health secretary who is now giving £50 million to support roll out of The Productive Ward in England.</p>
<p>Parish C (2008) Productivity programme could double time spent with patients. <i>Nursing Standard</i> 22 (36) 5</p>	<p>This article claims The Productive Ward has doubled time on patient care – handover cut by third, med rounds by 60%, food wastage reduced from 7 to 1%. Liz Ward – former ward manager now at the NHS Institute gives brief description of The Productive Ward. At Barnsley meal times were issue – saw time to give out meals cut from 30 mins to 12. Outlines £50 million from Alan Johnson (health secretary) will be managed and monitored by SHA nurse directors. Ward sisters have access. SHA nurse directors to report to Christine Beasley.</p>
<p>(2008) Nurse Manager 15(3) 5</p>	<p>Short news piece explaining roll-out of The Productive Ward and £50 million from health secretary.</p>
<p>Redgrave R, Beel H (2009) Releasing Time to Care: The Productive Ward.</p> <p>(Presentation at the Effective Modern Matron conference)</p>	<p>Presentation reporting on The Productive Ward at the United Lincolnshire Hospitals – 21 wards involved at present with all 63 to be started on process by Dec 2009 – further details given about the trust – current Productive Ward achievements listed. Describes LEAN working, who leads what and why, introduction to the role of the Modern Matron (MM) – key to sustainability and metrics on each ward. Explains metrics and two modules: Knowing How we are Doing/Patient Status at a Glance. The discharge module is highlighted – use of ward whiteboard to show patient discharge status leads to less delays. Sustaining and standardising – audits/metrics to challenge and celebrate/making it 'part of what we do' – various methods for each of these items. Information about MM role/their own support/importance/link between ward and management. Encourage staff to see importance and empower them to make change – MM is pivotal to process.</p>

<p>Bloodworth K (2009) Implementing The Productive Ward Programme. Breaking down barriers, driving up standards. The role of the ward sister and charge nurse (pg 25-6). London: Royal College of Nursing</p>	<p>Part of the appendix in the named document. Gives background about lack of direct patient care. Describes The Productive Ward programme as the NHS Institute intended it – use of techniques from industry. Need in the NHS for move from incremental changes to accelerated large scale change. Outlines support from project nurse over 13 weeks at half day then Ward implementation with matron and practice development matron supporting. Question of sustainability – measured at present by audit. Current improvement seen 2% point increase which averages at 30% direct patient care time increase. The Productive Ward on 42 wards and emergency department to date.</p>
<p><a href="http://www.ulh.nhs.uk/about_us/our_projects/productive_ward/Documents/Ward%20newsletter.pdf">http://www.ulh.nhs.uk/about_us/our_projects/productive_ward/Documents/Ward%20newsletter.pdf</a> [United Lincolnshire Hospitals newsletter issue 1]</p>	<p>Various newsletters from different trusts and SHAs. East of England SHA also provide one. Lincolnshire Hospitals shows current progress and plans with feedback</p>
<p>Nursing Times Supplement: The Productive Series (2009). Crump B. Nursing Times 105 (9) 2</p>	<p>Article describing The Productive Ward as a flagship programme for the NHS Institute. Outline of the future plans of the NHS Institute; supportive, ideas, building capacity for improvement. Using Lord Darzi's aim for change which empowers staff to make changes.</p>
<p>Nursing Times Supplement: The Productive Series (2009) Beasley C. Nursing Times 105 (9) 3</p>	<p>Overview of The Productive Ward and its positive impact and effects – 'clinically driven and locally led'. Outline of the support and interest of health ministers - £50m given by Health Secretary. Mention of Productive Series spread to Mental Health, Community, Operating Theatre and Boardroom.</p>
<p>Nursing Times Supplement: The Productive Series. Shepherd S (2009) This is a phenomenon. Nursing Times 105 (9) 4-6</p>	<p>Case studies of The Productive Ward and its impact. 'Meet the Productive Family' (list of The Productive Series). Launch of The Productive Ward membership – high impact solutions to big challenges. Can buy extra support – any money raised goes back into the scheme. Showcase wards – how they worked, how to implement, training available from NHS Institute. Looks at The Productive Mental Health Ward programme.</p>
<p>Nursing Times Supplement: The Productive Series. Bevan H (2009) The Six Lessons for Successful Implementation. Nursing Times 105 (9) 7</p>	<p>Introduction to Helen Bevan's role at NHS Institute. Six top tips: 1) Get everyone at every level playing their role to make a difference for patients. 2) Base it on the real world. 3) Work with improvement methods such as lean, but keep them in the background 4) Create pilots with pace 5) Work with 'identity groups' 6) Enable staff to bring their whole selves to work.</p>
<p>Nursing Times Supplement: The Productive Series. Torjessen I (2009) Productive Principles Applied in New Settings. Nursing Times 105 (9) 8-9</p>	<p>A look at the newer Productive modules; Community and Mental Health. List of test sites. Developments made to the Productive approach to fit new environments. Evidence to show improvements and changes.</p>

<p>Nursing Times Supplement: The Productive Series. Ward L, Parish K (2009) Putting it into Practice. Nursing Times 105 (9) 10-11</p>	<p>Liz Ward and Kim Parish describe their experience and journey into The Productive Ward/The Productive Community Hospital.</p>
<p>Nursing Times Supplement: The Productive Series. Shepherd S (2009) Rolling out The Productive Ward. Nursing Times 105 (9) 12-13</p>	<p>A look at Nottingham and Manchester as whole hospital roll-out sites for The Productive Ward. Outline of those involved and commitment, challenges and positives effects. Drop seen in infection rates, patient satisfaction increased, patient falls decreased, less food and other waste. A look at The Productive Leader.</p>
<p>Nursing Times Supplement: The Productive Series. Taylor J (2009) The Productive Operating Theatre. Nursing Times 105 (9) 14</p>	<p>Information about The Productive Operating Theatre, to be launched summer 2009. Global best practices which focuses on four dimensions of care focused on The Productive Operating Theatre; safety and reliability of care; patient flow, logistics and resources and patient and staff well-being outcomes. Standardising care, evidence based which also allows nurses to speak out, NHSI providing tools to enable changes to occur. Use of The Productive Ward modules that transcend into other arena – ‘Knowing How we are Doing’, team briefings, S5 process.</p>
<p>Nursing Times Supplement: The Productive Series. Callard L (2009) Working with Nurses in the Community. Nursing Times 105 (9) 15</p>	<p>Plans and Challenges to The Productive Community Services. Three areas of focus – The Productive Community Team (creating and supporting) leadership development (build and develop current leaders) Delivery of Care (Evidence-based, adaptable). Change of approach from original one – from high volume care pathways looking at wounds/strokes/continence to generic approach which will standardise care. Aim to not just release time to care but make time for effective care.</p>
<p>Quinn M. (2009) Time to care. British Journal of Healthcare Assistants: 3 (2) 75-77</p>	<p>Hospice (St Benedict’s) was pilot site for The Productive Community Hospital. Outline of methods and tools (process mapping) used to change processes and subsequent success and improvements (streamlining and reducing paperwork and repetitive questioning by healthcare professionals to pts; lengthening day care hours at patients request).</p>
<p>Wilson G. (2009) Implementation of releasing time to care – The Productive Ward. Journal of Nursing Management: 17 (5) 647-654.</p>	<p>Describes the implementation of the NHS Institute for Innovation and Improvement The Productive Ward - <i>Releasing time to care™</i> programme in terms of benefits and key successes and provides advice for those wishing to implement the programme. Describes evaluation in relation to each of the 15 modules rather than as the programme as a whole. It uses various methods including audit, observation, activity follow through, satisfaction surveys and process mapping. Each month data is collated for each of the 11 metrics which has shown a reduction in falls, drug administration errors and improvement in the recording of patient observations. Argues that the evidence shows that the programme improves patient satisfaction as it enables the provision of an increase in direct patient care by staff and subsequently improved clinical and safety outcomes. ward sister/charge nurse development includes leadership, project management and lean methodology techniques.</p>

## Appendix 2: Stakeholders who contributed to the review

Christine Beasley	Chief Nurse of England
Peter Carter	Royal College of Nursing
Tim Curry	Royal College of Nursing
Liz Thiebe	King's Fund (previously NHS Institute)
Helen Bevan	NHS Institute
Lizzie Cunningham	NHS Institute
Liz Ward	NHS Institute
Sean Manning	NHS Institute
Kirsty Marshall	NHS Institute (now Ealing PCT)
Kate Jones	NHS Institute
Maureen Davies	Assistant Chief Nurse NHS London
Adrian Childs	NHS South West SHA
Deborah Stubberfield	NHS South East Coast, SHA
Amanda Rolland	East Midlands SHA
Susan Osborne	NHS East of England SHA



### Appendix 3: Stakeholder interview topic guide

- 1: Professional background
- 2: We are interested in hearing your story of The Productive Ward.
- 3: How would you personally describe The Productive Ward to someone who is unaware of it, in terms of what it is and its purpose?
- 4: What would you say are the main ideas behind it, in terms of underlying values or philosophy?
- 5: What is it about The Productive Ward that appeals to NHS organisations? What types of factors and issues might be involved?
- 6: What is it about The Productive Ward that appeals to frontline NHS staff?
- 7: Do you think there are aspects of The Productive Ward that are off putting or viewed in a negative way, either by NHS organisations or frontline staff?
- 8: Overall, what would you say are the biggest successes of The Productive Ward?
- 9: In your opinion which elements of The Productive Ward have led to the most direct improvements – for organisations - for frontline staff - for patients?
- 10: In your opinion how should the impact of The Productive Ward be measured?
- 11: How do you think the successes achieved so far can be sustained?
- 12: What lessons do you think the NHS Institute can take forward in terms of the future development of: (a) The Productive Ward programme itself? (b) future developments or quality improvement initiatives?
- 13: Are there any other issues or questions relating to The Productive Ward that you feel are important for us to consider?
- 14: Can you suggest anyone else in your organisation or externally you feel it would be important for us to talk to?



## Appendix 4: Content and additional data from web-survey

### Online Survey questions

#### Q1. Which of the following best describes your place of work?

- General Hospital (teaching)
- General Hospital (non teaching)
- Specialist Hospital
- Other (please specify)

#### Q2. Is it:

- Private
- Voluntary sector
- NHS Foundation trust
- NHS (not Foundation status)

#### Q3. Which region do you work in?

#### Q4. Which of the following best describes your job?

- Executive (board member)
  - Clinical director
  - Service manager
  - Matron
  - Nurse consultant
  - Clinical nurse specialist
  - Ward manager / sister / charge nurse
  - Staff nurse
  - Student nurse
  - Auxilliary nurse / healthcare assistant
  - Ward clerk / administrator
  - Medical consultant
  - Medical practitioner
  - Physiotherapist/occupational therapist/other therapist
  - Social worker
  - Other (please specify)
- 



**Q5. When did your hospital first become involved with The Productive Ward?**

**Q6. Had you heard about The Productive Ward before your hospital began to be involved?**

**Q7. How did you first hear about The Productive Ward?**


- Read about it in the Nursing Times, Health Services Journal or Nursing Standard
- Read or heard about it somewhere else
- At a conference outside my workplace
- In an email alert or newsletter from outside my workplace
- Informally from someone who works elsewhere
- Informally from a someone at my place of work
- At a conference or presentation at my work place
- In an email alert or newsletter internal to my place of work
- In a formal meeting at work
- Other (please specify)

**Q8. What type of ward(s) is Productive Ward being implemented on in your organisation?**

**Q9. How many wards is The Productive Ward currently running on in your organisation?**

**Q10. Are there plans to run The Productive Ward on more wards in the future?**

**Q11. Which of the following best describes your role in The Productive Ward?**

- I am a manager/ executive with indirect responsibility for The Productive Ward
  - I am a manager with direct responsibility for The Productive Ward and other wards
  - I am project leader / facilitator for The Productive Ward initiative
  - I am manager of The Productive Ward itself
  - I work in The Productive Ward most of the time
  - I sometimes work in The Productive Ward
  - I do not have a direct role but my work is linked to it
  - I do not have a direct role in The Productive Ward but I am familiar with it
- 

**Q12. How long have you personally been involved with The Productive Ward initiative?**

**Q13. The Productive Ward includes modules covering different aspects of the work of a ward. Which modules have you been involved with?**

**Q14. In your opinion, which of the modules you have been involved with have had most impact?**

**Q15. The Productive Ward includes a number of tools to help wards identify priorities and plan implementation. Which parts of the toolkit have you used? (tick all that apply)**

**Q16. In your opinion which parts of the toolkit have been most effective? (tick all that apply)**

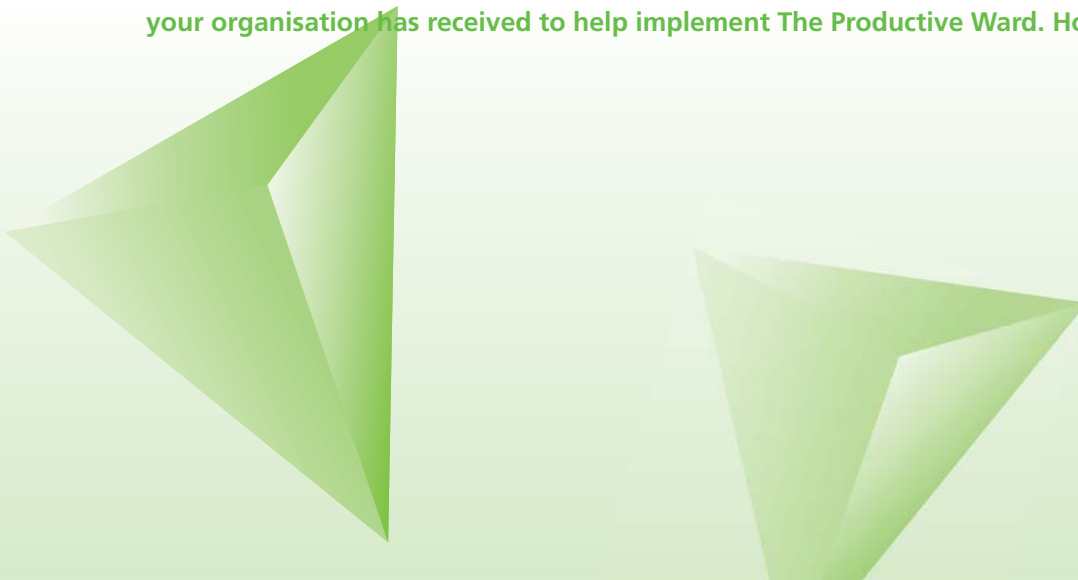
### **Q17. Support and engagement**

*Answer Options*

*Strongly agree Agree Neither agree/disagree Disagree Strongly disagree Don't know*

- There is a clear 'champion' for The Productive Ward in this organisation
- There is a strong clinical leader, respected by his/her colleagues, who supports The Productive Ward in this organisation
- Specific funding has been made available to help implement The Productive Ward in this organisation
- There is an experienced and skilled 'change team' in this organisation that facilitates and supports the implementation of The Productive Ward
- There is strong patient and carer involvement in the implementation of The Productive Ward in this organisation
- The Productive Ward fits well with what we want to do in this organisation
- 'Releasing time to care™' is a cause that I strongly identify with
- This organisation is sharing ideas and knowledge with other hospitals implementing The Productive Ward so that we all benefit from each other's learning
- The general communications and information about The Productive Ward are useful
- The overall project management associated with the implementation of The Productive Ward is good

**Q18. Please describe any external support (for example from the NHS Institute) or facilitation your organisation has received to help implement The Productive Ward. How has this helped?**



**Q19. Please describe any other support or resourcing your organisation has received to help implement The Productive Ward? How has this helped?**

**Q20. Are there any other networks or ways of sharing learning about The Productive Ward that you have made use of? Please describe.**

**Q21. Please read the following statements about the organisation you work in and tell us whether you agree with them.**

*Answer Options*

*Strongly agree   Agree   Neither agree/disagree   Disagree   Strongly disagree   Don't know*

- This organisation has a clear division of labour between departments and units, with each concentrating on its own strengths and not meddling too much in the work of others
- This organisation allows departments and units to make their own decisions
- Lots of staff in this organisation are familiar with working to improve services and can apply these skills to new projects like The Productive Ward
- This organisation makes adequate resources (money, staff time) available to help us implement new initiatives like The Productive Ward
- Staff in this organisation are good at identifying new ways of improving services
- Senior staff in this organisation encourage and facilitate the sharing of knowledge and idea
- Senior staff in this organisation provides strong and competent leadership and vision
- Middle management relationships and communication are good in this organisation
- In this organisation staff are rewarded not punished for taking risks
- Goals and priorities are clearly articulated in this organisation
- In this organisation there are good information and data systems to give timely feedback on the impact of initiatives like The Productive Ward

**Q22. Please identify three factors in your organisation that have facilitated The Productive Ward so far.**

**Q23. Please identify three barriers in your organisation to successful implementation of The Productive Ward.**



**Q24. Please rate The Productive Ward as follows:***Answer Options**Strongly agree Agree Neither agree/disagree Disagree Strongly disagree Don't know*

- The Productive Ward is a success for our organisation
- The Productive Ward has not made any improvement to the way we do things
- The Productive Ward is compatible with my existing values and preferred way of working
- The Productive Ward is a simple and straightforward idea
- It is difficult to see the benefits of The Productive Ward
- The Productive Ward programme is patient centred
- It is easy to measure the impact of The Productive Ward
- It is helpful to be able to test out The Productive Ward first before fully implementing it

**Q25. In your view, in which areas does The Productive Ward have the most impact?***Answer Options 5 (high impact) 4 3 2 1 0 (no impact)*

- Efficiency
- Clinical effectiveness
- Safety
- Patient experience
- Staff experience
- Team working

**Q26. Please give an example that best illustrates the positive aspects of The Productive Ward.****Q27. Have there been any measurable improvements as a direct result of Productive Ward?****Q28. Do you think there are any drawbacks of implementing The Productive Ward?****Q29. Based on your experience, what advice would you give to anyone implementing The Productive Ward for the first time?**

**Table: A4.1** Respondent profile

Respondent		Response count	Response percent
<b>Place of work</b>	General hospital (teaching)	96	64
	General hospital (non-teaching)	24	16
	Specialist hospital	8	5.3
	Other	22	14.7
	<i>Answered question</i>	150	
	<i>No response</i>	0	
<b>Sector</b>	NHS (non Foundation status)	88	59.1
	NHS Foundation trust	60	40.3
	Private	1	0.7
	Voluntary	0	-
	<i>Answered question</i>	149	
	<i>No response</i>	1	
Region	South East Coast	38	26
	Yorkshire and The Humber	24	16.4
	West Midlands	22	15.1
	London	20	13.7
	South Central	9	6.2
	South West	8	5.5
	East Midlands	8	5.5
	North West	7	4.8
	East of England	5	3.4
	North East	4	2.7
	Don't know	1	0.7
	<i>Answered question</i>	146	
	<i>No response</i>	4	

**Table A4.2:** Respondent role

Respondent	Response count	Response percent
<b>Job role</b>		
• Ward Manager / Sister / Charge Nurse	34	22.7
• Staff Nurse	22	14.7
• Matron	14	9.3
• Service Manager	9	6
• Executive (Board Member)	6	4
• Other (Clinical Nurse Specialist, Ward Clerk / Administrator, Clinical Director, Auxilliary Nurse/Healthcare Assistant, Nurse Consultant)	65	43.4
No responses were returned from individuals in the following roles: Student Nurse, Medical Consultant, Medical Practitioner, Physiotherapist/Occupational Therapist/other Therapist, Social Worker.		
<b>Role in Productive Ward</b>		
• Project leader/facilitator for The Productive Ward initiative	58	45.7
• Manager of The Productive Ward itself	19	15
• Work in The Productive Ward most of the time	14	11
• Manager with direct responsibility for The Productive Ward	9	7.1
• Manager/executive with indirect responsibility for The Productive Ward	8	6.3
• No direct role but work is linked to The Productive Ward	6	4.7
• Sometimes work in The Productive Ward	3	2.4
• No direct role but familiar with The Productive Ward	1	0.8
• Other	9	7.1
<i>Answered question</i>	127	
<i>No response</i>	23	



**Table A4.3:** Starting Productive Ward

Respondent		Response count	Response percent
<b>Duration personally involved in The Productive Ward</b>	6-12 months	38	29.9
	3-6 months	29	22.8
	More than a year	26	20.5
	1-3 months	24	18.9
	1 month or less	9	7.1
	Due to start soon	1	0.8
	<i>Answered question</i>	127	
<i>No response</i>	23		
<b>Duration hospital has been involved in The Productive Ward</b>	7-12 months	61	40.9
	13-18 months	27	18.1
	Within last 3 months	20	13.4
	3-6 months	18	12.1
	19-24 months	12	8.1
	Over 2 years	5	3.4
	Don't know	5	3.4
	It's not involved	1	0.7
	<i>Answered question</i>	149	
<i>No response</i>	1		

## Appendix 5: Participants in the case study interviews

Case study sites	Leeds Teaching Hospital NHS Trust	Royal Devon and Exeter NHS Trust	Nottingham Healthcare NHS Trust	St George's Healthcare NHS Trust	Medway Maritime NHS Trust
<b>Executive/Board Members</b> (chief executive, chief nurse/nurse director, medical director, director of estates and facilities)	1	2	2	3	-
<b>The Productive Ward teams</b> (deputy chief nurse/deputy director of nursing, The Productive Ward project lead, The Productive Ward project facilitator, The Productive Ward clinical facilitator /educator)	5	2	3	2	3
<b>Clinical Teams</b> (medical staff, clinical nurse specialist, matron, ward manager/ sister, staff nurse, auxilliary nurse / health care assistant, student nurse)	6	7	4	4	6
<b>Non-clinical/support functions</b> (stores/estates/facilities, housekeeping, ward receptionist, catering staff, I.T. / communications manager, patient Involvement lead)	1	1	1	2	3
Total no.	13	12	10	11	12














National Nursing Research Unit  
King's College London  
James Clerk Maxwell Building  
57 Waterloo Road  
London SE1 8WA  
nnru@kcl.ac.uk

NHS Institute for Innovation and Improvement  
Coventry House  
University Road  
University of Warwick Campus  
Coventry  
CV4 7AL  
Tel: 024 7647 5800  
Website: [www.institute.nhs.uk](http://www.institute.nhs.uk)

To find out more about The Productive Series visit:  
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