Implementing and evaluating the Productive Ward initiative in a mental health trust

Productive Mental Health Ward aims to reduce waste and free up time for direct care. A trust discusses the impact of the initiative on both patients and staff.

PRACTICE POINTS
I The Productive Mental Health Ward was developed by the NHS Institute for Innovation and Improvement to help staff redesign the way they work so they can spend more time with service users in direct care.
I “Showcase” wards are pivotal to preparing to implement PMHW, as they provide opportunities for others to see how the initiative works in practice and its potential impact.
I Audit visits conducted by senior leaders and managers from across the trust help to bridge the gap between the board and the ward by making them more visible. These visits allow senior staff to hear firsthand experiences of delivering and receiving care on the ward.

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The aim of this article is to reflect and share the experience of implementing Productive Mental Health Wards at South London and Maudsley Foundation Trust.

It highlights the processes involved and the outcomes. It also discusses the challenges encountered, the strategies employed to overcome them and changes to practice.

INTRODUCTION

The Productive Mental Health Ward (PMHW) initiative has focused attention on inpatient nursing care. It empowers frontline staff to improve the quality of care they deliver by using systematic processes and tools to change practice.

The scheme has started to show improvements in staff wellbeing, safety and reliability of care, patient experience and efficiency of care – the key areas identified for improvement within the initiative (NHS Institute for Innovation and Improvement, 2008).

PMHW is a modular based, self directed quality improvement initiative that teaches staff how to assess and redesign the way in which they work. The aim is to reduce waste in relation to time and costs inherent in ward systems and care delivery processes, which will lead to a better experience for service users and carers and to better clinical outcomes.

While the initiative is aligned nationally to quality priorities – as outlined in High Quality Care for All: NHS Next Stage Review (Department of Health, 2008) – within the trust it is a key component of the Achieving Quality Improvement Programme (AQUIP). This is a vehicle for delivering improvements across inpatient services and in embedding some internal and external quality assurance standards, such as those from the Royal College of Psychiatrists’ College Centre for Quality Improvement (2006) and Accreditation for Inpatient Mental Health Services (AIMS), as well as other initiatives such as Star Wards (Bright, 2006).

BACKGROUND TO PMHW

Evans (2007) identified that nurses reported spending about 40% of their time on direct care, which was less than their aspiration of more than 60%. Staff said the lack of time spent in direct care time had an adverse impact on patient care and job satisfaction.

PMHW was developed by the NHS Institute for Innovation and Improvement, and launched nationally towards the end of 2008 (NHS Institute for Innovation and Improvement, 2008).

It is part of the Productive series, which includes initiatives such as Productive Community Services and Productive Wards. These were developed to help staff redesign the way they work so they can spend more time with service users in direct care.

While some work has been published by Bloodworth (2009) and by Foster and Gordon (2009) on how the initiative has been implemented across acute hospitals, there is limited published work on the experience of mental health organisations. Like others in the Productive series, PMHW focuses on “how to do”, rather than “what to do”. It consists of three foundation modules and eight process modules.

The foundation modules are designed to help teams understand their performance by using data on matters that affect a team’s functioning. This can be drawn from data that is gathered routinely or after developing systems to capture it. Built into the tools and methods are some Lean principles and tools.

A key aspect of the foundation modules is organising the ward environment so that information and equipment are visible, easily accessible and available in the right quantities at the right time for the right people.

Teams have to complete the foundation modules before proceeding to process modules. Fig 1 shows all the modules contained in the PMHW “house”.

PREPARATION

This involved teams of multidisciplinary staff at different levels, as well as representatives from finance and the trust executive, visiting an acute and mental health trust to hear about the practical application of PMHWs, the process for trust wide implementation, and the benefits and challenges. They also learnt about resource implications, the level of commitment needed and the difference PMHWs had made to practice.

Before implementing the initiative, it was prudent to review it to ensure it was aligned to quality improvement programmes in the trust and to the trust’s values and objectives. The trust service quality executive – the internal committee that has a remit for approving quality initiatives – also needed to approve the scheme.

As soon as a strategic fit had been established and the visits had been completed, a communication and detailed
A pivotal part of the preparatory work was the selection of “showcase wards”. These were wards where staff were willing to participate in the project, share their knowledge and experiences, and provide opportunities for others to see the practical application of PMHWs and their potential impact.

The wards needed to satisfy a selection criteria set by the project team, which included such factors as having a ward leader in post and having fewer than 10% of posts vacant.

All 65 ward leaders were invited to apply. Following the shortlisting process, six wards were selected to be showcase wards. These represented different clinical services, such as acute adult psychiatry, older people, forensic and rehabilitation, and a national behavioural disorders unit; these were based at five different sites. Ward leaders included an occupational therapist, which demonstrated that the initiative was relevant not only to nurses.

A project bid was submitted to NHS London and the trust was awarded funding to support starting PMHWs on six wards for the first nine months, after which funding was provided by the trust board. The funding enabled the project team to employ two full-time improvement facilitators, purchase resources required and set aside money for anticipated minor works when it came to reorganising the ward environments.

Once the showcase wards had been selected, the project team held briefing meetings where staff could discuss their roles and responsibilities and the team could try to alleviate any anxieties. During these meetings, the ward teams were informed about the support that would be available to them, as well as the benefits to them.

A page was set up on the trust intranet with information and resources relating to the project. Information leaflets for service users, carers and staff were developed.

The NHS Institute initially provided training and support for ward leaders, improvement facilitators and the project lead. The training covered the foundation modules and one process module. Subsequent training to support rollout has since been developed and is delivered by the project team.

IMPLEMENTING THE MODULES
Our trust’s experience has been that it takes between three and four months to complete the foundation modules. The time it takes to complete a process depends on the unique features of each team but has ranged from between two and six months.

Ward teams are supported by improvement facilitators until they complete all the foundation modules and the first process modules.

The first action for each ward team, with input from carers, services users and its facilitator, was to develop a shared vision of what they wanted their ward to look and feel like. A variety of methods were used to capture all the views to ensure inclusivity.

This agreed vision was then displayed in prominent places on the ward and reviewed periodically. It showed there were common themes shared by service users, carers and staff that had never been discussed before.

Knowing How We are Doing
This module focused on identifying and selecting ward-based measures to help teams’ understanding of their performance on key objectives and to set actions for improvements. Table 1 shows the measures used to address the objectives.

Staff found the process of selecting and monitoring measures at ward level empowering. The performance data was displayed in a communal area that anyone visiting the ward could see.

The information displayed on the board formed the basis for discussions and reviews at PMHWs weekly meetings and, where possible, involved service users. These discussions encouraged openness and an acknowledgement of weaknesses, and highlighted what the team was doing to address any problems. It helped give a sense of shared responsibility between the service users and staff members to ensure improvements were made.

A key feature of this module was the “activity follows”. This involved a ward staff member following another member of staff at a similar grade with a similar professional background, noting what they were doing every minute for 12 hours.

When analysed, the activity data showed the proportion of time spent on direct care – referred to as “direct care time” – and that...
spent on non-patient related activities, and the number of interruptions to intended tasks. This information provided an indicator of the process modules that the teams needed to focus on to increase their direct care time and to reduce the type of associated interruptions to care delivery.

Well Organised Ward
The WOW module generated immense energy from the team members because of its practical approach, the immediacy of improvements and the use of visual management techniques.

It uses a variety of Lean tools to make information, resources and equipment easily visible, accessible and organised, which reduces time wasted looking for things, as well as cutting costs associated with over ordering items that might expire before use.

Teams have been able to develop inventories for stock items and to create systems for replenishing these in an efficient manner. Introducing the WOW module resulted in an average saving of £1,500 per ward from unused items in ward store rooms.

Patient Status at a Glance
The PSG module focused on developing patient status information boards to improve communication between team members, reduce interruptions to care related to patient status, and show at a glance risk issues related to mental state and physical health.

Not all wards in the showcase group used whiteboards to display patient information, so this was a challenge for those teams.

Confidentiality issues were discussed with service users where appropriate and advice was also sought from the trust’s Caldicott guardian in reaching agreeable solutions. Relevant standards were set for updating and monitoring the efficiency of the PSG boards through audits.

Feedback from teams indicated that it was now easier to know the whereabouts of service users, leave status and levels of observations and that it was quicker to access information that would normally be held electronically. Interruptions became significantly less frequent.

Process modules
Following the implementation of the foundation modules, the teams selected process modules to implement based on the information from the activity follows and the foundation modules.

The most popular process modules were shift handovers, medicines, ward round, safe and supportive observations and therapeutic engagement. Quantitative data on process modules is still being analysed for impact.

OVERALL BENEFITS
During the initial stages of the PMHWs initiative, most of the benefits were qualitative. However, some quantitative benefits have been emerging.

Improvement in efficiency of care: direct care time
Direct care time (DCT) has been variable across all the participating wards and has ranged from 11%-48% at baseline to about 41%-84% after 18 months, resulting in an average increase of 24% in 18 months.

Feedback from the service users’ survey indicate an increase of up to 50% in therapeutic time spent with a named nurse and a 40% increase in activities provides on the ward.

Table 2 shows the direct care time for a group of wards. The data are for individual wards recorded at six month intervals.

Staff wellbeing
The strengths of this initiative are that the focus is not only on service users and carers, but also on the wellbeing of staff.

As one service user on one of the showcase wards said, “happy staff makes a happy and productive ward”.

Monitoring staff stress allowed ward leaders to respond to individuals who might be stressed at work.

Fig 2 shows sickness absence levels in the showcase wards.

Reduction in violence and aggression
The initiative is making an impact on violence and aggression. There has been a 50% reduction in violence and aggression on two participating acute wards.

Fig 3 shows the reduction of violence and aggression in the showcase wards over a period of a year.

TABLE 2. DIRECT CARE TIME FOR WARDS AT SIX MONTH INTERVALS

<table>
<thead>
<tr>
<th>Unit</th>
<th>1st DCT</th>
<th>2nd DCT</th>
<th>3rd DCT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Older adult assessment</td>
<td>48%</td>
<td>67%</td>
<td>43%*</td>
</tr>
<tr>
<td>Behavioural disorders unit</td>
<td>46%</td>
<td>64%</td>
<td>84%</td>
</tr>
<tr>
<td>Community forensic rehabilitation</td>
<td>11%</td>
<td>33%</td>
<td>41%</td>
</tr>
<tr>
<td>Inpatient forensic rehabilitation</td>
<td>33%</td>
<td>38%</td>
<td>43%</td>
</tr>
<tr>
<td>Community adult rehabilitation</td>
<td>23%</td>
<td>51%</td>
<td>71%</td>
</tr>
</tbody>
</table>

*The ward had no leader for six months and staff found it difficult to cope; DCT = direct care time.
Valuing and empowering staff
Some staff said they felt more valued by managers and leaders. They also talked of the value of learning new skills, of having leadership development at all levels within the team and of a sense that they could bring about change and improve quality.

The bottom up approach is regarded as having empowered staff to take ownership of problems with their systems and processes, rather than being told what to do.

Bridging the board to ward gap
The audit visits, which are conducted by senior leaders and managers from across the trust, provided an opportunity for them to walk the floor, which helped to bridge the gap between the board and the ward.

It made leaders and managers more visible. They were able to hear from firsthand about the staff experience of delivering care and the patient experience of receiving care on the ward, as well as dealing with issues affecting the implementation of modules.

CHALLENGES
As with any management of change, there were challenges to implementing this initiative.

Sustainability
The biggest challenge was sustaining improvements in the context of constant organisational changes and competing demands.

The vision of the trust is that PMHW should not be seen as yet another service initiative that will run its course, but rather that it becomes a way of working that is firmly embedded into practice.

Approaches being used to ensure sustainability include:
- NHS Institute for Innovation and Improvement sustainability model;
- Regular audit visits by senior leaders;
- Attendance at project implementation team meetings and project board meetings (the project board is chaired by the chief executive and attended by the executive director of nursing and representatives from across clinical services);
- Ward audits of standards set in each module;
- Brief periods of focused intensive support from improvement facilitators;
- Communication from the project team and trust that the initiative is a way of working rather than a project with a start and end date.

Working on multiple sites
The trust is spread across a wide geographical area that can be difficult to get around. However, sound planning skills and mobile working using laptops has reduced unnecessary travelling back to the office to complete administrative work.

It has also been a challenge to get teams together for project implementation meetings, but rotating venues has helped with sharing practice, showcasing achievements and giving a better insight into work being carried out in other clinical services.

Data collection and analysis
Despite systems and processes being set up for collecting and submitting ward performance data, achieving this in a timely manner remains a challenge for ward teams. The improvement facilitators still have to chase teams for their monthly data.

In response to this, further training has been offered to ward administrators on the data requirements for the project because they have a key role in gathering other data for the wards. This is beginning to make a difference.

Teams are also encouraged to use the resources of team members who are more confident in using software packages.

CONCLUSION
An evaluation commissioned by NHS London and conducted by Deloitte in March 2009 identified several key ingredients to the successful implementation of the PMHW initiative.

These included the robust governance arrangements that were set up, the support the scheme received from senior managers and leaders within the trust and the emphasis and commitment to a bottom up approach.

Collaborative working towards quality improvement, the resources allocated and the training and coaching of ward teams by the improvement facilitators have also helped to ensure the scheme was able to benefit both patients and staff.

REFERENCES
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