How effective is Productive Ward?

In this article...

» The developing academic literature on Productive Ward
» Factors contributing to its uptake by healthcare organisations
» Evidence of positive achievement using Productive Ward

What is Productive Ward?

Since its initial pilot in 2006, PW has been extensively used to improve efficiency, patient safety and quality of care. Castledine has described how PW “empowers nurses to look at how their ward is organised and make changes that allow them to spend more time with patients” (Castledine, 2008). Robert et al (2011) highlighted that the initiative aimed to:

» Increase the proportion of time nurses spend in direct patient care;
» Improve experience for staff and patients;
» Make structural changes to use of ward spaces to improve efficiency in terms of time, effort and money.

In May 2008, the government invested £50m to support the dissemination and implementation of the PW throughout England. This large-scale investment was provided in the absence of any real evidence of impact or robust evaluation. The initiative did, however, have widespread commitment from senior nursing leaders and full support for implementation through the NHSI. Modules and toolkits to guide implementation were provided free via the NHSI website and support team. Hospitals could enhance implementation through additional training and support packages. Since recent reports suggest that appetite for it is diminishing (White et al, 2014a; Wright and McSherry, 2013) this article focuses on whether the PW initiative has delivered, and whether it will be sustained.

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Focus of PW

» Improving clinical leadership by giving ward leaders methods of leading and helping their staff to deliver safer, more dignified care
» Empowering ward-based teams to take ownership and control of ward-based processes
» Developing stronger, more confident front-line leaders
» Creating a ward-based culture of measurement and improvement
» Applying lean/improvement methods and tools in a ward setting
» Encouraging an entire patient focus for all of the changes or improvements
» Improving team-manager relationships through collaborative working and corporate engagement

Keywords: Productive ward/Releasing Time to Care/Quality improvement/impact review

This article has been double-blind peer reviewed
programme (White et al, 2014b; Morrow et al, 2012). Some authors have described and viewed PW through a practice development lens (Kemp et al, 2011). In the main, PW is best described as a long-term programme, not a one-off exercise, which can deliver long-term sustainable change and improvement. It is a modular, self-directed learning programme that focuses on a variety of quality improvement activities (Box 1).

Impacts, outcomes and outputs
A full review of the literature identified research papers, case-study reports and evaluations related to PW or its implementation, that reported impact, outcomes or outputs. The review was limited to material published between January 2006 and October 2014. The search methods, databases used and selection criteria were identical to a bibliometric analysis performed previously (White et al, 2014a). Four NHSI-commissioned evaluation reports were excluded as previous authors (Wright and McSherry, 2014) have highlighted a possible reporting bias. In total, 30 peer-reviewed papers and nine evaluation reports were examined and the reported impacts, outcomes and outputs from the abstracts and conclusions recorded (Table 1).

Results
Despite concerns raised in previous reviews (White et al, 2014a; Wright and McSherry, 2013), interest in PW, in terms of publications, continues to grow, with seven peer-reviewed publications in 2014 alone. The vast majority of papers and evaluation reports examined reported positive experiences, impact, outcomes and outputs. Five (12.8%) papers reported negative impact, outcomes or outputs [highlighted in bold in Table 1]. Positive outcomes reported varied widely: some of the most common are listed in Box 2.

Discussion and key questions
PW was promoted by its creators and the nursing and healthcare press as the panacea or “magic bullet” for all nursing and ward-based woes. However, following the closure of the NHSI in 2012, and its merger with the NHSIQ in 2013, interest in PW declined. This drop in momentum has been sensed throughout the UK NHS and in other countries where the initiative has been adopted, with a reduced number of reviews and reports in the nursing and healthcare press. The opposite can be said in relation to the academic literature, which has shown an increase in peer-reviewed papers published in recent years (White et al, 2014a). Much of the recent communication from NHSIQ is that it is “business as usual”. However, the level of interest from new or start-up PW sites in the NHS or internationally is less obvious, and this information is not readily available from NHSIQ.

Has PW delivered?
The results from this review highlight that, in many ways, PW has delivered. The initiative has been reported as being generally successful, with ample accounts of extremely positive impacts, outcomes and outputs. The small number of academic papers, research reports and robust evidence available suggest it has achieved and delivered many improvements and has improved both healthcare quality and patient safety. Most importantly it appears to have created a culture and an appetite for improvement that has been absent from nursing for many years. The organisations that have actively managed PW have reported achievements and improvements.

Some reports have criticised the lack of impact data, empirical evidence and evaluative research to substantiate PW. The small number of peer-reviewed publications identified in this article highlights that the research and evidence base in relation to PW is in its infancy and still developing. Accepting that there is a potential positive reporting bias in the literature (Wright and McSherry, 2013) for this improvement initiative (like other improvement initiatives), there is an onus on the nursing profession to contribute to the literature and to capture the data and evidence in relation to ward-based quality improvement initiatives such as PW. The National Institute for Health Research (NIHR) recently identified PW as an example of initiatives where there has been “no systematic evaluation of impact”. It is only when robust evidence is available from large-scale, independent impact evaluation studies that we will be in a position to judge the effectiveness of PW.

For those who have viewed this initiative through an efficiency or cost-savings lens, PW has probably disappointed. Analysis of the amount of investment required to achieve reported impacts, outcomes and outputs has yet to be made available. However, there is little doubt that any large-scale expected cost-savings have not materialised, or at least are not reported in any consistent systematic way.

While there are certainly reports of small-scale efficiencies at ward level, the introduction of PW has highlighted that quality improvement requires long-term investment. It is difficult for nurses and ward-based teams to find the time in busy clinical environments for improvement activities without the enabling resources. Some of the articles examined in this review have highlighted the tensions experienced by ward teams wanting to improve and not being able to find the time. The experience in Ireland to date confirms that the sites that have invested the most, in terms of financial and human resources, have yielded the most improvements.

For the majority of staff (nurses and ward-based teams) implementing PW, it has never been about efficiency or cost-saving. Their focus has been on improving patient and staff experience, and the ward environment and processes. In this regard, reading the reported impacts, outcomes and outputs highlighted in this review would indicate that PW has indeed delivered as nurses and ward teams intended.

Will PW be sustained?
To answer the question whether PW will be sustained, one needs to ask, or at least get a sense of, whether PW is still being used in many of the organisations that adopted it. Without the data from NHSIQ or any national reporting system, this is impossible to gauge. Experience in Ireland indicates it is not a simple matter to decide whether a site is a PW site or not. When does one decide that a ward or clinical environment is not on a journey of improvement? Some of the experience in Ireland suggests that some wards take an “à la carte” approach to PW, deciding to just use some of the tools and leave out elements that may not suit the ward at that time. This does not necessarily make them any less a PW site than a ward that has implemented the initiative “as prescribed”. Quality improvement initiatives such as PW are extremely complex social interventions (Øvretveit, 2011), and the experiences of implementation in Ireland to date demonstrate that the momentum of PW and

**BOX 2. POSITIVE OUTCOMES REPORTED**

- Improved patient care times
- Ward improvements
- Staff engagement
- Improved team working
- Leadership development
- Empowerment
- Positive change management
- Ward improvements
<table>
<thead>
<tr>
<th>Author(s)</th>
<th>Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allsop et al, 2009</td>
<td>Increased patient care times, ward improvements</td>
</tr>
<tr>
<td>Armitage and Hingham, 2011</td>
<td>Ward improvements, motivation, empowerment</td>
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<tr>
<td>Avis, 2011</td>
<td>Staff engagement, stronger patient focus, increased use of measurement</td>
</tr>
<tr>
<td>Avis, 2009</td>
<td>Ward improvements, positive staff attitudes, engagement</td>
</tr>
<tr>
<td>Blakemore, 2009</td>
<td>Empowerment, improved leadership</td>
</tr>
<tr>
<td>Bloodworth, 2011</td>
<td>Culture change for improvement, increased direct patient care times</td>
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<tr>
<td>Bloodworth, 2009</td>
<td>Gives control back to staff, involves the whole organisation</td>
</tr>
<tr>
<td>Brunoro-Kadash and Kadash, 2013</td>
<td>Improved patient safety, staff engagement, leadership opportunities, affirmative organisational cultural shift</td>
</tr>
<tr>
<td>Burston et al, 2011</td>
<td>Converging different strategies should be considered</td>
</tr>
<tr>
<td>Coutts, 2010</td>
<td>Positive change management, poor corporate leadership</td>
</tr>
<tr>
<td>Davis and Adams, 2012</td>
<td>Positive impact on staff attitudes, morale, development</td>
</tr>
<tr>
<td>Foley and Cox, 2013</td>
<td>Improved performance, patient safety, measurements, organisational culture</td>
</tr>
<tr>
<td>Foster et al, 2009</td>
<td>Increased patient care times, reduced infection rates</td>
</tr>
<tr>
<td>Grant, 2008</td>
<td>Lack of medical colleague involvement, engagement</td>
</tr>
<tr>
<td>Gribben et al, 2009</td>
<td>Valuable tools, improved communication and values</td>
</tr>
<tr>
<td>Health Quality Council, 2011</td>
<td>Ward improvements, engaged and motivated staff, more improvement and measurement training needed</td>
</tr>
<tr>
<td>Healthcare Improvement Scotland, 2013</td>
<td>Increased patient care times, efficiency savings, ward improvements</td>
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<tr>
<td>Kemp et al, 2011</td>
<td>Improved patient care times</td>
</tr>
<tr>
<td>Lennard, 2012</td>
<td>Improved teamworking</td>
</tr>
<tr>
<td>Morrow et al, 2014</td>
<td>Develops leadership skills</td>
</tr>
<tr>
<td>Morrow et al, 2012</td>
<td>Positive leadership, improved social and work environment</td>
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<tr>
<td>NHS Scotland, 2008</td>
<td>Increased patient care times, improved morale</td>
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<tr>
<td>NHSI, 2012</td>
<td>Improved patient care times, patient safety, quality</td>
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<tr>
<td>NHSI, 2009</td>
<td>Increased patient care times, efficiencies, time saved, reduced falls, reduced waste, ward improvements</td>
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<tr>
<td>Robert, 2011</td>
<td>Lessons for spread, communication, champions</td>
</tr>
<tr>
<td>Robert et al, 2011</td>
<td>Improved teamworking, staff experience, leadership</td>
</tr>
<tr>
<td>Rudge, 2013</td>
<td>Criticised for creating productivity as a desired state</td>
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<tr>
<td>Smith and Rudd, 2010</td>
<td>Improved absenteeism, reduced complaints, ward organised</td>
</tr>
<tr>
<td>Van den Broek, 2014</td>
<td>Confusing communication, poor long-term engagement</td>
</tr>
<tr>
<td>Van Bogaert et al, 2014</td>
<td>Improved teamworking, quality of care and job outcomes</td>
</tr>
<tr>
<td>White et al, 2014a</td>
<td>Reducing bibliometric interest in the initiative</td>
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<tr>
<td>White et al, 2014b</td>
<td>Positive work engagement (vigour, absorption, dedication)</td>
</tr>
<tr>
<td>White et al, 2013a</td>
<td>Seven key characteristics for implementation identified</td>
</tr>
<tr>
<td>White et al, 2013b</td>
<td>Leadership, empowerment, engagement</td>
</tr>
<tr>
<td>White and Waldron, 2014</td>
<td>Empowerment, leadership, engagement</td>
</tr>
<tr>
<td>Wilson, 2009</td>
<td>Positive patient satisfaction, improved patient care times, safety</td>
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<tr>
<td>Wright and McSherry, 2014</td>
<td>Enthusiasm, empowerment, improved team working, increased morale, patient care times</td>
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<tr>
<td>Wright and McSherry, 2013a</td>
<td>Improved patient safety, improved patient care times, patient/staff experience and financial savings</td>
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<tr>
<td>Wright and McSherry, 2013b</td>
<td>Improved patient care times</td>
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Note: comments in bold indicate less positive findings. Full reference list available on request from the author: whiteser@eircom.net
quality improvement activity ebbs and flows in accordance with ward life. In the Irish case, some PW sites have temporarily "suspended" PW activity to deal with the various crises that routinely affect wards and organisations.

PW, such as other quality improvement interventions, is dependent on context and implementation. However, some reports have already started to identify contextual and implementation characteristics that appear to affect the success of the initiative and how it is sustained (White et al, 2014c).

These include:
- Effective/engaging communication;
- Enabling front-line managers;
- Access to training and support;
- Project management;
- Leadership;
- Corporate engagement and support;
- A commitment to human and financial support.

As the literature develops around initiatives like PW and their implementation, so will our understanding develop of "what works" or at the very least "what might work" with this type of intervention.

Whether PW remains contemporary will depend on the NHSIQ and how it continues to market the initiative both in the NHS and internationally. It also depends on the intentions and adaptability of the organisations that have already adopted it. There are signs internationally, and within some NHS trusts, that PW has served its purpose as a quality improvement "apéritif", paving the way for organisation-wide lean initiatives. PW could also be consolidated into organisation-specific quality improvement programmes, as observed in Salford Royal Foundation Trust.

**Conclusion**

The evidence (however little) is that experiences of PW are overwhelmingly positive. Research interest in this relatively new ward-based initiative is gathering pace and the peer-reviewed PW literature is growing. In the absence of robust evidence, nurses must decide whether PW is the vehicle for delivering front-line, ward-based improvement. Waiting for more evidence will result in missed opportunities to improve our clinical environments, to improve the patient’s experience and to engage fatigued ward teams by allowing them to innovate and create solutions. The PW initiative is well reported to deliver ward-based improvements and should therefore be viewed, accepted and celebrated for what it has achieved and can achieve as a nurse-led, ward-based quality improvement initiative.

If PW had political aims or corporate intentions for the delivery of efficiencies and cost savings, it certainly appears to have under-performed. However, if the intention was to deliver ward-based quality improvements and cultivate a culture of improvement among ward-based teams, PW has delivered for many health-care organisations.

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