Producing Ward: Releasing Time to Care™ – one of the first national nursing quality-improvement interventions in NHS trusts in England – is now a decade old. Developed by the NHS Institute for Innovation and Improvement (NHSIII), and subsequently adopted outside the UK, the programme was based on lean principles from manufacturing and designed to improve productivity and reduce the waste of time, movement, effort and stock on the ward. Comprising 11 modules and several tools (Fig 1) to empower ward staff to make local improvements, it aimed to:

- Increase the time nurses spend on direct patient care;
- Improve the safety and reliability of care;
- Improve the experiences of staff and patients;
- Make changes to the physical environment to improve efficiency (NHSIII, 2008).

The experience of the programme has lessons regarding the design, implementation and sustainability of other large-scale quality improvement programmes. Trusts implemented the programme differently, affecting its assimilation into routine practice and, ultimately, its legacy and sustainability.

In this article...

- What was Productive Ward and what was it designed to do?
- The legacy of Productive Ward 10 years on
- Lessons for other large-scale quality improvement programmes

Key points

- Productive Ward, a nursing quality-improvement programme, was introduced into acute trusts in England 10 years ago.
- It aimed to free up more time for patient care by improving productivity and reducing waste.
- Ongoing use of Productive Ward has not been sustained but its impact on practices and quality-improvement strategies is still evident.

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Abstract

Productive Ward: Releasing Time to Care™ was a large-scale nursing quality-improvement programme introduced to English acute trusts a decade ago to improve productivity and reduce wastage on the ward. A multi-methods study looked at what remains of the programme today, how it was implemented and whether it has had any lasting impact. It concludes that it has useful lessons for the design, implementation and sustainability of other large-scale quality improvement programmes.

Citation


Producing Ward 10 years on

From 2016 until 2018, we conducted a study to investigate the legacy of Productive Ward had three distinctive features:

- Its systematic, sophisticated design and development process – it was designed in collaboration with industry partners and developed incrementally through piloting and refining modules in NHS trusts;
- The high speed at which it was adopted – three months after its launch in January 2008, the government invested £50m to support its implementation. By March 2009, 36% (n=140) of trusts (acute and non-acute) had purchased a support package (Robert et al, 2011) and, by May 2012, it was reportedly being implemented by 70% of all UK acute wards (NHSIII, 2012);
- The bold claims made about its impact, both potential and achieved.
Ward a decade on, and whether it had achieved sustained impact. We examined the nature and extent of any impact, and how this was shaped by the way the programme was implemented and embedded into routine practice.

Funded by the National Institute for Health Research’s Health Services and Delivery Research Programme, the study was led by King’s College London, which worked with researchers from the University of Surrey, University of Southampton and University Hospital Southampton NHS Foundation Trust. It comprised:

- An online national survey of directors of nursing and Productive Ward programme leaders in acute trusts in England;
- Interviews with former Productive Ward leaders;
- Case studies of Productive Ward in six acute trusts. Case-study sites were chosen that had adopted Productive Ward at different times in its history, and captured a range of trust types and regions. At each site:
  - Interviews were held with staff and (where these existed) patients who had been involved in Productive Ward;
  - A questionnaire was distributed to the ward manager and wards were observed for legacies of Productive Ward on environments and processes;
  - Routinely collected data was examined for Productive Ward-related outcomes.

The final research study report – Sarre et al (2019) – is now available, and the findings of trust types and regions. At each site:

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Findings

Our survey received responses from 73 acute trusts (48% of trusts). Most directors of nursing reported that Productive Ward was no longer in regular use; the average length of use was three years since initial adoption. Half of trusts that had stopped using it said the reason was lack of resourcing, especially of Productive Ward leader time, and only six trusts still had a designated Productive Ward champion. Nonetheless, some wards continued to use processes and practices arrived at through implementing Productive Ward (for example, display of metrics data, protected mealtimes) and some still retained ward storage systems they developed as part of Productive Ward as a material legacy of the programme.

One of the lasting impacts of Productive Ward was the extent to which it still informed trust-wide quality-improvement strategies. Nearly half of directors of nursing said it had informed or been integrated into the quality-improvement strategy of their trust, which had given the trust a formal quality-improvement role for the first time.

Implementation

Productive Ward guidance included steps to ensure the trust was ready to adopt the programme, but the expectation was that all acute hospitals should adopt it. As one director of nursing said:

“[Productive Ward] fell into the category of things that... were being promoted ... you get to a point where you almost have to have a good reason not to do it... If you didn’t do things that were perceived to be things that you should be doing, that always felt to be a bit risky... a risk that may not be worth taking.”

As the study was retrospective, there was limited information on steps taken by trusts to assess readiness, but it is possible that, in the swell of enthusiasm, some steps were missed.

The reputation of Productive Ward also suffered, to some degree, from extensive benefits being claimed without a strong evidence base. Many trusts, particularly later adopters, did not follow the detailed implementation guidance in the Productive Ward toolkit and fidelity suffered over time. Wards often rushed through the 11 modules or simply missed some out altogether.

Funding in larger organisations with more wards, although significant, was not available for long enough (typically two years) for Productive Ward teams to implement the programme the way its designers had intended. This was increasingly evident as they ran out of time, particularly as the most-challenging wards were typically left until last. As one Productive Ward lead at a case study site explained:

“So what we did [with the Well Organised Ward module]... we gave them a day of our time ... The other [modules], like Knowing How we’re Doing and Patient Status at a Glance, [with] some of the wards it was ... ‘This is a general introduction, what we’re going to do, and we need to change it’ and every once in a while, ‘Actually this has got to happen, we’re delivering a ‘[Knowing How we’re Doing’ or ‘Patient Status at a Glance’] ... some of the later wards we [just] dropped off the board.”

Local ownership

Ensuring local ownership of the programme by empowering ward staff was an underpinning principle of Productive Ward and had previously been found to influence successful implementation at a local level (National Nursing Research Unit and NHSIII, 2010). However, our study showed that, over time, implementation often became facilitator-led rather than ward-led and, although there were reports of positive staff engagement, some wards failed to involve lower levels of ward staff in any meaningful way.

In early-adopter sites, there was a noticeable shift over time: they moved...
away from empowering ward staff to take ownership of the programme by enabling them to implement the modules themselves and moved towards programme leaders and/or ward managers imposing ‘solutions’, as they focused more narrowly on the goals of Productive Ward and standardising implementation throughout the trust. In sites that adopted Productive Ward at a later date, this limited view was more common from the start.

**Design and resourcing**

One observed limitation of Productive Ward was that by focusing exclusively on ward and nursing processes, the original framing and format did not meet more recent demands for multidisciplinary team working and whole-system transformation. Trusts with strong cultures in terms of quality improvement or change management engaged central services at management level, which helped with implementation and broadened the potential impact of the programme.

Large-scale quality-improvement programmes need to be sufficiently resourced not only to release ward staff to carry out task-driven activities (which were reported by staff as being beneficial in implementing Productive Ward) but also to allow experiential learning relating to the programme’s underlying principles. Having a dedicated member of staff to coordinate activities and training was key to achieving sustained impact.

**Sustainability**

Some of the case-study sites lacked a clear sustainability plan, and a sustainability tool launched by NHSIII was criticised by some participants for measuring modules completed, rather than outcomes achieved and lessons learned. Robust measurement of impacts and costs (for a minimum of six months before and after implementation) and consistent data collection needed to be built in from the start, bearing in mind that the metrics valued by wards and organisations may be different.

Shediac-Rizkallah and Bone (1998) argued that a programme’s sustainability should be judged on whether it has evolved and adapted, rather than having simply remained in place unaltered. At an organisational level, quality-improvement programmes need to change and adapt so that learning and resources can be applied to new organisational or NHS priorities, rather than having to start again with new programmes. In many cases, measures introduced at ward level by Productive Ward were sustained only superficially; for instance, although data-visualisation boards were commonly found, they were often out of date and not regularly discussed with ward teams. However, where ward staff had been given a real understanding of the underlying principles of Productive Ward, they continued to apply them in new and innovative ways in response to changes on the ward.

**Involving service users**

Although Productive Ward guidance suggested roles for patients, visitors and patient representatives at ward and hospital level, our study suggested that such involvement was generally low to nonexistent. Recent interest in how coproduction can underpin quality-improvement work holds important lessons for meaningful and imaginative ways in which service users can, and should, be part of designing and evaluating large-scale quality improvement programmes (Batalden, 2018).

**Summary**

Our investigation into the implementation, assimilation, legacy and long-term impact of Productive Ward has useful lessons for the design, implementation and sustainability of other large-scale quality-improvement programmes (Box 1). It shows that, while the programme’s ongoing use as a quality-improvement approach has not been sustained, its impact on ward practices is still evident and it has informed quality-improvement strategies in some trusts.

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**Box 1. Lessons learned from Productive Ward for large-scale quality-improvement programmes**

- **Think beyond the ward** – engage managers at an organisational level to help with implementation and broaden the impact of the programme
- **Resource properly** – ensure sufficient resources, including appointing a dedicated member of staff to coordinate activities and training
- **Go for quality, not quantity** – keep programmes slimline and focused so they are easier for staff to implement; empower frontline staff to take ownership rather than imposing ready-made solutions; and measure success in terms of learning and outcomes, rather than completion of the programme
- **Build in sustainability and robust evaluation** – draw up a sustainability plan and build in robust systems from the start to measure impacts and costs using metrics that are useful at both ward and trust level
- **Adapt and change** – at an organisational level, adapt the programme to meet changing needs and priorities, while ensuring staff at ward level have a clear understanding of the underlying principles so they can apply them in new or different ways as ward requirements and circumstances change
- **Involve patients and carers** – look for new, innovative ways to involve service users in design and evaluation

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**References**


