

TIME AND MOTION

**A PROGRAMME FOR
EFFICIENCY IN THE NHS**

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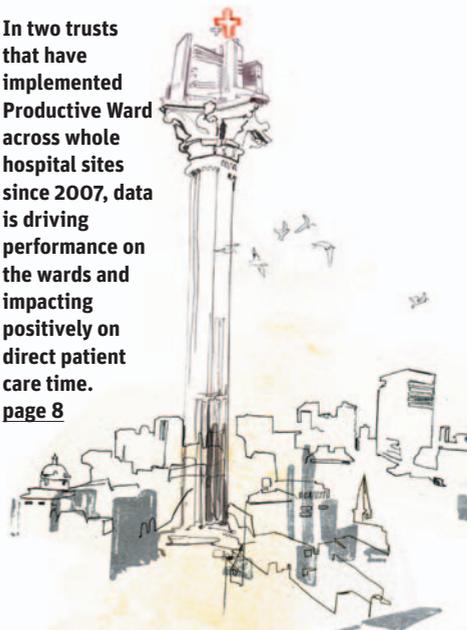
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A NOTE FROM THE NHS INSTITUTE

Shaping the future together

Welcome to the special *HSJ* supplement on the Productive series. The Productive programmes demonstrate how much difference can be made for patients and staff when we create a powerful partnership between the NHS Institute for Innovation and Improvement and its NHS customers. The “Productives” have been conceived as a result of feedback from frontline NHS staff about immediate priorities for change and learning from the rest of the world about the greatest opportunities for change.

This series is a flagship programme for the NHS Institute and a powerful symbol of its future course. We embarked on our own change programme in January 2008. This has involved listening to hundreds of our health service customers and reflecting on our direction and priorities. We want to be in the best possible position to support the growing demand for improvement ideas and skills. As we move to the implementation phase of the next stage review, there is a clear sense about *what* the NHS wants to do to improve health and healthcare but much less clarity about *how* to achieve the improvements we seek. The core of the NHS Institute in future will focus on three interconnected activities:

- supporting health service leaders to lead improvement;
- great ideas for innovation and improvement;
- building capability for improvement.

NHS leaders tell us they would like us to concentrate our leadership development activities more closely on leadership for improvement, so we will be making a stronger connection between leadership development and improvement activities, such as the Productive Ward. So, think about what a “typical” Productive programme from the NHS Institute can provide. You get a set of powerful improvement modules, based on world-class improvement thinking and tested in the local NHS context. You can access intensive skills training for facilitators and project managers and a network of peers in similar roles. Leadership development and executive coaching may be available. It is this combination of support that helps improve your change outcomes.

In future this integrated offering which covers ideas, skills and leadership development will become the norm for a much wider range of NHS Institute products.

We are ambitious in our aims for populations and patients and also about the contribution the institute can make. We want to work with the entire NHS and the wider health and social care system to help deliver great outcomes. ●

Bernard Crump is chief executive of the NHS Institute for Innovation and Improvement.



FOREWORD

The Productive series will allow staff to revolutionise the NHS

I have been involved with the Productive Ward, designed by the NHS Institute for Innovation and Improvement, from the very beginning of its development, and personally launched the initiative at the Royal College of Nursing conference in 2007. Since then, I have kept a close interest in its progress.

I am well aware of the frustrations experienced by staff who are dedicated to the care of patients but are prevented from spending time with them because working practices are inefficient or outdated. The Productive Ward offers a practical and common sense approach, which empowers ward teams to redesign their own processes and enables them to deliver better care.

Since the Productive Ward was piloted and rolled out to hospitals all over the country, I have met and spoken to a number of nurses who have found their working lives transformed by its ethos and have benefited from having access to the practical improvement tools.

They have told me that by involving the whole team in looking at their systems and finding ways of reducing the time spent on activities, such as paperwork, handovers and searching for equipment, they have significantly increased the amount of time available for patient care.

Health ministers have taken a keen interest in this work, regularly visiting hospital sites running the Productive Ward. They were impressed not only by the difference this programme made to working practices, but also by the enthusiasm of the staff implementing the changes.

As a result, the health secretary Alan Johnson announced last year that £50m has been set aside for trusts across the country to take advantage of the Productive Ward programme.

The changing needs and expectations of patients has led to different approaches to delivering healthcare and nurses have played a pivotal role

‘Nurses have found their working lives transformed by the ethos of Productive Ward and have benefited from the practical tools’

in these changes. As their role evolves, the day-to-day organisation of wards must change to ensure that they are able to spend as much time as possible on patient care.

We are now seeing the principles on which the Productive Ward is based being translated into other areas of the health service: across mental health and community services, for example. It is even being taken into the boardroom, through the Productive series. Empowering staff to drive forward improvements in the health service on the front line is a cornerstone of health minister Lord Darzi’s ongoing review of the NHS. The Productive Ward demonstrates the benefits of this approach to health reform: clinically driven and locally led. ●

Professor Christine Beasley is chief nursing officer.



‘THIS IS A PHENOMENON’

The NHS has seen countless initiatives but the Productive Ward seems different – in the sheer enthusiasm it provokes, the refreshing lack of jargon and the way it was developed from the bottom up. Stuart Shepherd explains

For the past 10 years Maggie Morgan-Cooke, the NHS Institute’s head of the Productive Ward and the Productive Community Hospital (and a nurse by background), has worked on improvement in the NHS. She considers herself fortunate to have been involved in several successful national change initiatives during that time – such as the 10 High Impact Changes series.

But as far as she is concerned, the Productive Ward is different. “I have never worked with a phenomenon like this before,” she says. “It really taps into those values of providing direct patient care that bring nurses and people from other disciplines into their profession. The real pull for Productive Ward modules comes from frontline staff who realise that this helps them lead change themselves. It is the same for the new Productive Community Hospital and Productive Mental Health Ward modular sets.”

The change she describes, which expresses itself in benefits to both patients and staff, is already proving considerable. Achievements noted across some of the first wards to introduce Productive principles and tools include:

- time spent on the medicine round reduced by 63 per cent;
- shift handover time cut by a third;
- patient observation reliability up 70 per cent;
- £10,000 a year saved on unnecessary meal requests;
- hundreds of pounds of stock returned to stores.

A similar impact is anticipated in those mental

‘From humble beginnings across a handful of development sites in early 2007, Productive Ward has spread like wildfire’



'NOT ONCE HAVE WE HAD TO DO A MAJOR TIDY-UP'

Helen Maw is the nurse manager of Elm Ward at The Queen Elizabeth Hospital King's Lynn trust. The hospital piloted Productive Ward on Gayton Ward, a male surgical unit, for several months before rolling it out across a further five wards, including Elm, this May:

"We saw and heard about a lot of the impressive progress being made on Gayton. You could tell it was really making a difference. Because our shift handover was taking too long, we picked up and implemented the improvement process for it on Elm Ward.

"That alone saved us 90 minutes every 24 hours. One

important lesson we learned from our early adoption of the principles is that there is a process to follow for each module.

"This has helped the team successfully work through the Knowing How We Are Doing and Well Organised Ward modules, observing the environment, taking photos, looking at the issues together and changing the layout in areas where it needs it.

"All I am really doing is facilitating the ward team to deliver change. Everybody gets involved, knows what's going on and why. For me, that's what makes the improvement sustainable. Staff can see on the

measures board how our performance compares with standards for things like patient observations.

"I have also put a lot of 'before and after' photos up, and the use of visual management techniques has a huge impact.

"The treatment room used to be a complete mess but now people really take notice. Not once have we had to go back in there and do a major tidy-up.

"There are knock-on effects. People can enjoy being at work, and with the patients, more and sickness levels are down. It's really positive and I don't see why it shouldn't continue."

health and community inpatient settings now taking up the newly released modules. And if you are looking for evidence of the popularity of this new approach to improvement, its principles and tools, the numbers alone speak volumes.

From humble beginnings across a handful of development sites in early 2007, Productive Ward has spread like wildfire. At the most recent count, of the 171 acute trusts in England, 154 have been using the materials. The NHS Institute has made available more than 5,500 comprehensive Productive Ward toolkits. That equates to nearly one-and-a-half kits for every ward in an English hospital.

"A number of organisations, such as Sheffield Teaching Hospitals foundation trust, are requesting the module sets," says Ms Morgan-Cooke. "They are just one of a growing band committing themselves, their wards and their staff to a Productive future."

She adds: "What has also been wonderful, and especially in this 60th anniversary year of the NHS, is the amount of interest Productive Ward has generated internationally. The NHS Institute has either licensed use of Productive Ward or is actively in conversation with healthcare systems in 17 countries – including Australia, Canada and Holland – which are looking for support and advice from us on how they might implement and reproduce the project in their own systems."

But what are the particular features of Productive Ward that have seen it grow to the extent that it enjoys an almost universal appeal? How has the approach developed to be more responsive to both ward and organisational needs? And how has its success helped to shape thinking around the creation of the new Productives, be they recently released, soon to be launched or still in the planning phase?

"Productive Ward is about applying known best practice improvement techniques from industry. We contextualise them for the setting and the people using them and make them entirely focused on the safety, reliability and dignity of care," says Nick Downham, one of the people who invented the Productive Ward concept at the NHS Institute.

One of the single most important features of the approach is the design of the self-directed learning modules. They support frontline leaders in facilitating the introduction of improvement thinking and principles without being loaded with academic argument or lean terminology.

Written in a straightforward and practical language, and with a strong visual identity, they contain a mix of tools and techniques that can be adapted to clinical areas.

These bring standardisation, not only to practice, but to the way in which people think about and approach the issues they identify. It helps them find their own solutions and set standards for actions that can be sustained with reliability.

"This is about giving nurse leaders methods for leadership," says Mr Downham. "Far from being simple, the processes going on in a ward are incredibly complex. Productive Ward gives ward teams the structure to take those processes apart and put them back together again in a form that is safer, more efficient and gives them more time for direct care."

Ward teams can only get so far by themselves, however. With consistent, visible, high-level → 3



3 ← organisational commitment, Productive Ward can provide a real shift in process reliability.

Productive Ward has a very different feel about it and represents a different way of working for the NHS Institute.

The course of its development has been far from typical too, as Ms Morgan-Cooke explains: “The NHS Institute normally works systematically to produce and then release finished products, seeking to encourage NHS organisations to take them up. In this case, though, we were seeing some dramatic improvements in the initial field test sites that we went on to share and collaborate on with the Royal College of Nursing. The chief nursing officer championed it from early on as well and this all helped to raise a widespread level of awareness.

“This has contributed to making it essentially a leadership development programme for nurses. Where the right mix of frontline motivation and senior leadership commitment and support exists, ward teams can implement Productive Ward themselves. The modules have been written to give nursing staff the know-how to make a change they can own. They tell us that having the

‘The tools and techniques bring standardisation, not only to practice, but the way people think. It helps them find their own solutions’

means and the capability to drive up standards is something they very much enjoy.”

The NHS Institute launched the Productive Ward membership scheme in January this year. The institute typically provides high impact solutions to big challenges within the NHS. However, a number of hospitals asked whether they could also provide direct training and implementation guidance to support the modules. As an experiment, the institute set up a pilot membership scheme where trusts could pay for extra support. Any money raised would be reinvested in improvement support for the NHS.

Standard membership lasts 12 months and costs £8,000. Accelerated membership costs £25,000. The accelerated package includes:

- executive team engagement and support;
- project leader training;

- module implementation training for up to 10 leads and facilitators;
- external clinical facilitator support.

“Executive support can be in the form of a briefing, perhaps along with additional coaching for the sponsoring director, who is frequently the director of nursing,” says Ms Morgan-Cooke. “We try to help executives make helpful linkages between Productive Ward principles and their own strategic goals. This is an important message for frontline staff and will impact on matters of standardisation and sustainability. When they are trying to deliver services, staff want consistency from above. They don’t want to feel like there are directives coming at them from all angles.”

A set of guides for the executive lead, the project lead and the ward leader includes pointers to how a trust might choose its showcase wards during the initial implementation phase. Even more importantly, they set out the required qualities for the project leader and the ward leader. Surprisingly, learning from Productive Ward shows that prior knowledge of improvement techniques is not a priority. Improvement skills can be acquired from the modules. Energy, motivation and a good leadership style in the clinical area are much more important in choosing the initial wards.

“We provide two days of leadership training for people in these roles,” says Ms Morgan-Cooke. “There are breaks built in to encourage project leads to apply their learning.”

Module implementation training runs along similar lines. Up to 10 ward staff and project leaders get together in a team about once every five weeks. They have an opportunity to practise skills they are about to apply in their own wards. This is successful because the number of staff involved supports the rapid development of skills transfer into an organisation.

The accelerated scheme also brings in ongoing clinical facilitator support. These are senior nurses working on secondment to the NHS Institute who have already successfully implemented Productive Ward in their own area.

“We created Productive Ward with frontline nurses,” says Mr Downham. “We have learned you can spread improvement method across the country and beyond without any mandate or push. The lessons are: engage with staff, get them to stamp their values on the programme, use plain language and make it simple to use.”

Taking that learning forward was important when it came to creating the Productive Mental Health programme. Mr Downham acknowledges that at first he expected that it would just be a

MEET THE FAMILY

- The Productive Ward: now available
- The Productive Mental Health Ward: now available
- The Productive Community Hospital: now available
- The Productive Maternity Ward: in development
- The NHS Productive Leader Programme: now available
- The Productive Operating Theatre: in co-production; estimated completion summer 2009
- Productive Community Services: being developed; estimated completion summer 2009
- The Productive Improvement Agent: concept being developed.

“variation on a theme”. Change a few of the visuals, a little of the focus, kick back and wait for the same kind of success.

It was soon clear, however, that mental health operates in a very different context and style. The mental health ward staff who helped to develop the modules placed a much greater emphasis on therapeutic interventions and dialogues. This, as with all the programmes still in development in the Productive series – Maternity, Operating Theatre and Community Services – was not a simple rebranding exercise. It required the same close and thoughtful partnership working so that staff could see themselves in the documents and tools they would be working with.

“Before I joined the NHS,” says Mr Downham, “my background was in manufacturing as a lean specialist. It’s an industry where you would not assume that safe processes and quality teamwork just happen – they require time and effort. When I started observing ward-based care, what I saw, however, was everybody working flat out just to maintain the status quo. The expectation was that the teamwork and the safety would just happen.”

He continues: “With Productive Ward, we are now acknowledging frontline staff as the best people to design the processes and giving them the headroom to do it in. The time it frees up is reinvested in quality – quality mealtimes, quality medicine rounds and quality handovers.” ●

➔ To find out more about the series, go to www.institute.nhs.uk/ and add any of the following to the end of the address: **theproductiveward, theproductivementalhealthward, theproductivementalhealthward, theproductivementalhealthward, theproductivementalhealthward, theproductivementalhealthward**

‘BEST THING THAT HAS HAPPENED TO THE NHS IN YEARS’: THE EALING STORY

At Clayponds Hospital, Ealing primary care trust is showcasing Productive Ward on three units: admission avoidance, neurology and rehabilitation. Julie Belton, service head for practice development and Productive project lead, explains the progress made to date.

“Early in the summer and as part of the package of support from the NHS Institute, the project facilitator and I did two days of project

management training before embarking on the module implementation programme with the wards.

“The Knowing How We Are Doing module helps form a performance baseline against a range of indicators, clarify areas and actions for improvement and identify project champions.

“It was also the opportunity for each of the ward teams, the patients and relatives to create a vision that reflected

the care package they wanted to see provided on their unit.

“With Well Organised Ward, the staff used the module process to go in to those physical areas previously identified as in need of standardisation, such as the sluice room, and using techniques like ‘spaghetti walk’, mapping and 5S, they rationalised and reorganised the space.

“Instead of 15 commodes,

there are now four and, now the improvement is being sustained, the team believe this action could save 22 nursing shifts of time per year.

“More recent key process module work has given a focus to patient observations – making sure it is done at the right time, that readings out of normal limits are reported, etc – and is now going on to consider how mealtimes can be best organised to meet the needs of the patients.

“Some of the facilitated project time is now being withdrawn and the next phase of the project will see the nursing teams take themselves through the rest of the modules.

“We have also adapted some of the modules for use on what we are calling our Productive Therapy Department.

“I think this is the best thing that has happened to the NHS in years.”



This is my 11th year as a national improvement leader in the NHS. During this time, I have led or supported more than 70 major national improvement initiatives, in priority areas such as quality, emergency care, waiting times, cancer services, leadership and care closer to home. Yet I have never experienced a phenomenon like the Productive Ward. It has spread more quickly, made a difference to more staff and patients and created more energy for change than anything I had experienced previously. All the indications are that the other “Productives” are going to follow a similar pattern.

The Productive experience made me reflect deeply on the whole process of implementing change. What can it teach other major improvement initiatives, such as the implementation strategy arising from Lord Darzi’s next stage review? These are my top six lessons:

- Get everyone at every level playing their role to make a difference for patients.

Productive Ward depends on the energy and talent of ward teams and managers, supported by matrons and executive nurse leaders. It is probably the best example I have seen of the magic that happens when senior leaders get firmly behind changes at the front line. It is also an excellent example of the positive role that strategic health authorities can play in supporting local change.

Productive Ward represents the NHS Institute at its most impactful, making powerful improvement ideas and skills available to NHS organisations.

- Base it on the real world, not Disneyland. Productive Ward is not a “magic bullet”. It requires leadership will, resources and staying power.

The executive training for the Productive Ward makes clear the resources and time commitments that will be required at every level of the organisation.

Contrast that with many local change initiatives, where we start taking action without really thinking through the resource implications. Then we wonder why the change

“
The programme is not a magic bullet. It requires leadership, resources and staying power
”

process flounders when we just have not got the time or space to implement or sustain the changes.

- Work with improvement methods such as lean, but keep them in the background.

All the Productive programmes are firmly based on lean improvement principles. However, you will rarely hear the word “lean” mentioned. That is because improvement methods work best in healthcare when we keep them in the background and focus on the results we want for patients and staff. If the Productive Ward had been called “The Lean Ward” rather than “Releasing Time to Care”, I doubt we would have had anything like the take-up.

- Create pilots with pace. We learned very early that it is more effective for trusts to start their Productive Ward programmes with just one or two wards, use this as an opportunity to really learn what is required, then systematically spread

the approach to the rest of the organisation. We have a tendency in the health service to start pilot schemes that are much too large. If you start the Productive Ward with six or eight pilot wards, rather than one or two, it is much harder to manage and learn. The paradox is that by starting smaller, we can go faster in the longer term.

- Work with “identity groups”. People are much more likely to embrace change when the message comes from someone in their own identity group – that is to say, other people who share the same values, beliefs and life experiences.

So a doctor is much more likely to change as a result of an interaction with another doctor than from an interaction with a non-clinical manager. In fact, a big factor in the rapid spread of Productive Ward is the impact and power of nurse identity groups.

We will be much more effective in our change communication if we work through and with natural identity groups, rather than trying to push messages down through hierarchical organisational structures.

- Enable staff to bring their whole selves to work. The best thing about the Productive Ward is seeing just how much energy can be unleashed by encouraging frontline teams to question how they work and providing simple tools and skills to do this.

Yet it is also a tragedy that it takes an improvement initiative to unleash the natural vitality and creativity of our staff.

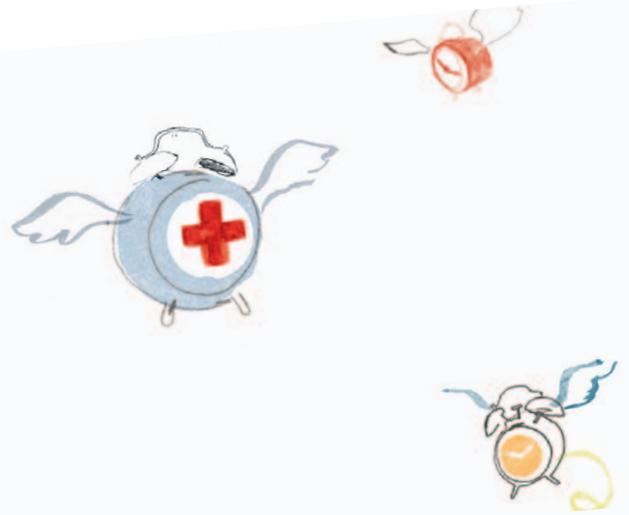
As NHS leaders, we typically don’t go about change in a way that energises and inspires our people. If we could replicate the best of the Productive Ward spirit in every care delivery environment in the NHS, we could truly transform the system.

So, let’s focus less on plans, strategies and controls. Instead, let’s concentrate on enlivening and emboldening our staff to put all their energies, flair and talent into work and making a difference for patients. ●

Helen Bevan is director of service transformation at the NHS Institute for Innovation and Improvement.



MAKING TIME FLY



Emails, meetings, sorting out that pile of paper: Jennifer Taylor looks at how the Productive Leader programme helps you cut tasks down to size

If you received an email with the subject line “next steps”, it is unlikely you would know what it was about, how important it was and whether you needed to respond. Should you drop everything and read it or leave it until later?

It is an irritation faced by most, if not all, senior leaders in the health service on a daily basis. The Productive Leader programme, launched in October by the NHS Institute for Innovation and Improvement, deals with this dilemma. As with other Productives, the programme is about releasing time – in this case to lead – and is aimed at chief executives, their executive team and personal and executive assistants.

It stems from senior leaders in the NHS wondering how they could manage a growing agenda without additional time and expressing their concerns to Helen Bevan, director of service

‘NHS culture is “we need to have a meeting”, but we’re encouraging people to think whether that’s productive’

transformation at the NHS Institute. Research by the Institute with chief executives, directors and assistants then showed that meetings were where the most time could be saved, with chief executives spending at least 70 per cent of their time in meetings over an average 54-hour week.

The programme has five modules, but before getting started, chief executives, directors and assistants complete a personal effectiveness questionnaire that measures their current performance against best practice statements such as: “I constantly look at my emails during the day?”. Scores are produced for individuals and teams, and participants also collect baseline data such as how many meetings they attend and how many emails they receive.

The first module, leadership team coaching, explores the fact that to experience the benefits of Productive Leader, personal behaviour change is often required. The module then explains the importance of the relationship between a leader

and his or her assistant, and of clarifying roles and responsibilities.

The second module looks at best practice for sending and receiving emails. For example, subject lines should say whether the email is for information or action, what the purpose is and any deadline.

Lynn Callard, national lead for the programme at the NHS Institute, says: “You still get the email, but it helps you prioritise it and understand your action from it much more quickly than just reading something that says: ‘next steps’”

Module three is about workload management: what you do that takes up your time and what your personal workload practices are. Is the office tidy? Is it an efficient office layout? How many meetings do you attend? How long are they?

The fourth module then focuses on the practicalities of running meetings, but starts with asking whether a meeting is needed at all. Ms Callard says: “The NHS culture is very much ‘we need to have a meeting’, but we’re encouraging people to think whether that’s the most productive way of achieving their purpose.”

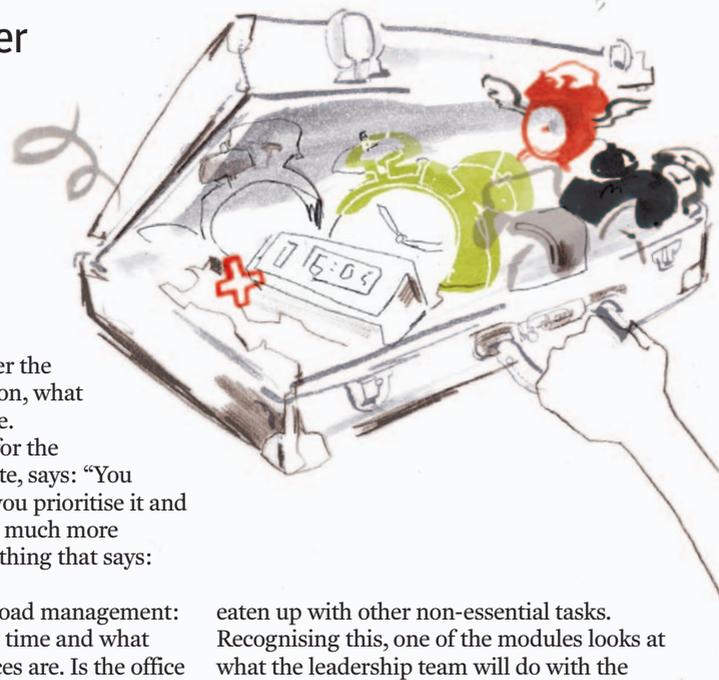
Dramatic results

After each of the first four modules, individuals and teams formulate their own improvement plans, identifying changes and how they will monitor progress. Module five revisits these commitments, focusing on the principles of improvement planning, and looks at how the organisation will change.

Ms Callard says: “It’s about the leaders taking it on, setting the example and then rolling it out down through their organisation.”

Going through the Productive Leader programme can produce dramatic results: one pilot site with very long meetings reduced the average length of meetings by 30 minutes; a group of personal assistants working with their directors on getting items for agendas in on time were able to save one hour a day; at the NHS Institute itself Ms Bevan and her team worked on email management and saved 10 hours a week.

The caveat, of course, is that the time could get



eaten up with other non-essential tasks. Recognising this, one of the modules looks at what the leadership team will do with the released time. Chief executives may want to be more visible in the organisation, visiting wards and departments. That is what Chris Burke, chief executive of Stockport foundation trust, has opted for. His hospital was a test site for the Productive Leader programme.

“One of the biggest benefits we brought in was a review of all our meeting structures,” Dr Burke says. “That has produced very good results in terms of better time-keeping and better-focused outcomes.”

He adds: “Being part of Productive Leader requires a lot of planning. You’ve got to work together as a top tier on how you’re going to use the programme. It is absolutely useless having one person trying to set the tone for the organisation. It’s as much a cultural change as a personal objective.”

“For it to be sustained,” he continues, “you’ve got to see the same behaviours reflected back on you, otherwise you end up in the wilderness. It’s really got to be engrained in the system.”

NHS leaders are taking up the challenge in droves. As Ms Callard reports, “nearly one-third of all the executive teams in the NHS have already attended Productive Leader workshops even before the programme was officially launched.

“It shows that the NHS leadership community is as ready to embrace principles of productive leadership as the leaders of global companies. Who says the NHS is slow to innovate?” ●

Operating theatres bring together some of the highest technical expertise and most intensive use of resources in a hospital. So why do patients have bad experiences, why are quality and cost so variable between NHS hospitals and why are some patients harmed by the theatre experience?

To tackle these questions, the NHS Institute for Innovation and Improvement is developing the Productive Operating Theatre, the latest programme in the Productive series and the first to target surgeons and anaesthetists.

According to Amanda Fegan, who leads the programme, the areas about which clinicians hold strong views will be the focus of any improvement programme.

The NHS Institute plans to launch a series of evidence based Productive Operating Theatre modules in the summer of 2009. Before that, the modules are being developed and tested with three health service field test sites.

As a starting point, the team at the Institute has defined four dimensions of quality to work on: safety and reliability of care; team working and leadership; patient flow, logistics and resources; and patient experience and outcomes. The programme will be based on global best practice. It will be about eliminating errors, having systems for briefing and debriefing so that everyone in the theatre team understands what is going on, and learning from near misses.

To some extent it is also about standardising



SURGICAL SOLUTIONS

SMOOTH OPERATORS

A programme targeted at surgeons and anaesthetists aims to ensure consistently excellent practice in operating theatres, says Jennifer Taylor

elements of care where possible so that patients receive what the evidence shows they should. For example, prophylactic antibiotics for patients having surgery are sometimes overlooked. Improving team dynamics has also been shown to make care safer and more reliable.

Afraid to speak up

“What we saw in the Productive Ward was just how dramatic it was when the ward nurses were given the opportunity to point out what the problems were in their daily work and we could then help them find solutions to make life much better for them,” says Hugh Rogers, a consultant surgeon who is the national clinical leader of the Productive Operating Theatre programme.

He believes the same can be done in the operating theatre if theatre nurses, operating department practitioners, surgeons and anaesthetists think about what headaches confront them on a daily basis and the Institute then gives them the tools to resolve them. These methods include assertiveness tools and tools to “flatten the hierarchy” so that all members of

the team feel able to confront poor practice or possible mistakes.

Mr Rogers says: “I’m a urologist and I know how often the wrong kidney gets operated on, and almost always there’s someone in the operating theatre who knows it’s the wrong kidney but didn’t feel able to speak up.”

Surgeons like to take control and Mr Rogers admits the new-found assertiveness of other staff could cause problems, but he believes that once they recognise the power of some of these systems to stop errors becoming harmful events for patients, relationships may change.

Sustainable results

The programme will also ask questions about where theatres are strategically positioned in a trust. Some, for example, do not have a clinical director for operating theatres.

While the programme will not aim to tell trusts they need a stronger focus on operating theatres at senior management level, it will highlight that it could help them make the most of the tools on the ground. But what will make this programme a

success, says Ms Fegan, is that there is a pull from the staff to do the work, rather than a pull from senior leaders to get them to do it.

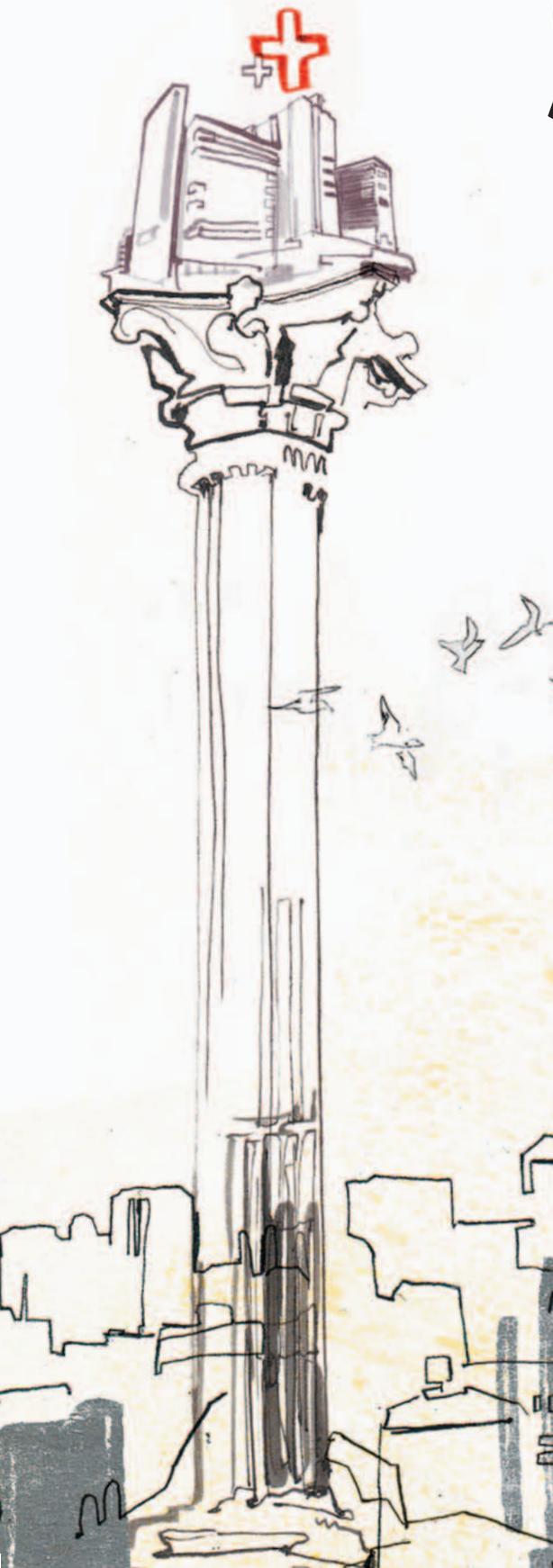
Mr Rogers points to the field test at West Middlesex University Hospital trust, where there is “great enthusiasm” and “huge energy” to take this forward.

Very straightforward changes are making a big difference, such as Knowing How We Are Doing boards outside every theatre, team briefings before every procedure and the 5S process to make stock cupboards and offices better organised.

“People are really beginning to believe that we will help them to make the changes that they think are a priority,” he says. “There’s always a lot of scepticism at the start of this sort of project: people think that someone’s going to come and tell them how to do everything.”

“But if the theatre team themselves have identified the problems to work on, and they’ve implemented the solutions, then not only is it going to be much more relevant to them, but it’s also much more likely to be sustained.” ●

WHOLE LOTTA SHAKE-UP



They have succeeded on individual wards, but are trusts in Nottingham and Manchester up to the bigger challenge of transforming whole hospitals, asks Stuart Shepherd

In September 2007, following the unprecedented success of the individual Productive Ward field test sites, two NHS trusts embarked on a strategy to implement the Productive Ward across their entire hospital systems. The trusts were invited to do this by the NHS Institute because both had an excellent track record in hospital-wide improvement initiatives.

Nottingham University Hospitals trust and Central Manchester and Manchester Children's University Hospitals trust were enthusiastic about the programme. They were confident of the potential of Productive Ward to increase the nursing time available for direct patient care dramatically.

Nonetheless, as "whole hospital" testing grounds, a vanguard for acute and other services far and wide, they knew they were stepping somewhat into the unknown and fully acknowledged the challenge ahead.

A year in, their learning is already proving to be invaluable and informing important further developments in the national roll-out of the Productive Ward and how its impact will be measured. Their progress has also contributed significantly to the continuing growth of the Productive series.

The Nottingham story

Having familiarised itself with the tools and principles of Productive Ward on two pilot wards, Nottingham began whole hospital roll-out in November 2007. Eight new teams from NHS England's fourth largest trust join the programme approximately every 10 weeks, and to date Productive Ward is being implemented in 34 wards as well in as the emergency department.

"Two years from the start of roll-out [November 2009], our aim is to have Productive Ward on 74 from a total of more than 90 wards," explains Kerry Bloodworth, assistant director of nursing and Productive Ward project lead. "The most advanced wards have completed all the foundation modules and are moving on to their fifth process module. Their Productive Ward 'house' is almost complete."

She adds: "We have a team of four senior project nurses – all former ward sisters with good communication and influencing skills but little or nothing in the way of a background in

improvement skills – to meet the demands those aspirations place on us."

Trust chief executive Peter Homa chairs the project's monthly steering group, which is also attended by directors from estates and informatics alongside representatives from the different ward cohorts in the implementation phase.

"The fact that he has not missed a single meeting is a clear indication of the commitment our chief executive gives to Productive Ward," says Ms Bloodworth. "It also means there is somebody there who can very quickly unblock any issues or resource needs that might otherwise get in the way."

'The working time available to nurses to spend with patients has gone up from 38 to 52 per cent'

Publicly displayed performance measurement boards on the wards running Productive Ward show the improvements to which the programme is contributing. These go up during the Knowing How We Are Doing foundation module and indicators on them include patient and staff satisfaction, healthcare-acquired infection rates, falls, pressure areas, length of stay and staff sickness. Where adverse or negative measures are recorded, the same boards also show which actions staff are taking to reduce or eliminate them.

Patients and visitors are responding positively to the data, Ms Bloodworth notes: "All our inpatients are given the opportunity to fill out a modified PICA survey which assesses their levels of satisfaction. This provides instant feedback to the staff teams about what patients think of their experience on the ward. The response varies across wards but overall the satisfaction rating is above 80 per cent."

As with many other trusts, there has been a huge drive at Nottingham – with good effect – to reduce healthcare-acquired infections. MRSA rates, for instance, are down by 68 per cent and *C difficile* by 54 per cent. While other contributing initiatives such as clean hands and deep clean need to be considered, a part of those outcomes,

it seems fair to say, may be attributable to Productive Ward.

"If you speak to a Productive Ward ward sister, what she will tell you is that up until having performance data, *she* would know where she could find the MRSA infection rate for her ward," says Ms Bloodworth. "Now with infection control data in public view, it is much more of a live issue for her and the clinical team and it reassures patients and families, who can see what is being done to tackle it and how it is coming down."

Anecdotal evidence arising from the trust's experience of implementing the Well Organised Ward module suggests savings of between £5,000 and £10,000 can be made by returning excess stock to stores.

One unequivocal measure at Nottingham that has improved with Productive Ward is direct care time. "Across the trust, the proportion of the total working time available to nurses to spend with patients has gone up from 38 per cent to 52 per cent," reports Ms Bloodworth. "Data is now driving performance on the wards. "When it starts to influence things like patient flow in the emergency department, the impact of Productive Ward leads us further to where we need to be, to what our chief executive describes as the Productive Hospital."

The Manchester story

"For us, Productive Ward came just at the right time. We have been able to use it as a single vehicle for delivering three distinct service development initiatives," says Gill Heaton, director of patient services and chief nurse at Central Manchester. "Now all our aspirations for the patient experience, patient safety, and productivity and efficiency can be pulled together in this one programme."

There are 82 wards or departments where Central Manchester wants to use Productive Ward (including some outpatient areas, children's high dependency and the adolescent mental health unit) and bring the skill sets into the clinical team.

"We plan to complete by 2010, using a 12-week roll-out that brings in between six and eight new areas at a time," says Dawn Pike, assistant director of nursing. "One of the challenges we face at the moment is that our hospitals are across three sites, so we have phased the introduction of Productive Ward to children's services for after their relocation in 2009. "We believe that we can bring service improvement to all of these areas."

The evidence suggests she is right. Every

quarter the trust has been using an "activity follow" process to measure the time available to registered nurses to give to direct patient care. Across all wards that figure has gone up by 8 per cent.

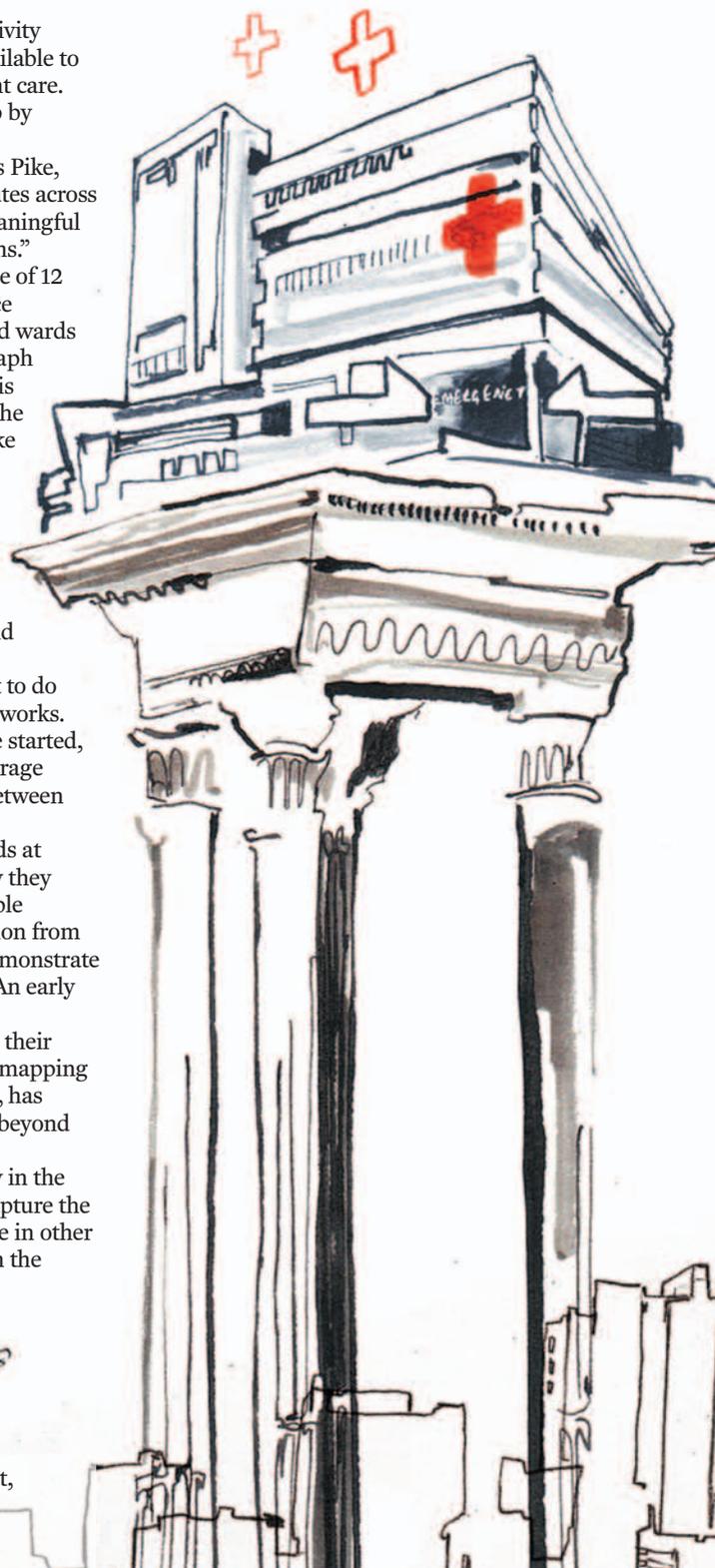
"That might not sound a lot," says Ms Pike, "but actually it equates to 57 extra minutes across a 12-hour shift and it is in this more meaningful form that we relay it to the nursing teams."

Those figures and others from a range of 12 quality indicators arrive as "performance dashboard data" on the Productive Ward wards each month in a visually striking bar graph format. Just as at Nottingham, the data is on public display and along with it are the actions the ward team are taking to make the necessary improvements.

"The data tells the team how they are doing and where the issues lie, as well as informing the improvement process. If the number of falls is going up, for instance, they might use process mapping and some of the other tools and techniques they have learned to better understand what's happening and what to do about it. We know it's an approach that works. Before the Productive Ward programme started, one of our first-phase wards used to average 12 falls a month. Now that is down to between three and four a month," says Ms Pike.

Evidence shows that Productive Wards at Central Manchester have improved how they identify nutritional risk among vulnerable patients. The trust is collating information from its first-phase wards that should also demonstrate a quantifiable reduction in food waste. An early briefing to the catering team about the implementation of the programme, and their subsequent involvement in the process-mapping of meal delivery from kitchen to patient, has helped to develop partnership working beyond the confines of the clinical area.

"It might be because we are still early in the journey, but it is hard to articulate, to capture the impact that Productive Ward might have in other departments, out across our trust and in the wider health economy," says Ms Pike. "We are talking with the Institute about how we progress our evaluation of the data across the whole hospital, about what measures we can put in place to be clearer about what, in terms of impact, Productive Ward is responsible for." ●



FOR GOOD MEASURE

The NHS Institute is working to support trusts such as Nottingham and Central Manchester to further understand how the data they are collecting from the wards can be interpreted at an organisational level.

"First, we have embarked on a major national study of the spend and impact of the Productive Ward across

the whole NHS with a leading academic partner," says Maggie Morgan-Cooke, NHS Institute lead on the Productive Ward and Productive Community Hospital.

"We are also developing a tool to help organisations benchmark the impact of Productive Ward across a dozen or so key indicators being

used at the whole hospital sites and elsewhere.

"This will help trusts to quantify more accurately the difference that Productive Ward makes, not just to time released back into direct patient care, but to safety issues including reductions in falls and medicine errors, to length of stay, time taken

in admission and discharge procedures and staff absenteeism."

Activities to measure and benchmark the impact of the Productive Ward are also underway at a regional level, led by NHS South East coast. The NHS Institute will build the learning from this into its current benchmarking tool development.

"There is a lot of interest in this area and we hope to be able to formally launch the benchmarking tool in December," says Ms Morgan-Cooke.

"It will allow NHS organisations to understand how well individual wards are currently doing, compare between wards in the hospital and

compare with other hospitals.

"At the end of the day, though, this is about measuring for improvement, not measuring for judgement or performance.

"It is about giving NHS organisations the tools to continuously strive to provide better experiences and services for patients."

FAR AND WIDE

The principles of Productive Ward are now being applied in community hospitals and mental health wards. But will the programme succeed outside its original context, asks Ingrid Torjesen

Building on the success of Productive Ward in acute care, the NHS Institute for Innovation and Improvement has produced and launched two new ranges of modules tailored to meet the needs of community hospitals and mental health wards.

The principles of the modules fundamentally remain the same. There are, however, important differences of emphasis and context. Community hospitals, for example, tend to be reliant on smaller numbers of staff, and the programme includes a dedicated module on multidisciplinary working. The frequency of self-medicating on mental health wards brings a different emphasis to medicines management. Handovers vary across all settings.

The Productive Community hospital was the second “productive” initiative developed after the Productive Ward. Maggie Morgan-Cooke, head of the Productive Ward and the Productive Community Hospital programmes at the NHS Institute, says it links in well with Lord Darzi’s next stage review’s “ambitious vision of a patient-centred, clinically led and locally driven NHS”, improving quality for patients and providing local services.

There are three areas of work in the community hospital package (inpatient, day hospital and minor injuries units) and 13 modules. The ideas were originally tested at Chippenham Community Hospital (Wiltshire primary care trust), 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).

The results show the programme has cut patient handover times while improving their quality; increased the number of professionals per patient case in day hospitals by 20 per cent, meaning more direct care time for patients; made referral management more efficient; and increased patient and staff satisfaction.

At Chippenham Hospital, staff chose to look at goal setting, “lean” techniques and handover.

The work on goal setting took place on Beech ward (a stroke ward) and was focused on a weekly meeting for planning patient care. Process mapping was used to identify the key steps in the planning, conduct and outcome of the meeting and unnecessary steps taken out.

Madelyn Griffiths, clinical improvement services manager for Wiltshire Community Services, says: “We didn’t need as many people around the table as we thought we did. What we were able to do was reduce the length of the meeting, agree which clinicians should be there to discuss patient care and who was going to feed that back to the patient in terms of goal planning.”

The process increased the meeting’s value-added time from 48-82 per cent, improved integrated working and made care more patient centred. Staff responding to a survey found the meeting more relevant and that it added to efficiency.

Ms Griffiths says: “They are able to be much more succinct about the patients they are talking about. The meeting is much more structured, there is not so much paper and one person, who heads up the meeting, does all the preparation.”

Lean techniques

In the minor injuries unit, redesigning the patient journey has reduced the average patient wait from 67-41 minutes. The unit has moved from “see and treat” to triage, repositioning rooms and nursing staff to cut down on patient movements. Ms Griffiths says: “We were able to demonstrate how this would improve quality of care for patients: they were more appropriately seen and we were able to give earlier analgesia.”

In addition, lean techniques have been used to rationalise equipment in the treatment rooms.

“In an accident and emergency unit, there is a tendency to want everything at one’s fingertips,” she adds.

By stripping down the equipment so each room holds only what is required for its specific function, patient service has been improved, items can be found faster and there is less walking time for staff. The minor injuries unit is



‘The tools provide strong evidence of releasing time for care in areas where it can be difficult to quantify the improvement’



Productive Ward has been applied across the board in NHS West Midlands, including older people's mental health services.

now performing well against national targets. Ms Griffiths says: "We have probably doubled our patient throughput, which is now at 97 per cent within two hours, compared with the government target of 70 per cent."

She also believes the changes made through goal setting on Beech Ward have reduced delayed discharges. The hospital is now undertaking work through handovers, discharge planning and the Productive Day, to reduce delayed discharges across the board. Ms Griffiths says the Productive Community Hospital's tools have proved very useful because they provide strong evidence of releasing time for patient care in areas where it can be difficult to quantify the improvement.

"Often you know that it releases time for additional care, but how you evidence that in nursing terms is sometimes hard," she says.

Test sites

"We were not planning to do a set of modules especially for mental health wards," Ms Morgan-Cooke says, "but we did a scoping study and recognised that there was a real pull from mental health colleagues for a set of bespoke modules so that they too could apply those principles in their particular context."

Two organisations have acted as test sites for the development of the Productive Mental Health Ward package – North Staffordshire Combined Healthcare trust and the Oakwell Centre,

Kendray Hospital, run by Barnsley PCT. Early results show that time spent by staff on direct patient care has increased, therapeutic engagement with patients has gone up, patient handover times have been cut by a third and their quality improved.

Rob Grant, programme lead for Productive Ward at North Staffordshire Combined Healthcare trust, explains that while over the past 12 months, the emphasis with Productive Ward was on acute trusts, NHS West Midlands bravely allowed the mental health trust to be involved.

The initial plan was to limit the process just to acute mental health services, but Mr Grant decided to apply it across the board, including rehabilitation and older persons' mental health services. A female acute admissions ward was chosen as a showcase ward using three modules: The Well-Organised Ward, Knowing How We Are Doing and Patient Status at a Glance.

The initiative has now been rolled out to three other wards: an acute inpatient ward, an inpatient rehabilitation ward and older persons' mental health ward. This roll-out will continue, with three wards joining every four months. On the showcase ward, the Well Organised Ward module began with the redesign of the clinic room.

"We have organised the environment based on the interventions that occur there and clustered

'Staff sickness levels have fallen and, while the number of clinical incidents has gone up, this is due to improved reporting'

the stock based on those interventions with a visual management system in place to support people finding what they need," Mr Grant says.

By identifying the type and frequency of stock used, £600 worth of items have been removed, reducing the amount likely to go out of date.

A stock reordering system is now being developed.

Well Organised Ward has also been applied within the clinical office to streamline processes and determine the ideal position for the ward clerk. This turned out to be the nursing office, where she could support the clinical teams with liaison work.

Transferable skills

As a result of Knowing How We Are Doing, performance information for the ward, including clinical incidents, staffing levels and absence, length of stay, number of admissions and action points, are displayed in the corridor. Staff sickness levels have fallen and, while the number of clinical incidents has gone up, this is believed to be due to improved reporting as a consequence of the focus on performance data and was predicted.

The patient information board in the nursing office has been redesigned through the Patient Status at a Glance module. Previously Mr Grant says the board did not give a great deal of information about the key stages of the patient pathway.

"We redesigned the board and it now mirrors our patient care pathway, so all the key stage interventions, liaison assessment and discharge planning that we need to go through are up there. We have got a traffic-light system, which means staff can see fairly quickly individual patients and where they are within that journey," he says.

Red denotes high risk or that something has not been started as a process, amber that the risk is reducing or that a process is not complete, and green that there is a low risk or that the process has finished.

The care pathway is now being process-mapped to streamline it and the board will be revised once it is complete. At present, 45 per cent of direct care time is spent with patients and it is hoped to increase this to well over 50 per cent.

Mr Grant points out that the ease with which North Staffordshire has applied the acute setting version of Productive Ward, which is geared towards bay wards, demonstrates they are key transferable skills and processes. However, he believes the dedicated mental health package with its recognisable visuals and methodology will help engage mental health services.

"It is really important that we get the roll-out of the mental health programme right and encourage mental health trusts to apply it, because it has been a really valuable experience for us, even though we are still in the early stages," he says. ●

LAUNCH

ROLL OUT, ROLL OUT

With services in the community going 'productive' in summer 2009, Nigel Hopps looks forward both to the opportunities and the challenges this presents

In the summer of 2009 we will launch the Productive Community Services. This presents us with both the biggest opportunity and the biggest challenge so far in the development of the Productive series.

The opportunity is clear. Developing an approach for local providers of community services to improve care in more than 380,000 patient contacts every year will be powerful. Motivating and mobilising a new improvement community of over 60,000 staff working in these services (around 20 per cent of the total NHS staff) could be revolutionary.

The challenges are also evident. The Productive Community Services will not be a tweaked version of the Productive Ward.

It requires a completely different approach. Community services are often geographically dispersed and more complex in organisation and delivery. They have interdependent relationships with secondary care providers, social services and third sector delivery organisations.

Historically, less attention has been paid to understanding, measuring and managing outcomes. Staff often operate independently, so the "team" and its leadership can be harder to define.

'Productive Community Services will not be a tweaked version of Productive Ward. It requires a different approach'

Working in partnership with a range of community service providers, we are determined to build on the success of the existing Productive programmes. Lord Darzi's next stage review reinforces the importance of community services in delivering the future healthcare models and cites the Productive Community Services programme as a major part of the process for improving them.

The tools and modules we produce will be instantly recognisable as Productives. They will be designed for frontline staff to develop team working and leadership skills that release time to care. As with the Productive Ward, the presentation will be simple and accessible, with evidence-based improvement tools and techniques such as lean and Six Sigma in the background.

The programme will be a co-production with

the NHS. The complexity of the services and the timescales mean we want to work more closely with our partners, particularly strategic health authorities and frontline service delivery organisations.

Already 13 learning partner provider organisations have signed up and will be among the first to develop and test new approaches and promote the learning. From this group a smaller group of sites will be earmarked to work with us on more intensive development and testing of tools.

Distinct work streams

The NHS Institute has identified some distinct but related streams of work that will come together to form the modules.

● The Productive Community team: we are working to find out what it takes to create a consistently great service for every patient. Often our staff work hard to provide good care in spite of the system, not because of it. We are working to remove activities that get in the way and to create new systems that make it easy to provide reliable care all the time.

● Leadership development: great local teams depend on great local leaders. We want to build on the existing leadership talent in community services and equip these leaders with the skills, tools and support to transform their services.

● The well organised pathway: as with the other Productive programmes, we want to develop an evidence based approach that can be adapted for use across the widest range of care pathways and that will resonate with frontline staff.

Our initial intention is to focus on pathways that impact on thousands of patients, account for a significant proportion of staff activity and represent a substantial cost to the NHS. We have selected three "high volume" pathways of care to start the programme:

- wound care;
- stroke care;
- continence services.

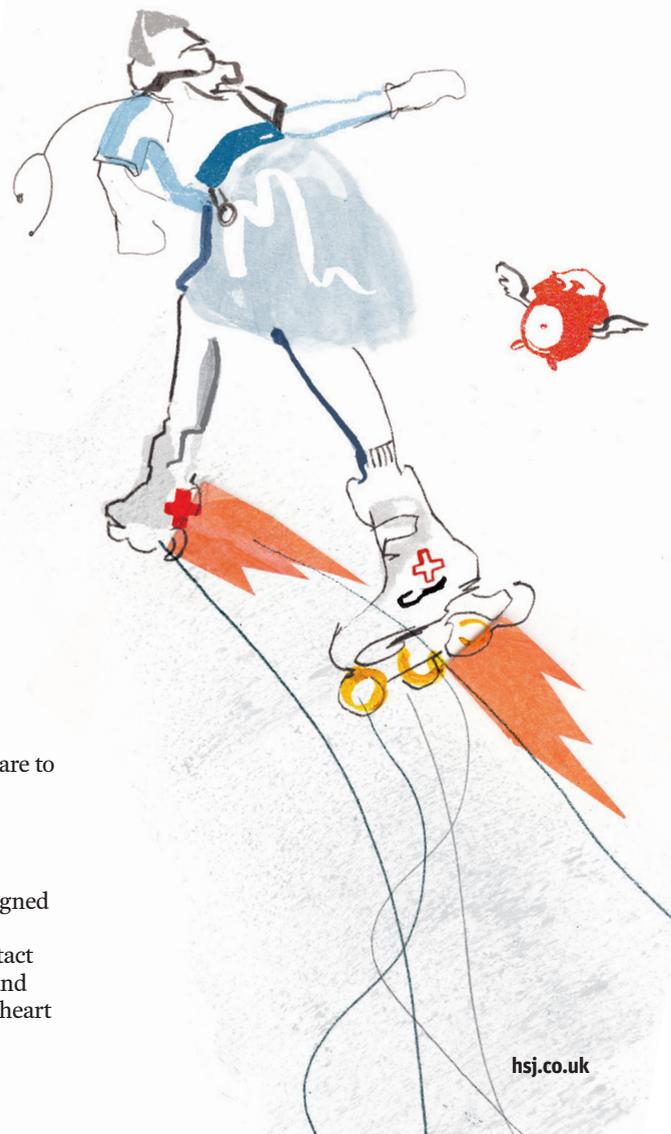
Much current improvement effort is designed to increase patient contact time. We do not have evidence, however, that increased contact time is leading to better clinical outcomes and enhanced patient experience. This is at the heart

of the programme. Our aim is not just to release time to care but to release time for effective care. We are going to test a "care bundle" improvement approach.

A care bundle is a small group of clinical actions that have been shown to improve outcome and are achievable and measurable yet not currently performed for most patients. The principle is that the benefit to a patient of the whole care bundle is greater than the sum of the parts.

We can see huge potential for the programme. These are early days, but already there is a lot of enthusiasm and interest. ●

Nigel Hopps is interim head of transformation at the NHS Institute for Innovation and Improvement.



NEXT STEPS

WINDS OF CHANGE

An exciting new role is beginning to take shape: people and organisations that can exemplify productive practice and guide others

The success of the Productive series to date has led to much thinking in the NHS Institute for Innovation and Improvement and consultation with the wider NHS improvement community about where the Productive brand should go next. Consensus is that there are three directions:

- making stronger links between the Productive approach and the role of commissioners;
- focusing on the improvement skills NHS organisations need to deliver all the potential benefits to patients and staff;
- creating more Productive products in specific settings, for instance general practice, other care settings and even the Productive Hospital.

The Productives have largely been viewed as provider programmes. However, they are also being picked up by leading edge primary care trust commissioners as a catalyst for the kind of care they want to commission for their patients and populations.

Best practice from the Productive Ward is being written into commissioning specifications

reliable care delivery can make a difference to many thousands more patients.

In recent months, much additional thinking has been done about how the Productive ethos might be further embedded in the multiple care settings that make up the NHS.

“Part of the function of the Productive programmes is to help build local skills for improvement,” says Sean Manning, senior associate in the Productives team at the NHS Institute. “To date, we have provided coaching and training support to more than 100 NHS organisations as part of the programmes. Many of these local NHS leaders have told us they would like to develop their own internal improvement practitioners so they can implement the programmes without support.”

He continues: “Importantly, they would like these practitioners to be equipped to adapt Productive principles and tools to areas where there currently isn’t a programme – an outpatient clinic or community pharmacy for example.”

Examples of organisations and individuals already employing such a flexible response has

led the NHS Institute to consider how it can support NHS organisations to develop this internal capability and capacity. This has led to the creation of the Productive Improvement Agent.

“This will be the next step up for us,” says Mr Manning. “The idea is that we start to formalise the skills required to deliver improvement support at different levels across an organisation. An Improvement Agent, supporting ward leaders with the introduction of Productive methods at ward or community clinic level, is going to have to use a different set of skills to somebody leading improvement across a division or a whole hospital.

“There is also demand from commissioners for the kind of improvement skills necessary to transform healthcare at a population level. That is the kind of capacity and capability we want to build in the NHS. We are looking at creating an improvement faculty and supporting syllabus.”

This may include accrediting improvement training already available. “We want to link up with other NHS improvement academies at local and SHA level. Ultimately what might emerge is an improvement profession and/or a nationally accredited qualification,” Mr Manning adds. “The people who might go on to become Productive Improvement Agents will be developing skills from a much wider base than just the Productive programmes and lean. As well as mastery of things like the technical side of lean, they will be learning more qualitative change management skills like facilitation, coaching and briefing.”

So how does he sum up his philosophy on innovation? “The Productive series has clearly set out a new chapter in how the NHS looks at improvement,” he says. “In the future it will continue to be co-produced and guided by local NHS leaders.

“My personal view is that, through the Productive series, there is the potential to help the NHS create a self-sustaining army of hundreds of thousands of passionate improvement leaders who are able to deliver tangible results for patients. And while we are at it, they can help save the wider NHS some of the millions of pounds it spends on improvement and innovation consultancy every year.” ●

→ www.institute.nhs.uk/theproductiveseries

‘As well as mastering the technical side of things, they will be learning more qualitative skills like facilitation and coaching’

and is part of the conversation about quality improvement between a growing number of commissioners and providers.

The NHS Institute is currently preparing *The Commissioner’s Guide to the Productives*, which sets out many ways in which the Productive programmes can act a positive driver for better patient care through the powerful mechanisms of commissioning. The release date is early 2009. In addition, the needs of commissioners are being built into the design of the programmes more explicitly, from the start. So, for instance, Productive Community Services will include modules for commissioners as well as providers of these services. The combination of excellent patient-centred commissioning with high quality,



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The Productive Improvement Agent

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