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The Well Organised Working Environment: A mixed methods study

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ABSTRACT

Background: The English National Health Service Institute for Innovation and Improvement designed a series of programmes called The Productive Series. These are innovations designed to help healthcare staff reduce inefficiency and improve quality, and have been implemented in healthcare organisations in at least 14 different countries. This paper examines an implementation of the first module of the Productive Community Services programme called 'The Well Organised Working Environment'.
Objective: The quantitative component aims to identify the quantitative outcomes and impact of the implementation of the Well Organised Working Environment module. The qualitative component aims to describe the contexts, mechanisms and outcomes evident during the implementation, and to consider the implication of these findings for healthcare staff, commissioners and implementation teams.
Design: Mixed methods explanatory sequential design.
Settings: Community Healthcare Organisation in East Anglia, England.
Participants: For the quantitative data, participants were 73 staff members that completed End of Module Assessments. Data from 25 services that carried out an inventory of stock items stored were also analysed. For the qualitative element, participants were 45 staff members working in the organisation during the implementation, and four members of the Productive Community Services Implementation Team.
Methods: Staff completed assessments at the end of the module implementation, and the value of items stored by clinical services was recorded. After the programme concluded, semi-structured interviews with staff and a focus group with members of the Productive Community Services implementation team were analysed using Framework Analysis employing the principles of Realist Evaluation.
Results: 62.5% respondents ($n = 45$) to the module assessment reported an improvement in their working environment, 37.5% ($n = 27$) reported that their working environment stayed the same or deteriorated. The reduction of the value of items stored by services ranged from £4 to £5039 across different services. Results of the qualitative analysis suggests explanations for why the programme worked in some contexts and not others, for instance due to varying levels of management support, and varying levels of resources allocated to carrying out or sustaining the improvement work.
Conclusions: Quantitative analysis of data generated during healthcare improvement initiatives can give an impression of the benefits realised, but additional qualitative analysis also provides opportunity for learning to improve future implementations.

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Targets set by commissioners for innovation should focus on sustaining improvement rather demonstrating one-off benefits, and implementation teams should not let their preconceptions of what will and what will not work prevent them from trying interventions that may benefit staff.

What is already known about the topic?

- The Productive Ward programme claims to have generated benefits to healthcare staff and patients including the reduction in wasted time, an increase in quality and an increase in patient contact time.
- Much of the existing research on Productive Series programmes consists of anecdotal research papers, and often use participants that have had heavy involvement in the implementation.

What this paper adds

- This paper identifies the contexts, mechanisms and outcomes of an implementation of the Productive Community Services 'Well Organised Working Environment' module.
- The findings indicate that although quantitative outcomes can provide an indication of the benefits of the programme, qualitative analysis can offer further insights to help improve future implementations.
- The findings suggest that commissioners need to provide targets that encourage sustained improvement rather than to demonstrate one-off benefits.

1. Introduction

In 2007 the 'Productive Ward©' was the first of a series of programmes launched to help frontline healthcare staff improve quality and reduce inefficiencies (Wright and McSherry, 2013) in order for more time to be spent with patients; thus 'Releasing Time to Care™' (NHS Institute for Innovation and Improvement, 2012). This series of programmes is called The Productive Series and it was designed by the English National Health Service Institute for Innovation and Improvement. The Productive Series has been expanded to apply to many different healthcare contexts, including General Practice and Mental Health wards (see NHS Institute for Innovation and Improvement, 2011), and has been implemented in at least 14 countries around the world (NHS Scotland, 2013) including Ireland (White et al., 2014a), Canada (see Avis, 2012) and New Zealand (see Moore et al., 2013).

Even though the Productive Series programmes have been implemented for nearly eight years, there is little peer-reviewed research available. Wright and McSherry (2013) carried out a systematic literature review, and using their quality assessment on publications between 2005 and 2011, only found 18 articles that passed their quality standard, and could only class five of these as empirical research. They also found that the publications were biased towards reporting positive results. White et al. (2014b) carried out a bibliometric profile of literature published regarding the Productive Ward programme and found a rise and decline of literature and grey literature in the period 2006–2013, but identified some evidence that internationally, "...the initiative continues to generate publications and create interest," (White et al., 2014b, p. 2414).

Work carried out during implementations of the Productive Ward has been reported to reduce the number of falls (Harrison, 2008; Wilson, 2009) and outbreaks of infection (Foster et al., 2009; Harrison, 2008; Smith and Rudd, 2010); increase staff satisfaction (Dean, 2014; Wright et al., 2012); increase time with patients (Blakemore, 2009), increase the efficiency of admission and discharge processes (Lennard, 2014), and reduce staff sickness (Smith and Rudd, 2010). However, as indicated in Wright and McSherry (2013), these reports mainly focus on the positive results achieved and pay little or no attention to any negative aspects or lessons to be learned for future implementations. One exception is in Wright et al. (2012), who details some of the negative financial implications of working through the module, such as the cost in staff time (£236 per meeting) required for the module.

In evaluations of the Productive Ward in eight Scottish NHS boards, NHS Scotland (2008) reported examples of increased efficiency (for instance reducing a process from 172 process steps to five process steps) and an increase in direct care time with patients from 13% to 43%. They also reported one-off savings, for instance in returnable or redistributed stock items previously held by services ranging from £700 to £3700 (stock items might include consumable clinical items such as wound dressings or antiseptic wipes). However it has been proposed that the Productive Ward programme's impact has been difficult to quantify due to the lack of definition of measurable outcomes (NHS East of England, 2010). An evaluation of the Productive Ward programme in the East of England found that a variety of factors, including organisational engagement and good communication from ward to board, were required to maximise the impact and sustainability of the programme (NHS East of England, 2010). The most important factor contributing towards the success of the programme was identified to be the support and encouragement of clinicians by organisational senior leaders (National Nursing Research Unit and NHS Institute for Innovation and Improvement, 2010).

Davis and Adams (2012) carried out semi-structured interviews with six members of staff who had implemented the Productive Ward to explore their perceptions about