The Productive Ward: Releasing Time to Care™ – What we can learn from the literature for implementation

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Aim This paper reviews the Productive Ward: Releasing Time to Care™ literature, identifying and discussing the key characteristics that may contribute to successful implementation.

Background It is 5 years since the official UK launch of the Productive Ward, and the Republic of Ireland commenced a phased, national implementation programme in 2011. Thus it is timely to reflect on the implementation lessons learned to date and described in the literature.

Evaluation Using taxonomic mapping, this paper evaluates the current state of the literature that pertains to Productive Ward implementation experience; success factors; reports, and assessments.

Key issues Seven common contextual characteristics were identified: robust and engaging communication; enabling and empowering roles; appropriate training; project planning and management; leadership; corporate/management engagement and support; and financial and human resource commitment.

Conclusion The key characteristics identified have a direct impact on the implementation of the Productive Ward. The interplay between these key characteristics and how this interplay influences successful implementation of the Productive Ward warrants further research.

Implications for nursing management Acknowledging and embracing the seven characteristics during implementation will positively improve the progress and success of the initiatives implementation.

Keywords: implementation, improvement, lean health care, Productive Ward, quality, releasing time to care

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Background
Health care organisations throughout the world are focusing their efforts on quality, cost and improvement. While focus in the past has been purely on cost, more emphasis is being directed towards Quality, Outcomes and Improvement. The Productive Ward: Releasing Time to Care™ (The Productive Ward) programme, is a relatively new initiative in nursing terms. It is best described as a ward-based ‘improvement’
programme created to help ward-based teams redesign and streamline the way that they work, freeing more time to care for patients and empowering nurses to improve the safety, quality and delivery of care. It was designed and developed by the UK’s National Health Service Institute for Innovation and Improvement (NHSI) in 2005 and it aims to: increase the proportion of time nurses spend in direct patient care; improve experience for staff and for patients; and make structural changes to the use of ward spaces to improve efficiency in terms of time, effort and money (National Health Service Institute for Innovation and Improvement and National Nursing Research Unit 2010a).

After early testing by the UK NHSI in 2006, the Productive Ward was formally launched in the UK by the Chief Nursing Officer for England, Dame Christine Beasley, at the Royal College of Nursing Conference in 2007. Early-phase implementation sites, also called ‘Learning Partner sites’, were recruited by the NHSI later in 2007 and widespread NHS implementation commenced in 2008. It has been positively reviewed and reported in the nursing and health-care press (Taylor 2006, Kay 2007, Nolan 2007, Castledine 2008, Blakemore 2009, Bloodworth 2009, Kendall-Raynor 2010, Smith & Rudd 2010, Davis & Adams 2012), well evaluated (NHSI & NNRU 2010a, 2010c, Avis 2009, Gribben et al. 2009, NHS Scotland 2008) and its implementation is proven to produce significant savings in productivity and efficiency (QIPP–NHS Evidence 2009, NHSI 2011). It has recently been adopted by nurses in Ireland, the Netherlands, Denmark, Australia, New Zealand, Canada and the USA (Oregon). This paper will therefore identify and discuss what can contribute to successful implementation of the Productive Ward through an examination of the literature.

There was early interest in the Productive Ward initiative in Ireland (Farrell & Casey 2011), but the Health Service Executive (HSE) and Ireland did not commence the planning of a phased implementation of the initiative until late 2010. The HSE’s Office of the Nursing and Midwifery Services Director established a national advisory group to oversee a phased implementation of the Productive Ward. First-phase sites were recruited during 2011. Implementation is co-ordinated by geographically based ‘Area Co-ordinators’ who support up to four sites with its execution. Seventeen organisations from across the country were selected in 2011 using the predetermined criteria to assess organisational readiness for implementation (NHSI & NNRU 2010b).

The NHSI offers the Productive Ward in the form of a self-directed improvement programme. The programme comprises 13 modules which provide tools and guidance that help nurses make the required changes to their ward environment and work processes. All modules and specific project role guidance are included in the Productive Ward box-set that is provided under licence from the NHSI. Twenty-one wards in Ireland commenced the NHSI’s Productive Ward module implementation in December 2011 and commenced working through the three foundation modules in early 2012. A second phase of interested sites were recruited at the end of 2012. As it is now 5 years since its official UK launch, it is both timely and prudent to reflect on the practical implementation lessons learned in this period that are described in the literature from which Ireland and others might learn.

**Literature review – method**

The purpose of this literature review was to identify key elements of implementation experienced during the introduction of the Productive Ward which are cited in the literature and could inform plans and strategies for its further implementation in Ireland. This commenced with an initial search of CINAHL, Academic Search Complete, ISI Web of Knowledge, Ovid Nursing, Ovid Journals, ABI/INFORM Global, PsycINFO, ScienceDirect, Wiley, Emerald Fulltext Management Xtra and Medline (January 2006 until June 2012). Key search terms used were: ‘Productive Ward’, ‘Productive Series’ and ‘Releasing Time to Care’. Papers that reported on multiple or eclectic initiatives (such as lean and transforming care at the bedside) were excluded. Further deselection was also carried out on articles reporting on the Productive Operating Theatre (tPOT).

The search retrieved a total of 318 references from the ‘Productive Ward’ search theme and 210 from the ‘Releasing Time to Care’ search theme. Once duplicate and non-relevant citations were removed, 109 potential references were screened for relevance and yielded 74 articles for consideration. A further search through the reference lists of the relevant publications yielded six additional references. A secondary trawl was undertaken with the same search criteria using ‘Google’ and ‘Google Scholar’ to include possible grey literature and related news items if appropriate. This search yielded a further 10 references, leaving a total of 90 potentially relevant papers and articles. We introduced further criteria for inclusion/removal with
specific reference to: ‘implementation/challenges/lessons learned’. The final result yielded 53 relevant articles (see summary in Table 1):

The 53 relevant articles were then subjected to an ethnographic content analysis (Bryman 2012), allowing categories and key issues to emerge from the literature. The categories and related key issues were then arranged into a taxonomic map that highlighted all of the findings for reporting (Hart 2010).

This process identified seven common contextual characteristics (key issues) of implementation in the literature, and these are represented in Figure 1. These implementation characteristics have been previously identified to some degree in the change and implementation literature (Pinto & Slevin 1989, Ferlie & Shorrell 2001, Kotter 2007); however, their presence in the Productive Ward literature suggests that they do not appear to have been fully utilized in the Productive Ward implementation to date. The seven key contextual characteristics are described below.

A robust, engaging communication strategy
Having developed or developing a robust communication strategy around the Productive Ward project is reported as a key success factor throughout the literature. Morrow et al. (2012) identified communication as a key facilitator that was expressed in a survey of policymakers, senior managers and health-care practitioners involved in implementation. NHSI & NNRU (2010b) report, a further NNRU (2011) report and commentary in the Management Services Journal (2011) all describe communication as one of the main ingredients for the spread of the Productive Ward. Keeping language simple, while engaging staff was an early implementation message reported by Shepard (2009), suggested by Robert (2011) and echoed in the evaluation report by Gribben et al. (2009). Attempting to ensure that everyone understands the project is identified as an on-going challenge by Svedahl (2009) and is described in more detail by the Health Quality Council’s (HQC) (2011) long-term care pilot project report.

Davis and Adams (2012) and the Saskatchewan Registered Nurses Association (SRNA) (2010) report on the large measure of success achieved by valuing communication during implementation of the Productive Ward initiative. Bevan (2009) encourages the use of nurse ‘identity groups’ to make communication more effective. ‘Releasing Time to Care’ leads in Saskatchewan found the opposite to be true, especially when allaying the fears that arise from change, and recommended talking one-on-one as a strategy that minimized the potential for resistance to implementation (Avis 2009). Coutts (2010) outlined the need for a robust and intense information campaign to counter the negative job-cut rumours that accompany improvement initiatives such as ‘Releasing Time to Care’. Similar convincing communication challenges in relation to change and the Productive Ward have been described by Armitage and Higham (2011) and Blakemore (2009).

It is apparent from the literature that developing communication strategies which deliver key messages at both the macro and micro levels are important. Ensuring that the strategy tailors the message to corporate and senior management audiences, but also pays particular attention to the front-line, engaging the entire ward team, patients and relatives, will have a positive impact on the smooth implementation of the Productive Ward.

| Table 1
| Search Results

**Peer reviewed papers**
Three had identifiable research aims and a transparent research methodology. (Robert et al. 2011, Davis & Adams 2012, Morrow et al. 2012)
Two of these authors were members of prior research and evaluation teams who were commissioned by the NHSI (Robert et al. 2011, Morrow et al. 2012)

**Evaluations & reports**
Five of these reports were commissioned by the NHSI to the National Nurse Research unit. (Morrow et al. 2010, NHSI & NNRU 2010a, 2010b, 2010c, NNRU 2011)

**Grey literature**
The remaining 29 papers were mainly news reports, cover stories and updates from professional journals and Newsletters.
The impact that seamless macro/micro communication strategies have on the success of the programme, and to what degree, warrants further scrutiny and reporting.

Enabling and empowering facilitator/ward lead roles

The importance of having an improvement resource to facilitate and support the ward and project leads has been identified and reported since early implementation (Nolan 2007, NHS Scotland 2008). Allsopp et al. (2009) views the role of facilitator as being key to the understanding and use of improvement techniques and the underpinning of the principles of the Productive Ward. This view is also reflected in the ‘Top Tips’ for spreading the Productive Ward within NHS Trusts’ (NHSI & NNRU 2010b). Gribben et al. (2009) describes the advantages of using ward leads that are skilled and experienced with practice development techniques and how these capture interest and engagement.

Facilitator roles have also enabled the transformation of staff ideas into actions (NHSI 2011). Smith and Rudd (2010) outline the requirement for ward leads to be enabling, supportive and involving. They describe the many elements of change encountered while implementing the Productive Ward and how encouraging the involvement of all staff influenced the sustained changes that took place. Staines (2008) reports that involvement and support helps nurses to help themselves when it comes to implementing improvements and describes the initiative as a ‘bottom-up supported change’. Ward and Parish (2009) also comment on the empowerment aspect of this facilitated change and how it can challenge the mindset and culture of top-down change processes.

Facilitating ideas from front-line staff into improvement actions was one of the key lessons learned in the Saskatchewan long-term pilot project report (Health Quality Council 2011). Discussing the determinants of ‘spread’ and the lessons learned from their extensive Productive Ward case study report, Morrow et al. (2010) identify programme leads as a vital role in encouraging staff at different levels in generating energy behind both the programme and the organisation. They also outline the relatively short nature of these seconded positions and the challenge of encouraging ward staff to work autonomously and take

Figure 1
Key contextual characteristics of Productive Ward implementation.
ownership of the initiative. This challenge and risk is echoed further by Avis (2011) who notes the loss of momentum or project halting when ‘Releasing Time to Care’ champions leave or burn out. The Coutts (2010), NHSI & NN RU (2010c) report provides operational guidance for the spread and adoption of the Productive Ward to improvement leaders and facilitators. These actions include: connecting with wider social and political agendas; understanding the needs and characteristics of the sites; engaging with these sites and individual champions, and supporting sites to examine their organisational context.

The key messages for implementation appear to be in the availability of the right people in the right roles, who adopt a facilitative, empowering and encouraging style of project management. Ensuring that ward staff connect with the initiative and make it their own is an aspect of implementation that is highlighted as crucial to success. The professional background, project and improvement experience, credibility and competence of the facilitator and ward lead will all have an impact on how the Productive Ward will be accepted, adopted and spread. The extent to which these role characteristics affect each Productive Ward site’s implementation and the amount of engagement that these roles can generate deserves further investigation and reporting.

**Appropriate training**

A key finding for implementation reported in the NHS Scotland (2008) Releasing Time to Care evaluation has been the need for training and support at ward and executive team levels. Similar findings from Gribben et al. (2009) in the Belfast Health and Social Care Trust evaluation include a requirement for internal and external training and support. The advantages of engaging with training and support packages from the NHSI is reported by NHSI & NN RU (2010a) as being generally positive, providing guidance and encouraging progress. Training and support in this report described multiple modes of delivery: NHSI facilitation, study days, conferences, module implementation training, tailored support, self-support networks and web-based support. Most notable findings are in relation to how many organisations had to tailor training and support because of the challenges of staff release and attendance, and the positive aspects attached to peer-support and networks where learning and ideas about implementation could be shared.

Allsopp et al. (2009) outline the tailored support programmes developed for ward leads in Nottingham University Hospital, which included action learning skills, improvement technique training and support workshops. Leadership training was also provided to some ward leads to enable them to implement, communicate and manage change.

In a review of the ‘Releasing Time to Care’ project in Saskatchewan, Avis (2011) reports on the leadership and management assumptions that are made of ward leaders, who implement ‘Releasing Time to Care’, and comments on the little preparation and training for this new ‘change’ role. Avis (2011) also refers to the importance of networking and sharing experiences for participants of ‘Releasing Time to Care’, and recommends sharing improvement stories that highlight the positive impact that quality improvement work has on patients, families and health-care employees. She describes how this was viewed as being important in maintaining momentum and focus in the Saskatchewan project.

The ability to fund facilitated training, study days and networking is described as a key facilitating factor by Morrow et al. (2012) and reported in Nursing Management (2011) as a method for overcoming scepticism with the project. Pilot sites in the long-term care pilot project (Health Quality Council 2011) found it extremely challenging to implement without having the training or experience with continuous improvement.

Although the Productive Ward initiative is designed and intended to be a self-directed programme, there is some evidence from reports in the literature, that this model of information transfer, support and reassurance is not what participants engaged in the Productive Ward want or require. Tailored training and support packages that are specific to each site appear to offer options in relation to project momentum, engagement, re-enforcement and encouragement that the mode of self-direction apparently cannot. The types of training and support packages that may maximize engagement and energy for this initiative is an area in the literature where reporting is weak and would benefit further exploration. Training and support is a high-cost element of this initiative and opportunities to examine models, modes and their impact should be a priority.

**Project planning and management**

Choosing the ‘right’ ward as a Productive Ward is a key feature for implementation outlined by the NHSI & NN RU (2010a). They describe this in terms of ‘going where the energy is’ and selecting wards that
want to work with the Productive Ward. Wilson (2009) reports on how most trusts in the East of England have asked their wards to apply to become Productive Wards, describing how the process of application and selection has assured motivation and readiness for change at the outset.

The importance of project planning and project management for the Productive Ward initiative is well described and detailed by Allsopp et al. (2009). Standardized communication, standardized resources, agreed time-lines, named responsibilities, agreed measures and project monitoring are all ingredients outlined in their preparation and planning. Bloodworth (2009) also emphasizes the need for effective project management to allow for reading, reflecting and preparation. Pre-implementation time and planning are prerequisite requirements according to Coutts (2010) who describes the time needed to create and entrench support from all. Clear goals, feasibility and stages of implementation are some of Robert’s (2011) checklist items that encourage the spread of Productive Ward.

One of Armitage and Higham’s (2011) learning points with implementation is the need for careful project management as interest in the project naturally reaches ‘highs and lows’. Allowing for these changes in the level of interest with the project and accepting them enabled their Productive Ward initiative to continue.

Farrell and Casey (2011) report the advantages of using the module planner incorporated within the project leader guide contained in the Productive Ward box-set. Structured meetings and goal setting enabled them to ensure targets were achieved. The step-by-step guides provided in the NHSI box-sets also appear to have helped the pre-implementation/preparation planning in Saskatchewan (Avis 2009). This report documents and provides details of a concise implementation strategy adopted following the pilot phase that includes naming responsibilities, naming champions, proposed timelines and reporting structures.

Robert et al. (2011) like the NHSI & NNRU (2010a) report, describe the local approaches to implementation planning taken in five case-study sites, with most sites describing a phased or staged implementation plan or strategy. Managing the expectations of all levels of stakeholders in relation to time-scales of implementation is discussed by Morrow et al. (2012). They report that the expectations of pace and scale of progress in the NHS is dependent on the perspective of the stakeholder. Issues of variations in perceived progress and outcomes will have a direct impact on project reporting and benchmarking of objectives.

Having a robust project or implementation plan appears to provide structure, direction and momentum to the implementation of the productive initiative. While grand-scale or organisational plans and strategies are important, local ward-based plans should also be encouraged. They facilitate participants to articulate their anxieties in relation to any changes and allows for open and honest discussions in relation to workloads and staff requirements. As the initiative is now emerging as a process of continuous improvement it is important not to emphasize an actual end-of-project-date and instead describe periods of evaluation, reflection and improvement cycles. The literature does not comprehensively define the ingredients of robust project management processes for the implementation of Productive Ward. More research is required into the extent to which it depends, interacts, interplays and enhances the other key contextual issues.

Role of leadership

The NHSI & NNRU (2010a, 2010b) reports outline the requirement for clear leadership during implementation of the Productive Ward. The need for an overall leader to take charge of implementation is described in the reports as being one of the significant factors for success. Bloodworth (2011), with experience in an organisation that has implemented the Productive Ward across 92 wards, highlights leadership and commitment from the top of the organisation as one of the essential ingredients for success. This point is well made in the form of a recommendation in the NHS Scotland (2008) ‘Releasing Time to Care Evaluation’. The absence of strong leadership from senior management has caused problems during implementation in Saskatchewan, manifesting itself in slow funding responses and irregular visits from senior managers to implementation sites (Coutts 2010).

Armitage and Higham (2011) view the role of leadership at ward level as one of the biggest influences on how well the Productive Ward is introduced. They outline how the timing of introducing the initiative was crucial. They describe starting their project with the backdrop of previous project learning and an assessment of readiness for change. They note the need for nurse leaders to share vision, inspire, empower and energize others in an attempt to ensure that ideas that are generated from the ward and not the Manager. Ford (2010) provides a headline: ‘Productive Ward boosts Leadership’ in response to findings in the NHSI & NNRU (2010a) report that
Productive Ward improved staff skills and ward level leadership. Details from some of the NHSI & NNRU (2010a) case study sites suggest that the Productive Ward provided practical leadership skills for all participants as it had allowed participants the opportunity to lead and manage modules or aspects of change and had unleashed talent at many levels of the organisation.

Blakemore (2009) reports on progress from ‘Productive Mental Health Ward’ sites and quotes an NHSI facilitator who attributes the success of the initiative to its devolution of power, concluding that Productive Ward is empowering nurses to become ‘fantastic leaders’. Morrow et al. (2010) also identify that in order for a programme to be spread and sustained, skills in communicating vision, goals and skills in encouraging others to lead and to manage are required. These skills are essentially leadership skills.

The literature clearly outlines and collectively agrees the many ways in which the role of leadership interacts with the implementation of the Productive Ward at all levels of the organisation. However leadership at ward level is considered to have the biggest impact. The subtle leadership decisions in relation to how and when the initiative is introduced, marketed, communicated, articulated, energized and maintained all appear to influence the success of the Productive Ward.

Corporate/management engagement and support

Giving people the time, permission and explicit support to do things differently was part of some key advice reported during early implementation (Clarke-Jones 2007). This sense of ‘permission’ is noted in results from the survey from Morrow et al. (2012) of frontline staff who had personal experience of Productive Ward implementation. These health-care staff valued the opportunity that Productive Ward gave them, to turn a critically reflective eye on their work practices and to make suggestions for change. The Productive Ward depends on engagement, support, energy and talent of everyone at every level (Bevan 2009). This wide and high level of support is also reported as one of the key ingredients for success in the Saskatchewan implementation (Saskatchewan Registered Nurses Association 2010). It is well-described as a critical success factor and ‘top tip’ in the NHSI & NNRU reports (2010a, 2010b). Their case studies demonstrate the requirement to match participant’s Productive Ward ambitions with a supportive organisational context in order to achieve progress. Organisational energy for Productive Ward is determined by levels of visible executive support (NNRU 2011). The authors outline that it is staff energy that drives the Productive Ward. They further describe how this can only happen when staff feel that they are backed by organisational energy and have time and support to participate in meaningful ways.

Mumvuri and Pithouse (2010) describe how they used senior managers to participate in ward audits in an attempt to involve the senior team in the project and bridge the ‘board to ward gap’. Wilson (2009) suggests that all board members need to visit the participating wards, listen to staff and patient stories and try and understand the ‘Releasing Time to Care’ concepts. She describes engagement with ‘Releasing Time to Care’ as an opportunity to create a powerful pathway between the ward and the board.

The Health Quality Council (2011) pilot report in long-term facilities outlined management support as vital to the success of ‘Releasing Time to Care’. The chief executive officer (CEO) and senior leadership were able to remove many of the barriers during implementation. Robert (2011) encourages the use of the executive team and existing structures to ensure a strong sense of governance for the spread of the project. Bloodworth (2011) views the need for senior executive commitment as being essential because initiatives such as Productive Ward are about changing the organisation and not just tinkering with systems and making small improvements. Without organisational engagement and support Productive Ward sites run the risk of running out of energy, losing momentum and spread, and creating ‘islands of improvement’ NHSI & NNRU (2010c).

It would be prudent to have corporate/management engagement and support for any improvement or change initiative. However the Productive Ward literature is collectively consistent in identifying visible, active involvement compared with distant boardroom or management approval. Encouraging and maintaining corporate/management engagement and involvement over the longer term of the Productive Ward initiative may well prove challenging as the initiative competes with other emerging projects and priorities. Morrow et al. (2012) identify the main limitation of their study in terms of their data being sourced from people and hospitals that had engaged and committed to the Productive Ward. There is an absence in reporting from sites where there has been little or no corporate or management engagement and support. There are many lessons to be learned by comparing success or degree of success with the amount and level of engagement and support at senior levels.
Financial and human resource commitment

Although promises of substantial financial support (£50M) were offered at the start of the Productive Ward initiative in the UK (Nursing Times 2008), there is an indication from some NHS sites that they have not received any financial support at all NHSI & NNRU (2010a). Securing financial resources to devote to this initiative in other countries has also proved challenging (Avis 2009, Gribben et al. 2009). An under-estimation of exactly what the initiative entails, the improvements required and no finish or end-point may not have helped.

Having dedicated financial support is reported as very important for implementation (Gribben et al. 2009, NHSI & NNRU 2010a, 2010b, Morrow et al. 2012), as start-up, equipment purchase and environmental changes all require budgetary resources. Reporting on the organisational determinants of spread of the initiative, Morrow et al. (2010) and the NHSI & NNRU (2010a) highlight how momentum of implementation can decline when funding dries up. They also suggest that this can be further compounded if ‘late starters’ to the project do not get the same levels of support with resourcing as early implementers. Robert et al. (2011) describe sufficient resource provision as being a ‘key organisational factor’ for implementation, especially in relation to the provision of backfill and staff-replacement for staff time spent on the project. Morrow et al. (2012) highlight funding for the implementation as being a key facilitator for implementation, with senior managers in their survey describing the available resources as invaluable. This point is well reflected in the NHSI & NNRU (2010a) top 10 tips for spreading the Productive Ward within NHS Trusts.

Challenges in relation to the human resource implications for implementing Productive Ward are well documented (Health Service Journal 2007, Gribben et al. 2009, Svedahl 2009, Dean 2010, Mumvuri & Pithouse 2010, NHSI & NNRU (2010a), Robert et al. 2011, Morrow et al. 2012). Many of the sites that have been evaluated found the module content and process improvement activity time consuming (Gribben et al. 2009) and exceeding the time allocated to them (NHS Scotland 2008). Early reports of essential elements for implementation, including time for staff, were highlighted during initial test phases (Health Service Journal 2007, Nursing Standard 2008). Further reports in the literature highlight staffing pressures having impacts on commitment (Kendal-Raynor 2010), understanding the purpose of the initiative (Svedahl 2009) and the overall success of the initiative (Dean 2010).

Sites involved in the NHSI & NNRU (2010a) evaluation reported clinical workload, bed shortages, sick-leave, increased winter activity and shortage of temporary/relief staff as barriers to progressing with some of the Productive Ward activities. Morrow et al. (2012) identified staffing shortages and the requirement to balance clinical demands as being key challenges to programme implementation.

It is evident in the literature that securing one-off resources for implementation of the Productive Ward will not sustain the initiative. It is slowly emerging that the initiative is a long-term project and, as such, requires long-term, recurring resourcing. It is important that organisations understand this financial and human resource implication and secure a long-term financial commitment before commencement.

Conclusions

Owing to the large volume of reports, research papers and grey literature that have been published about the Productive Ward and its implementation, the main challenge of this literature review was narrowing the many key messages and recommendations into practical themes that senior nurse leaders could use when planning for implementation of the Productive Ward. The literature published to date reveals that there are many styles, approaches, factors and key issues that are critical for successful implementation. NHSI & NNRU (2010a, 2010b, 2010c) reports use the dissemination, diffusion, adoption, spread, assimilation and sustained change theories to highlight critical success factors for the adoption and spread of the Productive Ward. Although this approach is extremely useful, by extensively searching the current literature we have shown there are some other subtle aspects of practical implementation and recommendation advice, namely, the role of appropriate training and robust project planning, which will have an impact on the start-up and successful implementation of the Productive Ward in countries such as Ireland, which are just commencing the Productive Ward journey. We have found that it is possible to map the reported aspects of practical experience and implementation recommendations into seven areas for consideration before, during and at regular intervals into implementation of the Productive Ward (Table 2).

The findings of this review concur with our experience in Ireland to date. There are key factors that influence the implementation of the Productive Ward:
A robust and engaging communication strategy.
A project team that enables and empowers others.
An agreed project plan.
Involved leadership.
Corporate/management engagement and support.
Financial and human resource commitment.
Appropriate training and support.

These key factors are interdependent and rely on each other to some degree. Our advice is to ensure that these factors are considered during planning and implementation. Many of these characteristics have been described in other change/implementation models (Pinto & Slevin 1989, Ferlie & Shortell 2001 Kotter 2007) but not necessarily all together. When viewed collectively and contextually they do not neatly fit into any particular change or implementation model. In this context the synergy of these seven characteristics appear to be a particular issue for the implementation of the Productive Ward, despite the fact that some of these characteristics have been identified in other studies. How some of these key factors interact, interplay and depend on each other warrants further investigation. It is possible to claim that there may well be other factors that influence the successful implementation of the Productive Ward initiative and these will only emerge as implementation continues in the UK, Ireland and other countries who are adopting it. There are also many lessons to be learned by investigating and reporting on sites that do not have successful implementation stories (Pressman & Wildavsky 1973).

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