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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Evaluating the co-production of active ward principles in an inpatient setting: staff developments from using person-centred practice development

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Abstract

Background: In the acute hospital environment deconditioning is a major risk factor, with around 90% of the day spent sitting or lying down. A physiotherapy and occupational therapy Active Wards Special Interest Group was formed to provide peer support and act as a platform for sharing resources and ideas to increase opportunities for physical activity in the inpatient setting. Drawing on the nine principles of Practice Development, a person-centred, participatory approach was adopted. These values promote time and space for the team to grow and develop together, accounting for best evidence, personal and professional experience. The group co-produced a toolbox of resources, active wards principles and formed a group of experts to help others.

Aim: To evaluate the experience of staff engaging in this work with the objective of learning from the experience and make recommendations for replication and continuation of the improvement process.

Methods: Members of the special interest group and their team leads were invited to complete an online self-reporting questionnaire defining their experiences of participating in the group.

Results: Engaging clinicians in improvement through person-centred practice development processes delivers benefits for patients, services and clinicians. Key findings for staff development were identified as significantly improved (response rate of 78%) through i) active learning principles used for meetings, ii) effective and diverse communication strategies, and iii) group cohesion by engaging in a practice-based initiative. Group members and team leads observed personal, professional and service development. Participants made new connections, had a sense of a common vision and felt part of a collaborative process where ideas and feedback were shared. Where changes in patient activity levels had been observed, at least two-thirds of teams attributed this to having a team member in the group.

Conclusions and implications for practice:

- Clinicians require adequate time, space and support to achieve improvements
- When engaged with active learning and participatory approaches, clinicians make better use of meetings to develop and form principles of practice relevant to their clinical context and patient groups
- Engaging in person-centred practice development processes enables clinicians to develop transferable skills
- Practice development methods can be readily replicated for initiating and engaging clinicians in other practice-driven development projects

Keywords: Hospital acquired deconditioning, person-centred, physical activity, sedentary behaviour, participatory leadership, service improvement

Introduction

Background to active wards project

Reducing sedentary behaviour and increasing physical activity is a clinical and research priority (Chastin et al., 2019). Patients attending acute inpatient services say they want opportunities to be more active when admitted to hospital (Clark et al., 2018; Harvey et al., 2018a). In the acute hospital environment deconditioning is a major risk factor, with around 90% of the day spent sitting or lying down (Grant et al., 2010; Harvey et al., 2018b; Kehler et al., 2019). This can lead to functional decline, reduced quality of life and decreased life expectancy (Gordon et al., 2019). The EndPJParalysis campaign has highlighted the need to reduce this deconditioning risk and engaged professionals widely to tackle this. (Dolan, 2017). Recommendations to increase physical activity and reduce sedentary behaviour must recognise the diverse needs of medically unwell patients. Clinical judgement and the preferences of patients and their social/care network must be valued, along with the need for the ward environment and culture to be conducive to movement within normal daily routines. Patients and patient-facing clinicians hold the knowledge and skills needed to enact change (Harvey et al., 2018a; Baldwin et al., 2020).

Context to the evaluation

Healthcare professionals have an opportunity to address deconditioning but may not routinely share experiences and learning in this area to influence a change of practice at a strategic level. As a starting point to this improvement work, therapy staff were asked by means of a survey to share their opinion on the barriers and opportunities to reducing sedentary behaviour in the clinical environment; this is published elsewhere (Harvey et al., 2018a). To take forward the learning from this survey, physiotherapists and occupational therapists, as experts in the subject of activity and movement, were invited to join an Active Wards Special Interest Group (SIG). The intention was to support the professional development of this staff group through peer support, reduced duplication of effort and forming a platform to share resources and ideas about opportunities for physical activity in the inpatient setting. Invitations were made via staff newsletters and email, with a broad outline of the aims.

The SIG members work in clinical areas across a large health organisation serving a population of approximately 1.2 million. The group brings together expertise at all levels from stroke, medical, surgical, orthopaedics, oncology and older people's services from nine hospitals. They meet, share and collaborate on solutions to reduce deconditioning across the various settings.

This work was led by a practice development physiotherapist (JH) working with the principles of practice development (McCormack et al., 2013), action learning (McGill and Brockbank, 2004) and active learning (Dewing, 2010). The evolution of the SIG was organic and, although facilitated by the physiotherapist, members were encouraged to use a participatory leadership style (Greenhalgh, 2018) in terms of the scope and progress of the group, and the content of meetings. They used a 'collaborative hub' model (Figure 1) to engage with patients and members of their own clinical teams to bring learning, development and informed opinion back to the group, and share learning and resources from it. The SIG also consulted more formally with patient and carer groups as appropriate. It was noted early on that while members work closely with their own multidisciplinary team and their specialist clinical networks to some degree, formal connections with those in the same profession across the wider organisation was limited. This suggested that sharing of good practice was also limited.

The group met every six to eight weeks (Table 1). The meetings served to provide peer support, and opportunities for collaborative, integrated and shared experiences of varying scope. They tested resources and change ideas to improve opportunities for physical activity in the local clinical area, working with patient groups, multidisciplinary teams and other teams inside and outside the organisation as appropriate. They shared their work widely in the hospitals via patient and staff engagement events and national and international platforms at conferences and seminars. Social media was also used, via the hashtag #ActiveWards. An intranet page was created, allowing resources and information, including a survey system for user feedback, to be held in one place accessible to

all staff across the organisation. The individual SIG members are considered active ward champions in their local areas and interested parties are encouraged to contact them for advice. Members working with local teams have noted varying levels of enthusiasm, knowledge and experience around increasing patients' physical activity and reducing sedentary behaviour. Therefore, in collaboration with other healthcare professionals and groups (patients, nursing, medical, allied health professionals, healthcare support workers, health improvement, and quality, equality and diversity representatives), the SIG has developed a common set of basic principles for staff (see Figure 2), intended to be used for communication in the clinical setting while considering patients' preferences and the complexity of the clinical environment. These principles informed the organisation's Excellence in Care and Care Assurance System standards to guide training, development and cultural change. They also provide a means of working towards consistent standards of care that can be evaluated in a person-centred way across the organisation.

Figure 1: Collaborative hub process

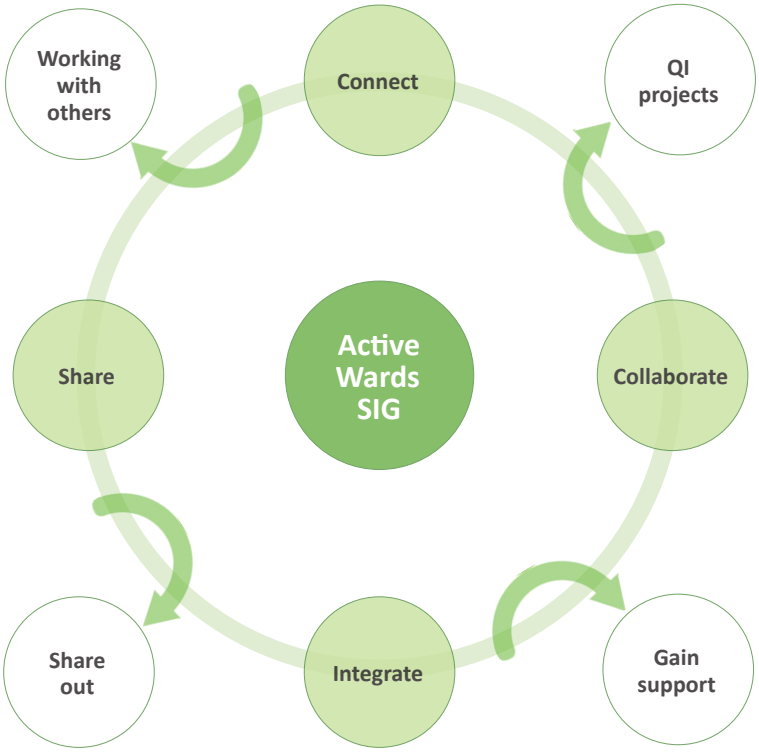


Figure 2: Active ward principles

- All patients and those involved in their care are supported to understand the benefits of being active in hospital and on discharge
- We take every opportunity to encourage patients to be physically active
- We minimise environmental barriers to promote physical activity*
- We have a culture where enabling physical activity is everyone's‡ responsibility

KEY

**Physical activity includes a wide range of energy expending activities involving body movement, the activity should be person-centred and tailored to individuals needs*

‡*Everyone is defined as all staff groups, patients, carers, family, friends*

NHS GGC active wards principles (Harvey, 2020)

Table 1: Summary of active ward group sessions

Meeting no.	Session summary			Useful?[5]
	What?	**So what?**	**Now what?**	
Meeting 1 (8 attendees)	• Share survey results (Harvey et al., 2018a) • Discuss context of practice and personal and professional beliefs and experiences, and existing evidence for change	• The survey results were representative of group views • It was recognised that change in behaviour and practices requires time and effort	• Permission granted from professional and team leads to form a group to explore these issues further	Average: 9/10 (2)
Meeting 2 (4 attendees)	• As a group define: purpose, role, communication • Application for funding avenues	• The group was able to discuss scope, knowledge and experience, defining where they could have influence and impact	• Creation of terms of reference based on discussion	Average: 8.3/10 (3)
Meeting 3 (12 attendees)	• Brainstorming change ideas, measurement, categorisation and priority planning	• Created a list of priorities and four subgroups to work on the priorities between larger group work activities	• One subgroup meeting for each member over winter period • Creation of closed group folder share site to allow members to share work between meetings	Average: 8.3/10 (4)
Meeting 4 (10 attendees)	• Update and review subgroup work • Discuss revised plan	• Attendance at subgroups poor and little work produced • Subgroups made work quite fragmented and difficult to put into normal practice, as dictating testing in clinical environment from central point rather than local need	• Improve attendance and coherence of group as a whole, along with subgroup work within larger group, but working towards the same topic • Group requires more 'forming and storming' work • All members to decide what to test in local area, ready to feedback a report at meeting 6, using same template	Average: 8/10 (4)
Meeting 5 (5 attendees)	• Facilitated VBRP[1] session • MAP exercise[2] exploring motivation and perception of current situation and potential for change, using Envision Cards[3], 6-minute journal on positive interaction about active wards and NAVVY[4] task	• Poor attendance at this session, but these more creative methods led to deeper discussion around issues and shared professional values	• Ensuring that our plan involves real engagement of staff and patients at a local level and that this is then fed back into the group • Staff to bring at least one resource toward this to next meeting	Average: 8/10 (5)
Meeting 6 (5 attendees)	• Written and verbal progress report by each individual, based on work in local area	• Only one person and facilitator brought a resource, verbal updates were provided with support of written reports from all in attendance, peer support and mentoring occurred • Discussed funding options	• Agreement for everyone to send facilitator a resource before meeting to allow discussion of each • Reports combined into annual review to be shared with leads and teams • Each member to 'fact find' in local sector • Inviting comment from wider nursing and AHP teams via newsletters	Average: 7/10 (4)
Meeting 7 (5 attendees)	• Each member sent resources used by facilitator, these were displayed on wall for discussion of each, dot vote regarding relevance for sharing to wider staff group and action planning	• This task produced a set of resources that had been tested at local sites with the intention of sharing with wider staff group via proposed intranet page	• Taking work further allows the opportunity to work with other staff groups and other organisations	Average: 8.1/10 (8)
Meeting 8 (5 attendees)	• Invited speakers from health improvement team, third sector physical activity organisations, nursing and volunteer services to speak about their work • Discussed opportunity for collaboration	• Opened networks for the group and individual teams within the group, along with ideas for funding avenues	• Need link between aim and resources, a way to help define work moving forward – develop a set of principles for staff? • Use of survey to bring initial ideas: what does an active ward look like? What does active ward sound like? What does it feel like to be in an active ward? What activities take place? What have patients told you they value in terms of active ward opportunities? What have patients told you they don't like about any active ward intervention?	Average: 7.4/10 (7)
Meeting 9 (10 attendees)	• Review feedback and response on defining active wards and development of draft (V1) principles	• This definition provides a start to what we are trying to achieve to allow meaningful consultation with others	• V1 of the principles were put into a consultation document and each member consulted with local team members or groups	Average: 8/10 (6)
Meeting 10 (13 attendees)	• V1 consultation review and revisions, and proposed measurement of each principle	• This produced a new set of principles based on engagement with various staff groups and grades	• The principles were then presented to patient and carer group, team leads and senior managers, with the intention of being taken forward to influence Care Assurance System standards • Survey SIG and team leads on experience of group	Average: 7/10 (6)
Meeting 11 (8 attendees)	• Collated annual review presented back to the group, reflection by group and acknowledgement of work. • Results of staff evaluation fed back to the group for discussion. • As survey was closed, meeting's usefulness[5] was indicated by marking a score on a flipchart on exit	• This gave an opportunity to take stock of what had been achieved and look forward to the next year, making plans for the work of the group	• Based on member feedback from the survey, reflection on annual review and discussion, meetings in the coming months should be shorter and more frequent (possible impact of pandemic unknown at this time) and use virtual learning environment, such as webinars, where appropriate • Share annual review with staff via newsletter • Submit survey results for peer-review publication	Average: 9.5/10 (8)

KEY: 1. *VBRP: Values Based Reflective Practice; 2. MAP = Motivation, Actual and Potential;* 3. *Envision Cards:* envisioningcards.com*;* 4. *NAVVY: Needs, Abilities, Voices, Values and You;* 5. *Useful: staff survey asking how useful they find the meeting in supporting work locally, rated 1-10 with 10 as extremely useful. No. of respondents in brackets*

Aim and objective

To evaluate the experience of staff and their team leads with being involved in a collaborative, participatory, person-centred SIG to increase physical activity and reduce sedentary behaviour in the clinical environment. To further refine facilitative methods for staff engagement in practice driven innovation that could be replicated for future work.

Method

Permission and participants

Ethical approval was not required as this was considered a service evaluation project, rather than research, as defined by the Health Research Authority (2020). Two surveys were conducted in order to improve the service provided within our healthcare organisation. Permission for this work was granted from the physiotherapy and occupational therapy professional leads. Participants were staff who were current and past SIG members (n=18) and the team leads of those staff members (n=12), all currently employed by the organisation. They were informed about the purpose of the study, invited to opt in and told they could withdraw at any time. They were assured of anonymity and confidentiality on page one of the survey. An anonymous self-reporting questionnaire was delivered via an online data collection system (Webropol, UK version 3). The contact information of the project lead was included within the survey instruction section so participants had a source of further information. The data collection period was 22 January to 14 February 2020.

Survey design

Survey to SIG members

The purpose of this survey was to evaluate the participants' experiences of being part of the SIG. The questionnaire started with some descriptive statistics about their profession, attendance at the group meetings and their interaction with the group, along with any personal/professional development they felt they have achieved. They were then asked more specific questions based on the person-centred practice development principles (McCormack et al., 2013) and action learning theory (McGill and Brockbank, 2004). This questionnaire was designed for this particular project and as such has not been validated. The full survey can be found in Figure 2.

Figure 2: Survey to Active Wards Special Interest Group members

Thank you for being a member of the physiotherapy/occupational therapy Active Wards Special Interest Group for 2019. It would be greatly appreciated if you could complete this questionnaire defining your experience of being part of the group. This work will be used to influence active wards work and other practice development workstreams. Collated and summarised results will be shared by publication and presentation as appropriate. No identifiable information will be shared.

Survey open 22/01/20 to 14/02/20. Contact: (*contact details of principle investigator*)

1. What is your profession? ☐Physiotherapist ☐Occupational therapist

2. What area do you work in? ☐Critical care ☐Medical ☐Older people's services ☐Oncology ☐Orthopaedics ☐Stroke ☐Surgical ☐Other (please specify)

3. Please indicate your meeting attendance (if the meeting was before you joined the group please state N/A). For each meeting attended, give a score from 1 to 10 to indicate how useful you found the meeting in supporting your work locally

Meeting date:	May 2018	Jun 2018	Aug 2018	Jan 2019	Feb 2019	Apr 2019	Jun 2019	Aug 2019	Oct 2019	Dec 2019
Attended? Yes/No/NA/Do not recall										
Rating (1-10)										

4. When you were unable to attend the face-to-face meeting, did you still provide input into the meeting (for example by emailing the facilitator comment or completing a survey)? ☐Never ☐Sometimes ☐Always

5. We have a shared vision as to what we are trying to achieve

0----------10

Strongly disagree Strongly agree

6. I feel comfortable to share my opinion and ideas in the group

0----------10

Strongly disagree Strongly agree

7. I feel able to give constructive feedback to others in the group

0----------10

Strongly disagree Strongly agree

8. I feel part of a collaborative process

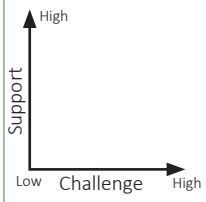
0----------10

Strongly disagree Strongly agree

9. By being part of the group I have made connections with other people I would not have normally

0----------10

Strongly disagree Strongly agree



Looking at the diagram

10. How much support do you feel you receive from being a group member?

0----------10

No support High support

11. How much challenge do you feel you receive from being a group member (how stretched do you feel)?

0----------10

No challenge High challenge

12. Our physiotherapy/occupational therapy Active Ward Special Interest Group aims to provide peer support and act as a platform to share ideas for increasing opportunities for physical activity in the inpatient setting. To what extent do you feel we are currently meeting this aim?

0----------10

Not at all Totally

13. What has been best about being a member of the Special Interest Group?

14. What could improve the Special Interest Group?

15. Please list any personal or professional development you feel you have achieved/gained by being part of the group (e.g., confidence, leadership, teambuilding, testing change ideas, measurement of change, presentation skills)

16. Have you shared your work in any of the following? (select all relevant) ☐Local in-service training ☐National presentation ☐International presentation ☐Article published in peer-reviewed journal ☐Article published in mainstream media ☐Blog ☐Using #ActiveWards on social media ☐Other (please specify)

17. Thank you so much for your time. Please use this box to add anything you feel may be relevant

Survey to team leads

Team leads release team members to attend the meetings and also have an overview of the impact of SIG membership on their team and clinical area. Their perspective was also sought on the impact of attendance at the group meetings on ward activity and awareness of the active ward resources, plus observed professional development of the individual member of the SIG. The questionnaire can be seen in Figure 3.

Figure 3: Survey to teams leads of Active Wards Special Interest Group members

Thank you for your support of the physiotherapy/occupational therapy Active Wards Special Interest Group by permitting a member of your team to be in the group. It is hoped that you can give some feedback on the influence and impact of the group by completing this short questionnaire. This survey is anonymous, results will be compiled and shared in written, visual and oral format with the purpose of evaluation of work to date and to influence work moving forwards. Direct quotes may be used but anonymity is assured as any reference to person, place or distinguishing information will be excluded. Please do contact me if I can be of any assistance. Survey open 22/01/20 to 14/02/20. Contact: (contact details of principle investigator)
1. Roughly, since your team member(s) joined the group, how many meetings have they attended? ☐None ☐<20% ☐20-40% ☐ 41-60% ☐61-80% ☐80% ☐I don't know
2a. Since a member of your team has been a member of the Special Interest Group have you noticed a difference in discussions and staff activities towards increasing physical activity and reducing sedentary behaviour in your area? ☐Yes, attributable to the group ☐Yes, somewhat attributable to the group ☐Yes, but not attributable to the group ☐No, there has not been any change in activity levels in our area **2b.** Please add any further comments based on your response
3a. Since a member of your team has been a member of the Special Interest Group have you noticed a difference in opportunities for patients to increase physical activity and reduce sedentary behaviour in your area? ☐Yes, attributable to the group ☐Yes, somewhat attributable to the group ☐Yes, but not attributable to the group ☐No, there has not been any noticeable change in this **3b.** Please add any further comments based on your response
4. Have you noticed any personal/professional development from the team member(s) that you can attribute to being part of the group ☐ Increased confidence to raise issues relating to activity on ward with team or individuals ☐Increased ability to problem solve with issues relating to activity ☐Leading team activities relating to activity on the ward, eg IST, brainstorming, consensus gaining ☐Increased motivation in change current practice ☐Increase networking with other teams/professions/groups ☐Improvement in measurement of change ☐Improvement in conveying results of change ☐Presentation skills, eg platform, poster ☐I have not noticed any personal/development that I can attribute to being part of the group ☐I have noticed something else (please specify)
5. Are you aware of: ☐The PT/OT active wards staffnet page ☐Where to find active wards resource library ☐How to feedback to the group experience of using active wards resources ☐ The development of active wards principles by the group ☐The Excellence in Care Standards
6. Thank you for your time. Please make any further comments here

Processing of data

For both surveys, descriptive statistics were used for quantitative data collected about the member and their attendance, along with the first overview questions on the group work. Qualitative data from both surveys were analysed and themed by the authors. Themes were listed for each set of results, and wordclouds used to demonstrate the frequency of certain words. Direct quotes help to illuminate the richness of the experience and learning, and examples are given for each of the main themes. Results were returned to the group members at the next meeting by transferring them to flipchart

paper for display on the wall, so that a walk round and discussion could occur actively. People were invited to add to the charts as findings were discussed. The Rolfe et al., (2001) method of reflection is used to consider the themes with the actual work completed in order to learn for future practice (summarised in Table 1 above).

Results

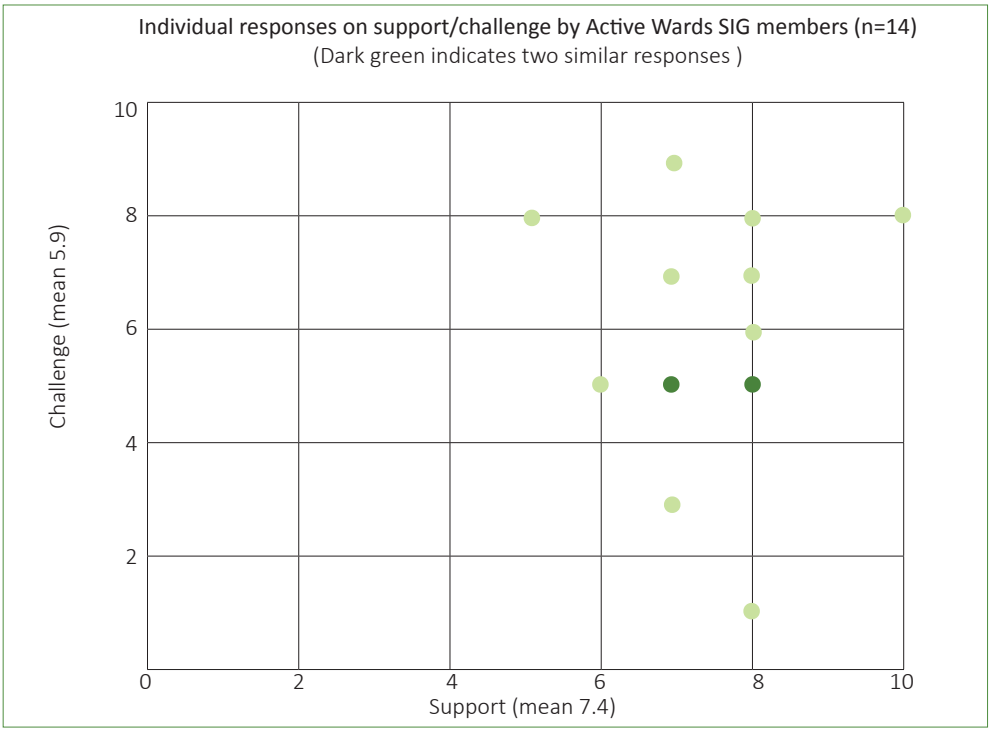
Survey 1: sent to SIG participants

Fourteen of 18 group members completed the survey – a response rate of 78%. Of respondents, 64% were physiotherapists and 36% occupational therapists, which is approximately representative of group membership ratios (and the staff ratio in the organisation). Asked to reflect on the perceived usefulness of each meeting they attended, they gave an average score of 7.9/10. All members were absent for two or more meetings. When unable to attend, they felt able to input either sometimes (n=11) or always (n=3) via electronic means. As shown in Table 2, members felt they had a shared vision, felt comfortable to share opinions and ideas in the group, able to give constructive feedback and part of a collaborative process. The data showed they received adequate support and challenge from group membership (Figure 4) with mean scores of 7.4 and 5.9 respectively. When asked to what extent they felt they met the aim of the group to provide peer support and act as a platform to share ideas around opportunities for physical activity in the inpatient setting, they gave an mean score of 7.6.

Table 2: Responses to statements about group belonging

Statement	Agree (mean score/10 ±SD)
We have a shared vision of what we are trying to achieve	8.9 ±1.2
I feel comfortable in the group to share my opinions and ideas	8.7 ±1.4
I feel able to give constructive feedback to others in the group	8.5 ±2.0
I feel part of a collaborative process	8.5 ±1.8
By being part of the group I have made connections with other people I would not normally have made	9.0 ±0.8

Figure 4: Indication of support and challenge received from being a group member



The group was asked what was best about being a member. The most commonly reported themes were around sharing ideas/resources, meeting with others, and mutual support and motivation to lead change in their local areas. The results can be seen in Figure 5.

Figure 5: Reports of what members liked about the group

Wordcloud showing frequency of response

Main themes

- Networking/meeting new people
- Sharing ideas and resources
- Hearing what others are doing
- Gaining knowledge of wider work or event
- Learning methods for improvement, change and people management/engagement
- Being inspired/motivated/empowered/ encouraged
- Support
- Time away from clinical work to reflect
- Personal development
- Promoting physical activity
- Facilitator

Direct quotes

'Networking with colleagues with a shared interest in service improvement'
'Benefiting from the ideas and resources of colleagues whom I otherwise would not get a chance to network with'
'Learning how other teams have overcome barriers to change'
'Facilitating improvements in practice'
'Feeling encouraged to keep striving for change on the wards'
'Feel empowered that we're trying to achieve a cultural change with regard to how activity is viewed on wards'
'Taking time to reflect on positive impact had within practice'
'Time out of clinical work to think about what we do'
'Support taking forward ideas'

The members were asked what could improve the group. Practical issues around meeting frequency, timing, format and venue were most commonly mentioned, along with more time and training, and more involvement and support from wider professional groups (Figure 6).

Figure 6: Improvement for the group reported by Special Interest Group members

Wordcloud showing frequency of response

Main themes

- Meeting design (location, day, mode, frequency, catering)
- Meeting content (regular reviews, more information on data collection, more direction, check-in/out)
- Involving other health care professionals
- Strategic precence and visible support from management

Direct quotes

'Personally, varying the location of meetings would help to accommodate all members'
'More direction to improve use of time'
'Senior nursing staff involvement at meetings'
'Getting more time during clinical to review items on webpage'
'More support from management to achieve aims'
'Move towards a board-wide strategy, with this group guiding'

The members were asked what personal and professional developments they had achieved by being part of the group. They most commonly reported development of improvement methodology knowledge, along with leadership skills (especially communication and working with teams) and some more practical skills, such as presentation; details can be seen in Figure 7. Figure 8 shows further comments made by the group members. There are no new themes emerging here but there is support for themes defined in previous sections.

Figure 7: Reports of gains identified by group members

Wordcloud showing frequency of response

Main themes

- Increased knowledge and skills on using model for improvement
- Improved personal abilities (leadership, confidence, communication)
- Improved presentation skills
- Increased knowledge on physical activity

Direct quotes

'Testing change ideas'
'Measurement of change'
'Improved communication with regard to change ideas'
'Increased confidence speaking out in group discussions'
'Confidence I have taken from group has transferred to my ward base when trying to implement change'
'Understanding of importance of physical activity in the inpatient setting'

Figure 8: Further comments

Direct quotes

'Shared with other members of the team at staff meetings'

'Great team to be part of'

'Thank you to <*group lead name*> for the creation of this group and the ongoing enthusiasm and inspiration given to drive this work forward!'

'I feel that the active wards group is very positive and a great team to be part of. With staffing pressures in my team over the last five months I don't feel I have dedicated enough time to it though, and have found it difficult to implement change as a result, which I feel disappointed about! Hope to be more involved going forward'

'Great project, just difficult to commit to time to meetings, when a lot of time is needed/utilised to implement, embed and monitor changes. In balance, the latter feels more important and therefore takes priority, but the support of the group and <*group lead name's*> guidance and expertise has been invaluable'

'Great to have SIG available – if I didn't have this I would be a wee fish in a massive pond. Now we are lots of wee fish together'

Survey 2: Sent to team leads of SIG members

Seven team leads responded to the team lead questionnaire (58% response rate). They were first asked to indicate perception of attendance at the group meetings. One didn't know, two indicated attendance of 20-40% and the remaining four indicated attendance of over 61%. Staffing levels and part-time staff working were cited as reasons for non-attendance. They were asked to indicate if they felt that there was a noticeable difference in opportunities for patients to increase physical activity and reduce sedentary behaviour in their clinical area. They were also asked to provide supporting statements where appropriate. Where a change in activity level had been observed at a clinical level

66% (n=4) of team leads could attribute it, at least to some extent, to having a team member on the SIG (Table 3). Five team leads had noticed a rise in discussions or staff activities around increasing physical activity and reducing sedentary behaviour that they could attribute in some way to the SIG (Table 4). Figure 8 shows team leads' perceptions of their staff member's personal or professional development since being part of the SIG; the most commonly reported benefits were leading staff activities (n=4), increased networking (n=3) and conveying results of change (n=3). Finally, when asked about knowledge of resources, the six who responded were all aware of our main source of information, our active wards intranet page and four of the six knew about the Care Assurance System standards.

Table 3: Indication by team leads (n=7) of the impact of active wards work at a clinical level

Selection	Response	Comments
Yes, I can attribute this to the influence of the group	43%	'I Can boards have been implemented and nursing colleagues educated on their use – working well with a very small number of nursing staff' 'New activity menus produced and piloted on ward, the staff member actively involved the team (this included enrolling a rotational physio to lead the audit of impact of the PA menus[1]) and other relevant stakeholders. Plan for activity prompts using wall stickers for another ward's dayroom' 'Team session looking at different options to improve mobility and each area committed to do this' 'I Can posters[2] now in use on rehab wards rather than traffic lights'
Yes, I can somewhat attribute this to the influence of the group	14%	No comment made
Yes, but I cannot attribute this to the influence of the group	29%	'Our clinical team had already commenced work…'
No, there has not been any noticeable change in this	14%	'There have not been changes in activity levels implemented yet on the wards due to staffing, but staff are now openly discussing active wards and how to implement change and how to make it meaningful'

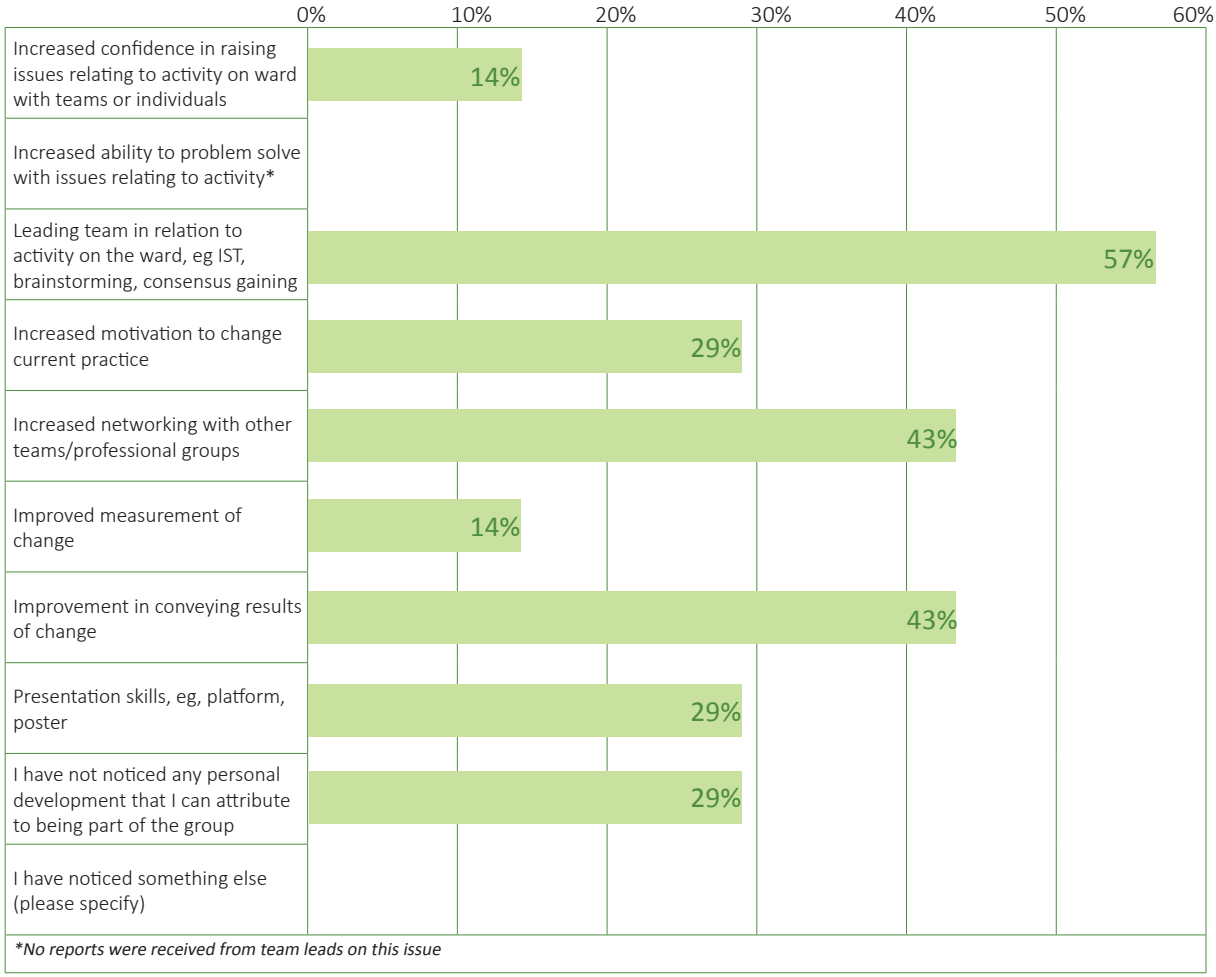
KEY: 1. *PA: Physical activity information tool resembling a menu;* 2. *I Can poster: a communication tool for staff, patients and carers about mobility and patient goals*

Table 4: Indication by team leads (n=7) about staff discussion and staff activities towards increased physical activity and reduced sedentary behaviour

Selection	Response	Comments
Yes, I can attribute this to the influence of the group	14%	'Staff are looking to use different methods/staff groups to do this: volunteers and activity coordinators'
Yes, I can somewhat attribute this to the influence of the group	57%	'Yes, within the OT/PT team but not in the wider MDT' 'This was being promoted via the team already and through other initiatives, e.g., health-related behaviour change training, including physical activity questions within core AHP documentation and the #Endpjparalysis campaign' 'Active wards update was given at a local team development afternoon. Active wards information wall now in department. Staff now discussing ways of implementing changes on wards for patients and how to sustain change'
Yes, but I cannot attribute this to the influence of the group	29%	No comments made
No, there has not been any noticeable change in this	0	

KEY: *OT: occupational therapist; PT: physiotherapist; MDT: multidisciplinary team; AHP: allied health professionals*

Figure 9: Reports by team leads (n=7) regarding observed changes in staff



Discussion and learning

Meeting design: promoting active learning

Attendance at the meetings was varied and no two group meetings contained exactly the same mix of attendees. It was ambitious to ask people to remember the usefulness of each meeting retrospectively and this is perhaps represented in the response rate to these questions, which range from 24% to 100%. However, there was no indication that responses were more likely to be made for meetings that were more recent. Responses regarding usefulness of the meetings ranged from 7/10 to 9/10 indicating they were generally found to be useful to the respondents' work locally.

Greenhalgh (2018) points out that, if a group is to function properly, there is a need to attend to members' physical and material needs (including time for preparation and reflection). The group sessions given the highest scores were those where there was a strong plan of action for the day to be interactive, including pre-meeting 'homework', where the participants were asked to submit something before the meetings. These pre-meeting submissions may be ideas for discussion, resources, survey responses or something that can be printed and displayed on the wall for arrival at the meeting. The tasks are also specifically designed by the facilitator to allow time and space for reflection and engage the senses. An example is asking members to consider, 'what does an active ward look, sound, and feel like?' encouraging them to form some thoughts on the purpose of the meeting before arriving and also seek input from others (patients, carers, multidisciplinary team). Sessions with lower usefulness scores were typically less interactive, for example, where guests were invited to speak but did not schedule enough time for the crucial interactive discussion section. This can be rectified with more thoughtful planning, using the insights from earlier sessions. One lower-scoring meeting came towards the end of

the active wards principles discussion, when the minutiae of the feedback from the final consultations were being reviewed; the laborious task of 'dotting the Is and crossing the Ts' was being conducted, with double-checking of information that was essential but unlikely to be perceived as immediately useful in terms of takeaways for local teams.

These findings are supported by the literature on active learning. This technique seeks to acquire authentic engagement within a learning process by facilitating activities where multiple senses are used. Dialogue is encouraged about personal beliefs, values and ideas over time, while intentional action relating to a learning activity and exploration of how a development was facilitated are also important (Dewing, 2010). The growth and cohesion of the SIG meant the members were able to co-produce the active wards principles and lead confidently on their implementation (Voorberg et al., 2015).

Using these fundamental elements of active learning has not only seen changes in practice relating to active wards, but to the way techniques are shared with others, as evidenced by the transferable leadership and change management skills reported in this article. The growth of individuals' skills and confidence in finding solutions for problems and facilitating change inevitably benefits the service as a whole (Walsh et al, 2006). Individual workstreams may have a start and endpoint, but engaging in methods of active learning for improvement work produces a culture of continuous development where staff are familiar with engaging in ongoing analysis, synthesis and evaluation in everyday practice, in addition to having a number of networks, tools and experiences to draw on (Dewing, 2010; Langley et al., 2009).

Communication strategies

Communication was another major consideration for the group. After the first few meetings it was realised that a layer of electronic means for groups to communicate was required (email, shared folder and electronic chat facilities, pre-meeting feed-in loop via an electronic survey system, social media with a common hashtag #ActiveWards). This meant each group member could sometimes (77% of the time), or always (23%) be part of the group meeting even if unable to attend in person. Thus it can be supposed that the electronic communication contributed, at least in part, to security in the group. Based on the feedback and subsequent discussion, the group has requested that meetings be shorter and more frequent with some conducted online, to increase the efficacy of the group. Three session times in the week were chosen by the group for the meetings to rotate between, accounting for part-time working and maximising the potential for attendance. Online communication became imperative due to social distancing restrictions and reallocation of duties during the Covid-19 pandemic as the NHS move rapidly to online models. This demonstrates the importance of the group being adaptable to meet the needs of circumstance and maintain group function (Greenhalgh, 2018).

One member mentioned requiring more direction to improve use of time. In the facilitation of person-centred participatory practice development, getting the right balance between guiding, supporting, challenging and experimenting is tricky (Sanders et al., 2013). The facilitator must grow with the group, be courageous to try new things and continuously learn about facilitation methods (Greenhalgh, 2018) with an ethos of 'enabling and not telling' (McCormack and Garbett, 2003). As the group has grown we have been able to create our own direction and influence direction across the organisation, but it is important to gain knowledge on participants' needs in terms of direction or structure to ensure trusting relationships and the right balance are achieved (Titchen, 2003).

Growth and cohesion of the group

Group members largely agreed with the statement that they were meeting the aim of the group, to provide peer support and act as a platform for sharing ideas in relation to opportunities for physical activity in the inpatient setting. Staff at all levels need to feel their input and experiences are valued and feed into ongoing evaluation, change and improvement (McCormack et al., 2013); the results of

this work indicates that this has occurred within this group, with genuine engagement from patient-facing staff. It did not happen overnight; it took time for the group to form, build trust, define its meaning and purpose, and take ownership of the work and its direction. In this way, the group was observed to transition through Tuckman's (1965) stages of group development: forming, storming, norming and performing, at times going back and forth in between stages. Members expressed a shared vision (8.9/10); felt comfortable to share opinions and ideas in the group (8.7/10); felt able to give constructive feedback (8.5/10) and felt part of a collaborative process (8.5/10). The design of the group was based on a collaborative, inclusive, participatory model, with engagement activities such as brainstorming, consensus exercises, small group discussions and the creation of pieces of work together in real time using various media, such as, sticky notes, flipcharts and interactive online systems. The meetings also had a visual and creative element, with posters and flipcharts displayed for members to add to/comment on, along with more formal methods of creative engagement such as the facilitated Values Based Reflective Practice techniques (NHS Education Scotland, 2020) which led to deeper discussion of issues and helped define shared values. An area of development indicated by the SIG group survey (Figure 2) is the support/challenge graph, where members scored the 'challenge' received at 5.9/10. This will be something to consider for future meetings. It is the intention of the practice development physiotherapist (JH) to take a step back from leading the group to allow challenge naturally to fall onto group members via a distributed leadership model. By taking the work across the organisation and to multiple professions, the experience of challenge should increase naturally as members take on more responsibility.

Initial meetings were heavily facilitator directed, but as the group has evolved it is now more participatory, vocal on actions moving forwards and, as evidenced by the SIG members and by team leads' observations, members are taking the lead in their local areas. The group has moved beyond following existing guidance or waiting for something to be put in place, to formulating guidelines as a group, based on members clinical and personal experience alongside best evidence. This work has then been taken on by the organisation to be integrated into its Care Assurance System standards, making it a good example of work led by clinicians, rather than a top-down imposition (Stark, 2006). Using participatory creative means, growth and development as a group was achieved to find solutions that are long term, fluid and not imposed by others (McCormack et al., 2013). In a broader sense, this type of work can only grow with the support of the organisation, a multiprofessional approach and a culture where the value of time and space to engage with these change processes is recognised. Stark (2006) indicates that tensions within professional groups, culture and context hinder development of practice away from the status quo. This work has used a collaborative hub model to feed information in and out of the group, which has had a ripple effect that has been noticed by senior leaders across professions and led to the emergence of further work, supported by them.

Impact on patients: increasing physical activity and reducing sedentary behaviour

The focus of this evaluation was on the process of the SIG work rather than outcomes, but it would be remiss not to mention the outcomes relating to the group's original purpose. Throughout the course of the project, group members have been engaging in test-of-change cycles using metrics such as patient satisfaction, functional tests and questions on wellbeing. Moving forward, these will become more standardised but there is unlikely to be a 'one size fits all' solution given the diversity of our patient population. This work will inform this process as we move to larger-scale change. For this evaluation, team leads were asked to report noticeable impact; as non-SIG members, did they observe a change in practice? At a clinical level, two-thirds of team leads attribute at least some impact to having a team member on the SIG. The team leads evidence this by citing many of the interventions implemented by group members, having observed opportunities for patients to be active. Those who did not observe change indicated initiatives had yet to start, or had already started before the group work began.

It is worth also considering the value of allocating adequate time to discuss and engage with others, as well as to personalise resources and adapt improvement ideas to one's own clinical area. For example, critical questions relating to the active wards principles themselves may include exploring:

are staff members aware of the principles? Has the patient-facing multidisciplinary team considered opportunities for change in their clinical area and decided what interventions they will test first? What would be the most appropriate method to determine if the change is an improvement in this clinical area? Measurement of the availability of time, space and resources to consider what changes were implemented and to monitor improvement should be embedded in future work.

Group members' personal and professional growth

Aside from the outcomes for patients, more general development of leadership and improvement skills has been observed through engaging in improvement activity in a collaborative, person-centred model. SIG members and team leads alike acknowledged this. Many of these skills are transferable so the benefits will be experienced throughout the organisation.

Limitations

Although the process of this work and the survey design is of interest and transferable to a wide audience, the results are not generalisable as they are specific to this cohort. They do demonstrate practice development methods that could be readily replicated; for example, we intend to reproduce the survey for future work and, from a design perspective, revise the 'usefulness of the meeting to support your work locally' question to include a definition of what is meant by 'usefulness' in context and clarify the purpose of each meeting. Decreasing the time between evaluation and the actual event will also be helpful for recall and accuracy of reflections, to elucidate positive elements of the group experiences and those that might need to be reviewed.

Future work

The active wards principles formed by the group will now be integrated into the organisation's Care Assurance System standards. The principles will expand into recommendations, which will be accompanied by training and support material produced by improvement work completed by the SIG members. Their purpose is to provide themes based on evidence and local experience indicating best practice. The principles offer the opportunity for multidisciplinary teams to come together to find solutions for their local area. Evidence of meeting each of the active wards principles will be collected across the organisation, this will look different for each area. In addition, the online library of active wards resources and information available in the intranet pages developed by the group will be added to as new learning emerges.

Based on the feedback from the respondents to both surveys, future SIG work will be based around being participatory and moving to distributed leadership. For future workstreams a similar formula can be followed, with the amendments described in the discussion section. As the work grows, the group will naturally form a larger network across the organisation and act as a reference group for more formal provision going forward.

Conclusion and implications for practice

Both groups surveyed credit participation in the SIG with personal, professional and service development. Members have made new connections, learned transferable skills, experienced a shared vision, and generally felt comfortable as part of a collaborative process for sharing ideas, support and feedback. They used the meetings to develop and form principles of practice relevant to their clinical context and patient groups, and the methods learned can be readily replicated for initiating and engaging clinicians in other development practice-driven innovation projects. Key findings for staff development were identified as significantly improved through active learning principles used for meetings, effective and diverse communication strategies, and group cohesion through engaging in a practice-based initiative from small tests of change to large-scale consensus work. Having observed the benefits of working with practice development methods and active participation techniques, the time and space required to achieve change and development should not be underestimated. Clinicians should be given appropriate support, opportunity and responsibility to lead change activity. Engaging clinicians in improvement through person-centred practice development processes delivers benefits for patients, services and clinicians.

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