THE STATE HOSPITALS BOARD FOR SCOTLAND

CLINICAL GOVERNANCE COMMITTEE

Agenda Reference:	Item 15
Date of Meeting:	13 February 2025
Report prepared by:	Karen McCaffrey, Director of Nursing & Operations
Title of Report:	Activity Oversight Group Annual Report
Review Period:	Jan 2024 – Dec 2024

1 Core Purpose of Service/Committee

As part of the Covid response, there was the introduction of the Operating Model Monitoring Group (OMMG) whose remit was to monitor the impact of Covid on the activity of patients. This was in recognition of the need for restrictions to protect patients, carers & staff. . All of which impacted on care delivered including access to activities which are an essential part of the care and treatment of our patients. It was thought that the OMMG still had an important role to play. However, the focus of the group should look beyond Covid regarding that which affects current patient activity.

The revised group was renamed the Activity Oversight Group (AOG) and has a more proactive, focused approach to monitoring and improving performance regarding patient activity. The aim of this group is firstly to return to pre-Covid standards of activity, achieve stability and then continue to build upon this.

Methodology

The AOG uses quality improvement methodology and analysis of data regarding our current key performance indicators and additional data sets. There was a review of the first year of the AOG and given the subsequent implementation of the new Clinical Model, the group felt that we were now in a position to build on what we had achieved last year and move to an approach which supported each service to identify their own priorities rather than the initial site wide approach. This was in recognition of differing risks, issues and opportunities across all services. The data sets were also split to provide each service with their own specific data set as well as the site wide.

It is the responsibility of the service leadership teams to monitor their data and respond accordingly. The Skye Centre being classed as the 5th Hub also continues to identify their own priorities and has their own data set.

The clinical quality team continue to support the group and revised the driver diagram (Appendix 2) to plan and organise the group's change ideas and associated actions for the coming year. Whilst focusing on the key areas, the data previously monitored by Clinical quality were still being captured and monitored. If the data indicated areas of concern, these would be escalated to the AOG to identify actions required.

2 Current Resource Commitment

The group agreed a terms of reference (Appendix 1) and met monthly throughout the year. The group's four work streams also met separately to progress their identified areas of focus. The membership included:

Director of Nursing & Operations, Chair
Lead Nurse, Deputy Chair
Medical Director
Head of Risk Management
Associate Medical Director
Clinical Leads
Head of Security
Senior Psychologist
Person Centred Improvement Lead
Skye Centre Manager
Head of Clinical Quality
Head of Corporate Planning & Business Support
Clinical Quality facilitator

3 Summary of Core Activity for the last 12 months

Clinical Quality Update

The Clinical Quality Department played a key role, in the first year of the Group, in ensuring the infrastructure was in place to ensure that the quantitative data were easily accessible through tableau and RiO. They worked with the Information and Business Intelligence Team to ensure the dashboards, both in Tableau and Rio were fit for purpose and would allow staff to measure if any tests of change had resulted in improvements. This was a considerable amount of work for both departments, but the end result now allows all staff to be able to measure activity at a patient and operational level.

2024, saw Clinical Quality and the Business Intelligence Team take this one step further and enhance the tableau dashboards so the patients who have had no physical activity or timetable activity over the course of the week are easily identified. This could be done before, but it was a very cumbersome process and saw Clinical Quality having to go into another system (RiO) to access this data. This now allows easier access to this information and the Service Leadership Teams are provided with the names of the patients so they can discuss ways to encourage these patients to engage more.

Over the last 12 months, Clinical Quality also worked with the Service Leadership Teams to understand which of the existing data indicators were most helpful to them and which were adding very little/no value to their discussion around activity and decisions about patient recovery. As a result of these discussions, changes to the tableau dashboards were made taking out the indicators that were adding very little value and replacing with

Table 1: Activity and timetable data from tableau

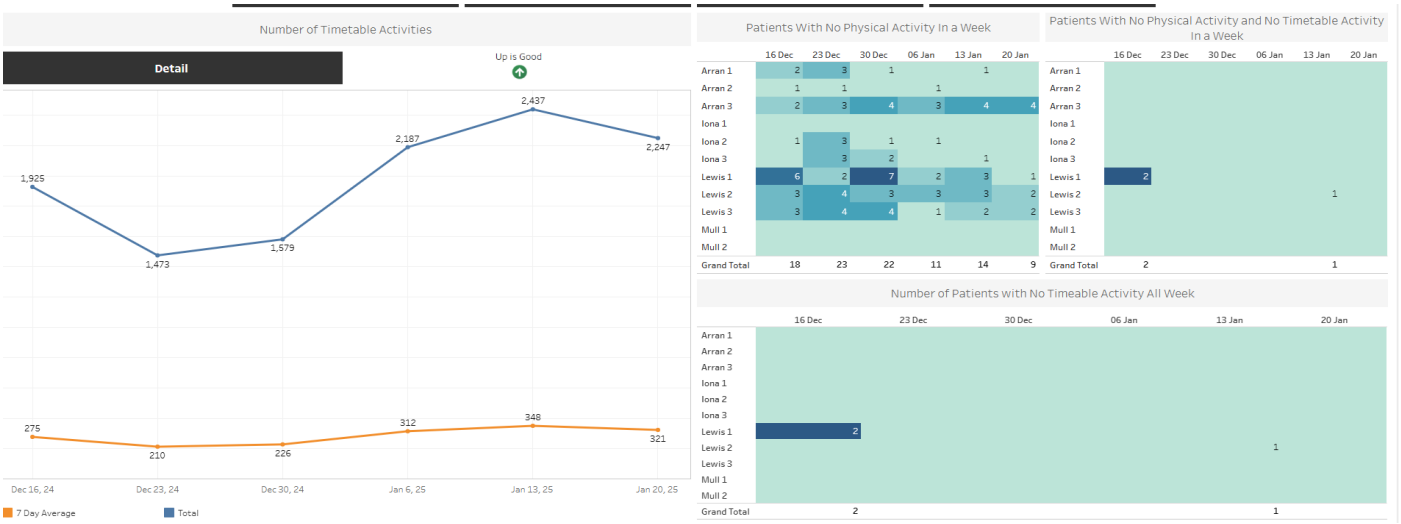


Table 2: Timetable and phone calls data

Scheduled Activities

	16 Dec	23 Dec	30 Dec	06 Jan	13 Jan	20 Jan	Grand Total
Scheduled Activities that did go ahead	307	179	250	482	587	569	2,374
Scheduled Activities that didn't go ahead	429	542	480	258	177	192	2,078
% That went ahead	41.71%	24.83%	34.25%	65.14%	76.83%	74.77%	53.32%
Form not completed so we dont know	13	11	18	30	22	22	116

Phone calls - Number of Activities(No of Patients)

	16 Dec	23 Dec	30 Dec	06 Jan	13 Jan	20 Jan	Grand Total
Arran 1	4 (4)	1 (1)	6 (4)	1 (1)	2 (2)	3 (3)	17 (8)
Arran 2	17 (8)	28 (10)	21 (6)	16 (7)	25 (9)	13 (5)	120 (12)
Arran 3	14 (5)	7 (6)	3 (3)	13 (6)	14 (4)	13 (5)	64 (7)
Iona 1	2 (1)	2 (1)	1 (1)	2 (1)	2 (1)	2 (1)	11 (1)
Iona 2	9 (4)	13 (4)	15 (5)	9 (3)	13 (5)	6 (4)	65 (5)
Iona 3	7 (5)	14 (6)	11 (5)	15 (6)	17 (6)	20 (6)	84 (6)
Lewis 1	0 ()	0 ()	3 (3)	7 (5)	8 (7)	25 (9)	43 (11)
Lewis 2	10 (6)	12 (7)	4 (4)	7 (6)	5 (3)	9 (6)	47 (8)
Lewis 3	14 (6)	11 (8)	11 (6)	8 (5)	6 (4)	11 (4)	61 (10)
Mull 1	23 (8)	22 (7)	51 (8)	39 (9)	41 (9)	12 (5)	188 (9)
Mull 2	33 (8)	35 (8)	14 (7)	15 (6)	25 (10)	13 (6)	135 (10)
Grand Total	133 (55)	145 (58)	140 (52)	132 (55)	158 (60)	127 (53)	835 (86)

Reason for non- attendance

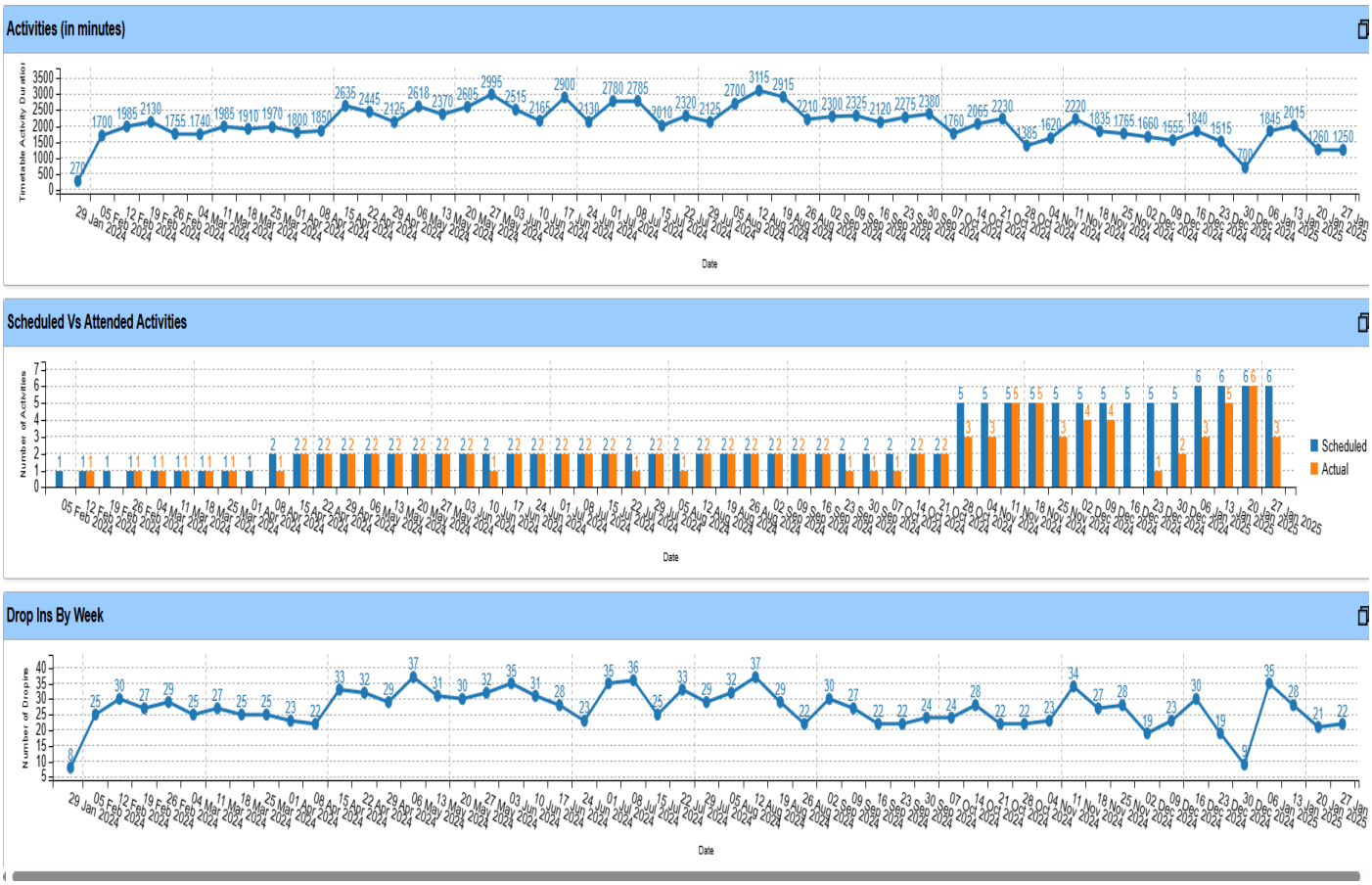
	16 Dec	23 Dec	30 Dec	06 Jan	13 Jan	20 Jan	Grand Total
Not Entered	15	24	12	3	6	2	62
Admin Error	1	0	4	0	0	0	5
Attending Other Services	38	1	0	5	12	6	62
Bad Weather	0	0	0	0	0	71	71
Declining to Engage	11	12	17	13	19	21	93
Department Closures	202	99	65	126	35	15	542
Facilitator on Leave	11	15	39	9	7	16	97
Other (please define in comments)	99	363	303	36	14	18	833
Outing	1	2	4	4	11	6	28
Poor Mental Health	26	8	12	27	14	13	100
Poor Physical Health	6	7	10	19	16	13	71
Professional Appointment	8	2	0	5	5	3	23
Shopping List Provided	10	3	13	6	17	5	54
Unable To Staff	0	2	0	0	16	0	18
Visitors	1	4	1	5	5	3	19
Grand Total	429	542	480	258	177	192	2,078

Activities Table - Number of Activities(No of Patients)

	16 Dec	23 Dec	30 Dec	06 Jan	13 Jan	20 Jan	Grand Total
Ward Quiz Night	4 (4)	38 (23)	25 (22)	6 (5)	0 ()	2 (1)	75 (36)
Ward Craft Activities	7 (6)	11 (4)	1 (1)	8 (5)	8 (2)	11 (4)	46 (11)
Ward Card/Board Games	66 (32)	77 (36)	65 (35)	122 (43)	129 (47)	125 (42)	584 (74)
Ward Bike	18 (7)	10 (5)	28 (8)	12 (3)	17 (7)	8 (4)	93 (13)
Walking-running for exercise (grou..	23 (20)	53 (31)	14 (14)	26 (22)	26 (17)	27 (25)	169 (64)
Walking Group	22 (10)	22 (13)	17 (9)	22 (14)	16 (9)	21 (13)	120 (23)
Walking for exercise (ward)	77 (32)	96 (25)	94 (31)	122 (36)	129 (49)	125 (42)	603 (63)
Walking Football	29 (16)	18 (7)	21 (10)	23 (11)	21 (9)	18 (6)	130 (16)
Walking 1-2-1	6 (5)	3 (2)	5 (5)	8 (6)	8 (6)	8 (5)	39 (15)
Volunteer Role (Sports)	24 (5)	20 (5)	19 (5)	22 (5)	18 (5)	21 (5)	124 (5)
Volunteer Role (Library)	10 (5)	10 (5)	10 (5)	12 (5)	14 (5)	14 (5)	70 (5)
Volunteer Role (Charity Shop)	3 (2)	4 (2)	4 (2)	4 (2)	5 (2)	5 (2)	25 (2)
Volunteer Role (Café)	15 (2)	12 (2)	14 (2)	8 (2)	10 (2)	6 (2)	65 (2)
Volleyball	45 (18)	28 (9)	30 (9)	39 (16)	31 (12)	25 (9)	198 (20)
Visitor:Advocacy	1 (1)	0 ()	0 ()	2 (2)	0 ()	3 (3)	6 (6)

With the upgrade of RiO, it was possible to create individual patient dashboards (Table 3) that all members of the clinical team can access. These sit on the front page of RiO and are easily accessible. They show the number of minutes the patient has spent taking part in activities for the week (planned and drop-ins), how many of their scheduled activities went ahead. The Activity Oversight Group have worked hard to try and put in processes to minimise the number of cancelled activities that patients experience. The final chart shows the number of drop-in activities that the patient has attended. In the example below, we can see that week beginning 6th January, the patient had 6 planned activities, with 3 of these not going ahead. Although the patient had 3 cancelled planned sessions, we can also see that he had 35 drop-in activities (this included drop-ins at the Skye Centre and using his grounds access). In total, he spent almost 31 hours doing activity.

Table 3



Clinical Quality continued to provide a flash report to every meeting, all reports included the strapline "Activity *is Everyone's Business*" as a reminder that activity is an integral part of the care and treatment we provide and the collective responsibility to achieve our objective.

The flash report included information on:

- Data showing improvement since the last report
- Data showing concern from the last report
- Areas with sustained levels
- Areas that have been worked on in relation to systems
- Any challenges with systems that are being addressed
- Any support that Clinical Quality need from the Activity Oversight Group to move forward with specific pieces of improvement work

The flash report not only contains data on the number of activities that have been provided but also includes some context on factors that may have contributed to the data that is within the activity report.

An excerpt from the flash report presented to the December OAG meeting can be seen below where Clinical Quality brought to the attention of the Group that there has been an increase in the median number of patients not accessing physical activity and also information on the services with patients that has not accessed fresh air (this had been reported to the SLTs within their flash reports with the names of these patients).

Table 4

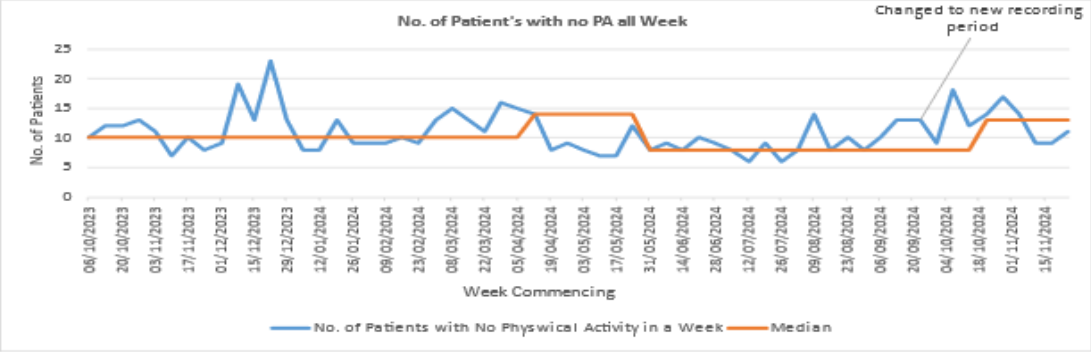
CLINICAL QUALITY FLASH REPORT TO ACTIVITY OVERSIGHT GROUP

Date: October & November 2024

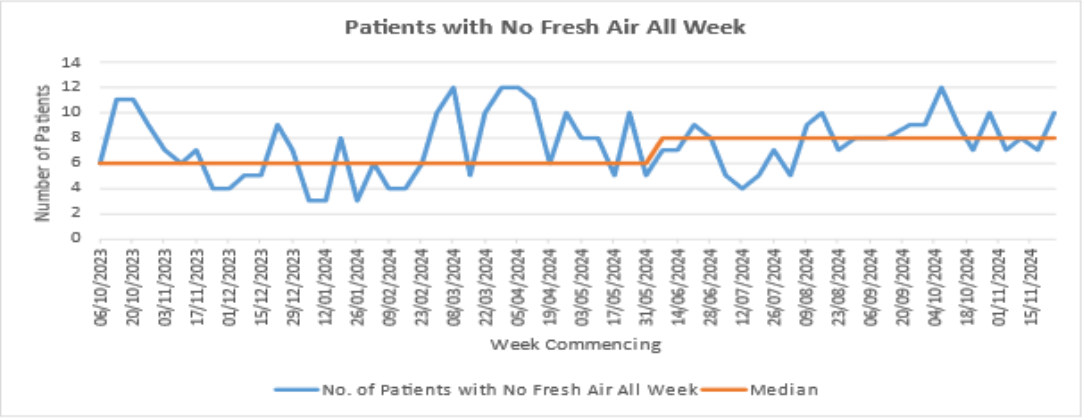
Data for discussion

The indicator data continues to show random variation hospital wide.

The indicator that looks at the number of patients that have had no physical activity at any point in the week saw an increase to the median from 8 to 13 week beginning 21st October. In recent weeks we have seen an improvement with this indicator with 9,9 and 11 patients across all services not accessing physical activity.



The indicator looking at the number of patients not accessing fresh air at any point of the week remained with a median of 8, with 3 weeks over the reporting period going into double figures. There was one patient in T&R that did not access fresh air for the 2 month reporting period, and 2 patients in ID that have not accessed fresh air over the month of November.



It should be noted that Clinical Quality monitor a significant number of indicators weekly that allows them to see any shifts, runs or trends in the data that require highlighted to the Activity Oversight Group.

The first year of the AOG allowed Clinical Quality to put the infrastructure in place to allow staff to measure activity across patients, wards and services. The current reporting year allowed us to review the indicators that had been agreed at the outset of Covid, review these, and streamline to the more meaningful ones for the Service Leadership Teams. The development of patient identifiable dashboards on Tableau has allowed Clinical Quality to provide more specific named data to the SLTs in a less resource intensive manner with the SLTs discussing this data with a view to improving patient engagement.

The final piece of work that Clinical Quality has been taken forward with the Lead Nurse and a small sub-group at the latter part of the year was the review of the overall timetable to streamline the number of options within this to make it less cumbersome for staff to complete. At the start of the current project there were 176 activities on the timetable that the staff had to scroll through to try and find the one the patient had engaged with. This has been streamlined down to 79 with the titles changed to include a pre-fix for the area to make it easier for staff to find. An excerpt is below in table 5. The recovery categories have also been reviewed as part of this project so SLTs can have data by individual activity or as a bundle e.g. physical. This project will conclude in 2025 with the reviewed timetable being implemented.

Table 5: Excerpt of reviewed activities on the timetable

Physical: 1:1 Escorted Walks
Physical: Grounds Access
Physical: Open Hub
Physical: Patio
Physical: Walking Group
Physical: Walking-running for exercise
Psychology: Anxiety Management
Psychology: Awareness & Recovery
Psychology: CBT for Personality Disorder
Psychology: CBT for Psychosis
Psychology: CBT Other

Further detail on the work of the Clinical Quality Department is demonstrated within the quality assurance and quality improvement sections of this report.

Skye Centre Update

The Skye Centre provide the AOG with a variety of data to measure the activity levels of patients and identify areas for improvement. The focus has been on ensuring planned versus actual is at a good level. There has also been a more in-depth look at the individual services to ensure any issues to attendance as well as opportunities for improvement are identified and actioned.

Chart 1 below provides an overview of the number of attendances over the past 12 months – January - December 2024. The table provides a comparison of the planned versus actual activity delivered, with the additional drop in activities also included. Over the past 12 months the service has delivered an average of 71% of planned activity, an improvement from an average of 63% the previous year. The timetable across all of the activity areas has been reviewed over the past three months with a more consistent service delivery and reduction in centre closures being reported during this period.

Chart 1

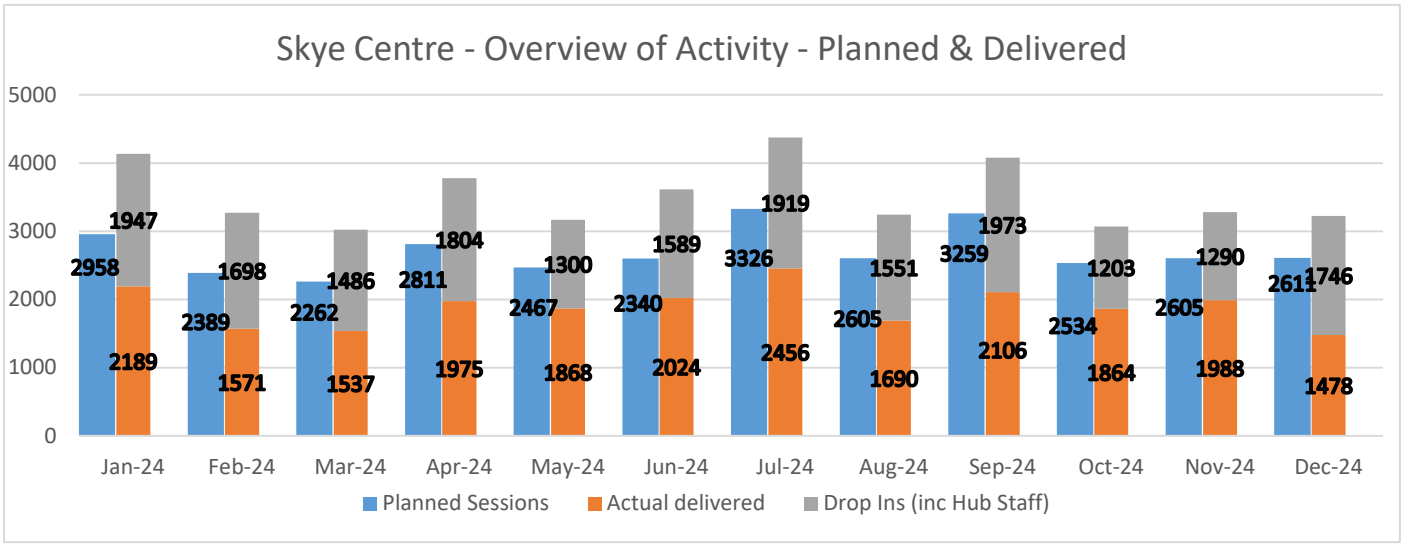
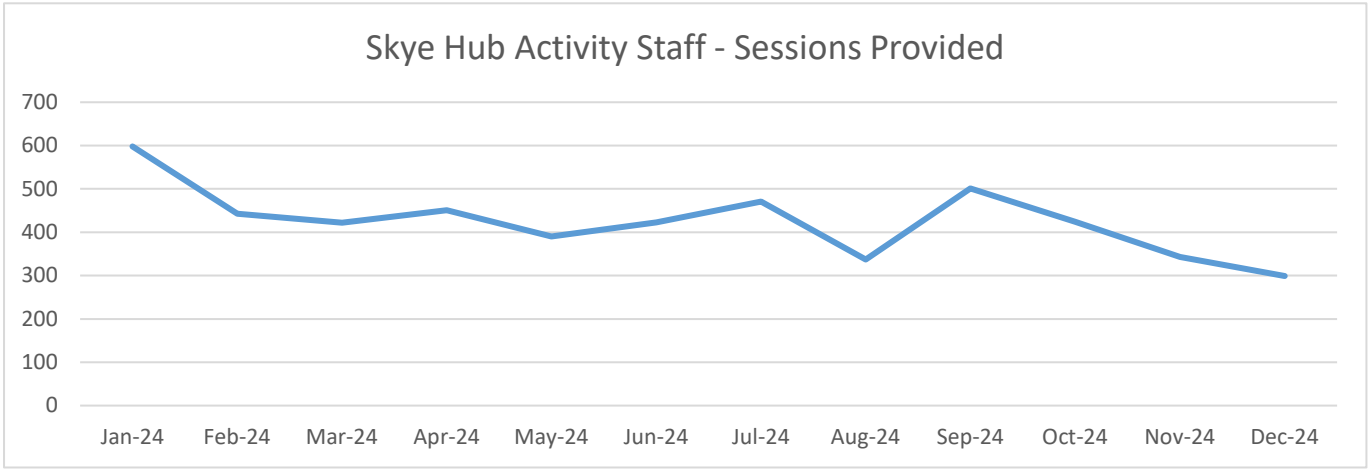


Table 6 - Sessions delivered by Department (including drop ins)

	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Atrium	1592	1085	996	872	1011	1201	1617	1324	1377	957	1061	994
PLC	305	227	268	405	360	380	427	335	358	359	399	184
Sports	1010	886	735	1153	883	946	1088	812	1042	717	732	725
Crafts	403	312	338	313	409	398	384	196	434	340	386	312
Gardens	295	254	237	304	282	223	390	304	339	286	297	292

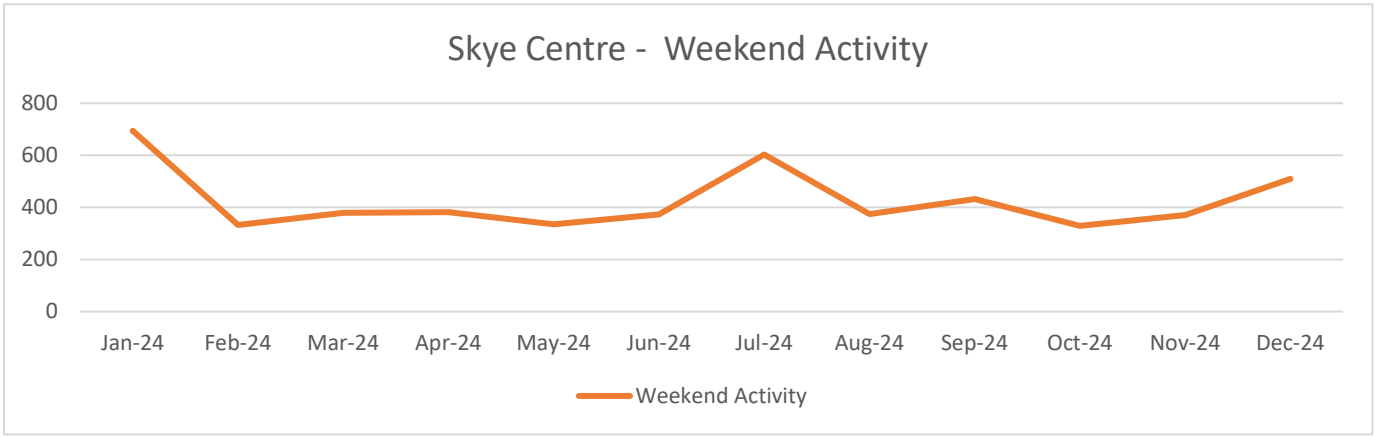
Hub Activity Staff Role & Remit – The timetable of activity for this staff group has also been reviewed. The activity is projected a week in advance and delivered reflecting the 5 over 7 shift roster. As a consequence there are variations to the number of sessions provided, as evident in Chart 2. The Hub staff group have been integrated with the Atrium staff group supporting a more consistent service delivery across the Skye Centre, Hub and wards.

Chart 2



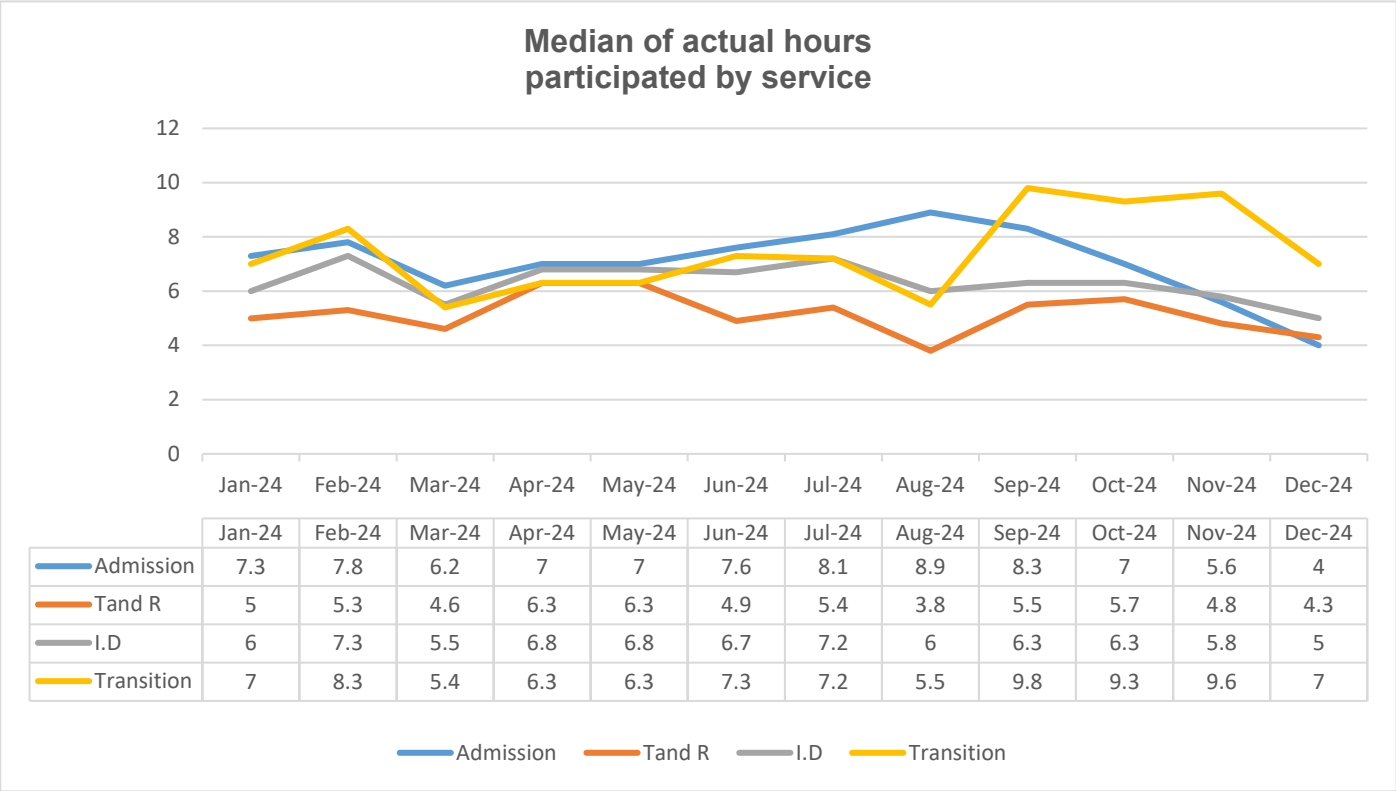
Weekend Activity – The delivery of weekend activity has fluctuated over the past 12 months (Chart 3). Activity is provided in the Skye Centre Atrium on a drop in basis in the mornings and staff are reallocated to resource weekend visiting in the Family Centre in the afternoons. This change came into effect at the end of January 2024, a registered nurse is provided from the ward resource to support the delivery of activity.

Chart 3



Medium of Actual Hours – Chart 4 provides details of the number of actual hours participated in by clinical service across the past 12 months. The Skye Centre timetable was reviewed in January 2023 and the duration of sessions were standardised to 1-hour slots, prior to this the duration of sessions varied. Throughout the past 12 months the number of hours participated in has remained fairly constant across each clinical service however the number of hours related to the Transition service has increased over the past three months.

Chart 4

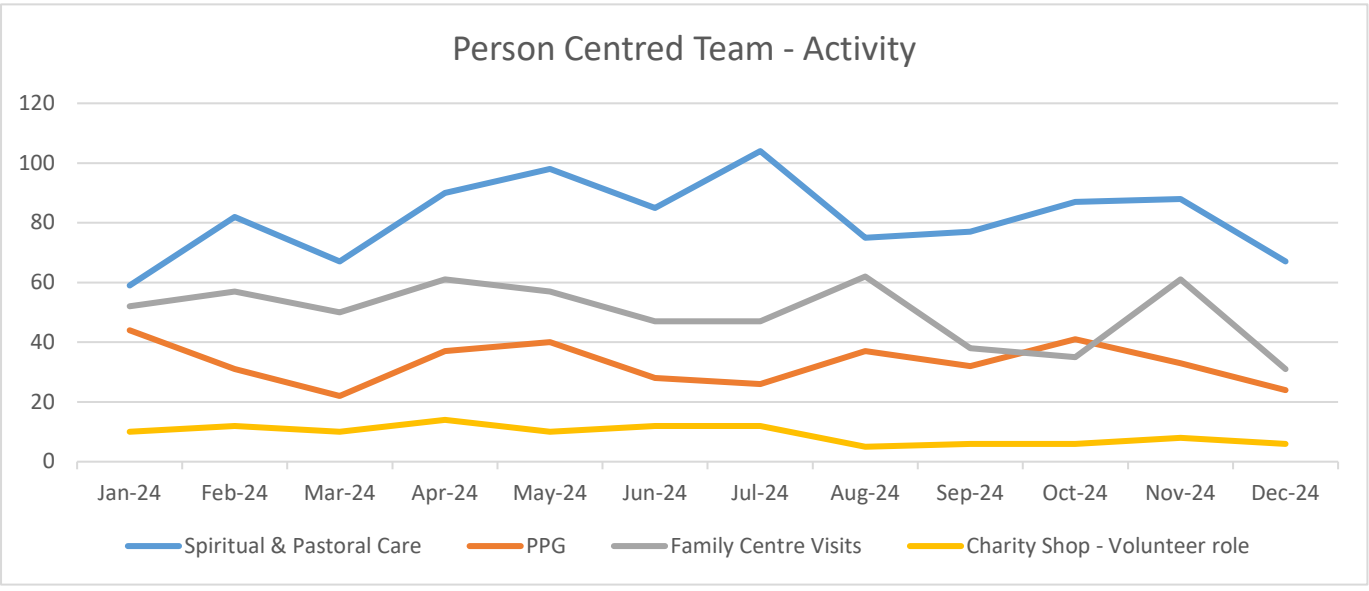


	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
Admission	7.3	7.8	6.2	7	7	7.6	8.1	8.9	8.3	7	5.6	4
Tand R	5	5.3	4.6	6.3	6.3	4.9	5.4	3.8	5.5	5.7	4.8	4.3
I.D	6	7.3	5.5	6.8	6.8	6.7	7.2	6	6.3	6.3	5.8	5
Transition	7	8.3	5.4	6.3	6.3	7.3	7.2	5.5	9.8	9.3	9.6	7

The Person Centred Improvement Team (PCIT) is now managed as part of the Skye Centre and their contribution to patient activity is included in the Skye Centre Report.

The activity facilitated by the Person Centred Improvement Team is detailed in chart 5 below. This team support the delivery of our Spiritual & Pastoral care groups, the attendance at which tends to fluctuate but as indicated attendances have continued to increase across the 12 months. With regards to visits, the increase during the months of December, April to July and November are attributed to the increased number of child visits arranged over these periods.

Chart 5



Sports first launched the Couch to 5k initiative two years ago which was a great success. This year, 18 patients participated with progress being recorded via a chart in Sports that participants can view, which aids in peer support and encouragement. This year's challenge started on Tuesday, 26 March 2024 and runs for 12 weeks, with patients' efforts culminating in an Outdoor 5K event on Thursday 27 June 2024. This was a very successful event and enjoyed by both participants and spectators. Thanks noted to all the staff and patients who took part and those who helped to organise this event. Further events planned in the coming months.

A Euro Football themed evening event is was held in the Atrium for patients during June, incorporating the live football and a range of social activities.

In terms of the RiO timetable project, information was obtained to identify the number of errors occurring in the entry of activity patients attended. The aim of this project was to focus on duplication of activity entries that effected the Skye Centre activity departments. The project aim was "By March 2024 all clinical staff will reduce errors on Rio timetables by 50%". To date, there has been a slight reduction in errors noted however work is ongoing to further reduce the number of duplicated activity entries across all services, including the Skye Centre.

As the Clinical Model is evolving the Service Leadership Teams (SLT) have been considering the levels of support their patient groups require in relation to activity. The Skye Centre Leadership Team through their development sessions are working to identify their service strategy which will include the service provision available from the Hub Activity staff. We will work in collaboration with the SLT's to support the delivery of activity for their respective patient groups.

Room 4U (previously referred to as Facility Time)

Room 4U are periods (up to one hour twice per day if an individual wishes this) or time out agreed as part of an individual's care plan. The Transitions service are testing out a more relaxed approach to Room 4U supporting patients in organising and filling their days and making positive choices regarding how they use their Room4U time. The Treatment and Recovery service are also currently testing incentives such as undertaking exercise using grounds access to gain additional Room 4U, this is part of a quality improvement project and will be evaluated later this year.

DTC

The DTC SLWG was to establish the root causes of DTC, establish a reliable data set to quantify the extent of the issue and measure improvements and to return DTC to a never event.

It was agreed at CMT on 7 August 2024, that the DTC SLWG has fulfilled its function and the remaining work would be overseen by AOG from a quality improvement perspective and operationally by OMT. This would be temporarily in place until all outstanding pieces of work have been concluded at which point DTC would be classed as a never even and managed through business continuity.

The AOG has met twice since taking over this role (Oct & Dec) and continues to work with the service leadership teams to use the data provided to support the reduction and eventual elimination of DTC. Other identified contributing factors to the occurrence of DTC such as sickness absence, vacancy and retention, including recruitment of outings staff will continue to report through NDWFG.

The table in Figure 1 shows the levels of DTC from January 2024 – 30th December 2024, DTC ranged from 0 - 800 hrs per week during the reporting period. The table also highlights events which have contribute to the occurrence of DTC and factors such as increasing activity and recruitment of staff which have affected positive change. The notable spike in instances of DTC is largely attributed to a combination of staff resourcing requirements (particularly during peak holiday periods) and the increased clinical acuity resulting in the use of SRK, seclusion and enhanced care plans.

Figure 1.

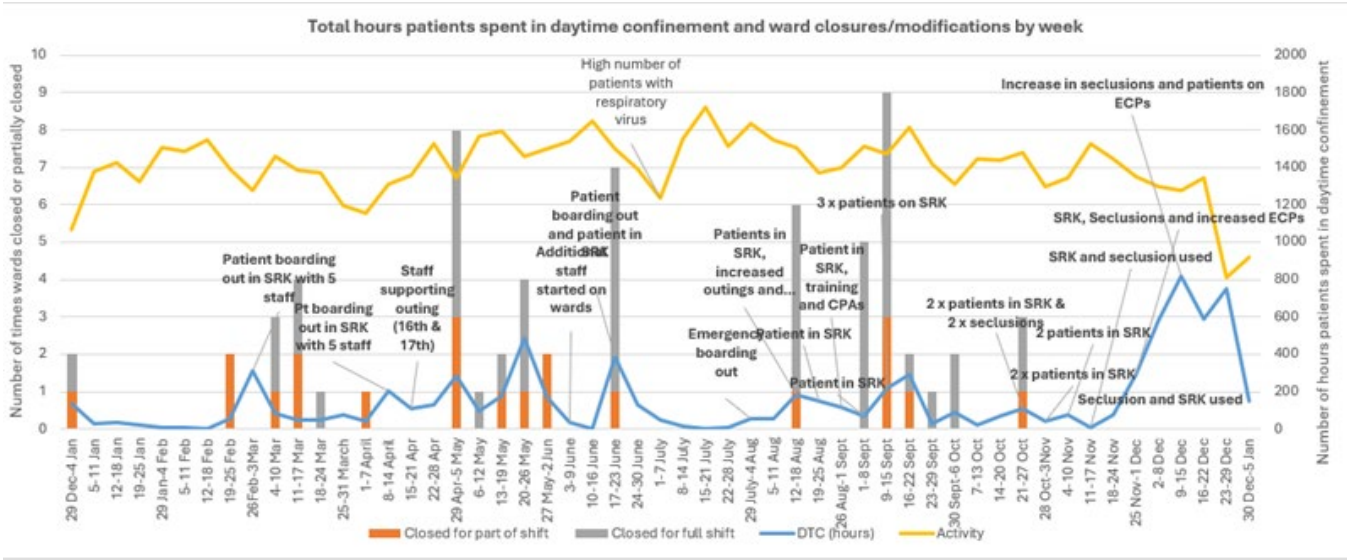
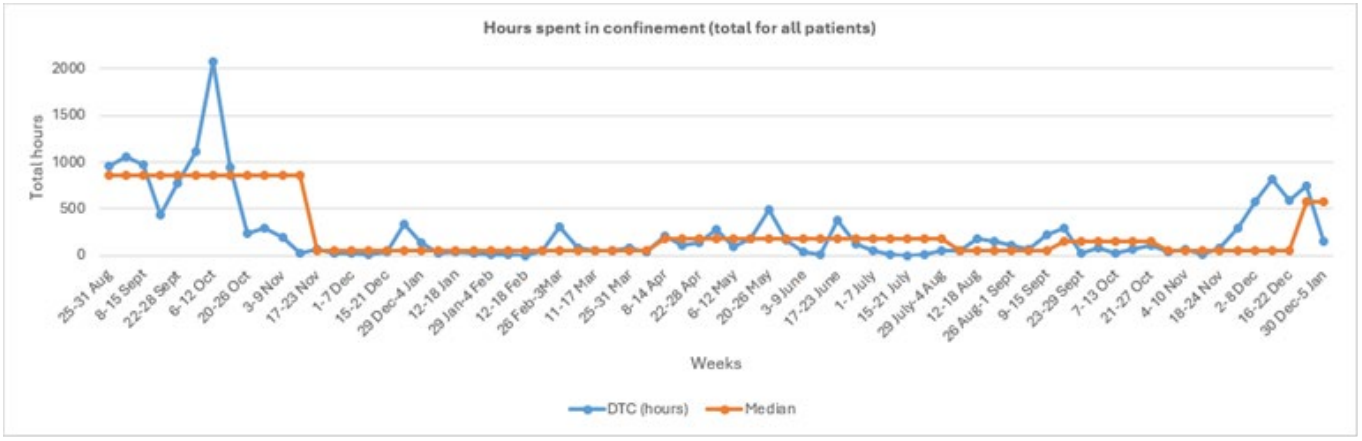


Figure 2.



The data set provided can now be drilled down to individual patient level. The AOG are supporting the service leadership teams to “own” this data and identify ways to reduce DTC as well as report impact on services and individuals. Recent data has shown there is a disproportionate impact on some services and variation within services. This is currently being explored and will be a focus going forward.

4 Comparison with Last Year’s Planned QA/QI Activity

Last year, the focus of the AOG moved away from assurance to improvement, focusing on the key areas of concern highlighted by the wealth of data collected in recent years. This provided a strong foundation from which the AOG has used and developed further with a focus moving to service led as opposed to the site wide approach with shared priorities. By enabling services to identify their own priorities we are able to continue a focused approach and concentrated effort on service specific key areas, which will have maximum impact. The recognition that activity does not just happen at the Skye Centre but on Hub reinforces the collective responsibility throughout the organisation regarding ensuring access to activity. The quality improvement methodology, continues to support the stakeholders to understand what the aim was and identify an agreed programme for change.

Key areas of focus during 23/24

- Develop measure definitions for KPIs and test these - this has been completed through corporate planning and performance.
- Engagement with Service Leadership Teams to build the will for the KPI and agreed standards for each service. – Ongoing will continue to progress this year

- Each service to look at timetable data and identify where they would like to see improvements- Work ongoing and all services engaged in this hope to have in place by summer 2025.
- Think about interest checklist and looking at in partnership with security - have an adapted version for admissions and a longer version for the other services, now implemented.

5 Performance against Key Performance Indicators –

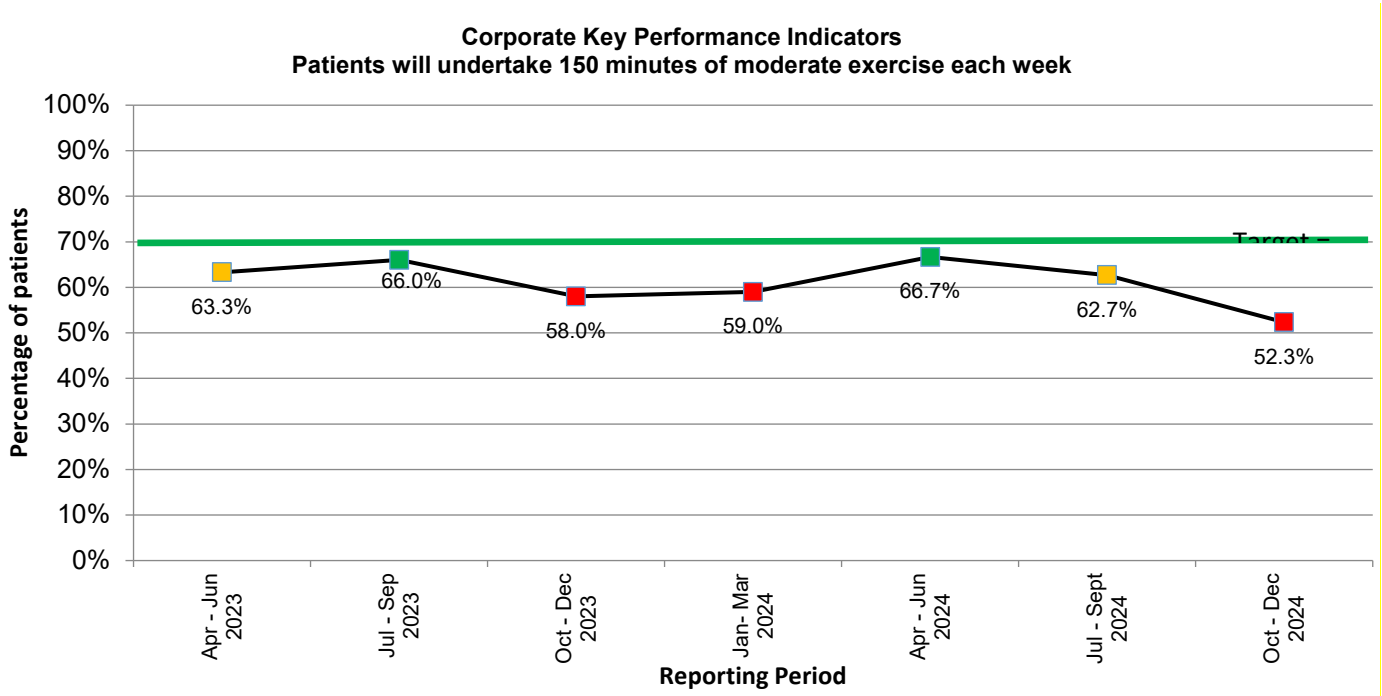
Assurance for the measurement of activity at the corporate level is carried out through the Corporate KPI's which are reported on 1/4ly to TSH Board. The current corporate KPI's for activity are:

- 70% of patients will undertake 150 minutes of exercise each week
- 90% of patients will be engaged in off-hub activity centres, this incudes drop-in sessions which take place in hubs, grounds and Skye Centre

70% of patients will undertake 150 minutes of exercise each week

This data is recorded and calculated when patients participate for more than 10 minutes of moderate activity and does not include patients being escorted / or using grounds access to and from the Skye Centre (unless it has been agreed by the patient's keyworker). It does include all other types of physical activity as per the timetable e.g. escorted walks, grounds access, football, hub gym.

Table 7

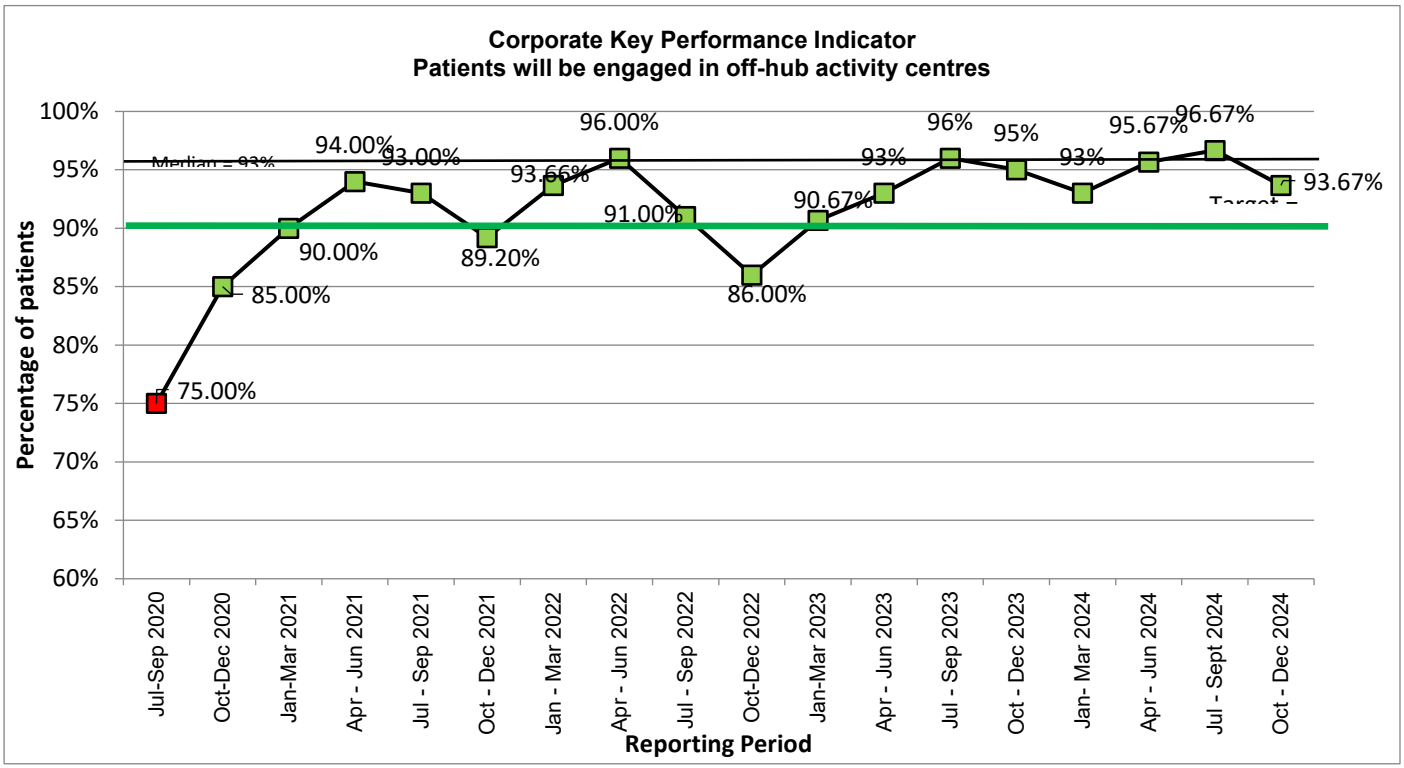


90% of patients will be engaged in off-hub activity centres, this incudes drop-in sessions which take place in hubs, grounds and Skye Centre

This KPI has been above the target of 90& since the start of 2023.

Service Based Activity

Table 8



Quality Assurance Activity

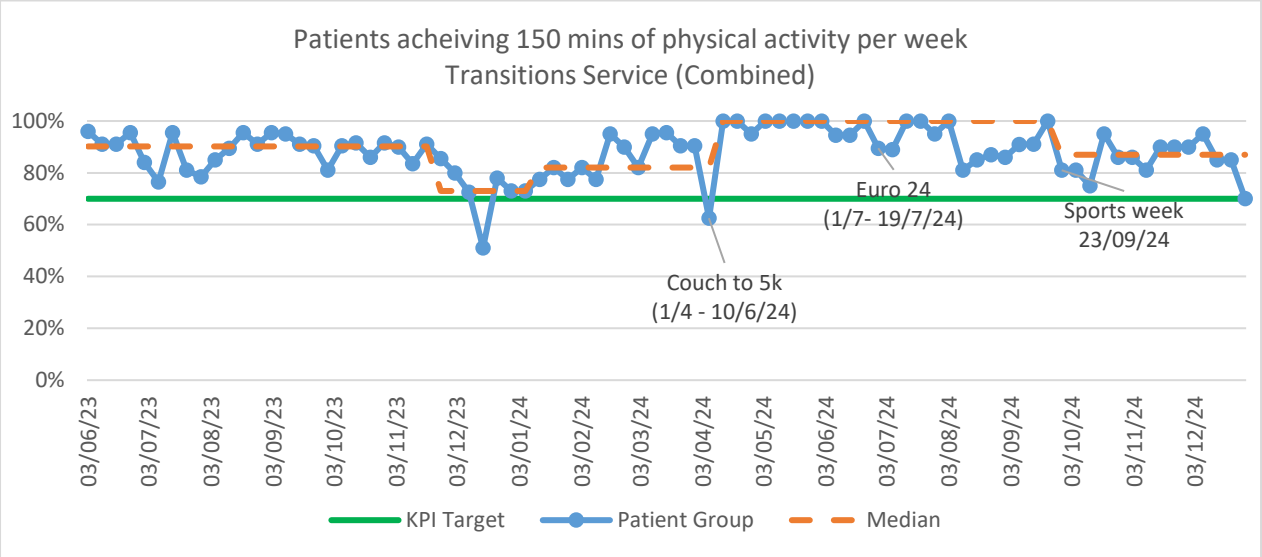
Clinical Quality continue to monitor a number of indicators weekly from the tableau dashboards and other hospital systems, to give assurance the systems and processes within the hospital are remaining in control with no shifts, trends or runs being noted. The indicators continuously monitored include:

- Episodes of daytime confinement (DTC)
- Number of hours patients spend in DTC
- Number of patients making calls
- Number of patients not accessing physical activity
- Number of patients using SRK
- Number of patients with 150 minutes of physical activity
- Number of Pts with no fresh air all week
- Number of Pts with no physical activity all week
- Number of pts with no timetable all week
- Number of seclusions
- Outings
- Patients on ECPs
- Percentage of planned that went ahead
- Staff required for outings
- Staff required for patients on ECPs
- Staff shortages Back
- Staff shortages Day
- Staff shortages Night
- Total number of planned activities that did not go ahead
- Total number of planned activities that went ahead
- Total number of timetable activities
- Total patients having PRN administered
- Total PRNs administered
- Total telephone calls

Although not all of these indicators are directly related to activity, all can impact on the activity the hospital is able to provide to their patients and are collected to give context to the data being measured.

The indicators are broken down to service level on a weekly basis with this data being monitored through the Service Leadership Teams, by exception (Table 9). Clinical Quality is a member of all the Service Leadership Teams.

Table 9



5 Quality Improvement Activity

There have been a number of quality improvement projects that have been taken through the Activity Oversight Group in the last year:

Physical Activity Forms

It was noted within a Clinical Quality flash report that there was a lot of duplication for staff on the wards when entering physical activity. If a patient left the ward to go out for a walk, the staff had to enter the amount of time the patient walked on a physical activity form within RiO and then go into the timetable section within RiO to add the walk as a drop-in and again enter the amount of time they had been walking.

Clinical Quality worked closely with the Information and Business Intelligence Team to make some required adjustments to the timetable categories that would allow ward staff to only complete the timetable when a patient had any form of physical activity. This was a significant piece of work for both teams, as the KPI target for physical activity was coming from the physical activity forms. All activities within the timetable had to be categorised into activities that resulted in physical activity (e.g. football, gym, walking) and those that did not (e.g. psychological therapies, arts and crafts), and then new reports written to ensure the data was robust. The project included a communication plan to all wards and departments to ensure they knew the new way of working that was being implemented.

This has now been successfully implemented, and Clinical Quality continue to monitor this data to look at any trends, variations across service etc and report this through the Service Leadership Teams and by exception to the Physical Health Steering Group and Activity Oversight Group.

6 Stakeholder Experience

The Activity Oversight Group (AOG) continue to hear patient, carer and volunteer feedback via the Skye Centre Manager, forming an integral part of the standing agenda items, ensuring stakeholder feedback is shared, discussed and acted on without delay. There is clear evidence of a positive organisational response to feedback from patients, carers and volunteers that, informs ongoing service delivery.

A wide range of methods continues to be utilised to share feedback. Members of the Person Centre Improvement Group (PCIG), the Patient Partnership Group (PPG), carer and volunteer representatives adopt a proactive approach to ensure that the organisation is aware of the experience of those impacted by service delivery.

PPG membership encompasses all wards, with the meeting held weekly to share their views and engage in solution focussed sessions with the agenda aligned to support ongoing patient engagement in a variety of key TSH projects such as the Clinical Service Delivery Model, Supporting Healthy Choices and Daytime Confinement.

The PPG Patient Chair provides an update to the PCIG on a monthly basis for review and discussion. PPG members are tasked with collating and sharing feedback received from peers within their ward and provide updates on the discussions and decisions made at the weekly ward Community meeting which further supports communication.

The ward community meetings were re-established in April 2024. The feedback from the meetings is displayed on ward notice boards for the patients to view and the format is focussed on the What Matters To You initiative – You Said, We Did, The Difference It Made. The remit of the meetings is as follows:

- To demonstrate how stakeholder feedback contributes to improvements to service delivery
- To promote, co-ordinate and collate outputs from the ‘What Matters to You?’ initiative, evaluate and monitor outputs arising from ward action plans
- Plan and create ward based activity timetable and events schedule

Table 10 below provides examples of Community Meeting and PPG feedback related to the provision of activity and the steps taken by in response.

Table 10: **Patient Feedback related to Activity**

You Said	We did	The difference it made
Patients requesting Table Tennis table to be utilised within ward.	Advised that ward can look at a weekend period for being able to facilitate this activity but there will be factors to consider in relation to clinical activity, staffing resource aspects. Ward staff reviewed upcoming rosters and scheduled dates for Table Tennis evenings to take place.	Positive feedback received from patients that they enjoyed the activity.
Patients listed several activities they would like to have on ward: Bingo, Film Nights, Karaoke, carpet bowls, quiz nights etc.	It was agreed that an activity timetable will be completed and prizes for specific activities (Quiz Nights, Bingo) will be provided out of ward budget. Bingo machine was borrowed from another Hub to support the activity.	Positive feedback received from patients that they were involved in developing the timetable. PPG rep provided feedback that the Bingo and Quiz were enjoyed by patients and ward staff were thanked for organising.
PPG reps for Mull advised that the hub does not have a table tennis table and this is one of the most popular activities in the Hub. Request for SCNs to consider purchasing a new one or moving one from a Hub where it is not used.	Lead Nurses were contacted to enquire it was possible to move one of the tables however it was advised that this was not possible as they are used regularly. Members of the group raised this again and funding was identified within the Corporate budget to purchase a new table. The new table is now located in Mull.	Patients were delighted with the arrival of the new table tennis table and provided feedback that this is being used regularly in the hub and inter-ward table tennis competitions are taking place with great success.
Enquiry and concern raised at PPG regarding the wander/running paths not being available during grounds access times. The paths are beginning to subside making it difficult under foot.	Estates department were contacted and confirmed that the wander paths are currently not suitable to be used due to damage caused by flooding and inclement weather causing subsidence. Work was scheduled to make improvements and commenced in April and May 2024.	Patients confirmed at PPG that the work carried out on the wander paths now allowed patients to access this area for walking. These improvements had also supported a small group of patients to establish a running group on Saturday mornings with patients reporting their enjoyment participating in this activity and also reported benefits to their mental and physical health.
Patients across several wards enquired if the Skye Centre could be opened in the evenings.	Feedback was provided that the focus of the Skye Centre Resource is presently on providing the delivery of activity Monday to Friday. However consideration was given to providing themed social events in the evenings over the summer months – i.e. Euros Football Evening	The events were very well attended by patients and positive feedback was received from both patients and staff that they enjoyed participating.

Planned Quality Assurance/Quality Improvement for the next year

On review, the members of the group felt that the format of the group and the focused QI approach were working well. The group recognised that this work began prior to the implementation of the clinical model and that if looking site wide we could miss how individual services are impacted. Therefore, there was an agreement that we would identify the KPI's and all four services would report against them. The annual report demonstrates the considerable amount of work involved to progress the agenda so far and much of the infrastructure developed will continue to support future development. This group also agreed that the continued partnership working with patients and their clinical teams is crucial to ensuring the activities provided are aligned.

Next steps for 25/26

- Continue to engage with Service Leadership Teams to build the will for the KPI and agreed standards for each service.
- Each service introduce the reviewed Timetable to all services, for more meaningful data.
- Continue to support the services to reduce DTC and impact on Patients.
- Increase base line of provided planned activity not Planned v Actual more consistent.
- Continued development of off hub activity appropriate for each service.
- Continued development of Activity Winter Plans and incorporate these into ongoing planning cycle.

Appendix 1

The State Hospital's Board for Scotland
Terms of Reference
Activity Oversight Group

1. Purpose

The Activity Oversight Group (AOG) formerly known as the OMMG, will provide monitoring and oversight regarding patient activity and factors which may impact on access to activities which are classified under the following headings:

- Therapeutic
- Physical
- Education
- Assisted Daily Living

The data collected through this forum will link with the strategic objectives and performance indicators.
The group will consider anything, which may impact on access to activities and explore opportunities to maximise the availability and uptake of activities. Ongoing feedback from patients, carers and volunteers will inform priorities to supporting patient activity.

The group will use the data gathered to support decision-making and focussed areas of quality improvement work.

2. Membership

Director of Nursing & Operations, Chair
Lead Nurse, Deputy Chair
Medical Director
Head of Risk Management
Associate Medical Director
Clinical Leads
Head of Security
Senior Psychologist
Person Centred Improvement Lead
Skye Centre Manager
Head of Clinical Quality
Head of Corporate Planning & Business Support
Clinical Quality facilitator

Due to the remit of the group, only senior deputies with authority to make decisions will be considered. These need to be discussed and agreed by the AOG.

3. Reporting structure

The group will report into the Clinical Governance Group (CGC) and the Operational Management Team (OMT). There will be standardised reports from the Skye Centre and the 4 HLTs. There will also be an annual report which will be tabled at the CMT, this will detail progress and identify following year's priorities.

4. Chair

The Chair of the AOG is the Director of Nursing and Operations. The Deputy Chair, Lead Nurse, will chair in the Chair's absence.

5. Quorum

50% attendance required for group to be Quorate.

6. Agenda and Frequency of meetings

The group will meet monthly.

7. Servicing arrangements

Admin support - There will be a standard agreed agenda. Minutes of meetings and a rolling action list, shall be prepared by the DoN's PA and will be circulated to all members, along with the agenda and associated papers for the next meeting, no less than 5 days prior to the next meeting.

8. Escalation

AOG chair will be responsible for escalating any matters to the CGG and/or the OMT.

9. Review

These Terms of Reference are to be reviewed annually.

Appendix 2 – Revised Driver Diagram