Healthcare Improvement Scotland

SCOTTISH PATIENT SAFETY PROGRAMME

Scottish Patient Safety Programme
Acute Adult Collaborative 2021–24

Full impact report

December 2024

SPSP24/7

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Executive Summary

Background

This report describes the impact and learning of the Scottish Patient Safety Programme (SPSP) Acute Adult collaborative, 2021-2024. SPSP is a national quality improvement programme which aims to improve the safety and reliability of care and reduce harm. SPSP is part of Healthcare Improvement Scotland (HIS), the national improvement agency for health and social care in Scotland.

NHS boards and partners identified falls and deteriorating patients as key priorities for reducing avoidable harm.

The aims of the collaborative

The SPSP Acute Adult collaborative aimed to:

- reduce falls and falls with harm, and
- improve the recognition and timely intervention for deteriorating patients.

Impact

Reduction in national hospital falls rate

Falls are a common cause of harm for people in hospital. The SPSP Acute Adult collaborative supported NHS boards to achieve a **9% reduction in the national rate of falls** in acute hospitals. The reduction, driven by sustained improvement in 38% (5/13) participating NHS boards, was associated with an estimated cost avoidance of £119,000 and avoided length of stay of 95 bed days.

NHS boards with sustained reductions in the rate of falls identified enablers of their success as:

- understanding their data
- leaders visibly prioritising falls
- shifting emphasis to promoting safer mobility
- multidisciplinary team working
- person centred approach

Deteriorating patients: improving under pressure

COVID-19 and subsequent system pressures had a significant impact on the pace and scale of deteriorating patient improvement work across the 14 participating NHS boards. Teams focused initially on understanding the changes in their system, and local approach to cardiac arrest data collection (read more in our case study and improvement resource). Reliability of data collection improved in six of the seven NHS boards who identified opportunity to improve.

Reliable data enabled teams to focus on understanding and improving their local recognition and response to deteriorating patients. Three hospitals sustained a reduction in cardiac arrest rates and three demonstrated an increase. SPSP continues to support teams to understand their data and use it to inform their improvement work.

How we did it

- The focus and content was co-designed with NHS boards and partners, underpinned by evidence and SPSP Essentials of Safe Care. The collaborative was delivered using a Breakthrough Series Model, from September 2021–March 2024.
- The SPSP Acute Adult learning system accelerated improvement, connecting more than 500 colleagues across Scotland. In addition to bringing teams together to share and learn, it published a range of resources including SPSP principles of structured response, and updated SPSP deteriorating patient and sepsis improvement resources.

Next steps

This report demonstrates that while improvement during current system pressures is possible, there is more work to do. Healthcare Improvement Scotland is committed to providing practical support that accelerates delivery of sustainable improvements in safety and quality across health and care services. As such, the SPSP Acute Adult programme will continue to work with NHS boards to reduce avoidable harm in hospital.

Introduction

This report describes the impact and learning from the Scottish Patient Safety Programme (SPSP) Acute Adult collaborative. SPSP is part of Healthcare Improvement Scotland (HIS), the national improvement agency for health and social care in Scotland. Healthcare Improvement Scotland's strategy[1], leading quality health and care for Scotland, sets out its commitment to delivering practical support that accelerates the delivery of sustainable improvements in safety and quality of health and care services across Scotland.

Scottish Patient Safety Programme

The Scottish Patient Safety Programme is a national improvement programme that aims to improve the safety and reliability of care and reduce harm. Since its launch in 2008 SPSP has expanded to support improvements in safety across a wide range of care settings.

The SPSP Acute Adult programme aims to reduce harm and improve the experience and outcomes for people accessing acute care.

SPSP Essentials of Safe Care

All SPSP programmes are underpinned by the SPSP Essentials of Safe Care, a practical package of evidence-based guidance and support that enables delivery of safe care for every person, within every setting, every time.

The SPSP Essentials of Safe Care formed the building blocks for the falls and deteriorating patient collaborative improvement resources.

SPSP Learning System

The SPSP learning system provides opportunities for participating teams to share and learn together.

The activity of the learning system is informed by the data and insights shared through the collaborative. Understanding these insights drives knowledge into action and can accelerate improvement.

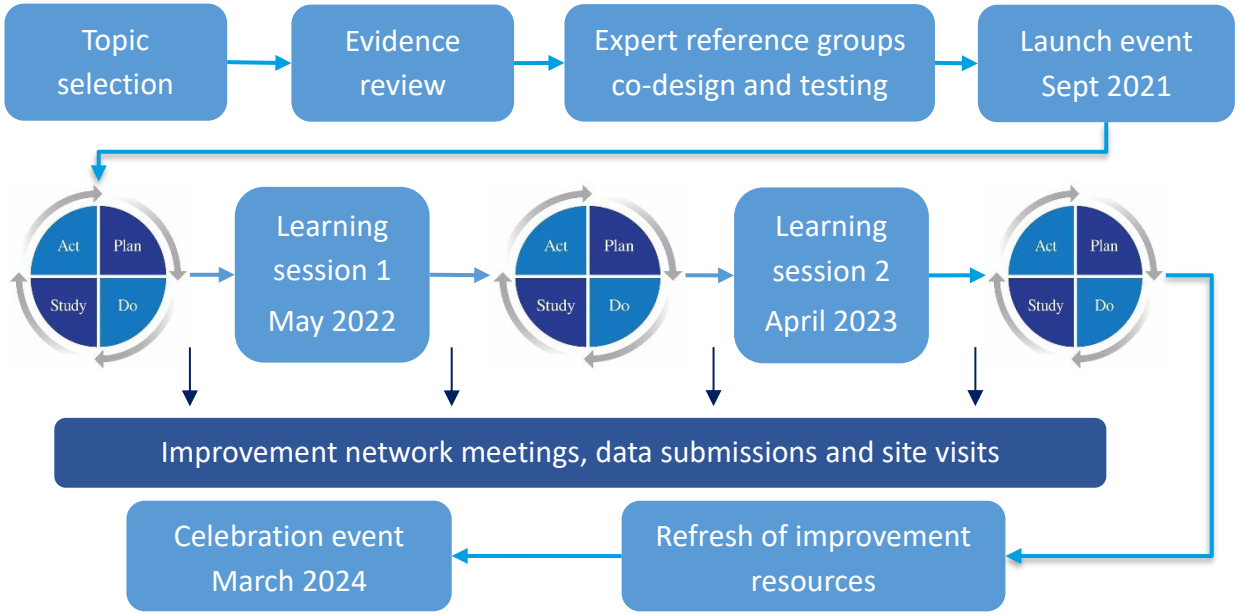
The SPSP Acute Adult collaborative

The SPSP Acute Adult collaborative aimed to reduce falls, falls with harm and improve early recognition and timely intervention for deteriorating patients. All Scottish NHS boards participated in the collaborative which ran from September 2021– March 2024.

What we did

Following the first wave of COVID-19 the Scottish Patient Safety Programme worked in partnership with NHS boards and key groups to identify improvement priorities for acute care. This engagement identified falls and deteriorating patients as the shared areas for focus.

The SPSP Acute Adult team co-designed and delivered the SPSP Acute Adult collaborative using the principles of the Institute for Healthcare Improvement (IHI)[2] breakthrough series collaborative. The figure below sets out the collaborative structure and key activities (for more detail, see Appendix 1).



Evaluation

The SPSP Acute Adult programme developed an evaluation framework to understand the impact of the collaborative. The framework was informed by the RE-AIM[3] framework, exploring the reach, effectiveness, adoption, implementation and maintenance of the improvement work undertaken during the collaborative.

This report draws on the findings from responses of 13 participating NHS boards to a survey evaluating the collaborative (Appendix 2).

How we did it

Co-design

- The collaborative was co-designed and delivered in partnership with NHS boards, the Acute Care advisory group, collaborative steering group, Scottish Government, external organisations, and teams across Healthcare Improvement Scotland (see Appendix 3).
- Expert reference groups co-designed the collaborative improvement resources. The resources were evidence informed and underpinned by the SPSP Essentials of Safe Care.

Flexible delivery

- Following the launch in September 2021, the collaborative was delivered using a hybrid model to maximise the opportunity for teams to participate despite geography or time pressures.
- The original timeline was extended by 12 months to March 2024 due to the impact of COVID-19 and subsequent system pressures on clinical and improvement team capacity.

Delivering as one team

- Teams across Healthcare Improvement Scotland worked together to deliver the collaborative, drawing on quality management, improvement, project management and clinical expertise.
- A national clinical lead provided clinical and improvement expertise to each workstream. Their input strengthened the clinical credibility of the work.
- Participating teams were supported to use recognised quality management and quality improvement methods.

Networks

- All NHS boards highlighted connecting with colleagues across Scotland as a key benefit of participation. Dedicated networks connected teams working on falls and deteriorating patient improvement. The networks provide a valued opportunity to share and learn together between learning sessions.

> "Being able to get together, as part of the network, was invaluable and we would ask that these are considered for inclusion in any future programme." Strategic lead, NHS board

Learning system in action

The SPSP Acute Adult learning system was the engine of the collaborative. Reaching more than 500 colleagues across NHS Scotland it used the HIS learning system structure to build knowledge through local and national opportunities for teams to share and learn together. The section below highlights practical examples of the collaborative learning system in action.

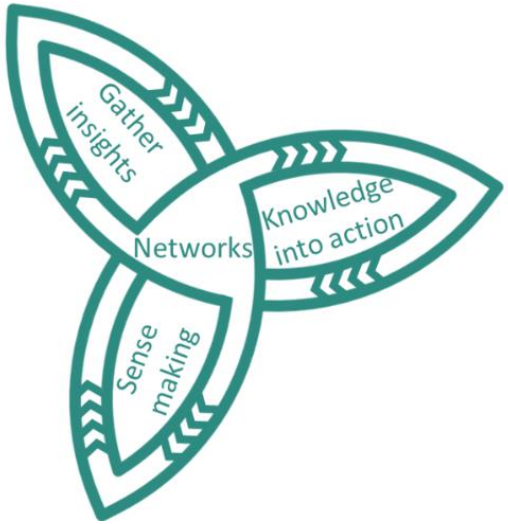
Gathering insights

Each NHS board captured their learning and progress through quarterly data reporting and six-monthly progress reports. During the collaborative teams contributed to:

11 national data reports

70 progress reports

88 site visits and coaching calls



Knowledge into action

Teams shared their improvement work and learned from others across Scotland during:

24 improvement network meetings

46 presentations from NHS board teams

4 webinars with 1635 attendees

The networks enabled spread of change ideas including reliable approaches to cardiac arrest reviews and focused improvement support for clinical areas with higher rates of falls.

Sense making

The learning system provided opportunities to understand what works, explore challenges and accelerate priority areas for improvement. For example:

- The SPSP Acute Adult team supported 10 NHS boards to understand the reliability of their cardiac arrest data collection. Of these, four progressed with improvement work. Read more in our case study and improvement resource.
- Following co-design of the SPSP principles of structured response the SPSP Acute Adult team supported 10 NHS boards to map the structured response of individual ward teams. The mapping enabled wards to share good practice and identify their priorities for targeted improvement work.

What the learning system produced

In addition to learning sessions, network meetings and webinars, the learning system produced a range of resources to support teams in their improvement work.

2021

Falls and deteriorating patient improvement resources.

2022

Cardiac arrest data collection improvement resource.

SPSP principles of structured response and mapping tool.

2023

Updated SPSP falls, deteriorating patient, sepsis, and falls improvement resources.

2024

Progressing towards a national definition of a fall and a fall with harm.

Involving people with lived experience

People with lived experience were key contributors to our work to update the SPSP sepsis driver diagram and change package. Reflecting on the updated resources, two contributors shared:

"This resource is fantastic, very clear and easy to understand and reflective of patient and carer concerns."

"The documents you have shared look better than I had hoped. In particular, the focus on patient centred care. I feel heard. Thank you."

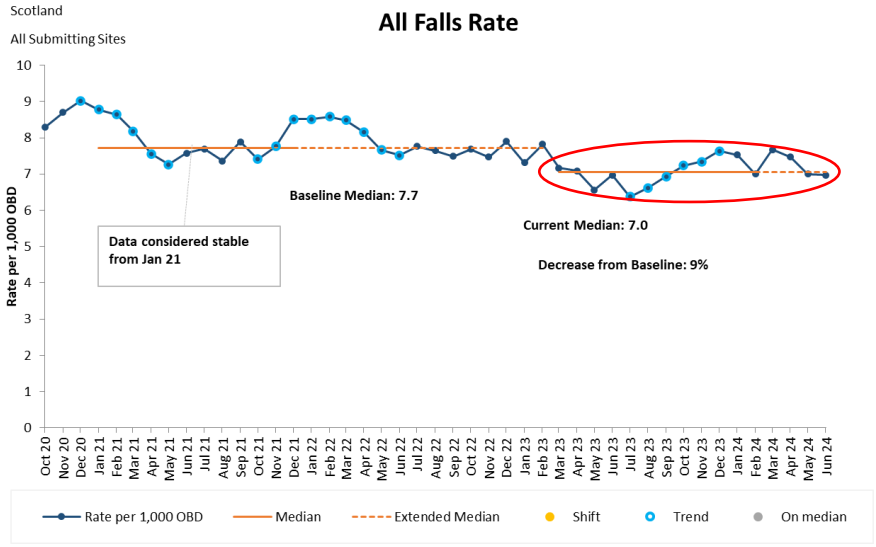
Learning from the falls workstream

National reduction in the rate of falls

The collaborative achieved a 9% national reduction in the rate of inpatient falls. This is a significant achievement given the clinical and system pressures facing teams, patients, families and carers in acute care.

13 NHS boards participated in the falls workstream, with data covering at least 90% of the Scottish population. A baseline median for nationally aggregated falls data of 7.7 per 1,000 occupied bed days was established from January 2021. HIS uses run chart methodology to measure changes from baseline. According to these methods, the national rate of falls has reduced by 9% from 7.7 to 7.0 per 1,000 occupied bed days, sustained since February 2023 (Figure 1). The reduction was driven by sustained improvement in 11 hospitals across 38% (5/13) participating NHS boards.

Figure 1. Rate of falls per 1,000 occupied bed days in NHS Scotland acute hospitals



9% reduction in national rate of falls in acute care

11 Acute hospitals demonstrated a sustained reduction in the rate of falls of between 9% and 21%

Further detail on measurement is available in the SPSP falls measurement framework.

Economic analysis

The cost avoidance associated with the 9% reduction in the rate of falls are estimated as £119,174. The calculation is based on research from the NHS in England (Appendix 4). Most of the costs avoided are from the impact of the reduced rate of falls on 95 avoided days in hospital. Cost avoidance related to avoided treatment costs were calculated based on the English NHS data because of the variation in definitions used across NHS Scotland to identify falls and falls with harm.

Falls with harm

There were sustained reductions in the rate of falls with harm in five hospitals, and an increased rate of falls with harm in three hospitals. Changes in rates of falls with harm did not consistently track changes in the all falls rate.

Across NHS Scotland there are differences in the definitions of a fall with harm. Because of these differences it was not appropriate to combine the falls with harm data in a national chart.

A national definition for a fall and fall with harm

The variation in definitions used to report falls and falls with harm across health and social care presents a challenge to understanding and improving care. Recognising this longstanding problem, Healthcare Improvement Scotland led a two-phase research study to establish a national definition for a fall and fall with harm for use in all clinical and care settings. More than 300 colleagues from across health and care in Scotland took part in the study. The proposed definition has been reviewed by key leadership groups and is proceeding to testing with volunteer NHS boards.

Hear from a team

In this video NHS Ayrshire & Arran highlight key learning from their falls improvement work.
https://youtu.be/PgUi2dhcJiI

Reducing falls: key enablers for success

Teams with a sustained reduction in the rate of falls shared their work through the evaluation survey and discussions with the SPSP Acute Adult team. In addition to understanding their data teams identified key enablers of their success. The enablers, set out below, centred on the primary drivers of the SPSP falls driver diagram, and directly link to the SPSP Essentials of Safe Care. For further detail on change ideas from teams see Appendix 5.

Leadership to support a culture of safety

Visible **prioritisation of falls** by senior leaders enabled teams to initiate local falls improvement work and test changes aligned with local priorities.

Change ideas with impact:
System wide falls strategy allowing small scale change in a large-scale framework.

Promoting safer mobility

Shift in culture towards promoting safer mobility and positive risk taking.

Change ideas with impact:
Promotion of activity and exercise through inclusion of exercises in falls information leaflets, prescribed mobility plans and the use of 'I Can' posters.

Person centred care

Involving patients, **families and carers** in safer mobility conversations.

Change ideas with impact:
Using meaningful activity and changes to observation practice to support patients with stress and distress.

Multidisciplinary approach

Multidisciplinary teamworking for falls improvement.

Change ideas with impact:
Quality improvement and falls teams working in partnership.
Design and implementation of multidisciplinary person centred falls bundles.

Learning from the deteriorating patient workstream

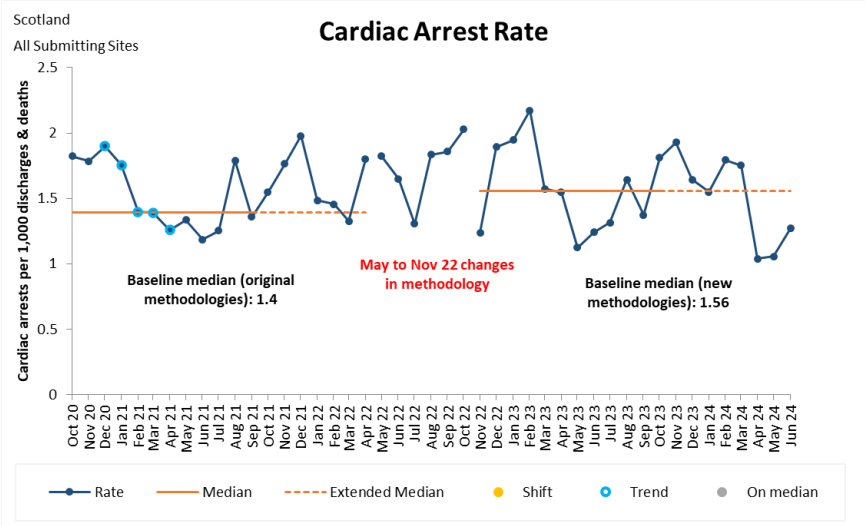
The deteriorating patient workstream aimed to improve the recognition and timely response to adults deteriorating in acute hospital inpatient areas. The clinical and system pressures of the COVID-19 pandemic affected the pace of the deteriorating patient workstream. Staff had reduced capacity to engage in improvement and, for some teams, there was disruption to processes which supported improvement.

Understanding the system: improving the reliability of data capture

Teams initially prioritised understanding their system, with an early focus on cardiac arrest data collection. All NHS boards submitted cardiac arrest data, defined as chest compressions and/or defibrillation in response to a 2222 cardiac arrest call, quarterly during the collaborative. The dataset excluded clinical areas out of scope, including emergency departments and critical care. Further detail is available in the SPSP deteriorating patient and sepsis measurement framework.

Six boards improved reliability of data collection following the baseline data period (October 2020-September 2021). To reflect the improvements in data collection the baseline median of the nationally aggregated cardiac arrest data (Figure 2) was reset at 1.56 per 1000 discharges plus deaths.

Figure 2. Cardiac arrest events per 1,000 discharges plus deaths (NHS Scotland acute hospitals)



- During the collaborative three hospitals across two NHS boards demonstrated reductions in cardiac arrest rate of between 20% and 52%.
- Three NHS boards demonstrated an increase in cardiac arrest rate without a change in data collection methodology. SPSP continues to support teams to understand their data and use it to inform their improvement work.

Focus of deteriorating patient improvement

Many NHS boards focused their deteriorating patient improvement work on strengthening their system for learning through visible leadership and:

Building a diverse team

Understanding the system

Data reliability and governance

Sharing and Learning

Clinically focused improvement work centred on improving recognition and structured response to deteriorating patients including:

Sepsis recognition and management

Escalation boards

Electronic observations

Cardiac arrest reviews

Quality and reliability of treatment escalation planning

National Early Warning Score 2 (NEWS2) implementation

Progress and focus was influenced by publication of the Scottish Intercollegiate Guidelines Network[4] (SIGN) 2023 deteriorating patient guideline and subsequent co-design of updates to the SPSP deteriorating patient and sepsis change packages.

Hear from a team

In this video NHS Lothian highlight key learning from their deteriorating patient improvement work.
https://youtu.be/uefQFpDMudI

What we learned

The SPSP Acute Adult collaborative commenced during the COVID-19 pandemic and was completed during a period of significant system pressures.

Improving in systems under pressure

All teams experienced the impact of system and staffing pressures on their improvement work. Changes to the hospital population were noted, particularly an increase in delayed discharges and use of non-standard clinical areas. Staffing pressures made it harder to release staff to participate in tests of change or to attend education.

Teams shared their reflections on how they have, or plan to, address the challenges to maximise their progress:

Increase involvement of patients and families

Increase diversity of clinical expertise in improvement work

Anticipate and manage competing improvement priorities

Undertake both system wide improvement activity and focused work with teams

Plan for impact of changes in guidance

Make it easier for clinicians to take part, including protected time

Next steps for falls and deteriorating patient improvement work

All teams indicated intention to build on their achievements with further improvement work. The SPSP Acute Adult team will continue to support teams to spread and scale their falls and deteriorating patient improvement work.

How our support enabled improvement

As part of the evaluation participating teams shared how the SPSP Acute Adult collaborative contributed to their local improvement work. Data analysis produced four themes: connection, focus, support and resources.

Connection

Inclusive opportunities to
come together to share and learn,
including between events.

Focus

"Data submissions acted as a prompt to make sure governance processes were in place, which in turn allowed us to highlight the improvement work across the organisation." Strategic leader, NHS board

Support

"The SPSP team are very approachable… should we have an issue we wish to discuss. They are great at linking you with teams working on similar projects."
SPSP lead, NHS board

Resources

Updated driver diagrams,
change packages and measurement frameworks
to support local improvement.

Delivering a national collaborative

Alongside teams from across Healthcare Improvement Scotland, the SPSP Acute Adult team took a quality management system approach to the delivery of the collaborative seeking to continuously evaluate, learn and improve. Appendix 6 sets out some of the key features of delivery in relation to the features of a high performing improvement collaborative as defined by The Healthcare Improvement Studies (THIS) Institute[5].

Transferable learning for next steps

The SPSP Acute Adult team provided flexible, approachable improvement support which enabled teams to progress their falls and deteriorating patient improvement work during the COVID-19 pandemic and subsequent system pressures. The table below sets out insights from participating teams about how the next phase of the SPSP Acute Adult programme could strengthen delivery on the features of a high performing improvement collaborative[5].

Feature	Learning for the next phase of SPSP Acute Adult
High quality coordination	• Plan for, and respond to emerging system challenges, noting that this may require narrowing the focus of programme activities. • Continue to pursue aligned reporting between SPSP and Excellence in Care.
Careful use of motivational levers	• Continue to offer platforms for teams to share their success. • Offer options for board-to-board site visits.
Mobilising leadership and building community	• Increase visibility of SPSP within clinical teams. • Expand opportunities for connection out with events. • Continue in person opportunities to connect.
Measurement and comparative feedback	• Expand data sharing, with permission, to include progress reports.
Learning from positive deviance	• Continue supporting connection and sharing between boards through networks and the learning system.

Contact us

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Next steps

Healthcare Improvement Scotland is committed to providing practical support that accelerates sustainable improvements in quality and safety. The SPSP Acute Adult programme will continue to work with boards to improve outcomes and reduce harm in hospital.

References

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Appendix 1. Further detail on collaborative activities and resources

Further detail on collaborative activities, resources and publications can be accessed via our website.

Design of the collaborative: SPSP Acute Adult expert reference group evaluation report

Learning session resources: SPSP Acute Adult collaborative learning session resources

Improvement resources and webinars for deteriorating patient and sepsis: SPSP deteriorating patient

Improvement resources and webinars for falls: SPSP falls

Improvement resources and SPSP learning system: SPSP Essentials of Safe Care

Appendix 2. Evaluation questions

Workstream stage update

Insert your teams' stage for each work stream using the Assessment Scale for Collaboratives developed by the Institute for Healthcare Improvement (IHI).

For each of deteriorating patient and falls and falls with harm board teams were asked the following questions:

Participating Teams

- Please make any changes to the following areas you have previously identified as participating in the collaborative
- What led to the areas above participating in the falls/deteriorating patient improvement work?
- If the number of participating teams changed during the collaborative, please briefly outline the reasons for this.
- Did your board have a clinical/topic expert lead for the falls/deteriorating patient work? (if yes, please add job title)

Reflections on progress

- To what extent have you been able to progress towards your aim? (consider any variation of success across participating sites/teams, and what may explain this)
- What are the key success(es) of the falls/deteriorating patient improvement work in your board, and what has enabled them?
- What have been the key challenges affecting progress across the collaborative?
- If you were designing your falls/deteriorating patient work again, would you do anything differently?
- How were patients and families involved in your falls/deteriorating patient improvement work?

Change Ideas

- What change ideas have been tested/implemented since your last narrative submission? (please add any key learning)
- Over the course of the programme which change ideas or approaches have had the biggest impact in your falls/deteriorating patient improvement work and why?

Next Steps

- What are the next steps for falls/deteriorating patient improvement in your board?

Thinking about the work your team has undertaken to support participation in the SPSP Acute Adult Collaborative:

- What local QI support did teams require during the collaborative? (you might want to consider what worked well and what adaptations, if any, you made to the support)
- To what extent were the necessary skills, governance, and resources to support collaborative work available to the QI team?
- What types of national support were helpful and should be included in the next phase of the SPSP Acute Adult programme? (For example, events, activities, resources, improvement networks, or improvement coaching)
- What improvements could be made to the national support in the next phase of the SPSP Acute Adult work? (For example, site visits, events, resources, networks and coaching).

Appendix 3. Contributors to the SPSP Acute Adult collaborative

The SPSP Acute Adult collaborative was led by the Perinatal, Paediatric and Acute Care portfolio in the Medical and Safety Directorate of Healthcare Improvement Scotland. The collaborative was co-designed and delivered in partnership with the following:

- Acute Care portfolio advisory group
- Care Inspectorate
- Healthcare Improvement Scotland: Adverse Events team, Data, Measurement and Business Intelligence, Excellence in Care, Evidence and Evaluation for Improvement Team (EEvIT), Quality Assurance Directorate, Perinatal, Paediatric and Acute Care portfolio, People Led Care team, and Scottish Intercollegiate Guidelines Network (SIGN)
- NHS Scotland health boards
- Public Health Scotland
- Scottish Government
- Sepsis Research, Fiona Elizabeth Agnew Trust (FEAT)
- SPSP Acute Adult collaborative steering group

Appendix 4. Calculation of falls economic analysis

Changes associated with falls reduction collaborative improvements

During the falls collaborative, 11 hospitals showed a sustained reduction in all falls (nationally a 9% reduction in the rate of falls per 1000 occupied bed days sustained for over 13 months). Median falls per 1000 occupied bed days has decreased from 7.7 to 7.0. The number of occupied bed days has increased at the same time as the observed number of falls has declined, so this was adjusted for, and estimate that approximately 240 falls will have been avoided overall.

Information from previous research on falls conducted by the NHS in England[6, 7] was adapted to understand the savings associated with avoiding these falls, based on the harms described in the table below.

Fall severity category	Definition (according to NHS Improvement Report)	Proportion of hospital falls estimated to occur by severity and age group (from NHS Improvement Report 2017)			Estimated number of falls avoided for each severity level
		Under 65	Over 65	Total	
No harm	No harm to patient for example no visible bruising	73.4%	71.1%	71.9%	173
Low harm	First aid, extra observation or medication required	24.9%	26.0%	25.5%	61
Moderate harm	Outpatient treatment or hospital admission	1.5%	2.2%	2.0%	5
Severe harm	Permanent harm, injury or disability likely result of fall	0.2%	0.6%	0.5%	1
Death	Death as a direct result of the fall	0.0%	0.1%	0.1%	0

Costs were dependent on the level of severity, the number of patients expected to have a fall of each level of severity, and the costs associated with treating falls at each level of severity, whereby:

- No harm falls took one hour of a Band 5 nurse's time to reassure patients (and relatives) and complete incident forms.[6]
- Low harm falls incurred this cost too, with an additional 30 mins first aid from the nurse and the cost of a dressing for any wounds. Less than 1% were assumed to require an x-ray. Length of stay was 10% higher than for falls that incurred no harm.[6, 7, 8]
- For moderate harm falls, the average cost of an A&E visit was used as a proxy for the approximate cost of treating injury.[7] In addition, 50% of those with a fall defined as moderate harm will incur further costs of surgery (based on hip fracture and other fracture procedure costs) and associated length of stay (50% higher than for falls with no harm).[6, 7, 9]
- For severe costs, treatment is again assumed to be equivalent to an A&E visit but 80% are assumed to require surgery (again based on inpatient hip and other fracture procedure costs) and associated length of stay is 80% longer than for falls with no harm.
- A cost of death has not been calculated as no falls were likely to have resulted in death during the collaborative as estimated by the severity criteria outlined above.

Conclusion

Overall, the avoided length of stay avoided was estimated at 95.3 bed days, saving £89,511. Avoided treatment costs saved a further £29,662 therefore overall, the Falls collaborative has saved approximately £119,174 from an NHS perspective.

Appendix 5. Reducing falls: key enablers for success

This appendix provides examples from boards of tests of change within each of the key enablers for success.

Leadership to support a culture of safety *Visible prioritisation of falls by senior leaders.*

For several boards falls reduction was set out as an organisational priority with dedicated and visible leadership. Examples from teams of visible leadership included: leadership walk rounds with a focus on falls, offering staff access to senior support, falls focus during safety huddles and ward handovers. System-wide falls strategies which enabled small-scale change in a large-scale framework provided teams with opportunities to test changes which were relevant to their local context and linked to the board wide improvement strategy.

Person centred care *Involving patients, families and carers in safer mobility conversations.*

Change ideas focused on person centred falls documentation and supporting people experiencing stress and distress. Examples of person centred falls documentation included reliable use of 'what matters to you' in care plans, use of multidisciplinary person-centred falls bundles, and falls intervention plans with evidence of patient, family and carer involvement. When supporting patients who experience stress and distress, boards introduced meaningful activity clubs, behaviour monitoring charts, and effective use of enhanced care observations and continuous interventions.

Multidisciplinary approach *Multidisciplinary team working for falls assessment, intervention and quality improvement.*

Teams identified that building the right multidisciplinary team was key to their falls improvement work. Collaboration between clinical and quality improvement teams was reported to increase staff engagement with improvement. Multidisciplinary working was also enabled by a whole system approach to falls, with integrated falls work.

Promoting safer mobility *Shift in culture towards promoting safer mobility and positive risk-taking.*

Board teams have focused on promoting safer mobility through improving positive communication of patient ability, for example using ‘I Can’ and posters to encourage patients to ‘Call Don’t Fall’. Promoting activity has been delivered through ‘Active Wards’ in two NHS boards, meaningful activity clubs, inclusion of super 6 exercises within patient facing falls resources, prescribed mobility plans, and raising awareness of deconditioning with patients, families, and staff. Promoting safer mobility includes environmental considerations with tests of change including environment checklists and processes to support appropriate bed placement for people at risk of falls. **To learn more**, contact: his.acutecare@nhs.scot

Appendix 6. Features of a high performing improvement collaborative

Mapping the SPSP Acute Adult collaborative delivery with reference to the five features of high performing improvement collaboratives.[5]

Feature	Approaches in collaborative delivery	Learning for the next phase
High quality coordination	• Structured communication of collaborative activities to maximise engagement. • Proactively connecting teams across Scotland who are working on similar challenges.	• Plan for, and respond to emerging system challenges, noting that this may require narrowing the focus of programme activities. • Continue to pursue aligned reporting between SPSP and Excellence in Care.
Careful use of motivational levers	• Submitted data were used for improvement not for judgement.	• Continue to offer platforms for teams to share their success. • Offer options for board-to-board site visits.
Mobilising leadership and building community	• Transitioning the expert reference groups to improvement networks provided a hub for leadership and community in the learning system. • Role of clinical leads in mobilising wider professional networks.	• Increase visibility of SPSP within clinical teams. • Expand opportunities for connection out with events. • Continue in person opportunities to connect.
Measurement and comparative feedback	• Focus on data quality through both reliable cardiac arrest data collection and work to define a national definition for a fall and a fall with harm. • Quarterly national data reports setting out site and board level data and, where appropriate, national aggregated data.	• Expand data sharing, with permission, to include progress reports.
Learning from positive deviance	• Identifying teams ready to share their improvement work. • Providing a range of platforms for teams to share.	• Continue supporting connection and sharing between boards through networks and the learning system.

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