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, the national improvement agency for health and social care in Scotland.

NHS Scotland 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 Scotland health 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 health boards, was associated with an estimated cost avoidance of £119,000 and avoided length of stay of 95 bed days.

For more detail see the full report.

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 health boards. Teams focused initially on understanding their emergent system, and local cardiac arrest data collection (read more in our case study and improvement resource). Reliability of data collection improved in six of seven 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 collaborative focus and content were co-designed with NHS Scotland boards and partners, underpinned by the evidence and SPSP Essentials of Safe Care. The collaborative was delivered using a Breakthrough Series Collaborative, 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 Scotland health boards to reduce avoidable harm in hospital.

For more detail on the impact and learning from the collaborative, please read our full impact report.