Scottish Patient Safety Programme (SPSP): Ten years of improving safety

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Introduction

2018 marks the 10th anniversary of the Scottish Patient Safety Programme (SPSP). SPSP is a national quality improvement programme that aims to improve the safety and reliability of care and reduce harm.

Global evidence prior to the launch of SPSP suggested that 1 in 10 patients admitted to hospital would be unintentionally harmed with 40% of incidents being avoidable.1

The Quality Strategy (2010)2 identified Safety as one of three national quality ambitions, followed by the 2020 vision3 and most recently the National Health and Wellbeing Outcomes4, reflecting the integrated context SPSP is now embedded within.

Method

Initially, the Institute for Healthcare Improvement (IHI) supported the Scottish adaption of existing evidence-based interventions delivered through robust application of improvement methodologies, including the Model for Improvement within a Breakthrough Series Collaborative.

This approach has evolved across the decade, adapting to the changing needs and context the programme is delivered within.

Key factors supporting improvement

• Will, belief, commitment and long term collaboration at all levels of the system to support a culture of safety and learning nationwide.
• Building of improvement capability, locally and nationally.
• Consistent application of method from small scale testing, adaption to sustaining at scale.
• Open and transparent use of qualitative and quantitative data to identify areas for improvement, inform learning and demonstrate impact.

National impact so far...

• 31% reduction in the cardiac arrest rate since 2012
• 21% reduction in sepsis mortality since 2012
• 31% reduction in pressure ulcers (Grade 2-4) since 2015 (see Figure 1)
• 10.6% reduction in hospital standardised mortality ratio since 2014
• 89% reduction in paediatric ventilated associated pneumonia to date
• 19.5% reduction in stillbirths since 2012
• 20% reduction in self-harm since 2014

Conclusion

With safety remaining a priority in the context of improving quality across health and social care, it is important to reflect on achievements so far, and use the learning to inform our approach to improve safety, resulting in Scotland-wide transformational change.

References: