

Patient Safety Commissioner Scotland

Key Principles for the Patient Safety Commissioner Scotland Office

Patient Safety Commissioner for Scotland Act 2023
<https://www.legislation.gov.uk/asp/2023/6/contents>

1. Listen, Include and Act on Patient Voice

The Commissioner will ensure that patients, families and the public are listened to and included at every stage of the safety system, particularly those whose voices have historically been marginalised. To prevent health inequalities, lived/living experience must shape how healthcare is delivered, at every stage. Patient feedback will directly inform, and be acted upon to prioritise, investigate and set recommendations.

Why it matters:

Systemic failures often begin when people are not heard. Listening must be inclusive, accessible and must lead to visible action. The patient voice is central to the design of services to implement shared decision making.

2. Make Safety a Shared, System-Wide Responsibility

Safety is everyone's responsibility across health and social care. The Commissioner will promote whole-system leadership, co-design, collaboration shared accountability and effective whole system risk management so that safety is embedded in everyday practice, not dependent on individuals or isolated organisations.

Why it matters:

No single body can deliver safety alone — it must be built into how the whole system works.

3. Focus on Systemic Learning and Improvement

The Commissioner will prioritise learning from patterns, trends and recurring risks, promoting restorative and learning-focused responses to harm rather than blame. The aim is to redesign systems, so harm is prevented and trust is rebuilt.

Why it matters:

Lasting improvement comes from fixing systems and learning well, not from assigning fault.

4. Champion Openness, Transparency and Accountability

The Commissioner will promote a culture of candour, psychological safety and transparency.

Health-care organisations should be open about safety incidents, share learning, and be accountable for acting on recommendations. Patients should feel empowered to speak up about safety concerns, with them acted upon with compassion and empathy.

Why it matters:

Trust and improvement depend on openness — secrecy allows harm to recur.

5. Use Evidence, Data and Insight to Drive Change

The Commissioner will use and promote robust evidence, data, research and lived experience to understand safety risks, measure improvement and make recommendations to government and health-care bodies.

Why it matters:

Evidence turns individual stories of harm into system-wide action and prevention.

6. Act with Independence, Integrity and Public Interest

The Commissioner will operate independently of government and health-care providers, acting impartially, proportionately and transparently in the public interest.

Why it matters:

Independence and integrity are essential for credibility, trust and impact.

Overall Theme:

Patient safety is a **system property**, not an individual failing; learning, equity, openness, and the **right to be heard** are central.