Patient Safety Commissioner Scotland

Patient Safety Charter

Patient Safety Charter (Section 6 of the Act) https://www.legislation.gov.uk/asp/2023/6/section/6

The **Charter** explains what patients and families can expect when safety concerns arise, and what the Commissioner expects from health-care providers and public bodies—particularly following **major incidents**.

Purpose of the Charter

- To make patient safety expectations clear and public
- To set out rights, responsibilities, and standards of behaviour
- To ensure learning and improvement after harm

Who the Charter Is For

- Patients and families affected by safety concerns or major incidents
- Health-care organisations and professionals
- Public bodies and regulators involved in safety oversight

Commitments of the Commissioner's Office

The PSC commits to:

- Listening respectfully and ensuring voices are heard
- Acting on concerns to drive system-wide improvement
- Focusing on systemic safety rather than individual blame
- Communicating clearly, openly, accessibly and inclusively
- Publishing findings and tracking responses to recommendations
- Treating all people with fairness, dignity, and compassion
- Using robust evidence and data to guide action
- Supporting restorative, learning-focused responses to harm
- Working collaboratively while remaining independent

Core Commitments of the Commissioner's Office

Commitment 1 – We will listen and ensure your voice is heard

- The PSC's office will provide clear routes for people to share their experiences, concerns or ideas about patient safety.
  We will ensure these voices inform our priorities, investigations and recommendations.

- You should feel that your concerns are taken seriously, and that what you say helps shape safer care for others.

Commitment 2 – We will act on what we learn

- Concerns, trends and patterns raised with the PSC will be analysed to identify systemic risks.
- Where action is needed, the Commissioner will make clear, evidence-based recommendations to the relevant bodies and follow up on their implementation.
- You can expect that what you share contributes to real, system-level improvement.

Commitment 3 – We will focus on systemic safety

- The PSC will concentrate on improving the **safety of systems** rather than on individual blame.
  Our work will help organisations learn and prevent recurrence of harm.
- We aim to make Scotland's health-care system safer for everyone.

Commitment 4 – We will communicate clearly and inclusively

- We will explain who we are, what we do, and what we cannot do in plain language.
- Our communication will be inclusive and accessible to people of all backgrounds.
- You can expect clarity, honesty and accessibility from our office.

Commitment 5 – We will be open and transparent

- Our findings, recommendations and progress reports will be published openly wherever possible.
- We will explain the reasons for our decisions and share learning across the system.
- You can expect openness and accountability in how the PSC works.

Commitment 6 – We will treat people with respect, fairness and compassion

- All engagement with patients, families and professionals will be undertaken respectfully and with empathy, recognising the emotional impact of safety incidents.
- The PSC will ensure that all voices are treated equally.
- You will be treated with dignity and kindness.

Commitment 7 – We will collaborate for improvement

- The PSC will work collaboratively with health-care providers, regulators, professional bodies and government to address shared safety challenges.
- Partnership is essential for meaningful and lasting improvement.
- You can expect the PSC to work with others to make change happen, not in isolation.

Commitment 8 – We will use data, evidence and insight to drive change

- We will use data, research and lived experience to understand risks and measure progress.
- Recommendations will always be based on evidence.
- You can expect that our work is thorough, factual and improvement focused.

Commitment 9 – We will support learning and restorative practice

- When harm occurs, we will encourage organisations to respond with openness, compassion and a commitment to learning.
- We will support approaches that rebuild trust rather than assign blame.
- You can expect the PSC to promote listening and learning, not punishment.

Commitment 10 – We will remain independent and impartial

- The PSC operates independently of Government, health-care providers and regulators.
- We will act only in the public interest, guided by evidence and integrity.
- You can trust that the PSC’s work is free from undue influence.

Expectations of Health-Care Providers and Public Bodies

Providers and public bodies are expected to:

- Listen and respond to patient and family safety concerns
- Be open and transparent about incidents and learning
- Act promptly to reduce risks and prevent recurrence
- Cooperate with the Commissioner and provide relevant information
- Foster a culture where staff and patients feel safe to speak up
- Communicate inclusively and accessibly

Accountability

- The Charter will be publicly available
- A safety management system will be used to log and manage concerns
- Progress will be reported through annual reporting
- The Charter will be reviewed regularly in consultation with stakeholders