Patient Safety Commissioner SCOTLAND

Annual Report 2025 - 2026

PSCS/2026/01

This report is prepared in accordance with section 22 of the Patient Safety Commissioner for Scotland Act 2023. It provides:

- a review of issues identified by the Commissioner as relevant to the Commissioner's functions during the reporting period;
- a review of the Commissioner's activities, including steps taken in connection with each of the Commissioner's statutory functions; and
- recommendations arising from those activities.

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Commissioner's Foreword

Karen Titchener

When Parliament established the office of Patient Safety Commissioner for Scotland, it made a quiet but significant choice: to give patients a voice that sits outside the system it is there to scrutinise. A year into this role, I have come to understand just how much that independence matters and how much responsibility it carries.

I came to this post after more than forty years in nursing and healthcare leadership, most of it spent asking a version of the same question: not "what have we improved?" but "how do we know it has actually changed anything for the person receiving care?" That question has shaped everything in my first year in office.

Over the past year, I have spent time meeting patients, families, carers, healthcare professionals and organisations across Scotland. I have listened to accounts of excellent care, but also to people whose experiences have left them feeling unheard or uncertain that their concerns have led to meaningful change. Those conversations have played a central role in shaping the priorities and direction of the Office.

Scotland's healthcare system is, in my assessment, improvement-rich but assurance-light**.** Across boards and specialties, I have found no shortage of ambition, innovation, and genuine commitment to doing better. What is harder to find, and what my statutory role exists to help provide, is that independent assurance that improvement commitments are embedded, sustained, and felt by patients, rather than simply stated. The gap between activity and assurance is where I have chosen to focus my attention this year.

I have set six national priority areas early in my term: maternity and neonatal safety; displaced care; single-sex hospital wards, acute mental health care, the healthcare inequalities experienced by people living in rural and island communities, and the National Health Service (NHS) Board restructure. These have emerged from what I heard directly from patients and families, frontline healthcare staff, and NHS boards themselves, about where the gap between improvement and assurance is widest, and where the consequences of that gap fall hardest.

Behind each of these priority areas are people. Throughout the year I have met people who have taken the time to share their stories, often in difficult circumstances and with the hope that others might not experience similar harm. A mother whose maternity care went wrong. A family who waited for an infant transfer that should have gone more smoothly. A patient

cared for in a corridor because no better option existed that day. A rural community watching services centralise without ever being shown how the risks of that change would be managed. I have met many of them this year, and their accounts are not complaints to be closed. They are evidence of where our systems are still failing to protect the people they serve, and evidence I have a statutory duty to use.

Alongside this, the Office has focussed on establishing strong foundations for the future. We have developed governance arrangements, appointed our first staff members, established an Advisory Group and begun building relationships across Scotland's healthcare system.

Independence does not require distance. These relationships support collaboration, learning and improvement, while preserving the freedom to provide challenge on behalf of patients when needed.

As this report is being finalised, one of the most significant structural changes to Scotland's health service in a generation has been announced. Such changes present both opportunities and challenges. My interest is not in organisational structures for their own sake, but in ensuring that patient safety, patient voice and effective independent oversight remain central throughout any period of change.

This Annual Report records the early work of the Office during its first year. It reflects what we have heard, what we have learned and where we believe further attention is needed. It is also the beginning of a longer programme of work. Improving patient safety requires persistence, openness and a willingness to learn from experience. I am in no doubt about the task ahead. Making Scotland safer through patient voice is not a slogan; it is the test I intend to be held to.

Thank you

None of this would have been possible without the patients, families, and members of the public who shared their experiences with the office this year, often at moments of real personal difficulty. I want to record my thanks to everyone who has done so, and to the healthcare professionals, NHS boards, third sector organisations, and the office's Advisory Group who have engaged so constructively as the office is establishing itself.

Karen Titchener RN ANP MSc
Patient Safety Commissioner for Scotland

Part 1: Establishing the Office

Introduction

The Patient Safety Commissioner for Scotland Act 2023

The Patient Safety Commissioner for Scotland Act 2023 established, for the first time, an independent statutory office dedicated to patient safety in Scotland, accountable directly to the Scottish Parliament, with an eight-year tenure. The concept of an independent Patient Safety Commissioner first gained national prominence through Baroness Cumberlege's 2020 review: ***First Do No Harm***, which recommended the role in response to systemic failures around sodium valproate, pelvic mesh, and Primodos, and led to the creation of the equivalent office in England in 2022.

Scotland's legislation established a broader remit, allowing the Commissioner to consider patient safety across healthcare services while retaining the central principle that patient experience should inform improvement and learning.

Karen Titchener was appointed as Scotland's inaugural Patient Safety Commissioner on 1 September 2025, and this report sets out the office's first year: how it has been established, the priorities it has set, and the early impact of its work.

Purpose and Functions of the Commissioner

The Act sets out a clear remit for the Commissioner: **to advocate for systemic improvement in the safety of healthcare, and to ensure that the experiences and concerns of patients, families and the wider public help shape meaningful change**.

The Office of the Patient Safety Commissioner is distinct from the existing complaints, regulatory and scrutiny processes available across Scotland's healthcare system. Instead, we look across individual experiences to identify patterns, emerging risks and wider opportunities for systemic improvement.

Those insights are then used to inform investigations, recommendations, research and wider horizon-scanning activity. Individual experiences are therefore central to our work, providing the evidence and understanding needed to identify patterns and drive lasting systemic change.

Governance and Accountability

The Commissioner's independence from Scottish Ministers and from the bodies within the Office's remit is the foundation of our work. That independence sits alongside proper

oversight: The Commissioner is accountable to the Scottish Parliament, and, as Accountable Officer, to the Scottish Parliamentary Corporate Body for the office's resources. The Commissioner's Office has worked closely with the Corporate Body throughout the year and benchmarked our approach against comparable bodies including the Scottish Public Services Ombudsman, the Scottish Biometrics Commissioner, and the Children and Young People's Commissioner Scotland.

Horizon scanning the healthcare systems in Scotland

In addition to responding to issues raised directly with the Office, we have sought to develop a broader understanding of the challenges facing healthcare in Scotland. This includes monitoring emerging risks, following the progress of major reviews and inquiries, and considering how wider changes in healthcare delivery may affect patient safety.

The Commissioner has deliberately held back from commenting on matters before statutory inquiries or active regulatory processes. The Office's role is best served by allowing those processes to reach their conclusions before considering what wider learning may be required.

At the same time, we have looked beyond Scotland's borders to the evolving relationship between assurance and regulation in England, and to how peer commissioners and safety bodies elsewhere are structured and resourced to test whether Scotland's own assurance architecture is fit for what lies ahead. We will continue to identify where the next gap between improvement and assurance is likely to open, before it becomes the next case we are asked to examine.

Building the Foundations

Key Principles and Charter

Two founding documents have shaped how this office operates: the Office's six **Key Principles**, and its ten-commitment **Patient Safety Charter**, required under section 6 of the Patient Safety Commissioner for Scotland Act 2023. Both were developed and tested with our Advisory Group, to ensure they reflect the lived experience as well as our own statutory analysis, before being agreed with the Scottish Parliamentary Corporate Body on 24th April 2026. These documents provide the Commissioner's foundational commitments to patients, families, and the public, alongside the standards it expects of healthcare providers and public bodies.

Key Principles

The office's six **Key Principles** set out how the Office intends to exercise the Commissioner's functions:

1. to listen, include, and act on patient voice, particularly where voices have historically been marginalised;
2. to treat safety as a shared, system-wide responsibility rather than the burden of any single body;
3. to focus on systemic learning over blame;
4. to champion openness, transparency, and accountability;
5. to use evidence and data to drive change;
6. and to act with independence, integrity, and the public interest at the centre of every decision.

Together, they reflect a single underlying theme: patient safety is a property of the system, not a measure of individual failing, and the right to be heard is central to making that system safer.

Patient Safety Charter

The **Charter** sets out what patients and families can expect from this office when safety concerns arise, and what the office in turn expects of healthcare providers and public bodies, particularly following major incidents.

Its ten core commitments are:

1. We will listen and ensure patients' voices are heard
2. We will act on what we learn
3. We will focus on systemic safety
4. We will communicate clearly and inclusively
5. We will be open and transparent
6. We will treat people with respect, fairness and compassion
7. We will collaborate for improvement
8. We will use data, evidence and insight to drive change
9. We will support learning and restorative practice
10. We will remain independent and impartial

In turn, the Charter sets out clear expectations of providers and public bodies:

- 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

We will report annually on progress against the Charter and review it regularly with patients, families and stakeholders to ensure it remains a practical and meaningful commitment.

Establishing the Office

Establishing a new parliamentary office has required substantial work to create the systems, processes and relationships needed to support the Commissioner's statutory functions. Much of this first year has therefore been about construction as well as action: establishing governance and financial processes proportionate to a small public body, recruiting the Office's first staff, and building the external relationships the Commissioner's functions depend on.

Karen Titchener operated as a sole officeholder for the first six months of the year, before recruiting Moira Manson, Executive Director of Patient Safety Investigations, in March 2026, followed by Gavin Bisset, Policy and Investigations Manager, in May 2026 and then David Stockwell, Corporate Services and Operations Manager, in July 2026.

Advisory Group

The Office's **Advisory Group** has been established under section 16 of the Patient Safety Commissioner for Scotland Act 2023, which requires the Commissioner to maintain a group to provide advice and information relating to the exercise of the Commissioner's functions. The Group is advisory only, with decision-making authority resting with the Commissioner. Nevertheless, its input has shaped the office's strategic priorities, engagement approaches and, as set out above, the Statement of Principles and Patient Safety Charter.

Terms of Reference

The Group's **Terms of Reference** were approved by the Advisory Group and the Commissioner on 13 March 2026 and are due for review in March 2026 after the first year in operation.

Membership

In line with the Act, at least 50% of the Advisory Group's members represent the interests of patients, alongside members with clinical or professional expertise, academic and regulatory experience, and experience in equality, human rights, and public engagement. Reflecting the office's commitment to ensuring the Group's composition captures the diversity of Scotland's population, including geographic representation.

At the time of writing, the current membership of the group is as follows:

- Dr Gordon Baird
- Kirsteen Campbell
- Fiona Collie
- Professor John Cuddihy
- Laura Jones
- Professor Jason Leitch CBE
- Dr Margaret McCartney
- Professor Donna O'Boyle
- Dr Gordon Shepherd
- Tom Steele
- Margaret Waterton

Meetings

The Group meets at least four times a year, in a hybrid format, with a secretariat function provided by our Office.

Investigations and Case Management

Our Office considers concerns raised by patients, families, carers, healthcare professionals and stakeholders as an important source of patient safety intelligence. While the Commissioner does not investigate individual complaints or seek to determine individual liability, enquiries received by the Office are assessed to identify recurring themes, emerging risks and systemic issues affecting the safety of healthcare in Scotland. Where evidence suggests that a matter has wider implications for patient safety, the Commissioner may undertake further examination through engagement, research, thematic review or a formal investigation. Investigations are conducted independently and are designed to understand the underlying systems, processes and organisational factors that contribute to patient safety concerns. The Office maintains a proportionate case management approach, ensuring that all enquiries are recorded, analysed and monitored, enabling patient experiences to inform learning, assurance and recommendations for improvement across Scotland's healthcare system. The Office's investigation framework is described in more detail later in this report.

Legal and Corporate Infrastructure

The Commissioner has specific statutory powers, including powers relating to legal proceedings and investigations, and the Office anticipates requiring specialist legal advice on the interpretation of the Act, public law matters, governance, and litigation where appropriate.

As a newly established independent parliamentary office, the development of robust legal and corporate infrastructure has been essential to supporting the Commissioner's statutory functions and ensuring the Office is equipped to operate effectively and independently. During the year, work has focused on establishing legal support and formal governance arrangements, policies, procedures and assurance mechanisms proportionate to a small public body while providing a strong foundation for future growth.

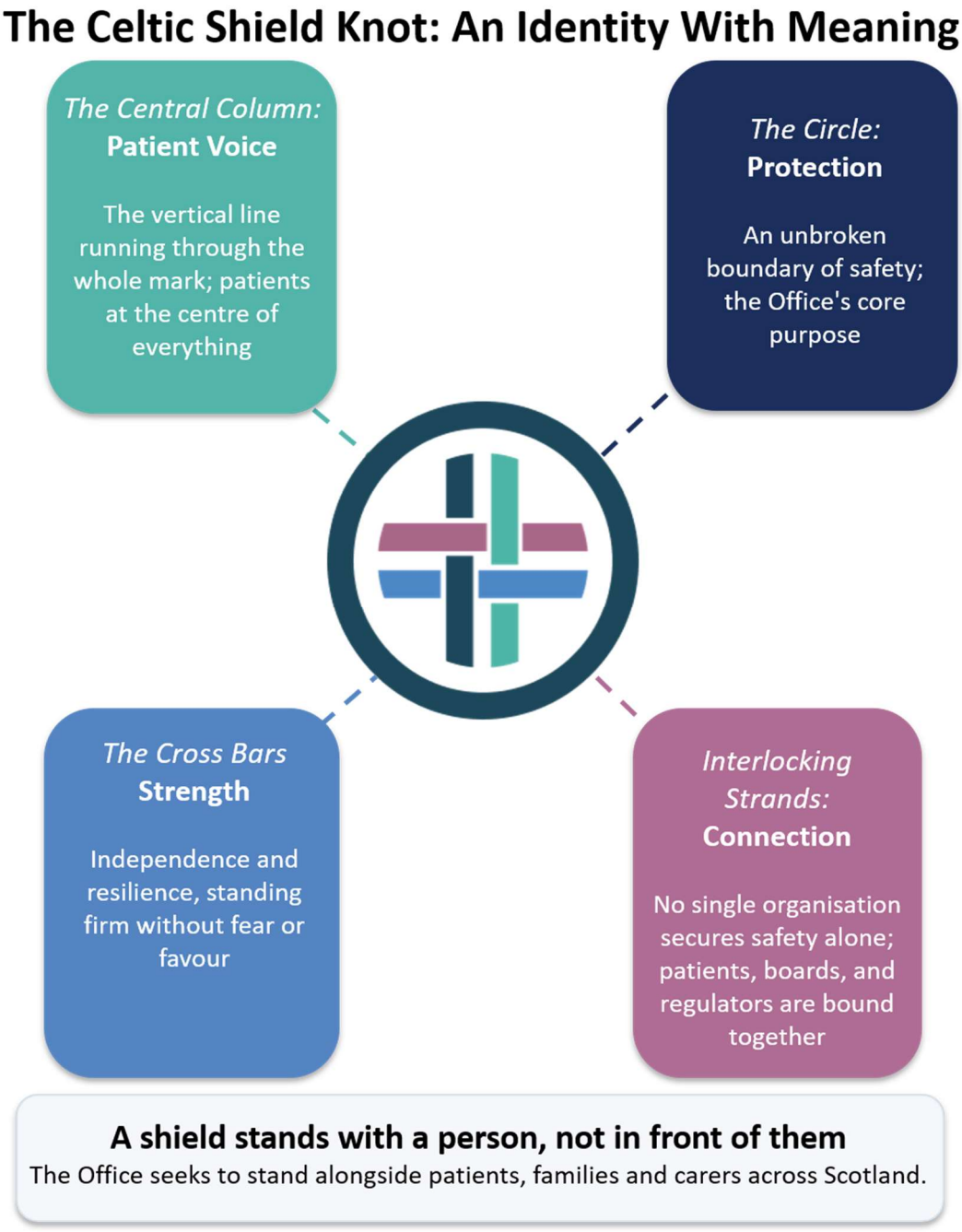
Developing the logo for the office

The Office's identity was designed to convey meaning as well as recognition. At the centre of the Patient Safety Commissioner for Scotland's mark sits a Celtic shield knot, a symbol with centuries of history across Celtic, Norse and Viking traditions, long associated with protection, strength and resilience. Its inclusion was a deliberate choice.

A shield provides protection while allowing the individual carrying it to remain at the forefront. It offers security without diminishing personal agency or voice. That reflects the role this Office seeks to play for patients, families and carers across Scotland: supporting and amplifying their experiences while helping to ensure that the systems surrounding them deliver safety, dignity and care.

The interwoven strands of the knot, each distinct yet connected to the others, also capture an important truth about patient safety. Safe care is achieved through relationships and shared responsibility. Patients, healthcare professionals, boards, regulators and policymakers all contribute to a system in which learning, improvement and accountability depend on cooperation and trust.

The symbol therefore represents more than protection alone. It reflects connection, collective responsibility and the belief that lasting improvements in patient safety emerge when lived experience and system learning are brought together. These principles sit at the heart of the Office's work and are embodied in its identity whenever it appears on a report, letter or public platform.



Part 2: Listening to Patients

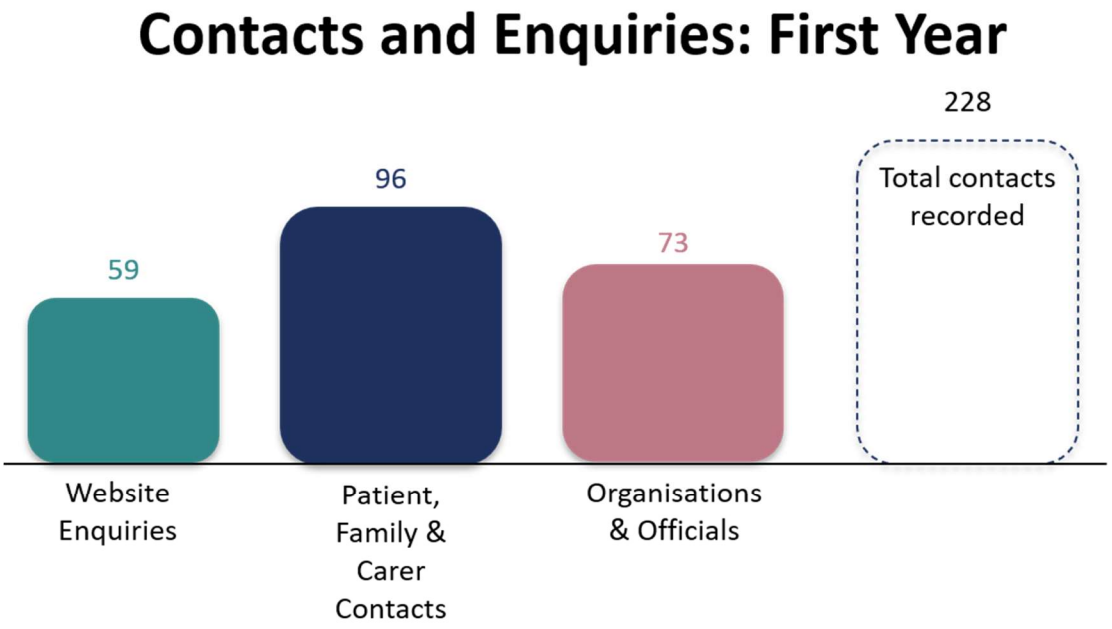
Patient Voices

Patient Engagement and Participation

Listening to patients, families and unpaid carers is central to the Commissioner's role. Throughout the reporting year, the Office has engaged with individuals and groups from across Scotland to better understand their experiences of healthcare and the patient safety concerns affecting them. These conversations provided valuable insight into how care is experienced in practice and helped inform our priorities, areas of inquiry and engagement activity.

Whilst the Commissioner does not investigate individual complaints or determine the circumstances of individual cases, the experiences shared by patients, families and carers provide an important source of patient safety intelligence. When considered collectively, these experiences can highlight recurring themes, emerging risks and systemic issues that may otherwise remain hidden within individual organisations or services.

Engagement was undertaken through meetings with patients and families, discussions with advocacy organisations and charities, attendance at events, engagement with healthcare professionals, and direct correspondence received by the Office. Together, these sources helped build a richer understanding of the patient safety challenges experienced across Scotland's health and care system.



Figures are estimated, based on records and numbers shared across a variety of platforms and individuals

Contacts and Enquiries

Central to our approach this first year has been getting out and making direct contact with the people this office exists to serve, and the systems it exists to hold to account. That has meant meeting patients, families, and carers in person and hearing their accounts directly; visiting NHS boards across the country; and building working relationships with regulators, professional bodies, and trade unions who each hold a piece of the patient safety picture.

The Office also received a significant number of contacts from patients, families, carers and members of the public seeking assistance, advice or support in relation to concerns about their care. We heard that individuals often contacted the Office because they were uncertain where to turn, felt that existing processes had not addressed their concerns, or wished to ensure that lessons were learned from their experiences. They also wanted to be heard, their concerns acknowledged and believed.

Each enquiry was reviewed to determine whether it raised matters relevant to the Commissioner's statutory functions. Although individual cases were not investigated, the information provided contributed to our understanding of wider patient safety issues and was used to identify recurring themes, areas of concern and opportunities for system learning. Collectively, these enquiries have built our understanding of recurring concerns, emerging risks and areas where further engagement or investigation may be required.

> From our initial correspondence and throughout the entire process, Karen was engaging, compassionate, and completely dedicated to supporting my complaint. She ensured that the dangerous shortfalls in care our four-day-old daughter experienced were highlighted to the most senior levels of management within the health board and the Scottish Ambulance Service (SAS).
>
> Karen assisted in facilitating communication between me and relevant senior parties within the investigation, making sure my voice was heard. Through her commitment and advocacy, together we have achieved improved honesty, openness, and constructive communication within the investigation, allowing for true reflection and learning, by both the health board and SAS. This has brought my family comfort and healing, while helping to restore our faith and trust in our local health services.
>
> Karen is a committed, professional, yet personable Commissioner who clearly stands strong for improving patient safety and care, staying true to her ethos, morals, and commitments. She is a huge asset to Scotland and an inspirational leader. She is also a very genuine, warm, and compassionate woman, to whom we, as a family, will be eternally grateful.
>
> - *Paula Buzasi*

How a Concern Becomes Learning

Not a complaints process

The Commissioner does not determine individual complaints or liability. Every account shared with the Office becomes part of the evidence base for identifying and correcting systemic patient safety risk across Scotland.

Key Themes Raised by Patients and Families

Although the concerns brought to our attention covered a wide range of healthcare services and clinical settings, a number of common themes emerged throughout the year:

Communication

Patients and families frequently described not feeling listened to, not receiving timely or accurate information, difficulties navigating complex healthcare systems and a lack of clarity regarding decisions affecting their care. Communication failures were often identified as contributing to anxiety, confusion and loss of trust. While the specific circumstances varied, communication was one of the most consistent themes raised with the Office.

Access to Care and Rural Inequalities

Patients living in rural and remote communities highlighted challenges relating to travel, service centralisation, delayed access to specialist services and reduced availability of local care. Many raised concerns regarding the cumulative impact of these challenges on both patient outcomes and patient experience.

Policy and Practice Conflicts

Patients and carers described situations where national policy, local guidance and day-to-day practice appeared misaligned. This often resulted in uncertainty regarding expectations, inconsistent delivery of care and variation between services and organisations.

Gaps in Operational Procedures

Concerns were frequently raised about escalation pathways, referrals, follow-up arrangements and coordination of care. In many cases, patients reported uncertainty regarding responsibilities, accountability and the processes available when concerns arose.

Fragmentation Between Services

Many patients described difficulties navigating transitions between services, organisations and professional groups. Repeated requests for information, inconsistent communication and unclear ownership of care were common concerns, particularly for those living with complex or long-term conditions.

Being Heard and Involved in Care

Patients, families and carers consistently expressed a desire to be active partners in decisions affecting their healthcare. Many emphasised the importance of being listened to, having their concerns taken seriously and receiving feedback on how concerns had been considered or addressed.

Emerging Patient Safety Concerns

In addition to recurring themes reported by patients and families, the Office identified several emerging patient safety concerns requiring further consideration. While not all concerns met the threshold for formal inquiry or investigation, they contribute to our understanding of potential risks within Scotland's health and care system.

Emerging concerns were identified through patient correspondence, engagement activities, meetings with stakeholder organisations, discussions with healthcare professionals and analysis of wider patient safety developments. While individual concerns may not initially appear significant, when viewed together they can reveal important patterns and emerging issues that merit further examination.

We consider the early identification of emerging concerns to be an important aspect of patient safety improvement, enabling issues to be recognised and addressed before they become entrenched or result in avoidable harm.

Part 3: Priorities and Themes

Our Priority Areas

Maternity and Neonatal Services

Safe maternity and neonatal care remains one of our priority areas. During our first year, concerns raised by patients, families, clinicians and stakeholder organisations highlighted the importance of effective oversight through stronger national assurance arrangements, greater transparency, timely learning and improved mechanisms for identifying and responding to safety concerns across Scotland.

We have welcomed the establishment of the Independent Maternity Services Review and look forward to supporting its work. The experiences shared with our Office have reinforced the importance of ensuring that women's voices, family experiences and frontline perspectives are reflected throughout the review process.

We will continue to engage constructively with partners to support learning and improvement in maternity and neonatal services and to promote arrangements that provide confidence that concerns are identified, understood and acted upon.

We consider this an illustrative example of why interim findings from significant national reviews, including the Independent Maternity Services Review, should be routed through a formal assurance function, allowing safety-relevant themes to be tracked and their resolution monitored independently, rather than assessed only at the conclusion of a review process. Such a function could include formal assurance receipt of interim findings, providing independent oversight of whether identified safety themes are being acted upon, rather than assessing progress only once a review has concluded.

Displaced Care and Hospital at Home

Increasing pressure on acute services continues to affect where and how care is delivered across Scotland. During our first year, we heard concerns from patients, families and healthcare professionals about people receiving care in environments that were not originally designed for clinical treatment, including corridor care and other forms of displaced care. These include areas such as ambulances stacking outside Accident & Emergency (A&E) departments awaiting handover, care delivered in surge bed areas, and A&E overflow into non-clinical or transitional spaces. Such situations can affect patient privacy, dignity, communication and the overall experience of care, as well as presenting potential safety risks.

We consider that care provided in any environment outside of standard patient care areas represents an inherent patient safety risk, regardless of the reason for its use or the intentions of the staff involved. These environments are typically not designed to support safe observation, monitoring, infection control or timely clinical response, and their use even where necessary in the short term should be recognised and treated as a safety issue in its own right, not simply an operational consequence of a busy system.

Through our engagement with NHS boards, staff and patients, it has become clear that these challenges are often symptoms of wider pressures within the health and care system. They should not be viewed solely as operational issues, but as matters with important implications for patient safety, quality of care and public confidence.

Alongside these concerns, we have also seen growing interest in alternatives to traditional inpatient care, particularly Hospital at Home services. Patients consistently tell us that, where appropriate and safe, receiving care in their own home can provide a better experience and help people maintain greater independence during treatment and recovery.

We support the continued development of Hospital at Home as a clinically appropriate alternative to inpatient care. Hospital at Home, properly delivered, means a patient who would otherwise occupy an acute bed instead receiving hospital-level care in their own home, with 24/7 access to a multidisciplinary team able to respond to their needs a model led by clinical need. This is a materially different model of care from virtual wards, which are principally a remote monitoring function and do not, on their own, provide the round-the-clock multidisciplinary response that hospital-level care at home requires.

As these services expand, it will be important to ensure a consistent national approach, supported by clear governance, appropriate workforce models and robust safety arrangements. Healthcare delivered at home should offer patients confidence that they will receive care that is safe, coordinated and responsive to changing needs.

Our engagement with NHS boards, including those serving rural and island communities, has highlighted examples of innovative practice and strong clinical leadership in this area. It has also demonstrated the variation that currently exists in how services are organised and delivered. Understanding the impact of that variation and identifying the factors that contribute to safe and effective care, will be an important area of work moving forward.

As Scotland's ambitions for Hospital at Home continue to develop, we will seek to understand how these services contribute to patient safety, what evidence exists regarding outcomes and experience, and what assurance mechanisms are required to ensure that expansion delivers benefits consistently across the country.

More broadly, the Office will continue to monitor the impact of displaced care on patients, families and staff. We believe there is value in developing a clearer national understanding of the safety risks associated with care being delivered in environments that were not designed for that purpose, and in ensuring that patient experience forms part of discussions about future service design and capacity planning.

Single-Sex Hospital Wards

Patients must be able to access healthcare in environments that are safe, respectful and protect their dignity. Concerns have been raised regarding the availability and operation of single-sex accommodation within some healthcare settings, particularly for vulnerable patients including those experiencing mental health crises, older patients with cognitive impairment, and patients cared for in emergency or assessment settings, where breaches of single-sex accommodation standards are most commonly reported.

Patient safety, safeguarding, privacy and dignity must remain central considerations in the design and delivery of hospital services. Existing NHS Scotland standards for mixed-sex accommodation provide a framework for these protections. Our interest is in understanding whether existing standards are being applied consistently in practice and, where they are not, what factors may be contributing to variation.

We recognise that breaches often arise from wider system pressures including bed capacity, patient flow and staffing, and consider this an area where systemic learning is required. We will continue to engage with patients, healthcare providers and other stakeholders to better understand these issues.

Acute Mental Health Care

Mental health services play a critical role in protecting some of the most vulnerable people in society. Evidence gathered during the year highlighted concerns about access to timely assessment and treatment, pressures on inpatient services, safeguarding arrangements and the overall patient experience of care. Evidence from our engagement suggests these pressures should be viewed as systemic risks rather than isolated service failures. We will continue to engage with service users and providers to understand their impact on patient safety and outcomes.

Adult Mental Health

Patients, families and professionals have reported concerns regarding delays in accessing appropriate mental health support, pressures on inpatient capacity and challenges in maintaining safe care environments during periods of high demand. These pressures have particular safety implications where they contribute to out-of-area placements, delayed discharge, or reliance on restrictive practices at times of peak demand. We consider these to

be systemic risk factors rather than isolated service failures and will continue to engage with service users and providers to better understand the impact of these pressures on patient safety and outcomes.

Children and Young People's Mental Health

The safety of children and young people requiring mental health care remains a significant concern. Long waiting times and difficulties accessing specialist services can increase risk and worsen outcomes for young people and their families.

Transitioning from Child and Adolescent Mental Health Services (CAMHS) to adult mental health services remains a significant concern. At this vulnerable stage, young people may experience gaps in care, delays in accessing adult services or disrupted support. Patients, families and professionals consistently told us that these issues can threaten continuity of care and patient safety and therefore require close attention.

Particular concern has been raised regarding delays in neurodevelopmental assessment and diagnosis, including for autism and attention deficit hyperactivity disorder (ADHD). Extended waiting times for diagnosis can delay access to appropriate support, including within education settings, where a formal diagnosis is often required before additional help can be put in place. We are concerned about the potential impact of extended waiting times on children's wellbeing, development and educational outcomes.

We will continue to ensure that the experiences of children, young people and those who care for them inform our work in this area.

Rural Healthcare Inequalities

People living in rural and island communities should have equitable access to safe healthcare. Concerns raised have highlighted the patient safety implications of service centralisation, travel requirements, delayed access to treatment and gaps in local provision. These concerns are often compounded by the practical realities of rural and island geography, including weather-dependent transport links, reliance on ferry and air ambulance services, and extended response times where distances to acute care are significant. These pressures are particularly acute in maternity and neonatal care, where the safety implications of service centralisation are addressed further in the Maternity and Neonatal Care section of this report.

Workforce recruitment and retention present a particular challenge in rural and remote areas, and we recognise this as a significant contributing factor to gaps in local service provision, rather than a separate or isolated issue. Digital and remote consultation models are increasingly used to mitigate rural access challenges; while these can improve access in some circumstances, we note that they may also introduce their own safety considerations,

including connectivity limitations and constraints on physical assessment, and should not be regarded as a substitute for local provision where clinically appropriate.

While service reconfiguration may at times be necessary, decisions should be supported by robust risk assessment, meaningful engagement with patients and communities, and clear plans to monitor outcomes following implementation. We will continue to examine how healthcare inequalities affect patient safety across Scotland's rural and remote areas.

NHS Boards Restructure

The Scottish Government's proposals to reduce the number of NHS boards represent a significant period of change for Scotland's healthcare system. Throughout this process, it will be important to ensure that patient safety considerations remain central to planning, implementation and evaluation. Patients, families, carers and front-line staff should have meaningful opportunities to contribute to discussions about future service arrangements, with subject matter expertise ensuring that rural and remote healthcare priorities are not lost within a larger, more centralised structure.

We are mindful that significant organisational change of this scale can create risks during the transition period as well as within the final structure. Loss of local relationships, institutional knowledge and established escalation routes can create safety gaps during periods of upheaval, distinct from the risks associated with the final configuration. Maintaining safe, functioning and trusted routes for staff to raise concerns throughout the transition, including adverse event reporting and whistleblowing channels, will be essential to ensuring safety-critical information continues to flow during a period of significant organisational change.

The specific concerns raised elsewhere in this report including safeguarding and dignity in hospital accommodation, safe staffing in acute mental health services, and healthcare inequalities in rural and island communities illustrate the kind of granular, service-level safety issues that must not be lost within a move to larger, more centralised board structures. We also note the relevance of the Independent National Maternity Review, whose findings on assurance and oversight will have direct application to how safety is assured across a restructured system.

We look forward to engaging with this work as it develops and will continue to monitor both the transition period itself and the safety implications of the eventual restructured system. Consistent and connected approaches to patient records, and to risk management including the management of adverse events and reporting, across a smaller number of boards will be an important safety consideration as this transition is planned.

A Flexible and Responsive Approach

As a small office, we must exercise judgement in determining where to focus our time, resource and attention. The priority areas set out above reflect the most significant and

consistent patient safety concerns identified through our engagement with patients, families, healthcare professionals and stakeholders to date. However, patient safety risks do not remain static. We recognise that priorities may need to evolve in response to emerging evidence, and the Office will remain responsive to new and developing concerns as they arise.

Overarching Themes

While many concerns align with our priority areas, the issues raised with our Office have also highlighted a number of overarching themes that warrant broader consideration.

Assurance Gap

Across a number of healthcare settings, patients, families and staff have described circumstances where concerns were known locally but where there appeared to be no effective mechanism for obtaining independent assurance that risks were being appropriately managed. This "assurance gap" can undermine public confidence and delay identification of systemic safety issues.

Our engagement has highlighted Scotland's patient safety landscape as improvement-rich but assurance-light: activity to identify and respond to safety concerns is frequently present at a local level, but robust, independent assurance that this activity is effective and consistently applied is often absent. This theme recurs throughout this report in maternity and neonatal care, in acute mental health services, in rural and island communities, and in the planning of NHS board restructuring and we consider it the central patient safety challenge facing Scotland's health system at this time.

We believe there is an opportunity to strengthen national oversight arrangements so that patient safety concerns can be tracked more consistently and learning can be shared more effectively across Scotland, rather than assessed only in retrospect or at the conclusion of individual reviews and inquiries

Culture, Speaking Up, and Moving Beyond Blame

The concerns raised with the Office this year highlighted persistent challenges in creating environments where people feel able to speak up, particularly where services are under pressure. Staff, patients and families described a familiar pattern: a concern is raised, reassurance is provided that there is "nothing to see here", and there is little visible opportunity for that concern to be examined independently.

This should not be understood as a reflection on the honesty or intentions of individual staff. Rather, it points to a wider challenge within systems that are still evolving from a culture of defending decisions towards one that actively welcomes examination, challenge and learning.

If confidence among patients, families, staff and the public is to be strengthened, concerns must be met with openness, scrutiny and a willingness to learn. Greater transparency, clearer accountability and a genuine commitment to learning are essential if confidence is to be strengthened among patients, families, staff and the public. The Office intends to support

that transition by promoting openness and ensuring that concerns receive proper consideration. When questions are raised, people should be able to expect a process of enquiry, evidence and learning, rather than a response that brings discussion to an end before issues have been fully explored.

Management of Adverse Events

Many of the concerns raised with the Office were linked to the management of adverse event reviews. In some cases, events had not been recorded on any healthcare data management system, and as a result had not been assessed to determine what, if any, level of adverse event review should take place, nor had any identified learning been shared to reduce the risk of recurrence.

Discussions with patients, families, carers and NHS staff indicate an inconsistent approach to the management of adverse events across NHS Scotland. This is despite the publication of Healthcare Improvement Scotland's National Adverse Event Framework in February 2025, and improvement is required nationally to ensure this framework is applied consistently, and that the voices of patients and staff are central to Significant Adverse Event Reviews.

Assurance processes should be documented to demonstrate that learning has taken place, that it has been shared both locally and, where appropriate, nationally, and that the impact of any resulting improvement changes has been recorded. Patient and family voice must be included at all stages of the review process, from initial notification through to the sharing of learning and monitoring of improvement.

Health Outcomes and Safeguarding

Patient safety extends beyond the prevention of immediate clinical harm and includes ensuring that healthcare systems identify, protect and support those at heightened risk of poor outcomes. Across several areas of healthcare, concerns were raised regarding safeguarding processes, the identification of vulnerable individuals, and the management of risks that may disproportionately affect certain patient groups. This includes patients with learning disabilities, older patients with cognitive impairment, patients experiencing mental health crises, patients with visual or hearing impairment, and patients from communities affected by wider health inequalities.

These concerns are reflected throughout this report, including in relation to safeguarding, privacy and dignity within hospital accommodation, and safe care in acute mental health settings. Our engagement suggests that safeguarding is a cross-cutting theme which affects many areas of healthcare rather than a distinct issue confined to specific services and is one which requires consistent identification and response regardless of care setting.

Robust safeguarding also depends on reliable assurance that identification and protection processes are being applied consistently in practice, not only that they exist in policy. We will continue to examine how healthcare systems can strengthen safeguarding arrangements and improve outcomes for those most at risk of harm.

Part 4: Engagement and Collaboration

Working Across Scotland

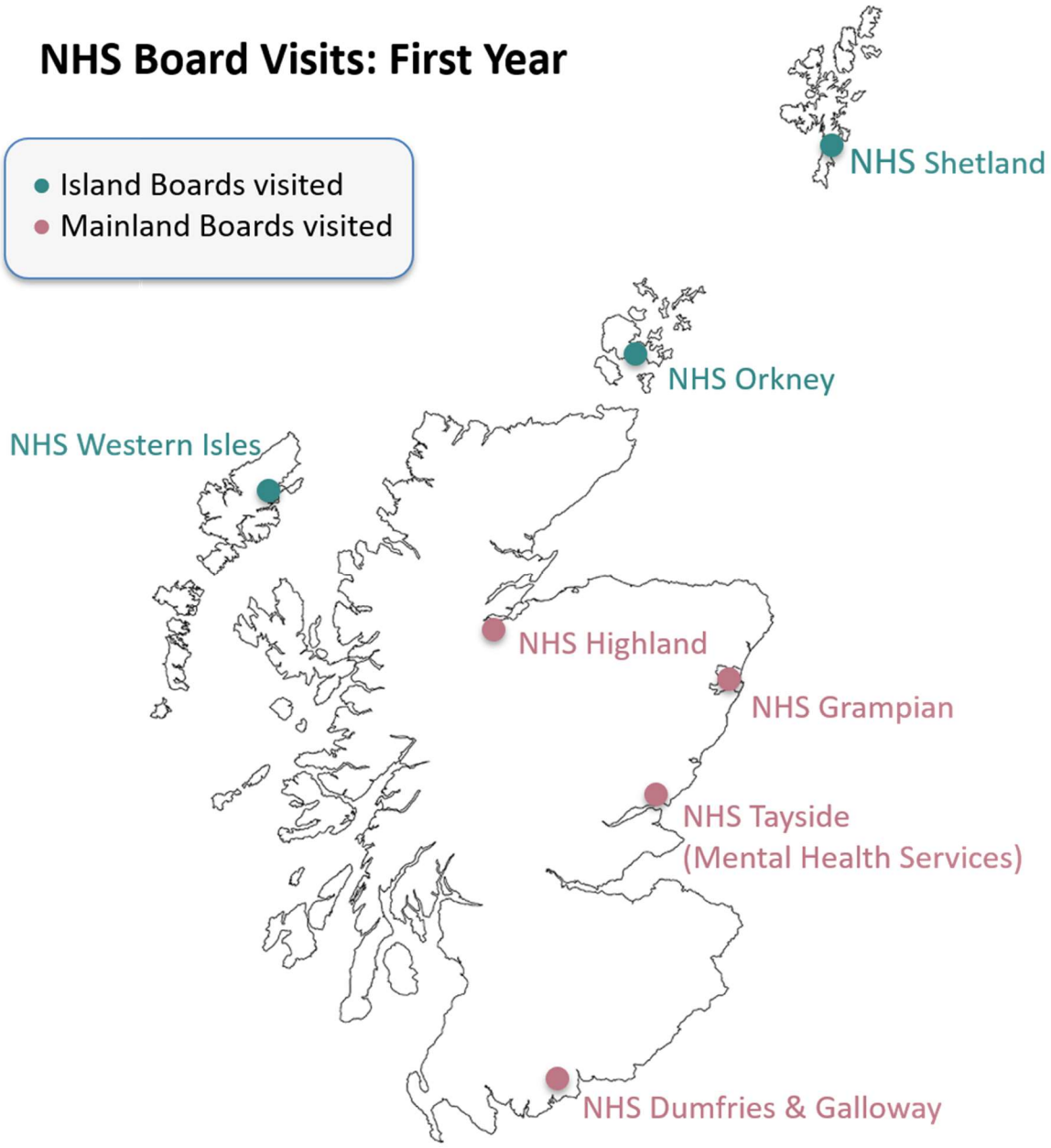
While Scotland is a relatively small country, engagement across 14 territorial NHS boards and four special health boards can be complex for a newly established national office. We are in the final stages of agreeing a Memorandum of Understanding (MoU) with an NHS Executive working group to establish clear arrangements for communication and the handling of enquiries from our Office. We are also nearing completion of a separate MoU with Healthcare Improvement Scotland, setting out how our organisations will work together, share expertise and exercise our respective functions in a complementary way. Both agreements reflect a shared commitment to improving patient safety across Scotland and recognise the importance of collaboration in achieving that goal.

Regular engagement has taken place with Scottish Government liaison officials, providing valuable opportunities to connect with the wide range of policy areas that contribute to the delivery and oversight of healthcare in Scotland. This has been complemented by planned engagement with NHS board Chief Executives, Medical Directors, Nursing Directors, Board Chairs and other professional groups. Our programme of introductory visits to NHS boards remains an important part of building constructive relationships, fostering the exchange of learning and good practice, and developing a shared understanding of patient safety challenges. Central to this approach is a commitment to open and transparent dialogue about the pressures and opportunities facing Scotland's health and care system. We are committed to working collaboratively with NHS boards and partners across Scotland in support of safer care for patients.

Following the Scottish Parliament election in May 2026, we wrote to all newly elected and returning MSPs to introduce the Office and offer opportunities for engagement. A parliamentary engagement event is scheduled for 30 September 2026, providing an opportunity to share reflections on our first year of operation and discuss our current priorities. The Commissioner also gave evidence to the Health, Social Care and Sport Committee in September 2025, and we look forward to maintaining a constructive relationship with the Scottish Parliament during the forthcoming parliamentary session.

Direct engagement with NHS boards continues to be a key element of our work. These visits provide an opportunity to understand local contexts, hear directly about patient safety challenges and innovations, and strengthen relationships with those responsible for delivering and improving services. We are committed to visiting every NHS board in Scotland. At the time of writing, visits have taken place to NHS Shetland, NHS Orkney, NHS

Western Isles, NHS Highland, NHS Grampian, NHS Tayside's Mental Health Services, and NHS Dumfries and Galloway.



We made an informed decision to initially visit rural and remote boards and agencies that play a critical role in supporting these communities, including the Scottish Air Ambulance, ScotSTAR, and HM Coastguard. Through our engagement with these services, we developed a firsthand understanding of how they operate seamlessly together, using efficient and patient-centred approaches to ensure the best possible outcomes for those requiring urgent care and assistance. We heard about some of the inequalities that exist and we wanted to understand more about the complexity of healthcare delivery in remote and rural areas.

At these visits, we were welcomed by Executive teams and visited a wide range of services where we had the opportunity to speak with leadership teams, staff on shift and patients

receiving care. We asked for a particular focus on these visits to have a deeper dive in specific areas such as emergency care where we had the opportunity to discuss and see first had increasing pressure on acute services which has added to our growing concern about patients receiving care in environments not designed for clinical treatment. We also focussed on community care in maternity and opportunities for hospital at home and the need for care to be delivered away from the front door. We also had a focus on mental health and are aware of the challenges faced in this area both in hospital setting and in the community with long lists for people awaiting diagnosis, treatment and management plans. We do have a growing concern where there are mixed sex wards, particularly in the hospital setting and are undertaking some research in this area to analyse this further.

The staff we met at these visits at every level from the Chief Executives though to frontline staff are dedicated and doing everything there can for their patients under real pressure. We would like to thank everyone that took the time to meet with us and share their views and ideas, and we look forward to continuing these interactions. It is important to recognise that innovation and improvement in patient safety should have a significant contribution from the people who deliver healthcare services.

Working with Patient and Third Sector Organisations

We recognise the vital contribution made by patient advocacy organisations, charities and third sector partners in amplifying patient voices and highlighting patient safety concerns. Throughout the year, the Office worked closely with a range of organisations representing diverse communities, conditions and lived experiences. These organisations provided valuable insight into patient experiences, emerging safety themes and opportunities for improvement across the health and care system.

Engagement with third sector partners helped ensure that the perspectives of people who may otherwise be underrepresented within formal healthcare structures were heard. These organisations often act as trusted advocates for patients and families, providing support, guidance and an important mechanism through which concerns can be raised and understood at a system level. Their contribution has been instrumental in helping us identify recurring themes, understand the impact of healthcare decisions on patients, and ensure that the work of the Office remains grounded in the experiences of those who use services.

We are grateful for the continued support, challenge and expertise provided by these organisations and looks forward to strengthening these relationships as the work of the Office develops.

Membership and Advisory Roles

During our first year, we have been honoured to contribute to a number of significant areas of work across Scotland. We remain firmly committed to ensuring that the voices of patients, families and carers are placed at the heart of these initiatives.

Our membership of the Scottish Government's Maternity and Neonatal Taskforce, and the subsequent National Maternity Review Programme chaired by Professor Christine McCourt, is of particular importance. This reflects the number of patient experiences and narratives shared with our office in this area of healthcare. We are committed to ensuring that the patient voice remains central to the development and delivery of this work.

As NHS board structures evolve, we will engage as appropriate with any restructuring process to ensure that the patient voice and patient safety remain central considerations. Our role in this respect is one of oversight and constructive engagement, ensuring that any changes to board structures strengthen, rather than dilute, mechanisms for patient safety assurance and accountability.

We have also contributed to a range of other national groups and forums, including the GMC Advisory Forum and the Mental Health and Learning Disability Collaborative.

As awareness of our organisation's work has grown through engagement with stakeholder organisations, our Office have been invited to present at a number of conferences and online events. These have included engagements with the Centre for Evidence and Values in Health at St Andrews University, the Realistic Medicine programme, and the International Hospital at Home community.

We were also pleased to contribute to the NHS event *Putting the Patient into Patient Safety* in March 2026. This provided an important opportunity to reinforce the value of placing the experiences of patients and families at the centre of learning when things go wrong. It also enabled us to promote collaborative working with NHS Boards and partner organisations to ensure that patient safety systems continue to learn from adverse events and are strengthened through continuous improvement.

Through these engagements, we have sought to champion the patient perspective and support the development of safer, more person-centred healthcare services across Scotland.

Working Across the United Kingdom

Our Office works closely with organisations, regulators, professional bodies and policymakers across the United Kingdom to share learning, develop relationships and contribute to improvements in patient safety. These connections ensure that Scotland benefits from developments elsewhere in the UK while also providing opportunities to share learning from the experiences of patients, families and carers who engage with our office.

England

This included engagement with the Patient Safety Commissioner for England, the Medicines and Healthcare products Regulatory Agency (MHRA), the Health Services Safety Investigations Body (HSSIB), the Department of Health and Social Care, and professional and regulatory bodies including the General Medical Council (GMC), Nursing and Midwifery Council (NMC), Professional Standards Authority (PSA) and Royal College of Nursing (RCN).

These discussions provided opportunities to exchange learning on patient safety, investigations, regulation, medicines and medical device safety, professional standards and the role of patient voice in driving improvement. We also participated in UK-wide discussions on issues including sodium valproate, patient information, adverse event reporting and wider system learning.

The Commissioner attended the All-Party Parliamentary Group (APPG) Patient Safety Symposium at Westminster, providing an opportunity to engage with parliamentarians, patient advocates, regulators and healthcare leaders on emerging patient safety priorities.

Our ongoing relationships with colleagues across England support the exchange of intelligence, learning and good practice on issues that affect patients across national boundaries and help ensure that developments elsewhere in the UK inform our work in Scotland.

Wales

We continued to strengthen relationships with colleagues in Wales, including engagement with the Chief Nursing Officer. These discussions provided opportunities to share approaches to patient safety, quality improvement and patient engagement, while also identifying areas of common interest and learning across the two nations.

Northern Ireland

The office engaged with the Regulation and Quality Improvement Authority (RQIA) in Northern Ireland to exchange learning and explore approaches to oversight, improvement and assurance within healthcare services.

These discussions have helped to build understanding of how different healthcare systems respond to patient safety concerns and have provided valuable opportunities to share insights from Scotland's independent Patient Safety Commissioner model. Maintaining links with colleagues across Northern Ireland supports our wider aim of learning from good practice wherever it is found and applying that learning to improve safety for patients in Scotland.

Taken together, these engagements reflect our commitment to working collaboratively across the United Kingdom. By building relationships with regulators, professional bodies, policymakers and patient safety leaders, we are able to contribute to national conversations, share learning from Scotland and ensure that our work is informed by developments across all four nations. This strengthens our ability to advocate effectively for patients, families and carers and to support improvements in healthcare safety across Scotland.

International Engagement

Patient safety challenges are rarely confined by national boundaries, and throughout our first year we have sought to build relationships with organisations and colleagues internationally. In New Zealand, we shared Scotland's experience directly with the Health Consumer Advocacy Alliance as it made the case to the New Zealand Parliament for an independent Patient Safety Commissioner, offering a candid account of what independence from government and regulators has meant in practice here, and where the model has and has not delivered.

We continued to draw on the Commissioner’s experience in Hospital at Home care to support international learning on safety and quality in complex care outside hospital walls, including webinars for the World Hospital at Home Congress on the safe delivery of oncology care at home, and will speak at the Nordic Hospital at Home Society Conference in October, sharing lessons from Scotland's approach to patient safety alongside the clinical model itself.

These international relationships test whether Scotland's own assurance architecture stands up to comparison, and they ensure this office learns from, rather than repeats, the mistakes and successes of comparable systems elsewhere.

Part 5: Investigations Protocol

Investigation Framework

During the reporting period we completed the development of our Investigation Framework, marking an important step in establishing how this Office will exercise its investigatory functions. The framework provides a structured, transparent and systems-based approach to examining patient safety concerns and identifying opportunities for learning and improvement across Scotland's healthcare system.

Consistent with the Commissioner's wider approach, the framework is rooted in systems thinking and human factors principles, with decision-making processes that will underpin future investigations undertaken by the office. It is designed to support independent, proportionate and evidence-informed investigations that seek to understand why safety risks emerge, how they persist, and what action may be required to reduce the likelihood of future harm.

Following a period of research, drafting, stakeholder engagement, and iterative refinement, the framework was approved by the Commissioner on 13th August 2026. This approval is subject to receipt of formal legal advice which is pending at the time of writing.

Patient, family, and carer experiences are central to the framework. The purpose of investigation is to ensure that concerns raised by the public contribute to meaningful learning and system improvement while maintaining transparency and independence.

Next Steps

During 2026-27, our focus will be on embedding the framework within the Office's operational practice and ensuring it remains effective, proportionate and responsive to learning:

- Reviewing and implementing any amendments required following receipt of formal legal advice.
- Applying the framework to investigations undertaken our Office.
- Monitoring the effectiveness and usability of investigative processes and supporting tools.
- Gathering feedback from patients, families, stakeholders, and professional partners.
- Incorporating learning arising from operational use

Stages of investigation

The framework consists of four interconnected stages which together support the identification of concerns, the assessment of risk, the conduct of investigations and the promotion of system-wide learning:

1. Intelligence and Review
2. Decision to Investigate
3. Implementation and Accountability
4. Systems Improvement

Intelligence and Review

During this stage, intelligence is received, gathered and analysed from a wide range of sources, including patient, family and carer concerns, inter-agency intelligence sharing, media monitoring, concerns raised by MSPs, and other relevant information sources.

Concerns are reviewed, themed and assessed against a scoring matrix to determine the most appropriate course of action. Where concerns can be addressed without a formal investigation, they may be managed through a Monitoring Patient Safety process.

The Monitoring Patient Safety process is recognised within the Memorandum of Understanding between the Commissioner and NHS Chief Executive Boards. It enables us to raise concerns directly with Chief Executives and seek resolution through engagement, assurance and improvement activity, without initiating a formal investigation.

Decision to Investigate

Information gathered during the intelligence and review stage is assessed to determine whether sufficient assurance has been provided through informal processes. Where concerns indicate the potential for significant systemic risk, or where sufficient assurance has not been obtained through informal engagement, we may decide to initiate a formal investigation.

A formal investigation begins when we publish the Terms of Reference, in accordance with Section 8 of the *Patient Safety Commissioner for Scotland Act 2023*. The Terms of Reference set out the scope of the investigation, identify any individuals or organisations to whom recommendations may be directed, and specify whether access to individuals' information is expected to be required.

Before finalising the Terms of Reference, we must consult the Advisory Group and may seek views from other relevant stakeholders.

The Terms of Reference must:

a) describe the issue to be investigated,
b) identify (by name or description) any person to whom we expect to address a recommendation in the report produced at the conclusion of the investigation,
c) state whether we expect to need access to individuals' information in the course of the investigation,
d) and, if we do expect to need access to individuals' information, state:
    i. why that is our expectation, and
    ii. why we expect to need that information in a form that does, or does not (as the case may be), allow individuals to be identified.

While informal engagement is often considered first, the Commissioner retains the authority to commence a formal investigation at any stage where circumstances warrant immediate action.

Implementation and Accountability

Formal investigations conclude with the publication of a report and associated recommendations, which are laid before the Scottish Parliament.

The Office will monitor implementation, seek assurance regarding progress, and evaluate whether actions taken are sufficient to address the risks identified through the investigation.

Where recommendations are not implemented or sufficient progress is not demonstrated, concerns may be escalated through established reporting arrangements. Escalation will normally begin with the Chief Executive of the relevant organisation and, where necessary, may progress to the Health, Social Care and Sport Committee and Scottish Ministers.

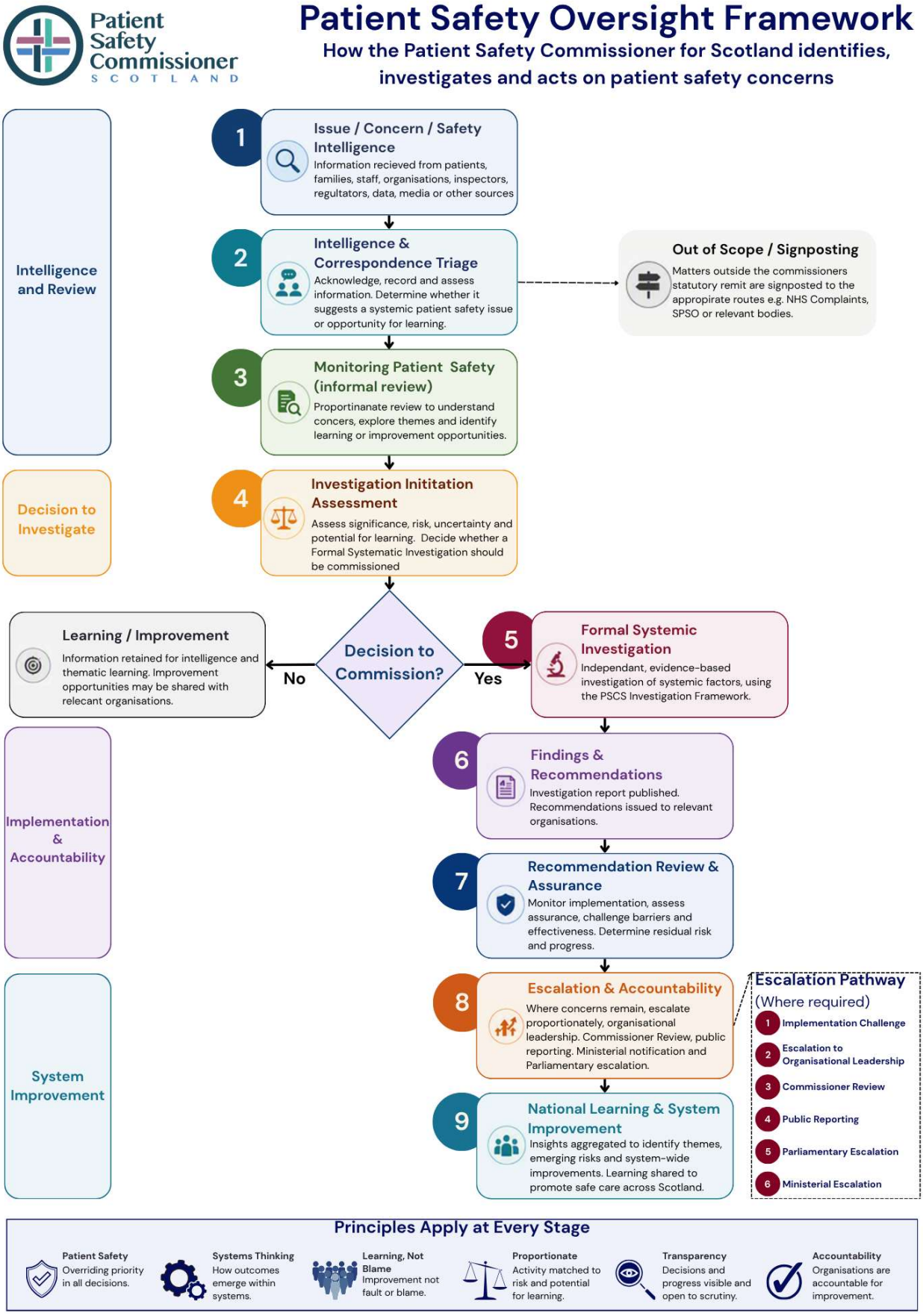
Systems Improvement

The ultimate purpose of both formal investigations and informal monitoring activity is to support system-wide learning and improvement.

Throughout the investigation process, themes, trends and recurring issues will be analysed to identify learning that can strengthen patient safety across Scotland. Findings and lessons learned will be shared with relevant organisations to support improvement, promote collaboration and strengthen existing systems and processes.

This continuous cycle of intelligence gathering, investigation, accountability and learning helps to drive sustainable improvements in patient safety and healthcare delivery.

The process flowchart on the following page provides a visualisation of this process.


Patient Safety Commissioner SCOTLAND
Patient Safety Oversight Framework
How the Patient Safety Commissioner for Scotland identifies, investigates and acts on patient safety concerns
Intelligence and Review
1
Issue / Concern / Safety Intelligence
Information recieved from patients, families, staff, organisations, inspectors, regultators, data, media or other sources
2
Intelligence & Correspondence Triage
Acknowledge, record and assess information. Determine whether it suggests a systemic patient safety issue or opportunity for learning.
Out of Scope / Signposting
Matters outside the commissioners statutory remit are signposted to the appropirate routes e.g. NHS Complaints, SPSO or relevant bodies.
3
Monitoring Patient Safety (informal review)
Proportinanate review to understand concers, explore themes and identify learning or improvement opportunities.
Decision to Investigate
4
Investigation Inititation Assessment
Assess significance, risk, uncertainty and potential for learning. Decide whether a Formal Systematic Investigation should be commissioned
Decision to Commission?
No
Learning / Improvement
Information retained for intelligence and thematic learning. Improvement opportunities may be shared with relecant organisations.
Yes
5
Formal Systemic Investigation
Independant, evidence-based investigation of systemic factors, using the PSCS Investigation Framework.
Implementation & Accountability
6
Findings & Recommendations
Investigation report published. Recommendations issued to relevant organisations.
7
Recommendation Review & Assurance
Monitor implementation, assess assurance, challenge barriers and effectiveness. Determine residual risk and progress.
8
Escalation & Accountability
Where concerns remain, escalate proportionately, organisational leadership. Commissioner Review, public reporting. Ministerial notification and Parliamentary escalation.
Escalation Pathway
(Where required)
1 Implementation Challenge
2 Escalation to Organisational Leadership
3 Commissioner Review
4 Public Reporting
5 Parliamentary Escalation
6 Ministerial Escalation
System Improvement
9
National Learning & System Improvement
Insights aggregated to identify themes, emerging risks and system-wide improvements. Learning shared to promote safe care across Scotland.
Principles Apply at Every Stage
Patient Safety
Overriding priority in all decisions.
Systems Thinking
How outcomes emerge within systems.
Learning, Not Blame
Improvement not fault or blame.
Proportionate
Activity matched to risk and potential for learning.
Transparency
Decisions and progress visible and open to scrutiny.
Accountability
Organisations are accountable for improvement.

Patient Engagement Working Group

During the reporting year, we have established the Patient Engagement Working Group (PEWG) as an advisory group to support the development of a co-produced national framework for NHS organisations and Scottish Government to engage with patient, family and unpaid caregivers. The Group brings together people with lived experience, unpaid carers, patient representatives, third sector organisations and system partners to guide NHS organisations and Scottish Government using shared principles for meaningful and consistent engagement and participation.

The PEWG was established in recognition that patients, families and unpaid carers provide a vital source of insight, assurance, learning and constructive challenge to NHS organisations and Scottish Government. Its role is to ensure that lived experience and patient voices help inform care design, service improvement, patient safety, governance and decision-making.

Working through a co-production model, the Group provides advice, challenge and scrutiny, helping to shape a Patient Voices Framework. The framework aims to reduce variation in engagement practice, strengthen transparency and accountability, and provide a clearer national understanding of what meaningful participation should look like in practice.

This work reflects our commitment to ensuring that the experiences of patients, families and unpaid carers are listened to, valued and acted upon. By supporting the development of shared principles and approaches to engagement, the PEWG is helping to create a healthcare system in which people are recognised as active partners in improving safety, quality and experiences of care.

A recent quote from a PEWG member highlights the importance of this work:

> Meaningful engagement with patients and families cannot rest on goodwill alone. It needs structures, standards and ways of working that ensure people are safe, respected and genuinely heard.
>
> Too often, those affected by harm, exclusion or poor care are expected to repeatedly explain, evidence and justify why the system should listen. That is an unfair burden, and it is not how a learning, compassionate safety culture should operate.
>
> I was encouraged this week by the inaugural meeting of the Patient Engagement Framework Group and by the ambition already evident in the work. The task now is to co-design a framework that is meaningful in practice, not simply well intentioned on paper.
>
> Patient and family voice is not an optional addition to quality and safety. It is essential evidence for better decisions, safer care and public confidence.
>
> I also want to thank the Patient Safety Commissioner for Scotland and her team for not simply listening to these concerns, but for acting on them with real pace and purpose. That responsiveness matters. It gives patients, families and those working alongside them reason to believe that their experience is being treated not as an afterthought, but as a vital part of building safer, more respectful care.
>
> *Professor John Cuddihy*

Part 6: Raising Awareness

Communications and Media

Public website

During the year, the Office established its **public website**, providing a dedicated platform for publishing information about the Commissioner, sharing reports and publications, engaging with patients and stakeholders, and improving public awareness of the Office's role. The website seeks to demonstrate the Office's commitment to openness, transparency and accessible communication. We are grateful for the support of the team at the Royal National Institute of Blind (RNIB) team for their expertise in working towards making the site accessible and inclusive for everyone.

You can access the website here: **https://www.patientsafetycommissioner.scot**

As with new organisations, building the mechanisms to reach the public comes in many forms. Our media activity has included the set-up **LinkedIn** and **Facebook** pages, where members of the public and organisations can engage with us and keep up to date with our work.

Media activity

Media coverage has been increasing with articles in some national publications alongside interviews with BBC Scotland Radio and TV news and STV. Some local engagement and interviews with local radio broadcasters whilst visiting remote and rural areas of Scotland has taken place. This has resulted in an increase in enquiries to the office from members of the public to share their healthcare journey.

It is important to create the mechanism for people to engage with our office in person. On-line engagement does not suit everyone and it’s important to meet people in person. Face to face interactions help in building trust and rapport which is crucial when having the privilege of listening to with someone's personal healthcare story. We have held surgeries in Stranraer, Dumfries and Galloway (town hall type event,) and in Wick, Caithness (individual patient and family meetings.) We would like to thank the Galloway Community Hospital Action Group and the Caithness Health Action Team (CHAT) for facilitating these sessions. During the next year, more local community in person engagement events are planned and we look forward to meeting people in person.

Conferences and Events

During our first year in office, we have been invited to attend and on occasion present at conferences with partner organisations, some of which are listed below.

- The Centre for Evidence and Values in Healthcare inaugural Conference as speaker.
- Putting the Patient into Patient Safety (NHS) as a speaker.
- Annual Realistic Medicine Conference (NHS) as a panel member.
- Independent Healthcare Providers Conference.
- Centre for Evidence-Based Healthcare, University of St Andrews.
- Royal College of Nursing Scotland Nurse of the Year Awards.
- *#StopTheDeaths* Scottish Drugs Forum Conference.

These events provide a valuable opportunity to engage with organisations and build networks who have the same aim in terms of improving patient care and ensuring voices of healthcare service users in Scotland are heard and their concerns are listened to and acted upon. We will continue to build networks with stakeholders through attendance at future events

In addition to this, plans are underway to host a **Four Nations Patient Safety Event** in May 2027, Edinburgh. This will provide the opportunity for all parts of the UK to join with aim of learning from each other and make connections. Further details of this will follow shortly.

Part 7: Corporate Governance

Corporate Services

Staffing and Workforce

The first year of operation has focussed on establishing a small, skilled and agile team capable of supporting the Commissioner's statutory functions. As a small organisation, the Office remains committed to developing a collaborative and flexible working environment that enables staff to contribute across a broad range of activities while maintaining a clear focus on improving patient safety.

As awareness of the Commissioner's role continues to grow, so too does the opportunity to deepen the Office's impact. The foundations established during this first year have positioned the Office well for future development, and we will continue to work constructively with the Scottish Parliamentary Corporate Body and Scottish Government to ensure that the organisation is appropriately resourced to fulfil its statutory role and respond effectively to the needs and concerns of patients, families and carers across Scotland.

Governance

As an independent statutory officeholder accountable to the Scottish Parliament, we have established governance arrangements designed to ensure compliance with statutory obligations, good public sector practice and to support effective decision-making, transparency and accountability.

The Commissioner is accountable to the Scottish Parliament for the exercise of the Office's statutory functions and, as Accountable Officer, is responsible for ensuring the proper stewardship of public resources. Regular engagement with the Scottish Parliamentary Corporate Body has provided support and assurance as the Office has established its governance, financial and operational arrangements.

We remain committed to maintaining the highest standards of governance, transparency and public accountability in the exercise of all statutory functions.

Risk Management

The Office has established a proportionate approach to risk management to support the achievement of its strategic objectives and statutory duties.

As a newly established office, risk management during the reporting period was supported through regular engagement with the Scottish Parliamentary Corporate Body and the governance and assurance arrangements that accompany the establishment of a parliamentary officeholder. These arrangements have provided oversight and support as the Office has developed its initial structures, systems and ways of working.

During the coming year, the Office will further strengthen its approach to risk management through the development of its own corporate governance framework, including the establishment of a corporate risk register. This will provide a structured mechanism for identifying, assessing and monitoring strategic, operational, financial, legal and reputational risks, ensuring that risks are managed proactively and proportionately as the organisation continues to mature.

Equality, Diversity and Inclusion

We are committed to ensuring that equality, diversity and inclusion are embedded throughout the work of the Office and inform the exercise of all statutory functions.

This commitment extends beyond organisational practices to the Commissioner's wider role in ensuring that patient safety improvements are informed by the experiences of diverse communities and those whose voices may not always be heard within healthcare systems.

During the year, consideration was given to accessibility, inclusive engagement, and ensuring that the Office's policies, publications and communication activities reflect the needs of Scotland's diverse population. We will continue to develop this work as the organisation matures.

Finance and Resources

Financial Statement

The Office operates within resources provided through the Scottish Parliamentary Corporate Body and is committed to ensuring that public funds are used effectively, efficiently and transparently.

Resource Utilisation

As a newly established organisation, much of the Office's expenditure during the year was directed towards building the foundations necessary to support the Commissioner's statutory role.

Resources were invested in staffing, governance arrangements, digital infrastructure, website development, case management systems, policy development, patient engagement activity and specialist professional services. These investments have established the capability required to support the Office's future programme of work.

We have sought to ensure that resources are directed towards activities that provide the greatest opportunity to improve patient safety and strengthen the role of patient voice within Scotland's healthcare system.

Value for Money

We recognise the importance of demonstrating value for money in the use of public resources.

As a newly established office, the approach taken throughout the year has been to build capability in a proportionate and sustainable manner, making use of existing public sector arrangements and shared services where appropriate, while maintaining the independence required by statute.

Procurement activity has focused on securing external expertise only where specialist support is required, including digital, accessibility and legal services. This approach aims to maximise organisational effectiveness while ensuring that resources remain focused on delivering our statutory objectives and improving outcomes for patients across Scotland.

Part 8: Looking Ahead

Future Priorities

As the Office enters its second year, our focus will be on strengthening the foundations established during 2025-26 while continuing to develop our understanding of the patient safety issues that matter most to patients and families across Scotland. Our expected priorities will be:

Strategic Plan

By February 2027, we will develop a Strategic Plan, setting out both a four-year and an eight-year vision for the office, so that Parliament and the public can hold the Commissioner to a clear and considered trajectory rather than a year-by-year account of activity.

Publication of the Investigation Framework

We will publish our Systemic Investigation Framework, giving boards, staff, and patients clarity on how and when this office will investigate, and on what basis.

Development of the Patient Engagement Working Group

We will continue to develop the Patient Engagement Working Group, ensuring the structures for hearing from patients and the public are as robust as the structures for engaging with boards and regulators.

Research and Evidence Programme

We are also establishing a Research and Evidence Programme, including a partnership with the University of St Andrews examining single-sex healthcare and the safety risks and outcomes associated with it. This work reflects our commitment to grounding this office's positions in rigorous evidence rather than assertion.

Memoranda of Understanding with HIS and NHS Boards

We will conclude Memoranda of Understanding with Healthcare Improvement Scotland and with NHS boards, formalising the working arrangements — including advance notification of significant findings that this office has so far relied on informal goodwill to secure.

Interim Findings from National Reviews

Healthcare Improvement Scotland’s August 2026 rapid engagement exercise, discussed above, illustrates why these matters: it surfaced safety-relevant themes directly from patients, but no formal mechanism currently exists to ensure such findings are tracked and

their resolution assured beyond the review process itself. We consider that interim findings from significant national reviews, including the independent maternity services review, should be routed through a formal assurance function, so that safety-relevant themes are monitored independently rather than assessed only once a review concludes.

Patient Voice at the Centre

Through all of this, we will continue to ensure that the patient voice remains at the centre of everything this office does: not a single strand of activity, but the test against which every other priority is set.

Restructure of the NHS in Scotland

We have a significant interest in the recently announced plans to reduce the number of NHS boards in Scotland. It is imperative that the voices of front-line staff, patients, families, and carers are central to how this redesign is shaped, and that the right subject matter expertise guides a transition of this scale including ensuring that rural and remote healthcare priorities are not lost within a larger, more centralised structure.

We also note the relevance of the independent national maternity review, whose findings on assurance and oversight are directly applicable to how safety is assured across a restructured system.

We look forward to the opportunity to engage as this work develops, to ensure patient safety remains a foundational consideration throughout. Consistent and connected approaches to patient records, risk management including the management of adverse events and reporting across a smaller number of boards will be an important safety consideration as this transition is planned, and one we will continue to monitor.

Statement: Use of Artificial Intelligence in preparation of this report

Artificial intelligence tools were used to support aspects of drafting, editing, accessibility checking and document production. All content was reviewed, verified and approved by the Office of the Patient Safety Commissioner for Scotland before publication.