Healthcare Improvement Scotland

Scottish Patient Safety Programme

SPSP National Learning Event

The Essentials of Safe Care

October 2025

Leading quality health and care for Scotland

NHS Scotland

Chair's welcome

Robbie Pearson
Chief Executive
Healthcare Improvement Scotland

Housekeeping

- Wi-fi name: **GJCH Public Wi-Fi**
- If you hear a fire alarm, please proceed to the nearest exit
- Please set mobile phones to silent
- Links to resources and recordings will be shared following the event
- We will be using Slido throughout the day to capture real-time audience feedback
- Poster displays within Central Plazza

slido

Welcome to our virtual audience

- Fully hybrid event
- Interactive plenary and breakout sessions with the opportunity to participate in Q&A and chat
- Cameras disabled
- This session is being recorded

Who is here today.....

Aberdeenshire Health and Social Care Partnership

National Centre for Sustainable Delivery

Royal College of Paediatrics and Child Health

Scottish Ambulance Service

Children's Health Scotland

Nuffield Health

Scottish Neonatal Nurses Group

NHS 24

Scottish Government

Healthcare Improvement Scotland

Marie Curie Hospice Glasgow

Public Health Scotland

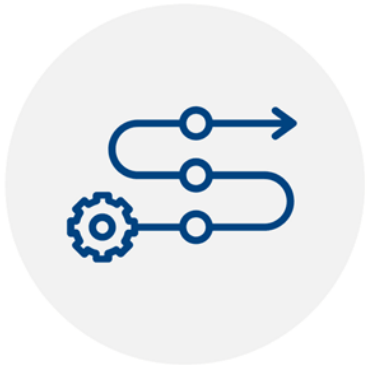
Care Inspectorate

NHS Education for Scotland

Aims of the day

- Provide a national platform for colleagues to connect, share learning and build knowledge to support ongoing improvements in safety
- Introduce the next phase of SPSP Essentials of Safe Care
- Build a shared understanding of how the SPSP Essentials of Safe Care may be applied across a range of settings to support the safe delivery of care



Morning programme

Time	Item	Lead
9.45am	Chair's welcome	**Robbie Pearson**, Chief Executive, Healthcare Improvement Scotland
9.55am	Ministerial address	**MSP Neil Gray,** Cabinet Secretary for Health and Social Care
10.05am	Creating a culture of safety	**Dr Suzette Woodward**, Professional and Clinical Advisor in Patient Safety, Visiting Professor of Patient Safety, Imperial College London
11.05am	Coffee break	
11.25am	• SPSP Essentials of Safe Care: The next phase • A Framework for Quality Improvement	**Joanne Matthews**, Associate Director of Improvement and Safety, Healthcare Improvement Scotland **Stewart Marshall,** Head of Community Health and Care Services, South Ayrshire Health and Social Partnership
12.25pm	Chair's Summary	**Robbie Pearson**, Chief Executive, Healthcare Improvement Scotland
12.30pm	Lunch and poster networking session	
1.35pm	**Afternoon Breakouts** • Continuous Improvement to Embed the EoSC within SPSP Adults in Hospital • SPSP Perinatal and Paediatric Approach to the SPSP EoSC • Applying the SPSP Essentials of Safe Care within SPSP Mental Health	SPSP Adults in Hospital Team SPSP Perinatal and Paediatric Team SPSP Mental Health Team
3.40pm	Chair's summary and reflections	**Robbie Pearson**, Chief Executive, Healthcare Improvement Scotland
4pm	Event close	

Healthcare Improvement Scotland

Our purpose

To support the design and implementation of changes that improve quality

Statutory duty

to protect and enhance the safety and wellbeing of those that need healthcare

Ministerial address

MSP Neil Gray
Cabinet Secretary for Health and Social Care
Scottish Government

Ministerial address

Creating a culture of safety

Dr Suzette Woodward
Professional and Clinical Advisor in Patient Safety,
Visiting Professor of Patient Safety, Imperial College London

Creating a culture of safety

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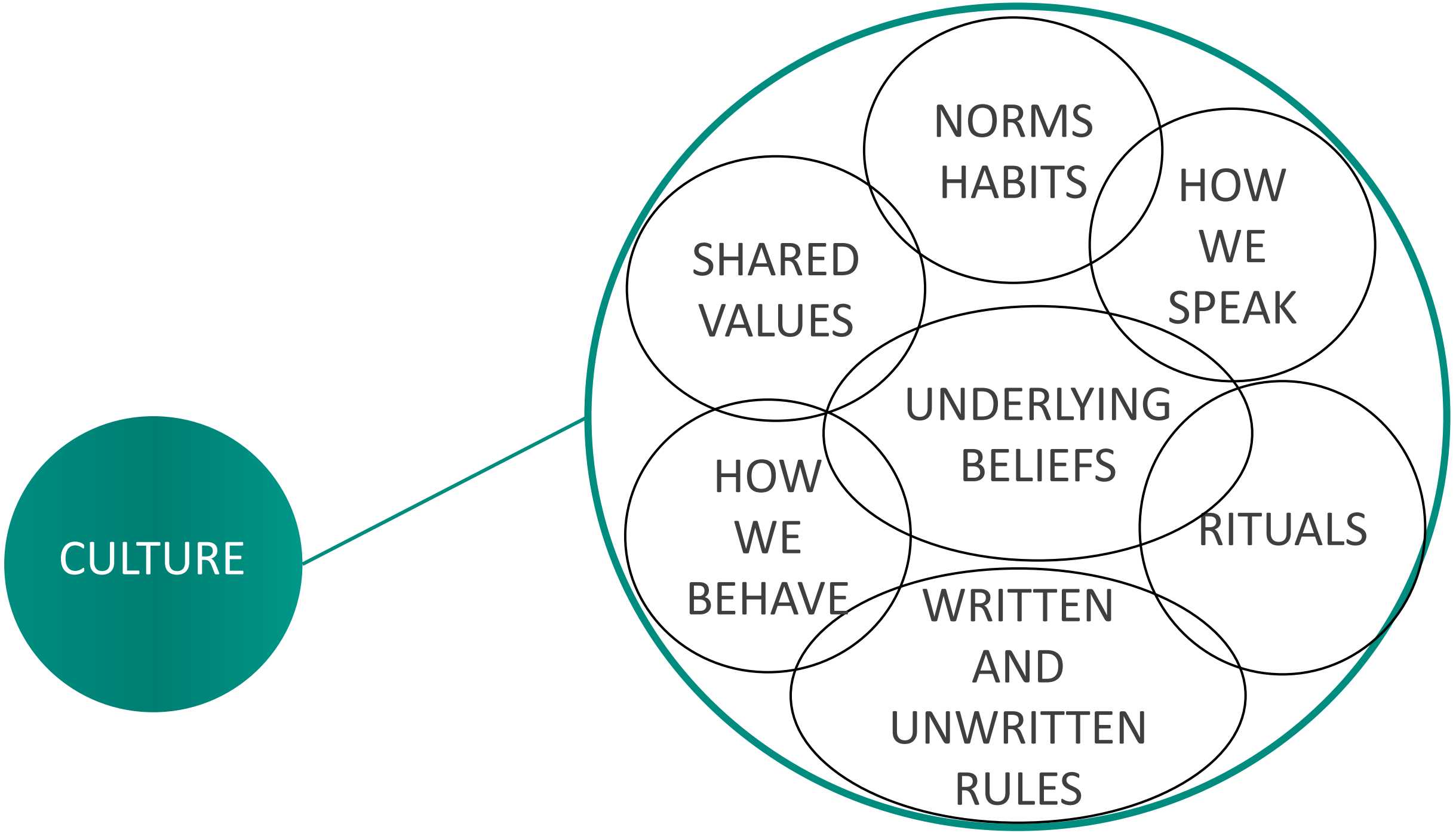
Essentials of Safe Care – Driver diagram

Our vision is	Delivered through ...	Which requires...
The delivery of safe care, improving outcomes for every person, every time across health and care	A people-led approach to the planning and delivery of safe care	People and professionals are equal partners in shared decision making
		Care and support is shaped to meet the needs of people
		People, families, carers and staff are systematically listened to, and concerns are acted upon
	Effective and inclusive communication	Communication tailored to individual needs and preferences
		People and teams feel safe and able to speak up
		Team communication and collaboration
	Leadership at all levels to support a culture of safety	Leadership is compassionate and inclusive
		Staff feel supported and valued
		Learning system for continuous improvement
		Everyone has the opportunity to learn and develop
	Safe clinical and care processes	Safe staffing and skill mix
		Care is up to date and evidence based
		Clinical and care governance structures support safety
		Information systems that work together

Recipe for a safety culture

- Step 1 Understand what we mean by a safety culture
- Step 2
- Step 3
- Step 4
- Step 5


CULTURE
NORMS
HABITS
HOW
WE
SPEAK
SHARED
VALUES
UNDERLYING
BELIEFS
HOW
WE
BEHAVE
RITUALS
WRITTEN
AND
UNWRITTEN
RULES


ELEVEN
全家 FamilyMart
LAWSON 罗森

Cultural change

- We are all different
- You can't design or engineer culture – true cultural change means changing shared values, beliefs, assumptions and practice
- It can only be evolutionary from the bottom up and slow

Recipe for a safety culture

- Step 1 Understand what we mean by a safety culture
- Step 2 Understand day to day reality
- Step 3
- Step 4
- Step 5

Ultra safe

- Routine predictable environments
- Policies effective tools to support
- Example: radiotherapy

High reliability

- Complex but stable environments
- Policies work hand in hand with expertise
- Example: routine surgery

Ultra adaptive

- High uncertainty environments
- Expertise more important than policies
- Example: emergency care, ICU, labour unit

Day to day reality

Work as normal

- Understand *how* the work normally takes place

Work as intended

- Look at what *should* happen

Work as done at this time

- Look for *what* happens in particular circumstances

Studying work as normal

- Finding the voices – holding conversations across teams, across areas and during different shifts
- Creating learning teams – to help understand the daily constraints and adaptions
- Observing the work – video reflexivity or ethnography
- Mapping the three different ‘works’; work as normal, intended and done at the time of a particular circumstance e.g. and adverse event – identify the similarities and differences

"The Messy Reality is characterised by the kinds of adjustments, adaptations, variations, trade-offs, compromises, and workarounds.

These are hard to prescribe and hard to see from afar, but can become accepted and unremarkable from the inside"

Steven Shorrock: https://humanisticsystems.com

Strong and weak signals

- We already have the *strong* signals
  - Adverse events
  - Incidents
  - Accidents
  - Grievances
  - Complaints
- What we are missing are the *weak* signals – subtle clues that signal deeper issues
  - Near misses
  - Daily habits and norms
  - Small compromises, adaptions and workarounds

“We always hope for the easy fix: the one simple change that will erase a problem in a stroke

But few things in life work this way”

Atul Gawande

8 out of 10 people liked your talk

Recipe for a safety culture

- Step 1 Understand what we mean by a safety culture
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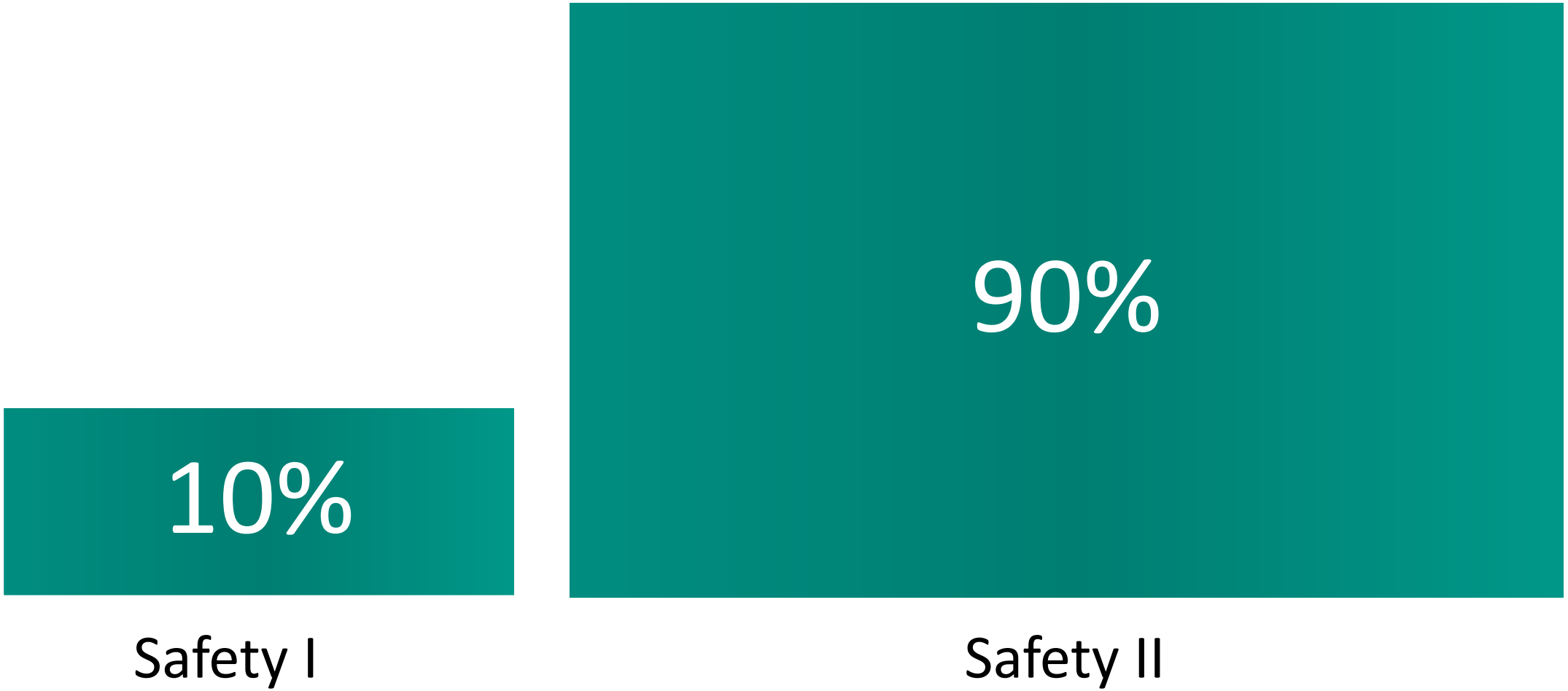
- Step 4
- Step 5

“Things go right far more often than they go wrong. That’s what we need to understand.”

Professor Erik Hollnagel


90%
10%


10%
90%
Safety I
Safety II

Safety I is like trying to understand a good marriage by only talking to divorced couples

Marit de Vos

Safety II is learning about marriage by talking to couples who are still together

Discovering the…..
daily habits
small compromises
and resilience that keep their relationship strong despite the challenges

Changes our language

- Safety-I:
  - Why did it go wrong? Who was to blame?

- Safety-II:
  - What does safer care actually look like in practice, and how can we support more of that?

  - How do healthcare practitioners work safely every day — and how can we make that easier and more reliable?

Why did it fail this time when it normally goes ok?

Creating the conditions for safety II to succeed

- *Redesign the way we do 'safety I' in order to create the conditions for safety II to succeed*

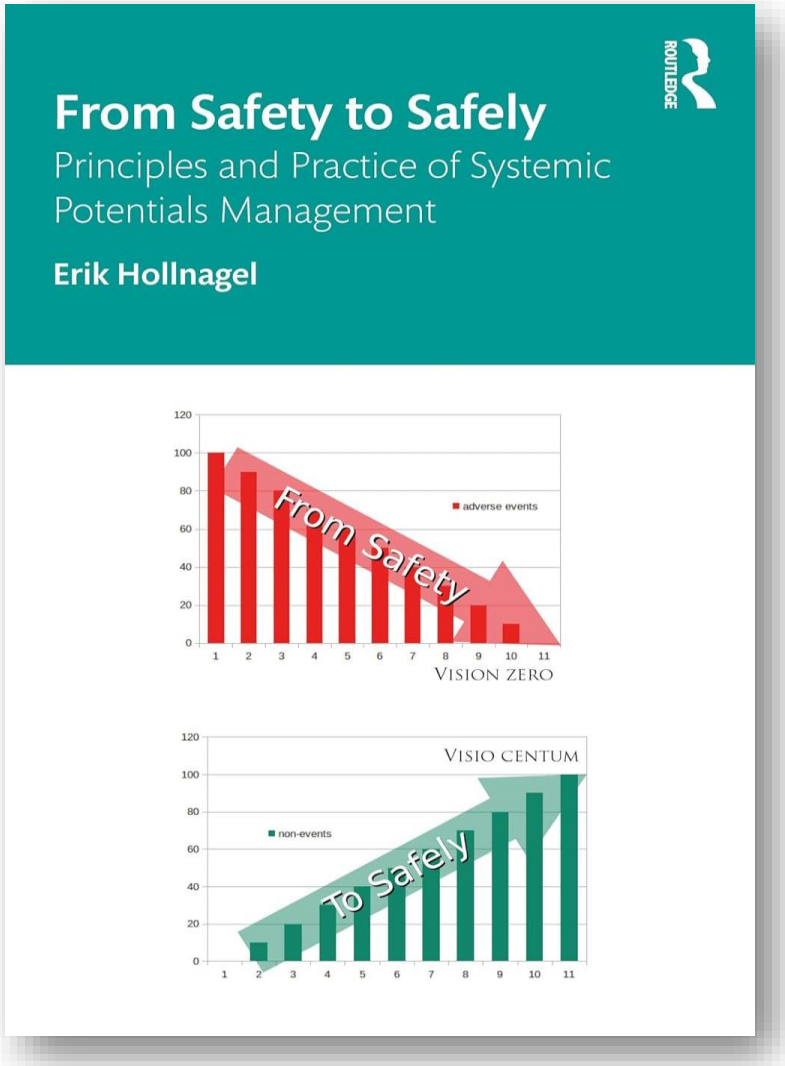
Information overload

“There comes a point where we need to stop just pulling people out of the river.

Some of us need to go upstream and find out why they are falling in.”

Desmond Tutu

From safety to safely



Recipe for a safety culture

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- Step 4 Care for your most valuable resource
- Step 5

The Timpsons Story

- They ask just one question in their staff survey:

- 'Are our colleagues happy and supported?’

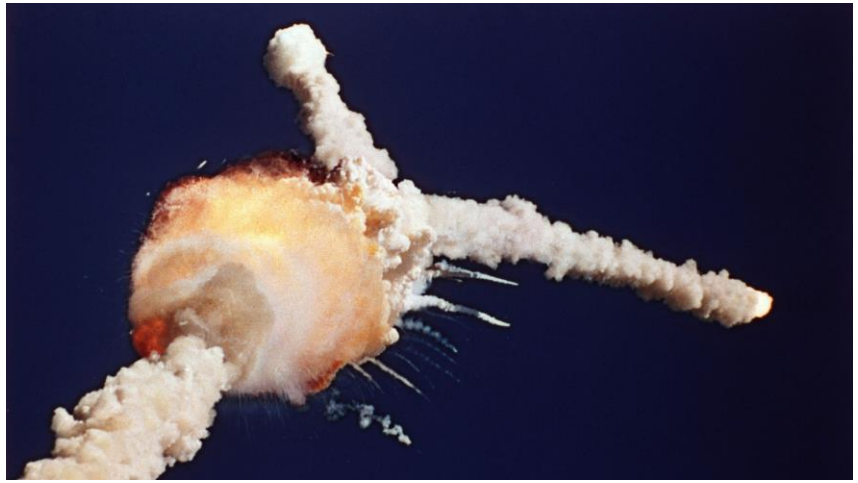
Janet Leighton
Director of Happiness

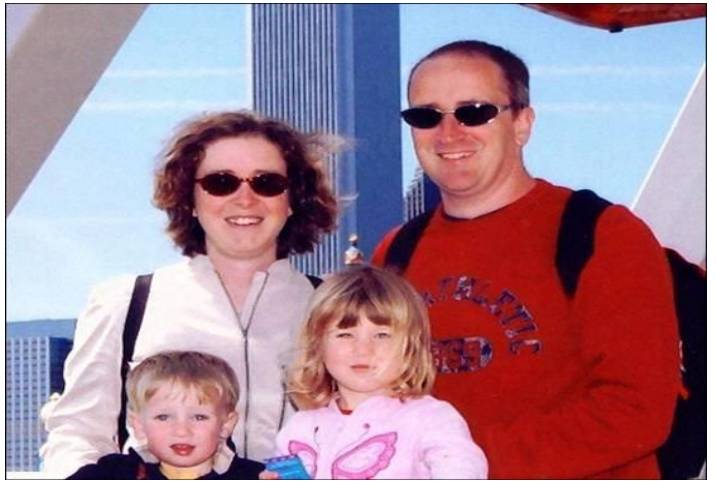
- Safer care is only possible if we care for those who care

- Helping people to raise their hand, ask a question or to say they don’t know what they are doing
- … or in fact that they may have done something wrong

- Without fear of repercussions

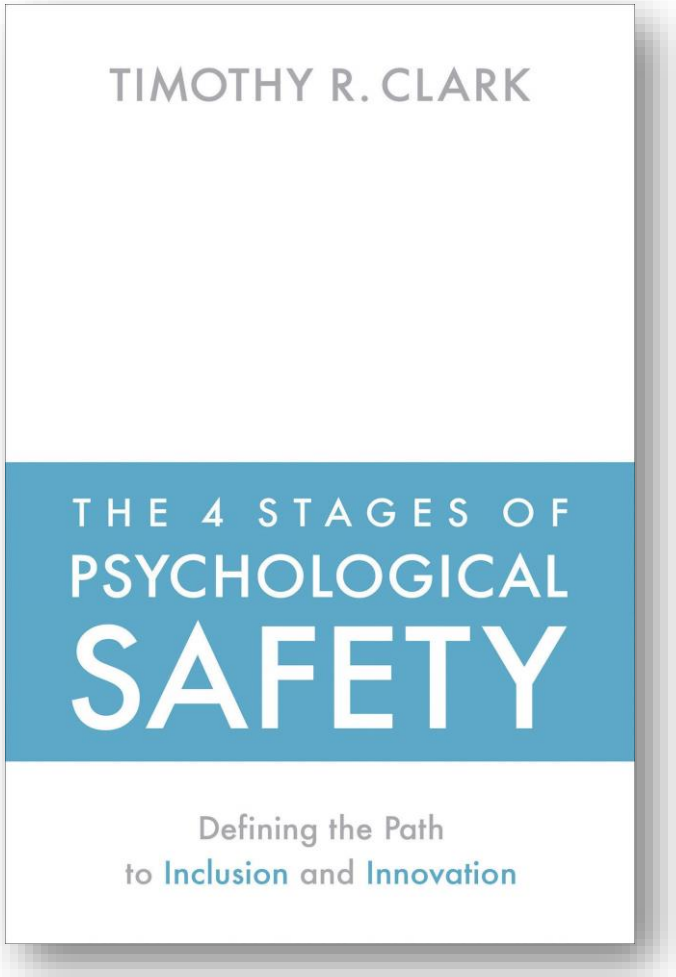
Amy Edmondson – the fearless organisation
Creating psychological safety in the workplace





Four stages of psychological safety

1. Inclusion safety
2. Learning safety
3. Contributor safety
4. Challenger safety

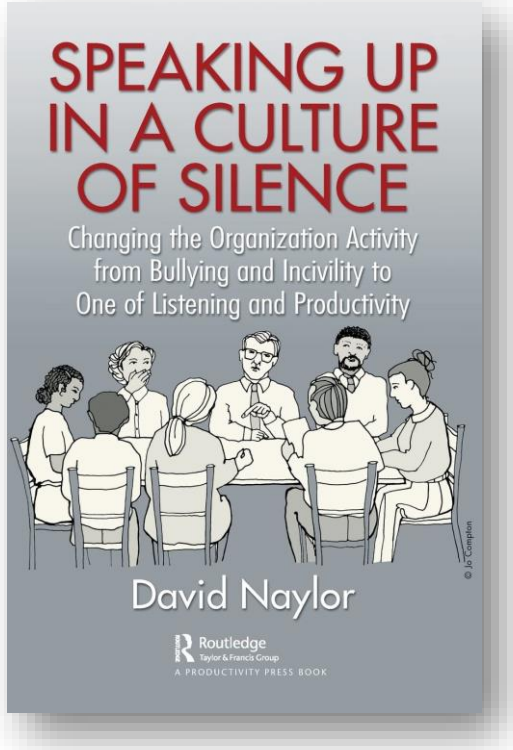


Project Aristotle

- Psychological safety
- Dependability
- Structure and clarity
- Meaning of work
- Impact of work

Silence always has a reason

- Acquiescent silence: I can do nothing here
- Imposter silence: I am not good enough to speak
- Power silence: I am not senior enough to speak
- Anxious silence: I am too frightened to speak
- Pro-social silence: I am protecting others
- Exhausted silence: I have nothing left to give



Tackle the factors that get in the way

- Work with the power and hierarchy
- Be consistent and fair and treat people the same
- Understand impact gender and ethnicity has on speaking up
- Use peer influence to your advantage
- Take the fear out of the equation
- Address incivility and bullying

Recipe for a safety culture

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- Step 5 How you respond really matters

Compounded harm

Harm created after an incident, complaint or grievance due to the processes and personal interactions that follow

Powerless

- Need involvement

Inconsequential

- Need to see learning

Manipulated

- Need honesty

Abandoned

- Need acknowledgement

De-humanized

- Need to feel seen

Disorientated

- Need support

Ref: Lauren Ramsey, Joanne Hughes, Debra Hazeldine, Sarah Seddon, Mary Gould, Jo Wailling et al

“When you’re low like that you don’t know what to do, you don’t know how to raise issues, you don’t know where to go…

To start with I did nothing. I was just like, completely dumbfounded.”

Patient

Just culture – work as judged

- In practice we form judgements from limited fragments of information about an adverse event or daily work
- We base our judgement on our own experience, or what the policy says should have happened
- We look for the facts that will confirm our preconceptions of what happened
- We judge on the outcome rather than the decision made at the time and believe events were predictable
- We judge harmful actions as worse than things forgotten

Just culture – is hard to achieve

- Conceptual barriers
- Personal and social challenges
- The very language we use can steer us to think in certain ways
- Different professions have different views on mistakes and competency
- Inconsistency is the enemy of trust

“When someone is blamed for a ‘mistake’, it is like a social oil spill. The pollution sticks around for a long time.”

Shorrock 2023

What can we do?

- Accept the core concept of a just culture – people make mistakes
- And, that it is not ‘blame free’ - sometimes but rarely – conduct is unacceptable
- Create a shared understanding
- Be fair, consistent, kind and supportive when things don’t go to plan - shift from blame focused language

“At the core of the organisation’s evolution was a focus on changing language.”

Adam Johns
Docklands Light Railway

Restorative just culture – a path towards healing

- Who was hurt
- What are their needs
- Who is responsible for meeting those needs

The Japanese art of Kintsugi

Respect and dignity for all

Everyone is treated with kindness, compassion and humanity

Recipe for a safety culture

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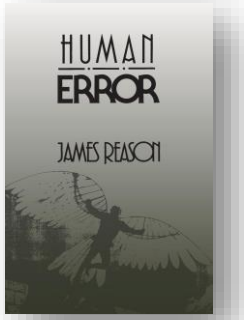
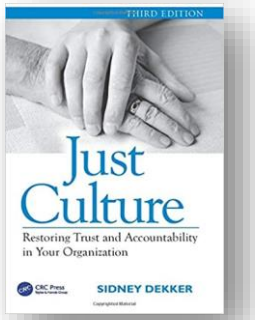
Method: Cook for ten years, checking every year – not freezable

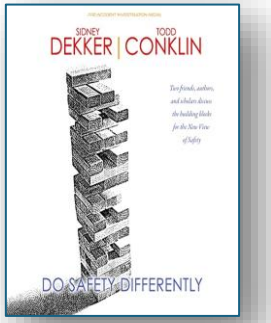
“You cannot get through a single day without having an impact on the world around you. What you do makes a difference, and you have to decide what kind of difference you want to make.”

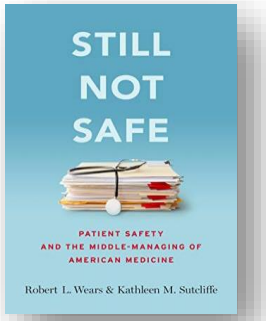
Jane Goodall

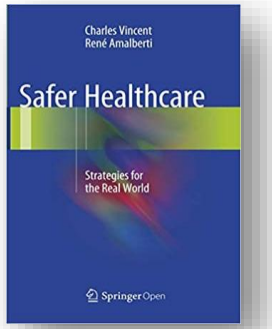
The library

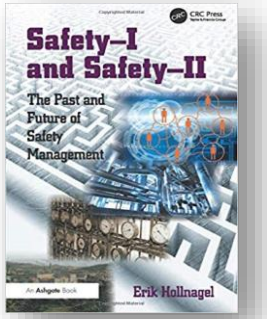

HUMAN
ERROR
JAMES REASON

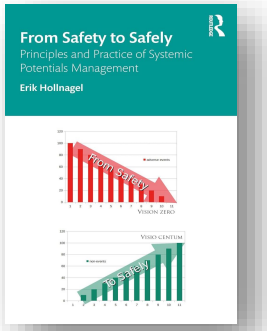

THIRD EDITION
Just
Culture
Restoring Trust and Accountability
in Your Organization
SIDNEY DEKKER

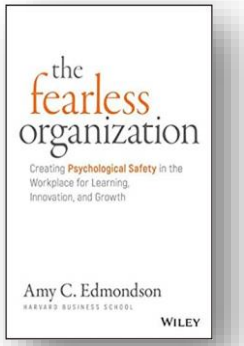

SIDNEY
DEKKER | TODD
CONKLIN
DO SAFETY DIFFERENTLY

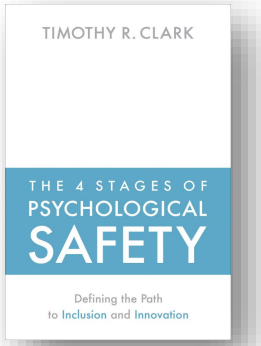

STILL
NOT
SAFE
PATIENT SAFETY
AND THE MIDDLE-MANAGING OF
AMERICAN MEDICINE
Robert L. Wears & Kathleen M. Sutcliffe

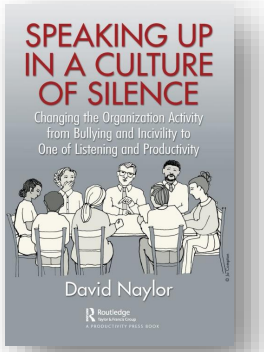

Charles Vincent
René Amalberti
Safer Healthcare
Strategies for
the Real World
SpringerOpen

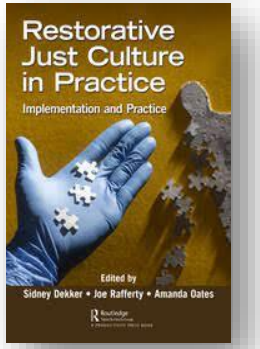

Safety–I
and Safety–II
The Past and
Future of
Safety
Management
Erik Hollnagel

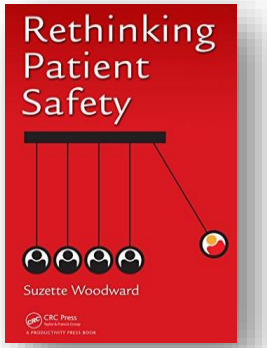

From Safety to Safely
Principles and Practice of Systemic
Potentials Management
Erik Hollnagel

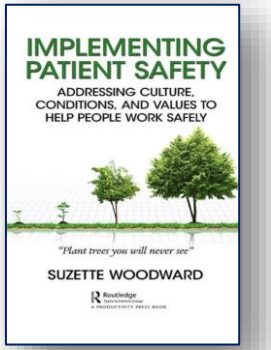

the
fearless
organization
Creating Psychological Safety in the
Workplace for Learning,
Innovation, and Growth
Amy C. Edmondson
HARVARD BUSINESS SCHOOL
WILEY

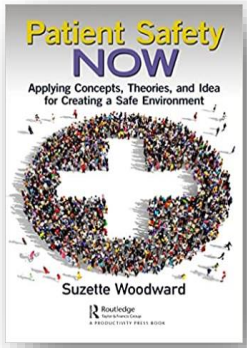

TIMOTHY R. CLARK
THE 4 STAGES OF
PSYCHOLOGICAL
SAFETY
Defining the Path
to Inclusion and Innovation

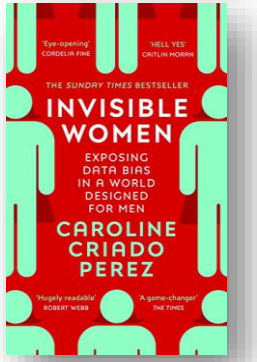

SPEAKING UP
IN A CULTURE
OF SILENCE
Changing the Organization Activity
from Bullying and Incivility to
One of Listening and Productivity
David Naylor

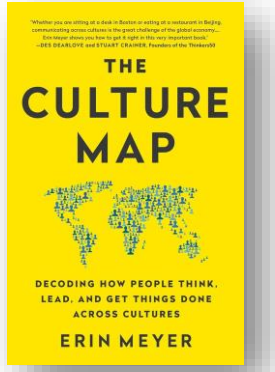

Restorative
Just Culture
in Practice
Implementation and Practice
Edited by
Sidney Dekker • Joe Rafferty • Amanda Oates


Rethinking
Patient
Safety
Suzette Woodward

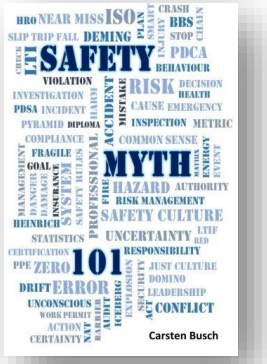

IMPLEMENTING
PATIENT SAFETY
ADDRESSING CULTURE,
CONDITIONS, AND VALUES TO
HELP PEOPLE WORK SAFELY
"Plant trees you will never see"
SUZETTE WOODWARD


Patient Safety
NOW
Applying Concepts, Theories, and Idea
for Creating a Safe Environment
Suzette Woodward


INVISIBLE
WOMEN
EXPOSING
DATA BIAS
IN A WORLD
DESIGNED
FOR MEN
CAROLINE
CRIADO
PEREZ


THE
CULTURE
MAP
DECODING HOW PEOPLE THINK,
LEAD, AND GET THINGS DONE
ACROSS CULTURES
ERIN MEYER


SAFETY SCIENCE
RESEARCH
EVOLUTION, CHALLENGES
AND NEW DIRECTIONS
EDITED BY
JEAN-CHRISTOPHE LE COZE


SAFETY
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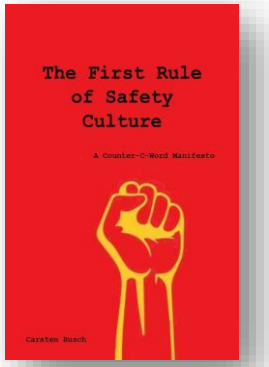
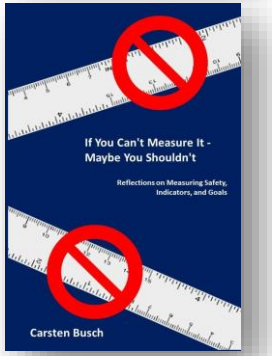
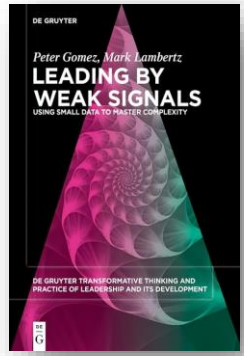
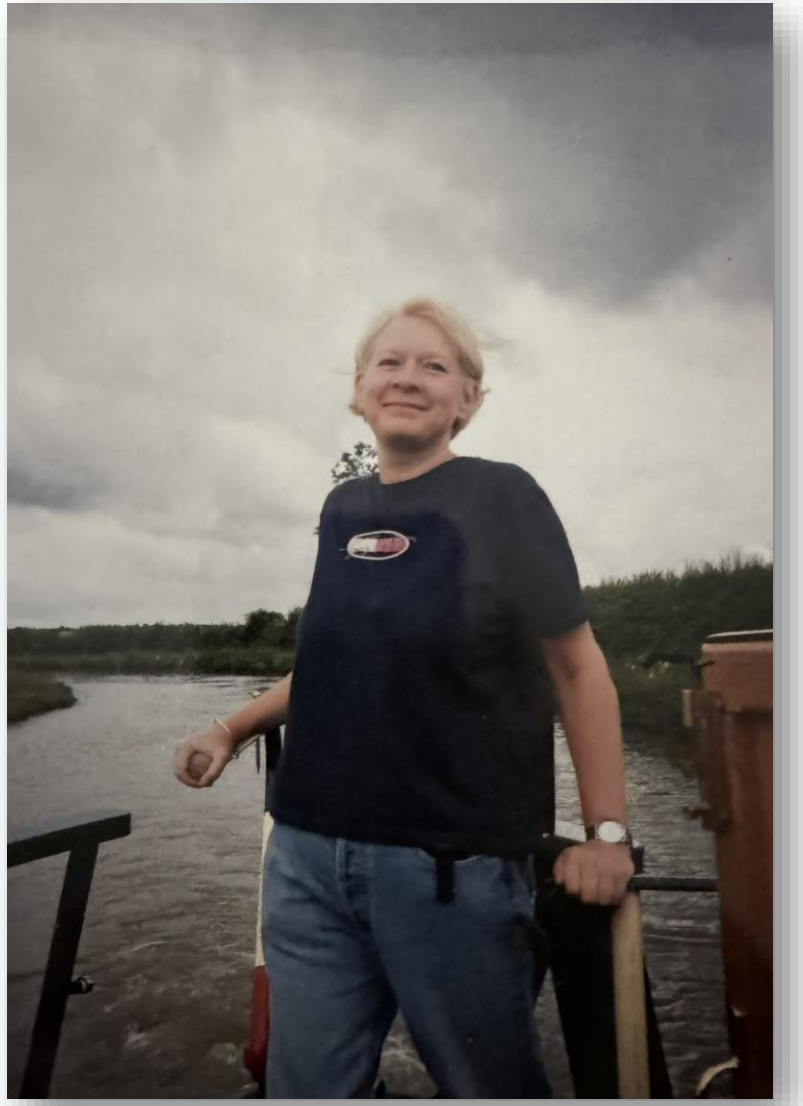
ERROR
CONFLICT
Carsten Busch


The First Rule
of Safety
Culture
A Counter-C-Word Manifesto


If You Can't Measure It -
Maybe You Shouldn't
Reflections on Measuring Safety,
Indicators, and Goals
Carsten Busch


DE GRUYTER
Peter Gomez, Mark Lambertz
LEADING BY
WEAK SIGNALS
USING SMALL DATA TO MASTER COMPLEXITY
DE GRUYTER TRANSFORMATIVE THINKING AND
PRACTICE OF LEADERSHIP AND IT'S DEVELOPMENT

And finally



Keep in touch

Email: suzette.woodward@gmail.com

Web: www.suzettewoodward.org

The Essentials of Safe Care: The Next Phase

Joanne Matthews
Associate Director, Improvement & Safety
Healthcare Improvement Scotland

The Essentials of Safe Care: The next phase

Joanne Matthews
Associate Director, Improvement & Safety
Healthcare Improvement Scotland

What are the essentials in your daily life?

Back in 2021!


TEST&PROTECT
PROTECT SCOTLAND
Help reduce the spread of coronavirus in Scotland
Contact Tracing
1:20
Free to download
Tracing


CUTICURA
ORIGINAL
ANTI BACTERIAL HAND GEL
CRISP & FRESH

2021 A new phase in SPSP

SPSP aims to improve the safety and reliability of care and reduce harm

Core themes

- **Essentials of Safe Care**
- **SPSP Programme improvement focus Perinatal, Paediatric, Adults in Hospital and Mental Health**
- **SPSP Learning System**

SPSP Essentials of Safe Care 2021

Aim

To enable the delivery of Safe Care for every person within every system every time

Primary Drivers

- Person centred systems and behaviours are embedded and support safety for everyone
- Safe communications within and between teams
- Leadership to promote a culture of safety at all levels
- Safe consistent clinical and care processes across health and social care settings

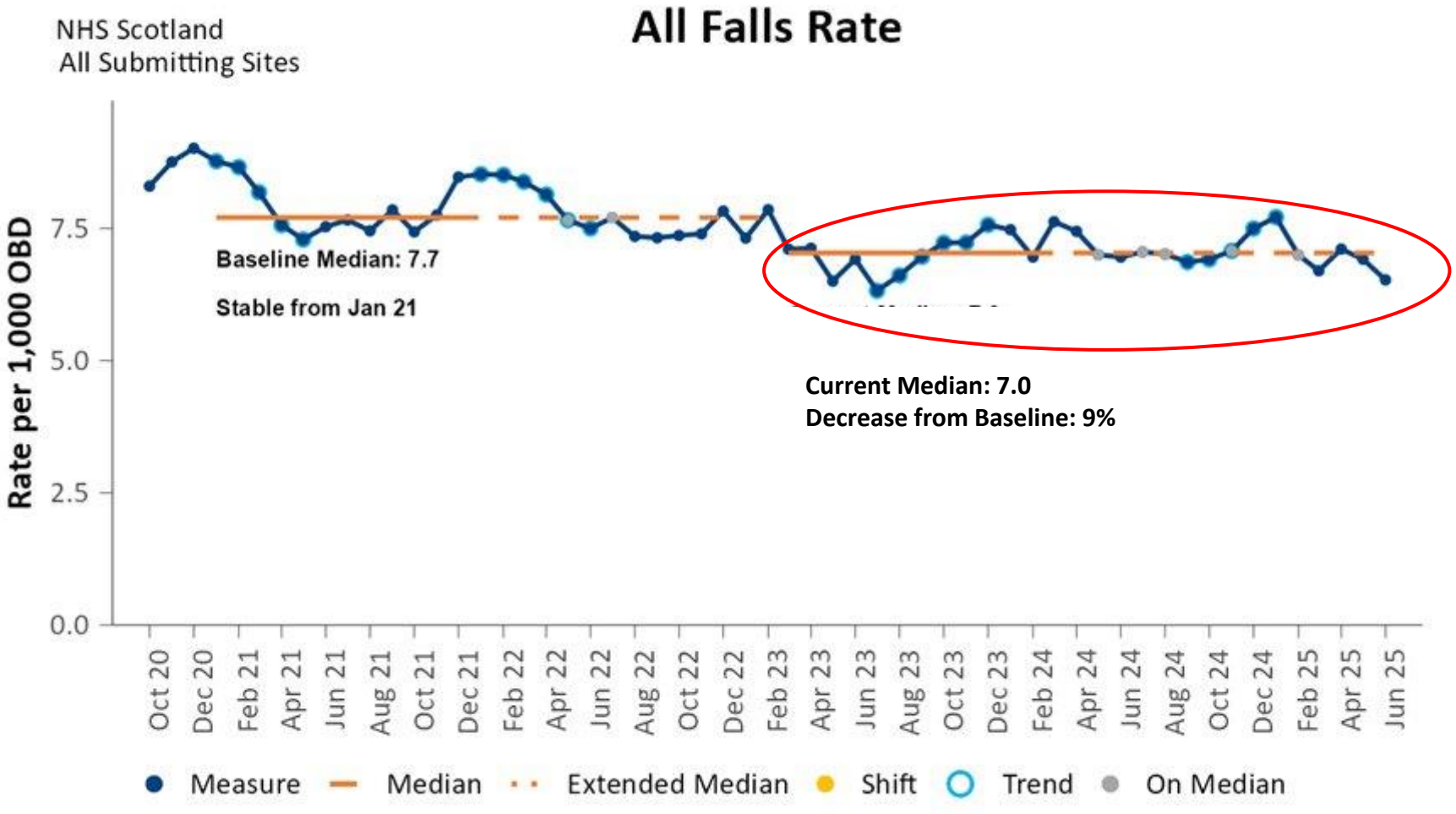
Secondary Drivers

- Structures & processes that enable safe, person centred care
- Inclusion and involvement
- Workforce capacity and capability
- Skills : appropriate language, format and content
- Practice : use of standardised tools for communication
- Critical Situations : management of communication in different situations
- Psychological safety
- Staff wellbeing
- System for learning
- Reliable implementation of Standard Infection Prevention and Control Precautions (SICPS)
- Safe Staffing

SPSP Essentials of Safe Care 2021

SPSP Acute Adult: Falls

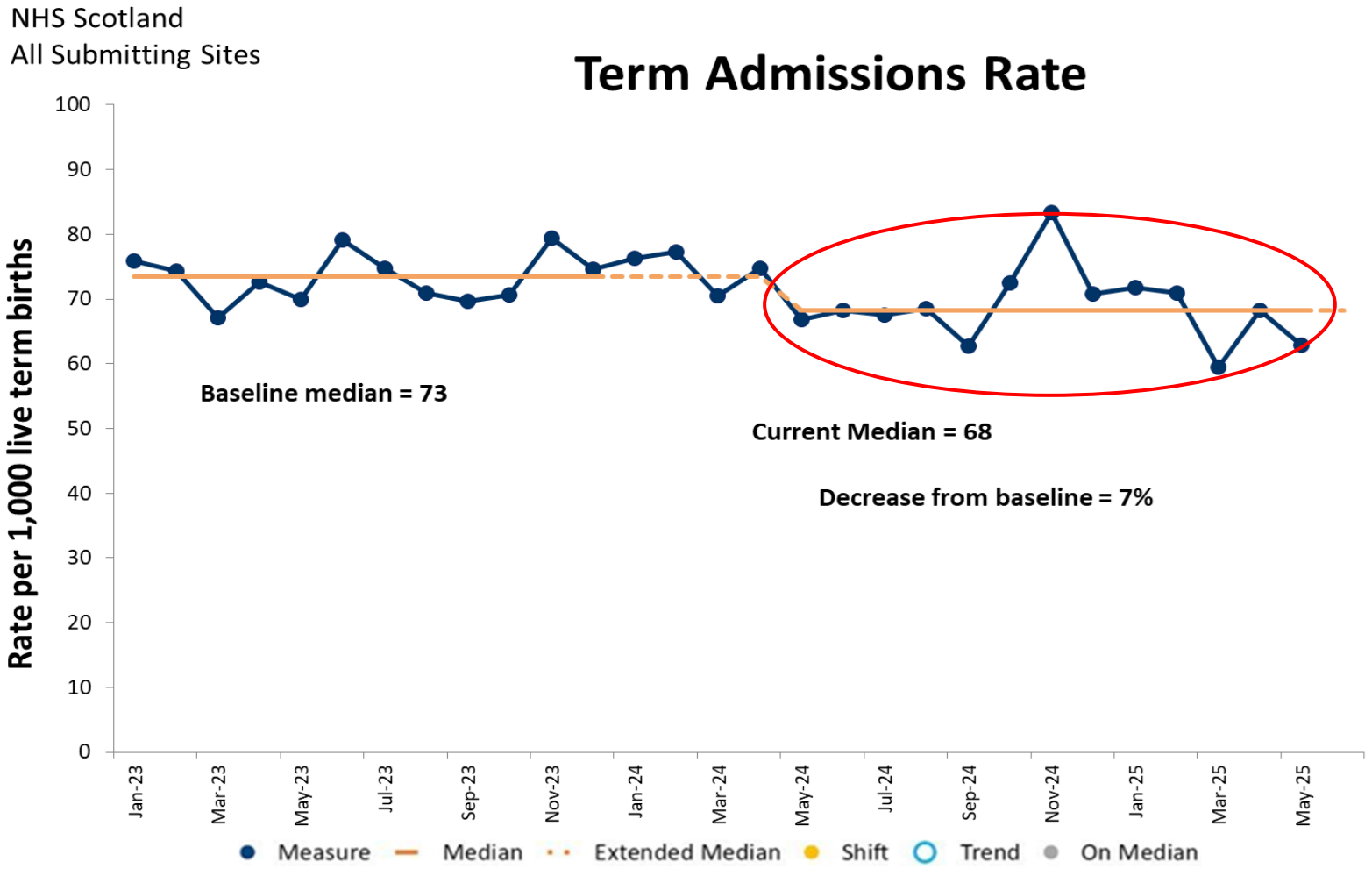
All Falls Rate per 1,000 OBD for Scotland – October 2020 to June 2025



- Leadership to support a culture of safety
- Person centred approaches to care
- Multidisciplinary team communication and approach
- Promoting safer mobility through clinical and care processes

SPSP Perinatal: Term admissions

Rate of Term admissions per 1,000 live term babies for 14 units in Scotland – January 2023 to June 2025



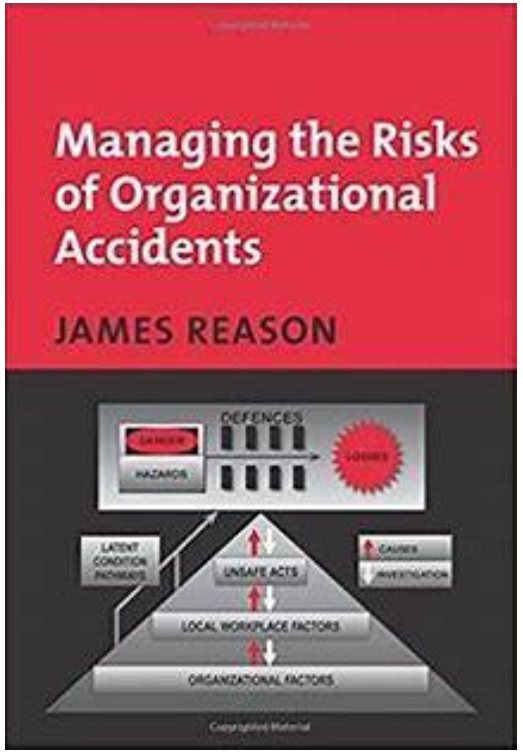
- Leadership to support a culture of safety
- Parent centred information
- Perinatal team communication
- Clinical and care processes

How have the Essentials of Safe Care been supporting improvements in your area?

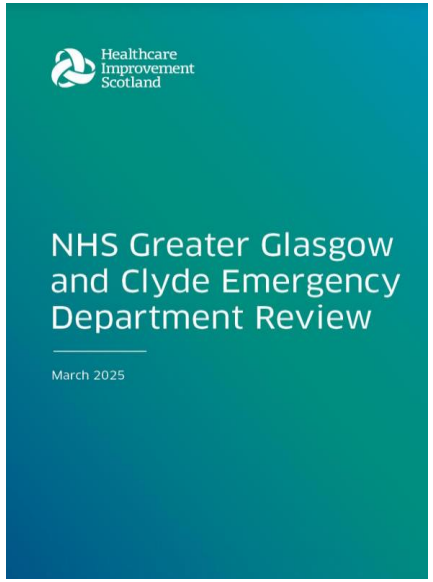
Why review?

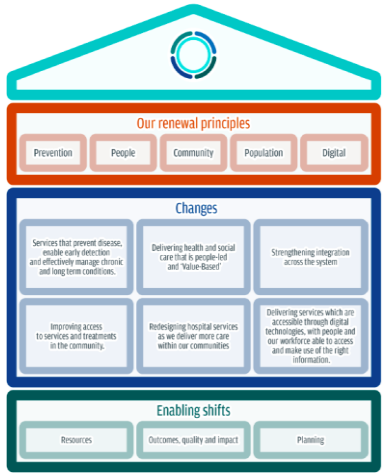
Securing safety is a task that cannot be finished ever. Safety is a continually emerging property of a complex system.

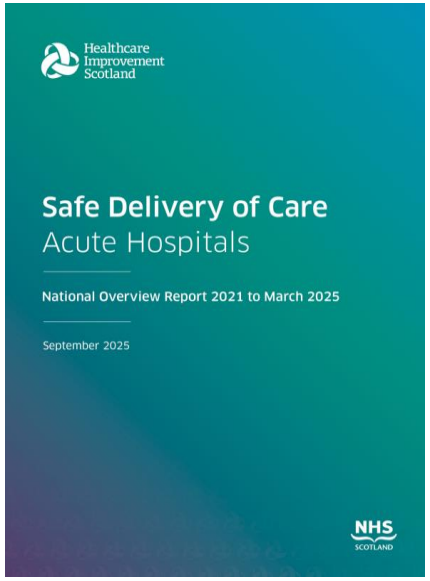
Professor James Reason



Today's context







Thank You

Public Health Scotland

Scottish Care
Social care that works for Scotland

MEALLMORE LTD

Scottish Ambulance Service
Working in Partnership with Universities

NHS SCOTLAND

ALLIANCE
HEALTH AND SOCIAL CARE
ALLIANCE SCOTLAND
people at the centre

care inspectorate

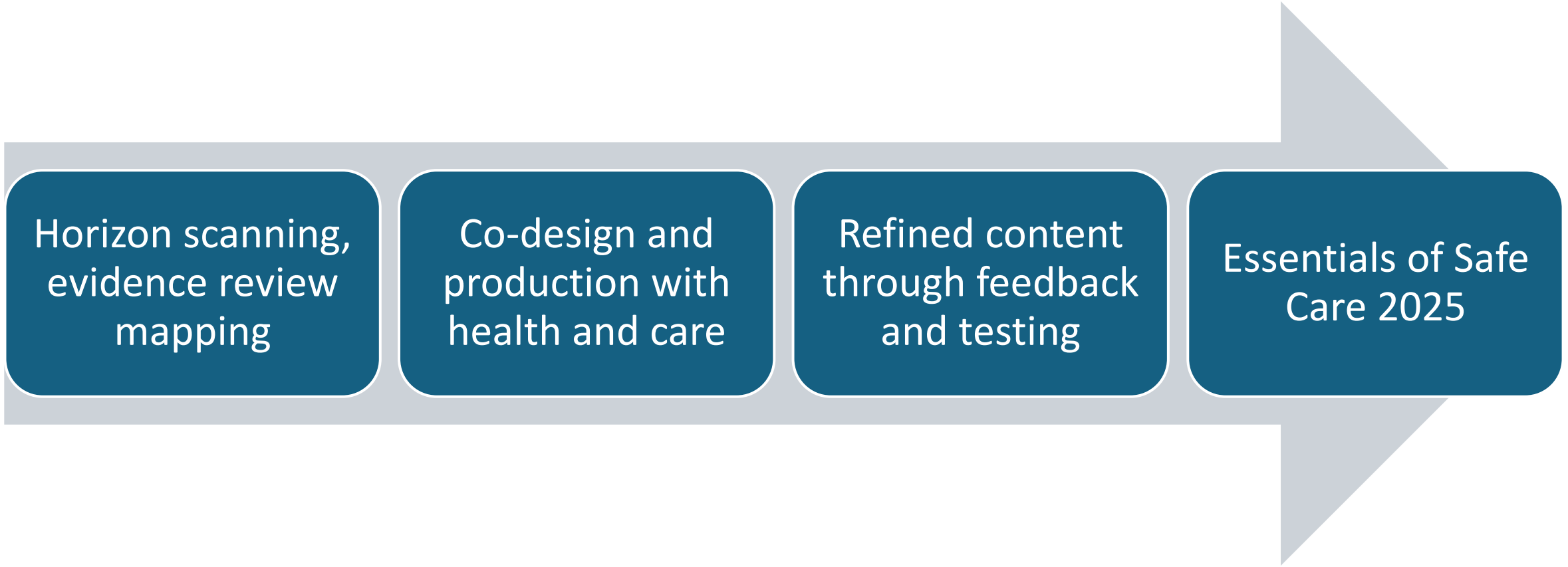
Royal College of Midwives

Royal College of Nursing

GCU
Glasgow Caledonian University
University for the Common Good

mental welfare commission for scotland

SPSP Essentials of Safe Care review 2025



Essentials of Safe Care 2025

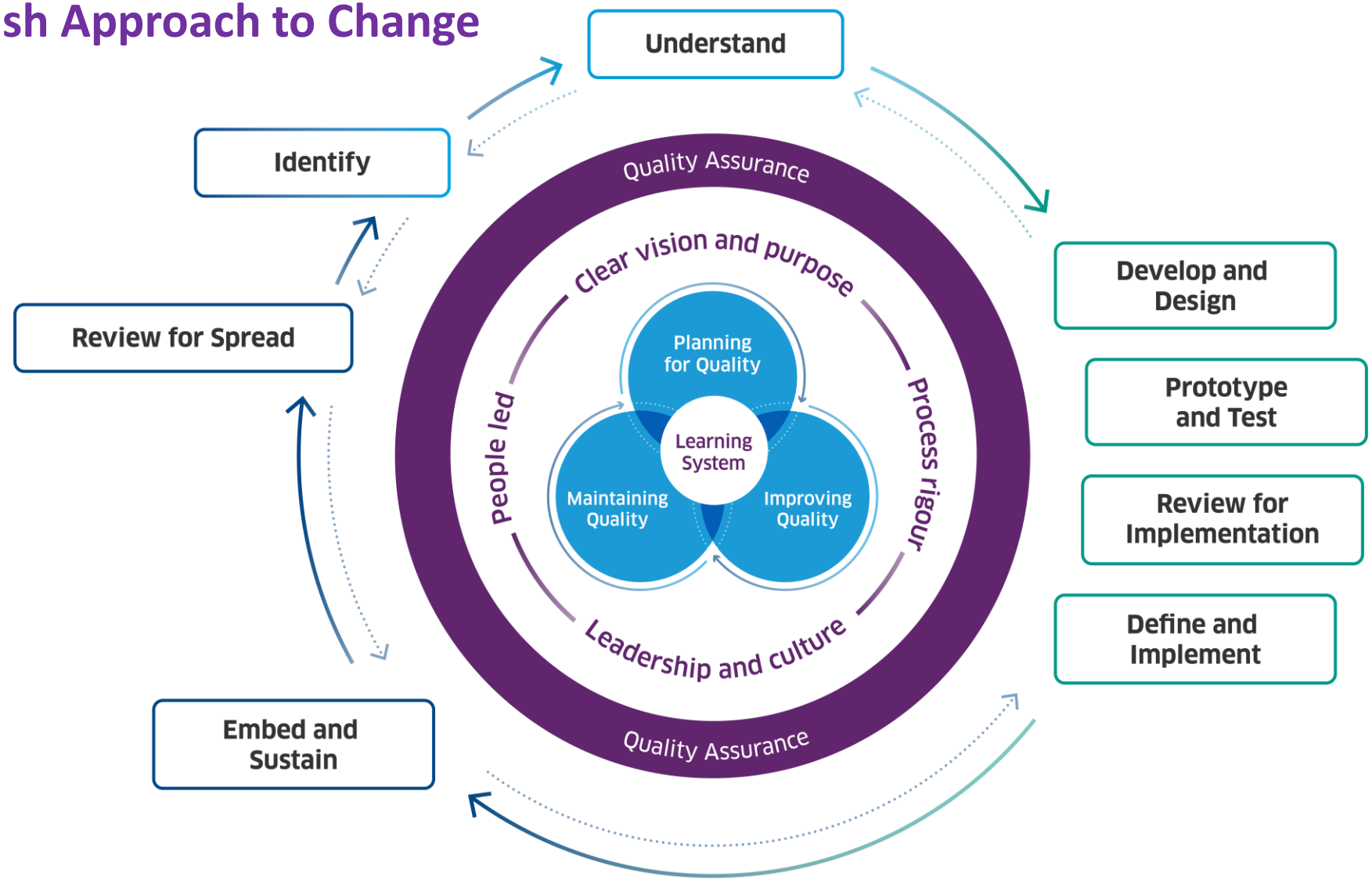
Our vision is	Delivered through ...	Which requires…
The delivery of safe care, improving outcomes for every person, every time across health and care	A people-led approach to the planning and delivery of safe care	People and professionals are equal partners in shared decision making
		Care and support is shaped to meet the needs of people
		People, families, carers and staff are systematically listened to, and concerns are acted upon
	Effective and inclusive communication	Communication tailored to individual needs and preferences
		People and teams feel safe and able to speak up
		Team communication and collaboration
	Leadership at all levels to support a culture of safety	Leadership is compassionate and inclusive
		Staff feel supported and valued
		Learning system for continuous improvement
		Everyone has the opportunity to learn and develop
	Safe clinical and care processes	Safe staffing and skill mix
		Care is up to date and evidence based
		Clinical and care governance structures support safety
		Information systems that work together

Key changes

Our Vision	**The delivery of safe care, improving outcomes for every person, every time across health and care**
New focus	**People Led, Inequalities, Clinical and Care Governance, Digital**
Change at each level	**Change Ideas developed at practitioner, service and organisational level**
Readiness for change	**Readiness for change assessment aligned to the Scottish Approach to Change**

How will the change happen?

Scottish Approach to Change



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SAHSCP Framework for Improvement

Stewart Marshall
Head of Community Health and Care Services

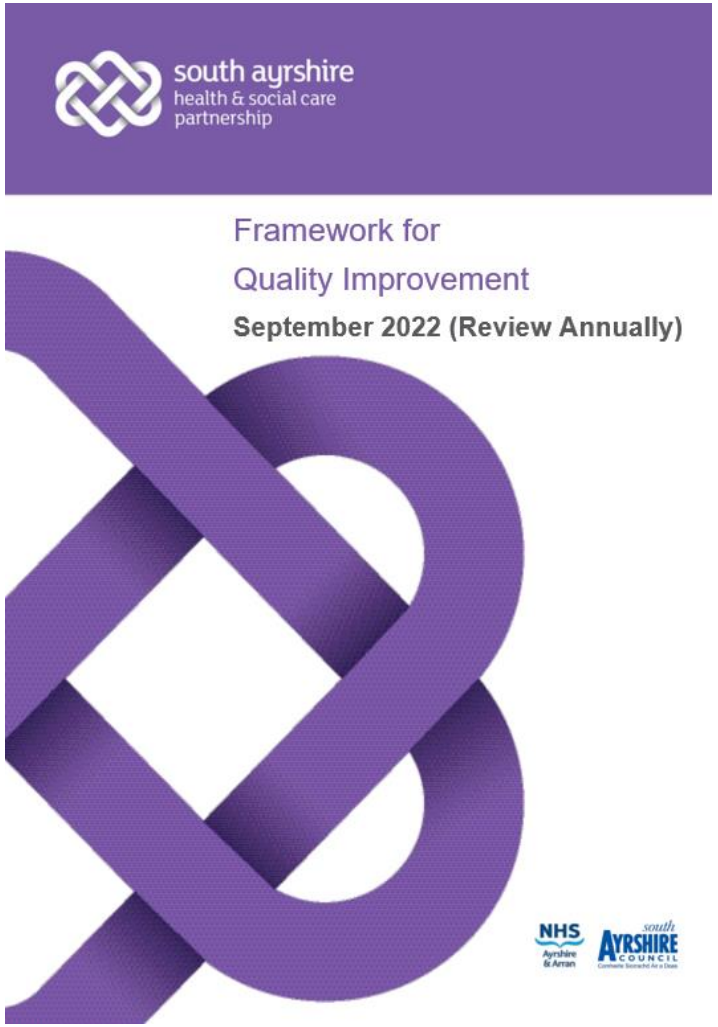
A Framework for Quality Improvement

Context

SA IJB Strategic Plan – Objective 5:

We are an ambitious and effective Partnership.

While our ultimate objective is to improve outcomes for our communities it is important that we look inwards as a HSCP to how we undertake our business and run our services effectively, driving continuous improvement and a performance culture in everything we do.



A Framework for Quality Improvement

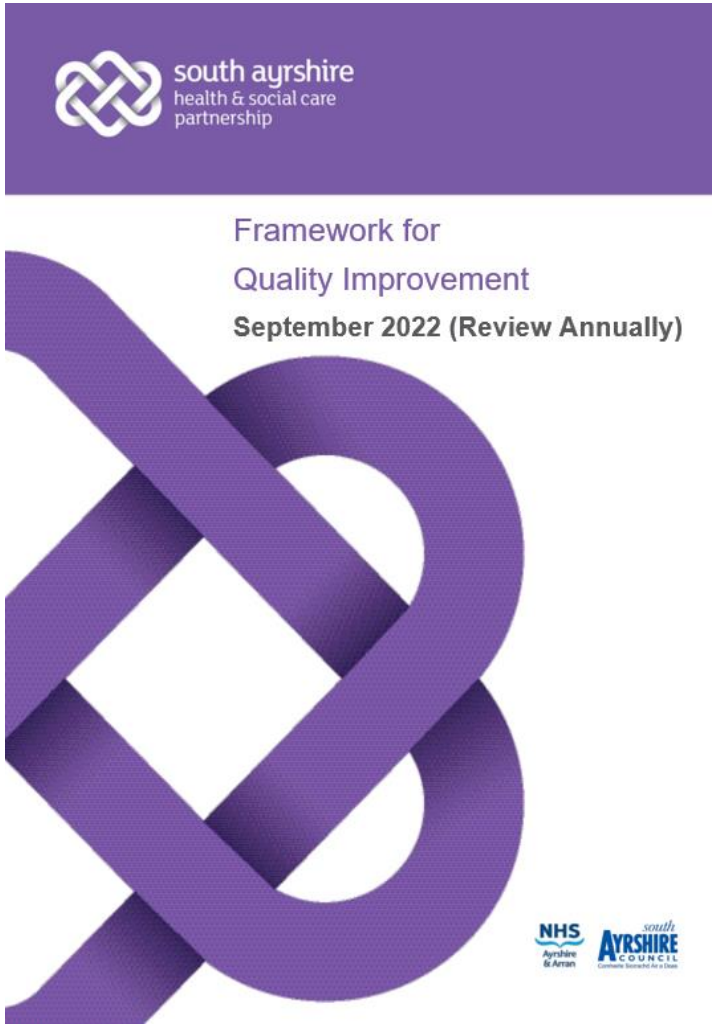
Vision

SAHSCP's Vision:

'empowering our communities to start well, live well and age well'.

SAHSCP's Vision for Improvement:

'empowering our workforce to deliver quality services, supported by a culture of continuous improvement'.



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Quality Management System

Quality planning

Identify the needs of the customer and population

Develop service models to meet the need

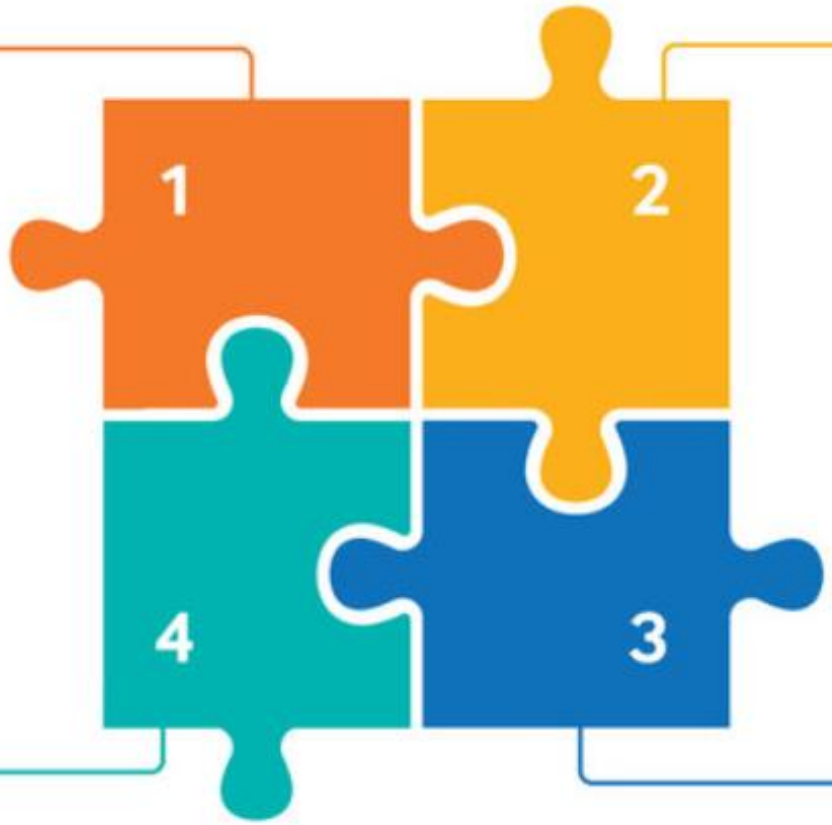
Put in place structures and process to manage the service

Quality control

Identify clear measures of quality for the service, and monitor these over time

Take corrective action when appropriate

Internal vigilance to hold gains made through improvement



Quality improvement

Identify what matters most

Design project and bring together a diverse team

Discover solutions through involving those closest to the work, test ideas, implement, and scale up

Quality assurance

Periodic checks to ensure the service is meeting the needs of the customer and population

Actions to address gaps identified

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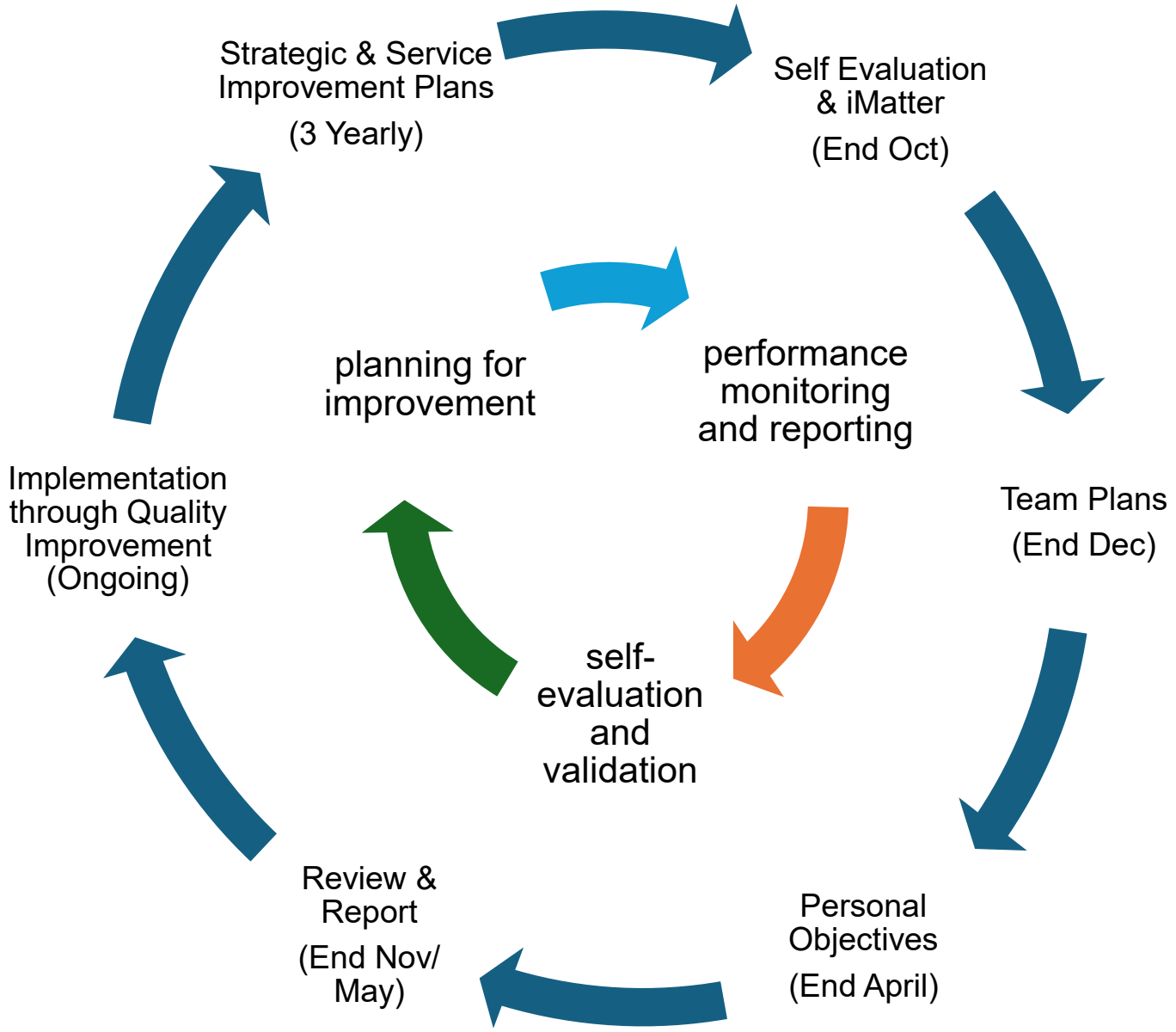
Performance Management Cycle



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Primary Drivers

- An improvement culture is embedded at every level of the organisation.
- A framework is in place to support a quality improvement approach.
- **A programme is in place to build capacity and capability.**
- A technology enabled community of improvers are equipped and supported to deliver improvements.
- A comprehensive communications plan ensures that a variety of methods are used to communicate and support the Partnership's Model for Improvement.

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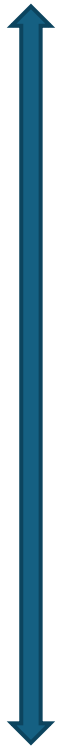
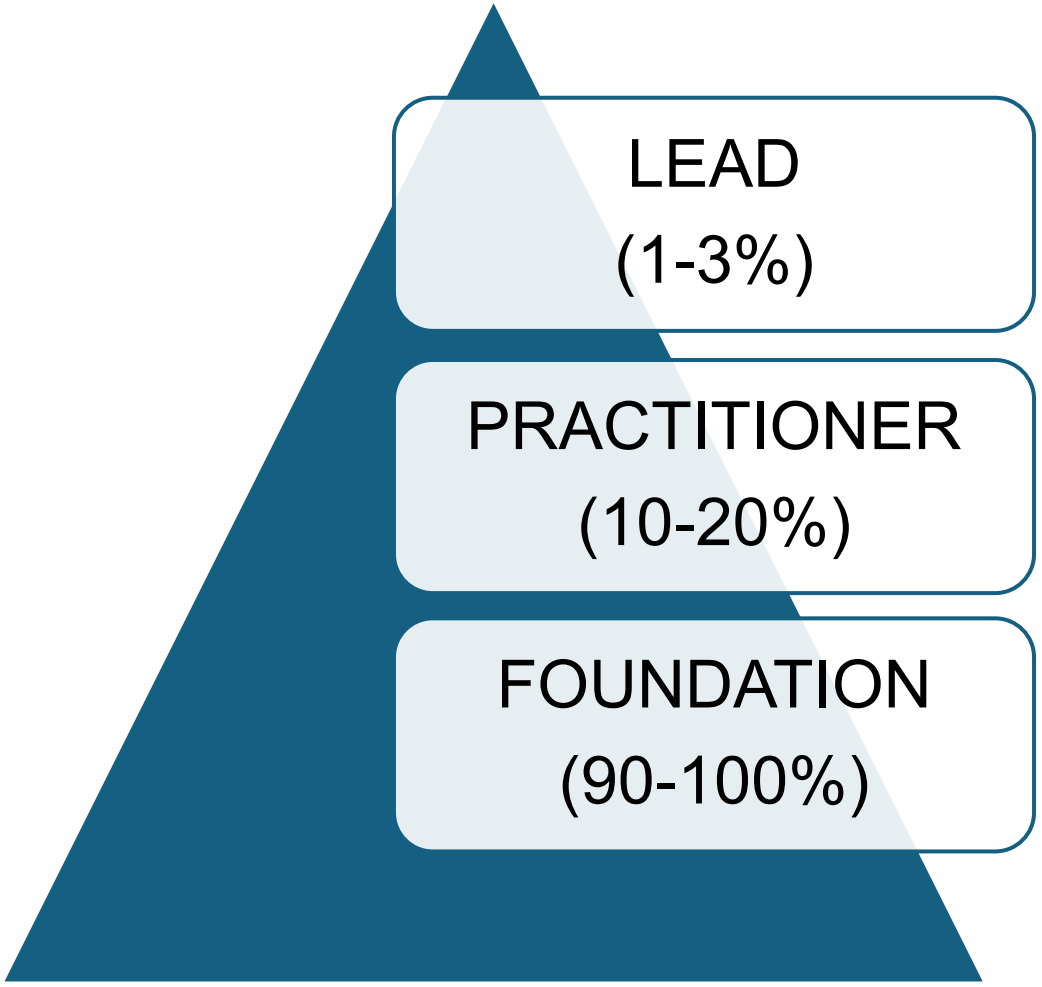
A Programme is in Place to Build Capacity and Capability

Few People – Deep Knowledge



Many People – Shared Knowledge

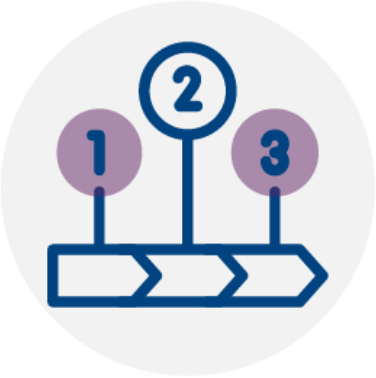


Enablers for change

Clear Vision and Purpose

People Led

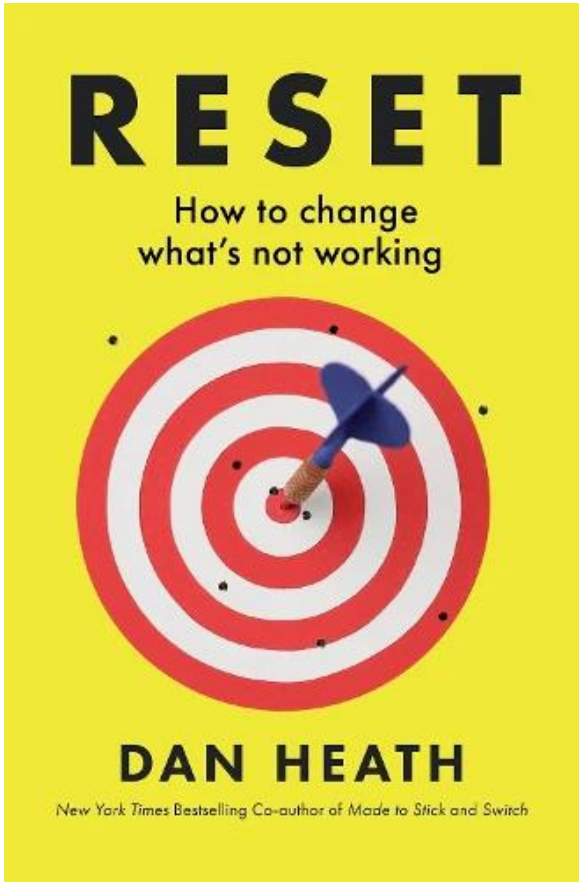
Leadership and Culture

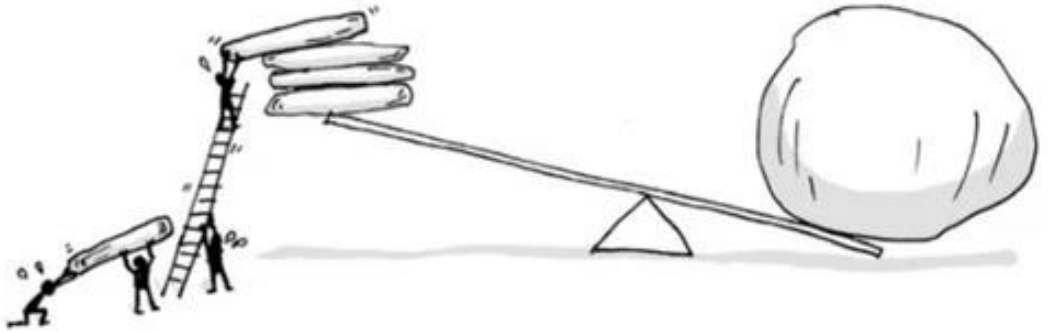


Process Rigour

Learning

What are your leverage points?





"Leverage points: Interventions or places where a little bit of effort can yield a disproportionate return"

Understanding your readiness

Assessing Readiness for Change

Assess if the right conditions for change are in place

Understanding Current Practice against the Essentials of Safe Care

Determine the extent to which these are already embedded

Prioritisation

Agree where to focus effort for highest impact

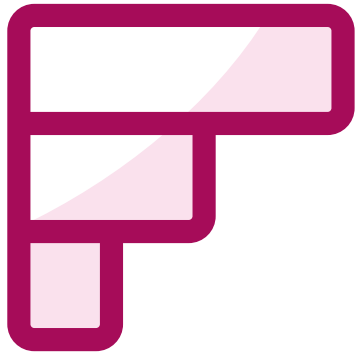
Continuous monitoring of readiness as part of Quality Management System

Readiness for Change Toolkit

Questions to consider

- How does your organisation approach change?
- Which enablers do you recognise within your change process
- Which enablers are least developed?
- How can you use the outputs from the tools to organise for safety?

How does you organisation approach change?



Which enablers do you recognise within your change process? (Please click and drag to rank in order of those most recognised)

Which enablers are least developed?

How can you use the outputs from the tools to organise for safety?

Summing up and next steps

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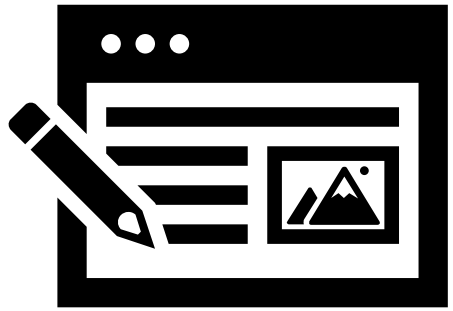
Essentials of Safe Care

Readiness for change toolkit

Thank you

Afternoon breakouts

- **Thank you to virtual audience: feedback survey to follow**



Afternoon Breakout Sessions: Commence 13.35pm

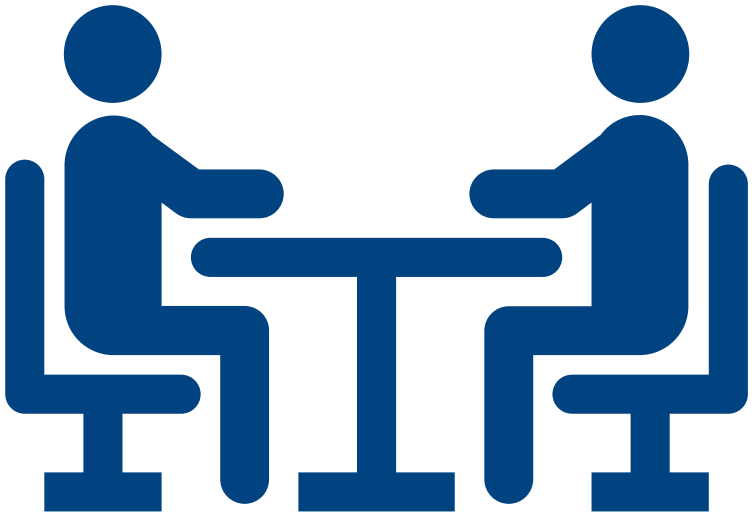
• Continuous Improvement to Embed the SPSP Essentials of Safe Care within SPSP Adults in Hospital	**Arcoona**
• Perinatal and Paediatric approach to the SPSP Essentials of Safe Care	**Inspiration 2&3**
• Applying the new SPSP Essentials of Safe Care within SPSP Mental Health	**Creation**
• Lunchtime workshop (HIS)	**Inspiration 1**

SPSP National Event: Morning Plenary Survey Virtual Audience

Chair's summary and reflections

Robbie Pearson
Chief Executive
Healthcare Improvement Scotland

Summary from afternoon breakouts



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