Health and Social Care

The Regulation and Quality Improvement Authority

A Framework for Safety Culture within Health and Social Care in Northern Ireland

Summary Guide
HSC Clinical and Non-clinical Staff

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Welcome to this guide

What is the Being Human Framework?

The Being Human Framework focuses on prioritising people over processes. It values patient safety and staff wellbeing equally to improve health and social care services. The Framework also acknowledges the inevitability of human error, and advocates for a compassionate learning-based approach. Staff are empowered to work with curiosity, to foster innovation, and to build stronger partnerships with their patients and colleagues.

The Framework recognises that people do best when:

- Their needs are met
- They are treated with kindness, respect and understanding
- They feel listened to and valued
- They experience real human connection.

Why was the Framework developed?

The Framework's person-centred approach moves away from a 'one-size-fits-all' way of delivering services. It was informed by patients and families with lived experience who co-produced the Framework with HSC staff and partners.[1] The Framework was developed in response to previous care failures linked to poor safety culture, where staff faced blame instead of collective learning. It recognises that mistakes can happen, and supports continuous improvement.

Who is this guide for?

A series of guides has been created for different audiences to ensure the Framework is shared and used by everyone.

This guide is for clinical and non-clinical staff working in health and social care services.

Why does safety culture matter?

Culture is about the shared values, attitudes, and behaviours that shape how the health and social care system works and treats people. The aim of the Being Human Framework is for a strong, safe, and caring culture to be the norm for everyone, not the exception.

Successfully transforming the culture will help boost staff morale, minimise burnout, and increase retention rates. It will also ensure improvements in patient safety, leading to better outcomes.

[1] **Co-production** means services are shaped together by professionals, carers, and people with lived experience, who are recognised as having valuable expertise and insights that should be part of the process.

The **purpose** of the Framework is to set out expectations of what a good safety culture looks like for the HSC system, patients and the public; and provide the foundation for assessing safety culture within HSC organisations.

About this guide

This guide explains the Being Human Framework so that you:

- Understand what a good safety culture looks and feels like
- Know what you should expect, and what's expected of you, in three areas:

1: Commitment to patient safety and staff wellbeing

2: Compassion, civility and respect

3: Curiosity and constructive challenge

What is a good safety culture?

Our values of **Teamwork - Openness and Honesty – Compassion – Excellence -** informed the Framework's vision of what a good safety culture looks like:

Safe and compassionate

- ✓ Patients and families are listened to with kindness, respect and understanding
- ✓ Patients are treated as partners in decision-making
- ✓ Leaders encourage and value staff input
- ✓ Everyone feels comfortable raising concerns about safety

Just and open

- ✓ Patients and families get early support and honest information when mistakes happen
- ✓ Harm is acknowledged and apologised for
- ✓ Staff are treated fairly if they raise concerns
- ✓ Leaders take responsibility for system failures

Continually learning and improving

- ✓ Mistakes are opportunities for learning, rather than blame
- ✓ Everyone is encouraged to ask 'why' and look for better ways of doing things
- ✓ Everyone's views matters, including staff, patients and families
- ✓ Learning is shared and leads to real improvements in care

1. Commitment to patient safety and staff wellbeing

Theme: Promoting collective accountability

❖ Everyone working in health and social care has a role to play

- **Responsibility**

➢ Everyone 'floor to board' has a shared responsibility for keeping patients and staff safe, no matter what their role is. This includes frontline staff, managers, senior leaders, and Trust Boards who have final responsibility for ensuring there is a strong safety culture.

➢ Staff speak up for patients if something isn't right or could affect their care; and are trained to understand safety risks and how to manage them.

- **Ownership**

➢ Leaders show what is expected by promoting a safety culture, setting clear goals, and putting action plans into practice. Staff take patient safety seriously, not as a 'tick-box' exercise.

➢ Staff have conversations about patient safety every day (e.g., safety huddles) and collaborate to improve care. The organisation also uses communication tools such as SBAR.

SBAR is a four-step framework - Situation, Background, Assessment, Recommendation - helping healthcare professionals share patient information efficiently and accurately, especially during handovers or emergencies. It standardises communication to reduce errors.

- **Being open**

➢ We check how safe our services are by gathering information from many places, including patient and staff feedback.

➢ Information is shared with the public about how effective our services are, including patient safety and staff wellbeing.

- **Learning from mistakes**

➢ We regularly check performance on safety and make sure risks are understood and acted on.

➢ We help staff improve in their role if needed, through early support and practical feedback.

❖ Patient care is informed by evidence-based practice

Decision-making on patient care can vary across Health and Social Care Trusts, leading to different experiences and outcomes.

- ➢ We aim to provide the same standard of safe, effective care for everyone:
  - Decisions about care are based on the best available evidence and clinical guidance, not where patients receive care.
  - Patients receive care in the right place, from the right professional, at the right time. Decision-making about admission, assessment, treatment, patient transfers, and home discharge is based on each person's needs.
  - If resources are limited, we are open and honest with patients and families, and discuss options and risks clearly. Staff receive training, support and guidance on ethical decision making and resource stewardship.

Staff deliver consistent good practice

- ➢ Staff use standard guidance to ensure there is consistent good practice. If care differs from this guidance, staff discuss the reasons with patients.
- ➢ Staff undertake training to ensure their practice aligns with current best evidence and Continuing Professional Development (CPD) standards.
- ➢ HSC professionals typically work in teams, but when working alone, staff can access advice and guidance to maintain safe, quality care, including:
  - Multidisciplinary team (MDT) colleagues
  - Supervision sessions
  - Peer support
  - Regional professional networks
  - Peer review processes

❖ Health inequalities are reduced

There are disparities in health across the population, and between different groups within society. We want every patient to receive the same high-quality care regardless of their background and where they live in Northen Ireland.

➢ Understanding and showing how health inequalities are being tackled is a safety priority at every level, from frontline staff to senior leaders.

➢ Population data and feedback from community organisations and under-represented groups is used to plan, design and improve our services.

Staff understand health inequalities

➢ Staff receive role-specific training to care for patients who face barriers to health and social care, and are at risk of poorer health outcomes, including:

- People living in deprived areas
- Minority ethnic populations
- People who have experienced trauma
- People with multiple and complex needs
- Socially isolated people
- People with disabilities and other protected characteristics

➢ Staff are trained to support people who may struggle to access, understand, and use literature to make informed decisions about their health.

Theme: Looking after staff well-being

❖ Staff are nurtured to perform at their best

➢ The organisation recognises and promotes staffs' core needs at work:

Autonomy: Having a voice and some control in your role

Belonging: Feeling part of a supportive team

Contribution: Knowing your work is valued and meaningful

Good practice

- ✓ Staff receive regular and helpful feedback
- ✓ Staff have protected time to train and learn
- ✓ Staff are supported to keep their skills and knowledge up to date
- ✓ There are opportunities for staff to learn together, including across different teams.

➢ Leaders and managers work proactively to:

- Ensure staffing levels and skills mix are safe

- Manage rotas and workloads to reduce burnout, stress and absence
- Recruit in a timely way and plan ahead to avoid gaps
- Listen and act when staff raise concerns about risks to patient safety

Support for staff

- ✓ Schwartz Rounds (reflective spaces)
- ✓ Coaching and mentoring
- ✓ Peer support forums
- ✓ Health and wellbeing initiatives
- ✓ Access to clinical psychology

➢ Staff can receive support for work-related stress and trauma.

➢ We monitor staff wellbeing, work with teams to understand concerns, and make improvements where needed.

'We look after our staff so that they can look after their patients.'

❖ Staff diversity is welcomed and championed

Health and Social Care staff from under-represented groups are more likely to experience poorer physical and mental health outcomes. This sometimes occurs due to discrimination, bullying and harassment at work. It can negatively affect the delivery of high quality patient care.

Our aim is that staff from every background experience:

- Fair treatment
- Equal access to opportunity
- Timely support when needed
- Protection from discrimination
- A culture of belonging
- Leadership that values their strengths

Equality, Diversity and Inclusion (EDI) is actively promoted and understood across teams and services to ensure that we are a more effective organisation.

➢ Career progression, training, and development is transparent, accessible, and not limited by background or personal circumstances. This is supported in various ways for under-represented groups, including those new to Northern Ireland, and colleagues with disabilities and additional needs:

- Mentorship and peer support
- Timely access to occupational health and reasonable adjustments
- Training opportunities, including online training, which all staff can participate in
- Inclusive recruitment and onboarding processes

➢ Mechanisms are in place to actively listen and gather feedback from diverse staff voices, to drive improvements in organisational culture relating to EDI.

Theme: Listening to patients, families and staff

❖ Feedback is welcomed

Patients, families and staff are well-placed to notice first when practice is unsafe. Taking action early means services can resolve problems before they become more serious. Staff may have a high threshold for escalating concerns through fear of negative consequences, and need support to speak out.

➢ We provide different ways for patients, families and staff to share their experiences, views, and concerns.

Feedback comes from:

- Staff forums
- Staff surveys/focus groups
- Story boxes
- Leadership walk-rounds
- Service user organisations
- Patient engagement forum
- Patient and family stories
- Complaints

➢ In addition to permanent staff, we gather feedback from those who bring distinct perspectives by virtue of rotating across HSC services and Trusts, for example: locum and agency workers; resident doctors; and students.

➢ Feedback is reviewed at clinical and governance team meetings. Patient and family stories are part of staff education and safety improvement programmes.

'Through listening, hearing and acting we can avert crisis'

2: Compassion, civility and respect

Theme: Leading with compassion

❖ Culture comes from the top

➢ Leaders set the tone for how everyone works together. They are visible, approachable, and update their skills through training and feedback.

➢ Safe, effective leaders 'do what's right', including making unpopular decisions and holding others to account for their behaviour.

Compassionate leaders:

- Fair
- Open and honest
- Listen carefully
- Understand
- Empathise
- Support others

➢ Leaders and managers strive to meet the core needs of staff in relation to Autonomy, Belonging and Contribution. This includes:

- Leadership responsibilities are collectively shared across staff teams, not just held by senior management.
- Staff are provided with opportunities to connect and reflect as a team, promoting open conversation to build trust and confidence.

➢ Line managers are trained to support staff using informal approaches, without over-reliance on HR procedures. This includes:

- Support with wellbeing issues
- Handling sensitive situations
- Having difficult conversations
- Managing performance issues
- Managing incivility and conflict
- Resolving concerns early

Theme: Empowering staff, patients and families

❖ Effective teamwork and psychological safety is nurtured

Psychological safety underpins effective teamwork which is essential for better communication, cohesion, and retention amongst staff, and safe patient care.

➢ We create psychologically safe environments

Psychological safety means that all staff in the team feel safe to speak up, ask questions, share ideas or raise concerns, without fear of blame, embarrassment, or poor treatment.

It applies to every team member, regardless of role, seniority, or background.

➢ We promote multidisciplinary working in which all professions and roles are valued.

Four stages of psychological safety

1. **Inclusion**
   Everyone feels they belong
   ⬇
2. **Learner**
   Staff can admit mistakes, ask questions and seek feedback
   ⬇
3. **Contributor**
   Staff share ideas confidently
   ⬇
4. **Challenger**
   Staff respectfully challenge decisions and offer feedback.

➢ We resolve barriers to effective team working, e.g., incivility, bullying, harassment and discrimination.

Effective teamwork

- ✓ Safe spaces
- ✓ Open communication
- ✓ Active listening
- ✓ Respect and trust
- ✓ Calm and supportive
- ✓ Collaboration to solve complex problems
- ✓ Learn from each other

➢ We provide Forums for teams to meet regularly to share ideas and discuss:

- Learning and feedback from incidents and governance activities
- Service development and improvement

➢ Staff of all roles, backgrounds, and levels are supported to contribute to discussions. A measure of success is when the 'quietest voice in the room feels safe and enabled to be heard'.

Example of good practice: Fostering psychological safety

Following the Ockenden Inquiry and staff survey feedback, the Belfast Health and Social Care Trust Maternity Department introduced initiatives to build a culture rooted in safety, compassion and learning, which included:

- **Confidential listening groups** to raise issues and inform practical changes.
- **'Growing a Culture of Kindness'** to support multi-disciplinary collaboration.
- **Training** for new staff on respectful challenge, civility and safe escalation. Ad hoc foetal monitoring training also became compulsory and was expanded to include human factors, just culture, and psychological safety.

❖ Incivility (poor behaviour) by staff is taken seriously

Incivility in the workplace is any action that is offensive, intimidating, or hostile. Staff incivility can have a significant impact on colleagues who experience it, increasing the likelihood of mistakes causing harm to patients.

➢ Leaders set clear expectations about values and behaviour, and this is understood by staff at all levels.

➢ Staff incivility is challenged and dealt with quickly, including:

- Behaviour which can be more obvious such as disrespect, bullying, discrimination or sexual harassment. Other forms of harassment include behaviours motivated by racist, misogynistic, sectarian, homophobic or transphobic attitudes.

- More hidden or subtle behaviour, such as manipulation, controlling behaviour, spreading gossip, or isolating people.

Interventions: Team engagement, mediation, negotiation, identification and mitigation of stressors, and holding individuals to account for their behaviour.

Training and support: Staff are advised on how to deal with 'red flag' behaviours from co-workers. They are trained to understand that incivility can affect patient safety; and what behaviour is also expected of them:

- Treat colleagues with kindness, respect and professionalism
- Speak up if behaviour feels disrespectful or unsafe
- Take responsibility for your own behaviour
- Engage constructively in mediation or resolution processes if needed
- Challenge harmful behaviour appropriately and report serious concerns

Example of good practice: Professional behaviours workshop

The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) have developed a joint three-hour workshop on 'Professional behaviours and patient safety'. Healthcare professionals are supported to recognise unprofessional behaviour, understand its impact on patient safety, reflect on their own responsibilities, and build practical skills to challenge concerns.

Expected minimum standard of behaviour from everyone using HSC services
The Being Human Framework recognises that staff can also experience harmful behaviour from patients, family members, or visitors. This includes aggression, threats, intimidation, harassment, or being filmed. It often happens when people are anxious, distressed or frustrated, but is always unacceptable. We aim to reduce harmful behaviour through awareness raising, and staff training.

❖ Patients and families are partners in care

Seeing patients as partners in health and social care, rather than passive recipients, is fundamental to enhancing safety and improving health outcomes.

➢ Staff receive training and support on person-centred care, shared decision making and informed consent. They work in partnership with patients to shift the focus from 'What's the matter with you?' to 'What matters to you?'

What matters to you?

- Staff consider the patients' medical, emotional, and social needs.
- Staff involve patients in decision-making, and asked for their views, preferences and choices.
- Staff give patients clear, honest information about their treatment options, including benefits, risks, and alternatives.

➢ Staff explain options in a way that patients can give informed consent:

- They have the ability to make the decision
- They are not pressured by others
- They understand the information

➢ Patients can get extra support to make decisions**.** This includes access to easy-read information, interpreting services and support organisations.

Theme: Enhancing openness, trust and mutual respect

❖ Staff listen, hear and act on concerns

Outcomes improve when patients and families feel heard, believed and supported. Ignoring their concerns can result in missed clinical details, and preventable harm. All Health and Social Care staff working well with their colleagues is key to the delivery of safe, effective care.

➢ Staff promote psychological safety in all interactions with patients and their families. They apply the principles of 'listening, hearing and acting' on immediate patient safety concerns:

'Any concern raised should be seen as vital information.'

- Staff welcome opinions and concerns raised within their team and from other professional disciplines.
- Staff encourage patients and families to ask questions or raise concerns about safety, during care or after a poor experience.

➢ Being asked by a patient or their family for a second opinion is welcomed as a valuable safeguard by staff and not seen as a criticism. Staff are not defensive in these circumstances. They understand that families can provide valuable insights into their loved one's condition.

❖ Everyone is treated fairly when mistakes happen

Most patient safety incidents happen because of complex systems, pressures, and human errors, not because someone intended harm. If staff are afraid of being blamed or punished, they will not speak up.

'Restorative' approach

- ✓ Open, honest and fair
- ✓ Sympathetic and caring
- ✓ Non-judgemental
- ✓ Access to counselling
- ✓ Encourages collaboration
- ✓ Solution-focused
- ✓ Learning and improvement

➢ We promote a just and restorative culture which focuses on learning and not blame when something goes wrong.

- Staff understand that fear of blame must not stop disclosure, and that reporting incidents is a professional responsibility.
- Leaders and staff understand that anyone can make an honest mistake. Ultimate accountability for patient safety sits with the Trust Board, not individual frontline staff acting in good faith.
- Everyone affected by patient safety incidents receive 'restorative' responses. Incident review panels are skilled and trained in restorative approaches.

Compassion and support applies to staff as well as patients. Counselling and clinical psychology are accessible for staff impacted by safety incidents.

➢ We distinguish clearly between human error and serious misconduct. Cases involving intentional harm, negligence, or dishonesty, are addressed through appropriate measures.

❖ People receive an honest response when care goes wrong

The duty of candour requires health and social care professionals to be open and honest with patients and families when things go wrong.

If something goes wrong, we:

- ✓ Talk to patients early
- ✓ Acknowledge what has happened
- ✓ Offer a meaningful apology
- ✓ Share what we know and don't know
- ✓ Explain what happens next

➢ Staff understand that candour promotes healing, recovery and restoration of trust for those who have experienced harm.

➢ When a concern is raised, we don't wait for things to escalate. Staff are trained in early engagement with patients / families.

➢ Formal investigations are not used as a reason to delay an explanation or provide support.

➢ We recognise that most people want to know that harm won't happen to anyone else, so tell them how we have learned and made improvements.

'There is power in an apology – it is not an admission of guilt but rather an opportunity to heal and repair.'

3. Curiosity and constructive challenge

Theme: Addressing fear and defensiveness within the HSC system

❖ Staff understand the investigations process

Defensiveness amongst staff impacts on the ability of people and organisations to learn and improve. This can happen from a fear of the consequences when care goes wrong. Reasons may include past trauma, unhelpful narratives and beliefs, blame culture and no prior experience of investigations.

➢ We recognise that staff may fear internal processes, such as HSC Trust processes, whistleblowing, complaints, safety incident reviews, litigation, coroner inquests, inquiries, investigations, and associated media coverage.

- Staff can access training, guidance and resources providing reliable, unbiased and balanced information on processes and possible outcomes.
- All staff in HSC Trust processes receive support. Those involved in public inquiries or coroner investigations, which can involve intense scrutiny, get enhanced support, including access to clinical psychology.

➢ Our processes are:

- Used only when necessary
- Applied fairly
- Free from bias and discrimination
- Guided by openness and accountability

➢ We use staff and patient feedback from review processes to improve how we apply our policies, and provide those impacted with support.

Theme: Making it safe for staff to speak up

❖ Constructive feedback is welcomed

Constructive challenge is vital for learning and improvement, but it can feel uncomfortable. Staff may hesitate to challenge colleagues, because if done insensitively or without shared understanding, it may harm team relationships.

➢ We create a collective understanding of the purpose of challenge. Leaders role model positive behaviours in providing and receiving constructive feedback, so that staff at all levels feel safe to challenge current practice.

- ✓ Helpful
- ✓ Practical
- ✓ Timely
- ✓ Professional
- ✓ Respectful
- ✓ Offers solutions

➢ Staff are encouraged to find better ways of doing things. We learn from other organisations, reviews and inquiries. External review and support is welcomed.

Example of good practice - 'Fairer Feedback' workshops

GMC has partnered with NIMDTA to offer workshops to all GP trainers across NI aimed at improving the quality and fairness of feedback conversations in medical education. The workshops focus on practical behaviour change and are also offered at all Trusts as part of the 'trainer forum' model. Topics include delivering high-impact feedback, and making feedback more inclusive.

❖ Speaking up is encouraged and valued

Staff have both a professional and moral responsibility to act, so must be protected from psychological harm in the process of raising safety concerns.

➢ Staff can confidentially raise concerns about patient and staff safety through formal mechanisms which include the independent Speak Up Champion at HSC Trust Board Level. Informal methods comprise Leadership Walk Rounds, Listening Exercises, Staff Forums, and Story Boxes.

Example of good practice – 'Speak Up Champion'

RQIA has appointed a Speak Up Champion so staff have someone independent they can talk to in confidence about any concerns at work. The Champion's role is to listen and help staff find ways to sort out their issues. What staff share is used to identify common themes for learning and improvement. Staff who have used this support say they felt heard and supported. The Champion's role has helped build a culture where speaking up is encouraged and valued.

Staff training and awareness

- Mechanisms to raise concerns
- Formal procedures
- Support available
- Statutory entitlements
- Legal protections

➢ Staff who speak up are offered peer support through the investigation process, and are protected from unfair treatment.

➢ When staff members raise concerns at team level or above, there is collective ownership for addressing the concern.

➢ Leaders openly show staff that raising concerns leads to positive change.

Theme: Being curious to learn and improve

❖ Staff teams reflect on the delivery of care

- ➢ Leaders create time and space for staff to talk about:
  - What is working well
  - What could have been done better
  - How care and safety can be improved.

➢ Leaders look honestly at their own actions and decision-making, and are open to doing things differently.

❖ Learning leads to real improvement

➢ Key safety messages are not forgotten. They are shared widely with frontline staff so more patients can benefit. This includes:

- Staff team meetings and huddles
- Governance meetings
- Staff training, education and events
- Leaflets and posters
- Letters and emails
- Videos, podcasts and infographics

Conclusion

Why Being Human matters for you:

- Prioritises staff safety and wellbeing
- Services focus on learning and improving, not blaming
- Promotes an environment where staff feel safe to speak up about concerns
- Supports a fair response to mistakes, encouraging openness
- Promotes psychological support for staff affected by incidents
- Fosters mutual respect between leaders, staff teams, patients and families.

Being Human is a living framework, which supports services to keep learning and getting better. The framework is meant to be:

- Used for reflection
- Talked about openly
- Improved over time

Further information

You can read the Being-Human-Framework-for-Safety-Culture here, or by visiting our website www.rqia.org.uk/beinghuman/

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