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 Trust Boards

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Welcome to this guide

What is the Being Human Framework?

The Being Human Framework prioritises people over 'tick-box' processes. It values patient safety and staff wellbeing equally, while also recognising that mistakes can happen. The Framework provides the foundation for assessing safety culture within HSC organisations, setting out expectations of what a good safety culture looks like. This includes for HSC Trust Boards, whose oversight role involves ensuring that learning translates into sustained change.

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 Being Human Framework was developed in response to numerous public inquiries into care failures linked to poor safety culture, where lessons were identified but not meaningfully embedded. It represents a fundamental shift away from *'Are systems in place?'*, towards *'Are we creating the right culture for those systems to work?'* The Framework's person-centred approach was informed by patients and families with lived experience who co-produced the Framework with HSC staff and partners.[1]

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 Health and Social Care Trust Boards (including non-executives).

Why does safety culture matter?

The behaviours, attitudes and decisions demonstrated in the most senior leadership and governance roles shape the culture experienced by staff and service users.

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 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.

About this guide

This guide explains the Being Human Framework and outlines 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.

➢ Ultimate accountability for making sure there is a strong safety culture sits with HSC Trust Boards. They uphold the Duty of Quality by ensuring safety management systems and monitoring are in place.

- **Ownership**

➢ HSC Trust Board Patient Safety and Quality Committees:

- Provide oversight and ongoing assurance; recognise early warning signs of a service in difficulty, and seek independent / external expert support if needed.[2]
- Triangulate information, including quantitative and qualitative feedback (patients / staff), to provide an overview of patient safety and staff wellbeing.
- Identify key safety priorities, and advise on strategic approaches to making improvements.

- **Being open**

➢ HSC Trust Boards lead and promote a just, open, and learning culture, ensuring that progress is tracked across all levels within HSC organisations.

➢ Leaders and managers encourage teams to openly raise patient safety concerns, and work together to address them.

➢ HSC Trust Boards, leaders and managers are open about organisational performance, patient safety and staff wellbeing. Metrics are publicly shared for transparency, assurance and benchmarking to support improvement.

- **Learning from mistakes**

➢ HSC Trust Boards demonstrate a commitment to continuous learning and improvement. They ensure that there are established systems and procedures in place to support the reporting and review of incidents.

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[2] The HSC Board Member Handbook supports Board Members in their oversight and assurance of safe, effective care.

❖ 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. This may be due to acceptable reasons like population-factor variations, case-mix, clinical needs, and patient preferences. Differences caused by variation in service planning, design and delivery, workforce issues and variations in clinical practice are unwarranted.

➢ HSC Trust Boards and Senior Leaders take a strategic approach to reducing unwarranted variation, aiming to lower avoidable harm, health inequity, and waste. They ensure effective Quality Management Systems are in place to identify, control and moderate variation, especially in clinical practice.

➢ We aim to provide the same standard of safe, effective care for everyone. Decisions about care are based on the best available evidence, clinical guidance, and individual needs, not where patients receive care.

- Staff consistently follow national and local clinical guidelines, and effective systems are in place for developing local guidance. If care differs from standard guidance, staff are able to explain the reasons to patients.

- If resources are limited, clinicians are supported to have balanced discussions with patients and families about risks, benefits, and care options.

❖ Health inequalities are reduced

HSC Trusts have a statutory duty to reduce health inequalities within the populations they serve.[3]

➢ We take a whole-system approach so that every patient in NI receives the same high-quality care regardless of their background and where they live.

➢ HSC Trust Boards and Senior Leaders demonstrate a strategic approach to tackling health inequalities and healthcare-related harm among under-represented groups.

- 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

- Population data, patient feedback and learning from the experience of under-represented groups is used to plan, design and improve services.

[3] Under the Health and Social Care (Reform) Act (Northern Ireland) 2009.

- From ‘floor to Board’, health inequalities are considered on the safety agenda at all levels within the organisation. This includes interactions with external stakeholders at policy, commissioning, public health level, and in engagement with the community and voluntary sector.

Theme: Looking after staff well-being

❖ Staff are nurtured to perform at their best

Evidence across the UK, including Northern Ireland, indicates that many healthcare staff experience stress, burnout, and sickness absence.

➢ Staff wellbeing is a core organisational value linked directly to patient safety and quality of care. Our shared ethos is that *‘we look after our staff so that they can look after their patients’.*

➢ Organisational planning to guide staff wellbeing initiatives is aligned with the DoH Health and Wellbeing Framework 2025.

➢ Senior Leaders are committed to developing a confident and capable workforce, which recognises and promote staffs’ core needs:


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

- Ensure staffing levels and skills mix are safe and appropriate
- Manage rotas and workloads to reduce burnout, stress and absence
- Recruit in a timely way and plan ahead to avoid workforce gaps
- Establish clear escalation mechanisms for staffing concerns
- Encourage staff to raise concerns without fear; listen and act when they do
- Ensure staff can receive support for work-related stress and trauma.

➢ When morale, burnout, or moral distress and injury are identified within HSC services, improvement plans are implemented to enhance working conditions, support staff wellbeing, and ensure safe service delivery.

➢ Concerns are escalated to commissioners if funded service capacity and capability cannot safely support patient needs.

❖ Staff diversity is welcomed and championed

HSC 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.

➢ We support inclusive recruitment practice and provide additional support for under-represented groups. This includes staff new to NI, and those with disabilities / additional needs.

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

➢ EDI is championed so that its value in strengthening organisational effectiveness is understood. Inclusive team cultures foster a sense of belonging:

- Staff at all levels actively seek out, welcome and respect different viewpoints and lived experiences.
- All staff, regardless of role, grade or background, have an equal voice and are supported to contribute.

Theme: Listening to patients, families and staff

❖ Feedback is welcomed

Taking action early means a problem can be resolved before it becomes more serious.

➢ HSC Trust Boards and Senior Leaders value the voices of patients, families and staff, who are well-placed to notice unsafe practice. We make them aware of all the ways they can 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

➢ HSC Trust Board Patient Safety and Quality Committee oversees assurance data, integrating quantitative and qualitative feedback from staff, patients, and families with other safety indicators. Data analytics and expert guidance help identify core safety priorities and solutions.

- Feedback from patients and families is included in HSC Trust Board Patient Safety and Quality Committee Assurance Reports.

- 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'

Compassion, civility and respect

Theme: Leading with compassion

❖ Culture comes from the top

Within HSC, the most senior roles must be held by those who demonstrate a proven commitment to leading with care - prioritising staff wellbeing, fostering psychological safety, and nurturing just and open cultures. This reflects the core principle that staff wellbeing is not optional but essential, and that patient safety must always remain paramount.

➢ We promote compassionate leadership with a 'being human' ethos as fundamental to achieving safe, effective, and person-centred care:

✓ Make time for genuine connections with staff

✓Build trust - be visible, approachable and consistent

✓Treat everyone with respect

✓Notice and support colleagues who are struggling

✓Know mistakes may arise from hidden suffering

✓ Value diversity

✓ Be curious and listen to others' perspectives

✓ Demonstrate humility

✓ Focus on learning, not blame.

Compassionate leaders 'do what's right', including making unpopular decisions and holding

➢ HSC Trust Executive Teams and Senior Leaders value and respect the contribution and autonomy of staff at all levels. They ensure that leadership responsibility is collectively shared, not just held by senior management.

➢ Leaders are accountable for their performance; and assessed on how well their actions align with HSC values and support staff wellbeing / patient safety.

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, staff retention, and safe patient care. Achieving psychological safety within high-pressured HSC environments requires a concerted effort. A measure of success is when the 'quietest voice in the room feels safe and enabled to be heard'.

➢ **HSC Trust Boards and Senior Leaders role model compassion, inclusivity, humility, and curiosity in order to foster psychologically safe environments. All staff feel safe to speak up, ask questions, share ideas or raise concerns, without fear of blame, embarrassment, or poor treatment.**

➢ Leaders receive training on psychological safety, civility and human factors.

- They ensure teams work well together by having:

- ✓ Shared purpose
- ✓ Clear roles and responsibilities
- ✓ Opportunities for team building
- ✓ Multi-professional learning
- ✓ Time for reflection

- They ensure psychologically safe team forums where staff from all backgrounds, roles and grades can meet to share ideas and discuss learning and feedback from incidents and governance activities.

❖ Incivility (poor behaviour) by staff is taken seriously

Incivility in the workplace is any action that is offensive, intimidating, or hostile. Given the significant human and financial costs - impacting patient outcomes, staff wellbeing, absence, retention, and organisational reputations - it is essential that managers and HR are supported and empowered to act decisively where poor behaviour occurs.

➢ HSC Trust Boards understand their statutory obligations, including a 'duty of

care' to staff and a 'duty of quality' to patients. Where harmful behaviours are identified, they take appropriate action in accordance with these duties to safeguard both patient and staff safety.

➢ HSC Trust Boards and Senior Leaders set clear expectations for staff in respect of values and behaviours consistent with a positive workplace culture.

- Staff receive training on the impact of incivility, expected conduct, and handling 'red flag' behaviours from colleagues.

Red flags include:

- Controlling behaviour
- Manipulation tactics
- Self-interest
- Lack of empathy
- Pitting colleagues against each other
- Isolating people

➢ Early action is taken to resolve incivility through team engagement, mediation, negotiation, identification and mitigation of stressors; and holding individuals to account. Formal HR processes are used when needed to address bullying, harassment, and discrimination.

❖ Patients and families are partners in care

Seeing patients as active partners in health and social care, rather than passive recipients, is essential for improving safety and outcomes. In doing so, HSC professionals must adhere to clinical guidelines and professional standards for shared decision-making and informed consent, given the legal, ethical, and patient safety risks of failing to do so.

➢ Senior Leaders demonstrate that person-centred care fosters safety and trust, and that harm is caused when empathy, dignity and respect are lacking.

What matters to you?

➢ Staff at all levels consistently demonstrate person-centred approaches to the delivery of care. This includes a culture shift away from 'What's the matter with you? to 'What matters to you?'

- Patients' medical, psychological, and social needs are considered.
- Patients are involved in decision-making, and asked for their views, preferences and choices.
- Patients receive clear, honest information about their treatment options, including benefits, risks, and alternatives.
- Staff receive training on shared decision making and informed consent.

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. HSC professionals have a legal responsibility to work well with colleagues in order to deliver safe, effective care. Mutual trust and respect between leaders, managers and staff is therefore essential.

➢ HSC Trust Boards seek assurance that organisational values are embedded in leadership behaviours and practice.

o Senior Leaders have a key role in shaping a culture where all staff consistently apply the principles of *'listening, hearing and acting'* on patient safety concerns:

- ✓ Role model active listening, empathy, responding and supporting
- ✓ Emphasise that patient and family voices are valued and must be heard
- ✓ Ensure staff understand that dismissing concerns can cause both psychological and physical harm
- ✓ Support staff to take all concerns seriously and respond appropriately
- ✓ Ensure staff understand how to respond to requests for second opinions
- ✓ Reinforce that second opinions are a valuable safeguard, and not criticism
- ✓ Ensure all staff know that everyone is responsible for patient safety once a concern is known.

❖ 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. Blaming and punishing staff for mistakes does not achieve improvements in patient safety, and only contributes to fear, secrecy, and further harm within the HSC system.

➢ Senior Leaders understand that a just and restorative culture is created through the collective behaviours and responses of everyone in an organisation following safety incidents.

- They understand that ultimate accountability for patient safety sits with the HSC Trust Board, not individual frontline staff acting in good faith.
- They embed just culture principles (fairness, openness, learning) into organisational systems, training, policies, procedures and approaches to managing incidents, concerns and complaints.

Restorative approach

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

➢ In the unusual event of deliberate negligence, wrongdoing, 'cover-up' or concealment, this is dealt with separately to the learning process.

Good practice: Incident review panels

➢ Staff feel confident to engage candidly in incident review panels, which are skilled and trained in restorative approaches.

"The patient safety incident review process is the vehicle by which the ability to learn and implement change to prevent harm, and most importantly save life, should be efficiently and effectively demonstrated with full honesty and openness. It is not a vehicle for the protection of individual and organisational reputations. If an individual or organisation acts correctly, honestly, and openly, their reputations will look after themselves." **(Expert by experience)**

❖ 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. Most people, when harm has occurred, need to know that it will not happen to anyone else.

➢ HSC Trust Boards demonstrate commitment to a just culture of fairness, openness and learning - this culture is also explicit within an organisational vision and strategy for Patient and Staff Safety and Wellbeing.

➢ From 'Floor to Board', there is:

➢ Senior Leaders champion candour as a core value, promoting a narrative that:

- There is protection in the truth;
- Power in an apology; and
- Healing in acknowledgement

- Routine sharing of patient safety and staff wellbeing metrics for accountability and improvement.
- Transparent communication supported by effective information-sharing mechanisms.

➢ Senior Leaders emphasise how candour helps rebuild trust with those who have experienced healthcare-related harm by sharing examples of where openness led to improvement.

➢ Formal investigations are not used as a reason to delay an explanation or provide support. Managers and staff are trained in early engagement with patients / families, and don't wait for things to escalate:

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

"There's only one little word that will heal, and that's the truth. I can cope with the truth, but I cannot cope with not knowing the truth... I can cope with what I know is the truth, but not with what I don't know. Cover up only compounds grief when the truth finally comes out." (Norma Sparkes, Mother of Stephen Sparkes)[4]

3. Curiosity and constructive challenge

Theme: Addressing fear and defensiveness within the HSC system

❖ Staff understand the investigations process

Staff defensiveness hinders organisational improvement, often due to a fear of the consequences when care goes wrong. Causes include negative beliefs, blame culture, and a lack of investigation experience. Political instability and trauma from 'The Troubles' legacy has also impacted culture in the HSC system.

➢ Senior Leaders challenge defensive cultures and actively reduce fear in the system by ensuring that staff receive training and resources to demystify what happens, when and why.

➢ All staff in HSC Trust processes receive meaningful support. Enhanced

[4] Norma Sparkes' son, Stephen Sparkes, is a deceased patient of Michael Watt. Since Stephen's death, Norma has advocated for improvements in patient safety within the HSC system in Northern Ireland.

support is offered to staff in public inquiries or coroner investigations, which can involve intense scrutiny. This includes access to counselling, clinical psychology and trauma-informed approaches.

➢ Policies and procedures are applied in line with HSC values, and not used to deflect responsibility, avoid conversations, or target individuals. Processes are:

- Escalated only when necessary, in line with their intent
- Applied fairly and proportionately
- Free from bias and discrimination
- Guided by openness and accountability
- Informed and refined by staff and patient feedback

❖ Concerns and complaints are resolved early where possible

NIPSO is leading complaints standards reform, and individual HSC Trusts are implementing mechanisms to view complaints from a patient's perspective and drive substantial improvement.

➢ To support this culture shift, HSC Trust Boards should seek assurance that complaints are approached through a patient safety lens, with emphasis on early engagement, timely resolution, and meaningful human connection. Examples of early resolution leading to system improvement are shared.

Theme: Making it safe for staff to speak up

❖ Constructive feedback is welcomed

➢ Senior Leaders create a collective understanding about the purpose of challenge for learning and improvement. They role model curiosity, openness, and humility when providing and receiving constructive feedback.

➢ HSC Trust Boards and Senior Leaders:

- Seek out learning from other organisations, external reviews and inquiries to drive internal system improvements.
- Ensure there is openness and transparency about learning and resulting improvement plans.

➢ When required, HSC Trust Boards seek support from external bodies – including the Department of Health, commissioners, regulators, and Royal College of Physicians review programmes - in the interest of gaining independent assurance and expert support.

❖ Speaking up is encouraged and valued

All staff have a professional and moral responsibility to act on safety concerns. Research shows that they may have legitimate fears about speaking up, including experiences of stress, retaliation, or career disadvantage. Leaders have a clear role to promote a culture where staff are protected from psychological harm when they speak up.

➢ HSC Trust Boards act to ensure that:

- There are secure mechanisms in place for staff to raise safety concerns:

✓ Formal systems (e.g., incident reporting, whistleblowing) may also include the independent Speak Up Champion at HSC Trust Board Level.

✓ Informal methods are evident through Leadership Walk Rounds, Listening Exercises, Staff Forums, and Story Boxes.

- Both quantitative and qualitative information from 'raising concerns' is integrated within their metrics for safety; and learning from poor experiences is used to implement improvements.

- Raising concerns is a standing agenda item at HSC Trust Board Patient Safety and Quality Committees; to include an overview of the concern raised, actions taken and staff support provided.

➢ HSC Trust Boards seek assurance that staff who raise concerns are not detrimentally affected, and that they are consistently supported and protected from unfair treatment.

➢ HSC Trust Boards and Senior Leaders promote the benefits of speaking up by sharing examples of it leading to improvements in patient safety.

'Whistleblowing is not an inconvenience or betrayal – it is an act of moral courage, integrity and kindness.

Staff training and awareness

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

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.

Theme: Being curious to learn and improve

❖ There is a culture of reflection across the organisation

➢ HSC Trust Boards make time within routine governance to understand how strategy and operations impact on performance, staff wellbeing, and patient safety. This includes fostering curiosity to explore impact, learn from others, and drive continuous improvement.

> Leaders 'hold up the mirror' and reflect on how they may do things differently. They ensure that reflection is embedded into daily conversations and decision-making.

➢ All staff are given time and space to talk about:

- ✓ What is working well
- ✓ What could have been done better
- ✓ How care and safety can be improved.

❖ Learning leads to real improvement

➢ HSC Trust Boards and Senior Leaders ensure that learning is shared in a meaningful way with frontline staff, and has a measurable impact.

- ✓ Learn from both good practice and harm
- ✓ Establish feedback loops to monitor progress and make adjustments
- ✓ Encourage teams to share what works and scale it
- ✓ Embed 'Appreciative Inquiry' and 'Investigating Success' approaches[5]
- ✓ Engage with staff, patients, families, and communities to assess HSC service benefits, workforce health impacts, and areas needing improvement

✓ Ensure the development of communication plans suited to each team so that staff know what changed, why, and the impact. This may include team meetings; governance meetings; staff training, education and events; leaflets and posters; letters and emails; or videos, podcasts and infographics

[5] 'Appreciative Inquiry' (AI) and 'Investigating Success' are strengths-based approaches which explore what is already working well and builds upon those successes.

Conclusion

Why Being Human matters for you:

- Addresses the root cause of repeated failures - culture, not just systems
- Recognises the intrinsic link between staff wellbeing and safe patient care
- Offers a strategic framework to reduce harm
- Recognises that changing culture is led from the top
- Builds leadership sustainability and self-awareness
- Embeds patient, family, and staff voice into governance
- Supports a fair response to mistakes, focused on learning and not blame.

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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