Health and Social Care

The Regulation and Quality Improvement Authority

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

The full document setting out the collective work undertaken to reach this shared vision of 'what does good look like' in a culture that is focussed on safety for all, is on the RQIA web site at www.RQIA.org.uk/BeingHuman

There is information there too about the phase ahead: working together as a whole system, preparing to adopt the behaviours set out in our shared vision; developing our implementation programme and how we will deliver it; and identifying how we will assess progress and chart improvements.

www.rqia.org.uk/BeingHuman
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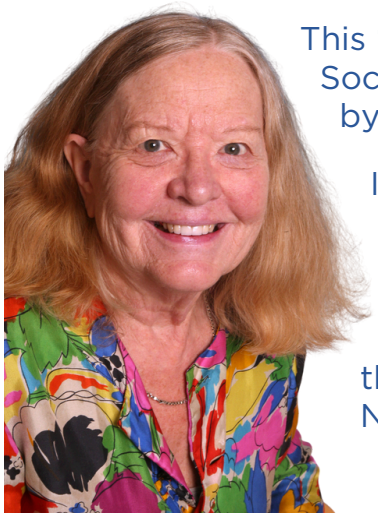
Being Human: A Framework for Safety Culture within Health and Social Care

Domains	Themes	Expectations
Commitment to Patient Safety and Staff Wellbeing	**Fostering collective accountability for Patient Safety**	There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust Board
		There is a 'Floor to Board' commitment to patient safety
		Clinical Care is consistently safe, effective and underpinned by Evidence-Based Practice
		Tackling Health Inequalities is a Key Safety Priority
	Looking after staff wellbeing	Staff are nurtured, supported and enabled to fulfil their potential
		Diversity is welcomed, championed and supported, understanding that it makes teams more effective
	Listening to patients, families and staff	Voices of staff, patients and families are embraced as an important barometer of safety
Compassion, Civility and Respect	**Leading with compassion**	Compassionate Leadership is fundamental to all other aspects of a safety culture
	Empowering staff, patients and families	Effective Teamwork and Psychological Safety is nurtured within teams
		Staff at all levels are kind and civil and work within 'Safe and Compassionate' teams
		Patients and families are empowered, enabled and informed
	Enhancing openness, trust and mutual respect	Staff at all levels Listen, Hear and Act on concerns of patients, families and colleagues
		All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions
		Openness and candour is promoted and supported at all levels in the organisation
Curiosity and Constructive Challenge	**Addressing fear and defensiveness**	Fear is addressed by acknowledging the impact of past trauma and by challenging unhelpful narratives and beliefs
		Early engagement is embraced as an opportunity for early resolution and system learning
	Making it safe for staff to speak up	Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system
		Speaking up is highly valued and encouraged and results in action to improve patient safety
	Being curious to learn and improve	Time and space for reflection is created at all levels in the organisation
		Learning is shared in a meaningful way that has impact



This “Being Human Framework”, based on our existing Health and Social Care Standards, has been developed through co-production by the Health and Social Care system and its users.

It comes at a critical juncture for the Health and Social Care system in Northern Ireland. It springs from RQIA’s Legacy Commitments, following from the Review of the Records of Deceased Patients of Michael Watt, the experience of the Hyponatremia Inquiry and other Inquiries, to ensure that sustainable action results from past failings within Northern Ireland’s HSC, and the NHS more widely. These all identified cultural issues as key to poor behaviours and poor patient safety.

The Framework is both a response and a renewal: a deliberate effort to reframe Patient Safety as a deeply human endeavour, not as some kind of “forced function” to comply with policy or procedures. The Framework recognises that no amount of procedural, policy or process change can or will change our culture and our behaviour. Changing the culture of an organisation, and the system as a whole, requires informed and intelligent leadership; a deliberate choice to change; and to sustain that change in mind-set and in behaviours.

This Framework aims to give the leaders of organisations, at all levels and in all roles, a shared vision of ‘what good looks like’ in terms of patient and of staff safety, and a shared means of assessing and evaluating their individual organisational Safety Culture. Between the vision and the evaluation comes the shared preparedness and the collaborative actions through improvement action plans, creating and sustaining the cultural and behavioural change.

The Framework provides the basis for a shared understanding and common approach to other policies, whether SAI’s, Being Open, MHPS. It does not require legislation; it requires determination, and shared purpose.

Historically, attempts to improve safety have led to revised regulatory and process-driven mechanisms. Yet, evidence and experience consistently demonstrate that mechanistic systems alone do not create safety — humans do. It is the interaction between human beings and systems, and the culture that surrounds them, that ultimately determines whether our care environments are safe. Safe for patients; safe for staff; and so creating safe space for the HSC as a whole system to learn and to improve.

People need to feel psychologically safe so they are able to ask questions, make suggestions and raise concerns. Concerns raised by patients, families or HSC staff must be heard, understood, and acted upon. To do anything else is a breach of trust and counter to the ‘Duty of Quality’ to patients and ‘Duty of Care’ to staff.

Northern Ireland’s HSC system is complex and varied. There are many examples of good practice, as well as many challenges. Where we have examples of safe and compassionate cultures within our system, these must be recognised, celebrated, promoted, scaled up and spread. Here, the recent incorporation of the Health and Social Care Quality Improvement unit into RQIA is a very welcome recognition, rationalisation and reinforcement of capacity. This change gives statutory backing to the QI Movement and reinforces its alignment with HSC’s strategic aims. It will strengthen support for the HSC Trusts through their QI Alliance, a resource that embeds collaboration and consensus. It will mirror and support the undertakings of the ‘Committee in Common’ for shared purpose and delivery.

The Being Human Framework sets out what good practice looks like. It harnesses appreciative inquiry to foster a culture that is person-centred and relationship-focused. It draws upon the core values of our Health and Social Care system — compassion, openness, honesty, collaboration, and excellence. It places recognising and meeting human needs and rights at the centre of care. It recognises that people flourish when their needs are met, when they are treated with respect, and when authentic human connection is fostered through compassionate leadership.

The Framework also acknowledges the inevitability of human error. It advocates for a culture where honesty is encouraged, and where learning and improvement are embraced. A culture where mistakes are not hidden but reported. When harm occurs, the response offers compassion, timely apology, acknowledgement, and answers. Accountability is not punitive — it is a pathway to healing for individuals and positive change for the system itself.

"Being Human" is a call to collective responsibility and collective leadership. It invites all of us — clinicians, leaders, regulators, and service users — to co-create a culture that prioritises safety, wellbeing, and trust. It is not a static document, but a dynamic Framework for reflection, dialogue, and continuous improvement. Working together we can cultivate a culture that is just, open, learning and improving, and safe and compassionate.

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"Being Human" — Our Shared Vision

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