Health and Social Care

The Regulation and Quality Improvement Authority

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

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This includes representatives from:

- Department of Health
- General Medical Council
- Health and Social Care Trusts
- Northern Ireland Medical and Dental Training Agency
- Northern Ireland Practice and Education Council for Nursing and Midwifery
- Northern Ireland Public Services Ombudsman Office
- Northern Ireland Social Care Council
- Nursing and Midwifery Council
- Patient Client Council
- People with Lived Experience
- Public Health Agency
- Regulation and Quality Improvement Authority (including Health and Social Care Quality Improvement Northern Ireland)
- Royal College of General Practitioners
- Royal College of Midwives
- Royal College of Nursing
- Royal College of Psychiatrists
- Royal College of Surgeons
- Trade Unions
- Ulster University
- Voluntary Sector Organisations

We very much appreciate their dedication and commitment to improving safety culture within Health and Social Care to ensure that it one which is 'Safe and Compassionate', 'Just and Open', and 'Continually Learning and Improving'.

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Foreword

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 mindset 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.

Foreword

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 and open'; 'learning and improving'; and, 'safe and compassionate'.

Christine Collins, MBE
Chair, RQIA

Executive Summary

In recent decades, there have been numerous public inquiries into repeated failings within the Health and Social Care service, and NHS more widely, where lessons have been learned, yet not learned in any meaningful way. As strategies to improve governance systems and processes by themselves have not led to substantial improvements in patient safety, the role played by culture within Health and Social Care (HSC) has become increasingly evident.

Being Human: A Framework for Safety Culture within Health and Social Care sets out what a good safety culture looks like within HSC in Northern Ireland. It defines safety culture as one that is 'Safe and Compassionate', 'Just and Open', and 'Continually Learning and Improving'.

'Being Human' delineates a shift away from rigid process-driven, 'tick box' approaches to health and social care, and focuses on embedding a relational, person-centred ethos at all levels of the HSC system; understanding that our shared humanity and the relationships we have with each other, as patients, family members, colleagues and leaders, are our greatest asset to ensuring a safe, high-quality HSC system.

Underpinned by HSC Values, and aligned to best-practice standards, including DoH Quality Standards 2006, the Framework defines three overarching domains that represent the collective mindset necessary to drive a strong safety culture.

- **Domain 1: Commitment to Patient Safety and Staff Wellbeing**
- **Domain 2: Compassion, Civility and Respect**
- **Domain 3: Curiosity and Constructive Challenge**

Each of these domains encompass a number of expectations for HSC Organisations, underpinned by a series of indicators, setting out the enabling system factors, behaviours and outcomes that provide evidence of a good safety culture. Accompanied by case studies, good practice examples, along with examples of poor behaviour, it is designed to be enabling and empowering for HSC staff, patients and families.

Recognising that 'culture comes from the top', the Framework is of particular benefit to HSC Trust Boards, and newly established Patient Safety and Quality Committees, as they determine how best to improve and assure safety for staff, patients and the public. It is not a one-off and standalone piece of work, but rather the continuation of an upward journey.

In the short-to-medium term, further work is required to develop the tools, guidance and any adjuncts necessary to facilitate Framework implementation and evaluation. In the longer term, it will require whole-system adoption in order to maximise safety culture within all aspects of Health and Social Care.

Meanwhile, the Framework should be embraced and utilised to shift mindsets, influence behaviour and define the actions required to embed a 'Safe and Compassionate', Just and Open and Continually Learning and Improving Culture within HSC.

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

Background and Context

The core purpose of the Regulation and Quality Improvement Authority, as the system regulator for Health and Social Care (HSC) in Northern Ireland, is to secure and improve the safety and quality of health and social care services.

In November 2022, RQIA made a number of Legacy Commitments in relation to the improvement and assurance of safety culture within HSC.[i]

These commitments were made following the stark learning arising from RQIA Expert Review of Records of Deceased Patients of Michael Watt[1], which raised significant concerns about how patients[ii], families and HSC staff experience culture within the Northern Ireland Health and Social Care System. RQIA had the privilege of meeting with families who shared testimony of not being listened to, not being treated with empathy, compassion or respect, and of healthcare professionals seeming disempowered to raise concerns. These concerns echo the findings of numerous Inquiries and Reviews within HSC, and the NHS more widely, undertaken in recent decades; all of which highlights a need for a concerted effort to improve safety culture within our Health and Social Care Service.

Following significant scoping work and engagement with stakeholders across the region through a series of Roundtable Discussions[2,3], it was determined that in order to fulfil RQIA's Legacy Commitments, there was a requirement for an overarching Framework to set out clear expectations for how safety culture may be strengthened and assessed within HSC.

In December 2024, RQIA secured a mandate from system partners and representatives with Lived Experience to take this work forward by co-production.

How we developed the Framework

Co-production Model

RQIA developed a Co-Production Model to ensure a robust approach to the Framework's development and a Co-Production Charter to ensure adherence to best practice principles in co-production.

The Framework was developed by Co-Production Partners working together in three work streams:

1. Safe and Compassionate;
2. Just and Open;
3. Learning and Improvement.

[i] Legacy Commitment 7: Strengthen the assessment of a safety culture, particularly around evidence of listening to patients and families, and evidence that staff feel safe to challenge each other and raise concerns.
Legacy Commitment 8: Require improvements if there is evidence of substandard systems, or poor culture or care.
Legacy Commitment 9: Use its position as independent regulator to support the adoption of openness and candour across all services, especially when reporting that care has gone wrong.

[ii] For the purpose of this document, it was agreed that the term 'patient' would be used throughout recognising that it is an umbrella term for an individual in receipt of Health and Social Care Services.

Background and Context

A Steering Group was established for oversight, assurance, advice and guidance around the approach to co-production, communication, engagement and involvement and publication plan in respect to the Framework.

An Expert Reference Group was established to quality assure outputs of the work streams, with feedback provided to each work stream to implement.

Engagement and Involvement

In parallel with development of the Framework, a sense-check process was undertaken to ensure alignment with other pieces of regional work currently underway to improve safety culture within HSC[iii].

Engagement and Involvement was undertaken with HSC Trust Boards, HSC staff groups, Lived Experience representatives, and Community and Voluntary Sector Organisations through a series of focus groups.

Approval

The final Framework was approved by the RQIA Authority in August 2025.

Scope of the Framework

HSC Trusts

The Framework is intended for use within HSC Trusts. Whilst its principles can be applied to other settings, such as primary care, the independent sector, and health and social care settings in other jurisdictions, the Framework has been developed with the specific intention of assuring and improving safety culture within the six Health and Social Care Trusts in Northern Ireland.

Primary Care

Primary Care is the first point of contact for people with health and social care needs. RQIA does not presently have regulatory oversight of Primary Care within Northern Ireland but recognises the vital importance of driving a safe and compassionate culture within Primary Care, particularly within the General Practice (GP) setting. Further work is required to adapt the Framework for use within Primary Care, including GP Services.

[iii] These included: DoH-Led Being Open Framework, Redesign of SAI process, Establishment of HSC Trust Board Patient Safety and Quality Committee, NI Practice and Education Council Quality Excellence Framework and Reform of Complaints Handling led by NI Public Services Ombudsman.

The Purpose of the Framework

Underpinned by the core values, principles and standards for Health and Social Care, including DoH Quality Standards 2006[4], the purpose of the Framework is:

1. To set out expectations of what a good safety culture looks like for HSC system, patients and the public.
2. To provide the foundation for assessing safety culture within HSC organisations.[iv]

The Framework, the process of developing it, and any accompanying tools and guidance, are intended to achieve an overall aim of fostering a culture within the HSC system that is safe and compassionate, just and open, and continually learning and improving.

The Framework is designed to:

- Define a culture within HSC that is safe and compassionate; just and open; continually learning and improving.
- Support HSC Trust Boards and senior leaders to foster a safe and compassionate; just and open; continually learning and improving culture within HSC services through: consistent compassionate leadership; scaling up and spreading good practice; and promptly identifying and addressing poor practice;
- Be meaningful and relevant to all those who use it, by setting out how its principles may be practically applied in real life situations
- Enable and empower HSC staff, patients and families to articulate the safe and compassionate environments they deserve to encounter, whilst empowering them to constructively challenge when standards fall short of what is required to ensure staff and patient safety
- Set out clear expectations for the HSC system, that are underpinned by core values, principles and standards for Health and Social Care, including DoH Quality Standards 2006.
- The Framework, underpinned by the DoH Quality Standards 2006, is designed to set out 'what good looks like' in relation to safety culture within HSC organisations. It will inform the development of assessment tools and guidance that can be used for self-assessment by HSC Trust Boards, and will be of value to newly established Patient Safety and Quality Committees.
- The Framework will be used by RQIA as part of its function to inform the DoH of the quality and safety of HSC services.[v]

[iv] Assessment methodology and tools to be developed as part of Phase 2.

[v] Under the 2003 Order, the Regulation and Quality Improvement Authority has statutory functions to conduct reviews, inspections and investigations of, and make reports on, arrangements by HSC Trusts for the purposes of monitoring and improving the quality of the HSC services.

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Introduction to Being Human: A Framework for Safety Culture within Health and Social Care in Northern Ireland

Health and Social Care (HSC) systems, clinical pathways and treatments, and the patient populations they serve, have become increasingly complex. Delivering high-quality care in the current climate of fiscal challenges and workforce pressures, can at times feel aspirational. Health and Social Care professionals frequently report burn out, moral distress and moral injury whilst the public express decreasing confidence and mounting frustration due to chronic issues with accessibility, at multiple points in the system – primary care, Emergency Departments, outpatient waiting times, and surgical waiting lists.

Furthermore, in recent decades, there have been numerous public inquiries into repeated failings within the Health and Social Care service, where putative lessons have been learned, yet not learned in any meaningful way.[5]

As strategies to improve governance systems and processes, by themselves, have not led to substantial improvements in patient safety, the role played by culture within health and social care has become increasingly evident.

No-one understands culture better than those who live it and are impacted by it. This includes patients and families who have Lived Experience of using services, some of whom have shared harrowing testimony of healthcare-related harm, and also staff who work within services daily to deliver care. Staff acutely understand the pressures within the HSC system, and may themselves have experienced harm due to cultures that are not as fair, open or supportive as they should be.

Our engagement with these Experts by Experience has sent a resounding message that the prevailing culture must fundamentally change. That is not to say that good practice does not exist. There are lots of examples of good practice, some of which are highlighted within this Framework. Where good practice is evident, it must be recognised, celebrated and spread. A strong safety culture must become the norm - not the exception.

It is a point recognised by our partners within HSC system – Department of Health, HSC Trusts, Patient Client Council, NI Public Services Ombudsman, NI Practice and Education Council and Professional Regulators – all of whom, are involved in leading important work to improve safety culture within HSC. The values, principles, and standards underpinning our collective efforts are referenced within this Framework.

Together, we have a shared vision for a safety culture within HSC that is safe and compassionate for patients and staff, just and open, and continually learning and improving. In order to realise this vision, we must first define it by setting out what good looks like and how we can achieve it.

Defining Safety Culture for Health and Social Care in Northern Ireland

A safety culture within HSC is one that is:

1. Safe and Compassionate;
2. Just and Open; and
3. Continually Learning and Improving.

1. Safe and Compassionate

What does this look like?

There is a continuous drive to provide safe and compassionate care to patients and staff. Staff are supported, nurtured and enabled so that they can look after their patients. Patients are listened to, receive empathy, compassion and respect, and are treated as partners in making decisions about their care.

There is psychological safety within teams, where staff feel safe to ask questions and learn, safe to discuss ideas on how to improve, and safe to communicate and raise concerns so that patients and staff can be safeguarded from harm.

There is also psychological safety for patients and families, who are empowered, supported and enabled to raise concerns about care and treatment, to have their voices listened to so that the HSC system can learn and improve.

2. Just and Open

What does this look like?

A just and open culture is one where fairness, openness and learning are embedded within the Health and Social Care system; and where staff are encouraged to raise concerns, safe in the knowledge that action will be taken and that they will be supported and protected from unfair treatment.

It is characterised by a compassionate and supportive environment for staff, patients and families, who can trust that in the aftermath of health-care related harm, their needs will be considered and that their confidence will be restored through open acknowledgement of impact of their experiences and a genuine commitment to drive system learning and improvement.

There is openness and candour at all levels in the organisation, where staff are supported to engage early with patients, victims and families who have experienced healthcare-related harm, in order to promote healing, restoration of trust through human interaction, sincere apology, acknowledgement of harm and provision of open and honest information.

3. Learning and Improvement

What does this look like?

There is a 'floor to Board' commitment to learning and improvement. It is characterised by a strong learning ethos which encourages contribution from all, recognising that the voices of staff, patients and families are an important barometer of safety.

There is a commitment to learning from good practice as well as from harm and to ensure that learning is shared in a meaningful way and has measurable impact.

Staff at all levels are empowered and enabled to achieve their potential; appreciating that diversity and inclusion results in more effective teams, and greater creativity and innovation.

What ensures we achieve a good safety culture?

Culture can be defined as the collective values, attitudes and behaviours of a group of individuals, working within a system, organisation, service or team.

Values

Values are an enduring set of principles and ideals that guide how people think, feel and behave.

A person's value-base may be shaped by their intrinsic nature, lived experiences, moral beliefs instilled through their upbringing, education and training, and codes of conduct set out by their profession or organisation.

Within Health and Social Care Organisations, there is an expectation that all individuals will adhere to HSC Values.[6]

These are:

- **Working Together** – Working well with colleagues, other teams, external organisations and agencies; working in partnership with patients and families;
- **Openness and Honesty** – Being open and honest, acting with integrity and candour;
- **Compassion** – Being kind, empathetic, supportive to patients, families, and colleagues;
- **Excellence** - Committing to being the best we can be, putting the needs and safety of patients before self-interest; reflecting the vocational and altruistic reasons why many enter health and social care.

Whether individuals remain true to HSC values, by consistently behaving in ways that are aligned to them, may be influenced by the context, environment, and prevailing attitudes and beliefs in the organisations within which they work.

Attitudes and Beliefs

The attitudes, beliefs and assumptions of individuals constitute a mindset. Mindsets may be shaped by organisational narratives and the lived experiences of how leaders and colleagues are observed to behave and act, including how they treat others on a day-to-day basis and at times of stress.

These narratives and experiences are crucial in setting an 'internal compass' or benchmark for behaviour that is perceived to be:

1. 'acceptable' (i.e. I must be professional, kind and civil at all times);
2. 'safe' (i.e. It is safe for me to raise concerns about patient safety);
3. 'moral' (i.e. I must be open and truthful at all times).

Perceptions around what are acceptable, safe and moral behaviours, further perpetuate the culture[7], otherwise known as how 'we do things around here' or 'how we do things around here when no one is looking'.

How do we ensure that our internal compass points in the right direction?

In the context of Health and Social Care, there are three high-level domains, for driving a culture that is safe and compassionate, just and open, and continually learning and improving.

Each domain represents a collective mindset for achieving and sustaining improvement in safety culture:

Domain 1: Commitment to Patient Safety and Staff Wellbeing

Domain 2: Compassion, Civility and Respect

Domain 3: Curiosity and Constructive Challenge

In the sections below, each domain is explored to identify expectations for the HSC system, along with a set of indicators; these represent the actions, behaviours and outcomes that are consistent with strong safety culture.

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Cultural Domain 1: Commitment to Patient Safety and Staff Wellbeing

Domains	Themes	Expectations
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Expectation 1: There is shared understanding of collective accountability at all levels, acknowledging that ultimate accountability for patient safety sits with HSC Trust Board

1.1 There is a shared vision for 'Patient and Staff Safety', understood by staff working at all levels, which clearly sets out a shared responsibility and collective accountability for 'Patient and Staff Safety'.[vi]

1.2 HSC Trust Boards demonstrate a commitment to the Duty of Quality. This is evidenced in their approach to: oversight and assurance of patient safety and staff wellbeing; openness and transparency around patient safety and staff wellbeing metrics; commitment to continuous learning and improvement.

1.3 HSC Trust Boards ensure that there are safety management systems in place, to support a strong safety culture within HSC services.

1.4 HSC Trust Boards, Senior Leaders and Leaders and managers are routinely open about organisational performance, patient safety and staff wellbeing. Metrics are routinely shared for the purposes of assurance, benchmarking performance and openness and transparency with staff, patients, families and the public.

1.5 HSC Trust Boards and Senior Leaders have in place robust monitoring arrangements for Patient and Staff Safety. These take into consideration a holistic approach to assurance, integrating patient and staff feedback with other indicators of safety.

1.6 HSC Trust Board Patient Safety and Quality Committees triangulate information, including both quantitative and qualitative patient and staff feedback, in order to provide a high-level overview of patient safety and staff wellbeing.

1.7 HSC Trust Boards, via Patient Safety and Quality Committees, work effectively to identify key safety priorities and advise on strategic approaches to improvements. This includes oversight and ongoing assurance, including an understanding of when independent assurance and external expert advice and support may be required.

1.8 HSC Trust Boards and Senior Leaders demonstrate an understanding that they are accountable for promoting a just, open and learning culture within the organisation.

1.9 HSC Trust Boards have arrangements in place to monitor a culture that is consistent with safety, compassion, fairness and openness.

1.10 HSC Trust Boards and Senior Leaders role model behaviours consistent with the values of HSC.

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

1.12 Staff at all levels understand the values and standards of behaviour to which they are expected to demonstrate and for which they will be held accountable.

1.13 Leaders and Managers at all levels are provided with training, resources and support to manage and address the behaviours of direct reports, staff and teams, that are not consistent with the values of HSC.

1.14 Where individual performance is of concern, managers in the first instance adopt a supportive approach in order to seek early resolution. Managers receive training and guidance on how to support staff with performance issues.

DoH Quality Standard: 4.3 Corporate Leadership and Accountability of Organisations

[vi] A broad definition of accountability is adopted which includes: acknowledging our roles and responsibilities, taking ownership of our actions and behaviours, being open and honest, a commitment to learning from mistakes, and contributing positively to system learning and improvement.

1.1 Collective Accountability

What is accountability?

Accountability is often interpreted as being synonymous with 'blame and punishment'.

In the context of HSC system failings, when the media and public speak about 'holding someone accountable' we often envisage that this means someone will be reprimanded, lose their job, be prosecuted or publicly shamed for their actions; these often unhelpful and anxiety-provoking connotations of accountability are also shared by HSC staff, leading to a pervasive sense of fear within the HSC system.

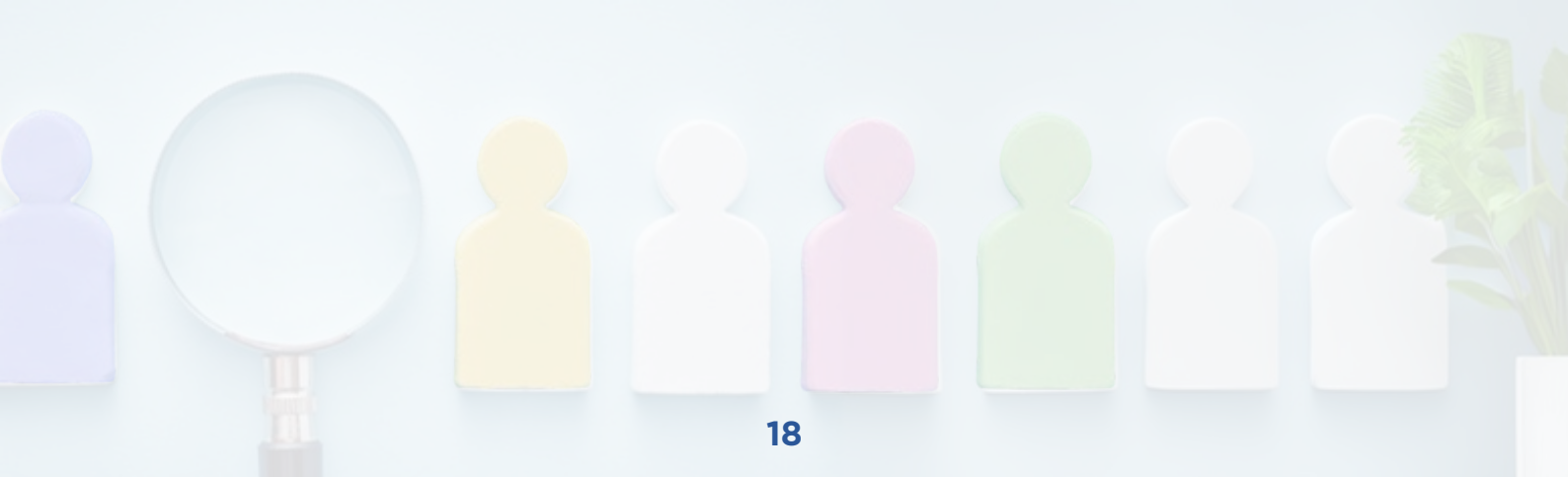
In the presence of fear, festers a culture of defensiveness, blame and secrecy; all of which are counter to the true meaning of accountability.

The true meaning of accountability

'Accountability is a privilege', needing not to be 'reframed', but properly understood, and claimed with pride by all who work within the Health and Social Care System.

Accountability can be viewed as encompassing four broad elements:

1. **Responsibility;**
2. **Ownership;**
3. **Being Open;**
4. **Learning from mistakes.**



Individuals demonstrate their commitment to accountability in the following ways:

Element	Individuals	Why accountability is positive
Responsibility	Accountability starts with acknowledging our roles and responsibilities and accepting that we have agency over our actions and behaviours.	It is a privilege to work within the HSC system, to have a role in serving and caring for those who need Health and Social Care.
Ownership	We take ownership of our actions and behaviours, ensuring that they align with HSC values, understanding that we are answerable for how we act and behave.	With this come dedication and commitment to living the values of HSC. When we experience challenges, we can be proud that we remained true to HSC values.
Being Open	Being open is an integral part of accountability. It means being open about our actions and behaviours, and their outcomes, even if those outcomes are not what we intended. Being open is an important aspect in maintaining the trust and confidence of others.	When care has gone wrong, we can feel proud of being open, honest and forthcoming, understanding that being open provides an opportunity for healing and recovery for those who have been harmed, and for system learning and improvement. Being open serves to maintain and restore trust and confidence in the Health and Social Care System.
Learning from mistakes	Accountability requires us to acknowledge and learn from our mistakes - seeing mistakes as an opportunity for personal growth. It requires us to accept responsibility for our actions and behaviours, to reflect on what went wrong, and take steps to rectify or improve.	When we make mistakes or are involved in safety incidents, we can be proud that we are committed to learning from what has happened for professional development and to contribute to making system improvements to avoid similar happening in future. This learning will improve patient safety going forward.

Accountability for individuals is to be viewed as a positive, to be held with honour as a staff member working within HSC. When we behave in ways that are accountable, we demonstrate that we are 'living the values' of HSC.

However, if our behaviours do not align with HSC values, as individuals we should all be prepared to be answerable for our behaviour and to accept responsibility for the consequences of our actions.

Behaviour such as dishonesty, deceitfulness and causing deliberate harm to patients and colleagues (including bullying and harassment) will have significant consequences for individuals. The majority of HSC staff do not behave in such ways and therefore have nothing to fear from 'accountability'.

What good looks like: Living the HSC Values

- Senior Leaders role model the behaviours consistent with HSC Values;
- HSC Organisations set clear expectations for staff in respect of values and behaviours;
- Staff at all levels understand the values and behaviours they are expected to demonstrate;
- Managers are provided with training, resources and support to address behaviours of individuals that are not consistent with the Values of HSC.

Whilst all individuals are accountable for their behaviours and actions, it is HSC Trust Boards that are ultimately accountable for patient safety through their 'Duty of Quality'.[vii]

[vii] The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003' applied a statutory duty of quality on the HSC Trusts.

HSC Organisations can demonstrate their commitment to accountability in the following ways:

Element	HSC Organisations
Responsibility	• There is a statutory 'Duty of Quality'[viii], ultimate responsibility for Quality and Safety sits with the HSC Trust Board.
Ownership	• There is a shared vision and strategic direction, clearly understood by staff working at all levels, which sets out a shared responsibility and collective accountability for Patient and Staff Safety. • HSC Trusts ensure there are appropriate safety management systems, oversight and assurance of patient safety and staff wellbeing. • There are robust monitoring arrangements in place for Patient and Staff Safety that adopt a holistic approach to assurance, integrating patient and staff feedback (qualitative and quantitative) with a range of other meaningful safety indicators. • HSC Trust Boards, via Patient Safety and Quality Committees, identify key safety priorities and advise on strategic approaches to improvement.
Being Open	• HSC Trust Boards, Senior Leaders and Leaders and managers are routinely open about organisational performance, patient safety and staff wellbeing. Metrics are routinely shared for purposes of transparency, assurance and benchmarking in order to drive improvement. • A just, open and learning culture is fostered at all levels within HSC organisation. There are arrangements in place for monitoring the culture. • There is organisational candour. Staff are supported and feel safe to be open and honest when care goes wrong.
Learning from mistakes	• HSC Trust Boards are committed to continuous learning and improvement. • There are systems and processes in place for incident reporting and review. Incidents are examined with an understanding of system and human factors. • Learning is identified with a view to driving system improvements in patient safety. Learning is shared in a meaningful way and has measurable impact.

[viii] The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003' applied a statutory duty of quality on the HSC Trusts.

Creating a Culture of Accountability

Creating a culture of accountability can serve to enhance shared responsibility for patient safety.

Leaders play an important role in fostering a culture of accountability by:

- Being explicit about goals and intentions;
- Setting clear expectations;
- Providing autonomy and support for staff;
- Monitoring performance with a focus on quality and safety outcomes;
- Creating systems for openly communicating performance;
- Motivating individuals and teams to strive for excellence.

Case Study: Fostering a Culture of Accountability

Cahal manages a stroke unit at Antrim Area Hospital. His nomination for the Royal College of Nursing (RCN) Northern Ireland Nurse of the Year Awards 2024 focused upon his exceptional achievements in leading a team that has fostered a culture of accountability and improved patient safety and care standards by reducing in-patient falls.

The unit opened in March 2023 and Cahal led the building, motivation, support and development of the team. He identified staff involvement and engagement as key to managing the challenges and ensuring that the unit would be a success. His management is based upon staff engagement and training, prioritising staff health and wellbeing, embedding falls safety and prevention as part of the daily routine, promoting greater awareness of falls, and seamless engagement with the wider multi-professional team. Cahal's nurse-led initiative has improved patient outcomes by developing staff skills to meet in-patient needs, as well as by making it clear that preventing falls is 'everyone's business'.

As a consequence, the number of falls within the unit reduced by 43% within the first six months, with no catastrophic, major or moderate falls. Radiology requests reduced by 44%, with an estimated average financial saving of £2,240 over a six-month period. Staff retention and morale is at an all-time high, with Cahal ensuring that his team feels valued and appreciated.

Cahal's nominator stated: "Cahal has created an environment in which clinical excellence flourishes, ensuring high standards of patient-centred care. Cahal is a wonderful advocate and ambassador for patients, and this is just the beginning of his success."

We are all accountable for our performance. There will be occasions when the performance of individuals or teams, fall below required standards. Suboptimal performance needs to be dealt with effectively, striking balance between supporting staff and keeping patients safe.

Where individual performance is of concern, managers should in the first instance adopt a supportive approach in order to seek early resolution. Managers should receive training and guidance on how to support staff with performance issues[8]. The majority of performance concerns should be managed and resolved informally between managers and employees, with advice sought from HR, when required.

Green Flag Leadership Behaviours for dealing with Poor Performance

Effective leaders do not unfairly apportion blame on individuals for poor performance but instead:

- Reflect on their role as leaders and how they can act differently to achieve better results;
- Engage with teams to actively listen, understand system issues or barriers that need rectified, and develop shared solutions;
- Respond compassionately to staff members who are suffering from burn out, moral distress, moral injury and trauma that may be impacting on performance – ensuring that support is provided;
- Provide support for individuals and teams to improve;
- Recognise that certain groups of staff, such as those who are newly qualified, or unfamiliar with the HSC Trust, i.e. locum and agency workers, may require enhanced support;
- Are prepared to have difficult conversations about improving performance in the interest of safeguarding patients from harm;
- Set targets and continue to monitor to ensure improvement occurs;
- If improvement does not occur, concerns are appropriately escalated to ensure enhanced scrutiny and additional support for improvement.

'Patient safety is paramount' and where there are 'Early Warning Signs' of a service in difficulty, the HSC Trust Board ensures that there is appropriate ownership for assuring and improving safety within the service, understanding ultimate accountability sits with HSC Trust Boards.[ix] Where Patient or Staff Safety is of significant concern, it may become necessary to invite independent assurance and secure external support for improvement.

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

There will be occasions when the culture does not foster collective accountability for patient safety. The following 'Red Flag Behaviours' are indicators of poor practice; their presence warrants further exploration of the safety culture with a view to improvement.

Red Flag Behaviours

1. Taking unnecessary risks;
2. Failure to identify and address safety problems;
3. Individuals are blamed or punished for system failings;
4. Resistance to external scrutiny;
5. Failure to implement recommendations from scrutiny activity. (i.e. reviews, investigations, inquiries)

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Expectation 2: There is a 'Floor to Board' commitment to patient safety

2.1 Staff at all levels take responsibility for ensuring patients are safe. On a day to day basis, all staff advocate for their patients and act in their best interests.

2.2 Senior Leaders and Leaders and managers ensure there is robust safety promotion, communication and training throughout the organisation, in accordance with safety priorities.

2.3 Staff induction and staff development programmes, include safety issues pertinent to their role and service area. Refresh updates are provided at regular intervals in accordance with safety priorities and areas of risk.

2.4 Staff are clear on their roles and responsibilities, in respect of assessing and managing risk – the importance of which is clearly understood, and is not perceived as a 'tick box' exercise.

2.5 Staff at all levels understand the importance of good communication in ensuring patient safety. A structured approach to communication is adopted throughout the organisation, i.e. SBAR communication tools or equivalent.

2.6 Communicating concerns about patient safety risks is normalised within the day to day activities of the organisation. I.e. safety huddles or equivalent.

2.7 Staff at all levels, regardless of role or grade, feel safe and empowered to communicate concerns and contribute to discussions about patient safety issues.

2.8 Leaders and managers encourage teams to discuss and raise patient safety risks and concerns, and support teams to openly discuss and work together to address patient safety issues.

DoH Quality Standard 5.3.1 Ensuring Safe Practice and Appropriate Management of Risk
DoH Quality Standard 5.3.3 Promoting Effective Care

1.2 Patient Safety is everybody's responsibility

The founding principle of Health and Social Care is to provide care to patients and service users. Staff at all levels are responsible for keeping patients safe and always acting in their best interests.

Healthcare is complex and carries inherent risks to patients. Prevention of avoidable harm depends on staff having shared responsibility for keeping patients safe. **'From floor to Board, everyone plays an important role in patient safety'**. As such, all staff need to be empowered and enabled to act on patient safety concerns.

Where staff identify concerns that they cannot address by themselves, they raise these in the interests of safeguarding patients from harm – understanding that **'patient safety is paramount'** and **'we are all patient advocates'**.

Furthermore, we have a duty to listen, hear and act on safety concerns shared with us by others, understanding that **'we cannot un-know what we know'** and that we are all responsible for acting in the best interests of patients.

What good looks like: Communication

- Staff at all levels understand their roles and responsibilities with respect to effective communication;
- Staff understand the importance of good communication in ensuring patient safety;
- A structured approach to communication is adopted throughout the organisation;
- Tools are adopted to facilitate staff to communicate effectively. These may include:
  - SBAR tools;
  - standardised checklists;
  - proformas.
- Communicating concerns about patient safety is normalised within day-to-day activities including at the front-line, i.e. safety huddles, safety briefs, handovers, patient transfer etc.
- All staff, regardless of role or seniority, feel safe and empowered to communicate concerns and contribute to discussions about patient safety.

Communication within and between teams in crucial in maintaining patient safety. The vast majority of patient safety incidents involve failures in communication. It is important that the culture, and underpinning systems and processes, support robust communication between individuals, teams, services, Trusts and sectors, including the independent sector and primary care.

Good Practice Example

Improving Communication between Primary and Secondary Care

In 2019, Royal College of General Practitioners NI undertook a project to improve relationships between primary and secondary care – one of the main drivers was to improve patient safety.

This work led to the publication of a paper entitled 'Professional behaviours and communication principles for working across Primary and Secondary Care Interfaces in Northern Ireland'.[9]

The paper outlines 10 agreed principles to ensure better working together and was agreed by the medical Royal Colleges in NI as well as being adopted and published in the UK by the Academy of Medical Royal Colleges in 2020. It was a precursor to the January 2024 'Working Better Together' guidance, produced by HSCNI, which sets out a roadmap for working relationships between primary and secondary care.

This document has been adopted by both primary and secondary care, and its implementation is ongoing.

If implemented in full, it will go a long way towards improving the cultures and communications on the primary and secondary care interface, breaking down silos, and ultimately leading to better patient outcomes.

Unfortunately, in services with a poor safety culture, patient safety is not viewed as a priority; the following red flags are indicative of a culture where collective responsibility is lacking .

Red Flag Behaviours

1. **Poor communication:**
   - Silo working;
   - Lone working;
   - Dysfunctional teams;
   - Lack of a structured approach to communicating within and between teams
2. **Poor attitude to patient safety risks, such as:**
   - Complacency, manifesting as taking unnecessary risks
   - Denial of safety risks or problems
   - Failure to follow safety protocols, procedures and clinical guidelines
   - Refusal to engage in governance activities, such as clinical audit and safety improvement
3. **Failure to accept responsibility:**
   - Poor understanding of individual responsibility for identifying and acting on patient safety concerns
   - Lack of clear direction and accountability
   - Avoidance of taking responsibility

Expectation 3: Clinical Care is consistently safe, effective and underpinned by Evidence-Based Practice

3.1 HSC Trust Boards and Senior Leaders demonstrate a commitment and strategic approach to reducing unwarranted variation in order to reduce: avoidable harm; health inequity; and waste.

3.2 Senior Leaders take measures to ensure that patients receive care in the right place, by the right person at the right time.

3.3 Assessment and treatment pathways are allocated in accordance with clinical need. Senior Leaders ensure that gate-keeping of resources for arbitrary reasons is avoided, and that clinical need takes priority.

3.4 Senior Leaders identify and address barriers to the delivery of safe, effective care in accordance with expected standards.

3.5 A person-centred approach is embedded throughout decisions for admission, diagnostic care and treatment pathways, patient transfer, and discharge home; where resources are limited, open and honest discussions with patients and families, along with a balanced discussion of risk.

3.6 Health and Social Care professionals at all levels receive training, support and guidance on ethical decision making and resource stewardship.

3.7 Senior Leaders embed evidence-based practice within HSC organisations by:

- Setting clear expectations that national and local guidelines should be followed;
- Ensuring effective systems in place for local guideline development.

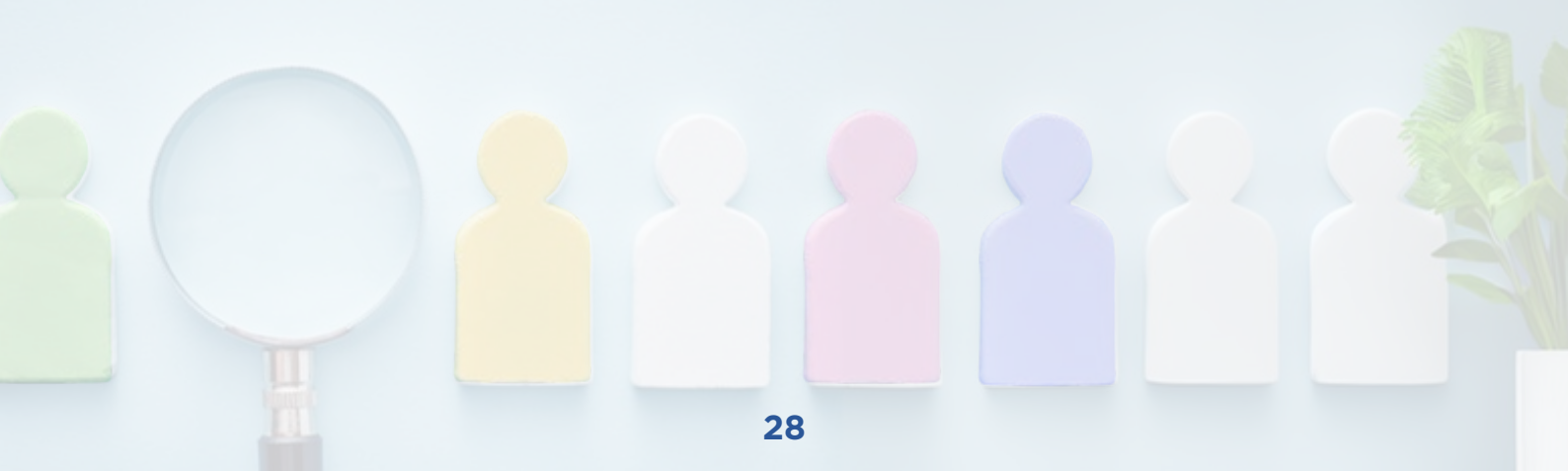
3.8 There are effective systems for clinical audit, monitoring outcomes and seeking assurance on adherence to national and local standards.

3.9 Staff at all levels follow relevant national and local clinical guidelines. Deviation from standard practice only occurs for justifiable reasons, is discussed with patients and carers, and documented within the care records.

3.10 Staff are supported to keep up to date with their practice through dedicated time for in-house education and training, and to meet Continued Professional Development requirements.

3.11 Health and Social Care professionals work as part of teams, and where lone working is unavoidable, there are mechanisms for oversight and assurance, to protect patients from harm and provide Health and Social Care professionalswith support and guidance. I.e. MDT support; in-house supervision and peer support; support through regional networks; peer review.

DoH Quality Standard 5.3.3 Promoting Effective Care



1.3 Safe, Effective Care is underpinned by Evidence-Based Practice

Health and Social Care outcomes can vary in respect of quality, safety and experience. Such variation is common and can occur for acceptable reasons (known as 'warranted variation') such as population-factor variations such as differences in case-mix, clinical need and patient preference.

Unwarranted variation is variation that cannot be explained by such variations, and instead is caused by variation in service planning, design and delivery, workforce issues and variations in clinical practice.[10]

Whilst some factors, are outside the control of HSC Trusts (for e.g. service configuration), those which are within the sphere of influence of HSC Trusts should be appropriately identified and managed. Quality Management Systems[11] can support HSC Trusts to identify variation that can be controlled and moderated.

One factor within the control of HSC Trusts and Health and Social Care professionals themselves, is variation in clinical practice.

Variation in clinical practice can cause:

1. Avoidable harm;
2. Health inequity;
3. Waste of resource.

Meaning that:

- Some patients get the care they need;
- Others do not get the care they need;
- Some may even get care that they don't need, exposing them to unnecessary risk;
- At the same time, resources are unfairly distributed, contributing to overall inefficiency within the health service.

'Decisions around care should never be made based solely on preference of individual Health and Social Care professionals or individual HSC Trusts'.

Unless there is clear justification, which is discussed in partnership with patients and families, care should be appropriately evidence-based and adhere to relevant clinical guidelines.

It is acknowledged that at times equitable care delivery is not possible due to unremitting pressures, issues with access and resource constraints; for these reasons, Health and Social Care professionals need to be supported with ethical decision making and resource stewardship.

Expectation 4: Tackling health inequalities is a key safety priority

4.1 HSC Trust Board and Senior Leaders demonstrate a true commitment and strategic approach to tackling health inequalities and addressing disproportionate levels of healthcare-related harm experienced by underrepresented groups.

4.2 From 'floor to Board', health inequalities are considered on the safety agenda at all levels within the organisation.

4.3 Senior Leaders proactively engage with advocacy representatives, local communities and the community and voluntary sector to understand quality and safety of health and social care services, including for underrepresented groups, in order to identify opportunities for improvement.

4.4 Data is monitored on demographics, population need and patient experience; utilising this for service planning, design, development and improvement with a view to tackling health inequalities.

4.5 Feedback is proactively sought from under-represented groups to enhance an understanding of how these groups experience health and social care services.

4.6 There is role-dependent training and awareness raising for staff on how to provide care to service users and families from a range of backgrounds, including cultural diversity, social complexity; and other protected characteristics such as disability, depending on case-mix of specific service populations.

4.7 Staff at all levels demonstrate an understanding of health inequalities as a safety priority, and can describe how health inequalities are being identified and tackled within their own service area.

4.8 Training for staff on improving outcomes for people with poor Health Literacy.

4.9 There is effective multi-agency working to improve outcomes for people with vulnerability factors.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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1.4 Tackling Health Inequalities

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

All people are adversely impacted when their needs are not met. However, for certain groups, by virtue of intersecting characteristics and overlapping vulnerabilities, the impact is compounded.

Within the NI population, there are high levels of socioeconomic deprivation, conflict-related and intergenerational trauma[12], childhood adversity and ongoing community tensions. All of these have adversely impacted on the vulnerability of the population, including on levels of health literacy and health empowerment, which co-exist alongside remnants of a paternalistic mindset within HSC.

Furthermore, we know that structural bias and discrimination contribute to ongoing inequality within our society. People from underrepresented groups may be impacted by social determinants of health, experiencing lower attainment of education, employment and income, poorer housing, less access to green spaces, social deprivation; all of which can contribute to poorer mental and physical health outcomes. It is an unfortunate reality that **'someone's postcode can have more influence over their health than their genetic code'.**

Over the past decade, the NI population has become more ethnically diverse; amongst immigrant populations, which includes asylum seekers and refugees who may be fleeing conflict or persecution in their home country, there is a high prevalence of trauma, social complexity and mental health need.[13]

There may be additional barriers in accessing HSC services due to immigration status and perceptions around payment, cultural and language differences, limited access to technology, precarious employment, travel costs and difficulty securing childcare.

Furthermore, people from underrepresented groups may have a poorer experience of healthcare services due to biases within service design and clinician-patient interactions. At its worst, patients from underrepresented groups, experience disproportionate levels of healthcare-related harm.[14]

For this reason, health inequalities should be on the safety agenda at all levels of the organisation, including in interactions with external stakeholders at policy, commissioning, public health level, and also in engagement with the community and voluntary sector, understanding that a whole system approach is needed to drive improvements in outcomes.

[x] Health and Social Care (Reform) Act (Northern Ireland) 2009 places a duty on each HSC trust to exercise its functions with the aim of improving the health and social wellbeing of, and reducing health inequalities between, those for whom it provides or may provide health and social care.

Case Study: Tackling Health Inequalities

Cathy practises as a clinical pathway nurse in unscheduled care and has developed and led the Care Navigator Project within the emergency department at the Ulster Hospital. Her nomination for the Royal College of Nursing (RCN) Northern Ireland Nurse of the Year Awards 2024 focused on her firm commitment to tackling health inequalities.

Patients attending emergency departments may have complex social issues with which Health and Social Care professionals are often not equipped to assist. This can leave patients vulnerable and may lead to increased attendances as complex issues are unable to be addressed.

Cathy provides preventative and early interventions to support marginalised patients and thereby help tackle health inequalities. This can have a positive impact on their overall health and wellbeing. In January 2023, the ten most frequent attenders recorded a total of 36 presentations to the emergency department. Following care navigator input, this reduced by December 2023 to just two attendances.

Cathy has led in building partnerships with over 30 different voluntary and community networks to access a variety of different services that can offer ongoing support. She acts as an advocate for patients and is extremely supportive to her team, providing regular caseload review meetings and debriefing when required. Cathy has developed a referral pathway for unscheduled care that enables nursing and medical teams to refer to the service. She also delivers teaching to medical and nursing staff regarding the service, which increases awareness throughout the directorate.

Cathy's nominator stated: "[Cathy's] passion and dedication to provide a service that ensures person-centred therapeutic interventions, improving the social, mental, physical and emotional wellbeing of patients, is inspiring."

Expectation 5: Staff are nurtured, supported and enabled to fulfil their potential

5.1 There is a shared vision for Patient and Staff Safety and Wellbeing, understood by staff working at all levels, that is underpinned by staff wellbeing as a core organisational value.

5.2 There is a shared ethos of 'we look after our staff so that they can look after their patients', understanding the intrinsic link between staff wellbeing and patient safety.

5.3 DoH Health and Wellbeing Framework 2025 is utilised for planning and implementing effective processes and resources for improving staff health, wellbeing and safety.

5.4 Leaders and managers work to optimise staffing levels, rota patterns, workloads and team relationships, in order to prevent burn out, work-related stress, staff ill-health and sickness absence.

5.5 There is a pro-active approach to maintaining safe staffing levels and skills mix within services. This includes: ensuring timely recruitment, effective succession planning, maximising skill mix of the current workforce, and clear mechanisms to escalate concerns about safe staffing.

5.6 Leaders and managers support staff to escalate concerns about staffing levels; when concerns are raised, these are listened to and acted upon.

5.7 When the funded capacity and capability of services is insufficient to safely meet the needs of the patient population, leaders escalate concerns to commissioners.

5.8 Line managers receive training and support in order to adhere to NICE Guidance NG13: Workplace health: management practices.[15]

5.9 Staff at all levels report that their safety and wellbeing is an organisational priority and that leaders and line managers are sensitive to core needs of Autonomy, Belonging and Contribution.

5.10 There are pro-active mechanisms to support staff wellbeing, such as Schwartz groups; mentorship; coaching; forums for peer support; and Health and Wellbeing Initiatives.

5.11 There is access to clinical psychology for staff trauma from moral injury, incidents, unhealthy workplace cultures.

5.12 There are arrangements in place for monitoring staff wellbeing across HSC services.

5.13 Where wellbeing issues are identified, leaders are supported to engage with teams to understand concerns and work together to identify practical solutions to improve working conditions.

5.14 When issues with morale, burn out and moral distress and injury within HSC services are identified, improvement plans are put in place to improve working conditions, address the wellbeing needs of staff and ensure safe service provision.

5.15 Senior leaders are committed to developing a confident and capable workforce. Staff and teams at all levels are empowered and enabled to fulfil their potential.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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1.5 Staff Wellbeing is a Core Organisational Value

Patient Safety is inextricably linked to staff wellbeing. Healthy, happy staff are better able to provide high-quality patient care. Conversely, staff who are demoralised, burnt out or suffering from moral distress and injury are not going to be able to provide the safe, compassionate care that we would want to see and receive.

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

NHS staff across the UK report higher levels of work-related stress, anxiety and depression than staff working in other sectors.[16] Rates of sickness absence are at an all-time high as well as the numbers of staff considering leaving the NHS. The harsh reality of mental health impact is reflected in stark statistics: one nurse completes suicide every week and one doctor every three weeks.[17]

Unfortunately, for staff wellbeing within HSC, Northern Ireland fares no better – and may even be worse.

In August 2025, the GMC published its findings on Workplace Experience.[18] Across the following metrics, doctors in NI reported significantly more negative experiences than the UK average:

- 73% working beyond rostered hours on a weekly basis (UK average 62%);
- 26% are at high risk of burn out (UK average 18%);
- 23% are 'doing well' with managing workloads (UK average 31%);
- 54% found it difficult to provide sufficient patient care at least once a week (UK average 40%);
- 69% experienced barriers to patient care, such as delays in care and treatment, investigation and screening (UK average 57%);
- 56% experienced poor organisational leadership – defined as, poor management communication, and lack of support (UK average 45%).

These figures indicate that a substantial proportion of NI medical staff are over-worked, at risk of burn out, struggling to provide sufficient patient care, and experience poor communication and lack of support from organisational leaders.

As the HSC Staff Survey has not run in recent years, there are no comparable results for other staff groups. Albeit, qualitative data from reports such as Royal College Nursing (RCN) Corridor Care Report[19], includes concerning statements from NI nurses:

> *"We lose sleep worrying about people, we lose love of the job. It's affecting our family lives because we are so unhappy in our work environment, and we take it home."*

> *"The moral injury is immense. I cannot provide the care I want to provide or the care my patients deserve. It is exhausting and demoralising. Within this last six months... I have thought more and more about leaving the [nursing] profession. In the previous seven years this never crossed my mind."*

It increasingly clear that there cannot be a true commitment to patient safety without also committing to maximising staff health and wellbeing.
'Staff need to be held.'

Research by the King's Fund[20] indicates that staff have three core needs:

- **Autonomy** – the need to have control over their work lives, and to be able to act consistently with their values;
- **Belonging** – the need to be connected to, cared for, and caring of others around them at work, and to feel valued, respected and supported;
- **Contribution**– the need to experience effectiveness in what they do and deliver valued outcomes.

All three of these must be met for people to flourish and ensure staff are **'thriving, not just surviving'.**

It is difficult for staff needs to be met when staffing levels are suboptimal, which increases workload, work-related stress, and tension within teams. It is well established that services with staffing shortages have higher incidence of poor staff wellbeing, burn out, illness, and cultural problems such as incivility and bullying, as well as higher patient safety incidents. **'Staffing levels must not be used to excuse poor safety culture'**, but rather should be addressed as a modifiable cause.

In addition to ensuring safe staffing levels, staff as individuals need to be enabled to meet their potential and be the best that they can be.

What good looks like: Enabling Staff to Fulfil their Potential

- Leaders and managers act as role models and seek out opportunities to champion, advise and teach their teams;
- Staff are provided with open and constructive feedback on performance including on living the HSC values;
- Staff are supported to keep up to date with their practice through dedicated time for in-house education and training, and to meet Continued Professional Development requirements;
- There is time and space for staff at all levels to learn together, including multidisciplinary teams;
- Staff are valued, recognised and appreciated for their skills, attributes and efforts; with particular focus on praising and rewarding attributes and behaviours consistent with HSC values.

Red Flag Behaviours

1. **Hierarchical mindsets**
   - Command and control style leadership;
   - Micromanagement;
   - Language used in staff communication is authoritarian.

2. **Undervaluing staff**
   - Staff are seen as bodies to fill posts;
   - Poor investment in staff training and development.

3. **Failure to support staff**
   - There is a lack of empathy and compassion for staff;
   - Staff support is minimal or tokenistic.

4. **Failure to address wellbeing issues**
   - Incivility and bullying goes unchallenged;
   - High sickness absence and staff turnover;
   - Lack of curiosity around sickness absence and how improve staff wellbeing.

Expectation 6: Diversity is welcomed, championed and supported, understanding that it makes teams more effective

6.1 Diversity is welcomed and championed by Leaders through-out the organisation. There is a shared understanding amongst staff at all levels that diversity makes teams, services and organisations more effective.

6.2 Staff at all levels seek out and welcome the views of others, valuing different perspectives and lived experiences.

6.3 Everyone within a team, regardless of characteristics, role or grade, has an equal voice and is actively enabled to use it.

6.4 Staff members who are new to NI are consistently welcomed, included and supported as valued members of HSC teams.

6.5 All members of teams are supported to have a sense of belonging; there is mentorship and peer support in place for staff members from underrepresented groups.

6.6 Leaders and managers seek to maximise the strengths and talents of all team members. Training and development opportunities are offered on a fair and equitable basis; and accessible to all. For e.g. online training takes account of accessibility needs.

6.7 Leaders and managers provide timely support for staff with disabilities and additional needs.

6.8 Line managers ensure prompt access to occupational health and timely implementation of reasonable adjustments.

6.9 There are mechanisms to ensure inclusive recruitment and enhanced support for staff from underrepresented groups, including those who are new to NI.

6.10 There are mechanisms in place to capture feedback from a diverse range of voices within HSC workforce, including under-represented groups; this is used to drive improvements in organisational culture with respect to 'equality, diversity and inclusion'.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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1.6 Equality, Diversity and Inclusion

The HSC workforce is becoming more diverse. This is a strength – **'Diversity makes us smarter'**. A group of human minds has greater capability and agility than a single mind, and even more so, when that group is able to bring a variety of perspectives and experiences, avoiding the common pitfall of 'group-think'[21].

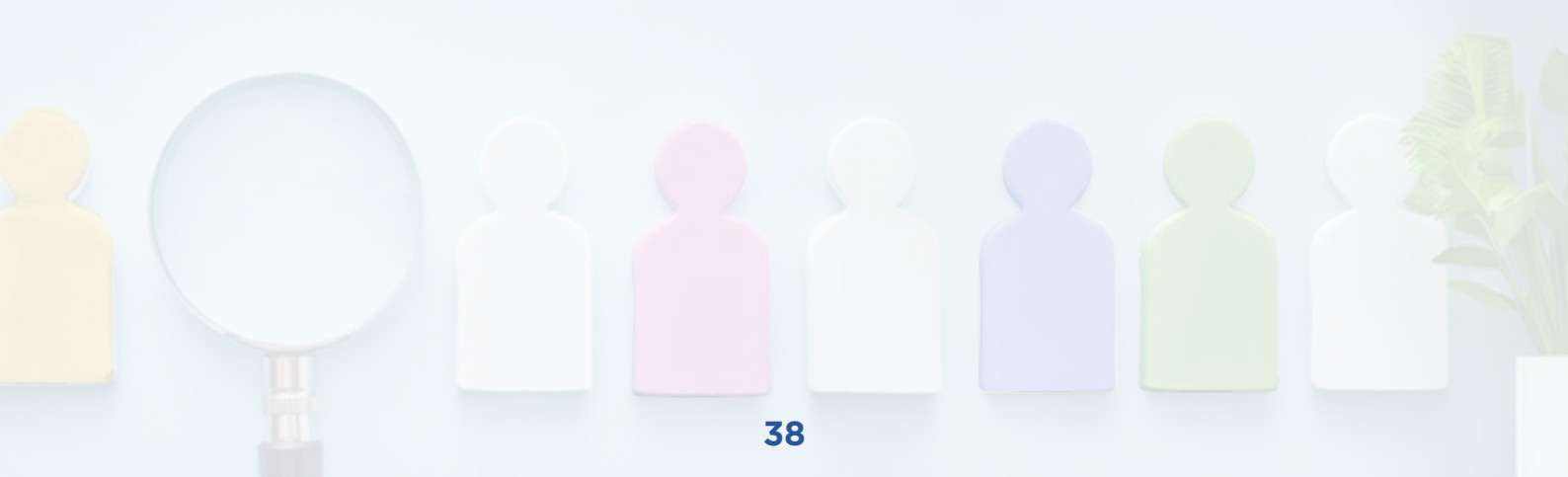
All staff deserve to be valued, respected and supported - we should be particularly thankful those who have made significant efforts, often facing considerable challenges, in order to work as part of our HSC system - including staff who have travelled from their home countries.It is an incontrovertible truth that HSC would not be able to function without the support of our colleagues from overseas, along with colleagues from other underrepresented groups.

Therefore, it is a sad indictment that Health and Social Care workers from underrepresented groups experience poorer physical and mental health outcomes than their counterparts; some of which can be attributed to discrimination, bullying and harassment within the workplace.[22]

This is an intolerable situation that not only impacts on the safety and wellbeing of HSC staff, but also has a significant impact on service provision and the quality of care that can be delivered to patients.

Patient safety issues, sickness absence, and staff turnover are more prevalent in organisations that fail to tackle workplace cultures which enable and reinforce disparities across different groups of staff.

Conversely, organisations that are inclusive, champion diversity and promote belonging, are more likely to succeed in empowering their staff to thrive, fostering psychological safety and improved staff wellbeing. As well as harnessing benefits from diversity of thought, to drive creativity and innovation, and deliver high-quality patient care. **'Diversity makes us more effective'**.



Expectation 7: Voices of staff, patients and families are embraced as an important barometer of safety

7.1 Feedback from staff is highly valued, encouraged and utilised to drive meaningful change.

7.2 There is a pro-active approach to gathering feedback from staff via a range of mechanisms: Leadership Walk-Rounds[23], staff surveys, forums, focus groups, story boxes etc.

7.3 HSC Trust Board Patient Safety and Quality Committee have oversight of assurance data which includes both quantitative and qualitative data from staff feedback, integrating this with a range of other indicators.

7.4 The voices of staff are given due attention, recognising that staff can effectively identify issues with quality and safety, and tend to have a high threshold for escalating concerns.

7.5 Feedback from patients and families is highly valued, encouraged and utilised to drive meaningful change.

7.6 There is a pro-active approach to gathering feedback from patients and families from a range of mechanisms: surveys; engagement forums; advocacy and participation; Care Opinion; Patient and Client Council; Community and Voluntary Sector; Complaints

7.7 There is a commitment to learning from the voices of patients and families at all levels within the organisation.

7.8 Clinical and governance team meetings openly discuss and learn from patient and family voices, including feedback and complaints.

7.9 Patient and family stories are regularly included as part of staff education and safety improvement programmes.

7.10 Testimonies from patients, victims and families who have been harmed by healthcare are welcomed, graciously accepted, and utilised to drive improvements at all levels within the organisation.

7.11 HSC Trust Board Patient Safety and Quality Committee Assurance Reports, include qualitative and quantitative data from patients and family feedback.

7.12 HSC Trust Boards and Senior Leaders value the voices of patients, families and staff, and consistently integrate these with a range of meaningful safety indicators to provide a reliable understanding of safety performance.

7.13 HSC Trusts harness the power of data analytics and expert advice on quality and safety to develop a reliable understanding of where the key safety priorities lie and how to address them.

DoH Quality Standard 5.7.1 Ensuring Safe Practice and the Appropriate Management of Risk

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1.7 Staff, Patient and Family Voices

Staff, patient and family voices are highly valuable to organisations in the assessment of safety; whilst quantitative feedback can be triangulated with other indicators to provide 'early warning signs' of safety issues within HSC services, qualitative feedback is incredibly rich, can provide nuance, and valuable insights into how to drive improvement.

Patients and families may recognise problems within HSC services long before they are identified on performance dashboards. By valuing patient and family voices and acting on concerns at an early stage, through routinely using patient and family stories to educate staff and inform service improvements, safety can be enhanced prior to the emergence of more serious concerns. Through **'listening, hearing and acting we can avert crisis'**.

Equally, the voices of staff should be given due attention, recognising that staff often have a high threshold for 'putting their heads above the parapet'. Staff can also help to identify problems before harm occurs; **'listening and acting on staff concerns is an important mechanism to prevent patient harm'**.

It is not just substantive staff that can provide a helpful insight, locum/agency workers, resident doctors and HSC students, may offer a unique perspective, by virtue of rotating through different HSC services and Trusts. Mechanisms should aim to capture feedback from all willing contributors.

Where the voices of patient, families or staff, paint an alarming picture, HSC Trust Boards should undertake a 'deep dive' to explore issues with staff and patient safety, and where safety concerns are identified, appropriate and early action should be taken to safeguard patients and staff from harm.

Importantly, when such information received from patients, families and staff has been used to drive improvements in patient safety- improvement efforts, along with any outcomes, should be shared with those who raised concerns – maintaining feedback loops.

By encouraging and supporting staff, patients and families to provide feedback, and valuing it is an important barometer of safety, not only do we demonstrate a commitment to learning and improvement, but we also foster trust and confidence amongst the workforce, patients and the public by showing - **'Your voice matters, you will be listened to and you can make a valuable contribution to improving patient and staff safety'**.

Even more so, when staff, patients and families who have raised concerns are offered an opportunity to contribute to improvement, as set out in the case study below.

Case Study: Listening to Family Voices to Improve Patient Safety

My Mum suffered avoidable harm following a fall in the Nursing Home.

She was left on the floor for 11 hours because she was on Warfarin and the Nursing Home staff were awaiting advice from the Ambulance Crew who were unavailable to attend.

The Ambulance Crew eventually attended and lifted her off the floor but unfortunately by this time my mum had already vomited and aspirated, leading to a lung infection.

I had a meeting with the Nursing Home Managers, COPNI, the Trust Social Worker and our GP afterwards. We persuaded Management that learning was all we wanted from this, not blame – we just wanted to ensure that this never happens to anyone again, that long lie risks and consequences would also be considered and not ignored in the future.

I raised this with the Chief Nursing Officer at the time and I became involved in a Regional Falls initiative with Public Health Agency, DoH, NI Ambulance Service etc. This took a lot of learning from this incident and will hopefully ensure that this never happens to anyone again.

Expert by Experience

Patient and family voices by themselves, can be powerful and compelling outlining the real-life impact of failings in care delivery, governance and culture. When patient and family testimonies are included as part of staff education and safety improvement programmes, it can greatly enhance staff learning and serve to drive improvements in clinical practice.

The Regulation and Quality Improvement Authority

HSC Health and Social Care

Changing the Culture through Education and Training

Stephen's Story, as told by his Mother Norma Sparkes[xi] is the central thread to 'Building a Safe and Compassionate Culture within Health and Social Care' eLearning programme.

The programme, developed through co-production, led by RQIA and in collaboration with Leadership Centre and other key stakeholders, is part of RQIA Legacy Commitment work to drive improvements in safety culture within HSC, following learning arising from Expert Review of Records of Deceased Patients of Michael Watt.

The Programme, available on LearnHSCNI on this link, covers the following topics:

- Evidence-based practice
- Person-centred care
- Listening, Hearing and Acting
- Candour
- Creating Safe and Compassionate Cultures for Health and Social Care professionals
- Governance

2 CPD Points

It is valuable to Health and Social Care professionals from all disciplines and at any stage of their career, from undergraduate level, right up to retirement.

SCAN ME

[xi] Norma Sparkes' son, Stephen Sparkes, is deceased a patient of Michael Watt. Since Stephen's death, Norma has advocated for improvements in Patient Safety within the Health and Social Care System in NI.

Domain 1: Underpinning standards, legislation and best practice guidance

- DoH Quality Standards 2006;
- Health and Social Care (Reform) Act 2009;
- Human Rights Act 1998;
- Disability Discrimination Act;
- Health and Safety at Work (NI) Order 1978;
- DoH Collective Leadership Strategy;
- NHS England Framework for involving patients in patient safety;
- NICE Guidance NG13. Workplace health: management practices;
- NICE Guidance NG212. Mental Wellbeing at Work;
- NHS England. Health and Wellbeing Framework;
- NHS England. Civility and Respect;
- NHS Resolution. Just and Learning Culture Charter.

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Cultural Domain 2: Compassion, Civility and Respect

Domains	Themes	Expectations
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.

Expectation 8: Compassionate Leadership is fundamental to all other aspects of a safety culture

8.1 Collective Leadership[xii] is embedded within the organisation.

8.2 HSC Trust Executive Teams and Senior Leaders ensure leadership responsibility is appropriately distributed throughout the organisation, valuing and respecting the contribution and autonomy of staff working at all levels.

8.3 HSC Organisations recruit, develop and nurture inclusive, compassionate leaders who live the values of HSC. This is supported by:

- Values-based recruitment and succession-planning into Senior Leadership commitment;
- Values-based appraisal;
- Leadership Training and Development;
- Mechanisms, such as 360-degree feedback, coaching and mentoring;
- Time and space for Senior Leaders to reflect, learn and improve;
- Accountability for Senior Leaders who do not behave in ways aligned to HSC values.

8.4 Senior Leaders role model behaviours of careful listening; understanding; empathising; and supporting other people;

8.5 The performance of leaders, at all levels, is assessed by the extent to which their behaviours align with HSC values and by their contributions to supporting staff wellbeing and patient safety;

8.6 Leaders and managers demonstrate an understanding that trusting relationships are crucial to patient safety, and strive to meet the core needs of staff in relation to Autonomy, Belonging and Contribution;

8.7 There is training and support for line managers in people management skills, including informal approaches to supporting staff in difficulty, without overreliance on HR procedures;

This includes:

- Supporting staff with wellbeing issues;
- Handling sensitive situations / having difficult conversations;
- Managing performance issues;
- Managing incivility and conflict;
- Early resolution to concerns.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

DoH Quality Standard 8.3 Effective Communication and Information

[xii]The HSC Collective Leadership Strategy promotes shared, collaborative and compassionate leadership in and across teams, and across the HSC system

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2.1 Compassionate Leadership

‘Culture comes from the top’ We know that leadership is the single most influential factor in shaping organisational culture – therefore some of the most impactful decisions made within HSC are about recruitment into senior leadership positions.

Senior leaders set expectations and role model the values and behaviours essential for a healthy workplace culture. The espoused values, behaviours and actions of senior leaders can have a profound impact on organisational performance with respect to: staff wellbeing, psychological safety, civility, just and open culture; and patient safety outcomes.

Safe, effective organisations are led by compassionate leaders who:

- **Listen carefully;**
- **Understand;**
- **Empathise;**
- **Support Others.**

Being Human

In many respects, compassionate leadership is about ‘being human’.

It involves:

- Creating time and space for authentic human connection;
- Developing trust and confidence amongst staff;
- Understanding that missed deadlines, mistakes and performance issues can arise from hidden suffering;
- Noticing, inquiring about and taking action to lessen suffering or distress of others;
- Valuing different views and perspectives;
- Being curious about the experiences of others;
- Commitment to equality, diversity and inclusion;
- Giving dignity and worth to people whatever their role, grade or background;
- Providing support and acting in ways that are altruistic for the benefit of others;
- Withholding blame and focusing on learning, supporting and improving;
- Avoiding rigid process-driven, legalistic or defensive approaches that inhibit human connection;
- Addressing toxic workplace cultures and unhealthy or harmful behaviours by deploying kindness and compassion.

It is important to note that compassionate leadership does not mean ‘being nice’. It means being fair, open and honest, and having the tenacity to **‘do the right thing’** – which can include making unpopular decisions and holding others to account for their behaviour in the interests of patient and staff safety.

Compassionate leadership is not an optional 'nice to have', it is essential – it should be a reality that **'compassionate leadership is part of the fabric of our HSC system'**.

For the most senior positions within HSC, only those with a proven track record of leading with care, fostering staff wellbeing, psychological safety, just and open cultures, should be considered for the job, understanding that **'Staff Wellbeing is a Core Value'** and **'Patient Safety is Paramount'**.

Compassionate Leaders do...	Compassionate Leaders do not...
Believe everyone plays an important role and it is their job to support and enable staff to do well.	Believe that they are the most important person in the room and people must admire and obey them.
Be visible and approachable.	Be inaccessible or evasive.
Distribute power to others, enabling staff to have autonomy and control over their work.	Micromanage, or operate a 'command and control' style of leadership.
Believe that patient safety is paramount, and staff wellbeing is a core organisational value.	Put personal or organisational reputation or finances before the safety of patients and staff.
Do not have all the answers; have humility and accept fallibility.	Believe that they have all the knowledge.
Create time and space for teams to come together.	Create unsustainable work pressures with no time for team building or reflection.
Enjoy listening to others and are happy to take a back seat to allow others to flourish.	Do all the talking and monopolise team meetings.
Demonstrate zero tolerance for harmful and abusive behaviour.	Themselves engage in bad behaviour.
When things go wrong, respond fairly with compassion and focus on restoration, learning and improvement.	Blame staff for honest mistakes.
Encourage staff to speak up and have genuine appreciation and support for those who do.	Pose a risk to those who speak up by seeking to ignore, punish or retaliate.

Case Study: Compassionate Leadership within North West Cancer Centre Radiotherapy Outpatients

Paula is the Treatment Lead Radiographer in North West Cancer Centre. Paula leads a team of 30-40 multidisciplinary staff who deliver radiotherapy outpatient services. Paula's commitment to compassionate leadership is exemplified through her approach to staff management:

Person-centred approach: Paula views staff holistically, considers what other pressures they are under, along with what support is required by their line manager.

Understanding what is important to staff: Staff polls, 1-2-1s and group interviews are undertaken to find out what is important to staff and consider what changes could be made to improve the working environment.

Implementing shared solutions: Paula is committed to implementing shared solutions. For example - As a result of staff feedback, flexible working has been adopted by the team. Each request is viewed on an individual basis - Paula always starts from a positive place of how can they make this work for the staff member and service. Paula describes that it is not always about saying yes but it is about being prepared to have compassionate and sometimes difficult conversations, allowing for follow-up and creating alternative solutions together.

Focus on staff wellbeing: Paula is trained as a coach and encourages Take 5 principles and reset during the working day. Through this approach she knows her staff well and can pre-empt situations which allows her to intervene early, listen to them and offer advice and support. Paula strongly encourages staff to access other Trust resources available, i.e. health and wellbeing initiatives and psychological support when needed

Encouraging Peer Support: The team supports each other using their skills and interests, for e.g. crochet, book clubs and a project on exercise to motivate staff to move.

Staff Development: There is a clear focus on career progression and staff development with staff encouraged to access HSC/CEC courses, as well as supporting their CPD.

Encouraging staff to speak up: Paula has an 'open door' policy. This open, supportive approach is replicated throughout the team.

Outcomes

- The department have lower sickness absence rates, high retention of staff and a waiting list of staff wanting to join their department;
- The staff support each other and are passionate about their patients and service;
- There is increased willingness to provide short notice cover when its required;
- There is an excellent patient care record within the department with over 500 pieces of patient feedback each year. The department has not received a patient complaint in over three years.

Conclusion

Through Paula's compassionate and supportive leadership there have been tangible benefits for staff and patients. This approach to listening, understanding, empathising and supporting staff is amenable to 'scale and spread' across the region.

Expectation 9: Effective Teamwork and Psychological Safety is nurtured within Teams

9.1 HSC Trust Boards and Senior Leaders role model compassion, inclusivity, humility, and curiosity in order to foster psychological safety within teams and within their interactions with staff at all levels.

9.2 There is training and awareness for leaders on psychological safety, civility and human factors.

9.3 Leaders and managers create psychologically safe environments by encouraging staff to contribute, suggest ideas, ask questions, raise concerns.

9.4 There are psychologically safe and inclusive forums for staff to suggest ideas and raise concerns.

There are forums for teams to meet regularly to:

- learn together;
- discuss learning and feedback from governance activities;
- discuss service development and improvement.

9.5 Staff, of all backgrounds, roles and grades, feel psychologically safe to contribute to discussions, suggest ideas, ask questions, raise concerns.

9.6 Effective multidisciplinary working is valued at all levels within the organisation.

9.7 Barriers to effective team functioning, such as incivility, bullying, harassment and discrimination, are quickly identified and addressed.

9.8 Leaders are proactive about supporting teams to work well together, such as ensuring:

- common purpose;
- clearly defined roles and responsibilities;
- opportunities for team building and to foster camaraderie;
- multi-professional learning;
- time to reflect together.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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2.2 Psychological Safety within Teams

'Effective teamwork is essential for safe patient care'. Conversely, when teamwork is lacking or when there are interpersonal tensions between team members - patient safety is put at risk.

Teams should have common purpose, role clarity, appropriate skill mix and effective communication but just as important are:

- **belonging;**
- **mutual respect;**
- **civility; and**
- **psychological safety.**

Psychological safety is defined as a "shared belief held by members of a team that the team is safe for interpersonal risk taking".[24]

The Institute for Health Improvement describes four attributes of psychological safety:[25]

1. Anyone can ask questions without feeling stupid;
2. Anyone can ask for feedback without looking incompetent;
3. Anyone can be respectfully critical without appearing negative;
4. Anyone can suggest innovative ideasAwithout being perceived as disruptive.

By anyone, this means any team member. **'We all play an important role in keeping patients safe – therefore we all need to feel safe to be heard'**.

Feeling safe is not the same as feeling comfortable and, in many respects, psychological safety is about **'feeling safe enough to have the uncomfortable conversations'**, without fear of negative repercussions.

Achieving Psychological Safety can be a journey and 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'**. The quietest voice may be the newest team member; most junior team member; the non-clinician amongst a team of Health and Social Care professionals; a team member from outside of Northern Ireland; or team members from an underrepresented group – which is why the foundational stage of psychological safety is inclusion and ensuring that everyone feels a sense of belonging. **'Equality, Diversity and Inclusion is not a 'nice to have' - it is essential for patient safety'**.

The four stages of psychological safety:[26]

1. Inclusion safety: lays the foundation for psychological safety by ensuring everyone feels a sense of belonging;
2. Learner safety: allows staff to make mistakes, ask questions and seek feedback without fear of negative repercussions;
3. Contributor safety: emerges when staff feel confident in sharing ideas and participating fully in their roles;
4. Challenger safety: the pinnacle of psychological safety. Staff feel secure enough to question the status quo, propose new ideas and offer constructive feedback.

The next stage of psychological safety is giving people safety to learn by encouraging them to ask questions, by not punishing mistakes and allowing staff to seek feedback without fearing repercussions.

As psychological safety grows within the team, staff will become more confident to contribute, fully participate in discussions and share ideas – this fosters creativity and innovation. It is hoped that at this stage, staff (regardless of role or grade) will also feel confident to raise concerns about patient safety.

However, the pinnacle of psychological safety is described as 'challenger safety' when staff feel safe to constructively challenge – this may involve a junior member of the team challenging a consultant when they are concerned that a patient safety issue has been overlooked.

The complex nature of healthcare means that prevention of avoidable harm can depend on timely intervention from any member of the team, of any role or grade. When this valuable safeguard is removed due to hierarchy or a lack of psychological safety, healthcare is intrinsically less safe.

Senior members of teams need to take the lead in flattening the hierarchy, fostering psychological safety for the quietest voice to challenge, and role modelling the behaviours that allow psychological safety to flourish.

Green Flag: Leadership behaviours for psychological safety

- Flattening the hierarchy;
- Champion and welcome diversity;
- Role model compassion, inclusivity, and humility;
- Embed processes to promote inclusion, contribution and challenge;
- Ensure effective multi-disciplinary team working;
- Recognition, appreciation and valuing of all staff;
- Zero tolerance for harmful behaviour;
- Tackle incivility.

Case Study: Fostering Psychological Safety within Belfast HSC Trust Maternity Services

In response to the findings of the Ockenden Inquiry report and the 2022 Belfast Trust Staff satisfaction survey, the Belfast HSC Trust Maternity Department has taken the decisive steps to foster a psychologically safe, just and learning culture across the service.

Key initiatives have included:

Promotion of Teamwork and Civility

- Confidential listening groups helped understand frontline challenges; these informed subsequent improvements;
- 'Growing a Culture of Kindness' initiative promotes multidisciplinary collaboration, reducing inter-professional barriers through principles of civility and respectful challenge.

Staff Training

- All new staff members receive training in human factors and just culture principles such as respectful challenge, civility and safe escalation;
- Royal Jubilee Maternity Service (RJMS) revised its fetal monitoring training from a half-day ad-hoc session to a full-day structured mandatory program, incorporating human factors, just culture, and psychological safety

Supporting Communication and Escalation

- ·"Team of the Shift" initiative, aligns staff names and roles at each medical handover to strengthen familiarity and teamwork;
- Visibility of team members is enhanced by photo posters displaying current medical and anaesthetic personnel.

Supporting safe and compassionate midwifery practice

- Counselling for women choosing care outside national guidance, led by senior midwives, with cases reviewed at weekly MDT meetings;
- Specialist legal training for midwives on homebirth care, ensuring legally sound practice.

Learning and Improvement

- Adoption of HSIB methodology in SAIs to focus on learning rather than blame, with positive feedback from both the Trust and DOH;
- The Maternity Learning and Improving Group (MLIG) integrates insights from serious adverse incidents (SAIs), Stillbirth Working Group, and Datix alerts into shared learning updates.

Together these initiatives represent a proactive, department wide approach to building a culture rooted in safety, compassion and learning.

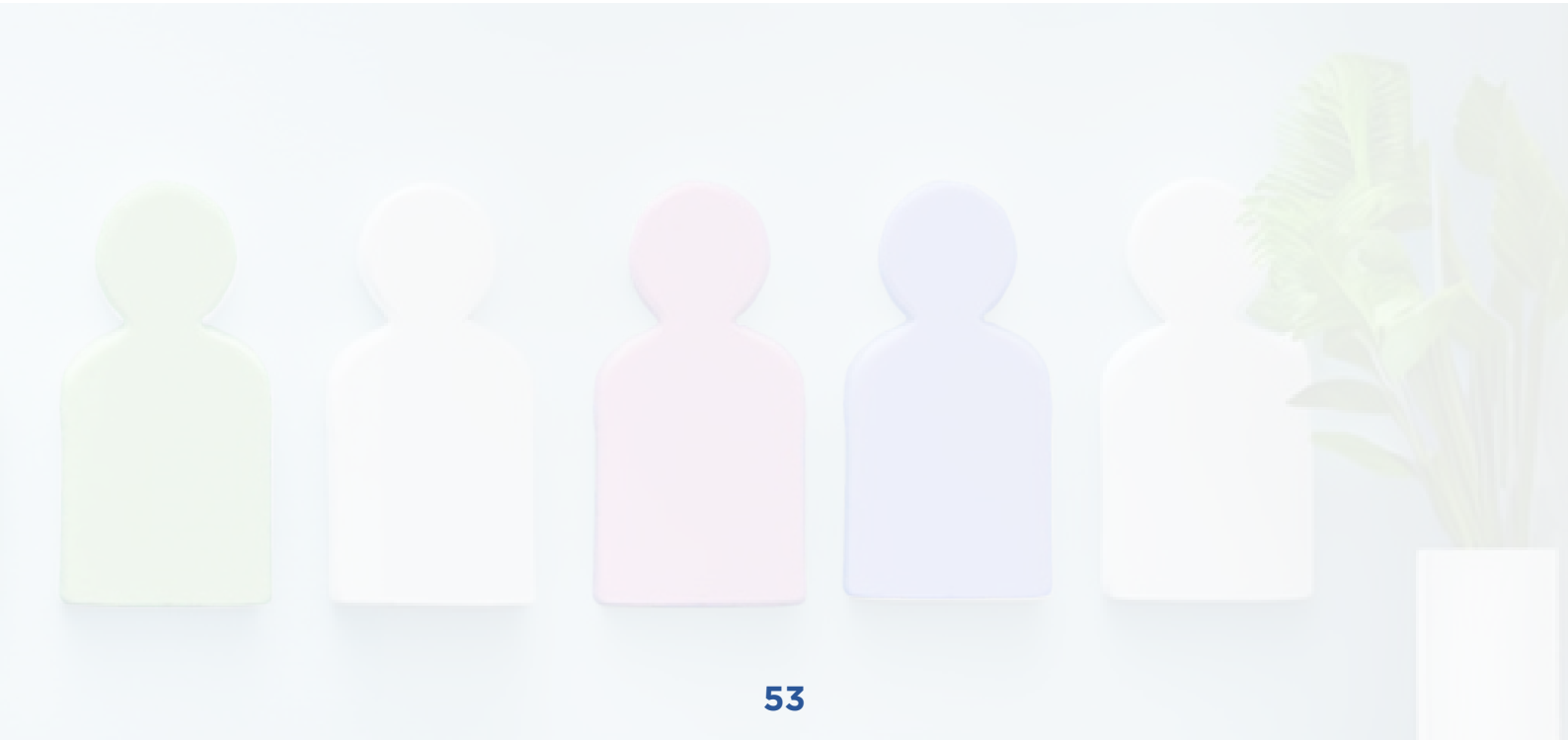
Red Flag Behaviours

1. **Lack of inclusivity**
   - Hierarchical attitudes;
   - Newcomers are not welcome.

2. **Poor behaviour**
   - Incivility;
   - Bullying.

3. **Dysfunctional team working**
   - Conflict;
   - Poor multidisciplinary working;
   - Tribalism.

4. **Challenge discouraged**
   - Low rates of constructive challenge;
   - Unfair treatment of staff who constructively challenge.



Expectation 10: Staff at all levels are kind and civil and work within safe and compassionate teams

10.1 Teams experience safe and compassionate working environments, where leaders and colleagues are civil and kind, and harmful behaviours such as incivility are addressed and eradicated.

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

10.3 Staff at all levels understand the values and standards of behaviour to which they are expected to demonstrate and for which they will be held accountable.

10.4 Line Managers at all levels are provided with training and support to deal with behaviours that are not consistent with the values of HSC.

10.5 There is training and awareness raising for staff on the importance of professionalism, civility and effective teamwork.

10.6 Staff at all levels demonstrate an awareness that incivility is patient safety issue, impacting significantly on cognitive performance, decision making and team functioning.

10.7 Awareness raising on Incivility, such as 'Civility Saves Lives', is embedded within the organisation.

10.8 Incivility is called out and resolved through appropriate interventions, which may include team engagement, mediation, negotiation, identification and mitigation of stressors, and holding individuals to account for their behaviour.

10.9 Leaders and Line Managers at all levels are trained and supported to understand the difference between incivility and team conflict that arises because of situational stressors - and bullying, harassment and discrimination which is intentional and deliberate.

10.10 Bullying, harassment and discrimination of any kind is appropriately identified and dealt with via HR procedures.

10.11 Individuals are held to account for their behaviour and where a case of bullying and harassment is upheld, serious consideration is given to whether such individuals should manage staff going forward in accordance with HR procedures. Understanding that clear parameters, conditions and evidence of reform should be required before these staff members are assigned line management responsibility.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

DoH Quality Standard 8.3 Effective Communication and Information

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2.3 Tackling Incivility and Eradicating Harmful Behaviour

Staff behaviours within the workplace are an inherent manifestation of any culture and form an integral part of how workplace environments are experienced and perceived.

Unkind or uncivil behaviour is not only unprofessional and unpleasant; it is a serious patient safety issue. **'Incivility costs lives'** – a fact substantiated by research and forms the premise of the Civility Saves Lives Campaign.[27]

Uncivil behaviour between colleagues results in a significant reduction in cognitive ability in both recipients and witnesses, impacting on clinical decision making and increasing the chances of medical error and patient harm.

Furthermore, incivility is the antithesis of a psychologically safe working environment, creating a climate of fear where team members may avoid challenging peers or asking for help when required, all of which compromises patient safety.

Civility Saves Lives

Incivility is a patient safety issue. Research has demonstrated that when staff members are incivil, rude, unkind, hostile, this has a significant impact on colleagues who are on the receiving end of their behaviour. This increases the likelihood of human error causing harm to patients.

Uncivil behaviour causes a 61% reduction in cognitive ability in recipients

In addition, there are other impacts on staff:

- 80% lose time worrying about the rudeness;
- 78% reduce their commitment to work;
- 63% lose time avoiding the offender;
- 48% reduce their time at work;
- 38% reduce the quality of their work;
- 25% take it out on others, including service users;
- 12% leave their job.

The Civility Saves Lives campaign aims to raise awareness and encourage civility in the workplace in order to improve patient safety.

CIVILITY SAVES LIVES

Given the very real and serious risks to patient safety, team functioning and staff wellbeing, it is important that incivility is tackled and harmful behaviour eradicated.

Case Study: GMC and NMC Joint Workshops on Professional Behaviours & Patient Safety

Background
The General Medical Council (GMC) and Nursing and Midwifery Council (NMC) recognise that there is an established body of evidence demonstrating the harmful impact of unprofessional behaviours, including bullying and undermining, on working environments, staff morale and patient safety. There is also evidence that highlights the financial implications of accepting such cultures.

Objective
To help doctors, nurses, midwives and employers improve patient safety through early intervention training that promotes professional behaviours and develops individual's skills and confidence in challenging unprofessional behaviours.

Workshops
GMC and NMC guidance states that Health and Social Care professionals have a responsibility to challenge unprofessional behaviour of colleagues, but we know they find this difficult in practice. GMC and NMC have developed a three-hour workshop to support Health and Social Care professionals to:

1. Define and identify unprofessional behaviours in practice, and reflect on their own behaviours and responsibilities;
2. Understand the harmful impact of unprofessional behaviours on patient safety;
3. Develop individual and practical skills to challenge unprofessional behaviours in the workplace.

GMC and NMC recognise that educating and upskilling groups of Health and Social Care professionals is just one part of the solution for achieving culture change. To have significant and sustained impact, we also need to collaborate with organisations to share good practice and create the optimum environment for positive professional behaviours to thrive.

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Eradicating Harmful Behaviour

The first step to eradicating harmful behaviour is recognising it. Some harmful behaviours are overt, such as bullying and harassment, and are intended to undermine confidence, offend, intimidate, or cause emotional or physical harm.

Examples of Harmful Behaviour:

- Physical or verbal abuse;
- Constant criticism;
- Humiliation;
- Allocation of unfair workload;
- Spreading lies or malicious gossip;
- Exclusion from meetings or events;
- Sexual Harassment;
- Other forms of Harassment, including behaviours motivated by racist, misogynistic, sectarian, homophobic or transphobic attitudes.

Other behaviours are covert and insidious, yet just as damaging. The following 'Red Flag' behaviours are explicitly stated with the intention of empowering others to identify them and raise concerns when they see them, acknowledging that it is not always safe for people to directly 'call out' the behaviour of individuals, who may pose a danger to others.

Red Flag Behaviours of Individuals in the workplace

- Excessive self-interest – putting one's own needs (e.g. for status, admiration, attention etc.) before the wellbeing of colleagues or patients;
- Lack of empathy for the suffering of others;
- Controlling others by using position of power, fear, obligation or guilt;
- Manipulation techniques, such as:
  - 'Playing the victim' to gain sympathy or support;
  - Love-bombing, excessive praise or flattery;
  - Distorting or omitting the truth to get someone to agree to do something;
  - Gas-lighting – denying or distorting reality with the intention of undermining someone's confidence in their own perception or memory;
- Pitting people against each other, or 'divide and conquer', with the intention of maintaining power and control;
- Withholding information to maintain power and control, avoid scrutiny, or with the deliberate intention of affecting a staff member's performance;
- Isolating someone from their support network.

Advice for staff on how to deal with Red Flag Behaviours from co-workers

1. Avoid unnecessary interaction;
2. Stay neutral and professional at all times;
3. Keep firm boundaries;
4. Maintain good relationships with trusted co-workers;
5. Make contemporaneous documentation of events;
6. Speak with and gain support from a Trade Union representative;
7. Raise a concern with your line manager (where appropriate) or Speak Up / Raising Concerns Champion;[xiii]
8. Seek support for your mental health and wellbeing.

Remember: you are not responsible for the behaviour of others; you can only control how you respond (i.e. staying calm, documenting events, seeking advice, raising concerns)

Individuals who display such behaviours can be exceptionally challenging for managers and HR to deal with - in part because some behaviours may arise from fixed personality traits which can be difficult to modify, and also because individuals may not respond well to being challenged or held to account. This should not deter staff from speaking up and is for senior managers and Human Resources to manage.

Red Flag Behaviours in response to being challenged

- Expression of anger or annoyance at being challenged;
- Refusal to accept responsibility or accepting minimal responsibility for one's actions;
- Blaming others or external factors (i.e. work pressures) for their behaviour
- Lack of empathy for those impacted by their behaviour;
- Discrediting victims or witnesses by attacking someone's character or credibility;
- Denial or distortion of events, attacking the victim's character, and making counter-allegations positioning themselves as the 'real' victim (Reversal of Victim and Offender roles);
- Threatening to use HR processes, regulatory referral processes, or legal action to deter scrutiny or avoid accountability.

Tailored training, resources and support are required for Senior Leaders, Line Managers and HR employees when dealing with these complex behaviours.

Given the cost, both human and financial to the health service, from impact on patient safety, staff wellbeing, sickness absence, staff retention, and also reputational risk to HSC services and organisations, it is exceptionally important Managers and HR are not deterred from acting against employees who display harmful behaviour.

[xiii] Speak Up / Raising Concerns Champions are recognised as Good Practice by NI Audit Office - Raising Concerns – Good Practice Guide (NIAO, 2014). RQIA Review of Whistleblowing Arrangements (2016) recommended that each HSC Trust Board appoint a non-executive director for oversight of Raising Concerns.

'Leaders and managers should always do the right thing to protect patients and staff from harm'

Ultimately, individuals are accountable for their behaviour. Accountability for harmful and abusive behaviour, includes disciplinary processes, with the possibility of dismissal and, where applicable, referral to professional regulators.

HSC Trust Boards have a 'duty of care' to staff and a 'duty of quality' to patients – these are statutory duties. Where harmful behaviours are identified, HSC Trust Boards in accordance with their statutory duty should act to 'do the right thing' to ensure that patient safety and staff safety is protected.

'There is no place for harmful or abusive behaviour within HSC'

Violence and Aggression within HSC

Unfortunately, as service pressures have increased, HSC staff have borne the brunt of public frustration, which at times can escalate into violent, aggressive and threatening behaviour. Threatening behaviour can include bullying, intimidation, harassment, inappropriate use of social media, such as filming staff, and threatening staff with weapons.

There is a need for increased public understanding that service pressures are beyond the control of front-line staff, and that abusive or threatening behaviour towards HSC staff does not help the situation and only serves to makes care less safe for patients.

DoH has produced a Framework to tackle 'Violence and Aggression in the Workplace'.[28] It highlights that service users and relatives may be anxious and worried and it is important for HSC staff to be aware of the potential for this anxiety to escalate into aggressive behaviour. Viewing behaviour through a 'Trauma Lens', can improve staff understanding of how unmet needs may impact on patient and family interactions with HSC staff.

Equipping staff to recognise behavioural changes and deploy de-escalation techniques can help prevent incidents of violence and aggression.

It calls for service users, including families and visitors, to understand and respect that there is an expected minimum standard of behaviour towards staff.

'Any behaviour that puts staff, service users or other persons at risk is not acceptable'. This includes behaviours motivated by prejudice or discrimination against a person on a protected characteristic, for example racism or homophobia.

Expectation 11: Patients and families are empowered, enabled and informed

11.1 Senior Leaders demonstrate an understanding that understanding that person-centred care fosters safety and trust – and that conversely, harm is caused when empathy, dignity and respect are lacking.

11.2 Staff at all levels consistently demonstrate person-centred approaches to the delivery of care.

11.3 Patients are treated as partners in decision making processes, where there is a focus on 'what matters to you?'

11.4 The principles of Shared Decision Making and Informed Consent are adhered to throughout all aspects of the patient journey.

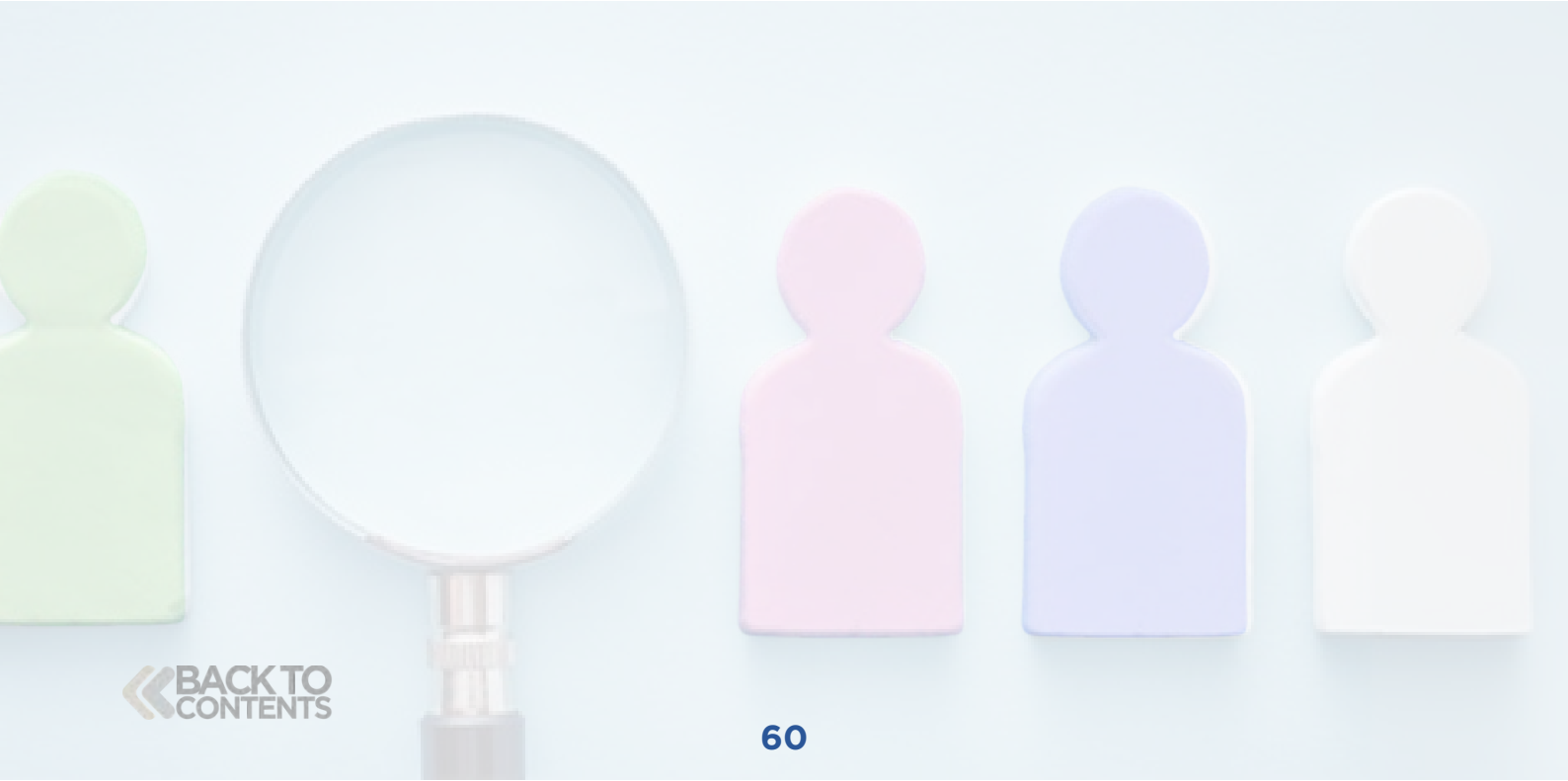
11.5 There is training, resources and support for staff on Person-Centred Care, Shared Decision Making and Informed Consent.

11.6 Range of accessible information materials and patient decision aids to support patients and their families with decisions about their care and treatment, along with access to advocacy support and interpreting services.

11.7 Trauma-informed practice is embedded within pathways of support for patient populations with high incidence of trauma.

11.8 There is effective multi-agency working in providing care to patients and clients with vulnerability factors.

DoH Quality Standard 6.3.2 Service Delivery for Individuals, Carers and Relatives
DoH Quality Standard 8.3 Effective Communication and Information



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2.4 Empowering Patients and Families

Person centred care involves working in partnership with patients to meet their medical, psychological and social needs - shifting the focus from 'What's the matter with you?' to 'What matters to you?'. It can be described as personalised, co-ordinated and enabling, and involves treating patients with dignity, compassion, and respect.[29]

'Person-centred care fosters safety and trust'

Trust and co-operation are maximised when patients are afforded autonomy, provided with full unbiased information on treatment options and regarded as partners in decisions about their care.

Conversely, harm is caused when empathy, dignity and respect are lacking

Empowering patients to be partners in their care creates psychological safety within the therapeutic relationship by counteracting hierarchy and paternalism. Research shows that providing person centred care can have a positive impact not just on patient outcomes and experience but also on staff morale and wellbeing.

Person-centred care does not require additional clinical skills, but rather a shift in mindset. Initiatives such as 'What matters to you?' can help embed a culture of person-centeredness.

> **"What matters to you?"**

Valid and Informed consent

All patients have a right to be involved in decisions about their care and treatment, if able to do so. Valid consent ensures that patients have mental capacity to make decisions about their care and do so voluntarily, without coercion from others. Informed consent ensures that patients are given full information on benefits, risks and alternative options.

Informed consent has been topical since the 2015 Montgomery Vs Lanarkshire ruling[30,31], a landmark case that stipulated patients should be given information on all material risks. A failure to seek informed consent for treatment has legal and ethical implications and can result in harm to patients.

To avoid these issues, it is important that Health and Social Care professionals adhere to clinical guidelines and professional standards in Shared Decision Making and Informed Consent.

Good practice in Shared Decision Making[32] and Informed Consent

1. Give patients clear, accurate and up to date information on all their options, describing the potential benefits and risks of each, including the option to take no action.
2. Be open, honest and forthcoming about treatment options, their benefits and risks. Tell patients about any risk of serious harm, however unlikely it is to occur.
3. See patients as individuals. Clarify the patient's needs, hopes and expectations. Tailor the discussion to each individual patient, in accordance with what matters to them, and share information in a way that they can understand.
4. Consider using visual or explanatory aids. Make special arrangements for patients who have challenges with communication, understanding or learning.
5. Answer questions openly and honestly, including where there is uncertainty around the diagnosis, the most appropriate treatment, or the likely impact from a particular treatment.

Sharing information with patients and carers

All patients benefit when they are provided with clear and accurate information on their care and treatment. Providing patients with access to lay language clinic and discharge letters can promote better patient engagement, empower people to manage their health and, where appropriate, challenge the quality of care and treatment they are receiving.

Information should be provided to patients and carers in a way that they can understand. Patients may require access to interpreting services or other reasonable adjustments, and these should be facilitated.

Case Study: Supporting adults with learning disability through their cancer pathway using a visual Story Book

Background
Evidence reports that people with a learning disability often have poorer access to services, evidenced by lower screening uptakes and delayed cancer diagnosis. In order to be inclusive and to support people to navigate services, information must be tailored to service user needs.

Therefore, a designated cancer pathway for learning disability was developed to enable reasonable adjustments to ensure patients with a learning disability were afforded the same choices and equity.

The need for supportive literature was identified and this would take the form of a visual aid storybook, detailing what to expect when attending the North West Cancer Centre (NWCC).

This would provide easy to understand information for the service user enabling them to understand, participate and be involved in the decisions about their care.

Development of the Story Book
A collaborative, co-production approach was used incorporating professionals from learning disabilities, cancer services and service users/carers.

Focus groups were held within the Macmillan Support Centre with reasonable adjustments to facilitate service user participation in the co-production process.

The Story Book was launched to coincide with World Cancer day 2025.

Outcomes
The visual storybook enables better engagement with adults with learning disabilities in order to improve access to cancer services, and support people to make decisions about their care.

Alongside the HSC Learning Disability Hospital Passport and cancer for Learning Disability pathways, this ensures a more inclusive and equitable service for this population.

Service users with complex needs or additional vulnerabilities, may benefit from independent advocacy services, trauma-informed approaches, and effective multi-agency working in order to effectively tailor approaches to meet their needs and preferences.

Red Flag Behaviours

1. Paternalistic attitudes towards patients and families

- Failure to listen to patients, carers and families;
- Absence of shared decision making.

2. Lack of empathy and compassion for patients and families

- Failure to provide dignity and respect.

3. Failure to adopt person-centred care

- Blanket 'one size fits all' approaches to patient care;
- Refusal to take patient needs and preferences into account.

4. Inadequate provision of information

- Lack of informed consent;
- Underutilisation of interpreting services.

Expectation 12: Staff at all levels Listen, Hear and Act on concerns of patients, families and colleagues

12.1 Senior Leaders role model the behaviours of active listening, understanding, empathising, responding and supporting.

12.2 Senior Leaders promote a narrative that patients and family voices are valuable and should be listened to at all times.

12.3 Staff at all levels demonstrate an understanding that patients and families have a valuable contribution to make in raising concerns about safety of care both during the patient journey and in the aftermath of a poor experience.

12.4 Health and Social Care professionals demonstrate an understanding that being dismissive of patient and family concerns can cause both psychological and physical harm.

12.5 Clinical teams, Health and Social Care professionals, and non-clinical staff promote psychological safety in all interactions with patients and their families.

12.6 Health and Social Care professionals understand their professional responsibilities to respond to requests for second opinion.

12.7 Second opinion requests are viewed as valuable safeguards against patient harm, and are not be viewed as criticism or an indication of individual weakness.

12.8 Managers and Health and Social Care professionals understand that they have a duty to listen, hear and act on safety concerns shared with them by others, understanding that 'you cannot un-know what you know' and that we are all responsible for keeping patients safe.

DoH Quality Standard 5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

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2.5 Listening, Hearing, and Acting

The clinician-patient interaction itself has been demonstrated to confer a therapeutic benefit. When patients and their families are listened to and feel that their concerns are validated and acted upon; this has benefits that go beyond the clinical treatment itself. Not listening to patients or family members, misses an opportunity to enhance trust, allay distress and improve clinical outcomes.

> "When I tried to politely explain that the range for the investigation was wrong, the Consultant walked up and down the floor saying that he was the expert, there was nothing wrong with the range, and I was interrupting him. I wasn't interrupting him as I was barely able to get a word in…"
>
> Expert by experience

Being dismissive of patient and family concerns, risks missing important clinical information from a safety perspective, but can also cause harm to patients as they feel unsupported during a vulnerable period of ill-health and associated psychological stress.

Listening to Families

Families can provide a valuable insight into their loved one's condition; if a patient or their family asks for a second opinion, then this should be facilitated[xiv, 33] – a request for a second opinion should not be perceived as a criticism or weakness by the clinical team providing care. A second opinion can serve as a valuable safeguard against patient harm, or may simply provide reassurance to the patient and their family.

Martha Mills died in 2021 after developing sepsis in hospital, where she had been admitted with a pancreatic injury after falling off her bike. Martha's family's concerns about her deteriorating condition were not responded to, and in 2023 a coroner ruled that Martha would probably have survived had she been moved to intensive care earlier.

Whilst Martha's Rule has not been implemented in NI, the same principles of **'listening, hearing and acting'** should apply.

[xiv]GMC Good Medical Practice (January 2024). States "You must recognise a patient's right to choose whether to accept your advice, and respect their right to seek a second opinion".

Listening, Hearing and Acting on the concerns of other professionals

Professional regulators stipulate that Health and Social Care professionals must work well with colleagues in order to deliver safe, effective care. Part of working well with others involves listening, hearing and acting on immediate patient safety concerns – this includes concerns raised within teams, but also by colleagues from other disciplines and other sectors.

> "The PSNI officers who had spent hours waiting with the patient and talking with him were very concerned about the risk posed by the patient. The [healthcare professional] admitted to talking to them for "less than 30 seconds". He ignored what the PSNI were trying to say; he did not obtain collateral information from the PSNI. This had fatal consequences."
>
> Expert by Experience

'Patient safety is paramount'. When a colleague raises a concern, regardless of how busy we are, or who the colleague is, be it a junior member of the team or a staff member from another team, service or sector, **'any concern raised should be treated as vital information'** and must be appropriately considered in order to safeguard patients from harm. **'We all play an important role in keeping patients safe'**.

Listening, Hearing and Acting enhanced by mutual trust and respect

Supporting safety within and across the HSC system necessitates both trust and respect.

Where HSC leaders and managers trust and respect their staff, staff, in turn, trust and respect leaders and managers.

Health and Social Care professionals must behave in ways that are trustworthy and respectful towards patients, carers and families, who are likely to feel anxious and vulnerable during their care episode. Such anxieties and vulnerabilities can be exacerbated in situations where HSC system pressures lead to suboptimal delivery of care and treatment. In these circumstances, staff often bear the brunt of patient and public frustration.

There is a need for greater awareness amongst the public around HSC system pressures. Open and honest conversation can serve to enhance public understanding of the pressures HSC staff face and serve to ensure that respect is two-way.

In empowering patients, families and staff to raise concerns about quality and safety, there is an onus to support people to do so in ways that are both effective and respectful, just as there is a duty on the HSC system to **'Listen, Hear and Act'**.

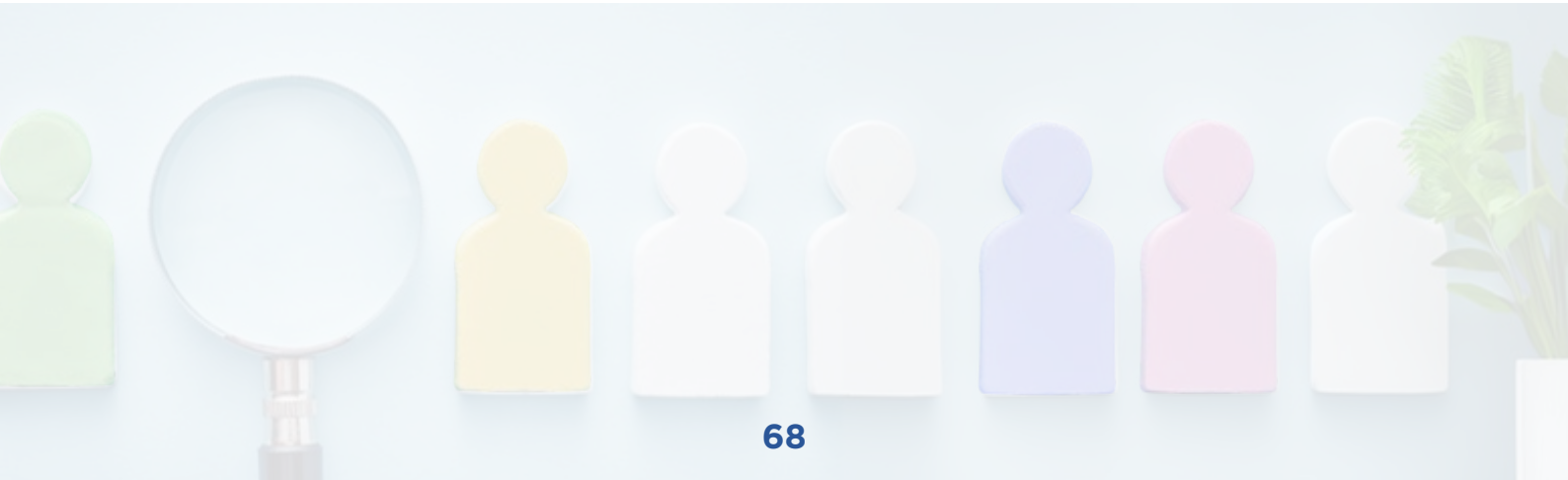
Red Flag Behaviours

1. **Dismissive of concerns**
   - Being dismissive of patient and family concerns;
   - Failure to listen to the concerns of colleagues;
   - Attempts to discredit a patient, family or colleague's character in order to justify not listening to their concerns.

2. **Failure to allow or accept other professional opinions**
   - Rejecting requests for a second opinion;
   - Dismissing the opinion of other professionals.

3. **Working in isolation**
   - Working in isolation from colleagues.

4. **Failure to participate in appraisal and governance**
   - Failure to respectfully and constructively participate in appraisal and governance activities, such as clinical audit, quality improvement and Mortality and Morbidity meetings.



Expectation 13: All impacted by patient safety incidents experience fair, compassionate and restorative responses and actions

13.1 Just culture principles of fairness, openness and learning are embedded within systems, policies, procedures and approaches to managing incidents, concerns and complaints.

13.2 Senior Leaders showcase examples of just and restorative culture leading to: openness, healing for individuals and teams, improvements in patient safety.

13.3 Training for Leaders and managers on patient safety, human factors, and the application of just and restorative approaches and principles.

13.4 Incident review panels are skilled and trained in empathetic, compassionate and restorative approaches to approaches to engaging with those involved in safety incidents.

13.5 When harm occurs, all those impacted by the harm, which may include staff, patients, victims and families, experience empathy, compassion and support, along with thoughtful consideration of their needs; including the need for professional or clinical support.

13.6 There is access to counselling and clinical psychology for patients, families and staff impacted by safety incidents.

13.7 Staff feel confident reporting incidents/errors, engaging in incident reviews, and do not fear blame or punitive action.

13.8 Staff involved in patient safety incidents and complaints are supported to engage candidly in review processes for the purposes of system learning and improvement.

13.9 Senior Leaders demonstrate an understanding that accountability is collective and that ultimate accountability for quality and safety sits with the HSC Trust Board.

13.10 Leaders and managers demonstrate an understanding that most of the time when things go wrong, it is because of complex, imperfect systems and challenging working conditions.

13.11 Staff at all levels demonstrate an understanding that 'anyone can make a mistake' – and when mistakes happen, we must all learn from them, and use the learning to improve the system.

13.12 Senior Leaders demonstrate an understanding that there is clear distinction between intentionally harmful, negligent or deceitful behaviour - and human error.

13.13 Leaders and managers demonstrate an understanding that punishing people for mistakes does not achieve improvements in patient safety and only contributes to fear, secrecy, and further harm within the HSC system.

13.14 Blame and punishment for individuals is rare, and reserved for deliberate negligence, wrongdoing, 'cover-up' and concealment.

DoH Quality Standard 5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

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2.6 Just and Restorative Culture

Just and restorative culture refers to the collective actions and behaviours of individuals within an organisation in response to safety incidents.

It is about treating people fairly, but also responding compassionately to meet the needs of individuals and restore confidence and trust in the HSC system, with an understanding that **'ultimate accountability for patient safety sits with the HSC Trust Board'**.

'Just culture is critical for harm prevention'. A just culture is necessary for open culture; and an open culture is necessary for learning and improvement.

Unless there is a culture of openness and confidence in staff that they will be fairly treated and that there will not be undue punitive action, staff will be too afraid to make disclosures during incident investigations.

This fear of blame not only adversely affects staff wellbeing, it hampers system learning, hinders improvement and impacts negatively on patient safety.

In a Just Culture, Leaders understand that there is clear distinction between intentionally harmful, negligent or deceitful behaviour - and human error.

We are all human and **'anyone can make a mistake'** – when mistakes happen, we must all learn from them, and use the learning to improve the system. Most often when things go wrong it is because of complex imperfect systems and challenging working conditions.

Leaders understand that **'blaming and punishing people for mistakes does not achieve improvements in patient safety'** and only contributes to fear, secrecy, and further harm within the HSC system.

Therefore, when harm occurs, it is viewed through a lens of system learning and improvement, individuals are supported to learn and improve, and to contribute constructively to patient safety.

In the unusual event that there has been deliberate harm or negligence, this is dealt with separately to the learning process.

Tool such as NHS 'Being Fair'[34] can be used to assist employers with making decisions when negligence or Fitness to Practice Concerns arise. However, it should be noted that such algorithms or tools are not for routine use, understanding that the vast majority of quality and safety incidents occur, not because of the sole actions of an individual, but because of an interplay of system factors, human factors and honest mistakes. Remembering that **'blaming and punishing people for mistakes does not improve patient safety'**.

Good practice in reviewing patient safety incidents

A good Patient Safety Incident Review will:

- Compassionately support all those impacted, consider their needs and appropriately involve them in the review process;
- Adopt an empathetic and sensitive person-centred approach, creating psychological safety for openness and candour amongst those engaging with the review panel;
- Aim to establish the facts of what happened, and why, providing answers to all those affected;[xv]
- Derive Learning and inform timely improvements in Patient Safety.

By its nature, a Patient Safety Incident Review is not a punitive or evasive process. However, poor application of an incident review process can mean it may be perceived as punitive by staff and as evasive, lacking in candour, compassion and sensitivity for those who have been harmed.

The following case sets out two Serious Adverse Incident reviews, both conducted for the same safety incident described below. The First Review is considered as an example of poor practice, and the second Review represents good practice.

Case Study

My parents-in-law were violently killed by a mental health patient. In the five days preceding the killing, the patient sought help four times, at three different hospitals, in two different Trusts. On two of the occasions there was significant interaction with the PSNI. The patient presented with worsening paranoia, delusional-thinking and self-harm. At no time did he receive the help he so desperately needed. At the inquest into the deaths of the victims, the coroner found the deaths to be "entirely preventable".

Expert by Experience

[xv] Patients, victims, families and HSC staff

	First Review	Second Review
Adhering to Procedure	The SAI Procedure for investigating 'mental health homicide' was not followed correctly.	The SAI procedure was followed and the panel was provided with training on the SAI procedure.
Level of SAI Review	The Level of Review was inappropriately assigned to Level 2. As such, the SAI did not have a fully independent panel.	The Level of Review was appropriately assigned to Level 3. The SAI had a fully independent panel.
Drafting a Terms of Reference	The Terms of Reference did not include mandatory requirements and were not sufficiently robust.	The Terms of Reference were drafted in compliance with the procedure and with involvement of the victims' family.
Involving families	The family of the victims was excluded from involvement in the SAI review. When the family asked to be involved, the request was rejected and the family were hurt and re-traumatised.	Families were sensitively involved from the outset. They were given regular updates. Their questions were answered and they were provided with draft copies of the report for comments, which were subsequently taken into consideration.
Gathering and analysing evidence	Only six people were interviewed as part of the process; inappropriate given the number of organisations and agencies involved in the incident. Information provided by interviewees was accepted at face value with no attempt to verify the information. Information provided to the panel was subsequently demonstrated to be false. Analysis of information was suboptimal. A factual account of events was not achieved.	Over sixty people were interviewed, including PSNI Officers. Information was triangulated in order to establish facts, to understand what happened, and why. The Review Panel met their commitment to: Evaluate the standard of care delivered by all agencies involved in the SAI objectively.
Drawing Conclusions	The review concluded "there were no factors in the health & social care services and interventions delivered or omitted to "xxx" that caused or influenced the suspected homicides"	The review identified two factors that were "*causal*" in the deaths and twenty-two factors that were "*contributory*".
Preventing similar harm occurring in the future	There was a missed opportunity to identify learning that could have prevented further deaths within the region.	Consequently, the SAI Review made a total of eleven recommendations all of which had the potential to help prevent further incidents and save life.

"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

Red Flag Behaviours

1. **Blame culture**
   - Incidents are seen as due to staff errors;
   - Patients and families are blamed for safety incidents;
   - Punitive action against staff.
2. **Lack of support for those impacted by safety incidents**
3. **Lack of candour**
4. **Lack of learning and improvement**
   - Learning derived from safety incidents is limited;
   - Failure to implement improvements following safety incidents.

Expectation 14: Openness and candour is promoted and supported at all levels in the organisation

14.1 There is an Organisational vision and strategy for Patient and Staff Safety and Wellbeing that is explicit about the requirement for just, open and learning culture.

14.2 There is HSC Trust Board-level commitment to a just culture of fairness, openness and learning.

14.3 Senior Leaders understand that they are accountable for creating fair, open and supportive cultures where there is compassion for those who make mistakes and where speaking up is highly valued and encouraged.

14.4 Floor to Board, there is routine openness about patient safety and staff wellbeing metrics enabling collective accountability and system improvement.

14.5 From 'Floor to Board', there is open, honest and transparent communication; supported by effective mechanisms for sharing information.

14.6 Senior Leaders promote a narrative that 'there is protection in the truth' and share examples of how openness and candidness has been responded to with compassion, support and has led to improvements.

14.7 Senior Leaders consistently demonstrate that when people are open and honest, and willing to learn, are not blamed or punished for mistakes.

14.8 Staff at all levels demonstrate an understanding that candour promotes healing, recovery and restoration of trust for those who have experienced healthcare-related harm.

14.9 Managers and Health and Social Care professionals are supported to engage early with patients, victims and families who have experienced healthcare-related harm, in order to provide a meaningful apology; acknowledgement of harm; and any information that is known, with an open acknowledgement of what is unknown or uncertain, and a caveat that a formal investigation may find different facts.

14.10 Whilst information on formal procedures is provided, it should not be used to delay apology, acknowledgement and, if possible, answers.

DoH Quality Standard 5.3.2 Preventing, Detecting, Communicating and Learning from Adverse Incidents and Near Misses

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2.7 Open Culture

‘A just culture is necessary for open culture; and an open culture is necessary for learning and improvement.’

HSC Trusts are responsible for fostering a culture of openness; a pre-requisite to this is just culture, and a clear sequitur is a learning and improvement culture.

People will not be open, unless they feel psychologically safe, and they will not be able to learn and improve unless there is both psychological safety and a culture of openness.

McBride (2024) identifies three key aspects of cultural openness:

1. Routine Cultural openness;
2. Openness focused on constant learning;
3. Openness when things go wrong.

Candour

Candour is about ‘being open’ and honest with patients and families when care has gone wrong. Candour facilitates psychological healing, physical recovery, and may serve to restore trust in the health and social care system.

Good Practice Example

I’ve had a long-term health condition for many years that requires management with specialist drugs. A GP once prescribed an antibiotic which caused an interaction with one of them. I became very unwell.

When I saw a doctor at the specialist unit, I said it was my fault, as I thought, in a way, I was partly to blame. I did not want the GP blamed. The doctor replied, ‘no it’s our fault’. There was complete transparency. There was no blame [of the GP].

Later I was also told by a doctor at the unit that because of what had happened to me a letter had been circulated to all their patients’ GPs with a list of medications that reacted with the specialist drugs they used.

As such, there was transparency, learning, action taken to improve patient safety, and no blame.

Lived Experience

When harm occurs, it is important that those impacted by the harm experience compassionate, restorative behaviours of listening, understanding, informing, and a commitment to making things right; actions taken should include an acknowledgement that harm has occurred and a meaningful apology.

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

"I sat in a meeting last week where a client asked for an apology for what had happened and no-one spoke, the client was in tears. Still no-one spoke until I said 'an apology is literally in the guidelines and wasn't an admission of guilt, just an acknowledgement'. Still no-one spoke, so we left..."

Patient Advocate

What good looks like:
Being open and honest when care goes wrong

Leaders, managers and all staff are supported to understand that there is:

- Protection in the truth;
- Power in an apology;
- Healing in acknowledgement.

... and 'it is OK to not have all the answers', as long as you are open and honest that you don't!

Most people, when harm has occurred, need to know that it will not happen to anyone else. Those impacted should be offered an explanation of next steps to review the incident so that learning and improvement can be derived.

"My experience was regarded as a 'never event' and the senior doctor on call that night said it would be investigated however no action was taken. The lead consultant detailed a vague and inaccurate report of events... There was zero openness and honesty around my care, nobody wanted to identify or take responsibility for what happened or indeed learn."

Expert by Experience

Importantly, be it in the immediate aftermath, or during the course of an incident review, patients and families must be facilitated to get answers and to be told the truth.

Candour promotes healing, recovery and restoration of trust for those who have experienced healthcare-related harm. Conversely, a failure to be open and honest with patients and families compounds harm and reduces the opportunity for learning and improvement.

> **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**[xvi]

Professional regulators stipulate that Health and Social Care professionals have a duty to be open and honest when care goes wrong.

However, organisational cultures can make it difficult for Health and Social Care professionals to 'be open' or 'speak up'. In some cases, there can be a realistic threat to people's jobs, careers and professional reputations, creating a climate of fear.

This raises important ethical questions about where the balance of accountability should lie – on individual Health and Social Care professionals or on organisations to support them by making it safe to 'be open' and 'speak up' without fear of being isolated, scapegoated or experience further retribution.

When people experience intense fear and anxiety, they may shut down, deflect blame or tell investigators what they think they want to hear; at its worst fear can cause people to conceal or 'cover up' what really happened; meaning the truth needs to be "dragged out of them" by Public Inquiries.[xvii]

In order to achieve a culture of openness and honesty, Health and Social Care professionals require confidence that 'being open' will not result in punitive action. It needs to be **'a lived reality that there is protection in the truth'**. Crucially, that people who are open and honest, and willing to learn, are not punished for mistakes. This requires compassionate leadership within the HSC system and an understanding that HSC Trusts are accountable for driving just, open and learning cultures.

[xvi] 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 Health and Social Care System in NI.
[xvii] Quote from Justice O'Hara following publication of IHRD Inquiry (2018). Children's hospital deaths were avoidable - BBC News

Red Flag Behaviours

1. **Staff are discouraged from or punished for candour, i.e.:**
   - instructed not to submit incident reports;
   - criticised or punished for submitting incident reports;
   - instructed not to be open and honest;
   - punished for being open and honest.

2. **Policies and procedures are misused, i.e.:**
   - to avoid openness and transparency;
   - to avoid accountability;
   - as weapon for victimisation.

3. **Attempts to mislead investigators, regulators, coroner's, independent reviews or inquiries**

4. **Resistance to external scrutiny**

Domain 2: Underpinning standards, legislation and best practice guidance

- DoH Quality Standards 2006;
- Health and Social Care (Reform) Act 2009;
- Human Rights Act 1998;
- Disability Discrimination Act;
- Health and Safety at Work (NI) Order 1978;
- DoH Collective Leadership Strategy;
- NICE Quality Standards QS15. Patient Experience in adult NHS Services;
- NICE Guidance NG197. Shared Decision Making;
- NIPSO HSC Model Complaints Handling Procedure;
- Social Care Institute for Excellence - Dignity in Care, Freedom to choose;
- NHS England Framework for involving patients in patient safety;
- NICE Guidance NG13. Workplace health: management practices;
- NICE Guidance NG212. Mental Wellbeing at Work;
- NHS England. Health and Wellbeing Framework;
- NHS England. Civility and Respect;
- NHS resolution- Just and Learning Culture Charter.

Cultural Domain 3: Curiosity and Constructive Challenge

Domains	Themes	Expectations
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.

Expectation 15: Fear is addressed by acknowledging the impact of past trauma and by changing unhelpful narratives and beliefs

15.1 Senior Leaders allay fear within the HSC system by seeking to shift away from mindsets that promote defensiveness and a lack of openness, which are counter to learning, and towards healthier mindsets of acceptance, resilience, and an unwavering commitment to openness, learning and improvement.

15.2 Senior Leaders make a concerted effort to change unhelpful narratives and beliefs around processes that staff are fearful of and find stressful.
[See Good Practice on Page 82]

15.3 Senior Leaders and all staff demonstrate an understanding that HSC Trust processes should not be used as a barrier to human interaction and engagement, and that all staff involved in a HSC Trust process should be offered meaningful support.

15.4 Managers who utilise HSC Trust policies and procedures demonstrate a clear understanding of the spirit within which the procedure was drafted and are accountable for using policies and procedures fairly and proportionately.

15.5 HSC Trust Policies and procedures are applied fairly in accordance with HSC values, and are not be used to avoid openness, transparency and accountability, or as weapon for victimisation.

15.6 HSC Trust Policies and procedures are only initiated when necessary (i.e. policy thresholds are met), understanding that processes can be experienced as stressful, bureaucratic, and lengthy.

15.7 There are assurance mechanisms in place to ensure that HSC Trust policies and procedures, and their application are fair, and free from bias and discrimination.

15.8 Feedback is proactively gathered on the experiences of patients and staff who have engaged in incident, complaints or raising concerns procedures; information gathered is used to drive improvements in the application of policies and support available for those impacted.

DoH Quality Standard 7.3: Promoting, Protecting and Improving Health and Social Wellbeing

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3.1 Addressing Fear and Defensiveness within the Health and Social Care System

The legacy of 'The Troubles' and political instability on HSC structures, HSC workforce and NI population has undoubtedly had an impact on culture within HSC.

Direct rule, socio-economic inequalities and intergenerational trauma stemming from sustained periods of violence is likely to have contributed to engrained cultural elements, such as hierarchical mindsets, blame culture, mistrust of authority, and a lack of openness and transparency.

There is also an impact on HSC staff previously involved in investigations, litigation and inquiries[xvii], whereby the trauma of investigation processes and a perception of blame, may compound pre-existing psychological adversity. The repercussions of these traumatic experiences can be significant and longstanding, affecting entire clinical teams and services.

For this reason, HSC staff involved in public inquiries and coroner investigations, which involve intense scrutiny, accompanied by media coverage, should be offered enhanced support, such as access to clinical psychology and the adoption of trauma-informed approaches by leaders and managers.

It is important to acknowledge that there is also fear within the HSC system amongst staff who themselves have had no previous experience of investigative processes; this occurs because fear is engrained within the culture, perpetuated by unhelpful narratives and beliefs within organisations, causing an unnecessary level of anxiety and defensiveness, counter to openness and learning - 'Fear hinders learning and hampers improvement'.

> "As a young student, during my nursing training I remember being told **'watch out for the big wigs!'** and that's something that has stayed with me for so long... there can be a real fear of making mistakes and a lack of psychological safety within the HSC system."
>
> Lived Experience of a clinician

It is important that this cultural fear is addressed by Senior Leaders within HSC organisations in order to promote mindsets consistent with openness, learning and improvement.

[xvii] For e.g.: Serious Adverse Incident Reviews, Coroner processes, Litigation, Public Inquiries, Regulatory Review and Investigations

15.2 What good looks like: Allaying fear within HSC System

Staff may fear processes such as internal HSC Trust processes, whistleblowing, complaints, safety incident reviews, litigation, coroner inquests, inquiries, investigations, regulation and associated media coverage.

Efforts to allay fear of such processes involves:

- demystifying processes;
- training, guidance and resources for staff;
- providing reliable, unbiased and balanced information on processes, including the range of possible outcomes and support available;
- enhanced support for staff, including access to counselling and clinical psychology;
- providing case examples where staff have been supported through processes.

The task for HSC organisations and regulators is to embed just culture principles within the systems and processes for learning from harm and support their staff in a trauma-informed way that lessens fear and anxiety, creates psychological safety to encourage open, candid disclosures, maximising healing for those impacted, and learning and improvement for the HSC system.

What good looks like: Preventing Defensiveness

Defensiveness impacts on the ability of individuals, teams and organisations to learn. It arises from a fear of repercussions amongst staff, when care goes wrong.

Effective leaders adopt a number of strategies in order to promote mindsets that prevent defensiveness and create receptiveness to learning, in order to improve patient safety. These may include a concerted effort to:

1. Foster psychological safety, just and restorative culture – (i.e. if I make a mistake, I will be treated with compassion, and supported to learn and improve);
2. Promote curiosity in everyday practice – (i.e. things did not go well today, I wonder how we can do better for patients and for staff);
3. Encourage reflection – (i.e. I am going to take time to intentionally reflect on my practice, the culture within our team, and how we impact on the patients we provide care to);
4. Promote a 'growth mindset' - (i.e. Mistakes are an opportunity for personal learning and growth).

Alongside changing mindsets, it needs evidenced to staff that they will indeed be treated fairly and supported, should they become involved in processes, including HSC Trust processes, which should always be applied in a consistent and fair way, without bias or discrimination.

Equally, external agencies, including both professional and system regulators, must demonstrate that they will act fairly and proportionately, when concerns with quality, safety and clinical practice are identified.

Expectation 16: Early engagement is embraced as an opportunity for early resolution and system learning

16.1 Early engagement in response to concerns/complaints from patients and families is embedded within the organisation for the purpose of listening to concerns/complaints, understanding and recording any questions patients/families want answered, offering a meaningful apology and acknowledgement of harm/poor experiences, identifying learning and driving improvement.

16.2 Leaders and managers are equipped and supported to seek early resolution to concerns, negative feedback and complaints.

16.3 Training and resources for managers and Health and Social Care professionals to support early engagement with patients and families who have concerns and complaints.

16.4 There are mechanisms to derive learning from the early resolution of complaints; learning is used to drive improvements in systems for safety and care delivery.

16.5 Leaders and managers showcase examples of early engagement leading to early resolution and system improvement.

16.6 Senior Leaders role model compassion, humility, and a desire to learn and learn and improve.

16.7 Leaders, managers and all staff are supported to understand that there is:

- protection in the truth;
- power in an apology;
- healing in acknowledgement;

And 'it is OK to not have all the answers', as long as you are open and honest that you don't.

DoH Quality Standard 8.3 Effective Communication and Information

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3.2 Early Engagement and Resolution

> "The [HSC system] cannot seem to learn that it is better to acknowledge mistakes and other problems early… rather than continue pouring petrol on the fire…. Compounding more harm on compounded harm."
>
> Patient Expert by Experience

When patients and families have had a poor experience of healthcare, including when care goes wrong, they might have unresolved care issues that need addressed and will often want to know that what happened, will not happen to anyone else.

When someone raises a concern about their care and treatment, with the motivations of rectifying issues in their own care and / or with the motivation of improving patient safety for others, they are often directed into a formal complaints process.

> "Nobody attempted to raise what happened internally. After I raised it as complaint, it sat for a year before being raised to a SAI, which took another 16 months to investigate….."
>
> Patient Expert by Experience

The difficulty with complaints processes is that patients and families can experience them as:

- Unnecessarily lengthy;
- Bureaucratic;
- Lacking in human connection;
- And importantly, failing to address patient safety issues – either for the patient as an individual (in the case of unresolved care issues) or for the wider patient population.

It should be noted that following the Independent Neurology Inquiry, improvements are being made to complaints handling within the region. NIPSO is leading reform of the complaints standards[xix], and individual HSC Trusts are implementing mechanisms to ensure that complaints are viewed through a patient safety lens. These changes are anticipated to make substantial improvements and it is important that these are capitalised upon, in order to drive a cultural shift towards early engagement and resolution of concerns.

When people are engaged early there are benefits that go beyond what a complaints process can deliver. When an apology and acknowledgement of harm is delivered in a meaningful way it can promote healing and recovery, and restore trust in the HSC system. It also provides an early opportunity to understand and record any questions that patients and families may have, to provide answers (if available) and to derive early learning and improvement for the system.

[xix] NIPSO are leading on a transforming complaints standards in the Health and Social Care (HSC) sector. The HSC Model Complaints Handling Procedure (MCHP) sets new Standards for how the sector in Northern Ireland manages complaints.

Expectation 17: Staff at all levels are empowered to provide and receive constructive feedback as a means to learning and improving the HSC system

17.1 Senior Leaders foster a culture of curiosity and embrace constructive challenge by role modelling positive behaviours and creating psychological safety for staff at all levels to be curious, to constructively challenge, and to drive learning and improvement.

17.2 Senior Leaders role model compassion, humility, and a desire to learn and learn and improve.

17.3 Leaders and managers welcome and respond graciously to constructive criticism, expressing gratitude, acknowledgement and a commitment to ensuring issues with patient safety or staff wellbeing are addressed.

17.4 Staff at all levels are empowered and supported to receive and provide constructive feedback as a means to learning and improving.

17.5 Senior Leaders role model and demonstrate the humility to receive constructive feedback in the manner that it is intended and use this to drive improvements.

17.6 Senior Leaders deliver feedback in a constructive and professional manner. All staff are supported to receive feedback in the spirit within which it is intended in order to drive learning and improvement.

17.7 At all levels, staff feel safe and supported to constructively challenge the status quo.

17.8 Senior leaders encourage staff at all levels to continually strive to find ways to understand if things can be done better for the benefit of patients, families and staff.

17.9 HSC Trust Boards and Senior Leaders seek out learning from other organisations, reviews and inquiries in order to drive internal system improvements.

17.10 HSC Trust Boards and Senior Leaders demonstrate courage to welcome external scrutiny and there is routine openness and transparency around the learning derived and improvement plans.

17.11 HSC Trust Boards recognise the value in external scrutiny, and when required, actively seek support from external bodies. i.e. DoH, Commissioners, Regulators, Royal College Invited Service Review programmes, in the interest of receiving external assurance and support to improve Patient and Staff Safety and Wellbeing.

DoH Quality Standard 8.3 Effective Communication and Information

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3.3 Embracing Constructive Challenge

Constructive challenge is essential in an open, learning and improving system.

Challenge, by its nature, can feel difficult. For HSC staff from underrepresented groups, it can feel even more difficult to provide challenge. This can be due to non-inclusive working environments; also in some countries outside of UK, it can be considered culturally disrespectful to challenge authority.[xx] For these reasons, HSC staff from diverse backgrounds may require additional support to feel empowered to challenge.

Challenge can feel uncomfortable for not just for those providing it but also for those receiving it. If the intention behind the challenge is not mutually understood or if it is delivered in a way that is harsh or insensitive it can evoke feelings of embarrassment and humiliation, and impact negatively on team relationships – all of which are counter to learning and improvement.

This is why **'challenge must always be constructive'**.

In order to embrace constructive challenge as an effective means to driving improvements in patient safety, the following actions need to be taken:

1. Create a collective understanding of the purpose of challenge;
2. Role model positive behaviours in providing and receiving challenge – curiosity, humility, and a desire to learn and improve;
3. Ensure that when challenge is delivered it is respectful and constructive; providing training and resources to support staff;
4. Support people to receive challenge in the way that it is intended – to remove the ego and understand **'it is not about me – it's about doing the best for patients'**;
5. Normalise constructive challenge – by building it into everyday business.

Skills in 'constructive challenge' can be practiced through the delivery of 'constructive feedback' when supervising or training students and junior colleagues.

Constructive feedback in itself is a skill, underpinned by a desire to support training and professional development, without inadvertently undermining or demoralising those receiving the feedback. The intention is to develop the next generation of capable and competent HSC staff, not to elevate the ego of trainers at the expense of learner confidence.

[xx] This can be due to non-inclusive working environments; also in some countries outside of UK, it can be considered culturally disrespectful to challenge authority.

Good Practice Example - Fairer Feedback

The General Medical Council (GMC) offers "Fairer Feedback" workshops to improve the quality and fairness of feedback in medical education.

This initiative aims to address issues related to feedback in postgraduate medical education and its impact on doctors in training and trainers, with a particular focus on disparities in educational outcomes.

Commitment to reducing inequalities in medical education and training

The GMC has set a target to eliminate discrimination, disadvantage and unfairness in education and training by 2031. Research by the GMC has identified that underrepresented groups of doctors, particularly those from minority ethnic backgrounds and international medical graduates (IMGs), may face systematic disadvantages in medical training, leading to differential attainment.[xxi]

The international medical graduate proportion of medical workforce in NI has doubled within the last 5 years and now represents 10% of the overall workforce; proportion of international medical graduates within the first year of GP training is currently 52%.

Workshops:

In 2025, GMC made a commitment to NIMDTA to offer fairer feedback conversations to all GP trainers across Northern Ireland. Fairer feedback conversations are also offered at all HSC Trusts as part of the "trainer forum" model.

The purpose is to improve the quality and fairness of feedback conversations in medical education. 2.5-hour workshop covers the following topics:

1. Differential attainment: what is it, what the GMC is doing, risks and protective factors;
2. Feedback conversations: impact, effective feedback conversations, feedback models;
3. How to make feedback conversations fairer: cultural competencies, humility, micro-validations.

Outcomes:

Participants have reported positive experiences of the workshops, meeting learning objectives and improving confidence in delivering Fairer Feedback.

GMC continues its programme of delivery of Fairer Feedback workshops.

[xxi] Differential attainment refers to the observed differences in outcomes when comparing groups based on protected characteristics and socio-economic background

Red Flag Behaviours

1. Failure to receive constructive challenge in the way that it is intended, such as:

- Accusations of undermining in response to constructive challenge;
- Lack of willingness to take on board feedback to improve safety.

2. Punitive action towards those who provide constructive challenge, such as:

- Bullying, isolation, exclusion, unfairly labelling staff who constructively challenge as 'difficult'.

3. Low rates of constructive challenge in situations where it would normally be expected i.e.:

- Meetings to discuss complex cases, morbidity and mortality meetings etc.

Expectation 18: Speaking up is highly valued and encouraged, and results in action to improve patient safety

18.1 HSC Trust Boards ensure there are clear mechanisms in place for staff to safely raise concerns about patient and staff safety. These should include formal mechanisms for 'raising concerns' and may also include:

- HSC Trust Board Level Speak Up/ Raising Concerns Champion;
- Informal mechanisms through Leadership WalkRounds[36], Listening Exercises, Staff Forums, Story Boxes.

18.2 HSC Trust Boards integrate both quantitative and qualitative information from 'raising concerns' in their metrics for safety.

18.3 HSC Trust Boards actively seek out and monitor feedback from staff experiences of raising concerns through an independent channel. Learning from poor experiences is captured and improvements implemented.

18.4 HSC Trust Boards seek assurance that concerns raised by staff, results in action to improve safety, and does not result in detriment to the staff members raising concerns.

18.5 Raising concerns is a standing item at HSC Trust Board Patient Safety and Quality Committees; information provided should include an overview of the concern raised, action taken to address concerns and support staff.

18.6 Raising concerns is normalised within the organisation and embedded within day-to-day operational activities.

18.7 There is evidence of patient safety improvements following patient complaints and staff raising concerns.

18.8 When staff members raise concerns at team level or above, there is collective ownership for addressing the concern, ensuring that the focus of any subsequent process becomes the concern itself and not the individual raising it.

18.9 HSC Trust Boards and Senior Leaders promote the benefits of speaking up by demonstrating that speaking up results in action to improve patient and staff safety. They may share examples of speaking up leading to system improvements.

18.10 HSC Trust Boards and Senior Leaders consistently ensure support and protection from unfair treatment for those who raise concerns. Senior Leaders seek to prevent and tackle any negative impact experienced by employees, as a result of speaking up about patient safety.

18.11 There is training and awareness for staff at all levels on: mechanisms to raise concerns; formal procedures; support available; and statutory entitlements and protections from victimisation under Public Interest Disclosure legislation.

18.12 Staff at all levels feel actively encouraged and supported to raise concerns.

18.13 Staff feel confident raising concerns and do not fear negative repercussions as a result.

18.14 All staff who raise concerns are provided with meaningful support (for e.g. – peer support or a buddy system) along with a dedicated mechanism to escalate any concerns about unfair treatment or victimisation that may arise.

18.15 Staff at all levels, of all roles and grades, feel safe and confident to report incidents, errors and mistakes.

DoH Quality Standard 5.3.1 Ensuring Safe Practice and the Appropriate Management of Risk

3.4 Speak Up Culture

'Staff are the HSC system's most powerful resource in identifying concerns about patient safety' – that is, if they are enabled to be.

There remains a disconnect between intention and reality, what on paper looks like an effective system, in practice may not be; this is not unique to NI, as it exists across the NHS.

Professional regulators state that Health and Social Care professionals must speak up if they have concerns about patient safety. All HSC Trusts have systems and procedures in place for raising concerns:

- Incident reporting;
- Escalation of concerns;
- Internal whistleblowing/raising concerns policy for raising serious concerns (i.e. making a protected disclosure in the public interest).

Furthermore, organisations have a statutory 'duty of quality' for patients, a 'duty of care' to staff; staff raising concerns about patient safety, have whistleblowing protections set out in law.

However, stipulating that staff 'must' raise concerns and having systems and processes, and even statutory protections in place, does not always address the biggest barrier to staff speaking up - 'Fear'.

Sadly, there are legitimate reasons for staff to be afraid. Research on the experiences of 'NHS whistle-blowers' shows that staff who raise concerns may experience:[37]

- Extreme stress during the whistleblowing process;
- Organisational retaliation and reprisal, including disciplinary processes, referral to professional regulators, and unfair or constructive dismissal;
- Victimisation by colleagues through impact on career progression; bullying; ostracisation;
- Failure to achieve the desired outcome of safeguarding patients from harm.

It is unacceptable that staff are harmed in the process of raising concerns about patient safety, when they have both a professional and moral responsibility to act.

Furthermore, it is unethical to demand that staff speak up, if concerns are ignored, and staff silenced, disempowered, or harmed through retaliation and/or victimisation.

Not only is this approach counter to the ethos of **'Patient Safety is Paramount'** and **'Staff Wellbeing is Core Value'**; it is antithesis of a just, open and learning culture.

HSC organisations can foster a 'Speak Up Culture' through the following actions:

1. Senior leaders role model positive behaviours in relation to raising concerns;
2. Act on concerns in order to improve patient and staff safety;
3. Make it is safe for staff to raise concerns;
4. Value staff who raise concerns;
5. Normalise raising concerns;
6. Celebrate improvements following raising concerns.

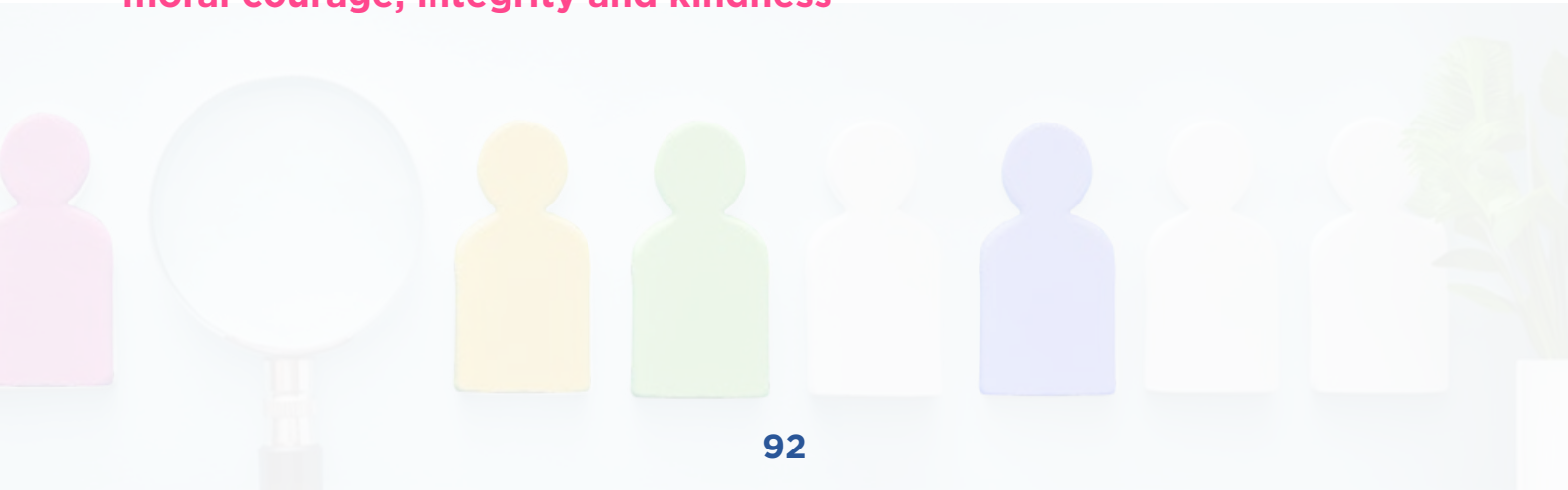
The behaviours and reactions of senior staff in response to challenge determines whether staff feel enabled, empowered and safe to raise concerns about patient safety.

Senior leaders who excel in fostering a 'speak up culture' are:

- Proactive about seeking concerns – they 'test the silence' and 'do not assume that no news is good news';
- They are visible, accessible and proactively speak to staff, patients and families at the coal-face in order to know where the problems are;
- They adhere to the principle of 'you cannot un-know what you know', by taking ownership of the problem;
- When issues are raised that reflect poorly on their leadership they do not see it as an inconvenience or betrayal but rather as an act of kindness – providing HSC organisations and Senior Leaders with an opportunity to rectify problems and do better;
- They foster collective ownership for addressing concerns, shifting the focus away from the individual raising the issue, to appropriately reviewing, understanding and resolving the issues in order to safeguard patients.

They ensure that staff who raise concerns are appropriately supported and safeguarded from victimisation and retaliation, and they hold staff, who bravely put their 'heads above the parapet', as role models for patient safety.

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



Good Practice Example - RQIA Speak Up Champion

RQIA is committed to creating an environment where RQIA staff safe and supported to 'speak up' with confidence that RQIA will listen, and will respond, using fair and rigorous processes.

As part of this commitment, Sarah Wakfer, an RQIA Authority Member, has been appointed as the Authority's Speak Up Champion.

The role of the Authority's Speak Up Champion is to be a set of ears for RQIA staff to speak to about any concerns at work. The Speak Up Champion is an accessible point of support, who helps signpost and empower staff, ensuring that all staff have a voice that counts.

The Speak Up Champion's role is to listen impartially and signpost people to all available routes that can offer resolution, including relevant Policies and Procedures.

The Authority hold regular discussions, led by the Speak Up Champion, to consider thematic information emerging from the role to inform wider learning and actions.

RQIA staff who have engaged with Sarah report a very positive experience of having their concerns listened to and receiving impartial advice.

The RQIA Speak Up Champion Role has played an important part in fostering a Speak Up Culture within RQIA.

Red Flags

1. **Low Raising Concerns Rates – through both formal and informal channels**

2. **Whistleblowing to external agencies**

3. **Evidence of unfair treatment of staff following raising concerns:**

   - Exit Interviews;
   - Grievances;
   - Employment Tribunals arising from unfair treatment of whistle-blowers.

Expectation 19: Time and space for reflection is created at all levels in the organisation

19.1 Senior leaders promote a culture of reflection within the organisation.

A narrative is promoted that reflection is essential and is a positive, empowering teams to reflect on what has gone well, as well as what needs to improve.

19.2 Time and space for reflection is created at all levels in the organisation.

This will depend on the particular setting but may include dedicated time within job plans or protected time within the working week for teams to meet and reflect.

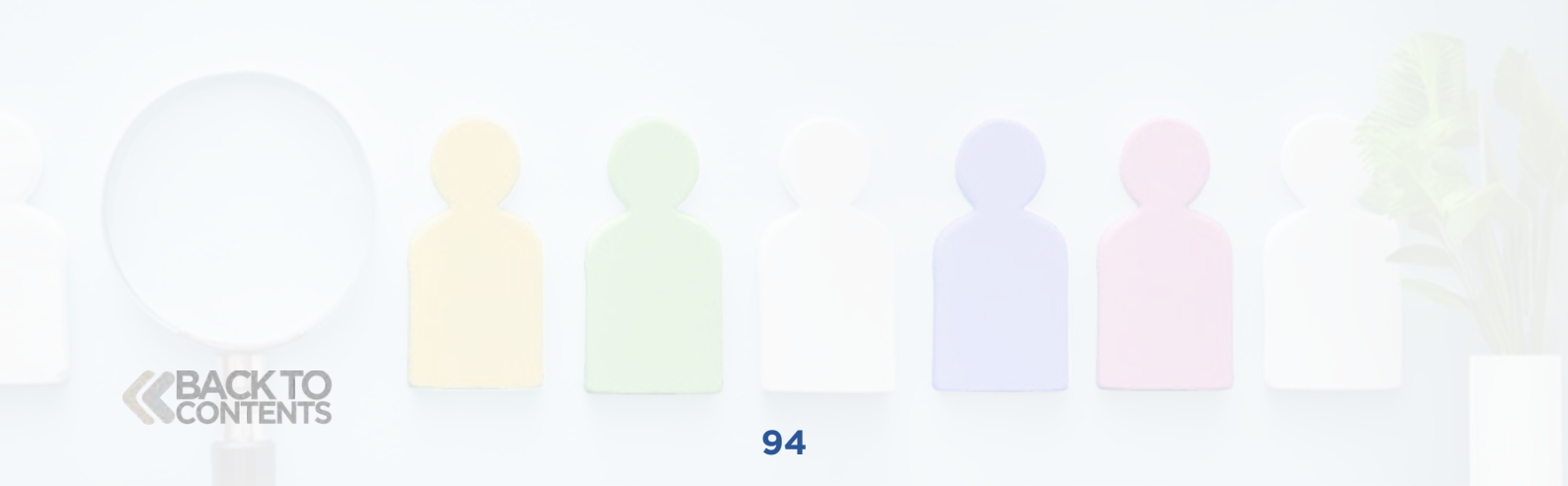
19.3 Senior Leaders demonstrate a consistent drive for curiosity and self-reflection, which involves:

- Having the confidence to 'hold up the mirror' and reflect on how they may do things differently
- 'testing the silence' on matters with respect to staff and patient safety
- Being genuinely curious about organisational performance with respect to just, open and learning culture

19.4 Senior Leaders proactively gather information to understand the value added by HSC services, the impact on the health and wellbeing of the workforce, the local population, and to identify areas for improvement:

- 360 degree appraisals;
- Leadership Walk-Rounds;
- Mechanisms for engagement with staff;
- Mechanisms for engagement with communities e.g. Local communities, Councils, Community and voluntary sector.

DoH Quality Standard 5.3.3 Promoting Effective Care



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3.5 Creating a culture of curiosity and reflection

Cultivating a just, open and learning culture requires a curious mindset and time and space for reflection to be embedded at all levels within the organisation.

At a clinician level it is well established that reflective practice encourages improvement in clinical practice. It enables Health and Social Care professionals to reflect on what has happened, what has gone well and what requires improvement, and to determine an action plan to take those improvements forward.

Just as Health and Social Care professionals reflect on their clinical practice, the HSC system needs to take time to intentionally reflect on organisational practices.

This requires HSC Trust Boards and Senior Leaders to build time into their everyday work to understand how organisational strategies and operations are impacting on organisational performance, efficiency, staff wellbeing, quality and safety of patient care; and to identify where the organisational approach may benefit from improvement, as well as celebrating and capitalising upon successes.

It also creates space for curiosity – to think about impact, how things may be done differently and how things are done elsewhere.

Curiosity is increasingly recognised as beneficial for driving learning and improvement.

IHI sets out five simple rules for curious leaders:[38]

1. Ask rather than tell;
2. Listen to understand rather than respond;
3. Hear every voice rather than those easiest to hear;
4. Prioritise problem framing rather than problem solving;
5. Treat vulnerability as a strength rather than a weakness.

There is recognisable commonality with compassionate leadership, with similar advantages in fostering psychological safety, inclusion and staff wellbeing.

Curiosity is also a key characteristic of an effective HSC Trust Boards, who under a 'duty of quality' must **'seek assurance, not reassurance'**, around patient and staff safety, including assurances that a just, open and learning culture is being fostered within the HSC organisation.

Red Flag Behaviours

1.Lack of curiosity

- Lack of curiosity within the organisation – ‘no news is good news’.

2.Failure to listen

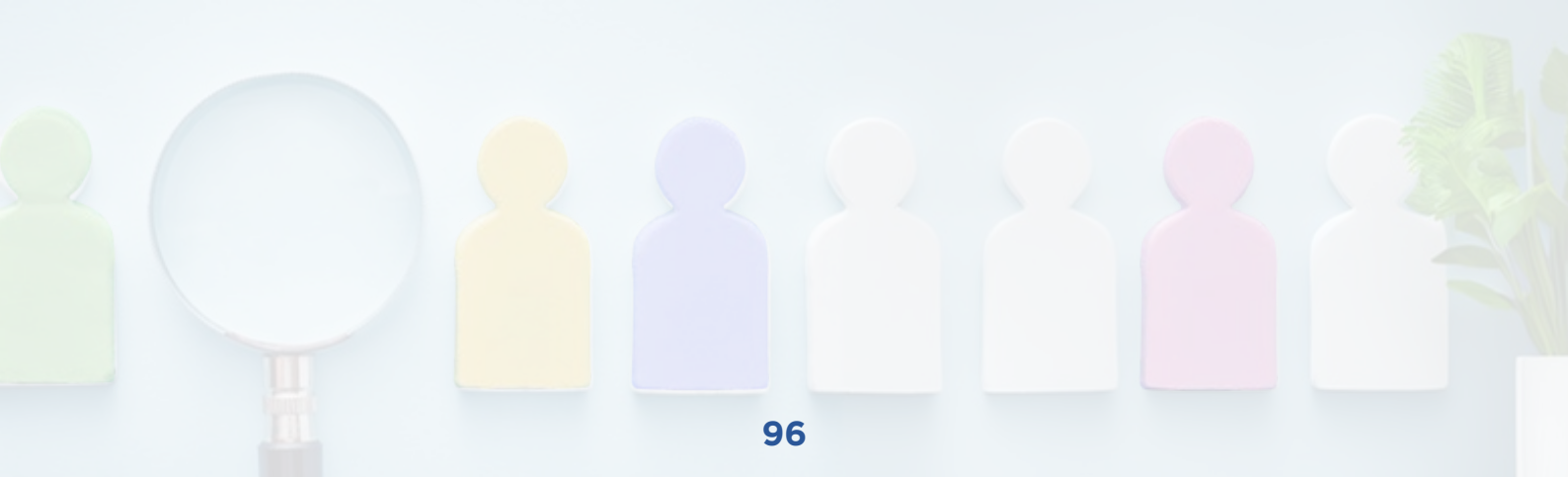
- Staff, patient and family feedback not acted upon.

3.Denial of problems

- Leaders and managers maintain a narrative that ‘everything is fine’;
- Lack of willingness to accept or understand problems.

4.Resistance to reflection

- Lack of willingness to consider alternative approaches or improvements;
- No downtime for reflection.



Expectation 20: Learning is shared in a way that is meaningful and has impact

20.1 There is a HSC Trust-Board and Senior Leadership commitment to identify learning, which includes learning from good practice as well as learning from harm, and to ensure that learning is shared in a meaningful way with frontline staff, and has a measurable impact.

20.2 Feedback Loops are maintained, whereby the impact of learning and improvement, positive or negative, can be promptly identified and addressed.

20.3 Senior Leaders are as committed to learning from excellence, as they are to learning from harm.

20.4 Leaders and managers, are committed and supported to seeking out examples of good practice.

20.5 Approaches such as appreciative inquiry[xxii] and investigating success are embedded within services and teams.

20.6 When good practice is identified, there is a desire to share it, and to consider scale and spread.

20.7 Learning from incidents and complaints is shared in a way that is meaningful and has impact.
[See Good Practice on Page 97]

20.8 At all levels, there is a shift away from a tick box approach to sharing learning and towards one that strives to achieve and demonstrate measurable impact.

20.9 Robust communication plans ensure that learning is shared with staff by a variety of means, appropriate to the specific service(s).

20.10 Where relevant, learning is embedded within education programmes, staff guidance, QI initiatives.

20.11 Senior Leaders and Team leaders have responsibilities for sharing information and providing feedback on how the learning has been utilised to drive improvements, and its impact.

20.12 Senior Leaders proactively engage with staff, patients, families and local communities to understand the value added by HSC services, the impact on the health and wellbeing of the workforce, the local population, and to identify areas for improvement.

DoH Quality Standard 5.3.3 Promoting Effective Care

[xxii] Appreciative Inquiry is a strengths-based approach to driving change that focuses on building on what is already working well. Instead of focusing on problems, Appreciative Inquiry encourages participants to explore past successes and envision future possibilities to drive innovation and positive change. It uses questions to elicit positive stories and collaboratively create a shared vision for the future.

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3.6 Sharing Learning in a meaningful way that has impact

Learning is a fundamental part of a safe, effective and continually improving system. This includes learning from good practice as well as from when care goes wrong.

'Learning from Excellence' recognises that despite system complexity, human factors and a large number of variables, most of the time care is satisfactory and outcomes are good. The benefits go beyond improving staff morale through recognition; there is value in understanding and replicating the key ingredients to success in order to improve consistency and reliability of systems for safe delivery of care. There needs to be a cultural shift towards identifying and sharing the good practice, not with the primary motivation of recognition, reward and praise, but for the purposes of improving the HSC system (which is reward in itself).

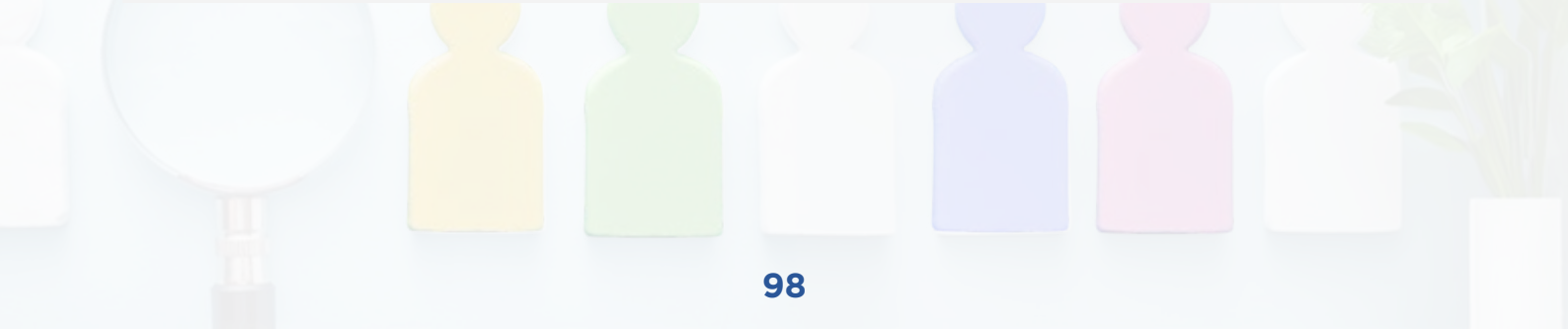
When care goes wrong we must also learn. If we do not learn, then we will not improve. We must also be assured that what we have learnt has been used to drive improvements, and that these improvements have had the desired impact on patient safety.

> "It is a learning process and if we don't do learning we are never going to move on... If you make a mistake, and you ignore that mistake... then you're only going to keep making the same mistake, time and time again..."
>
> Norma Sparkes, Mother of Stephen Sparkes

Despite the myriad ways in which learning can now be shared, this has become increasingly challenging in our complex, highly pressured and busy HSC system. It is incumbent upon the HSC system to ensure that when incidents and complaints have been investigated and reviewed, be it through HSC Trust processes or external processes, that the learning is embedded to make clinical practice, systems and processes safer for patients going forward.

This requires moving beyond a 'tick box approach' to sharing learning and being very intentional in how we get the key safety messages shared so that they are not forgotten and enter into the collective consciousness of 'how we do things around here'.

> "The implementation process must become a seamless part of the [learning] process. Nothing should be signed off [as implemented] until physical verification of the implementation of change has been carried out."
>
> Expert by Experience



20.7 Good Practice in Sharing Learning from Incidents and Complaints

Robust communication plans ensure that learning is shared with staff by a variety of means, appropriate to the specific service, such as:

- Team meetings and huddles;
- Governance meetings;
- Staff training and education sessions and events;
- Written information: leaflets, posters, letters, emails;
- Videos, podcasts, infographics.

Where relevant, learning is embedded within education programmes, staff guidance, QI initiatives.

Red Flag Behaviours

1. Failure to implement improvement plans or recommendations;

2. Failure to check implementation;

3. Recurring serious adverse incidents due to failure to implement learning;

4. Poor corporate memory in relation to previous learning.

Domain 3: Underpinning standards, legislation and best practice guidance

- DoH Quality Standards 2006;
- Public Interest Disclosure (NI) Order 1998;
- NIAO Good Practice in Raising Concerns;
- NIPSO HSC Model Complaints Handling Procedure;
- CQC Best Practice Guidance;
- NICE Guidance – Practical Steps to Improving Quality of Care.

Conclusion

Being Human: A Framework for Safety Culture within Health and Social Care sets out what a good safety culture looks like within HSC in Northern Ireland. It defines safety culture as one that is 'Safe and Compassionate', 'Just and Open', and 'Continually Learning and Improving'.

Recognising that culture, shaped by values, attitudes and beliefs, is characterised by the complexity of human interactions and behaviours, 'Being Human' delineates a shift away from rigid process-driven, 'tick box' approaches to Health and Social Care. Instead it focuses on our shared humanity and embedding a relational person-centred ethos at all levels of HSC; understanding that authentic human connection, and the relationships we have with each other as patients, family members, HSC staff, and leaders, are our greatest asset to ensuring a safe high-quality HSC system.

It identifies compassionate leadership as fundamental to all other aspects of safety culture. When HSC senior leaders authentically exhibit and role model the behaviours of active listening, empathising, understanding and responding with meaningful action, we foster organisational cultures that embody HSC values and remain true to the founding principles of HSC, fulfilling a 'duty of quality' to patients and 'duty of care' to staff.

There is an intrinsic link between staff wellbeing and patient safety that must be recognised and continually nurtured. With its antecedent arising from the voices of those who have experienced healthcare-related harm, the Framework sets out the requirements for 'compassion, civility and respect' to be embedded within the HSC system, not just for patients and their families, but for HSC staff.

Respect necessitates listening and acting. Patients and families need to be heard and where concerns are raised, feedback should be provided on system learning and improvement; even better, when patients and families can be involved in making those improvements.

Staff need to feel confident that they will be listened to, as well as supported and protected from unfair treatment, should they 'put their heads above the parapet' and raise concerns about safety. The staff voice needs to be recognised and celebrated as HSC's most powerful resource in preventing harm to patients.

By listening, hearing and acting in response to staff, patient and family voices, HSC organisations can take preventative and early action to address issues with staff and patient safety. Where staff and patients are afforded psychological safety, high-quality care will be protected and flourish.

Unfortunately, care will not always go according to plan and it is inevitable that some people will experience poor outcomes. As we strive to reduce avoidable harm, it is incumbent upon all of us as individuals, to demonstrate accountability by owning our actions, being open and honest, learning from mistakes and contributing positively to system learning and improvement.

It is equally incumbent upon HSC organisations to foster a just, open and learning culture in the understanding that most of the time safety incidents occur, not as a result of deliberate negligence or wrongdoing, but as a result of an interplay between system and human factors.

Blaming and punishing staff for mistakes does not improve patient safety but rather leads to defensiveness, secrecy, and compounded harm; patients and families do not receive the answers they need to move forward, and neither does the HSC system.

Evidencing a just and open culture is crucial to lessening fear and defensiveness within the HSC system. In the absence of fear and defensiveness, early apology, openness and honesty, restorative action and learning, is more likely to be forthcoming in order to support healing and recovery for all individuals impacted; patients, victims, their families and HSC staff.

A just culture is essential for an open culture; and an open culture is a pre-requisite for a learning culture. Continuous learning and improvement, also require curiosity, constructive challenge, time and space for reflection, at every level of the HSC system; particularly at senior levels, where consideration should be given to how to scale up and spread good practice, as well as how to address poor practice, and do things differently.

Recognising that 'culture comes from the top', the Framework will be of particular benefit to HSC Trust Boards, and newly established Patient Safety and Quality Committees, as they determine how best to improve and assure safety for staff, patients and the public. It is not a one-off and standalone piece of work, but rather the continuation of an onward journey.

In the short-to-medium term, further work is required to develop the tools, guidance and adjuncts necessary to facilitate Framework implementation and evaluation. In the longer term, it will require whole-system adoption in order to maximise safety culture within all aspects of Health and Social Care.

Meanwhile, the Framework should be harnessed and utilised to shift mindsets, influence behaviours and define the actions required to embed a 'safe and compassionate', 'Just and Open', and, 'Continually Learning and Improving' culture within HSC.

Glossary of Terms

Term	Description
Agency Worker	A HSC agency worker is someone employed by an employment agency who provides temporary or interim staff to HSC organisation. The agency worker's contract is with the agency, not directly with the HSC trust they are working for.
Burn Out	Burnout is emotional, mental and physical exhaustion which arises from prolonged period of stress.
Candour	Being open and honest when care goes wrong.
Constructive Challenge	Constructive challenge refers to the practice of asking questions and offering feedback in a way that is designed to improve decision-making, performance, and overall quality of care, while maintaining a positive and collaborative environment. It is a vital aspect of good governance and leadership, particularly within Boards and committees.
Continuing Professional Development (CPD)	Continuing Professional Development (CPD) refers to the process of maintaining and enhancing the knowledge, skills, and experience necessary for professional practice.
Co-production	A way of working where people who use services, carers, and professionals collaborate as equal partners in designing, delivering, and evaluating services. It emphasises shared decision-making and recognises that individuals with lived experience possess valuable expertise that should be integrated into the process.
Coroner Investigations	Coroners are independent judicial officers who investigate deaths reported to them. They will make whatever inquiries are necessary to find out the cause of death, this includes ordering a post-mortem examination, obtaining witness statements and medical records, or holding an inquest.
Department of Health (DOH)	The Department of Health (DoH) is responsible for health and social care, public health and public safety in Northern Ireland. It has a mission to improve the health and social wellbeing of the people of Northern Ireland.
Diversity	Diversity refers to the presence of a variety of people from different backgrounds, experiences, and characteristics within a workforce or service user group. It encompasses a broad range of factors, including age, gender, ethnicity, race, religion, sexual orientation, disability, and socioeconomic background.
Duty of Quality	The 'Health and Personal Social Services (Quality, Improvement and Regulation) (Northern Ireland) Order 2003[1] applied a statutory duty of quality on the HSC Board and Trusts. This means that each organisation has a legal responsibility to ensure that the care it provides must meet a required standard.

Term	Description
Experts by Experience	An expert by experience, has gained their expertise through Lived Experience.
Evidence-based practice	Evidence-based practice is the conscientious and judicious use of current best evidence in conjunction with clinical expertise and patient values to guide health care decisions.
Framework	A framework in healthcare refers to structured approaches or models that guide the delivery and improvement of healthcare services.
Group-think	A psychological phenomenon in which people strive for consensus within a group. In many cases, people will set aside their own personal beliefs or adopt the opinions of the rest of the group.
Governance	A system through which Health and Social Care organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care.
Health and Social Care (HSC)	Services available from health and social care providers across a variety of settings, including hospitals, care homes, agencies and community settings.
Health and Social Care (HSC) Trusts	Collective reference to all six HSC Trusts: · Northern HSC Trust · Belfast HSC Trust · Southern HSC Trust · South Eastern HSC Trust · Western HSC Trust · Northern Ireland Ambulance Service (NIAS)
Health Inequalities	Health inequalities refer to systematic and avoidable differences in health status between different population groups. These differences are linked to social, economic, and environmental disadvantages, meaning that some groups of people experience poorer health outcomes than others due to circumstances beyond their control.
Human Factors	Human factors, also known as ergonomics, is a scientific discipline focused on understanding the interactions between humans and other elements of a system.
Human Resources (HR)	Human Resources (HR) encompasses the management and support of staff. This involves a wide range of activities, from recruitment and training to implementing employment policies and fostering a positive work environment.
Informed Consent	Informed consent, means a patient agrees to a medical treatment, test, or examination after being fully informed about its benefits, risks, and potential alternatives.
Locum Personnel	Locum staff are individuals who temporarily fill a vacant position or shift.

Term	Description
Martha's Rule	Martha's Rule, implemented in England and Wales in April 2024, enables staff, patients and their families to seek an independent medical review if they feel their concerns about a patient's care are not being adequately addressed.
Moral Distress	Occurs when Health and Social Care professionals experience psychological unease due to constraints that prevent them from acting in accordance with their ethical values and beliefs.
Moral Injury	Psychological harm experienced by Health and Social Care professionals when their actions, or inactions, conflict with their moral or ethical code.
Multi-agency Approach	A multi-agency approach in the NHS involves different services working together to improve outcomes for individuals, particularly those with complex needs or those requiring safeguarding. This collaborative effort aims to pool resources, expertise, and information to provide a more co-ordinated and effective response.
Multi-disciplinary Approach	Involves professionals from various disciplines working together within a single organisation or team to provide comprehensive care to patients.
Never Events	In HSC (Health and Social Care), a "Never Event" is a serious, largely preventable patient safety incident that should not occur if existing national guidelines and safety recommendations are followed. These events are considered preventable because strong, systemic barriers should be in place to prevent them.
NICE	National Institute for Health and Care Excellence. Produces evidence-based guidance for the NHS and wider health and social care system.
Non-Executive Directors	Non-executive directors work alongside other non-executives and executive directors as an equal member of the HSC Trust Board. They share responsibility with the other directors for the decisions made by the board and for success of the organisation in leading the local improvement of healthcare services for patients.
Northern Ireland Public Services Ombudsman	Investigate unresolved complaints about public bodies in Northern Ireland. Investigations check to see if a public body acted properly or whether someone was treated unfairly. When things go wrong they suggest what can be done to put things right.
Patient	The Department of Health acknowledges that the HSC system utilises a range of terminology for individuals using services. While not exhaustive, it includes terminology such as service recipient, client, individuals who receive social work/social care support and/or service users. For the purpose of this document, it was agreed that the term 'patient' would be used throughout recognising that it is an umbrella term for an individual in receipt of Health and Social Care Services.

Term	Description
Patient Client Council	The Patient Client Council (PCC) is a statutory body which provides an independent voice for the public on health and social care issues across Northern Ireland.
Patient Safety Culture	The extent to which an organisation's culture supports and promotes patient safety. A safety culture within HSC is one that is that is safe and compassionate for patients and staff, just and open, and continually learning and improving.
Person Centred Care	Working in partnership with patients to meet their medical, psychological and social needs. It can be described as personalised, co-ordinated and enabling, and involves treating patients with dignity, compassion, and respect.
Primary Care	Primary care services provide the first point of contact in the healthcare system, acting as the 'front door' of the NHS. Primary care includes general practice, community pharmacy, dental, and optometry (eye health) services.
Professional Regulators	Professional Regulators, such as the General Medical Council and Nursing and Midwifery Council, provide oversight and certification to specified regulated occupations. Professional regulators have a duty to regulate their professions in the public interest, which may not necessarily reflect the interests of their registered professionals.
Psychological Safety	Staff feel safe to ask questions and learn, safe to discuss ideas on how to improve, and safe to communicate and raise concerns so that patients and staff can be safeguarded from harm. Patients and families, are empowered, supported and enabled to raise concerns about care and treatment, to have their voices listened to so that the HSC system can learn and improve.
Public Inquiry	An official investigation established by a government minister, under the Inquiries Ac 2005[1] to examine matters of public concern regarding specific events or actions. These inquiries are conducted by an independent body and aim to provide transparency and accountability in addressing significant issues that affect the public.
Quality Management System (QMS)	An approach to quality management that integrates quality planning, quality control, and quality improvement activities across the organisation, supported by leadership practices that foster a culture of learning.
Regulation and Quality Improvement Authority (RQIA)	Regulation and Quality Improvement Authority (RQIA) is the independent body responsible for monitoring and inspecting the availability and quality of health and social care services in Northern Ireland, and encouraging improvements in the quality of those services.
Safe Staffing	Ensuring there are enough qualified, skilled and experienced people, who receive effective support, supervision and development to work together effectively to provide safe, effective care.

Term	Description
Safety Management Systems	A Safety Management System (SMS) is a proactive and integrated approach to managing safety. It sets out the necessary organisational structures and accountabilities to ensure that safety is integrated into an organisation's day-to-day activities. SMS incorporates four broad areas: Safety Policy; Safety Risk Management; Safety Assurance; Safety Promotion.
SBAR (Situation-Background-Assessment-Recommendation)	SBAR is an acronym that stands for Situation, Background, Assessment, and Recommendation. It's a structured communication tool used to convey critical information, especially in healthcare settings, to ensure clear and concise communication between professionals. The SBAR framework helps to standardise communication and improve patient safety by providing a consistent way to share information and escalate concerns.
Secondary Care	Secondary care is specialised medical care typically provided by Health and Social Care professionals upon referral from a primary care provider. It encompasses diagnostic, therapeutic, and surgical procedures delivered by specialists in hospitals or specialised clinics.
Second Opinion	When a service user chooses to see another healthcare professional, typically a doctor or specialist, after being given a diagnosis or treatment plan for a medical condition.
Senior Leadership Team	Is a group of senior managers who lead the strategic direction and operational management of the HSC in Northern Ireland. This team, often including a Chief Executive and Directors, is responsible for various aspects of the HSC, including setting priorities, monitoring performance, and ensuring effective service delivery.
Service Users	Service Users - individuals who receive care or services across a range of HSC services and settings.
Shared Decision Making	Health and Social Care professionals and patients working in partnership to make informed decisions about treatment and care. NICE guidance on Shared Decision Making promotes patient-centred care, ensuring that individual preferences, beliefs, and values are considered in the decision-making process.
Strategic Planning and Performance Group (SPPG)	The Strategic Planning and Performance Group plans and oversees the delivery of HSC services for the population of Northern Ireland. The Group is part of the Department of Health and is accountable to the Minister for Health. It is responsible for planning, improving and overseeing the delivery of effective, high quality, safe HSC services within available resources.
System Partner/s	A range of HSC organisations, agencies and registered providers, collaboratively delivering HSC care.
Trauma Informed Practice	A model that acknowledges the impact of trauma. It guides how healthcare and social care professionals engage with those affected. It considers the prevalence and impact of trauma. This approach adapts the delivery of care to support healing and avoid re-traumatisation.

Term	Description
Trust Board	A Trust Board functions as the corporate decision-making body. It has Executive and Non-Executive members who are full and equal members. Their role is to provide effective leadership, strategic direction and management of the Trust's activities. It is accountable, through the chairman, to the Permanent Secretary at the Department of Health Social Services and Public Safety, and ultimately to the Minister for Health.
Unwarranted Variation	Variation in care quality and safety that cannot be explained by patient need or preference. It can be due to inconsistencies in service planning, design and delivery, workforce issues and variations in clinical practice.
Whistleblowing	A term used to describe a situation where a worker raises concerns about wrongdoing in the workplace. Also referred to as 'raising concerns in the public interest' or 'making a protected disclosure'.

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