Quality and Safety Summit 2026 - summary of discussions and proposed actions

Analysis of Session 1

Key Overarching Message

Participants consistently emphasised that lasting improvement will not come from new processes alone. Success depends on creating a culture that promotes **openness, learning, curiosity, accountability, and psychological safety**, where staff, patients, and families can speak up without fear and where concerns are acted upon promptly.

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1. Culture and Psychological Safety

Culture emerged as the most important theme throughout the discussions. Participants highlighted the need to:

- Move away from fear-based and compliance-driven approaches.
- Encourage openness, honesty, and constructive challenge.
- Create environments where staff feel safe to raise concerns and challenge poor practice.
- Value whistleblowing as a contribution to learning and patient safety rather than something negative.
- Embed compassion, inclusion, curiosity, and strong leadership throughout organisations.
- Ensure patient safety becomes an intrinsic part of care rather than a separate governance function.

There was recognition that many inquiry findings reflected cultural problems rather than procedural failures, including closed cultures, defensiveness, and a failure to listen to concerns. Participants stressed that culture is shaped from the top but must also be built from the bottom up.

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2. Governance and Board Effectiveness

A major focus was the effectiveness of Boards and governance arrangements. Key concerns included:

- Boards receiving large volumes of information but lacking sufficient time for detailed scrutiny.
- Non-Executive Directors (NEDs) requiring clearer roles, enhanced training, support, and development.
- The need for governance systems that support learning and improvement rather than bureaucracy.
- Recognition that quality and safety should run through all Board business and not be treated as standalone issues.
- The importance of creating time for reflection, challenge, and informed decision-making.

Participants also suggested more direct engagement by NEDs with frontline services to gain a realistic understanding of what is happening "on the ground."

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3. Data, Intelligence and Assurance

There was widespread agreement that organisations already possess significant amounts of data but often struggle to turn it into meaningful intelligence. Key messages included:

- Data quality, interpretation, analysis, and triangulation are more important than data volume.
- Boards require meaningful insight rather than excessive reporting.
- Quality and safety indicators should be prioritised alongside activity and performance data.
- Patient, family, and staff experiences should be considered alongside quantitative metrics.
- Better systems are needed to identify trends, outliers, risks, and warning signs.
- AI and new technologies could support earlier identification of emerging risks and "sentinel indicators."

Participants repeatedly cautioned against over-reliance on dashboards and crude metrics as measures of organisational health.

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4. Patient, Family and Staff Voice

A strong theme was that inquiry reports often reflected failures to listen.

Participants emphasised:

- Embedding patient and service-user voices within governance arrangements.

- Creating clear feedback and escalation routes.
- Improving engagement with patients and families.
- Ensuring concerns are acknowledged and addressed before they become formal complaints.
- Listening more actively to frontline staff.
- Using complaints, incidents, and patient experience data as sources of learning rather than threats.

There was a recognition that people frequently felt ignored or not heard, and that rebuilding trust requires genuine engagement and visible responses to feedback.

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5. Learning, Improvement and Curiosity

Participants advocated for a more inquisitive and learning-focused system by:

- Embedding professional curiosity and appreciative inquiry.
- Understanding why failures occur rather than simply identifying non-compliance.
- Focusing on root causes rather than individual blame.
- Using a case-finding approach to identify risks and outliers proactively.
- Learning from high-performing services across Northern Ireland and elsewhere.
- Linking recommendations across multiple inquiry reports into a coordinated programme of improvement.

There was concern that organisations often respond reactively when crises arise rather than addressing underlying causes.

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6. Leadership and Accountability

Leadership was viewed as critical to change. Discussions highlighted the need for leaders to:

- Demonstrate humility and openness to criticism.
- Encourage challenge and learning.
- Model desired behaviours.
- Support staff to raise concerns safely.
- Promote transparency and honest communication.
- Balance accountability with a learning culture.

Participants stressed that accountability remains important but should not create a culture of fear or defensiveness.

Accountability needs to be fair and appropriate, ensuring that individuals are held responsible in a consistent, proportionate, and supportive manner that reflects their role, actions, and the context in which decisions were made.

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7. Rebuilding Public Trust

Rebuilding public confidence was identified as a significant challenge following recent inquiries. Suggested actions included:

- Being transparent about lessons learned and improvements made.
- Demonstrating visible leadership.
- Communicating both successes and areas requiring improvement.
- Involving patients, communities, and representative organisations from the outset.
- Creating a more open relationship with the public and media.

Participants felt that trust would only be restored through sustained improvements in culture, governance, and patient safety.

Overall Conclusion

The workshop concluded that the key lessons from recent inquiries are not primarily about creating more policies, committees, or reporting requirements. Instead, they point to the need for:

1. Stronger organisational cultures built on openness, curiosity, and psychological safety.
2. More effective governance and Board oversight.
3. Better use of data, intelligence, and lived experience to identify risks.
4. Greater emphasis on listening to patients, families, and staff.
5. Leadership that prioritises learning, transparency, and accountability.
6. A coordinated system-wide approach to implementing inquiry recommendations and rebuilding public trust.

The dominant message across all discussions was that **culture is the foundation of patient safety, quality improvement, and effective governance**, and that meaningful change requires both systemic reform and behavioural change at every level of the organisation.

Analysis of Session 2

Summary of Discussions

The discussions focused on how lessons from recent inquiries can be translated into sustainable improvements in quality, safety and governance across Health and Social Care. There was strong consensus that meaningful change will depend less on introducing new processes and more on creating a culture of openness, curiosity, accountability and psychological safety. Staff, patients and families must feel confident to raise concerns, while Boards must become more visible, inquisitive and effective in their challenge and scrutiny roles.

Participants highlighted the need to strengthen Trust Board capability, clarify roles and responsibilities, improve leadership development, and ensure quality and safety receive equal prominence alongside financial performance. Better use of data and intelligence was seen as essential, with greater emphasis on triangulating information from multiple sources, including patient stories, staff experience and complaints data.

There was widespread support for a regional approach to sharing learning, benchmarking performance and implementing inquiry recommendations consistently. Participants also stressed the importance of visible leadership, patient and family involvement, workforce development, and maintaining long-term focus on implementation rather than introducing additional frameworks that are not sustained.

Overall Priority

The key message from the discussions is that **stronger culture, visible leadership, better use of intelligence, meaningful patient involvement and effective Board oversight must be pursued together through a coordinated regional approach if sustainable improvements in quality and safety are to be achieved.**

Proposed Actions

Short-Term Actions (0–12 months)

Culture and Leadership

- Issue clear leadership messages prioritising patient safety, openness and listening.
- Increase visibility of Chairs, Chief Executives and Board members across services.
- Establish psychologically safe mechanisms for staff and patients to raise concerns.
- Promote and celebrate good practice to reinforce positive culture.

Governance and Boards

- Conduct Board skills, capacity and training needs assessments.
- Review Board structures, Non-Executive Director capacity and committee arrangements.
- Baseline current governance arrangements against new Patient Safety and Quality Committee requirements.
- Consider co-opting expertise to address immediate Board capability gaps.

Data and Assurance

- Complete Trust-wide baseline assessments of quality and safety metrics.
- Develop standardised tools and guidance for data interrogation and reporting.
- Review assurance frameworks, risk registers and escalation processes.
- Identify high-risk services and establish enhanced monitoring arrangements.
- Improve early response mechanisms for complaints and concerns.

Learning and Collaboration

- Undertake organisational gap analyses against inquiry recommendations.
- Share learning and best practice across Trusts.
- Begin regional benchmarking of governance, patient safety and quality arrangements.

- Explore opportunities for greater collaboration among clinical governance teams.

Medium-Term Actions (1–3 years)

Board Development and Capability

- Implement structured leadership and development programmes for Board members.
- Introduce quality improvement, clinical governance and data literacy training.
- Review recruitment and selection processes for Board and senior leadership roles.
- Strengthen regional peer learning and collaboration between Boards.

Culture and Engagement

- Embed Being Open and Being Human principles in organisational practice.
- Improve engagement with patients, families and people with lived experience.
- Develop more effective staff engagement and feedback mechanisms.
- Introduce structured approaches for capturing and sharing patient and family stories.

Intelligence and Improvement

- Standardise regional data definitions, collection methods and reporting.
- Improve the use of intelligence through triangulation of complaints, incidents, patient feedback and workforce data.
- Explore AI and analytical tools to support risk identification and assurance.
- Establish regional learning repositories and mechanisms for sharing improvement activity.

Regional Working

- Increase transparency through public reporting of progress against inquiry recommendations.
- Strengthen collaboration between Trusts, ALBs, PCC, RQIA and other partners.

- Review patient engagement and advocacy arrangements to improve consistency.

Long-Term Actions (3–5 years+)

Cultural Transformation

- Achieve a system-wide culture where speaking up, learning and improvement are routine.
- Ensure staff feel valued, empowered and psychologically safe.
- Transition from compliance-based assurance to learning-focused governance.

Governance and Accountability

- Fully establish and embed Patient Safety and Quality Committees.
- Create robust independent assurance arrangements for Trust Boards.
- Maintain clear accountability while balancing learning and performance management.
- Review and modernise public appointment arrangements for HSC Boards where required.

Data and Intelligence

- Create a mature regional intelligence system that converts data into actionable insight.
- Improve integration and availability of health and social care data.
- Develop sophisticated benchmarking, predictive analytics and risk identification capabilities.
- Ensure Board information supports proactive challenge and decision-making.

Sustainability and Public Trust

- Build a sustainable workforce with the right skills, capacity and values.
- Embed co-production and a "people as partners" approach throughout services.
- Rebuild and sustain public confidence through transparency, engagement and demonstrable improvement.
- Establish a continuous cycle of learning, implementation and review across the whole HSC system.