RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

SIRAN
SAFETY INCIDENT RESPONSE ACCREDITATION NETWORK

2023

2nd Aggregated Report

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FOREWORD

This is the second report produced by the Safety Incident Response Accreditation Network (SIRAN), previously named Serious Incident Review Accreditation Network, since it was established in 2020. SIRAN is a growing and developing network, and we are delighted that there is now membership across all of the devolved nations. It is a unique process looking at organisations' internal processes concerning serious incidents, and aims to support and drive the improvement of the quality of patient safety investigations. SIRAN will continue to reflect changes associated with the Patient Safety Incident Response Framework (PSIRF) where relevant and will continue to support our members in ensuring patient safety standards are of high quality.

It continues to be an honour to work with professionals and experts in patient safety from across all of the devolved nations, and to learn and share experiences about the approaches that have been used in the different areas. We would like to thank the organisations that were part of the initial pilot – we have learnt a lot from their contributions, and they have supported us in identifying improvements and in the promotion of the sharing of learning between organisations.

Organisations that are part of SIRAN have implemented significant improvements, and involvement with SIRAN has encouraged and supported organisations to think about the use of quality improvement to promote changes to their serious incident processes. Many organisations who were members of SIRAN and who were also implementing PSIRF found their involvement with SIRAN to be invaluable. Areas of improvement that we have seen within organisations include better links between action plans for individual investigations to the wider organisation improvement plans, and implementation of early learning tools. Organisations have also identified improvements that have ensured that their reviews feel more personal, for example including a pen portrait about the individual.

Over the last year, Liz has joined the accreditation committee as a carer representative. Hearing the patient and carer voices is an essential part of the process, as is ensuring that information about learning is shared with patients and families. During the review process, we hear from carers, as well as staff members, and ensure that their experience is consistent with the principles of openness and learning. Some years ago, Liz experienced a care home being closed shortly after a serious case review that she was a member of the panel for, which led to concerns that there would be defensiveness, fear, and that communication with families would be so strained that any answers they received would be hard to come by, with learnings from an event becoming just as difficult to achieve. However, it is pleasing to see that things clearly have moved on since then and there has been no sign in the reviews of these concerns being realised.

Liz's role during the peer review process is about ensuring not only that the voices of carers are heard, but that they have confidence they have been heard. How do you sensitively gather the vital feedback that is necessary for real learning to be achieved whilst also minimising the risk of putting family/carers through even greater hurt? Getting the process right is crucial, but there is also an extra element that is more intuitive. How might it feel to be a carer who has been asked to provide feedback? What is the process, how flexible is it? What support is there for carers, are they kept updated? Is there a culture that invites open conversation in challenging circumstances? From a family perspective, it was reassuring to hear about organisations where there was a person assigned to be a single point of contact who came across as warm, competent, approachable, and caring. Having someone with those qualities in that role in every organisation would make a huge difference to the carers. It is a huge ask to get this process right, and we can only continue to do our best and carry on learning from each and every experience.

We hope that over the next year more organisations will be able to join the SIRAN network and that they will be able to share and develop together as the work to improve learning from patient safety events continues at pace.

We would like to take this opportunity to thank all of the organisations that have been involved in this work and are a part of this report. Their open and honest approach has led to valuable learning opportunities across different organisations to facilitate improvement.

Elena Baker-Glenn, Consultant Psychiatrist and SIRAN Accreditation Committee Chair and Liz Rye, Carer Representative, SIRAN

WHO WE ARE AND WHAT WE DO

Who we are

The Safety Incident Response Accreditation Network (SIRAN), previously named Serious Incident Review Accreditation Network, was established in 2020 to promote quality improvement within and between organisations conducting serious incident investigations. It is one of 28 quality networks, accreditation and audit programmes organised by the Royal College of Psychiatrists' Centre for Quality Improvement.

What we do

We adopt a multi-disciplinary approach to quality improvement within patient safety and review processes.

Our comprehensive peer review process allows for a two-fold outcome. Firstly, through a culture of openness and enquiry we serve to identify areas for improvement. Secondly, through discussions led by managers, SI reviewers, and staff affected by incidents, we highlight areas of achievement. Overall, the model is one of mutual support and learning rather than inspection.

Another key component of the network is the facilitation of sharing of ideas and best practice across member organisations. This is accomplished through peer reviews, as well as various webinars and events held throughout the year.

Our Standards

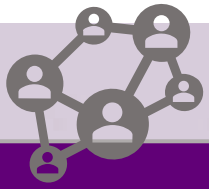
We published the 3rd Edition of Standards for Serious Incident Reviews in January 2022.

A consultation was held with key stakeholders and member organisations that took part in the pilot year (2020 – 2021). The aim was to assess the appropriateness of the standards and identify any areas that needed improvements. The standards can be found on our website.

Our Accreditation Committee

SIRAN is governed by a multi-disciplinary group of professionals who represent key interests and areas of expertise in the field of patient safety, as well as a carer representative who has lived experience dealing with and being affected by serious incidents. A list of the accreditation committee members can be found in Appendix 2.

MEMBERSHIP BENEFITS



Review and network with other organisations conducting serious incident reviews

Receive a detailed service report with bespoke recommendations for further developments

Benchmark your practices with other similar services and share ideas in line with good practice

Involvement in the development of nationally agreed standards for patient safety and incident reviews

Free attendance at SIRAN online events and training

THE REVIEW PROCESS

Annual Review Cycle

The peer review process consists of **two phases**:

- The completion of a **self-review** assessment
- The external **peer review** day

Self-Review

Organisations complete a workbook which includes a self-rated score and comment against each standard and any accompanying evidence. Questionnaires are distributed to managers, SI reviewers, and staff members.

The self-review process is an opportunity for organisations to score themselves and provide commentary against each of the standards for safety incident responses and reviews. Organisations are able to identify whether they have met or not met specific standards and reflect on their own challenges and achievements.

Peer Review

A visiting multi-disciplinary peer review team meets with those working in the organisation (including managers, reviewers and staff members) to validate the information provided at the self-review stage. The service receives feedback on the preliminary findings at the end of the review, drawing on achievements and areas for improvement.

The peer review process allows for greater discussion on aspects of the service and provides an opportunity to learn from each other in a way that might not be possible in a visit by an inspectorate.

Organisational Level Report

The data that is collected from the peer review is recorded in an organisational level report, which summarises the areas of good practice and areas in need of improvement.

The reports are comprehensive and provide a clear overview of how organisations have performed overall against the standards for serious incident reviews. If standards are not met, the report contains recommendations as to how they can work on and evidence these areas.

Following receipt of the report, organisations are given one month to make any changes and provide further evidence before being presented to the *Accreditation Committee (AC)* for consideration.

Accreditation

Using organisational level reports and any further evidence provided, the AC will provide the service with one of three outcomes:

1. Accredited
2. Deferred
3. Not Accredited

The AC can defer organisations up to two times. As a result, organisations have multiple opportunities to make changes and collect further evidence for the AC. Throughout the process, the network provides organisations with time, support, and guidance to help them reach accreditation.

Events

In 2022, we held a special interest day focusing on the importance of the Family Liaison Officer (FLO) role in mental health organisations. We hosted some excellent presentations from Southern Health NHS Foundation Trust, the not-for-profit Making Families Count and the RCPsych Patient Safety Group.

In 2023, we hosted an in-person event on 'putting safety at the center of quality' which covered a range of presentations and workshops focusing on various aspects of patient safety within both community and inpatient mental health services.

Peer Reviewer Training

We host multiple peer reviewer training sessions every year to train staff from member organisations to become part of the review panel during peer reviews.

Qualifying as a peer reviewer will allow staff to:

- Gain useful experience and knowledge of how the SIRAN peer review visits are managed and run.
- Network with other organisations and share good practice.
- Develop deeper insight into the experiences of staff, SI reviewers, patients and families.

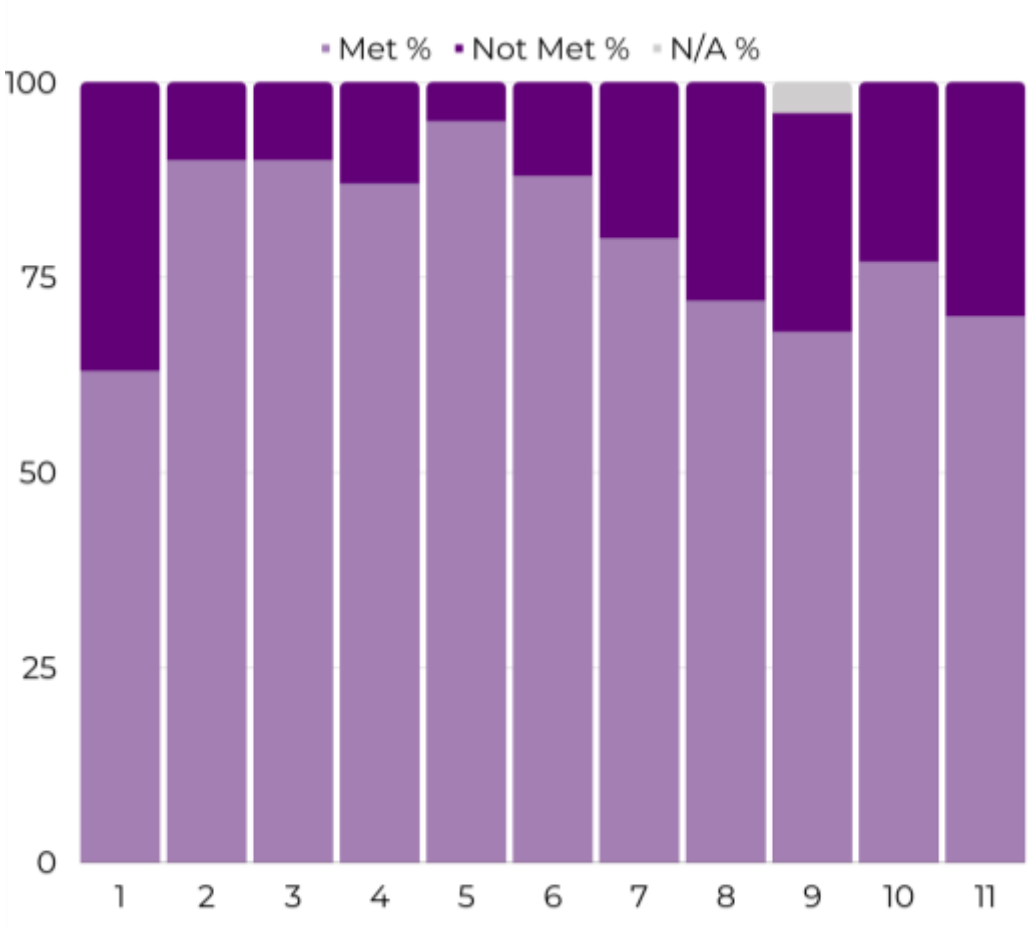
INTRODUCTION

This report uses the data collected from member services who completed their peer review from January 2020 to January 2023 against the **Safety Incident Response Accreditation Network (SIRAN) Standards.**

Overall, 12 mental health organisations took part in this peer review cycle during this time period and data used in this report has been gathered from these services. Data is anonymised per organisation using a randomly assigned service code. A list of members can be found in Appendix 1.

Key findings

On average, member organisations fully complied with **80% of standards** for patient safety and incident reviews at the point of their peer review prior to being awarded accreditation. The table below demonstrates the average compliance of the participating organisations.



Organisational Processes

This section considers what processes are in place to investigate serious incidents. Performance in this section was high with organisations meeting an **average of 91% of the standards**.

Higher scored standards

Organisations have robust organisational processes in place for reporting serious incidents. These are formalised into policies and used in practice through incident reporting systems. Moreover, in the majority of organisations, board members regularly receive a report relating to serious incident reviews.

Lower scored standards

However, many local policies do not include a section that clearly addresses the mechanisms of accountability for reviewers. This includes a mechanism that ensures families or staff have the right to complain or challenge the process, should any issue arise within the review process.

Good Practice Examples

Southern Health and Social Care Trust

The organisation became aware that their SI reviews were taking a long period of time to complete. This meant that sharing lessons learned was often delayed. As a result, they have implemented a new structured **early learning tool** to identify any potential learning early on.

Leicestershire Partnership NHS Trust

There has been a shift within the organisation from assigning smaller individual actions and dealing with them separately to considering **wider quality improvement initiatives**. For example, there are now separate processes followed with incidents that are part of a frequently occurring theme, such as Covid-19 or pressure-ulcer related incidents.

South London and Maudsley NHS Foundation Trust

The organisation implemented **clinical governance safety huddles** and **a safety committee.** The Trust is also trialling thematic reviews, where each Directorate analyses **emerging themes**, and considers **Trust-wide improvements**. The organisation further participates in a Learning Forum, which is an opportunity for all providers across London to get together and share learning.

Incident Review Processes

This section analyses the incident processes themselves and how incident reviews are led by the investigative team. Organisations met an **average of 88% of the standards**.

Higher scored standards

Overall, services scored relatively high on incident review processes. In particular, organisations ensure that reviews are led by people independent of the treating team and who have relevant experience, expertise or training to conduct reviews.

Lower scored standards

Nevertheless, organisations have difficulties meeting locally agreed timescales for individual reviews. Moreover, organisations are not always able to make available a reviewer to the incident review panel that has service-specific knowledge.

Good Practice Examples

Birmingham and Solihull Mental Health NHS Foundation Trust

The Trust has a centralised SI reviewer team, all of whom completed RCA training. As a result, they provide a consistent approach to conducting reviews and writing reports. They work closely together, holding team meetings to discuss terms of reference and compile reports collaboratively.

South West Yorkshire Partnership NHS Foundation Trust

The Trust ensures all reviews are undertaken by trained medical reviewers who have an allocated weekly session dedicated to undertaking SI reviews. The Trust can also access trained bank reviewers to ensure extra capacity when needed.

North East London NHS Foundation Trust

The Trust has a dedicated team of Investigative Officers (IO), which allows for a small group to develop expertise in conducting reviews. The Trust also allocates reviews to the most appropriate IO depending on expertise

Norfolk and Suffolk NHS Foundation Trust

The Trust recently introduced a Forum for the discussion and agreement of the terms of reference for serious incident reviews. The panel is confident that, as the forum develops, it will help ensure that clinical staff involved in incidents have the opportunity to learn of and influence the terms of reference of a review at an early stage.

Reports

This section focuses on the content of reports drafted by review teams following a serious incident.

Organisations met an **average of 75% of the standards**.

Higher scored standards

Organisations produce well-structured reports that clearly state the name and role of each reviewer. Moreover, potential learning is evident within the reports and reviewers regularly create improvement or action plans to implement any recommendations identified.

Lower scored standards

Most reports do not include any glossaries to explain abbreviations used. There is often no reference to any other reviews related to the incident, or any incidental findings. Lastly, most recommendations do not refer to existing action plans or wider quality priorities identified by the organisation.

Good Practice Examples

Central and North West London NHS Foundation Trust

The reports reviewed contained helpful explanations of clinical services and a glossary of terms.

Berkshire Healthcare NHS Foundation Trust

The sample of reports provided contained a good example of a pen portrait describing the patient, which suggested that the patient's family had been closely involved and had contributed to the report.

South London and Maudsley NHS Foundation Trust

The Trust has been considering how to humanise the SI reviews and reports through trialling pen portraits. Pen portraits are informal descriptions about a person that passed away, providing information such as what they did, hobbies, what they meant to the family and similar. This is a very sensitive initiative which puts the person at the heart of the process.

Involvement of Clinical Staff

This section considers how clinical staff that have been affected by a serious incident were involved in the review process.

Organisations met an **average of 80% of the standards**.

Higher scored standards

Organisations get in touch with affected staff members at the outset of the review process. Moreover, they let staff know who is conducting the review, and they invite staff to contribute to the process. Lastly, staff are informed of the outcome of the review, and are treated respectfully and sensitively throughout.

Lower scored standards

Organisations struggle with making terms of reference available to staff members. Moreover, staff are not always informed of realistic timelines for the reviews or of any delays and the reason for them. Finally, staff are not always invited to meet with the review team to reflect on the quality of care provided.

Good Practice Examples

South London and Maudsley NHS Foundation Trust

The organisation have various support initiatives for staff members affected by an incident. For example, they have an automatic referral system in place, which sends out an employee referral to the support team as soon as staff members log a serious incident. Moreover, the organisation offers wellbeing sessions, staff counselling services, as well as Care First which is a 24/7 helpline for psychological and legal advice.

NHS Lanarkshire

There is a strong sense of collaboration and staff feel that reviews follow a supportive process, with plenty of access to supervision and peer support. There is also an emphasis on a 'no blame' and 'non-threatening' culture within the organisation with regards to the SI review processes.

South West Yorkshire Partnership NHS Foundation Trust

There is a very positive attitude around staff involvement in review processes. Staff are included in and kept informed of the progress of SI reviews. In particular, the three stages of meetings (set up meetings, post incident meetings and the learning events, in addition to individual staff interviews) appeared to be very helpful to staff.

Involvement of Patients and Families

This section looks at how patients and families affected by a serious incident are considered and treated throughout the incident review process.

Organisations met an **average of 76% of the standards**.

Higher scored standards

Services ensure that patients and families are contacted at the outset of a review process and are aware who is in charge of the investigation. In addition, when formulating the scope of the review, services consider the views of patients and families and invite them to contribute to the review process.

Lower scored standards

However, patients and families are not always invited to check the report for factual accuracy prior to publication. Moreover, patients and families are not consistently informed of delays within a reasonable time and do not receive enough opportunities to provide their feedback about the review process.

Good Practice Examples

Southern Health and Social Care Trust

The service introduced a Family Liaison Officer (FLO) which has been beneficial when working with families and patients. The FLO is their first point of contact, and offers telephone or face to face conversations. The organisation compliments these with letters with regular updates on the review progress. The FLO further tailors approaches depending on the family and the sensitivity of the issue. Initiatives include reading the report to families if they are struggling to get through it themselves and offering individual time to give support and guidance. Overall, communication with families is compassionate and holistic, and full consideration is given to the difficult experiences they may be facing.

The service also uses a checklist on engaging with families and patients, which is included at the of reports.

Southern Health NHS Foundation Trust

Family input is obtained from the outset and that the terms of reference are amended based on the family's recommendations. The review team also noted that they liked seeing a sentence in reports that acknowledges how the family have asked for the patient to be called in the report. The use of a patient/family leaflet to detail the investigation process is also commended.

COMMONLY UNMET STANDARDS

The following standards have been found to be commonly unmet across all organisations that were assessed as part of the peer review process. The aim of the accreditation process it to support organisations in meeting the required thresholds for type 1 and type 1 standards. Therefore, the data below has been collected at the peer review stage, rather than the final accreditation stage where a higher threshold of standards has been met.

Type	Standard	% Met
2	Recommendations refer to the organisation's existing action plans and quality priorities	18%
2	There is a process whereby patients and/or families involved can give feedback about the review process if they wish to.	27%
1	Staff and professional stakeholders involved in the patient's care are informed about any delays in a timely fashion and provided with the reasons for those delays.	28%
2	The report states whether there are, or have been, other reviews related to this incident.	46%
2	The locally agreed timescale for the individual reviews is adhered to.	55%
1	Patient and/or families are informed of delays in a timely fashion and provided with the reasons for them.	55%
1	Significant incidental findings lying outside of terms of reference are noted and acted upon.	55%
1	Patient and/or families are invited to check for factual accuracy prior to the publication of reports.	55%
2	Reports refer to existing organisational policies or relevant guidance.	64%
1	Staff and professional stakeholders involved in the patient's care are informed of a realistic timeline for a review.	64%

CASE STUDIES

NHS Lanarkshire

What were your organisation's key priorities for joining SIRAN?

We were interested in SIRAN accreditation as the reviews of deaths, particularly in Mental Health services, can be a challenge for all involved. If the process goes poorly, it can affect families and staff adversely, however if it goes well it can bring a sense of closure and hope, as well as stimulating service improvement. We were thus keen to improve our processes.

What did you find most helpful about the peer review process?

The high bar set by the SIRAN standards was initially intimidating, but gave us a goal to work towards which we did not previously have. This allowed us to focus on specific improvements that made our processes better, and supported staff and families better.

Since being awarded accreditation, how has this helped your organisation?

Since achieving SIRAN accreditation, we have found that the wider organisations we deal with have objective evidence of the quality of the processes we have out in place. This is assurance for all concerned that standards are high.

What can other organisations gain from going through this process?

I would encourage organisations to take part, as it is a process to stimulate further improvements in local processes and provides assurance to staff and service users.

CASE STUDIES

North East London NHS Foundation Trust

What were your organisation's key priorities for joining SIRAN?

- To ensure that our processes are of an exceptionally high quality.
- For the quality to be continually measured and monitored as part of the peer review process.
- To gain insight from other organisations, with a view to learn and improve our own internal processes.
- To strengthen partnership working with other agencies who are either SIRAN accredited or are going through the accreditation process.
- To standardise processes across the organisation.
- To be provided with support from SIRAN regarding internal incident management processes.

What did you find most helpful about the peer review process?

- The peer review process was an opportunity to listen to other organisation's processes and to learn from them.
- The peer review process allowed NELFT SI team to review the standards of other organisations, to improve our working methods and arrive at a consistent system.

Since being awarded accreditation, how has this helped your organisation?

- Supported us to develop standardised processes.
- Has allowed the team to develop audit processes within the SI framework (soon to be PSIRF) to monitor internal incident reporting processes associated with SI's.
- Has supported the role of the FLO and developed this role across the Trust.
- The accreditation has also revised and strengthened our incident reporting policy.

What can other organisations gain from going through this process?

- Support from experts in incident management.
- Training and awareness opportunities for the team as part of the services provided by SIRAN.
- Evidencing that a FLO is essential for SI/PSIRF support.
- Having a network of organisations to measure standards and learn from one another.
- The SIRAN accreditation supports the requirement of people affected by serious incidents, including carers/families, and allows them to feedback their experience of the process.

CASE STUDIES

Southern Health and Social Care Trust Northern Ireland

What were your organisation's key priorities for joining SIRAN?

Our main priorities were to improve the SAI process within the Mental Health & Disability Directorate by assessing it against externally agreed expert standards.

This would assist us in enhancing staff, patient and family involvement in the process. Ultimately a more robust process would produce more effective learning for clinical teams.

What did you find most helpful about the peer review process?

Overall, this was an extremely positive experience. Timely and Accessible Support was provided by the SIRAN Facilitators. We wound the emphasis on Staff & Family Support/ involvement helpful as was the constructive challenge element and the promotion of adopting a healthy natural curiosity in improving a service. SIRAN were willing to Source and Share Good Practice (e.g. formal family questionnaire) to assist us in our development. SIRAN were open to our explanations for regional variances in practices.

Since being awarded accreditation, how has this helped your organisation?

Our SAI process has become more robust with notable enhancements in the area of family/patient support. The Trust hopes to use the Accreditation status, among other achievements, as something to help attract healthcare staff to work in the Trust.

What can other organisations gain from going through this process?

SIRAN participation will allow them to monitor/review and adapt their SAI Process so that tangible improvements can be made.

These will in turn increase the ability of the organisation to generate meaningful learning from reviews and improve the safety of the system. We plan to share our experience at NI regional events.

APPENDIX 1: LIST OF MEMBERS

Members of the Safety Incident Response Accreditation Network (SIRAN)

Due to their time of joining the network, not all the organisations listed below have been included in this report as their data had not yet been collected at the time of publication.

Belfast Health and Social Care Trust
Cardiff and Vale University Health Board
Berkshire Healthcare NHS Foundation Trust
Birmingham and Solihull Mental Health NHS Foundation Trust
Central and North West London NHS Foundation Trust
Leicestershire Partnership NHS Trust
NHS Lanarkshire
Norfolk and Suffolk NHS Foundation Trust
North East London NHS Foundation Trust
South Eastern Health and Social Care Trust
South London and Maudsley NHS Foundation Trust
South West Yorkshire Partnership NHS Foundation Trust
Southern Health and Social Care Trust Northern Ireland
Southern Health NHS Foundation Trust
Surrey and Borders Partnership Trust
Sussex Partnership NHS Foundation Trust

APPENDIX 2: ACCREDITATION COMMITEE

SIRAN is governed by a group of professionals who represent key interests and areas of expertise in the field of serious incident reviews, as well as a carer representative.

SIRAN Accreditation Committee members

Elena Baker-Glenn, East London NHS Foundation Trust (Chair)
Adam Osborne, Southern Health NHS Foundation Trust
Andrea Sullivan, Cardiff and Vale University Health Board
Catherine Howe, Norfolk and Suffolk NHS Foundation Trust
Elizabeth Cork, Norfolk and Suffolk NHS Foundation Trust
Elizabeth Rye, Serious Incident Review Accreditation Network
Helen Degruchy, Berkshire Healthcare NHS Foundation Trust
Maria O'Kane, Southern Health & Social Care Trust
Mayura Deshpande, Southern Health NHS Foundation Trust
Robert Poole, Bangor University
Samantha Munbodh, Birmingham and Solihull Mental Health NHS Foundation Trust
Tracy Ward, Leicestershire Partnership NHS Trust

APPENDIX 4: CONTACT DETAILS

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