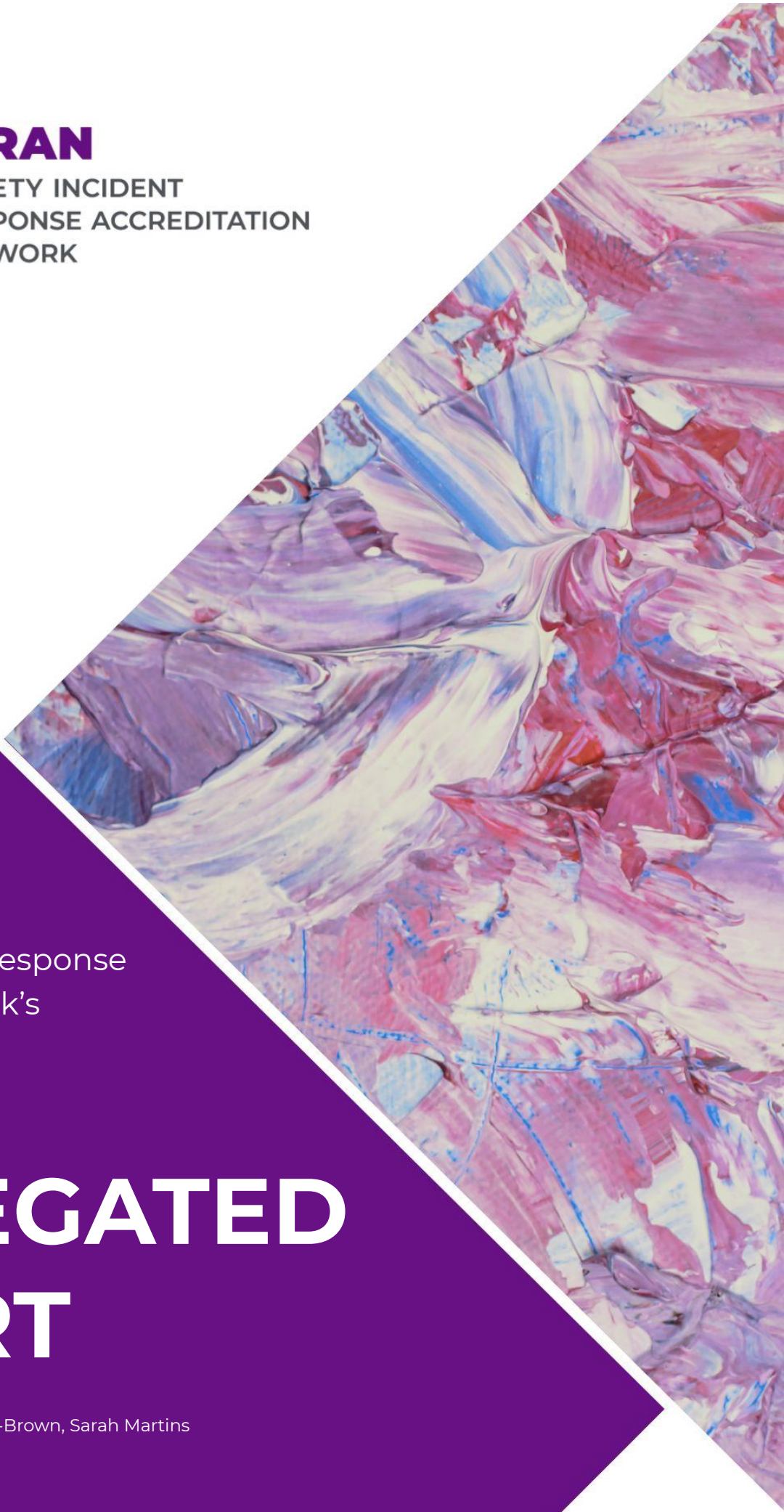
RC PSYCH
ROYAL COLLEGE OF PSYCHIATRISTS

SIRAN
SAFETY INCIDENT RESPONSE ACCREDITATION NETWORK



The Safety Incident Response Accreditation Network's

3rd AGGREGATED REPORT

Editors: Jemini Jethwa, Holly Hunter-Brown, Sarah Martins

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Foreword

As chair of the SIRAN Accreditation Committee, I am pleased to introduce the third aggregated report of the Safety Incident Response Accreditation Network (SIRAN), following the launch of revised standards in 2025. It has been a privilege to be part of SIRAN's ongoing development and to witness continued progress in patient safety across member organisations.

With membership spanning all devolved nations, SIRAN plays an important role in supporting and driving improvements in patient safety investigations. The network was established in 2020 and continues to reflect developments associated with the Patient Safety Incident Response Framework (PSIRF) and other relevant local frameworks. Member organisations have demonstrated a collective commitment to strengthening responses to patient safety incidents in a compassionate way, with a clear and consistent focus on learning.

Peer review remains central to this work. It provides valuable opportunities for shared learning, with organisations demonstrating a commitment to transparency, improvement, and a culture that prioritises learning over blame. The voices of patients and carers are integral to this process, alongside the need to ensure that learning is communicated clearly to patients and families. It is equally important to recognise the impact of incidents on staff and to ensure psychological safety and appropriate support throughout.

The five workshops delivered by SIRAN this year have been instrumental in enabling the sharing of improvement work across the network. These sessions explored key areas including family liaison officers, systems for learning, the embedding of patient safety partners, safety team structures, and staff involvement and family support.

I would like to extend my sincere thanks to all member organisations, peer reviewers, and contributors who have supported this work. Your openness, professionalism, and dedication to learning make this network invaluable. In addition, this collaboration is essential in fostering honest dialogue and sustaining improvements in quality and learning, while ensuring that patients, families, and staff are supported.

As we move into the coming year with refreshed standards, we remain committed to progressing this shared journey towards a safer, learning-focused healthcare system.

Dr Elena Baker-Glenn, Clinical Director and Consultant Psychiatrist, East London NHS Foundation Trust and SIRAN Accreditation Committee Chair

Introduction

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 29 quality networks, accreditation and audit programmes organised by the Royal College of Psychiatrists' Centre for Quality Improvement.

This report

Findings from the SIRAN peer reviews are presented in this report, which outlines compliance with the standards and highlights examples of good practice. It also identifies common gaps in patient safety at a national level and showcases where strong practice is being demonstrated.

What we do

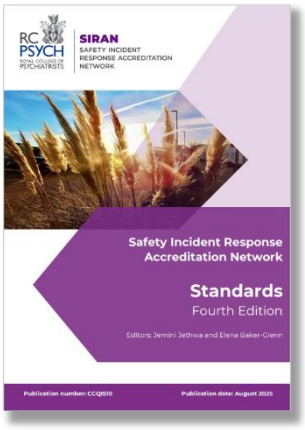
We adopt a multi-disciplinary approach to quality improvement within patient safety and review processes.

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, Patient Safety 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 4th Edition of Standards for Safety Incident Reviews in August 2025.



A consultation was held with key stakeholders and member organisations. 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.

The review process

All members of SIRAN undergo the same peer review process which is explained below.

The 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, Patient Safety 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 processes

This section of standards outlines the organisational processes required to ensure effective management and review of patient safety incidents. It emphasises clear procedures, accountability, timely implementation of improvements, and appropriate information sharing with partner agencies and regulators.

68%

AVERAGE COMPLIANCE ACROSS ORGANISATOINS

Higher scored standards

Organisations demonstrated having a structured and transparent approach to managing patient safety incidents. Standard compliance demonstrates that a majority of organisations had clear and accessible processes for reporting incidents and identifying which ones required a further review. It was also highlighted that organisations were able to clearly demonstrate that these processes are consistently followed.

Lower scored standards

However, many organisations were not sharing reports with the Board to cover learning response activity in relation to patient safety. This indicated gaps in how learnings from patient safety incidents are reported, acted upon, and overseen. In addition, organisations experienced challenges with timely implementation of improvements, and clear accountability structures.

Good practice examples

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

There is a strong leadership oversight for patient safety. This is evident from the level of involvement of the directors which was reflected on during the peer review day. The corporate governance that is in place is also commendable, including the patient safety oversight group which is innovative in developing strategies and providing feedback to make the necessary changes to the improvement of patient safety review processes.

SOUTH LONDON AND MAUDSLEY NHS TRUST

The organisation demonstrates strong governance structures, including regular clinical safety huddles and a dedicated safety committee. The Trust is currently piloting thematic reviews, enabling each Directorate to identify emerging trends and propose Trust-wide improvements. Additionally, the Trust actively participates in the London-wide Learning Forum, where it recently shared lessons learned from a previous investigation.

NHS LANARKSHIRE

The organisation ensures that every new or updated policy or strategy is accompanied by an Equality Impact Assessment (EQIA) for each service. While this represents best practice, it is also a demanding standard to consistently meet. The team work hard to ensure this is in place consistently and maintain fairness and inclusivity.

Incident review processes

In this section, the standards are focused on how the organisation engages with those affected by incidents, fulfils its duty of candour, and conducts reviews. It includes expectations around compassionate and timely engagement, independent and experienced review leadership and the inclusion of specialist advice.

90%

AVERAGE COMPLIANCE ACROSS ORGANISATOINS

Higher scored standards

All the organisations that were reviewed in this period engaged compassionately with those affected by the incident as soon as reasonably practicable to ensure their needs were met. They had at least one reviewer with service specific expertise relevant to the review or, if not, specialist advice was sought. Where there were multiple organisations involved in the patients care, there was usually evidence of multi-agency learning and sharing of information.

Lower scored standards

A standard that was most challenging to meet in this domain was adhering to the locally agreed timescales for individual reviews, which could result in delays to the review process. It was discussed in peer review days that it was a challenge given the complexities of cases and especially when reviews required multi-disciplinary input for partner agencies.

Good practice examples

SOUTHERN HEALTH AND SOCIAL CARE TRUST

The organisation became aware that the SAI review process could take a long period of time to complete. This meant that the identification and sharing details of any lessons learned was often delayed. As a result, they have implemented a new structured early learning tool (SELT) to identify any potential learning early on. This is an excellent initiative, which also draws on the RCPsych best practice guidance.

NORTH EAST LONDON NHS TRUST

The collaborative approach that the patient safety team has towards providing a holistic approach is also a great commendation to their hard work. The team are able to reach a large geographical area due to the connections they have built with neighbouring Trusts. This has also helped with providing faster access to those affected by patient safety incidents that do not live within the Trusts' remit. The team are able to liaise with their residents' Trust to access the support they need.

SOUTH WEST YORKSHIRE PARTNERSHIP NHS FOUNDATION TRUST

Having medical investigators as part of the review team for patient safety reviews can be very difficult in other Trusts due to demand and engagement. However, in this team it is standard practice even with this not being a national requirement. This shows great practice and a true commitment from a wider staff body to support every patient safety review to be robust.

Reports

This section of standards is centred on ensuring reports are clear, evidence-based, and actionable. Reports must include key information, align with organisational policies and relevant guidance, and be understood by all stakeholders. Conclusions and recommendations should be focused on shared learning and actions.

82%

AVERAGE COMPLIANCE ACROSS ORGANISATOINS

Higher scored standards

Organisations demonstrated that recommendations in reports were clearly supported by robust analysis, including evaluation of clinical decision-making processes. Improvement plans were well-defined, with clear rationale, and included named individuals accountable for delivery within specified timescales. These actions reflect a strong commitment to clarity, evidence-based practice, and structured implementation for continuous improvement.

Lower scored standards

Services frequently did not provide clear, case-specific terms of reference at the outset of reviews, which limited the ability to define scope and objectives effectively. In addition, there was often no evidence of a quality improvement (QI) or audit programme focused on learning for improvement. These gaps indicate a need for stronger processes to ensure clarity in review parameters and a systematic approach to embedding learning and continuous improvement.

Good practice examples

CARDIFF AND VALE UNIVERSITY HEALTH BOARD

The terms of reference included within the reports appear to be very clear and comprehensive. There is a good amount of detail in the terms of reference which are tailored specifically to the case. Patients and families are also invited to contribute and add to the terms of reference and some examples of this were also observed within the report audit. The new action plan template using AMAT is also a good way of monitoring live updates and monitoring progress.

CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

The considered wording and layout of the team's safety reports was highly praised. The service implemented a style of writing that is easily understood and concise, without missing any information or being jargon heavy. This was a noticeable achievement noted by the peer review team and showed the consideration of the patient and families that the reports are shared with.

NORFOLK AND SUFFOLK NHS FOUNDATION TRUST

The content of the reports is detailed with high quality and analysis and findings. The service reference the current framework in their reports which allows for a refresher for anyone who reads it. They also reference the tools used to collect their evidence to provide some context and understanding for how they carry out their work. It was positive to see that there is space for acknowledgements to staff and families made at the beginning of their reports, thanking them for their contributions.

Involvement of clinical staff

This section of standards outlines requirements for engaging staff and professional stakeholders throughout the review process, with regular updates and realistic timelines. It also covers the need for staff to contribute to the review, verify factual accuracy, and comment on findings prior to publication. It also covers staff support.

72%

AVERAGE COMPLIANCE ACROSS ORGANISATOINS

Higher scored standards

Services demonstrated strong engagement with staff and professional stakeholders by inviting them to contribute meaningfully to the review process. Additionally, learning was actively recognised and incorporated where appropriate, reflecting a commitment to continuous improvement and collaborative practice.

Lower scored standards

Services often did not inform staff and professional stakeholders about delays in a timely manner or provide clear reasons for those delays. In many cases, staff were not invited to meet with the review team to reflect on the quality of care provided, and there was no consistent process for staff to give feedback on the review process. These gaps highlight the need for improved communication, engagement, and mechanisms for staff involvement throughout the review.

Good practice examples

BELFAST HEALTH AND SOCIAL CARE TRUST

Staff reported they feel very supported and are well debriefed following patient safety incidents. This is related to both at the time of the incident as well as any support they require thereafter. Staff reflected that they felt they had a voice which was heard as well as feeling that the end of review process wasn't a hard finish but there was always an open door in the case of further support being needed.

SOUTH LONDON AND MAUDSLEY NHS TRUST

The organisation excelled in staff support initiatives for staff members affected by an incident. 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 safety incident. This is proactive and provides immediate support to individuals affected by an incident. This was also praised by staff members who felt that they were well supported by the Trust. 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.

NORTH EAST LONDON NHS FOUNDATION TRUST

Further to the essential supervision and monthly team meetings, there is a strong effort to provide psychological support for staff in the patient safety review process. There is allocated time for reflections after PSIG meetings to allow for a psychologically safe space to reflect on what has been heard and is offered to all colleagues who join. There is also bespoke reflective practice provided by a psychologist for colleagues in the patient safety incident team. Staff expressed that the review process of patient safety incidents felt like an 'ongoing conversation rather than an interview'.

Involvement of patients and families

This section focuses on how organisations engage with patients and families during the review process. It emphasises compassionate inclusion, ensuring their views are considered and they are invited to contribute. The standards also require a dedicated section in the report for their questions, appropriate support for gathering feedback.

90%

AVERAGE COMPLIANCE ACROSS ORGANISATOINS

Higher scored standards

Services ensured that patients and families were engaged from the outset of the review process by providing clear communication about details for the review team and offering opportunities to contribute. Any specific questions raised by patients or families were addressed in a dedicated section of the report. These practices demonstrate a commitment to transparency, responsiveness, and meaningful involvement of patients and families throughout the review.

Lower scored standards

Services often lacked a clear process for enabling patients and/or families to provide feedback on the review process if they wished to do so. This gap limits opportunities for meaningful engagement and learning from the experiences of those directly affected, highlighting the need for structured mechanisms to capture and act on patient and family input.

Good practice examples

BERKSHIRE HEALTHCARE NHS FOUNDATION TRUST

The Trust are very sensitive with patients and their families when carrying out reviews. Staff approach their relationship with the patient family in a flexible and dynamic way to allow for a more organic development and better family involvement. An example was shared where a patient's family sought support a year after the incident and the staff member who led on this, provided support for this family all that time later. The Trust have also appointed a Family Liaison Practitioner since their first SIRAN accreditation in 2020 and have had a fulltime role in post since 2021.

CENTRAL AND NORTH WEST LONDON NHS FOUNDATION TRUST

There is a family needs assessment tool in place, which is comprehensive and considers what ways would be most appropriate to engage with families. Furthermore, the opportunity to have an addendum to the report was an innovative way of including the families' comments about the safety incident review, even after the review has been concluded. Allowing the family to engage at their own pace whilst still having their voice heard shows the real effort this service is making with engaging with families.

LEICESTER PARTNERSHIP NHS TRUST

The Trust actively fosters a culture of candour with their patients and family members. This was clear through the patient/family letters submitted by the organisation, from the Patient Safety reports, the processes in place to involve patients and family members and the feedback received from reviewers. This was reflected in the patients and families survey responses.

Workshop summaries

One of the aims of the Safety Incident Response Accreditation Network (SIRAN) is to enable collaboration across organisations by creating opportunities to share learning, insights, and examples of good practice. To support this, we set out to create a dedicated space where patient safety teams could come together to explore key topics, exchange ideas, and learn from one another's experiences.

Following our 2023 patient safety event, we invited attendees to tell us which areas they felt would benefit most from deeper discussion and shared learning. Their feedback directly shaped a programme of interactive workshops held throughout 2024.

Each workshop focused on a specific topic identified by participants. We invited one or two organisations to present their approaches and initiatives in that area, offering real-world examples of how they are addressing challenges and driving improvement. These presentations were followed by open group discussions, giving attendees the chance to reflect, ask questions, and contribute their own perspectives.

To encourage openness, the sessions were not recorded. Instead, we've compiled written summaries of each workshop, which you can explore in this section of the report. These summaries capture the key themes, insights, and learning shared across the sessions.

The topics for each workshop are as follows:

FAMILY LIAISON OFFICERS (FLOs)

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PROCESSES AND SYSTEMS FOR LEARNING LESSONS

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EMBEDDING PATIENT SAFETY PARTNERS

PAGE 16

SAFETY TEAM STRUCTURES AND ROLE COMPOSITION

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STAFF INVOLVEMENT AND SUPPORT

PAGE 17

Family liaison officers (FLOs)

This workshop focused on the role of Family Liaison Officers (FLOs). Kirk Wilson and Ian Orr from Norfolk and Suffolk Foundation Trust shared how they've embedded this role into their organisation to provide meaningful support to families following patient safety incidents.

The Role of FLOs

FLOs are responsible for supporting patients and families involved in safety incidents. Their role includes building trusting relationships, gathering accurate information, helping families contribute personal statements, and keeping them informed throughout investigations. They also liaise with coroners and investigation teams, and signpost families to additional support services where appropriate.

Considerations before engagement

Before assigning a FLO, several factors are considered: the FLO's current workload, recent deployments, and personal wellbeing, as well as the family's background, communication needs, and any potential conflicts of interest. FLOs must be appropriately trained and experienced to take on this sensitive role.

Full-time role or additional responsibility?

In some Trusts, it is a full-time position with administrative support; in others, it is an additional responsibility within an existing role. This contrasts with more standardised approaches seen in other sectors, such as policing, and raised the question of whether a more consistent model is needed.

Managing workload

There was discussion around how many families a FLO can realistically support. While this varies depending on the complexity of each case, there was consensus that a cap is necessary to maintain quality of support. The end point of FLO involvement is also difficult to define, especially when inquests or reviews are delayed.

Organisational differences in FLO Involvement

Participants shared how FLOs are used differently across organisations. Some support all PSII reviews and suicide post-action reviews, while others are involved in a broader range of incidents, including sudden deaths and mental health reviews. This variation highlighted the need for more consistency in how FLOs are deployed.

Collecting feedback from families

Gathering feedback from families remains a challenge. Formal surveys can feel inappropriate or intrusive, especially during distressing times. Some organisations are exploring more sensitive approaches, such as informal check-ins, QR-coded leaflets, and working with family-led groups like Making Families Count. There was also discussion about removing Trust branding from surveys to encourage more open feedback.

Safety team structures and role composition

In this session, Kathryn Mason and Colin Quick from the Priory Group shared how their patient safety team is structured and how they've implemented the Patient Safety Incident Response Framework (PSIRF). The discussion also explored how outcomes are measured and how learning is shared across their services.

Patient safety team structure

The Priory Group operates across England, Scotland, Wales, and Northern Ireland, which means their patient safety team must navigate different legal and regulatory environments. While some staff have dedicated patient safety roles, many combine this work with clinical duties. The team includes representatives from various regions and specialties, supported by patient safety partners and network leads.

To support shared learning, the team meets quarterly to review reports and identify themes across services. This thematic approach helps ensure no key issues are missed and informs both local and national safety work.

PSIRF implementation

The Priory found PSIRF aligned well with their existing practices, thanks to early input from national providers. One challenge was the need for individual sign-off from each commissioner, which added complexity. However, PSIRF has helped surface lower-level learning and measurable aspects of care quality.

PSIRF in Devolved Nations

Currently, PSIRF is only formally adopted in England. While the devolved nations hadn't yet implemented it at the time of the workshop, Priory has integrated some PSIRF principles across all regions. So far, this has not caused any major issues.

Measuring outcomes

Outcomes are assessed by scoring each service, although comparisons between services can be difficult due to the varied nature of care provided. Instead, the focus is on tracking progress within individual teams over time. New software systems are also supporting this work.

Using triangulated learning

Each site is responsible for analysing local data such as PALS feedback and complaints. They have their own governance processes and triangulation methods, supported by a central data team that provides national oversight and identifies broader trends.

Reflections from other organisations

The session also included a discussion on how other organisations structure their safety teams. One participant noted the benefits of having a dedicated team, while others highlighted the challenges of implementing PSIRF in larger teams, particularly around delivering consistent training and embedding cultural change.

Processes and systems for learning lessons

This workshop featured two presentations on how organisations structure their systems for learning from patient safety incidents:
Southern HSC Trust – Dr John Simpson and Tony Back
The Priory Group – Colin Quick and Kathryn Mason

Structured Early Learning Tool (SELT)

Southern HSC Trust uses a reflective tool to review cases with learning potential. It looks at the quality of care rather than outcomes, helping to reduce bias and to promote a culture of continuous improvement.

How it works:

- Teams review relevant phases of care and rate quality using a shared scale.
- Disagreements in scoring are recorded to prompt further discussion.
- Learning points, good practice, and improvement areas are identified.
- Recommendations are developed by the team and reviewed by governance leads.
- A central SELT library captures themes and informs wider learning across the directorate.

Benefits: Empowers clinical teams to lead quality improvement, encourages timely, reflective practice, provides an alternative to traditional incident review methods and supports collaborative working and realistic, team-owned recommendations.

Use and scope: SELT is used within the mental health directorate by teams reflecting on their own care delivery. It works best in environments with strong collaborative cultures.

Patient Safety Learning Approach

The Priory's approach to learning includes several interconnected forums and tools.

Learning structure: The Priory Group uses a multi-layered approach to patient safety learning, combining local meetings, learning forums, and quality improvement (QI) initiatives. Learning is shared through the Healthcare Cascade, a system that distributes key insights across services via newsletters and the intranet, creating a centralised "learning on a page" resource.

Lived experience: Service users are actively involved in all local forums. Their lived experience informs patient safety work through co-produced initiatives and tools like the "temperature check," ensuring learning is grounded in real experiences.

Triangulated learning: Learning is drawn from a wide range of sources. This includes incidents, complaints, inquests, audits, safeguarding, and more. These are reviewed quarterly to identify trends and direct actions to relevant teams. Insights are shared through quality briefings and embedded into governance processes.

Embedding Patient Safety Partners

This workshop was led by Tracy Mclean, a Patient Safety Partner from Norfolk and Suffolk NHS Foundation Trust (NSFT) who presented on the PSP role and how it has been implemented in NSFT.

What is a Patient Safety Partner (PSP)?

PSPs are individuals, often service users, carers, or laypeople who are recruited to represent the voice of patients and the community. Their role is to influence governance and leadership with a focus on safety. PSPs are typically employed outside the service they support to maintain independence and offer a fresh perspective. Roles may be paid or voluntary, depending on the organisation.

Core responsibilities

PSPs contribute to governance, support safety improvement projects, attend meetings, help prioritise risks, and assist with incident reviews and training. They also participate in investigation oversight groups and promote openness by engaging with patients, staff, and the public.

Collecting Feedback from Families

Before introducing PSPs, organisations should consider recruitment processes, tailored induction and training, support structures, and how the role will be integrated across teams. It's also important to ensure the PSP is well-supported and that their role complements existing patient engagement structures.

Discussion points

Lived experience: There was no formal requirement for PSPs to have lived experience, though the group discussed whether this should be essential given the role's focus on patient advocacy.

Tenure: At NSFT, PSPs were voluntary with no fixed term. Other organisations reported using fixed-term contracts, often around two years.

Patient engagement: At the time of the workshop, PSPs at NSFT were not directly involved in patient engagement, as this was covered by other roles such as Family Liaison Officers and the service user council. The importance of avoiding duplication in patient contact was noted.

Experiences from other Trusts: Participants shared varied experiences. Some had PSPs actively involved in PSIRF implementation and learning oversight groups. Others noted differences in recruitment, with some PSPs already working in lived experience roles. There was general agreement that more clarity is needed around the role before widespread implementation.

Staff involvement and support

In this workshop, Dr Rowena Carter presented findings from a survey on the impact of violence and aggression on trainee psychiatrists, highlighting its effect on wellbeing and retention.

Compassionate investigation and PSIRF

The Patient Safety Incident Response Framework (PSIRF) promotes compassionate engagement and psychological safety during incident reviews. It encourages separating performance concerns from systemic issues to avoid blame and support open reflection. Anonymous surveys during After Action Review (AAR) invitations were suggested as a way to gather honest feedback from staff who may not feel comfortable speaking in groups.

PSIRF is designed to drive cultural change, focusing on prevention and learning. Its implementation requires support from executive leaders and middle management, who play a key role in shaping how staff are supported. Staff survey results are being used as a secondary measure of progress.

Critical incident staff support (CISS)

The CISS team provides structured post-incident support through a manualised pathway. A meeting is held 72 hours after an incident, followed by a second session four weeks later. These sessions focus on factual discussion and peer support, not psychological therapy. Staff can request CISS support via Datix, and feedback has been very positive.

Impact on Trainees

Around 10% of trainees reported leaving their training due to violence or aggression, often verbal or physical. Many incidents go unreported, and when they are, they are not always escalated or followed up appropriately. Trainees also reported limited support following such incidents.

Stalking risk and training

Trainees face a higher risk of stalking from patients, estimated at 20% over a career, compared to 2–8% in the general population. Supervisors often feel unsure how to support staff in these situations. Mandatory training on stalking, including cyberstalking, is being developed in collaboration with the Suzy Lamplugh Trust and the Metropolitan Police.

Challenges and implementation

Participants discussed the challenges of implementing PSIRF, especially with limited resources. Unlike the more structured Serious Incident Framework (SIF), PSIRF requires a shift in approach and mindset. Complex team dynamics and the need to distinguish between systemic and individual issues were noted as barriers. Gradual rollout, prioritisation of high-impact incidents, and phased training were seen as necessary for successful implementation.

Member feedback

Following each peer review visit, we are very keen to hear what our members have to say about the peer review process and the network in general. We are committed to providing an excellent service to our members and are always happy to hear feedback on what we've done well and where we can make improvements.

Responses from our peer review feedback survey have been largely positive:

Of respondents felt that it was made clear that the review was intended to be a supportive process, designed to promote the sharing of good practice.

Of respondents found the opportunity to meet people from other services useful.

Of respondents had the opportunity to discuss issues relevant to patient safety

"We had a pre-meeting with the lead reviewer where we could ask questions about the best way to present information. We had previous experience so that helped in our planning and organisation and presentation of information."

"Really helpful having the full timetable ahead of time, and the peer review day kept to time and was very well managed. Also really nice having a number of peer reviewers from a range of organisations and services."

"The chance to self-reflect on processes leading up to the accreditation [worked particularly well on the review day], and this is something we should do collectively at regular intervals.

YOU SAID	WE DID
A more detailed introduction at the meeting with clinical staff to ensure they are aware of the reasons for the meeting, understanding of SIRAN accreditation, purpose of their contribution.	To best prepare clinical staff for the meeting, we developed a one-page information sheet that can be sent to staff who are willing to attend the meeting, ahead of time. At the beginning of the meeting, the reason for the meeting is introduced.
More of an introduction by the lead reviewer at the beginning of the peer review to understand more about what was expected from the agenda.	We have an introductory meeting at the start of every peer review where we now go into detail about the review timetable and what to expect for the day.
Despite acknowledging the clear benefits of teams, I do think it would have enhanced the experience if the review could have taken place face-to-face.	The possibility of running in-person reviews is an idea that is considered often. However, there is the logistical challenge of some organisations not having physical bases whereby they could host.
A more streamlined way of requesting and reviewing evidence so that the same information is not requested at two separate time points.	The new standard revision has included an overhaul on what is required from organisations to submit as evidence. The evidence checklist has been reviewed to ensure we continue to ask for what is necessary. The report audit has been completely renewed so as to make evidencing standards clearer.

Appendix 1: List of members

The following list consists of organisations that are current members of SIRAN. Due to the timelines of peer reviews, not all services' data has been included in this report.

Belfast Health and Social Care Trust
Berkshire Healthcare NHS Foundation Trust
Cardiff and Vale University Health Board
Central and North West London NHS Foundation Trust
Leeds and York Partnership NHS Foundation Trust
Leicestershire Partnership NHS Trust
NHS Lanarkshire
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
Surrey and Borders Partnership Trust

Appendix 2: Accreditation Committee

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.

Elena Baker-Glenn, East London NHS Foundation Trust (Chair)
Andrea Sullivan, Cardiff and Vale University Health Board
Elizabeth Rye, Safety Incident Response Accreditation Network
Helen Degruchy, Berkshire Healthcare NHS Foundation Trust
Maria O'Kane, Southern Health & Social Care Trust
Jo Nicholls, Leicestershire Partnership NHS Trust
Hannah Brookes, Norfolk and Suffolk NHS Foundation Trust
Richardson Allen, North East London NHS Foundation Trust
Paul Magowan, Belfast Health and Social Care Trust

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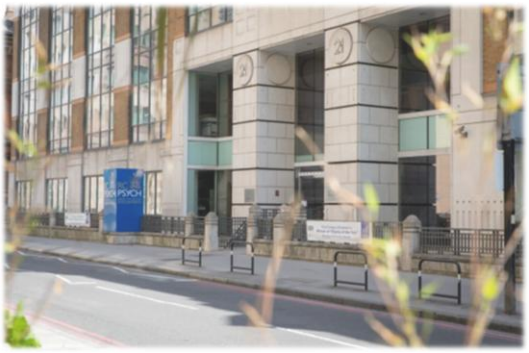

Website

https://www.rcpsych.ac.uk/improving-care/ccqi/quality-networks-accreditation/siran

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