COLLEGE CENTRE FOR QUALITY IMPROVEMENT

RC PSYCH ROYAL COLLEGE OF PSYCHIATRISTS

Serious Incident Review Accreditation Network (SIRAN)

1st Aggregated Report

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Foreword

SIRAN is a unique accreditation process that examines organisations internal processes concerning serious incidents, in contrast to other CCQI networks that focus on clinical services. The pilot project that developed RCPsych-approved principles and standards for serious incident investigations was established following discussions with a number of external national bodies, particularly the National Confidential Inquiry into Suicide and Safety in Mental Health, about the need for such standards. The group that led the pilot project recommended that the standards could form the basis of a CCQI framework. The purpose is to use the College's standards to improve the quality of serious incident investigations in mental health care provider organisations across the UK. This required operationalisation of standards concerning processes so that they could be applied with objectivity and consistency.

Simultaneously, in England, NHSE/I were developing the Patient Safety Incident Response Framework (PSIRF). Information was shared between the groups to ensure that there were no conflicts, and some of the early adopter Trusts for the PSIRF have been part of SIRAN. The key difference between the two is that SIRAN standards are applicable in all providers in the mental health sector in all four UK countries, whereas PSIRF applies to all specialties in England. The organisations involved in the SIRAN program are diverse, some only providing mental health care and others offering a full range of community or secondary care services. This creates challenges when comparing processes across very different organisations.

The Invited Review Service at RCPsych has significant expertise in serious incident reviews and their input in developing the standards was greatly appreciated. It was 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 also like to thank the organisations that were part of the initial pilot and who have been part of SIRAN in its formative phase. We have learned a lot from their contributions and their honest approaches have helped us to identify improvements and to start to share the learning between the organisations. Our patients and carers groups were involved in the development of the principles and standards, and we hope that experts by experience will become a key part of this work as it moves forwards.

We have seen that organisations involved in SIRAN have implemented significant improvements, and have benefited from being part of the Network and being able learn from other organisations. It has encouraged and supported organisations to think about the use of quality improvement to support changes to their serious incident processes. This report gives some suggestions for shared learning that can be applied across many organisations.

It is intended that the standards and their operationalisation will continue to evolve, and that they will be subject to ongoing development and review. One of the key challenges for the future is to ensure that learning and improvement

happens, and to find ways to measure this learning. Communication with, and updates for, patients and families were frequently identified as areas that required improvement. As SIRAN moves forward, clarity about best practice to provide support for families and adoption of family questions as an essential component of reports will be a key development. Mechanisms for families to provide feedback about SI processes require improvement across many organisations. More work is required to involve the clinical staff in SI processes, ensuring that they get updates when required, with feedback on conclusions.

We hope that over the next year more organisations will be able to join the SIRAN network. We would welcome more members to contribute and share their own processes of serious incident reviews and allow us to support them in the improvement process. Adopting a culture of continuous improvement is essential to improve the learning from investigations and to improve the investigation process itself.

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Introduction

In 2016, the Royal College of Psychiatrists identified a need for a set of governing principles that could set a bar for how serious incident reviews are conducted for mental health services. A working group was established to develop a draft set of standards, chaired by Dr Elena Baker-Glenn, who was at the time Clinical Lead for Quality Improvement and Mortality Reviews at Cambridgeshire and Peterborough NHS Foundation Trust and Professor Rob Poole, Co-Director at The Centre for Mental Health and Society and. These standards formed the basis for a pilot review of the investigation processes of three early-adopter organisations who had agreed to participate. This initial review led to the publication of 'Principles for full investigation of serious incidents involving patients under the care of mental health and intellectual disability provider organisations', published in February 2018 by The Royal College of Psychiatrists[1]. This document set out a series of 24 principles for how serious incident reviews should be conducted.

Following this, 10 organisations took part in a second pilot programme. This involved undertaking a self-review against the SIRAN standards. In 2019, peer-reviews were conducted for these services and the SIRAN standards were revised once more.

The final version of the standards was then given to the College Centre for Quality Improvement (CCQI), which has a more than two-decade history of establishing and running 'quality networks', seeking to set standards for mental health services and measure the performance of services who subscribe to the networks against these standards.

On 6 January 2020, the Royal College of Psychiatrists and the CCQI launched its completed set of 60 standards and the newly titled 'Serious Incident Review Accreditation Network' at a launch event held in London. Following this event, membership of the network was opened to any healthcare organisation in the UK.

The months that followed brought about many challenges for healthcare organisations and the College due to the COVID-19 epidemic. Despite this, an initial cohort of 11 organisations signed up to be part of the network and undergo a self-review followed by a peer review (see Appendix 1 for a list of members).

The College allowed Trusts a high degree of flexibility in the timing of their self-review and peer review, to work around the challenges of COVID-19. One Trust chose to delay their peer review until later in 2021 and so this report analyses the findings of the other ten peer reviews, which were held between 20 October 2020 and 6 January 2021.

[1] Principles for full investigation of serious incidents involving patients under the care of mental health and intellectual disability provider organisations

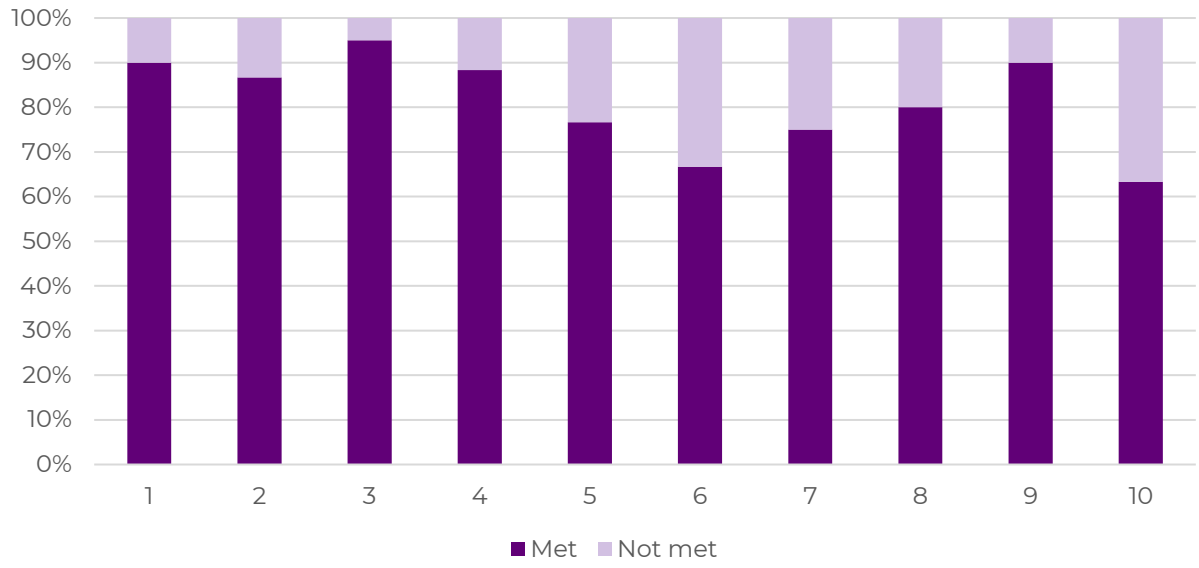
Attainment of the SIRAN standards

The 60 SIRAN standards are organised in to five sections, as follows: Organisational Processes, Incident Review Processes, Reports, Involvement of Clinical Staff, and Involvement of Patients and Families.

Each of the standards was first marked by the organisation itself based on a self-review as either 'met' or 'not met'. Then, following consideration of the information provided by the organisation and the peer review, each standard was also marked by the peer review team. The outcome of the review was based on the peer review team's ratings, rather than the self-review, and those are also the ratings on which this report is based.

After their peer reviews, each Trust can make further improvements prior to being presented to the 'Accreditation Committee'. The final level of standards attainment for each Trust will therefore likely be higher in most cases.

The overall attainment of the 60 standards for the 10 participating Trusts was as follows:



Trust	1	2	3	4	5	6	7	8	9	10
% Met	90%	87%	95%	83%	77%	67%	75%	80%	90%	63%

As the table and figure above shows, no Trust attained 100% of the standards at the peer review stage. Overall, however, attainment was high, with no Trust scoring lower than 63% and nine out of ten Trusts meeting at least two thirds of the standards and eight of ten meeting three quarters of the standards. The median number of standards met was 50 out of 60 (83%).

The attainment of the standards varied not just between Trusts, but also between sections and individual standards. What follows is an analysis of the level of attainment of the individual standards in each of the five sections described

above. For each section, there is also a qualitative analysis of trends in the notable areas of achievement and areas for improvement that were identified.

The Accreditation Committee

The SIRAN Accreditation Committee (AC) consists of representatives from stakeholder organisations and professional bodies. The AC reviews the results of the self-review and peer-reviews, along with any additional evidence that services provide.

The AC has the power to change decisions that have been made by the peer-review team on peer-review visits. The AC also make decisions on whether services are awarded accreditation, deferred or not accredited.

Organisational processes

The 10 Trusts performed well for the standards in this section, with none of the standards being met by less than 80% of Trusts and four being met by all ten Trusts.

No.	Standard	Met
1	There is a process in place for reporting incidents.	100%
2	There is a process in place for deciding which serious incidents require further review.	90%
3	The process for reporting incidents is set out clearly and made available to staff.	100%
4	There is evidence that this process is followed.	100%
5	The Board receive a report related to serious incident reviews.	100%
6	There are clear processes to ensure action plans/improvement plans have been implemented in at least 50% of the examined reports.	90%
7	Information governance agreements are in place to ensure information sharing.	80%
8	There is a mechanism of accountability of the reviewers set out in the local policy.	90%

Areas of achievement

In Trusts who performed well, individuals at the senior management level were well informed of and involved in serious incident processes, complementing service and divisional level responsibilities.

Another hallmark of good performance was prioritising the training of staff, as well as junior doctors, in incident reporting. Trusts who scored well described training for staff upon induction but also refresher training and targeted training where statistics indicated under-reporting.

All Trusts made use of an electronic incident reporting system, with some taking advantage of this system to track action plans and remind staff of their responsibilities to report on or implement actions. Incident reporting statistics were typically shared at divisional and board level. One Trust also invited patients and families to share their stories at Board meetings, which was a very powerful tool to ensure that the Board got a real sense of what the incidents meant to those involved.

Well-performing Trusts had an effective triage system, such using a structured judgement review tool, to identify which incidents should be classified as being serious incidents. Some also had multiple processes in place to identify serious incidents. In particular, the review team was impressed by a Trust which had twice daily discussions of incidents at a 'shop floor' level as well as a high-level review of all mortalities.

Trusts who performed well also ensured there was ownership at clinical service level of the development and implementation of actions and good working relationships between clinical and governance teams. One Trust that was reviewed had improvement panel meetings, as a mechanism of accountability for ensuring that actions were carried out and that evidence could be provided of how these actions had affected change.

Areas for improvement

While most Trusts' incident reporting policies were satisfactory, some lacked detail of important aspects of the process and some were overdue for review. Furthermore, one Trust had two different processes for reporting incidents, which it was felt may be confusing for some staff.

Action planning was an area that was not consistent in some Trusts. For some, there appeared to be a disconnect between the patient safety and clinical teams in how action plans were being produced. There were also some Trusts who shared action plans which included several overdue actions, suggesting that action implementation tracking could have been better.

Another area that some Trusts had found difficult was sharing learning from serious incidents across the wider organisation. Also challenging for some was routinely ensuring that high-level actions, particularly those which might feed into Trust-wide priorities and initiatives, were considered, and identified because of serious incident reviews. This was particularly problematic for larger Trusts.

Incident review processes

This was another section for which the 10 Trusts performed well for almost all standards in this section, with seven of the eights being met by at least eight out of ten Trusts. The notable exception was standard 13, regarding meeting timescales for reviews, which only four Trusts could evidence meeting at the peer review. This is discussed further below.

No.	Standard	Met
9	The organisation attempts to contact the patient and/or family within three working days of the incident being reported in order to provide support.	80%
10	Reviews are led by someone who is independent of the treating team.	100%
11	The review is led by someone who has relevant experience, expertise, or training in reviews.	100%
12	At least one reviewer has service specific expertise relevant to the review or, if not, specialist advice is sought.	90%
13	The locally agreed timescale for the individual reviews is adhered to.	40%
14	Terms of reference are agreed by senior managers.	100%
15	The review team can access appropriate specialist advice when required.	100%
16	The review team are confident that they can access the specialist advice in a timely manner when needed.	90%

Areas of achievement

All Trusts had a process to undertake a rapid review of serious incidents, typically within the first 48 or 72 hours of the incident being detected. Often, a panel was convened to review the information gathered and set the initial terms of reference for the serious incident review. In the best examples, these panel meetings allowed for input from the relevant clinical team(s) to help inform the terms of reference at an early stage.

In conducting these reviews, two different models of serious incident investigation were seen. One included a Trust training a number of its staff to undertake reviews on a semi-frequent basis. The other involved Trusts appointing and training a smaller number of dedicated, full-time serious incident reviewers to conduct these reviews very regularly.

Trusts who followed the model of having 'part-time' reviewers and who did so to a high standard provided extensive training to their reviewers, including providing training materials for them to refer to. The reviewers were also supported by a central Trust patient safety team, co-ordinating the process, supporting reviewers and ensuring timescales were met. In the best examples, this central co-ordination team had good relationships with all the Trust's boroughs or divisions to support their liaison work.

Those Trusts which utilised a model of a small, centralised team of full-time reviewers were assured that reviews were conducted independently and by a trained reviewer and often had the most consistent approach to conducting reviews and writing reports. They also supported one another in complex reviews or providing cover when needed. Those that utilised this model particularly effectively allocated reviews to the member of this central team with the most relevant previous experience. One Trust also supported its central team with a bank of other, trained reviewers, undertaking this work semi-regularly.

The Trusts that performed the best in these reviews also had a panel of trained clinical reviewers, with one of these joining the review team for every serious incident. One Trust also had a list of designated subject matter experts, who could be contacted to provide specialist insight and advice for a review.

Areas for improvement

Some Trusts that fell slightly short in this area needed to provide refresher training to their serious incident reviewers and introduce a mechanism to ensure reviewer guidance was being followed. Some were also encouraged to provide further training of modern review techniques. Some Trusts also needed to provide more guidance to clinical reviewers to improve the consistency and quality of their involvement in reviews.

In those Trusts using a system of 'part-time' reviewers it was found to be a demanding role, difficult to fit in around their regular, day to day work. It was felt that, in these cases, it would be ideal if staff were able to be allocated dedicated, protected time for this work. Some Trusts were also advised to provide additional supervision and support to ensure reviewers knew what was expected of them and support them in carrying out these duties.

Some Trusts had ad hoc processes for reviewers identifying and contacting subject matter experts and so were advised to develop a list of experts who could be contacted for advice. Trusts were also encouraged to define the roles and responsibilities of subject matter experts and provide them with support, including protected time and supervision.

The standard is this section least frequently met was meeting local timescales for completing serious incident reviews. All the Trusts reviewed were following NHS England's Serious Incident Framework, which states that

"Serious incident reports and action plans must be submitted to the relevant commissioner within 60 working days of the incident being reported to the relevant commissioner, unless an independent investigation is required, in which case the deadline is six months from the date the investigation commenced."

Only four of ten Trusts were found to be routinely meeting this 60 working day timescale. Other Trusts, however, did have appropriate processes in place to seek extensions from their commissioners. It was also noted that some of these serious

incident reviews were conducted during the COVID-19 pandemic and so some delays could not be avoided.

Reports

The 'Reports' section of the standards is the largest of the five sections. With 22 standards, it makes up more than a third of the total.

No.	Standard	Met
17	Reports state the name and professional role of each reviewer.	100%
18	There are clear terms of reference.	100%
19	Terms of reference are specific to the case.	70%
20	A timescale for the review is set out in the terms of reference.	80%
21	Appropriate legal framework concerning openness and candour is considered and applied.	90%
22	The report states whether there are, or have been, other reviews related to this incident.	70%
23	Reports are succinct and written in plain English.	90%
24	All specialist vocabulary, acronyms and jargon are explained in the report.	80%
25	There is a glossary to explain abbreviations used.	60%
26	The rationale for the conclusions is clear from evidence set out in the body of the report.	80%
27	The rationale for recommendations is clear from evidence set out in the body of the report.	90%
28	Reports evaluate clinical decision-making processes relevant to the incident.	80%
29	There is a clear improvement/action plan where required.	100%
30	It is clear how the improvement/action plans are derived.	90%
31	Improvement/action plans are implementable.	90%
32	The improvement/action plan are monitorable.	90%
33	There is a specific individual, named in the report, that is accountable for delivering the action plan within a specified timescale.	90%
34	Reports refer to existing organisational policies or relevant guidance.	90%
35	Recommendations refer to the organisation's existing action plans and quality priorities.	20%
36	There is a recognition of potential learning evident in the report.	100%

37	Significant incidental findings lying outside of terms of reference are noted and acted upon.	60%
38	Where case notes and staff are inaccessible to the reviewing team, reports acknowledge any limitations.	90%

Attainment of these standards was much more varied as differences in who undertook reviews, and how, made a significant difference to how consistently high-quality reports were produced. Some areas (4/22 standards) were done universally well, and the majority (15/22) were done well in most cases, by between seven and nine out of ten Trusts. This was not a case of most Trusts doing everything well and a minority doing everything poorly, but rather a range of a few different issues affecting most of the ten Trusts reviewed.

Three areas stood out as being met particularly infrequently. Standards 25 (the use of a glossary of terms) and 37 (reporting significant incidental findings) were both met by just six out of the ten Trusts. Standard 35 (citing organisational level priorities or plans) was almost never done well and by only two out of ten Trusts.

Further discussion of the key successes and shortcomings of Trusts in writing serious incident reports are described below.

Areas of achievement

Most reports shared by each of the ten Trusts reviewed contained a clearly labelled set of Terms of Reference (ToR), which could be easily understood. Some built upon a standard set of ToR, adding specific items to an otherwise generic list, while others wrote their ToR from scratch. General terms of reference were helpful to ensure important areas are routinely explored. Most were suitably specific although, in some cases, a generic list of ToR was used 'whole-cloth' and would have benefited from being tailored to make them more specific to circumstances of the incident.

Often, the ToR included specific questions provided by the patient or their family, the process for which is discussed is covered in a subsequent part of this report. One Trust regularly sought permission to use the patient's name in the ToR, which made them read as being more personal and individual focussed.

Many reports provided clear, comprehensive explanations of the clinical services, diagnoses, medications, and other agencies involved in a patient's care, and these really helped the readability of the reports. Most also included a detailed chronology of the patient's case to set out the background for readers.

Where relevant, reports often tried to highlight examples of good practice as well as areas of concern. In some cases, it was suggested that significant good practice examples be incorporated in reports' executive summaries to give these points more visibility.

Reports typically included an appendix containing a table of the actions identified, alongside the deadline for these actions, who was responsible for them and the

measurement criteria for assessing if the actions had been implemented successfully. This made it clear in most cases what the actions were, how and when they would be implemented and monitored and by whom.

As noted previously, Trusts had various mechanisms for monitoring actions, and where this was done well most actions were completed on time and it was known when actions were overdue and there were plans to address this.

Trusts performed generally well at citing their relevant organisational policies in documents and, in the best examples, other relevant national guidance was also referenced.

Areas for improvement

It was noted in several instances that serious incident reports did not contain any reference to whether there had been other reviews related to the incident. Some Trusts referenced their 48-hour or 72-hour reports, but others did not. Outside of these, it was commented that, typically, serious incident reports were completed before other reports, such as those compiled by the police or Coroner, were commenced and hence they could not be referenced.

The issue that affected readability most often was their length. Some reports seen were very long and detailed. In some instances, such as those of complex circumstances, this is difficult to avoid but some reports were overly exhaustive in their descriptions of events and others unnecessarily repeated some information. Some also included lengthy descriptions of process, which could have been moved to an appendix.

The use of and explanation of jargon was varied and technical terms that lay readers may not have understood did creep in at times. The use of some of this jargon could have been avoided, but where it was necessary it could have been defined or described better. Some Trusts had recently introduced glossaries of terms, while others would have benefited from adopting this approach.

Almost all the reports seen contained a set of conclusions and for most there was a clear rationale for where these conclusions had come from. In some instances, however, there was found to be a lack of deep analysis of the care and service delivery problems identified, exploring why these might have occurred. In some instances, it was felt that the conclusions reached likely did not get to the core of the underlying issues and, perhaps because of this, there were also examples seen in which an overall conclusion was not highlighted. In some instances, this had affected the recommendations made and actions identified, with a lack of a clear understanding of the contributing issues leading to actions that were not likely to effect meaningful change.

There were also some reports seen that had a confusing structure, that made it hard to follow from the findings to the conclusions and on to the recommendations and actions. In some instances, it appeared that this might be due to reports being produced by filling in various boxes in a software package

that then brought the final report together, although seemingly not in a coherent order.

The shortcoming identified most often in these reviews, to the extent that it was almost ubiquitous, was a lack of consideration in serious incident reports of how the findings might fit with organisation action plans or quality priorities. The concern was that learning from these reviews that should have contributed to existing work to improve quality at an organisational level was being missed. The issue appears to arise from there being no routine prompt and no established mechanism for reviewers conducting serious incident reviews to check if the issues they have found align with existing working going on in the Trust. Several Trusts identified this issue themselves, marking the relevant standard as 'not met' in their self-review, and indicated a desire to address this issue.

In a few cases, reports did not demonstrate that there was a process for prompting consideration of incidental findings lying outside of the terms of reference and including these in the report. It was suggested that this be included in Trusts' serious incident report templates to provide a prompt to look for incidental findings.

Involvement of clinical staff

To help them to assess these standards, the review teams had access to the information provided by the Trust but also the results of a staff survey and interviews with staff members during the peer review. The median rate of attainment of these standards was lower than the three previous sections and only two standards (inviting staff to contribute and treating them with respect) were met by all ten Trusts.

Ten of the other 11 standards were met by most (between six and nine) Trusts and, as noted before, this was mostly a case of a few different issues affecting each Trust rather than some performing very well and others poorly overall. The standard met least often related to keeping staff informed of delays to serious incident reviews, which only three out of ten Trusts did consistently.

No.	Standard	Met
39	Staff and professional stakeholders involved in the care of the patient are formally contacted at the outset of the review process.	80%
40	Terms of reference are made available to staff and professional stakeholders.	60%
41	Staff and professional stakeholders are informed who is conducting a review at the outset.	90%
42	Staff and professional stakeholders are informed of a realistic timeline for a review.	70%
43	Staff and professional stakeholders are informed about any delays in a timely fashion and provided with the reasons for those delays.	30%
44	Staff and professional stakeholders are invited to contribute to the review.	100%
45	Staff and professional stakeholders are invited to check for factual accuracy prior to publication of the report.	70%
46	Staff and professional stakeholders are informed of the outcome of the review and are invited to comment on the findings of the report.	80%
47	Staff within the organisation are made aware of how to access support.	80%
48	Staff are able to meet with the review team and reflect on the quality of care provided.	60%
49	Staff are able to review their contribution to the review.	60%
50	Staff are treated respectfully and sensitively during the review process.	100%
51	Learning is recognised in the review process where appropriate.	90%

Areas of achievement

Although review teams found that all Trusts sought contributions from staff, the best examples included meetings between clinical staff and the reviewer(s) throughout the process. This meant that clinical staff felt as though they were contributing to the review rather than being the subject of it. Examples included involving clinical staff in panel discussions at the stage of setting the terms of reference and round table discussions of the events leading up to the incident. In some instances, staff were also involved in panel discussions of the clinical decision-making processes.

Well-performing Trusts also organised debrief sessions and learning events to reflect on what happened and the learning that could be drawn from incidents. As show in the scores above, not all Trusts held debriefs or, when they did, some staff were not included.

Most Trusts ensured staff were given some support when participating in a serious incident review. This was said often to come from their line managers but, in some Trusts, staff were also said to receive the offer of professional support from a Trust psychologist or a counselling service. Where this was not the case, the review teams highlighted the need to sign-post to this sort of support mechanism or to occupational health.

Staff described that, in some cases, they had gone on to be part of Coronial reviews of incidents. Some felt that they had been well support by their Trust's legal teams and well prepared for this challenging process. Others described how anxiety-provoking it had been to have the prospect of a Coroner's inquest 'hanging over' them, often for quite some time, indicating more support could have been provided.

In several reviews staff talked about witnessing a change in culture in their organisation over the past several years. They noted that the experience of being part of a serious incident review had improved considerably and some commented that they now believed there to be a 'no blame' culture in their Trust.

Some staff also shared good examples of seeing real improvements coming about because of serious incident reviews. They shared examples of how these reviews had led to changes in practice. Some noted, however, that learning could, at times, be quite local and that it would help to share their learning across the organisation and learn from others.

Areas for improvement

In most cases, the majority of relevant staff were notified when a serious incident occurred. It was, however, reported that all contact was via a staff member's line manager. While this allowed the manager to provide support, for some parts of the process, it served as a barrier to obtaining staff input in a timely manner.

Conversely, in other instances, line managers were not informed at all when their staff were being contacted about serious incidents.

It was apparent for several of the Trusts undergoing review that there were inconsistencies in how they involved staff in serious incident reviews. In one Trust, some staff felt included, consulted, and kept informed whilst others felt completely 'out of the loop'. To some extent, this appeared to be a result of variability in how the review process had been applied, possibly due to inconsistencies in the ways of working of the serious incident reviewers. One of the solutions suggested to counter-act these issues was developing template correspondence to ensure all the important messages were being delivered consistently.

Another contributing factor was found to be the service that individual staff members belonged to. When an incident occurred, the care team who had most recently or most frequently cared for that patient might be appropriately included in the process, but staff from other teams, who had also contributed to that patient's care, were sometimes overlooked. Additionally, and potentially because of this issue, some staff were not proactively offered as much support as others were.

As the results above show, most Trusts struggled to ensure that staff were consistently kept informed of the progress of reviews and cause of delays. Staff described how waiting a long time for the outcome of a serious incident review could be a source of stress and anxiety, which delays and uncertainty could compound.

As stated above, the production of action plans did not always include clinical staff sufficiently. In some instances, actions were written by those drafting the serious incident reports and the clinical teams seeing these actions considered them to be unrealistic or unhelpful. In the worst cases, actions were devised and assigned to staff without them being aware of this until they were asked to give an account of that action's progress.

Involvement of patients and families

Information for this section of reports came from descriptions of the process provided by Trust staff and evidence in serious incident reports, such as comments and questions contributed by patients or families. In the future, we plan to develop a patients and families survey for organisations to distribute, to gather direct feedback from people about their experience of the serious incident process.

Trust performance in these standards was split: about half of the standards (five out of nine) were met most of the time (by 80-100% of Trusts), while the other half (four out of nine) were only met about half of the time (by 40-50% of Trusts).

No.	Standard	Met
52	Patient and/or families are contacted at the outset of the review process.	90%
53	Patient and/or families are informed who is conducting investigations at the outset.	90%
54	Patient and/or family views are considered when formulating the scope of the review.	100%
55	Patient and/or families are informed of a realistic timeline for reviews.	50%
56	Patient and/or families are informed of delays in a timely fashion and provided with the reasons for them.	50%
57	Patient and/or families are invited to contribute to reviews.	100%
58	Patient and/or families are invited to check for factual accuracy prior to the publication of reports.	40%
59	Patient and/or families are informed of the outcome of the review and invited to comment on the findings of reports.	80%
60	There is a process whereby patients and/or families involved can give feedback about the review process if they wish to.	40%

Areas of achievement

Most Trusts were routinely making contact, wherever they could, with patients or families about serious incidents and, in the best examples, they were asked about their preference for further contact and offered email, telephone or in person communication. Verbal and in-person meetings were then summarised in a letter and, where Trusts did not provide summary letters, this was suggested by the review team.

As discussed above, patients and families were usually asked to contribute questions for the review and these were seen in the terms of reference.

Good examples of representing the patient in reports included 'pen portraits' of the patient contributed by the family, as well as notes in reports describing how families had asked for patients to be referred to.

Patients and families were said to receive support from clinical staff members that they already knew from previous contact with clinical services. Several Trusts also had Family Liaison Officers, whose role it was to communicate with and support families. These individuals helped with communication in most cases, although in some Trusts there was confusion about what was the responsibility of the Family Liaison Officer and what fell to the Serious Incident Reviewer(s).

When presenting the outcome of the review in the form of the final report, some Trusts helpfully offered to deliver the report through a 'supported reading' so that they could be there to answer any questions the patient or family had about the contents. Some also shared 'example' reports with families to help set their expectation of how the report relating to their loved one was likely to read.

Areas for improvement

One area that half of the ten Trusts struggled with was demonstrating how they had communicated timescales to patient and families and kept them informed of any delays. In some cases, it was said that communication with families was good at the start and end of the process but, in the middle, it was left to them to contact the serious incident reviewer for an update. In other cases, there was said to have been good communication throughout, but that this was not recorded so it was hard to demonstrate.

As described above, most Trusts sought questions from patients or families and included these in their reports. In some cases, however, the answers to the questions were provided in an appendix or families were directed to find the answers elsewhere in the report rather than all answers being provided in one place. In terms of the structure of the report, Trusts were advised to present the patient or family perspective and responses to their questions 'front and centre'.

A standard that less than half of Trusts met was inviting patients and/or families to check serious incident reports before they were published or finalised. Several Trusts stated that they did not share reports until they were signed off and finalised. Some Trusts did share draft reports with patients or families at all, and some stated that they would 're-open' a report to add further comments or even go back to answer any further questions submitted at this stage.

Finally, most Trusts were unable to demonstrate that they routinely sought feedback from patient and families about their views of the quality of serious incident reports. The advice was given to sign-post directly to Trust complaints policies or otherwise seek feedback. Some Trusts described planning to introduce a feedback survey, which was thought to be a very positive idea.

Future work of the SIRAN

This report represents a look back on the first year of carrying out reviews following our first edition of a complete set of standards. It is just the beginning of a journey seeking to help healthcare organisations raise the quality of their reviews of serious incidents in mental health services.

Looking ahead, we hope to encourage more organisations to join the network, to take part in the self-review process and subsequently undergo a peer review. This will allow organisations to work towards accreditation, which was awarded for the first time to two Trusts in January 2021. A larger network of members will also allow us to grow our opportunity for sharing learning through conducting peer reviews, holding events, and encouraging direct discussion between members.

Our processes will also not stand still. In the coming year, we plan to develop a patient and families survey in order to collect direct feedback about how well they feel organisations involve them in serious incident reviews. We will also continue to monitor changes to the landscape of incident review guidance and best practice, as well as learning from our experiences, and incorporate all of this into future revision of our standards.

As the network grows and develops, we will also look to continue to share learning as widely as possible through further publications such as this.

Project team contact details

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Appendix 1: List of members

The following list details the participating members whose data is included in this report. The data is not ordered in the same order as it is below, to assure anonymity.

Organisation	Team
Berkshire Healthcare NHS Foundation Trust	Berkshire SI Team
Birmingham and Solihull Mental Health NHS Foundation Trust	Birmingham SI Team
Central and North West London NHS Foundation Trust	CNWL SI Team
Cambridgeshire and Peterborough NHS Foundation Trust	Cambridge SI Team
Greater Manchester Mental Health NHS Foundation Trust	Manchester SI Team
North East London NHS Foundation Trust	NELFT SI Team
Norfolk and Suffolk NHS Foundation Trust	Norfolk & Suffolk SI Team
Surrey and Borders Partnership NHS Foundation Trust	Surrey SI Team
Southern Health NHS Foundation Trust	Southern Health SI Team
South West Yorkshire Partnership NHS Foundation Trust	SW Yorkshire SI Team

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