Our Ref: 760
December 2025

Doncaster and Bassetlaw Teaching Hospitals
NHS Foundation Trust

Freedom of Information Act Request

Thank you for your request. Please find below the information available regarding the engagement of independent specialists:

Use of independent specialists

1. **The number of occasions on which independent specialists (with no connection to the Trust) were engaged to support:**
   a) Patient safety investigations (including any previous or alternative terminology used by the Trust)

1. **Patient Safety Investigations**

In line with established FOI disclosure practice, all figures under five have been replaced with the symbol "#".
This approach is used to reduce the risk of indirect identification of individuals where low numbers may relate to specific cases, staff, or patients.

Where "#" is used, it indicates a number fewer than five.

The data below reflects declared Patient Safety Incident Investigations (PSII) and Serious Incidents (SI) for each year, along with the number of external reviews undertaken.

A total of 18 external reviews were conducted during this period by the Maternity Neonatal Safety Improvement Programme and the Health Service Investigation Branch, all relating to maternity and neonatal care.

Figure1.

Year (April–March)	No. of SI/PSII	External Reviews
2020–2021	39 SI	#
2021–2022	38 SI	#
2022–2023	46 SI	#
2023–2024	44 SI/PSII	#
2024–2025	29 PSII	#
2025–2026 (YTD)	11 PSII	#

Our current DATIX risk management system does not allow identification of cases where external subject matter advisors were allocated, so no additional data is readily available.

In 2025, a small number of cases (fewer than five) sought external expert opinion to support organisational learning. A small number of additional cases (fewer than five) involved partnership investigations jointly commissioned with a Mental Health Service provider.

2. Complaints Investigations

Our DATIX system does not record whether external subject matter advisors were engaged specifically for complaints investigations. However, in routine practice, where guidance is sought across the South Yorkshire Acute Federation. This typically involves service-to-service requests for subject matter advice to support complaint responses.

47 cases that have been reviewed for investigation by the PHSO between 2020 and 2025

For each occasion identified in Question 1, please provide:

- **The date (or month and year) the independent specialist was engaged**
- **The specialist's area of professional expertise**
- **Whether the engagement related to a patient safety investigation or a complaint**

Our current DATIX risk management system does not allow identification of data regarding allocation of external subject matter advisors; therefore, full data is not readily available to report.

However, during 2025, a small number of patient safety investigations (fewer than five) involved external subject matter advice, including clinical expertise in radiology, paediatrics, and emergency medicine. These engagements related solely to patient safety investigations and supported learning and improvement.

The external reviews referenced previously in Figure 1 were conducted by the Maternity Neonatal Safety Investigation Programme and the Health Service Investigation Branch, which are independent bodies responsible for maternity and neonatal investigations.

Additionally, the Parliamentary and Health Service Ombudsman (PHSO) acts as an independent body for complaints unresolved within NHS services and represents the final stage of the NHS complaints process. Relevant data regarding PHSO involvement has been included above, 47 cases that have been reviewed for investigation by the PHSO between 2020 and 2025

Decision criteria
The Trust's documented policy, procedure, or guidance that sets out:

- **The criteria or triggers for involving independent specialists**
- **The role or level of responsibility authorised to make that decision**

If this information is held in more than one document, please provide the relevant extracts.

The Trust has a structured process for determining when external support is appropriate to aid learning:

- **Criteria/Triggers:**
    - Complex complaints or patient safety events requiring enhanced investigation.
    - Cases meeting referral criteria for the Maternity and Neonatal Safety Investigation (MNSI) programme.
    - Situations where impartial expertise is needed (e.g., multiple clinicians involved in care).
- **Decision-Making Process:**
    - Cases are reviewed at the Learning from Patient Safety Events (LFPSE) Panel, held twice weekly.
    - Recommendations are escalated to the Trust Executive Patient Safety Oversight Group, chaired by the Chief Nurse, for final decision and authorisation.
- **Guidance:**
    - The panel follows the NHS England Framework for Independent Investigation, which sets out principles for external involvement.

The Trust has not commissioned any external companies to author any Patient Safety Investigations under the Patient Safety Incident Response Framework, as investigations are conducted by a trained central team. The executive team have oversight and sign off all incident investigations and complaint responses.

Collaboration and Partnership working with other acute providers, Children's Services, and Mental Health services is used for impartiality in complex cases.

Collaboration across South Yorkshire with a monthly Patient Safety Specialist Forum allows external support with complex cases and peer support.

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