Royal United Hospitals Bath
NHS Foundation Trust

Patient safety incident response policy

Reference Number:	7068	
Author & Title:	Christopher Lafferty	**Associate Director of Patient Safety & Quality**
Responsible Director:	Toni Lynch	**Chief Nurse**
Review Date:	30th April 2027	
Ratified by:	Insights and Improvement Committee	
Date Ratified:	23rd February 2026	
Version:	Final	
Related Policies and Guidelines	Complaints Policy Duty of Candour Policy PSIRF Plan Risk Management Policy Royal United Hospital Bath Trust Strategy	

Index:

Amendment History

Issue	Status	Date	Reason for Change	Authorised
1	Previous issue, replaced	25/03/2024	Review overdue – set to 1 year as new implementation	J Lugg

Policy Summary

This policy sets out the Royal United Hospitals Bath NHS Foundation Trust's approach to meeting the requirements of the NHS England Patient Safety Incident Response Framework (PSIRF). It describes how the Trust will develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improvement. There will be no remit to apportion blame or determine liability, preventability or cause of death.

PSIRF promotes a collaborative, coordinated, and data-driven response to patient safety events. It embeds incident response within a wider culture of continuous improvement and supports a shift towards systematic patient safety management. This policy contributes to an effective patient safety incident response system by integrating the four aims of PSIRF:

- Compassionate engagement and involvement of those affected;
- Use of a range of systems-based approaches to learning;
- A considered and proportionate response to events and safety issues; and;
- Supportive oversight focusing on system functioning and improvement.

This policy should be read alongside the Patient Safety Incident Response Plan (PSIRP), which describes how the Trust will implement these requirements over a 12-18 month period.

Scope

This policy applies to patient safety incident responses undertaken solely for learning and improvement. Responses use a systems-based approach, recognising that safety is generated by interactions across the healthcare system rather than by individual actions. Therefore, responses must not take a person-focused or blame-attributing approach. The following principles underpin patient safety incident oversight:

- Improvement is the focus;
- Blame restricts insight;
- Learning from patient safety incidents is a proactive step towards improvement;
- Collaboration is key;
- Psychological safety allows learning to occur; and;
- Curiosity is powerful.
-

The following processes fall outside this policy because they determine liability and/or apportion blame or cause of death. Information may be shared with these processes, but their remit must not influence patient safety incident responses:

- legal claims;
- human resources investigations;
- professional standards investigations;
- information governance concerns;
- estates and facilities concerns;
- financial investigations and audits;

- safeguarding concerns;
- coronial inquests and criminal investigations; and;
- complaints (except where a significant patient safety concern is highlighted or falls within the remit of the defined PSI (PSI) Investigation types in the PSRIP).

Our patient safety culture

The Trust is committed to fostering a fair and psychologically safe culture. Staff are supported to raise concerns, confident they will be heard and that the focus will remain on improvement and learning. Staff involved in engagement with patients and families after an incident will receive appropriate training, and leadership development will emphasise compassionate engagement. Those affected may have a range of needs (including clinical needs) as a result and these must be met where possible as part of our duty of care.

Patient safety responses exist solely to support learning and improvement and do not to determine accountability, liability, or cause of death. Involving those affected enhances our understanding of what happened and increases opportunities to prevent recurrence. This engagement supports openness, transparency, and improved reporting.

Definition of Terms Used

Datix: The Trust's patient safety event reporting system, incorporating LFPSE taxonomy.

Engagement and Involvement: The meaningful involvement of patients, families and staff to support learning and improvement.

Freedom to Speak Up (FTSU): A route for staff to raise concerns safely and confidently.

LFPSE: Learn from Patient Safety Events: The national system for recording and analysing patient safety events.

PSE: Patient Safety Event: Patient safety events are unexpected or unintended events which occurred or failed to happen, that could have or did lead to harm. Patient safety event is an umbrella term which is used to describe a single event or a series of events that occur over time including "near misses". A patient safety event can also be thought of as something that did not go as intended or expected – whether an act or an omission - and as a direct result the event could have or did harm.

PSE Validation: The process of ensuring that the details patient safety event record is factually accurate.

PSE Management: The end-to-end process of validating, learning and improving from a PSE.

LR: Learning Response: A proportionate, systems-based process to understand events or themes of concern.

PSII: Patient Safety Incident Investigation: A detailed systems-based investigation undertaken where there is potential for significant new learning.

PSIRF: Patient Safety Incident Response Framework: The Patient Safety Incident Response Framework (PSIRF) sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

PSIRP: Patient Safety Incident Response Plan: This patient safety incident response plan sets out how the Royal United Hospitals Bath intends to respond to patient safety incidents over a period of 12 to 18 months.

Fair Culture: The aim is to create a culture where staff feel supported to report patient safety events and are not blamed.

SEIPS: System Engineering Initiative for Patient Safety: SEIPS is a framework for understanding outcomes within complex socio-technical systems. SEIPS can be used as a general problem-solving tool focussing on wider system issues, not individuals, to guide how we learn and improve following a patient safety incident, to conduct a 'horizon scan', and to inform system design.

Duties and Responsibilities

Managing Director: The Managing Director is accountable and responsible to the Trust Board for ensuring that resources, policies, and procedures are in place to ensure the effective insight, improvement and engagement related to patient safety events. In practice the Managing Director may delegate the day-to-day responsibility for this to Executive Directors.

Chief Nursing and Chief Medical Officer: The Chief Nursing and Medical officer jointly are the executive leads for patient safety. They are accountable for ensuring an appropriate level of investigation for incidents and ensuring organisational learning and improvement takes place.

Associate Director of Patient Safety & Quality: Responsible for ensuring incident reporting and investigation is appropriate and organisational learning and improvement takes place.

Executive Team: The Executive Team holds the divisions to account regarding the learning and improvement identified following patient safety events, maintaining oversight of emerging patient safety themes and delivery of improvement work related to these. It receives assurance that our policies regarding Being Open and Duty of Candour are adhered to.

Divisional Management Teams: Includes Divisional Directors, Divisional Directors of Nursing and Divisional Directors of Operations, Responsible for delivery of PSIRF within the division through; ensuring compassionate engagement and involvement of those affected by patient safety events, the application of a range of system-based approaches to learning from patient safety events and taking a considered and proportionate response to patient safety events and safety issues.

Specialty Management Teams: Encouraging an open culture of recording, learning and improving from patient safety events within their teams. Employing a fair culture approach to all patient safety events. Ensuring the timely validation, review and management of all patient safety events recorded within their area of responsibility. Actively participating in the daily divisional patient safety review processes and supporting any learning responses identified from these. Reviewing patient safety event data, insights and improvements as part of the specialty governance process. Engaging with the development and delivery of improvement related to trust wide and local themes for patient safety improvement.

Patient Safety Specialists (PSS): The NHS Patient Safety Strategy requires every NHS organisation to appoint one or more Patient Safety Specialists (PSS). These specialists are senior patient safety experts who provide visible leadership, expert guidance and strategic oversight.

Patient Safety Partners (PSP): Patient Safety Partners are volunteers who will work alongside staff, patients and families to influence and improve patient safety within our hospital. They will influence, support and challenge safety cultural issues, and work collaboratively in the development of patient safety initiatives. Roles for PSPs will include:

- Membership of Divisional and Trust wide safety and quality committees whose responsibilities include the review and analysis of safety data
- Working with the trust and divisional boards to consider how to improve safety
- Involvement in staff patient safety training
- Participation in patient safety governance groups
- Supporting the development of processes to engage and involve; patients, families and their carers

The PSP role is to provide objective challenge, ensure the patient voice is represented, and scrutinise the actions and evidence underpinning our safety work. PSPs remind us that responding when things go wrong is not solely about reviews and reports, but about recognising the impact on patients, families and carers. They help bridge the gap between patients and staff, supporting real-time listening rather than delayed Duty of Candour discussions, and offering an accessible route for speaking up. PSPs will be supported in their voluntary role by the Associate Director of Patient Safety & Quality.

Insights and Improvement Committee: The Insights and Improvement committee reports to the QAC and acts to promote quality and safety as a core RUH value and ensures the implementation of the quality strategy. Quality encompasses clinical effectiveness and outcomes, patient safety and staff, patient and carer experience. The group ensures that the

Trust has effective and efficient arrangements in place for quality assessment, quality improvement and quality assurance ensuring that the perspectives of staff, patients and carers on quality is at the heart of what we do.

Quality Assurance Committee: The Quality Assurance Committee (QAC) provides assurance to the Board on the overall delivery of the trust's strategic objectives in the context of quality of care and services and the effective mitigation of identified risk, relating to the quality of care and services.

Patient Safety Event Review Group (PSERG): The Patient Safety Event Review Group provides a weekly oversight of the triage of incidents, the learning opportunities and tools used. It will report to PSEOG; the key performance indicators in PSE management, and any emerging themes in patient safety events that may require development of new improvement programmes. The PSERG will oversee decision-making on the level of review required for PSE and review developing themes, ensuring cross divisional collaboration. The group will provide advice on the appropriate lead for any review as well as involvement of subject matter experts. It will provide advice and guidance to members on the PSIRF process and provide recommendations on the ongoing improvement. The group will meet weekly and will report directly to the Patient Safety Event Oversight Group.

Patient Safety Event Oversight Group (PSEOG): The Patient Safety Event Oversight Group oversees the delivery of the key performance indicators relevant to the management of patient safety events. These include the delivery of PSIRF training relevant to staff role, the processes of incident management and Duty of Candour. It will provide recommendations to IIC of emerging patient safety themes and opportunities for improvement.

Quality and Safety Improvement Group (QSIG): The Quality and Safety Improvement Group leads the oversight of the delivery of improvement activity of the Trust patient safety priorities and other corporate quality improvement work.

Clinical Divisions: All data relating to patient safety; incidents, patient and staff experience, structured judgement reviews (SJRs), claims and litigation alongside will be reviewed daily by the clinical divisions. The clinical divisions will be responsible for validating, triangulating and triaging this data and agreeing the most appropriate response based upon the opportunity for risk, learning and improvement. The data, learning and improvement will be monitored through the divisional governance processes.

Patient Safety Incident Response Plan

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm. Our Patient Safety Incident Response Plan sets out how the Royal United Hospital NHS Foundation Trust (RUH) intends to respond to patient safety events from March 2026 to April 2027.

It will set out the circumstances which will instigate a PSII. The System Engineering Initiative for Patient Safety (SEIPS) approach will be used when conducting a learning response and/or PSII. The plan will be flexible and updated as required. The Trust will take a proportionate approach to its response to patient safety incidents to ensure that the focus is on maximising improvement. To fulfil this, we will take regular reviews of our current resource for patient safety response and our existing safety improvement workstreams. We will identify insight from our patient safety and other data sources both qualitative and quantitative to explore what we know about our safety position and culture.

Responding to patient safety incidents

All staff are responsible for recording any potential or actual patient safety events on the Trust's incident recording system (Datix) as soon as identified. PSIRF encourages recording not only when a patient safety event has occurred but also proactively when a potential event is identified. The individual recording the PSE will select the division responsible for the area where the event occurred. This can be corrected, if necessary, at the time that the Datix record is validated.

Patient safety event responses will be proportionate to the opportunity for learning from the event and undertaken using an approach that will maximise systematic learning and opportunities for improvement. This approach requires assessment of ALL patient safety events and a learning response that is determined by the potential for learning and improvement at both local and system wide level, rather than the level of harm sustained.

In February 2024, Datix was updated to reflect the amended national recording system, Learning from Patient Safety Events (LFPSE). LFPSE on Datix will enable records from other organisations to be viewed on our system if relevant to our organisation.

PSIRF Escalation / Process Flowchart

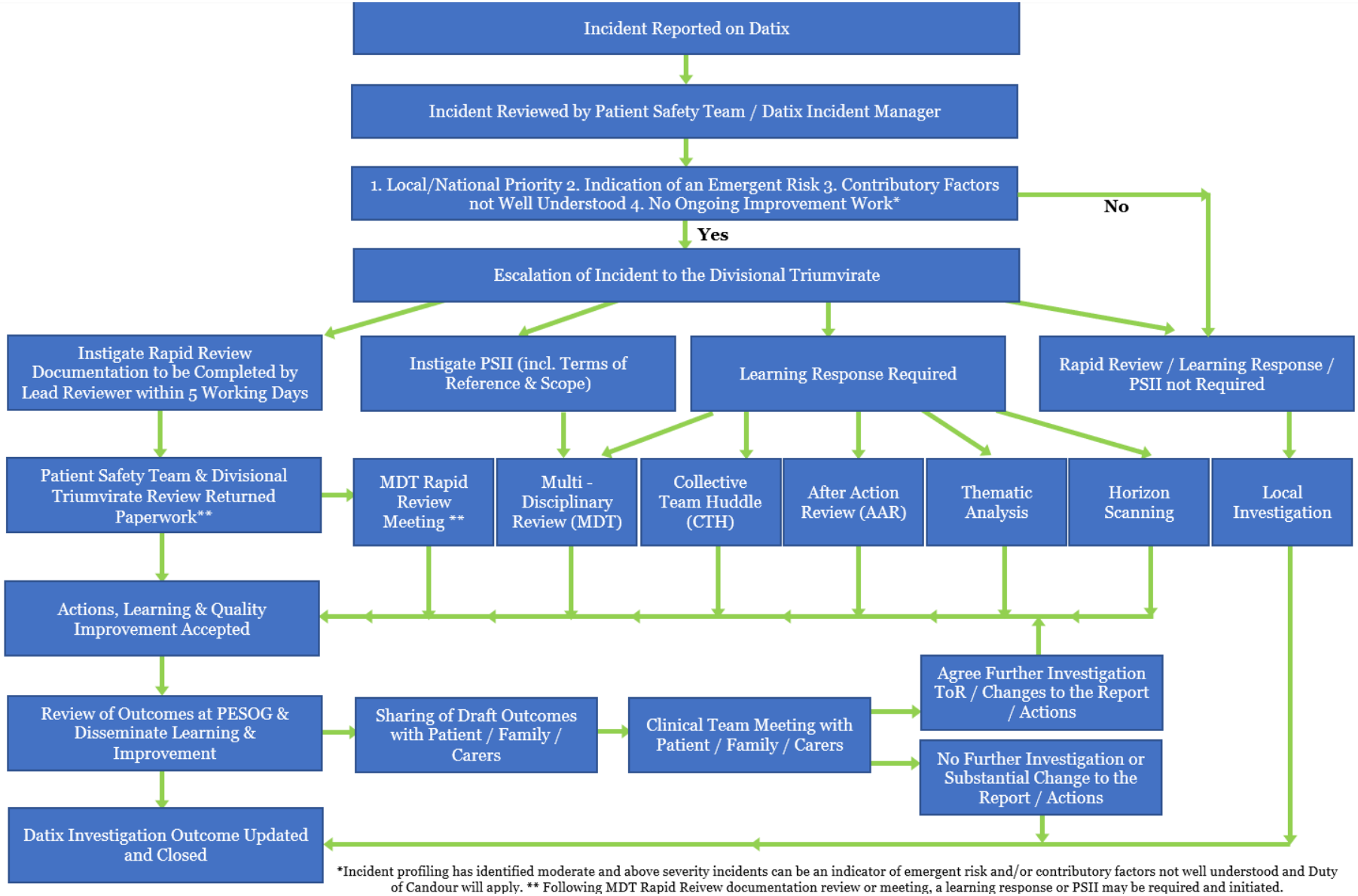

Figure 1: PSIRF Escalation/Process Flowchart

PSE Validation

Validation of a patient safety event (PSE) should take place as soon as possible after the event is recorded. The purpose of validation is to ensure:

- Identification details in the PSE record are correct;
- Information in the record is accurate, maintains confidentiality;
- The level of harm is validated against national guidance;

Physical Harm Grades	Psychological harm grades
No physical harm	No psychological harm
Low physical harm	Low psychological harm
Moderate physical harm	Moderate psychological harm
Severe physical harm	Severe psychological harm
Fatal	n/a

Table 1: NHSE Patient Safety Event Harm Definitions

- Appropriate patient, family or carer engagement has begun, as described in Engaging and involving patients, families and staff following a patient safety event; and;
- Reported to a divisional safety brief / PSERG as appropriate.

Event of Concern

Certain events require immediate escalation. Examples include:

- Event where a patient safety event is considered to have directly contributed to a death;
- A never event; and
- A near miss with a high risk of recurrence.

Escalation should occur immediately and jointly to the Divisional Management Team, and the Associate Director of Patient Safety & Quality. Out of hours, escalation must be made to the on-call manager.

Patient Safety Event Review Group (PSERG)

A summary of all divisional patient safety events, themes, and progress of formal reviews will be presented by a Divisional representative at the weekly PSERG. The group supports:

- Identification of Trust-wide themes including good practice;
- Opportunities for cross-divisional collaboration;
- Oversight of proposed for learning responses; and;
- Escalation of concerns requiring further review which may in turn be reported to the weekly patient safety huddle (with executive management) representation.

PSERG will review data as necessary to identify emerging themes and report to the Patient Safety Event Oversight Group (PSEOG).

Learning Response and PSII

Whilst RUH operationalises PSIRF and agrees specific local priorities, careful consideration will be given to new and emerging themes which are related to the Trust's local patient safety priorities and where quality improvement workstreams to address specific concerns are not yet be established and therefore, may require a PSII learning response.

The Trust will apply a systems-based review methodology to investigate, learn from and improve safety. The Trust has implemented a series of tools to support a systems-based review of incidents at all levels in the organisation:

Rapid Review: Escalation of incidents to the Divisional triumvirate to consider incidents against Local/National priority for Rapid Review and/or where an incident appears to indicate an emergent risk and/or where contributory factors are not well understood and there is no ongoing improvement work. Actions learning, Quality Improvement (QI) priorities may be accepted at this stage or an MDT After Action Review meeting may be arrange if further analysis is required. At this stage a learning response or PSII could also be initiated.

Collective Team Huddle (CTH): a quick incident response huddle that allows for the review of an incident in a non-punitive way. Ownership by the local team to identify learning and actions that work for the area. These will be captured and shared and monitored by the patient safety team. CTH's are time sensitive, and the richest learning is yielded when done soon after the event. As further training is developed, it is anticipated that collective team huddles are initiated by the local team as appose for waiting for the patient safety team to initiate.

After Action Review (AAR): a facilitated team discussion, used where the incident affects more than one team or service and requires more structure and facilitation to identify learning and promote psychological safety. Learning will be captured and shared and monitored by the patient safety team.

Multidisciplinary Panel Review (MDT): An MDT Panel Review is used where it is more difficult to collect staff recollections of events either because of the passage of time or staff availability and generally explores more complex issues such as a safety theme, pathway, or process. The purpose is to identify learning from incidents (including multiple incidents and/or themes) through having open discussions, identification of contributory factors and system gaps, barriers and enablers, pathway, process or safety themes. It seeks to examine system factors and gain insight from 'work as done'.

Thematic Analysis: Identification of patterns in data with learning shared. Clear questions and methodology should be applied from the outset.

Horizon Scanning: Prospective look forward at current or potential safety themes and issues with learning shared and monitored by the patient safety team. This technique can be used when explore change in the system with the aim of designing safety systems and processes from the outset.

Once the divisional triumvirate accept the learning response or investigation it will be disseminated for discussion at appropriate Trust assurance committees and shared with wider specialist groups and staff in the Trust. All learning responses and investigations remain in draft until agree with the patient and/or family and/or carers.

Where a more detailed review is required, a Patient Safety Incident Investigation (PSII) will be undertaken by staff who have protected time and appropriate training. RUH patient safety staff have received nationally accredited PSIRF training and will maintain competency in line with national standards. The PSII will apply a systems-based methodology to identify learning that informs current and future improvement work. If a PSII is required, it should commence as soon as possible after the incident is identified and will aim to be completed within six months.

Safety Action Development, Improvement and Monitoring

The Trust will design, implement and monitor safety actions arising from any form of learning response. Safety actions will follow the approach outlined in NHS England's Safety Action Development Guide (2022), which includes:

- Agreeing improvement - identify where change is needed without prescribing solutions;
- Defining the context - establishing factors that will shape the development of safety actions;
- Developing safety actions - system-focused, co-designed with teams involved in the work;
- Prioritising safety actions - identifying which actions should be tested and implemented first;
- Defining safety measures - determining how impact will be assessed and assigning responsibility for any related metrics; and
- Ensuring safety actions meet SMART principles - clearly written, measurable, time-bound, and with an identified owner

Monitoring of all safety actions will take place through divisional Quality and Safety meetings. Where learning responses identify wider system issues, an overarching safety improvement plan will be created and monitored using the same governance processes.

Governance, Oversight & Training

Clear records will be kept of all decision-making related to patient safety incident responses. The Patient Safety Team will maintain established processes to communicate and escalate relevant incidents to NHS commissioning bodies, regional organisations and the CQC in line with statutory and regulatory reporting requirements.

The Central Patient Safety Team will act as the liaison point for cross-system incidents. They will work with partner organisations on a case-by-case basis to agree ownership of investigations, establish robust procedures and terms of reference, ensure timely information flow, and minimise delays to joint working.

PSEOG will review and maintain oversight of all learning responses, PSII investigations and associated action plans. Its responsibilities include:

- Ensuring recommendations are grounded in a systems-based approach;
- Confirming that safety actions are robust, valid and aligned with existing safety improvement plans;
- Identifying where new improvement plans are needed; and;
- Providing assurance that incident management and the Trust's PSIRF response remain effective and proportionate.

PSEOG will report to the Insights and Improvement Committee (IIC), ensuring appropriate organisational oversight and alignment with the Trust's quality strategy.

Monitoring requirement	Responsible individual	Process for monitoring	Frequency of monitoring	Responsible group for monitoring
Compassionate engagement and involvement of those affected by PSE	Divisional Management Teams	• Audit of DoC • Feedback from those involved in PSII • Staff experience data	Bi-annually	PSEOG
Use of a range of system based approaches to learning	Divisional Management Teams	Data from Datix for number type and trends of incidents recorded	Quarterly	PSEOG
Considered and proportionate response to PSE	Divisional Management Teams	Data from Datix for number type and trends of incidents recorded	Quarterly	PSEOG

Table 2: Governance and oversight of PSIRF process

The Trust board will undertake oversight training providing assurance that the Trust is meeting the requirements of PSIRF.

The Trust will agree ongoing training requirements to ensure that learning response leads:

- Have completed at least two days of formal training in learning from patient safety incidents and have experience in PSE response;
- Continue their professional development in incident response and participate in networking or peer-learning activities at least annually; and
- Contribute to a minimum of two learning responses per year.

Learning response leads must demonstrate the following competencies:

- Apply human factors and systems-thinking principles to gather and analyse qualitative and quantitative information**;**
- Summarise and present complex information clearly, including in report format**;**
- Manage conflicting information from internal and external sources; and;
- Communicate highly complex/sensitive matters effectively, including in challenging situations**.**

Managers are responsible for ensuring that staff receive the appropriate initial and refresher training for their roles. The National Patient Safety Syllabus e-learning (Levels 1 and 2) is available to all staff. Employees must refer to the Mandatory Training Profiles on the intranet to identify which patient safety training applies to their role and how frequently it must be updated.

Engaging and involving patients, families and staff following a patient safety event

Patients, their families and carers are often the only people who have insight into every stage of the patient's journey. Their involvement is essential to forming a complete understanding of what happened. Failure to engage meaningfully with them and with staff involved risks losing valuable information and results in an incomplete picture of the event. Staff provide critical insight into the incident, including the environment, pressures and system conditions at the time. They must be supported to share their account openly and safely.

Engaging with those affected improves our understanding of the event and increases opportunities to prevent similar incidents in the future. Active, compassionate involvement is a core requirement of PSIRF and forms part of a systematic, learning-focused approach to patient safety. Engagement includes working with those affected to answer their questions, support their needs and signpost to appropriate services. The stages of engagement are outlined in Figure 2. Engagement activities may be led by the learning response lead, a senior member of the clinical team, or a family/staff liaison officer.

Figure 2: Engagement with patients, families and their carers

Every healthcare professional must be open and honest with patients when an unintended or unexpected incident occurs during their care. Being open includes informing patients and families, offering an apology, providing appropriate support, and explaining any known or potential short- and long-term effects. The statutory Duty of Candour requirements are set out in the Trust's Being Open and Duty of Candour Policy. Although PSIRF moves away from harm-based triggers for learning responses, the legal Duty of Candour still applies when an incident results in moderate harm, severe harm, or death. The RUH Patient Support and Complaints Team provides information and support to patients, families and the public, including:

- Non-clinical information and advice;

- A contact point for suggestions on service improvements;
- Support for patients and relatives/carers, including signposting to other services or organisations; and;
- Management of complaints.

People affected by a patient safety event may have a range of needs, including clinical, practical, psychological and emotional needs, which must be met as part of our duty of care to patients, carers and staff. Appendix 1 provides information on available support resources. The Trust recognises that patients, carers or representatives may sometimes be dissatisfied with the outcome or learning from a learning response or PSII. Concerns or complaints can be raised through the Patient Support and Complaints Team. NHS patients also have access to the Parliamentary and Health Service Ombudsman (PHSO) if they remain dissatisfied.

Monitoring Compliance

Key Elements	Process for Monitoring	By Whom (Individual / group / committee)		Frequency of monitoring
Activity against agreed PSIRP	Activity and assurance reports	PSEOG	ICC	Annual - Activity against agreed PSIRP
Compliance with policy	Internal Audit	Internal Auditors	Audit Committee	Minimum every 3 years

Table 3: Compliance Monitoring

Review

It is recognised that interim updates may be required in response to new or amended regulations, statutory provisions, Codes of Practice, or guidance issued by the Department of Health and Social Care, NHS England or relevant professional bodies. Where such changes occur, the policy will be updated as soon as practicable to ensure Trust practice remains current and compliant. The Patient Safety Incident Response Plan is a 'living document' and will be amended and updated as necessary to reflect learning from ongoing use. The plan will also be reviewed alongside the policy, to ensure it remains aligned with emerging learning and current priorities. Updated versions of the plan will be published on the Trust website and will replace previous iterations.

References

NHS England - Patient Safety Incident Response Framework (PSIRF)
Document first published: 16 August 2022, Last updated: 29 January 2026
https://www.england.nhs.uk/publication/patient-safety-incident-response-framework-and-supporting-guidance/

Appendix 1: Signposting for Staff, Patients, Families and Carers

We recognise that there might also be other forms of support that can help those affected by a Patient Safety incident and will work with staff, patients, families, and carers to signpost to their preferred source for this.

Staff Support in the RUH: Health & Wellbeing: https://webserver.ruh-bath.nhs.uk/welfare/staff_wellbeing.asp
National guidance for NHS trusts engaging with bereaved families: https://www.england.nhs.uk/wp-content/uploads/2018/08/learning-from-deaths-working-with-familiesv2.pdf
Learning from deaths – Information for families: https://www.england.nhs.uk/publication/learning-from-deaths-information-for-families/ Explains what happens after a bereavement (including when a death is referred to a coroner) and how families and carers should comment on care received.
Help is at Hand – for those bereaved by suicide: https://www.nhs.uk/Livewell/Suicide/Documents/Help%20is%20at%20Hand.pdf Specifically for those bereaved by suicide, this booklet offers practical support and guidance who have suffered loss in this way.
Mental Health Homicide support: https://www.england.nhs.uk/london/our-work/mental-health-support/homicide-support/ Resource for both staff and families. This information has been developed by the London region independent investigation team in collaboration with the Metropolitan Police. It is recommended that, following a mental health homicide or attempted homicide, the principles of the duty of candour are extended beyond the family and carers of the person who died, to the family of the perpetrator and others who died, and to other surviving victims and their families.
Child death support: https://www.childbereavementuk.org/grieving-for-a-child-of-any-age and https://www.lullabytrust.org.uk/bereavement-support/ Both sites offer support and practical guidance for those who have lost a child in infancy or at any age.
Complaint's advocacy: https://www.voiceability.org/about-advocacy/types-of-advocacy/nhs-complaints-advocacy The NHS Complaints Advocacy Service can help navigate the NHS complaints system, attend meetings and review information given during the complaints
Healthwatch: https://www.healthwatch.co.uk/ Healthwatch are an independent statutory body who can provide information to help make a complaint, including sample letters. You can find your local Healthwatch from the listing (arranged by council area) on the Healthwatch site: https://www.healthwatch.co.uk/your-local-healthwatch/list
Parliamentary and Health Service Ombudsman: https://www.ombudsman.org.uk/ The PHSO makes the final decisions on complaints patients, families and carers deem not to have been resolved fairly by the NHS in England, government departments and other public organisations
Citizens Advice Bureau: https://www.citizensadvice.org.uk/ Provides UK citizens with information about healthcare rights, including how to make a complaint about care received