Patient safety incident response framework (PSIRF) policy

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Purpose

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) and sets out Oviva's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

This policy is specific to patient safety incident management conducted for the purpose of ensuring patient safety, and supporting learning and improvement across Oviva UK.

Responses under this policy follow a systems-based approach. This recognises patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

Where other processes exist with a remit of determining liability or to apportion blame, or cause of death, their principal aims differ from a patient safety response. Such processes, along with those listed below, are therefore outside of the scope of this policy. For example:

- Information governance concerns
- Safeguarding concerns
- Complaints handling
- People operations investigations into employee concerns

Oviva considers the above processes as separate from any patient safety investigations. Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Roles and responsibilities

Patient safety is the responsibility of everybody working at Oviva, however, the PSIRF Executive Lead has overall accountability for ensuring that the Oviva PSIRF policy meets the statutory requirements. It is the responsibility of the Oviva staff member who identifies a patient incident to report as per the appropriate protocol outlined within this document.

To ensure key staff (see below) involved in the patient safety incident processes have adequate time to fulfil their responsibilities, it is recommended they protect 1 hour per week to review patient incidents. Time requirements should be regularly assessed and a discussion with their Line Manager sought should it be insufficient to fulfil responsibilities.

Key staff include:

- PSIRF Executive Lead:
    - Clinical Services Senior Director
- Learning Response Leads:
    - UK Medical Lead, Director of Clinical Quality and UK Clinical Quality Manager
- Patient Safety Oversight Role:
    - PSIRF Executive Lead and Director of Clinical Quality
- Engagement Leads
    - UK Medical Lead and UK Clinical Quality Manager

Our patient safety culture

Oviva is committed to ensuring the implementation of a just culture which is focused on fairness, openness and learning to support patient care improvement.

A just culture is promoted by ensuring patient safety investigations utilises a systems-based learning approach which examines the components of a system (e.g. person(s), tasks, tools and technology, the environment, the wider organisation) and understanding they may contribute to patient safety. A system-based approach aims to identify where changes need to be made within the healthcare system to improve patient safety, rather than attributing blame to an individual. If staff are potentially involved in an incident, a just and proportionate approach must be taken, as outlined in the Patient Safety Incident Response Plan (PSIRP).

Patient safety partners

Oviva will gather employee and patient feedback on an ongoing basis to support safety improvement, as follows:

- Oviva patient feedback is reviewed on a monthly basis via a variety of sources (e.g. Friends and Family Test (FFT), Facebook, Trustpilot), this includes the identification of themes such as patient safety. Patient feedback themes are reported to the senior programme teams on a monthly basis for review and action, and the Clinical Governance meeting on a quarterly basis to ensure across-programme learning and alignment.

- Patient Safety Partners (PSPs): Oviva maintains a dedicated team of patient champions, known as Oviva Champions, who actively contribute to our programme and product enhancements through focus groups, surveys, workshops, and product testing. These champions will be periodically involved to assist in patient safety improvement initiatives to provide service user views and comments. For example, this may be related to specific incident responses (e.g. to better understand and clarify contributing factors and improvement actions) or change proposals to patient safety policy or processes.
- Oviva employees are asked about their views on patient safety on an annual basis. The results of which are reviewed by the Learning Response Leads to identify areas of systems-based improvement.

To support the addressing of health inequalities, the following principles have been established:

- Communication considerations for how to engage and involve patients, family and carers following a safety incident, for example, for those with a language barrier or living with learning disabilities and autism:
    - Avoidance of jargon
    - Allowing processing time
    - Check understanding - listener and patient
    - Speak clearly with appropriate pace
    - Be aware of tone and approach matching communication without 'talking down'
    - Open ended questions and provide support as needed
    - Reasonable adjustments are changes that have been made to a service so that people with any disability can use them like anyone else
    - Translation service offered to support patients whose first language is not English
- Where possible, Oviva will triangulate data on patient safety incidents and ethnicity and health inequalities (e.g. Index of Multiple Deprivation data). This analysis will be led by the Learning Response Leads and included within the quarterly incident report presented at Clinical Governance meeting for review and system-based action alignment.

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

The PSIRF recognises learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. An effective patient safety incident response system prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Oviva recognises the importance of involving patients and families following patient safety incidents, and engaging them in the investigation process if one is indicated. Patients and families often provide a unique, or different perspective to the circumstances around patient safety incidents, and / or may have different questions or needs to that of Oviva.

Involving patients & families - Duty of Candour

The duty of candour (CQC - Regulation 20) is the responsibility of all Oviva staff to be open and transparent with people using our healthcare services and their families, in relation to their treatment and care when a notifiable safety incident occurs. All staff, on induction to Oviva, are provided with training regarding the importance of duty of candour and patient safety incident reporting.

Regardless of an incident being notifiable or a patient safety incident investigation (PSII) being indicated, the Learning Response Lead will assess all reported patient safety incidents (figure 1) to review if openness and transparency with the patients, family and/or carers is indicated.

This includes:

1. Telling the person/people involved (including family and carer where appropriate) that a safety incident has taken place
2. Apologising and providing a true account of what happened, explaining whatever is known at that point.
3. Confirming if they would like any further communication or involvement in the incident response process. If so, what their preferred method of communication (e.g. face-to-face meeting, video call)
4. Explaining what we are going to do to understand the events. For example, reviewing the facts and developing a brief timeline.
    - This includes reviewing the incident with the patient, family and/or carer (if they wish so) to clarify their account of events and understand their associated priorities, concerns and questions
5. Ensuring the patient, family and/or carer is aware of how to contact Oviva's Engagement Lead.
6. Following-up by confirming the above information, and an apology, in writing (including email), and providing appropriate updates and clarification. For example:
    - Taking the patient through the timeline and seeking any further clarification.
    - Providing updates on improvement actions related to the incident and seeking their input
7. Keeping a secure written record of all meetings and communications

- If a learning response is initiated, written feedback must be sent to the affected patient, family and/or carer about the outcome of the investigation and associated improvement actions. A meeting with an Oviva Engagement Lead should also be offered to discuss the findings and action plan outcomes.

If duty of candour is required, the patient and their family / carer (if appropriate) should be contacted as soon as possible and kept up to date by an Oviva Engagement Lead on a regular basis (frequency agreed with the patient) to ensure patient engagement and involvement throughout the patient safety improvement process.

Involving staff and healthcare partners

Involvement of staff and colleagues (including healthcare partners such as commissioners and sub-contractors) is of great importance when responding to a patient safety incident. In the case of an incident being reported, the following actions will take place:

- Learning Response Lead engagement with reporting staff member(s) to ascertain further information if required
- In the event of a learning response being indicated, Learning Response Lead engagement and regular communication with staff associated with the incident to support understanding of system-based factors which may have contributed to the incident and creation of an improvement plan.
- Staff feedback regarding patient safety incident learnings, improvement plans and priorities are circulated via the weekly Oviva UK newsletter and biweekly pathways Huddles. Additionally, emergent safety learnings and improvement priorities are fed-back to the UK Leadership team via weekly Squads and quarterly Clinical Governance meetings. The UK Clinical Quality Manager is responsible for collating and distributing key learnings and insights to the relevant teams and staff members. These communications aim to promote just culture principles focused on fairness, openness and learning to support patient care improvement.

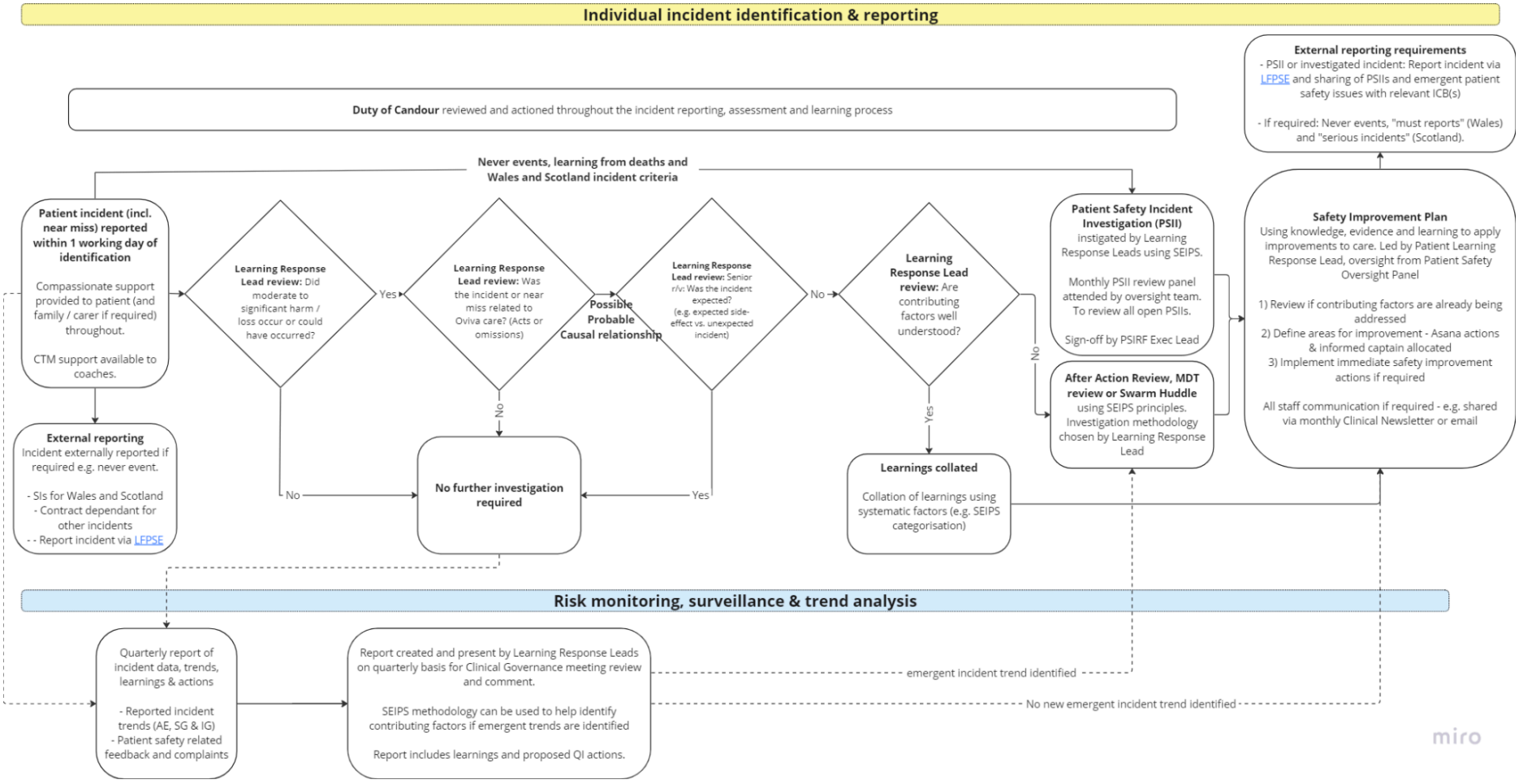
Oviva recognises staff and colleagues need to continually feel supported to speak out and openly report incidents and concerns without fear of recrimination or blame. We will continue to closely monitor incident reporting levels and staff feedback and promote an open and just culture to support this.

Patient safety incident response planning

Oviva aims 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.

Beyond nationally set requirements (e.g. never events), Oviva will explore local emergent incidents and trends and patient safety incidents potentially linked to Oviva care provision which were unexpected/untoward, rather than all incidents which meet a defined threshold. Our patient safety incident response plan (PSIRP) details how this will be achieved.

Figure 1: Oviva incident response overview



Resources and training to support patient safety incident response

Training

Oviva is committed to ensuring we fully embed PSIRF and meet its requirements. We have therefore used the NHS England patient safety response standards (2022) to frame the resources and training required to allow for this to happen. The following training requirements are stipulated by Oviva drawing on NHSE guidance and recommendations:

Key roles	Internal incident reporting training	Essentials for Patient Safety Training (Level 1)	Essentials for patient safety for senior leadership teams (Level 1) & Access to Practice (Level 2)	Systems approach to learning from patient safety-related incidents training	Systems approach to learning from patient safety-related incidents oversight training	Engaging with patients, families, and staff following a patient safety incident training
All clinical and patient support staff	✔	✔				
Clinical Service Managers, Senior Managers and Leads	✔	✔	✔			
Learning Response Leads	✔	✔	✔	✔		
Patient Safety Oversight Role	✔	✔	✔	✔	✔	✔
Engagement Leads	✔	✔	✔			✔

The below PSIRF roles are allocated to the following Oviva staff members:

PSIRF role	Oviva staff members
Learning Response Leads	UK Medical Director & UK Clinical Quality Manager
Patient Safety Oversight Role	PSIRF Executive Lead and Director of Clinical Quality
Engagement Leads	UK Medical Director and UK Clinical Quality Manager

Resources
Those staff affected by patient safety incidents will be afforded the necessary managerial support and be given time to participate in investigation, learning and engagement responses. Learning Response Leads will work with other functions such as People Operations and Clinical Services to ensure there is a dedicated staff resource to support such engagement and involvement.

Oviva will ensure learning responses are not led by staff who were involved in the patient safety incident itself or by those who directly manage those staff. To support this, multiple learning response leads will be trained to provide appropriate resources to learning responses.

Everyday patient-safety queries will be supported by the Clinical Duty Managers who can escalate to Clinical Leads or Learning Response Leads for further support. Oviva will monitor employee capacity and workload to ensure timely patient safety-related incident reporting, support and assessment.

Our patient safety incident response plan

Our PSIRP sets out how Oviva intends to respond to patient safety incidents over a period of 12 months. The plan is not a permanent set of rules that cannot be changed. We will remain flexible and consider the specific circumstances in which each patient safety incident occurred and the needs of those affected, as well as the plan. This includes ongoing improvement work as our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 12 to 18 months. Updated plans will be published on the Oviva website, replacing the previous version.

A proportionate approach to incident response has been developed which is appropriate to Oviva service provision and resources (including employee time) to support system-based learning. Figure 1 provides an overview of how Oviva proportionally responds to patient safety incidents, including day-to-day patient safety queries from employees.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with Oviva's lead integrated care board (ICB)) to ensure efforts continue to be balanced between learning and improvement. This more in-depth review will include reviewing our response capacity, mapping our services, a wide review of organisational data (for example, PSII reports, improvement plans, complaints, claims, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement, including PSPs.

Responding to patient safety incidents

All Oviva staff are responsible for reporting any potential (i.e. near misses) or actual patient safety incidents via Oviva's patient safety incident reporting system. Once an incident has been reported, the UK Clinical Quality Manager is automatically informed to ensure timely review of the incident (figure 1).

National and internal reporting requirement adherence is required to ensure the appropriate implementation of PSIIs or learning responses. For further information, please refer to the PSIRP.

Cross-system issues will be identified via the systems-approach to learning responses and quarterly audit of incident data which is further outlined in the PSIRP.

Patient safety incident response decision-making

PSIRF itself sets no further national rules or thresholds to determine what method of response should be used to support learning and improvement. Oviva has developed its own response mechanism to balance efforts between learning and through responding to incidents or exploring trends and issues.

Figure 1 provides an overview of how Oviva proportionally responds to patient safety incidents via Learning response lead review of reported incidents. To confirm Oviva's method of proportionate response, 2 years worth of Oviva incident data was reviewed and summarised to inform the PSIRP.

Responding to cross-system incidents/issues

Oviva will work with partner providers and the relevant ICBs to establish and maintain robust procedures to facilitate shared learnings and the free flow of information and minimise delays to joint working on cross-system incidents. The UK Clinical Quality Manager (Learning Response Lead) via The Patient Incident Review MDT Panel will act as the liaison point for such working. When appropriate, Oviva will defer to an ICB for coordination where a cross-system incident is felt to be too complex to be managed as a single provider.

Internal cross-system learning issues will be identified by using a systems-approach to PSII (i.e. SIEPS) and surveillance trends and learnings. If cross-function learnings are identified the appropriate function lead (e.g. Director of Product & Pathways, Director of Clinical Services, Head of Partnerships) will be informed to ensure action coordination by the Learning Response Lead. Patient feedback and complaint trends related to patient safety will be fed back to the Clinical Governance meeting group for comment, review and action alignment.

Timeframes for learning responses

All reported incidents should be initially assessed (figure 1) by a Learning Response Lead within 5 working days of reporting.

A learning response (including PSIIs) must start as soon as possible after identification and be completed within 6 months of the incident being reported. As part of setting the terms of reference for a PSII, the timeframe for completing the PSII should be agreed with those affected by the incident, provided they are willing and able to be involved in that decision. A balance must be drawn between conducting a thorough learning response, the impact that extended timescales can have on those involved in the incident, and the risk that delayed findings may adversely affect safety. In exceptional circumstances, a longer timeframe may be required for completion of a learning response. In this case, any extended timeframe should be agreed between the Patient Incident Review MDT Panel and those affected.

Where external bodies (or those affected by patient safety incidents) cannot provide information, to enable completion within six months or the agreed timeframe, the Learning Response Lead should work with all the information they have to complete the response to the best of their ability. In such cases, the incident response may be revisited later, should new information indicate the need for further investigative activity. As above, oversight will be confirmed by the Patient Incident Review MDT Panel.

Record keeping

It is essential that records of the investigation/actions taken throughout the management of a patient incident are maintained and kept secure within the incident reporting spreadsheet.

When reviewing incidents on Oviva's patient record system, Learning Response Leads (e.g. incident review) and Clinical Duty Managers (day-to-day support) will ensure:

- All documentation relating to the incident is retained/secured for future reference in the event of:
    - an external independent investigation;
    - legal proceedings being issued;
    - a criminal investigation
    - For patient safety incidents the medical records from Oviva's system (OCS) are preserved in coordination with the Chief Technology Officer. Where records are required for the purposes of an external investigation, i.e. an inquest or criminal investigation, hard copies should be produced and retained in secure storage by the Managing Director.

Oviva staff guidance for patient safety incident documentation

- For more information, please refer to incident documentation guidance
- All patient safety letters and notifications (see below) must be uploaded to the patient's OCS profile once sent.
- The reporter should provide clear and objective documentation on OCS regarding the incident:
    - Objective, non judgemental, non value-laden language.
    - Avoid using written (and verbal) language which attributes responsibility (or blame) to a person for the development of their long-term condition or its consequences.
    - Avoid language that infers generalisations, stereotypes or prejudice, or links one individual with previous experience of others of a similar background or in a similar situation

    - Ensure the record is logical and easy to read. Use of paragraphs where appropriate, and order notes logically so they are easy to understand
- The “Important information” box must be completed in the event of an incident (date and type of incident). This is to help notify others that an incident has occurred.
- If an Oviva staff member does not have access to editing OCS (including the “important information box”), they should inform the incident assessor who will complete it on their behalf.

Safety action development and monitoring improvement

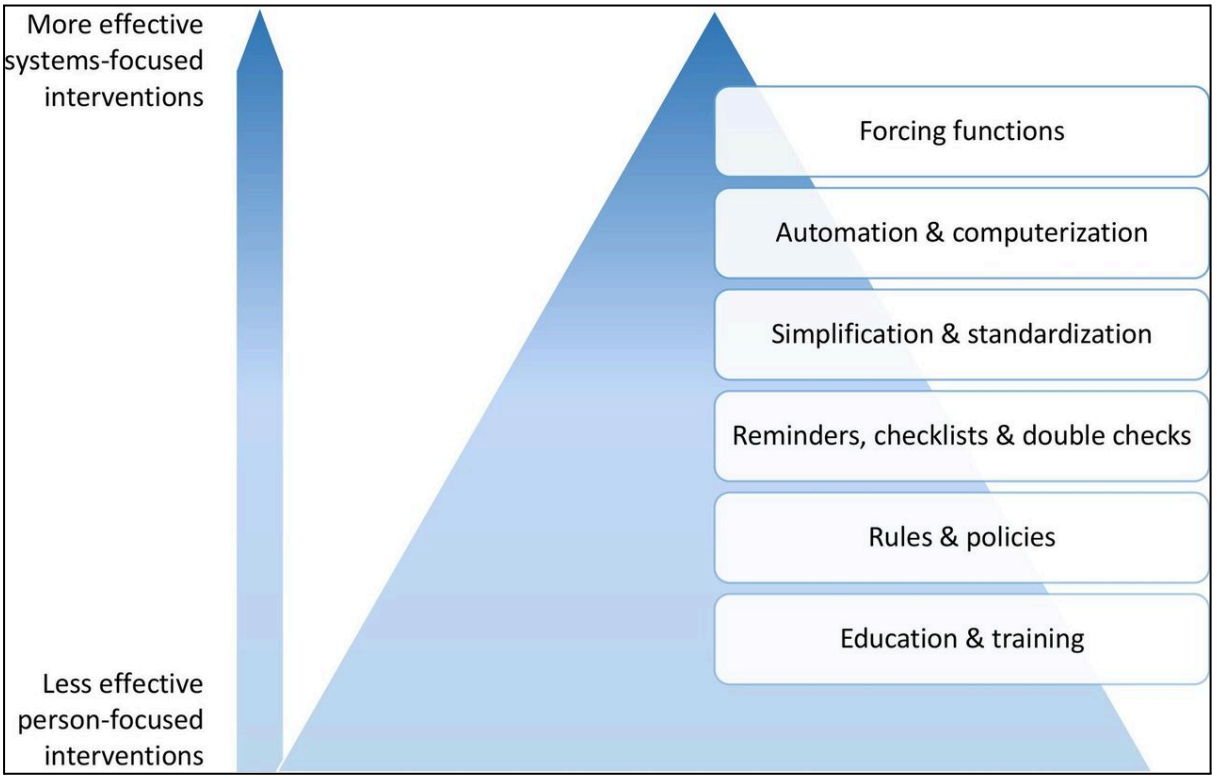
Areas for patient safety improvement action development and monitoring may be as a result of a learning response, PSII or quarterly incident data analysis. If contributing factors are not well understood the SEIPS tool will be used to ensure a systems-approach is taken to investigate and identify and rationalise improvement actions. All actions will be assigned and monitored via Oviva’s work management platform with an assigned informed captain allocated with an associated completion date.

Safety action development
Oviva will use the process for development of safety actions as outlined by NHS England in the Safety Action Development Guide (2022) as follows:

1. Agree areas for improvement – specify where improvement is needed, without defining solutions
2. Define the context – this will allow agreement on the approach to be taken to safety action development
3. Define safety actions to address areas of improvement – focussed on the system and in collaboration with teams and stakeholder involved (including patients and staff involved or impacted)
4. Prioritise safety actions to decide on testing for implementation
5. Define safety measures to demonstrate whether the safety action is influencing what is intended as well as setting out responsibility for any resultant metrics
6. Safety actions will be clearly written and follow SMART principles and have an informed captain (designated owner) and due date for completion.

When improvement actions are required, corrective actions and patient safety improvement should take into account the hierarchy for intervention effectiveness with a focus on system improvement. This includes, not solely relying on staff education and training to enhance patient safety.

Figure 2: The hierarchy of intervention effectiveness



Systems-focused interventions:

- **Forcing functions** are those that prevent the patient or an Oviva staff member from making a mistake or an undesired action. Forcing functions involve designing processes or systems in a way that compels individuals to follow specific steps or take certain actions before proceeding. The emphasis is on enforcing specific behaviours or checks to prevent errors and promote consistency and safety.
- **Automation & computerisation** refers to the use of technology to perform tasks or processes with minimal human intervention. Automation aims to streamline repetitive and routine tasks by transferring them to machines or computer systems. Automated processes are typically faster and more consistent than manual processes, and they can help reduce human error
- **Simplification & standardisation** involves establishing uniform procedures, protocols, and practices for specific quality processes. The aim is to ensure consistency, reduce variation, and support predictable outcomes. The CQF represents an initiative to standardise clinical quality standards across Oviva.

People-focused interventions

- **Reminders, checklists & double checks** are used to ensure critical steps are taken by staff, for example, important information is verified before prescribing medication. These strategies help promote consistency, reduce variability, and enhance the reliability of healthcare processes
- **Rules & policies** provide clear guidance, establish expectations, and create a framework for consistent and safe practices.
- **Education & training** aims to equip Oviva staff with the knowledge, skills, and competencies needed to provide effective and safe care.

Safety action monitoring

- Safety improvement actions are monitored by the Patient Incident Review MDT Panel and monthly risk register meeting to ensure any actions put in place remain impactful and sustainable.

Safety improvement plans

Safety improvement plans bring together findings from various responses to patient safety incidents and issues. Safety improvement plans will be informed and created on the basis of quarterly patient safety trend analysis or a combination of individual or multiple learning responses (including PSIIs). Safety improvement plans will be aligned on and monitored in the monthly clinical risk register meeting to ensure alignment with wider organisational priorities and monitoring of progress.

Individual incident assessment and improvement actions

As per figure 1, incidents which caused or could have caused moderate to severe harm, potentially related to Oviva care that were unexpected will be subject to a learning response and the quality improvement process initiated.

- If improvement actions are Pathway specific, they are triaged by the Learning Response Lead to the associated Pathway Squads.
- If across-programme, improvement plan alignment will be conducted via the monthly clinical risk meeting. Progress will be monitored via the risk management action board.
- In both cases, Learning Response Leads may seek clinical expertise via the Patient Incident Review MDT Panel

Quarterly analysis and improvement actions

Patient safety incident data trends (including PSIIs) and recommended improvement actions are reviewed and reported on a quarterly basis by the Learning Response Leads. Improvement actions must have a clear safety measure to determine whether improvement is made. Data must include analysis comparing frequency of incidents to the number of patients enrolled on each programme.

- The Clinical Governance Committee will be consulted regarding actions, priorities and recommendations relating to patient safety improvement.
- The informed captain of the function most related to the action will be the final decision maker, consensus is not required.
- The quarterly report actions must be collated by the minute taker within the Clinical Governance action board. Actions must be updated by the assigned action owner / informed captain.

Oversight roles and responsibilities

Oviva aims to design our PSIRF oversight systems in a way that ensures improvement, rather than purely policy compliance. Oviva maintains a monthly clinical risk register meeting to oversee the operation and decision-making of the Learning Response Leads and the appropriate prioritisation of learning responses (including PSIIs) and patient safety improvement actions.
Oviva will aim to meet the following patient safety oversight principles:

1. Improvement is the focus PSIRF oversight, and should focus on enabling and monitoring improvement in the safety of care, not simply monitoring investigation quality.
2. Blame restricts insight. Oversight should ensure learning focuses on identifying the system factors that contribute to patient safety incidents, not finding individuals to blame.
3. Learning from patient safety incidents is a proactive step towards improvement. Responding to a patient safety incident for learning is an active strategy towards continuous improvement.
4. Collaboration is key. A meaningful approach to oversight cannot be developed and maintained by individuals or organisations working in isolation – it must be done collaboratively.
5. Psychological safety allows learning to occur. Oversight requires a climate of openness to encourage consideration of different perspectives, discussion around weaknesses and a willingness to suggest solutions.
6. Curiosity is powerful. Those providing patient safety oversight in Oviva have a unique opportunity to do more than measure and monitor. They can and should use their position of power to influence improvement through curiosity. A valuable characteristic for oversight is asking questions to understand rather than to judge.

Patient safety oversight will be implemented in the following three forums / meetings. Oviva aims to design a PSIRF oversight system in a way that ensures improvement, rather than purely policy compliance. Oviva maintains the below key forums to support learning responses, clinical expertise feedback and improvement plan alignment.

Firstly, the **biweekly Patient Safety MDT**, supports the following:

- Update of safety event trends and themes
- Discussion of clinically complex cases to help inform if an event / trend requires a PSII
- Review incident response actions and the organisational safety improvement plan and priorities.
- Review and timely final sign-off for all learning responses (including PSIIs).
- Ensure the implementation of a just culture focused on fairness, openness and learning

Chaired by the UK Clinical Quality Manager, attendees include Clinical and Medical leadership, the Senior Director of Clinical Services. Other staff may be invited as required depending on the nature of the incidents being reviewed. Business will only be conducted if the meeting is quorate. The MDT will be quorate with the chair (Clinical Quality Manager) and at least two other members, including representation from medical or clinical leadership, being present.

Secondly, the **monthly Clinical Risk Register** meeting:

- Ownership of UK clinical risk register and patient safety actions / improvement plans which require cross-functional group review, implementation and oversight
- Ensuring timeliness of improvement plan implementation and a just culture focused on fairness, openness and learning
- Chaired by the Director of Clinical Quality, attendees include, Clinical and Medical Leadership, Senior Programme and Pathway and Clinical Services Leadership and the UK Safeguarding Lead.

Thirdly, quarterly **Clinical Governance Committee** reviews:

- Quarterly patient safety incident trends and emergent findings to support across-function learning and coordination of required improvement activities.
- Quarterly review of timeliness of safety event responses and PSII completion
- Cross-function audits and reports are also scrutinised in this forum which may identify emergent patient safety issues. For example, complaints and patient feedback trends and clinical delivery concerns which may impact patient safety
- Ensure the implementation of a just culture focused on fairness, openness and learning
- Chaired by the Director of Clinical Quality, reviews, attendees include function Directors, Head of Clinical Quality, Legal and Compliance Counsel Safeguarding Lead and Clinical Leads.

Oviva patient safety representatives will continue to attend monthly Patient Safety Management Network Meetings which provides a peer-support forum for sharing knowledge, concerns and questions (including PSIRF).

As Oviva's largest ICB commissioner, PSIRF policy sign-off was assured by Mid and South Essex ICB (MSE). Oviva's PSIRF policy will be shared with its other ICB partners following MSE sign-off. Oviva will take all necessary steps to ensure transparency with CQC regarding PSIRF policy, with regard to patient-safety policy, learnings responses, improvement initiatives and patient safety data.

Complaints and appeals

Patient feedback and complaints regarding patient safety issues is covered within the Oviva complaints policy and process guide, including a complaints appeal. Oviva reviews patient feedback 3 times a week via a wide range of channels, including Facebook, FFT, Google reviews, Trustpilot and App store.

- Patient feedback regarding a patient safety incident will be actioned within 24 hours of identification.
- Patient feedback themes are collated and reviewed in Clinical Governance meetings on a quarterly basis, including patient safety concerns.