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1. Policy Statement

The NHS Patient Safety Strategy was published in 2019 and describes the Patient Safety Incident Response Framework (PSIRF) which replaces the NHS Serious Incident Framework (SIF). PSIRF sets out a new approach to learning and improving following patient safety incidents across the NHS in England. Compassionate engagement and involvement of those affected by patient safety incidents is central to the PSIRF approach. Children's Hospice South West (CHSW) is required to implement these PSIRF principles as an independent provider contracted under the NHS standard contract.

2. Purpose & Scope

This policy supports the requirements of the PSIRF and sets out CHSW's approach in developing and maintaining effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety, and 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.

The PSIRF advocates a co-ordinated and collaborative 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 is specific to patient safety incident responses conducted solely for the purpose of learning and improvement across CHSW.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single point of blame. 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.

There is no remit to apportion blame or determine liability, preventability or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as non-patient safety complaints, human resources investigations into employment concerns, professional standards investigations, coronial inquests and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

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.

This policy is written in accordance with:

- The Care Quality Commission (CQC) 'Guidance for Providers on Meeting the Regulations', Regulation 20 (Duty of Candour) and Regulation 12 (Safe Care and Treatment)
- The Health and Safety Act 1974, Reporting of Injuries, Disease and Dangerous Occurrences Regulation 1995 (RIDDOR)
- Patient Safety Incident Response Framework (PSIRF) and Tools

3. Definitions

Patient Safety Incident (PSI) – Something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm.

Patient Safety Incident Investigation (PSII): Is undertaken when an incident indicates significant patient safety risks and potential for new learning. The purpose is to identify what happened and why, so that we can try and reduce the chances of it happening again.
We will look at the circumstances that led to the incident, and review procedures and practices using a systems-based approach, to identify areas that need to be changed or improved.

Patient Safety Incident Response Team (PSIRT): Made up of Deputy Directors of Care, Lead for Children and Families, Lead for Clinical Services, Lead for Learning and Development, Heads of Care and Medical Directors. Where a PSII is required, members of this team who are not from the site at which the incident occurred will form the investigation team.

After Action Review: A method of evaluation that is used when outcomes of an activity or event have been particularly successful or unsuccessful. It aims to capture learning from these to identify the opportunities to improve and increase to occasions where success occurs.

Huddle/Debrief: initiated as soon as possible after an incident occurs. Staff involved in the incident meet to gather information about what happened and why it happened and (together with insight gathered from other sources wherever possible) decide what needs to be done to reduce the risk of the same thing happening in future.

Harm Levels:

The table below sets out the NHS levels of harm descriptions which CHSW use to record and review incidents.

Harm Level	Psychological	Physical
No Harm	Being involved in any patient safety incident is not pleasant, but please select 'no harm' if you are not aware of any specific psychological harm that meets the description of 'low psychological harm' or worse. Pain should be recorded under physical harm rather than psychological harm.	No physical harm
Low Harm	Low psychological harm is when **at least one** of the following apply: • distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit • distress that did not or is unlikely to affect the patient's normal activities for more than a few days • distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition	Low physical harm is when **all of the following** apply: • minimal harm occurred – patient(s) required extra observation or minor treatment • did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit • did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication • did not or is unlikely to affect that patient's independence • did not or is unlikely to affect the success of treatment for existing health conditions.
Moderate Harm	Moderate psychological harm is when at least one of the following apply: • distress that did or is likely to need a course of treatment that extends for less than six months • distress that did or is likely to affect the patient's normal activities for more than a few days but is unlikely to affect the patient's ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within six months	Moderate harm is when **at least one** of the following apply: • has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment, and did not need immediate life-saving intervention • has limited or is likely to limit the patient's independence, but for less than 6 months • has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or

		accelerated disability described under severe harm.
Severe Harm	Severe psychological harm is when **at least one** of the following apply: • distress that did or is likely to need a course of treatment that continues for more than six months • distress that did or is likely to affect the patient's normal activities or ability to live independently for more than six months • distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, and recovery is not expected within six months	Severe harm is when at least one of the following apply: • permanent harm/permanent alteration of the physiology • needed immediate life-saving clinical intervention • is likely to have reduced the patient's life expectancy • needed or is likely to need additional inpatient care of more than 2 weeks and/or more than 6 months of further treatment • has, or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, of their existing health conditions • has limited or is likely to limit the patient's independence for 6 months or more.
Fatal		You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death, including stillbirth or pregnancy loss. You will have the option later to estimate to what extent it is considered a patient safety incident contributed to the death.

4. Our Patient Safety Culture

CHSW is an organisation which embeds its core values to promote an open and transparent culture around patient safety, incident reporting and learning.

Our Core Values:

Care and respect for each other:

Recognising and accepting our responsibility for safeguarding babies, children, young people and adults and protecting them from harm

Acting fairly and with consideration treating others as we would wish to be treated ourselves

Finding out what other colleagues do, encouraging them and recognising the value that each brings to the organisation

Embracing and recognising the importance of difference and diversity

Honesty, openness and accountability:

Behaving with openness, integrity and honesty

Communicating swiftly and openly and listening to the views of others respectfully

Taking responsibility for your own actions and being accountable for them

Strive for excellence :

Seeking to continuously develop and improve for your own benefit and the charity

Always protecting the reputation of the charity

Celebrating success

Work together:

Ensuring dynamic and harmonious team working to achieve success

Working with and involving our families, supporters and volunteers, understanding who they are and what their needs might be

Making the best use of organisational resources; having regard for sustainability, efficiency and respect for the environment

CHSW fosters a 'just culture' approach and understands that creating an environment where colleagues feel able to report incidents and raise concerns without fear of recrimination is essential to improving safety. We encourage and support incident/event reporting where any member of staff feels something has happened, or may happen, which has led to, or may lead to, harm to patients, family, employees, service and reputation.

CHSW uses Vantage as our electronic incident reporting system, and a transparent and robust incident reporting culture is promoted across all teams. Incidents are reviewed by the senior management team in each Hospice, and centrally by the Patient Safety Incident Response Team (PSIRT) at our weekly Incident Response Meeting (IRM).
During this meeting proportionate and appropriate learning responses are allocated to each

incident, focusing on maximising learning. CHSW work hard to create a resilient workforce who are encouraged to reflect on incidents and participate in working groups which help develop learning outcomes. Learning from incidents is also captured and shared at our monthly Learning and Sharing Forum.

At CHSW we want our teams to feel respected and valued and to know that we welcome their views, suggestions and concerns. We have Freedom to Speak Up champions across all teams at all sites, as well as a Freedom to Speak Up Guardian.
Staff complete Freedom to Speak Up training by way of an E-Learning module. Updates are regularly provided via bulletins and Team Meetings on how to access our Freedom to Speak up team, and the different avenues through which staff can raise any concerns. All concerns raised are dealt with in line with CHSW's Freedom to Speak Up and Whistleblowing policy.

5. Patient Safety Partners

Patient Safety Partners (PSP) is a new and evolving role developed by NHSE to help improve patient safety across the NHS.

This is a role which CHSW is keen to develop as we recognise the benefits of having PSP perspectives and involvement in all aspects of improving our organisation's patient safety. It is envisaged that this may include contribution to documentation including policies, plans and reports, and attendance at safety meetings and Quality Governance meetings, to ensure that patient safety is at the forefront of everything we do.

At present we are exploring ways in which PSP's could work in a meaningful and proportionate way within our organisation. Our first steps are to work with the Family Advisory Board (FAB) which is in its initial stages of development.
We are also engaged in working as part of a national Hospice UK group, looking at patient safety and benchmarking incidents across children's hospices.

6. Addressing Health Inequalities

CHSW is committed to reducing health inequalities by improving access to paediatric palliative care services and promoting choice, independence and individualised care. We value diversity and promote a culture of respect for all.

We will aim to better use incident data and learning responses to support health equality and identify any disproportionate risks to patients with protected characteristics.

We wish for all aspects of our service to be accessible and inclusive for every child /young person and family under our care, regardless of their background or circumstances.

Engagement of families and staff following a patient safety incident is crucial to the review process and learning response. We will work to identify any potential inclusivity issues and where required we will ensure that available tools such as translation and interpretation services are accessed to support the needs of those involved in incidents/investigations.

7.0 Engaging and Involving Patients, Families and Staff Following a Patient Safety Incident

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

7.1 Children and Families:

When an incident occurs, or something goes differently to how we expected/intended or where concerns are raised, our patient safety culture recognises the importance of involving the children and families involved at the earliest opportunity. This can contribute to minimising harm and maximising learning, whilst transparency and honesty encourage confidence in our service.

Where concerns or complaints are raised, we aspire to resolve and learn from these in a timely manner, ensuring that individuals are listened to, and engagement is compassionate and respectful.

Our care teams understand their responsibility and accountability in reporting incidents and informing those involved if an error has occurred. Apologies are meaningful and saying sorry does not mean admitting blame when something goes wrong.

In addition to meeting our professional and regulatory requirements for Duty of Candour, at CHSW we want to be open and transparent with the children and families we care for regardless of the level of harm caused by an incident. This is why our first response is always to inform those involved, and work with them in our learning responses.
We will also work to obtain feedback from children and families involved in patient safety incidents.

7.2 Staff and Volunteers:

Involving the staff and volunteers involved in patient safety incidents in a compassionate way is a fundamental part of our patient safety culture.
PSIRF does not seek to apportion blame but is a route to identifying learning and areas for improvement. Engagement with those involved is key to development of systems which enhance patient safety.

We are committed to creating a no blame culture and have redefined our Incident Response Meeting structure and process to reflect this and create an environment which encourages participation and a collaborative approach.

8.0 Patient Safety Incident Response Planning

The 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. Beyond nationally set requirements, organisations can explore patient safety incidents relevant to their context and the populations they serve rather than only those that meet a certain defined threshold.

8.1 Resources and training to support patient safety incident response

CHSW is committed to fully embedding PSIRF and ensuring that all care team members actively contribute to our organisation meeting its requirements.

Training for staff varies depending on their role but every staff member within CHSW Care is expected to have a basic understanding of patient safety event recognition, reporting and candour.

- **All CHSW Care Staff** including Health & Safety, facilities and Senior management team (SMT) are required to have completed:
  Level 1 - Essentials of patient safety within our ELfH E-learning training system. Annual refreshers are ongoing.

- **Senior Care Teams, Central Care Leads, Deputy Directors of Care** are required to have completed (in addition to Level 1):
  Level 2- Patient Safety Syllabus access to practice within our ELfH E-learning training system. Annual refreshers are ongoing.

- **SMT and CHSW Board** are required to have completed Essentials of Patient Safety for Boards and Senior Leadership within our ELfH E-learning training.

  PSIRT are required to have completed NHS recognised specialist PSI training which is provided by an external training provider. These courses are designed for those who have an integral part within CHSW patient safety Investigations. These courses are:

Course Title	Content
Systems approach to learning	• Complex systems, systems thinking and human factors • Investigation practices such as interviewing, using systems frameworks, utilizing data and report writing • Developing effective safety actions and recommendations • Engaging and involving those affected by PSI
Involving those affected	• Creating the right foundations • Before and initial contact • Continued and closing contact • Additional considerations
PSIRF Oversight	• Principles of Patient safety oversight • Mindset and culture underpinning effective oversight • Theory and practice of measurement • Monitoring patient safety

8.2 Our Patient Safety Incident Response Plan (PSIRP)

Our plan sets out how CHSW will respond to patient safety incidents over a period of 12 – 18 months, and learn from them, to continually improve the quality and safety of the care we provide. The plan will also detail how we will capture our successes and share our examples of good practice.
This plan is not a permanent set of rules that cannot be changed. We will remain flexible in our approach and consider the specific circumstances in which each patient safety incident occurred, and the needs of those affected.

The development of our PSIRP was overseen by a small working group made up mainly by members of our Patient Safety Incident Response Team.
Incident data was analysed, complaints and concerns raised were reviewed, and engagement with clinical working groups contributed to defining our safety priorities.

Our PSIRP can be accessed via the following link:
https://www.chsw.org.uk/sites/default/files/2025-01/PSIRF%20Plan.pdf

8.3 Reviewing our Patient Safety Incident Response Policy and Plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 12 to 18 months to ensure our focus remains up to date as with ongoing improvement work our patient safety incident profile is likely to change. This review 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 our website, replacing the previous version.

A rigorous planning exercise will be undertaken every four years and more frequently if appropriate (as agreed with our 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, patient safety incident investigation (PSII) reports, improvement plans, complaints, staff survey results, inequalities data, and reporting data) and wider stakeholder engagement.

9.0 Responding to Patient Safety Incidents

9.1 Patient Safety Incident Reporting Arrangements

All staff are responsible for reporting any actual or potential patient safety incidents via Vantage, our electronic reporting system.

We are committed to ensuring that staff have the time and capacity to respond to patient safety incidents in the moment, providing immediate action and reporting incidents as soon as practicable to enable the review and appropriate learning responses to begin in a timely way.

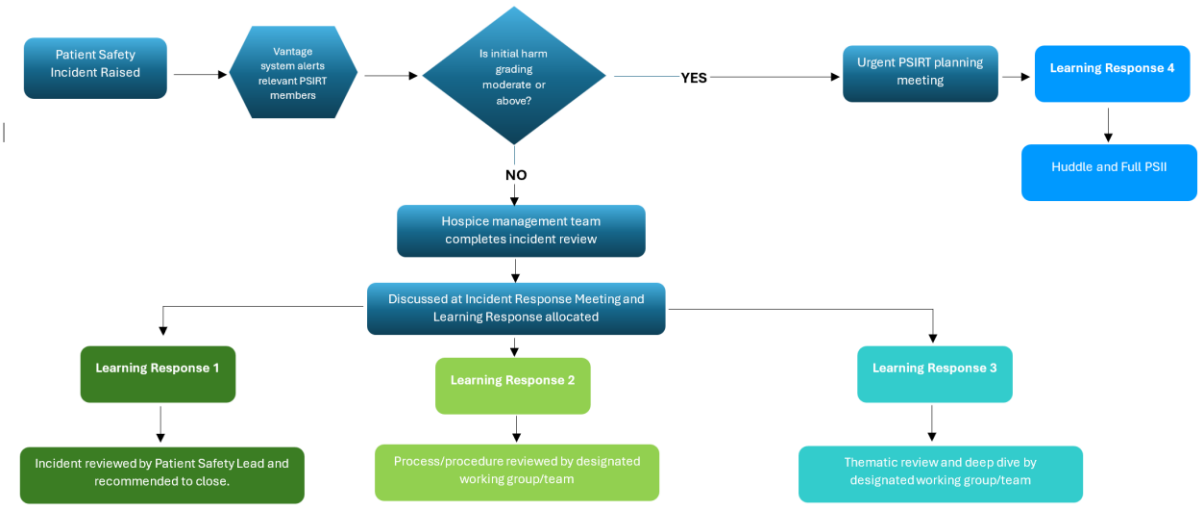
The framework in place within care provides a process for escalation and a robust system of support for all those involved in patient safety incidents.

Automatic alerts are triggered to hospice site level management for all no/low harm incidents. Site management teams have responsibility for daily review of incidents, immediate actions and escalation.
If a moderate or above harm incident is raised the PSIRT are automatically alerted. In this instance hospice site level management are responsible for ensuring immediate actions are complete, and an urgent initial meeting comprising of required members of the PSIRT is held within 24 hours to plan next steps and initiate a PSII.

The Patient Safety Lead is automatically alerted of all incidents.

All incidents are reviewed centrally at the weekly Incident Response Meeting and an appropriate Learning Response is allocated.

See process below:



The Patient Safety Lead and Learning and Development Lead will review each incident and once satisfied that all hospice level actions are complete, will recommend the incident to close. Closing of all incidents is carried out by the Deputy Directors of Care. Any safeguarding incidents will be reviewed and recommended for closure by the Lead for Children and Family Services.

Where it is anticipated that a learning response will lead to a more prolonged piece of work, or safety action, this will be moved to the Project Hub on Vantage to enable work being carried out by working groups and designated teams to be tracked and monitored.

All incidents are also reviewed and analysed a minimum of quarterly to identify any themes and contributing factors which may not have been immediately apparent. These reviews are completed by relevant working groups such as Medicines Safey Group, Respiratory Working

Group and the Moving and Handling Working Group. Where themes fall outside of areas with specific working groups, designated members of the PSIRT will complete the review.

Any incidents which require reporting externally are overseen by the Patient Safety Lead, Lead for Children and Families and Deputy Directors of Care. Where incidents meet the national requirement for PSII we will work transparently and collaboratively with our ICB.

As encouraged by our ICB we will report all relevant Patient Safety Incidents to the NHS Learning From Patient Safety Events (LFPSE) portal.

9.2 Patient Safety Incident Response Decision-making

Our Patient Safety Incident Response Team have defined different responses to incidents to ensure that all incidents raised are dealt with in a systematic and proportionate way, which maximises the opportunity for learning and quality improvement.

Response 1 – After Action Review (AAR).

- For incidents which meet no/low harm criteria, and no similar incidents have occurred previously.
- All immediate actions taken at time of incident and overseen by Duty Manager.
- Incident reviewed at weekly Incident Response Meeting (IRM) and can be closed once deputy director satisfied that managers section and any in house actions have been completed.

Response 2 – Fact finding and review

- Any PSI which relates to process concerns where there have been similar near misses/occurrences previously and a process/policy/ procedure may need to be reviewed eg. Documentation errors.
- Incident response team will decide which team/working group would be best placed to fact find and review. Patient Safety Lead will oversee this review.

Response 3 – Thematic review, deep dive and shared learning

- Any groups of no/low harm PSI's where there are similar themes or contributing factors, or where there is potential for learning.
- The incident response team will decide which group would be best placed to undertake the review and deep dive. Outcomes and learning will be shared at the monthly Learning and Sharing Forum.

Response 4 – Huddle and Patient Safety Incident Investigation

- Any incident which results in moderate or above harm will require a full patient safety incident investigation.
- Immediate actions will be overseen by the Hospice Duty Manager and a huddle/debrief involving all team members involved will take place as soon as possible after the event has occurred.
- An initial meeting involving relevant members of the Patient Safety Response team will take place to plan the investigation within 24 hours of the incident occurring.

Response 5 – Good Practice AAR

- where examples of good practice are highlighted these will be recorded on Vantage and reviewed as part of Team Meetings. Any shared learning which results from these good practice examples will be shared as part of the monthly Learning and Sharing Forum.

At the weekly Incident Response Meeting the incident Response Team will work collaboratively to determine the most appropriate response to each incident, including those that fall outside of the PSIRP's specific priority areas.

It is important to note that in addition to the harm level and potential for learning, the response decision will also consider the views of those affected including the families involved, what is known about the factors that led to the incident, and whether there is already improvement work underway in relation to any contributing factors.
All incidents can be reviewed at any time and responses can be escalated where this is deemed appropriate.

9.3 Responding to Cross-System Incidents/Issues

Where an incident occurs which involves multi-organisational and cross system working, CHSW are committed to involving, working with, and learning from all organisations involved. Collaboration with external organisations will bring diverse perspectives and will help create innovative solutions and enhance learning.

Learning from incidents is paramount for continuous improvement, and sharing incident information and insight with other organisations encourages a transparent and open culture which maximises learning.

At CHSW we have close working relationships with the community teams, hospital teams and transport teams with whom we work. Our work also spans across multiple ICB's and we will ensure we seek guidance and support in managing cross-organisational incidents from the appropriate ICB where necessary.

We will ensure that we raise all cross-system incidents within our own incident reporting module and will include the actions and learning gathered from other organisations involved in our review of the incident.

9.4 Timeframes for Learning Responses

Learning responses begin as soon as possible after any incident occurs. Timeframes for completion will be agreed in discussion with those affected by an incident. A balance between conducting a thorough review and not delaying actions which may impact safety will be sought.

We will seek to complete all learning responses within one to three months and completion of PSII should not exceed six months. Where a longer timeframe may be required this will be communicated and discussed with those affected.

9.5 Safety Action Development and Monitoring Improvement

At CHSW we understand that patient safety learning responses are the key to understanding the circumstances surrounding incidents, but this may only be the beginning. Robust safety actions and improvement plan actions are required to successfully reduce risk and improve patient safety.

9.6 Safety Improvement Plans

There are no thresholds for when a safety improvement plan should be developed. At CHSW we will collectively review output from learning responses when it is felt that there is sufficient understanding of underlying issues.

We will take a SMART approach to our safety improvement planning to ensure that actions are Specific, Measurable, Attainable, Relevant and Time-scaled. Safety and improvement actions will be tracked and monitored on the 'projects hub' on Vantage.

We will also seek to create an organisation-wide safety improvement plan which aligns with our quality improvement plan and annual Quality Account.

Safety improvement plans will be overseen by our Patient Safety Incident Response Team who will report to CHSW's Quality Governance group.

10. Oversight Roles and Responsibilities

Oversight of the PSIRF will be maintained by the central leadership team. We will share Patient Safety Incidents and examples of good care with NHSE via Learning from Patient Safety Events (LFPSE), and with our ICB.

Our PSIRT are our patient safety incident action leads and responders and have accountability for the management of learning responses and effective engagement with those involved and affected by incidents.

Deputy Directors of Care

The overall responsibility for effective risk management in the Hospice, including incident reporting and management lies with the Chief Executive (CEO). At an operational level, the Deputy Directors of Care are designated with responsibility for governance and risk management.

Responsibilities in respect of incident reporting and management are:

- Notifying the Trustees Board of incidents reported as Never Events
- Notifying the Board of Directors of incidents considered as meeting the criteria of a PSII
- Presenting reports to the Quality Governance committee of any Patient Safety Incidents Investigations identifying issues of concern, outcome and learning and assurance.

Heads of Care

Responsible for:

- Ensuring that all incidents that occur in their area of responsibility are reported in a timely manner and in accordance with Hospice Policies and Procedures
- Receiving all Vantage reporting system reports occurring in their area(s) of responsibility and ensuring that immediate action has been taken to manage the incident

- Identifying causes of incidents and putting in place measures to minimise the likelihood of recurrence by establishing any lessons to be learnt and implementing these locally
- Investigating incidents reported for their area(s) of responsibility
- Informing their staff of any lessons to be shared both Hospice wide and in the wider health community
- Initial Engagement with families and CYP that are /have been affected by the incident(s)
- Escalating any significant concerns to the Leads and Deputy Directors of Care
- Ensuring that staff are adequately supported following an incident and as required during an investigation
- Liaising with the Human Resources department regarding any precautionary measure, capability or disciplinary action proposed regarding a member of their staff following an incident
- Conducting and/or partaking in PSII for other sites as part of the PSIRT

Lead for Clinical (Patient Safety Lead), Lead for Learning & Development, Lead for Children & Families

Responsible for:

- Chairing weekly Incident Response Meeting
- Ensuring accurate categorisation of incidents
- Collating and analysing data to inform improvement actions
- Reviewing incidents and recommending for closure once all local actions have been completed
- Monitoring safety and improvement actions
- Communicating learning at monthly Learning & Sharing Forum
- Conducting and/or partaking in PSII as part of the PSIRT

All CHSW Staff

All staff are responsible for:

- Reporting incidents and near misses promptly. Staff working in the Hospice on a locum or agency basis, or as a contractor or volunteer must also report incidents via the Vantage system and informing their manager. Where a member of the public has been involved in an incident, staff must complete an incident form on their behalf.
- If a witness to or directly involved in an incident, addressing the immediate health needs of the person(s) involved in an incident, ensuring that the situation is made safe, informing their manager, and completing an incident on Vantage.
- Undertaking immediate action to manage the incident and identifying actions needed to minimise the chances of recurrence.
- Engaging in the investigation of incidents and providing information where required

11. Complaints and Concerns

Any concerns or complaints raised relating to CHSW's response to patient safety incidents will be dealt with in line with the organisation's complaints procedure. We will seek to work with those affected and involved to resolve issues where possible, maximise learning and improve our service.