When less is more: lessons learned from toy building blocks

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As we move forward into the new normal much of what is written is around lessons learned, keeping hold of the good things from the pandemic and not reverting back to pre-pandemic habits. This sounds like a very sensible plan; we should be reviewing what happened, identifying the things that worked well and building on them. We should also identify what didn't work well, both during and before the pandemic, and avoid continuing them into the future.

But all too often, it seems that by adopting these new things we are adding to the burden of already overworked clinicians. Good improvement methodology also includes stopping doing things that didn't work, "failing fast" and moving on, and this was something that happened a significant amount of the time over the last 18 months either because we had no information — or because the information we had changed on a weekly basis.

But as we move into the next year will this change? It seems we have a tendency to start brilliant new ideas that seem to make a real difference to begin with but then fail after the immediate well-supported implementation phase as staff do not have the time to do them. Why is this?

There is a fascinating study (Gupta, 2021) that identifies that people prefer to add items or tasks significantly more than remove them. They cite a really simple example of levelling up a bridge made with toy building blocks (*Box 1*), which really struck a chord with what is happening for me. There has been so much innovation, so many examples of really creative practice, flexible working, teams coming together to work in different ways, services stretching their roles to do their best for patients and it is hoped that much of this will be sustained. But we have to consider whether these services were able to work in this way because so much else was stripped away? Non-essential work was forgotten about and care was prioritised in a completely different way; the mundane and arcane tasks and activities that underpin many of our daily routines were abandoned — does this matter? Of course it does, we are seeing growing waiting lists for routine outpatients appointments, elective surgery and regular reviews and we are starting to generate data showing the impact this has all had on patients

Box 1. How to stabilise a bridge?

- Picture a bridge made of toy building blocks. One side has three support pieces, the other two. How would you stabilise the bridge?
- Most people would add a piece so that there are three supports on each side. But why not remove a piece so that each side has two supports instead?

Many clinicians did not collect data in the same way over the last year because either they were redeployed or their service changed beyond recognition. As a result, we do not have good data on the impact that creative working and innovation has had on patients. We don't know if healing rates improved as we encouraged more self- or shared-care over the pandemic, or whether there has been an increase in complications, such as infections or amputations. In the chaos of March, April and May 2020, there was not time to plan ahead or to think of possible repercussions; it was about surviving from day-to-day and doing our absolute best despite being petrified and exhausted.

But now we have time to think, we have had the time to reflect, and we are planning the way forward, Let's use this golden opportunity when service redesign is high on everyone's agenda to not only look at what we can carry forward, but also consider what we should leave in the past. Some significant changes in the patient safety reporting systems are coincidentally chiming with this mantra:

- The National Reporting and Learning System (NRLS) will be changing to patient safety incident management system (PSIMS)
- It will replace the current NRLS and Strategic Executive Information System (StEIS)

- PSIMS is not about measurement but instead, event recording for the purposes of learning. PSIMS does not look at incidence, capture grading or any formal reporting data. Information will be gathered instead on how things have gone wrong, for lessons learnt and to inform future intervention design
- NRLS will be decommissioned in about 12–18 months' time (NHS, 2020)
- The Serious Incident (SI) Framework will be changing to Patient Safety Incident Response Framework (PSIRF)
- PSIRF outlines how providers should respond to patient safety incidents and how and when a patient safety investigation should be conducted
- Final version of the PSIRF will be published in Spring 2022 (https://www.england.nhs.uk/patient-safety/incident-response-framework/#introductory-version-of-the-psirf)

For those in Tissue Viability these are significant moves, the PSIRF system advises against carrying out a root cause analysis for each and every incident, instead preferring to look at themes from groups of incidents. Underpinning this is the belief that what happens in a single unique case may indeed be unique to that specific patient, and making changes (preferably improvements) may make no difference to any other patient. So instead by looking for commonalities, things that happen to multiple patients, we will find the areas to focus on and improve!

Hopefully over the next 12 months we will start to see the impact of some of these changes in the way we think and practice. What we see should be improvements not only for the patients and families in receipt of care, but also for the staff involved in delivering that care. WUK

REFERENCES

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