

Using Clinical Microsystems and Mesosystems as Enablers for Service Improvement in Mental Health Services

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Based on the service improvement work undertaken by

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June 2006

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In this paper we argue that Clinical Microsystems has proven to be an effective method for working with front line teams in Mental Health.

We believe that the Mesosystem acts as a vital mediator between Clinical Microsystem and the strategic imperatives of the wider NHS. This relationship can be positive or negative. We argue that an understanding of both can be obtained by working through a Clinical Microsystems approach at both levels. This can lead to greater harmony and more effective working.

We argue that Clinical Microsystems can be applied to Mental Health Service teams and our hypothesis is that it has similarities with Brief Therapy.

Working with Clinical Microsystems in Mental Health service teams appears to show that the main problem at the front line level is a lack of purpose and clarity. We argue that the Clinical Microsystem approach appeals to front line workers because it is patient centred. We further argue that the same approach can be taken at what might be called the Mesosystem level, replacing patient centeredness with patron centeredness. This may prove a useful way of resolving the tensions between the micro and meso levels of NHS mental health services.

Clinical Microsystems are different in nature to Mesosystems and this leads to tensions between the two which need to be resolved if effectiveness is to be achieved.

Since the formulation of the Humber Mental Health Modernisation Team in September 2003, the team was influenced by the five simple rules as outlined by the Director of the Modernisation Agency, David Fillingham (2002). Over time they have proved to be the backbone of all of our work.

- 1. See things through the patient's eyes**
- 2. Find better ways of doing things**
- 3. Look at the whole picture**
- 4. Give frontline staff the time and tools to tackle the problem**
- 5. Take small steps as well as big leaps (Fillingham 2002)**

Like all other areas of the NHS, Mental Health services can be divided into smaller groups of people who have a specific geographical area or a clinical expertise which sets them slightly apart from others. In the very simplest form this is a clinical microsystem. The use of Clinical Microsystems as a framework for service improvement has been developed at Dartmouth Hitchcock Medical School in the United States. Ian Golton, National Lead for Clinical Microsystems in the United Kingdom, describes Clinical Microsystems as:

"...the small, functional, front-line units that provide most health care to most people. They are the essential building blocks of the

health system. They are the place where patients and health care staff meet. The quality and value of care produced by a large health system can be no better than the services generated by the small systems of which it is composed.”

Teams are all different in makeup and strength of clinical ability. Like a family, there are different component parts which all affect the smooth running of a household. Gill Gorell Barnes explains it as “ Family patterns are made up of interpersonal relationships involving people with individually specific constitutions and past histories, living in a particular social network in a particular culture” (Gorell Barnes 1984). Clinical Microsystem Service Improvement work helps to get the very best from what you have. It sometimes states the obvious and does not appear at times to be complex and that can be very appealing to health staff that are busy and want to make changes to their working environment. The strength of a workplace can be assessed according to Buckingham and Coffman (1999) using their “*Measuring Stick*”. They have reduced it down to 12 questions which have been refined from many thousands of questionnaires. Much of the power lays in the extremes of the questions designed to invoke a response. The questions are not surprising in their content but surprising in their simplicity.

The Measuring Stick

- 1. Do I know what is expected of me at work?*
- 2. Do I have the materials and equipment I need to do my work right?*
- 3. At work, do I have the opportunity to do what I do best every day?*
- 4. In the last seven days, have I received recognition or praise for good work?*
- 5. Does my supervisor, or someone at work, seem to care about me as a person?*
- 6. Is there someone at work who encourages my development?*
- 7. At work, do my opinions seem to count?*
- 8. Does the mission / purpose of my company make me feel like my work is important?*
- 9. Are my co-workers committed to doing quality work?*
- 10. Do I have a best friend at work?*
- 11. In the last 6 months, have I talked with someone about my progress?*
- 12. This last year, have I had the opportunities to learn and grow?*

The Measuring Stick. Buckingham & Coffman (1999)

The Dartmouth Hitchcock Medical School lead by Paul Batalden, Professor and Director and Marjorie Godfrey, Director Clinical Practice Improvement, have developed with others a way of taking the best of the measuring stick and applying it to a team. Some of the best practices are contained in *Clinical Microsystem Action Guide* (Godfrey et al 2002). The Clinical Microsystem has to have a shared identity or purpose in some way which defines them as a microsystem and the 5P model can help with the focus and identification.

5P's

Patients; *who are they, how do you know what they want from you, how do you communicate with them informally?*

People; *Who is in your team? What skills do you all have? How can you make the most of everyone?*

Patterns; *How do things vary? What happens when things go wrong? How could it be better?*

Processes; *How do things happen in the team? What systems do we have and are they right for us now?*

Purpose; *Is what we do clear to everyone? Are there competing demands on our service?*

Dartmouth Hitchcock Medical Centre

Within our Mental Health Service our work has concentrated on the 5P's as the basis of our Service Improvement work. Our instincts told us that using the 5P's would be easily accepted by busy Mental Health Professionals as it simple and it goes right to the core of most staff belief systems. With my colleague Mike Gill, we developed a service improvement course which we could facilitate with teams based on the 5P's. In fact we based it on the 4P's with "Purpose" being included at all points of our discussions, not as a main topic item. The main aim with the facilitation was to encourage front line teams of staff within Mental Health Services to look at themselves, their patients, their processes and patterns and to look at ways in which they could see improvements and then to action plan for the improvements. When we were thinking about the questions to be put to the teams it became very clear to me

these were the same questions I asked individuals when I was a Community Psychiatric Nurse. Our first eureka moment, “Systemic or Brief Therapy for teams”.

Taking our thinking forward, our researches lead us to a book, “The Solution Focus” by Paul Jackson and Mark McKergow (2002). This book offers subtle yet powerful ways to positive change using a solution focused approach, building on the positive, not searching for the problem. The book details a simple ways of working allowing bespoke interactions. This work reaffirmed our systems thinking and enriched our Microsystem questions for the teams.

Prof. Andrew Derrington (1999) compared solution focused brief therapy with other therapies and said:

“. . . in choosing a therapy I would steer clear of experts who professed to be able to analyse my problem. It's not that I don't care what the problem is. It's more that I don't think they would know any better than I. And anyway, it's more important to identify the solution than to understand the problem.

The therapy that takes exactly this view is solution focused brief therapy. It helps clients to find solutions to their problem by using two questions. The first is called the miracle question.

"Imagine you were to wake up tomorrow and a miracle had happened during the night: your problem had disappeared. What would be different about the way you feel?" The second question, known as the scaling question, is simpler. It asks clients to put a number on how they feel where 0 is the worst [it could possibly be] and 10 is the way they would feel the morning after the miracle.

The sequel to the scaling question is to ask clients to imagine what they may be able to do to move themselves half a point up the happiness scale. “Whenever I have a dose of the glums I ask myself this question. The thing that amazes me, and convinces me that I shall never need therapy, is that I always know the answer. Try it yourself. You will put your therapist out of business.”

Our Clinical Microsystem Questions

Simple and easy to understand, we believe that these questions have never been asked of Mental Health teams before within service improvement.

- What do you do well?
- What could be better?
- How could you make it better?
- How many times do you think you could try that before next time?
- If everything suddenly was working at it best, what would it look and feel like?
- Let’s do that and if it is no good, we can try something else.
- Are these changes going to benefit the patient? If not, why are we doing it?

Plan, Do, Study and Act cycles (PDSA cycle), have played a large part of the Clinical Microsystem service improvement. Walter. A.

Shewhart first discussed the concept of PDCA in his 1939 book, *Statistical Method from the Viewpoint of Quality Control*, although it was Shewhart's protégé Deming who encouraged a systematic approach to problems solving and promoted the now widely recognised four step process for continual improvement.

Deming refers to it as the PDSA Cycle (Plan Do Study Act) or the Shewhart Cycle. The Japanese call it the Deming Cycle. Others call it the PDCA Cycle (Plan Do Check Act) or the Deming Wheel.

Having made contact and discussions with senior managers within our Trust, we formalised our project plan, and we embarked on our largest microsystem programme. To our knowledge, no one else has embarked on a service improvement programme of this type within Mental Health Services in the UK. Our plan had us working with three Community Mental Health Team offering services the adult population. The three teams were similar however all different due to history and mainly the individuals in the teams. We went about formulating a plan which would be based on Clinical Microsystems, which we thought would improve team members concept of Purpose, clearly start to define the patients served, look at smoothing out processes and patterns and to help the individual teams to identify their own areas to improve and to enable to teams to formulate action plans based on the areas they have defined.

Sessions

- *Three 5 hour sessions*
- *All members of the local Microsystems to be invited. (admin, nurses, medical staff, social care & therapies)*
- *Facilitated by M Gill & M Gray*
- *Opened and closed by local team leader*

Day 1 (People and Patients)

Introduction to the Modernisation Team and Clinical Microsystems.

Completion Staff Survey and information regarding the Patient Survey.

Star Chart; *who the team links to? Where are the strengths?*

“What works well in the team, what could be better and how are we going to make it better?”

Prioritisation of work streams.

Developing actions

Detailed Action plan 1. (What, When, to Whom & By)

Day 2 (Patterns)

Action Plan 1 feedback

Staff Survey Results. *What are the big topics for the team, can we define it and what are we going to do about it?*

Patient Pathway, *process mapping*

What currently works well, what could work better and where can we improve?

Develop actions

Detailed Action plan 2. (What, When, to Whom & By)

Day 3 (Processes)

Action Plan 1 & 2 Feedback

Caseload Weighting *feedback to the team.*

Managing Meetings *presentation. What could you as a team do better and how would you do it?*

Plan, Do, Study & Act *thinking.*

Action plans

Follow up ½ Day

Revisit action plans

What has been happening?

What is going well now?

What still could be better?

Actions (What, When, to Whom & By)

Evaluation of the Community Mental Health Teams Service

Improvements

Our evaluation and feedback to the teams we have worked with involves written reports which include digital photographs of all flipcharts of work produced on the days. We have found this to be a very accurate way of making sure everyone who attends can see what they did and what they agreed to take forward. We have also found this to be a very time effective way of feeding back to managers and commissioners of our work.

Throughout the workshops with the Community Mental Health Teams, it was apparent that each team had issues with communication which had not been previously been identified. The roles of the Joint Team Managers, Senior Nurse and other senior staff became crucial in the development of action plans and developments. Staff needed to be offered the time and tools necessary to make things happen and to give the actions sustainability.

Within the sessions we kept a “Parked Issues” board which logged issues which we could not comment upon or there were no answers to. “We need more staff” would be a good example. To stop these issues clouding a day or taking up time, parking them and giving them to the manager of the service to resolve within

normal meetings. It makes sabotage difficult and it respects what people have said without having to deal with situations there and then.

The Microsystem approaches (the teams), supported by the management group (team managers / operations managers) feels strong, resilient and owned by the staff.

“Why are we doing all this work with the Microsystem when the next layer up seems to need help as well?” In our evaluation we started thinking that the ripples we had created in the Microsystem would have effects elsewhere. This took us back to our “Brief Therapy or Teams” statement.

Ecological level	Definition	Examples	Issues affecting care offered to service users / customers
Microsystem	A setting where people engage in face-to-face interaction	Home, CMHT, Day Centre, Inpatient unit.	Quality of interactions Responsiveness of Staff Quality of relationships
Mesosystem	The relations between two or more settings in which effects patient care. Not direct patient contact	Relations and communication between Trust management to management teams to clinical staff and reverse	Respect for each other Support for each other Collaborative decision-making Understanding
Macrosystem	Blueprints for how the other components of the system should operate	Ideology Direction Culture Health policy	Individualist or collectivist orientation Democratic or autocratic orientation How mental health is defined

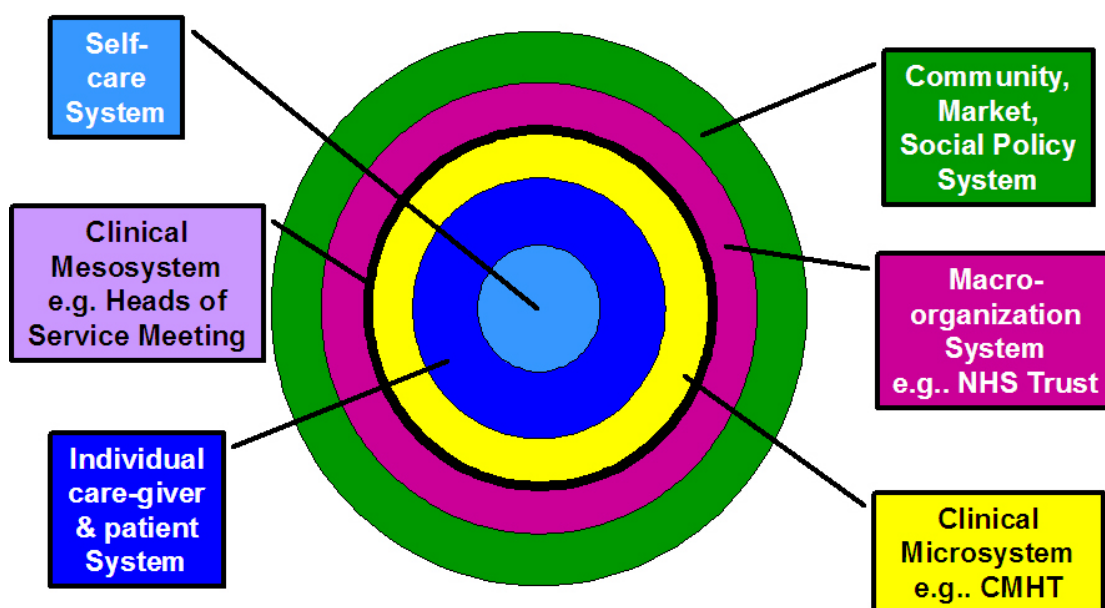
The System Layers

Effective Microsystems need Great Mesosystems

It became apparent that the relationship with the management structure above the Clinical Microsystems was critical in the effective running of a team. At a meeting in York attended by Ian Galton (UK National Lead for Microsystems) and facilitated by Laura Hibbs (UK national Coordinator for Clinical Microsystems), Ian used the word Mesosystem to describe the management layer. For me this was our second “*eureka*” moment.

We now describe the Mesosystems as a semi permeable membrane between the Microsystems and the Macrosystem (the larger Trust as a whole). Information and briefings have to pass through the membrane quickly without too much alteration, going in each direction. If the Mesosystem can make information understandable to the Microsystem and to present it properly, the Microsystem has a good chance of making things work. We decided that we had to engage with some Mesosystems within the Trust. The Heads of Service in the Nursing Directorate were keen to be involved. Our approach was similar to the microsystem approach.

Layers of the onion: a mesosystem is the membrane between the Macro and the microsystem, which everything passes through.



Identifying the Mesosystem. Picture adapted from (Godfrey et al 2004)

Our first day was one to learn from and never to repeat. Whereas in the Microsystem we encouraged the team to make comment and discuss, the Mesosystem were a team of talkers and thinkers and we could not keep them down. They seemed to be a team of achievers who were very happy talking strategy and working with high level processes. However, sometimes it appeared that they were not good with the simplistic things, e.g. chairing a meeting or using each others skills and sometimes it was the smaller things which caused bottlenecks in their processes or stopped events from happening the way they should.

The 5P's came back into play however the first P, Patients, was no longer appropriate. We changed the Patient P to patrons as in

“who are the Mesosystems customers?” The Mesosystem has to have the same knowledge about the Microsystem as the Microsystem has to know about the patients. The Mesosystem has to know how the teams they manage work and what makes them tick. Our Mesosystem work showed that most members had worked in Microsystems and thought they knew what made them work. But things change!

Working within the Mesosystem, it felt to us that we had to keep reminding the managers what they already knew, but had forgotten and what they didn't know but were assuming to be fact. In all the Mesosystem work we have done this has been a common theme and has resulted in action plans which have identified time for managers to talk to the staff in the clinical Microsystems and to improve the communication at all levels. Our statement “*Effective Microsystems need Great Mesosystems*” seemed to become our mantra.

Who would work in a place like this?

As a two person team, we have now worked with more than 10 teams of staff which represents over 160 members of mental health staff. In not one instance have we found staff to be negative or ambivalent to the Clinical Microsystem / Mesosystem approach. We have found staff interested and very willing to see things

through the patient's eyes. Referring to the 5 simple steps for modernisation (Fillingham, 2002) we have seen small steps and large leaps and have seen managers thinking of how to make space so that improvements can be completed and sustainable. In a very short space of time, we have seen staff energised and equipped to embrace change making things better for the service users and inadvertently for themselves.

Our statement "*Effective Microsystems need Great Mesosystems*" seems stronger than ever. Different approaches need to be adopted with the Microsystem compared to the Mesosystem but the aim is the same. When the two systems overlap this it appears to open doors which were perhaps before transparent, but closed.

As facilitators of the team days, we have not had a hidden agenda with ideas for the teams or areas where they should get better. It has come from the individuals in the teams and their managers. We have been amazed by the variety and scope of the action taken on by teams and have often remarked that had we suggested some of the actions, we would have been shouted down.

The Improving Working Lives Agenda appeared to link into our Microsystem / Mesosystem work. If a change makes it more attractive for staff to be at work, the staff should be in a better

frame of mind to work effectively with patients. Our statement to staff groups, “If it’s not good for the patients, then don’t do it” suddenly feels broader and more meaningful than originally intended.

Henderson stated in 1938, “Microsystems are the basic building blocks of health care. Connecting the work of one clinical microsystem to another is illustrative of leaders who recognise the integrity of the clinical microsystem as a functioning “building block” of health care.” Wenger (1998) states “Microsystems are the locus of control for many if not most, of the variables that account for patient satisfaction with health care”

Importantly, we have seen individuals and groups of staff within teams grow in confidence and become more assured of their role in providing patient centred excellent mental health services that all feel safe, effective and deliverable.

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References

Buckingham M, Coffman C: *First, Break all the Rules*. Free Press Business 2001

Derrington Prof. A: *Financial Times Weekend* (3-4 April 1999 & 29-30 January 2000)

Fillingham D: *TAKE FIVE* Health Service Journal February 7 2002

Godfery MM et al: *Clinical Microsystem Action Guide*. Hanover NH: Dartmouth Medical School, Jan 2002

Godfery MM et al: *Clinical Microsystem Action Guide*. Hanover NH: Trustees of Dartmouth Collage, Version 2 Rev 4.13.2004

Gorell Barnes G: *Working With Families*. McMillan Education Ltd 1984

Golton I et al: *The NHS Clinical Microsystems Awareness and Development programme Final report* January 2005
<http://www.neynlha.nhs.uk/LocalProjects/ClinicalMicrosystems/AssociatedDocuments/report.pdf>

Henderson LJ: *The physician and patient as a social system*. N Engl J Med 212:819-823, 1938

Jackson P, McKergow M: *"The Solution Focus. The simple way to positive change"* NB Publishing (2002).

Wenger E: *Communities of Practice: Learning, Meaning and Identity*. Cambridge, UK: Cambridge University Press, 1998