CLINICAL MICROSYSTEMS AND MESOSYSTEMS IN MENTAL HEALTH

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AUTHOR Mike Gray, MBA, DipHSM, LSMS, RMN, is organisational risk specialist, Humber Mental Health Teaching NHS Trust.


This article looks at the service improvement work by Mike Gray and Mike Gill of the modernisation team, Humber Mental Health Teaching NHS Trust. It argues that clinical microsystems (see Background Box) are an effective method for working with frontline teams in mental health. Clinical microsystems have similarities with brief therapy. The same approach can be taken at the mesosystem level. Clinical microsystems are different from mesosystems, which leads to tension. The mesosystem acts as a mediator between clinical microsystems and the wider NHS, and an understanding of both can be obtained by taking a clinical microsystems approach at both levels.

INTRODUCTION

The Humber Mental Health Modernisation Team has found five simple rules to be the backbone of our work (Fillingham, 2002):

1. See things through a 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 problems;
5. Take small steps as well as big leaps.

The clinical microsystem has to have a shared identity or purpose. Godfrey et al’s (2002) five Ps model can help with the focus and identification:

1. Patients: Who are they? How do you know what they want from you? How do you communicate with them informally/formally?
2. People: Who is in your team? What skills do you have? How can you make the most of everyone?
3. Patterns: How do things vary? What happens when things go wrong? How could it be better?
4. Processes: How do things happen in the team? What systems do we have and are they right for us now?
5. Purpose: Is what we do clear to everyone? Are there competing demands on our service?

We have concentrated on the five Ps as they are simple and go to the core of most staff belief systems.

We developed a service improvement course that we could facilitate with teams, based on the five Ps. We used four Ps, including ‘purpose’ at all points of our discussions, not as a main topic item.

The main aim of the facilitation was to encourage frontline teams in mental health services to look at themselves, patients, processes and patterns, look at ways in which they could see improvements and make action plans for 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. It was a ‘eureka moment’ – systemic or brief therapy for teams.

Our research led us to The Solutions Focus (Jackson and McKergow, 2002). This book offers ways to bring about positive change by building on the positive, not searching for the problem. We drew up clinical microsystem questions that focused on the positive.

Having held discussions with senior managers, we formalised our project plan, then embarked on our largest microsystem programme.

Our plan involved our working with three community mental health teams providing services to adults. All members of the local microsystems – nurses, medical staff, administration, social care and therapies – were invited to the sessions.

We had both managed community mental health teams previously. We formulated an improvement plan based on clinical microsystems, which we thought would improve team members’ concept of purpose, clearly start to define the patients served, and look at removing bottlenecks in the referral process and streamlining the talking therapies.

We also thought it would help the teams to identify their own areas for improvement and formulate action plans based on these areas.

EVALUATION OF THE MENTAL HEALTH TEAMS’ SERVICE IMPROVEMENTS

It became apparent that each team had issues with communication that had not previously been identified.

The roles of the team managers, senior nurse and other senior staff became crucial in the development of action plans. Staff needed to be offered the time and tools necessary to make things happen and to ensure their actions had a lasting effect.

Within the sessions, a ‘parked issues’ board logged matters that we could not
BACKGROUND

| Mental health services can be divided into smaller groups by a geographical area or area of clinical expertise. Each group is a clinical microsystem. |
| Ian Golton, national lead for clinical microsystems

In the UK, describes clinical microsystems as ‘the small, functional, frontline units that provide most healthcare to most people... 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’ (Golton et al, 2005).

Service improvement work helps to get the very best from what you have.

comment on or to which there were no answers. ‘We need more staff’ would be a good example. These were given to managers to resolve at a later date.

‘Why are we doing all this work with the microsystem when the next layer up seems to need help as well?’ was a question that we kept on asking ourselves after sessions. We started thinking that the ripples we had created in the microsystem would have effects elsewhere.

EFFECTIVE MICROSYSTEMS NEED GREAT MESOSYSTEMS

It became apparent that the relationship with the management structure above the clinical microsystems was critical.

We describe the mesosystem (the management layer) as a semipermeable membrane between the microsystems and the macrosystem (the trust as a whole). Information and briefings have to pass through the membrane quickly without too much alteration, in each direction.

If the mesosystem can make information understandable to the microsystem and present it properly, the microsystem has a good chance of making things work.

We decided that we had to engage with some of the mesosystems at the trust. The heads of service in the nursing directorate were keen to be involved. Our approach was similar to the microsystem approach.

Those in the mesosystem were confident when talking strategy and working with high-level processes but appeared to be less taken up with the fine detail of day-to-day frontline matters. Sometimes, it seemed to us that a lack of attention to the fine detail led to progress not being made in the way it should.

The five Ps came back into play. The first P, patients, was changed to ‘patrons’. We asked ‘who are the mesosystem’s customers?’ The mesosystem has to have the same knowledge about the microsystem as the microsystem has to know about the patients.

Most mesosystem members had worked in microsystems and thought they knew what made them work. However, microsystems had changed since some of the managers had been part of one.

We encouraged the managers to challenge assumptions and beliefs about the microsystem, and discussed the realities of microsystems with them. These themes have been common in all the mesosystem work we have done.

This work has resulted in action plans that include setting aside time when managers can talk to the staff in the clinical microsystems and which aim to improve the communication at all levels.

IMPROVEMENTS IN A SHORT TIME

We have worked with more than 10 teams of staff, which represent over 160 mental health employees. 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 five 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 are sustainable.

In a very short time we have seen staff energised and equipped to embrace change, making things better for service users and themselves.

Overlapping areas of the mesosystem and microsystem approaches give teams a common starting point where both sides can contribute.

We have been amazed by the variety and scope of the action taken on by teams. Had we suggested some of the actions, we felt we would have been shouted down as they may have seemed difficult, bizarre or insignificant. Because the team owned their ideas, they were prepared to run with them.

Our statement to staff groups – ‘If it’s not good for the patients, then don’t do it’ – feels broader and more meaningful than originally intended.

Wenger (1998) stated: ‘Microsystems are the focus of control for many, if not most, of the variables that account for patient satisfaction with healthcare.’

We have seen staff become more confident and more assured of their roles in providing patient-centred excellent mental health services that all feel safe, effective and deliverable.