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Implementing a strategic plan for child health: a Sydney case study

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Abstract

Aim: The aim of this paper is to describe the implementation of a strategic plan, 'Health Gain for Children and Youth of Central Sydney", over a 10 year period to December 2005.
Methods: Descriptive information was obtained from the records and minutes of all relevant committees, interviews with key workers who were involved with the committees, managers and senior health professionals, and from the involvement of the authors throughout the process of the implementation.
Results: An implementation steering committee was established to oversee the implementation of the plan. Rather than adopting a uniform approach to assigning responsibility for the implementation of each strategy in the plan or developing specific costs and time frames for each strategy, a more pragmatic, flexible and opportunistic approach was taken. Most of the plan's strategies were implemented over a 7 year time frame using a combination of service reorientation and implementation of new programs, some of which were funded from sources not anticipated during the development of the plan. Implementation required a dedicated driver, commitment at senior level and participation by many staff at many levels. Outcomes, monitored through data collected at 5 year intervals, revealed positive trends in a number of child and youth health indicators.
Conclusions: The successful implementation of the strategic plan required pragmatism, flexibility, opportunism and the commitment and involvement of staff at all organisational levels. . It is envisaged that this approach provides a firm base for future evidence based developments to benefit the health and well being of children, youth and their families and reduce health inequities.

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Key Words: Strategic plan, implementation, strategies, multisectoral, evidence-based, outcomes

Key Points:

1. Strategic plans should identify priority programs but not include too much detail about implementation. Circumstances change and opportunism is required.

2. Successful implementation of a strategic plan requires pragmatism, flexibility, and the involvement of many staff from multiple disciplines and many other non-health sectors

3. Collaborative service delivery is most successful when it builds on collaborative planning

4. Changing established ways of working requires strong management support and investment in staff development

Implementing a strategic plan for child health: a Sydney case study

Introduction

Published research during the 1980s and early 1990s had indicated that many services provided by the Community Health Services of the Central Sydney Area Health Services (CSAHS) required change or re-orientation. *Health Gain for Children and Youth of Central Sydney: Strategic Plan* (the plan) was developed for the CSAHS and published in November 1996 to tackle this situation.[1] The planning process and outcomes have been published previously.[2] The plan, using the 'Health Goals and Targets for Australian Children and Youth'[3] as the basic framework, was developed with participation of all major stakeholders (government, non-government and local community). The plan was preventive and population oriented, focussed on equity and social justice and was evidence based. Ten main strategies or categories of interventions, with detailed rationale for each, were proposed:-

1. Nurse home visiting program
2. Health Promoting Schools (HPS) program
3. Health worker education initiatives
4. Early intervention strategies through community development, early literacy and parenting programs
5. Multidisciplinary assessment and multimodal therapy for children with Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD)
6. Individual and public health education
7. Local community based health promotion
8. Targeted screening for some conditions and reduction of universal screening for certain conditions
9. Universal screening for congenital sensorineural hearing loss
10. Advocacy around child and youth health issues and services

A matrix of the priority issues and strategies identified in the strategic plan is depicted in Table 1. As is evident, most health issues can be addressed by more than one strategy, and many interventions impact on multiple health issues.

Since 1996 the plan has been implemented through a variety of structures. The aim of this paper is to describe those structures, the process of implementation, challenges faced and major achievements to December 2005. From this we draw out some important lessons for the implementation of future strategic plans. (CSAHS became Sydney South West Area Health Service, Eastern Zone, in 2005 but for clarity CSAHS will be used throughout this paper.)

Methodology

The description of the implementation phase of the plan was obtained by analysing information from the minutes of the 9 relevant committees, interviewing approximately 30 committee members, and interviewing managers and senior health professionals, and from the authors' involvement throughout the process. Details of implementation for each strategy, including initiation of strategy, process of implementation, achievements, challenges and attainment of full service capacity were organised in a tabular form, and then transposed into a time line format. The information will be reported in the following categories – implementation structure, process of implementation, achievements, challenges and implementation time line.

Implementation Structure

A coordinating committee was established in May 1997 to facilitate the implementation of the plan. The committee had representation from relevant units within the health service, and other relevant government and non-government organisations. The committee was chaired by a senior executive member of the Area Health Service.

The main role of the committee was to guide the implementation of the plan through eight complementary strategies:-

1. establish project teams for each of the interventions proposed, eg. home visiting, health promoting schools, health worker education, etc;
2. provide advice, review and endorse project teams' implementation plans and monitor progress of implementation;
3. make recommendations to the Area Executive on resource issues (including investment, disinvestment or reallocation);
4. ensure co-ordination of services;
5. approve significant changes in policies and procedures;
6. monitor and report on population outcomes;
7. advocate for child and youth health issues;
8. ensure consumers and community were appropriately involved in the planning, management and monitoring of services.

In January 2000, nearly 4 years after the committee was established, the CSAHS received Families First[4] (FF) funding. The NSW State government provided approximately $120 million over four years state-wide for the Families First Initiative (recurrent funding). This is a coordinated strategy to improve health, developmental, educational and social outcomes for children and families (antenatal – 8 years) through early intervention and prevention services supporting parents who are expecting or caring for a new baby, focusing on disadvantaged families and communities. The initiative is population focussed, with a combination of universal and targeted strategies and services. It involves several NSW government departments (health, community services, education, disability and housing) in planning and implementing services, is based on the best available evidence, and has a prevention and early intervention focus.

Since many of the strategies in the plan were the same as the FF strategies, and since many of the plan's other strategies were being implemented or were close to being implemented, early in 2001 the coordinating committee was replaced with the Families First Implementation Steering Committee, which continues to function to date. Working groups which had been formed to address issues outside the FF framework (eg. to develop a plan for multidisciplinary assessment and multimodal therapy for children with ADHD) continued until their tasks had been accomplished.

Process of Implementation

Rather than adopting a uniform approach to assigning responsibility for the implementation of each strategy in the plan or developing specific costs and time frames for each strategy, a more pragmatic, flexible and opportunistic approach was taken. For example, some of the priority strategies were delegated to:-

- a specific unit, eg. the Health Promotion Unit (HPU) has used the plan to determine priorities for the child and youth health components of their annual business plans, and the two Divisions of General Practice in the CSAHS have addressed targeted screening for lead exposure and iron deficiency.

- an existing program within a unit, eg. the Health Promoting Schools Committee of the HPU has addressed health promotion issues and strategies in school aged children and youth, and the School Link program within Child, Adolescent & Family Mental Health Services has tackled depression and related disorders in adolescents.

- a project officer employed to progress a particular strategy, eg, Home Visiting of new mothers and babies by Child and Family Health Nurses.

- a new committee, eg. a committee was established to develop universal screening of newborns for congenital sensorineural hearing loss.

In addition to FF funding, when other resources became available these were used opportunistically to recruit staff. For example, work with children of families with a mental illness, programs for early identification of children with mental health problems and mental health programs in schools and co-ordinate parenting programs within the Area Health Service. Wherever possible, existing funds were redirected to priority strategies, for example the HPU funded a position to work on Health Promoting Schools.

A great deal of the implementation required breaking down 'silos' within health services and between health and non-health services; reorienting services towards prevention, health promotion and early intervention, and setting goals for population and individual child health outcomes; developing a culture of searching for and questioning the evidence for strategies and interventions; and developing the structures necessary for multisectoral planning and implementation of coordinated services.

Consequently, most of the strategies required a significant change in the way that services (for instance Community Health Services, Mental Health, Obstetrics and Newborn Services, HPU, Public Health Unit and Drug Health) worked, separately and together. Management support through systematic supervision and staff development (for example training of all child and family staff in the Family Partnership Model[5]) were essential for this to occur.

Achievements

Significant achievements between 1998 and 2005 include:

- Working relationships between antenatal, Drug Health, Mental Health and Community Health services have been significantly improved through the development of clinical pathways requiring workers from various departments to interact with each other regularly, including during committee meetings, case conferences, and patient care planning.
- Multisectoral planning and implementation of strategies is now the normal way of working, especially at middle and upper management levels. The multisectoral development of the Strategic Plan facilitated ownership by all involved (government and non-government) and successfully initiated collaborative working. Subsequently, the FF process consolidated this collaborative interagency working model.
- The focus on populations, and not only individuals, has taken a greater mind shift and is still developing among some health professionals, especially those involved solely in direct client

contact and care. The shift has occurred most successfully among managers and some clinician groups, particularly nurses.

- In addition to reviewing evidence of interventions through the strategic planning process, the consideration of evidence in implementing strategies has been facilitated by the constant supply of evidence-rich literature to staff, and organising seminars and opportunities for discussion. There is substantial evidence in minutes from committee meetings, business plans and reviews of clinical services that many of the staff in the Child, Adolescent and Family Health teams now routinely consider evidence in assessing and considering implementation strategies, and the authors are regularly challenged by many staff on the evidence for existing and new programs.
- Assisted by the National Health and Medical Research Council review of Child Health Surveillance and Screening published in 2002[6], universal school entry screening for hearing and visual defects has been abandoned and replaced by targeted screening in the most disadvantaged schools. This has allowed child and family health services to redirect their work on activities within a Health Promoting Schools framework.

To monitor the outcomes for children and youth, baseline data were published in the strategic plan and more comprehensive sets of follow-up data were published in 2000 and 2005 as Child and Youth Health Report Cards[7,8]. The report cards contained health, educational and social outcomes data from all the collaborating departments. There have been positive trends in relation to many outcome indicators from 2000 to 2005. These include: earlier access to antenatal care, lower smoking rates in pregnancy, particularly among Aboriginal women, higher breastfeeding rates at discharge from hospital, lower mortality rates due to Sudden Unexplained Death in Infancy, lower infant mortality and youth suicide rates, lower hospitalisation rates due to asthma, non-fatal drowning and accidental poisoning, more smoke free households and lower youth crime rates. We have also been able to demonstrate a reduction in health inequalities in relation to maternal smoking in pregnancy, perinatal mortality, low birth weight and prematurity between the Aboriginal and non-Aboriginal populations. However, these data have multiple determinants and it is not possible to attribute these trends directly to the CSAHS services.

Challenges

Many of the strategies are still incomplete with respect to desired coverage of the population or settings within the population, eg. some programs such as sustained (intensive) nurse home visiting will require substantially more resources to implement a best practice model. Similarly, without significantly greater funding for Health Promoting Schools our ability to cover most schools in the CSAHS is unrealistic (over 10 years only 67 of 167 schools in the CSAHS have developed a whole of school approach to health promotion, and are functioning, to various degrees, as Health Promoting Schools). Many more Schools as Community Centres (connecting communities to schools and other services to improve children's readiness to start school and to develop community capacity) would be required to cover all the disadvantaged communities within the CSAHS.

Health worker education is an on-going process, not only because there is constantly new information from research and information changes, but also because there is always staff turnover.

A number of programs related to individual and public health education and community health promotion have not been implemented. Nevertheless, the plan is still used by the HPU to progressively address more issues relevant to child and youth health.

Implementation Timeline

Figure 1 summarises the time lines of some of the strategies implemented from January 1998 to December 2005. The implementation of the strategic plan and many of the specific strategies was given a boost by funding that was not anticipated when the plan was being developed, particularly FF funding. Some strategies were initiated and implemented very early and relatively rapidly, eg. health promoting schools, whereas others were put on hold due to responsibility being assumed by other agencies. For example, the universal newborn screening for congenital sensorineural hearing loss was delayed because we were aware that the NSW government had committed to a State-wide program, which was initiated the end of 2002.

Discussion

The strategic plan *Health Gain for Children and Youth of Central Sydney* was a very ambitious project requiring a significant investment (the development of the plan alone required the employment of a project officer for 18 months and the time of approximately 90 people across all sectors who met in various working groups for 1.5-2 hours every 6 weeks for about 12 months), reorientation of services and ways of working, a shift in focus from individuals only to include populations, and a culture change in considering research and evidence when proposing or initiating new projects. As is evident from the timeline, the reorientation of services and implementation of new programs has required development over a number of years. However, it is unlikely that the development or implementation of the plan could have occurred any faster. Implementation has required dedicated drivers, commitment at a senior level and participation by many staff at many levels over a substantial period of time. In our experience, the Area Community Paediatrician, who provided clinical expertise, credibility and an extensive knowledge of the research related to improving child and youth health from a population perspective, performed a driver role very successfully. Furthermore, the reorientation of services and ways of working has required additional financial resources for service development. The total cost of implementing the plan has not been calculated. It is clear, however, that without the Families First and other additional funding much of the program development (particularly health home visiting and the establishment of the four Schools as Community Centres) would have been much slower or curtailed.

There was much criticism initially of the lack of specific costing and time frames for the implementation of strategies. In our view, the experience over the ensuing decade has demonstrated the wisdom and value of that approach. The strengths of the planning process – multisectoral ownership, a strong evidence base, the development of a set of clearly defined objectives and strategies and an agreed set of priorities by all staff - enabled the Area Health Service to exploit windows of opportunities for new funding through grants or projects. We believe that going through a process of costing strategies and establishing time frames would not have resulted in a better outcome, since we would have had to adjust our time frames and order of implementation as opportunistic sources of funding became available, and as some programs were unexpectedly implemented by other services. Importantly, since the plan utilised the best available evidence, we were able to capitalise on external policies and funding opportunities (such as FF) based on similar research evidence.

In addition, there is consensus at all organisational levels that the plan and the process have been of value to both the workforce and the community. Also, consequently, several other Area Health Services in New South Wales subsequently undertook a similar, but abbreviated, process in planning their child and youth health services or used the information from the CSAHS plan to assist their planning. The applicability of a similar planning and implementation process at a State or National level would require more discussion and research. However, it is clear that involvement and ownership at the local level is critical to the success of any similar change process.

Conclusion

The implementation of the strategic plan did not follow orthodox methodology, but was successfully achieved in a more pragmatic, opportunistic and flexible manner. The implementation is an on-going process that is modified or changed as new information becomes available. It is envisaged that the planning and implementation process will facilitate future evidence based developments with even greater participation by a more knowledgeable staff, and that it will contribute to improved health and well being of children, youth and their families and a reduction in health inequities in CSAHS.

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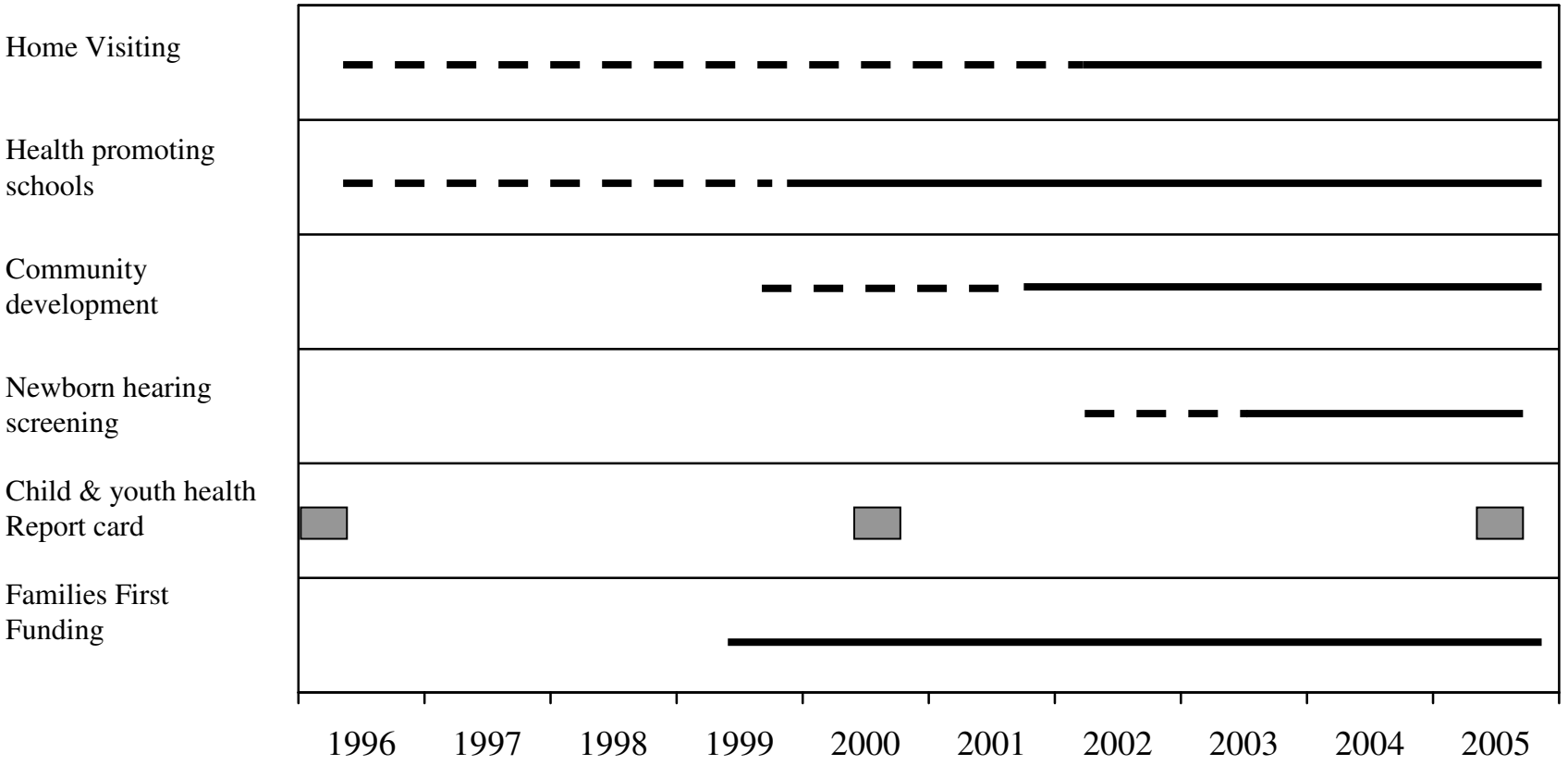
Home Visiting
Health promoting schools
Community development
Newborn hearing screening
Child & youth health Report card
Families First Funding
1996
1997
1998
1999
2000
2001
2002
2003
2004
2005

Figure 1. Legend: Implementation of some key elements along a time line (dotted lines represent the time from initiation to full service capacity) .

Table 1. High priority issues and strategies

ISSUE/ STRATEGY	Home Visiting	Health Promoting Schools	Multi – disciplinary assessment/ modal therapy ADD & ADHD	Health Worker Education	Community development /Early literacy/Parenting	Public/ individual education	Community based health promotion	Advocacy & Lobbying	Screening
Tobacco	X	X				X	X	X	
Alcohol & other substance abuse.		X				X	X	X	
Low birth weight/Prematurity	X							X	
Perinatal/ Infant Mortality								X	
Self harm/ Suicide		X		X			X		
Depression		X		X			X		
At risk behaviours (Oppositional Defiant Disorder/Conduct Disorder)		X					X		
Sexual health related		X				X	X		
Child abuse	X								
ADHD			X						
Children of parents with mental illness or substance abuse	X				X				
Excessive sunlight exposure		X				X	X		
Vaccine preventable diseases	X			X	X	X			
Domestic Violence				X		X	X		
Learning difficulties/ intelligence related disabilities.		X	X		X				
Nutrition related (incl. antenatal, breastfeeding, obesity)	X	X			X	X	X	X	
Social / environmental	X	X			X	X	X	X	
Lead and Iron deficiency						X			Targeted
Otitis Media & Conductive Hearing Loss (Aboriginal children)		X							Targeted
Congenital Sensorineural Hearing Loss									Universal