PRIMARY HEALTH CARE GROUP

Working paper for managers: 1

Coordinating change in child health services

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Liz Winn is a project officer with the Primary Health Care Group at the King's Fund Centre for Health Services Development. Her current interests include the development of user participation in community health services, and helping health authorities to plan appropriate services for homeless families.

The **Primary Health Care Group** is a multidisciplinary team based at the King's Fund Centre for Health Services Development. Its aims are to improve primary and community health services, particularly in inner London; to encourage experiments with new ways of working; to disseminate 'good practice'; and to contribute to debates about primary health care policy. The group provides information and advice about primary care developments; works with NHS managers to establish and evaluate demonstration projects; organises workshops and conferences; and publishes papers and reports.

The group's current interests include strengthening the management of primary care services; collaboration between district health authorities and family practitioner committees; decentralising community health services; and services for disadvantaged groups. The work is financed by the King's Fund and the Department of Health and Social Security.

This **series of working papers** is intended to make material from work in progress readily available to a wider audience. Each paper records the experience of putting a new idea into practice and draws out the lessons learned.

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COORDINATING CHANGE IN CHILD HEALTH SERVICES

Decentralisation of clinic administration in Newham Health Authority

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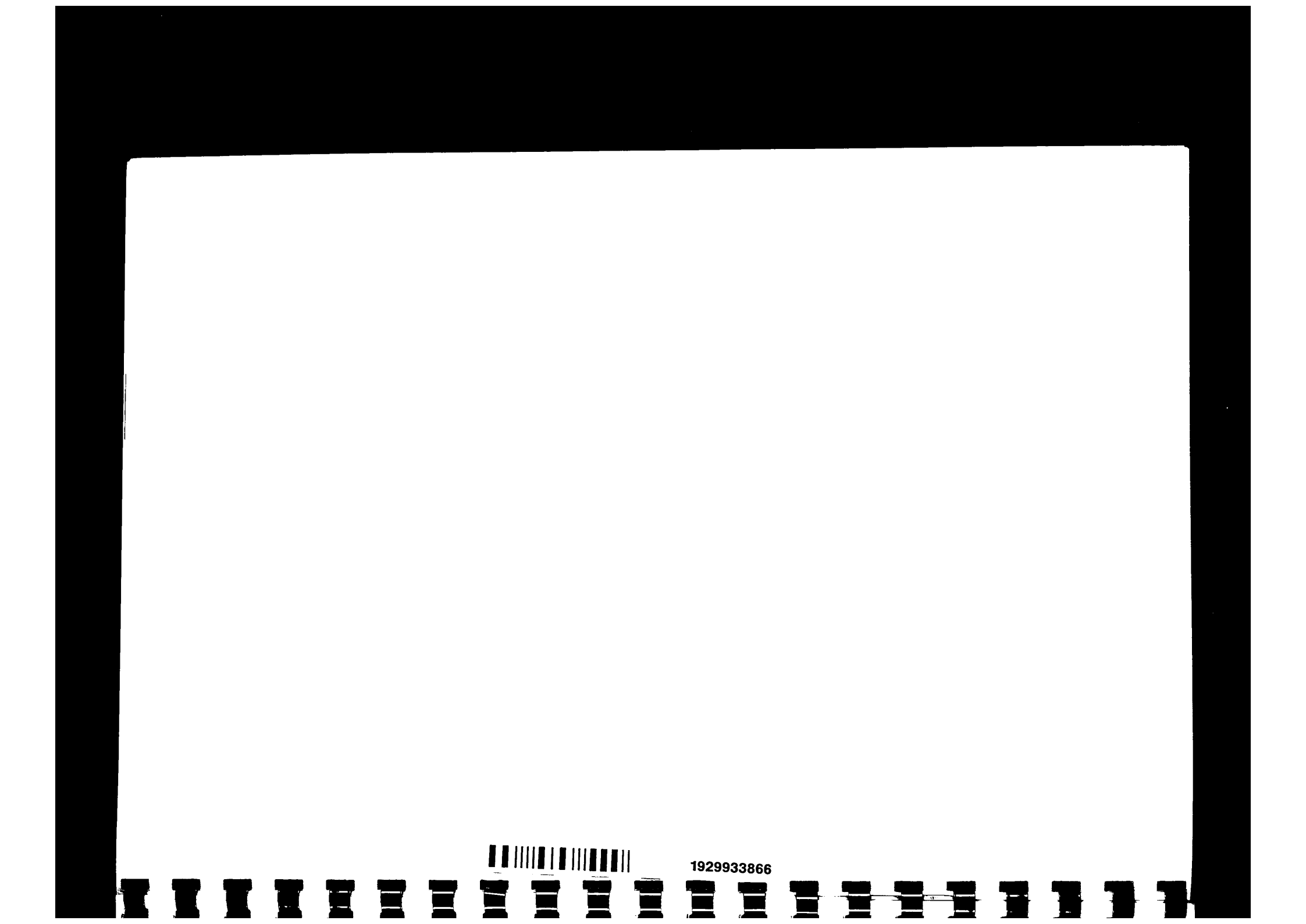
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COORDINATING CHANGE IN CHILD HEALTH SERVICES

Introduction

The introduction of general management at district and unit level, together with the new opportunities for experimentation in the organisation of services triggered for example by the Cumberlege Report and by the growth of the 'locality planning' movement, give increased significance to the need to understand the mechanics of change and the predisposing factors for the smooth introduction of new ways of working. The Newham experience of bringing about changes to their child health service offers an opportunity to examine the processes involved and the keys to successful implementation.

Until March 1986, the child health section of Newham's Community Health Service Unit organised the administration of its clinics and health centres from a central office. Administrative staff were responsible for the various functions of clinic and community health service work for children (e.g. developmental assessments, prophylaxis), but not for all services provided from one clinic or centre. As a result, staff were isolated from others who organised complementary services for children in the district, there were few opportunities to make personal contact with users, and there was considerable duplication of records. Service managers felt that new objectives should be set, both for the service and for staff development. In particular, they felt that the child health service should be more closely orientated towards the needs of users, and that all staff should become more involved in the management of the service.

On 24 March 1986, after just over a year's planning*, most of the administrative activities for child health were decentralised to nine clinics and health centres in the district. The change has resulted in savings of around £40,000 (through a reduced need for temporary staff), job enhancement for retrained staff, clearer lines of communication between field staff and managers, rapid access to records, reduction of duplication, and a stronger sense of 'localness' for both staff and users.

Those in Newham who were responsible for managing the changes have identified the elements of their planning process which they think were significant in enabling the relatively smooth introduction of locally administered child health services. These are discussed below.

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* Appendix I sets out the chronology of the change.

(1) Multidisciplinary planning

When the proposed reorganisation was mooted in the autumn of 1984 it was clear that it had important implications for the work practice and management of a range of community health service staff. Planning for the changes also involved the examination of a wide range of activities for those implementing them - it was not simply an administrative tidying-up confined to the work systems within one area of activity. The cooperation and input of many staff and managers therefore contributed to the success of the reorganisation. A Decentralisation Working Party was set up to plan and coordinate the changes. Its members were those who were able to judge the ramifications of the general and detailed changes that would occur, from the point of view of the professions they represented, and so consisted of managers from administration, community nursing, school nursing, health visiting, clinical medical officers and community paediatrics. The group met regularly to plan the changes, monitor progress and tackle any problems along the way. They also developed the detailed administrative procedures for appointment making, recall, and record and register keeping.

(2) Consultation and communication

The nature of the reorganisation, which called for fundamental attitude changes for a number of long-standing members of staff, meant that consultation and participation were particularly important management methods, both as a means of gaining commitment and also as a way of gathering information about the implications and foreseeable pitfalls of the changes. All administrative staff were individually consulted about the proposed new way of working at the very beginning of the planning period. There were a number of opportunities for the central office staff to visit clinics in the district and for all staff to spend a day in a clinic in a neighbouring district where a decentralised clinic administration service was already in operation. Everyone was asked to make suggestions, feed in ideas and air any uncertainties. The redesigned forms and records, for example, incorporate a number of suggestions and ideas from staff and, once training on the new procedures began, one administrator developed an easy reference summary of the by then fairly weighty manual. Indeed the various stages of the whole training process were characterised by input and feedback from 'trainees', and further training needs are currently being identified by staff in the clinics and central office.

From the beginning, therefore, those involved in mapping out the changes tried to make sure that the practical implications of each new procedure were communicated to all staff. But probably most significant, the objectives of the new way of working and the reasons behind the proposal were also discussed and reiterated. Some of the reasons were potentially off-putting, e.g. "the Community Administration and Clerical staff budget is overspent by £45,000 this year; we need to make savings", and obviously made staff anxious about the inevitability of cuts. However, staff were also involved in discussions about possible ways forward that could have advantages for them, in terms of career development, and for

service users who would have a 'local' service. Helping staff to understand and acknowledge the reasons why the particular path was chosen created a climate of cooperation and interest. When they became aware of the potential for job diversification, promotion and training as side effects of the provision of a better but cheaper service for users, staff were enthusiastic and supportive of the changes. This support from staff was relevant when, shortly after the changes were tentatively proposed, the local NALGO branch was consulted. It too was positive about the changes.

(3) Drawing up the new structure

Developing a new staffing structure was dependent upon tapping a variety of information sources and expertise. All clinics were 'surveyed' to establish the availability of office space and storage facilities (for records). However, the existing managers were initially unsure about how many of the staff at the central office should be relocated in clinics. The availability of space was important but was obviously not the determining factor; existing work levels had to be measured, and the effects of the proposed changes on new workload had to be assessed.

To foster some sense of 'impartiality' and to be seen to be fair, it was decided to import some expertise from outside the district. The regional Management Services Division (MSD) was asked to assess and report on staffing requirements. The results of the MSD survey of current activity and future needs highlighted areas for investigation and guided the task of designing appropriate staffing structures. However, their report was by no means the only information taken into consideration, and again managers responsible for implementing decentralisation spent time collecting views and opinions of their staff. Time that had been identified as 'spare' by MSD might be considered a vital, though informal, opportunity for liaison or consultation by staff.

The structures that were eventually drawn up were therefore founded on information gathered from surveying the physical environment of clinics, from formal workload measurement techniques, advice and expertise from MSD, together with the opinion and experiences of the staff themselves.

[The structures 'before' and 'after' the decentralisation are represented diagrammatically as Appendix II and Appendix III. In essence, ten clerical officers who were previously based centrally and who were responsible for making appointments and transferring records, were moved out to the clinics which were grouped into five local areas. Each local area was headed by a newly created GAA post which was responsible for managing HCOs and COs in the clinics. The patches were determined partly on the basis of population number (about 5,500 children) and partly on the basis of the pattern of catchment areas for local schools. The nursing officer responsible for school health looked at the flows from feeder schools to comprehensives in Newham, and drew the boundaries so that in most cases children remain in the same patch when they move on from feeder schools. This allows the school nursing service to have the

same base as health visitors which should help continuity and liaison.]

(4) Training

Staff were naturally apprehensive about their proposed relocation in clinics throughout the district. Some would be geographically separated from their managers and at the same time would be required to fulfil a new set and wider range of tasks. Training was obviously a lynchpin and consisted of two main strands:-

(i) attitude training:

(ii) procedure training.

Staff moving out to the clinics and health centres would greatly increase their contact with health professionals and service users. They felt that they would need new skills and attitudes to help them make the best use of this contact. and they all received two days of training based on a training pack for 'shop window' staff and help from the District Training Officer. The package covered communication skills, helping individuals to identify their needs, working relationships, and offering positive alternatives instead of no/sorry/can't help. The objectives of the new way of working were restated at the beginning of the training session.

The second training session was run during the week immediately prior to 'De(centralisation) Day' and covered the new procedural arrangements. Both sessions were led by the two heads of the community administration department who had jointly prepared the content of the sessions. The new General Administrative Assistants (GAAs), whose posts were created to supervise staff out in the clinics, were equipped to pass on the details of the procedures to their own staff with support from the two administrative heads. The GAAs were also encouraged to feed back teething problems and grievances so that central office staff could coordinate responses and changes. The GAAs still meet regularly to discuss common concerns and to highlight any procedural problems. The forum also offers the opportunity to discuss both informal and formal training needs for the future.

(5) Other factors

Other factors have also been identified by Newham staff as being important in contributing to the smooth introduction of decentralisation. The clinics were closed down (except for drop-in services and routine immunisation/vaccination sessions) for the week immediately before the new system came into operation. This meant that time was formally allocated to the business of 'moving out', and allowed training on procedures to take place just before staff needed their new knowledge thus making the exercise more real.

The time of year was also important. The changes took place towards the end of the school year, which meant that staff would have time

to settle into their new roles before they had to cope with the September influx of schoolchildren and the subsequent organisation of the necessary school health services.

Postscript

The themes and characteristics of the planning process remain significant in what is now the monitoring and evaluation stage of the changes in Newham. Feedback from staff is an essential part of the monitoring process, and the regular meetings of GAAs continue to provide a forum for review and suggestions for change. The administrative heads of the Child Health Services report each month to the District's Child Health Group which can then learn from the experience of decentralisation.

Although the system has been in operation for only a few months and formal evaluation is not yet sufficiently established to provide us with 'hard' data, there are already signs that decentralisation has brought benefits to both staff and users of the community child health services. Clinic attendances appear to have risen, administrative staff feel valued, competent and part of the population they serve, and nursing and medical staff have better access to up-to-date records. Plans for evaluation include a survey of staff attitudes and users' perceptions of the changed service.

There have been problems which could have been planned for, but which were difficult to predict; some clinics are finding they have inadequate storage for records and most are having problems with folders not durable enough to prevent records getting battered in a few years' time. These problems are, of course, being investigated as part of the continuous monitoring process. The managers responsible for the changes feel that if they had to undertake the whole exercise again, they would be more mindful of the massive attitude shifts and changes in knowledge which were required of staff at all levels. With hindsight they think that the timescale for the changeover was too tight, especially for the teaching/training process. They also warn that changes in one aspect of the health service nearly always have implications for other units, professions and care groups, and that sometimes chiselling away at established procedures may unearth bad practice in a number of fields.

Whether or not the decentralisation of child health administration in Newham is deemed a success after formal evaluation, clear lessons remain about the implementation of change in community health services - lessons which could prove valuable for community managers keen to experiment with new management/organisational structures. Formal, multidisciplinary planning groups, active and regular consultation with staff, and a structured training/induction plan all contributed towards the effective coordination of change in child health services.

Liz Winn
May 1987

APPENDIX I

CHRONOLOGY

A Case Study in the Management of Change

April 1984 — Ideas about decentralisation first mooted. Stimulated by arrival of a middle manager from a district already working in this way.

October 1984 — Personnel changes created opportunities for restructuring and introduction of new ideas.

January 1985 — 1) Team of managers met to discuss opportunities for decentralisation.

* Office Manager - Community Health Services
* Senior Administrator - Centres/Clinics

Community Paediatrician

3 x SCMO

Director of Nursing Services

Nursing Officer (School Nursing)

Nursing Officer (Health Visiting)

* *serviced the group and researched alternative examples of decentralised services. Later to become Administration Manager - Community Health Services, and Operations Manager - Community Health Services, respectively.*

Appendix I (2)

The group became the Decentralisation Working Party.

2) Administration and Operations Managers invited clinics and health centres in the district to examine existing systems and to discuss with staff the objectives and implications of the changes. Also investigated availability of office space and storage.

3) Plans for decentralisation approved in principle at Unit/District level.

February/March 1985 1) Administration and Operations Managers visited other districts to get a firmer idea about the practical implications of their proposal.

2) Unions consulted about proposed changes. Positive.

April 1985 Request for help in measuring staffing requirements to Management Services Division (MSD).

May/June 1985 1) MSD survey of clinic activity.

2) Similar survey on centralised activity and estimation of staffing levels needed for a decentralised structure.

Appendix I (3)

MEANWHILE

Decentralisation Working Party established procedural arrangements, e.g.

- location of records
- location and boundaries of the patches served by clinics
- allocation of schools to patches/clinics
- identification of centralised registers - child abuse; observation register; special educational needs; special needs; doctors' rotas; transfer of records (if movements outside the district).

3) DHA received formal proposal for decentralisation.

MEANWHILE

Administrative staff were given regular updates and opportunities to discuss and make suggestions about changes. In particular, new records were designed with input from staff.

Appendix I (4)

August-October 1985	MSD in consultation with Office Manager and Senior Administrator-Centres/Clinics about overall manpower requirements in central office/each clinic. Structure and gradings drawn up.
November 1985	Meeting with staff to present new structures and gradings. Job descriptions also discussed. Effectively a job for everyone (due to resignations and previous use of temporary staff) and opportunities for promotion and training.
January 1986	1) Interviews for new posts. 2) Discussed training plans.

MEANWHILE

Meetings with Working Party and staff to finalise operational procedures. Production of procedural manual.

February 1986	1) Discussion with District Training Officer. Finalised training package.

2) Carried out first training session - two days for each member of staff.

March 1986

1) Training on the procedures involved in new roles. GAAs trained to train their own staff with support from Administration and Operations Managers. Training on procedures carried out immediately prior to decentralisation.

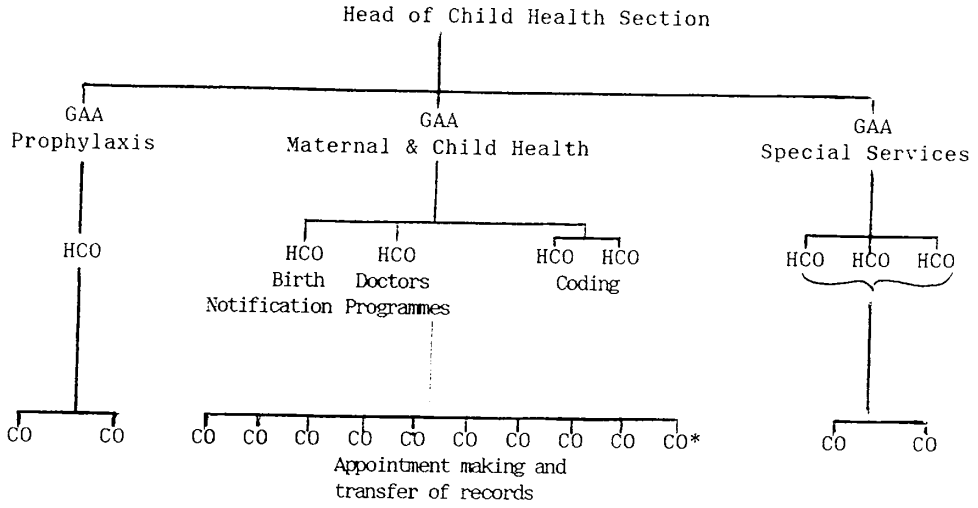
2) Clinics were closed for one week before decentralisation (except for walk-in and immunisation sessions).

3) Records sent out to clinics. Offices organised.

4) 24 March 1986: decentralisation in practice.

APPENDIX II

Structure before the changes:
Centrally-based services



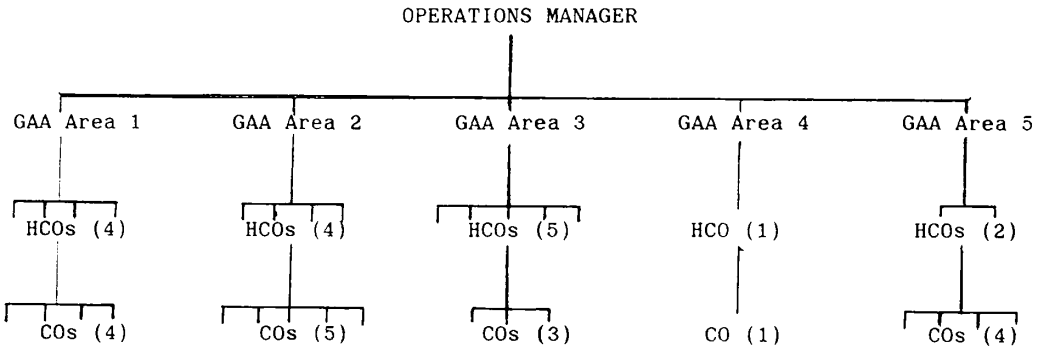
* These were the staff who moved out to clinics following decentralisation.

Clinic-based staff consisted of seven HCOs who covered nine clinics and four health centres.

APPENDIX III

Structure after the changes

(i) **Simplified diagram of decentralised child health services in Newham**



(ii) **Services remaining in central office**