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ISSUES FOR LONDON DHAs:

POLICIES FOR CHILD HEALTH

A report of a conference held at the King's Fund Centre on

23rd September 1982

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King Edward's Hospital Fund for London

ISSUES FOR LONDON DHAs: POLICIES FOR CHILD HEALTH

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ISSUES FOR LONDON DHAs : POLICIES FOR CHILD HEALTH

This conference was the second in the series 'Issues for London DHAs' held at the King's Fund Centre following restructuring of the NHS in 1982.* The purpose of the day was to promote discussion about some of the issues that London District Health Authorities must face when deciding policies and planning services for children. The debate that took place illustrated a variety of views on the best ways of organising child health services, especially those concerned with surveillance and screening.

Chairman's introduction Lady Riches, Member of the Board of Governors, The Hospital for Sick Children, Great Ormond Street, and Member of City and Hackney D.H.A.

Lady Riches opened the conference by saying that she was sure all participants fully appreciated the importance of our inheritance of children and the need to promote child health. The earlier in life good patterns of health behaviour could be established, the healthier our nation was likely to be.

Lady Riches emphasised the value of including preventive medicine and health education in an integrated child health service, particularly in inner city areas, where services may not be available or poorly used. She observed that over the last decade there had been a move from concern solely with children who were ill to interest in the upbringing of the healthy child and a concentration on measures to preserve health. This conference reflected current concern about child health and the future of services for London's children.

Lady Riches then introduced the first speaker, Dr Andrew Boddy, to talk about improving child health.

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* Other conferences in the series included Policies for the elderly[1]; Policies for community-based mental handicap services[2]; and District psychiatric services[3]. Copies of the reports of these conferences are available from the King's Fund Centre.

Improving child health Dr Andrew Boddy, Director of the Social Paediatric and Obstetric Research Unit at the University of Glasgow

Dr Boddy prefaced his talk by saying that the field of child health was one in which everyone had their own set of priorities. He therefore asked conference members to forgive his sins of omission and to accept as well-intended the generalisations he was bound to make.

Dr Boddy stated that the problem was not what policies we should have for child health: numerous prescriptions had been put forward in the past decade. Ten years ago, the phrase 'waiting for Court' was perhaps some excuse for inaction. Unease about the quality and effectiveness of child health services dated back to at least the late 1960s and reform was to have been one of the fruits of the NHS reorganisation in 1974. However, little substantial progress had been made towards adapting and improving services provided for the child population as a whole throughout this period.

Dr Boddy offered two reasons why this should be so. Firstly, child health services, more than any other area of the National Health Service, were still tri-partite. This tri-partite health service had to deal extensively with other child-caring agencies, notably Education and Social Services, so that services were thus often multi-partite as far as the child was concerned. Secondly, services themselves had failed to adapt to the changing needs of children. This was largely due to the failure to develop effective planning and management arrangements and had resulted in doubts and uncertainties being raised about the continuing and future validity of some areas of childrens services, for example the School Health Service. There had been a failure to provide the appropriate training and specialist status for child health doctors working in the community and this had given rise to a lack of morale and an entrenched conservatism which delayed the process of change.

A further consequence of the failure to define and pursue relevant policies for child health had been the devising of solutions to problems in ways which solved organisational, professional or administrative difficulties but which were not themselves based on coherent policies for child health. To illustrate this trend, Dr Boddy cited the proposal to equate the training of clinical medical officers with that of general practitioners as a way of solving difficulties over specialist registration; a second example was proposals from the B.M.A. and the Royal College of General Practitioners concerning developmental

monitoring on a fee-for-service basis. While there might be good professional reasons for adopting these proposals, they did move away from the well-established philosophy that the main purpose and trust of child health services should be with the public health needs of children. A wide range of agencies and people should be involved with child health and these were outside the fairly narrow confines of general practice as it was presently organised, particularly in inner city areas.

There was a need for redefinition of the goals of child health services to bring them up to date. It was also necessary to look less for central direction regarding policy and to concentrate on finding solutions at district level.

Dr Boddy identified five broad goals for child health services:

1. The maintenance of existing standards; improvement of present methods of monitoring and surveillance; early diagnosis.

2. The provision of primary health care.

3. The improvement and development of skills and technology in the coordinated care of chronic illness and handicap.

4. The diagnosis and management of behavioural disorder.

5. The planning of services and deployment of resources to reduce inequalities of health experience.

Having defined these goals Dr Boddy then selected the main priorities within each of these broad headings. He stressed that they were neither exclusive nor comprehensive but rather his personal list of priorities.

1. Maintaining existing standards, surveillance and early diagnosis.

a. The importance of maintaining vaccination and immunisation rates.

b. The continued monitoring of children to achieve early identification of disability and handicaps and to allow effective planned management.

c. The continued support of children at "non-specific risk". Support to their families and a recognition of the vital preventive role of health visitors.

d. The importance of establishing information services for the planning, organisation and provision of community care.

2. **The provision of primary care.**

Problems in the provision of primary health care largely resulted from the tri-partite system. All three parts, in an uncoordinated way, were providing "bits and pieces of the whole". General practitioners usually concentrated on short-term illness; community child health services provided surveillance and monitoring; while hospitals had other functions they also provided a primary care back-up service through their accident and emergency departments. It was essential that these different aspects of the whole spectrum of primary care provision fitted together in a way which made better sense to the patient. The priorities in this area were:

a. Ease of access and availability.

b. A more positive approach to relationships between different professional groups i.e. general practitioners, health visitors, clinical medical officers and social workers; the promotion of team care and links with other services.

c. Establishing who does what: screening and other activities involving <u>all</u> children.

d. Establishing who does what: the provision of care for children with <u>special needs</u>.

e. The scope of primary care: not necessarily the province of people defined as health workers: what is health and what is illness?

3. **The coordinated care of chronic illness and handicap.**

One of the important practical proposals of the Court Report has been its account of the District Handicap Team.[4] However, though widely adopted,

these had often achieved limited success. This area required development, because, in Dr Boddy's view, the only coherent way of providing effective care for children with significant handicap was through a team approach.

a. Recognition of the reality of the District Handicap Team. The importance of establishing a common organisational framework to facilitate the joint use of resources by different agencies.

b. To meet the underlying requirements for joint action with an effective information system, communication and common approaches to management.

c. The provision, and acknowledgement of the need for professional skills and specialist provision; their relationships within professions and to other professions.

d. The methodology (and technology) of care in the community; what do we seek to provide ?

4. The management of behavioural disorder.

Dr Boddy emphasised his inclusion of behavioural disorder as he felt it was an area of child health that health services had been slow to acknowledge and respond to. Rutter's survey of an inner London borough had reported a prevalence of 25% in ten year olds.[5] Also the work of Lee Robins in the United States had shown that the longer-term prognosis for many of these children in terms of social maladjustment, adult mental health or even physical illness, could be disastrous.[6] Support for these findings in the United Kingdom came from Michael Wadsworth's analysis of the later history of the 1946 birth cohort.[7] Our response remained inadequate and confused, leaving child mental health a neglected area.

a. The requirement for a greater Health Service input with improved training for community personnel.

b. More effective cooperation with other agencies, especially Education.

c. Exploration of different approaches to care; innovation in

management methods over the longer term.

d. Early identification and the development of a team approach to management.

5. **Reducing inequalities of health experience.**

Dr Boddy's final list focussed, in his view, on perhaps the main issue in child health policy and also served as a summary of his presentation. The ill-health of children was still highly correlated with other measures of social disadvantage and child health problems were increasingly concentrated in this fairly small proportion of the whole population. At present we tended to "spread our butter evenly across the whole slice of bread" and, by investing heavily in hospital care left ourselves little room for manoeuvre to respond to the problems of inequality of which we were aware. The priorities in this area were:

a. Improved "public health" monitoring of areas of greater need; resource deployment.

b. Better recognition of Health Services priorities with an increase in community resources.

c. Exploration of alternative models for the delivery of care; innovation.

d. More effective relationships with other agencies in respect of health policies and issues.

e. More action in response to the particular needs of different minorities.

In conclusion, Dr Boddy emphasised that if we wished to improve child health we must first define our goals and then be prepared to change and adapt our existing services to satisfy them. This required a willingness to try alternatives and to provide scope for innovation. It also needed improved collaboration with other agencies. Dr Boddy ended his presentation by stating that we had little reason to be complacent.

Turning next to look in more detail at London's children, the Chairman introduced Dr William Kearns to discuss his paper (see Appendix I) which had been prepared as background material for the conference.

Characteristics of London's child population Dr William E Kearns, District Medical Officer, Paddington and North Kensington Health Authority

Dr Kearns began his presentation by making some general observations about the paper. It was intended to be complementary to the background paper by Elizabeth Watson (see Appendix II) and to link with the presentations of other speakers at the conference. It was structured into five sections ranging from demography and social factors to morbidity and mortality. It was inevitably selective and therefore, in some respects, incomplete. The style of the paper was necessarily specific and concise with little text, hence the requirement to study it in conjunction with Elizabeth Watson's background paper as it provided measurements for many of the characteristics she described.

Dr Kearns then discussed some of the problems encountered in drafting the paper. There was enormous variation within London as there was in the rest of the country. In some instances information was given for Greater London, Inner London and Outer London and it was interesting to note that in many cases Outer London and the rest of the country had more common characteristics than Outer London and Inner London. Where possible the paper provided the range of values within areas of London to assist participants to make comparisons with their own boroughs or health authorities. Dr Kearns said that it had often been difficult to obtain information in a usable form and some information was not available because it was sensitive or confidential.

Dr Kearns then proceeded to emphasise certain points raised in the paper. He acknowledged that people were aware of many of the characteristics illustrated but the merit of the paper was that it quantified these characteristics.

Looking first at demography, children form a smaller percentage of the population of Inner London than of Outer London and in Greater London as a whole there is a smaller percentage of children than in England and Wales (table 1). The population of younger children aged 0 to 4 years is decreasing but the population of older children aged 5 to 14 years is increasing in Greater London (table 2). Dr Kearns pointed out that this was within a reducing total population and child population in Greater London (tables 3 and 4).

Considering birth factors next, Dr Kearns said that it was interesting that the statistics for perinatal and infant mortality in Greater London compare favourably with the country as a whole, despite the detrimental social and environmental factors in London (table 5). However, rates for individual London boroughs show the wide variation with the capital (table 6).

In common with other large cities, London has particular social characteristics which are relevant to child health. Inner London has a high percentage of households living in rented accommodation, both privately and council owned, and a low proportion of owner-occupied homes (table 7). Nationally, only 3% of households with dependent children live in accommodation on or above the second floor. These households contain 300,000 children under 16 years of age. Of these children more than half live in London (table 8). This is a particular feature of Inner London. In the provision of basic housing amenities and overcrowding Inner London also compares unfavourably with the rest of the country (tables 9, 10, and 11). This has particular relevance for mothers returning home from hospital with infants. Homelessness is also common in Inner London. Families with children are often affected and consequently are concentrated into the substandard accommodation made available to the homeless. The relationship between poor housing and health problems is well known and many children in London are likely to experience illness related to inadequate housing conditions.

Looking at other social factors, Dr Kearns pointed out that more married women with children in London work than elsewhere in the country (table 13).

London also has twice the national proportion of single parent families (table 14). It was noted that definitions of a household containing one adult could vary, but in certain London districts the rate for one parent households was over 25%. Children in London are therefore more likely to require day care. There are extreme variations in the number of full-time day nursery places provided by local authorities in London.

One particular feature of London's population is its cosmopolitan nature. The concentration in Inner London of people from minority ethnic groups is shown by data from the 1981 Census (table 15) and by the birthplaces of mothers who had live births in 1979 (table 16). For children this has implications in terms of different language, culture, educational aspirations, etc., and could be linked to language difficulties.

Dr Kearns drew attention to the very large number of children in care in Greater London. Inner London has a rate almost three times as high as England and Wales (table 17). There are, however, very wide variations between different boroughs (table 18).

The sections on education and crime in the paper illustrate the difficulties of collecting data on sensitive subjects. However, it could be deduced that the figures for adult crime in the Metropolitan Police district had increased considerably since 1980 whilst those for juvenile crime have remained constant.

The section on epidemiology shows that there is wide variation in the acceptance rates for measles vaccination in particular between inner and outer London and the rest of the country (table 20). Dr Kearns thought that it was significant that the rate for measles notifications in Britain was two hundred times the rate in the US, where an initiative to eliminate indigenous measles by Autumn 1982 was proceeding satisfactorily (table 21). The importance of preventive policies was also demonstrated by considering conditions contributing to morbidity and mortality in children. Although relatively few children die between the ages of one and fourteen years, many of these deaths are potentially preventable, especially those classed as accidents, injury, poisoning and infectious diseases (tables 22, 23, 24 and 25).

Dr Kearns concluded his comments by emphasising how different London,

especially Inner London, was from the rest of the country. In Inner London population mobility was high and this accentuated problems like poor housing, working mothers, single parent families and children in care. However, infant and perinatal mortality rates for London was surprisingly good in the circumstances. Chidl health policies had profound effects on such areas as morbidity and mortality. Dr Kearns said he hoped the information in his paper gave an indication of areas where policies for child health in London might be reviewed.

Questions and discussion

In discussion following Dr Kearns' paper, several participants indicated further information they would have liked included in the paper. Mr J Burrows, member, Greenwich DHA, felt that it would have been useful, particularly for lay members, to have more data on the incidence of physical and mental disability. Dr Y Hollis, Specialist in Community Medicine, Hillingdon DHA, would like to have seen future population projections, particularly for under five year olds and Mr L A Patrick, Camberwell DHA, felt that more attention should have been paid to the incidence of non-accidental injury.
Miss A While, Lecturer, the Department of Nursing Studies, Chelsea College, asked whether mental health statistics were available for Inner London.

Dr Kearns agreed that there were omissions in the paper. However, there had been a requirement to produce a document of a reasonable size, and the time taken to compile the paper had to be taken into account. With regard to statistics on non-accidental injury he commented that work was being done on this in Paddington and North Kensington DHA, but the statistics were difficult to interpret.

Much discussion took place regarding the data on vaccination and immunisation rates. Dr Y Hollis asked whether it was possible to compare data from the United States with British data as she questioned the accuracy of the figures from the United States. Dr R Graham, Specialist in Community Medicine (Child Health), Richmond, Twickenham and Roehampton DHA, commented that in the United States compulsion was exercised as children could not attend school without having been vaccinated and, though disliked, this policy did lead to progress. Mrs P Belson, member of Victoria DHA, stated that data was difficult to obtain on children under five years old in the United States.
Miss S Goodwin, Honorary Secretary, Health Visitors' Association, felt that it

would be useful if primary health care teams could have the vaccination and immunisation rates for their individual areas. Dr J Richards, District Medical Officer, Tower Hamlets HA, stated this information was available on a clinic centre basis, be it a general practitioner clinic or a child health community clinic, from the National Child Health Surveillance Programme, though to gain access to it required the cooperation of regional computer centres.

Dr Kearns commented that the United States had a deliberated eradication policy for measles which bore some resemblance to the smallpox campaign of a few years ago. He stated that their data on vaccination and immunisation rates were comparable with Britain though artifacts in this data were likely.

Dr Boddy took up Dr Kearns' point on the surprisingly good figures for perinatal and infant mortality in Inner London. The rate had reduced dramatically over the past ten years and reflected the effects of hospital services. However, the determinants of infant and perinatal mortality remained the same. The deman for more resources and active intervention in obstetric care in the hospital sector was a post hoc solution, concentrating increasing sums of money on to a small proportion of children while not changing while not changing the underlying nature of the problem.

Dr G Curtis Jenkins, General Practitioner Paediatrician, Ashford, Middlesex commented that, as the child population was now falling, professional staffing ratios should be improving yet results were not improving. He therefore questioned the present management organisation. This point was taken up by Miss S Goodwin who stated that the brief and responsibilities of health visitors had changed, for example through their attachment to general practitioners, so figures could not be usefully compared. Dr Kearns agreed that it was difficult to quantify the effect of having increasing numbers of professional staff in the community sector.

Other issues briefly raised at this point included the need to look at statistics on a sub-district level for effective local organisation of services; the importance of computerisation; and the need for more information about behavioural disorder.

The Chairman then introduced the next speaker, Dr Anthony Jackson, to describe the progress made towards an integrated child health service in Tower Hamlets.

Progress towards an integrated child health service in Tower Hamlets

Dr Anthony Jackson, Post-graduate Sub Dean, The London Hospital Medical College, and Consultant Paediatrician

Dr Jackson began by saying that integration had been considered a very important issue in the Court Report. The Government's response to the report in January 1978 had confirmed that policy should encourage integration between hospital paediatric departments, community child health services, and general practitioners in primary care. It had also suggested that authorities should encourage paediatric specialists to move from hospitals into the community, that district handicap teams should be established, and that the training needs of all three groups of doctors should be examined. Dr Jackson referred to Paul Harker's study in the British Medical Journal[8] which had illustrated the large number of medical posts linking hospital and community which were now being established: of the eighty-four authorities participating in the study only eleven had no linked posts. Some progress towards integration had therefore been achieved.

Dr Jackson went on to outline specific developments made towards integration in Tower Hamlets. These were as follows:

1. **Integration of medical staff**

   a. The senior clinical medical officer on the District Handicap Team held a follow-up baby clinic to assist the transition for mother and baby from hospital to community.

   b. One senior house officer post proceeded, after six months, to one year's clinical medical officer post.

   c. One senior house officer post, filled by a general practitioner vocational trainee, was based for half of each week in the hospital while the remaining half was spent in the community as a clinical medical officer. A clinical medical officer then spent half his time in the hospital to cover the senior house officer.

d. A senior clinical medical officer with experience in hospital paediatrics acted as a visiting registrar to wards in the District General Hospital and did ward rounds with the senior house officer each weekday morning.

e. Five out of the eight community medical officers involved in child health participated in hospital work and were on the hospital duty roster. This enabled them to maintain an interest in education and training in hospital paediatrics and facilitated more reasonable duty rosters.

f. A consultant paediatrician held a child health clinic in a deprived area of Tower Hamlets.

g. The consultant member of the District Handicap Team visited special schools and day nurseries for pre-school handicapped children with other team members and held peripatetic consultation in a child health clinic at a local group practice.

2. Integration at health visitor level

a. A nursing officer on the District Handicap Team liaised between the team and health visitors, though at a child's initial assessment the family's health visitor was usually present.

b. Communication between hospital nurses and community nurses was facilitated by the appointment of liaison health visitors in the paediatric clinic, the childrens ward and the obstetric ward.

3. Integration through the Pre-School Unit

The Pre-School Unit, a joint medical school, health service and local authority project, was serviced by child psychiatrists, psychotherapists, teachers and social workers. It concentrated on families where children had behavioural difficulties which required specialist assessment and advice.

4. Integration through the district community child psychiatric service

The district community child psychiatric service offered open access. It had links with the hospital psychiatric service.

5. Integration through the District Handicap Team

The team provided an ideal focus for the integration of hospital, community and primary care.

6. Integration through the district review committee on non-accidental injury

The district review committee on non-accidental injury included representatives from the police and probation service and acted as a useful point of communication.

7. Integration through the Centre for the Study of Primary Care

The plans to develop a Centre for the Study of Primary Care in Tower Hamlets had the potential to assist the integration of child care services.

8. Integration through the Committee on Child health Services

There was no division of paediatrics or child health in Tower Hamlets. However, a committee on child health services, called the Section for Child Health Services, reported to the division of medicine through the consultant paediatricians who were members of both committees. It was also attended by the district medical officer. Its members were as follows: all consultant paediatricians, one consultant obstetrician, one consultant child psychiatrist, a representative from child dentistry, paediatric junior medical staff, senior clinical medical officers involved in child health, nursing officers for community and obstetrics, sisters from the paediatric ward and the special care baby unit, a hospital social worker, the district hospital liaison social worker and two general practitioners. Though the committee met only six times per year and not all members attended each meeting, it did allow discussion to take place between the three arms of the service and it made a valuable contribution towards the formation of district child health policies.

Dr Jackson then talked about the career structure and training of community child health doctors, which had formed part of the Government's response to the Court Report in January 1978. Dr Jackson was involved in discussions on this subject as a member of the British Paediatric Association, the Joint Paediatric Committee of the Royal Colleges of Physicians and the British Paediatric Association, and as a member of the Forfar working party. He stressed his disappointment at the loss of the Area Specialist in Community Medicine (Child Health), and emphasised the importance of having a named doctor with direct responsibility for child health in each District. Senior clinical medical officers and clinical medical officers should be allowed to be specialists with independent clinical status and for this to be so they required a formal, approvable training. The above-mentioned groups had recommended a three year training course for clinical medical officers, comparable with the general practitioner vocational training course, commencing after registration and would qualify them for a post of principal in general practice. Senior clinical medical officers could have four years further specialist training leading to an appointment as consultant paediatrician with a special interest in community child health. Dr Jackson emphasised that there were already doctors who filled this role.

Dr Jackson concluded by stating that there had definitely been a move towards integration in Tower Hamlets, and perhaps in the rest of the country too. He felt that the NHS was slowly moving towards a proper organisation for community child health service and for the doctors who worked within it.

Questions and discussion

At the end of the morning session, conference participants were given the opportunity to question speakers on the platform and to raise further issues for debate.

The problem of children in care was raised by Mrs N. Honigsbaum, Chairwoman, Paddington and North Kensington CHC. Dr Kearns' paper had shown the large number of children in care in inner London, yet there appeared to be no satisfactory monitoring system for their health care needs. She suggested that the physical and behavioural problems of these children would be difficult to separate. Dr A. Jepson, District Medical Officer, Hammersmith and Fulham DHA, followed up this point and stressed the lack of medical background information available for children in care.

Psychiatric problems were an area which required particular attention and additional resources. Both Dr Boddy and Dr Jackson agreed that there must be named health personnel responsible for these children who could 'monitor' their health. This role might be filled by either a general practitioner or a clinical medical officer. Dr A. Nicoll, Lecturer, Department of Child Health, University of Nottingham, suggested that a senior medical officer could be specifically trained to have responsibility for children in care. General practitioners would still be important but their care tended to be based on episodes of illness.

The importance of medical advice to juvenile courts was stressed by Mrs B.J. Banham, Chairwoman, Paddington and North Kensington DHA. As a magistrate, she felt that often too little medical advice was available and magistrates needed to be educated to listen to such advice. This point was disputed by Mrs R. Holloway, member, Barnet DHA, who felt that the courts did look at a child's medical needs. Dr Jackson emphasised the importance of doctors attending courts to give evidence, though many would have little experience of this. The organisations involved with the abused child should refer the child through hospital, community child health, or primary care services.

The problems regarding the school medical service were raised by Mrs M. Roberts, member, Greenwich DHA, and were the subject of much discussion. Most speakers expressed reservations about the value of routine medical examinations as presently practised. However, Dr B. Edwards, Principal Physician (Child Health) Brent DHA, emphasised that the cooperation of school health doctors was vital if change was to occur. She also stressed the importance of cooperation between education services and health services. Dr R. Beaver, Specialist in Community Medicine (Child Health), Redbridge DHA, stated that various policies for change had been promulgated but additional resources were required for their implementation. Dr J. Richards felt that 1982 marked the 'watershed' of the school medical service. There was a need to go back to the roots of the problem with the aim of monitoring and promoting child health. In her view emphasis should be placed on the role of the school nurse whose influence had been extensive up to the 1960s. The doctor's input could then be problem-orientated and the number of routine medical examinations could be reduced to one for all five year olds, which would assist in the monitoring of pre-school services. Recruitment for school nurses was now good and a better training should be offered to them.

The role of the general practitioner was briefly discussed. The main point emphasised was the importance of adequate training for general practitioners in looking after their younger patients. Dr J. Robson, member, Tower Hamlets DHA and a general practitioner, stated that some general practitioners did take a preventive role but Dr Boddy felt that this varied between practices. He accepted that general practitioners should be encouraged to be involved in the preventive aspects of child health but there was no guarantee that all would take on this responsibility. Dr Y. Hollis emphasised that general practitioners usually concentrated on the family as a whole and there was a need for brokerage for the individual child outside the family. This was a controversial point and both Ms E. De'ath, Developmental Officer, National Children's Bureau, and Mrs P. Belson stated that importance of the parents' role in child health.

Dr N.D.L. Olsen felt that health education was currently a neglected area. Concentration should be placed on behavioural characteristics which could predict ill-health in the future. Health visitors and community medical officers needed to look for health indicators, such as parents smoking, rather than being too preoccupied with child abuse. Schools should be encouraged to play a positive role in health education. Mrs B.J. Banham supported this, particularly with regard to the problem of alcoholism.

Dr G. Curtis Jenkins raised the problem of access to professional help. The most vulnerable members of the community were often those least able to accept professional help and a more informal relaxed approach was required. He quoted the findings of a study in Norwich which reported that when disadvantaged mothers in an antenatal clinic were asked where they received help and advice from, 60% said from their peers. Only 15% sought help from their health visitor. Dr Boddy followed up this point by stating that health professionals tended to put too high a price on the help they offered and there was a need to look at the way this was done. Dr Jackson finally commented that the help most required by vulnerable members of the community was not the sort of help that health professionals were best suited to give.

The main topic for discussion in the afternoon session of the conference was child health surveillance. The Chairman introduced the first of the speakers on this topic, Dr Angus Nicoll.

Approaches to child health surveillance Dr Angus Nicoll, Department of Child Health, University of Nottingham

Dr Nicoll began by commenting that community child health services, in contrast to hospital paediatric services, were undergoing change in many areas throughout the country. This could be for better or for worse. Many conference participants would be involved directly in these changes, others would be asked to approve new policies. He defined community child health services as being all children's services outside the hospital ward and suggested important features of local systems which should be looked for by conference participants. Dr Nicoll illustrated where children could receive help at the present time, i.e. from the hospital, the general practitioner, the child health clinic or their place of education or day care. Then, with the aid of a series of amusing slides, he described some characteristics of **bad** approaches to child health promotion. These were as follows:

1. **The over-ambitious approach**

An over-ambitious system of child health surveillance had been inherited from the past. This involved a series of rigorous pre-school examinations for each child and was exemplified in MCW46 forms. The result was that too much pressure was placed on the doctor so attention could not be given where it was really needed. Also, too much pressure was placed on the clinic causing a well-documented fall-off in the attendance of mothers. A survey in Nottingham had shown that by the age of eighteen months only a third of children were still being brought to the clinics in the inner city area.[9] The two-thirds of children not attending were those with the most problems. As the major proportion of handicapping, preventable and treatable diseases were not diagnosable until after eighteen months of age, the consequences of non-attendance were dramatic. The fall-off in attendance was not inevitable and could be avoided with much persistance and more resources. However, large numbers of visits to clinics could be a waste of scarce resources. Dr Nicoll disagreed with the view that all routine checks should be abandoned: a powerful tradition of clinic attendance had been built up since the last century and it could have covert benefits. However, the number of routine baby checks could be cut down and could be undertaken by adequately trained general practitioners and health visitors rather than by clinic doctors, who could then concentrate on examining older children, particularly those with problems.

2. The rigid approach

Families and children cannot be rigidly categorised and problems do not occur regularly, although various centrally-devised child surveillance systems tended to assume this. Dr Nicoll illustrated this point by describing the two different toddler clinics in Tower Hamlets.

The first aimed to see all children at fixed ages for routine checks, the second saw all children at any age but only when the parents or health visitor had identified a problem. The first clinic identified few problems while the second, by adopting a more flexible approach, identified more abnormal children with multiple problems. Rigid, centralised systems could not adapt to the mobile populations of inner cities. Also, they presented difficulties for health professionals as such systems attempted to reduce child health to a series of yes/no questions thus over-simplifying problems and making doctors and nurses dull 'box-tickers'.

Dr Nicoll then illustrated some characteristics of **good** approaches to child health promotion:

1. The flexible approach

In community paediatrics children are inevitably seen by many health professionals and there is an overlap of diagnostic skills. It was therefore important that everyone, including the parents, knew who would deal with what problems. The importance of a fall-off in clinic attendance would be reduced if a child's problems were identified by the health visitor. Dr Nicoll felt that both parents and health visitors should be able to screen for the doctor.

2 The small approach

Integration was vital for flexibility and the first principle of integration was that everyone should know each other. A small geographical unit was therefore required, particularly in London with its mobile population. The question of health visitor attachment to general practitioners then had to be considered. Dr Nicoll favoured organisation of health visitors on a 'geographical patch' basis in inner city areas, though not necessarily throughout

the country, as general practitioner's lists often covered a wide geographical area in cities which could involve health visitors in excessive amounts of travelling. Also in inner city areas many children under five years of age would not be registered with a general practitioner. However, a good relationship was still essential between health visitors and general practitioners.

3. The people-based approach

Child health surveillance depended upon competent professional people doing a satisfying job over which they had some control. To achieve this more training was required for clinic doctors and general practitioners; and more status should be given to school nurses. These criteria could be achieved with a small outlay of resources, but the 'will' to achieve them was far more important. The current health service reorganisation left child health services in a vacuum which presented an opportunity for districts to implement their own plans, but Dr Nicoll feared that in some districts community services would be left 'in the doldrums' or stripped of resources by more powerful forces.

In conclusion Dr Nicoll urged the conference members to ensure the future of community services in their own districts.

The Chairman then introduced Dr S.M. Jenkins, Community Paediatrics Section, St. Mary's Hospital Medical School to continue with the topic child health surveillance.

Dr Jenkins began by stating that, according to Dr Nicoll's categorisation, she could probably be labelled 'overambitious'. She then described the recent study undertaken by the Thomas Coram Research Unit which had looked at the health needs and use of services of two populations of under five year olds in North London.[10] The aims of the study were to look at the epidemiology of illness, developmental and behavioural problems; the availability and effectiveness of medical care for the groups of children and to attempt to assess parental satisfaction. The clinics set up as part of the study aimed to provide an 'optimal service' with a weekly evening clinic, and home visits as required.

The study focused on two geographical areas in Paddington and Camden. In each area the caseload of one health visitor, i.e. 200-240 families, was

involved and children were identified by house-to-house visits. Mobility in the areas varied between 25% and 30% and the study covered all children who were born in or moved into the areas but those who moved out were not followed up. Children were seen at the ages of six weeks, six months, one year, eighteen months, two years, three years and four and a half years and, in addition, whenever the parents wished. There was a 95% attendance rate for routine checks at all ages and this accounted for approximately one-third of the total examinations undertaken. Approximately two-thirds of all attendances were for non-routine checks. In the first year of life there was an average of thirteen clinic visits for each child, excluding routine visits.

Children in the geographical areas were registered with 152 general practitioners but approximately 5% of the children were not registered. This reinforced the point made by Dr Nicoll that health visitors in inner city areas needed to be responsible for a geographical area, as liaison with general practitioners could be difficult to organise.

Only 1% of the visits to general practitioners were for developmental or behavioural difficulties as they mainly dealt with physical problems. However, attendance was high at both hospital outpatients and general practitioner surgeries.

Each geographical area involved in the study had a children's centre as its focal point. The Dorothy Gardener and Thomas Coram centres provided facilities for parents including nurseries, mothers' rooms, mother and toddler groups, launderettes and integrated child health clinics with pre-school facilities. The centres also held various social functions which promoted communications and parental involvement. Evening sessions provided as flexible a service for parents as possible.

Dr Jenkins then described the results of the study.

1. Physical problems

Over 20% of the children included in the study had problems which required intervention or follow up. Of these, 20% were physical problems, the most common being ear infections and upper respiratory tract infections (table 1).

Table 1: History of respiratory illness in different age groups

	0-1 year %	1-2 years %	2-3 years %	3-4½ years %
URTIs more than once per month	14	14	16	9
LRTIs at least once in last year	13	10	11	9
Otitis Media at least once in last year	15	16	15	24
Total n =	274	280	329	274

(in all tables prevalence rates are given for the five year period)

2. Behavioural problems

Until this study there had been little data on behavioural problems of pre-school children. Table 2 illustrates the prevalence of behavioural problems in under-five year olds.

Table 2: Prevalence of behavioural problems by age

	6 wks n	%	6 mths n	%	1 year n	%	18 mths n	%	2 years n	%	3 years n	%	4½ years n	%
Parents worried about behaviour	22	6	11	3	23	8	15	6	34	11	48	15	35	13
Doctor assessed behaviour problem	14	4	8	2	16	6	15	6	32	11	55	17	35	12
Total n =	352		331		278		251		302		327		276	

Problems peaked at three years of age. Under one year old the problems were mainly night waking while for children over 2 years old they were tantrums, clinging and dependency (table 3).

Table 3: Percentage of children at each age with common behavioural problems

	6 mths	1 yr	18 mths	2 yrs	3 yrs	4½ yrs
Night waking						
4 or more nights per week	13	21	17	15	12	10
2 - 3 nights	6	6	9	6	9	6
Temper tantrums						
3 or more a day				6	5	2
Nearly every day				13	13	9
Frequently difficult to manage				5	8	7
Total n =	331	278	251	302	331	272

(temper tantrums and management difficulties were only recorded from two years onwards)

3. Developmental problems

Approximately 10% of the children included in the study had developmental problems at each age. The most common were speech and language delays or abnormalities (table 4).

Table 4: Percentage of children with abnormal speech and language

	2 years		3 years		4½ years	
Speech and language	%	n	%	n	%	n
Possibly abnormal	17	(50)	12	(38)	7	(19)
Definitely abnormal	5	(14)	8	(25)	5	(13)
Total n =		296		323		269

The study showed the interrelationship of health, development and the behaviour of children. There was an excess of children with behavioural problems amongst those who suffered chronic minor illness. Children with speech and language delays had significantly more behavioural problems, although the same link was not found for children with major health problems. This accentuated the importance of studying the whole functioning of the child. Health professionals in the community require more training so that they can look at all aspects of the child and ask relevant questions to elicit these problems.

Dr Jenkins admitted that it was difficult to assess the achievements of intervention as it was not easy to undertake control studies. However, the results of the study did show that children remaining in the area since birth when examined at 3 years presented behaviour problems in approximately 5% of cases, while children moving into the area presented problems in 17% to 18% of cases.

Dr Jenkins compared these findings with those of Barber in Glasgow who studied developmental surveillance in one general practice over a four year period.[11] The families included were mainly social classes three, four and five. There was a 10% default rate and 23% of the children studied had physical or developmental problems requiring management. At two years, 15% of the children had physical problems which had not been previously detected and 11% had abnormal or delayed development. A study by Spies, of three year olds in Kensington, Chelsea and Westminster, similarly revealed that 54% of the children observed had problems of either development or behaviour requiring follow up.[12]

Dr Jenkins concluded that a more flexible approach to child surveillance was required for all children at every age. The service must be understood by parents and be one that they would wish to use. There was a need for competent, adequately trained doctors and health visitors with clinical responsibility for a particular geographical area giving continuity of care. Home visits and health education for mothers of normal and abnormal children were vital. These gave opportunities for positive reinforcement of motherhood and for discussion of problems such as maternal depression and stress. Dr Jenkins finally emphasised the need for more research into the value of intervention if the continuance of pre-school surveillance was to be justified.

Questions and discussion

The Chairman invited Miss Valerie Packer, Director of Nursing Services (Community), Enfield DHA and Dr Graham Curtis Jenkins, General Practitioner Paediatrician, Ashford, Middlesex, and Coordinator, Developmental Paediatric Research Group, to open the discussion on the previous presentations.

Miss Packer concentrated on the problems faced by nurse managers in inner city areas and referred to the Acheson Report on primary health care in inner London.[13] She felt that there was an urgent need to review the manpower levels necessary to carry out policies in community health. It had been twenty years since the last review and many changes had taken place. It was increasingly difficult to recruit and retain community nursing staff in inner London. Young health visitors and district nurses worked in inner London for a short time to gain experience then moved elsewhere, leaving the staff who remained to continually support new employees and provide some continuity for the local community.[14] Miss Packer outlined the reasons for this mobility in the inner city:

- The enormous burden of stress on community nurses because of their contact with problem families. Nurse managers needed to be aware of this and to support their staff.

- The difficult of keeping up to date with new techniques in community health. Continuing education was required, backed by money and facilities. Miss Packer commented that the Government had given an increased allocation for health visitor training to inner city areas in reponse to the Acheson Report. However, this had come too late for 1982 as the colleges had completed their recruitment programmes and students had arranged their placements with authorities.

- Field staff needed to be informed about new policies and the implications for their work. They have to set priorities and these are influenced by the problems of their clients, demands from other professional colleagues and from their managers. It was vital that they should be able to feed their difficulties back to nurse managers, who had to make a contribution to the policy-making process which ended with the district health authority.

- The increasing difficulties for field staff and nurse managers resulting from the pressure for services for the elderly, as well as for under-five year olds, had to be recognised.

Miss Packer emphasised the importance of a multidisciplinary approach, coupled with the recognition that the priorities of various professional groups would often vary. There was a need for good consultation and communication systems with adequate clerical support. Decisions had to be taken regarding the growing demands for specialisation in community nursing, not least how this should be funded.

Miss Packer said that it was important to learn what services people in the community felt they needed. She recognised the potential for self-help within the community, which through voluntary groups, for example, was a resource to be harnessed as the need for increased manpower and finance imposed limitations on services. Miss Packer concluded by stating that though the Court Report[4] had advocated the attachment of community nurses to GPs, she thought this could result in a diluted service to under-five year olds.

Dr Curtis Jenkins concentrated upon the importance of the team approach to child health care in his presentation. He bagan by stating that he had 'come to praise the General Practitioner, not to bury him'.

Nationally, 20% of GPs were undertaking some sort of child surveillance, working in teams with health visitors, clinic nurses, midwives and secretaries and running child health clinics. However, it was a common complaint that primary health care teams were not working well, particularly with regard to child health. The reason for this, said Dr Curtis Jenkins, was that, while team members had pride in their achievements, had loyalty to the team and worked with inter-dependent professionalism towards the highest standard of child surveillance they could accomplish, interference from nurse managers often frustrated their aims. This was often due to lack of understanding and experience by nurse managers who seemed unable to fully understand the revolutionary change that occurs when teams work well.

Dr Curtis Jenkins agreed with Dr Boddy's views on surveillance. Many general practitioners undertook child surveillance for no extra payment and, in his own case, he estimated that 25% was added to his weekly face to face patient workload because of this. Surveillance was not about items of

service but was rather the acceptance of responsibility and the effective organisation to deliver care, preferably with the cooperation, not the active antagonism, of those able to control resources and it cannot be done without expenditure of money.

The catalytic process, as described in Elizabeth Watson's background paper, was vital for child health care. Dr Curtis Jenkins quoted from a national child health survey involving 6,000 children which had been undertaken by twenty general practitioners and had resulted in nearly 30% of mothers still breast-feeding at seven months. This illustrated the importance of the team looking at total care of the child and its parents. He emphasised the importance of health education and of the correct information being communicated to parents. A tangible effect of the efforts of the team in his practice was that in 1979 every child in his practice was fully immunized and 163, out of the total of 177, had triple vaccine the rest receiving diptheria tetanus vaccine alone. These results had been achieved through a team effort on a micro-scale with a sensitive personal approach. The enemies of this approach were firstly bad management and secondly nurse managers who did not accept the reality of the team and attempted to interfere with its function, seeing loyalty to the team as a threat to their own position.

Dr Curtis Jenkins concluded by stating that change was vital - but at a micro- rather than a macro-level, particularly in inner London. Planners had to be aware of differences in morbidity and mortality rates at ward and street level so that resources could be deployed sensitively to match needs.

Conference participants were then given the opportunity to take up some of the points raised by the platform speakers.

Much discussion took place regarding the siting of health clinics.
Dr S.M. Jenkins commented that authorities often had only old, unsuitable premises available to them. However, they could be more flexible in the services they offered, for example linking pre-school facilities with clinic facilities, and in the times they opened. Imagination and resources were required to achieve this. Dr J. Richards agreed with this point and suggested that one way of solving the problem was to site clinics in primary schools with falling roles, or, alternatively, to invite other services into the

old premises by agreement with local authorities and general practitioners. It was important to site clinics near other facilities for mothers. However, Miss V. Packer pointed out that in an established area, with little redevelopment, there were often very limited opportunities to move clinic premises. If an opportunity did present itself the decisions had to be taken on a multidisciplinary basis as different professions often had differing expectations and priorities. Delays could cause loss of the necessary funds. Mr D. Russell confirmed this point from his experience as an ex-town planner: Authorities had to know exactly what they wanted.

Mr A. McNaught, Senior Lecturer in Health Service Management, South Bank Polytechnic, felt that there was too great a preoccupation with buildings: authorities should concentrate on taking services out to the community. Dr Curtis Jenkins commented that, while he agreed with this point, it would not be cost-effective. Health workers needed to be sensitive to the needs of parents who, for various reasons, would not leave their homes, but in the majority of cases going to the clinic was a positive step for a mother to make. He was against dropping clinics as he feared that mothers would receive differing advice from many sources rather than that which had the consensus of the health care team. Dr Nicoll added that it was important for health professionals to go where there were children, for example in nursery schools and pre-school groups, to support workers and parents so they would know where to turn for help and advice.

The question was raised as to whether norms of child behaviour were being imposed on to different cultural groups. Dr S.M. Jenkins agreed that behavioural norms should not be forced on to any parent as degrees of tolerance towards behavioural problems varied. It was difficult to assess the effect of cultural differences and the Thomas Coram study had not particularly highlighted this. However, she disagreed with Dr Curtis Jenkins who stated that social class created more differences than ethnicity.

The role of nurse managers was also a subject for debate. Miss N.M. Lyne, District Nursing Officer, Ealing DHA, accused Dr Curtis Jenkins of 'nurse manager bashing', but accepted some of his comments. A change of attitudes was required and reorganisation presented an opportunity for the nursing chain of command to be shortened. She emphasised the importance of ensuring that there was a general practitioner input into the newly-created community units of management as GPs had their part to play in providing

information to assist in the organisation of community nursing services. Miss S. Rumney, Nursing Officer (Community), Bloomsbury DHA, agreed with Miss Packer's view that young community nurses needed support from nurse managers. This was further emphasised by Dr S.M. Jenkins who commented upon the stressful workload often carried by community nurses. Miss Packer reiterated that the problem with teams was often their members' differing priorities, which in turn might be different from those of their managers. It had to be remembered that health authorities, not general practitioners, were the employers of the nurse members of primary care teams.

The Chairman introduced the final session of the conference, on joing financing, which was opened by Dr Jean Richards.

'Joint financing - what can be done? Dr Jean Richards, District Medical Officer, Tower Hamlets Health Authority

Dr Richards commented in her opening remarks that earlier speakers had shown how inner city children had more and not less health needs than children in more affluent parts of the United Kingdom. However, this was not reflected in the financial allocation to District Health Authorities in inner city areas. She was delighted that the conference had presented a positive outlook on these problems: it made a refreshing change. Joint finance was a useful source of funding which could be used to boost these services.

Joint financing was different from joint funding, which could be used for any items needing joint provision by social services and health authorities, for example district handicap teams. Joint finance was an additional sum of money allocated to the health service for new joiht projects between health services and social services. It had resulted from the change in emphasis from cure to care and allowed resources to be syphoned off from acute to chronic care by a 'pump-priming' process.

In Tower Hamlets, with a community allocation of only 6.5% of the total district budget, joint financing gave flexibility and an opportunity to build up services that would keep people out of hospital. Officers and members of both the health and local authority had to agree on schemes and

consultation took place through joint care planning teams and joint consultative committees. Joint financing monies rarely allocated 100% to one project. Schemes could be based on capital or revenue, though at the time present capital schemes were most popular as they were without the problems of 'pick-up'. Revenue schemes had to be amongst the top priorities for both the health authority and the local authority otherwise they could not be continued when joint finance ceased. 'Horse trading' relationships between the health authority and the local authority were vital and much of the success of schemes hinged upon good relationships. Changes of officers and members could affect the success of schemes.

Difficulties which could affect the success of joint financing were as follows:-

- scheduling difficulties: the taking up of a scheme by, for example, the local authority might be delayed so other schemes would need to be cancelled. This could result in a backlog of schemes.

- capital schemes may not acquire their revenue consequences.

- withdrawal from schemes which were obviously not working was difficult, particularly if the agency funded was a voluntary agency. It was vital to give fixed term contracts when future funding was in doubt.

- local authority and health authority planning cycles do not coincide.

- a change of local government could cause delays. A hiatus occurs when a local authority is re-elected and new members need to be elected on to the social services committee.

- district management teams may be tempted to use joint finance as a 'prop' for the district mainstream community budget.

A list of projects undertaken by joint financing had been compiled by the National Association of Health Authorities. Dr Richards gave examples of

the uses of joint financing as follows:-

Handicapped children

Establishing child development centres.

Establishing day units for the observation and care of children with developmental delay or threatened with child abuse.

Residential units for mentally handicapped children.

Staff for special schools.

Child abuse

Establishing multidisciplinary training.

Establishing registers.

Providing secretarial staff for case conference.

Grants to the NSPCC.

The completion of procedure booklets.

Family care

Establishing centres for research and training of primary care staff.

Establishing crisis units for parents.

Fostering self help groups in the community.

To provide interpreters. These were vital for communication with mothers who spoke no English.

To provide special care home nurses. Tower Hamlets had the highest rate of low birth weight in the Region and these nurses could help to get these babies home earlier.

To provide family aides. These were a combination of district nurses and home helps and their employment caused a reductiop in the number of social admissions to hospital.

Dr Richards concluded her presentation by urging conference members to return to their districts and make their claims on joint finance monies for child health services.

Mr Don Russell, District Treasurer, City and Hackney Health Authority, then gave a treasurer's view of joint financing

Mr Russell warned conference members that his view of joint financing was a cynical one. Authorities had always experienced difficulty in spending joint financing monies as local authorities tended to regard it as money given to health authorities for local authorities to spend. The money had been taken originally from the National Health Service budget to be used for purposes agreed by both health and local authorities.

The actual sum of maney was subject to specific joint financing rules. Health authorities could add to the sum allocated from their own budgets. Projects funded by joint financing should normally span seven years, they could be extended for a maximum of three years at 100% funding, then the funding had to taper off, though it could be extended for a further two years. Capital projects were generally favoured. This was because local authorities had to pay interest on the capital they borrowed but joint financing money was interest-free. Local authorities therefore generally preferred to increase their revenue contribution towards a scheme, if the health service joint financing monies provided the capital.

Mr Russell then described the new proposals put forward for joint financing which emphasised its use for moving patients out of hospital. Projects could be extended for ten years with a possible addition of three years at 100% funding. Also, local authorities would be able to purchase health service properties using joint finance monies, and planning could take place, not only with Social Services, but also Education and Housing Departments. Seventeen million pounds had been allocated to launch these new proposals: 2.1 million pounds for 1983/4; 4.5 million pounds for 1984/5; 5.6 million pounds for 1985/6 and 5.8 million pounds for 1986/7. However, the allocation was at those years' prices so it would probably buy the same level of service each year. The new proposals did allow an extension of joint planning but Mr Russell had identified the following difficulties with this scheme:

- Health and local authorities always had problems in identifying projects on which to spend joing financing monies.

- It was always difficult to get the 'bill' from local authorities for the projects undertaken. DHAs were still only allowed to carry over 1% of their budgets into the following financial year. If joint financing monies were not spent, they had to be reabsorbed into the district budget and quickly spent on other requirements. However, the following year the sum for joint financing had to be reallocated from the district budget.

- It was vital that local authorities carried out the chosen schemes to an agreed timetable.

Mr Russell concluded by encouraging conference participants to learn the rules of joint financing so that they could ensure that these monies were spent on appropriate and worthwhile schemes.

Questions and discussion

Miss Valerie Packer commented that schemes seemed to get confused as they passed through the various committees for approval; feedback to the originator of schemes was slow, and by the time a scheme had been agreed it was often forgotten. The comment was also made that local authorities were reluctant to support schemes which involved them in long term expenditure when joint financing monies had run out; for example the long term care of patients moved from hospital into the community. Mr Russell took up this point and stated that usually the patients concerned were more appropriately cared for in the community. Local authorities could either arrange a 'quid pro quo', whereby people in the community who should be in hospital were found beds, or they could seek an allocation from a health authority's mainline budget on a permanent basis.

It was also noted that in the future education departments of the local authority could accept joint financing monies in their own right. In the past, only mainline funding could be used for this purpose. Mr Russell illustrated the potential of this by describing a scheme in Barking and Havering where a school had been organised in Highwood Hospital.

Questions were also raised regarding other sources of funding. Dr Richards

explained that Section 11 money was a Home Office allocation which could be claimed by local authority departments to employ specialised workers for immigrant groups. Before 1974 it could be used to employ health visitors, but this was no longer so. Many special allocations were available from sources like the Urban Aid Programme and Inner City Partnerships, and both Dr Richards and Mr Russell agreed it was worthwhile for conference participants to familiarise themselves with these sources of money.

Chairman's summary

In summing up the day's discussions, Lady Riches reminded participants that nearly 25% of the population were children. Children have widely differing needs but the thread connecting them is that they are growing and developing, moving from complete dependence towards increasing independence. This development, with the potential for improvement but also susceptibility to damage, makes childhood such a special and important, but also particularly vulnerable, period of life.

Services must be integrated to reach all children, said Lady Riches, especially deprived and handicapped children. The needs of the child and his family ought always to be at the centre of our thoughts. Health care for children should be given priority since conditions were best prevented or treated early rather than managed for a lifetime.

Lady Riches concluded the day's procedings with a quotation taken from the Court Report.

> "By health, I mean the power to live a full adult living breathing life in close contact with what I love. I want to be all that I am capable of becoming".

Lynne Regent
King's Fund Centre
March 1983

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APPENDIX I

CHARACTERISTICS OF LONDON'S CHILD POPULATION

Prepared for Day Conference on Issues for
London District Health Authorities: Policies for Child Health

Conference organised by King Edward's Hospital Fund for London.

Thursday 23 September 1982

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CHARACTERISTICS OF LONDON'S CHILD POPULATION

1. INTRODUCTION

This paper presents information on the characteristics of London's Children. In her backgound paper for the Kings Fund day Conference on Issues for London DHAs: policies for child health, Elizabeth Watson concentrated on policies for child health and their implementation. This paper will provide complimentary statistical data. It aims to give the demographic, socio-economic and epidemiological information which may form a basis for consideration of policies for child health in London.

Throughout the paper there is a reference to Inner London. The thirteen Boroughs which constitute Inner London as defined by the 1981 Census, are Camden, Hackney, Hammersmith and Fulham, Haringey, Islington, Kensington and Chelsea, Lambeth, Lewisham, Newham, Southwark, Tower Hamlets, Wandsworth and the City of Westminster. Outer London consists of the remaining nineteen London Boroughs which make up Greater London.

2. DEMOGRAPHY

TABLE 1 Children as a Percentage of the Population by Age Group

AGE	INNER LONDON		OUTER LONDON		ENGLAND & WALES	
	Nos	%	Nos	%	Nos	%
0-4	138,260	5.7	246,795	5.9	2,911,295	6.0
5-15	317,757	13.1	619,079	14.8	7,860,498	16.2
Total Pop	2,425,630	100	4,182,968	100	48,521,596	100

(Absolute numbers for Inner and Outer London are derived from percentages)

Source: OPCS 1981 Census

TABLE 2 Child Population as a Percentage of Total Population

Greater London 1951 - 1981

AGE	1951 %	1961 %	1971 %	1981 %
0-4	8.1	7.0	7.2	5.8
5-14	11.4	12.7	13.9	14.2*

NB. In 1965, there was a boundary change.

* Age group 5-15

TABLE 3 Child Population of Greater London

Age	1971	1981
0-4	535,465	383,298
5-14	1,035,760	938,420*

* Age group 5-15

Source: OPCS 1981 census

TABLE 4 Total Population Change 1971-1981

	% (+) increase/(-) decrease
Inner London	-18.0
Outer London	-5.0
England and Wales	+0.8

Source: OPCS 1981 Census

Tables 1-4 show that the child population and indeed the total population has been decreasing especially in Inner London. Children aged 0-4 years now comprise only 5.8% of London's population compared to 8.1% in 1951 (Table 2). In 1981 compared to the national average, London had a smaller proportion of children in the population.

London's population is also mobile, and this leads to many difficulties in the provision of primary care for children. Data on population mobility are poor. The 1971 Census recorded that 7.6% of persons enumerated in Inner London had lived at their present address for less than a year, compared to 5.8% for England and Wales as a whole.

3. BIRTH FACTORS

In general, statistics on infant deaths in Greater London compare favourably with those in England and Wales as shown in table 5, but these averages conceal wide variations in different boroughs (table 6)

Definitions:-

Stillbirth rate : deaths after 28 weeks gestation per 1,000 live and still births.

Perinatal mortality rate : stillbirths and deaths in the first week of life per 1,000 live and still births.

Neonatal mortality rate : deaths in the first 28 days of life per 1,000 live births.

Infant mortality rate : deaths at ages under 1 year per 1,000 live births.

TABLE 5

	Greater London	England and Wales
Live birth rate	13.7	13.3
Still birth rate	6.9	7.2
Illegitimate live births as a % of all live births	16.3	11.8
Infant mortality rate	11.9	12.0
Neonatal mortality rate	7.2	7.7
Perinatal mortality rate	12.4	13.3

Source: OPCS 1980

TABLE 6

	Borough Ranges in 1980	
	Maximum	Minimum
Infant mortality rate	16.9	5.9
Neonatal mortality rate	11.1	1.9
Perinatal mortality rate	17.8	6.4

Source: OPCS 1980

4. SOCIAL FACTORS

London in common with other large cities has special social problems which are relevant to child care.

(a) Housing

Inner London has a high percentage of households living in privately rented accommodation and in Council owned property, and a low proportion of owner occupied homes (Table 7) compared to the national average.

TABLE 7 Housing Tenure

	Owner Occupied%	% of households rented	
		Council	Private
Inner London	27.3	42.8	29.9
Outer London	61.9	23.2	15.0
England and Wales	57.8	28.8	13.4

Source: OPCS 1981 Census

The General Household survey in 1978 examined the type of accommodation of families with children in Great Britain (Table 8).

TABLE 8 Accomodation of families with children in Great Britain 1978

%	
88	of families live in a house or bungalow
8	1st floor flat or below
2	2nd floor flat
1	3rd floor flat or above
1	other

Source: GHS 1978

Therefore, nationally, only 3% of households with dependant children live in accommodation on or above the second floor. These households contain 300,000 children under 16 years of age. However of these 300,000, 57% live in London, which means that many of London's children will be subject to the problems associated with high-rise flat accommodation.

Housing conditions and amenities are poor in London, in comparison with the rest of the country. In a survey carried out in Paddington and North Kensington Health District in 1980/81 amongst mothers having babies in that year, it was found that basic amenities were often shared and there was significant overcrowding. (Table 9)

TABLE 9 Access of Mothers to basic household amenities

%	
17	sharing WC facilities with other households
2	no access to hot water
18	living in one room only
39	taking their babies home to already overcrowded accommodation (defined as > 1.5 people per room)

Table 10 presents data for 1971, showing that overcrowding in Inner London was much higher than the national average, and this was confirmed by the survey findings in Table 9. The definition of overcrowding was changed from > 1.5 persons per room in the 1971 Census to > 1.0 persons per room in the 1981 Census. In 1981, data reveals that overcrowding in London has improved in the last decade, although the rate for Inner London (7.1% of households being overcrowded) is still twice that for England and Wales (3.4%).

TABLE 10 Percentage of Households with more than 1.5 persons per room

Inner London	5.0
Outer London	2.0
England and Wales	1.4

Source: 1971 Census

However, table 11 shows that Inner London still has a much higher proportion of households lacking exclusive access to a bath than the national average.

TABLE 11 Percentage of households lacking or sharing a bath

Inner London	9.2
Outer London	3.7
England and Wales	3.2

Source: 1981 census

Inner London has a large number of families who are homeless. Table 12 shows that Inner London has two and half times more homeless households than for England as a whole.

TABLE 12 Homeless households : rate per 1,000 households

Inner London	4.2
Outer London	1.9
All England	1.7

Source: Social Trends 1980 : Dept of Environment 1978

All the above data shows that London's housing problems are still extremely severe. The relationship between poor housing and health problems is well known, and many children in London are likely to experience illnesses related to their inadequate housing conditions.

(b) **Working Mothers**

London has a high, and increasing proportion of married women with young children who are working. Table 13 shows that in 1971 more working women in London had young children than in England and Wales as a whole. In 1981, 60% of all married women in Inner London between 16 and 59 years old were economicaly active.

TABLE 13 Married women working more than 30 hours/week with children under 5, as a % of all married women working these hours

Inner London	8.5
Outer London	6.6
England and Wales	5.9

Source: 1971 census

(c) **Single Parents**

One in eight children under the age of 16 in Inner London lives in a household containing only one adult. This rate is twice as high as for England and Wales as a whole (Table 14).

TABLE 14 Percentage of usually resident children under 16 years in households containing 1 adult

Inner London	12.7
Outer London	6.5
England and Wales	6.0

Source : 1981 Census

d) **Day Nurseries and Childminding**

Children in London are therefore heavily dependant on adequate day care, as so many have only one parent, or two working parents.

In March 1981 the number of full time day nursery places provided by local authorities in London for every 1,000 children under 5 ranged from 77.1 in Camden to 3.2 in Bromley.

Brent, Hammersmith, Islington, Kensington and Chelsea, Westminster } provided over 50 places/1000 under 5's

Bexley, Croydon, Enfield, Harrow, Redbridge, Sutton } provided less than 10 places/1000 under 5's

Source : London Voluntary News 1982

In Great Britain there are approximately 10 full time day nursery places per 1,000 children under 5.

There are 43,000 registered childminders in Britain, and nearly 9,000 of these are in London. This is 9 per 10,000 population in Britain and 14 per 10,000 in London. Mothers still experience difficulties in finding day care in London, and are often forced to rely on unregistered childminders.

e) Ethnic Composition

London has a high proportion of people who belong to ethnic minority groups. No one culture is predominant; the particular feature of London's population is its cosmopolitan nature. For children this has implications in terms of different language, culture, educational aspirations etc. which may lead to social or health problems.

Table 15 shows that London, especially Inner London has a high percentage of people not born in the UK and of people living in households with a head who was born in New Commonwealth countries or Pakistan. Table 16 shows that Greater London has proportionally more women having babies in 1979 who were born outside the UK than in England and Wales as a whole.

TABLE 15 Birthplace of London's Population

	% of population In households with head born in NCWP	% of resident population born outside UK
Inner London	18.8	24.3
Outer London	11.7	14.6
England & Wales	4.5	6.6

Source : 1981 Census

TABLE 16 Birthplace of mothers who had live births in 1979
(all mothers = 100%)

	%			
	UK	Irish Republic	NCWP	Elsewhere
Greater London	65	4	22	9
England & Wales	87	2	8	3

NCWP = New Commonwealth and Pakistan

Source : OPCS 1979

f) **Children in Care**

In 1978 there were 19,358 children in care in Greater London. Table 17 shows that Inner London has a rate almost three times as high as for England and Wales as a whole.

TABLE 17

	Rate of Children in care per 1,000 population under age 18
Inner London	21.0
Outer London	8.2
England and Wales	7.7

Source : Jarman report

However, there were wide variations in the rates of children in care in different boroughs. Seven boroughs had above average rates of children in care per 1,000 population under 18 in 1978. (Table 18) This means that, for example, Tower Hamlets had about 1200 children in care, Kensington and Chelsea approximately 640 and Westminster approximately 690.

TABLE 18

Borough	Rate per 1,000 population under 18
Tower Hamlets	32.5
Kensington and Chelsea	26.5
Hackney	24.3
Westminster	22.9
Lambeth	22.8
Southwark	22.2
Islington	22.0

Source : Jarman Report

In 1980 there were 18,010 children in care in Greater London, so the numbers have stayed fairly constant. The boroughs listed in Table 18 continued to have the highest rates (although the order varied slightly.)

g) **Education**

(i) Language

One of London's particular problems in schools, is that of language. According to the 1981 ILEA language survey, nearly 45,000 or 13.9% of school children use a language other than English at home. These pupils represent 16% of children in primary schools, and 11.5% of those in senior schools. Over half of all these children, particularly the younger ones, were judged not to be competent in English. The survey identified 131 different languages being used by children. Bengali has taken over from Greek as the most common language spoken after English.

(ii) Dental Care

A survey carried out by the school dental service amongst ILEA school children at primary and secondary schools found that 38% of children inspected required dental treatment.

(iii) Special Education

The Warnock report in 1978 stated that broadly 1 in 6 children will be in need of Special Education at any one time. We were unable to gather information on rates of Special Education for London as a whole, but we do have the rates in our own health district. In 1981 there were 378 children resident within Paddington and North Kensington Health District in Special Education.

TABLE 19 Children aged 5-16 in Special Education : rate per 1000 children aged 5-16

Paddington and North Kensington District	32
UK	13

h) **Juvenile Crime**

In the Metropolitan Police District over 50% of all crime is committed by people aged under 21. Statistics for juvenile crime refer to the age group 10-16 inclusive, (a child of less than 10 years is below the age of criminal responsibility)

In 1981 there were 35,076 referrals of juveniles for offences committed within the Metropolitan Police District, of these 16,515 were first ever offences.

The referral rate for juvenile crime has remained constant since 1980, with an overall change of -0.4% for the Metropolitan Police District. There were 22 homicides committed by juveniles in the Metropolitan Police District in 1981, 205 offences involving drugs, and 578 cases of drunkeness. Drug offences had increased to some extent compared to 1980, but drunkeness offences remained at a fairly constant level.

5. EPIDEMIOLOGY

a) Primary Care

Problems in the provision of Primary care services in London have been highlighted by the Jarman and Acheson reports. One particular problem is that of non-registration with a general practitioner.

The Acheson report reveals that a sample survey in one ward of an Inner London borough found that 1 in 7 children under the age of 5 living in high rise flats were not registered with a GP.

Another survey of Accident and Emergency Departments in February 1981 found that 10-12% of patients in Inner London living near the hospital were not registerd with a GP, compared to 3% in Outer London.

Elizabeth Watson has covered the problems of primary care in London in greater depth.

b) Immunization Rates

Immunization acceptance rates are available for children born in 1975 and immunized by the end of 1977. The rates for tetanus and polio are similar for London and England and Wales. The acceptance rates for measles, diptheria and pertussis are shown in table 20.

TABLE 20

	Measles	Diptheria	Pertussis
Inner London	32.6	74.2	42.9
Outer London	40.3	77.2	37.6
England and Wales	50	78	41

Source : Jarman report

It is of interest to note the number of measles notifications for England and Wales. In 1979 there were 77,386 measles notifications, and in 1980 there were 139,485 notifications. Also there were four deaths from measles in Greater London in 1980 in children aged 1-4.

This contrasts with the USA where a provisional total of 3,032 cases of measles were notified in 1981. An initiative to eliminate indigenous measles from the United States by autumn of 1982 is proceeding satisfactorily.

TABLE 21 Measles notification rates per million total population

England and Wales (1980)	2830
USA (1981)	14

c) **Mortality and Morbidity in Children**

Although relatively few children die between the ages of one and 14 years, (Table 22) many of these deaths are preventable especially those classed as accidents, injury, poisoning and infectious disease.

TABLE 22 Causes of Death in Children under 14 : 1980

	Greater London		England and Wales	
CAUSE OF DEATH	Age 1-4	Age 5-14	Age 1-4	Age 5-14
All Causes	159	211	1093	1635
Injury, poisoning, accidents	42	66	276	554
Congenital abnormalities	28	17	199	149
Diseases of Respiratory System	24	18	167	149
Neoplasms	16	55	129	351
Infectious disease	12	3	69	46
Diseases of Nervous System	10	14	97	129
Diseases of Digestive System	11	6	39	33
Diseases of Circulatory System	2	15	32	74
Other Causes	14	17	85	150

Source : SD25 1980

Although death rates do appear to be a little higher in Greater London than in England and Wales as a whole, data for one year is only sufficient, given the small numbers involved, to give an indication (Table 23).

TABLE 23 Causes of Death in Children : per 10,000 populatiin

	Greater London		England and Wales	
	Age 1-4	Age 5-14	Age 1-4	Age 5-14
All causes	5.3	2.2	4.8	2.1
Injury, poisoning, accidents	1.4	0.7	1.2	0.7

Source : SD25 1980

TABLE 24 Deaths in Children from Accidents in the home in Great Britain 1977

Type of accident	Number of deaths	
	Age 0-4	Age 5-14
poisoning	16	11
falls	29	7
fires	61	53
suffocation	146	19
other (including fireworks, corrosives, and electric shocks)	55	14
all accidents	307	104

Source : Social Trends 10

The most common cause of death from accidents is by fire and suffocation (Table 24)

Britain has the worst child pedestrian casualty rate in Western Europe. The BMJ reported in 1976 that 80% of all recorded injuries to children in road accidents occur while the child is crossing the road, and a quarter occur in the road where the child lives. One third of preschool children injured crossing the road are in the charge of an adult at the time of the accident.

Dr Meer's study of child attendances at Accident and Emergency departments in Paddington and North Kensington District in 1980 confirmed the high proportion of attendances resulting from trauma in general (table 25).

TABLE 25 Child attendances (0-16 years) at Accident and Emergency Departments in District

Diagnosis	% of all attendanes (0-16 years)
Lacerations	15
Acute respiratory infections	11
Fractures, ligamentous injuries and dislocations	10
Contusion	9
Ear, nose and throat problems	8
Infectious disease	7
Eye problems	6
Acute intraabdominal disease	5
Symptoms, NAD	3
Diagnosis not made	12
Other	14
	100

Information is available from patient flow data on the number of admissions to paediatric wards and special care baby units for London and England in 1977.

TABLE 26 Child Admissions 1977

	Numbers of admissions	
	Paediatrics	Special Care Baby Units
Greater London	49,697	14,850
Ranges for Inner London boroughs	2,274-1,164	851-170
Ranges for Outer London boroughs	2,455-751	900-132
England	241,000	102,800

Therefore the admission rate per 1000 children aged 0-15 in 1977, in Greater London was 37.6 and in England was 23.7.

Although other inner cities in England and Wales exhibit some of the same features of deprivation, Inner London is unique in the scale and complexity of its urban deprivation problem. London's children are, then, subject to great difficulties in terms of their social development and health, that will put great demands on social and health services, and especially on primary care. The information presented in this paper gives some indication of areas where policies for child health in London might be reviewed.

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APPENDIX II

KING EDWARD'S HOSPITAL FUND FOR LONDON
KING'S FUND CENTRE

ISSUES FOR LONDON DHAS: POLICIES FOR CHILD HEALTH

BACKGROUND PAPER FOR CONFERENCE ON 23 SEPTEMBER 1982

Introduction

Since the turn of the century improvements in the health of Britain's children, measured by the infant mortality rate, (deaths of infants under one year of age per 1,000 live births) have been dramatic. Most of the killing or disabling diseases of the 19th century have been eradicated or brought under control. Between 1900 and 1980 the infant mortality rate fell from 150 to 11.9.

This improvement was probably due to the rise in the standard of living which had begun in the second half of the 19th century and also the development of services specifically for children, particularly the infant and child welfare services including school health, which were developed progressively from 1906. These factors were reinforced by specific measures for prevention and treating disease in the individual.

Nevertheless the bland figures conceal much. Internationally our record is poor. Twenty years ago this country had one of the lowest infant mortality rates but since then we have fallen behind other countries, including France, Sweden, Japan and Finland.

Similarly there are wide variations between regions and localities within the country and variations also exist within social classes. In 1980 the infant mortality rate ranged from 8.9 for Social Class I, to 16 for Social Class V. The Black Report (Inequalities in Health, DHSS 1980) stated that "A child born to professional parents, if she or he is not socially mobile, can expect to spend over five years or more as a living person than a child born to an unskilled manual household". In 1979, over 1,000 children died from accidents in Britain, the mortality rate being five times higher in the lower social classes than in the upper (Healthier Children - Thinking Prevention, 1982).

The Court Report (1976) confirmed that children who live in urban conditions are "more likely to suffer from ill-health than those who do not and children in inner London are twice as likely to be psychologically disturbed as their counter-parts in rural areas. The physical health of inner-city children is likely to be poorer and yet the services in urban areas, especially in the North and Midlands are likely to be less numerous and of a poorer quality".

Services for Children

Between 1948 and 1972 children's services were never identified separately either in the finances or planning of the National Health Service. Expenditure was largely planned and recorded according to the type of service (hospitals, GPs, health visitors, health centres etc) and not according to specific groups in need of a service.

The 1973 National Health Service Reorganisation Act enabled the child health service to unite on an organisational basis when the provision of the school health service became the responsibility of the Area Health Authority. Specialists in Community Medicine with specific responsibilities for child health were appointed. The 1960s and 1970s saw a welcome upsurge in practical concern for children and particularly disadvantaged children - the National Children's Bureau (1964) the Child Poverty Action Group (1965) and the significant Children's Act (1975) which gave the child intrinsic rights within the law, sometimes overriding those of parents.

The Court Report (Fit for the Future, 1976. Cmnd 6684) clarified the issues involved in planning child health services.

The essential points were:-

1 The changing pattern of child health with chronic illness, handicap and psychiatric disorders assuming greater significance.

2 The extent to which ill-health among children is preventable, and the significance of social and geographical factors in determining survival and healthy development.

Services must accordingly reflect:-

1 The importance of the family dimension in all child health care and the need to develop a closer partnership between parents and professional staff.

2 The inter-relationship between the health, education and social needs of children and their families.

3 The need for integration within the child health service.

4 The need to ensure that resources are deployed where they will have most benefit.

Specific recommendations included the creation of general practitioner paediatricians and child health visitors who would combine preventive and curative nursing responsibility for children and who would work in close professional association with the general practitioner paediatricians.

This report met with little favour with the general practitioners who objected to the concept of the general practitioner paediatrician and it signally failed to take account of the problems of socially deprived areas. As Alberman et al (1977) wrote "The report of the Court Committee is a splendid statement of the needs of children and of policy goals, but an unsatisfactory guide to the organisation of health services and to the improvement of child health". Professor Court himself acknowledged (1977) that there had been a failure "to spell out clearly enough the kind of service the inner city areas need.... The problem is much bigger than medical services: it concerns urban renewal of a highly complex kind".

Government Policy

In the Eleanor Rathbone Memorial Lecture (1978) the Secretary of State delivered the DHSS response to the Court Report.

Agreeing with the central recommendations the department felt that while liaison with local authorities should take place and local experiments in child health care provision should be encouraged the creation of sub-specialities within primary care would prove counter-productive. Specialist paediatric services should be extended into the community, numbers of health visitors should be increased and their work developed, and all general practitioners should have adequate training in child health and play an increasing role in preventive work particularly for children below school age.

For inner cities where infant mortality rates were highest the policy should be one of positive discrimination for the most socially deprived areas or pockets of disadvantage.

Following on the Report of the Royal Commission on the National Health Service (1979, Cmnd 7615) and the conclusion that the 1974 Reorganisation did not provide the best framework for the delivery of care to patients the consultative paper 'Patients First' (1979) was published. The Government's approach was to propose "those adjustments to the present structure which experience suggests are needed to achieve better services to patients". Its proposals have four main elements:-

A The strengthening of management arrangements at local level with greater delegation of responsibility to those in hospitals and in the community services.

B Simplification of the structure of the service in England by the removal of the area tier in most of the country and the establishment of district health authorities.

C Simplification of the professional advisory machinery so that the views of clinical doctors, nurses and of the other professionals will be better heard by the health authorities.

D Simplification of the planning system in a way which will ensure that regional plans are fully sensitive to district needs.

By this paring of the structure it is anticipated that the re-organised services can become more sensitive to client needs in a locality. In addition it is envisaged that links with local authorities in the provision of services may be improved. The present statutory requirement for the establishment of Joint Consultative Committees will be retained. The Government favours flexibility in the use of NHS community manpower, for example a single doctor might combine child health with other responsibilities. Experiment and local initiative are the keys to the new service.

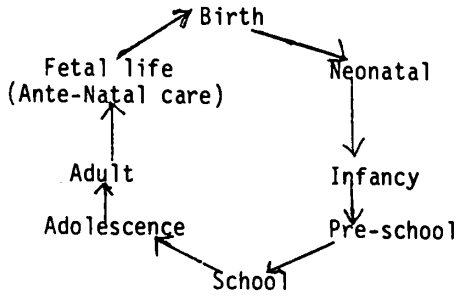
The new reorganisation has yet to be evaluated but some disquiet has already been expressed that within the new structure it will not be possible to have separate posts for child health such as the SCM (Child Health). The now defunct Children's Committee expressed concern about how advice for child health will be provided by new District Health Authorities and Wilson (1982) wrote "There is no doubt that the introduction of a generic physician is a retrogressive step and every effort must be made by professionals caring for children to safeguard the standards. In the future consultant paediatricians and senior clinical medical officers will have the necessary clinical expertise but they will not have the authority to implement the improvements in the service or to appoint, deploy, and train the child health doctors".

The DHSS also made available for information, not guidance, its paper "Prevention in the Child Health Service" (1980) which suggested a modest programme of child health surveillance.

A Report from General Practice Healthier Children - Thinking Prevention (1982) examines the present state of child health in the United Kingdom and analyses the problems in order to determine how best they might be tackled. The main problems identified are environmental, taken in the broadest sense, or to do with deficiences in medical services.

The report agrees with Court that therapeutic and preventive child care should be fused and based within primary care. It states that "the main factors affecting the health and deaths of children are to be found most often in the child's environment, especially the home and family. The opportunities that exist in the environment for prevention are many and depend on the provision of local, accessible and technically competent primary health care teams. The tradition of general practitioners, health visitors and district nurses of visiting homes and caring for families makes them well placed to take on these new responsibilities".

It is recognised that opportunities to prevent childhood illness and to promote health can be identified at points around the continuous circle of child rearing and development. This has been identified as "The Brimblecombe cycle"



The Brimblecombe cycle underlines the theoretical advantage of having a generalist operating at all stages of the cycle simultaneously.

The report makes a good case for the ideal of general practitioners undertaking total care of children, both curatively and undertaking minimum checks on children. More controversially the report suggests a set of financial incentives to take on this extra work load, but it does not address itself directly to the practical problems of implementing the recommendations in the inner city.

The Equation of Government Policy and Guide Line Reports for Maximising Child Health with the Problems of Inner London

While many deprivation factors are to be found to a greater or lesser extent in other urban environments it is generally agreed that the scale and combination of problems in different boroughs and neighbourhoods in London is unique and exerts enormous pressure on the health services, particularly primary care.

In inner London as a whole there are higher numbers of lone parents with children, a higher percentage of households lacking exclusive use of basic amenities, a much higher proportion of births to mothers born outside the United Kingdom than in England and Wales as a whole, and many more children in care. In addition the infant mortality rate, and in particular the post neo-natal mortality rate (deaths of infants between 29 days and one year per 1,000 live births) is higher in inner London than in the country as a whole, although individual areas outside London have higher rates.

A report prepared by a working group for the Royal College of General Practitioners A Survey of Primary Care in London (1981) has shown that certain social and medical characteristics tend to occur together and that there are great variations within inner London. The most striking differences exist between the East End boroughs (Tower Hamlets, Hackney, Newham and Southwark) and the West End boroughs (Kensington Chelsea and Westminster, Camden and Hammersmith).

In the "East End" there is a still relatively stable yet deprived population living in poor environmental conditions. There are higher proportions of social classes III, IV and V, more council housing, lower educational levels, higher infant and post neo-natal mortality, and single parent families.

In the "West End" the population is generally less stable, highly mobile with considerable numbers of disadvantaged groups. There are lower proportions of married couple households, higher proportions of one-person households and 'bedsitters', high population density, a high abortion rate (for residents), a high death rate for children 1-4, and a high suicide and mental illness rate.

Nevertheless the problems of providing appropriate primary care to socially disadvantaged groups are common to the whole of inner London. The Acheson Report (Primary Health Care in Inner London, DHSS 1981) highlights many of the deficiencies in primary care in the inner city; the large number of single-handed practitioners (59 per cent not working in group practice compared with 28 per cent as the national average); the low levels of practice attached nurses (25 per cent as against 68 per cent for the country as whole); the large numbers of elderly general practitioners and particularly the disproportionately high number of general practitioners not born or trained in Great Britain (47 per cent of doctors in inner London as compared with 26 per cent in England and Wales). Very importantly the Acheson Report considers the problem of recruiting and retaining the community nurses. Acknowledging its debt to the work of Hughes and Roberts (1980) the report describes the high proportion of young, newly qualified staff who cope with demanding case-loads exacerbated by difficult social conditions. Among its 115 recommendations 9 are specifically related to the needs of children as a special group in the community.

These reports highlight the twin problems of inner city deprivation and deficient organisation of health care but how do they help us to solve the problem of curing and caring for children in London?

Various local initiatives may be showing the way. A recent study by the Thomas Coram Research Unit looked at the health needs and use of services of two populations of under-fives in North London. The study areas had fairly typical inner-urban characteristics. Nearly all the families lived in flats. In one area, a third of parents were born outside the UK and the social class was below the national average. In the other area, the parents were of less modest means but still had the disadvantages of bringing up children in overcrowded conditions with inadequate play space.

The children received regular medical and developmental checks together with a parental questionnaire on various aspects of behaviour, illness and use of services. The checks took place at six weeks, six months, one year, eighteen months, two years, three years, and four and a half years. The clinics were run on a walk-in basis which the mothers appreciated as very often the clinic doctor was able to provide reassurance; the doctors did not prescribe although many mothers wished prescriptions were available. Bax et al (1980) found that 20 per cent of children attending their clinic had significant problems and in particular that an excess of respiratory infections, developmental delay, and behavioural problems were interrelated. Adverse social findings, particularly stress in the mother, and the health and behaviour of the pre-school child were closely correlated. The researchers found some indications, although there were methodological problems, that by comparing children in the experimental area in which their clinic operated with children in a control area, there was a diminution in behaviour disturbance and a reduction in speech and language disorders in those who had attended the experimental area clinic for three years. Parents appreciated the wider view of child health surveillance and continued to attend regularly in contrast to the sharp fall off in attendance which occurs in many child health clinics.

In the inner city area of Nottingham the department of child health has linked with the community child health service to jointly undertake responsibility for most clinics, schools and social service day nurseries in two areas of the inner city. Certain child health clinics have limited dispensing facilities although antibiotics are not prescribed. The number of routine health examinations has been reduced and great emphasis is placed on dealing with problems identified by parents, health visitors, social workers, nursery staff, and teachers. A "family centre" for families with particular difficulties has been established which involves a multi-disciplinary team. Families identified in the clinic and elsewhere are given support, advice and help with many problems by the team. Doctors are working alongside audiologists and speech therapists to detect speech, language and hearing problems in pre-school children. Treatment strategies are then being worked out with all the revelant professionals involved. The key role of the health visitor is recognised and it is advocated that she should undertake primary care work, referring children, where appropriate, to a named doctor either a general practitioner or a trained community medical officer. "The underlying philosophy is that the child health services should be people-based, rather than mechnical or computerised" (Angus Nicoll, Personal Communication).

One health authority is experimenting with the Court Report ideal of integrated child health services focused on general practice in the inner city. The project has rejected child health surveillance in favour of what is seen as a more demanding priority. The first priority of Newcastle upon Tyne's Riverside Child Project is that parents should be given the information to take a greater share of the responsibility for the health of their children. Dr Michael Downham heads a team which sees its duty as stimulating and focusing demand by providing parents with useful clinical information. It mounts campaigns against selected childhood conditions such as asthma, bedwettting, home accidents, epilepsy, any urinary tract infection which early research found were both common and commonly misunderstood. More informed pressure from parents is what Dr Downham sees as a major priority and the team anticipates major benefits through developing the newly established parents' groups, aimed to be autonomous, educational and fully informed of parents' right.

The DHSS has now allocated half a million pounds for a study of standard setting and performance review for child care in the North of England following on approaches made to the joint regional advisers in general practice by Professor John Webb and Dr Michael Downham of the Department of Child Health in Newcastle.

In Tower Hamlets integration of the child health services is gradually being developed. "The first principle of integration is that everyone knows everyone else" (Anthony Jackson, Personal Communication). Clinical medical officers work in hospital on the District Handicap Team and on the Newborn Baby Follow Up; the transition from hospital to child health services in the community is being effected smoothly in this way. Senior house officer and community medical officer posts have been developed on a rotational basis with clinical medical officers helping to cover busy paediatric departments at night. General practitioners are gradually becoming more involved with screening and a general practitioner vocational training scheme is in operation at the London Hospital. This involves senior house officers on a three year stint, two years in hospital and one year in general practice. A centre for primary care research is being established.

Therapists - physio, speech and occupational - are actively involved in the community and make a significant contribution to the District Handicap Team. The principle underlying all these innovations is the attempt to achieve an integrated child heatlh service within the three arms of the service. There are particular problems of staffing in Tower Hamlets with the large non-English speaking population, immigrants from a rural community.

Liaison with the local authorities is being extended and joint funding used exclusively for primary care is helping particular disadvantaged groups in the community, for example the handicapped.

There is in the inner city a recognition of the continuing role of Accident and Emergency Departments. In one local childrens' hospital there has been a three hundred per cent increase in new patients under twelve in the last six years in an area where the child population is falling. The tendency for inner city parents to use hospital services for primary care has its roots in history, but it is hoped that the development of health centres and the increase in group practice may encourage parents to use primary care services more effectively.

All the initiatives outlined above are variations on the basic theme of the best way to promote child health by professionals. Equal weight should be given to the consideration of social policies for the family, which must take cognisance of parental prime responsibility for the health of their children and the state's duty to provide sufficient economic means to maximise the family's social welfare.

Until comparatively recently the state's attitude to the family has been one of 'benign neglect' (The Observer, 1978). This policy has been in marked contrast to French government attitudes where sizeable child allowances have been a major plank in public policy for over a century. Now both major political parties have espoused the cause of the family. In 1977 Margaret Thatcher told the Conservative Conference that 'We are the party of the family' and has not only returned to the theme in two recent Conferences but has constituted a Family Policy Committee. Child benefit and extra benefit for the family have been increased in recent budgets, although not significantly. Labour, out of office, has pledged in "Labour's Programme 1982" to increase and index-link child benefit.

The Black Report gives high priority to its recommendation that "the abolition of child poverty should be adopted as a national goal for the 80s".

It is increasingly recognised that there is strong evidence that if a child does not have a substantial experience of good family life in its early years, its chances of being able to support its own children without welfare assistance are considerably reduced.

What is needed is to develop a catalytic process "which involves society at all levels (including central and local government, professional organisations, voluntary agencies and the general public at large) which will give the family with young children a far higher priority as a vital group in society charged with the responsibility of giving the new generation of children of this country the opportunity to achieve their full potential" (Brimblecombe 1980).

Conclusion

Within the context of inner city deprivation a particular challenge exists for all those involved in planning district child health policies to develop holistic family services which will ensure that every inner city child has as good a chance as any child in the country to realise its maximum development. How this challenge may best be met is open to discussion but the following questions may help to focus attention on some of the issues.

1 How far can the particular needs of children in inner London be met within the framework of the reorganised health service?

2 Should general practitioners in the inner city be encouraged to undertake surveillance of children?

3 Should health visitors be attached to general practice or work in a particular 'patch'?

4 Should the community nursing services take on further duties in relation to child health in schools?

5 Should the role of Accident and Emergency Departments as providers of primary care for children be legitimised in the inner city?

6 How effective is the health care of children in local authority care?

7 How far will reorganisation facilitate the forging of closer links with local authorities?

8 Is it possible to provide optimal care for children under the entrepreneurial system of general practice?

9 How best can a "catalytic process" be encouraged in the inner city to ensure that family policy becomes a realistic objective of district planning?

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APPENDIX III

KING EDWARD'S HOSPITAL FUND FOR LONDON

King's Fund Centre

ISSUES FOR LONDON DHAS: POLICIES FOR CHILD HEALTH

Conference held on Thursday 23rd September 1982

List of participants

	Dr E ABEL	Lecturer	California State University
	Mrs P ADAMS	Member	Ealing DHA
	Mr ANDERSON		Health and Social Service Journal
	Mrs M BAINS	Member	Haringey CHC
	Mrs B J BANHAM	Chairman	Paddington and North Kensington DHA
	Mrs L A BARUCH	Member	Ealing DHA
	Dr R BEAVER	Specialist in Community Medicine (Child Health)	Redbridge DHA
	Mrs P BELSON	Member	Victoria DHA
	Miss R K BETTS	Chief Nursing Officer	Greenwich DHA
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	Mrs J BROOME	Member	Lewisham and North Southwark DHA
	Dr C BURNS	Specialist in Community Medicine	Victoria DHA
	Mr J BURROWS	Member	Greenwich DHA
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	Miss H CHAPMAN	Divisonal Nursing Officer (Community)	Islington DHA
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	Mrs J DAVIS	Director	National Association for the Welfare of Children in Hospital
	Miss D DENNEHY	Director of Nursing Services (Community)	Victoria DHA
	Ms E DICKS	Coordinator	V O L C U F
	Mrs E DUNWOODY	Member	West Lambeth CHC
	Dr B EDWARDS	Principal Physician (Child Health)	Brent DHA

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Mr D GOMEZ	Member	Paddington and North Kensington DHA
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Mrs J HALL	Member	Hounslow and Spelthorne DHA
Mr D M HANDS	Assistant Director	King's Fund Centre
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Lady MENTER	Member	Tower Hamlets DHA
Mr B MERKEL	Principal	D H S S
Miss P MIDDLEMISS		GP Magazine
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Dr M H ROBERTSON	Member	Redbridge DHA
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Mrs J RODIN	Member	Greenwich DHA

Ms J ROWE	Health Visitor	Ealing DHA
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Mrs R M STALLARD	Member	Redbridge DHA
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