Remembering the Riverside Child Health Project 1979-82

In the current multiple crisis triggered by extreme neoliberalism - global heating, species extinction, pandemic, destruction of democracy, hunger, racism and sexism – two of the social consequences which stand out are grotesque child poverty, and the breakdown of the NHS.

In the 1970s concerns about the deteriorating health of children and about the inadequacy of health services to meet their needs triggered an initiative in Newcastle upon Tyne called the Riverside Child Health Project. Here five members of the original Riverside Project team offer their reflections about working together in the West End of Newcastle between 1979 and 1982. They share their experiences of 40 years ago in the hope that they might contribute in a small way to addressing the current plight of children and their families in cities throughout Britain.

It's perhaps fitting that this "I Daniel Blake" website, set up by activists in Edinburgh mainly for the purpose of promoting and discussing showings of Ken Loach's film across the poorer parts of their City, should publish reminiscences about children and families in the west end of Newcastle, where Ken Loach chose to set both "I Daniel Blake" and his subsequent "Sorry I missed you". Many of the extras in both films are Riversiders.

Arthur Paynter

Introduction

It is now over 40 years since I started working at the Riverside Child Health Project. It is impossible for me to write anything which is either objective or scholarly. This article can only be a personal reflection.

In retrospect it is impossible (for me) to reflect about the Riverside Project without an initial reference to the Court Report.

The Court Report (Report of the Committee on Child Health Services).

In 1973 Sir Keith Joseph commissioned a report on the child health services nationally. The committee was chaired by Professor Emeritus Donald Court (previously Professor of Child Health in Newcastle University). The long-awaited Court Report came out in December 1976.

At that time health services for children were provided by three separate organizations.

Family-based general practice provided primary care. Essentially this was care for acute illness in childhood. Parents would take their children to GPs only when they were ill. GPs were not commissioned to provide preventive care - immunization, screening and surveillance.

Preventive services were provided by Local Authorities through the Community Child Health service, operating in preschool welfare clinics and in schools, including special schools for children with disabilities. The doctors working in welfare clinics and schools in particular developed skills and insights into the needs and care of children with disabilities.

Specialist paediatric services were provided by hospital-based consultant paediatricians and their teams.

The Court Report recommended an **integrated child health service.**
GPs would continue to provide primary care but expand their remit to include prevention. GPs would work in group practices, each practice having a GP with a special interest in child health who would take responsibility for immunization, screening and surveillance for the children in their practice, supported by practice-based health visitors. GPs with a special interest in children would be called GPPs (GP Paediatric). Health visitors specialising in child health would be called CHVs (Child Health Visitor).

The Report also recommended that the specialist services for children should be expanded to include specialist support for prevention and for children with disabilities. This service would be staffed by a new category of consultant paediatricians, called Consultant Community Paediatricians, who in addition to hospital-based training had had special training in childhood disability, educational medicine, and social paediatrics, which included liaising with social services and adoption and fostering services.

The Report recommended the gradual phasing out of the doctors' posts in the community service for children provided by Local Authorities in welfare clinics and schools.

The Riverside Child Health project

The Riverside Child Health project was initiated by the University Department of Child Health in 1979. It aimed to explore local implementation of some of the ideas of the Court Report, which had not been implemented, and at the same time investigate why the health of children was so poor in some wards of the City, where measures of social and economic disadvantage were high.

Three wards in Newcastle were selected to receive additional inputs for children and their families – Scotswood, Benwell and Elswick. The overall project area was bounded on the north by the West Road, on the south by the River Tyne, on the east by the city centre, and on the west by Denton Road.

The project was the vision of Mike Downham, a senior lecturer in child health. He had studied the incidence, morbidity and distribution of RS virus bronchiolitis, and the distribution of childhood deaths across the city, including sudden infant death syndrome ('cot deaths'). Whatever he chose to study, incidence was concentrated in a small number of wards. Would providing additional input for some of these wards result in improvement of child health?

In the chosen Project area the statutory child health services previously provided in schools and welfare clinics by the Local Authority, were provided instead by the University Department of Child health. The staffing for these services was greatly increased. This was partly to increasing provision in an area where the needs of children and their families were higher than in other areas of the City, and partly for the purposes of research and training. We had a lead consultant paediatrician (Mike Downham); there was myself, a trainee in community paediatrics at senior registrar level; there was sometimes a paediatric registrar; and at different times there were either one or two senior house officers (either paediatric or GP trainees).

In addition to the medical staff, we were given by the Local Authority one Health Visitor, whose role was to liaise with all the other Health Visitors already working in that area, as well as carrying a reduced case load of her own. We had a full-time social worker with a reduced case load to liaise with social workers already in post in the area. We had a full-time community worker, whose role was to relate to the local communities, particularly parents, to empower them to use the services better and more to their advantage and encourage them to participate in services rather than be passive recipients. And we had two full-time administrators - indispensable and equal members of the team, who in the event often formed or strengthened invaluable links with families in the project area.

The services for children in those days were very fragmented. Although there was little the project could do about bringing all management structures together, it was hoped that by fostering a closer relationship between all the workers, and providing opportunities for them to communicate better with each other, the health and wellbeing of children and their families would improve.

There was the recognition that the health and well-being of children was not a matter just for health services, but that social services, educational services and community work were every bit as important. The project aimed to create better links between the different agencies in the project area. It aimed to explore models of working across disciplines, and to provide joint in-service educational opportunities.

Office and meeting space for the project was offered by Atkinson Road Primary School, at the geographical centre of the project area. Because of the demolition of much of the old housing in the school's catchment their building became larger than they needed. They gave us the whole upper floor of the school, comprised of three classrooms and a big hall. One classroom was used as office space, one for large meetings and teaching space, and one for small meetings and as a drop-in for families. We only occasionally used the big hall.

The Local Authority furnished the rooms simply, according to our requests. An important design feature of the office was that it was open-plan, with movable shoulder-high screens between the stations. This enabled all members of the team to communicate with each other easily, while giving each worker adequate privacy.

My experience of working in the project

In August 1979 I had completed my two years as rotating paediatric registrar in the Newcastle hospitals. I was unclear what I wanted to do. Some of my colleagues were looking to train in the super specialities - paediatric nephrology, paediatric cardiology, paediatric oncology, etc. I was quite sure that I did not want to train as a specialist. I did not want to become an "ologist" of any shape or form, and I was always keen on maintaining a broad skill base and in becoming a good generalist. I was interested in learning more about the community in which I worked - to look outward rather than upward!

It was either Dr Parkin or the Professor Webb who informed me about the Riverside Project coming up which aimed at offering community paediatric training. I cannot even remember now whether the post was advertised. It was suggested that I talk to Mike Downham. The post was described as a Fellowship in Community Paediatrics and aimed to provide specialist training towards accreditation as a consultant community paediatrician, as described in the Court Report. There were at that time no such posts in the UK, in fact it was not until 1986 that such posts became available.

In September 1979 I became a Fellow in Community Paediatrics under the supervision of consultant Mike Downham, based at the Riverside Child Health Project. The post was funded by the Spastics Society and the Association for Spina Bifida and Hydrocephalus.

My work at Riverside included being the school doctor for a primary school (Denton Road Junior School). I was also to provide medical input to a social services day nursery (Rye Hill Nursery), a nursery for children from vulnerable and disadvantaged families. I also had responsibility for one child welfare clinic (Cruddas Park Clinic).

In addition to the Riverside work I had one day a week at the Child Development Centre (RVI) under the supervision of Dr.Ellis, and another day in Child and Adolescent Mental Health under the supervision of Dr.Nichol. I also had one outpatient clinic a week at the RVI to which consultants would channel suitable new referrals. I had some acute responsibilities at the RVI as the receiving registrar on alternate Friday nights.

It took a little while to get used to working in the community rather than in hospital. It is in fact a cultural difference. In hospital we become accustomed to being in a position of power. Children and their parents show a certain deference for hospital doctors, and children are often a little nervous and disempowered. However when you meet people on their own territory they are in a stronger position, and we are the guests. When you see a child in hospital he may be nervous, but see the same child in a school, on his own territory, and he is a completely different person, greeting you with confidence. This is refreshing, but I had to get used to being treated with less deference! This was my first experience of working outside hospital.

Working in a school

I had no previous experience of being a school doctor. I was of course expected to provide the statutory school health services which included the routine medical inspection of school entrants. But I was able to spend much more time in the school than their previous local authority doctor could provide. The previous model was that the school doctor would examine school entrants and refer any children who required medical attention to their GP.

However I rarely needed to refer them. Although we were not able to prescribe, we had an excellent relationship with the local GPs and could easily liaise with them to get appropriate prescriptions if necessary and thus avoid families having to make an additional visit to the GP. Seeing school entrants was but a minor aspect of my work in the school. Working closely with the school nurse I was able to make myself available to teachers who had concerns about specific children or families. I visited the school frequently to see specific children and parents to help with a range of health and social issues. I could liaise with social workers and was closely in touch with them about housing issues and welfare support. I learned to work with educational psychologists. Previous school doctors didn't have the time for this targeted work.

Working in a preschool welfare clinic

These clinics were for babies and preschool children. They were structured to see children frequently during the first year of life and regularly but less frequently until school entry. The focus was on immunization, growth monitoring and developmental surveillance.

We changed the model of these clinics considerably. They had previously been run according to the traditional model of the medical consultation between parent and doctor. We made the clinics more open and educational. Of course if mothers (or the occasional father) wanted to see the doctor and/ or health visitor alone, that facility was always available and private and confidential But most parents were already sharing a lot about their child's progress and development with other parents in the hall/waiting area, which was well supplied with play equipment. Much of the time the doctor and the health visitor would be in the hall where we could open up individual consultations so that they became collective. The clinic became a community occasion for education and sharing. We as doctors and health visitors initially found this quite challenging, but parents were happy to have their concerns and uncertainties shared with other parents. This was and still is the way in which child welfare clinics in developing countries operate. It was frustrating not being able to prescribe, but again our relationship with GPs was so close that this was not a problem. The vast majority of both pre-school and school healthcare is not about medical intervention, but about education. This collective model of working is more democratic, and prevention and treatment are more integrated. To quote David Morley, "Doctor on tap rather than doctor on top".

Working in a social services nursery

The nursery took very young children, some below the age of one, all from disadvantaged families, often single parent families. I was available to see specific children and parents at the request of nursery staff or parents, and got to know the families well. Here again, my role was supportive and educational rather than intervening medically, although I was able to liaise with GPs and Health Visitors and get prescriptions for them as necessary.

Lunchtime interdisciplinary meetings

Between us the Riverside team ran open lunchtime discussion every Wednesday. We would invite speakers to discuss a range of topic, especially topics we felt we had limited knowledge about – for example adult mental health services, child psychiatric services, common ENT problems in children, common skin problems in children. These meetings were open to GPs, Health Visitors, School Nurses, Teachers, Social Workers, Community Workers,

Psychologists and parents. The discussions were not didactic but were informal and inclusive.

In all my areas of work in the project, my link with child and adolescent mental health was invaluable, because many of the preventative problems and early intervention situations in the children I was seeing were not in the area of physical health but in the areas of development, behaviour, bonding and attachment. Here again, the medical model of diagnosis and treatment - diagnosis before treatment - is all wrong! One has to discard this model and expand one's horizons to think in terms of vulnerable children in vulnerable situations.

How did I benefit? What did I learn?

I had a wonderful time in my three years at Riverside. The training in childhood disability at the Child Development Centre was invaluable, as was the training in child mental health. It was important to have my weekly hospital outpatient clinic and to continue with some acute responsibilities - just enough to keep me in touch with hospital paediatrics and hospital paediatricians. It was very refreshing however to leave the hospital and get involved with the community - to gain insights into the way people lived, and the environment in which children were being brought up. In hospital one becomes conditioned to seeing oneself as very different from one's patients. The specialist environment unconsciously develops a "them and us" culture, not only between those who provide the service and those who receive it, but also between categories of workers, (doctors and nurses, healthcare workers and social workers, etc.). The development of these situations is I'm sure unconscious, but part of a hidden curriculum engendered by a very competitive culture. In hospital one gets protected from the real world, despite the suffering one sees. One can unconsciously become judgmental, with a tendency to blame parents for the prolems their children are experiencing. Once out in the community, one actually sees this world in which children are growing up. We see the real situations - the families in which they grow, the day-to-day practical difficulties which parents are up against, and the poverty. We become less judgmental and more empathetic. We also see the great strengths of the community - the resilience in adverse circumstances, and the wonderful sense of humour.

Medical interventions, diagnosis and treatment are but a small part of healthcare. Much of healthcare is about understanding people, supporting them and above all empowering them to take control of their own lives.

One area in which I came to take a different approach was child abuse and neglect. Perhaps it was inevitable that having come to a recognition of this problem as a hospital doctor, one defaults to seeing this as a medical problem and imposing a medical model - diagnosis and treatment. “If your only tool is a hammer all your problems look like nails” (Mark Twain). Once I learned of the wider issues for parents though working in the community and came up against a huge range of parenting difficulties, most of which had obvious social and economic causes, I was far less judgmental. I began to see child abuse and neglect as a situation which was preventable; that with close community support and education we shouldn't see the situation at all. Could we actually begin to see child abuse and neglect as a failure of community child health services?

Did the project achieve its aims?

I don't know. Steve Turner, a statistician / epidemiologist, joined the project in its third year. His main findings I think can be summarised into two points. First, it was too short a time for the intervention to show statistically significant results for standard measures of children's health, though the trends were encouraging. Second, it could be judged a great qualitative success according to the feedback he collected from a sample of families and from another sample of health, social and educational professionals working in the Riverside area.

I'm sure we did make it much easier for people to access and use both GP and hospital services. The absence of the therapeutic arm in the old child welfare clinics, and the bureaucratic process of referring on to GPs had previously given parents the impression that the clinics weren't much help to them. The effect of this was to weaken prevention – clinic attendance was low. In the Riverside Project we were able to smooth the access to GPs for families and if necessary get medication for children quickly. Most of us had direct access to hospital in that we had our own outpatient clinics where we could see a child ourselves, or if we thought it was a specialist problem ask the relevant consultant to see the child – by-passing the complex and lengthy referral system. I soon discovered that if I wanted to get a child seen by a specific consultant it worked best to speak to the consultant's registrar. As a result of these processes clinic attendance increased rapidly after the Project began, according to both clinic staff and parents, though we didn't measure it.

Thereafter

As my time at the Riverside Project was coming to an end I was facing the decision as to what to do next. One day a GP trainee colleague working in the project told me he was going to the Solomon Islands and showed me an advertisement in the BMJ for a consultant paediatrician there. I didn't even know where the Solomon Islands were! It sounded exciting so I applied for the job and got it! This was a very exciting time for me. After two years working abroad and three years at the Riverside Project, I had strayed far from the orthodox career training pathway. Furthermore my attitude changed so much that I found that my values and thinking were very different from those of my peers. I became a Community Paediatrician eventually West Cumbria, Carlisle and Eden.

What became of the Riverside Project? In the final year we started to spread our work into Walker, in the disadvantaged area of the east end of the City, where the project became equally popular with families and professionals. We argued for establishing a permanent interdisciplinary service in both the Riverside area and Walker, but neither the Local Authority or the NHS were prepared to invest, and the University Child Health Department did not press the case.

It is clear to me that the most important impact of the project was not the increased medical staffing. By far the most important work was in empowering people in the local community, particularly women. This work was continued by the community worker on her own for many years. A powerful women's group emerged and became established. It continues to be active and much respected 40 years later.

2. Marge Craig

My background.
I had lived in North Benwell in the 1970's, first working at the General Hospital as a biochemist in the Path Labs, then after re-training I taught children in Cowgate Primary school and later in Denton Road Primary school in Scotswood. Both schools served overlooked and under-resourced areas of the City where there were high levels of unemployment and few prospects for work.

I was influenced by the work of the Community Development Project (CDP), a government scheme set up in the 1970's, to tackle poverty and 'the cycle of deprivation' in 12 different localities in the country. The CDP had a shopfront on Adelaide Terrace, in the heart of Benwell, which collected information, provided a meeting place and also gave legal advice, for example around housing and benefits.

Rather than blaming individuals for their difficult situations the CDP looked at the systemic and historic causes of poverty, exclusion, neglect and disadvantage in the west end of N'cle, and published seminal documents about housing policy, disinvestment in local industries and the changes over years.

The Black Report had been published in August 1980. It concluded that the inequalities in mortality and morbidity were not mainly attributable to failings in the NHS, but rather to many other social inequalities influencing health: income, education, housing, diet, employment, and conditions of work. In consequence, the Report recommended a wide strategy of social policy measures to combat inequalities in health. These findings and recommendations were virtually disowned by the then Secretary of State for Social Services, very few copies of the Report were printed, and few people had the opportunity to read it.

Early days at the Project.
When I joined the Riverside Child Health Project in 1981 as a community development worker, I saw my role as being something of a bridge between the professional paediatricians and the local community, particularly mothers of young children. The aim of the organisation was to improve the health prospects of the next generation. I had a small child myself, and had helped set up several playgroups including one in North Benwell so I was aware of some of the difficulties of caring for babies and young children.

We brought groups of mothers together so we could identify their concerns and understand their experiences of using the various health services, both locally at GP and clinic visits, and at the hospital. We hoped this would change the nature of the services, to make them easier to use, and I guess we wanted to change the attitudes of powerful professionals who had been in post for many years.

We learned about the realities of women's lives. I think everyone working in the RCHP wanted to show compassion and concern for their worries and fears and lived experiences.

Being based in the local primary school gave us relatively easy access to those parents and children waiting in the school yard at the beginning and end of the day, and I remember Alan Colver identifying children who probably had asthma but had been diagnosed as having bronchitis by the local GP.

There was therefore work to be done with local GP surgeries, as well as other services such as social services, midwifery, mental health services, health education, etc. Working as a team we had many discussions about finding the best way to bring about change.

Bringing people together, and enabling them to gain knowledge about how the health services worked as well being listened to and understood, meant that we developed some strong relationships with local people. The meetings were positive, often full of laughs, and mums developed informal networks of support which proved valuable and longlasting – even to this day, when they are now grandmothers.

We soon realised that the bigger issues, like poor housing, inadequate transport, lack of safe places to play, domestic violence, difficulties in finding affordable childcare to enable women to get paid work, and low levels of school attainment all affected the babies' and children's health.

Some families were renting homes (owned by private landlords in High Cross) which the Housing Department described as not fit for habitation. We put them in touch with the Tenants' Federation, an organisation fighting for improvements in housing (see Archive for Change on the web, 1980. The Tenant's Fed was wound up in January 2020)

I can remember taking a group of mothers with babies and toddlers and buggies to meet with the local bus company at the depot, in order for bus drivers to understand the needs of families with young children. The women gave the buggies (empty) to the drivers and encouraged them to try to get on and off the bus without help. Lots of laughs again, but nowadays lowering the step for wheelchair users and people with buggies is part of the service.

We brought together the toddler group leaders and playgroup workers in the area to form the Under Fives Group, which recognised the value of pre-school provision, and brought this to the attention of the local authority education department and social services. This linked in strongly with the need for childcare for women wanting to enter education or work, because we recognised that financial independence for women was much-needed if they wanted to move on in their lives once their children reached school age, or to get out of abusive relationships.

The community development work at RCHP in those early days linked with two other community development in health projects in N'cle, one in North Kenton and the other in Walker. It was helpful having these other projects in the City, and we had regular meetings about Citywide issues, often around funding and support for the work and influencing local and national policy.

3. Allan Colver

How the Riverside Project influenced me

Listening to parents

I learned the importance of listening to parents and starting with how they saw a problem, not how I saw it. Few of the children brought by mothers to clinics had medical problems which required a medical diagnosis of the sort I had been trained to identify. But there were anxieties about possible illness or developmental problems. Finding a solution to such anxieties required trying to understand all the pressures that a mother was facing, some of which were channelled into anxiety about their child.

The opportunity to do research

During my time at Riverside I was able to do research into both children's accidents and childhood asthma. Here are the summaries of the two articles which were published.

> Home accidents are the main cause of death and morbidity in early childhood. Working-class children are at greatest risk. A study in an inner city area of the effects of a national television campaign about child accident prevention and of a locally designed health education initiative showed that 55% of families with young children in the study area did not watch any of the television programmes. Only 9% of a group specially encouraged to watch the programmes took any action to make their homes safer. In a comparable group who also received a home visit at which specific advice was given 60% took action to make their homes safer. The families studied were well aware before the television campaign of the importance and preventability of children's accidents. The problems disadvantaged families face are therefore not ones of ignorance or apathy about hazards but practical difficulties in converting their concern into action. Administrative arrangements must be developed for providing health workers - especially health visitors - with detailed local information to pass on to parents.
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> Asthma in children is common, underdiagnosed, and undertreated. We report a childhood asthma campaign in an inner city area, initiated by school doctors who then worked closely with family doctors. The campaign aimed to detect children with asthma, to institute or improve treatment, and to provide information about childhood asthma for families, teachers, school doctors, school nurses, and general practitioners. The symptoms and school attendance of most asthmatic children were reported by parents to have improved after the campaign, which was well received by both families and professionals. Similar campaigns focusing on other common childhood problems may provide concrete opportunities for collaboration between school health services and general practitioners and for improving children's health.

This experience of doing research in a community and public health setting reinforced the belief I came to Riverside with that such activities needed good quality research. I continued to do research in Northumberland around child health surveillance and screening. I also led major research projects around children with cerebral palsy in Europe; and in the UK around the transition of young people with long-term conditions from child-oriented to adult-oriented services.

Working in a multidisciplinary team

I learned about the benefits of working in a multidisciplinary team. It was extremely important that I was introduced to this because for most of the next 20 years it was necessary for me, as a community paediatrician, to work closely with social services,

education services, and professionals allied to medicine such as health visitors, physiotherapists and speech and language therapists.

Living circumstances of families

I had the opportunity to see, rather than read about, the very difficult circumstances in which some people live (especially mothers). By circumstances I do not mean just poverty and housing, but also the emotionally difficult and sometimes abusive relationships mothers experienced.

A first computer and an associated outcome

I bought a second hand ZX81 computer (advertised on the back of magazines) from the headmaster of Condercum School for children with learning difficulties, which I visited regularly during by time at Riverside to offer health advice to families. I was intrigued by it and got it linked to our television at home. I then kept abreast of developments in computers and was able to undertake my own programming and analyses with a confidence that few paediatricians had then or now. When I moved to further training in Northumberland, I was able to take advantage of an immunisation system that Steve Jarvis had introduced. This was a flexible local system on which I could undertake analyses or print reports for GPs. The national system was extremely cumbersome and very difficult to get someone at its nerve-centre to produce any report other than the few they had built into the software.

I was able to give feedback on immunisation to individual GPs and showed that this dramatically increased rates of immunisation in Northumberland, whereas the rest of the Northern Region did not change. I can claim some credit for the eventual introduction of immunisation targets in general practice because when Chief Medical Officer Liam Donaldson introduced them nationally, his only references were to my two letters to the Lancet.

4. Pauline Pearson

I had been working as a health visitor for just over a year when I was asked to join a novel new project which was beginning work in four wards of Newcastle's West End. Looking back, the recruitment process would not have passed muster nowadays – I was picked because I was (unusually at that time) a nursing graduate, and this project was innovative, aiming as it did not only to provide focused extra medical input for children in an area of high need, but to promote integration of health, care and educational services for children locally, and to work with families and the local community to encourage them to assume a greater share of the responsibility for their children's health. In addition, there was an intention to develop resources to educate health professionals for work in this and similar areas. Whilst it was not what I had envisaged doing at that point, it shaped my career in many ways going forward.

The original project base was in two classrooms in a Victorian infants school, with one forming an open plan office (with pairs of desks separated by screens) in which all of the team worked, and the other a room for meetings, events and quiet working. Five doctors and two secretaries had been the original team, joined in Autumn 1980 by a director of social and community work, a community worker and another secretary. In February 1981 I was seconded to the team, and sat opposite the director of social and community work (Dendy Platt). This situation encouraged me to make use of his expertise when thinking about individuals on my caseload and about the wider community's needs. Our office facilitated informal conversations between us all. As a team, we met regularly to discuss our

activities and develop work. We would also enable local professionals to meet together for lunch, hosting weekly discussions with diverse topics such as 'speech and language problems' or 'unemployment and health'. Being part of a multidisciplinary co-located team was important in our learning with and from each other.

I had a small caseload (54 families with children aged 0-5 and 46 families of over 65 - about half the usual size for that time) linked to a singlehanded GP working in the area. When I eventually handed over the caseload to a colleague, I realised how many issues families I visited were experiencing. I was also very aware that for many of them who for one reason or another engaged with social services, turnover of staff was quite rapid. I was a more consistent presence in their lives over the near 5 years I worked there.

Awareness of the struggles that people lived with, and the structural injustices which exacerbated these were influential in my professional and personal life. I think that being part of the project led me not only to respond as a professional but to see a bigger picture in relation to these. One thing which helped in this was visitors. Two visits stand out in my memory, though there were many more.

One was from a community project in Northern Ireland (where 'The Troubles' were still part of daily life). I recall showing the visitors round our area, talking about the issues faced by our community – including relatively high parental unemployment – and hearing their account of life in their community, where not only was unemployment significantly higher, but of course they were dealing with levels of local tension and mistrust which were absent in our area.

The second visit which I recall was a fact finding visit as part of work on Archbishop Runcie's 'Faith in the City' Report. We eventually featured as a paragraph or so in the report, but for me the questions asked by the visitors put our work into a bigger framework, and highlighted a connection between my faith and social justice, which has endured.

I was free in the remaining part of my week to liaise with colleagues, and to develop work with families and the local community to promote health and encourage healthier behaviour. I remember going into Ashfield Nursery, both to do checks on children, but also, and more often, to work with parents' groups to encourage them to learn for example simple first aid – how to deal with a choking child for example. It was in one such group that the question came up 'What *do* health visitors do?' Those parents were not alone in asking that, but it sparked me to begin looking at just how parents thought about both health and health visitors – which in time became the core of my PhD study, and an ongoing interest in the views of patients and the public about healthcare. As a project, listening to parents' views was an important facet of our approach –seeking to involve them in the design of provision to meet their needs. A local mother joined us after some time to be a sessional worker, and enabled us to connect with many more parents – at the same time as taking her own steps to gathering new skills and knowledge. I believe she later undertook a degree.

I was also involved in work with medical, nursing and other students, for example developing ways to help them to understand the limitations of the local shops for parents trying to bring up children healthily on a limited budget. I sent them out on foot to find a range of things parents might need like fresh fruit and electrical socket covers. We had a degree of freedom to be creative in enabling students to engage with the community and see the contexts in which parents lived that fed into my later moves into first medical and then nursing education and research.

Being part of the Riverside Child Health Project had a significant impact on me and my career. I believe as a model it also has much to offer health and social care[1] professionals and agencies now. For me, learning about parents (and other service users) views – and seeking to work with them – became a conscious imperative. It is a focus which I see becoming stronger once again in calls from Joseph Rowntree, Church Urban Fund and other groups to hear and respond to community voices. It should be embedded in health and social care work now. Health Visitors (if there were more of them!) could be at the forefront of enabling communities and colleagues to build community capacity now. I believe working in a multidisciplinary team shaped the way I thought about other professions and my own, opening my eyes to the different contributions which each of us have in health and social care and beyond. Having the opportunity to be creative and to ask questions and seek to answer them would shape my career as a researcher and educator as well as a practitioner over the next decade. And as I have said, being part of the project led me not only to respond as a professional to individual struggles and structural injustices, but brought the wider picture into focus through the connections we made, and encouraged me to work for change beyond the immediate situation.

5. Mike Downham

I can add further memories of the Riverside Child Health Project, and a brief account of work I did subsequently with children and families. I'll also offer some reflections about the relevance of our experiences 40 years ago to NHS services today, and to the current health and wellbeing of children.

Memories

Why was the Riverside project set up?

Arthur is right to point to two immediate triggers for the Project – research into the distribution of hospitalisations and deaths of children across different city wards, and the failure of the Labour Government to take action on Donald Court's recommendations for improvements in health services for children.

But the Riverside project also grew out of work I had been doing in the West End of Newcastle for the previous four years, which in turn grew out of my time as a children's doctor in Zambia.

In 1970, with only a year and a few months behind me as a junior doctor in paediatrics, I took a contract with the copper mining company in Mufulira to develop a child health service for the population of 100,000 people. When Zambia won independence in 1974 the British left behind a grossly inadequate infrastructure – in particular, bad roads, which turned to mud in the wet season, appalling housing (in contrast to the luxury homes with swimming pools built for expatriates), and a health service which featured over-crowded hospitals, a rudimentary primary health/preventive service, and no medical school. The mining companies, desperate to hold on to their rights, undertook responsibility for health services in each of the Copperbelt towns to strengthen their bargaining position with the Zambian government.

I spent the first two months working intensively in the under-twos ward of the black hospital. There were 30 cots with an occupancy which only fell below 60 for the few hours it

[1] I am conscious that this term has now been captured to mean care of older or disabled people, but in this instance I mean community engagement and social work with families facing a wide variety of economic and other challenges

took to clean up after a child had died and to admit another one. There was an excellent nursing team, led by dedicated expatriate nurses, mostly from Scotland. We were well-supplied with medicines and medical equipment. I set about treating meningitis, gastroenteritis, pneumonia or measles as I had been taught in Britain, but however hard I tried to get the right things done and to do them quickly, most of the children died. Nearly constant wailing came from the mothers in the concrete shacks provided for them across from the ward. The children were too undernourished and were getting to the hospital too late in their illnesses to respond to treatment.

I trained the expatriate nurses to do peritoneal rehydration and lumbar punctures – a relatively easy task given that they were already skilled at putting up drips in collapsed children – some of them more skilled than I was. Then I spent the remaining 22 months of my contract in the eight township clinics, coming back at the end of each day to do a quick ward-round. In the clinics I worked with the local orderlies, who had received very little training. We sat side by side seeing children and their mothers together. Once we'd got to the end of the queue we worked out the details of health and nutrition advice we thought were necessary. Between us we deigned an immunisation programme, and a programme of sessions for mothers to learn more about nutrition and the early signs of serious illnesses. Some of the orderlies were haltingly literate, so I produced written guidelines about each of the common serious infections and a growth chart to be kept by mothers on which immunisations could also be recorded by the orderlies.

In contrast to the failures of hospital treatment, the work with mothers and the clinic orderlies was immediately beneficial. During my two years in Mufulira death rates, especially from measles, showed signs of falling significantly. Sometimes we had empty cots on the ward.

I left Zambia in 1972 to join the Child Health Department in Newcastle University, by which time the first Zambian doctors were emerging from the new medical school in Lusaka. I applied to Newcastle, reckoning that it was the next best thing to Zambia in that it would give me an opportunity to build on what I had learned from poor Zambian families, within an academic department which had a long history of investigating the needs of poor families and setting up services for them. It took me three years rather than two months to cut lose and spend most of my time in the West End, but for me it was a logical step.

Wednesday lunchtime meetings

As Arthur has described, on most Wednesdays we invited parents, GPs, heath visitors, school nurses, teachers, social workers, community workers, and psychologists from the Riverside area to a lunch-hour meeting, to discuss a specific of topic. They brought their own sandwiches, and we supplied the coffee.

These meetings are among my best memories of the Project. Often more people turned up than we had chairs for – the others sat on the wall working-tops or the floor. Discussion was animated and everyone ate while we talked – these were extremely busy people with challenging jobs or families. We learned a lot from each other. Parents told me that they felt strengthened.

Working alongside GPs

At the start of the Project we phoned all the GPs in the area to ask whether they would like one of the Project doctors to join them in seeing children they were concerned about. We ended up doing joint clinics with many of the GPs, either regularly or on request. This was a two-way learning process. GPs see many children who have difficult symptoms but ones which they feel aren't the sort of symptoms they should refer to a specialist. Hospital

paediatricians get no experience of the first signs of illness or dysfunction. This was a central point of Donald Court's Report, which recommended that one GP in every practice should have a special interest in children, with appropriate training. Our experience of joint consultations confirmed that many GPs felt challenged by the children they see. They know that children's illnesses can develop more quickly. But when should they send them to hospital or refer them for an out-patient appointment? Putting our hospital experience together with their community experience was clearly beneficial to many of the children and families we saw together.

Children in women's refuges

Later in the project we realised that there were children in the two women's refuges in the area who were specially vulnerable, partly because they were often from the poorest families with associated poor health, but also because the mothers were often fearful of leaving the safety of the refuge to take their children to the GP or to hospital. This was tricky work for a male doctor, but we sometimes had no women doctors in our team. My offer of going into the refuges to make myself available to see any children that mothers had worries about was at first greeted with appropriate hesitation by the staff. But they consulted with the women, and they let me in as an exception. This was a privilege which I valued personally. It gave me a better understanding of the impact of domestic violence, and I was sometimes able to help mothers with advice about their children, arranging referrals to hospital services when I thought it was necessary.

Reactions of trainee doctors to their attachment to the Project

Over the three years we must have had around ten junior doctors attached to the Project, usually for six months, as part of their training to be either paediatricians or GPs. Allan, one of these, has already contributed his memories and reactions. The trainees brought new life, ideas and enthusiasm to the Project. For some it was difficult at first to be working more irregular hours than in hospital, to get into the new way of working across the disciplines, and engaging with families who often had multiple difficulties. But nearly all of them came to be extremely positive about their time at Riverside. Most kept in touch with me and told me they had found the experience valuable in their subsequent work and lives. I enjoyed the privilege of working with and supervising all of them. I remember them as an exceptional bunch of people.

Team solidarity

The task of trying to contribute something useful to the difficult lives of families in West End of Newcastle was often stressful. At times I found it extremely challenging personally. While there were things I could do, these things often seemed insignificant in relation to the needs and conditions I came to know intimately. It was these needs, on our doorstep, which held us together as a team.

The end of the Project

In 1982, after three years which had shown indisputable evidence of the Riverside Project's popularity with families and statutory services in the Project area, we were unable to persuade either the Child Health Department of the University or the NHS to extend the experiment. The political climate had by that time deteriorated drastically in terms of the interests of poor families, with the swerve to the right led by Thatcher and Reagan and the founding of neoliberalism. The policy-makers of Newcastle knew they were staring down the barrel of a gun. To continue the project would have made it politically impossible for

them not to incorporate it into regular service provision. They had the strength to swim against the national tide, but they chose to go with the flow. Poor families should look after themselves – they were not worth spending money on.
Realising that there was little I could do as a doctor to change the daily lives of families in the West End of Newcastle, I gave up practising medicine. I was 43. Over the seven years of working with families in Scotswood, Benwell and Elswick I met and came to know intimately some of the finest people it's been my privilege to work with. They changed my life, but I had not changed theirs.

Children and families in Cumbria

After giving up practicing as a doctor it took me two years to decide what to do next. Then Ruth and I moved to Cumbria to produce most of our food from a wet but affordable 12 acres. We milked a small herd of cows, made cheese and yoghurt every day, raised the bull-calves for our own beef, ran a small flock of sheep and grew a lot of fruit and vegetables. Our four young children were not just involved in the work - we couldn't have managed without them. They were necessary to the farm's economy. After 12 years we moved to a commercial-scale farm
Soon after I arrived in Cumbria people began to ask me for medical advice, especially when their children were ill. I was nervous about this at first, not wanting to get between families and their doctors. But it became clear that existing services were often not meeting their needs. I was sometimes faced with emergency situations where I thought it highly probable for example that a baby had meningitis, or that a child had leukaemia. And there were longer-term problems like bed-wetting or constipation which parents felt they weren't getting enough help with. Whatever the ethics of my position, I found it impossible not to respond. The most part of what I did was to help families decide whether, when and how to get in touch with their GP, or whether and when to take a sick child straight to hospital. But there were also many examples where GPs made mistakes because they had too little experience of children's illnesses – the same of lack of experience which Donald Court had pointed to and had proposed solutions for – and the same problem the Riverside Project had tried to address.
One of the most important milestones for me as a junior hospital doctor was when a consultant paediatrician told me that if I was ever unsure of the diagnosis in a sick child, I should ask the mother. Working with families in the West End of Newcastle, I came to respect more and more the capabilities of parents in understanding whether their children were seriously ill or not. That respect further deepened over 31 years of living in remote community.
I felt that parents and other members of the community had the capacity to learn more about illness. With the help of an experienced health trainer, I designed a course of six two-hour workshops called 'Responding to illness' and publicised it locally. 15 people signed up for the course, all of them women - eleven parents of young children, and four older people. We met one evening a week for six weeks, and covered some common medical emergencies, some common childhood illnesses, and some longer-term illnesses. Specific illnesses were chosen by the participants at the start of each session. We used facilitated discussion to share experiences of the symptoms of each condition, and whether and when participants had gone to the doctor or sought other advice.
Armed with analysis of our discussions and feed-back from these workshops I approached a local General Practice to suggest that they might like to try something similar for their patients. The diversity of unconvincing reasons the doctors gave for declining the suggestion

(litigation risk, time restraints, room-space …) gave me the impression that the underlying reason was a reluctance to share their expertise.

Implications for health services today

Looking back now over these 50 years – practising as a doctor in Zambia and Newcastle, and living but not practising in Cumbria, I offer these reflections about health services today.

Closing the gap between general practice and hospital

The gap between general practice and hospital which the Riverside Project tried to plug for children in the Project area has widened. This is as bad for adult patients as it is for children, and it's generalised, not restricted to disadvantaged communities.

GPs know a lot about common conditions and about the lives of their patients – although in some large practices the identity of patients gets lost because of seeing different doctors, instead of building a relationship with the same one. Hospital doctors' knowledge and experience is restricted to narrow contexts. Undergraduate training tries to address this, but the bulk of a doctor's training takes place on the job after qualifying. Specialisation soon dominates.

There's an organisational gap as well as a knowledge gap. Once GPs have referred patients to hospital out-patients or for admission, they have no further say in how their patients are managed. As hospital waiting lists lengthen, exacerbated at this point by Covid, GPs have to care longer for the patients they've referred, some of whom deteriorate significantly while they are waiting. GPs seem to have less and less power to expedite appointments.

Exchanges between hospital doctors and GPs are limited to letters, which sometimes get lost and regularly take a long time to arrive on the right desk.

When patients tell me about their problems these days, they often describe how their GP is saying one thing and the hospital something entirely different.

Reducing the workloads of NHS workers

Chronic underfunding of the NHS by governments over the 40 years since the Riverside Project – governments of all political parties restricted by the dominant neoliberal ideology – has resulted above all in understaffing of hospitals. Exhaustion and frustration have become institutionalised. Only the persistent commitment of NHS workers to the original ideal keeps the service running.

While we must go on arguing for more staff, there's also much more that could be done to share responsibilities more widely, involving more specifically trained workers. It seems there's still a closed-shop attitude among too many doctors in relation to sharing their expertise, but to do so would be in the interests of patients and doctors alike.

Decentralising and democratising health service delivery

Health service needs vary significantly between different localities, in both quality and quantity. In places like the Riverside Project area, where many families are struggling with day-to-day crises, often without affordable transport, it's immediate access to health advice that counts. In Havana every neighbourhood has a doctor and a nurse who live on the block and share responsibility exclusively for that neighbourhood's health.

It's the people living in each locality who know best what services they need. In 2017 Westminster civil servants, some of whom proved to be ignorant even of the whereabouts of West Cumbria, let alone the needs of a post-industrial community for whom poverty has become all they can expect, insisted that acute paediatric and maternity services at the West Cumberland Hospital should be abolished. Despite widespread protests by residents and local health workers, the civil servants got their way. The over-riding priority of the ministers they answer to is to cut costs. Mothers with dangerously ill young children or with

difficulties in labour were forced to survive an hour's ambulance drive to Carlisle along the notoriously accident-prone A595. There's still no acute paediatric service in West Cumbria, but two years later, after continuing protests, a full maternity service was restored.
Protest can be effective in the long run, but if we truly value the health of our communities, above all the health of our children, it's time to set up Neighbourhood Health Committees, their locally elected members a mix of residents and local health workers, with statutory powers to design and deliver health services for their neighbourhood.

Learning how to deal with illness

My experiences in Zambia, Newcastle, and Cumbria of providing opportunities for members of communities to learn more about dealing with illnesses have led me to think that the NHS has from the start missed a fundamental opportunity. If health services are to be provided free and at the same time increase, in step with expanding technology and knowledge, not even the best organised state will be able to afford the costs in the long run. But those costs could be reduced by steadily increasing the population's understanding of health and illness – not just though promotion of healthy lifestyles and prevention, but also by providing opportunities to learn how to deal with illness – how different illnesses present, to what extent they might be urgent, and whether and when to seek help from services. This learning could start in schools and be promoted as an adult education option in communities and workplaces.

Poverty and power

Neoliberalism, the latest version of capitalism, founded at the time of the Riverside Project, remains the system we are subjected to today. It continues to cut and privatise services. It has become more extreme, more unscrupulous, as capitalism has become more desperate to reverse its decline.
Many of the families who lived in the west end of Newcastle 40 years ago still live there. They still have underpaid, insecure jobs, or no job at all. Their homes are still overcrowded, poorly ventilated and expensive to keep warm. Much of the food they eat is bad for their health, thanks to the stranglehold of profitable supermarkets. Many are dependent on food banks. The services which struggle to support them are understaffed, underpaid, and demoralised. It's the same story across large parts of all cities in the UK and some rural areas too.
As I write this in August 2021, the UK Government is about to inflict a perfect storm on poor families. At the end of September, on the verge of winter and with the Covid epidemic still raging, the Government will terminate furlough, reduce Universal Credit back to its insulting pre-pandemic level and increase the cap on energy prices to an unprecedented figure. Large additional numbers of families will be driven into fuel poverty, having to choose between keeping their home warm or putting food on the table.
The only way life will change for poor families is through fundamental change in the economic system which has been imposed on them. This system rests on the exploitation of the many for the benefit of the few. This system, along with the politics which sustains it, is responsible not only for poverty, but also for the devastating and unfair impact of the Covid epidemic, managed by the UK Governments in the interests of the few. It's also entirely responsible for the failure of governments to effectively address global warming. The resulting change in climate as reported this month by the Intergovernmental Panel on Climate Change, is already impacting on families, particularly poor families, in every region of the world. The reality is that Governments across the world, whatever they say, have

accepted a three- or even four-degree temperature rise. The impacts of austerity and of the pandemic will shortly be dwarfed by those of climate.

Six women

Fundamental change in the system will only be triggered by the people most impacted by it. In 1981, by which time we had come to know many families well, the Riverside Project started to provide opportunities for small groups of parents to meet informally with a member of the Project team to raise and discuss issues they were particularly concerned about. In one of these sessions a self-formed group of six women told me how they'd all experienced having their children, aged between three and six, taken screaming from them by a nurse in the corridor outside the anaesthetic room, to have their tonsils removed at the local hospital.

They asked me to write to the senior anaesthetist about this. After several rebuffs he accepted the women's invitation to meet with them at the Project. Confronted by the mothers asking him why parents couldn't stay with their children until they'd been anaesthetised, he agreed to get the policy changed. It was.

CHILD PROTECTION AND THE RIVERSIDE PROJECT

For current procedures, see https://newcastlechildcare.proceduresonline.com/index.htm

"To provide extra medical input for children in an inner city area where we know that child health needs are unusually high and child health services are unusually stretched".

In this draft we shall describe how the Project's first and most general aim affected the management of a particularly sensitive aspect of those needs: child protection from abuse. Child abuse relates to the ill treatment of children by their parents or guardians, and may involve non-accidental injury, neglect, or emotional deprivation. The Court Report ("Fit for the Future" HMSO 1976) estimated that 5,000 children were the subject of abuse each year in England. If this estimate applied equally to all the country's children, the Riverside area, with around 9,000 children, could expect four cases of child abuse per year.

But there is considerable evidence that those authorities responsible for the protection of children from abuse in Newcastle (i.e. the Local Authority Social Services and Education Departments, the Health Authority and the NSPCC) had a disproportionate number of cases from the Riverside area. In 1973, Riverside children represented 18 per cent of the city's under sixteens, but made up 34 per cent of the Social Services Department's child protection caseload, and 46 per cent of children in care of the Local Authority - both likely responses to child abuse (Source: "The Social Characteristics of Newcastle upon Tyne Social Services Department, N.M.B.C. 1974).

Evidence on this topic related to the Riverside Project's role comes from six sources:

1) Project held records of referrals containing an element of suspicion of child abuse.
2) Details of children in the Riverside and control areas recorded on nursing management "at risk" files for the period 1978 to 1982.
3) Cross-reference of names of children referred to the Project with the NSPCC register of "at risk" children.
4) Hospital admission for NAI and suspected NAI for Riverside and Control area under fives, 1978 to 1982.
5) Material from interviews held in 1981 and 1982 with nursery and Social Services staff, school nurses, teachers and head teachers, and G.P.s.
6) Material from interviews with parents using local day nurseries and infant schools.

By 1982, the Riverside's share of children in care had dropped to 32 per cent, and that of the Control area had increased to 16.5 per cent (both areas by then accounted for a slightly smaller proportion of the city's children). Children in the Riverside were still twice as likely to find themselves in care as were children in the city as a whole, and three times more likely than Control area children to be on the “at risk" file kept by nursing management. But these figures represent administrative action rather than the actual incidence of child abuse. Another such measure, based on the number of under-fives admitted to hospital for non-accidental injury (N.A.I.) does not confirm this differential between the Riverside and Control areas. For the years 1978 to 1981 inclusive, both areas had admission rates for N.A.I. and suspected N.A.I. of around 1 per 1,000 resident under-fives per year - a figure much closer to the Court Report estimate of the incidence of child abuse. This discrepancy alerts us to the problem of measuring child abuse by using figures based on cases where abuse is suspected rather than proven.

We can distinguish two types of possible error in defining child abuse:

1) Mistaken diagnosis, where physical symptoms of rashes for example, are mistaken for suspicious injury;

2) Injury defined as suspicious on insufficient grounds.

In this draft we use three categories of child abuse: "mistaken"; "possible"; and 'likely"; referrals that have not yet been categorised will be referred to as "suspected" child abuse. The Riverside Project sought to influence the management of child abuse by improving the decision making by which "suspected" cases are defined as likely, possible or mistaken. The importance of this is related to the detrimental effects of taking action in cases of "mistaken" or "possible" child abuse on the child, the parents, and on relationships between them and professionals taking such action.

The incidence of child abuse, even based on figures which may be inflated through the inclusion of "mistaken" or "possible" cases, is rare in the Riverside. Non accidental injury (whether "likely, "possible" or "mistaken") accounted for only 11 per cent of all admissions of injured under-fives from the Riverside in 1978-81. Only one Riverside child in fifty was in care in 1982 and around one in 300 was placed on the nursing management "at risk' file each year from 1978-81. Local G.P.s and school nurses generally reported that child abuse cases seen by them were few in number. But interviews with parents in the Riverside area revealed a sensitivity to the possible accusation of child abuse, even when injuries happened innocently to their children. Some said that children were kept at home to avoid such suspicion.

Social Services, Education and Health Workers charged with the responsibility of maintaining safeguards against child abuse, are issued with guidelines with which to respond to this sensitive situation. We will now refer to these guidelines before going on to examine the Project's role in child abuse management, in terms of the extra resources it brought to this type of child health need.

Management of child abuse in Newcastle in the 1980s

The guidelines relating to child abuse distributed to professionals in Health, Social Services, Education, and voluntary bodies, laid down when and how referral should be made to medically qualified staff to investigate a child's injuries (1). They quote a variety of ways in which a doctor may have been involved, from the first step suggested to teaching staff of seeking "such medical opinion and advice as may be readily available"; (P.3) to more specific, but not categorical, instructions: "ensuring a medical investigation is made without delay, preferably by a paediatrician in a hospital". (P.4) and:

"the parents should be encouraged to take the child to the Accident and Emergency Department of the R.V.I. or General Hospital .... or (to) consult the family doctor" (P.4)
Social workers, to whom responsibility for care management was normally given, had instructions to ensure that the child was examined without delay by a paediatrician". (P.17)
When cases come to the attention of G.P.s or C.M.O.s, they are advised to arrange for admission or consultation through the hospital paediatric registrar or another paediatrician when there was strong suspicion of abuse, and these suspicions are not firm enough to insist on referral to hospital against the parents' wishes, advice should be sought from a paediatrician or the specialist in community medicine (child health) or the Area Director of Social Services" (P.7)
(1) "Guidelines for the Management of cases of Suspect Child Abuse in the City of Newcastle upon Tyne"' Area Review Committee, February 1982
The guidelines therefore give a range of possibilities for referral to doctors in such cases, and do not always insist on the despatch of the child to hospital.
The Project as a new referral point.
The Riverside Project provided extra resources within this recommended pattern of referral in four different ways. Firstly Project C.M.O.s and S.M.O.s tried to be more accessible to staff and parents in sessions in clinics, schools and nurseries. More frequent visits to schools, more informal access in clinics, and open G.P./Project child health sessions, are the more obvious examples of this. But equally important was the direct access by telephone to doctors at the Project base. It developed closer support of day nurseries, where child abuse, mistaken, possible and likely, may arise more often than in other settings. A a network of more indirect and irregular contact between doctors and local families developed through the activities of the Project's medical, health visitor and community work staff with local groups. As well as easing referrals, this work may also have provided opportunity for prevention. Finally, the Project medical staff included doctors of seniority and specialty not normally available in a community setting. Until September 1982, the Project included a consultant paediatrician and a paediatric registrar. After that time, the team had one senior C.M.O., one paediatrician of senior registrar status, and one paediatric registrar. Those doctors serviced regular sessions at local clinics, schools, day nurseries and with G.P.s.
If a social worker or school nurse favoured the examination of a child by a paediatrician, but wished to avoid a hospital referral, the Project gave her the opportunity of doing so. There is evidence from G.P.'s, teachers, nurses, health visitors, social services and day nursery staff that the opportunity for an earlier referral for medical examination and decision within a community setting was welcome and often taken up. It is also clear that this initial examination did not necessarily bypass the established procedure of referral to hospital, case conference, etc.
The scale of the Project's involvement
The Project team may have seen a case of suspected child abuse directly, through their work in clinics, schools, nurseries, day nurseries and G.P. child health sessions, or indirectly through referral, mainly by Educational or Social Services Department workers. These referrals may have gone to any of the settings listed above, or to the Project base in Atkinson Road School. More than one Project doctor may have been involved, if a non-paediatrician wanted paediatric advice, and other Project staff may also have been involved through their work in clinic settings or with groups of children and parents. Project held records of referrals confirm the pattern of the relatively uncommon nature of child abuse

referrals. From September 1979 to the end of 1982 the Project team (including those C.M.O.s working in the Project area but not based at the Project office) recorded 103 cases - approximately one every two weeks. Judging from these records, each individual doctor may on average have expected to receive a child protection referral roughly once every four months.

The number of referrals of suspected child abuse declined, from 44 in 1980 to 27 in 1981, and 23 in 1982. There are several possible reasons for this trend. Fewer "mistaken" cases may be initiated, as referrers gain more confidence in recognising and taking responsibility for them. Fewer incidents may actually have occurred or come to the notice of professionals. Or those professionals may have referred fewer cases to the Project because of their concern that it was an unhelpful or "risky" option and referred to the hospital instead. One cannot completely rule out any of these, although admissions to hospital showed no increase over these years. As we shall see, there is evidence from local professionals that the first explanation - fewer "mistaken" cases - had some validity.

If we examine the numbers of cases referred to the Project according to the subsequent action taken — that is, the "likely" cases which led to care proceedings and/or registration by N.S.P.C.C. or nursing management, and the "possible" or "mistaken" cases where no such action was taken, we find there was a decrease in both groups after 1980. There were 13 of the first group referred in 1980, 5 in 1981 and 5 in 1982. Numbers in the second group "possible" and 'mistaken' referrals where no procedural action was taken, declined from 31 in 1980 to 21 in 1981 and 17 in 1982.

The Impact of the Project.

The procedural guidelines on management of child abuse were drawn up in an effort to ensure consistency of action when cases of suspected child abuse were encountered, including the notification of cases to a senior level in each department, and to relevant staff in other departments. It could be argued that the Project, by acting as an alternative to referral to hospital, had undermined these safeguards, and made for possible mismanagement.

But it is misleading to see the Project as a separate and alternative child abuse management structure. Nearly one case in every four seen by Project doctors ended up with the child registered or in care. One in three were the subject of a case conference, usually with a Project member in attendance. Sixteen cases were sent to hospital for investigation after being seen by a Project doctor. This leaves 59 cases where there was no immediate referral to hospital, case conference, registration by nursing management or N.S.P.C.C. or placement in care.

Is there any evidence that any of these cases were mismanaged? One sign that this may be so would be if children handled in this way were the subject of later referrals, leading to more serious action. We could find no cases where a child, seen by a Project doctor and not referred on to hospital, case conference or register was later the subject of registration as a result of a later incident.

It is relevant to point out that the avoidance of 'procedural' steps in these 59 cases does not mean that no action was taken, including upward and sideways notification of the incident, and a decision to arrange local support to the family. Such action was taken in at least 31 of these 59 cases. In addition 11 cases involved children attending day nurseries where the situation could be easily monitored by staff and doctor. In the 25 cases seen by Project doctors where no further action was taken, only one had "reappeared' later (i.e. up to the end of 1982). In this case the child was seen on the second occasion in hospital and a case

conference was arranged, but no decision to place in care or on the register was taken (the child had been attending day nursery since before the first referral, so daily surveillance was easily maintained.

The views of professionals and parents.

The Social Services Department plays a central role in the management of child abuse, from first detection to managerial responsibility (usually at Area Director level) for referral and convening of case conferences, and to continuing support through social work (often as the 'key worker') and the placement of children in care. Informal interviews were held by the researcher in 1981 with the Assistant Director of Social Services, the two Area Directors and the day nursery matrons in the Riverside: child protection was one of the issues raised with them.

The Assistant Director of Social Services was positive:

> "Feedback from area offices have been favourable: social workers see an advantage in having quick help available in an informal way. SWs may be fearful of using full legal procedures – the alternative may be informal expert help. GP links with SS weak in child abuse cases. They don't come across it very often, and don't come to case conferences. So we go straight to a paediatrician. The paediatricians are quite willing to do this, and if the HV is involved and attached to the GP, the GP is quite happy to let her take responsibility".

Two Area Directors of Social Services also made positive comments:

> "I was impressed by the relationship between the RP and this SW team – it's a tremendous asset, in being able to have an informal check on kids, rather than go through the General. The RP may not refer cases to me because it's felt not to be necessary – they've enough expertise to decide".
>
> "NAI and failure to thrive are the main point of contact with health services… (the Project) has filled a very major gap for resources in our area … links with GPs are poor – there's no formal links".

Day nursery matrons were in the frontline in this respect, seeing possible cases of child abuse at an early stage:

> "I contact a Riverside doctor, preferably the current day nursery doctor. They come as soon as they can. The alternative is to contact a social worker who will contact the family. (The Project) is quicker, more positive response, the explanations can be deciphered quicker".
>
> "The primary (nursery) worker refers to a senior staff member, who refers to a social worker on the duty office, and we decide together. If we want a paediatrician, we contact the Project doctor and ask him in first so we don't have to go to hospital with the parents. It prevents worry about parents, and helps the nursery workers - maintains trust. (The doctor) is conscientious and we do take it further if there's any doubt. The advantage is that he sees repeated bruises, etc., on the same child"

School based staff - heads, teachers and school nurses, were likely to be first to come across suspected child abuse among children old enough to attend school. Schools were the most common source of referrals to the Project, generating 39 of the 103 recorded cases. The five school nurses serving Riverside primary schools had all come across such cases in the school year which ended July 1982, while eight of the 19 school nurses working elsewhere in the city had not. One school nurse said she had seen "dozens" of cases in the school year, although two others remembered only one or two. All five nurses said they followed the guidelines – contact their Nursing Officer and the head, who then had the responsibility for

further action, including possibly taking the child and its parents to the hospital, or contacting Social Services.

Like the Social Services managers, some head teachers made comments on the disadvantage of the guidelines, and the value of the Riverside Project as an alternative.

"I'm rather inclined not to push it unless it recurs… the machinery is so heavy so a lot of schools hold back unless it's a blatant case ... often you just want another opinion".

"(The Project) gave me their phone number if I needed it and would come up without waiting for a week".

"None were referred to Social Services, they were referred to the (Riverside Project) doctor. Some went up to hospital. I'd ring them up and they come in and decide if it needs to be pursued. Never managed that before".

"We automatically as teachers make ourselves aware of child abuse because we assume it's more likely. One of the values (of the Project) is that there has been more co-ordination and communication".

It is perhaps significant that Riverside heads and teachers were more likely to have come across suspected child abuse cases than those in the Control area, but were no more likely to have referred cases to Social Services or hospital. In the reception classes, where the Project's input was greatest, only one out of approximately ten suspected child abuse oases in the school year was known by the teacher to have been referred to hospital or Social Services. Some nurses, heads and teachers suggested that the Project's presence may also have a preventive effect.

"(The parents) like to see the nurse coming in, let her see them, it's another bit of social life".

"They do know the doctor is in a lot - it could have some effect".

"It's helped parents - they regard health and school as intermingled - they would come to us with queries".

"Again it gets back to the doctor and nurse being part of the scene now ... it's been nice to know we can have the service of a doctor we can contact anytime if teachers have felt unsure, they can chat with the doctors".

"Because the doctors have been regular, they get to know the doctor, aren't frightened of her".

G.P.s tended to play a less central role in child abuse referrals than either school or Social Services staff. Only seven local G.P.s said they had had contact with the Riverside Project over cases of child abuse - although others had of course been involved independently. None of these seven were critical when asked what their view of the Project involvement in such cases were: three made detailed comments - the first two are from G.P.s running child health sessions with the Project:

"On a couple of occasions I discussed with them - not formally. I have informal contact with them, if it's suspicious, some have gone to hospital".

"The Project's involvement can be useful. NAI is a matter of teamwork, they have the time to contact schools, etc. We have no immediate knowledge of their background, so it can help".

"From this point of view, it's excellent, the approach has been most useful. The Riverside Project has brought it to the fore."

Another G.P. working in co-operation with the Project in a child health session, while unable to recall individual cases, had some unease about the Project's role.

"It's helpful from the individual patient's view, but my feeling is they may spend a lot of time on very few, it may not be the most at risk. It's another area where there's been some fragmentation, because of health visitors' areas. One works in Scotswood and takes her worries to Riverside doctors there. The other comes to us. So we're less aware of child abuse in our patients. Is it cost effective?"

Because of the limited use made of them by referrers, a case coming to the attention of a G.P. was probably of the "likely" category of child abuse and most, according to these G.P. were sent to hospital for examination or admission, given case conferences, or placed in care. As we have seen, educational and social services staff had reservations about involving G.P.s in child abuse referrals, and it was in the initial assessment of mistaken and possible child abuse along with those that were likely, that the Project had its greatest impact.

Interviews with 39 Riverside **day nursery parents** were held early in 1982. They give support to the argument that the Project had provided a less threatening means of making an initial assessment of child abuse. Parents made favourable comments about the informal, friendly, unhurried, attentive or well informed manner of the nursery doctors. Only one made a negative comment. Some also suggested that the danger of child abuse was reduced as a result of the knowledge and support gained from the group discussions that the Project and the nursery staff had encouraged. As one of several mothers said:

"I've learnt how to cope with his temper".

More supporting evidence comes from interviews with parents of **infant school entrant children**. This group were less likely to have had direct experience of suspicion of child abuse - none of the 50 Riverside parents had ever been asked by the school to take their child to hospital, for example.

But there is some evidence of the heightened sensitivity of Riverside families to this issue. Ten parents said they thought that parents rather than the school should be responsible for deciding whether to take a child to hospital. In interviews in the Control area, only one of 23 parents held the same view.

Conclusion

Child abuse management was a difficult problem for school nurses and head teachers in particular. It would be wrong to suggest that the Project had "solved" the problem by seeing children before they were referred to hospital or Social Services. Some feeling persisted that the Project was weakening safeguards designed to protect the child. The most critical comment came from a school nurse.

"The guidelines say one thing, they do another. They want to handle referrals in their own way but sometimes things weren't done. It's the Riverside view only — not a case conference with all parties. They wouldn't involve health visitors and social workers if they knew they disagreed. They don't come to case conferences. You need a plan of action, it's been very difficult".

We have attempted to evaluate the effect of the extra resources brought by the Project in relation to child abuse management. It has shown that the Project did not work completely outside the procedure for child abuse management: case conferences were common, some children were sent to hospital, some placed on the 'at risk' register or in care. SSD Staff interviewed had no complaints about failure to refer or to notify, and valued the new accessibility of informal but specialised consultation that the Project had brought - especially to day nurseries. Finally, there is no assurance that all 103 cases the Project dealt with would have swiftly come to the attention of an alternative medical authority, had the

Project not been as accessible as it was widely recognised to be. Some children would have gone to hospital, perhaps unnecessarily. But others may have been missed altogether, with unpredictable results.
The evidence we have available from case records, professionals and parents suggest that the extra medical input that the Project gave was relevant to the high need and unusual stress on services that the incidence and management of child abuse represented, and was also consistent with its aim of increasing parental responsibility through its selective use of a procedure which seemed to many parents to assume guilt from the onset.
In this draft, we have attempted to evaluate the effect of the extra resources brought by the Project in relation to child abuse detection, prevention and management. We have shown that the Project does not work completely outside the procedure for child abuse management: case conferences were common, some children were sent to hospital, some placed on the 'at risk' register or in care. Staff seen in the Social Services Departments had no complaints about failure to refer or to notify, and valued the new accessibility of informal but specialised consultation that the Project had brought — especially to the day nurseries.
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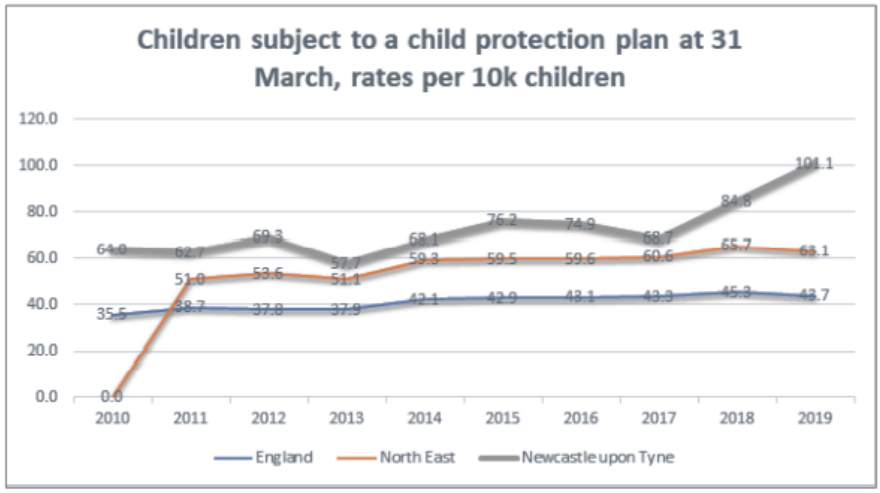
Update: Child protection and child poverty in the 21st century

A child protection plan should ensure that children who are likely to suffer significant harm are protected and that they and their families are receiving the services necessary to bring about the required changes in the family situation. At 31 March 2019, the rate of Newcastle children subject to a child protection plan stood at 101.1 per 10,000 (587 children). This was higher than the North East rate (63.1) and the England rate (43.7). Rates were relatively stable between 2010 and 2017 ranging from 57.7 (2013) to 76.2 (2015). However, rates have increased each year since 2017 in Newcastle, although they decreased in both England and the North East between 2018 and 2019 [57, 58]. Due to the low numbers involved, ward breakdowns of these figures are not published. (I have asked for these figures – March 2022). However, in general there is a relationship between higher levels of deprivation and higher rates of children in need of help and protection. Elswick and Benwell/Scotswood remain in the worst five Newcastle wards for children living in households experiencing poverty

57 Department of Education, 'Children in need and child protection', table B1, online here (accessed 31 March 2021: http://ow.ly/rUcm50Eu7mT Newcastle Future Needs Assessment City Profile – Updated April 2021 24

Figure 3.2-1 Children in Newcastle subject to a child protection plan in 31 March



Note: Categories given as the reason for the child protection plan are an 'on the day' count, and thus the data provide a snapshot picture at 31st March each year since 2010 (Regional-level North East data was not available in 2010, due to missing data from Durham.)

In Newcastle, 14,646 children were living in relative low income families in 2018-19, the equivalent of 28% of children. In terms of absolute low income, the number of children was slightly less at 12,072 (23%). Figure 2.2.2-1 shows that over the past five years there has been a consistent and marked rise in the relative low income measure, with the absolute measure also experiencing an increase, but to a lesser extent.

41 House of Commons Library, 'Poverty in the UK: statistics', 31 March 2021. Online at (accessed 19 April 2021): http://ow.ly/z4JC50Eu5NV 42 UK Statistics Authority, 'Code of Practice for Statistics'. Online at (accessed 19 April 2021): http://ow.ly/tAIi50Eu6Go

Ward-Level Statistics Wards that have a high proportion of children in poverty (under both relative and absolute measures) are clustered around the central area of Newcastle and include Byker, Wingrove, Benwell and Scotswood, Walker, Elswick, and Arthur's Hill. Table 2.2.3-1 shows that significant child poverty is evident in the latter two wards, where more than half of children may live in families below the poverty line, depending on the measure used.

Table 2.2.3-1 Worst wards in Newcastle – Relative poverty

Ward	Children living in households experiencing relative poverty
Elswick	56%
Arthur's Hill	51%
Byker	42%
Wingrove	42%
Benwell and Scotswood	35%
Walker	35%

Table 2.2.3-2 shows the proportions of children in these wards living in families below the poverty line when the absolute poverty measure is used.

Table 2.2.3-2 Worst wards in Newcastle – Absolute poverty

Ward	Children living in households experiencing absolute poverty
Elswick	48%
Arthur's Hill	43%
Wingrove	35%
Byker	33%
Benwell and Scotswood	29%
Walker	27%

Child protection assessments: role of health professionals

The assessment triangle in Working Together to Safeguard Children provides a model, which should be used to examine how the different aspects of the child's life and context interact and impact on the child. It notes that it is important that: "Assessment should be a dynamic process, which analyses and responds to the changing nature and level of need and/or risk faced by the child from within and outside their family. It is important that the impact of what is happening to a child is clearly identified and that information is gathered, recorded and checked systematically, and discussed with the child and their parents/carers where appropriate."

Assessment Triangle

3. Conducting Section 47 Enquiries

Where a decision has been made to undertake a joint interview with the child as part of the criminal investigations. Health professionals should: Undertake appropriate medical tests, examinations or observations, to determine how the child's health or development may be being impaired; Provide any of a range of specialist assessments. For example, physiotherapists, occupational therapists, speech and language therapists and child

psychologists may be involved in specific assessments relating to the child's developmental progress. The lead health practitioner (probably a consultant paediatrician, or possibly the child's GP) may need to request and coordinate these assessments; and Ensure appropriate treatment and follow up health concerns. All involved professionals should: Contribute to the Assessment as required, providing information about the child and family; and Consider whether a joint enquiry or investigation team may need to speak to a child without the knowledge of the parent or caregiver

EVALUATION OF A PROJECT TO IMPROVE CHILD HEALTH SERVICES IN A DEPRIVED URBAN AREA OF THE U.K.

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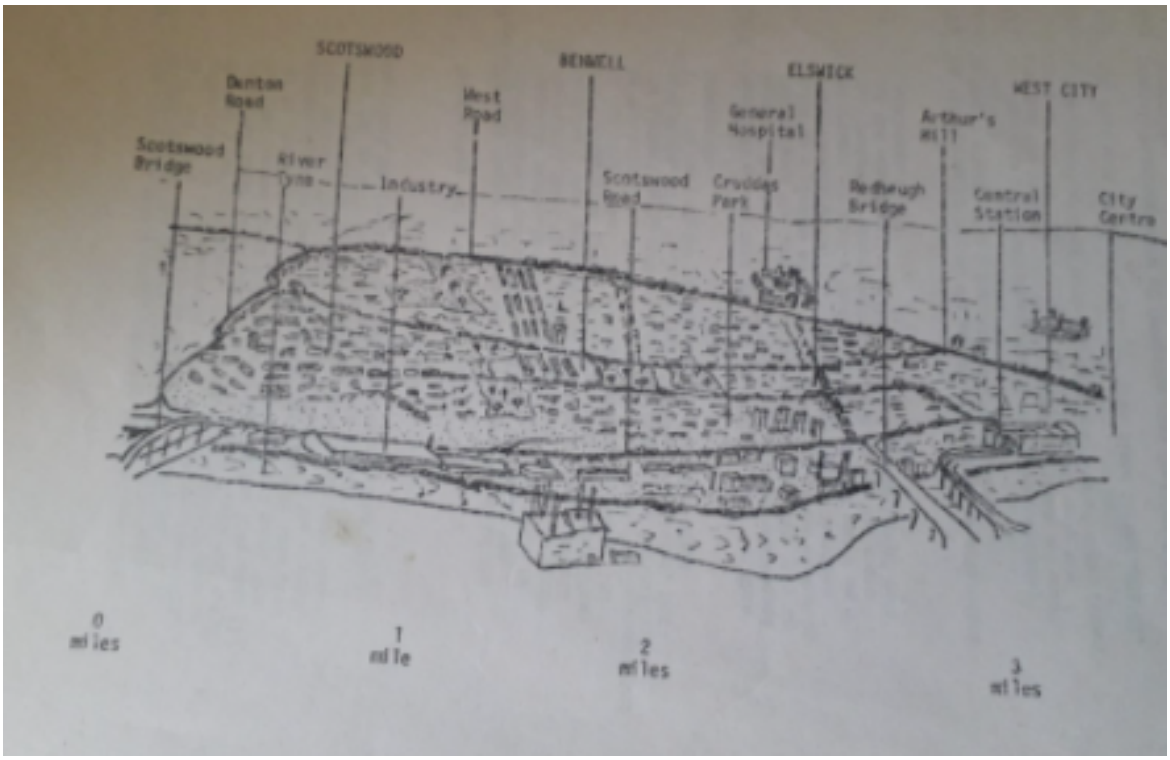
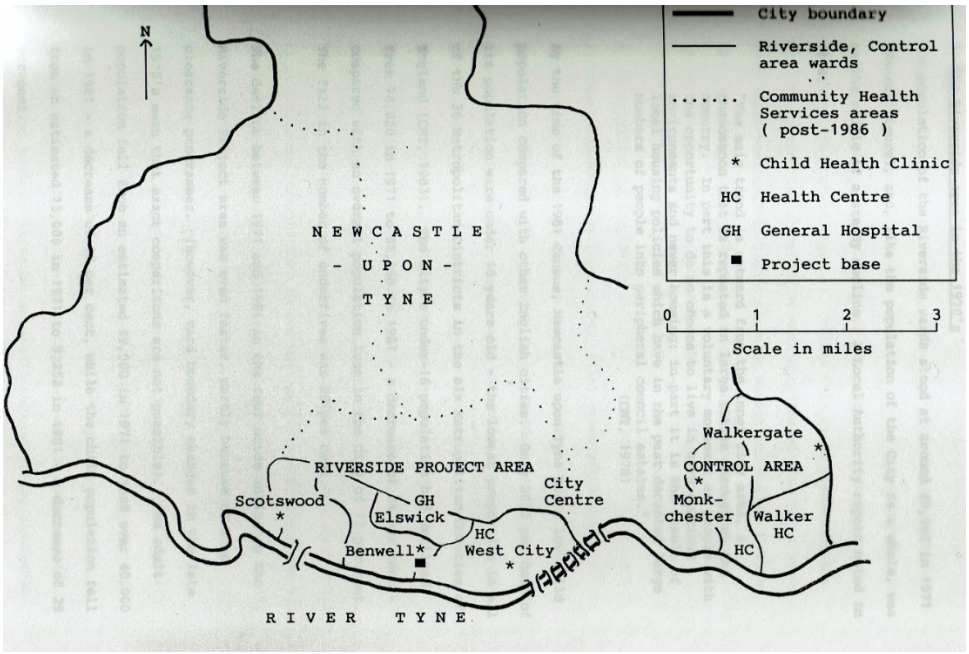
Thesis awarded as Master of Science in the Faculty of Medicine, 1991


SCOTSWOOD
Denton Road
West Road
BENWELL
ELSWICK
WEST CITY
General Hospital
Arthur's Hill
Scotswood Bridge
River Tyne
Industry
Scotswood Road
Crudgas Park
Redheugh Bridge
Central Station
City Centre
0 miles
1 mile
2 miles
3 miles

ABSTRACT

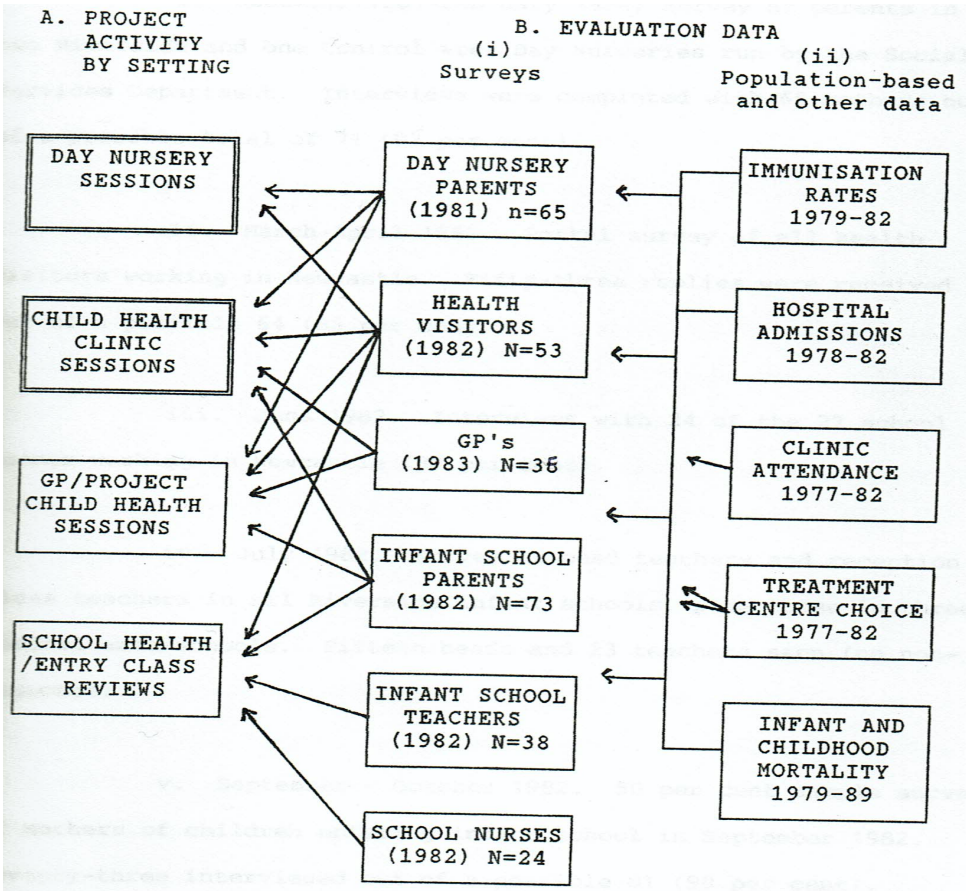
Following the publication of the Court Report on Child Health Services in 1976, a Project was established in Newcastle upon Tyne with the aim of implementing some of the Report's proposals on a local basis. A multidisciplinary team took over community child health services in an area of West Newcastle known to have particularly poor levels of child health and service use, as well as suffering from severe social and economic deprivation. This thesis presents an evaluation of the Project, using a range of measures and methodologies, and covering the period 1979 to 1989.

Measures include a number based on data covering the whole population, namely infant, post-neonatal and childhood mortality rates, hospital admission rates, immunisation rates, and measures of use of services. A number of process measures were also collected using interview and postal surveys of professionals and parents. The range of data was also collected for a control area in another part of the City (see map).



Many of the population-based measures indicated an improvement in child health and service use compared with the period before the Project was established, but not when compared with the control area. Responses from professionals and parents were generally favourable towards the work of the Project. It was concluded that while a causal link between the Project's activities and certain outcome measures could not be proven, it was likely to have influenced the level of attendance at clinics and GP child health sessions, the referral of children to hospital, the degree of inter-disciplinary cooperation and liaison, and the quantity and quality of contacts between providers and users of child health services in the area. It may also have contributed to the decline in post-neonatal mortality. The main qualifications relate to the limited success in involving GPs in preventive and developmental child health, and to the problems of evaluating this type of service initiative.

Figure 6.1 Flow Diagram of the Evaluation of Project Activity 1981-83



KEY: ▣ settings with medical, nursing and social/community work inputs.
□ settings with mainly medical and nursing inputs.

DISCUSSION*

(* adapted from Ch.11 of the 1991 thesis)

1. Introduction

In the first part of this thesis, an account was given of how the Court Report on Child Health Services, published in 1976, gave the impetus for the establishment of the Riverside Project in Newcastle three years later. The principles adopted by the Project owed much to the critique of current services and recommendations for change made in the Report, and were based on the

> "belief that some of the proposals by the Court Committee could be implemented on a local level". (Riverside Child Health Project Annual Report, 1980)

The Project's principles, aims and methods may be summarised as emphasising a locally based, multidisciplinary teamwork approach to providing child health services in an area of the City identified as deprived in terms of child health, service provision and socio-economic disadvantage. The Project aimed to provide extra medical and nursing input, encourage interdisciplinary and inter-authority integration and the involvement of families and the community in services, and to learn more about child health problems in such an area by acting as a research and training base.

The aims of the project refer to changing the process and structure of health services, and not specifically to outcomes such as improved child health, lower mortality, higher protection rates through immunisation, greater parental satisfaction with services, less absenteeism from school through sickness and so on. The Project was not set up as an initiative with aims which could be assessed according to a limited number of agreed criteria of success. That the approach adopted by the Project would be beneficial, not only in terms of its explicit aims, but also implicitly in terms of improved outcome for the health of the children in the area, was taken, at least initially, as read. It was not until the Project was established that consideration was given to its evaluation, and not until 18 months into its life that an appointment was made within the University of Newcastle upon Tyne Department of Family and Community Medicine with responsibility to provide such an evaluation. The problems faced were by no means unique to this Project: Smith and Cantley describe the difficulties in evaluating novel programmes in health and welfare services:

> "When setting up evaluative studies we discover the controls of the clinical trial are very seldom available. Frequently, also, the nature of the programme that is to be evaluated is unestablished at the start of the investigation and, anyway, it typically changes quite rapidly over time. This is especially true if it is a novel programme... Furthermore, since, frequently, it is not easy to locate any clear statement of the objective of a new programme and since there are variable views from different groups about what constitutes success in the programme's achievements, the evaluator has the problem of defining and selecting a criterion for evaluation". (Smith and Cantley, 1985)

The methodological approach recommended by Smith and Cantley involves the collection of a multiplicity of measures relating to a plurality of individuals and interest groups which, taken together, will help to explain how services function, the processes involved, and provide at least some conclusions about the success of the services on a range of criteria. In the absence of pre-defined criteria of success, evaluation of the Riverside Project was based on a range of measures selected for their relevance to child health and service use, sensitivity to changes brought about by the Project, comprehensiveness and feasibility of

collection. The measures were of differing character and foci, and sometimes direct relevance to child health outcomes had to be sacrificed for sensitivity, and vice versa. Thus clinics may be shown to be more popular and better attended because of the Project's involvement, without proving that the children's health had benefitted: conversely, infant mortality may have decreased, without identifying the Project as a clear cause or contributory factor.

The first step was to measure change: specifically, to establish to what extent progress had been made in the following four areas:

1. Improved infant and childhood mortality;
2. Improved morbidity and management of morbidity;
3. Better service use (e.g. immunisation uptake, clinic attendance) and increased parental satisfaction with services;
4. Evidence of greater integration of services (e.g. GP provision of child health services, school reviews), teamwork and parental involvement.

In the remainder of this Chapter, the results of the study are assessed under each of these four headings, together with a discussion of the validity of the findings.

1. Mortality

The use of mortality rates as an indicator of the Project's success has certain advantages: it is uncontroversial both in terms of its relevance to child health and in the interpretation of change as either desirable or undesirable; the statistics are universally and easily available, down to ward level, over a continuous sequence of years, and have good reliability. These features make possible comparisons with other areas, periods and even countries. Distinctions between mortality rates for different age groups, based on accepted definitions, may increase the sensitivity of the measure.

However, infant and childhood mortality rates in the population of an area the size of an electoral ward are based on small numbers of deaths, which may cause rates to fluctuate from year to year, reducing reliability and complicating comparisons between areas. It may also be argued that mortality rates may not be a sensitive measure with which to assess a service development predominantly in contact with a large number of children in non-critical situations such as routine clinic or school attendance. This, and the likelihood of other variables confounding any possible causal link between input and outcome, limit the validity of mortality measures.

The possibility that the Project may have helped reduce mortality in the area is based on the argument that certain potentially life-threatening conditions, such as gastro-enteritis and subsequent dehydration in infants, may be better detected, given more weight, and consequently better managed. This result may be achieved by earlier hospital admission, or management in the community, either directly through the activities of community based paediatricians, or through improved parental and professional awareness of symptoms, preventive and curative measures.

The evaluation used details of trends over 13 years in infant, post-neonatal and childhood mortality rates, comparing rates in the Riverside with those in the Control area, the City and nationally. By using averages over 3 year periods, the problem of year to year fluctuations is reduced, while retaining the ability to detect trends over the life of the Project.

Tables 2.1 to 2.3 show how infant and post-neonatal mortality rates were considerably lower in all of the three year periods of 1980-2, 1983-85, 1986-88 and 1987-89, compared with the period 1977-79 before the Project began. Infant mortality in 1987-89, the last

period used, was 9.4 deaths per thousand live births. This compares well with the rate of 8.8 for England and Wales over the same period. However, infant mortality rates are dominated by deaths in the first month of life, which are commonly related to prematurity and congenital factors outside the direct influence of community child health services. Post-neonatal mortality (deaths in the period between one and twelve months of age) is likely to be a more sensitive indicator of deaths with a social element in causation: the Riverside rate for 1987-89 was 4.2 per thousand live births, which also compares well with the national rate of 3.9. Rates for the Riverside remained high for the City of Newcastle however, especially when compared with the wards in East Newcastle selected as a control area, which achieved mortality rates better than the City average.

Table 2.1: Infant mortality by area: 1977-1989 (3 year averages)

	1977-9	1980-2	1983-5	1986-8	(1987-9)
Riverside area	21.8 (36)	13.2 (26)	10.4 (22)	12.5 (28)	9.4 (20)
Control area	18.7 (19)	5.2 (6)	4.6 (6)	8.4 (11)	4.7 (6)
Newcastle upon Tyne	13.9 (139)	9.5 (100)	8.7 (93)	8.3 (94)	7.4 (81)
England & Wales	13.3	11.3	9.7	9.3	8.8

Deaths in first year of life, expressed as a rate per 1,000 live births, aggregated for each 3 year period. Source: NRHA, OPCS Vital statistics for wards; Health and Ill-health in Newcastle upon Tyne, First Report of the Director of Public Health, NRHA, 1990. ( ) = N.

Table 2.2: Post-neonatal mortality by area: 1977-1989 (3 year averages)

	1977-9	1980-2	1983-5	1986-8	(1987-9)
Riverside area	10.3 (17)	5.6 (11)	3.8 (8)	5.4 (12)	4.2 (9)
Control area	6.9 (7)	0.9 (1)	0.8 (1)	0.8 (1)	0.8 (1)
Newcastle upon Tyne	6.0 (60)	3.4 (36)	3.0 (32)	2.8 (32)	2.4 (26)
England & Wales	4.5	4.5	3.4	4.2	3.9

Deaths between 28 days and 1 year of life, expressed as a rate per 1,000 live births, aggregated for each 3 year period. Source: NRHA, OPCS Vital statistics for wards; Health and Ill-health in Newcastle upon Tyne, First Report of the Director of Public Health, NRHA, 1990. ( ) = N.

Despite the improvements in mortality rates since the Project's inception, it remains relevant to point out that mortality was still much higher in the Riverside than in the City as a whole. One third
of the deaths of infants aged one to twelve months during the years 1986-89 came from an area with fewer than one fifth of the City's births.

Table 2.3 shows deaths between one and fourteen years for the resident population of that age group. These rates are based on low numbers of deaths (generally no more than around two per year on average for the Riverside and Control areas) and the most common cause of childhood deaths is accidents (NCB, 1987). Unlike infant and post-neonatal mortality rates, there was no clear downward trend over the thirteen year period in the Riverside, Control area, or indeed in the City. It could be argued that such a low level of mortality through disease may be susceptible to improvement for only certain conditions on rare occasions, which would not show an effect on statistics for small-area, or even city-wide, populations.

Table 2.3: Childhood mortality by area: 1977-1989 (3 year averages)

	1977-9	1980-2	1983-5	1986-8	(1987-9)
Riverside area	0.19 (5)	0.29 (7)	0.44 (10)	0.19 (4)	0.19 (4)
Control area	0.34 (7)	0.23 (4)	0.20 (3)	0.40 (5)	0.32 (4)
Newcastle upon Tyne	0.28 (48)	0.24 (34)	0.29 (40)	0.28 (34)	0.34 (42)
United Kingdom	0.34	0.31	0.28	0.26	0.25

Deaths 1-14 years of age per 1,000 resident population. UK figures are for 1978, 1981, 1984 1nd 1989 respectively. Area population estimates for 1-14 age group are based on 1981 Census and CNT estimates. Sources: Urban Trends, CNT, 1978; city Profiles, CNT, 1981 and 1986; The City's Population, CNT, 1986; OPCS Vital statistics for wards,; Key Population and Vital Statistics: Local Government and Health Authority areas, England and Wales (series VS, HMSO); Annual Abstract of Statistics, 1989, Central Statistical Office, HMSO. ( ) = N.

3. Validity of mortality data

It has been argued that of the three measures of mortality discussed, infant mortality was largely outside the possible influence of the Project, and childhood mortality based on such small numbers as to make measurement of trends unreliable. Post-neonatal mortality, while still suffering from the problem of small numbers, has at least face validity, in that it is both relevant to the evaluation and potentially sensitive to the Project's activities. Attendance records for Child Health Clinics show that most children attending are under 1 year, with few attending after 18 months (source; NHA). The post-neonatal mortality rate was considerably higher in the Riverside than in the Control area or in the City before the Project began. There is a possibility therefore that the work of the Project influenced the 50 per cent reduction in post-neonatal mortality rates in the ten years between 1977-79 and 1987-89.

Without analysis of cause of death, or ideally, in-depth studies of the medical and service-contact histories both of fatal and non-fatal cases of identical conditions in matched children, no clear causal link between this lower level of mortality and the Project's work can be assumed. Furthermore, with no such link it would be invidious to deny the

contribution of local GPs, Health Visitors and hospital staff when discussing the role of health professionals in reducing mortality rates. The problem of untangling causal factors in changes in infant mortality was also encountered in a study of post-neonatal mortality in Nottingham (Madeley et al, 1986). The study aimed to reduce the number of infant deaths by assigning risk scores to new born babies, and following up the high-risk group with intensive health visiting.

Although post-neonatal mortality fell from 8.7 to 3.6 per thousand, there was no evidence that the intervention had increased the already established decline, or that deaths from particular causes had declined disproportionately. The Riverside Project, of course, was neither as focussed as this study, nor established with a built-in evaluation component.

4. Morbidity

The measure of morbidity used in this study is based on analyses of records - in this case - hospital admission notes - which, as Mechanic (1968) points out, may be biased through various factors which operate on the selection of people into hospital care, including service availability, referral practices and admission policies, changes in parental awareness and behaviour relating to child health, as well as of course changes in morbidity in a population. As a result, it is not completely clear what is being measured by admission data. Furthermore, as these data are not routinely available on a ward population basis, they cannot be used to generate statistics covering the whole of the Project's life in the same way as for mortality figures. If the specificity of the measure is less clear than for mortality rates, its sensitivity may be greater, given the greater number of health events involved, and the possibility that changes in detection of conditions in the community and in the management of those conditions may be reflected in patterns of admission over time and in comparison with those from the Control area.

In the five years for which hospital admission data are available, there was a clear jump in the frequency with which under-fives from the Riverside were admitted to hospital (Table 4.1). This increase began before the Project was established, and was mirrored to some extent in the Control area (though not in the City as a whole). In both areas, most of the increase related to children aged 1 to 4, rather than to babies under 12 months old (Table 4.2).

Table 4.1 Hospital Admission of Under-fives by area, 1978-82 (rate per 1,000 resident under-fives.

	1978	1979	1980	1981	1982
Riverside area	135	158	170	198	152
Control area	98	98	119	155	107
Newcastle upon Tyne	81	91	89	83	N/A

Area population estimates for 0-4 age group are based on 1981 Census and CNT estimates. Sources: hospital ward admission books; Hospital Activity Analysis returns, NRHA; Urban Trends, CNT, 1978; City Profiles, CNT, 1981 and 1986; The City's Population, CNT, 1986; OPCS Vital Statistics for wards,; Key Population and Vital

Statistics: Local Government and Health Authority areas, England and Wales (series VS, HMSO); Annual Abstract of Statistics, 1989, Central Statistical Office, HMSO. ( ) = N.

Table 4.2: Hospital Admissions of Infants under 1 year old by area, 1978-81 (per 1,000 live births).

	1978	1979	1980	1981
Riverside area	307	322	334	365
Control area	270	267	252	317

Sources: hospital ward admission books, NRHA; OPCS Vital statistics for wards.

Analysis of Riverside admissions showed an increased rate of admission of cases relating to conditions with a social causation - respiratory infections, diarrhoea and vomiting, social admissions and non-accidental injury, and infant feeding problems (Table 7.6). Such conditions could be held to be open to differing medical assessment, and therefore vulnerable to the specialised contribution of paediatricians in the Project. Admissions due to injuries and ingestions are more likely to be emergencies, and so less likely to involve contact with the Project team, or indeed primary care services in general. The rate of admission for such causes was relatively stable over the period. Admissions for congenital conditions rose; some of these may have been suspected rather than confirmed, as the incidence of most congenital conditions is relatively stable in a population. It is also important to view the trends in hospital admission in conjunction with those in infant and childhood mortality. While more children from the area were being admitted to hospital, fewer (at least very young children) were dying.

5. Validity of morbidity data

The potential weakness of the morbidity data presented in this work lies in the internal validity of the measure itself, i.e. whether hospital admissions actually reflect morbidity rates; and in the identification and control of confounding factors. While the second problem may be reduced by comparison with the Control area, this does not necessarily guarantee that potentially confounding factors are not operating differently in the two areas. (An example of this is given by the discovery that a sudden and sustained fall in infant admissions from one locality in the Control area was due to the decision of a consultant paediatrician to move his weekly community session to a peripheral housing estate).

The problem of the internal validity of the measure is illustrated by the quite feasible explanation that paediatricians in the Project team had a certain control over beds in children's wards, and would tend to fill them with children with whom they came into contact. On the other hand, children in areas seen by doctors with no such command over resources may be less likely to be admitted. In other words, the Project had redefined the criteria for hospital admission for some of the city's children but not for others, and so had shifted the balance of available resources in favour of children from the Riverside.

The relationship between morbidity and hospital admission data is a facet of a more general problem of reliably defining and recording morbidity. Given the apparent elasticity of need (or eligibility) for hospital admission from areas like the Riverside, it may be that the main value of the measure is in reflecting service use, or more specifically, doctor/patient contacts and resource mobilisation. However, the point that the Riverside Project was

established in an area of poor child health (partly assessed through the rate of hospital admissions) may be used to justify this "positive discrimination" towards the children of the area. In addition, the implication of MacLure and Stewart's findings (1984) is that a high level of hospital admissions is to be expected from severely deprived areas, and it could be argued that the pre-Project level of admissions from the Riverside area was inappropriately low. If it can be assumed that the new high level of admissions was appropriate to the prevalence of health problems amongst children in the area, then this result can be interpreted as evidence of success.

The strongest evidence for the validity of the data, as opposed to the measure - that is, in terms of the Project influencing the level of hospital admissions, whether or not this reflects morbidity - comes from analysis of admissions of children registered with the four practices working closely with the Project. Table 8.5 shows a very large increase in these admissions in 1981, in contrast to the pattern in a nearby comparable practice. In the face of this and other evidence, it would seem justifiable to conclude that the Project's work in clinics and with local GPs had had a significant effect on admissions from the area. This may imply, although this is more arguable, an improvement in the level of detection of morbidity.

The reduction in admissions which followed in 1982, at least for some conditions, still left admissions from the four practices working with the Project higher than those from other Riverside area practices. One possible explanation for this reduction is that, with increasing expertise, more acute episodes were managed in the community.

6. Service Take-up: Immunisation Rates

Immunisation rates may be viewed both as an outcome measure, in that the "herd immunity" of a population to disease represents a positive gain in health, and of process, in terms of increased level of contacts with health services and therefore of opportunities to give advice, raise problems and build relationships between professional, parent and child. In recent years, considerable effort has been placed in making childhood immunisation records accurate and complete, mainly in order to maximise uptake, through for example, the computer-generated issue of appointment cards. This increased accuracy also enables year on year and area comparisons of performance to be made. Given that rates are based on high proportions of the population, the problems of small numbers that make the interpretation of mortality figures difficult, do not arise.

Problems in interpreting trends in immunisation rates come from the variety of factors which may affect uptake. Improved records and appointments systems, advice given at ante-natal and post-natal consultations, level of payments to GPs, fears of side-effects, epidemics of the disease or of other infections, variations in policy and practice regarding the giving of vaccines to children with certain infections or other conditions, and the effort and organisation invested in follow-up of non-attendance, are all likely influences. The Riverside Project's policy was to use immunisation appointments as an opportunity to hold a wider consultation with the parent, and to this end introduced a system of spreading immunisation appointments within routine clinic sessions, rather than running special immunisation session perhaps once a month.

Table 6.1 shows that the early years of the Project saw a steady improvement in the protection rate in the child population of the area, although it was still several percentage

points lower than in the Control area and in the City. Interpretation of these results is complicated by the fact that protection rates were recovering at this time from the scare over the safety of the pertussis vaccine.

Table 6.1 Immunisation Rates by Area and Year of Birth

	Protection rate for 1979-born children after 2 years		Protection rate for 1980-born children after 2 years	
	Diphtheria & Tetanus	Pertussis	Diphtheria & Tetanus	Pertussis
Riverside area	69.5%	42.3%	75.4%	51.4%
Control area	74.4%	43.4%	85.3%	58.1%
Newcastle upon Tyne	77.6%	47.2%	82.7%	57.3%

Source: NRHA Computer Files

Table 6.2 compares rates for those children using a GP/Project team as their treatment centre, and those using child health clinics, and shows that the former group compared well on its level of protection with all children in the City. Nevertheless, the children in the Control area had consistently better levels of protection.

Table 6.2 Immunisation Rates by Treatment Centre, Area and Year of Birth

Treatment centre/ area	Protection rate for 1979-born children after 2 years		Protection rate for 1980-born children after 2 years	
	Diphtheria & Tetanus	Pertussis	Diphtheria & Tetanus	Pertussis
GP/Project sessions	74%	45%	81%	56%
Riverside clinics	70%	44%	75%	49%
All R'side children	70%	42%	75%	51%
All Control children	74%	43%	85%	58%
Newcastle children	78%	47%	82%	57%

Source: NRHA computer files. Note : numbers of Riverside children using the four GP/Project practices as their treatment centre were 55 (1979 births) and 94 (1980 births).

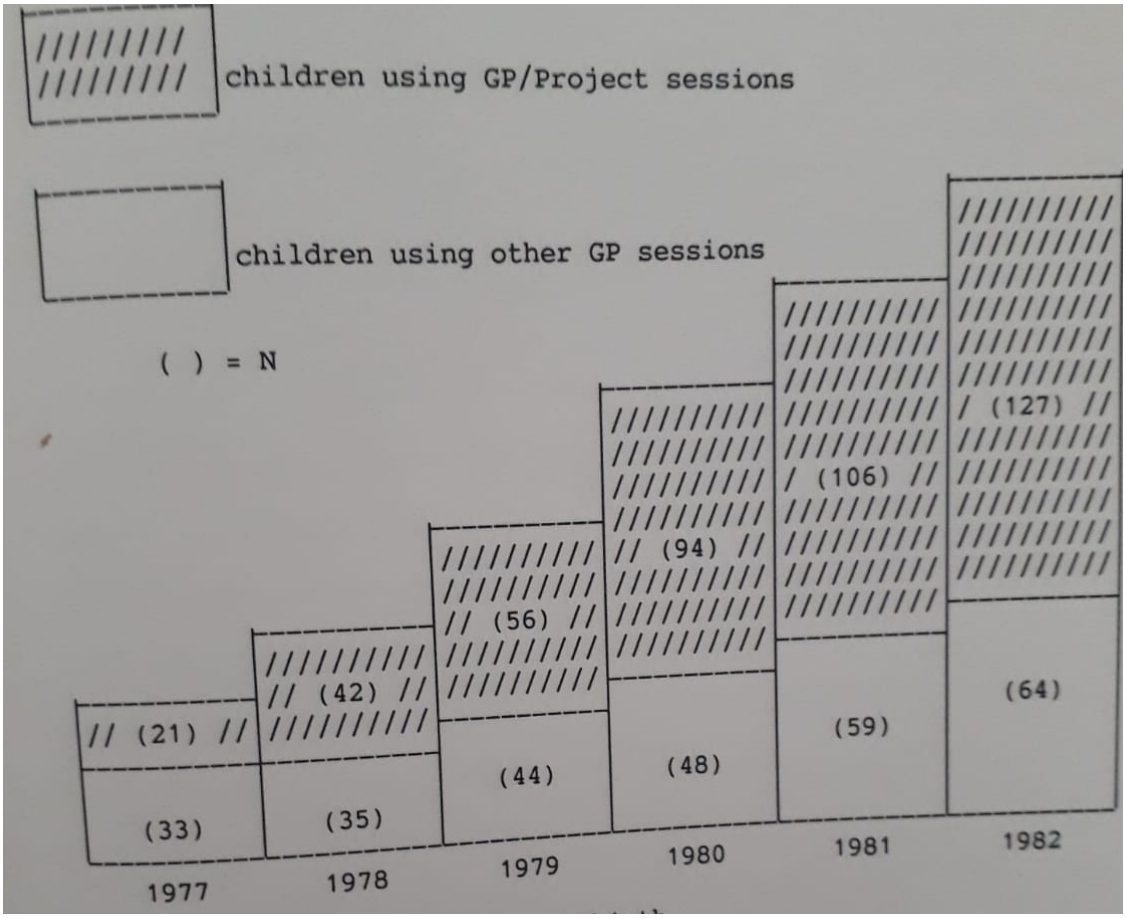
Source: NRHA Computer Files. Note: numbers of Riverside area children using the 4 GP/Project practices as their treatment centre were 55 (1979 births) and 94 (1980 births)

The relationship between immunisation uptake and social conditions is discussed in a study by Jarman *et al* (1988), who argue that comparisons of rates between areas should be adjusted to control for variations in social conditions. The implication of this argument for

this study is that, given the extreme level of deprivation in the Riverside area wards, the evidence of improvements in protection rates in the area should not be assessed by direct comparisons with less deprived areas or with City-wide or national figures.

7. Service Take up: The Use of GP/Project Child Health Sessions and Child Health Clinics
The percentage of local babies recorded as using their local GP as a treatment centre for immunisations and developmental checks rose from 11 per cent of all live births in 1979 to 30 per cent in 1982 (Figure 7.1).

Figure 7.1 Riverside area Children using GP Child Health Services 1977-1982 (*ie* GP recorded as treatment centre)



Much of this increase was due to greater use of four practices which had established regular joint child health sessions with members of the Project team. Children using these sessions had a higher level of protection against diphtheria, tetanus and whooping cough than did other children in the area, and also they were more likely to be admitted to hospital. At the same time, attendances were up in the three local child health clinics run by the Project, mainly through more frequent attendance of the same children rather than through an overall increase in attenders (Table 7.1).

Table 7.1 Child Health Clinic Attendance by area, 1977-82

	1977	1978	1979	1980	1981	1982
Riverside clinics						
Average No. of sessions/clinic	61	71	72	72	72	80
Average attendance per session	31	29	30	34	30	30
Rest of City clinics						
average No. of sessions/clinic	63	65	64	65	62	64
Average attendance per session	27	26	26	27	25	24

Source: Community health Sector, NHA.

Similar results were achieved in a study of an inner city child health clinic in Nottingham which adopted a community paediatric team approach (Nicoll et al, 1986). The CMO's work was moved away from routine surveillance towards seeing children referred by parents and professionals, while the Health Visitors took on more responsibility for child health surveillance. The staffing for each session was organised so that families attending a particular session during the week would be seen by the same team. Limited drug dispensing facilities were agreed with local GPs (an issue faced but not resolved in the Riverside Project). Routine medicals after 18 months of age were abandoned.
The re-organisation led to significantly older children attending the clinic, and most of the children requiring follow-up for medical conditions were over 1 year old. Overall, there was a higher level
of detection of treatable medical disorders. The study also reports greater cooperation with GPs based in the health centre which houses the clinic, and more efficient use of doctor's time.

8. Validity of service use data

As with hospital admissions, there remain potential uncontrolled factors which may confound the apparent relationship between the Project's work and trends in immunisation rates, and clinic and GP child health session use. For all these measures however, there is corroborative evidence from survey material - for example, Health Visitors' views on the organisation of immunisation sessions, or
those of parents on their use of clinic and GP services - which helps to strengthen and clarify the relationships. From the methodological stance of Smith and Cantley (1985), summarised above, this range of sources, reflecting the different interests of both professional and non-professional groups, can be said to give a greater degree of meaning to the evaluation of the Project's impact.

9. Integration and teamwork

The evidence from the Riverside evaluation confirms that contact with community based child health services, whether supplied by GP or clinic, increased after the establishment of the Project and the beginning of its co-operation with some local practices. In terms of the fourth criterion of success, that of assisting the integration of services particularly through the development of GP child health provision, the early progress represented by the establishment of four joint child health sessions, and their popularity with local parents, was not built upon. No other practices started similar co-operative initiatives, and the choice of using their GP for curative, preventive and developmental services remained available only for a minority of Riverside children. Evidence reported in chapters 9 and 10 supports the claim that the integration of services improved in the clinic and school settings covered by the Project. The comments of school nurses, Health Visitors, teachers and parents reflect the changes in structure brought about (e.g. the primary school intake review system) and the general agreement that the process of child health care had benefited. Callaghan and Colver (1987) support the view that routine school entry medicals are an ineffective and inappropriate use of doctor's time, and argue that their abandonment allows more time for selective support of children in school.

The policy of the Project towards greater selectivity in place of routine screening led increasingly to the Project's intensive involvement (by no means solely medical in nature) with a relatively small number of vulnerable families. This work has implications for the prevention and management of child abuse in the area. A useful area of further evaluation would be to assess the impact of this work on the level of child abuse and the numbers of children taken into Local Authority care.

Many of the comments of professionals given in chapters 9 and 10 stress the value placed on improved communication and teamwork brought about by the Project. Without evidence of this aspect of health service provision in the area before the Project was set up, no more objective measure of this change can be established. Certainly, few Health Visitors or nurses from outside the Riverside area who took part in these surveys were critical of the lack of teamwork in their area. In 1986 the principle of multidisciplinary teamwork was accepted by Newcastle Health Authority as an appropriate strategy for the development of community health services. The staff employed by the Health Authority with the Project team became the Central Child Health Team (Riverside), with responsibility for an extended area, within a pattern of four such area based multi-disciplinary teams (see map above). The integration of a Project such as the Riverside into mainstream service provision (and mainstream funding), with the adoption of many of its principles and methods of working, is in itself a measure of success. The Project itself continued as a locally managed initiative, funded mainly by the Save the Children Fund, working alongside and with the full involvement of the Riverside Team.

10. Validity of survey data

The question marks concerning the validity of the survey data presented here are different from those hanging over the interpretation of the mortality and morbidity data. They involve methodological issues like the presence of bias in the selection of respondents, the danger of leading questions, and the possibility that responses may have been different if the survey was repeated or

timed differently. Most of the surveys did not use samples, but rather focussed on parents and professionals most involved in the use or supply of child health services, either in the two areas, or in the City as a whole. The possibility that responses may change over time is one which is inevitable in a one-off survey design focussing on an on-going service initiative. The strength of the data rests on the capacity of the surveys to focus on specific aspects of the Project's work, and to reflect the views of the respondents on its effect on their activities, knowledge, satisfaction with services, and on the health of local children.