[Report of the Medical Officer of Health for London County Council].

wellcome collection

Wellcome Collection
183 Euston Road
London NW1 2BE UK
T +44 (0)20 7611 8722
E library@wellcomecollection.org
https://wellcomecollection.org

LONDON COUNTY COUNCIL

Report of the County Medical Officer of Health and School Medical Officer for the Year 1952

Published by the London County Council
and may be purchased, either directly or through any bookseller, from
Staples Press Limited, Mandeville Place, London, W.1, agents for the sale of the publications of the
London County Council
1953

No. 3827 2s. 6d. Postage extra

LONDON COUNTY COUNCIL

Report of the County Medical Officer of Health and School Medical Officer for the Year 1952

By J. A. SCOTT, O.B.E., M.D., M.R.C.P.

COUNTY MEDICAL OFFICER OF HEALTH AND SCHOOL MEDICAL OFFICER

THE COUNTY HALL
WESTMINSTER BRIDGE, S.E.1

A*

CONTENTS

	Page
Introduction	3
Vital Statistics	4
Population	4
Fertility	5
Mortality	7
Infectious diseases	16
General Public Health	23
Housing	23
Tuberculous milk	24
Sanitary inspection	25
Blind persons	25
Registration of nursing homes	26
Welfare Committee establishments	27
Chronic sick	27
Chemical Branch	28
Special Survey of Health Services	35
Health Service Premises	42
Care of Mothers and Young Children	50
Expectant and nursing mothers	50
Child welfare	52
Premature infants	53
Marriage guidance	55
Day nurseries	55
Children neglected or ill-treated in their own homes	57
Unmarried mother and her child	58
Domiciliary Midwifery Service	60
Health Visiting and Nursing Services	68
Home Nursing	73
Domestic Help Service	78
Immunisation and Vaccination	80
London Ambulance Service	83
Prevention of Illness: Care and After Care	90
Tuberculosis	90
Foot clinics	97
Venereal disease	97
Recuperative holidays	98
Health education	99

	Page
Mental Health Service	104
Staff	104
Co-ordination	105
Voluntary associations	106
Prevention of illness	106
Lunacy and Mental Treatment Acts	107
Mental Deficiency Acts	109
School Health Service	115
Organisation	115
Medical inspections	116
Medical treatment	120
Audiology centres	123
Bathing centres	124
Infectious diseases	124
Rheumatism scheme	125
Psychiatry	126
Speech therapy	128
Remedial exercise classes	129
Handicapped children	129
Epileptic children	129
Diabetic children	130
Children under five years	130
Dental services	131
Staff	135
Special investigations	136
Finance	138
Visitors to the Department	139
Reports by the Divisional Medical Officers	140
Appendix	151
(A) Deaths and Sickness in London, December, 1952	151
(B) Poliomyelitis and inoculations	163
(C) Statistical tables	172
(D) Staff of the department	192

(W. & S. Ltd. 60324) 27.11.53 123997

INTRODUCTION

THIS REPORT, which records the activities of the Department for the year 1952, comes at the end of four and a-half years' experience of the working of the National Health Service. In accordance with the request of the Ministry of Health a special survey of this Service was carried out and the findings are included in the report. General comments on administration, co-ordination and co-operation with other services and the use of voluntary organisations are given on page 35 while comments on the individual services are included in the appropriate sections.

The other outstanding event of the year was the enormous mortality associated with the fog period of December which in a space of a week contributed an extra 0·5 per thousand population to the year's total death-rate. A detailed statistical account of this catastrophe is given in Appendix A, page 151. But for this sudden increase in the number of deaths in December the total rate would have been back to approximately the 1950 level of 11·3 per thousand compared with 12·6 in 1951 and 12·0 in 1952 (page 8).

The year 1952 was also the first year of the tripartite arrangement in Division 9 whereby the divisional medical officer is also medical officer of health for the two metropolitan boroughs constituting the Division. This interesting experiment in the co-ordination of the personal and environmental health services will be closely watched ; already after but one year's experience it appears very promising.

The birth-rate (15·3 per thousand population) was slightly lower than in the previous year (15·6) (page 6).

The death-rate from cancer, which is at 2·30 the second leading cause of death in London (diseases of the heart being the first), continues to show a slight increase (page 9).

Infant mortality was again lower at 23·1 per thousand live births (25·4 in 1951). The neo-natal rate (deaths in the first four weeks of life) dropped to 15·8 per thousand live births, a new low record for London (page 12).

The number of confirmed notifications of poliomyelitis, 309, which was higher than in 1951 (112) was considerably lower than for the epidemic years of 1947, 1949 and 1950 (page 20). An analysis of the 1949 epidemic in its relationship to previous inoculation is given in Appendix B, page 163.

The Council's first comprehensive health centre, at Woodberry Down, was completed in September, and the ceremonial opening was performed on 14th October. A summary of the accommodation provided will be found on page 48. The centre has attracted many visitors ever since its opening, over 600 visiting before the end of 1952.

The number of pregnant women making at least one attendance at a Council ante-natal clinic continues to decline (page 50). It is believed that the other women receive advice either from their family doctor or from the hospital which they propose to enter for the confinement. The percentage of children attending a Council child welfare centre at least once in the first year of life remains fairly constant, more than eight out of every ten attended last year (page 52).

The demand on the services of the District Nursing Associations, who carry out home nursing on behalf of the Council, continues to increase, over 1,600,000 visits being paid last year—an average of fourteen visits daily for each nurse (page 73). The demand on the Domestic Help Service continues to grow, nearly 28,000 cases being assisted last year.

A regrettable feature in the Council's campaign for immunisation against diphtheria is the continued drop in the estimated percentage of children under five years of age who have been immunised. It is now only 50·2 per cent. Efforts are being made to increase this percentage (page 80).

During the year the Department was co-operating in five research projects, and details of them are given on page 136.

VITAL STATISTICS

Population

THE TOTAL home population of the County in the middle of 1952, according to the Registrar-General, was 3,363,000, compared with 3,358,000 in 1951.

Corresponding estimates for metropolitan boroughs are shown in Table 2 on page 173 and the rates given in this annual report are calculated upon these figures.

Table 1 shows the age distribution of the population, as estimated by the Registrar-General, at the middle of each census year since 1921 and of each more recent year. The total numbers have now been fairly stable for several years at about 3⅓ million, a figure considerably lower than the 4½ million odd which was the size of the County's population for the first twenty-five years of this century. It would be rash, however, to make any prediction as to how these numbers will vary in future. The population of the County of London, as is probably the case with the central area of any other great conurbation, differs from the population of the country as a whole, in that the effects of migration upon its constitution are constantly present and far from negligible ; changes in the pattern of migration, which can easily occur on a large scale in such an area, may have very rapid effects. The large movements of population, to which London has been subject since 1939, have, however, left unaffected one of the more important contemporary aspects of population change—the constantly increasing proportion of elderly people. The figures below, based on the Census reports, show the proportion of the total population of London aged over 65 to have risen from just over 4 per cent. in 1901 to over 11 per cent. in 1951, and this rise follows, slightly more steeply, the corresponding rise in the country as a whole.

Percentage of total population aged over 65

	1901	1911	1921	1931	1951
London A.C.	4·09%	4·89%	5·80%	7·32%	11·06%
England and Wales ..	4·67%	5·21%	6·05%	7·42%	10·90%

Migration

In the report for 1951 detailed estimates were given, by kind permission of the London Transport Executive, of the diurnal movement into and out of the central areas of the County ; the publication of the London volume of the 1951 Census, which is expected soon, will, it is hoped, as in the 1921 Census, provide an even more detailed picture of that part of the daily movement contributed by travel to and from work. It does not need emphasising that a daily influx on the scale which is characteristic of London affects considerably the epidemiological characteristics of the area ; nor should it be forgotten that many of the Health Authority's services are provided to the day time, no less than to the resident, population.

The resident population itself is subject to a continuous process of change by families moving house into, out of and within the County. The total number of families who move in a year is unknown ; but among children under five there are currently at least 30,000 movements a year, which is about 12 per cent. of the population under five, and represents change of residence by about 24,000 families ; these movements show a net balance of about 4,000 children a year outward from the County, or a net loss each year of 2 per cent. of the population under five. The net percentage rates of migration of children of school age can be deduced from the table below which shows for each year of age the difference between the number on school rolls in January, 1952, and in January, 1953, expressed as a percentage of the numbers in January, 1952.

London A.C.

Net decrease (—) in numbers of children in school between January, 1952, and January, 1953, as percentage of numbers in January, 1952

Age last birthday January, 1952	*Net decrease*	*Age last birthday January, 1953*
5	— 3·3%	6
6	— 1·4%	7
7	— 1·6%	8
8	— 1·0%	9
9	— 1·5%	10
10	— 0·5%	11
11	— 0·1%	12
12	— 0·4%	13
13	— 2·1%	14

Since the values of q_x* at these ages are less than 0·002 the major part of this decrease represents the net migration among children of these ages. The same calculation for 1950/51 and 1951/52 show very similar results. In short, at all ages from birth to ten years old there is a constant net movement of children out of the County, such that at the age of ten only about 83 per cent. of the life table population of the County are in fact residing there ; thereafter the net movement seems at present to be small until just before school leaving age. These movements of children presuppose corresponding movements of their parents and if, as is currently the case, the total population of the County remains fairly stable, these net outflows must be balanced by net inward movements, presumably among young adults. This hypothesis is lent support by the table below which shows the comparative age distribution of the population of England and Wales and London A.C. in 1951.

Persons at various ages per 1,000 *total population. 1 per cent. sample, 1951 Census*

Age Group	*England and Wales*	*London A.C.*	*Excess (+) or defect (—) London A.C. over England and Wales*
0–	85	83	— 2
5–	72	64	— 8
10–	65	51	— 14
15–	62	49	— 13
20–	66	75	+ 9
25–	75	89	+ 14
30–	70	81	+ 11
35–	76	82	+ 6
40–	77	77	0
45–	241	239	— 2
65–	111	110	— 1
All ages–	1,000	1,000	0

Since 1940 the crude live birth-rate in London has been substantially the same as in England and Wales ; for a number of years before that date it was between 10 per cent. and 15 per cent. lower. The defects in the London population at the younger ages are, therefore, a true reflection of the effects of net outward migration at or below these ages and the excess at the young adult ages considerably understates the amount of net inward migration at these ages.

Fertility

The total births allocated to London for 1952 were :

Live	51,558
Still	1,008
Total	52,566

* *Probability of dying within one year.*

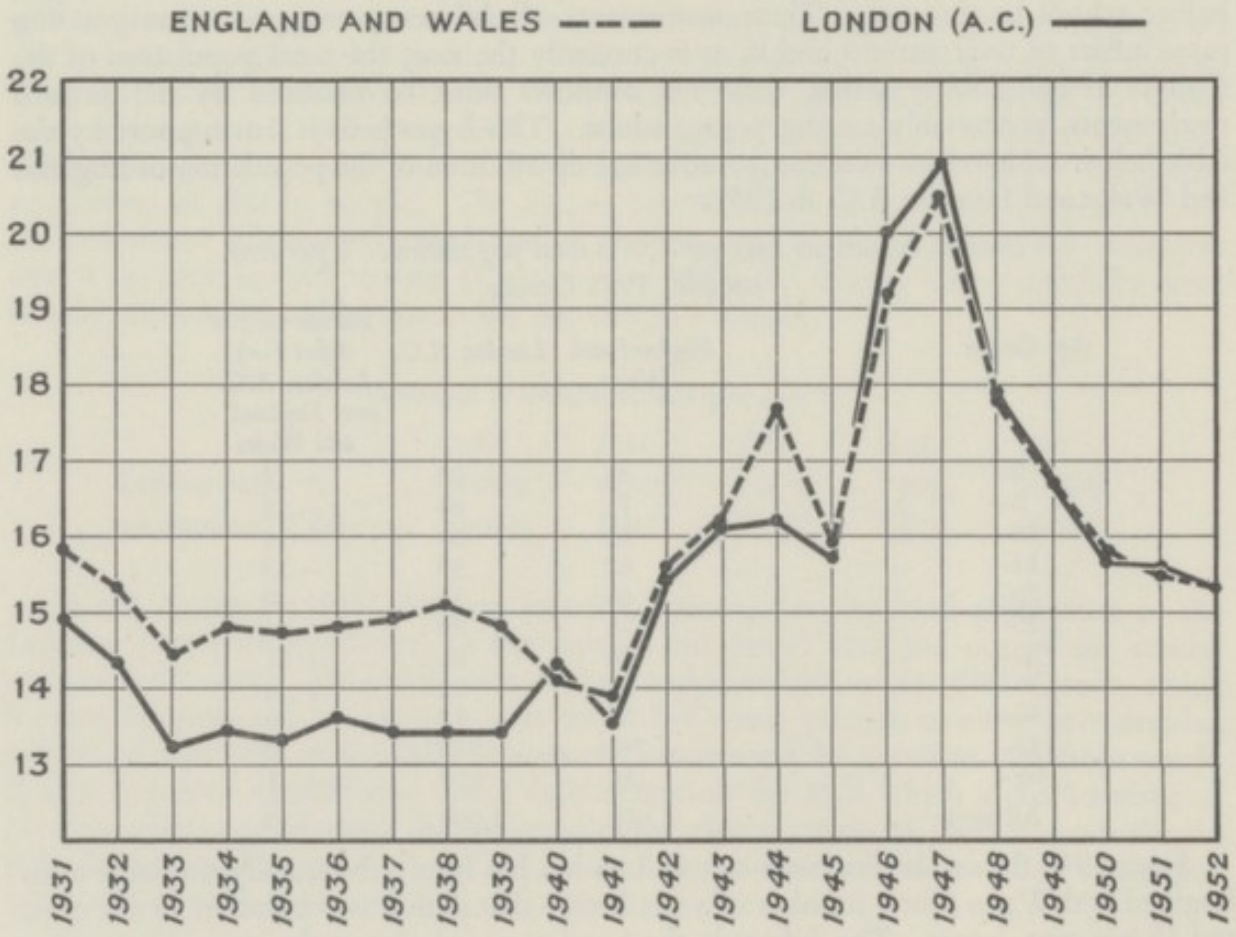
The live birth-rate in 1952 was 15·3 per 1,000 total population, compared with 15·6 in 1951. Births allocated to London, i.e., those of mothers residing within the County, are less than those actually registered as occurring in the County owing to the fact that a number of mothers come to London to be confined in hospitals and nursing homes. This excess of registered over allocated births amounted to some 7,900 births in 1952. The corresponding figure in 1951 was 7,700

The number of marriages registered in London in 1952 was 33,482, or 19·9 persons married per 1,000 of the total population, compared with 20·6 in 1951.

The birth-rate in London tends to follow the same trend as for the country as a whole. The diagram below shows the course of the two rates since 1932. The actual rates for London are given in Table 5 (page 176).

LIVE BIRTH RATE IN ENGLAND AND WALES AND LONDON (A.C.) 1931-1952

PER 1,000 TOTAL POPULATION



Although the live birth-rate per 1,000 total population in 1952 was the same in London as in England and Wales, London's population has a greater proportion of women of child-bearing age. If the live births be expressed as a rate per 1,000 women aged between 15 and 45, the figure for London is 65 as compared with 71 for England and Wales, showing London women to be substantially less fertile than the female population as a whole. In view of the considerations brought forward in the next paragraph, the difference in fertility is probably even greater than the figures imply.

There were 3,577 illegitimate live births (6·9 per cent. of the total live births). The percentages in recent years are : Illegitimacy

Year	London A.C.	England and Wales
1938–42	6·6	4·7
1943	8·2	6·3
1944	9·3	7·2
1945	11·4	9·4
1946	8·0	6·7
1947	6·7	5·3
1948	7·0	5·4
1949	6·9	5·1
1950	7·0	5·1
1951	6·9	4·7
1952	6·9	4·8

The peak of the war-time rise occurred in 1945, with a rapid reduction after the end of hostilities. The Registrar-General has demonstrated in his Statistical Review of England and Wales (Text 1940–1948) that this rise was more than balanced by a fall in the numbers of pre-maritally conceived legitimate births and that, in fact, extra-maritally conceived maternities were a lower proportion of all maternities during the war years than in 1938. The higher apparent rates of illegitimate births in London as compared with England and Wales (in 1952 in London 11·6 live births per 1,000 unmarried women aged 15–45, as compared with 9·7 in England and Wales) seem to reverse the position as found in the live births as a whole. In fact it is doubtful whether the true illegitimate fertility rate in London is now as high as in the country as a whole. Registrars must accept the residential addresses which they are given, and it is known that a very considerable number of pregnant unmarried women come to reside temporarily in London from the rest of the country, and also from Eire, for the sole purpose of bearing their children in the anonymity of a large city. Such births are allocated to London but the mothers are not, of course, part of the true residential population. This factor, which has always been present, and has been accentuated since the coming of the National Health Service, has the effect of considerably increasing the London illegitimate fertility rate above its true value and concomitantly increasing, but not so considerably, the total London fertility rate.

Deaths under one year among illegitimate infants amounted to 33 per 1,000 illegitimate live births compared with a rate of 22 for legitimate births. The corresponding rates in 1951 were 35 and 25 respectively. A detailed comparison of deaths in the legitimate and illegitimate groups is given in Table 6 (page 177).

There were 1,008 still-births in 1952 or 19·2 per 1,000 of all births (legitimate 18·6, illegitimate 27·2). The number of still-births and the rate per 1,000 total births in each year since 1931 is shown in Table 5 (page 176), from which it will be seen that after remaining stable for many years the still-birth rate fell sharply in 1943 and continued to fall until 1948, since when it has remained fairly stable. Still-Births

Mortality

The total deaths in 1952 amounted to 40,368, or 12·0 per 1,000 of the population. Detailed figures are given in Tables 2, 3 & 4 (pages 173–6). Mortality from infectious diseases is discussed below under that heading and tuberculosis is dealt with separately (see page 21). For the latter and other principal causes of death the trend is indicated by the diagram on pages 10–11.*

**The sharp changes that occurred between 1939 and 1940 are attributable to two causes. In the first place, the Registrar-General abandoned the rates of selection which had hitherto operated in multiple causes of death, and, as from 1940, accepted the principal cause of death as shown on the medical certificate. In addition, the International List of*

The death-rate from all causes, which, with the increasing age of the population, had been slowly rising before the war, again rose sharply in 1940. This increase was partly due to the war-time statistical basis as explained above, but the heavy toll of air raids was an important contributory factor. Between 1944 and 1950 there was, however, a decline in trend. The rate of 12·0 in 1952 is somewhat lower than that of the previous year; 1951 was a year in which there was a severe influenza outbreak, sufficient to raise the annual death-rate from 11·3 per thousand of 1950, to 12·6 per thousand. In 1952 the general rate would have been back to the 1950 level but for the enormous mortality associated with the fog period of December which, in a space of a week, contributed an extra ·5 per thousand to the year's rate. A detailed statistical account of this catastrophe will be found on page 151, but it should be noted here that its effects on the year's specific death-rate were as profound as on the general rate, and more particularly in the bronchitic and heart disease group and, of course, the degenerative group.

Bronchitis and heart disease

The death-rate for the bronchitic and heart disease group which was 4·64 in 1952 compared with 5·01 in 1951 has followed a similar trend to that of the rate for 'all causes' of which it forms a large part. Figures for the component diseases are shown in Table 3 (page 174).

Cerebral hæmorrhage

The death-rate from vascular lesions of the nervous systems in 1952 was 1·27 per 1,000, compared with 1·22 in 1951. The average for 1941–45 was 1·15, but a large proportion of the apparent reduction in the interval was due to the increase in the civil population upon demobilisation, a purely 'statistical' effect.

Nephritis

For nephritis the death-rate in 1952 amounted to 0·11 per 1,000, compared with 0·12 in 1951, and an average of 0·36 over the years 1931–40.

Degenerative diseases

If, as an indication of mortality from degenerative diseases, heart disease, other circulatory diseases, cerebral vascular lesions, nephritis and bronchitis are combined, the following trend becomes apparent:

Mortality (per 1,000) from cardiovascular—renal disease and bronchitis

1931–40 (average)	5·33	1946	6·11
1941	7·93	1947	6·27
1942	6·93	1948	5·47
1943	7·23	1949	6·11
1944	7·12	1950	5·99
1945	6·67	1951	6·82
		1952	6·64

Causes of Death, which was revised in 1938, was applied in 1940, in accordance with international agreement. The general movements resulting from these alterations are estimated to be:

Cause	*Approximate change as a percentage of those formerly assigned to this cause†*
Influenza	*— 11 per cent.*
Cancer	*— 3 ,, ,,*
Diabetes	*— 30 ,, ,,*
Heart diseases	*— 10 ,, ,,*
Other circulatory diseases	*— 6 ,, ,,*
Bronchitis	*+ 100 ,, ,,*
Pneumonia	*+ 5 ,, ,,*
Other respiratory diseases	*+ 50 ,, ,,*
Nephritis	*+ 12 ,, ,,*
Diseases of pregnancy, etc.	*+ 10 ,, ,,*

†Based on the dual classification of deaths for England and Wales, 1939.

The second cause affecting the statistics was the outbreak of war. The young and healthy section of the population was, from September, 1939, excluded from the mortality statistics, which henceforth related only to civilians. This selective factor was bound to inflate the death-rates, since the population in respect of which they were calculated was now on the average older and less healthy.

To reduce the confusing effect of the large scale reclassification of deaths, heart diseases and bronchitis have been combined.

The true effects of the war cannot be separated from the statistical influences described in the footnote on page 7 (particularly the change in 1940). The rates in recent years appear to be running higher than pre-war. Degenerative diseases thus continue to attain greater importance, and are responsible for over half the death-rate.

Cancer

The cancer death-rate for all ages in 1952 was 2·30 per 1,000, slightly higher than in 1951.

The death-rate from cancer, which is largely a disease of the latter half of life, can be substantially changed by variations in the age constitution of the population. Some form of standardisation of the crude rate is, therefore, essential for true comparative purposes. Age group population estimates were not available for London between 1939 and 1946.

Age specific rates since 1947 are shown below :

Administrative County of London : Cancer Mortality Rates per 1,000 *living (total population)*

Age and Sex	1947	1948	1949	1950	1951	1952
Males :						
0–14	0·02	0·03	0·06	0·11	0·10	0·11
15–44	0·35	0·30	0·29	0·38	0·35	0·37
45 + ...	5·34	5·61	5·81	6·18	7·45	7·35
All Males	2·13	2·21	2·27	2·45	2·60	2·61
Females :						
0–14	0·04	0·03	0·05	0·07	0·09	0·08
15–44	0·34	0·36	0·33	0·37	0·35	0·35
45 + ...	4·27	4·44	4·42	4·51	4·83	4·87
All Females	1·88	1·95	1·93	1·98	1·99	2·02
All Persons	2·00	2·08	2·09	2·20	2·27	2·30

Up to 1951, for England and Wales, the comparative mortality index for females had fallen to 0·92 (1938 = 1·000), while the male index had risen to 1·11.

In London, for both sexes combined, the long-term trend of cancer mortality can be seen from Table 3 (page 174). The increase there shown between 1891 and 1940 is due partly to the increasing age of the population and partly to improved diagnosis, but some part is doubtless attributable to increased incidence, particularly cancer of the lung. The small drop in the death-rate for males over 45 in 1952, which is the first decrease for a considerable time, is entirely due to a decrease in the deaths registered as from cancer of the digestive organs (International Classification numbers 150–159) ; in 1951 the death-rates from cancer of these sites in this age sex group were 3·04 per 1,000, while in 1952 they were 2·81 per 1,000.

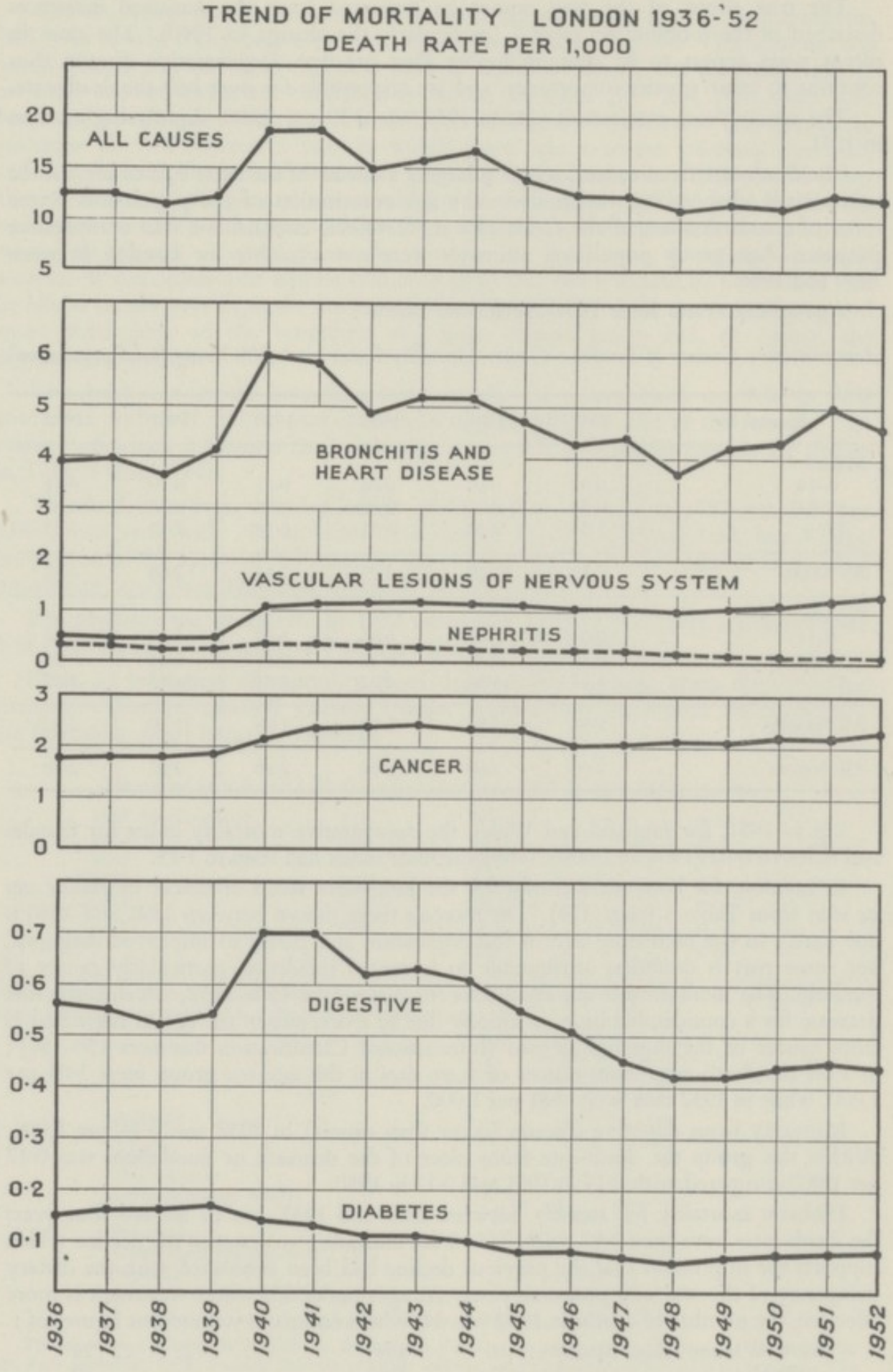
Digestive

Mortality from digestive diseases (other than cancer) in 1952 was 0·44 per 1,000. Within this group the death-rate from ulcer of the stomach or duodenum was 0·17 per 1,000 compared with 0·19 in 1951 and 0·17 in 1950.

Diabetes

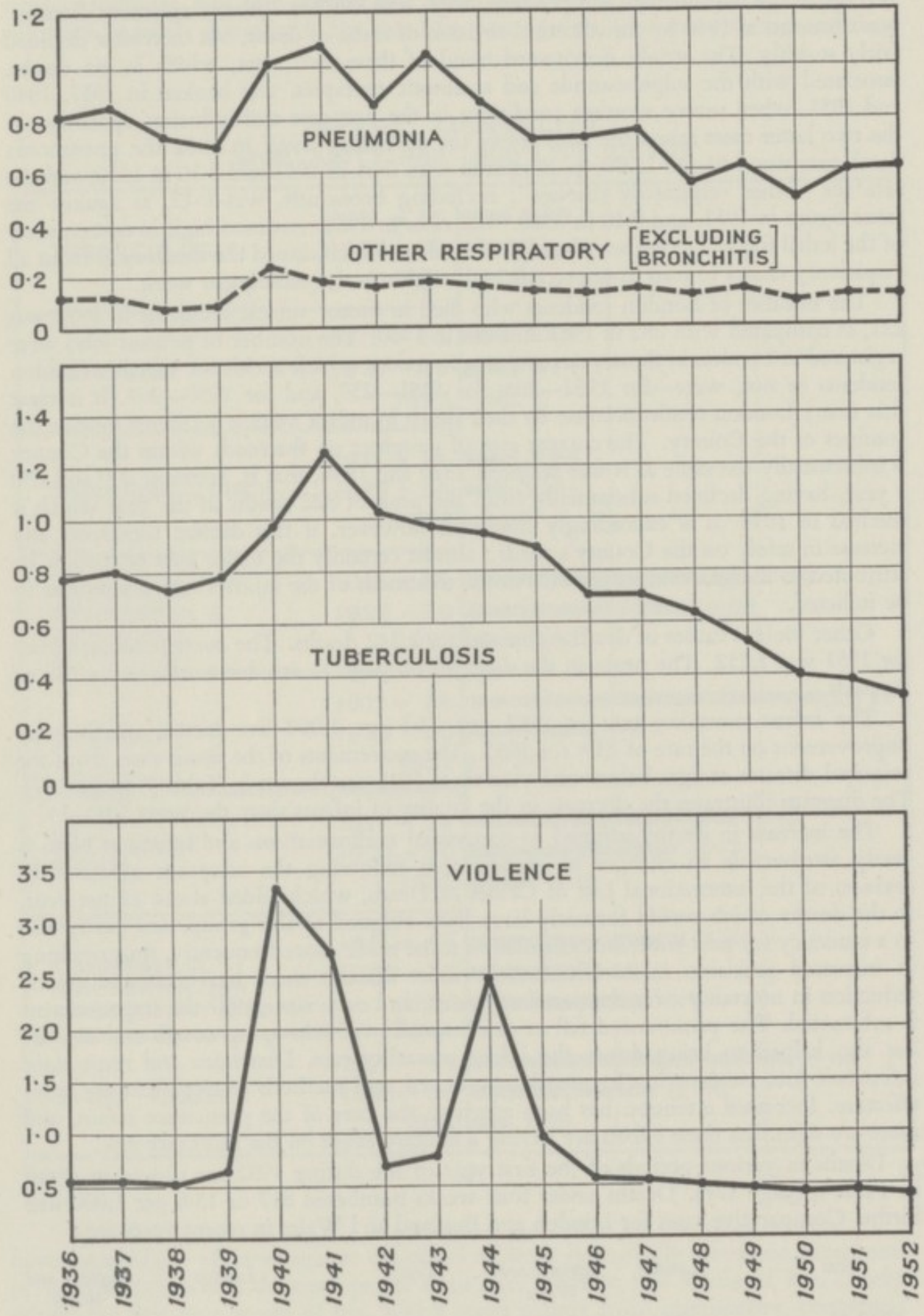
Diabetes mortality fell steadily between 1939 and 1947, but in the last four years the death-rates have been 0·07, 0·08, 0·09, 0·08, indicating an arrest in the decline which supports the impression that the previous decline had been connected with the dietary stringency of the war and post-war years. At ages under 55, where treatment is more effective, the number of deaths in 1952 was 34, which compares with recent figures of :

1936–38 (mean annual deaths) ..	86	1949	26
1939–41 („ „ „) ..	71	1950	39
1942–44 („ „ „) ..	42	1951	34
1945–47 („ „ „) ..	31	1952	34
1948	27		


TREND OF MORTALITY LONDON 1936-52
DEATH RATE PER 1,000
ALL CAUSES
20
15
10
5
BRONCHITIS AND
HEART DISEASE
VASCULAR LESIONS OF NERVOUS SYSTEM
NEPHRITIS
6
5
4
3
2
1
0
CANCER
3
2
1
0
DIGESTIVE
DIABETES
0·7
0·6
0·5
0·4
0·3
0·2
0·1
1936
1937
1938
1939
1940
1941
1942
1943
1944
1945
1946
1947
1948
1949
1950
1951
1952

TREND OF MORTALITY - LONDON 1936-'52

DEATH RATE PER 1,000



Pneumonia and other respiratory diseases

Mortality from pneumonia rose sharply in 1940 and remained higher than formerly until 1943, when it began to fall, reaching in 1945 and 1946 a level lower than the average of the intermediate and pre-war years. The rate for ' other respiratory diseases ' was distorted in 1940 by the statistical revision of cause of death, but thereafter declined fairly steadily. The steady downward trend of these two rates, which is, no doubt, associated with the sulphonamide and antibiotic therapies, was broken in 1947, 1949 and 1951, when severe weather conditions in the first case and influenza epidemics in the two latter cases raised the rates above the prevailing level. In 1952 the pneumonia death-rate was 0·61 per 1,000, as compared with 0·64 in 1951 and 0·50 in 1950, and the rate for ' other respiratory diseases ', excluding bronchitis, was 0·12, as against the same figure in 1951, and 0·10 in 1950. The rates in 1952 remained high in consequence of the lethal fog in December, already referred to, which caused the death-rates from all respiratory causes to leap to unprecedented heights in the subsequent week.

Road accidents

The number of London residents who died in motor vehicle accidents in 1952 was 221, as compared with 282 in 1951 and 245 in 1950. The number of persons who were registered in London in those years as dying in motor vehicle accidents, whether London residents or not, were—for 1952—205, for 1951—259, and for 1950—207. It is clear that many London residents come by their death in motor vehicle accidents outside the confines of the County. The current rate of slaughter on the roads within the County is substantially the same as it was between 1870 and 1890, that is, between 200 and 250 a year, having declined substantially from the peak of 822 deaths in the year which it reached in 1930. It is exceedingly doubtful, however, if this decline represents any increase in safety on the County's roads ; almost certainly the major part of it must be attributed to the great improvements in the treatment of the injuries which continue to be inflicted.

Other violence

Other violent causes of death accounted for 1,142 deaths. The corresponding figure for 1951 was 1,252. The peaks in the diagram on page 11 are due to the heavy toll of air raids.

Infant mortality

The infant mortality rate in 1952 was 23·1 per 1,000 live births, which is an improvement on the rate of 25·4 for 1951. The movements of the death-rates from the principal diseases at ages below one year since 1911 are shown in Table 7 (page 177). The diagram illustrates the decrease in the fatality of infants since the years 1911–14.

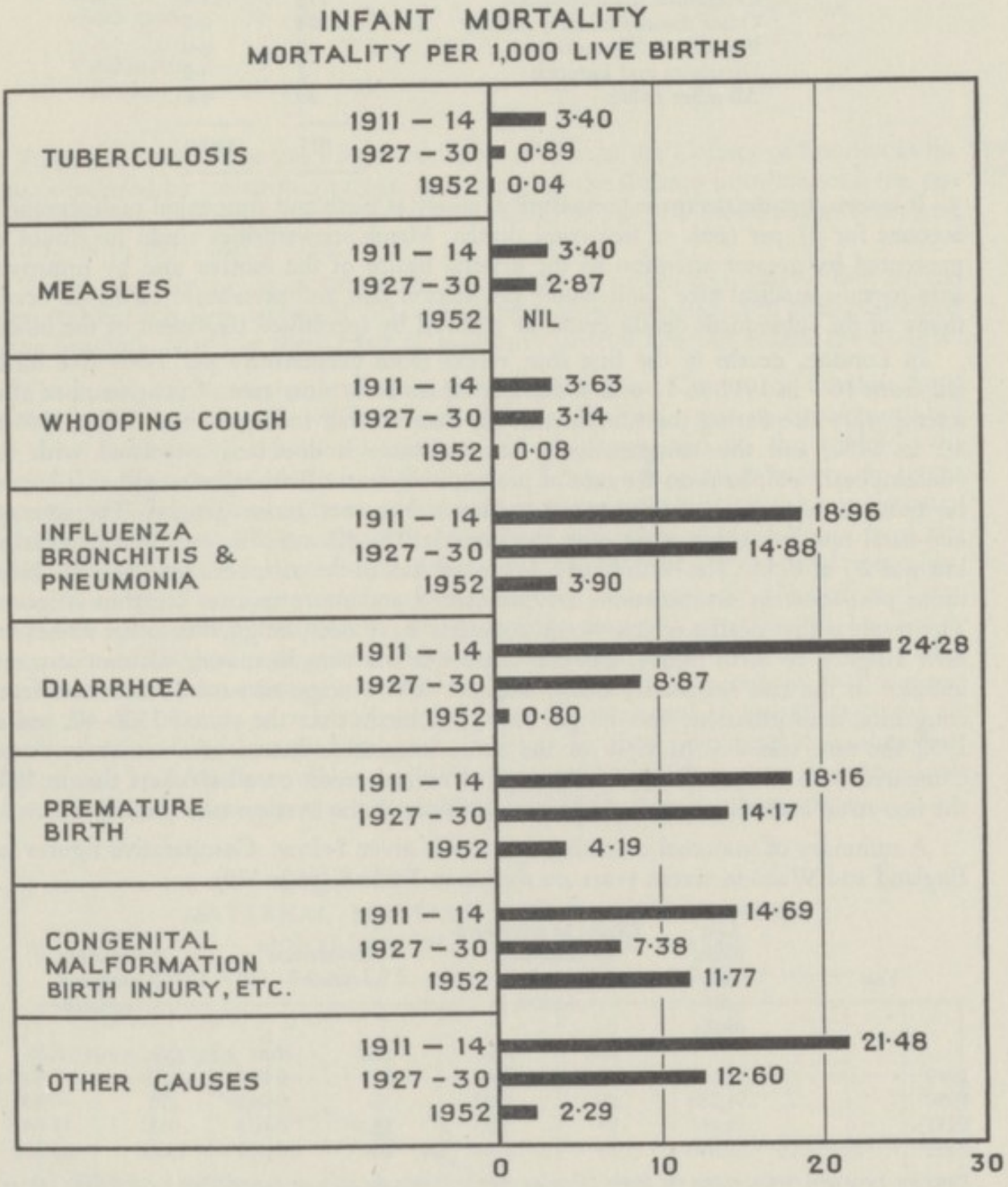
The increase in deaths assigned to congenital malformations and injury at birth is partly attributable to changes in classification following the adoption of the fifth revision of the International List of Causes of Death, which added about 12 per cent. to the deaths which would formerly have been assigned to this group, and partly also to a tendency for post-mortem examination to be made more frequently, thus resulting in increased precision in certification. In most diseases there has been a dramatic reduction in mortality over the past forty years, and even since 1927 the improvement is substantial. The pronounced fall in case mortality of whooping-cough and measles has also helped to bring down the infant mortality rate. Diarrhoea and respiratory infections, too, are now less frequently contracted, and methods of treatment are more effective. Increased attention has been given to the care of the premature infant, and there are signs that these efforts are having a salutary effect on the mortality risk.

Neo-natal mortality

Deaths in various periods of the first year of life during 1952 are shown in detail in Table 6 (page 177). Deaths under four weeks numbered 817 or 15·8 per 1,000 live births. Comparative rates for London and England and Wales in recent years are :

Year	*London*	*England and Wales*	*Year*	*London*	*England and Wales*
1931–35	25·1	31·4	1948	17·5	19·8
1936–40	22·9	29·0	1949	17·5	19·3
1941–45	23·4	25·9	1950	16·9	18·5
1946	22·2	24·2	1951	17·3	18·9
1947	18·1	22·7	1952	15·8	18·3

There is some irregularity in the decline in both sets of rates and the margin between them has varied in extent. In London there was a wartime increase arising from the severe conditions, but this setback was soon recovered at the end of the war. The reduction in infant mortality in the past fifty years is a result of many factors and they



have mainly been effective against the causes of death (principally infections, diarrhoeal or respiratory), which do not operate until after the first few weeks of life. Deaths within the first four weeks of life, which result mainly from prematurity, congenital malformations and injury at birth, have been more resistant to reduction.

The distribution of causes of death in the first four weeks of life in 1952 was as follows :

Cause	*No. of deaths*	*Per cent. total*
Prematurity	209	25·5
Post-natal asphyxia and atelectasis	178	21·8
Birth injury	141	17·3
Congenital malformations ..	118	14·4
Other diseases of early infancy ..	74	9·1
Pneumonia of newborn	56	6·9
Diarrhoea and Enteritis	2	0·2
All other causes	39	4·8
Total	817	100·0

It is seen that deaths from prematurity, injury at birth and congenital malformations account for 57 per cent. of neo-natal deaths. Many prematurities could no doubt be prevented by greater attention to the general health of the mother and by improved ante-partum medical care ; and where prevention fails and premature births do occur, many of the subsequent deaths could be reduced by specialised treatment of the infant.

In London, deaths in the first four weeks from prematurity per 1,000 live births fell from 16·1 in 1911 to 11·6 in 1938, a comparatively slow rate of progress, but after a temporary rise during the war the rate has been further reduced from 11·6 in 1944 to 4·1 in 1952, and this comparatively large advance is doubtless associated with the contemporary emphasis on the care of premature infants. Birth injuries will, it is hoped, be reduced as specialised obstetrical assistance becomes more general. The average neo-natal rate from this cause over the period 1936–40 was 2·2 per 1,000 live births, but was 2·7 in 1952. The birth injury death-rate has, in the past, been understated. Now more post-mortem examinations are performed and more injuries are thus detected. The result is that deaths which would formerly have been assigned to other causes are now assigned to birth injury, and the death-rate has thus increased, without any real increase in the risk necessarily being implied. The average neo-natal death-rate from congenital malformations was 2·8 per 1,000 live births over the period 1936–40, and in 1952 the rate was 2·3. In view of the more intractable nature of these three causes compared with causes of an infective type, it reflects credit on all workers that in 1952 the neo-natal mortality rate was about two-thirds of the average rate for 1931–35.

Maternal mortality

A summary of maternal mortality statistics is given below. Comparative figures for England and Wales in recent years are shown in Table 8 (page 178).

Year	*Live births and still-births*	*Deaths in pregnancy or child-birth excluding abortion*		*Post-abortion deaths*		*Notification of puerperal pyrexia*	
		No.	*Rate*	*No.*	*Rate*	*No.*	*Rate*
1949	57,679	23	0·40	17	0·023	433	7·51
1950	54,335	29	0·53	9	0·012	371	6·83
1951	53,460	24	0·45	18	0·023	911	17·04
1952	52,566	35	0·67	15	0·019	1,860	35·38

Rates per 1,000 total births, except for deaths following abortion where the rates are expressed per 1,000 females (15–44).

The maternal mortality rate in 1952 was officially 0·67, as compared with 0·45 in the previous year. It is, however, necessary to point out that one case assigned by the Registrar-General (under the International Rules of Classification) to pregnancy or child-birth, experienced her last pregnancy 40 years ago, so that a truer maternal death-rate for 1952 is 0·65. The total number of maternal deaths in the County during a year has now fallen to such a low level that purely chance fluctuations will affect them considerably, and there is little value in giving the rates for component causes in

individual years. The following analysis has, therefore, been made on the basis of numbers and not rates.

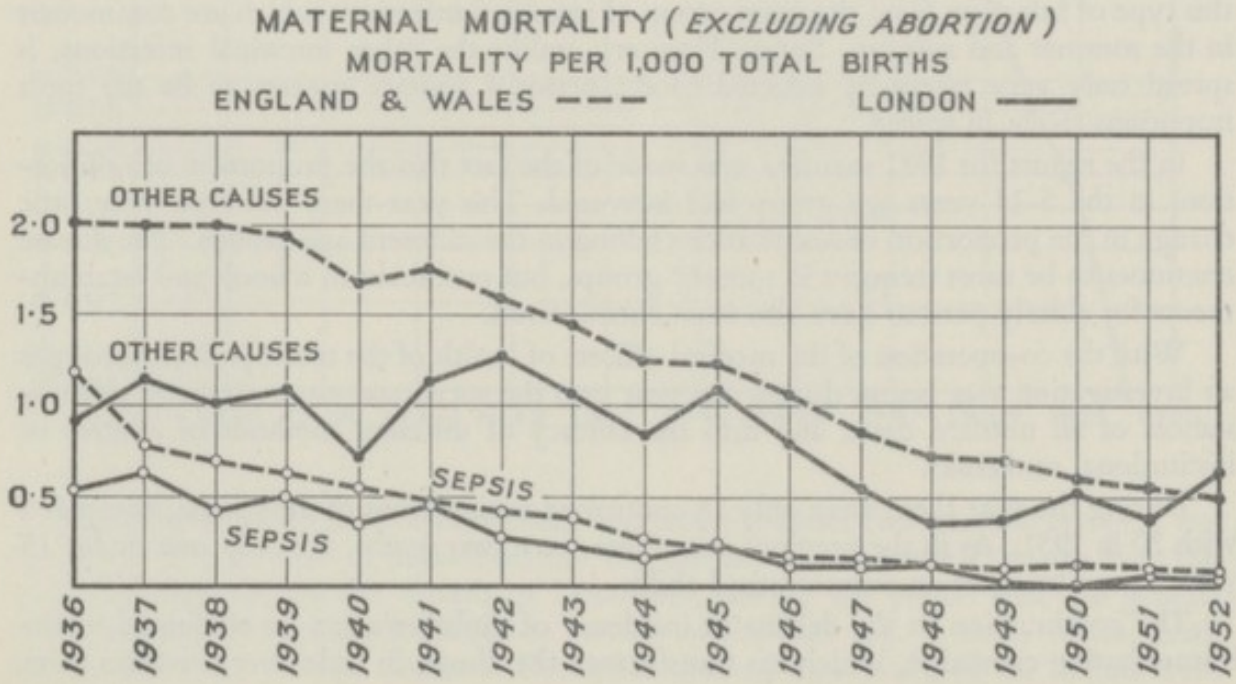
Cause of death	*Post-abortion*			*Other pregnancy and child birth*			*Total*		
	1950	1951	1952	1950	1951	1952	1950	1951	1952
Sepsis	7	13	10	—	3	2	7	16	12
Other causes ..	2	5	5	29	21	33	31	26	38
Total maternal deaths	9	18	15	29	24	35	38	42	50

Puerperal Pyrexia

Puerperal fever is now no longer notifiable as such in the County of London as the term is covered by puerperal pyrexia, thus bringing the County into line with the rest of the country. The notification rate in 1952 was 35·38 per 1,000 total births, compared with 17·04 in 1951, and 6·83 in 1950.

This large increase in notifications since 1950 is misleading and is due to the Puerperal Pyrexia Regulations of 1951 which now require the inclusion of cases notified in the hospitals. Many of these relate to maternity patients residing outside the County.

The trend of maternal mortality in the Administrative County of London from 1891 is shown in Table 3. It will be observed from this Table that maternal mortality fell very slowly until the introduction of the sulphonamides in the middle '30s, resulting in a substantial decline in the mortality from puerperal infection. In recent years puerperal sepsis has lost its position as the most serious mortality risk in pregnancy and has been displaced by toxaemia, haemorrhage and other accidents (trauma of the pelvic organs, etc.), which now contribute the greater part of the total mortality, though the risk of death from this cause has also been falling rapidly. The effect of war conditions in arresting temporarily the decline in maternal mortality in London is shown by the following diagram, which indicates the movement of the rates in both London and over the country as a whole. The sharp rise in London in 1941 was not shared by the country as a whole, and this can be attributed to the effect of the air bombardment, which reached its peak intensity in that year, and the subsequent evacuation. These factors rendered it difficult to maintain the normal high standards of maternal care. Since the war further considerable progress has been made.



General

The leading causes of death in London in 1952 were as follows :

	Deaths	*Rate per 1,000 population*
Diseases of the heart	11,946	3·55
Cancer	7,726	2·30
*Pneumonia, bronchitis	5,699	1·69
Vascular lesions of the nervous system	4,528	1·35
Other circulatory	2,070	0·62
Digestive diseases	1,492	0·44
Violent causes	1,363	0·41
Diseases of early infancy (prematurity, birth injury, congenital malformation, etc.)	1,071	0·32
Tuberculosis	1,019	0·30
Hyperplasia of prostate	366	0·11
Nephritis	361	0·11
All other causes	2,727	0·81
Total	40,368	12·01

* *Now includes pneumonia of the new born.*

Infectious diseases

The attack rates and death-rates of the principal infectious diseases in London during 1951 and earlier years, and for the constituent metropolitan boroughs in 1952, are shown in Tables 2, 3 and 14. In order to preserve uniformity with national statistics the notification figures used in this section of the report have been corrected as far as possible to take account of changes of diagnosis made after the original notifications had been received (see footnote to Table 14). Table 15 has not previously appeared in these reports ; it shows, in age groups, the distribution over the weeks of the year of the notifications of the following—dysentery, measles, meningococcal infection, pneumonia, poliomyelitis, scarlet fever and whooping cough. It should be noted that the totals in this Table, being for 53 weekly periods and not adjusted for final late corrections of diagnosis, will not correspond with the yearly corrected totals in Table 14.

Anthrax

There were no notifications of anthrax during 1952.

Dysentery

Although the number of notifications was considerably less than the record total of 4,069 in 1951, the level of 1,704 notifications recorded in 1952 has been exceeded in only two previous years, viz., 1945 and 1951. As in recent years the highest incidence was in the months of February, March and April, this being a characteristic which distinguishes this type of infection from the main group of intestinal infections which are commonest in the summer and autumn. Sonne dysentery, unlike the other intestinal infections, is spread only very rarely by infected food ; personal contact appears to be the most important factor in spread.

In the report for 1951 mention was made of the fact that the proportion of notifications in the 5–14 years age group had increased. This year there has been very little change in the proportion of notifications falling in the different age groups. The disease continues to be most frequent in nursery groups, but outbreaks in schools and establishments for elderly persons have also been encountered.

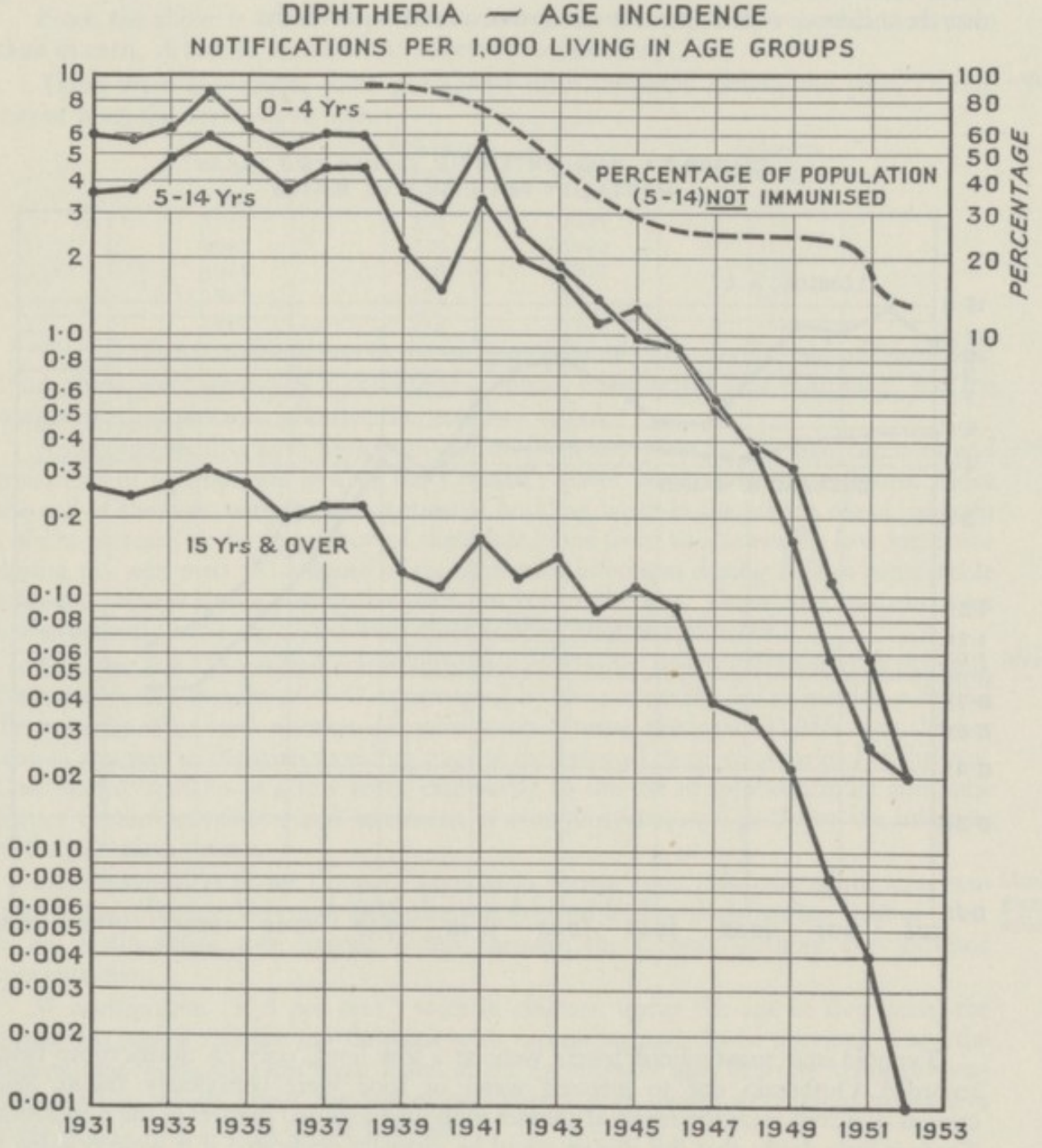
With the co-operation of the medical officers of health of the metropolitan boroughs an investigation was begun during the year into the social and environmental circumstances of all notified cases, and into the efficacy of different methods of control of institutional outbreaks.

Diphtheria

During the year there were only 18 confirmed notifications of diphtheria, compared with 30 in 1951. As in the previous year there were two deaths, the only one under 15 years of age being of an unimmunised child.

The continuation in the decline in incidence of diphtheria can be attributed to the immunisation campaign, which has transformed the disease in little over ten years from

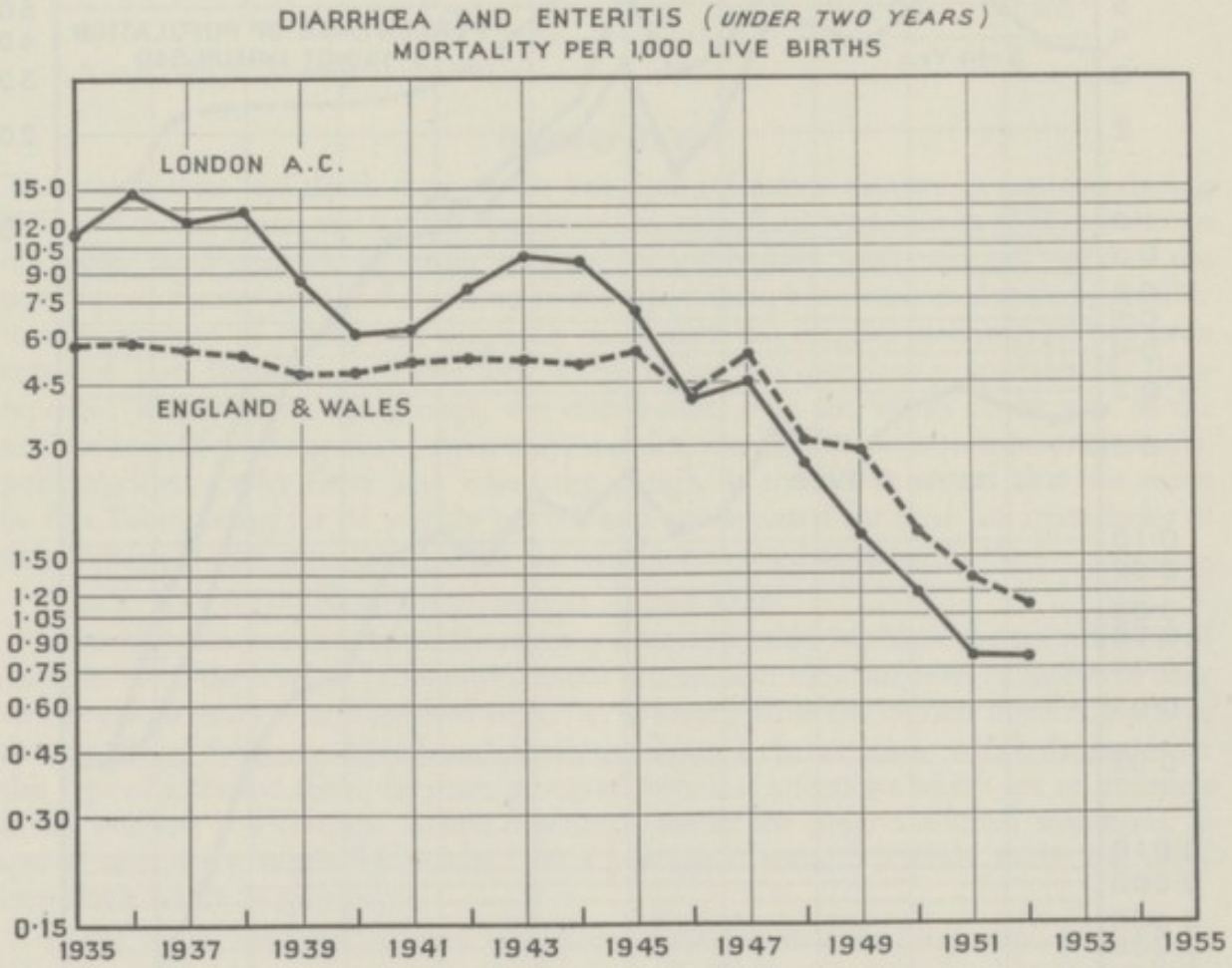
a scourge of mankind to a rarity. The improvement is well shown in the diagram, and once again it may be pointed out that the rate of improvement at ages under 15 years began to accelerate as soon as the immunisation campaign commenced in the early 1940's, but that the rate of improvement over the age of 15 years improved only in 1946, by which time a substantial number of those immunised in school had passed into this age group. In looking at this diagram it must be remembered that the logarithmic scale tends to obscure the full measure of achievement. The number of cases in 1941 was more than a hundred times that met with in 1952.



The number of deaths from diarrhoea and enteritis under two years of age (43) was one lower than in 1951. A notable feature was the fact that 10 of the 43 deaths from this cause occurred during the month of December, during the period that the general mortality rate was greatly increased as a result of the cold fog. A study of the death certificates of the enteritis deaths in December showed that nearly all the infants were

Diarrhœa and enteritis

at the time of death suffering from a respiratory infection in addition to the enteritis. It is reasonable to suppose that the fog was responsible for the majority of the December deaths, and that if it had not been for the fog there would have been a continuation of the remarkable decline in the enteritis death-rate which has continued since the end of the war. Whereas before the war the enteritis death-rate in London was constantly higher than the rate for England and Wales, since the war it has been well below the national level. Many possible causes can be put forward for this decline, and all may have played a part. The use of national dried milk in infants' feeds, health education, particularly on the preparation of feeds, better treatment of the disease, and improved social conditions, have all been important factors, but there are reasons for believing that the incidence of the disease is also lower now than formerly.



Enteric fevers

Typhoid and paratyphoid fevers were at a low level, only 25 notifications being recorded. Outbreaks due to infected water or food were completely absent. Such cases as occurred were the result of contact with unrecognised carriers in the population. There is little doubt that this disease could be virtually eradicated if it were possible to detect and neutralise all carriers. Two methods of achieving this are the energetic search for the source of infection in all cases, and careful bacteriological examination of all those recovering from the disease to bring to light the convalescent carrier.

Erysipelas

There were 467 notifications of erysipelas in 1952, giving an attack rate of 0·139 per 1,000, compared with 0·148 in 1951. The incidence of this disease has been declining continuously since 1941. There was one death in 1952.

Since the beginning of 1949 food poisoning has been a notifiable disease in London. In 1952 612 cases were reported giving an attack rate of 0·18 per 1,000, compared with 787 cases (0·23) in 1951. The sex and age distribution was : Food poisoning

Age	*Males*	*Females*
0– 4	47	44
5–14	40	32
15–44	124	164
45–64	63	62
65 + ...	9	26
Age unknown	—	1
	283	329

From the above it would appear that cases are more frequently reported in women than in men. A female excess is also observed in dysentery.

There were 162 deaths (0·05 per 1,000) from influenza during the year. During recent years the deaths have been : Influenza

Year	*Influenza deaths*	*Year*	*Influenza deaths*
1941	397	1947	284
1942	198	1948	78
1943	726	1949	372
1944	206	1950	256
1945	171	1951	809
1946	371	1952	162

The last major outbreak was in the early months of 1951. By the end of December, 1952, there were signs that a considerable spread of influenza was beginning, but the weight of the epidemic fell after the year had ended.

Arrangements that have been in operation for many years for the ascertainment and treatment of leptospirosis among the Council's sewer workers have continued. Since the end of the war, with the resumption of building work in the sewers, there has been a slight increase in the frequency of these infections from the unusually low incidence during the war years. The figure of six confirmed infections during 1952 is comparable with the average figure during the years just before the war. Occasional sporadic cases in the general public associated with river bathing continue to occur. Leptospirosis

The year saw the gradual rise in incidence of measles which culminated in the peak during the early months of 1953, interrupted by the customary fall in incidence during the autumn. The total number of notifications during the year, 31,055, was higher than in any year in the corresponding stage of the biennial cycle since the end of the war. Case fatality remains at a low level, due partly to the use of sulphonamides and antibiotics in the prevention and treatment of complications, and partly to the mildness of the prevalent disease. Measles

Incidence was at about the same level as in recent years. No part of the year was free from the disease, although incidence was as usual higher in the spring than at other times. Notifications were spread widely through the County without any localised concentration. Meningococcal infections

51 notifications (54·5 per cent.) were in children under the age of five years, the disease becoming steadily less frequent with increasing age. As in previous years, the highest case mortality rates were found at the extremes of age, this rate being particularly high in infants under the age of one year. Of 24 deaths in children under five years of age, 18 were less than a year old.

The ratio of notifications to deaths at various ages was as follows :

Age	*Deaths*	*Notifications*	*Deaths as percentage of notifications*
0–4 years	24	51	52·8
5–14 years	2	17	11·8
Over 14 years	3	14	21·4

Ophthalmia neonatorum

The incidence of ophthalmia neonatorum which, since 1921, has remained fairly constant between 8 and 10 new cases per 1,000 live births, commenced to fall slightly towards the end of the period 1931–40 and, in recent years, has fallen to below five per 1,000 live births. There were 202 cases in 1952 (3·9 per 1,000 live births), full details of which are shown below :

Ophthalmia neonatorum

Number of cases	*Domiciliary confinements*	*Institutional confinements*	*Total*
Notified during the year	47	138	185
Removed to hospital for special treatment ..	9	33	42

The condition at the end of the year of the 202 cases notified was :

(*a*) Vision unimpaired	175
(*b*) Vision impaired	—
(*c*) Vision lost	—
(*d*) Died	1
(*e*) Under treatment	3
(*f*) Removed from the County ..	6
Total	185

The difference between the 202 notified cases and the 185 cases included in the above analysis arises from the fact that the analysis includes only those cases of which the mother was a resident in the County.

Pneumonia

Notified cases of pneumonia in 1952 numbered 1,908 or 0·567 per 1,000, compared with 0·717 per 1,000 in 1951. This disease is considerably under-notified, particularly at ages over 65, and it is believed that over the whole age-range only about one-quarter to one-third of the total cases are notified. There is, however, no reason to believe that this fraction varies from year to year so that the notifications may still be used as a relative index of incidence. It will be seen from Table 14 that the 1952 notification rate is lower than either war-time or pre-war rates. (See page 12 for comment on the death-rate.)

Poliomyelitis

The number of confirmed notifications of poliomyelitis (309) which was higher than that in 1951, was considerably lower than in the epidemic years 1947, 1949 and 1950. The weekly notifications rose sharply to 30 in the thirtieth week, and did not return to the inter-epidemic level until ten weeks later. Of the total notifications during the year, 204 were paralytic and 105 non-paralytic. At school ages the non-paralytic cases slightly exceeded the paralytic in number, but at all other ages the paralytic cases exceeded the non-paralytic.

The age incidence in 1952 was as follows :

Age	*No.*	*%*
0– 4	95	30·7
5–14	105	34·0
15 + ...	109	35·3
Total	309	100·0

There was a slight increase in the proportion of notifications falling in the 0–4 years age group, but this is seen in better perspective in the following figures :—

Year	*Percentage of notifications in the 0–5 age group*
1947	27·9
1948	33·3
1949	53·3
1950	34·9
1951	24·1
1952	30·7

Deaths in London from rheumatic fever in 1952 were 25, of which 7, as in 1951, were children under 15. Rheumatic fever

Account must also be taken of all deaths under 45 years assigned to heart disease, since, apart from deaths due to congenital heart disease, the vast majority of these deaths are rheumatic in origin. The following Table shows the distribution of heart disease deaths under 45 years, according to age, in recent years :

Deaths from heart disease under 45 years

Year	0–4	5–14	15–44	*Total*	*Rate per 1,000 living* 0–44
1946	1	10	376	387	0·194
1947	1	11	398	410	0·197
1948	1	9	338	348	0·167
1949	5	3	350	358	0·172
1950	—	4	379	383	0·184
1951	1	1	338	340	0·156
1952	2	4	316	322	0·149

There would appear to be a fairly steady downward trend in the death-rate, interrupted in 1949 and 1950, but subsequently resumed. Under the age of 15 the number of deaths is so small that considerable fluctuation must be expected from random causes, and the six deaths in this age group in 1952 does not necessarily mean that any significant rise has taken place.

Scabies became notifiable in London in August, 1943. Notifications in 1952 numbered 535, as compared with 572 in 1951, continuing the decline since the initiation of notification. The attack rate (0·159 per 1,000) in 1952 was less than 1/40th of the rate experienced eight years earlier. Scabies

Scarlet fever incidence was higher in 1952 than in 1951. There were 5,263 cases (1·56 per 1,000), compared with 1·10 per 1,000 in the previous year. Only three deaths from scarlet fever or streptococcal sore throat occurred in 1952. Fifty years ago the annual death roll in London was over 500. Scarlet fever

There were no notifications of either smallpox or typhus in London during 1952. Smallpox and typhus

Detailed figures of new cases of tuberculosis notified in 1952 are show in Tables 9 to 12 (pages 178 to 181). Non-civilians are included in the statistics and total (home) populations are used. Tuberculosis

The general trend of morbidity and mortality since 1921 is indicated in Table 9 (page 178) and is also illustrated by the diagram below. The consistent decline in deaths and notifications during the inter-war years was substantial. New cases of pulmonary disease were reported at the rate of 2·1 per 1,000 population in 1920, and only 1·3 per 1,000 in 1938, a fall of about 40 per cent. in just under 20 years. During 1938 the death-rate from pulmonary tuberculosis was 0·64 per 1,000, *i.e.*, about 40 per cent. lower than in 1920 ; a reduction of some 1,600 deaths annually at the 1938 population level. In the years of the war the general deterioration in living conditions, the strain placed upon the population by bombardment and the increased opportunities for the spread of infection, all combined to reverse the trend of both morbidity and mortality and by 1941 the ground gained in inter-war years had been lost. Mortality rates rose to a peak of 1·02 per 1,000 for pulmonary disease and 0·14 per 1,000 for non-pulmonary disease in 1941. In so far as this rise was mainly due to the impact of the hard conditions of war upon existing advanced cases, it was short-lived and mortality began to decline again as the war proceeded. By 1946 the mortality rates had fallen below the pre-war levels and they may now be regarded as having fallen below even the level to which they might have been expected to decline on the basis of the pre-war trends.

The death-rates per 1,000 living in 1952 in London and for the whole country were:

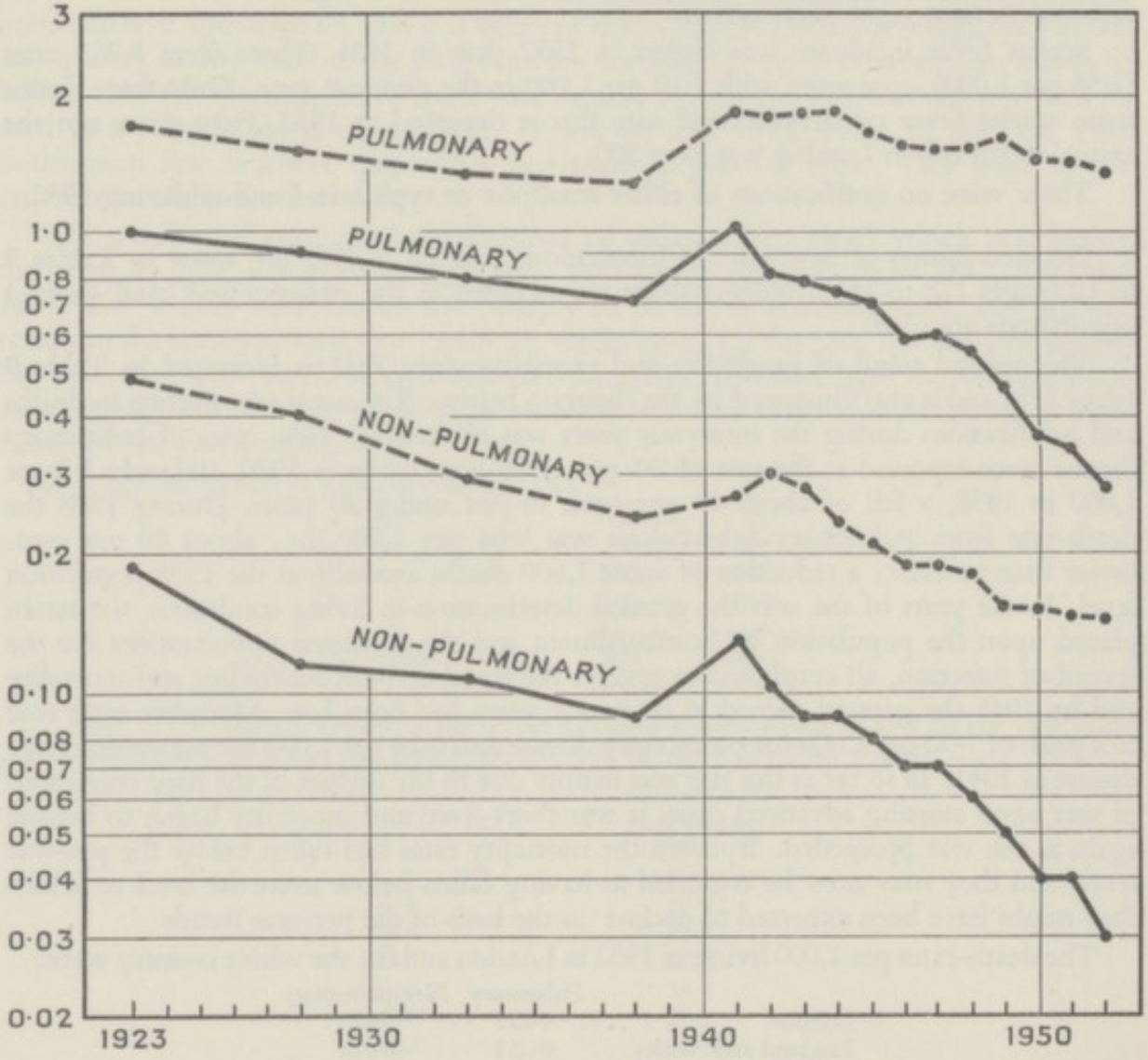
	Pulmonary	*Non-pulmonary*
London	0·277	0·026
England and Wales	0·212	0·028

With regard to morbidity the rate of diagnosis of new cases of pulmonary tuberculosis rose by nearly 50 per cent. between 1938 and 1941, remaining at the higher level until the end of the war, when a decline took place, at first quite rapidly. The statistical improvement, however, was short-lived, for between 1947 and 1949 the notification rate rose slightly. It must, however, be remembered that diagnostic services are now more used than ever before and also that new methods, such as mass miniature radiography, now discover early cases which normally might have recovered without notification or would not have been notified until the disease was more advanced. It is likely that part of the rise in notification was due to improved case-finding and that pre-war and post-war rates are not strictly comparable. It is, therefore, all the more gratifying that the primary notification rate of pulmonary disease in 1952, of 1·40 per 1,000, was less than the rate of 1·46 per 1,000 recorded in 1951. A war-time increase in non-pulmonary tuberculosis was less severe than for the pulmonary form and the rates have fallen below the pre-war level and have continued to decline to a very low level. The non-pulmonary notification rate in 1952 was 0·15.

The age distribution of new notifications of tuberculosis is shown in Table 10, and specific notification and death-rates are show in Tables 11a and 11b.

TUBERCULOSIS
MORTALITY & MORBIDITY 1923-1952

ANNUAL DEATHS PER 1,000 LIVING ——
ANNUAL NOTIFICATIONS PER 1,000 LIVING – – –



Whooping cough

There were 5,587 notifications of whooping cough during the year compared with 10,488 in 1951 and 10,875 in 1950. The two latter years were covered by one continuous epidemic with its peak at the turn of 1950-51. In contrast, 1952 was a year of light incidence. During the year there were nine deaths, giving a death-rate of 0·003 per 1,000, and a crude case mortality of 0·16 per cent. The corresponding rates for the previous two years were :

1950—Death-rate 0·009 per 1,000, case mortality 0·28 per cent.
1951—Death-rate 0·006 per 1,000, case mortality 0·20 per cent.

Table 15 shows that during 1952 the notifications of whooping cough were fairly evenly spread over the year. It is seen from Table 3 that the fatality from this disease, which has been declining since the end of the last century, has fallen with dramatic rapidity in more recent times.

Infectious diseases in schools

The numbers of cases of various infectious diseases reported from schools in 1952 and previous years is shown in Table 13 (page 181).

GENERAL PUBLIC HEALTH

Housing

DURING THE year 13,162 houses and flats were erected by the Council and/or the metropolitan borough councils. Of these 7,318 were in London (2,922 by the Council and 4,396 by the borough councils) and the remainder (5,844) were erected by the Council outside the London area.

The total number of houses or flats owned by the Council at 31st December, 1952, was 154,511 (an increase in the year of 8,710) of which 74,314 are situated in London and 80,197 outside the county.

The number of applications registered on the Council's housing waiting list on 31st December, 1952, was 180,366 compared with 171,567 in 1951. Approximately 34,000 new applications were registered during the year. The housing waiting list is divided into three categories in accordance with urgency on the basis of the total number of points awarded under the Council's points scheme as follows :

Category A—Urgent cases.
Category B—Cases with some housing need, but not of an urgent character.
Category C—No basic housing need.

Preferential rehousing

During the year 37,748 requests for preference in rehousing on health grounds were considered, and suitable recommendations made to the Director of Housing and Valuer. This figure includes a number of applications which had been considered in previous years but were reviewed in the light of changed medical or domestic conditions. The number of new applications considered was some 3,000 less than in 1951. The continuing large number of applications on health grounds is no doubt largely attributable to the natural anxiety of applicants to put forward any claims which might possibly lead to prospects of early rehousing. Inevitably many have to be disappointed, but all applications are carefully considered and many enquiries are made to enable fair decisions to be reached. Once again, the great assistance given by medical officers of health of metropolitan boroughs and out-county authorities, of hospitals and of family doctors in providing reports is gratefully acknowledged. Of the applications considered on general health grounds, 4 per cent. (1,590) were recommended for special preference because rehousing was urgently necessary to reduce the danger of infection arising from inadequate accommodation for persons suffering from active pulmonary tuberculosis, 13 per cent. were classified as ' most urgent ', and 34 per cent. as less urgent but justifying preference on health grounds. After careful consideration, it was decided that the degree of medical urgency disclosed by doctors' certificates did not warrant additional preference for the remaining 49 per cent.

Slum clearance

In 1949, the Council decided that six unfit areas, on which clearance procedure had been stopped by the war, should be resurveyed with a view to commencing clearance action under Part III of the Housing Act, 1936.

Of these priority areas, four were represented to the Council during the period 1949–51, and the remaining two during the year under review. These six areas extended over approximately 31 acres and contained 1,291 houses.

Reference was made in my report for 1951 to the submission to the Housing Committee of a detailed draft programme of slum clearance to be undertaken during the years 1951–55 by both the Council and the metropolitan borough councils. The task of implementing this programme, which provides for the demolition of 10,131 houses, was continued during the year, and 23 areas containing 1,187 houses were represented to the Housing Committee. In addition, preliminary surveys were completed in respect of a further 24 areas containing 793 houses and 11 blocks of dwellings.

Five public local inquiries were held by the Minister of Health and confirmation of four of the Council's Orders was received. The result of the remaining inquiry was awaited at the end of the year. One additional Order was confirmed without the holding of a public inquiry.

Notifications under section 33 of the Housing Act, 1936, of intention to deal with 542 unfit houses contained in 44 areas were received from 16 borough councils.

Surveys were made of 95 houses contained in four areas, apart from those mentioned above, in connection with proposals for their acquisition by the Council.

Improvement grants

Surveys were made in respect of four applications for improvement grants under section 20 of the Housing Act, 1949, and recommendations as to the suitability of the properties made to the Director of Housing and Valuer.

Dangerous structures

During the year 2,359 searches were made in connection with enquiries concerning properties scheduled as dangerous structures.

Tuberculous milk

The following are details of the sampling for biological examination of milk coming into London in churns by road and rail and the results of the examinations :

Source of sample	*Designation*	*Samples*				*Percentage positive of completed samples*	
		Total	*Positive*	*Incomplete*	*Negative*	*1952*	*1951*
(*a*) Supplied to London by road and rail in churns	Ordinary ..	336	8	9	319	2·4	1·8
	Accredited ..	30	3	—	27	*	*
	Tuberculin tested	117	—	3	114	—	—
(*b*) Plant at London depots	Pasteurised ..	15	—	1	14	—	—
(*c*) Residential schools	Tuberculin tested	2	—	—	2	—	—
	Total	500	11	13	476	2·4	1·8

* *A percentage would be unreliable owing to the small number of samples taken.*

There has been a considerable increase in the amount of tuberculin-tested milk coming into London.

As a result of investigations by the Ministry of Agriculture and Fisheries into the origin of positive samples in 11 herds, 5 tuberculous cows from five herds were removed and slaughtered under the provisions of the Tuberculosis Order, 1938. The source of infection in three other herds was presumed to be cows disposed of before investigations into the origin of positive samples were complete. No source of infection in one herd

could be traced, and investigation is still proceeding in the case of five herds, including three from which cows have already been slaughtered.

All raw milk from which positive samples were obtained had been pasteurised before sale to the public.

Sanitary inspection

Disinfestation

Reports of 189 instances of infestation were received from 156 establishments controlled by the Council, *e.g.*, school meals centres, schools, rest centres and parks. Infestation by rats, mice, cockroaches, bugs, ants, flies, fleas, mosquitoes and clothes moths were dealt with and 177 of the infestations satisfactorily remedied by the end of the year.

The disinfestation of dwelling houses owned by the Council is undertaken by the staff of the housing and valuation department. Advice on the latest methods of control is given as occasion arises.

Talks on the most effective measures for controlling and eliminating pests were given to staff employed in the restaurants and catering department, the London Fire Brigade, and at the Council's large welfare homes.

Restaurants and catering

Over 1,300 visits of inspection were made to school meals centres, dining centres and kitchens. Twenty-five reports of illness following consumption of school meals were investigated. In no case was contamination of food confirmed bacteriologically.

Welfare establishments

Regular inspections, at least once a quarter, were made of 72 homes, hostels, rest centres and other premises in connection with sanitary conditions.

Complaints

A large number of complaints of insanitary and overcrowded home conditions was received from the public. These were referred to the health departments of the appropriate boroughs.

Food by-laws

By-laws for the protection of food made by the Council under section 15 of the Food and Drugs Act, 1938, were confirmed by the Minister of Food and came into operation on 3rd November, 1952.

Lectures on food hygiene were given to the staff of welfare establishments and to civil defence personnel.

Advisory and research work

Advice was given to staff of other departments within the Council's service on problems relating to sanitation, drainage, and other public health matters in connection with the preparation of plans for new buildings and for the adaptation of existing premises.

Experiments were carried out during the year, in association with the architect's and the housing and valuation departments and the Plumbing Research Committee of the Department of Scientific and Industrial Research, to test the value of certain new plumbing theories. As a result of the exhaustive tests which have been applied to different plumbing systems specially installed in the Council's multi-storeyed dwellings in various parts of the county, it would appear that it may be practicable to instal a new and simple type of plumbing, known as the 'single pipe' system, which would prove less costly to provide and more economical in the use of materials than the conventional systems.

Representation on committees of outside bodies

The Chief Inspector continued to represent the Council on a number of committees of the British Standards Institution, and is chairman of two committees and two sub-committees appointed to consider standards in relation to sanitary appliances, dustbins, traps and flushing cisterns. He is also a member of the Plumbing Research Committee of the Building Research Board of the Department of Scientific and Industrial Research.

Blind and partially-sighted persons

The following figures show the number of persons examined under the National Assistance Act, 1948, for certification of blindness and the results. The figures do not include those relating to children of school age, details of which are to be found in the table on page 185.

Examinations by the Council's ophthalmologists

Classification	Certified blind			Not blind			Grand Total
	Male	Female	Total	Male	Female	Total	
New cases	271*	455*	726*	115	250	365	1,091*
Previously blind, still blind ..	53	64	117	—	—	—	117
Previously not blind, now certified	32	53	85	—	—	—	85
Previously not blind, still not blind	—	—	—	48	126	174	174
Previously blind, now not blind	—	—	—	16	24	40	40
Total	356*	572*	928*	179	400	579	1,507*

* *These figures include 8 boys and 9 girls under 5 years of age.*

The standards used are those prescribed by the Ministry of Health (Circular 1353/5.10.33). The cases ' previously blind, now not blind ' are mainly those in which cataracts have been removed surgically.

Two hundred and forty-nine certificates were accepted from other authorities, hospitals and private ophthalmologists as follows :

Blind persons .. 223 (104 male, including 5 children under 5 years ; 119 female, including 1 child under 5 years).

Not blind persons .. 26 (15 male, 11 female).

The causes of blindness in the 23 children under five years of age who were certified during the year were as follow :

Retrolental fibroplasia	7
Congenital, hereditary and development defects ..	6
Congenital optic atrophy	2
Cataract	2
Birth injury	2
Albinism	1
Encephalitis	1
Meningitis	1
Tubercular meningitis	1

The number of partially-sighted persons recommended for inclusion in the Observation Register was 343 (104 male, 239 female).

Blind persons examined as to suitability for training and the results were :

	Male	Female	Total
Suitable for training	19	4	23
Unsuitable for training	—	1	1

Registration of nursing homes

At the end of the year 48 nursing homes on the register were functioning compared with 53 at the end of 1951. In the 48 homes there were 864 beds distributed as follows :

Number of beds in home	Number of homes	Patients accommodated		Total
		All types†	Medical and surgical only*	
25 or over	5	227	87	314
20 to 24	11	78	160	238
15 to 19	4	8	59	67
10 to 14	13	57	92	149
5 to 9	11	36	48	84
Under 5	4	2	10	12
Total	48	408	456	864

* *Numbers include beds for medical and surgical patients which cannot be used if a maternity patient is accommodated in the same room.*

† *Each bed is registered for a medical, surgical or maternity case.*

The number of maternity patients admitted to nursing homes during the year was 1,091 compared with 1,243 in 1951.

Thirty-eight exemptions from the operation of Part XI of the Public Health (London) Act, 1936, were granted.

Visits of inspection to the homes were undertaken at regular intervals by medical officers (103 inspections) and public health inspectors (153 inspections).

Close overall supervision of the homes and more frequent inspections of a number of them resulted in an improvement in the general standard.

Welfare Committee establishments

The arrangements in regard to the medical supervision of all types of establishments under the control of the Welfare Department, *i.e.*, large homes, mother and baby homes, rest centres, reception centres for persons without a settled way of living, lodging houses, small homes for the aged and infirm, homes for the blind and hostels for persons in employment, to which reference was made in my report for 1950, were continued during 1952.

Homeless families units

At the end of the year 300 mothers and 634 children (of whom approximately 58 per cent. were under 5 years of age and 22 per cent. under 1 year of age) were accommodated in the eight homeless families units attached to large homes. The occasional overcrowding of these units, due to pressure on the available accommodation, coupled with the wide variation in the standard of living among the large groups of mothers and children, continued to give rise to many difficulties. Regular inspection of the units was undertaken by medical officers on the central staff to supervise medical arrangements and hygiene, and in particular to advise on the control of infection which, among communities of this type, demands constant vigilance. Advice was also given to the welfare department in regard to special diets for children under 5 years of age, and regular weekly visits were made by health visitors to advise mothers and to give talks on mothercraft. Mothers were also encouraged to attend sessions at neighbouring maternity and child welfare centres, and at one of the large units a weekly session was held on the premises.

Nursery classes for children aged between 3 and 5 years were conducted under direction of the education officer at one of the large homes and at two of the rest centres.

Mother and baby units

Close supervision of the health of infants accommodated in mother and baby units was continued during the year, and advice given on matters relating to diets and general hygiene.

There were 9 cases of infective hepatitis during the year among families residing at one of the rest centres. All those affected over a period of eight months were children whose ages ranged between 2 and 11 years, and the many adults at risk escaped infection. In one family, three children were affected. The exact mode of spread was not determined, but syringe transmission was excluded.

Care of the chronic sick

Attention has continued to be given to the needs of the considerable number of chronic sick persons who remain in the Council's homes because of the acute shortage of suitable hospital beds. While arrangements were made for a number of them to be exchanged for suitable recovered infirm persons in hospital who could not be discharged to their own homes, the number accommodated in the homes at the end of the year was 479 (144 men and 335 women). A large proportion of these residents were either permanently bedridden or in need of treatment in varying degrees and their continued care has given rise to many varied and complex problems. Sick bays have been provided in some homes for the care of the aged suffering from temporary illnesses for whom hospital beds were not available.

A further conference of visiting medical officers was held at County Hall during the year to discuss problems associated with the care of the aged and chronic sick, and preliminary arrangements were made for a similar meeting to be held early in 1953.

CHEMICAL BRANCH

THE WORK of the branch was carried on during the year at the three laboratories at County Hall and the Northern and Southern Outfall Works, and the Chemist-in-Chief has submitted the following report :

One of the most important features of the National situation during the year 1952 was the financial stringency which developed, with the consequent need for exercising strict economy, having due regard, of course, to the preservation of efficiency. In this introduction it may therefore be appropriate to devote a short space to the consideration, from this aspect, of the use of the Chemical Branch to the service of the Council. A good example of the enormous scale on which this operates is in relation to paint ; for 200,000 gallons of paint are used each year and, including the labour cost of the work, more than one million pounds is spent on this operation. The opportunity for effecting economy by ensuring that only paint of suitable quality is used and early failures thus prevented is readily apparent. Also many articles, including some foodstuffs, lubricating oils, polishes, etc., are purchased in large quantities. Tenders are invited for materials which must comply with quality specifications issued by the Council and samples submitted with the tenders are examined in the laboratory, the cheapest satisfactory material being recommended to the Chief Officer of Supplies for acceptance. The work of the Chemical Branch in the sewage treatment field is of direct economic value ; for example, the development of a chemical method for cleaning air diffuser tiles in the activated sludge plant showed a large saving as compared with previous procedures. Other work done by the branch may be classified as ' insurance premiums ' ; for example, that on ensuring the satisfactory quality of water supplies (chlorinated) from private wells and the maintenance of efficient treatment of swimming bath waters. There must also be borne in mind the statutory work which has to be done in connection with various Acts administered by the Council ; for example, the Fertilisers and Feeding Stuffs Act, 1926, the Petroleum Consolidation Act, 1928, London Building Act, 1930, Town and Country Planning Act, 1947, etc. The amount of advisory and consultative work devolving upon the senior officers of the branch from these and other activities increased considerably during the year and the very necessary and valuable time spent on Government committees dealing with matters of interest to the Council also increased; these committees related, for example, to the condition of the River Thames, Atmospheric Pollution, Flue Gas Washing at electricity generating stations, etc.

The number of samples received for examination in 1952 showed a considerable increase and was the largest on record. It amounted to 26,642, as compared with 25,666 in 1951. The classification was :

Air tunnels, etc.	267	Miscellaneous	293
Building materials	268	Oils, lubricating, fuel, etc.	60
Chemicals, drugs and medical supplies	142	Paints, varnishes and distempers	2,145
Clay, subsoils and borehole waters	1,265	Petroleum and allied samples	98
Detergents and soaps	94	Plastics	54
Disinfectants and insecticides	9	Rainwater (atmospheric pollution deposit gauges)	84
Fertilisers and feeding stuffs	106	Rubber and rubber substitutes	10
Floor oils and polishes	53	Scouring powders and lavatory cleansers	12
Fuel (coal and coke)	16	Sewage and effluent	4,637
Foods	715	Sludge, primary, digested and activated	3,178
Gases, sludge digestion plant, flue, degreasing plants, etc.	412	Sulphur gases and smoke in air	1,956
Insulating materials for hot water systems	29	Water, steam-raising plants	1,794
Lamps, gas detector	411	Water, drinking	1,551
Laundry tests	92	Water, swimming bath	1,231
Liquor, effluent from gasworks	406	Water, river	4,823
Meals	93	Water, miscellaneous	96
Metals	34		
Milk, liquid, condensed, dried	208	*Total*	26,642

The following paragraphs give a general indication of the source of origin of these samples and of the consultative and advisory duties carried out for the various services and departments of the Council.

Rivers and drainage

Throughout 1952 the whole of the sewage flow to the Northern Outfall Works was treated by sedimentation and approximately one-quarter of it subsequently by the activated sludge process. At the Southern Outfall Works the whole of the flow continued to be treated by primary sedimentation only. Regular sampling and examination were done to assess the results of the treatment. In the case of both outfall works, the plants functioned satisfactorily throughout the year and achieved as large a saving of B.O.D. (biochemical oxygen demand) load on the water of the River Thames as could be expected.

The sludge digestion plant at the Northern Outfall Works was subject to analytical control, the rate of charge being decided accordingly, and it worked satisfactorily, the gas produced (containing about 70 per cent. methane) being used for power production at the works.

The composting of sewage products (mainly screenings) with household refuse was continued and a large amount of the finished product was available for transport to farms, mostly those at hospitals.

As mentioned in a previous annual report, in an endeavour to improve the condition of the water of the River Thames a programme of additions to the existing sewage treatment works has been agreed by the Council. At the end of the year the completion of the new detritus pits at the Northern Outfall Works was approaching as was also that of the ' old reservoir ' sludge digestion plant. Progress had been made there on the construction of the new sedimentation tanks. The other works approved in principle by the Council comprise additional 60 million gallons per day diffused air activated sludge plants at both the Northern and the Southern Outfall Works and, also at both works, sludge digestion plants to deal with the whole of the sludge produced. None of these had been started at the end of the year owing to the fact that they had not been licensed for the supply of materials by the Ministry of Housing and Local Government. Towards the end of the year the Minister received a joint deputation from the Council and the Port of London Authority which emphasised to him the necessity, in view of the condition of the water of the River Thames, for proceeding at the earliest possible date with the additional works for treating the sewage of London in order to lessen the pollution load on the river.

In the report for 1951 it was mentioned that consideration had been given to any temporary palliative measures which could be adopted to improve the condition of the water of the river in the summer months and that chlorination of part of the effluent from the Northern Outfall Works had been tried as the only possible practicable policy. In 1952 chlorination of that part of the effluent from those works which was not subsequently subjected to secondary treatment was again started in May and continued until the end of August. The dosage adopted was one-third of the chlorine demand, which was about 40 parts per million ; *i.e.*, the addition of 13 parts per million of chlorine. This was achieved by dissolving it in final effluent from the activated sludge plant in absorption towers and adding the relatively strong solution to the primary effluent to be treated. In spite of this, as will be explained in more detail later, the condition of the water of the river at the end of August was bad over a long stretch of its course and it was decided to cease chlorination—which was a very expensive procedure requiring about 50 tons of chlorine per week—and use September as a ' control ' period. Actually, the water of the river in that month did not become generally worse, although it still remained bad. It was concluded that chlorination on the scale which its great cost and quantity made feasible did not produce sufficiently beneficial results to justify its future use and the procedure was therefore abandoned ; also that the only way of improving the condition of the water of the river was by lessening the pollution load added to it, which could best be accomplished by proceeding, as soon as possible, with the additional sewage treatment works.

The state of the water of the river is of great concern to the Council and a weekly examination of it is therefore made at 25 points between Teddington Weir and the sludge dumping area in the estuary. In addition, the water off the two outfall works is sampled daily at both high and low tide.

An important factor in determining the pollution load with which the water of a river will deal satisfactorily is the fresh water flow ; in the case of the River Thames, this is the amount coming over Teddington Weir after the Metropolitan Water Board has, above that point, abstracted the quantity required for water supply. By Statute, no abstraction is permitted which will have the effect of reducing the flow over the Weir to below 170 million gallons per day, although the appropriate Minister can, by Order, permit the reduction of the flow to as low as 50 million gallons per day. The rainfall in the summer of 1952 was rather below average and hence the average fresh water flow over Teddington Weir was also rather below average. It was, indeed, considerably less than that for 1951, though much greater than that in the dry year 1949. In the summer months of 1952 the condition of the water of the river became extremely poor and was bad over a considerable stretch of its course for several weeks, particularly between London Bridge and Gravesend, with a complete absence of dissolved oxygen and the development of sulphide (with its characteristic odour).

There are now two Government Committees considering and investigating the condition of the River Thames ; the Thames Survey Committee of the Department of Scientific and Industrial Research set up at the request of the Port of London Authority in June, 1949, and the Heated and Other Effluents Committee of the Ministry of Housing and Local Government set up early in 1951 with wider terms of reference. The Chemist-in-Chief is a member of both these Committees.

Close liaison was maintained with other research work, both in this country and in the United States, on the problems of sewage treatment and river sanitation.

The laboratories at the two outfall works carried out the chemical analyses necessary for the control of the various plants during the year. Research work was also done on several aspects of the sewage treatment problem and particularly in reference to the dewatering of sludge by a new process involving freezing after the addition of chemicals; the pilot plant for dealing with one ton of sludge came into operation early in the year and research on the filtration of the material produced proceeded satisfactorily.

The question of trade discharges into sewers was investigated in a number of cases as to compliance with the appropriate sections of the Public Health (London) Act, 1936. Attention was also directed to the ventilation of sewers and, in view of certain complaints of emanations, a joint working group of officers of the Council and of the Metropolitan Boroughs' Standing Joint Committee was set up to investigate the problem. It was decided that the increase in trade wastes was an important factor and that it was desirable to initiate legislation in order to obtain more effective control. The Chemist-in-Chief was a member of this Working Group.

Safety lamps used in sewers were tested and adjusted periodically and an officer of the Chemical Branch gave advice and assistance in training men employed on sewerage work in the use of oxygen breathing apparatus under emergency conditions.

The sewage treatment service is a joint function of the Chief Engineer's and Public Health Departments and special mention should be made of the cordial relations which have so greatly helped in maintaining the efficiency of the operations. Weekly conferences of the Divisional Engineer (Main Drainage) and the Chemist-in-Chief and their senior officers have been of the utmost value in this respect.

Housing

The work done by the Chemical Branch for this service covered a very wide field. The largest section was on paints and other decorative finishes, the economic aspect of which has already been mentioned. The Interdepartmental Paint Committee and Sub-Committee held periodical meetings during the year and progress was made with the completion of ' approved lists ' of brands of paint which must be used on work for the Council whether by direct labour or by contractors. Lists were compiled for hard-gloss paint (both interior and exterior), flat oil paint, semi-gloss paint, emulsion paint,

chlorinated rubber paint and bituminous paint, the classification depending primarily on the results of the analyses and tests made by the Chemical Branch. Samples of deliveries were also taken at the sites in order to ensure that the quality complied with the standard required. The technique of paint testing has advanced considerably in recent times and, in order to ensure the efficiency of the examination, the Council agreed during the year to expenditure necessary for equipping a new paint-testing laboratory at County Hall with the latest apparatus. In addition to facilities for determining the film hardness, flexibility, etc., provision is being made for an accelerated weathering test apparatus. A feature of the year's examination of products for approval was the large number of emulsion paints submitted. The majority of these were based on water emulsions of polyvinyl-acetate and it was necessary to study the properties of such materials and work out a suitable scheme of examination.

Examples of a few defects were (*a*) the use of lithopone in a paint for exterior work; (*b*) offensive and toxic nature of the medium ; (*c*) insufficient mixing before use. Special matters dealt with referred to : (*a*) colour permanence of applied paint (*i.e.*, the fastness to light), (*b*) primers for hard-boards, (*c*) fire resistant paints, (*d*) paints for specially corrosive conditions, *e.g.* sewage.

Much advice was sought regarding building materials and allied problems. A few examples were in relation to cements, asphalts, bitumen sheeting for roofing, etc., synthetic floorings, sand, plasters, mortars, etc. For example, many types of flooring materials were examined to ascertain their chemical composition, water absorption, shock and fire resistance, thermal conductivity, durability and liability to staining by certain materials. Their composition varied widely : coloured Portland cement, magnesium oxychloride, bitumen and sawdust, high alumina cement and rubber latex, powdered wood and resin were typical examples. Such a variety introduces not only problems in regard to construction but also as to cleaning and polishing. Plaster defects were investigated in some cases and the causes diagnosed. Asphalts were generally satisfactory as regards the bitumen content but in some cases adverse comment was made as to the grading of the aggregate. Materials for the eradication of wood-boring insects were examined and recommendations made. On the planning side the advice of the Chemical Branch was sought in many cases in regard to the Use Classes Order, 1950, relating to the Town and Country Planning Act, 1947 ; guidance was sought as to the exact classification of proposed industries with respect to the possible causation of nuisance or effect on the amenities of the areas in which their sites were located.

Public health

The examination of water supplies is an important part of the work of the branch from this aspect, for, although in the majority of cases the water is derived from the mains supply, there are a number of schools and other premises at which it is drawn from private wells. In these cases, before use, it is chlorinated by means of automatic dosing appliances. The Chemical Branch carries out regular monthly inspections (in addition to the daily free chlorine tests made by the resident engineer) and samples are taken for chemical analysis and bacteriological examination in the laboratory. Some hospitals formerly under the control of the London County Council which have private well supplies have, at the request of the hospital committees, continued to be included in the regular examination programme.

The air in the Council's vehicular tunnels under the River Thames was regularly tested in order to ensure that the carbon monoxide content did not exceed the safety limit. In view of the continued use of petrol containing lead compounds, the lead content of the air was also checked periodically and found to be safe. Since nitrous fumes can be caused by diesel engines this constituent also received attention but it was well within safety limits.

Considerable work was done during the year on atmospheric pollution, assays being made by various methods of the polluting matter (total deposit, tarry matter, sulphur gases, smoke, etc.) in the air at various places within the County and also, for comparison, at two observation stations outside it. This work was done in conjunction with a scheme sponsored by the Department of Scientific and Industrial Research.

The results during the year again showed variations in different localities of the County due to factors such as local sources of pollution ; there was also a well marked contrast between urban and rural conditions. Seasonal fluctuations were clearly evident during the cycle of months. The generally higher level of pollution found in winter months is due to the combined effect of increased coal consumption and the occurrence of meteorological conditions unfavourable to dispersal of particles and gases emitted from chimneys.

Apart from its long-term detrimental effects, atmospheric pollution is particularly objectionable in meteorological conditions where there is a lack of convective up-currents of air, since the contaminants may then accumulate to concentrations acutely dangerous to health. An extreme case of such conditions occurred during the period 5th to 8th December, 1952, when there were four consecutive days of frost and dense fog. During the period midday Saturday 6th, to the morning of Monday, 8th December, pollution rose to the highest yet recorded in the Chemical Branch records, namely, sulphur dioxide 1.34 parts per million, and smoke 4.46 milligrams per cubic metre at County Hall. Official notifications of deaths for the week ending 13th December showed that abnormally large numbers of persons had died from causes connected with difficulty of breathing, and this high general death rate was comparable with the peak mortality of such events as the cholera epidemic of 1866 and the influenza pandemic of 1918.

By virtue of a standing agreement with the Ministries concerned, the Chemist-in-Chief accompanied the Chief Alkali Inspector of the Ministry of Housing and Local Government on his visits of inspection to test the efficiency of the flue gas washing plant at Battersea Power Station. Similar facilities for inspection were sought and obtained in regard to the newly constructed Bankside Power Station which is also to incorporate flue gas washing plant.

Other fields of public health work which have been closely watched are those dealing with insecticides and disinfectants and assistance and advice have been given as required. The Chemist-in-Chief was a member of the Working Group set up by the Medical Officer to consider all aspects of disinfection in relation to all branches of the service and to make recommendations accordingly.

Problems and work on industrial hygiene and safety ranged over a wide field ; examples were : (*a*) safety precautions after the spillage or leakage of petroleum spirit ; (*b*) some yellow coloured chalks for schools contained lead chromate and were rejected ; (*c*) precautions were advised to prevent dermatitis when using water-insoluble synthetic resin glues.

Public control

Samples taken under the Fertilisers and Feeding Stuffs Act, 1926 (under which the Chemist-in-Chief is the Official Agricultural Analyst for the County), were examined as to whether they complied with the statutory statement of ingredients which is required to be given with every sale and also (in the case of feeding stuffs) as to their freedom from deleterious substances ; several were reported upon adversely. Many samples were also examined under the Petroleum (Consolidation) Act, 1928, the provisions of which govern licences for storage and safety precautions regarding petroleum spirit and petroleum mixtures. Cases were also considered and examined relating to certain sections of the London Building Acts, 1930–39, referring especially to dangerous businesses and to means of escape when inflammable materials are stored or used ; alterations to plant were recommended in certain instances. Another Act with which the Chemical Branch was concerned was the L.C.C. (Celluloid, etc.) Act, 1915.

Many samples of bread were analysed under the Bread Order, 1951, to determine whether the short weight supplied was due to the bread being either ' fancy bread ' or ' protein fortified '. In some cases, where this was not so, court proceedings were attended by an officer of the Chemical Branch to support the certificate given. Premises of degreasers and rubber spreading works operating under licence were visited periodically and samples of the atmosphere in the machines were taken for subsequent analysis to ensure that the safety regulations regarding the limitation of inflammable gases, derived from volatile solvents, were being duly observed.

Parks

Although some work was also done for this department on fertilisers, soils and other matters the most important aspect of it related to the swimming baths and ponds provided for public use. The 13 open air baths have chlorination plants which provide continuous treatment of the water. The Parks Department, Chief Engineer's Department and the Chemical Branch are all concerned in these operations and close liaison was maintained which resulted in a high standard of purity of the water being maintained throughout the bathing season. Frequent tests for free chlorine were done by the staff at the baths and periodical visits were made by an officer of the Chemical Branch who took samples of water for chemical analysis and bacteriological examination in the laboratory. The investigations of a research team including officers of the Chemical Branch and the Chief Engineer's Department resulted in inexpensive changes being made to some of the plants which caused a considerable improvement in the efficiency of operation. The fundamental principles of the chlorination process were studied and it was proved, for example, that in an open-air bath the action of sunlight caused a greater loss of free chlorine residual than the impurities normally added by the bathers.

School meals, education and children

The work done in co-operation with the Restaurants and Catering Department was continued and many meals were analysed as to their nutritional value by the determination of their fat, protein, carbohydrate and mineral contents and their calorific value. The results generally showed a reasonable approximation to the standards aimed at for the several nutritional factors for the various age groups concerned.

Swimming bath waters and drinking waters at residential schools were examined. Pending the authorisation by the appropriate Ministry of the expenditure for installing automatic treatment plants at these baths, they continued to be treated by an improvised chlorination system. The research team, already mentioned as working on swimming baths, devoted considerable attention to those of this type and devised improvements which, in the case of the particular bath where they were tried, rendered the operation partly automatic so that the length of period for which the water could be used without emptying and refilling was greatly increased.

Instructional visits of school parties to both the County Hall and the Northern Outfall Works laboratories should be mentioned.

Supplies

The materials examined for this service covered a very wide field, and many of them are dealt with in other paragraphs concerning the services which use them ; for example paints and building materials for housing. Particularly close liaison was maintained with officers of all branches of the Supplies Department which facilitated discussions on matters on which a scientific aspect could be helpful.

Many foodstuffs of all types were examined, the main purposes being (*a*) to allocate contracts to the tenderers of the cheapest satisfactory material, (*b*) to check the quality of deliveries, (*c*) to investigate complaints and (*d*) to assess whether new preparations could be of potential use in the service. Generally, a high standard of quality was maintained for the foodstuffs in use and there were only a very few justifiable complaints. A careful watch was kept on the quality of the liquid milk supplied and condensed and dried milks were examined as required. Other materials which might be mentioned included chemicals, drugs and medical supplies, lubricating and other oils, floor and other polishes, soaps, solders and other metals, etc.

Careful attention was given to the development of synthetic detergents and many types were examined though the Council's own specification for a washing-up powder was still considered to be the most satisfactory. The use of plastics as substitutes for china and earthenware in certain instances was investigated and many of the several different compositions now on the market were examined. For some, for example melamine, the curing in manufacture is particularly important and under-curing may result in an undue proportion of the incorporated zinc oxide being extractable by acid liquids.

Fire brigade

Much of the work in this field was of a consultative and advisory nature, including the discussions of the British Standards Institution's Technical Committees on Inflammability of Films and Definitions of Fire Resistance and Incombustibility. Other subjects

dealt with were (*a*) the fire-resistant treatment of fabrics, (*b*) the efficiency of foaming compounds for fire extinguishers, (*c*) the relative efficiency of various fire retarding coatings for wood, (*d*) cause of fires, *e.g.* the careless use of a painter's blow-lamp.

Steam raising, heating, etc., plants ; laundries

Much consultative and advisory work was done for both the Chief Engineer's and Architect's departments involving examinations *in situ* and subsequent analysis of samples in the laboratory regarding scale formation, scale removal and corrosion problems. Samples from some of the larger installations were examined regularly. Phosphate conditioning of boiler water has now become standard practice though in some cases the use of soda ash and quebracho is being continued. An interesting investigation related to corrosion in a hot water circulating system ; it was, most unusually, found to be due to the action of sulphate reducing bacteria which had gained access to the feed tank. Heat insulating materials of the magnesia plastic and hardsetting types were analysed as to their suitability for use.

In co-operation with the Chief Engineer's Department investigations were made into the operation of the many laundries maintained by the Council. The problem was approached not only from the detergency angle but also from that of the effect on the clothes in the process. Both these aspects are now capable of being examined by scientific tests and, although the whole range had not been completed by the end of the year, it had already been possible to introduce certain improvements in operation.

Miscellaneous

Many other matters were dealt with of which a few examples are :

(*a*) Estimating the thickness of chromium and other electroplating on manufactured goods.

(*b*) Death of fish in a pond.

(*c*) Assessing scientifically the approach to truth of the colour of colour photographs supplied by contract.

(*d*) Civil Defence matters were considered.

Attention was paid to the development of new analytical methods and close liaison was maintained with many Research Associations, Government Scientific Establishments, etc. During the year many visitors, both from home and abroad, were welcomed to inspect the work of the various laboratories. The Library of the Chemical Branch continued to develop and is an essential part of its equipment. The Chemist-in-Chief served on four committees of the Ministry of Housing and Local Government, four of the Department of Scientific and Industrial Research and nine of the British Standards Institution. The Deputy Chemist (Dr. S. G. Burgess) served on a committee of the Ministry of Food and on five committees of the British Standards Institution.

Publications and lectures during the year were :

(*a*) ' The Condition of the Tidal Portion of the River Thames '—C. J. Regan.

(*b*) ' Cleopatra's Needle '—S. G. Burgess in collaboration with R. J. Schaffer of the Building Research Station, D.S.I.R.

(*c*) ' Investigations into Swimming Bath Water Treatment '—S. G. Burgess and D. Burns, in collaboration with C. W. Tidy of the Chief Engineer's Department.

(*d*) ' Chemistry of Water Conditioning with respect to Economy '—S. G. Burgess.

(*e*) ' Science and Painting Problems '—S. G. Burgess.

(*f*) ' A Method of Estimating Sulphides in Waters '—J. E. Houlihan and P. E. L. Farina.

(*g*) ' Total Hardness of Water by the Versenate Method : Direct titration with Ethylene diamine tetra-acetate (EDTA) '—J. E. Houlihan.

SPECIAL SURVEY OF LOCAL HEALTH SERVICES

AS REQUIRED by the Minister of Health (Circular 29/52) a special survey was prepared of the services provided under the National Health Services Acts and forwarded to him early in March, 1953. The information given in the survey relating to individual services is included in the appropriate sections of this report. The following is the other information which was given :

Administration

For the purpose of administration the County is divided into nine divisions consisting of groups of from 2 to 5 of the Metropolitan Boroughs as follows :

Metropolitan Boroughs arranged in divisional order	*Estimated home population mid 1951*	*Metropolitan Boroughs arranged in divisional order*	*Estimated home population mid 1951*
Division 1		*Division 5*	
Chelsea	52,430	Bethnal Green	58,000
Fulham	122,400	City of London	5,200
Hammersmith	118,300	Poplar	73,260
Kensington	171,300	Stepney	98,850
Division 2		*Division 6*	
Hampstead	97,750	Deptford	76,040
Paddington	125,400	Greenwich	89,390
St. Marylebone	76,160	Woolwich	149,800
St. Pancras	139,100		
Westminster, City of	100,000	*Division 7*	
		Camberwell	179,500
Division 3		Lewisham	227,200
Finsbury	35,620		
Holborn	24,540	*Division 8*	
Islington	235,800	Bermondsey	60,380
		Lambeth	229,100
Division 4		Southwark	97,930
Hackney	170,800		
Shoreditch	45,010	*Division 9*	
Stoke Newington	49,440	Battersea	117,000
		Wandsworth	332,300

With the exception of the domiciliary midwifery, ambulance and mental health services the day-to-day administration of the personal health services is carried out on a divisional basis.

The statutory Health Committee consists of the Chairman, Vice-Chairman and Deputy Chairman of the Council (*ex-officio*), 30 other members of the Council and 16 persons not being members of the Council of whom not fewer than 10 shall be appointed by the Council from members of the City Corporation or the Metropolitan Borough Councils after consultation with the City Corporation and the Metropolitan Boroughs' Standing Joint Committee. The Committee's constitution provide for representation of the Local Medical Committee for the County of London, the London Executive Council, the Metropolitan Regional Hospital Boards and the Teaching Hospitals Association.

A Divisional Health Committee has been constituted for each of the nine divisions. These committees are sub-committees of the Health Committee and their constitution is as follows :

Exclusive of *ex-officio* members, not more than eight or fewer than four members of the Council or the Health Committee; not more than 15 or fewer than eight members of the Metropolitan Borough Councils (or the City Corporation) appointed after consultation with the Metropolitan Boroughs' Standing Joint Committee (or the City Corporation); and not more than six other persons co-opted for special reasons.

Each divisional health committee includes representatives of the Local Medical Committee for the County of London, the London Local Dental Committee and the district nursing associations. Representatives of the Royal College of Nursing, Royal College of Midwives, Women Public Health Officers' Association, Local Pharmaceutical Committee, and of branches of the British Postgraduate Medical Federation (*i.e.*, Institute of Obstetrics and Gynaecology, Institute of Child Health) are also included on individual committees.

Arrangements have been made for the medical officers of health of the City of London and the City of Westminster and of all the metropolitan boroughs except St. Marylebone to participate in the day-to-day administration of the divisionalised personal health services.

Particular mention may be made of the special tripartite organisation in one division, comprising the Boroughs of Battersea and Wandsworth, where an officer has been jointly appointed to act as divisional medical officer for the Council and as medical officer of health for the two boroughs. He has two assistants, each of whom acts as assistant divisional medical officer and as deputy medical officer of health for one borough. In addition to these special arrangements, two of the Council's divisional medical officers have been appointed by metropolitan boroughs (Paddington and Stoke Newington) as their medical officers of health, on a part-time basis. Other divisional medical officers have on occasion acted as borough medical officers of health, *e.g.* during sickness or holidays of the regular incumbent or hiatus between two regular appointments. Five of the Council's assistant medical officers are at present regularly employed for part of their time as deputy borough medical officers of health (in Finsbury, Fulham, Hampstead, Islington and Paddington). All the regular arrangements include appropriate financial adjustments between the Council and the metropolitan boroughs concerned and the officers carrying out the additional duties receive appropriate allowances in accordance with the relevant Industrial Court awards governing medical salaries generally.

Conferences with appropriate officers from head office are held at regular intervals in order to ensure co-operation and co-ordination throughout the service, viz., with divisional medical officers ; divisional administrative officers ; divisional nursing officers ; chest physicians.

In addition conferences are held at divisional level with the borough medical officers of health concerned with the day-to-day administration of the Council's health service.

Arrangements are made for whole-time medical staff to attend short refresher courses from time to time. About 100 medical officers have so far attended, the majority of them at week-end courses arranged by the Society of Medical Officers of Health.

Co-ordination and co-operation with other parts of the National Health Service

Whilst an excellent spirit of co-operation exists throughout the various branches of the health service in London, co-ordination in the complex circumstances of the metropolis is not easy. Whilst there is one Local Health Authority and one Local Executive Council for the whole of the County area, there are parts of four Metropolitan Regional Hospital Boards whose boundaries cut across no less than five metropolitan boroughs. There are also, under the Boards, 25 hospital management committees, and in addition, 12 undergraduate and 14 postgraduate teaching hospitals each with independent boards of governors.

The constitutions of the Health Committee and of the divisional health committees as set out in paragraphs 4 and 5 indicate the extent to which co-ordination has been achieved at member level with other bodies concerned with the health service. The report of the Central Health Services Council on co-operation between hospital, local authority and general practitioner services is receiving careful consideration and preliminary consultations are proceeding with the other bodies concerned to decide whether the Council could usefully convene a regional conference to devise further machinery for co-operation.

Conferences are held periodically at officer level to ensure co-ordination and co-operation in the administration of the services with the senior administrative medical officers of the four Metropolitan Regional Hospital Boards, the medical officers of health of the Home Counties, representative house governors of teaching hospitals, and representative metropolitan borough medical officers of health.

Each of the nine divisional medical officers is a member of at least one hospital management committee in the area. Senior divisional staff also serve on many voluntary committees concerned with health (*e.g.* nursing associations, tuberculosis care, care of old people).

From the inception of the National Health Service Act, 1946, the Council, through its divisional staff, fostered close co-operation between the almoners of hospitals and the divisional organisation in view of the fact that the two services are interdependent for a full knowledge of the patient, his background and his needs, and that the two services have a common concern in the well-being of the patient and the maintenance of his health. In view of Ministry of Health circular 160/48, negotiations took place with the hospital authorities and the Institute of Almoners on the after-care arrangements for persons discharged from hospitals. A scheme was introduced early in 1951 whereby the Council undertook through its divisional organisation to carry out home visiting and provide after-care for patients referred by hospital almoners. Under this scheme, the direct approach of almoners to the Council's fieldworkers for mutual discussion and exchange of information is encouraged, but all correspondence on arrangements for home visiting and after-care is conducted through the divisional medical officers.

There was a good record of co-operation between hospital maternity and pædiatric departments and the ante-natal and child welfare clinics at welfare centres before the National Health Service, and this has been maintained and developed since 1948. So far as the discharge of maternity patients from hospital is concerned, the Council introduced, with the co-operation of hospital authorities, a form which hospitals could use when notifying the Council's divisional medical officers of such discharges which has worked well.

On the receipt of Ministry of Health circular LHAL 1/51 enclosing a copy of the memorandum RHB (51)74, divisional medical officers offered to co-operate with local hospitals by advising on admissions on social grounds. This is closely allied to the problem of the number of home confinements and the work of the domiciliary midwife. Detailed reference to the origin of the circular and its first results is made in the section on the domiciliary midwifery service. Reference may be made here to the approach which has been made to the secretaries of the Metropolitan Regional Hospital Boards and of hospital management committees and boards of governors of all hospitals with maternity beds, suggesting that the time has arrived for a review of the progress made in co-operation in this and allied matters, relating to the maternity services, under the following heads:

(*a*) Selection of maternity patients for admission to hospital.

(*b*) Co-operation between hospital maternity departments and the Council's ante-natal clinics.

(*c*) Notification to the Council of the discharge of maternity patients from hospital.

(*d*) Provision of care and after-care for maternity patients as part of the scheme for provision of care and after-care at the request of hospital almoners.

Reference is made in the section on the domiciliary midwifery service to the liaison between ante-natal clinics and the general practitioner. Arrangements have been in force for a long time for exchanging information between the Council's domiciliary midwife and the booked general practitioner obstetrician on the ante-natal examination of their patients. There is in existence also a form for notifying the general practitioner, subject to the patient's consent, that one of his patients is pregnant.

General practitioners are notified when any of their patients (mothers or children) are referred from maternity and child welfare clinics to hospital out-patient departments for further advice and treatment. Co-operation is encouraged between general practitioners and the Council's health visitors and in some divisions arrangements have been

made for regular meetings between numbers of general practitioners and health visitors working in their areas. Health visitors discuss with the family doctor questions relating to a patient's treatment which may arise in the course of duties in the home or centre. There is no doubt that this co-operation is of benefit. Not only are the health visitors able to advise the general practitioners on the various local health authority and voluntary services available in particular cases, but they are able to supplement the treatment given by the doctors by visiting the patients in their homes. Further development of such co-operation between health visitors, hospital staff and doctors in general practice is restricted only by the general shortage of health visitors.

Liaison is maintained with the mass miniature radiography services of the four Metropolitan Regional Hospital Boards who assist the Council to carry out its duties for the prevention of tuberculosis. The tripartite nature of the tuberculosis services in London creates continuous need for liaison which is not always easy, smooth or effective. Nor does it always ensure that the Council's viewpoint or wishes necessarily prevail.

Publicity

In 1949 a pamphlet was prepared for general distribution to the public. There were nine editions of the pamphlet, the appendix of clinic addresses and times differing in each. Similar information is supplied from time to time to local information centres, etc., as part of a loose-leaf publication on all services of the Council. Special information is supplied on request for directories, borough guides, etc. Information on the health services is often given in newspaper and magazine articles and through B.B.C. programmes. Every facility is offered to journalists for this purpose. On the introduction of the National Health Service, all general practitioners in the County were notified by letter of the services provided by the Council as local health authority. A further circular is in course of preparation reminding them of the services available and the method of obtaining them for their patients.

Joint use of staff

About 180 doctors in general practice are employed by the Council on a sessional basis, about 115 on work under the National Health Service Act, and the remainder in the school health service. The general practitioners work on an average two sessions a week each and are responsible for about one-third of all sessions taking place. General practitioners carry out all types of work for which non-specialist medical staff are employed, *e.g.* ante- and post-natal, child welfare, vaccination, immunisation and dental anaesthetics.

The Council's proposals for carrying out duties under the National Health Service Act envisaged discussions with the four Metropolitan Regional Hospital Boards with a view to making joint appointments, on an agreed basis, of medical specialists to be employed in both the hospital and local health authority fields. Arrangements have now been made with all four regional boards and with a number of the teaching hospitals for the payment by the Council of three-elevenths of that part of the salary of chest physicians that is attributable to work in the chest clinics. In certain cases the Council also contributes towards the salaries of clerical and social workers employed by the hospitals in the chest clinics, as an alternative to the practice, in the majority of cases, of the Council itself providing staff in these grades for the care and after-care work of the chest clinics.

By the end of 1952 arrangements for the exchange of medical officers, employed by the Council at maternity and child welfare centres and undertaking child welfare sessions, with pædiatric registrars were operating at the following hospitals :

St. George's Hospital (Tite Street Branch).
The Hospital for Sick Children, Great Ormond Street.
Westminster Children's Hospital.
Paddington Green Children's Hospital.
Queen Elizabeth Hospital for Children (Bethnal Green Road and Shadwell Branches).
King's College Hospital.
Guy's Hospital.

In addition there is an exchange system with St. James's Hospital, Balham, and a pædiatrician from St. Thomas's Hospital goes to North Lambeth Babies' Care Welfare Centre to take weekly child welfare sessions and is paid the ordinary rate for a non-specialist session.

Among the services taken over from the metropolitan borough councils were a number of specialist clinics for expectant and nursing mothers and children (*e.g.* gynaecological, special women's, physiotherapy). Although these were provided under the maternity and child welfare powers of the borough councils, they were not services proper to the local health authority under the National Health Service. Negotiations have, therefore, been proceeding with the Metropolitan Regional Hospital Boards with a view to their assuming full responsibility for the administration of such clinics. In some cases, responsibility has been accepted for clinics held in Council premises; in others the work has been transferred to hospital premises or terminated. Negotiations are still proceeding in some instances. The Council has continued the employment, under arrangements made by the borough councils, of specialists provided by teaching hospitals for ante-natal advice (5 sessions a week) and child welfare (3 sessions a week). Generally speaking, however, specialist advice for maternity and child welfare patients is obtained by referring the patient to a hospital specialist clinic and there is adequate liaison between the clinics and the hospitals for this purpose.

Voluntary organisations

From the inception of the National Health Service the Council continued to utilise existing voluntary committees as in the case of the home nursing service which is carried out entirely by voluntary district nursing organisations on a grant-aided basis. Encouragement has also been given, in appropriate cases, to the formation of new committees such as those for tuberculosis care and the care of old people to which reference is made below. The use of voluntary associations in connection with mental health is dealt with on page 106.

When the Council assumed responsibility for the maternity and child welfare services, an agreement to cover the period from 5–7–48 to 31–3–50 in the first instance was made with 24 voluntary organisations providing maternity and child welfare and/or day nursery services, arrangements being made for the Council to be represented on the managing committees of these bodies and to inspect the premises and services, and for a grant to be paid by the Council on a modified deficiency basis. The administration of two maternity and child welfare centres has since been assumed by the Council. New agreements in the light of the experience gained since July, 1948, are being negotiated with the remaining voluntary organisations, and in the meantime, by mutual consent, the original agreements have been extended.

Arrangements were also made with the Mothercraft Training Society, Cromwell House, Highgate, for the Council to be financially responsible for the attendances of London residents at their two out-patient clinics for mothers and children (*a*) at 42 Penywern Road, Kensington, and (*b*) at Cromwell House, Highgate, and for financial responsibility to be accepted for the admission of London residents to the in-patient unit at Cromwell House for mothers and babies with breast-feeding difficulties and babies with dietetic upsets. These arrangements were terminated when the Society ceased its activities at the end of July, 1951. Records relating to London children who normally attended the out-patient clinics were passed to the appropriate divisional health office so that these mothers and children might be referred to convenient welfare centres. Patients who would have been referred by the Council for in-patient treatment at Cromwell House are now referred to the residential unit at the Violet Melchett Infant Welfare Centre (see page 51).

Many of the former voluntary hospitals provided maternity and child welfare services, both ante- and post-natal clinics, child welfare clinics, and health visiting services, before the 'appointed day' often by arrangement with one or more of the metropolitan

borough councils, by whom they were assisted financially. Two of the Council's former hospitals provided ante- and post-natal facilities for metropolitan borough councils by agreement but without payment, and others provided dental services for expectant and nursing mothers and children under five years of age, payment being made on a case basis.

Ante- and post-natal clinics may be provided under Part II of the Act of 1946 by hospitals for their own booked maternity patients, but in view of the ruling that a service for healthy babies and a health visiting service can be provided only by a local health authority either directly, or through a voluntary organisation on an agency basis, consultations took place with representatives of the teaching hospitals and of the Metropolitan Regional Hospital Boards about these services. It was pointed out during the course of these consultations that it would be possible for a medical school to be regarded as a voluntary body and to act as an agent of the Council in providing child welfare services. It was found that 10 hospitals were providing only consultative clinics or clinics for schoolchildren which were within their powers under Part II of the Act. Three child welfare clinics were being held at hospitals under the jurisdiction of the Metropolitan Regional Hospital Boards, but although the Council was willing to continue these, the hospital management committees concerned decided to discontinue them and arrangements were made for the children in attendance to be transferred to nearby Council welfare centres. Child welfare clinics were being provided at five teaching hospitals, one by agreement with the City of London on behalf of that authority. It was agreed that the Council should continue the same arrangements as the City Corporation. At one of the teaching hospitals it was agreed with the consent of all parties concerned that the Council should take over the services hitherto provided and run the clinic in the hospital premises as a municipal centre, paying rent to the hospital authorities. At the three remaining hospitals it was agreed that the medical schools would run the service as voluntary organisations grant-aided by the Council. A similar arrangement was subsequently made with the Institute of Obstetrics and Gynaecology for the provision of child welfare services at Queen Charlotte's Hospital. Broadly speaking the arrangements with these teaching hospitals is for the medical school to pay a rent agreed by the Council to the hospital authorities for the use of the clinic premises. The medical school also provide and pay for staff except health visitors. The Council reimburses the medical school at the rate of 90 per cent. of approved net expenditure subject to the payment by the Council of the full non-specialist rate for the services of the pædiatrician. The other ten per cent. of the expenditure with the balance of any specialist rate paid to medical staff is found by the medical school and is regarded as a fair return for the teaching facilities which are enjoyed at the clinic. By mutual agreement, at one hospital one health visitor is employed by the medical school and her salary is allowed to rank for the purposes of the Council's grant. These arrangements have been working very satisfactorily since their inception and are shortly to be confirmed by agreements between the Council and the medical school. The Council's health visitors attend the hospital child welfare clinics where they work to the pædiatrician in charge, but they remain under the direction of the Council's divisional medical officer for their work outside the clinic.

All the Council's duties under section 25 of the National Health Service Act, 1946, are carried out on its behalf by voluntary organisations. There are 24 district nursing associations, the Ranyard Nurses, the Nursing Sisters of St. John the Divine and the Catholic Nursing Institute, their work being co-ordinated by another voluntary body, the Central Council for District Nursing in London. All these organisations are grant-aided by the Council (see page 73), but retain their independent and voluntary status. The loan of equipment to patients being nursed at home has been undertaken on behalf of the Council by the district nursing organisations and by the City of London and the County of London Branches of the British Red Cross Society, which are grant-aided by the Council (see page 73).

Since the appointed day the Council has continued and extended its use of voluntary organisations for the provision of services related to the prevention of tuberculosis and the care and after-care of tuberculous persons. The work of these organisations has enabled the Council conveniently to fulfil certain of its duties in this field and to meet needs which otherwise, at the present time, would be difficult to satisfy. Except in the case of the local tuberculosis care committees, the Council either makes grants-in-aid related to the expenditure incurred by the voluntary body on the service concerned (as in the case of the Invalid Children's Aid Association, British Council for Rehabilitation, district nursing associations and Invalid Kitchens of London) or meets the specific charges levied by the voluntary body (as in the case of the village settlements). Payments of grants from official funds are not made by the Council to the local tuberculosis care committees, but regular contributions are made to these committees from the Sunday Cinema Fund, which the Council administers through its Public Control Committee. Secretarial assistance and office facilities are provided by the Council without charge to the committees.

There are 25 voluntary tuberculosis care committees in the administrative county serving 26 metropolitan boroughs; one of the committees was established after 5th July, 1948. These committees hold an important place in the Council's care and after-care arrangements. The scope of their activities is not fully demonstrated by statistical information, but the general outline contained in paragraphs 156–8 on extra nourishment, diversional therapy, articles on loan, etc., gives some measure of the services provided jointly by the Council and the care committees. The work of these committees and the Council's care organisers (who act as secretaries to the care committees) towards relieving, with advice and practical help, the personal, domestic and financial anxieties of tuberculous patients and their dependents, has not relaxed since the introduction of the National Health Service. This work necessarily involves close co-operation with statutory and voluntary bodies in order to bring to the patients' aid the help and benefits available from these sources. The funds of the care committees derive from voluntary contributions, grants from the Sunday Cinema Fund, sales of work and, in the case of affiliated committees, the sale of Christmas seals provided by the National Association for the Prevention of Tuberculosis. A divisional tuberculosis care committee has been set up in each of the nine health divisions to co-ordinate the activities of the local tuberculosis care committees in the division.

Comments on the work of the other voluntary associations in connection with the tuberculosis service are given in the relative paragraphs.

The Invalid Kitchens of London, a voluntary organisation established in 1905, provides meals for invalids and sick people in London from five centres, the meals being supplied at dining rooms attached to the centres or delivered by motor van to the homes of patients who are unable to attend. Meals are supplied only on the production of a medical certificate to the aged sick, persons discharged from or awaiting admission to hospital, cripples and invalids, *e.g.* diabetics in need of special diets. One meal is provided daily from Monday to Friday, additional meals for the week-end being supplied on Friday, if required. In London the service provided extends at present only to the whole or part of the following boroughs: Bethnal Green, Camberwell, Finsbury, Hackney, Hammersmith, Holborn, Islington, Kensington, Lambeth, St. Pancras, Shoreditch, Southwark and Stepney, but it is proposed to provide a new service in the borough of Fulham and to replace the existing kitchen in Bethnal Green by a larger and better one during 1953. The number of meals supplied during the year ended 30th September, 1952, was in the neighbourhood of 123,000. With the approval of the Minister of Health the Council has, since 1950, made an annual grant to this organisation in respect of the services it provides for sick people in London.

HEALTH SERVICE PREMISES

THE CONTINUED shortages of certain building materials, especially steel, and the national policy of restricting capital expenditure has not permitted the provision of specially designed clinic buildings and day nurseries at the rate necessary to overcome the difficulties inherent in maintaining some of the services in improvised accommodation in church halls, rented and requisitioned premises. Attention was drawn to this difficulty in the Annual Report of the medical officer of health for the year 1948, but since then steps have been taken in many instances, as opportunity has arisen, to secure a more permanent basis of tenure by acquiring leasehold or freehold interests or more satisfactory rental arrangements. Nevertheless, the continuance of the service still has to depend to a considerable extent on the continued availability of premises which provide only improvised accommodation, often held on insecure tenancies.

The maintenance of the day nursery service presents the greatest difficulty in this respect, and the tendency has been that nursery premises have to be relinquished faster than replacements can be provided. The continuation of requisitioning powers to December, 1955, and the strict application of a priority system for admission to day nurseries has so far postponed a serious crisis in this service, but the occupation of day nursery premises under requisitioning powers remains a serious potential danger to the future of this service unless requisitioning powers are to be further extended in time, or considerable capital expenditure is to be incurred in the near future on the acquisition of premises or the building of replacement nurseries.

It appears likely that the building of comprehensive health centres will not take place for many years in sufficient numbers to provide the much needed improvements to the standards of the maternity and child welfare clinic accommodation, especially by the replacement of church halls, or to provide new clinics on housing estates. Although these improvements should not be deferred until health centres can be built, it would be inappropriate to build maternity and child welfare clinics on the old pattern which could not be incorporated into health centres in due course. Accordingly, where there is an urgent need for a new clinic and a suitable site can be obtained for a health centre, plans will be prepared to erect a maternity and child welfare centre as a first instalment of a health centre. In suitable cases opportunity will be taken of incorporating some, or all, of the school health services required for the area in the new clinic, so that fuller integration of the two services can be achieved. The design of maternity and child welfare centres, and combined maternity and child welfare and school health centres, is now on the basis of multiple use of rooms for various purposes at various times. This effects substantial economies in the space required and consequently the land and capital expenditure needed.

The areas served by the various centres are now more clearly defined and are adjusted if necessary when new centres are established to meet local demands due to increased population, erection of housing estates, etc. Every endeavour is made to ensure that no mother has to travel more than one mile to her nearest child welfare centre. It is to the advantage of mothers and children to attend the appropriate centre so that contact with the health visitor of the area can be maintained, but complete freedom of choice is given to mothers in this matter.

Building programmes

Further progress was made in the planning and building of new clinics and day nurseries and the adaptation and improvement of existing premises. Restrictions on expenditure and on the use of steel made it necessary, however, to modify some schemes and to postpone others. Early in the year advice was received from the Minister of Health that it was unlikely that it would be possible for steel authorisations to be given during the year for schemes which had not already received a starting date. He also requested that various schemes in hand should be revised with a view to avoiding the use of steel or reducing the amount and spreading requirements over more than one quarterly period.

Schemes in preparation

In accordance with the procedure recommended by the Local Government Manpower Committee, an annual capital building programme comprising eighteen new schemes, costing more than £1,000 was submitted in November. In addition a number of schemes remained from previous programmes, and these were carried forward as part of the building programme for the next financial year. Unless, however, there is a marked relaxation in the restrictions on steel and expenditure it seems inevitable that many of these schemes will have to be held over until later and less stringent times.

Details were included in the report for 1951 of 41 schemes submitted in that or previous years to the Minister. Of these, one had been cancelled by the Health Committee, two were withdrawn, because they were for adaptations of office accommodation which had become matters for reference to the Minister of Housing and Local Government, two had failed to receive the approval of the Minister of Health, five had been completed, eight were in progress and twenty-three were either under consideration by the Minister or full details had not been submitted to him. Five other schemes (Brook ambulance station, Eridge House day nursery, Moatside occupation centre, Pear Place temporary ambulance garage and Queen's Road centre Interim Stage II, adaptations), which were not included in any previous programme were approved for submission to the Minister of Health during the year.

The capital building programme for 1953–54, comprising 18 schemes therefore brings the total number of schemes submitted to 61 excluding the three already cancelled or withdrawn. During the year one more scheme was cancelled by the Health Committee, while action on three others was postponed. Seven schemes were completed, and works on nine more were in hand at the end of the year.

Particulars of the 33 schemes outstanding from earlier programmes, five extra schemes, and of the 18 schemes submitted in November, 1952, are as follows :

Schemes for which approval was refused

Division 2—Daleham Gardens, Hampstead.—Combined maternity and child welfare centre. Following a review of the clinic facilities in the metropolitan borough of Hampstead, a further proposal that the Minister should be asked to reconsider his decision not to approve this project or, if he could not do this, to agree in principle to the erection of part of the building which would be modified to form a maternity and child welfare and school treatment centre was under consideration by the Health Committee at the end of the year.

Division 5—Brewhouse Lane, Stepney.—Permanent day nursery and child welfare centre. Following the Minister's refusal it was decided to investigate the possibility of retaining the Old Church Road day nursery or finding a site for its replacement.

Scheme withdrawn

Division 1—Gloucester Road and Clareville Grove, Kensington.—In view of the Minister's inability to sanction the provision of a day nursery and staff hostel on the site, and the fact that there was no immediate prospect of final approval being given to the provision of a maternity and child welfare centre, the Health Committee decided that no further action should be taken to develop this site for health service purposes and that the property should be relinquished by the Committee.

Schemes postponed

Division 1—Westway, Hammersmith.—The Minister of Health had asked for a revised plan for a smaller and cheaper day nursery. It was decided, however, to review the need for this nursery in twelve months' time, and in the meantime to retain the site, which is large enough for a day nursery and a health centre, and to seek the approval in principle of the Minister of Health to the erection on the site of a combined maternity and child welfare centre and school treatment centre to be designed as the first instalment of a comprehensive health centre.

Division 7—Queen's Road Centre, Camberwell.—The scheme for the second stage of the adaptation of these premises provided for the installation of a supplementary heating and hot water supply system, installation of a passenger lift shaft, the conversion of a portion of the premises into classrooms, redecorating, electrical work and lay-out of grounds. The Minister of Health intimated that the steel required for these adaptations could not be authorised during 1952; nor could the allocation of building resources to

the work be justified as providing facilities for further education connected with the more essential industries. It was, therefore, not possible to carry out all the second stage adaptations as planned. An interim scheme was put in hand which included the partitioning of classrooms, electrical work and temporary supplementary heating by oil stoves during the winter months.

Foxley Road, Kennington.—Conversion of a former fire station to an ambulance station. The Minister of Health suggested that the scheme should be reconsidered with a view to eliminating the use of steel entirely or reducing the amount to a very small quantity. The scheme was under review at the end of the year.

Schemes approved but works not yet in hand

Division 3—*St. Alban's (C. of E.) School, Holborn.*—A scheme of adaptation as a day nursery to replace the former day nursery in Clark's Buildings, which was demolished to make way for new buildings, was approved by the Minister of Health and a starting date awarded. Delays in securing completion of the lease of the part of the building to be adapted resulted in postponement of the work, which will be commenced as soon as the lease is completed.

Division 5—*Peel Grove, Bethnal Green.*—Maternity and child welfare centre. The Minister of Health approved the erection on this site of temporary buildings which it is intended to replace by a permanent comprehensive health centre in about 15 years' time. Commencement of work was deferred as the necessary steel could not be authorised until January, 1953.

Division 9—*Stormont Road, Battersea.*—Maternity and child welfare centre. The Minister of Health approved, subject to agreement with the Borough Council on the use of the site, a scheme for the erection of a centre which would form the first instalment of a comprehensive health centre. A settlement as to the use of the site had not been reached at the close of the year.

Fleet Road, Hampstead.—Erection of accident ambulance station.

Works completed

Division	*Premises*	*Service*	*Work involved*
3	Springdale Road, Stoke Newington	Day nursery ..	New building
4	St. John's Day Nursery, Hackney Churchyard, Mare Street, Hackney	Day nursery ..	New building
7	60A Amott Road, Camberwell ..	Maternity and child welfare centre	Extension
7	Queen's Road Centre, Camberwell (Stage I)	Day nursery ..	Conversion of existing building
8	West Norwood Welfare Centre, 12 Hannen Road, Lambeth	Child welfare centre	War damage and maintenance repairs
–	Branstone Street, Kensington ..	Occupation centre..	Building of additional classroom
–	Roland House, Littlehampton .. (Stages I and II)	Holiday home ..	Conversion of existing building

Starting dates awarded and works in hand at end of year

2	Westbourne Park Road, Paddington	Day nursery ..	Completion of building
5	Christian Street, Stepney ..	Day nursery ..	Provision of play space
5	University House, Bethnal Green	Day nursery ..	Extension
6	Merton Place, Greenwich ..	Maternity and child welfare centre	New building
7	Queen's Road Centre, Camberwell (Interim Stage II—Adaptations)	Maternity and child welfare centre and evening institute	Conversion of existing building and temporary heating
–	Eastern Ambulance Station, Hackney	General ambulance station	Adaptations — work on second block (B) will be subject to approval of revised scheme to reduce steel requirements
–	Fulham Ambulance Station ..	Accident ambulance station	Improvements

Division	*Premises*	*Service*	*Work involved*	
–	South Western Ambulance Station, Lambeth	General ambulance station	Extension	
–	West Smithfield Ambulance Station, City of London	Accident ambulance station	New building	
1	Eridge House, Fulham	Day nursery ..	Repairs on acquisition	Starting dates not yet awarded
1	Highlever Road, Kensington ..	Maternity and child welfare centre	New building	
3	Muriel Street, Islington	Day nursery ..	New building	
5	Galbraith Street, Poplar	Maternity and child welfare and school treatment centre	Conversion of first-aid post	
5	Mary Hughes Centre, 22 Underwood Road, Stepney	Maternity and child welfare centre	Extension to form a child welfare centre in association with London Hospital	
–	Brook Ambulance Station, Greenwich	General ambulance station	Re-instatement after war damage	
–	London Headquarters Ambulance Station, Waterloo Road, Lambeth	Headquarters of ambulance service	Conversion of fire station	
–	Pear Place, Lambeth	Ambulance accommodation	Provision of temporary garage accommodation	
–	South Eastern Ambulance Station, Deptford	General ambulance station	Extension	
–	Upper Richmond Road Ambulance station, Wandsworth	Accident ambulance station	New building	
–	86 Fulham High Street, Fulham..	Occupation centre..	Adaptation of existing building (former Moatside Restaurant)	
–	9 Spencer Park, Wandsworth ..	Occupation centre..	Conversion of existing premises.	

The building programme for 1953–54 which was submitted for the Minister's consideration was as follows: Programme for 1953–54

Division	*Premises*	*Work involved*
1	Fulham Babies Hospital, Broomhouse Road, Fulham	Conversion of first floor for additional residential accommodation
1	129 Fulham Palace Road, Fulham ..	Adaptation for maternity and child welfare centre (a replacement of the Greyhound Road centre) and additional office accommodation
2	86 Carlton Hill, St. Marylebone ..	Essential repairs on acquisition of requisitioned day nursery
2	Hampstead Health Institute, Dynham Road, Hampstead	Adaptation as school treatment centre and maternity and child welfare centre in replacement of the West End Lane welfare centre
3	Basire Street (Coleman Fields), Islington	Erection of day nursery
3	Charles Lamb School, Popham Road, Islington	Adaptation as maternity and child welfare and school treatment centre, in place of Tibberton Square maternity and child welfare centre
3	Drayton Hall, Islington	Extension of maternity and child welfare facilities and addition of a school treatment centre
5	Rochelle Street School, Bethnal Green..	Adaptation as new maternity and child welfare centre for West Bethnal Green
5	1A Wellington Way, Stepney	Re-instatement of war damaged front block of maternity and child welfare centre as residential accommodation for staff.
6	Amersham Road Health Centre, Deptford	Adaptation of first floor as day nursery, and provision of offices and lavatories on ground floor
6	Burney Street, Greenwich	Permanent maternity and child welfare centre to replace the centre in Bardsley Lane, Coroner's Court

Division	*Premises*	*Work involved*
8	Cynthia Moseley Day Nursery, Lambeth	Extension of heating and consequential internal decorations
9	'Southlands', Shuttleworth Road, Battersea	Demolition of war damaged building, adaptations to and severance of, maternity and child welfare centre and office accommodation, services, etc., from borough council premises
–	Eastern General Ambulance Station, Hackney	Demolition of buildings and tar paving in connection with major scheme of alterations
–	Shoreditch Accident Ambulance Station	Improvements to entrance, widening carriageway and rebuilding wall
–	Hostel for M.D. girls	Adaptation of accommodation to be found
–	Hostel for tuberculous men	Adaptation of accommodation to replace Highbury Quadrant Hostel
–	Hurlingham Lodge, Fulham	Adaptation as an additional hostel for tuberculous men

Day nurseries

The Health Committee, having decided in 1951 that the day nursery accommodation should remain substantially at its existing level, no additional nurseries were provided during the year. The completion of three building schemes enabled day nurseries to be transferred to accommodation designed for the purpose, and existing accommodation to be released; a fourth building was completed but transfer was not effected by the end of the year. Two other day nurseries where the premises were required for other purposes, were closed. Details of the changes are as follows:

Replacement

Division 3—*Springdale Road, Stoke Newington.*—Erection of a hutted day nursery, to be known as Springdale day nursery was completed for opening early in 1953 to replace a day nursery in requisitioned premises. Although situated in Division 4 it is near the boundary between Divisions 3 and 4, and will be administered by Division 3 whose area it will mainly serve.

Division 4—*Woodberry Down Day Nursery.*—This nursery, adjacent to the Woodberry Down Health Centre, was opened on 15th October. The day nursery at Woodberry Hall, in requisitioned accommodation, was closed. Further details of the new nursery will be found in the description of the Woodberry Down Health Centre on page 48.

Division 4—*St. John's Day Nursery, Hackney.*—This hutted day nursery was completed and opened on 20th September. The accommodation, formerly occupied in Ram's Episcopal school, Hackney, was released for educational purposes.

Division 7—*Queen's Road Centre, Camberwell.*—Completion of the adaptation of part of the ground floor of this centre to form a day nursery and modification of the kitchen enabled the day nursery to be opened on 31st December. The nursery was formerly accommodated at 34 St. Mary's Road, which was derequisitioned.

Closure of day nurseries

Division 3—*Pembroke Street Day Nursery, Islington.*—This prefabricated day nursery stood on a bombed site required for part of a borough council housing estate. It was relinquished on 11th April. No replacement was available but it is hoped that this will be provided by a new day nursery, which it is proposed to erect on a health centre site in Muriel Street, Islington and by the day nursery in St. Alban's School, Holborn. Children displaced were accommodated, as far as possible, in neighbouring nurseries.

Division 6—*Avonley Road Day Nursery, Deptford.*—This day nursery was in accommodation at the New Cross General Hospital. The Hospital Management Committee required this accommodation for use by resident nurses and the day nursery was closed on 28th March. Alternative accommodation for 30 children was made available by utilising part of the first floor of the Amersham Road health centre. This was originally designed and used for a time as a small day nursery, and by alterations in the use of rooms and the transfer of sunlight sessions elsewhere, part of the floor was readily adapted for a day nursery. It is proposed to consider taking over the whole of the first floor at this

centre for day nursery purposes at a later date when a more extensive scheme of adaptation can be undertaken.

At the end of the year the following scheme, for which plans had been completed and Ministry sanctions obtained, was in hand : Building works in progress

Division 2—Westbourne Park Road, Paddington.—Completion of prefabricated buildings which were partly erected during the war to form a new day nursery, to be known as St. Stephen's day nursery, was almost reached at the end of the year. When opened it will replace an existing nursery in a requisitioned dwelling-house.

Maternity and child welfare centres

Division 9—Blegborough welfare centre, Wandsworth.—This centre was held in a church hall, but the church authorities were no longer agreeable to the Council using the main hall. The centre was, therefore, closed on 28th April, and the clinic sessions were transferred to the Riggindale Centre. Closure of centres

Division 2—Dynham Road welfare centre, Hampstead.—This centre, which had been temporarily transferred from 60 West End Lane while the latter premises were reconditioned and repaired, was closed on 4th September when 60 West End Lane was re-opened. Replacement of centres

Division 2—Bickersteth Hall welfare centre, Hampstead.—This centre was in very unsatisfactory accommodation in a church hall. The Hampstead metropolitan borough council having agreed to the Council using a community centre in a block of flats on one of its housing estates, the welfare centre was transferred there on 27th October and called the Hampstead Wells welfare centre.

Division 4—Woodberry Hall welfare centre.—This centre, in requisitioned accommodation, was transferred to the new Woodberry Down health centre (see page 48) on 15th October, when the former premises were de-requisitioned.

Division 3—Bentham Court, Islington.—Midwife's clinic. Arrangements were made with the Islington metropolitan borough council for accommodation in a community centre in one of its blocks of flats to be made available for a midwife's session to be held weekly from 5th March. Provision of additional centres

Division 9—Fairlight welfare centre, Wandsworth.—A centre was opened in Fairlight Hall on 5th December to supplement the clinics at Longley Road welfare centre, which was less accessible to mothers living in the area served by the new centre.

Division 7—Merton Place, Greenwich. Maternity and child welfare centre.—The erection of a prefabricated hut, which had been sanctioned by the Minister of Health was well advanced by the end of the year. This centre will replace a centre in unsatisfactory premises in Division 7 which will be discontinued. It will also serve areas in Division 6, where there is an increasing demand due to the erection of flats and will be more convenient for mothers who live a considerable distance from existing centres in that division. Building work in progress

Accommodation for tuberculous persons

The Minister of Health agreed to consider a scheme for the adaptation of Hurlingham Lodge, Fulham, to be rented from the Parks Committee as a hostel for 25 tuberculous men.

Recuperative holiday home

The adaptation of Roland House Holiday Home, Littlehampton, was completed. The home which could not be used to capacity was closed for a short period during the summer holidays for installation of a new boiler, and was re-opened for full occupation on 14th September.

Occupation centres for the mentally defective

Details regarding premises used for occupation centres will be found on page 114.

School health service

Centre closed

Division 8—*St. John's Hall, Larcom Street, Southwark.*—This minor ailment centre formed part of the St. George's Dispensary Trust. The accommodation was not satisfactory for the purpose, and with the consent of the Trustee the centre was closed and the service transferred to the Walworth Road health centre on 1st September.

Works completed

Division 1—*Chelsea school treatment centre, Bramerton Street.*—Works of adaptation and improvement on acquisition were completed.

Schemes in progress

Division 2—*Westminster school treatment centre, Westminster.*—The adaptation of 40 Alderney Street, Westminster was nearing completion at the end of the year. When completed these premises will replace accommodation rented at 38 Rochester Row and 41 Greencoat Place.

Division 7—*East Dulwich school treatment centre.*—Adaptation of 475 Lordship Lane as a school treatment and maternity and child welfare centre was nearing completion at the end of the year. When this work is completed, the school treatment centre at 29 Amott Road, Camberwell, will be closed and the premises, which are unsatisfactory for health service purposes, disposed of.

Division 8—*St. George's Dispensary,* 86 *Blackfriars Road, Southwark.*—As mentioned in the report for 1951, this property was vested in the St. George's Dispensary Trust which was offered to the Council. The scheme for transfer of the trust and premises to the Council was still in preparation at the end of the year.

Division 9—*Tooting school treatment centre,* 1071 *Garratt Lane, Wandsworth.*—The freehold of this property was offered for sale, but the premises are unsuitable for acquisition by the Council owing to age and structural condition and the centre will have to be closed. The purchase of other premises at 193 Mitcham Road and preliminary expenditure on their adaptation was approved subject to agreement on covenants in the lease. This was still under negotiation at the end of the year. When terms are agreed a detailed scheme of adaptation will be prepared.

Office accommodation

The following changes in office accommodation were made during the year :

Division 1—The home help organiser's office was transferred to 31/33 Bramerton Street from 21a King's Road, Chelsea.

Division 5—The health visitors and clerical staff at 43 Whitehorse Road, rented from the Stepney metropolitan borough council, were transferred to the Mary Hughes welfare centre, Underwood Road.

Division 9—By arrangement with the Battersea metropolitan borough council, additional rooms were made available at ' Southlands ' Shuttleworth Road, to which the divisional treatment organiser's office was accordingly transferred from Stowey House School, Clapham.

Health centres

Woodberry Down health centre

The Council's first comprehensive health centre at Woodberry Down, Stoke Newington, was completed in September, and the ceremonial opening was performed by Mr. Somerville Hastings, M.S., F.R.C.S., M.P. on 14th October.

The centre will serve about 23,000 people. The site, about one and a half acres in extent, including one third of an acre for a day nursery, lies in the south-west corner of the Council's Woodberry Down Housing Estate, which is nearing completion.

The planning, equipping and staffing of the building was carried out after discussion and consultation between the public health and the architectural departments of the Council, the London Executive Council, the London Local Medical Committee and the London Local Dental Committee. The Ministry of Health and the Ministry of Education were also consulted, and made additions and alterations to the plans before final approval was obtained.

A fuller description of the building and services is contained in the descriptive brochure* published by the Council.

The following units are provided :

General Medical and Dental Practitioners Unit.—This has six suites of rooms for medical practitioners. Each suite comprises a waiting room, consulting room, examination room and dressing cubicle. Night duty accommodation and an operating theatre, clinical side room, specialists' consulting suite, common rooms, etc. are provided on the first floor. Two dental suites and a dental workshop are provided for general dental services and X-ray facilities are available.

School Health Unit.—This includes a minor ailment treatment room, doctor's consulting room, two dental surgeries (one used also for nursing and expectant mothers), an eye room and orthoptic room.

Child Welfare Unit.

Ante-natal Unit.

Child Guidance Unit.—A playroom and rooms for a psychiatrist, psychiatric social worker and an educational psychologist are available.

Foot Clinic.—This clinic was transferred to the centre from another part of the division.

Remedial Exercise and Light Clinic.—Remedial exercises will be provided for both school children and expectant mothers.

Other Accommodation.—Staff rooms and refreshment rooms are available and sanitary accommodation for all units is provided. There is a caretaker's flat on the second floor and garage accommodation for general practitioners. Central heating is provided by a low pressure hot water system working at low temperature vario-statically controlled to maintain an equable temperature irrespective of outside temperature changes.

Day Nursery.—A day nursery for 45 children is on the same site, and shares the engineering services.

Staffing.—Specialist services are provided by the North-East Metropolitan Regional Hospital Board. The appointment of general practitioners and dental surgeons for the general dental services will be made by the London Executive Council. The general medical and dental services had not been started at the end of the year.

Equipment.—Equipment and furniture of modern design was provided throughout the centre in keeping with the general design and decorative treatment.

Future developments

The Woodberry Down Health Centre was the first full scale comprehensive health centre to be authorised by the Minister of Health, and the experience gained from its use will be valuable and have a considerable influence on future health centre developments. It appears likely, however, that in existing circumstances the building of comprehensive health centres will not take place for many years in sufficient numbers to provide the improvements to the standards of the maternity and child welfare clinic accommodation which are much needed in many areas in London, or to provide clinics on new housing estates. Although these improvements should not be deferred until health centres can be built, it would be inappropriate to build maternity and child welfare clinics on the old pattern which could not be incorporated into health centres in due course. Accordingly where there is an urgent need for a new clinic and a suitable site can be obtained for a health centre, plans will be prepared to erect a maternity and child welfare centre as a first instalment of a health centre.

Reservation of sites

During the year the London Executive Council agreed to the Council's proposals for the reservation of a further nine sites for health centres.

* *No. 3784, price 6d.*

Acquisitions and leases

All possible opportunities have been taken to acquire properties and sites, when suitable, or to secure long term leasehold tenancies. The following acquisitions and leasehold tenancies were completed during the year :

Property	*Interest obtained*	*Service*
DIVISION 1		
Eridge House, Fulham	Freehold	Day nursery
86 Fulham High Street, Fulham	Freehold	Occupation centre
9–11 Holland Street, Kensington	Leasehold	Maternity and child welfare centre
1B and 1C Kenley Street, Kensington	Leasehold	School treatment centre
DIVISION 2		
13 Woodchurch Road, Hampstead	Freehold	Day nursery
Hampstead Health Institute, Hampstead	Freehold	Maternity and child welfare and school treatment centre
40 and 44 Westbourne Park Road, Paddington	Freehold	Day nursery
1 Ebury Bridge Road, Westminster	Leasehold	Maternity and child welfare centre
DIVISION 3		
Pine Street, Finsbury	Freehold	Maternity and child welfare centre
14–15 Lloyd Square and 9 Lloyd Street, Finsbury	Leasehold	Day nursery
DIVISION 4		
135a Holmleigh Road, Hackney	Freehold	Day nursery
Sun Babies, Upwey Street, Shoreditch	Leasehold	Day nursery
13 Goulton Road, Hackney	Leasehold	School treatment centre
67 Stoke Newington Church Street	Leasehold	School treatment centre
DIVISION 5		
Galbraith Street First Aid Post, Poplar	Freehold	Maternity and child welfare centre
2 Whitechurch Lane, Stepney	Leasehold	Mental health offices
DIVISION 8		
Chestnut Day Nursery, Barston Road, Lambeth	Freehold	Day nursery
21–25 Pear Place, Lambeth	Leasehold	Ambulance station
Bishop's House, Southwark	Leasehold	Day nursery
DIVISION 9		
Cresset Street, Wandsworth	Freehold	Day nursery
37 Riggindale Road, Wandsworth	Leasehold	Maternity and child welfare centre

CARE OF MOTHERS AND YOUNG CHILDREN

COMMENTS ON the provision of clinic premises will be found on page 47.

Expectant and nursing mothers

First attendances at ante-natal clinics of all women needing ante-natal care have dropped from 52 per cent. in 1949 to 41 per cent. in 1952. Those who do not attend the Council's welfare centres may receive advice from the hospitals where they have booked for their confinement or from their doctors who have been booked for the delivery. There is perhaps a tendency for expectant mothers more and more to avail themselves of the general practitioner obstetrician service. There has been a corresponding decline in the attendances for post-natal examinations. Attendances at special breast feeding sessions tend to decline, mainly owing to the fact that breast feeding advice is given at the ante-natal and child welfare sessions, and at many of the latter test feeds are also carried out. It will be noted that there has been a satisfactory expansion in attendance at educational sessions, partly due to the increased efforts on the part of the health

visitors to expand these activities (see page 101). The following table gives comparative statistics:

Year	Ante-natal					Post-natal	
	Clinics at end of year (including combined ante-natal and post-natal)	Sessions per month	Attendances		Percentage of pregnant women making at least one attendance at ante-natal clinic	Clinics at end of year	Sessions per month
			First	Total			
1949.. ..	117	957	29,917	184,018	52	31	263
1950.. ..	114	910	26,979	176,993	50	6	31
1951.. ..	112	905	24,819	162,667	45	6	17
1952.. ..	115	1,145	21,959	145,088	41	5	11

Year	Post-natal—contd.				Special breast feeding		Educational	
	Attendances							
	First		Total					
	At post-natal clinics	At combined ante- and post-natal clinics	At post-natal clinics	At combined ante- and post-natal clinics	Sessions per month	Total attendances	Sessions per month	Total attendances
1949	2,614	3,225	3,396	4,090	44	1,554	133	21,779
1950	2,534	3,400	3,335	3,920	41	1,436	138	22,681
1951	1,669	3,993	2,218	4,642	33	1,303	196	30,414
1952	530	3,888	1,031	4,479	22	1,119	216	33,596

In some divisions relaxation exercise classes for expectant mothers have been started. Physio-therapists and health visitors have co-operated in this aspect of the preparation of the expectant mother for childbirth.

Tests

Every expectant mother attending the Council's ante-natal clinics for the first time has a specimen of her blood taken in order that tests may be made for the Rhesus factor and for the Wassermann and Kahn reactions. In Rhesus negative cases further specimens are taken for antibody tests at the thirty-fourth week and the Council's midwives also take cord blood in those Rhesus negative cases which are fit for home confinement. Towards the end of the year, arrangements were made for routine haemoglobin tests to be carried out in eight divisions.

The necessary laboratory services continued to be carried out at hospital laboratories free of charge. Pregnancy diagnosis tests are carried out for the Council at certain hospital laboratories or at the Ministry of Health's laboratory in Shrodell's Hospital, Watford.

Mothercraft training

The educational activities at the maternity and child welfare centres have been reviewed as the result of a report of a small working party of officers representing medical and nursing opinion and considerable expansion has already taken place. Details are given in the section on health education (page 101).

The Violet Melchett Infant Welfare Centre, a voluntary organisation undertaking services on behalf of the Council under section 22 of the National Health Service Act, 1946, maintains a residential unit where treatment is provided for mothers and babies experiencing breast feeding difficulties and for babies with dietetic upsets. The North Islington Infant Welfare Centre, a voluntary organisation undertaking services on behalf of the Council under section 22, provides similar non-residential facilities.

Rehabilitation of mothers

Approval was given by the Minister of Health to an addition to the Council's proposals, to provide, where necessary, for expectant and nursing mothers, and mothers

who have children under five, to be sent to a recuperative centre for several weeks for training in mothercraft, appropriate charges being made under the Council's assessment scales. Such mothers are generally below par physically and the health of the children may be affected as home circumstances may make them unable to benefit from the child welfare and school health services. This is an experiment the results of which will be carefully watched.

Joint arrangements with other local authorities

Reciprocal arrangements were continued with the Kent County Council whereby expectant mothers and those with young children living in the Mottingham area may attend either the Kent or London maternity and child welfare centre, whichever may be nearer to their homes.

The arrangements whereby mothers and young children living in that part of the county borough of West Ham adjacent to North Woolwich may, if they so wish, attend the Council's North Woolwich Welfare Centre, Fernhill Street, E.16, were continued.

Family planning

In some health divisions the Council holds family planning sessions totalling six per week to which women for whom further pregnancy would be detrimental to health are referred. Where no such facilities exist, women are referred to the Family Planning Association, a per capita payment being made to the Association, and during 1952, 917 women were referred. Accommodation at certain of the Council's welfare centres is also let conditionally free of charge to the Family Planning Association for the purpose of holding family planning clinics. At the end of the year 32 weekly sessions were being held by the Association in Council or other premises.

Child welfare

It will be seen from the table below that attendances in the first year of life at child welfare centres amounted to 86 per cent. in 1949, 82 per cent. in 1950, 87 per cent. in 1951 and 84 per cent. in 1952. Those infants who attend in their first year do so about 12–15 times. It is general experience that during the first eight or nine months the mother is anxious about the progress of her baby and she brings him to the clinic regularly for weighing, medical advice, and for mothercraft guidance. With normal progress, attendances tend to fall off rapidly after this first year. All mothers are, however, encouraged to bring their children to the child welfare clinics or special toddlers' clinics, invitation cards to the latter being sent on birthday anniversaries of children in the 2–5 year age group. It has been found that about one-fifth of the infants who attend in response to the invitations to the toddlers' clinics are referred to family doctors or hospitals for treatment for ailments which the parents might not otherwise have recognised.

Year	*Clinics at end of year (including toddlers)*	*Sessions per month*	*Attendances*					*Percentage of infants attending a centre at least once in the first year of life*
			Under 1 year		*Over 1 year*		*Special toddlers*	
			First	*Total*	*First*	*Total*		
1949 ..	165	1,784	48,489	683,089	6,641	282,202	35,500	84
1950 ..	169	1,815	43,916	649,983	5,496	245,484	41,817	79
1951 ..	169	1,893	45,534	626,164	4,540	235,942	43,145	82
1952 ..	169	2,029	44,452	653,759	4,147	229,134	43,976	84

Child guidance

Two child guidance clinics for the pre-school child, taken over from the metropolitan borough councils, have been continued because of the value of the work done and as an experiment in this particular field. The psychiatrists see children, and their parents, referred from local child welfare centres because of various behaviour disorders. Expansion is not taking place, however, until experience has shown the most appropriate methods of meeting the needs of the pre-school child. To this end, arrangements

have been made to train centre doctors and health visitors to select children for reference to the school child guidance units, and lectures in mental health have been provided. A survey was instituted in one of the health divisions in 1952, to gauge the extent to which a psychiatric service for young children is necessary.

Reference is made in the section on mental health (page 112) to the provision of special child welfare services for backward children.

Care of premature infants

When premature infants are nursed at home, with a midwife in attendance, steps are taken to ensure that the midwife, in addition to her normal care of mother and baby, has adequate time to devote to the infant by relieving her of other work. The supervisors of midwives visit all premature infants to give advice, including recommendations for supply of any special equipment needed. Twenty-seven sets of special equipment (divided into five packs, *i.e.*, cot pack, scales, clothing pack, nursing pack, feeding pack) are provided (three for each of the nine health divisions). Small deposits are made for the loan of the packs and these are refunded in full when the equipment is returned in good order, subject to fair wear and tear. Nine of the sets are placed at strategic points throughout the County, mainly at district nursing association premises or at welfare centres with a resident caretaker. These particular sets are available at week-ends and public holidays for collection and delivery by the ambulance service to any home requiring equipment immediately. There is not a great demand for the special equipment, except in health division 4. The number of times sets, or part sets, were supplied to homes was as follows :

(Part year) 1948	1949	1950	1951	1952
Nil	23	92	74	52

Special transport facilities for premature infants who have to be removed to hospital are operated. Specially heated cots and supplies of oxygen are carried in the ambulances and were used on 43 occasions in 1952.

Before the Council assumed responsibility for the welfare services, the Shoreditch Borough Council had organised a special service for premature infants, including the appointment of a trained health visitor as a premature baby visitor, who devoted the whole of her time to the care of premature infants in that borough and to a breast feeding clinic. The Council felt that continuity of home visiting was essential if the health visitor was to be accepted as the friend and counsellor of the family. It is undesirable that when a premature infant is born, the health visitor who normally visits the home should be replaced by another officer who is unknown to the mother. Moreover, as the present syllabus of training of health visitors includes advice on the care of premature infants, it is considered that no additional training, except for a refresher course from time to time, is necessary. The aim has been to ensure that all health visitors have the necessary knowledge to advise on the care of premature infants and that these children are given priority in visiting. The special visiting arrangements in health division 4 were therefore gradually discontinued. There is, however, a special premature baby clinic held at one of the welfare centres in Shoreditch, at which each infant is able to receive a thorough medical examination at the age of 4, 8 and 12 months.

As far as is known, the following hospitals have special units or cots for the reception of premature infants—Hammersmith, King's College, University College and British Hospital for Mothers and Babies, Woolwich. Other hospitals are able to take them into cots attached to the maternity units. There is a close liaison between hospital almoners and the Council's health visitors to ensure immediate follow-up on discharge from hospital.

Premature babies born at home

During 1952, 449 infants weighing 5½ lbs. or less were born on the district to 404 mothers; 276 of these infants were between 5 lbs. and 5½ lbs. in weight and by the dates were of at least 38 weeks gestation and showed no clinical signs of prematurity. There were 46 twin pregnancies. In 50 instances the mothers were small in stature themselves or had had small babies previously.

No cause to which abnormality could be attributed was found in 342 cases and in the remaining 62 cases abnormalities of pregnancy were as follows :

Toxaemia	25
Trauma	5
Ante-partum haemorrhage	10
Anaemia and malnutrition	22

The degree of prematurity by dates was :

Under 32 weeks	11
32–36 weeks	70
Over 36 weeks	321
Unknown (unbooked)	2

and the weights of the infants :

Under 3½ lbs.	15
3½ lbs.–4½ lbs.	48
4½ lbs.–5 lbs.	74
5 lbs.– 5½ lbs.	312

67 infants were transferred to hospital within a few hours of birth, 11 were transferred later owing to an unsatisfactory condition developing, and the remaining 371 were nursed at home.

Of the 449 infants 416 made good progress and were alive and well when discharged by the midwife or from hospital and 329 (79 per cent.) of these were completely breast-fed. 18 infants showed some congenital abnormality, for example, talipes, hypospadias, spina bifida, congenital heart.

There were 33 deaths, i.e., 8 per cent. of the total. Four of these occurred at home very shortly after birth : two were non-viable infants of less than 2 lbs. and less than 30 weeks gestation ; one was a 4½ lb. baby with multiple deformities, and one (2¾ lbs.) an unbooked emergency. The remaining 29 deaths were in hospital : six were feeble infants under 3 lbs. ; 11 were feeble infants between 3 and 5½ lbs., either very premature by date or showing marked clinical signs of prematurity ; six had congenital abnormalities ; one died from cerebral haemorrhage, and five died from pneumonia having been transferred to hospital later in the neo-natal period.

Maternity and child welfare services provided by hospitals

Details of the arrangements whereby the medical schools of four teaching hospitals, acting as voluntary organisations grant-aided by the Council, provided child welfare centres on its behalf are given on page 39.

Drugs, medicaments, welfare foods, etc.

Cod liver oil compound, tablets of vitamins A and D, national dried milk and concentrated orange juice are distributed under the Government's welfare foods scheme. In addition a number of proprietary brands of dried milk and of nutrients, including cod liver oil and malt, cereals, glucose D and vegetable and iron products, are made available when approved by the clinic medical officer, at fixed charges, subject to abatement where necessary. Simple drugs according to an approved list are provided free of charge when recommended by the clinic medical officer. The list of items is reviewed by a departmental committee from time to time to keep abreast of modern medical development.

Non-proprietary items are supplied wherever possible.

Sunday cinema grants

The Council continued to receive contributions from the Sunday cinema entertainments, out of which an allocation was made to each of the nine health divisions for the purpose of providing amenities for mothers and children attending the welfare centres and day nurseries. The amenity funds are administered by small voluntary committees.

Marriage guidance

In accordance with its decision to give financial aid over a period of five years (commencing in April, 1951), the Council agreed to make a grant to each of the three marriage guidance organisations operating in London—the London Marriage Guidance Council, the Catholic Marriage Advisory Council and the Family Discussion Bureaux of the Family Welfare Association—for the year ending March, 1953. The Council also agreed to an expansion of the arrangements whereby the London Marriage Guidance Council holds sessions in available accommodation at a number of welfare centres. A similar facility was also granted to the Catholic Marriage Advisory Council, who are commencing to establish divisional centres.

Day nurseries and occasional crèches

Day nurseries

On 5th July, 1948, there were 114 municipal day nurseries and six voluntary day nurseries. This number dropped to 111 municipal and six voluntary by June, 1951, when the first annual review of day nursery accommodation was carried out. The guiding factor of this review, and the subsequent annual reviews, was that the total day nursery provision should remain substantially at the level then obtaining, with every effort being made to secure full occupation within the limits imposed by the scheme of priorities for admission. Any indication of redundancy has been kept constantly under review, and where necessary day nurseries have been closed. The position following each annual review was :

	Number of day nurseries		
		Voluntary	
Date	*L.C.C.*	*(Grant aided)*	*Total*
At 30– 6–51	111	6	117
At 30– 6–52	106	6	112
At 31–12–52	105	6	111

The accommodation provided at the above day nurseries at 31st December, 1952, was :

Age group	*L.C.C.*	*Voluntary*	*Total*
0–2 years	2,017	50	2,067
2–5 years	3,879	189	4,068
Totals ..	5,896	239	6,135

The priorities and rules for admission to the day nurseries are as follows :

(1) (*a*) The first priority as regards admission to be given equally, subject to the other rules, to the children (including adopted children) of :

(i) mothers who are widows, separated or divorced wives, or wives whose husbands are totally disabled or in prison, or unmarried mothers, provided they are maintaining an independent home and are employed at least 35 hours a week, including meal times ;

(ii) parents where the mother is in ill-health and cannot care adequately for the child, or during the mother's confinement ;

(iii) parents who are living in housing conditions detrimental to health, or where other environmental factors are such that it is desirable for the health of the child that it should be admitted to a day nursery ; and

(iv) widowers, or where the mother has left the home.

(*b*) The second priority as regards admission to be given, subject to the other rules, to the children of parents where, because the father is unemployed or his earnings are so low, the mother is compelled to go to work as an economic necessity, providing that in all cases the mother is employed at least 35 hours a week, including meal times.

(2) The divisional medical officer to have over-riding discretion to admit any other cases presenting special features—any appeal from his decision to be considered by the Chairman of the Divisional Health Committee.

(3) In assessing applications for admission, an over-riding consideration to be that the parent(s) is/are unable to make other satisfactory arrangements for caring for the child.

(4) A review of the circumstances of the parents of all children admitted to day nurseries, including, where appropriate, verification of parents' incomes, to be made at six-monthly intervals from the date of admission and parents to be required to withdraw their children from nurseries after reasonable notice as and when the cases no longer fall within the approved priority classes.

(5) Arrangements for all admissions to be made by the divisional medical officer and not by individual nurseries.

The number of children on the priority waiting lists was 4,797, 1,932, 977 and 1,130 at the end of 1949, 1950, 1951 and 1952 respectively.

The Council's standard charge for a child in a day nursery was 1s. a day in 1948. This was subsequently raised to 2s. a day, assessable according to means, and as from 1st January, 1953, was increased to 4s. a day (the charge for the second and subsequent children of the same parents or parent is 2s. a day).

As a result of the comprehensive enquiry into the day nursery service undertaken in the latter part of 1950 the following action was taken :

(i) In an endeavour to secure maximum occupation, extra children were allowed on the registers up to 25 per cent. above the number of approved places. This was done to offset absences due to illness, etc.

(ii) A new ratio was adopted of non-domestic staff to children of 1:3 and 1:8 for children aged 0–2 and 2–5 years, respectively. This ratio was based on the number of approved places in each of these age groups, with a relaxation of the standard in day nurseries catering for children aged 2–5 years only. The ratio was subject to the over-riding consideration that in no day nursery should there be fewer than five places for children of all ages to one unit of non-domestic staff.

(iii) The former ratio of three nursery students to one staff place was replaced by a ratio of 2:1.

(iv) The number of training nurseries has been gradually reduced by approximately one-third.

(v) It was decided that overalls or dungarees should be provided, washed and kept in good repair by the mothers of children attending the day nurseries. A small stock of a simple type apron is held in each day nursery for use in emergency or in cases of genuine hardship.

(vi) The hours of day nurseries generally were fixed as 7.30 a.m. to 5.30 p.m. on Mondays to Fridays, with provision for remaining open until 6 p.m. when local conditions so required. Nurseries which were previously opening later than 7.30 a.m. have continued to do so as far as practicable. Approval was given, in principle, to all day nurseries being closed on Saturdays, and only two are now open on Saturday mornings.

(vii) Experiments were instituted in selected day nurseries with a view to determining whether economies could be effected in the relatively high expenditure on provisions and in the method of laundering day nursery articles.

Occasional crèches

The limited number of sessions in occasional crèches (nursery play centres) which the Council took over on 5th July, 1948, has remained substantially unchanged. Consideration was given to the possibility of extending the facilities, but no further action was taken in view of the opinion of the Minister of Health that the time was inappropriate for such expansion, having regard to the national financial position.

Nurseries and Child-Minders Regulation Act, 1948

Private day nurseries

The number of private day nurseries statutorily registered under the Nurseries and Child-Minders Regulation Act, 1948, and the number of places provided were :

	At 31st December				
	1948	1949	1950	1951	1952
Number of private day nurseries statutorily registered	8	28	41	49	63
Number of places provided	367	972	1,294	1,583	1,841

During the year one of the two private day nurseries provided by industrial undertakings closed.

Child-minders

The child-minders who are statutorily registered under the Act are persons—other than relatives—who, for reward, look after during the day more than two children under the age of five years from different households. Voluntary registered child-minders are women who look after one or two children and voluntarily register with the Council, receiving a weekly registration fee in return for which they are subject to inspection by the Council. The number of child-minders, both statutorily and voluntarily registered, together with the number of children looked after, are shown in the following table :

	At 31st December				
	1948	1949	1950	1951	1952
Number of child-minders statutorily registered ..	35	73	96	93	96
Number of children minded	243	501	570	604	504
Number of child-minders voluntarily registered ..	284	584	766	749	794
Number of children minded	323	579	834	840	856

The small variation in the numbers of registered child-minders since 1950 suggests that the service has found its own level.

Children neglected or ill-treated in their own homes

After considering the joint circular from the Home Office, Ministry of Health and Ministry of Education (78/50), the Council decided that the main objects of the circular were being achieved under the Council's existing organisation. Measures were taken in each of the health divisions to bring together the Council's officers and the officers of other official and voluntary bodies interested in the welfare of children in their own homes. The aim of these measures was to co-ordinate the efforts of all concerned so that neglect and ill-treatment might be prevented, or, if it had come to light too late, suitably remedied. Neglect and ill-treatment often arise from the same conditions of health and environment which produce juvenile delinquency and maladjustment and form one great problem. An attempt to face the problem as a whole was planned in two health divisions by holding experimental conferences attended by all organisations (voluntary or statutory) who are interested in or can help the children who live under these conditions. These conferences were held early in 1952. Their main object was to examine the co-ordination which already existed between local organisations with regard to (*a*) the welfare of parents and children (including the problem of the neglected or ill-treated child) and (*b*) the prevention of juvenile delinquency. In particular, they were asked (i) to exchange information about the action taken by various agencies, (ii) to consider ways in which such action might be more closely co-ordinated, (iii) to consider whether, under the existing system, any particular aspect of a problem might fail to be dealt with by local workers concerned, (iv) to consider whether it might be desirable in some cases for one agency to help with the problem of a family when it appeared that one visitor would make more progress than several. The conclusions reached at these conferences were considered by the appropriate committees of the Council. In view of the real value of these conferences in bringing together all the organisations and persons concerned, in reminding the voluntary organisations of what each does and of the extent of the work done in the field by the Council's own services, and in making a broad survey of the problems of the locality, similar conferences are being held in all health divisions.

It had been found in some health divisions that the maintenance of a central register of problem families at the divisional health office was of real value. The Council's officers and voluntary and other bodies had been asked to notify to the divisional health office cases with which they were dealing and which presented special problems for inclusion in a register for the information of other interested departments and organisations. Each voluntary organisation retained full discretion whether information at their disposal should be passed on and the register does not involve building up a dossier of confidential matters relating to the family. After due consideration it was

felt that such an index, with the co-operation of all the statutory and voluntary bodies concerned, would become a record of action taken on behalf of problem families and would tend to encourage voluntary workers and others to consult the Council on any new problem. Further, when action is required in any particular case, all those interested could be consulted and, if necessary, brought together. Their knowledge could be pooled, the next step planned, under the aegis of Council officers, and carried out effectively by the most appropriate organisation. The general aim would be to reduce the number of workers visiting the family to one, if possible, but in more complex problems where more than one worker's help was needed the aim would be to keep the number to the minimum ; the family, therefore, would be saved the embarrassment and confusion resulting from overlapping visits and enquiries. The appropriate committees of the Council have therefore agreed to the development of divisional indexes of families where there appears to be a need for help in bringing up the children, the index to be adapted to suit local needs.

Where considered desirable, the establishment in each of the health divisions of a small standing committee of the Council's officers, with representatives of other bodies, as desired, to co-ordinate the case work has been recommended, no obstacle being placed in the way of a merger with other case conferences held in the divisions, e.g., for maladjusted children or those referred to the N.S.P.C.C. It was also decided that health divisions should prepare and publish a directory of organisations undertaking social case work for circulation to all interested parties.

Medical supervision of residential establishments for children

The public health department has continued during the year to supervise the health of the children in the Council's residential establishments. Apart from unusually heavy outbreaks of measles at one residential nursery, chicken-pox at another and infective hepatitis and Flexner dysentery at a third, the pattern of sickness was much as usual. There was an outbreak of influenza in one residential nursery school in January.

The children in the residential nurseries and nursery schools are under the medical care of the visiting medical officers, who examine them periodically, as well as on admission and discharge, and as may be required. Close co-operation is maintained with the Children's Officer in regard to questions affecting the children's health. With this in view the establishments are visited at frequent intervals by senior members of the Council's central medical and nursing staff.

The high incidence of infection in the Council's three large residential nurseries (The Downs, Ladywell and St. Margaret's) was the subject of a conference between representatives of the Home Office and the Council. A large nursery with a large turnover of admissions inevitably produces a large crop of infections and many of the hospital admissions to which the Home Office drew attention were mild infections. Other children were admitted to hospital for diagnosis. The children nursed in the nurseries represented either the ' secondary crop ' or those for whom no hospital bed could be found.

The Cliffs Residential Nursery school, Dawlish, was closed on 30th June, and the children transferred elsewhere.

Adoption and boarding-out

During the year 743 children were referred by the Children's Officer for opinion as to their suitability on medical grounds for adoption or boarding-out in accordance with the duties placed upon the Council by the Children Act, 1948. Of these 122 were passed as fit for adoption and 621 fit for boarding-out.

Care of the unmarried mother and her child

The Council's duties for the care of expectant and nursing mothers and young children include the care of the unmarried mothers and their babies. This duty is performed

mainly through the agency of voluntary organisations in accordance with the policy recommended by the Ministry of Health in circular 2866/43 and endorsed by the Council in its proposals under the Act. As stated in the Council's proposals, some women not admitted to voluntary mother and baby homes, chiefly because of their unsuitability, are accommodated in two mother and baby homes and two special units under the management of the Welfare Committee. This arrangement has continued since the ' appointed day ', although provision was made in the National Health Service (Amendment) Act, 1949, to make charges for residential accommodation and this enactment would thus have enabled the Council to provide such accommodation under its National Health Service Act powers and to charge therefor in the same way as the voluntary homes have always done. The Council's Welfare Committee also accepts financial responsibility for the maintenance on a ' per capita ' basis for unmarried expectant mothers in voluntary mother and baby homes in circumstances where the unmarried mother is unable to pay for her own maintenance.

Grants in aid for maintenance and upkeep of voluntary mother and baby homes are paid annually by the Council. Before the inception of the National Health Service Act, 1946, the Council paid grants to 21 mother and baby homes and five baby homes under section 101 (6) of the Local Government Act, 1929. Since 5th July, 1948, the Council has paid similar grants under section 22 of the National Health Service Act, 1946. In 1948, 23 homes were concerned, the total payments amounting to £19,286, and in 1952 there were 20 homes, the total payments amounting to £13,114. Following the inception of the Children Act, 1948, the responsibility for ' deprived ' children was taken over by the Council's Children's Committee and the grants to the five baby homes were dealt with by that committee.

Before 5th July, 1948, the Metropolitan Boroughs Standing Joint Committee made payments on behalf of the boroughs to moral welfare associations in London who employed moral welfare workers. Under section 22 of the Act, the Council took over responsibility for the payment of grants to five moral welfare associations (two C. of E., two R.C. and one Jewish), and in 1952 the grants amounted to £9,260. The head-quarters of the five large associations are visited periodically to review the service provided and to discuss matters of mutual interest. An annual Moral Welfare Conference is held at which the past year's work is reviewed and current problems brought forward.

The voluntary homes take expectant unmarried mothers during the later stages of pregnancy and for several weeks after confinement which, except at two homes, takes place in hospital. The homes are visited by medical officers of the public health department at least twice a year. Standards of staffing, space and management which have been approved by the Ministry of Health are carefully applied to the running of the homes. Grants towards the expenses of the homes are made subject to the carrying out by the voluntary bodies of any improvements suggested by the Council. The Council is represented on the home committees. The moral welfare associations undertake the case work for unmarried mothers during the ante-natal and the immediate post-natal period. The voluntary committees and matrons of the mother and baby homes also assist in this sphere.

Ante-natal care

Particular attention has been given to the ante-natal care of the unmarried expectant mother. Moral welfare workers and health visitors work closely together with the aim of giving the mothers the full benefits of the ante-natal clinics. Experimental evening clinics have been held. To obtain definite information of the extent to which the unmarried expectant mother avails herself of the services provided, a survey of the ante-natal care received by each new admission to the mother and baby homes under the control of voluntary organisations and of the welfare department of the Council was planned for the first six months of 1953.

Welfare of illegitimate children

The welfare of the children of unmarried mothers has also been given attention and in order to find out what changes take place in the child's environment, the effects of these changes in the child's mental and physical development and the proportion of unmarried mothers who achieve a continued association with their children it is

proposed to undertake a survey to try to follow up all illegitimate children born in London during a specified period in 1953. The co-operation of voluntary associations dealing with the unmarried mothers and their children has been promised and it is proposed that the survey shall be carried out within the scope of the normal work of the health visitors who will make visits at specified intervals until the children reach school age. Changes in the child's environment will be noted and the effect observed of such changes on physical and mental development, behaviour and habits. Incidence of illness and accidents will be included. The survey will extend to boarded-out children and to those placed in residential, voluntary and private nurseries. The fact of adoption will be noted when it occurs. From the survey there should emerge a picture of the number of mothers who do manage to maintain a stable relationship with the child.

DOMICILIARY MIDWIFERY SERVICE

THE COUNCIL'S domiciliary midwifery service had its origin in the Midwives Act of 1936, which laid on the Council the duty of providing an adequate service of midwives for attendance on women in their own homes in London. To provide this service the Council employed salaried midwives and entered into agreements with voluntary hospitals and district nursing associations already employing midwives, and the service commenced in 1938. Midwives attended patients either as midwives on their own responsibility or as maternity nurses under the direction of a doctor and were encouraged to make the fullest use of the maternity and child welfare services then provided by the Metropolitan Borough Councils. The hospitals and voluntary associations received payment from the Council for each confinement undertaken. Every woman attended by a midwife in her own home was charged a fee which was reduced if necessary, but medical aid, if summoned by the midwife, was provided free to the patient.

The service underwent no fundamental change as a result of the coming into force of the National Health Service Act, 1946, except that it became a free service. The main result of the Act was to effect closer integration of the domiciliary midwifery service with the maternity and child welfare services and the other health services for which the Council became responsible under the Act, and also with the maternity medical services provided under Part IV of the Act. The service is still administered centrally and the whole county is kept under close and constant supervision, the service being adapted to the changing character and requirements of the area.

Every effort has been made to integrate the domiciliary midwifery service with the maternity medical services provided by general practitioner obstetricians and general practitioners under Part IV of the National Health Service Act, and with the maternity services already provided by the local authorities and by hospital authorities. Early consultation was established with the London Local Medical Committee to ensure co-operation between doctors providing maternity medical services and the midwives engaged in domiciliary practice. This co-operation and understanding has been gradually increased by continued emphasis to the midwives of the need for good liaison with the family doctor and the introduction of forms for exchange of information between doctor and midwife.

Doctors who agree to give maternity medical services to a patient send this information to the midwife and let her know the services they propose to undertake so that the midwife may know whether she is to act as a midwife or a maternity nurse. The midwife reports her findings to the booked doctor on the 1st and 36th week ante-natal examinations. The doctor returns her report form after each examination with his findings, if different from her own, and adds any instructions he may wish to make on the care of the patient. Midwives are encouraged to try to conduct these examinations with the general practitioner but in practice this is very difficult to arrange. Attached to the form is the analgesia certificate which the booked doctor fills in and sends to the midwife. The midwife sends the doctor a notice of the delivery of a booked patient

within 36 hours of the baby's birth. After discussions with the London Medical Committee, the midwife is now asked to notify, with the patient's consent, the list doctor when she has been booked for a home confinement. The introduction of these forms for the exchange of information has greatly facilitated co-operation between midwives and doctors providing maternity medical services.

The number of domiciliary confinements since the end of the 1939–45 war shows a steep increase in 1946 and 1947, the immediate post-war period, and a gradual decline since 1948. The following table and diagram show the number of home confinements attended during the years 1945–52 by the Council's midwives, hospital district midwives and association midwives. The chief factors affecting the decline in the number of home confinements have been :

(*a*) the fall in the birth-rate ;

(*b*) shortage or unsuitability of housing accommodation ; and

(*c*) the attraction of hospital confinement and the increase in the number of maternity beds provided.

Owing to the reduction in the number of home confinements any developments in the domiciliary midwifery service must be looked for not in any expansion but in the quality of the service provided by the midwives and the measure of co-operation and integration with other health services and with the maternity medical services provided under the National Health Service Act.

L.C.C. midwives

Five hundred and seventy-three of the confinements attended by Council midwives during 1952 were primigravidae and 5,474 multi-gravidae. The figures do not include women booked by the Council's midwives who were subsequently taken to hospital before confinement. The number of midwives employed at the end of the year was 98 compared with 111 at the end of 1951 and 121 at the end of 1950. The average number of confinements attended by each midwife was approximately 61 compared with 62 in 1951 and 57 in 1950.

Agency organisations

At the end of the year, 71 (including supervisory staff) midwives for domiciliary confinements were employed by hospitals and 42 (including supervisory and part-time staff) by district nursing associations.

Ante-natal sessions

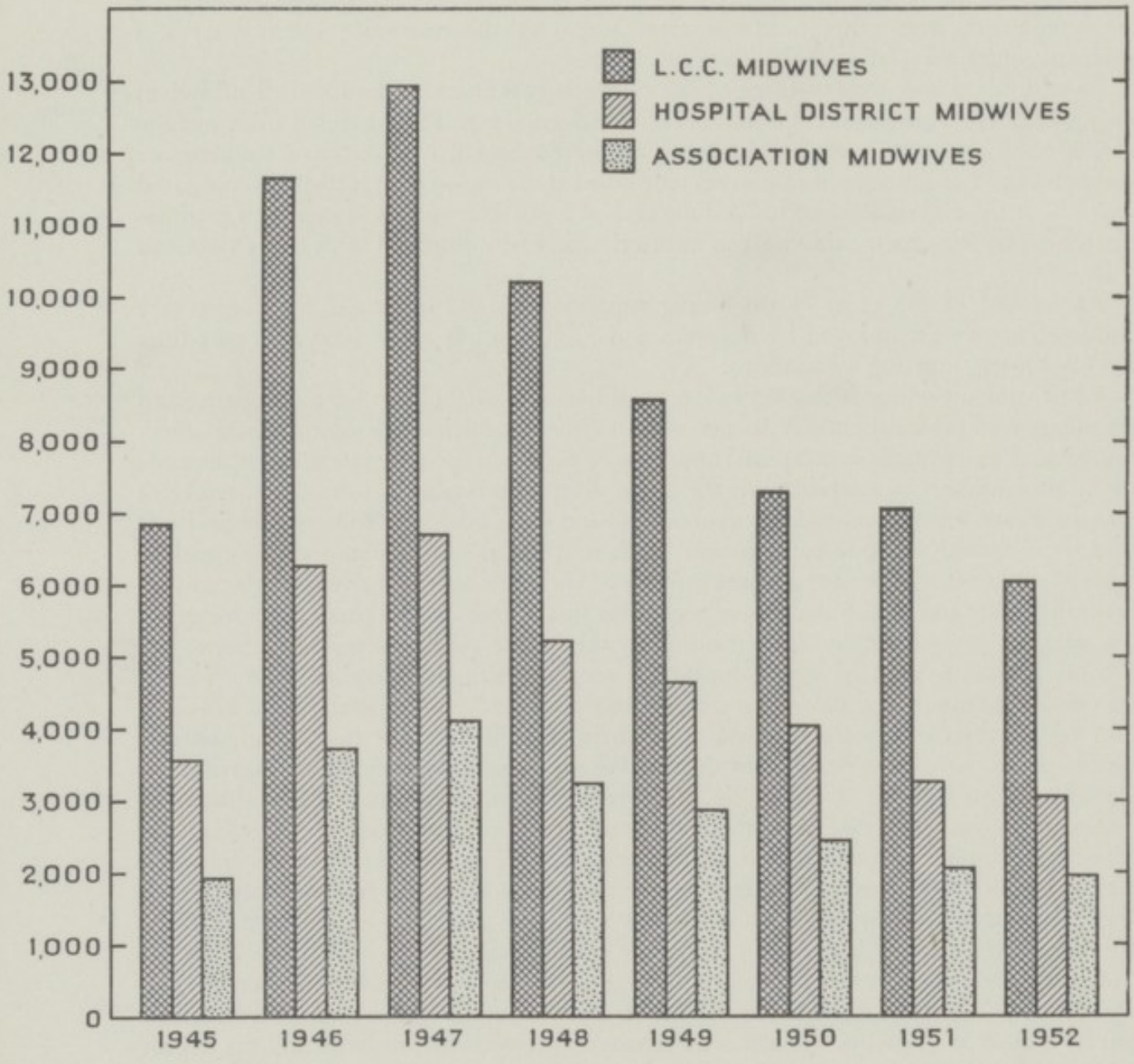
The Council's policy is that midwives shall use ante-natal clinics for the booking and examination of their patients. A doctor, who is either a full-time assistant medical officer or a general practitioner with special experience, attends all or alternate sessions depending on the numbers in attendance at the clinic. Emphasis is placed on the importance of ante-natal care and the midwife is expected to hand over a delivery to her relief midwife in order to attend her ante-natal session. Each midwife does one clinic session weekly. A health visitor is also present at most midwives' clinics in order to give talks to mothers on mothercraft and health education generally. In some divisions, these talks are given as a series of demonstration talks arranged by the health visitor on separate afternoons. In other divisions, talks are given during the sessions to small groups of mothers or to individuals. Many of the newer centres are equipped with demonstration kitchens and cases for exhibits of layettes, etc. Most of them have libraries of books and journals which can be lent to expectant mothers. Classes are held for relaxation exercises by physiotherapists in some divisions but midwives take such sessions at a few clinics.

Specimen blood is taken from all mothers attending ante-natally and tested for Wassermann and Kahn reaction and for Rhesus factor. In eight of the nine divisions, routine haemoglobin tests are made. Further specimens are taken for antibody tests in Rhesus negative cases at the 34th week and midwives also take cord blood in those Rhesus negative cases which are fit for home confinement.

General practitioners who have arranged to give maternity medical service to their patients are encouraged to send them to the centres for intermediate ante-natal examination by a booked midwife. Reports are exchanged between the midwife and the doctor on the 1st and 36th week examinations (see above). If, as occasionally happens, the general practitioner wishes to take full responsibility for the whole ante-natal care of a patient, he may send her to the centre for a blood specimen to be taken. It is known that general

Domiciliary confinements attended by L.C.C., hospital and nursing association midwives, 1945–1952

Year	Maternity nursing cases				Midwifery cases				Grand total
	L.C.C.	Hospital	Association	Total	L.C.C.	Hospital	Association	Total	
1945 ..	440	53	327	820	6,427	3,502	1,584	11,513	12,333
1946 ..	805	129	501	1,435	10,834	6,120	3,225	20,179	21,614
1947 ..	899	169	390	1,458	12,025	6,525	3,716	22,266	23,724
1948 ..	630	116	290	1,036	9,533	5,095	2,940	17,568	18,604
1949 ..	749	112	285	1,146	7,831	4,532	2,581	14,944	16,090
1950 ..	649	131	219	999	6,659	3,881	2,213	12,753	13,752
1951 ..	679	102	161	942	6,361	3,144	1,912	11,417	12,359
1952 ..	708	145	146	999	5,339	2,897	1,791	10,027	11,026



practitioners are, in the main, willing to allow their patients to attend centres for intermediate ante-natal examination by a midwife, especially if they have stated that they do not wish to be called in to the confinement unless needed.

Mortality

Patients attended by	*Maternal deaths*	*Still-births*	*Neo-natal deaths*
London County Council midwives	2	53	14
Hospital district midwives	2	26	7
Association midwives	2	23	6
	6	102	27

Transport

Transport by ambulance cars continued to be available for the use of midwives in emergencies, particularly at night-time and when undertaking additional relief duties.

Housing of midwives

Accommodation for domiciliary midwives continued to be provided by the Council. On 31st December, 1952, 53 midwives were housed in 51 houses and flats, of which 31 were owned by the Council and 20 taken on leave or licence.

Payments to district nursing associations and hospitals

Payments to district nursing associations under section 23 of the National Health Service Act, 1946, continued to be merged in the grants made to them for home nursing services provided under section 25 of the Act.

The rate of payment to hospitals providing midwifery services on behalf of the Council continued at the rate of 10 guineas a patient, except in the case of the Mothers Hospital (Salvation Army) where the rate was £9 15s. Some of the district midwives employed by that hospital are members of the Salvation Army and do not receive the full Whitley Council rates of salary.

Maternity outfits

Every woman delivered at home under the National Health Service is eligible for a free maternity outfit, containing accouchement sheet and dressings required for the confinement. The Council supplies these outfits to its own midwives and to district nursing associations and hospitals providing a domiciliary midwifery service.

Emergency obstetric service

During the year 66 calls were made to hospitals for the emergency obstetric service ; 36 of these calls were made by doctors and 30 by midwives. The time interval between the calling and arrival of the service was :

10 minutes	4 cases.
15 to 30 minutes	45 cases.
30 to 45 minutes	12 cases.
50 to 60 minutes	3 cases (cause of delay not stated).
Time interval not recorded	2 cases.

The conditions necessitating the use of the service were :

	Primi-para	*Multi-parae*	*Parity unknown*	*Total*
Obstetric shock	1	—	—	1
Post-partum haemorrhage with shock	1	3	1	5
Post-partum haemorrhage (following delivery of placenta) ..	4	22	2	28
Retained placenta with post-partum haemorrhage	11	11	2	24
Retained placenta	—	1	—	1
Retained membranes	—	2	—	2
Acute inversion of uterus with adherent placenta	—	1	—	1
Secondary post-partum haemorrhage	—	1	—	1
Ante-partum haemorrhage	—	1	—	1
Malpresentations	—	1	—	1
Abortions	—	1	—	1
	—	—	—	—
	17	44	5	66
	—	—	—	—

The action taken by the emergency obstetric service was :

Treatment given	*Removed to hospital*	*Remained at home*	*Total*
OBSTETRIC SHOCK			
Blood transfusion	1	—	1
POST-PARTUM HAEMORRHAGE WITH SHOCK			
Blood transfusion		4	4
Administration of drugs	—	1	1
POST-PARTUM HAEMORRHAGE (FOLLOWING DELIVERY OF PLACENTA)			
Blood transfusion	8	14	22
Plasma transfusion	—	1	1
Dextrose transfusion	—	1	1
Administration of drugs	2	—	2
No treatment	2	—	2
RETAINED PLACENTA WITH POST-PARTUM HAEMORRHAGE			
Blood transfusion	9	2	11
Dextrose transfusion	2	—	2
Administration of drugs	1	—	1
Manual removal with blood transfusion ..	1	5	6
No treatment	4	—	4
RETAINED PLACENTA			
Administration of drugs only	—	1	1
RETAINED MEMBRANES	1	—	1
Administration of drugs	1	—	1
Manual removal of membranes	—	1	1
ACUTE INVERSION OF UTERUS WITH ADHERENT PLACENTA			
Blood transfusion. Manual removal of placenta and replacement of uterus ..	1	—	1
SECONDARY POST-PARTUM HAEMORRHAGE			
Blood transfusion	1	—	1
ANTE-PARTUM HAEMORRHAGE			
Blood transfusion	1	—	1
No treatment required	—	1	1
ABORTIONS			
No treatment	1	—	1
	35	31	66

All 66 cases to which the service was called were true obstetric emergencies. There was only one maternal death and this occurred 11 hours after an acute inversion of the uterus. In all other cases the mother made a good recovery.

Analgesia

Gas and air

The use of gas and air analgesia by the Council began in 1946. The apparatus is held at selected ambulance stations throughout the county and delivered by ambulance to the patient's home on the request of a midwife. The number of midwives qualified to administer analgesia has steadily increased and, since 1950, all midwives employed by the Council have been so qualified. Progress in its use has been rapid and its administration, shown as a percentage of all domiciliary confinements, has risen from 3 per cent. in 1946 to over 75 per cent. in 1952. A similar increase in the use of gas and air analgesia has also been effected in confinements attended by hospital district midwives and association midwives. Analgesia is always offered by the Council's midwives. The cases in which it is not used are those in which the mother refuses or sends too late in labour, is considered medically unfit to receive it, or the doctor giving maternity medical services himself provides the analgesic or anaesthetic. The following table shows the progress made :

Administration of gas and air analgesia, including percentage of confinements attended

Confinements attended by		1948	1949	1950	1951	1952
London County Council midwives ..	Number	3,447	5,479	5,027	5,338	4,588
	Percentage	(34)	(64)	(68)	(75·8)	(75·8)
Hospital district midwives	Number	1,838	1,571	2,783	2,323	2,310
	Percentage	(35)	(55)	(69)	(72·5)	(75·9)
Association midwives	Number	903	3,033	1,400	1,443	1,401
	Percentage	(28)	(65)	(57)	(68)	(72·3)

Pethidine

Statutory Instrument No. 380, issued under the dangerous drugs regulations, came into operation on 1st April, 1950, and authorised certified midwives who had notified intention to practise to the local supervising authority to be in possession of and to administer medicinal opium, tincture of opium and pethidine so far as is necessary for the practise of their profession of employment as midwives. Conditions were laid down which provided that midwives could only obtain supplies of these dangerous drugs by production of a drug book and their personal registers of cases. Records of supplies and administration of the drugs have to be kept in the drug books. To ensure that all practising domiciliary midwives in London were qualified to administer pethidine, lectures on the subject were arranged. The number of administrations of pethidine by midwives was :

The number of women given pethidine by midwives

Administered by	*As midwives*		*As maternity nurses*	
	1951	1952	1951	1952
London County Council midwives	1,442	1,287	175	194
Hospital district midwives	158	638	43	53
Association midwives	205	316	52	26

Trilene

For many years the use of trilene by midwives in domiciliary practice has been under discussion. At the request of the Ministry of Health, the Council's domiciliary midwifery service is participating in a trial of trilene inhalers organised by the Joint Sub-Committee of the Medical Research Council and the Royal College of Obstetricians and Gynaecologists. To enable the domiciliary midwives to participate in this trial, lectures and demonstrations on the types of inhalers to be used were attended by all the Council's midwives and by midwives employed by the district nursing associations. The trial is in progress at present and special reports on the cases selected for inclusion are being sent to the Medical Research Council who will assess the result.

Maternity beds in hospitals

On 1st November, 1950, the Minister of Health received a deputation from the Council with regard to the domiciliary midwifery service and was asked to make a policy decision regarding the provision by hospitals of maternity beds. At the Minister's suggestion, a conference was held in January, 1951, between officers of the Council, the four Metropolitan Regional Hospital Boards and Boards of Governors of the 14 teaching hospitals in London to discuss policy regarding the provision of maternity beds in relation to the domiciliary midwifery service. The Minister of Health was informed of the results of the conference and asked to indicate his policy with regard to what the ratio should be of maternity beds to the estimated number of births. As a result of these representations, the Minister of Health addressed a circular (LHAL. 1/51) and memorandum to all local health and hospital authorities on the subject of the selection of maternity patients for admission to hospital. On the issue of this circular, divisional medical officers arranged to co-operate with the hospitals on the lines suggested.

The response from the hospitals to the offer of co-operation was varied. In one or two instances the Council was approached by the regional hospital boards when proposals to close or open maternity beds were under discussion, but on the whole it was felt that there was room for co-operation to be further developed. The varied practice of different hospitals within the same regional board area, in asking for the co-operation of the local health authority in applying social standards for the admission of women to maternity beds reacts unfavourably on neighbouring hospitals who loyally co-operate. A further approach has been made to the hospital authorities to review the progress made since the issue of the Ministry's circular and to obtain agreement on the best means for establishing and improving mutual co-operation in the fields in which the interest of the hospitals and the local health authority converge. The main problems on which co-operation is desired are :

(*a*) Selection of maternity cases for admission to hospital, (*b*) co-operation between hospital maternity departments and the Council's ante-natal clinics, (*c*) notification of the discharge of maternity patients, and (*d*) provision of care and after-care for maternity patients at the request of hospital almoners.

Midwives Act, 1951

The Council, as local supervising authority, has the duty to inspect midwives and maternity nurses practising in its area in accordance with the rules of the Central Midwives Board. Originally, these inspections were carried out by medical supervisors but in 1939 two positions of non-medical supervisor were substituted for two of medical supervisor. The number of non-medical supervisors employed by the Council subsequently rose to six in 1948 but as the number of domiciliary confinements declined, the number of non-medical supervisors employed has been reduced to four. These supervisors maintain a 24-hour supervision of the domiciliary midwifery service. They supervise the work of the L.C.C. midwives and supervise and inspect the district midwives employed by hospitals and district nursing associations. They carry out the routine inspections required by the rules of the Central Midwives Board of all independent midwives and maternity nurses, investigate all cases of puerperal pyrexia, skin and eye infections, neo-natal deaths and still-births occurring on district and arrange, if necessary, for the suspension of midwives coming into contact with infection and inspect all medical aid notices issued by midwives.

Notifications of intention to practise

Notifications of intention to practise were received as follows :

	1948	1949	1950	1951	1952
As midwives	1,213	1,252	1,275	1,337	1,331
As maternity nurses	289	242	241	205	232

An analysis of the notifications for 1952 shows :

	Midwives	*Maternity nurses*
Practising in hospitals	1,023	—
Practising in nursing homes	13	54
London County Council domiciliary	118	—
District nursing associations	79	—
Hospital districts	87	—
Nursing co-operations	—	162
Independent	11	16
	1,331	232

The number of medical aid notices issued by midwives during 1952 was :

By domiciliary midwives	6,110
By midwives in institutions with less than 15 beds and/or no R.M.O.	89
	6,199

Summoning of medical aid

The following statement shows the number of claims received from doctors in respect of medical aid provided by them under the Midwives Act and the total amount of fees paid each year by the Council. The introduction in 1948 of the maternity medical services has had a bearing on the number of claims received which have shown an expected decline. A few cases have occurred where, as a result of checks made of claims submitted to the Council against payments made by the London Executive Council, duplicate payments have been disclosed, and action has been taken to recover any fees wrongfully claimed. The effect of the introduction under the National Health Service Act, 1946, of the general medical services and the maternity medical services has been to restrict the period under which attention is given to the period of 14 days after the confinement, as medical attention after this period is now provided by the family doctor as part of the general medical services. The only exception to this is when a doctor—not being the family doctor or the booked doctor—is called in by the midwife for an emergency between the 15th and 28th day after confinement.

Number of claims received from medical practitioners and amount of fees paid under the Medical Practitioners (Fees Regulations) since 1948

	1948	1949	1950	1951	1952
Number of claims received	6,354	5,368	4,216	3,932	3,135
Total payments	£15,594	£15,829	£12,682	£12,042	£9,491

Training of midwives

Pupil midwives

The Council provides facilities for the district training of Part II midwifery pupils through its domiciliary midwifery service. Midwives employed by the Council are approved by the Central Midwives Board as district teachers for pupil midwives. In spite of the progressive decline since 1947 in the number of domiciliary confinements attended by the Council's midwives, there has been a great expansion of the arrangements for providing pupil midwives with their district training. At the end of 1948, 45 out of 155 midwives were approved as district teachers whereas, at the end of 1952, 71 out of 98 midwives were approved. The number of pupils for which the Council undertakes to provide district training has also risen from approximately 20 each quarter to 65 and during 1952, a total of 191 was received. The majority of these pupils reside with the midwife during their district training, but a few remain resident at their Part II training school, and come out to cases on notification by the teacher. Allowances for board and lodging and tuition fees while the pupils are on district are paid direct by the hospitals employing the pupil midwives to the L.C.C. teachers or the associations concerned.

In addition to the training arranged by the Council through its midwives there are eight hospitals and two district nursing associations in London approved as complete Part II training schools. At the two associations pupils spend the whole of the six months Part II training on district. A few pupils take their district training outside the London area but, on the other hand, some 14 pupils from Part II training schools outside London are accepted for district training by associations in London.

Refresher courses

The Council, in conjunction with the County Councils of Middlesex and Surrey, arranges for the provision annually of two courses, each of six lectures, for all midwives in these areas who have notified their intention to practise. The lectures are held at the County Hall, S.E.1, in the early months of the year and distinguished lecturers are engaged. In all, about 350 midwives attend these lectures each year. For the L.C.C. midwives attendance is compulsory. In addition, three whole-day intensive courses, comprising demonstrations at hospitals and other centres are held in the autumn of each year for domiciliary midwives (including independents) working in London, Middlesex and Surrey. About 45 midwives and supervisors attend these demonstrations in groups of about 15. The lectures and demonstrations arranged by the Council under section 17(*g*) of the Midwives Act do not, however, constitute a complete refresher course as envisaged by section G of the rules of the Central Midwives Board, which is at present in abeyance.

Domiciliary midwives attend refresher courses every five years in accordance with the recommendations of the former Midwives Salaries (Rushcliffe) Committee. The courses are arranged by the Royal College of Midwives and last a week, the Council meeting all expenses (except, in the case of courses held out of London, for a contribution of 15s. by the midwife towards the cost of board residence). Non-medical supervisors attend in rota a special refresher course for teachers, also arranged by the Royal College of Midwives and the courses organised by the Association of Supervisors of Midwives. By these means, midwives are kept abreast of developments in obstetric teaching.

HEALTH VISITING AND NURSING SERVICES

THE TRANSFER of the Council's hospitals to the regional hospital boards in July, 1948, greatly reduced the number of nursing and ancillary staff employed in the public health department. This was to some extent compensated by the taking over of the maternity and child welfare and tuberculosis functions and staff of the metropolitan boroughs.

The central and divisional administrative nursing staff of the department, under the direction of the chief nursing officer, advises on the recruitment, selection and appointment of nursing and allied staff not only to day and residential establishments administered by the Health Committee, but to a number of welfare homes and mother-and-baby homes administered by the Welfare Committee, boarding and special schools by the Education Committee, and certain children's nurseries and homes administered by the Children's Committee.

The total nursing and allied staff employed in the public health department at the end of 1952, was 2,347.

Health visitors, tuberculosis visitors and school nursing sisters

The following table shows the number of such staff in the service of the Council as on 5th July, 1948, and on 31st December, 1952.

	1948	1952
Health visitors	319	413
School nursing sisters	367	331
Tuberculosis visitors	67	70
Clinic nurses	11	33
	764	847

The Council has been handicapped in fulfilling its policy of expanding the functions of health visitors to cover the whole range of duties envisaged in section 24 of the Act and in the Ministry's circular 118/47 because of the fact that the health visiting and school nursing services in London were statutorily separated until 5th July, 1948. A result of this separation is that the Council has in its employ nearly 300 school nursing

sisters who cannot play a part in the health visiting service because they lack the qualification specified in the National Health Service (Qualifications of Health Visitors and Tuberculosis Visitors) Regulations, 1948. Since the coming into force of the Handicapped Pupils and School Health Service Regulations of 1945, under which school nursing sisters are required to possess the health visitor's certificate, efforts have been made to encourage the school nursing sisters to secure this qualification. A special intensive course was instituted in 1947 to this end, and with the approval in principle of the Ministry arrangements are now in hand for the establishment of a similar course of training for the certificate. It is hoped that this course will lead to an additional 30 school nursing sisters obtaining the health visitor's certificate. Selected school nurses may be granted up to one year's leave without pay to enable them to take other courses of training to qualify as health visitors and 25 school nurses have taken advantage of this concession since 5th July, 1948. The fact remains, however, that the majority of the school nursing sisters are unable to secure the health visitor's qualification as they are not accepted, because of age, for the normal training courses.

Of the 847 public health nursing staff employed on the maternity and child welfare, tuberculosis and school health services of the Council at the end of 1952, 463 were qualified as health visitors. Some progress has thus been possible in extending the function of the health visitor to cover the care and welfare of the family as a whole. As a step towards this there is increasing co-operation and consultation between health visitors, general medical practitioners and the voluntary and statutory organisations which serve the family.

Arrangements have been made for health visitors to extend their sphere beyond the visiting of expectant and nursing mothers and young children but, because the possibilities are governed by the general shortage of health visitors, and by local needs, the degree to which it has been possible to bring the whole family within their sphere has varied between divisions and indeed within divisions. Although the importance of regular visiting of young children is fully appreciated it has been found possible, on the principle of putting first things first, to enable health visitors to meet the needs of others, such as old people, homeless families units and after-care of patients discharged from hospital, by exercising discretion in the frequency of visits paid to those children who appear to be well cared for. To make the best use of the health visitors available the practice has been followed of allocating the greater proportion of the health visitors to those parts of the county where their services are most likely to be needed. Thus the areas allocated to health visitors in districts where conditions are generally poor are smaller than elsewhere.

The opinion has been formed that if health visitors were available in sufficient numbers to meet the needs throughout the whole county, their working time could most suitably be allocated on a basis of one-half to maternity and child welfare and one-half to school health and other duties.

Health education

Health visitors are trained to undertake individual and group health teaching in the normal course of their duties. Some, however, have obtained special qualifications after attending advanced courses in educational psychology and methods of teaching. Altogether 48 health visitors (including 18 specially selected and granted financial assistance under a scheme approved by the Health Committee) have obtained such a qualification.

During the year an outline syllabus on the teaching of parentcraft was prepared as a guide for health visitors responsible for health education work in maternity and child welfare centres and for school nursing staff taking classes in citizenship courses in secondary modern and grammar schools.

Requests continue to be received for health visitors to assist in polytechnics and institutes in training courses and refresher courses for nursery matrons, nursery nurses, wardens and house-mothers. Some also undertake special classes in certain Teachers' Training Colleges. During the year the syllabus of general nurse-training was revised by the General Nursing Council and a number of hospitals, including Teaching

Hospitals, have sought the help of the department in providing student nurses with theoretical and practical instruction in personal and communal health and the social aspects of disease. This forms part of their training for admission to the Final Examination for State Registration and is intended to provide every nurse with an insight into the public health services.

Tuberculosis visitors

The tuberculosis visitor is an important link between the diagnostic and curative work of the chest clinics and the preventive and care measures in the patient's home. Approximately 70 tuberculosis visitors are employed in 31 chest clinics. Each visitor paid an average of 1,400 home visits during the year.

Training scheme

The main source of recruitment to the health visiting service is the training schemes operated by the Council in conjunction with Queen Elizabeth College (University of London) and with the Royal College of Nursing.*Approximately 40 students are appointed each year for a one year course leading to the examination of the Royal Sanitary Institute. Liaison with the University and the organisation of practical field instruction is carried out by the Council's health visitor tutor. During training students receive three-quarters of the minimum commencing salary of a health visitor and are required to continue in the service for six months after qualification. More than two-thirds of the students remain on the permanent staff after this six-months service is completed.

Home visits

An average of 367 health visitors were employed by the Council during the year in connection with the various health services, excluding the tuberculosis service. During 1952, these health visitors made 864,107 visits, equivalent to about eight home visits per working day, apart from clinic and other duties. The following table analyses the visits paid since 1949 :

Health visiting—Visits paid

	1949	1950	1951	1952
Expectant mothers—				
First	29,011	25,166	25,439	25,226
Revisit	20,649	20,212	19,311	18,708
Per cent. of notified live and still-births ..	50	45	46	47
Premature babies—				
First	1,979	1,698	1,601	1,834
Revisit	3,818	4,406	4,552	5,509
Still-births—				
First	1,092	949	918	930
Revisit	494	490	390	349
Per cent. of still-births	99	88	86	90
Children under 1—				
First	54,562	50,436	49,605	48,755
Revisit	171,288	174,935	180,901	183,816
Per cent. of live births	97	93	92	91
Children 1 to 5—				
First .. .. }	361,313	5,796	5,188	4,572
Revisit .. .. }		391,589	387,383	377,986
Infectious diseases	26,287	17,429	26,518	13,396
Miscellaneous .. .. }	158,181	42,971	48,334	51,278
Unsuccessful .. .. }		141,626	137,108	131,748
Total	829,674	886,751	887,247	864,107
Health visitors (whole-time, plus whole-time equivalent) at end of year	354	376	373	382

Departmental enquiries into social and public health problems

Increasing use is being made by the department and by various organisations of the knowledge of social conditions obtained by health visitors in the course of their work. During 1952 they co-operated in a number of enquiries and researches aimed at measuring social and public health problems. (See page 136.)

* From October, 1953, the courses will be at University of London Institute of Education, the Royal College of Nursing and the Battersea Polytechnic.

Nurseries

Day nurseries

The number of nursing and ancillary child care staff employed in day nurseries numbered (at the end of the year) 1,273, and included matrons, deputy matrons, nursery nurses, wardens, nursery assistants and students. At any time during the year there were 290 nursery students undergoing a two years' training in preparation for admission to the examination of the National Nursery Examination Board. This included those who received special instruction in the care of the child under six months in order to apply for an endorsement of their N.N.E.B. certificate in infant care.

The supply of nursery students varies from one division to another. Since the number of approved training nurseries has been reduced it is possible to make a more suitable selection from available candidates. A number of experienced nursery nurses and nursery assistants have been referred for further training in Supplementary and Senior Child Care Reserve courses arranged by the Education Department prior to appointment as nursery wardens.

The ratio of non-domestic staff to children is 1 : 3 and 1 : 8 for children aged 0–2 and 2–5 years, respectively, based on the number of approved places in each of these age groups, with a relaxation of this standard in day nurseries catering for children aged 2–5 years only, subject to the over-riding consideration that in no day nursery shall there be fewer than five places for children of all ages to one unit of non-domestic staff. The ratio of nursery students to staff places in the Council's maintained and grant-aided training day nurseries is 2 : 1.

Residential nurseries

The medical officer of health remains responsible for the staffing of five of the larger residential nurseries under the Children's Committee accommodating a preponderance of children under two years of age. This includes the recruitment, selection and training of nursery students. During 1952, the recruitment of junior grades of staff has considerably eased because qualified nursery nurses are available in increasing numbers, but senior grades capable of undertaking responsibility for the 24-hour care of young children are in short supply. It has been necessary to engage State Registered Nurses without previous nursery experience from nursing agencies to fill senior vacancies and this is not regarded as satisfactory.

Training

Nursery students undergoing training in day and residential nurseries for admission to examination of the National Nursery Examination Board during 1952

	Day nurseries										*Res. nurseries*	*Grand total*
	Health division									*Total*		
	1	2	3	4	5	6	7	8	9			
Number of students undergoing training in day and residential nurseries on 1st January, 1952 ..	33	51	10	44	20	7	27	44	59	295	97	392
Number of students who resigned from the training scheme before completing training in 1952 ..	—	11	3	9	11	—	3	11	24	72	10	82
Number of students who entered for N.N.E.B. examination during 1952	17	32	3	19	2	7	11	12	11	114	56	170
Number of students who passed the examination	16	25	2	15	1	2	9	10	10	90	45	135
Number of students who successfully passed the N.N.E.B. examination and who have remained or intend to remain for 6 months as staff nursery nurses in the service	6	13	2	4	1	1	1	7	6	41	12	53
Number of nursery students remaining in training on 31st December, 1952	33	60	14	43	22	3	23	43	57	298	93	391

Residential boarding and special schools and children's homes

Thirty-seven state registered nurses and nine state enrolled assistant nurses are employed whole-time in residential establishments administered by the Education and Children's Committees. Their duties are to recognise early symptoms and prevent the spread of infection, apply first-aid measures in the event of accident, undertake the bedside nursing of children for whom admission to hospital is unobtainable and generally to be responsible for the health educational aspects of the care of children. Owing to the shortage of trained staff for appointment the most effective use has to be made of those available. In certain special schools in out-County areas it has been possible to obtain non-resident nursing staff willing to give part-time services. This scheme is working well, particularly where residential accommodation for whole-time staff is limited. Every effort is made to ensure that nursing staff in out-County schools and homes who work rather in isolation are visited regularly by a senior member of the central administrative nursing staff and lectures and demonstrations are arranged to keep them familiar with modern techniques in child care.

One nursing sister is in charge of the unit for diabetic children attached to Hutton Children's Home.

School camps

Three National Holiday Camps are open each year from March to November. Six school nursing sisters are seconded for duty with the parties of London school children sent every fortnight during this period.

Roland House

It was found possible during the year to maintain a stable nursing staff at this Holiday Home which is now open to the fullest extent for the reception of 36 children between four and eight years. (See page 98.)

Large welfare homes

Forty-three state registered nurses are employed as ward sisters in the large welfare homes for duties concerned with the care of old and infirm residents and those confined to bed who need nursing attention. Considerable difficulty is experienced in securing the admission to hospital of acutely ill as well as chronic sick patients and the nursing establishment of these homes had to be increased during 1952 to meet the demand. A high standard of nursing care is maintained by welfare assistants working under the direction and supervision of trained nursing staff.

Medical examination section at County Hall

The volume of work in the medical examination section required the services of four school nursing sisters throughout the year with additional relief and help for special sessions. Duties undertaken include the medical examination of new entrants to the service, sick staff, and large numbers of children attending for special examination. The nursing staff is also available for the treatment of casualties or sudden illness amongst staff and visitors to County Hall and they undertake first-aid duty at all receptions held in County Hall.

Inspection of nursing agencies

A senior member of the central administrative nursing staff is available to the public control department for advice and consultation in the inspection, under the Nurses Act, 1943, of agencies supplying trained nurses.

Refresher courses and post-entry training

All nursing staff engaged on health education duties are given facilities to attend approved refresher courses periodically. In addition to these refresher courses lectures, discussions and staff conferences at County Hall are arranged at intervals to ensure that staff are kept

fully informed of developments in all aspects of public health work. Examples during 1952, were 'The Family in a Changing Society' and 'Tuberculosis and the Public Health' at which lecturers included Professor A. Moncrieff, M.D., F.R.C.P., M.R.C.S., Institute of Child Health, A. T. M. Wilson, Esq., M.D., B.SC., Tavistock Institute of Human Relations, Professor Richard Titmuss, London School of Economics and Political Science, Professor F. R. G. Heaf, M.D., F.R.C.P., Welsh National School of Medicine, Cardiff.

HOME NURSING

HOME NURSING in London is carried out on behalf of the Council by the undermentioned voluntary organisations :

24 district nursing associations, employing at 31st December, 1952, the equivalent of 282½ whole-time nurses

2 religious organisations (the Nursing Sisters of St. John the Divine and the Catholic Nursing Institute), employing between them at 31st December, 1952, the equivalent of 7 whole-time nurses

The Ranyard Nurses, employing at 31st December, 1952, the equivalent of 115½ whole-time nurses.

Male and female, full-time and part-time, resident and non-resident nurses and assistant nurses are employed. Eleven of the organisations participate in the Council's domiciliary midwifery service (see page 60). The activities of the voluntary bodies are co-ordinated by another voluntary body, the Central Council for District Nursing in London, which in addition to transmitting decisions of the Council to the home nursing organisations and, in reverse, collating information for presentation to the Council, is responsible for such matters as adjustment of boundaries between nursing areas and arranging for the continuation of the home nursing service if a voluntary organisation should cease to function in any area.

All these organisations which act as the Council's agents receive grants, the Central Council for District Nursing in London—£450 a year; the Catholic Nursing Institute—£900 a year (subject to review should their work expand or contract appreciably); and the others, 90 per cent. of approved net expenditure on the service. Apart from the financial control implicit in the expression 'approved expenditure' the voluntary organisations have almost complete freedom of action and retain their individual and independent status.

Premises

The Council is prepared to consider applications from district nursing organisations for loans to enable them to undertake capital works (*e.g.*, extension of premises), the loan charges being approved for grant purposes. The successful employment of non-resident nurses, both male and female, may, however, indicate that extensions to residential accommodation will be less necessary than has been thought in the past.

During 1952 the Council agreed the preliminary plans and costs of a new building which the Duchy of Cornwall Estate proposes to erect for an association in South London. The Council will lease the premises from the Duchy Estate and will sub-let to the nursing association. Several associations effected considerable repairs and decorations to their nurses' homes in order to bring them up to a reasonable standard. Much detailed checking of plans by the Council's technical staff is obviated by the associations employing approved firms of surveyors for this work.

The director of housing and valuer does all in his power to find accommodation for the Ranyard Nurses, who do not work from district homes, but several requests were still outstanding at the end of 1952.

Liaison

Liaison with the other local health authority services is maintained at member and officer level, (*a*) by a member of the divisional health committee and the divisional medical officer or his representative representing the Council on the voluntary committee

of each home nursing organisation; (*b*) by direct personal contact (particularly divisional nursing officer to superintendent); and (*c*) by joint membership of the divisional home nursing voluntary committee. One of these committees has been set up in each of the nine health divisions. They include representatives of all organisations administering the home nursing service in the division; the principal divisional officers of the Council; and representatives of all allied services with which co-operation should be maintained, *e.g.*, general medical practitioners, nurses, midwives, hospital almoners and the British Red Cross Society. There is still evidence that home nursing superintendents make insufficient use of the divisional health office facilities and that some visits of a purely social nature are paid by home nurses, and particular attention is to be given to these matters. Consideration is being given to the possibility of extending liaison arrangements to include field workers, *i.e.*, by direct contact between district nurse and health visitor, home help organiser, and care committee workers, etc.

There is a long-established tradition of co-operation with general medical practitioners and hospitals. The Central Council for District Nursing supplies printed forms for use by general medical practitioners and hospital almoners by which application may be made for the services of a district nurse for any patient needing nursing care at home, but the telephone is used at least as frequently as the forms. The majority of the cases attended by district nursing organisations are referred by general medical practitioners, somewhat under one-fifth being referred direct by hospitals. Maternity patients who either develop some infection or are discharged from hospital before the last day of the puerperium are referred to the general district nurses for home care unless they are booked patients of one of the Council's midwives. Where a district nurse calls in response to an application from other than medical services (*e.g.*, from relatives of the patient) she will not normally make more than two visits unless a doctor has been called in, and she will work under the doctor's instruction.

Staff

The number of nurses employed at the end of 1952 was 455 whole-time and part-time (whole-time equivalent 405 nurses). This compares with 341 whole-time and 114 part-time nurses (397 whole-time equivalent) employed at the end of 1951.

The employment of state enrolled assistant nurses on a limited scale has been of assistance in easing the work of the district nurses, but some organisations are reluctant to use them and the Council has not so far seen fit to bring any pressure to bear. Where these nurses are employed the view has been expressed that one S.E.A.N. working to five trained district nurses is appropriate. Now that S.E.A.N.s are required to have experience in the care of sick children it is likely that their services will be utilised to a greater extent than hitherto. The use of nursing auxiliaries to supplement the work of the trained staff has also been found to vary in extent, and here again the desirability of enrolling such workers where they were available has been left entirely to the discretion of the individual organisations.

Transport

The bicycle remains the form of transport most widely used by district nurses, although autocycles are increasingly in evidence, particularly among male nurses. Some organisations possess cars, and the Council has embarked on a programme of supplying cars on loan to those whose work justifies the provision of additional means of transport, but who are unable for various reasons to acquire a car. The basis of the scheme is that the Council licenses, insures and periodically overhauls the vehicles, running costs being borne by the organisation and ranking for grant from the Council. At the end of the year eight associations were operating Council cars under this arrangement. One car was lent to an association until the delivery of a new car which the association had ordered.

Consideration is being given, in association with the Central Council for District Nursing, to the provision of a lighter nursing bag to ease the district nurses' work, but the replacement of all bags by new types will necessarily be a long process.

Night service

Owing to the pressure on the staff, consideration of a night service has had to be postponed until such time as more staff, and more accommodation for them, may be available. Several of the district nursing organisations, however, are able to arrange

(from sources outside their own staff) for the services of persons who are prepared, for a small fee, to ' sit in ' with chronic sick and other patients for whom night attendance is required but is not otherwise available. Notes on the Council's new service of night home helps are given on page 78.

Statistics

Statistical returns rendered to the Council by nursing organisations have been standardised since 1948 and have been designed to meet the requirements of the Ministry of Health. Some organisations have from time to time experienced difficulty in adapting their clerical methods to the standard returns, and where waste of time and effort has been apparent advice has been offered by the statistical section of the public health department. The whole question of records and returns is now under review with the object of devising less laborious methods and persuading the home nursing organisations to use them.

The total number of visits paid during the year was 1,610,428 compared with 1,452,410 in 1951, giving an average of 14 visits daily for each nurse (13 for 1951). The average case load of a nurse at any one time was 22 patients (21 in 1951). Treatments completed totalled 58,213 and there were 9,680 patients still in nursing care at the end of the year. The completed treatments were diagnosed as :

	Number	*Percentage of total*
Infectious and parasitic diseases	1,639	2·8
Tuberculosis	2,070	3·6
Cancer and other neoplasms	2,378	4·1
Diabetes	1,454	2·5
Mental and other nervous diseases	669	1·1
Ear, eye and other sense organs	4,426	7·6
Cerebral lesions of vascular origin	1,840	3·2
Heart and arteries	5,593	9·6
Veins and other circulatory diseases	729	1·3
Respiratory diseases	13,402	23·1
Digestive diseases	5,074	8·7
Genito-urinary	3,713	6·4
Pregnancy	611	1·0
Skin	5,938	10·2
Bones and organs of movement	1,368	2·3
Injuries	1,411	2·4
Other diseases or ill-defined	5,878	10·1

These patients were referred to the nursing organisations as follows :

	Number	*Percentage of total*
By General practitioners	46,060	79·1
Hospitals	9,191	15·8
Public health authorities	635	1·1
Direct application	1,199	2·1
Chest clinics	1,128	1·9

The bad atmospheric conditions in December caused extra pressure on the service owing to the increase in respiratory complaints.

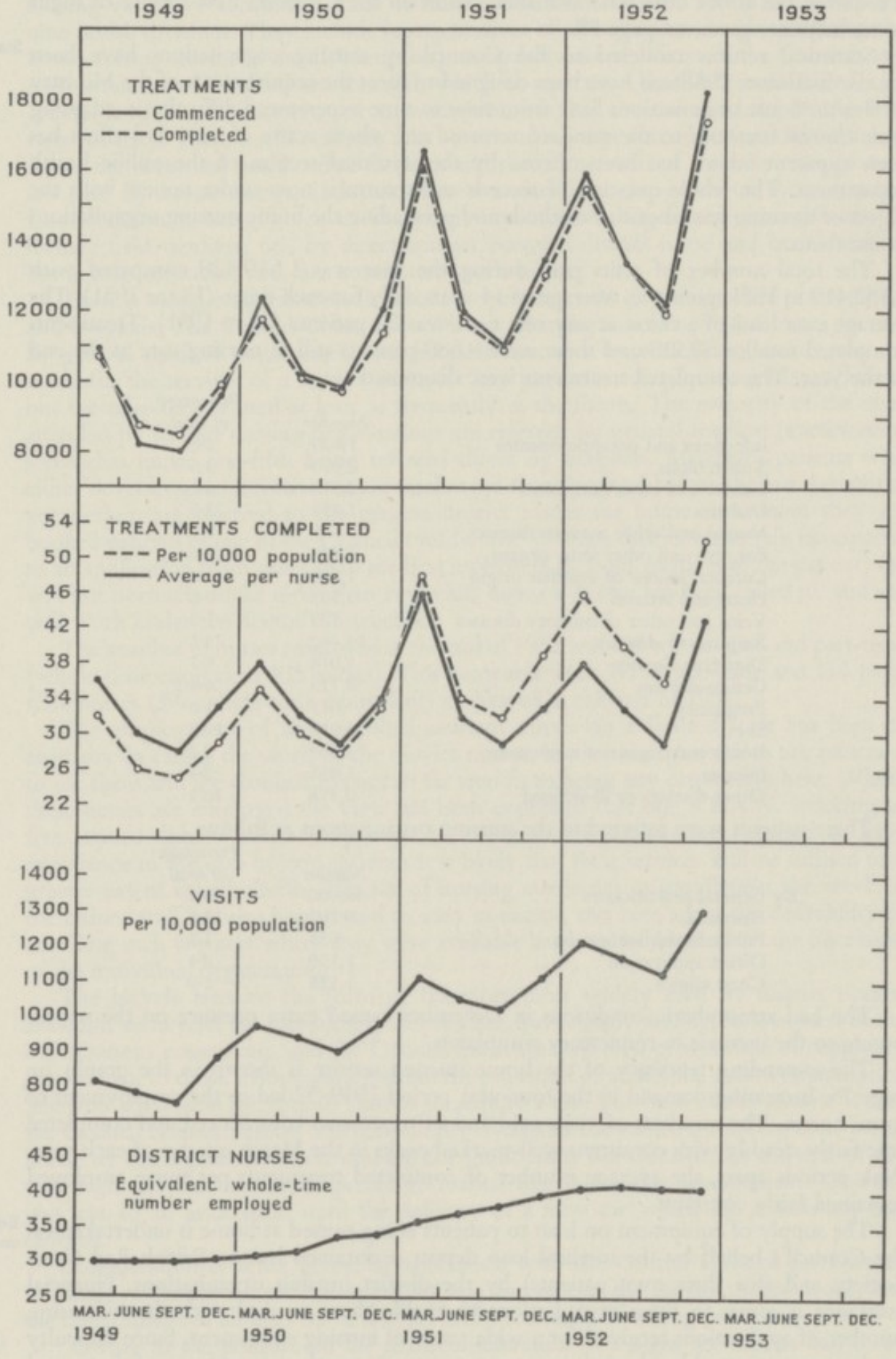
The expanding tendency of the home nursing service is shown in the graphs on page 76. Increasing demand in the four-year period 1949–52 led to the employment of more nurses. The numbers of visits paid and of treatments commenced and completed rose fairly steadily with consistent well-marked peaks in the March quarter of each year. Peak periods apart, the average number of completed treatments per nurse employed remained fairly constant.

Equipment on loan

The supply of equipment on loan to patients being nursed at home is undertaken on the Council's behalf by the medical loan depots maintained by the British Red Cross Society and (for their own patients) by the district nursing organisations. Financial assistance is given to these organisations to enable them to deal with the increasing number of applications received for a wide range of nursing equipment. Since difficulty has been experienced by the voluntary committees in purchasing and storing large and expensive items of equipment and in replenishing stocks when articles are on loan for

LONDON COUNTY COUNCIL

HOME NURSING IN THE ADMINISTRATIVE COUNTY OF LONDON



long periods, the Council will in future itself supply all equipment to patients suffering from tuberculosis, and large articles to all patients. The type of equipment supplied ranges from special bedsteads and Dunlopillo mattresses to hot water bottles, and a deposit and a small charge varying from 3d. to 1s. a week are required from those who can afford to pay.

Training

Training of district nurses in London is undertaken by the Ranyard Nurses and by certain district nursing associations approved for this purpose by the Queen's Institute of District Nursing. Not all the students trained subsequently work in London, but the Council nevertheless recognises for grant purposes all expenditure incurred by the home nursing organisations in connection with the training schemes, including the payment of a fee of £6 to the Queen's Institute of District Nursing in respect of each student district nurse trained under their auspices, this fee representing an agreed contribution toward the overhead costs of the Queen's Institute scheme. The Council also pays for the hire of a hall used by the Queen's Institute for lectures to student district nurses. The training offered by the Ranyard Nurses covers much the same ground as that of the Queen's Institute, but the approach is necessarily different, since the Queen's Institute system of district nursing is based on a number of group nurses' homes each in charge of a superintendent, whereas the Ranyard system is based on individual nurses each living in her own home and subject to supervision by peripatetic district superintendents. Both types of training overlap to some extent the syllabus of instruction for the health visitor certificate in their approach to the social side of nursing and both will undoubtedly be affected, both in length and content, by the experiments now being planned by area nurse training committees following the publication by the General Nursing Council of the revised syllabus of general nursing training which will be compulsory from 1st January, 1954. In this connection, it is of interest that state enrolled assistant nurses employed in the home nursing service are generally given one month's introduction to home nursing and then succeed very well under supervision.

The Queen's Institute of District Nursing have been pressing for some time for the statutory recognition of district nursing training, and their initial approach to the problem seemed to indicate a desire that their own particular method of training, backed as it was by many years of experience, should be recognised for the award of a national certificate. Local health authorities generally, however, have felt that in view of the great changes impending in nurse training schemes it would not be advisable at this stage to interfere with existing arrangements. It is clear that whilst the Council is using as its agents differing types of voluntary bodies employing nurses trained by different methods, it cannot well support the claims of any of them against the others.

Post-certificate training for district nurses is also organised by the Queen's Institute of District Nursing on a national basis, and London associations send members of their staff on some courses. Where a course is regarded as necessary for the improvement of the service to the people of London, the Council approves, for grant purposes, the expenditure incurred in sending the nurse to it. Instances have occurred, however, of nursing staff being sent to courses designed to enable them to acquire certificates which are neither required nor recognised for district nurses by the Whitley Council, and in these cases the organisation has itself paid the cost out of its own resources. It is rare for post-certificate courses to be held in London, but it is hoped that London nurses may eventually be able to get refresher courses nearer home.

Inspection

Inspection of most district nurses and district nursing homes in London is undertaken by the Queen's Institute of District Nursing and by the district superintendents of the Ranyard Nurses. The cost to the Queen's Institute is covered by the payment by the district nursing associations inspected of an ' affiliation fee ' of £3 15s. annually in respect of each Queen's Nurse employed on duties under section 25 of the National Health Service Act, 1946. These payments are approved by the Council for grant purposes. Three of the district nursing associations and the two religious organisations, however, are not affiliated to the Queen's Institute and their work is not inspected professionally although their voluntary committees keep in close touch with the daily work of the

nurses. The Council's staff have not so far carried out professional inspections, but there is no doubt that in future this work will be increasingly undertaken in the proper fulfilment of the Council's duties. Such a development would enable the Queen's Institute to shed their administrative functions, which are strictly within the province of the local health authorities.

DOMESTIC HELP SERVICE

THE DOMESTIC help service in London has been until 31st December, 1952, essentially a day-time service, normally available on five and a half days a week, although a small number of households (particularly old people living alone) receive some assistance at week-ends and on bank holidays, when no other help is available. Approval has been given to the inauguration from 1st January, 1953, of a limited service of night home helps to attend certain categories of chronic sick persons in their own homes and afford some measure of relief for one or two nights each week to the relatives of the patient, who would otherwise be ' on call ' every night. This service will operate between 11 p.m. and 7 a.m. and will be staffed initially by members of the existing day-time service. They will be paid at slightly higher rates than for day-time work, will work from 11 p.m. to 7 a.m. and perform those duties for the patient, other than nursing, which a relative would normally do.

Although no separate statistics have been kept, it is known that a large proportion of the householders receiving service are aged or chronic sick persons who require semi-permanent help; this is reflected by an increase in the number of cases on the books (other than maternity and tuberculous) from 9,634 at 31st December, 1950, to 14,208 at 31st December, 1952. First priority is given to maternity cases and the occasions when the needs of these people cannot be met are rare: in fact, no maternity case has had to be refused help in the past two years. The home helps who attend tuberculous households volunteer to do so and no pressure is put upon them to undertake this work; special instructions are issued as to the precautions to be taken.

The Council provides overalls for the use of its whole-time home helps and of part-time workers employed for more than 20 hours a week, the overalls remaining the property of the Council and being returnable on cessation of employment. A small quantity of household equipment is held in each of the nine health divisions for use by home helps attending households where brushes, brooms, etc. are not available, but ordinarily the provision of this equipment is regarded as the responsibility of the householder.

The service is organised on a divisional basis, a total of 30 organisers and 32 assistant organisers, with appropriate clerical assistance, being employed. The organisers' areas were originally coterminous with metropolitan boroughs, but in the interests of efficiency and of convenience to the public, adjustments have been made so that each organiser now has approximately the same responsibilities. The organisers' offices are in the main situated apart from the divisional health offices and so placed as to be of easy access to residents in the area served. At 31st December, 1952, 196 whole-time and 2,725 part-time helps were employed, being the equivalent of 1,692 whole-time workers. Applications for the services of a home help may be made to the organiser's office or to the divisional health office. The organiser or her assistant will visit the household and assess the amount of help required, but in cases where this cannot be done at once the health visitor will often make a preliminary assessment to enable the service to start without delay, the allocation of help being revised when the organiser has investigated all the circumstances. The employment of a relative of the householder as a home help may be authorised in special circumstances provided that the relative has given up paid employment in order to care for the householder; each case is subject to the approval of the divisional health committee and is kept under constant review.

The income from the service is about 7 per cent. of the cost and many households enjoy a free service. The needs of each household are reviewed periodically and such modifications as may be necessary are made in the number of hours' service provided and the charge made. The normal service for maternity cases is 44 hours a week for two weeks.

Under arrangements made with the National Institute of Houseworkers, Ltd., a total of 191 of the Council's home helps were tested in 1949. 166 were successful and were awarded the diploma of the Institute, in virtue of which their rate of pay was enhanced by 1d. an hour. A short refresher course was organised in association with the Institute in November, 1951, and was attended by 14 of the Council's home helps, but it was not an unqualified success. No further arrangements for courses or tests have been made, and it may well be that future plans in London, as in other parts of the country, may be made in association with the education service rather than with an outside body.

In some areas specially selected home helps have been allocated to households which presented certain social problems—*e.g.* neglectful mothers; parent discharged from mental hospital, etc. It has been found that a contribution can be made by the home help, by example and advice, towards the rehabilitation of the family. In one health division a home help has been allowed to work with a Family Service Unit to help problem families who come within the categories set out in section 29 of the National Health Service Act, 1946.

One way in which the domestic help service could be of further use to the community is, to look after children in their own homes when they are temporarily deprived of the care of both parents. It is thought that a scheme which would overcome the need for such children to be taken into residential care under the Children Act, 1948, with consequent emotional disturbance, could not but be of benefit. A certain amount of help is already given in some of these cases, but it is a matter of great difficulty to arrange for morning and evening care (when most of the home helps have their own domestic commitments to consider) and it is not easy to see at present how help of this kind can be extended. The suggestion is being explored that a home help might sleep in the home, her duties starting with the preparation of the children's tea and ending with the children's departure for school or a day nursery on the following morning. Negotiations as to an appropriate rate of pay are in progress; it is not yet apparent whether the cost of such a service would be prohibitive.

The growth of the service is shown by the following table :

	1949	*1950*	*1951*	*1952*
Cases assisted	25,933	25,805	26,542	27,896
Hours worked	2,783,000	3,159,728	3,441,152	3,834,688
Home helps employed at end of year ..	2,310	2,525	2,663	2,921
Equivalent of whole-time staff	1,265	1,381	1,562	1,692

The demand on the service and the extent to which it was met in 1952 is shown by the following figures :

	Maternity	*Tuberculosis*	*Other*	*Total*
Applications received	2,673	804	15,063	18,540
Households attended :				
(*a*) Completed periods of help	1,989	602	10,290	12,881
(*b*) Service incomplete at end of year ..	134	673	14,208	15,015
No. of applications refused or deferred :				
(*a*) Owing to inability to supply ..	—	23	192	215
(*b*) For other reasons	1,275	96	1,361	2,732

Although every effort is made to supply at least a little service to all who need it, some households have had to be refused or service deferred because of inability to supply, but this number was smaller in 1952 (192) than in 1951 (385). Help is never refused to a

maternity case, the disparity between the number of applications and the number of cases helped being usually caused by the mother's being admitted to hospital for her confinement or making other arrangements for help.

Normally the services of a home help are given to maternity cases for two weeks of 44 hours each. The average number of hours service given to non-maternity cases in 1952 was five, which continued over an average period of 45½ weeks.

IMMUNISATION AND VACCINATION

THE COUNCIL'S arrangements for securing infant vaccination against smallpox and primary immunisation against diphtheria fall into two main parts: (*a*) work performed by full-time or part-time medical staff employed by the Council in child welfare centres, etc., and (*b*) work performed independently by general medical practitioners, who are paid a fee of 5s. on receipt of each record of a completed course of immunisation or of a successful vaccination or two unsuccessful attempts. Prophylactic material approved for national free issue is provided by the Council to general medical practitioners on request.

The following table indicates the amount of work done in the last four years :

Prophylaxis	*1949*	*1950*	*1951*	*1952*
Smallpox vaccinations—				
Cases completed by L.C.C.	18,585	22,349	28,297	22,866
Cases completed by general practitioners ..	5,942	9,707	19,597	14,542
Diphtheria immunisation—				
Cases completed by L.C.C.	36,033	34,345	33,270	33,954
Cases completed by general practitioners ..	4,767	3,600	5,020	5,532
Whooping cough inoculation—				
Cases completed by L.C.C.	7,987	7,354	8,874	17,632
Cases completed by general practitioners ..	823	324	432	1,129
Whooping cough and diphtheria combined—				
Cases completed by L.C.C.	15,797	7,101	559	1,815
Cases completed by general practitioners ..	1,332	2,559	1,490	1,657
Grand total of diphtheria immunisations	57,929	47,605	40,339	42,958
Estimated percentage at end of year of population 0—4 who had at any time been immunised against diphtheria	54·7	55·4	53·0	50·2

The health visitor, midwife and clinic doctor constitute the joint spearhead of the attack on smallpox and diphtheria. Health visitors are advised of the birth of every child in their area, so that they may visit the homes. They are able to do much to encourage the parents of newly-born infants to have their children vaccinated and immunised when the time is ripe and, in respect of children born at home, the ground will already have been prepared by the midwife. This continuous propaganda campaign is supplemented in varying ways in each health division. Ministry of Health and Central Council for Health Education publications are used in all divisions, and in some special administrative action is taken to follow up or introduce the health visitor's approach to parents.

One division has a highly developed administrative system of records based on birth notifications and all parents are circularised when the children reach the ages of four months, eight months and 12 months, with a personal follow-up by the health visitor after this age where parents have resisted all previous efforts. These records provide a complete picture of the immunisation and vaccination state of all children born in or entering the area since the commencement of the scheme. Another division has recently arranged for immunisation against diphtheria to be available at all child welfare sessions instead of only at special sessions, and the results of this experiment will be watched

with interest. Close contact is maintained with general medical practitioners undertaking vaccination and immunisation and circular letters are sent to them from time to time, with the approval of the local medical committee, encouraging them to intensify their efforts and offering them further supplies of propaganda material. Intensified efforts are made in all divisions during national campaigns, local ' health weeks ' or following an outbreak of infection. A mobile clinic and loudspeaker van are used with success on these occasions. A keen interest in the work is taken by members of the divisional and central health committees, who receive regular progress reports.

Parents who are being asked to consent to the vaccination, primary immunisation or further protection of their children are advised of the alternative means available. Prominent notices are displayed at appropriate centres announcing the days and times of special sessions, and pamphlets are also issued in which are listed all the local health authority services available in each health division, with sessional details.

Particular attention is paid to the vaccination and immunisation of children in the Council's residential establishments inside and outside the county, and all visiting medical officers appointed to such establishments are required to give the necessary injections, subject to parental consent, as one of the routine duties of medical care. Immunisation against whooping cough is undertaken in all residential nurseries and residential nursery schools.

Diphtheria immunisation

The steady decline since 1949 in the number of children receiving primary immunisation, referred to in my last report, has now been checked. General apathy because of the low incidence of diphtheria, and concern over the possible association of paralysis in poliomyelitis with the site of recent injections (see below), are still present, but the determined efforts made to combat these by increased publicity and personal approach have resulted in 42,232 children receiving primary immunisation in 1952 compared with 40,656 in 1951, and 27,820 children receiving reinforcing doses in 1952 compared with 22,908 in 1951. This increase must be accelerated if an increase in diphtheria incidence is to be prevented.

Public alarm about the danger of paralysis following inoculations causes great difficulty both in the maintenance of a continuous propaganda campaign and in explaining to parents the necessity for postponing immunisation during the season when poliomyelitis is most likely to occur. From this point of view it is perhaps unfortunate that national immunisation campaigns tend to be launched just before the poliomyelitis season and it seems that much might be gained by intensifying propaganda as soon as possible after poliomyelitis has ceased to be widely prevalent.

Difficulty has been experienced in devising an adequate scheme of dealing with ' booster ' doses owing to the incomplete records available of work done before the operation of the National Health Service Act, 1946. Since 1942, a note has been made against each name in the school registers indicating whether the child has been immunised, but this information has frequently been obtainable only from the parents without any supporting evidence. Generally the head teachers send out letters to parents of children requiring primary or boosting doses and special sessions are arranged in schools or welfare centres. The opportunity is to be taken of reviewing this scheme with the entry into school of the first generation to be fully documented under the National Health Service Act, 1946, and it is hoped to link the ' booster ' dose more closely with the statutory routine medical inspections of children under the Education Act, 1944. In one division duplicates of the school registers are kept in the divisional office,and after the information therein has been checked with all other available records the following-up for primaries and ' boosters ' at appropriate ages is done by means of letters, followed by a personal approach by the school nurse where necessary. In many cases health visitors arrange for children to have ' booster ' doses before starting school.

In the Council's residential establishments for children inside London, 52.8 per cent. of the children were fully immunised at 31st December, 1952; parental consent had been

refused for 3.4 per cent. of the children and the remainder were either awaiting immunisation, awaiting parental consent or were not suitable for immunisation. The corresponding figures for out-county establishments were 82.6 per cent. immunised, 1.9 per cent. parental consents refused, 15.5 per cent. awaiting immunisation or parental consent or unsuitable for immunisation.

Whooping cough immunisation

There is no organised scheme in London for promoting immunisation against whooping cough, although the matter is kept under close watch with a view to the establishment of arrangements as and when medical developments justify. Parents who ask to have their children immunised against whooping cough can have the work done at a session in one of the Council's centres by arrangement, and the Council pays the standard fee for records of such immunisation received from general practitioners. It is generally found that parents enquire about immunisation against diphtheria and whooping cough at the same time and it frequently happens that the two protections are given at about the same age, either by the use of a combined prophylactic or by concurrent courses of immunisation; but efforts are being made to secure the immunisation of infants against whooping cough at an age considerably younger than that officially recommended for diphtheria, in order that protection against whooping cough can be given at an age when it can save lives.

The amount of whooping cough immunisation performed increased greatly in 1952. 17,632 children were immunised in the Council's centres and day nurseries compared with 8,874 in 1951, and 1,129 children were immunised by general practitioners compared with 432 in 1951. In residential nurseries and nursery schools 49 per cent. of the children had been immunised at 31st December, 1952 ; parental consent had been refused for less than one per cent. of the children, and the remainder were either awaiting immunisation, awaiting parental consent or were not suitable for immunisation. The use of combined diphtheria and whooping cough antigen has been recommenced since the latest types available have proved to be satisfactory; 3,472 children were immunised with the combined antigen during the year.

Vaccination

There has been a fall in the number of persons vaccinated this year. This was anticipated after the exceptionally high figures for 1951 resulting from the outbreak of smallpox in Brighton. The number of vaccinations of children under five (26,406) is, however, higher than in 1950 (24,796) or 1949 (20,093) and apart from the abnormal conditions of 1951 the figures appear to be following a welcome upward trend. Full details of the amount of work done follow. Figures for 1951 are shown in brackets.

Age at date of vaccination	*Under 1 year*	*1 to 4 years*	*5 to 14 years*	*15 or over*	*Total*
Vaccinations	23,106 (19,700)	3,300 (8,614)	1,025 (2,712)	2,002 (4,444)	29,433 (35,470)
Re-vaccinations	61 (35)	252 (254)	804 (1,330)	7,230 (15,641)	8,347 (17,260)

One child vaccinated in London in 1952 was removed to the area of another authority and there developed generalised vaccinia. There was also one case of post-vaccinal encephalitis.

Primary vaccination of older children is not recommended in the absence of smallpox, but re-vaccination of school children is undertaken as part of the Council's scheme. Parental consents had been refused, at 31st December, 1952, for 6·2 per cent. of the children in the Council's residential establishments inside London, and 3·6 per cent. in out-county establishments. 49·5 per cent. children in in-county, and 54·3 per cent.

in out-county establishments had been vaccinated. Parental consents were being obtained for the remainder.

Discussions have been held with the Ministry of Health, the County Councils Association and the Association of Municipal Corporations on, among other matters, the necessity for maintaining records of vaccination of adults, particularly those who are vaccinated before leaving the country. Although the Ministry did not consider it essential to maintain records of the latter category, they wished to have full statistical information of all other vaccination and it was decided to continue to keep records in London of both infant and adult vaccinations, including those performed on persons going overseas. Vaccination of staff and patients in hospital was considered to be a hospital responsibility and the Ministry have arranged for local health authorities to obtain, without charge, information of the extent of such vaccination.

LONDON AMBULANCE SERVICE

AS IN every previous year since the inception of the National Health Service there was during 1952 a substantial increase in the demand for ambulance transport, the number of patients conveyed by the General section of the service being 660,206 compared with 550,621 in 1951, an increase of 20 per cent. The increases in the number of journeys made and in the mileage run in dealing with this increased demand, 13 and 12 per cent. respectively, are appreciably lower than the increase in the number of patients carried and this is due to the additions made during the year to the list of hospitals to which some degree of decentralisation is applied and, so far as the road mileage is concerned, to the still increasing number of 'ambulance-train-ambulance' removals which, though adding considerably to the administrative work of the headquarters staff, result in very appreciable reductions in road mileage run and in vehicle and man hours occupied and hence in an increased availability of ambulance vehicles within the area of the county, besides effecting a considerable financial saving. In 1952, a total of 4,759 patients, travelling a total of 377,501 miles by rail, were conveyed by this means compared with 3,998 patients, travelling approximately 302,000 miles by rail, in 1951.

Railway stretchers

In collaboration with the chief officer of supplies and with a firm of manufacturers, modifications were made in the design of the special stretcher used in the Service for the conveyance of immovable recumbent patients by rail and 51 stretchers of this latest design were added to the existing stock.

Decentralisation—ambulance vehicles stationed at hospitals, etc.

As mentioned above, the arrangements under which ambulance vehicles are stationed at hospitals, etc., for varying periods on weekdays to convey patients to and from these hospitals on the instructions of the hospital Transport Officers were extended during 1952 and more hospitals, etc., were brought into the scheme, bringing the total to 43.

Review of administrative organisation and of methods of operational control

The ever growing demands upon the service have led to very severe pressure upon the central control room and upon the administrative and control staff both at headquarters and at the general ambulance stations as well as upon the operative staff and vehicles. A comprehensive review of the various clerical and operational procedures employed in the service was accordingly undertaken with a view to the elimination of outmoded practices and the promotion of greater service efficiency. This review was conducted in close collaboration with officers of the organisation and methods section of the department of the clerk of the Council, to whom I am greatly indebted for much expert advice and practical assistance. As a result a number of changes in procedure have already been adopted and others are in contemplation, designed to reduce the pressure upon the central control room, to simplify the control work at the general ambulance stations and at the same time to promote still closer association between the hospitals and their local ambulance stations.

Concurrently with these changes, arrangements were made to discontinue the maintenance of separate stores at each of the six general ambulance stations and to centralise these in the existing headquarters stores. The preparation of local wages sheets at the general stations, also, was discontinued and this work was absorbed by the department's central finance section.

The lying-in-state and funeral procession of His late Majesty, King George VI

Among the special tasks falling to the service during the year was the removal of casualties from among the very large number of people witnessing the lying-in-state and funeral procession of His late Majesty, King George VI.

At the request of the Lord Great Chamberlain an accident ambulance was stationed in the courtyard adjacent to Westminster Hall from 3 p.m. on Monday, 11th February, and a stretcher party of two drivers stood by at the Hall from 8 a.m. on Tuesday, 12th February. On the day of the funeral, Friday, 15th February, following consultation with the metropolitan police, a number of ambulances stationed near the route of the procession were specially reserved for emergency purposes and, at the request of the Railway Executive, an accident ambulance stood by at Paddington Station from 7.30 a.m. until the funeral train had departed. Letters of thanks for the arrangements made were received from the Lord Great Chamberlain and from the Railway Executive.

Festival of Britain—South Bank site demolition

Direct telephone communication between the South Bank Exhibition site and the central control room was maintained during the demolition of the exhibition buildings and a total of nine emergency calls, involving ten patients, were received during the year.

Major accidents

The emergency call involving the removal of the greatest number of casualties during the year was to the London Pavilion on 10th April, where a plaster cast light fitting had fallen from the dress circle into the stalls. Twenty-three casualties were conveyed to various hospitals.

Among other major accidents were :

21st April	..	11 persons overcome by gas fumes in a deep tunnel in Holborn and taken to hospital.
21st April	..	Collision between two buses in Rye Lane, Camberwell ; 21 casualties taken to hospital.
16th June	..	Collision between a bus and a coach at Hyde Park Corner ; 22 casualties taken to hospital.
16th August	..	Collision between a bus, a coach and a taxi in Brixton Road, Lambeth ; 11 casualties taken to hospital.
17th August	..	Collision between two buses in King's Road, Chelsea ; 14 casualties taken to hospital.
30th December	..	Bus caught on Tower Bridge as one half of the bridge began to rise ; 13 casualties taken to hospital.

In addition to these accidents, with which the service was directly concerned, assistance was rendered to the Middlesex Fire and Ambulance Service in the task of dealing with the very large number of casualties resulting from the railway accident at Harrow and Wealdstone Station on 8th October. Six ambulance vehicles in all were made available to that service for varying periods on the day of the disaster.

Following this tragic incident, advantage was taken of the experience of the Middlesex service to review and improve the already existing procedure for dealing with major accidents and to augment the reserve stock of equipment held against the possibility of an accident of similar magnitude occurring within the County of London.

Abnormal weather conditions

The dense fog which persisted in the London area from 5th to 8th December imposed a very severe strain upon the service. During this period every essential call was answered, although all other forms of road transport were virtually at a standstill and the movement of ambulances was possible in many cases only with one member of the crew walking ahead carrying a flare. Some members of the operative staff of the service walked many miles in this way and a total of 5,036 removals, consisting of 3,824 general cases and 1,212 emergency calls, were dealt with.

In the days following the fog the number of requests for ambulance transport for the admission to hospital of patients suffering from respiratory conditions rose to a very high level and in order to deal with this situation it was necessary at times to restrict the service provided for non-urgent cases—mainly the conveyance of out-patients to and from hospital.

A number of letters were received from the Emergency Bed Service, hospital management committees, etc., expressing appreciation of the work of the service during and on the days immediately following the fog.

Calls for medical assistance

Calls are frequently received in the Control Room in circumstances indicating that the summoning of medical assistance, rather than the despatch of an ambulance, is required. In such a case the caller is either recommended to call the patient's own doctor or is given the names, addresses and telephone numbers of local medical practitioners who may be summoned in emergency. During the year 780 such calls were dealt with.

Inter-authority financial adjustments

Following the refusal, in 1951, of some local health authorities to accept recommended increases, from 2s. to 2s. 9d. a mile for ambulances and from 6d. to 1s. 3d. a mile for sitting-case vehicles, in the rates of charge previously agreed on a national basis for application to ambulance work performed by local health authorities on behalf of other such authorities, the Council decided to adopt the recommended rates as its standard rates for inter-authority charges with effect from 1st October, 1952, or, in certain special cases, 1st April, 1952, with the proviso that any authority charging the Council at higher rates should be charged the full cost of any ambulance services provided by the Council. To obtain as wide an area of uniformity as was practicable with the discontinuation of the nationally agreed rates, it was decided further that adjustments between the Council and local health authorities in the home counties should, on a reciprocal basis, be at the rates of 2s. 6d. a mile for ambulances and 1s. a mile for sitting-case vehicles.

Agency arrangements

Home service ambulance department

With the continued operation of the arrangements referred to in my report for 1951, whereby the home service ambulance department of the Joint Committee of the Order of St. John of Jerusalem and the British Red Cross Society took over a large proportion of the work involved in conveying patients to and from the limb-fitting centre of the Ministry of Pensions at Roehampton, the number of patients conveyed by vehicles of the home service ambulance department and the mileage run each shows an increase over the figure for 1951 from 10,111 to 13,682 patients and from 263,087 to 285,075 miles. It will be observed that the increase in mileage is small compared with the increase in the number of patients. This improvement in the ratio of patients to mileage is due in part to the continuing substitution of ' ambulance–train–ambulance ' journeys for long road journeys of the type with which the home service ambulance department dealt almost entirely prior to 1951 and, for the rest, to the greater economy of the ' decentralised ' arrangements in operation at the limb-fitting centre.

Hospital car service

Both the number of patients conveyed and the mileage run by the County of London hospital car service decreased during the year as compared with 1951 but the decline in mileage from 1,740,930 miles to 1,504,138 miles is greater, proportionately, than that in the number of patients—from 149,046 to 135,523. This again, reflects the greater proportion of ' ambulance–train–ambulance ' journeys.

During the year the last of the four area offices of the hospital car service occupying rented premises was transferred to accommodation provided at one of the Council's general ambulance stations.

Arrangements in North Woolwich

The arrangement whereby the West Ham county borough council provides, on behalf of the Council, ambulance services in the two parts of the metropolitan borough of Woolwich which lie north of the River Thames, continued during the year.

Premises

During the year, following long delays due to the restrictions upon capital investment and, more recently, to the shortage of steel, work proceeded on three of the proposals contained in the Council's scheme, approved by the Minister of Health in 1948, for the development of the ambulance service, as follows :

Eastern ambulance station—Adaptations to provide increased vehicle accommodation. Block A, commenced in November, 1951, was completed in June, 1952. Work on Block B, which was delayed owing to the necessity of revising the scheme to reduce the quantity of steel required, commenced in December, 1952, and was still in progress at the end of the year.

South-Western ambulance station—Adaptations to increase the vehicle accommodation, to provide a new administrative block and to improve the entrance to the station. Work commenced in September, 1952, with the demolition of the former office block. This stage was completed and the extension of the garage was commenced.

' V ' (City of London) accident ambulance station—Replacement of former temporary structure by a permanent building. Work commenced in December, 1952, and, by courtesy of the Board of Governors of the nearby Royal Hospital of St. Bartholomew, arrangements were made for the ambulance and crew to be temporarily accommodated within the precincts of the hospital during the rebuilding period.

In addition to the above-mentioned items, major works were carried out during the year at ' A ' (Fulham) accident ambulance station to provide a new petroleum store, additional lavatory accommodation and improved facilities for civil defence training. Other development proposals have been further delayed owing to the need to revise building plans to reduce the use of steel.

Vehicles

During the year, two large ambulances and five single-stretcher ambulances were added to the fleet and four large ambulances were modified to take either recumbent or sitting patients. To complete the revised 1952–53 vehicle replacement programme approved by the Council, ten single-stretcher ambulances remain to be delivered and 21 large ambulances to be similarly modified. In December, 1952, the Council authorised the purchase in 1953–4 of 15 taxi-cab type vehicles to assist in dealing with the mounting volume of sitting-case work.

Road safety

During the year, facilities were made available to a number of newspapers and periodicals in connection with articles on road safety, etc., and vehicles, equipment and off-duty staff were made available to the British Broadcasting Corporation in connection with three documentary programmes on this and other related subjects.

Staff

Her Majesty the Queen was graciously pleased in Her 1952 Birthday Honours to award the British Empire Medal to Driver F. W. Summerfield for his outstanding devotion to duty during his 32 years' service in the accident and general sections of the London Ambulance Service. The citation stated that his duties had always been carried out in such a manner as to leave no doubt of his concern for the sick and injured. The Medal was presented to him by the Lord Lieutenant of the County of London at an investiture at the County Hall on 22nd October. Award of British Empire Medal

The Council, in 1938, resolved that a silver medal should be awarded to any officer or employee in the London Ambulance Service whose conduct in the execution of his duty should be considered to be sufficiently meritorious. In July, 1952, Driver H. C. Legon, headquarters station, supervised the removal of a workman who, whilst engaged on the demolition of the Dome of Discovery on the Festival of Britain site, had been trapped by a fallen wall 50 feet above ground where he could be reached only by way of a broken staircase and a steel girder. The action taken by Driver Legon was considered by the Council to merit the award of the medal, which was presented to him on 28th October by the Chairman of the Health Committee. Award of Meritorious Conduct Medal

I stated in my Annual Report for the year 1951 that owing to the continued difficulty in obtaining suitable male ambulance drivers to fill vacancies, the Health Committee had authorised the recruitment, in a temporary capacity, of women ambulance drivers and by the end of that year 30 women had been so engaged, resulting in a total increase in the numbers of operative staff from 628 to 699. During 1952 the standard of candidates seeking employment showed a considerable improvement, with the result that wastage due to retirements and resignations was more than made good and the total number of operative staff employed rose by the end of the year to 692, including 45 women ; 54 of those employed were temporary reliefs engaged to take the place of those absent owing to sickness or on annual leave. All new entrants to the operative staff are required to obtain a recognised qualification in first-aid to the injured, normally within six months of engagement, and receive an additional 6s. a week for holding the qualification. They are then examined orally and practically by a medical officer on the staff of the department to ensure their competence. Recruitment

Members of the operative staff received increases of 1½d. an hour with effect from 28th February, 1952, and 1d. an hour with effect from 27th November, 1952, which were authorised by the Council in accordance with a recommendation of the National Joint Council for Local Authorities' Services (Manual Workers) and an award of the Industrial Disputes Tribunal, respectively, thus resulting in a basic wage of a driver qualified in first-aid of 147s. a week. This wage could be enhanced by payments for shift, Sunday and stand-by duties. The Council also adopted further recommendations of the National Joint Council regarding the payment of subsistence allowances, the effects being (*a*) an increase from 17s. 6d. to 20s. for absence on duty necessitating absence from home for a period of 24 hours and (*b*) an increase from 2s. to 2s. 6d. and from 5s. to 6s. for absence from the usual place of employment of five and under nine hours, and of nine hours and over, respectively. Wage increases

The revised occupation groupings for motor drivers approved by the National Joint Council with effect from March, 1949, and adopted by the Council, made no provision for the extra payment for drivers qualified in running repairs, which had been payable under the former grading of motor drivers. The running repairs test was, therefore, suspended but after negotiation the allowance of 3s. a week was restored to those drivers who had passed the test prior to its suspension. In October, 1951, the test was re-instituted and the Council approved, with certain provisos, the payment of the allowance to drivers who passed the test. Running repairs allowance

In September, 1952, a new scale of issue of uniform to members of the operative staff was approved whereby the period of replacement of some items of uniform was extended and a cheaper overcoat provided. It had been the practice for some years to Uniform

allow staff to discard their jackets in summer months provided white shirts were worn and an issue of these shirts, which were not previously provided, will be made in future for use in hot weather.

At the end of the year, the staff comprised, in addition to the headquarters administrative and clerical staff :

1 Chief Superintendent
8 Superintendents
7 Assistant Superintendents
21 Station officers
692 Operative staff (drivers and attendants).

Included in the above the following were engaged on civil defence training :

1 Superintendent
2 Station Officers
15 Operative staff.

Civil defence

During the year the first stage in the training of the operative staff of the service in their wartime duties in an expanded civil defence ambulance service was almost completed.

The arrangement continued whereby the basic general training of all volunteers in the ambulance section of the Council's Division of the Civil Defence Corps was given by the metropolitan borough councils. On completion of this preliminary training further instruction is given by the Council and considerable progress was made during 1952.

The main emphasis has continued to be placed on first aid, in which a very satisfactory proportion of volunteers attained pass standard in the theoretical and practical examinations at the conclusion of their courses. A comprehensive course of training for instructors in the duties of the ambulance section, which was also attended by senior members of the Council's administrative staff who would have operational responsibilities in war, was held in the early part of the year and the instructors who qualified then undertook the further training of those volunteers who were qualified in first aid.

Ambulance section and first-aid training is undertaken at 7 ambulance stations throughout London and, where there is considerable demand for facilities in any particular area which is not immediately adjacent to a training station, additional premises are utilised.

The number of volunteers remained inadequate, having regard to the heavy responsibilities which would face the ambulance service in London in war. A house to house canvass designed to arouse interest in, and obtain recruits for, civil defence was successful in securing some increase in numbers but it is essential to bring about a considerable expansion of trained volunteers if the service in London is to be adequate in any national emergency. I am pleased to report that in this, as in other matters relating to civil defence training, there is the closest co-operation between the officers of the Council and those of the metropolitan borough councils.

Statistics

The statistics for the directly provided service are divided into two sections—Accident and General.

The Accident section statistics include not only street accidents and other emergencies but also the bulk of maternity removals and the conveyance of analgesia apparatus to women being confined at home.

The following tables show :

(i) comparative statistics for 1938 (the last full year before the war); 1947 (the last full year before the inception of the National Health Service) and subsequent years for both sections of the directly provided service and for 1948 and subsequent years for the agency and supplementary services.

(ii) an analysis of the Accident section work for 1952 and a comparative analysis for 1951 ;

Work performed by the directly provided service

Year	Accident Section				General Section			Total		
	Patients	Non-patient carrying journeys	Total journeys (calls)	Mileage	Patients	Journeys	Mileage	Patients	Journeys	Mileage
1938 ..	54,070	4,126	56,318	293,166	217,908	171,000 (est.)	1,930,172	271,978	227,000 (est.)	2,223,338
1947 ..	61,136	5,007	64,560	362,880	182,206	155,122	1,768,550	243,342	219,682	2,131,430
1948 ..	59,912	7,764	66,373	367,627	239,157	192,881	2,072,545	299,069	259,254	2,440,172
1949 ..	65,989	11,391	75,901	410,917	362,963	279,600	2,808,550	428,952	355,501	3,219,467
1950 ..	73,853	11,523	83,791	437,416	480,048	340,876	3,041,569	553,901	424,667	3,478,985
1951 ..	77,661	11,488	87,012	443,683	550,621	361,664	3,092,902	628,282	448,676	3,536,585
1952 ..	78,692	10,851	87,691	442,268	660,206	410,469	3,470,442	738,898	498,160	3,912,710

Work performed by the agency and supplementary services

Year	City of London Police		Home Service Ambulance		Hospital Car Service		West Ham C.B.C.		Total	
	Patients	Mileage	Patients	Mileage	Patients	Mileage	Patients	Mileage	Patients	Mileage
1948 ..	907	2,546	5,454	204,048	30,052	430,121	37	469	36,450	637,184
1949 ..	835	2,619	9,557	376,564	107,667	1,496,090	113	1,468	118,172	1,876,741
1950 ..	—	—	7,966	281,223	144,669	1,787,434	246	4,373	152,881	2,073,030
1951 ..	—	—	10,111	263,087	149,046	1,740,930	208	3,338	159,365	2,007,355
1952 ..	—	—	13,682	285,075	135,523	1,504,138	591	7,806	149,796	1,797,019

Work performed by both sections of the directly provided service and by the agency and supplementary services

Year	Total Emergency Work		Total General Section Work		Grand Total	
	Patients	Mileage	Patients	Mileage	Patients	Mileage
1938 ..	54,070	293,166	217,908	1,930,172	271,978	2,223,338
1947 ..	61,136	362,880	182,206	1,768,550	243,342	2,131,430
1948 ..	60,819	370,173	274,669	2,706,755	335,488	3,076,928
1949 ..	66,824	413,536	480,300	4,682,672	547,124	5,096,208
1950 ..	73,853	437,416	632,929	5,114,599	706,782	5,552,015
1951 ..	77,661	443,683	709,986	5,100,257	787,647	5,543,940
1952 ..	78,692	442,268	810,002	5,267,461	888,694	5,709,729

NOTES :—1. *The figures are based on the Council's definition of a 'patient,' which differs from that adopted by the Ministry of Health.*

2. *The agreements with the agency and supplementary services have been in operation only since 5th July,* 1948, *the 'appointed day' under the National Health Service Act,* 1946, *and that with the City of London Police terminated on 4th July,* 1949.

3. *The work carried out by the City of London Police consisted of the removal of accident cases and has been included in the table for 'Total Emergency Work'; that performed by the other agency and supplementary services is almost entirely analogous to the 'General Section' work of the directly provided service and has been included in the table for 'Total General Section Work.'*

Analysis of Accident section work

(*a*) Number of patients of various types :

	1951	*1952*
Street accidents	13,631	13,655
Other accidents	17,858	18,080
Assault cases	1,559	1,612
Attempted suicide	381	591
Mental	602	611
Epilepsy	1,379	1,226
Other sudden illness	17,873	17,625
Maternity	24,249	25,169
Special journeys with patients	129	123
	77,661	78,692

(*b*) Non-patient carrying journeys :

Delivery of analgesia apparatus	5,848	5,069
Special journeys without patients	234	276
Ambulance not required	5,406	5,506
	11,488	10,851

The average time taken to reach street accidents in 1952 was 7.2 minutes.

PREVENTION OF ILLNESS : CARE AND AFTER-CARE

Tuberculosis

THE COUNCIL'S services for the purpose of preventing tuberculosis and of the care and after-care of persons suffering from tuberculosis are provided or continued to the extent directed by the Minister of Health in Circular 118/47. A subsequent development has been the scheme for the B.C.G. vaccination of susceptible contacts of known cases of tuberculosis which, with the Minister's approval, was started in September, 1950. Before the National Health Service came into operation, most of these services formed part of the Council's comprehensive scheme for the treatment of tuberculosis although some were performed by the metropolitan borough councils with grant-aid from the Council and the Ministry.

The difficulties inherent in a service for the care and treatment of the tuberculous divided between local health authorities and regional hospital boards have called for close integration and liaison on matters where responsibilities meet and overlap. The progress made in London owes much to the regular meetings between the medical officer of health and the senior administrative medical officers of the Metropolitan Regional Hospital Boards. The medical officer of health also holds regular meetings with the London chest physicians. Many of the services mentioned below involve co-operation with general practitioners. Contact is also maintained with local and central representatives of the Ministry of Labour and National Service and of the National Assistance Board.

Chest clinics

There are 31 separate clinics in London and six of these are in 'teaching' hospitals. They vary in size from a register of 67 tuberculous at St. Bartholomew's Hospital to one of 2,745 at Lewisham Clinic. There were 35,388 patients on the registers at the end of 1952, of whom 32,008 were suffering from pulmonary tuberculosis. The medical staff, the radiographer and the physician's clerks at chest clinics are provided by the Metropolitan Regional Hospital Boards or Boards of Governors of teaching hospitals, which also maintain the premises and equipment. The Council reimburses the Metropolitan Regional Hospital Boards three-elevenths of the salaries of the chest physicians for the local health authority aspects of their work. It rents from the hospital management committees the clinic accommodation used by its own staff, which include tuberculosis

visitors, tuberculosis care organisers and their clerks, and handicraft instructors. Most of the health visitors' time is spent in visiting patients in their homes to ascertain the domiciliary, social, and economic conditions under which the patients live to provide a basis for measures to improve them. The care organisers are concerned with the patient's social needs other than medical and nursing. They also act as the secretaries to the local tuberculosis care committees, whose activities are co-ordinated by divisional tuberculosis care committees.

T.B. visitors

The tuberculosis visitor remains an important link between the diagnostic and curative work at the chest clinic and the preventive and care measures in the patient's home. She works in association with the chest physician while remaining under the local direction of the Council's divisional medical officer. She is in touch with the hospital services and voluntary home nursing organisations and, as regards after-care measures in the home, with the tuberculosis care organiser. Tuberculosis health visitors are provided by the Council to work in chest clinics at an average spread of one visitor to 400 registered tuberculous patients. The introduction of a scheme for B.C.G. vaccination has added to her clinical duties. The increasing number of epidemiological investigations carried out as a result of cases of tuberculosis at schools, nurseries and welfare homes has also to be taken into account. In order to relieve generally the pressure of nursing work at the clinic it has been necessary at certain chest clinics to employ state registered nurses.

Care organisers and local care committees

The importance of relieving tuberculous patients of domestic, social, industrial and financial anxieties cannot be over-emphasised. Most necessitous tuberculous persons receive a higher rate of financial grant from the National Assistance Board than do other necessitous persons. In 1952, clinic care organisers made first investigations in respect of 5,951 patients ; 2,559 newly assisted patients received extra nourishment ; 541 were provided with beds and bedding ; 496 were provided with nursing requisites ; 961 were provided with clothing and 606 with other commodities. At the end of the year 2,234 tuberculous patients were receiving extra nourishment from the Council or care committee resources and 673 were receiving the services of home helps. In addition to arranging for the provision of food, clothing, etc., as outlined above, the Council's care organisers made arrangements, where possible, for better housing, more suitable employment, foster homes for child contacts, diversional therapy, and gave help or guidance in many other problems of personal or family concern.

Home care and treatment

At the end of 1952, there were 738 tuberculous persons in London awaiting admission to hospital, compared with 773 at the end of the previous year; 808 patients (compared with 658 at the end of the previous year) were under special treatment in their own homes. Many of these were awaiting admission to hospital, but where the patient's domestic and home conditions permitted, chest clinic physicians introduced home treatment by rest, chemo-therapy, collapse therapy, or combinations of these forms of treatment. This treatment involved the services of health visitors, home nurses and home helps, and the boarding-out of susceptible children from the homes to avoid the risk of infection or to ensure their safety and care while mothers were undergoing treatment at home or in hospital. At the end of the year 367 patients were receiving attention by the Council's home nursing service.

The Council's ambulance service rendered valuable assistance to the home treatment scheme by conveying many patients by car or ambulance from homes to clinics or hospitals for X-ray examinations, for lung collapse therapy, or associated minor surgical treatment.

Domestic help

The Council has recruited a body of home helps willing to work in tuberculous households and they are advised by printed notice to take certain precautions whilst employed on this work. There has been a steady increase in the number of tuberculous persons receiving domestic help (536 at the end of 1951, rising to 673 at the 31st December, 1952). The use of home helps when mothers are in hospital or in bed at home enables the family to keep together and reduces work and anxiety for the patient.

Hostels for homeless infective ambulant tuberculous men

One effect of the fragmentation of the Council's pre-1948 tuberculosis service was to leave uncertain the position as to responsibility for the care of ambulant chronic infective tuberculous persons not requiring further treatment but having no homes. When the Council was a hospital authority it made arrangements for care of these persons in suitable residential establishments in various parts of the country. The Minister of Health having ruled that responsibility for the care of these persons rested with the local health authority, the Council established in October, 1951, a hostel at 20/22 Highbury Quadrant, Islington, N.5, providing 35 beds, for tuberculous men, the criteria for admission to the hostel being homelessness, infectivity, and ability to keep up and about. The men are under the close supervision of the local chest physician and continuous medical care is provided by local general practitioners. Premises in Fulham, South-West London are being adapted to provide a second residential hostel. The need for hostel accommodation in London is estimated to be approximately 80 beds per 30,000 tuberculous adults (male and female), mostly for unemployed elderly men with advanced disease and therefore in practice only intermittently ambulant. Experience will in due course show whether this kind of provision for men in this category is an adequate substitute for special wards in a chronic hospital. There does not appear to be any demand for hostel accommodation for tuberculous women. No special nursing facilities are provided, but use is made, when needed, of the local home nursing service. These hostels are a good social service for indigent disabled tuberculous men who are thereby provided with good meals and good lodgings at a charge each is able to bear.

At the beginning of 1952, 17 men were in residence at the Islington hostel, and 37 more severely disabled men were accommodated by arrangement in a private establishment, St. Catherine's Hostel, Sopwell House, St. Albans. The arrangement for the use of the accommodation at St. Catherine's Hostel was terminated on 6th September, 1952, some of the residents being transferred to the hostel at Islington and the remainder to accommodation made available temporarily at the British Legion Village, Preston Hall, near Maidstone, Kent, pending the establishment of the second hostel.

During the year 61 recommendations for admission to a hostel for homeless infective tuberculous men were approved and at the end of the year 32 men were in residence at the Council's hostel and 12 at the British Legion Village.

Rehabilitation

Selected patients recommended by chest physicians are sent by the Council to village settlements where they undergo courses of instruction in work suitable to their capacity and temperament. The Council has in the main met little difficulty in agreeing financial terms with the settlement managements and, with the regional hospital boards, the stage at which a patient is deemed to come within the Council's after-care. Maintenance charges are the Council's responsibility when the patient is judged fit for work at the settlement for five hours a day. The Council was financially responsible for 31 patients at the end of 1948. At the end of 1952 the Council was responsible for 23 ex-service men and two women at the British Legion Village, Preston Hall, near Maidstone ; 16 men and one woman at Papworth Village Settlement, nr. Cambridge ; 18 men at the Enham Alamein Village Centre, Andover, Hants ; and two men at East Lancs. Tuberculosis Colony, Barrowmore Hall, nr. Chester, a total of 62 patients.

The Council arranges for the facilities for correspondence courses provided by the British Council for Rehabilitation to be available for tuberculous patients undergoing prolonged medical treatment at home who wish to train for their future occupation but are not fit to attend technical colleges ; 25 patients were accepted for training in this way in the six months ended 30th September, 1952.

The problem of the disabled patient's resettlement in industry, primarily the concern of the Ministry of Labour and National Service, is marked by the difficulty of finding suitable employment and may, particularly in the case of the infectious patient, call for delicate negotiations with prospective employers. Chest physicians give valuable assistance in this connection, with the Council's care organisers and the voluntary care committees. In pursuance of the Ministry of Health Circular 7/52 (8–4–52), dealing with

the occupational resettlement of tuberculous persons, London chest physicians are undertaking on behalf of the medical officer of health the necessary approval and surveillance of places of employment of persons with open tuberculosis, having regard to the patient's physical capacity and the risk to the health of others. In view of limited housing facilities the managements of the village settlements now prefer to admit, for training, tuberculous persons who have prospects of returning to normal civilian life. The one London Remploy factory affords only limited facilities for the employment of 83 tuberculous workers. Considerable difficulty is, therefore, experienced in providing suitable training and employment, especially part-time, for substantially handicapped and potentially infective tuberculous persons and for this group there is a need for more sheltered workshops. The Council has for some time considered the establishment of a sheltered workshop for disabled tuberculous workers, but lack of suitable premises and the general need for economy have restricted progress.

B.C.G. vaccination

The Council's scheme for the B.C.G. vaccination of tuberculin negative contacts of known cases of tuberculosis was started in September, 1950. The number of contacts vaccinated by chest physicians under the Council's approved scheme, and, by co-operation of other local health authorities concerned, by chest physicians of areas in which children are boarded-out under the Council's tuberculosis contact scheme, is as follows :

	1950 (*since September*)	1951	1952	*Total*
Vaccinated by London chest physicians ..	271	2,287	3,034	5,592
Vaccinated by out-County chest physicians (as notified by them)	42	220	139	401

In addition, 73 children, the majority of whom were newly-born babies, were vaccinated in hospital during 1952, prior to boarding out. During the year, 67 children were boarded-out solely for segregation during vaccination, but it has been found that many of these could not return home after converting to Mantoux positive owing to adverse home conditions or to the mother becoming unfit to undertake the care of the child.

Boarding out of child contacts

Under a scheme which has been in operation for over 25 years the Council arranges for the boarding-out of children exposed to infection by tuberculosis in their own homes or whose parent or parents are receiving residential treatment for tuberculosis. The Invalid Children's Aid Association, as the Council's agents, arrange for the placing of the children with suitable foster parents, or in private nurseries or voluntary homes. All remain under surveillance by the chest physicians of the clinics covering the areas of the foster homes and regular reports are received on their progress. Since the war, overcrowding and the housing shortage, the long hospital waiting lists and the steady increase of domiciliary treatment of tuberculosis have led to heavier demands on this service. Concurrently with the greater competition for foster homes following the passing of the Children Act, it has become increasingly difficult to find and retain sufficient suitable foster homes. The need for segregation of children during B.C.G. vaccination has also led to a widening of the boarding-out arrangements. The average number of children boarded-out at any one time in 1952, under these arrangements, was 460 (including 18 children boarded-out solely for segregation during B.C.G. vaccination) compared with between 130 and 140 before 1939, 180 in 1946, 230 in 1947, 257 in 1948, 326 in 1949, 405 in 1950, and 448 in 1951. The total number of children boarded-out during the year was 991 (949 in 1951), of whom 434 were children whose stay extended from 1951. The number of children, included in these figures, who were segregated for the purpose of B.C.G. vaccination was 82 of whom 15 remained boarded-out from 1951. Arrangements are made to ensure that B.C.G. is given to negative reactors.

At the end of the year 464 children remained boarded out. The co-operation of medical officers of health and chest physicians outside London has been excellent in the boarding-out scheme.

Boarding open-air schools

Residential convalescent care is provided for children with a history of incipient or recent tuberculosis, at boarding open-air schools maintained by the Council under the Education Acts and, by arrangement, in voluntary open-air schools. The co-operation of the local health authorities of the areas in which the schools are situated permits regular surveillance of these children by the local chest physician during their stay at the school.

No child with known 'open' or infectious tuberculosis is, however, admitted. The schools maintained by the Council's Education Committee in 1952 were :

Burrow Hill Colony School, Frimley.
George Rainey School, St. Leonards-on-Sea.
Warnham Court, Horsham, Sussex (moved from White Oak Hospital, Swanley, in March, 1952).
Kathleen Schlesinger School, nr. Henley.
Wanstead House, Cliftonville, Margate.
Bowden House School, Seaford.
Wainwright Residential School, Broadstairs.

These schools provide 425 places for delicate children. In addition some children were accommodated in private open-air boarding schools.

The total number of children with a history of primary tuberculosis accommodated in open-air boarding schools during 1952 was 80 (44 boys and 36 girls), 33 of whom (17 boys and 16 girls) were children whose stay extended from 1951. At the end of the year 29 such children (20 boys and 9 girls) were still in these schools, while 11 children (4 boys and 7 girls) were awaiting admission in January, 1953. This is a service which provides suitable convalescence and educational facilities, in good surroundings, for children who need 'building up' for several months to tide them over a 'primary' infection.

Protection of children against tuberculosis

Measures suggested in recent Ministry of Health and Home Office circulars for the protection of organised groups of children against the risk of infection by adults suffering from tuberculosis were introduced in 1952. They provide for chest X-ray examinations, on appointment and annually, of certain staff whose employment brings them into close contact with children, and for epidemiological investigations among contact staff and children at establishments where cases of tuberculosis have occurred. The following summary gives the results of investigations made during 1952 at Council schools, nurseries, etc., where a case of tuberculosis in a member of the staff or a group of cases in children had been reported.

Health education in tuberculosis

During 1952, a sample survey of adult public opinion on tuberculosis was undertaken throughout the administrative county. The questions asked were designed to explore and measure public knowledge of facts on the origin, symptoms, treatment and prevention of tuberculosis. 1,063 persons whose opinions represented a fair sample of the main social adult groups were successfully interviewed. The findings revealed marked ignorance on causation, prevention and infectivity of tuberculosis, valuable indications being gained of what is lacking in public knowledge of tuberculosis, so that a basis on which to plan educative measures is now available.

Mass miniature radiography

Co-operation with the mass miniature radiography service of the metropolitan regional hospital boards allows the Council to carry out certain of its preventive measures. In conjunction with the service epidemiological investigations are made on tuberculosis contacts at schools, nurseries, welfare homes and other establishments (see page 95). The mass X-ray examination of school-leavers is now a feature of the programmes of the London units. The units also provide facilities for the periodic examination of the Council's staff working in close contact with children. Details of the movements of the mobile units are regularly circulated throughout the Council's service and this information is also given to the public on enquiry. Facilities for propaganda by poster and leaflet are also provided at the Council's establishments. The existence of three static units in London has been of special help in this regard. One of these units established in Islington attempted during 1952 a borough-wide X-ray survey of the resident and local working population.

Summary of investigations made into tuberculosis 'incidents' at Council establishments in 1952

Establishment	*Notified case*	*Children*				*Adults*	
		Tuberculin tested	*Positive result*	*X-rayed*	*Abnormal cases*	*X-rayed*	*Abnormal cases*
Home for aged and infirm (1)	Resident ..	—	—	—	—	16	1
Homeless Families Units (4) ..	Adult resident ..	101	40	30	4	—	—
	Adult resident ..	3	2	—	—	—	—
	Adult resident and 2 children ..	13	9	13	2	13	5
	3 Adult residents ..	85	41	75	7	55	1
Schools (16) ..	Teacher ..	314	61	140	—	23	—
	Teacher ..	—	—	—	—	24	—
	Teacher ..	—	—	674	2	23	—
	Teacher ..	—	—	559	3	19	—
	Teacher ..	369	12	369	2	12	—
	Teacher ..	—	—	88	1	6	—
	Student ..	—	—	—	—	45	—
	Teacher ..	—	—	160	—	19	—
	Student ..	—	—	309	1	48	—
	Pupil ..	—	—	78	1	—	—
	Pupil ..	6	1	12	1	—	—
	Pupil ..	—	—	738	3	17	—
	Pupil ..	—	—	226	1	—	—
	Gatekeeper ..	—	—	—	—	90	—
	Cook ..	460	12	67	—	27	—
	Kitchen helper ..	—	—	457	—	24	—
Nurseries (2) ..	Nurse ..	74	4	74	2	27	—
	Nursery asst.	23	—	—	—	24	—
Occupation Centres (2)	Attendant ..	—	—	40	2	3	—
	Pupil ..	—	—	40	—	4	—
Totals ..	—	1,448	182	4,149	32	519	7

Pulmonary tuberculosis mass X-ray units, 1952

Regional Hospital Board unit	*Metropolitan boroughs visited during 1952*	*Total number X-rayed during year (a)*			*Diagnostic classification*						
					Active				*Inactive*		
		Males	*Females*	*Total*	*Males*	*Females*	*Total*	*Rate per 1,000*	*Males*	*Females*	*Total*
N.W.											
5A	Hammersmith, Kensington ..	35,065	31,268	66,333	79	69	148	2·23	*	*	*
5B	Paddington, St. Pancras, Holborn, St. Marylebone	34,619	30,002	64,621	49	59	108	1·67	168	94	262
5D	Static—Islington	14,233	18,811	33,044	111	117	228	6·90	231	190	421
N.E.											
6B	Stoke Newington, Poplar, Hackney, Bethnal Green ..	4,598	6,140	10,738	6	5	11	1·02	90	97	187
6D	City, Finsbury	29,794	21,114	50,908	55	53	108	2·12	1,639	563	2,202
S.E.											
7A	Woolwich, Camberwell, Bermondsey, Southwark	21,198	17,623	38,821	98	79	177	4·56	*	*	*
7D	Camberwell, Lewisham, Woolwich, Deptford, Southwark ..	10,224	8,534	18,758	64	17	81	4·32	*	*	*
S.W.											
8C	Westminster, Battersea, Wandsworth, Fulham, Chelsea ..	25,260	20,785	46,045	73	61	134	2·91	971	662	1,633
8D	Fulham Westminster .. .. Static May–Dec., serving all S.W. London.	14,882	15,510	30,392	136	95	231	7·60	734	672	1,406
Total	London Administrative County ..	189,873	169,787	359,660	671	555	1,226	3·41	*	*	*
Tavistock Square	Civil Service	*	*	32,366	*	*	132	4·08	*	*	427

(a) These are not all Londoners but persons attending units while operating in County area.

** Figures not available.*

I am indebted to the four metropolitan regional hospital boards and to the Ministry of Health for the figures (page 96) showing the number of persons (mostly working adults) examined during the year by their mass X-ray units operating in London and the number of cases of tuberculosis whose diagnosis was established during 1952. It will be seen that a number of the diagnoses completed during 1952 related to persons X-rayed in 1951. Likewise a number of persons X-rayed during 1952 will remain under surveillance until a firm diagnosis becomes established in 1953.

Foot clinics

The Council has continued to operate the 26 foot clinics established by the metropolitan borough councils before 5th July, 1948, but the demand for foot treatment continues to be unsatisfied. There is need not only for a further expansion of the service at existing foot clinics but for the establishment of new foot clinics in areas which at present are very poorly served. Liaison between clinics, general practitioners and hospital orthopaedic departments is good, although the need remains for the laying down of standards for the types of foot conditions which are suitable for treatment by a chiropodist and those which should be referred to a general practitioner or hospital. In some divisions it has been possible by grouping chiropodists into larger units so that three, four or even five work simultaneously at one session, to make it economical to provide a clerk to relieve the chiropodists of clerical work. Arrangements have been extended for dealing with special categories of patients, viz., children and the infirm aged. School children found to be suffering from *verrucae pedis* and other foot conditions can be referred for treatment. For infirm aged and housebound patients unable to reach a clinic in any other way, transport has been provided. In one division, diabetic patients have been treated in association with a local hospital which has a special unit for such persons.

The following are particulars of sessions, attendances, etc. :

Year	**Clinic sessions*	*New cases*	*Attendances*	*Staff (in terms of whole-time units)*
1949	7,673	9,446	129,682	35
1950	9,811	10,165	153,687	44
1951	9,759	10,348	162,163	43·5
1952	10,971	10,828	169,598	43·2

* Some sessions are attended by more than one chiropodist.

The majority of treatments provided at the clinics are for superficial excrescences (corns, callosities, etc.) and malformed nails. Advice is given on shoe fitting, foot hygiene and exercises.

Venereal disease

A summary of the work done in 1952 at the London V.D. clinics will be found in Table 20, page 189. Approximately 75 per cent. of the patients were resident in the County of London. The figures show a continued decline in the number of patients suffering from syphilis. There was, however, a slight increase in the number suffering from gonorrhoea. A large number of persons who were not suffering from venereal disease again attended the clinics.

There was no appreciable change in the defaulter rate. The table below gives the number of patients completing treatment and of defaulters as shown by analysis of the returns from the clinics for 1952.

	Syphilis		*Gonorrhoea*	
	Male	*Female*	*Male*	*Female*
Number of patients discharged after completion of treatment and final test of cure	743	774	2,302	605
Number of patients who ceased to attend after completion of treatment but before final tests of cure	690	267	2,257	481
Number of patients who ceased to attend before completion of treatment	161	111	233	56
Number of patients who died from the disease while still undergoing treatment	11	3	—	—

Under section 28 of the National Health Service Act, 1946, the Council's male and female welfare officers have continued to undertake the tracing of contacts of patients, details of whom have been provided by hospitals, by medical services of the British, Dominion and United States Armed Forces, and by local health authorities. The welfare officers have also been available to assist clinics in case of difficulty in following up patients who have defaulted.

At the request of the Prison Commissioners the part-time services of a welfare officer were made available during 1950 for attendance at clinics at Holloway Prison and for following up contacts and prisoners on discharge, and arrangements were made in 1952 for the appointment of a whole-time welfare officer to undertake this work. Despite the many difficulties encountered, good results continued to be achieved in overcoming the reluctance of prisoners to attend out-patient clinics on discharge or, where necessary, to complete treatment in hospital. The task of following-up patients and their families for the purpose of securing tests involves much visiting and enquiry and is carried out in close co-operation with Probation Officers and other social workers engaged in this field.

Thirty-three notifications were received from the Service authorities of demobilised men who were under treatment or surveillance for V.D. and these men were interviewed with a view to persuading them to continue attendance at civilian clinics.

Recuperative holidays

In 1948 demands for recuperative holidays outstripped the available accommodation. Recuperative holiday home accommodation has increased during the intervening years, and now there is sufficient accommodation for all categories of persons medically recommended for a recuperative holiday. Accommodation for mothers and babies has been particularly difficult to obtain, and in addition to using the larger type of recuperative holiday home a policy has recently been followed of using small private residences accommodating one or two mothers with their babies, where the mothers live in with the family.

The Council uses accommodation (36 places) in its own recuperative holiday home for children at Roland House, Littlehampton and makes a 90 per cent. grant towards the approved maintenance expenditure of the Women's Voluntary Services' recuperative holiday home for children at Aldeburgh, in return for which it has the first claim on the beds at the home. Selected children in parties of 30 are sent to a private hotel on the Kent coast and their supervision is undertaken by a holiday organiser and two assistants. Persons are also sent to homes belonging to voluntary organisations, and to those under private ownership.

Recuperative holidays are provided for expectant and nursing mothers and children under five years of age under section 22 of the National Health Service Act, 1946, and under section 28 for other adults. No charge is made to school children for recuperative holidays provided under the Education Act, 1944, but a standard charge, subject to abatement, is made to other categories of persons sent for recuperative holidays under

the provisions of the National Health Service Act, 1946. School children are medically examined on return from the holiday.

Unaccompanied children

The services of voluntary organisations such as the Invalid Children's Aid Association, Women's Voluntary Services, Jewish Board of Guardians, Children's Country Holiday Fund and the Wandsworth Peace Memorial, are used in providing recuperative holidays for unaccompanied children.

Special arrangements were made during 1952 to send a limited number of educationally sub-normal children for recuperative holidays and additional facilities were obtained for recuperative holidays for physically handicapped children.

Expectant and nursing mothers, accompanied young children and other adults

The majority of adults, expectant and nursing mothers and accompanied young children are placed in recuperative holiday homes direct by the Council but the Family Welfare Association is used as a placing agent in a few especially difficult cases. The services of the St. Henry Convalescent Fund were also used in 1952 for the provision of recuperative holidays for a small number of adults and accompanied children living in the City of Westminster. The Spero Fund for the Welfare of Tuberculous Workers co-operates with the Council in the placing of tuberculous persons in recuperative holiday homes.

Statistics

The number of recuperative holidays since 1948 is shown in the following table, from which the marked drop in the number of holidays provided for children under five years of age in 1952 emerges significantly as a hopeful pointer to the improvement in the health of the children in this age group, and to the general reluctance of medical practitioners to send young children, especially those under two years of age, on recuperative holidays apart from their mothers.

Year	*Unaccompanied children*		*Expectant and nursing mothers and accompanied young children*		*Other adults*	*Total*
	Under 5 years	*School children*	*Mothers*	*Children*		
1948 (6 months)	637	1,098	128	148	754	2,765
1949	1,517	3,121	379	671	2,779	8,467
1950	1,548	4,255	340	566	3,439	10,148
1951	1,309	3,501	219	386	3,154	8,569
1952	686	3,507	190	352	3,308	8,043

Health education

As part of its proposals under section 28 of the National Health Service Act, 1946, for the prevention of illness, the Council decided to develop, as opportunity should permit, a comprehensive educational programme in physical and mental health, and for this purpose to seek the co-operation of the metropolitan borough councils and to utilise the services and material available from the Central Council for Health Education and other appropriate bodies. During 1952 a senior medical officer of the Council reviewed the existing arrangements for health education in the county. Concurrently, two public health departmental working parties studied (i) educational activities in maternity and child welfare centres, and (ii) the prevention of accidents in the home. Comments on the three subjects follow.

Health education review

The review confirmed the general impression that since July, 1948, the metropolitan borough councils have tended to concentrate on propaganda for those services remaining under their control, while the County Council has concentrated on ' personal ' health services. The subjects covered by the boroughs include clean food and food handling, infectious diseases, pests and flies. The devices adopted to encourage health education are: Lectures, exhibitions, public meetings, films, campaigns, posters, pamphlets and show-cases. There is a general concensus of opinion that while lectures to large audiences

are ineffective, talks to small groups in a more intimate manner give good results. The use of films and other visual aids is considered to be important.

The subjects covered by the Council's headquarters and health divisions naturally differ from those of the boroughs. Apart from the teaching of mothercraft the main aim of divisional propaganda is protection against smallpox, diphtheria and whooping cough. Great reliance is placed on the personal services and influence of the medical officers and of the health visitors both in the homes and in the centres. As in the boroughs, experience shows that talks to small groups have greater value than talks to larger audiences. Increasing use is being made of films, film-strips and other demonstration material. The departmental collection of films and film-strips on health education is augmented as necessary by hiring from outside. Show-cases at centres serve a useful purpose and lead to questions by the mothers, but exhibits need to be changed sufficiently often to stimulate interest. Apart from material provided centrally, health visitors are encouraged to make their own demonstration material, the Council providing the necessary paints, brushes, wax, etc. Posters and pamphlets are used in all divisions and are purchased, mainly from the Central Council for Health Education. Some district nursing associations are supplied with leaflets on diphtheria and smallpox. Open days are held in some divisions, as a means of improving contacts with voluntary agencies, general practitioners and teachers. Similarly, divisional lending libraries have been started at maternity and child welfare centres and liaison established with borough libraries.

The Central Council for Health Education to which this Council contributes an annual sum of £1,700, provides an advisory service on the content and methods of health education, courses on health education technique for staff, exhibition topics, and, at cost price, leaflets and posters. The National Baby Welfare Council, to which this Council contributes an annual sum of £5 5s., has a permanent exhibition on maternity and child welfare at its headquarters and also publishes leaflets and a monthly book 'Mother and Child'. The latter is purchased for circulation amongst divisional staff, and some of the leaflets are purchased for distribution at welfare centres. Leaflets are also purchased from the National Association for Maternity and Child Welfare to which the Council contributes £10 10s. a year.

In the Council's schools health education takes the following forms :

Primary (including nursery schools and classes) and special schools—The inculcation of cleanliness and hygiene.

Secondary schools—The curriculum of all schools includes physical education. At some biology is included either as a special subject or as part of a general science course. Housecraft and mothercraft teaching is given in girls' schools. Opportunities for health teaching occur in all schools and, in addition, much incidental teaching is given.

Polytechnics and technical institutes—Certain of the polytechnics arrange courses in subjects connected with health—hygiene and public health, sister tutors, health visitors, sanitary inspectors, nutrition, dietetics, first-aid, home nursing, etc. The technical institutes maintained by the Council have similar lectures in health subjects.

The evening institutes provide instruction in first-aid, home nursing, infant care, hygiene, parentcraft, physical exercises, keep fit and various forms of dances.

Health education in schools is properly a matter for teachers though there are times when doctors and, more especially, health visitors can help. Health education of children, not only for their own personal benefit but also because of their influence as future parents of the next generation, is so important that no effort should be spared to improve the standard in this country. The present crisis in juvenile delinquency and maladjustment is sufficient evidence of the gaps in this form of education.

For many years school nursing sisters and health visitors have given courses of instruction in mothercraft to girls in secondary schools and during 1952 a small committee drew up some notes for a course of 12 lessons with a list of appropriate demonstration

material and visual aids. A school health council, composed of the school children assisted by the staff, was inaugurated in a South London comprehensive secondary school in the autumn. The object of the council is to enquire into the needs of the school and the community for health, physical and mental, and into how these needs are being met. There are great possibilities in this experiment and the outcome will be watched with interest.

The review showed that health education in London is being developed satisfactorily along the broad lines of the proposal approved by the Minister. The possibility of improving existing methods and stimulating new ideas will be kept under constant review. The only new recommendation arising out of the review related to lectures. As already stated, talks to small groups are a valuable means of health education, but no special effort has so far been made to stimulate a demand that undoubtedly exists, because of the difficulty of providing speakers, although any requests have been met wherever possible and in particular sex education talks to youth organisations have been arranged by the employment of approved lecturers. Lectures are best given by staff engaged in the work rather than by lecturers from outside the service, but if lecturers are to be selected from the Council's staff the question of recompense for attendance at evening meetings must be considered. Normally it is not possible to give equivalent time off duty unless sessional staff are employed to take their place. The alternative is to pay fees for talks given outside official hours and the Council has agreed to do this. It is proposed to prepare syllabuses of health talks (with visual aids) suitable for various audiences and to select lecturers.

Educational activities at maternity and child welfare centres

Since 1948 the Council has continued to emphasise the part played by the maternity and child welfare centre in attracting mothers for advice on their own health and that of their children and for lessons on mothercraft. Centre staffs appreciate the need for planned group instruction, and excellent efforts have been made and are being made in spite of the limitations sometimes imposed by unsuitable premises and inadequate equipment.

The working party (i) considered the opportunities for health education in centres and suggested methods by which such teaching could be carried out, (ii) prepared an outline syllabus of talks as a guide to health visitors, and (iii) recommended suitable demonstration material and other visual aids. The outline syllabus has since been printed, copies being distributed to divisions as a guide to health visitors and others preparing courses of lectures. The working party's general proposals were that :

(*a*) Wherever possible each maternity and child welfare centre should have a room, apart from the general waiting-room, capable of seating 10 to 20 mothers and another room equipped with play equipment where children could be minded apart from their mothers.

(*b*) Where possible centre premises might be made available in the evenings for use as parents' clubs, the social activities being organised by the parents themselves, with centre staff assisting on a voluntary basis, as these clubs afford an excellent opportunity for health education.

(*c*) The main responsibility for health education should remain with the health visitors, although it is useful for specialists in particular fields (*e.g.*, midwife, domestic science teacher, sanitary inspector) to speak or demonstrate, from time to time. Courses in instruction and in teaching methods, including the use of the epidiascope and film-strip projector, should be provided for health visitors, and appropriate journals should be circulated regularly in each division.

(*d*) All suitable centres should prepare a scheme of health education to meet the needs of the mothers concerned.

Divisional review of existing educational activities showed that many of the suggestions covered by the working party's proposals had become standard practice, although the extent varies between centres and between divisions. These include :

(*a*) Short informal talks by health visitors to mothers and at the larger and better equipped centres, weekly mothercraft classes ; (*b*) cookery and needlework classes, conducted by an evening institute instructor ; (*c*) divisional files of posters and pamphlets, kept up to date by central office ; (*d*) at larger centres, displays of (*e.g.*,) infant layette and model garments, bathing and needlework equipment, play equipment, etc. ; (*e*) a lending library at the centre or by arrangement with the municipal libraries ; (*f*) parents' clubs at a few centres in some divisions ; (*g*) voluntary workers who, among other duties, look after children while their mothers are at classes, etc.

Film shows are arranged on request. Film-strip projectors have been provided for general use on the basis of one for each division, with a small reserve for issue to divisions requiring a second apparatus on certain occasions, and a small pool of epidiascopes. Information on suitable films and film-strips is already provided. Unfortunately there are few film-strips suitable and available for health education at welfare centres and divisions are being encouraged therefore to co-operate in the making of film-strips by inviting divisional staff who show special interest to attend one of the courses on this subject arranged for teachers by the education officer. Health visitors qualifying from 1950 onwards receive instruction in teaching methods, including the use of film-strip projectors and epidiascopes, as part of their basic training and arrangements are being made for selected health visitors from among those trained before 1950 to attend special courses in these subjects. Most divisions have designated an officer (usually an assistant divisional nursing officer) to deal with health education as part of her normal duties. The present staffing position does not make it possible to adopt a suggestion that a health visitor should be detailed to deal solely with educational activities.

There remained a number of proposals for development or expansion which divisional medical officers wished to carry out. Some of these could be put into effect by administrative action, *e.g.*, :

(i) improvement of standard of decoration, lighting and hygiene at welfare centres, as these are considered to be important factors in health education ;

(ii) extension of mothercraft classes at the larger and better equipped centres to which mothers normally attending smaller centres or at church halls can be invited ;

(iii) mothers themselves to be invited to participate in health education sessions or discussion groups and to be encouraged to set up ' good neighbour ' movements whereby efficient mothers can help others in practising the technique taught at the centres.

Approval has been given generally to the lines of development of educational activities at maternity and child welfare centres set out above and the question of their detailed application referred to the Divisional Health Committees.

Prevention of accidents in the home

Much attention has been paid in recent years to the prevention of accidents in the home and a public health departmental working party which had assistance from members of other departments of the Council, from a medical officer of the Ministry of Health and from the Royal Society for the Prevention of Accidents has studied the problem. At the instance of the Ministry of Health, Dr. Leslie Banks, Professor of Human Ecology at the University of Cambridge, is initiating an inquiry into the causes of sudden death in infants which are usually classed under the heading of suffocation, and the Council has agreed that the health visitors shall supply details of home circumstances where these accidents occur.

Accidents in the home are not notifiable and there is no exact information available of non-fatal accidents, but the cost of hospital treatment of accidents in the home in 1949 was estimated at between £4,000,000 and £5,000,000, of which £1,000,000 was due to in-patient treatment of burns and scalds. These figures take no account of the indirect cost to the community through absence from work, provision of sickness benefit and financial relief, or through the allocation by local health authorities of health visitors, home nurses and home helps to such cases.

Since 1947 a Government Interdepartmental Committee, including representatives of the Home Office and the Ministries of Health, Education and Works, has been studying the problem. The experience of the Interdepartmental Committee has confirmed that education of the individual in the home is the best way of preventing accidents. Posters, pamphlets and films play a part, but are not thought to be very effective on their own. The Home Safety Department of the Royal Society for the Prevention of Accidents have produced some very useful posters and pamphlets which are in use in the Council's maternity and child welfare centres.

The housing and valuation department of the Council is very conscious of the importance of trying to eliminate accidents by means of good design. Balustrades on staircases are of various designs and are constructed in several types of materials, but very particular attention is paid in the design to eliminate footholds which might encourage children to climb on them ; attention is paid to safety as well as to appearance in the design of sun balconies, and protective rails are usually provided ; steps within flats have been totally eliminated ; much attention has been given to the construction of safe windows, which are designed so that they can be cleaned from the inside and with the bottom pane of glass fixed so that it cannot be opened ; side-hung opening windows have safety catches fitted to the casement stays to limit initial opening. Other measures which have been taken include the siting of meters and fuses, so that they can be reached without standing on chairs and yet be out of reach of small children.

The working party came to the conclusion that accidents in the home are caused mainly through (*a*) the personal carelessness or negligence, physical frailty or infirmity of some individual, not necessarily the victim ; (*b*) the bad design or misuse of appliances and equipment ; (*c*) defects in the structure or maintenance of buildings, and (*d*) overcrowding, particularly where children and old people are concerned. Having regard to the unnecessary loss of life, the deformity and disablement not infrequently left in survivors, the distress caused to the victims and their relatives, and the heavy cost, particularly in personnel, of the ensuing medical and nursing treatment, accidents in the home should be considered a major public health problem. It may be considered that it is the responsibility of local authorities to try to make people more aware of the dangers of accidents in their home and that the best way to do this is through the education, by its own staff, of the individual in the home. As the health visitor already visits the home and is accepted as a trusted friend and adviser, it is considered that she is the most suitable person on whom to base the work, more particularly since over 75 per cent. of all deaths caused through accidents in the home are among children under five years of age and the elderly—those with whom her work is normally associated. Midwives, district nurses, home helps and sanitary inspectors could also help in educating people as they are in close contact with the homes. Other ways in which the local authority can help are in the relief of overcrowding and the provision for the elderly, the blind, etc., of homes in which the risks of fire and falls on stairs are minimised. The working party took the view that it is desirable to establish practical means of measuring the incidence of and morbidity from accidents in the home and the collection of information additional to that already available (mainly from the Registrar-General) is, therefore, necessary. They regarded the need to secure information about non-fatal accidents as particularly vital and suggested means of collecting such information.

The first suggestion of the working party was that the Council could most fruitfully and quickly approach the subject of home accidents through its existing organisation covering health education. It proposed that information of fatal and non-fatal accidents in the home should be collected and analysed so as to provide indices of trends and information of those accidents against which propaganda is especially needed. This information could be obtained by analysis of accident reports in the health visitors' records, by seeking the co-operation of the district nursing associations in the reporting of home accidents, by extraction of detail of home accidents from the ambulance service reports, by the inclusion by teachers of notes of accidents on their daily return of

infectious diseases and by asking certain hospitals to extract information about out-patients attending for treatment as a result of accidents in the home. The inauguration of an analysis on the lines suggested would be a task of some magnitude but as a first step it is proposed to investigate the possibility of obtaining some samples so as to judge the need to consider the extension of all or any of the recommended methods.

Another recommendation, for the holding of a series of one-day training courses on home accident prevention as part of the normal post-entry training carried out for the Council's nursing staff will be implemented and it is intended to offer places to the borough medical officers of health for their staff. One person in each division will be responsible to the divisional medical officer for continuous effort in the prevention of home accidents.

Consideration is being given to the inclusion of talks on the prevention of home accidents in the syllabuses of classes in mothercraft, domestic science and education in citizenship.

The working party felt that additional exhibition and demonstration material, including working models showing the causes of home accidents, should be provided. In point of fact three working models showing three common causes of accidents in the home (falling down stairs, non-provision of a fireguard and pulling cloth off table) have been acquired from the Royal Society for the Prevention of Accidents. These have been shown in some of the welfare centres and also at the recent mothercraft exhibition in the Central Hall, Westminster.

The working party felt that an annual intensive campaign should be held to supplement the everyday effort and consideration is being given to this. The need to continue to bear in mind the importance of home safety in the designing, erection and management of houses and flats was emphasised by the working party and the subject is being discussed with the chief officers concerned, bearing in mind the Heating Appliances (Fireguards) Act, 1952. The co-operation of voluntary associations should be sought in publicising these problems and this will be done at divisional level.

MENTAL HEALTH SERVICES

THE COUNCIL'S Health Committee, which is charged by the Council with the control of the mental health services, has a Mental Health Sub-Committee which deals with all matters relating to mental health, except those concerned with policy and staff.

Staff

The equivalent of approximately three full-time medical officers are employed on mental deficiency work. All the medical officers engaged on this work, who include a principal medical officer and a senior assistant medical officer, are specially experienced in mental deficiency and all also carry out other medical duties in the Council's general and school health services. Five women inspectors (including one senior inspector) are employed on the work of ascertainment and guardianship of mentally deficient persons. The inspectors either possess a social science certificate or have had considerable experience in dealing with mentally deficient persons over a period of many years. Twenty-eight women social workers (including the psychiatric social worker already mentioned), almost all of whom possess a social science certificate or diploma, are employed on the

work of supervising mental defectives living in the community and are allocated between four district offices as follows :

District	*Address*	*Area covered. The metropolitan boroughs of*	**Total number of staff authorised*
A	37–38 Strand, W.C.2 ..	Finsbury, Hampstead, Holborn, Islington, Paddington, St. Marylebone, St. Pancras, Westminster	6
B	2 Whitechurch Lane, E.1 ..	Bethnal Green, City, Hackney, Poplar, Shoreditch, Stepney, Stoke Newington	7
C	250 King's Road, S.W.3 ..	Battersea, Chelsea, Fulham, Hammersmith, Kensington, Wandsworth	7
D	12 Baldwin Crescent, S.E.5	Bermondsey, Camberwell, Deptford, Greenwich, Lambeth, Lewisham, Southwark, Woolwich	8

* *Each office is under the direction of a local organiser included in the total staff mentioned. Consideration is being given to the need for the employment of an additional unit of staff to cope with increased numbers of cases.*

The basis of staffing the Council's occupation centres for mentally deficient children and adults is one supervisor for each centre plus one assistant supervisor for each 15, or substantial part of 15, pupils on roll, except the first 15. At present, 17 supervisors and 30 assistant supervisors are employed, of whom six possess the qualification of the National Association for Mental Health for staffs of occupation centres. Women attendants are employed as required, provided that at no centre is the ratio of the total number of staff (*i.e.*, supervisors and attendants) to pupils of 1 to 10 exceeded. Two boot-repairing and two woodwork instructors are employed at the four elder boys' centres. Each instructor undertakes duty at two centres. An organiser of occupation centres is employed to exercise general supervisory control over all the centres. This position is at present held in an acting capacity by one of the supervisors.

A consultant psychiatrist is employed for two sessions a week as medical adviser in mental health on matters other than those relating to mental deficiency and child guidance. One psychiatric social worker, who is also employed on the work of supervising mental defectives living in the community, undertakes part-time the visitation of patients boarded out in Mental After Care Association homes and other miscellaneous duties in connection with the psychiatric care and after care service.

A senior mental welfare officer, 17 mental welfare officers and five assistants are authorised to take initial proceedings in providing care and treatment for persons suffering from mental illness. All the officers are men.

Training of staff

Almost all staff employed by the Council in connection with its mental health services possess appropriate qualifications. All new staff are carefully instructed and initiated into their duties by experienced officers. Refresher courses have been arranged periodically for occupation centre staff. Visits to mental deficiency institutions and other establishments are also arranged for staff.

Co-ordination

Close co-operation is maintained by means of correspondence, telephone and meetings, where necessary, with the staff of the four metropolitan regional hospital boards, hospital management committees and boards of governors of teaching hospitals. It has not been found necessary or practicable to consider the joint use of officers. Patients on trial from mental hospitals are not supervised by officers of the Council. It is understood that this work is undertaken by psychiatric social workers employed by the hospitals. Patients on licence in London from mental deficiency institutions (throughout England

and Wales) are supervised by the Council's social workers from the four district offices on request from the physician superintendents concerned. Medical reports are also provided when necessary to avoid the return of defectives to institutions at the time of statutory consideration and reconsideration of orders and when discharge is under consideration. Of the six mental deficiency institutions which have catchment areas wholly or partly in London, two (St. Lawrence's and the Fountain Hospitals) now undertake the supervision of their own patients on licence by their own social workers who, in the case of the Fountain Hospital, also report on home conditions as required in connection with the statutory consideration and reconsideration of orders and the consideration of the grant of leave of absence or discharge. This latter duty is undertaken by the Council's social workers in respect of relatives of defectives living in London for all institutions other than the Fountain Hospital.

Voluntary associations

The Guardianship Society, Brighton, assists the Council to find suitable guardians for patients under the Mental Deficiency Acts and carries out supervisory duties in respect of those patients so placed on payment of agreed charges. In addition, the Council makes use of voluntary associations in carrying out services provided under section 28 of the National Health Service Act, 1946 (see page 39).

Prevention of mental illness and care and after-care

Domiciliary After Care Service

Following the receipt of circular 146/48 from the Ministry of Health, arrangements were made for the National Association for Mental Health and the Mental After Care Association to provide between them, on behalf of the Council, on payment of 90 per cent. of the cost of the service to each Association, care and after care for persons suffering from psychiatric illness. The service, which was a continuation and extension of the after care scheme for ex-service personnel which had been operated by the National Association since 1943 at the request of the Board of Control and the Ministry of Health, is largely carried out by means of domiciliary visits. The service provides help and guidance in problems of adjustment to social and home life and in finding employment, etc., for those persons suffering from psychiatric illness who do not need, or no longer need, in-patient or out-patient treatment. It was made clear to the two Associations that the arrangements for them to carry out the work on the Council's behalf were of an interim nature only. A recent review of the cases dealt with by the associations revealed that about one-third of the cases referred, or seeking help themselves, are dealt with comparatively quickly and with little difficulty by being referred to psychiatric out-patient clinics or to their own doctors or by other similar means. One-third require help of a varied nature which usually involves co-operation with Government departments, such as the Ministry of Labour, Ministry of Pensions, etc. The remaining one-third are long-term cases requiring supervision and domiciliary visits over a prolonged period. Since the inception of the scheme up to 31st December, 1952, 1,129 cases have been dealt with, 705 by the National Association for Mental Health and 424 by the Mental After Care Association. At 31st December, 1952, there were 231 active cases on the registers. Careful consideration has recently been given to this service and it has been decided that to enable the work to be carried out under the immediate supervision and direction of the Council's medical adviser in mental health, the work shall be done by the Council's staff and the arrangements with the two associations terminated on 31st March, 1953. The thanks of the Council have been conveyed to both associations for the satisfactory manner in which they have carried out this important and useful service. It is proposed to employ two psychiatric social workers and additional clerical help as necessary on this work.

Social clubs and rehabilitation centre

A grant is made to the Institute of Social Psychiatry of 90 per cent. of the cost incurred for London patients attending the rehabilitation centre and five psychotherapeutic social clubs run by the Institute. The centre is open each morning and afternoon on five days

a week and provides training and occupation under the direction of an occupational therapist for mentally sick patients with a view to their rehabilitation to normal life. The clubs meet on one evening a week and are attended by persons living in the community who need a measure of mental support and assistance to enable them to carry on their normal lives. The Council is represented on the board of governors of the Institute.

Long term care

The Council has undertaken responsibility for the cost of maintenance of a number of mentally sick persons in homes owned or sponsored by the Mental After Care Association and in one home managed by the National Association for Mental Health. There are at present 71 patients boarded-out under this scheme and they are nearly all chronic or senile patients who have neither homes nor relatives able to care for them and do not require hospital or nursing care. It is considered that the maintenance of this type of patient in these special homes provides a very valuable service as the patients need a greater degree of supervision than can be given in ordinary welfare homes or hostels. The patients are visited regularly by the social workers of the Mental After Care Association and also by one of the Council's psychiatric social workers. The weekly charge made by the Mental After Care Association was increased from 54s. 10d. to £3 3s. a head for those patients maintained in homes sponsored, but not owned, by the Association and to £3 13s. 6d. a head for those maintained in homes owned and managed directly by the Association. Patients are assessed according to their means and some contribute towards the cost of maintenance. Those who have no means receive 6s. 6d. a week pocket money from the National Assistance Board. In suitable cases, voluntary patients on their departure from hospital and certified patients on discharge are maintained for periods up to a maximum of three months in Mental After Care Association homes to enable them to adjust themselves to community life and to find employment.

Recuperative holidays

Recuperative holidays are provided in Mental After Care Association and other selected holiday homes on medical recommendation for persons suffering from mild psychiatric disability, including those attending psychiatric out-patient clinics, who primarily need rest, fresh air and good food and who present no special behaviour difficulties. A contribution towards the cost of each holiday is recovered according to the means of the person for whom the service is provided; 158 recuperative holidays were provided in 1952. This figure, which includes cases of certified and voluntary patients discharged from mental hospitals maintained temporarily in Mental After Care Association homes, shows a considerable increase compared with 1951, when 93 holidays were provided. There is no doubt that holidays arranged in the early stages of mental illness, in conjunction with suitable out-patient treatment, if necessary, often avoid the necessity for admission to hospital. The cost of maintenance rose considerably during the year and the average weekly cost per head was approximately £3 18s. compared with just over £3 in 1951. The average length of each holiday was three weeks.

Work under the Lunacy and Mental Treatment Acts

Removal of persons of unsound mind

The Council's proposals under section 51 of the National Health Service Act, 1946, provided that the work performed by duly authorised officers of securing that persons of unsound mind are placed under care and control and subsequently of obtaining reception orders for their detention if necessary, should be carried out from the four district offices from which mentally defective persons are supervised. Owing to problems caused by the shortage of beds in observation wards and office accommodation difficulties, however, it was not possible to arrange this and, with the approval of the Minister, the work was centralised at the County Hall as a temporary measure. The question of decentralisation has been reconsidered from time to time but the shortage of observation ward accommodation has persisted and this and the further factor that decentralisation would involve considerable additional expenditure and manpower have resulted in a continuation of the centralised arrangements. The question has been reviewed annually. It was the intention that the duly authorised officers (mental welfare officers) should

follow the practice previously taken by relieving officers in London of taking action under section 20 of the Lunacy Act, 1890, in all cases of persons alleged to be of unsound mind needing to be placed under control by removing them to an observation ward in the first instance before taking steps to secure certification. Owing to the shortage of beds in observation wards this has not been possible in a considerable number of instances since July, 1948, and, as will be seen from the statistics submitted with this report, during the year 1952, it was necessary for 1,130 patients to be brought directly before a Justice of the Peace for examination with a view to certification without being admitted to an observation ward and for 39 patients to be admitted directly to mental hospitals under urgency orders made under section 11 of the Lunacy Act, 1890. As the following table shows, the number of persons in respect of whom the duly authorised officers have been required to take action has increased steadily since the appointed day :

Year	*Number of cases dealt with*		
	Male	*Female*	*Total*
1947	2,049	2,603	4,652
1948*	1,047	1,485	2,532
1949	2,333	3,017	5,350
1950	2,399	3,163	5,562
1951	2,488	3,303	5,791
1952	2,570	3,533	6,103

* *5th July to 31st December only.*

These figures are now considerably higher than pre-war. Notwithstanding this increase the number of beds available in observation wards in London is now 217 compared with 353 in 1938, making it necessary, as shown in the following table, to deal with an increasing number of patients otherwise than by admission to an observation ward.

Observation ward accommodation

Because of its concern at this situation and at the shortage of institutional accommodation for mental defectives, referred to later (page 110), the Council, in December, 1951, sent a deputation to the Minister of Health to urge the pressing need for more accommodation to be provided for London cases in observation wards and in mental deficiency institutions, particularly in the latter case for infants and young children. The accommodation position in observation wards remains unaltered but some minor reliefs have been afforded as regards mental defectives (see page 110). The shortage of accommodation in observation wards is aggravated by the inadequacy of the accommodation in Tooting Bec and Abbots Langley Hospitals for senile patients and there is little doubt that if additional methods of dealing with this type of patient were available, the problem of accommodation in observation wards would be very much reduced. The Council's medical adviser in mental health has recently reviewed the records of a large number of patients over 65 years of age dealt with by the mental welfare officers and he is of the opinion that the provision of an adequate number of psychiatric geriatric units with in-patient and out-patient facilities would avoid the certification and admission to mental hospitals of all old people, except those who are grossly disturbed and obviously require immediate psychiatric care.

Conveyance

Patients are conveyed to observation wards and, in cases of direct admission, to mental hospitals whenever possible by private car but ambulances are used when necessary. Patients transferred from observation wards to mental hospitals are conveyed by ambulance and are escorted by nurses from the observation wards as was the practice prior to the 'appointed day'.

Statistics

The following table shows the number of persons dealt with by the Council's mental welfare officers during 1952 and the action taken :

	1952			1951
	Male	*Female*	*Total*	
Admitted for observation to hospitals designated under section 20 of the Lunacy Act, 1890 ..	2,142	2,792	4,934	4,880
Dealt with in their own homes, etc., under sections 14 and 16 of the Lunacy Act, 1890	407	723	1,130†	890*
Admitted direct to mental hospitals under section 11 of the Lunacy Act, 1890	21	18	39	21
No action under the Lunacy Acts found necessary..	702	1,058	1,760	1,602
Total	3,272	4,591	7,863	7,393

* *Of these 144 male and 323 female patients were certified and removed to mental hospitals.*
† *Of these 263 male and 410 female patients were certified and removed to mental hospitals.*

The following table shows the ultimate disposal of the patients admitted to observation wards (including 167 patients in wards on 1st January, 1952) :

	1952			1951
	Male	*Female*	*Total*	
Certified and sent to mental hospitals	761	1,045	1,806	1,762
Admitted as voluntary patients to mental hospitals..	482	699	1,181	1,009
Admitted as temporary patients to mental hospitals	11	32	43	28
Discharged to care of relatives (Section 22) ..	7	31	38	43
No order made by Justice and patient discharged ..	29	18	47	118
Transferred to general wards..	65	61	126	148
Transferred to Tooting Bec Hospital without certification..	114	160	274	277
Transferred to Abbots Langley Hospital without certification	4	8	12	27
Transferred to Mental After Care Association homes	1	1	2	3
Died	77	72	149	208
Discharged by Medical Officer	572	661	1,233	1,238
Dealt with privately	5	7	12	13
Dealt with under Mental Deficiency Acts	3	8	11	10
In ward on 31.12.52	75	92	167	167
Total	2,206	2,895	5,101	5,051

Work under the Mental Deficiency Acts

Ascertainment and supervision

All the arrangements for the ascertainment and supervision of defectives and the presentation of petitions continue to be carried out as envisaged in the Council's scheme under section 51 of the National Health Service Act. These arrangements are working satisfactorily. The medical work involved in ascertainment is carried out by medical officers on the Council's central staff and the necessary social enquiries are made by women inspectors also on the central staff. The medical examination of defectives or alleged defectives is normally carried out at the County Hall but where necessary, *e.g.* the defective is severely physically handicapped, a visit is paid to the home.

The Council has continued to carry out the supervision of defectives in their own homes by social workers employed in the four district offices. During 1952 a total of 17,498 visits were paid to persons under statutory supervision or on licence from hospitals. In addition, 802 visits were paid to persons under voluntary supervision.

It has not yet been possible on economic grounds to institute an arrangement for the systematic medical re-examination of defectives under supervision at regular intervals.

1,867 visits were paid on behalf of hospital management committees and local health authorities to ascertain the home circumstances of patients in connection with the statutory reconsideration of orders and the consideration of applications for leave of absence or discharge.

Petitions

Petitions for orders for institutional care or guardianship under section 6 of the Mental Deficiency Act, 1913, are normally presented once a week by an authorised office ron the central administrative staff to a Judicial Authority who attends at the County Hall by special arrangement. As a matter of convenience, children and other persons placed by their parents under section 3 of the Act are also dealt with at these sessions. The necessary medical certificates are provided by the Council's approved medical officers following examinations immediately prior to the proceedings. The senior inspector or one of the local organisers from the district offices joins the petitioning officer in making the statutory declaration.

Attendance at Magistrates' Courts

The arrangement has been continued whereby one of the Council's medical officers attends at Courts, on request, after examination of alleged defectives in prison or on bail, to give evidence on the mental condition of defectives charged with criminal offences to enable the Courts to consider dealing with them under section 8 of the Mental Deficiency Act, 1913.

Institutional accommodation

The reduction in the amount of institutional accommodation for mental defectives available for London by about 25 per cent. as a result of the re-allocation of accommodation by the four Metropolitan Regional Hospital Boards in 1948 has given rise to serious concern and difficulty, although within the limits of the resources available the utmost co-operation has been received from all four Boards and the Hospital Management Committees in attempting to solve a problem which is nation-wide but which prior to 1948 caused little anxiety in London. This co-operation enabled the Council, during the year, to secure the admission to hospital of no fewer than 369 mentally deficient persons. This figure is not only higher than in 1951 when 303 were admitted but exceeds the number of London patients admitted to institutional care during any year since 5th July, 1948, and is somewhat greater than the annual number admitted for some years prior to that date. Nevertheless, more patients were awaiting institutional care at the end of the year than at 31st December, 1951. There were then 154 patients awaiting institutional care, while there were 169 on the waiting list at 31st December, 1952. There were thus 81 more cases requiring institutional care during the year than in 1951.

Of the 154 persons for whom beds were needed at the end of 1951, no fewer than 117 were infants and young children awaiting admission to the Fountain Hospital. At the end of 1952, however, only 89 were awaiting admission to that hospital. The reduction in the waiting list for this hospital is all the more satisfactory because during the year the Hospital Management Committee provided greatly increased facilities for the admission of patients for short term care.

Temporary care

Although not specifically authorised to do so, the Fountain Hospital had, during 1951, admitted children for short periods to provide a measure of relief to hard pressed parents. The position with regard to this short term care was regularised by the issue of Ministry of Health Circular 5/52 on 21st January, 1952, which authorised local health authorities to find temporary accommodation and pay for the maintenance therein of mentally defective persons to enable emergencies, such as the illness of a parent, to be overcome and permitted Hospital Management Committees to admit such persons temporarily without legal formality when their condition made them unsuitable for accommodation in homes found by local authorities or they needed hospital treatment which could not be given in a general hospital. The circular limits the provision of such care generally to periods not exceeding two months.

The Council decided to exercise the authority given by the circular and during the year has provided temporary care for 12 persons for an average period of 4 weeks 2 days each. Accommodation was found for adolescent and adult patients with nominees of the Guardianship Society, Brighton, and for infants and young children at Lynsted, the

home run by the National Association for Mental Health at Walmer, and Orchard Dene, Rainhill, Liverpool, a home managed by the same association on behalf of the National Association of Parents of Backward Children. The Council recovers a contribution towards the cost of maintenance in such cases according to the means of the patient's family. In view of the power conferred on local health authorities by the circular the arrangement for the admission of children to Lynsted at the expense of the South East Metropolitan Regional Hospital Board was discontinued by the Board.

38 London patients were admitted to hospitals under the provisions of the circular for a variety of reasons during the year for an average period of approximately one month each.

The demand which has developed since the issue of the circular has indicated that the provision of these facilities fills a real want and reports show that the families of patients have benefited considerably as a result of the temporary relief afforded to them.

Farm training

Although no boys leaving special schools for the educationally sub-normal had been placed under the Y.M.C.A.'s British Boys for British Farms scheme, which enables suitable boys to be given farm training and placed in employment, since July, 1951, when it was agreed with the Association that such boys would be accepted, it was decided, when the matter was reviewed after twelve months, that the arrangement should be continued. Subsequently one boy was provided with training under the scheme and was found employment on a farm.

Guardianship

Guardianship is not now provided for defectives solely to enable financial assistance to be given and a number who were placed under guardianship for this reason now receive National Assistance grants and have been discharged. Generally speaking, patients are placed under guardianship when they have no homes or their homes are unsuitable and institutional care is unnecessary. A number of patients are placed in foster homes, small homes, hostels and convents in and around London under the guardianship of the matron or superintendent. The Guardianship Society, Brighton, also finds suitable foster homes for defectives, some of whom are self-supporting.

During 1952, 24 patients were placed under guardianship. Of these 17 were school leavers who, it was felt, would justify a trial in the community as they were likely with careful supervision and guidance, to be able to support themselves. They were placed under the guardianship of the Council's inspectors who became responsible for placing them in foster homes of approved standard and finding suitable employment or, alternatively, finding resident employment within the scope of their abilities. For guardianship of this type of patient to be successful, it is essential that the patients themselves should be mentally capable of work, that they should be relatively stable and of normal social behaviour. It has been decided to provide a hostel in or near London for girls leaving special educationally sub-normal schools at the age of 16 years who have no homes (or unsuitable homes) and do not need care and training in an institution. An endeavour is being made to acquire suitable premises for a hostel to accommodate not more than 12 girls who will be placed under the guardianship under the Mental Deficiency Acts of officers of the Council. The hostel will be in the nature of an experiment and the possibility of setting up a similar hostel for boys will be considered in the light of the experience gained.

At 31st December, 1952, 222 patients remained under guardianship. Of these 45 were under the personal guardianship of the Council's inspectors, 68 under the guardianship of nominees of The Guardianship Society, Brighton, 91 under the guardianship of relatives and friends, and 18 under the guardianship of superintendents of voluntary homes.

Maintenance costs which have continued to increase during the year are paid in accordance with the rates shown in the following table :

To	*Maximum allowances*
The Guardianship Society, Brighton	53s. 1d. a head a week made up as follows: maintenance 40s., clothing 6s., pocket money 6s. 6d., medical fee 7d. In addition, a fee of £8 3s. a year is paid for supervision.
Foster parents of patients placed under the guardianship of inspectors of the public health department	56s. a head a week made up as follows: maintenance 42s., clothing 6s. 6d., pocket money 7s. 6d. An initial outfit of clothing is provided in accordance with needs.
Relatives or friends and superintendents of small homes, hostels, etc.	35s. a head a week. In addition clothing may be supplied in appropriate cases.

In special cases the Council authorises allowances in excess of these maxima.

An allowance of 10s. a head, for Christmas extras, was made, in certain cases, to patients under the guardianship of the Council's inspectors.

As in previous years, holidays have been provided for patients under guardianship for whom it has been considered necessary on medical grounds.

Patients under guardianship in London (including 14 for whom other local health authorities were responsible) continued to be visited not less frequently than once a quarter, every third quarterly visit being made by one of the Council's medical officers.

In addition to the statutory visits and reports made by the officers of The Guardianship Society, Brighton, each London patient in the care of a nominee of the Society was visited, unannounced, by an inspector of the Public Health Department at least once during the year. The conditions of guardianship were found generally to be satisfactory.

Welfare centre

Some parents are reluctant to take their mentally deficient children to ordinary maternity and child welfare clinics, especially when, as is frequently the case, the children are not of normal appearance. Moreover, at these clinics, the doctor is not always able to discuss fully the needs of mentally deficient children and the mothers feel that their special requirements are not being met. Arrangements were, therefore, made for a special clinic for backward children to be set up at the Mary Hughes welfare centre, Underwood Street, E.1, in January, 1953, as an experiment. Sessions will be held once a month to begin with and will be conducted by a medical officer experienced in mental deficiency and in child welfare. If the centre proves successful, the possibility of setting up similar centres in other parts of London will be considered in due course.

Students

During the year facilities were given for 14 students taking university courses of training in social science to spend periods up to eight weeks in the district offices of the supervision section to enable them to gain practical experience in social work. Nine students (6 women and 3 men) attending the full-time course of training for occupation centre staff organised by the National Association for Mental Health each spent six weeks in a London centre as part of their practical training. Centre and students both benefit from the facilities given.

Statistics

The following table shows the sources from which cases have been brought to notice under the Mental Deficiency Acts and the action taken thereon :

Sources of information	*1949*	*1950*	*1951*	*1952*	*Totals from 1.4.14 to 31.12.52*
Supervision section	8	12	8	14	1,575
Local education authority	357	439	453	570	15,553
Police authority (section 8)	28	39	31	32	1,973
Transfers from prison (section 9)	1	1	—	—	229
Transfers from approved school (section 9) ..	5	2	2	—	565
From hospitals and institutions	111	89	103	124	514
Miscellaneous	168	157	187	222	10,522
Total	678	739	784	962	30,931

The position at 31st December, 1952, with regard to the cases referred to in the last column of the preceding table is shown in the following table, together with the position on the same date in the three preceding years :

	1949	*1950*	*1951*	*1952*
Detained in institutions	7,720*	7,767*	7,809*	7,862*
Discharged from institutional care	2,584	2,738	2,902	3,075
Removed to mental hospitals	509	522	543	555
Not subject for action	9,098	9,403	9,668	9,922
Died	4,251	4,380	4,523	4,678
Total removed from active list	24,162	24,810	25,445	26,092
Under guardianship	246	229	221	222
In places of safety awaiting the presentation of a petition	11	5	8	11
Under supervision	3,964†	4,092†	4,222†	4,556†
In hospitals, residential nurseries, etc. awaiting the presentation of a petition	54	45	52	41
Still under consideration	9	4	21	9
Total remaining on active list	4,284‡	4,375‡	4,524‡	4,839‡
Grand Total	28,446	29,185	29,969	30,931

* *This figure includes cases on licence who are visited at regular intervals by officers of the Council on behalf of the regional hospital boards as follows :*

1949	*1950*	*1951*	*1952*
338	366	352	259

† *In addition to the cases under supervision, persons known to the local authority to be mentally defective but not subject to be dealt with, are visited on a voluntary basis, as follows :*

1949	*1950*	*1951*	*1952*
970	968	1,020	1,040

‡ *Of these the following were awaiting institutional care.*

1949	*1950*	*1951*	*1952*
135	139	154	169

The following is a summary of the cases dealt with during 1952, with the comparable figures for the three preceding years :

	1949	*1950*	*1951*	*1952*
Placed in institutions	293	330	303	369
Placed under guardianship	12	9	10	24
Placed in places of safety pending the presentation of a petition	23	37	56	70
Placed under supervision	453	591	618	787
Discharged from institutional care or guardianship	212	192	182	203
Removed to mental hospital under the Lunacy Acts	22	19	27	21
Ascertained not subject for action	51	58	68	69
Withdrawn from supervision	238	258	217	201
Removed to other areas	40	44	49	65
Died	111	128	140	165
Total	1,455	1,666	1,670	1,974

Occupation centres

There are now 17 occupation centres provided for mentally deficient persons in London as follows :

Centre	*Accommodation*
Centres for children	
Branstone Street School, N. Kensington, W.10 (also takes elder girls) ..	75
Cecil Rooms, Woolwich Road, S.E.10	45
Christ Church Hall, Mowll Street, S.W.9	40
Claremont Central Mission, White Lion Street, N.1	60
Earlsfield Congregational Hall, Earlsfield Road, S.W.18..	60
Lewisham Methodist Church Hall, Albion Way, S.E.13	30
London Mission Methodist Hall, Shepherd's Bush Road, W.6	40
Orchard Mission, Mission Place, Peckham High Street, S.E.15	40
Oxford House, Mape Street, E.2 ..	30
St. Michael and All Angels' Hall, Northwold Road, E.5	60
Centres for elder girls	
Fellowship Hall, 182, Hammersmith Road, W.6	30
Old Gravel Pit Hall, Vallette Street, E.9	40
St. Chrysostom's Hall, Goldsmith Road, S.E.15	45
Centres for elder boys	
All Saints' Hall, Blenheim Grove, S.E.15	55
Dalston Congregational Hall, Bay Street, E.8	45
19, Compton Terrace, Islington, N.1	30
St. Michael's Hall, Darley Road, S.W.11	30

With one exception the centres have been established in hired premises (mainly church halls) which are the best obtainable but in many cases are not entirely suitable. At Branstone Street the premises, originally provided and used as a school, serve the needs of a centre very satisfactorily. The Minister of Health has approved proposals to adapt a large house, No. 9 Spencer Park, Wandsworth Common, and a prefabricated former restaurant building in Fulham High Street for use as permanent occupation centres and arrangements are proceeding for the adaptation of the premises as soon as the necessary starting dates are given. Plans are also being made for the opening of new centres and the transfer of existing centres to more suitable premises. The centres are open from 10 a.m. to 4 p.m. daily from Monday to Friday during primary school terms. Accommodation is now provided for a total of 755 children and adults. Fares of pupils attending the centres are paid by the Council under the same conditions as apply to children attending special schools for the educationally sub-normal, viz., if they are over 12 years of age and have to travel two miles, or 1½ miles if under that age, or for shorter journeys if one of the Council's medical officers certifies that conveyance is necessary on medical grounds. It has been possible to arrange for the conveyance of children attending the Branstone Street centre by two vehicles released from the ambulance service and operated by the education transport service. Three private hire coaches are used to convey children attending the Oxford House Centre and the St. Michael and All Angels' Hall Centre. Children and older persons attending the other centres are, if necessary, escorted by guides employed by the Council. Mid-day meals are provided at all centres at a small charge, which is waived in cases of hardship. Cod liver oil and malt (or halibut liver oil) is provided for children under the age of 16 years at a small charge or free where recommended by one of the Council's medical officers. Regular medical inspection is arranged.

The provision of home teachers has been considered from time to time but in view of the number of occupation centres available, the fact that transport is now provided at three centres and that it is hoped to extend these facilities to other centres, no arrangements have been made to provide home teaching which would be an expensive service. The matter is, however, kept under constant review and when conditions permit, it is hoped that it will be possible to provide home teaching for those who are unable to attend at an occupation centre.

Inspections

Visits by Inspectors of the Board of Control were paid to all centres during the year and their reports were generally satisfactory. Members of the Health (Mental Health Sub-) Committee also visited centres in their areas.

Open days and sales of work

Parents and friends were invited to displays of work and sales of articles made at the centres. Sales realised £39 17s. 5d. at junior centres, £453 8s. 4d. (including £144 11s. 6d. for shoe repairs) at elder boys' centres and £119 15s. 6d. at elder girls' centres. At the elder boys' centres some apparatus, furniture and toys were also made for the occupation centre service.

Outings and holidays

Owing to the absence of adequate outdoor recreation space at the centres, those attending were again taken by school coach to nearby parks or open spaces during the summer months, approximately once a fortnight, when the weather was suitable.

During May a party of 178 children and adults attending the centres, accompanied by staff, again spent two weeks at a holiday camp at Dymchurch, Kent. The Council bore the expenses of the staff and wholly or partly those of 47 necessitous children and adults. Apart from three cases of infectious disease which developed during the period, the holiday proved to be as successful as last year's and again drew the praise of the Director of the camp for the organisation and conduct of the party.

Gifts

Some centres were provided with outings to a circus or a pantomime by parents' associations and these associations presented a cinematograph projector to one centre and a folding wooden slide to another.

Christmas parties

Christmas parties and entertainments were arranged for all centres and parents and friends were generous with gifts of extra food, sweets, etc., and some donations towards the cost of entertainment were received.

SCHOOL HEALTH SERVICE

Organisation

DURING 1952 the school health service continued to carry out its prescribed role in the examination and inspection of school children, the detection and arrangements for the treatment of defects, the control of communicable disease in schools, and the examination and recommendation for ascertainment of handicapped pupils.

The 'following-up' of children found at medical inspections to be in need of treatment is the responsibility of the voluntary care committees. This work is regarded by care committees as one of their most interesting responsibilities, and often results in constructive family case work, including preventive measures. The care committees' main channel of information is through the children's care organisers who work in the public health department. There are now 2,330 voluntary workers, and the number is steadily rising. This arrangement, unique to London, is a good example of service given to the community by means of a partnership between official and voluntary workers.

Pupils on school rolls

At the end of 1952 there was a total of 425,362 pupils on the day school roll—302,998 children of primary and secondary school age were in attendance at County schools and 101,303 at voluntary or assisted schools ; 14,436 children under five years of age in nursery schools and classes or in primary schools and 6,625 children in day special schools.

Medical inspections

Medical inspections made during the year, with comparable figures for the three previous years, are summarised in the following table :

Routine (detailed) inspections

	1949		1950		1951		1952	
	No.	%	No.	%	No.	%	No.	%
Nursery	10,021	6·2	11,294	6·5	12,320	7·1	9,063	4·9
Entrants	40,287	24·8	41,598	24·1	45,324	26·1	58,039	31·1
7 year old	29,541	18·2	32,607	18·9	34,597	19·9	32,902	17·6
11 year old.. ..	31,725	19·6	33,037	19·2	31,415	18·1	28,558	15·3
Leavers	26,382	16·3	27,464	15·9	27,272	15·7	26,908	14·4
Other ages	22,115	13·6	23,742	13·8	19,952	11·5	28,300	15·2
Special schools ..	1,633	1·0	2,143	1·3	2,215	1·3	2,319	1·2
Training colleges ..	465	0·3	543	0·3	533	0·3	482	0·3
Total ..	162,169	100·0	172,428	100·0	173,628	100·0	186,571	100·0

Other inspections

Special inspections*	110,026	—	119,901	—	122,302	—	139,908	—
Re-inspections ..	87,915	—	106,350	—	112,667	—	121,751	—
Residential schools..	9,845	—	10,441	—	9,961	—	8,077	—
Total ..	207,786	—	236,692	—	244,930	—	269,736	—
Grand Total ..	369,955	—	409,120	—	418,558	—	456,307	—

* *These are non-routine inspections of a miscellaneous nature and include pupils urgently brought to the attention of the school doctor, inspections for employment certificates, for school journeys and holiday camps, periodical inspections of handicapped pupils (for their special defect), etc.*

The school population is still expanding under the influence of the post-war rise in the birth-rate and as a result medical inspections in 1952 reached the highest total since the war. Children seen at routine inspections formed 43·9 per cent. of the total of 425,362 on school rolls.

The percentages of these children who were referred for treatment (other than for infestation or teeth) compared with the preceding years were :

Pupils referred for treatment

Age Group and Sex		1949	1950	1951	1952
Nursery	Boys	16·5	15·1	16·4	13·0
	Girls	14·5	13·0	14·4	11·3
Entrants	Boys	18·7	17·8	17·4	15·6
	Girls	17·2	16·5	15·3	14·1
7 years old	Boys	21·6	20·4	19·8	18·9
	Girls	20·6	19·7	18·6	18·4
11 years old	Boys	18·8	17·5	16·5	16·1
	Girls	20·4	18·8	18·2	18·0
Leavers	Boys	14·4	13·6	12·2	12·2
	Girls	18·9	16·0	16·6	16·9
Other ages	Boys	18·0	17·1	16·1	16·2
	Girls	23·6	21·5	21·7	20·6
Total Boys and Girls*		18·9	17·6	17·0	16·2

* *Exclusive of special schools and training colleges.*

Referral rates in 1952 were generally lower in all age groups except leavers and markedly so among nursery children and entrants.

The following table shows the percentages of the principal defects found in children of all age groups inspected at routine inspections and referred for treatment or observation, with comparable figures for previous years :

	1949	*1950*	*1951*	*1952*
*Numbers examined	160,071	169,742	170,880	183,770
		Percentages		
Skin diseases	1·22	0·97	1·13	1·14
External eye diseases	0·58	0·57	0·71	0·72
Defective hearing	0·41	0·44	0·51	0·58
Otitis media	0·75	0·69	0·87	0·94
Enlarged tonsils and adenoids ..	8·91	8·98	8·44	8·26
Defective speech	0·62	0·60	0·63	0·72
Enlarged cervical glands ..	1·33	1·38	1·67	1·71
Heart and circulation	0·68	0·69	0·80	0·78
Lung disease (not T.B.) ..	1·44	1·62	1·95	1·83
Orthopædic defects	4·66	4·84	4·52	4·83
Defects of nervous system ..	0·34	0·33	0·31	0·41
Psychological defects	0·75	0·70	0·72	0·81
Anæmia	0·31	0·36	0·33	0·34

* *Excluding special schools and training colleges.*

Increased incidence in nursery, entrant and seven year old girls was mainly responsible for higher rates for otitis media. Higher rates for defective hearing were found in entrants and 11 year olds. For speech defects, rates were higher in nursery and eleven year old groups of both sexes, and in girl entrants. An increase in orthopaedic defects was noted in all age groups except nursery children and entrant girls. Eleven year old boys and entrants account for the rise in nervous defects, and for psychological defects higher rates were found in nursery and 11 year old groups, and in entrant and seven year old boys.

Cleanliness

Improvement in personal hygiene is shown by the percentage of verminous children found at nurses' rota visits :

Rota visits

	Total No. of inspections	*No. found to be verminous*	*Percentage found to be verminous*			
			1949	*1950*	*1951*	*1952*
Boys	442,336	4,919	1·9	1·7	1·4	1·1
Girls	466,431	17,424	6·1	5·0	4·1	3·7
Infants	530,617	9,562	3·4	2·7	2·2	1·8
Total	1,439,384	31,905	3·8	3·2	2·6	2·2

During the year the number of individual children found to be verminous at these inspections as distinct from the number of occasions on which vermin was found (in which one child might appear more than once) was 17,051 (18,503 in 1951, 22,159 in 1950, and 22,063 in 1949). The total of advice cards issued during the year was 20,259 compared with 25,177 in 1951. Children who attended the cleansing centre after the issue of advice cards numbered 14,531 (16,938 in 1951); the number of statutory notices served was 2,788 (3,848); 1,007 (1,084) of the children concerned attended voluntarily, and 1,667 (2,089) were cleansed compulsorily.

Vaccination

The upward trend in the proportion of pupils vaccinated against smallpox noted in the post-war years although interrupted in 1951 was resumed in 1952. Vaccinated pupils formed 57·6 per cent. of those inspected in 1952, 55·8 per cent. in 1951, 56·5 per cent. in 1950, and 54·9 per cent. in 1949.

Vision

The percentages of children inspected found to have a visual acuity standard of 6/6 (Snellen) are contained in the following table :

Visual acuity 6/6 (with glasses, if worn)

		1949 %	*1950* %	*1951* %	*1952* %
7 year old	Boys	78·2	78·3	77·8	75·7
	Girls	76·5	76·3	76·7	73·4
11 year old	Boys	80·1	80·9	80·3	80·3
	Girls	76·9	77·9	77·0	77·3
Leavers	Boys	79·7	80·1	80·7	80·5
	Girls	76·0	76·5	76·1	76·6
Other ages	Boys	77·4	78·8	79·8	80·4
	Girls	73·4	75·2	75·0	76·8

A further table shows the percentage of children referred for treatment of defective vision :

Total		*1949* %	*1950* %	*1951* %	*1952 Percentage already wearing spectacles*	*1952 Percentage not wearing spectacles*	*1952 total*
7 year old	Boys	6·8	7·2	7·0	0·7	6·4	7·1
	Girls	7·5	7·5	7·5	0·7	6·8	7·5
11 year old	Boys	9·3	8·4	8·6	2·0	6·2	8·2
	Girls	10·4	10·0	10·0	2·5	7·0	9·5
Leavers	Boys	9·3	9·2	8·6	2·7	5·5	8·2
	Girls	12·4	10·8	11·3	4·0	7·2	11·2
Other ages	Boys	9·3	8·5	7·3	2·1	6·3	8·4
	Girls	12·0	10·8	11·2	3·0	7·7	10·7

As can be seen a proportion of those referred for treatment of defective vision were already wearing spectacles. This proportion rose from one-tenth at age seven to about one-third at age 15. The higher total percentages of children referred for treatment at older ages were thus almost wholly due to the need for adjustment of lenses with the passage of time.

The two tables above show that, in 1952, the incidence of defective vision and the percentage of pupils referred for treatment of defective vision remained fairly stable compared with the preceding years. As experienced over many years the recorded incidence of defective vision was greater among girls than boys.

Squint was most prevalent in the entrant group falling to an insignificant level in the leaver group. The percentage of pupils of all ages referred for treatment of squint was 1·1 per cent. compared with 1·0 per cent. in 1951, 0·9 per cent. in 1950 and 1·1 per cent. in 1949.

Co-operation of parents and care committee

The attendance of over 90 per cent. parents at routine inspections showed that their co-operation, especially for the earlier age groups, was quite good. Care committee representatives attended about 94 per cent. of the routine inspections, except for the 'leaver' and 'other ages' groups which include the grammar and technical schools where the committees do not function.

Choice of employment

Children advised against particular forms of employment formed 15·0 per cent. of both sexes examined.

Forms of employment involving eye strain, those requiring normal vision and heavy manual work, again headed the list of contra-indications for both sexes. Next came exposure to bad weather and prolonged standing or quick movement. Details are given in Table 16 (page 182).

Re-inspections

Each child referred for treatment is re-inspected by the school doctor a few months after medical inspection and further re-inspections are made, if necessary, to ensure that, as far as possible, every child gets adequate treatment. During the year, 121,751 such re-inspections were carried out.

General condition

Since 1947, in accordance with Ministry of Education requirements, medical officers conducting routine medical inspections classify the ' general condition ' of the pupils on a 3-point scale, ' Good ', ' Fair ' or ' Poor '. This classification replaced a 4-point scale for recording the doctor's assessment of ' nutrition ' as ' excellent ', ' normal ', ' sub-normal ' or ' bad '. All these terms are subjective, and it is to be expected that it will be a matter of years before the statistics of assessments on the new scale settle down sufficiently to enable significant conclusions to be drawn from year to year comparisons :

	Excellent	*Normal*	*Sub-normal and bad*
1946	18·0	76·4	5·6
	Good	*Fair*	*Poor*
1947	42·0	54·3	3·7
1948	40·8	56·0	3·2
1949	41·8	55·1	3·1
1950	46·3	50·9	2·8
1951	47·6	49·8	2·6
1952	50·5	47·1	2·4

However, within any one year, comparisons between groups of pupils may be accepted as valid, and the following figures for the different age groups in 1952 are of interest :

	Good	*Fair*	*Poor*
Nursery ..	54·2	43·8	2·0
Entrants ..	47·6	49·4	3·0
7 year old ..	46·3	50·7	3·0
11 year old ..	49·4	48·2	2·4
Leavers ..	59·0	39·9	1·1

The percentages of children referred for treatment or observation on account of nutrition were :

Referred for	*1949*	*1950*	*1951*	*1952*
Treatment	1·0	1·0	0·9	0·9
Observation	0·7	0·7	0·8	0·8
	1·7	1·7	1·7	1·7

Although the proportion of ' poor ' children appears to have diminished gradually, no corresponding reduction is found in the percentage of children noted for nutritional defects.

Pupils receiving school meals, milk, halibut liver oil or cod liver oil and malt on the recommendation of the doctor, head teacher or care committee are re-inspected by the doctor each term. During 1952 the total number of ' nutrition re-inspections ' carried out was 57,851. The classification of general condition at these inspections was :

	Good	*Fair*	*Poor*
1951	10·5	65·5	24·0
1952	10·7	68·0	21·3

School meals and milk

A return to the Ministry of Education for a typical day in October, 1952, showed that 212,743 children, 55·3 per cent. of the number in attendance, were provided with school dinners. Of these 18,837 received free dinners. On the same day 340,578 day school pupils, 88·5 per cent. of the number in attendance, were provided with milk.

Between October, 1951, and October, 1952, the number of centres at which school children dined rose from 878 to 911; the number of kitchens of all kinds in October, 1952, producing school meals being 596 (including 563 school and central kitchens). The

school meals service aims at concentrating the maximum food value into the quantity of food a child is willing to eat. It has set the following standard :

	Age group	*No. of calories*
(i)	Under 7 years	Minimum of 500
(ii)	7–11 years	„ „ 650
(iii)	Over 11 years	„ „ 800

Meals for children in Groups (ii) and (iii) are planned to contain a minimum of 20 grammes of first class protein; a minimum of 25 grammes of fat; and a minimum of 400 milligrammes of calcium.

The diet of the children taking meals was under the supervision of the Council's honorary nutritional consultant, Dr. T. F. Macrae, O.B.E., D.SC. To provide a close check on the quantities and qualities of served meals, random samples were analysed by the Council's chemist-in-chief from time to time (see page 33).

Weighing and measuring of school children

At the beginning of the year the Council decided that in future school pupils should be weighed and measured at the time of the four routine medical inspections held during their school life. This terminated the practice of six monthly weighing and measuring which was introduced in 1935, primarily as part of the measures then taken by the Council for the supervision of the nutritional condition of school children, and the selection of those in need of special investigation at nutrition centres, or of milk, cod liver oil or meals in school.

With the many published articles on the subject now available, a brief retrospect of the Council's experience in this field may be of interest. The original concept was that Livi's index ($100\ \sqrt[3]{W}/H$) was to provide the 'yardstick' by means of which an individual pupil could be 'screened' for special investigation. Later on the results of the 1938 biometric survey (L.C.C. publication No. 3464) were used as the standard. By this time the classic paper of Huws Jones (Jour. R. Stat. Soc. 101. 1–34) had clearly demonstrated the defects inherent in attempting to use physical indices as clinical screens.

Whatever the limitations of using biometric standards for assessing individuals, the potential value of such standards for comparing *groups* was evident, and the Council accordingly carried out surveys, and comparative standards were computed in 1942, 1943, 1946, 1947, 1949 and 1950. (See Medical Officer 27.5.44; 5.6.48; and L.C.C. publication No. 3692. The 1950 results have not been published.) The problem now was one of the interpretation of the real physiological meaning behind such results as 'over some 30 years there has been an average increase of 5·6 cm. in the height and 3·4 kg. in the weight of boys' (1938 report) and 'between 1938 and 1949 the average height of London school children increased by about 2 cm. and the average weight increased by 0·8 kg.' (1949 report). Authorities differ radically in their interpretations of results such as these. For example, Morant (Proc. Roy. Soc. B. 137.443) thinks that the final adult stature is unchanged, while on the other hand, Weir (B.M.J. 10.5.52, p. 1006) thinks that there has been a real secular increase in height.

Since growth is a complex involving many factors—general health, nutrition, race, environment, social status, climate, season, etc.—it would appear that caution is needed in the interpretation of the results of large scale surveys of heterogeneous groups. It is interesting to recall that this is virtually what the late Dr. F. C. Shrubsall—one of the pioneers of the London school health service—told the Board of Education Consultative Committee in his 'Notes on the Growth of School Children' as long ago as 1922.

Medical treatment

Although the duty of the Council as local education authority, under the Education Act, 1944, to secure the provision of free medical treatment of school pupils was not statutorily modified by the National Health Service Act, 1946, administrative decisions by the Ministries of Health and Education indicate the principles upon which the responsibilities for the treatment of school pupils should be shared between the Council and the various elements of the national health service.

The freedom of choice of the individual parent necessarily remains. For example, a school pupil's spectacles may be provided through a school treatment centre, through a teaching hospital or by an optician; the cost falling, respectively, upon a hospital management committee, a board of governors, or an executive council. Similarly, if the parent wishes, a school pupil may obtain dental treatment at a school health service dental surgery, a teaching or other hospital or from a general dental service or a private practitioner. Certain anomalies in the charges which the parent may in certain circumstances be called upon to pay, arise from the regulations in the various statutory instruments which govern the parallel, but differing, health services.

In certain cases, *e.g.* repair of spectacles in lack of care cases, the Council can and does make a payment to other health services to prevent a charge falling on the parents; while in others, *e.g.* provision of orthodontic appliances, prescriptions for medicines, etc. the Council cannot take this action.

The co-ordination of these services, to provide a scheme for the treatment of school pupils which is both comprehensive and efficient, and at the same time economical of both exchequer and local rate expenditure, is a matter for continuous liaison and co-operation between the Council and the various bodies administering the national health service. By no means has finality yet been reached in this matter.

Specialist clinics

The responsibility for the provision of specialists at rheumatism, ear, nose and throat, vision and orthoptic clinics held in school treatment centres has been accepted by three of the metropolitan regional hospital boards; negotiations are continuing with the fourth. In addition, facilities for such specialist treatment are available at many hospital clinics. The Council remains wholly responsible for the minor ailment, audiology, special investigation, nutrition and dental clinics.

School treatment centres

At the end of the year there were 103 school treatment centres, 76 run directly by the Council and 27 by voluntary committees. Negotiations continued with the voluntary committees for formalising their arrangements with the Council in new agreements, the old ones having lapsed.

The following table shows the number of clinics available in school treatment centres for the treatment of each defect :

Type of clinic	*L.C.C.*	*Voluntary Committee*	*Total*
Minor Ailments	60	24	84
†Dental	42	17	59
*Vision	28	14	42
*Orthoptic	6	2	8
*Ear, Nose and Throat	9	3	12
Audiology	6	3	9
Speech Therapy	20	6	26
*Enuresis	—	1	1
Special Investigation	11	3	14
Nutrition	23	7	30
*Rheumatism (Supervisory) ..	12	2	14

* *Specialists provided in most cases by regional hospital boards.*
† *Several of these are 'twin' surgeries.*

Treatment of school pupils at hospitals

Before July, 1948, the Council had made special arrangements with a number of hospitals for the treatment of school children, and it is gratifying to be able to report that the hospitals have been willing to allow them not only to continue, but also to develop. The co-operation between the school health service and the hospitals takes several forms, most of which depend upon the important part played by the medico-social workers of the childrens' care organisation in the school health service. At 23 hospitals, special sessions are provided for the treatment of school pupils, and organisers make the appointments and attend the sessions. At ten other hospitals the organiser undertakes the making of appointments, although she is not present at the sessions. In addition, at 16 hospitals one or more of the Council's organisers attends to act as the link between the children's out-patient department, the specialist clinics, the school health

service and the children's care organisation. The wide scope of this type of work is well exemplified by the report of the work of the organisers attached to Guy's Hospital, of which the following is a summary :

Department	*New cases*	*Attendances*
Children's	344	1,249
Ear, Nose and Throat ..	454	750
Vision	224	1,610
Orthoptic	98	810
Orthopædic	134	294
Skin	204	474

The total attendances of school pupils in departments of this hospital covered by the organisers was 6,645.

The following table summarises the numbers of clinics for school pupils held in hospitals in association with the Council's treatment scheme :

Children's Medical ..	9	Enuresis	6
Minor Ailments	1	Rheumatism	10
Dental	1	Nutrition	1
Eyes	13	Skin	1
Ear, Nose and Throat ..	19	Orthopædic	1

Children were also referred to 23 child guidance units at hospitals and clinics within the national health service, but organisers do not attend these clinics.

Treatment statistics

The Ministry of Education annual returns call for information on all treatment known to have been provided, whether by the Council or otherwise. From what has been said above it will be clear that all treatment statistics are essentially incomplete. No figures are available from general medical or dental practitioners or from opticians. No figures are available from the many hospitals that have no direct link with the Council's organisers. Even at some of the co-operating hospitals, the medical records and documentation adopted by the hospital, for the purposes of their own returns to the Ministry of Health, do not enable separate figures for the L.C.C. school pupils to be extracted. Great caution should therefore be exercised before attempting to draw any conclusions about the incidence of defects or the extent to which treatment has been obtained, from the figures that follow. An additional point in this connection is that the function of certain clinics has developed and changed, and the compilation of statistics lags behind these changes. For example, ' special investigations ' were not separable from ' enuresis ' until halfway through the year.

Type of clinic		*1949*	*1950*	*1951*	*1952*
*Vision	New Cases ..	32,292	32,462	34,231	35,649
	Attendances ..	79,777	85,364	86,758	91,693
*Orthoptic	New Cases ..	—	942	1,435	1,401
	Attendances ..	—	12,745	15,385	15,784
*Ear, Nose and Throat	New Cases ..	5,749	6,974	7,289	7,769
	Attendances ..	14,815	15,138	16,565	17,408
Audiology	New Cases ..	—	—	—	1,206
	Attendances ..	—	—	—	2,407
Minor Ailments	New Cases ..	171,731	163,658	155,080	151,903
	Attendances ..	1,002,051	1,014,155	1,005,549	954,532
Dental	New Cases ..	102,495	82,650	82,564	93,823
	Attendances ..	203,523	166,874	172,063	202,571
*Rheumatism	New Cases ..	1,375	1,224	1,100	971
	Attendances ..	10,887	10,088	9,202	7,988
Nutrition	New Cases ..	1,222	1,350	1,380	1,151
	Attendances ..	9,420	10,067	10,984	11,162
Special Investigation	New Cases ..	—	—	—	590
	Attendances ..	—	—	—	3,027
*Enuresis	New Cases ..	830	911	1,267	952
	Attendances ..	3,977	5,110	6,344	5,449

* *Hospital and specialist services provided by boards of governors or regional hospital boards.*

Vision

During 1952 the hospital eye service assumed complete responsibility for the testing of sight and provision of spectacles for school pupils attending school treatment centres, and the interim and agency arrangements with the supplementary ophthalmic services terminated. The attendance at each session of an optician for the convenience of parents was continued, but it was made quite clear, both on the prescription form and by notice, that the parents could take the form to any optician of their choice. The Council continues to be responsible for the cost of replacement or repair to school pupils' spectacles which are deemed to be due to lack of care.

Special investigation clinics

Reference was made in last year's report to the development of ' consultative' and ' reference ' clinics, and it was pointed out that too much attention should not be paid to the name of the clinic, since both ' nutrition ' and ' enuresis ' clinics have been used in this connection. The name of ' special investigation ' has now been adopted for these clinics, and at the end of the year 14 were functioning.

Enuresis

Special enuresis clinics were held at six hospitals, although some children were seen at the special investigation clinics. The following summary of the report from the Westminster Hospital (All Saints Urological Centre) exemplifies the work being done at these clinics :

Three sessions a week are available for school pupils. The number of new cases seen was 445—a reduction on the previous year. This was because it was felt that the number of new cases accepted in 1951 made the sessions too heavy for real personal work to be done, thus defeating the object of these clinics. Boys formed 62 per cent. of the current cases. An analysis of the cases over a period of two years gave the following results :

	Percentage improved	
	Males	*Females*
Attended twice only	21%	33%
Still attending	34%	37%
Attended a course of treatment ..	49%	54%

Minor ailments

During the year further reductions in the hours of opening were made, thus releasing nurses for other work. This is a matter which is under continuous review by the divisional medical officers, and the part-time opening of these centres at certain ' peak ' hours effects a useful economy without lessening the value of the service. About a million attendances are made at these centres each year, and the value of this service in relieving hospital out-patient departments and general practitioners from treating such a large number of miscellaneous minor defects, while reducing the loss of schooling to a minimum, is obvious.

Audiology centres

By the end of 1952 plans for the future development of these nine centres were formulated. At present they are used for the investigation of suspected deafness not obviously due to conditions requiring treatment, and advice is given on the need for special educational treatment and hearing aids. It is proposed that a certificated teacher of the deaf should join the existing team of otologist, medico-social worker and nurse, and that the centres should be used for the pre-school training in speech and understanding of very young deaf children from the age of nine months or so, and for advice and help for the parents.

The centres would also be used for teaching lip-reading to children becoming deaf after recovery from meningitis, and for supervising those children who have been transferred to ordinary schools from partially-deaf schools.

Audiometer testing

During the year routine group gramophone testing continued throughout the nine health divisions of the county. Children failing two consecutive group gramophone tests are tested individually with a pure tone audiometer and referred, if necessary, to the otologist at the audiology centre. Ideally the deaf child should have been detected before the age of five years, but some are not. The next best thing would be to carry out group tests on all school entrants, at about five years of age. At this age, however, the child is still too young to achieve the degree of co-operation required by the gramophone test. The

Council's endeavour therefore, is to test each year all junior school children at about eight years of age. During 1952 52,865 school pupils were tested, 1,252 of whom failed their pure tone test, and were referred to audiology centres. It is likely that the gramophone test will be succeeded in a few years' time by some other form of testing that can be effectively used at a younger age.

Bathing centres

The cleansing of verminous school pupils (see page 117) is carried out at eight bathing centres run directly by the Council and, by arrangement with the metropolitan borough councils concerned, at 21 borough cleansing stations.

Scabies, impetigo and ringworm

Children treated for scabies totalled 657, compared with 777 in 1951. The number of verminous children treated at bathing centres fell by 3,137 to 15,850, while treatments needed decreased by 1,812 to 27,017.

Cases of impetigo treated at minor ailment and bathing centres numbered 2,063, compared with 2,224 in 1951.

The incidence of scalp ringworm (29 cases) was lower than in the previous year (40).

Sanitary accommodation in day schools

The Standards for School Premises Regulations, 1951, lay down scales of provisions for cloakrooms, wash basins, changing rooms, showers, water closets and urinal stalls. Of the 1,358 schools for which the Council is responsible, many were built over 60 years ago, and at many old schools these modern sanitary standards are not attained. For example a number of schools are still equipped with trough closets. Although these are outmoded they are not inherently insanitary given regular flushing and during the year steps were taken to ensure that the necessary rates of automatic flushing continued to be available and used. Medical officers when visiting schools do not confine themselves to seeing the children but interest themselves in general hygiene arrangements and the condition of the sanitary accommodation in so far as these may affect the health of the pupils and staff.

Residential schools

In accordance with the Memorandum by the Home Office on the Conduct of Children's Homes the public health department takes responsibility for the health of the children in residential schools and other establishments under the direction of the Children's Committee (see also page 72). There were seven residential schools with accommodation for 2,800 children, four approved schools with a total accommodation of 482, two remand homes with accommodation for 142 children, and a number of other smaller establishments—reception centres, small homes, family homes and after-care hostels. At the larger establishments a visiting medical officer, appointed by the Council, attended for routine medical examinations, and also took the children on to his national health service 'list.' Periodic visits were made by senior medical and nursing officers from County Hall. Arrangements were made for the dental treatment of the children, and visits were made by the Council's psychiatrists (see also page 126).

The problem of enuresis in residential establishments had been the subject of a survey by Dr. H. G. Williams, one of the Council's psychiatrists in the previous year, and in 1952, a pamphlet was issued containing his notes on the problem of enuresis for the guidance of housemothers, and other staff concerned with the residential care of children.

Infectious diseases in schools

When a pupil is absent from school, and the cause is either known or suspected to be due to infectious disease, the headteacher immediately notifies the divisional medical officer, as well as the borough medical officer of health. Table 13, page 181, gives the number of such cases reported during 1952. As these figures are uncorrected for diagnosis they differ from the notifications shown in Tables 14 and 15, pages 183-4, which are discussed on pages 16 to 23.

Nevertheless the figures reported from schools do indicate the trend of infectious disease in the child community, and are the only available figures for diseases which are not notifiable to the borough medical officer of health. For example, during 1952, an epidemic of german measles was starting when the schools reopened after the Christmas holidays. The peak was reached towards the end of March, when over 2,000 cases a week were reported. The outbreak tailed off very gradually and over 100 cases a week were still being reported during July.

Diphtheria outbreak at St. Michael's School, N.W.1

At the end of October and during the first half of November four cases of diphtheria were notified as having occurred among the pupils attending this school. Swabs had been taken and these showed the presence of *C. diphtheriae* though apparently only one case showed actual clinical signs of the disease—slight membrane formation. One of the cases was rediagnosed as tonsillitis and discharged home from hospital. On 18th November a medical officer visited the school and took swabs from the nose and throat of 26 selected pupils and four staff. As a result one carrier was discovered; he had recently been absent with a 'cold' and showed 'unhealthy mucous membrane of the nose.' It was decided that all other pupils attending the school and also the staff should be swabbed. This work occupied seven sessions and in all 185 swabs were taken from the children and 17 from the staff. It was found that seven pupils were carriers of *C. diphtheriae* (*intermedius type*) six of them being virulent. These carriers were at once excluded from school and sent to their own doctors for treatment, and some of them were sent to hospital by their doctors. While it was not possible to say exactly how this rather indefinite epidemic began, it is possible that it may have had some connection with the fact that one of the school carriers lived in the same house as a young woman who had come from Cyprus about two months previously, and who was removed to hospital at the beginning of December, suffering from diphtheria. As a result of all these activities there was an increase in the number of children immunised against diphtheria at this school, and the percentage of these rose from about 74 to 84. There were no further cases reported after the beginning of January, 1953, and all the carriers were permitted to return to school.

Rheumatism scheme

The number of admissions to the acute unit at Queen Mary's Hospital for Children, Carshalton, seem to have become more stabilised during the past few years, and the drop that has been noticeable since 1948 is now less marked; in fact in comparison with 1951 there was a slight rise in 1952:

	1949	*1950*	*1951*	*1952*
Nominations received	344	270	185	219
Outstanding from previous year ..	4	5	4	4
	348	275	189	223
Admitted to rheumatism unit ..	331	250	177	216
Nominations withdrawn	5	11	4	2
Not suitable for unit	7	10	4	1
Awaiting on 31st December ..	5	4	4	4
	348	275	189	223

As would be expected with a smaller number of cases, the percentage of severe cases remains high since the less severe cases can be dealt with elsewhere:

Percentage of children with cardiac involvement admitted to the special rheumatism unit

1938	1939	1940	1941	1942	1943	1944	1945	1946	1947	1948	1949	1950	1951	1952
36·7	35·4	32·1	40·7	67·3	66·7	68·4	60·3	62·4	67·7	70·2	51·7	60·8	49·1	43·7

The number of children suffering from chorea of such severity as to need institutional treatment still seems to fall, but it is noted that the percentage of those with cardiac and valvular damage has risen somewhat, and that this is more noticeable amongst the girls than amongst the boys (see Table 18, page 188).

The schools for physically handicapped children still prove a valuable haven of refuge for cardiac cripples and enable them to return to a more satisfactory attitude of mind with regard to their disability. The modified activities and rest periods which are available for them, help to tide over that period between invalidism and competitive life which would otherwise engender strain to their cardiovascular system and cause possible relapse. Table 19, page 188, gives details of the condition on discharge from hospital.

The role of the streptococcus as a factor in causing cases to relapse has always to be kept in the forefront of the picture, and physicians in charge of rheumatism supervisory centres are careful in checking upper respiratory infection and sore throats at the earliest possible stage ; while it has now become routine to deal with dental extractions in cardiac cases under a penicillin umbrella.

The following table gives details of the rheumatism supervisory scheme :

	1950	*1951*	*1952*
Number of children under supervision of school doctors on 31st December	306	186	177
Number of children under supervision at rheumatism supervisory centres on 31st December	2,790	2,696	2,218
Number of supervisory centres	24	24	23
Number of sessions at supervisory centres	930	905	877
Number of children attending for first time	1,224	1,100	971
Total number of attendances at centres	10,088	9,202	7,988

Child psychiatry

Child guidance units

In London most child guidance clinics have always been provided by or in association with the teaching hospitals and by voluntary associations taken over by the metropolitan regional hospital boards. There are now 23 such clinics which, however, draw their patients from a wide area in the south of England and which tend to be concentrated in central London, so that there are parts of the County which are not so well served. The Council opened its fourth child guidance unit in October in a well designed suite in the new comprehensive health centre at Woodberry Down. The consultant psychiatrist and medical director is employed by the regional hospital board and the rest of the staff, educational psychologist, psychiatric social worker and clerk, by the Council. All the units have more cases than they can treat and a child has to wait for between two weeks (Earls Court) and three months (Woodberry Down) before being seen, but more serious is the much longer period of up to six months before therapy can be commenced for those children found to require it.

The Earls Court unit continued throughout the year without any staff changes.

At Battersea the psychiatrist resigned in June and a new appointment was made ; the educational psychologist's sessions were increased from four to six weekly and the psychiatric social worker gave all her time (instead of only eight sessions a week) to the work of the unit.

At Brixton one of the psychiatrists and one of the psychiatric social workers resigned during the year and the other psychiatric social worker transferred to other work in the school health service ; two new social workers and one educational psychologist were appointed. The medical director continued to be responsible for the training of a number of child psychiatrists from the Institute of Psychiatry and, in addition to the therapeutic work in the clinic, was able to develop educative work among teachers, health visitors, and other adult groups in the area. The senior Registrar at the unit attends two of the local infant welfare centres each week and it is noteworthy that more than 10 per cent. of the new cases referred were under the age of five.

Though only opened in October it was apparent by the end of the year that the demand in the area of the Woodberry Down unit was going to be larger than had been expected and that more sessions from the psychiatrist and from a psycho-therapist will be required if the needs of the local community are to be met.

The two clinics at Harrow Road and at John Street which are run in association with the local infant welfare centres continued (see page 52).

Maladjusted children

There are 15 day classes for maladjusted children in addition to any remedial teaching in child guidance clinics. As an experiment some maladjusted educationally sub-normal children attend these classes.

There are five boarding schools for 147 maladjusted children. In addition, 362 children were at the end of the year in 93 schools and homes run by other local authorities or by voluntary bodies. The experiment of attaching a psychiatric social worker to Bredinghurst School was so successful that it was agreed to attach part-time workers to each of the other four schools to enable skilled case work to be continued with the families against the time of the child's return. Though the families present even greater problems than most of those coming to child guidance units (otherwise the child would not have been recommended for admission to a boarding school), yet these social workers do enable many of the children to return home more quickly than would otherwise have been possible. Psychiatrists visit each of these schools frequently, with the exception of Buckshaw House, where the Dorset County Council has arranged for their consultant psychiatrist to visit regularly. The valuable work of a lay psycho-therapist at Bredinghurst School has continued and has been increased to eight sessions per week.

Other types of residential establishments

Two additional part-time psychiatrists were appointed in September to visit regularly the residential establishments where such visits were thought desirable. The object of this is not to undertake the treatment of individual children presenting emotional or behaviour problems, which is properly the duty of the hospital authority, but to advise the members of the staff on psychological aspects of the problems of child care and to see individual children to decide whether psychological treatment is needed and to arrange for it to be obtained. It is perhaps by this kind of training that preventive psychiatry will exert its greatest effect. At Ardale Approved School a psychiatrist from a local hospital visits each week.

Reception home

A whole-time psychiatric social worker is employed at the Council's reception home and a psychiatrist visits weekly to help in deciding on the most suitable placing for each child.

Remand homes

The Maudsley Hospital has assumed responsibility for the psychiatric examinations in the two remand homes of children appearing before juvenile courts. Some difficulty has been experienced in obtaining reports on children who have for one reason or another been placed in remand homes outside London. A part-time psychiatric social worker has been appointed to Cumberlow Lodge, the home for girls, in addition to the whole-time psychiatric social worker at the home for boys. She also visits Wood Vale where are placed a number of children who have not committed offences, but who are to be brought before the court as being in need of care or protection. The part-time psychiatrist here is employed by the South-East Metropolitan Regional Hospital Board.

Summary

The plan of child psychiatry and its development for London schools is now becoming clearer. The local authority and the hospital authority can work together in providing treatment facilities, for early treatment and prevention are inseparable. The training of 'lay' staff in the care of children, particularly in residential 'homes' is properly preventive medicine and true health education and the continual demand for therapy must not be allowed to obscure the need for prevention. The need for co-operation in the detection and prevention of psychological problems between the health and educational services is axiomatic and it is interesting to see how each year greater interest is taken in the problems of the younger child. In the spring a series of lectures and discussions, with psychiatrists, psychologists and psychiatric social workers were

held for medical officers ; they dealt with the detection of psychological problems in children at as early a stage as possible. In this sphere, as in others, it is not possible to draw any distinction between work for the pre-school child and that for schoolchildren.

Child guidance unit statistics

	Brixton	*Battersea*	*Earls Court*	*Woodberry Down (opened Oct., 1952)*	*Total*
No. of applications received	239	89	95	25	448
No. awaiting first interview at 31st December	9	29	19	11	68
No. interviewed and awaiting treatment	Nil	13	10	5	28
Number of patients					
In treatment at 1st January	41	26	57	—	124
New cases treated	199	68	97	9	373
	240	94	154	9	497
In treatment at 31st December ..	144	26	63	9	242
Discharged	96	68	91	—	255
No. of follow-ups	—	5	25	—	30
No. of home visits by psychiatric social worker	61	32	19	12	124
No. of school visits by staff	52	49	102	1	204
*Disposal of patients**					
Treatment completed	32	35	42	—	109
Transferred to other treatment ..	17	10	3	—	30
Further attendance impossible ..	12	6	10	—	28
Unco-operative	37	17	23	—	77
Placed or placement recommended	—	—	3	—	3
Not stated	—	2	10	—	12
Total	98	70	91	—	259
Closing status of completed treatments					
Recovered	11	12	14	—	37
Improved	19	17	20	—	56
No change	2	6	8	—	16
Worse	—	—	—	—	—
Total	32	35	42	—	109

* *The disposal classifications are not mutually exclusive and a patient may appear under more than one of these headings.*

Speech therapy

During the latter part of 1952, speech therapy clinics were opened in 16 day schools and two boarding schools for the physically handicapped and at one boarding school for the educationally sub-normal. The opening of the clinics in the schools for the physically handicapped was a new venture which revealed a considerable demand for speech therapy at these schools. The number of clinics for children attending ordinary schools rose to 28 and it was found possible to make increases in the number of sessions provided at some of the 22 clinics for children at day schools for the educationally sub-normal.

At the end of the year 1,059 children were still under treatment at the Council's clinics. New admissions during the year totalled 778 and 250 children were discharged cured or improved ; 101, most of whom were improved, ceased to attend for various reasons. Further visits were paid to the homes of children who required speech therapy but who were too severely handicapped to attend school.

The staff employed on this work was increased in 1952 and at the end of the year comprised, under the supervision of a senior assistant medical officer, one senior speech therapist, eight whole-time and four part-time speech therapists and two employed on a sessional basis.

Remedial exercise classes

Special classes to correct foot defects, before they develop into permanent disabilities, were introduced in 1948. They are held mainly in primary schools, mostly for children in their last year in the school and are taken by a class teacher who has attended a course given by the Council's consultant on postural defects Dr. Doris Baker, and the senior inspectors of physical education of the Education Officer's department. A refresher course was held in December, 1952. The general medical supervision of the classes is undertaken by one assistant medical officer in each division who is also responsible for selecting the children and for their discharge on improvement. Dr. Baker visits each class at least once during each year.

Difficulties are experienced in holding the classes owing to shortages of staff and accommodation. Because of these difficulties the number of classes dropped from 74 to 65 during the year.

Handicapped children

7,238 examinations were made during the year to determine whether special educational treatment should be provided or whether it should be discontinued.

The number of examinations in each category was as follows :

Vision	263	Delicate	2,274
Hearing	255	Physically handicapped	627
Epilepsy	67	Dual defects	56
Educational subnormality	2,758	Speech defects	938

In addition to these examinations, 414 children were considered with regard to the need for special educational treatment as maladjusted pupils and four as diabetic pupils.

Table 17 in the appendix gives details of the results.

Furthermore, pupils in special schools or units were examined to ensure that the special educational treatment they were receiving was still suitable to their disability.

Epileptic children

To obtain some idea of the number of epileptic school children in the County, a central register has been kept since January, 1951, and school physicians have been asked to notify all cases of epilepsy that they come across in the course of their work, stating the type of fit and the education provided. Where special educational treatment is considered necessary the children are seen at the County Hall by a medical officer. The consultants at hospitals, particularly at the Maudsley and National Hospitals, have been most co-operative in carrying out special investigations and reporting on them. At the end of the year there were 350 names on the register. Of these 214 were in ordinary schools, 30 in day schools for educationally sub-normal children, 27 in day schools for physically handicapped children and 58 in boarding schools for epileptics. This does not represent all the epileptic children in London schools as there are still some in ordinary schools who have yet to be notified.

Considerable work has been necessary to gain for these children the sympathy and help which they need if they are to establish themselves in the community. The Council's medico-social workers have been particularly helpful in the many social problems presented by these children and the British Epilepsy Association has helped many parents, while the Council's youth employment officer has been most co-operative in the difficult task of fitting children leaving school into suitable employment. These children present one of the most difficult problems of social medicine where all agencies, medical, educational and social have to work closely together to achieve success.

Diabetic children

The Council's diabetic unit is housed in the residential school at Hutton, Essex, and at the end of 1952, contained 38 pupils. Children suffering from diabetes mellitus, which cannot be adequately controlled at home, and who are of such intelligence as to profit by their stay are admitted. The principles of the control of the disease and the importance of dietary are taught at the unit, and the children are trained to render their own insulin injections and to guard against the accidents of a diabetic life. They take part in all school activities, including a fortnight's visit to a holiday camp.

A visiting medical officer and nursing staff with special experience provide the day to day care and a consultant visits fortnightly and at such other times as are necessary. The laboratory work to ensure control is undertaken by a technician under the direction of the consultant.

During the year the Diabetic Association organised a scheme whereby diabetic children from various parts of the country attended holiday camps at Walton-on-Naze, Essex, Pateley Bridge, Yorkshire, and Deal, Kent. A small number of diabetic children attending ordinary schools in London were sent to these camps and benefited not only from the holiday itself but also from instruction in the diabetic way of life. The accommodation at Martello Camp, Walton-on-Naze, was provided by this Council and the camp was held in conjunction with the Council's diabetic unit.

Children under five years of age

An inspector of the Education Officer's Department continued to visit primary schools with accommodation available for nursery classes after the needs of the children over five had been met, and in those cases where she was prepared to approve a nursery class, the divisional medical officer was consulted, and arrangements were made to introduce some approximation to nursery school conditions.

At the end of 1952 there were 157 nursery classes with accommodation for approximately 4,710 children aged 3 to 5 years. In addition to a midday meal, these children had one-third of a pint of milk daily and cod liver oil and other vitamin preparations ; for those who required them medicaments containing iron were also prescribed. Nursery class children attend during the ordinary school hours of primary schools, but nursery school children attend from 8.30 a.m. to 4.30 p.m. and have breakfast (when necessary), dinner and tea, and two-thirds of a pint of milk daily in addition to the other supplements supplied to the nursery class children.

At the end of the year there were 20 maintained day nursery schools with accommodation for 1,220 children from 2 to 5 years and five aided day nursery schools with accommodation for 230 children.

School nurses attended nursery classes and schools daily and each child was examined every term by a school doctor.

There was a total of 14,436 children under five years of age on the day school rolls, 12,532 being in the Council's schools and 1,904 in voluntary or aided schools.

Research and investigation

A joint committee of the Institute of Child Health (University of London), Society of Medical Officers of Health and the Population Investigation Committee has been following the health, growth and development of 6,000 children born in one week in March, 1946, who are drawn from all social classes and from all parts of Great Britain. The chief aims are to collect information on accidents, illnesses, growth and development, to show the effect of environment on the health and growth of young children, to compare the history of prematurely-born children with those born at term, and to observe the achievement of children against the background of their ability, health and opportunities. The Council, in common with other local authorities, has assisted in

the inquiry since its inception. During 1952, the children came under the supervision of the school health service and detailed forms of inquiry were completed by school doctors and school nursing sisters.

In the latter part of the year facilities were granted to Professor F. S. Cotton, Professor of Physiology at the University of Sydney, Australia, to carry out research into the physiology of exercise and sport by testing children in primary schools.

DENTAL SERVICES

THE COUNCIL'S Chief Dental Officer reports as follows :

In 1952, for the first time in several years, the graphs (page 132) of the school dental service showing the numbers of dental inspections and of treatment sessions ceased to drop and showed an upward trend. Attention for the pre-school child and for expectant and nursing mothers also showed some improvement. A main difficulty, as formerly, was insufficiency of staff and for a further year it was impossible to attempt an educational drive and a systematic inspection programme, without which full dental care is unlikely to be possible. Systematic follow-up of absentees and revisional treatment of patients rendered dentally fit were operated only to a slight extent where a better staff-patient ratio permitted or by special selectivity on the part of a dental officer. The 1952 staff figures show a considerable improvement compared to those of 1951 and fewer officers with lengthy experience of the Council's dental service resigned.

The signs throughout the year were, generally of a return to the possibility of building a sufficient dental care service to improve the ameliorative treatment service still operating.

Reference has been made in reports on preceding years to efforts to clarify the responsibility for the provision of dental service by the authorities responsible for Part II (hospital), Part III (local health authority) and Part IV (general dental) services. During 1952 continued effort was almost entirely successful. The principal problem remaining was in relation to dental treatment of expectant and nursing mothers at hospitals where, under Part II service, charges to patients in respect of dentures supplied were introduced by the Act of 1951. In the Council's (Part III) service such appliances are provided free of cost to the patient. Consultations on the possibility of reference of patients to the Council's service, or of payment by the Council of the patient's share of cost were inconclusive.

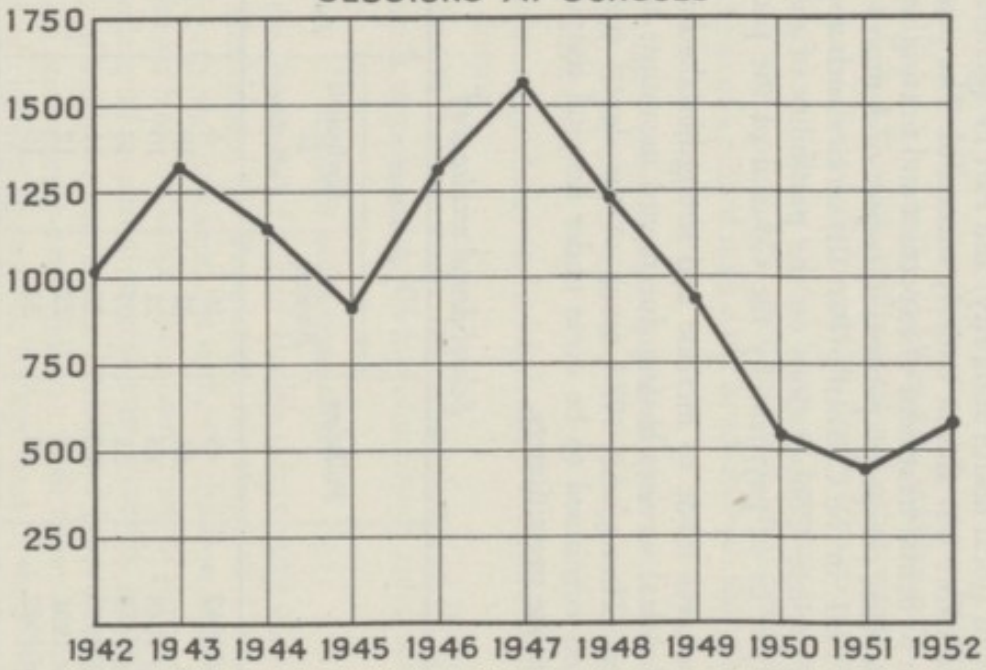
Every effort was made to increase and strengthen the maternity and child welfare section of the dental services having due regard meantime to the dental needs of the school children. Throughout 1952 much of the dental treatment of expectant and nursing mothers continued to be done under hospital auspices or by general dental service and private practitioners.

School dental service staff

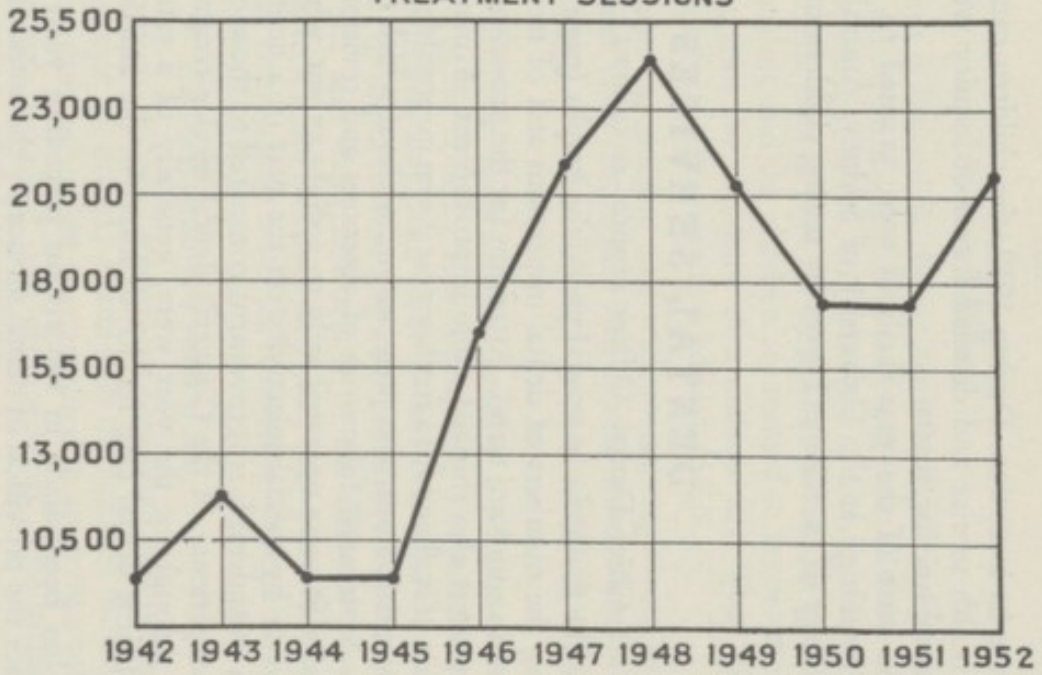
	Full-time	*Part-time*		*Total Full-time*	*Establishment Full-time*
		Number	*Equivalent to Full-time*		
At end of 1947 ..	43	19	6	49	66
At 5.7.48	51	21	10	61	66
At end of 1948 ..	43	21	10	53	66
At end of 1949 ..	31	27	14	45	66
At end of 1950 ..	26	25	14	40	66
At end of 1951 ..	28	22	12	40	66
At end of 1952 ..	35	32	16	51	66

SCHOOL DENTAL SERVICE

NUMBER OF INSPECTION SESSIONS AT SCHOOLS



NUMBER OF TREATMENT SESSIONS



Attendances and treatments

	1949	*1950*	*1951*	*1952*
Number of inspection sessions held at schools	946	544	441	584
Number of children inspected at schools by Dentists	96,201	52,931	46,473	59,677
Number found to require treatment	61,445	32,733	29,397	38,069
Percentage requiring treatment	63·9%	60·8%	63·2%	63·8%
Additional number inspected at centres	65,380	63,583	65,501	71,452
Total number found to require treatment	126,825	96,316	94,898	109,521
Total cases treated	102,495	82,650	82,564	93,823
Attendances	203,523	166,874	172,063	202,571
Ordinary treatment sessions	19,133	15,890	15,760	19,563
General anæsthetic sessions	1,685	1,559	1,516	1,494
Temporary teeth extracted	109,467	101,066	93,981	96,561
Permanent teeth extracted	18,103	16,247	15,850	17,283
Temporary teeth restored by fillings	34,506	23,960	21,684	26,353
Permanent teeth restored by fillings	67,395	53,388	54,356	66,680
Fillings in temporary teeth	36,341	25,191	24,206	27,556
Fillings in permanent teeth	73,740	58,000	60,568	72,369
Other operations—temporary teeth	38,649	33,489	39,523	45,985
Other operations—permanent teeth	32,888	25,485	28,199	30,291
Local anæsthetics for extraction	24,328	20,557	21,300	24,667
Local anæsthetics for conservative treatment	2,926	1,577	1,607	3,753
General anæsthetics	39,455	35,102	34,097	33,448
Cases for whom immediate treatment was completed	‡	‡	8,481*	13,135
Cases discharged as dentally fit	‡	‡	40,369*	63,638

‡ *Figures not available;*
* *Figures for May–December only;*

Ratio of permanent teeth restored to permanent teeth extracted

1945	4·04 to 1
1946	4·2 to 1
1947	4·93 to 1
1948	4·58 to 1
1949	3·72 to 1
1950	3·29 to 1
1951	3·43 to 1
1952	3·86 to 1

Residential establishments

The decline in the dental service in residential establishments appeared to be arrested in 1952 but the problems in this particular field remain pressing. Every effort was made to obtain dental aid for the children but the rise in the percentage found to require treatment is ominous. The following table indicates the sessional attendance and treatments given, but an unknown volume of treatment was given in addition by local dental practitioners:

	1949	*1950*	*1951*	*1952*
Ordinary treatment sessions	572	524	449	488
General anæsthetic sessions	12	10	7	2
Number of children inspected	5,648	5,783	4,635	3,912
Number found to require treatment	2,333	2,355	2,045	1,836
Percentage requiring treatment	41·3%	40·7%	44·1%	46·9%
Attendances for treatment	4,179	3,791	3,427	3,622
Temporary teeth extracted	1,128	920	950	690
Permanent teeth extracted	271	172	173	179
Temporary teeth restored by fillings	1,058	854	699	703
Permanent teeth restored by fillings	1,555	1,547	1,365	1,936
Fillings in temporary teeth	1,116	976	746	721
Fillings in permanent teeth	1,715	1,708	1,515	2,037
Completed scalings	700	583	346	246
Temporary dressings, etc.	745	511	455	432
Local anæsthetics for extraction	832	666	580	546
Local anæsthetics for conservative treatment	71	53	113	103
General anæsthetics	163	272	332	145
Cases completed	2,357	2,363	1,911	1,909

Sodium fluoride treatment and dental hygienists

During the year the investigation on the efficacy of applying a 2 per cent. solution of sodium fluoride to teeth was continued, but the resignations of two of the three dental hygienists employed on the work caused difficulties in the planned investigation. The remaining hygienist drew first part of the investigation to a close towards the end of the year but an account of it was not available for inclusion in this report.

Dental hygienists—Attendances and treatments

	1950	*1951*	*1952*
Sessions	1,370	1,499	1,592
Number invited to attend for first treatment	2,389	4,188	4,348
Number invited to attend for subsequent treatment	2,851	4,232	1,284
Attended—first treatment	2,109	3,365	3,653
Attended—subsequent treatment	2,662	3,936	1,237
Treated—first treatment	2,104	3,359	3,652
Treated—subsequent treatment	2,660	4,033	1,235
Discharged—treatment completed	1,834	3,121	3,618
Discharged—failed to complete treatment	*	104†	72
Gum treatments	365	395	495
Scalings (cleanings)	3,122	3,986	3,989
Polishings (of artificial restorations)	1,823	2,553	1,695
Oral hygiene instruction	2,562	4,655	4,137
Sodium Fluoride :			
First application	658	1,220	260
Second application	597	1,170	270
Third application	559	1,102	262
Fourth application	494	1,074	215

* *Figures not available.*

† *Figures for June-December.*

Orthodontics

At the close of 1951, owing to the resignation of orthodontists, only three sessions per week were expressly reserved for the urgently required service for the correction of malocclusions. It was not possible throughout 1952 to augment this service and only 50 patients could be completed by the part-time orthodontist, a reduction of 172 compared with the preceding year. Clinicians, however, in addition to their routine treatments treated a further 209 malocclusions and 47 additional patients were referred to dental teaching hospitals.

The following table summarises the work done by the part-time orthodontist :

	1950	*1951*	*1952*
Sessions	425	245	134
New cases	266	117	85
Attendances	5,339	3,247	1,816
Unsuitable for treatment	84	51	17
Still under treatment (at 31st December)	491	187	205
Fixed appliances fitted	199	155	122
Removable appliances fitted	452	127	159
Discharged, treatment completed	424	222	50

Such meagre figures, compared to the widespread clinical evidence of need for this type of treatment, are disturbing and very many children who might have benefited had perforce to be turned away untreated.

Maternity and child welfare dental service

The slight increase in maternity and child welfare treatment during 1952 is shown by the following table :

	1949	*1950*	*1951*	*1952*
Number of ordinary sessions	2,682	2,238	1,980	2,031
Number of general anæsthetic sessions	364	368	333	306
Number of appointments offered	31,338	26,308	23,342	24,609
Failed to attend	6,477	5,876	5,060	5,614
Attendances—By appointment	24,861	20,432	18,282	18,995
Other	5,392	3,891	3,313	2,162
Examinations	12,057	8,579	7,661	7,362
Treated—first treatment	7,032	5,116	4,753	5,444
others	13,447	11,851	10,216	10,339
Silver nitrate treatment	2,938	2,180	1,818	2,907
Scalings	1,364	859	669	739
Prolonged gum treatment	212	210	214	228
Fillings	8,564	8,255	7,929	8,852
Inlays	23	22	27	18
Crowns	5	11	6	12
Number of teeth conserved	7,988	7,841	7,507	8,388
Extractions	16,560	11,257	9,289	8,463
Dressings	2,236	2,077	1,687	2,090
Anæsthetics—local	1,784	1,457	992	844
general	4,563	3,372	3,318	2,837
Number of patients prepared for dentures	3,359	2,518	1,822	1,471
Number of patients supplied with dentures	960	918	590	476
Dentures supplied—new full	652	655	335	310
new partial	795	782	536	400
Remakes	7	19	10	10
Repairs	126	84	63	47
Number of patients X-rayed	56	23	65	105
Number made dentally fit	5,283	5,057	4,654	5,479

Conclusion

Towards the close of the year an important decision was taken by the Council which, if recruits are forthcoming, will do much to assist the development of the school dental service. For the first time in the history of the service an ultimate dental staff—school-child ratio of 1 : 3,000—was officially approved and an immediate establishment of the equivalent of 93 whole-time dentists authorised. Every effort is being made to secure the additional staff which will enable this goal to be reached and to provide the additional accommodation necessary.

The period under review was one of improvement compared with the preceding year but much remains to be done before the ground lost in the past few years is regained and satisfactory progress made to implement the Council's statutory obligations under the 1944 Education Act and the National Health Service Acts.

STAFF

IN STAFF matters there were no developments of any magnitude during the year. As in most fields of employment there was an upward trend in salaries and wages. Many groups of staff received increases, some as a result of agreements reached by national negotiating bodies and others, not covered by such agreements, by reason of action taken by the Council itself.

Visiting medical officers

An agreement on the remuneration of visiting medical officers to residential establishments was implemented by the Council during the year. This agreement was negotiated in 1949 with the primary object of dealing with the new situation arising from 5th July, 1948, under the National Health Service Act, 1946, whereby residents in local authority establishments, in common with the populace at large, became entitled to ' family doctor ' medical treatment under arrangements made, and paid for,

by the State, whereas previously this responsibility had rested on the authorities providing the establishments. The new agreement fixed the remuneration to be paid by local authorities for services rendered by visiting medical officers outside the 'family doctor' services paid for by the State. Because of the national economic situation the date of operation of the agreement was deferred for nearly two years. The Council took the opportunity presented by the need for reviewing the terms of remuneration of its visiting medical officers to bring up to date the duties of these officers and to standardise their conditions of service.

Dental officers

A number of dental surgeons offered their services to the Council as whole-time dental officers and for the first time for some years the Council was in a position to appoint whole-time dental officers to the staff. The number of dental surgeons prepared to give part-time service to the Council also increased, following appeals made to the London Local Dental Committee and a more intensive advertising campaign, coupled, perhaps, with an improvement which the Council made in the sessional fees for this work.

Health visitors

The Council's scheme for the training of health visitors continued to play an important part in providing qualified staff for this work and once again the number of health visitors showed an increase during the year. Since the commencement of the scheme 155 student health visitors have been appointed including 40 at present under training. Of the 114 students who had qualified as health visitors, by the end of 1952, 86 were still in the service at that date. The work of health visitors is dealt with on page 68.

Co-operation with the borough councils

Co-operation between the Council and the metropolitan boroughs in public health matters was further extended during the year. Details of joint appointments of medical staff are given on page 36.

Staff medical examinations

The number of references made to the department for medical examination or advice concerning the health of staff, or the fitness of candidates for appointment, totalled 13,436, compared with 12,455 in 1951 ; 189 members of the staff were found to be permanently unfit for further duty with the Council and 252 candidates unfit for appointment. The Council's staff medical examiners made 70 home visits to examine members of the staff who were unable to travel, compared with 95 during 1951.

Reciprocal arrangements with provincial authorities for the examination locally of new entrants were continued. Provincial medical officers of health arranged for the examination of 21 entrants to the Council's service and the Council's medical officers examined 38 candidates for provincial appointments.

Staff of the department

A statement showing the staff employed in the department is given on pages 192-3.

SPECIAL INVESTIGATIONS

THE FOLLOWING research projects were undertaken in 1952 :

Inquiry into virus infections during pregnancy

In the Report for 1950 (page 55) details were given of an investigation sponsored by the Ministry of Health to estimate the frequency with which certain virus diseases (rubella, measles, chicken-pox, mumps, poliomyelitis) during pregnancy are followed by congenital abnormalities in the children. The Ministry of Health were able to obtain a sufficient number of mothers for the purposes of the main inquiry and up to the end of the year 951 women (290 virus infection, 661 control) had been registered in London. Some of these were lost to the survey by removals out of London, refusal to co-operate and other reasons. London, in common with a few of the larger authorities, was asked to continue to register and follow up any rubella cases occurring in their areas as it was hoped to obtain additional information on the effects of this infection.

Nutritional investigation in day nurseries

Facilities were granted in 1951 to Professor John Yudkin, Department of Physiology, King's College of Household Science (University of London), to carry out a nutritional investigation at four day nurseries. The main purpose of the investigation was to determine whether the present-day diet contains all the nutritional factors necessary for the best growth and development of children and was designed to ascertain the effect on the height and weight of young children by the daily administration of a vitamin B preparation.

Of the original 75 children, 15 left during the experiment, so records of growth were available for 60 children (31 boys and 29 girls) and as no differences in growth between the boys and the girls were evident, the results for both sexes were combined. Of the 60 children, 32 (17 boys and 15 girls) were in the experimental group and 28 (14 boys and 14 girls) in the control group. Average absences from the nurseries were almost the same for the two groups. It was calculated that the average consumption of liver powder by the children in the experimental group amounted to 1.2 g. daily for the 91 days (13 weeks) of the test. The 32 children taking the supplement gained on average about $\frac{1}{4}$ inch (0.6 c.m.) more in height and 10 oz. (285 g.) more in weight than the 28 control children (i.e., roughly 20 per cent. and 40 per cent. more than the control group). For various reasons, Professor Yudkin is of the opinion that the dietary factor responsible for the effect on growth is not vitamin B_{12}. He is continuing his work to determine the distribution and nature of the growth factor.

Inquiry into prematurity

At the request of the National Birthday Trust Fund the Council agreed to co-operate in an inquiry, the object of which was to investigate the causes of prematurity with special reference to the effect of the mother's employment during pregnancy. Briefly, the inquiry required health visitors to complete questionnaires in respect of (i) all live-born premature first births in each of the months of December, 1952, and February, April, June and August, 1953, and (ii) all live-born non-premature first births on the 7th, 14th, 21st and 28th of each of the months mentioned (the control group). The health visitors were supplied by the Trust Fund with notes for guidance in completing the questionnaires.

Inquiry on retrolental fibroplasia

In October the Ministry of Health expressed concern at the increasing number of cases of retrolental fibroplasia in premature infants, resulting in blindness or seriously impaired vision. The Ministry stated that the Medical Research Council was conducting an inquiry, but that there might be epidemiological factors which might not be revealed by this investigation, which was mainly clinical and pathological. The Ministry therefore requested the co-operation of local health authorities in a wide survey to throw light on the incidence and distribution of the disease and the Council agreed to participate in the survey. The survey concerned all premature babies born in 1951, weighing up to 4 lb. 6 oz. at birth, surviving two months or more and still resident in the County (or who had died in the County at more than two months old). Schedules were supplied by the Ministry to provide for information (in addition to birth weight, etc.) under the following heads : (i) place of birth (if born at home, whether admitted to hospital or nursing home within first two months) ; (ii) date of death (if child died after two months old) ; (iii) condition of eyes (present condition of eyes, or at time of death, if known). Schedules were completed in respect of 480 babies.

Investigation into the early detection of infantile cerebral palsy

Dr. W. F. Dunham of the Department of Physical Medicine at Charing Cross Hospital, asked for facilities in connection with a scheme of research on the early detection of infantile cerebral palsy. During the past six years, by arrangement with the Medical Research Council, he has been conducting an investigation into disorders resulting from central nervous disease in the adult. He has also studied special problems of infantile cerebral palsy at the Unit at Queen Mary's Hospital for Children, Carshalton, and has come to the conclusion that, in general, the earlier treatment is begun the better are the results attained. Early diagnosis is, therefore, of prime importance. Diagnosis of cerebral palsy at birth, however, is possible for only a relatively few babies who show gross central nervous abnormalities. The majority of those children who are subsequently found to have cerebral palsy show no abnormal signs for some months after birth on the application of the usual methods of examination. Dr. Dunham is of the opinion, therefore, that new methods of examination are required and his object was to develop these from a study of infantile reflexes. He has already carried out some work along these lines but he wished to have facilities for further investigation in order to corroborate what had been done by applying it over a period to a series of apparently normal babies. At the same time, steps would be taken to prevent abnormal function.

The Council agreed that facilities for a pilot investigation should be granted in health division No. 9 (covering the boroughs of Battersea and Wandsworth) and that if successful, similar facilities in other divisions might be made available. The pilot investigation commenced towards the end of the year.

FINANCE

Capital

THE TOTAL capital expenditure on the health services of the Council in the year ended 31st March, 1952, was £287,098, details of which are as follows :

	£
Ambulance service	112,692
Central Dental Laboratory	72
Children's Holiday Home, Littlehampton	2,118
Day nurseries—acquisition and adaptations	24,656
District nursing—purchase of cars	4,411
Maternity and child welfare centres—acquisition and adaptations	13,821
Occupation Centre—appropriation and adaptation	2,297
Queen's Road Centre	67,472
Woodberry Down Health Centre	59,559
	£287,098

Maintenance

After allowing for Government grant the services administered by the public health department cost the London ratepayer a rate of 9⅓d. in the £, divided as follows :

	d.
Ambulance service	1·18
Day nurseries	1·5
Domiciliary midwifery service	0·4
General health services	0·76
Maternity and child welfare	1·57
Mental health	0·33
Prevention of illness (home nursing, domestic help, care of tuberculous, etc.)	2·45
School health	1·14
	9·33

The gross cost of the various services in 1951–52—including central administrative charges and contributions to the Superannuation Fund but excluding debt charges—and the contributions recovered from recipients of the services were :

Service	*Cost*	*Amount recovered in charges*
	£	£
Ambulance service	645,344	—
Day nurseries	872,874	119,226
Domiciliary midwifery service	184,423	—
General health services (including £135,504 contribution to metropolitan borough councils for salaries of sanitary officers)	223,386	—
Maternity and child welfare	821,504	50,343
Mental health	156,342	3,288
Prevention of illness—		
Home nursing	275,940*	—
Domestic help	489,692*	38,777
Other preventive services	435,140	19,713
School health	699,576	16,841
	£4,804,221	£248,188

* Excluding central administration.

VISITORS TO THE DEPARTMENT

INDIVIDUAL VISITORS to the department during 1952 totalled 259 from 53 countries, including 71 visitors from Great Britain. The foreign countries from which visitors were received, with the number from each were Aden 2, Argentina 1, Austria 1, Australia 18, Belgian Congo 2, Bombay 2, Brazil 4, British Honduras 1, Burma 1, Chile 1, Cyprus 1, Ceylon 2, Denmark 2, Egypt 1, Ethiopia 1, Finland 3, Formosa 1, France 3, Germany 2, Gold Coast 5, Greece 3, Holland 1, India 23, Indonesia 1, Israel 2, Italy 1, Japan 2, Korea 1, Malta 1, Malaya 2, Mexico 1, Nigeria 2, New Zealand 3, Norway 9, Pakistan 8, Palestine 1, Persia 2, Portugal 1, Salvador 1, Sierra Leone 1, South Africa 6, Sweden 9, Southern Rhodesia 2, Syria 4, Sudan 2, Switzerland 2, Thailand 4, Trinidad 2, Uruguay 1, U.S.A. 31, U.S.S.R. 2, Viet Nam 1, West Africa 1, Yugoslavia 1.

These visitors were given, according to their individual needs, programmes covering visits to maternity and child welfare centres, school treatment centres, day nurseries, occupation centres, etc., and in practically every case talks by senior medical, nursing or administrative staff.

In addition to these individual visitors, 549 visitors, including 226 from Great Britain, came in organised parties, sometimes for talks and sometimes for visits as set out above. These visitors were :—

146 American university students in six parties.
60 postgraduate students from Society of Medical Officers of Health.
27 German social science students.
70 delegates to the National Council of Nurses.
17 Surrey County Council health visitor students.
5 from the International Labour Office of the United Nations.
4 Indian public health doctors.
18 German local government officials.
15 students from various countries.
4 medical officers from the Middlesex County Council.
25 Norwegian Government employees.
9 Soroptimists.

4 Dutch journalists.
11 nurses from Staff College for Ward Sisters.
6 employees of the Emergency Bed Service.
5 The Minister of Health and party.
11 students of Institute of Hospital Administrators.
112 medical officers attending the National Association for Mental Health Conference.

An indication of the volume of visitors to the department is given in the following table :

	1949	1950	1951	1952ø
Individual visitors	147	195	202	259
Parties	203	200	400	549

ø *Excluding visitors to Woodberry Down Health Centre*

Endeavours are made to meet all reasonable requests for visits as the exchange of views and information is of mutual benefit.

Woodberry Down Health Centre

From its opening in October, to the end of the year, there were 641 visitors to this health centre, very few of whom are included above.

REPORTS BY THE DIVISIONAL MEDICAL OFFICERS

Division 1, comprising the boroughs of Chelsea, Fulham, Hammersmith and Kensington.

Dr. Violet Russell reports :

Expansion of services

There has been a considerable expansion of the work during the year, most notably in the home nursing and home help services. The smaller waiting lists at day nurseries were offset by a large increase in the number of child-minders registered under the Council's scheme.

The popular chiropody sessions have been increased, the new sessions being devoted to the treatment of old people and expectant and nursing mothers.

To meet an increased demand, more audiology sessions have been instituted for school children. A speech-therapy class has been moved to improved accommodation in Fulham, and further sessions began in Kensington and Hammersmith. An additional session for orthoptic treatment is being held at Fulham school treatment centre.

In the tuberculosis service the number of patients receiving extra nourishment free or at reduced cost increased substantially and now amounts to about 10 per cent. of those on the register.

Ante-natal sessions

The maternity and child welfare service has carried on its excellent educational work but there has been a decline in the number of women attending ante-natal sessions. As a result two weekly ante-natal sessions in Fulham and one in Hammersmith have been discontinued. This decline is associated with the increasing proportion of mothers who have their confinements and ante-natal care at hospitals ; the percentage of home confinements in the division is the lowest in London.

Marriage guidance

I am glad to report the institution of a weekly advisory clinic conducted by the London Marriage Guidance Council in the division.

Homeless families

Early in 1952 a weekly infant welfare session was started at the Homeless Families Unit in Fulham Road, Chelsea, as there had been difficulty in persuading the mothers resident there to attend the local welfare centres. The new session is appreciated by the mothers and is doing good educational work. A mothercraft session has been organised by the health visitors, who give lectures on mothercraft and hygiene.

Ill-treatment and neglect of children and juvenile delinquency

Two conferences were held in the division with a view to co-ordinating measures for the prevention of ill-treatment and neglect of children and juvenile delinquency : the conferences were attended by representatives of the public health, education, and housing departments, a borough council housing department, the police, the

probation service, the local hospitals, and about 25 voluntary organisations. A standing committee of the divisional medical officer, the divisional education officer, the area children's officer, and the district care organiser was formed for the purpose of keeping the problems under constant review.

Problem families

Official interest was first drawn to problem families in West London before July, 1948, when a pilot enquiry in Kensington was organised by the Eugenics Society. The results of this investigation are now published and the Eugenics Society have elected one of the health visitors in the division an honorary Life Fellow in recognition of her work on the enquiry.

In October, 1948, a branch of the Family Service Units started work among the problem families in Kensington and Paddington. The divisional staff have kept in close touch with the unit, whose workers co-operate with health visitors and children's care workers. A home help is provided to serve problem families in the division, working in collaboration with the staff of the unit.

Home nursing

A great expansion in the work of the district nurses has helped to solve difficulties which might otherwise have been caused by the demand for hospital beds. Improved recruiting of staff has been reflected by visits showing an increase of 500 a week compared with 1951 and 1,000 a week compared with 1950. The popularity of the service is well deserved by the efficiency and devotion of the nursing staff.

Home help service

The steady increase in the volume of home help work continued throughout the year. The Kensington home help office has been transferred to North Kensington, where it is more conveniently situated for the majority of the clients. At the same time the boundary between the Kensington and Chelsea home help areas was adjusted so that most of South Kensington is now served by the Chelsea office, which has been transferred to a more central point off King's Road, Chelsea.

Co-operation with local hospitals

For some time there has been useful co-operation in the Division between the child-welfare clinics and children's hospitals. A paediatrician from the Victoria Hospital for Children conducts a weekly infant-welfare session at South Kensington welfare centre, and in exchange one of the Council's assistant medical officers acts as clinical assistant at a weekly hospital session. There is also an interchange of medical officers between Westway welfare centre and the Institute of Child Health at Hammersmith Hospital ; one of the hospital registrars takes a weekly welfare session, and one of the Council's medical officers attends a weekly follow-up clinic for infants at the hospital.

Conclusion

In conclusion I must record my thanks to the Divisional Health Committee for their support and encouragement, to the borough medical officers of health for their ready co-operation, and to the divisional staff for their admirable work during the year.

Division 2, comprising the boroughs of Hampstead, Paddington, St. Marylebone, St. Pancras and Westminster.

Dr. H. L. Oldershaw reports :

Staff

The arrangement by which most of the medical officers have experience of both maternity and child welfare and school health services was continued, and most of them will also have the opportunity of clinical experience in one of the children's departments of certain of the hospitals in the division. One of the medical officers was appointed deputy medical officer of health by the Paddington borough council which is in accordance with the policy approved by the County Council.

It is pleasing to report that no less than 26 of the health visitors in the division now undertake combined work.

Day nurseries and child-minders

There was another reduction in the waiting list for day nursery accommodation, and at the end of the year only 195 priority cases were awaiting admission. On the other hand accommodation provided by private day nurseries increased from 541 places in 1951 to 621 places in 1952. The occupation in the Council's day nurseries increased from 81·2 per cent. in 1951 to 88·2 per cent. in 1952.

The number of child-minders showed a further increase, but the children concerned are not necessarily priority cases.

Home help service

The gradual expansion of this service has continued. The number of home help units was increased by 29, but what is of greater significance is that there was an increase of over 20 per cent. in the number of cases assisted as compared with the previous year.

Ante-natal clinics

It was decided to commence an evening ante-natal clinic in Paddington to meet the convenience of working mothers who find it difficult to attend in the day time. This experiment at once proved successful, and arrangements are already in hand for similar clinics to be opened in Hampstead and St. Marylebone.

Old people (foot clinics)

The divisional committee gave approval to accommodation being made available in premises in both Hampstead and Paddington for foot clinics organised by the local old peoples welfare committees. Facilities had already been granted for a similar clinic to be opened in St. Marylebone.

Research

All grades of the divisional staff have contributed their share to the many investigations and research projects which have been initiated both from County Hall and elsewhere.

Diversional therapy

A divisional therapy service for people suffering from tuberculosis and confined to their homes is to be started as an experiment in Paddington. The handicrafts to be taught will include weaving, tapestry making, leather work, basket work, jewellery and lampshade making. A part-time occupational therapist has been engaged and if the project is successful, consideration will be given to its extension to other parts of the division.

Premises

During the year the following additional accommodation was acquired by the Council :

Hampstead Health Institute.—The Council completed the purchase of these premises which will be adapted for maternity and child welfare and school health purposes. A scheme has been prepared and is awaiting necessary approvals.

Hampstead Wells House centre.—Through the co-operation of the Hampstead borough council a suite of rooms for use as a maternity and child welfare centre is now rented in their Wells House estate.

Westminster treatment centre.—These premises are now adapted and their use as a school treatment centre will commence early in 1953.

St. Stephen's day nursery (Paddington).—This purpose-built nursery will accommodate 51 children, and replaces requisitioned premises.

Conclusion

I express my sincere appreciation of the loyal co-operation and successful work of all my colleagues in the divisional health service.

Division 3, comprising the boroughs of Finsbury, Holborn and Islington.

Dr. Bertha E. A. Sharpe reports :

Medical officers

The Division lost the services of Dr. A. B. Stewart as divisional medical officer during the year by reason of his promotion to the position of deputy medical officer of health for the County. Co-operation with the hospital and specialist services and the environmental health services in the Division was encouraged. Regular meetings with the medical officers of health of the three boroughs were continued when problems were discussed and concerted action agreed.

The scheme for interchange between hospital registrars at the Hospital for Sick Children, Great Ormond Street and the Council's assistant medical officers continued satisfactorily throughout the year. The exchange of experience has become mutually appreciated. The number of full-time assistant medical officers employed in the Division has been increased by one, viz. from 5 to 6.

Co-operation with hospitals and general practitioners

Special arrangements continued with the Hospital for Sick Children whereby medical reports were received following the discharge of patients. All cases were followed up by the health visitors and school nursing sisters and the reports were made available without delay to the doctors responsible for the children. Requests were received from hospitals in the area for reports on home conditions before patients were

discharged, and reports on patients after their discharge were given to the hospitals when they were asked for.

Close co-operation was maintained with the family doctor and regular meetings with hospital almoners were held to improve co-ordination.

General

The following services show expansion :

Recuperative holidays by 23 per cent., viz. from 777 in 1951 to 951.

Home help service—the total number of households attended increased by 17 per cent. compared with the corresponding figure for 1951.

Vaccinations of under one's—Compared with the total live births occurring during 1951 and 1952 the percentage of vaccinations of children under one year increased from 41 per cent. to 43 per cent.

Foot clinic—9 per cent. increase in attendances.

Housing—Reports on applicants for priority on medical grounds increased from 3,863 to 3,954.

Other services which need special mention are :

Care of mothers and young children—15 maternity and child welfare centres (including branch clinics) were in full operation in the Division during the year. There were 79,000 attendances and first attendances of infants under one year was 86 per cent. of the total of live births. 263 women were referred for advice to the two family planning clinics in the Division.

Day nurseries have been reduced by one because the site was required for housing purposes. The number of priority cases awaiting admission on 31st December, 1952 was 328 compared with 146 twelve months ago. One of the three private day nurseries registered under the Nurseries and Child-Minders Regulation Act closed during November, 1952.

A mobile clinic for diphtheria immunisation equipped with a loud speaker was again in use during the summer months. In September an intensive effort was started to strengthen the state of immunity amongst school children by increasing the numbers of school sessions for administering reinforcing injections to children immunised in infancy, and for immunising those who had not been protected in infancy. Based on the population figures as at 30th June, 1951 it is estimated that at 31st December, 1952, 51 per cent. of children 0–4 years had been immunised against diphtheria. Only two cases of diphtheria were confirmed during the year.

Vaccination and immunisation

During the year, two vaccination sessions were combined with two immunisation sessions with a consequential saving in man-power and sessional fees to medical officers. Sessions for the re-vaccination of school children were started during the Christmas holidays to save the children's school time. It is proposed to extend this service at all holiday periods and on Saturday mornings.

The special investigation clinic at Pentonville school treatment centre continued to achieve encouraging results. Of 117 first attendances during the year, only two cases (where parents were of low type and unco-operative) failed to respond to treatment.

School health service

The ear, nose and throat Clinic, although now operated by the Regional Hospital Board, was still, for convenience, held at the Islington school treatment centre and the majority of children was referred by school doctors. Discharging ears were quickly cured, a large proportion resulting from nasal catarrh. The audiology clinic worked very smoothly, partly due to the fact that the same specialist attended both this and the ear, nose and throat Clinic at the same centre.

Twelve vision sessions a week were devoted to schoolchildren only at the Royal London Ophthalmic Hospital (Moorfields) and two at the Westminster Hospital.

Early in 1952 accommodation at the East Islington welfare centre was made available to the North West metropolitan regional hospital board for the establishment of a static mass radiography unit. The advertising of the scheme, which aimed at securing the X-ray of all the adult population in Islington, was assisted by the Council's divisional organisation. The unit was used for the routine examination of the Council's divisional staff.

Tuberculosis

About 3,764 children from 14 schools in Islington had tuberculin skin tests and 974 of these had X-ray examinations at the mass radiography unit : 412 were positive reactors to the skin test and 3,352 were negative. Seven children were subsequently referred to the local chest clinic for further examination and observation.

The hostel for tuberculous men at Highbury Quadrant was opened on 29th October, 1951. There is accommodation for 37 residents which includes two chalets installed in the gardens towards the end of the year. The hostel has been fully utilised and is visited on a rota basis by members of the Divisional Health Committee.

Health education

Lectures and demonstrations, supplemented by films were given at welfare centres. A programme of health publicity was followed by which the same topics were concentrated upon at each centre. The various establishments exhibited posters and distributed leaflets according to this programme, the topic being changed once a month. Short articles on health matters were published from time to time in the Islington public library bulletin.

General practitioners and hospitals in the area assisted the Council's campaign for immunisation against diphtheria by displaying posters on their premises.

Conclusion

As a newcomer to the division I should like to say how much I have appreciated the interest shown and the encouragement given by the Chairman and Members of the Divisional Health Committee. I have also much valued the help and co-operation of the three borough medical officers of health ; and I owe gratitude to many general practitioners, voluntary societies, hospital staffs and last, but not least, to my own divisional staff, medical, nursing and administrative.

Division 4, comprising the boroughs of Hackney, Shoreditch and Stoke Newington.

Dr. S. King reports :

Woodberry Down health centre

This comprehensive health centre was opened on 14th October, 1952, and by the end of the year 41 sessions of local health authority services were being held each week. The general practitioner and dental services, which are the responsibility of the London Executive Council and which are to be open to the public generally had not been commenced by the end of the year. A mothers' club and sewing class have been inaugurated successfully and the hall at the centre has been used for a number of lectures. The centre has attracted considerable publicity and by the end of the year well over 600 visitors had been conducted over the premises.

Maternity and child welfare

Attendances at infant welfare and ante-natal sessions and home visits by health visitors all showed improvement compared with the previous year, despite the continuing shortage of health visitors. Under an arrangement made with Hackney Hospital some mothers have, since 17th November, 1952, been referred from the hospital to the Council's clinics for interim ante-natal care. It is hoped that this co-operation may be extended to other maternity hospitals in the division.

Day nurseries and child-minders

Two day nurseries were transferred to newly erected premises (Woodberry Down and St. John's, Hackney Churchyard) during the year. The move to the new nurseries reduced the total available accommodation in the division from 668 to 666 child places. The priority waiting list for nursery admission contained the names of 110 children at the end of the year compared with 163 a year earlier.

Five private day nurseries registered under the Nurseries and Child-Minders Regulation Act, 1948, provide accommodation for 177 children and there are three statutorily registered child-minders approved for the care of 13 children.

There were at the end of the year 71 approved daily minders having in their care 57 children under school age.

Vaccination and immunisation

Considerable work has been done in the division in carrying out schick-tests on schoolchildren over ten years of age. It is of interest to note that approximately one-third of those children tested gave a positive reaction and were immunised against diphtheria. Only two cases of diphtheria (one adult, and a child for whom no record of immunisation is held) occurred in the division during the year.

A total of 899 holidays were provided, including 453 for schoolchildren and 60 for children under school age. Recuperative holidays

Help was given to 2,928 cases during the year, of which 1,255 were new cases. Home help service

Various minor improvements to premises have been made or commenced during the year, such as the acquisition and laying-out of additional play space to provide grass and hard areas for the children, the provision of improved heating in a staff dormitory and the installation of additional pedestal closets at day nurseries. Premises and minor improvements

Redecoration in the modern colour schemes provided by the Council's architect has been completed at several establishments with pleasing effect.

Division 5, comprising the boroughs of Bethnal Green, Poplar, Stepney and the City of London.

Dr. G. O. Mitchell reports :

In January two special investigation clinics were established, one at the Ida Samuel school treatment centre, Underwood Road, Whitechapel, and the other at the Bromley school treatment centre, Coventry Cross, Bromley-by-Bow, being held on Thursdays alternately at each centre. These clinics provide an opportunity for a full-time assistant medical officer to examine and investigate more thoroughly those children who present certain abnormalities at routine school medical examinations, e.g. enuresis, minor behaviour problems, doubtful cardiac conditions, etc. These clinics are a successful experiment. The great majority of children referred to them suffer from enuresis. Special investigation clinics

During the year the final step in decentralising the health visitors was taken when those health visitors based on the Stepney public health department in White Horse Lane were transferred to the Mary Hughes centre in Whitechapel, and the Council's policy of locating health visitors in or near their districts is now fully implemented in the division. We were, and we remain, rather short of health visitors ; the East End does not seem to have any special attractions for new entrants in the Council's service. Health visitors

Towards the end of the year a piece of vacant land opposite the Christian Street day nursery was developed as a playground for the nursery children. This was a welcome addition to the day nursery amenities since the limited site of the nursery affords practically no external playspace at all. Day nursery playground

Last year I lamented the decline in the school dental service. During 1952, however, things began to brighten up a bit with the appointment of a full-time dental surgeon at the Ida Samuel centre and the re-introduction of school dental inspections. There are encouraging signs of further development in this direction and we hope for an expansion of the dental services for children under school age and for expectant and nursing mothers, as well as for school children. School dental service

The periodic meetings with almoners in the division continued during the year, and the scheme whereby the health visitors supply special reports to almoners continued to work well. In addition to these reports, the almoners frequently made contact with the health visitors by telephone in urgent cases. Liaison with almoners

An indication of the work of the district nursing associations may be obtained from the fact that for the September quarter the visits paid per 1,000 of the population were the highest of any division, while the average visits per nurse were also the highest, as indeed they were for the quarter preceding. District nursing

Immunisation against diphtheria continued at a fairly satisfactory level, and many re-inforcing doses were given in the schools, but in spite of continual propaganda by health visitors and doctors, vaccination for protection against smallpox is still relatively unpopular, and our vaccination figures continued to disappoint us. The only sure stimulus to increased vaccination in these parts seems to be the immediate threat of an outbreak of smallpox. Immunisation and vaccination

There was a small but steady expansion of the home help service during the year, and a pleasing feature was the entertainment of some of the house-bound old people at Christmas parties organised by the home helps. Home helps

Child-minders

The registration of approved daily minders has been actively pursued and at the end of the year 77 such women were caring for 62 children. This scheme is a useful addition to the day nursery service which, of course, continued to admit only those children coming within the Council's priority groups. There were 111 children on the priority waiting list at the end of the year.

Day nurseries

Problem families

Some concern has been felt about the best way of tackling the problem of the family where difficulties in bringing up the children exist, or where questions of moral and physical danger to the children may arise. As a result several conferences were held with the area children's officer, the divisional education officer, the district organiser of children's care work and the N.S.P.C.C. inspector, and plans have now been formulated for a continuation and extension of this liaison, with special emphasis on the prevention, wherever possible, of the development of a ' problem family '.

Division 6, comprising the boroughs of Deptford, Greenwich and Woolwich.

Dr. F. R. Waldron reports :

Adminis-tration

Upon the appointment of a joint medical officer of health for Deptford and Greenwich, the sub-offices in those two boroughs were combined, with consequential saving of clerical staff.

Liaison

Among the methods used, the following deserve special mention : (i) The monthly meetings with the borough medical officers of health have continued to facilitate the day-to-day running of the personal health services ; (ii) At both the British Hospital for Mothers and Babies, Woolwich, and St. Alfege's Hospital, Greenwich, monthly meetings have again been held between the Council's medical, nursing and midwifery staff and the consultant and nursing staffs of the hospital maternity and paediatric departments. These gatherings have proved very helpful in solving many common problems.

Prophylaxis

Diphtheria immunisation and vaccination have both been carried out at six sessions held weekly for this combined purpose. The work is also undertaken (*a*) at some outlying centres in conjunction with ordinary infant welfare sessions and (*b*) at day nurseries. Inoculation against whooping cough is available on request. Diphtheria immunisation ' booster ' sessions have been arranged at schools ; 1,987 cases were completed. Subcutaneous inoculation and separate antigens are used except at one centre where a trial commenced in September of a combined diphtheria and whooping cough subcutaneous antigen. Only four confirmed cases of diphtheria occurred during the year, three in children at a rest centre who had not been immunised and the other in a soldier 27 years of age whose immunisation state is unknown. There were no fatalities.

Day nurseries

The day nursery (60 places) which occupied a ward in New Cross General Hospital was closed. Accommodation in lieu for a 30-place nursery, which has proved adequate to the need, was made available at the Health Centre, Amersham Road, Deptford.

Special investigation clinics

To the special investigation clinic in Greenwich, two others have been added, viz., in the Health Centres at Amersham Road, Deptford and Market Street, Woolwich. Children are referred from welfare centres or school medical inspections for investigation of minor behaviour problems, and improvement has occurred in many instances.

Old people

Exchange of information has extended between the Council's officers and staffs of the Greenwich-Deptford and Woolwich hospital management committees who have shown special interest in geriatric problems. The old people's welfare committee in Deptford is now amongst the voluntary bodies on which the division is represented.

Home help service

This service has further expanded. On 31st December, 1951, the households attended numbered 1,450. At the end of 1952, they were 1,665.

Chiropody

Attendances totalled 73,000 or a rate of increase of 50 per cent. over those of five years ago.

Other services

Other maternity and child welfare, school health and care services have continued to do a great volume of varied work. Behind the organisation and the figures lie much

endeavour to help in the very human task of improving personal health, as the following eloquent plea received from a clinic for a piece of equipment brings out :

' We know that auriscopes are dear
But when a child's in pain
To know what's wrong inside its ear
Is worth financial strain.
Shall we send them to " Special Ears " ?
Appointments must be made
And minor turn to major fears
And still the drum not saved ! '

The auriscope was provided.

Division 7, comprising the boroughs of Camberwell and Lewisham.

Dr. H. D. Chalke reports :

Accommodation

The need for a number of more suitable premises still remains. No new centres were opened during the year but adaptations to a house in Lordship Lane were completed and a small hutted unit is in process of erection on a site near Blackheath Hill. The Amott Road Centre has been enlarged and the St. Mary's Road Day Nursery transferred to new premises in the nearby Queen's Road Centre.

Clinics

The main feature has been a slight reduction in the number of ante-natal clinics and some increase in those for older children, and for diphtheria immunisation. A mobile immunisation unit toured the division in July. The use of combined diphtheria and whooping cough immunisation is being extended. An ' all purpose ' clinic in the early evening for the benefit of those unable to attend at normal opening times was started at a Lewisham centre : this is largely experimental.

Health education

' Open days ' at the centres were held as before. Health educational evening film shows were arranged throughout the division at which the attendances were very encouraging. Talks to Parent Associations and schoolchildren were extended. A health exhibition held at the Central Lewisham Welfare Centre was very well attended ; the response of the public is an incentive to further effort in this direction. A special exhibition of pictures on the prevention of tuberculosis was held, for one week, at a centre in each of the two boroughs.

Care of the aged

The welfare of older members of the community has received considerable attention. The results of a divisional survey have been published* ; they may prove of some assistance to those who are concerned with the welfare of older people in their own homes. There are many reasons why the majority of old folk are much better off in their own homes than in institutions, provided they can be given adequate attention and assistance. It was found that home care was far less costly than treatment in hospital.

Home helps

This service has now established itself as an essential part of the personal health services. Problems of administration have multiplied with its expansion ; nevertheless, in no case in which the need existed was help not provided. Where considered essential, weekend service was given in a number of cases. There is still a tendency on the part of the public to forget that the duties of the home help must be confined to cleaning, cooking, light washing, shopping and so on.

School health service

There has been a welcome increase in the number of dental clinics. Some reduction has been made in the minor ailment sessions. In a number of schools chest X-rays of the pupils have been taken by arrangement with the mass miniature radiography unit.

Day nurseries

Attendances and new applications suggest that the need for this service has not diminished. Some children have been admitted for reasons connected with their physical or mental health or that of their parents, and on account of adverse environmental circumstances : this has proved well worth while.

Health visiting and school nursing

Health visitors have been called upon to an increasing extent in connection with family problems and difficulties ; this work shows great enterprise and enthusiasm. Arrangements have been made which should increase the co-operation between general practitioners and health visitors.

*Lancet **1**, 588, 1953

General

The number of research projects undertaken has added greatly to the work of the divisional staff. A survey of the housing conditions of the infectious tuberculous on a chest clinic register yielded interesting results, which have been published.†The setting up of a regular problem family conference at the divisional office in connection with the difficult problem of child neglect and delinquency and the problem family—from its preventive aspect—has already given good results. This work is closely related to the keeping of ' family folders,' one of the advantages of which is to prevent unnecessary visiting to the homes.

I am greatly indebted to the staff of the division and to my medical and lay colleagues in the area for their great help and co-operation during the year.

Division 8, comprising the boroughs of Bermondsey, Lambeth and Southwark.

Dr. W. H. S. Wallace reports :

Premises

The redecoration of premises in the division has been continued during the year. Three day nurseries, two infant welfare clinics and the foot clinic in Bermondsey, were completely redecorated.

Day nurseries

Efforts have been made to ensure the fullest economy in the running of the day nurseries. The scheme to allow matrons to do their own housekeeping, within set financial limits, was put into operation and has worked successfully. The nurseries have been working to capacity, the daily average attendance reaching 99 per cent. of the approved places. This has been due, in part, to the fact that temporary vacancies have, wherever possible, been given to children whose mothers have been ill or have had to go to hospital.

Home help service

The home help service was re-organised in June and the division divided into three areas for the purposes of administration of the service. Permanent appointment of three home help organisers was made, one in charge of each area. The new scheme has worked satisfactorily and the demand for the service is increasing steadily. The number of home helps on a full-time basis has increased from 223 in 1951 to 290 in 1952.

Foot clinics

By re-arrangement of the sessions at the foot clinics in Bermondsey it has been possible to open the clinic in the evenings. This has improved the service considerably and reduced the waiting list so that applicants can now obtain appointments soon after booking.

Diphtheria immunisation

There has been a considerable increase in the number of children receiving diphtheria immunisation. Two additional immunisation sessions have been opened, one at Stockwell and one at the Rose McAndrew centre. Special sessions have also been arranged in schools to ensure that children receive the ' booster ' dose.

The number of children under five who were immunised during the year was 5,320 compared with 4,535 during 1951.

School health service

The work of the school health service has continued during the year and arrangements were made to keep the family doctors informed of all defects found at school medical inspections. The scheme has worked smoothly and the vast majority of private practitioners welcome the arrangements made for treatment through the Council's services.

The work of ensuring that all school children found to be mentally retarded are fully investigated and properly treated has always been a difficult task. Fortunately, it has been possible to place one medical officer with special experience in the examination of these children in charge of the work and thus to ensure that the children are properly placed without delay.

There is still a considerable waiting list for refraction examination of school children. The South-East Metropolitan Regional Hospital Board have been unable to provide additional refraction sessions but an orthoptic session has been opened.

The situation regarding dental treatment has improved slightly and the Cutten Memorial dental clinic was re-opened for the first time since the war.

†Medical Officer **89**–183

The work of the Brixton child guidance unit has increased steadily during the year. It has been found to be particularly important to treat children with behaviour difficulties at an early age. Many children under five have been referred to the unit and doctors from the unit have attended the maternity and child welfare clinics to advise mothers on problems of child management. Child guidance

The demand for recuperative holidays has remained about the same as last year. It is of interest to note that a large proportion (25 per cent.) of applications are cancelled before placing is arranged. This is usually due to the fact that mothers are unable to leave their families or to make other arrangements for the care of their children. Unfortunately, Fairby Grange, a home for mothers and young children, was closed and there has been some difficulty in finding alternative accommodation. Recuperative holidays

The work of health education has been carried on throughout the year. The window of the sub-office in Brixton Road, Lambeth, has been used for the display of health education material. Health education

Division 9, comprising the boroughs of Battersea and Wandsworth.

Dr. J. T. R. Lewis reports :

I had the honour to commence my duties as divisional medical officer, division 9, on 7th January, 1952, and so this is the first report which I am privileged to make on the health services in this division, which were formerly in the capable charge of Dr. Bertha Sharpe. My two senior medical colleagues were also newly appointed to the division as assistant divisional medical officers, and the divisional administrative officer, after extensive experience of the public health service in another division had been in this division only since the previous November. The divisional nursing officer took over her duties at the inception of the divisional organisation and her experience of the work in the area proved of the greatest value. Much time, therefore, has been spent in ' feeling our way ,' but some measure of positive work has also been achieved, to which brief reference is made in the following report.

The Gideon child welfare centre in Battersea was closed for some months while the adjoining school was demolished, but was later re-opened and returned to normal working. A new child welfare centre was opened at Fairlight Hall, Tooting. Premises

Steps have been taken to obtain additional school treatment accommodation to replace premises which will shortly be vacated in Tooting.

The number of children immunised against diphtheria and whooping cough remained about the same as that for 1951, but the number of persons vaccinated was 20·7 per cent. fewer. Immunisation and vaccination

In the fourteen day nurseries there are 683 places. Eleven of these nurseries are recognised for the training of students. A review of places and attendances was carried out during the year. Day nurseries

The total number of sessions held at these clinics, which are concerned with the problem of bed-wetting, was 220 and the attendance was 1,957. This shows an increase of 5·2 per cent. and a decrease of 2 per cent. respectively on the figures for 1951. There were 256 new patients. Special investigation clinics

The number of applications for recuperative holidays has remained fairly steady, but there has been a slight decrease in the percentage placed through the division ; 55 per cent. of the total placing were made direct compared with 62 per cent. in 1951. Recuperative holidays

Home helps attended 2,580 households, an increase of 10 per cent. over the previous year's figures. Home help service

Home nursing equipment has been lent to 24 patients compared with eight in 1950 and 29 in 1951. At the end of the year 19 patients were still using the equipment. District nurses paid 183,814 visits, an increase of 19·5 per cent. Home nursing

As mentioned in last year's report, arrangements were made for officers of the borough councils to give talks to school children on milk and its processing and bottling, designed to improve the condition of milk bottles returned from schools. These talks Health education

have continued and have been much appreciated. By the end of the year, and since the inception of the scheme, 65 talks had been given to 14,390 children. During the year further talks to school children were introduced on food hygiene, with special reference to cleanliness in the kitchen, totalling 13 talks to 1,040 children.

Careful consideration has been given to the whole subject of health education and my senior colleagues and I have taken every opportunity of speaking to parent-teacher associations and similar organizations. The department took part in an Old People's Exhibition which brought to the notice of the public the work done in the division for this section of the community.

Business premises in prominent positions were loaned for a public exhibition illustrating various branches of the personal health services, and this aspect of health education is being actively pursued.

Child neglect

Particular attention has been paid to this problem during the year and meetings and discussions have been held with colleagues of other Council departments in the division. Arrangements were made for the maintenance of a register of neglected children and for the exchange of information between departments. It is essential that this very important work should be on a firm basis.

Welfare of old people

A close liaison has been maintained between the divisional staff and the other statutory and voluntary bodies concerned with this important work, and members of the divisional staff sit on various Committees dealing with this question. Particular attention has been paid to the arrangements made for the removal of old people to hospitals or homes and considerable success has been achieved in this direction without resort to statutory powers. Home helps have been provided where necessary and the health visitors made a large number of visits to old people.

Review of sessions

A comprehensive review of maternity and child welfare sessions and sessions held at school treatment centres was undertaken. Within the division the work has been re-organized on an area basis with, so far as practicable, one assistant medical officer undertaking all the clinical duties in that area. Child welfare sessions have been made 'combined sessions' where immunisation and vaccination are carried out in addition to child welfare work.

Co-operation with general practitioners and teachers

The closest co-operation has been maintained with teachers' organizations and meetings have been held with representatives of both the Battersea and the Wandsworth head teachers' associations.

There has also been close contact with general practitioners, both through the local division of the British Medical Association, on which senior medical officers are represented, and with individual doctors.

Cerebral palsy investigation

An investigation is proceeding into the problem of cerebral palsy, in association with workers appointed by the Medical Research Council.

Organization

A brief reference might be permitted to the tri-partite arrangement in this division whereby the divisional medical officer is also medical officer of health for the two metropolitan boroughs constituting the division. There is, of course, everything to be said for the personal and the environmental health services being as closely co-ordinated as possible, and one way of achieving this end should be by means of the arrangement which operates in this area. No effort has been spared, therefore, to weld closely together the environmental health services, for which the borough councils are responsible, and the personal health services, which are the concern of the county Council.

The new arrangement is of particular benefit and value in connection with those services which may be partly the responsibility of the borough councils and partly the responsibility of the county Council. For example, it is now possible to employ both borough and county Council staff, as may be desired, in the investigation and control of infectious disease, and the same principle applies in such matters as housing and the care of old people and their removal to hospitals or institutions.

After only a year's experience of the new procedure it would be unwise to arrive at any final conclusion as to the practicability of the new scheme, but while maintaining

every caution in this respect a modest claim to some degree of success might, I think, be justifiable. In an effort of this kind the most important single factor making for success is the team-work and co-operation of all persons at all levels who are concerned with the services. I should, therefore, like to say a word of appreciation and thanks to everybody engaged in this important work at both member and officer level.

I am very happy to record that I have received the greatest possible encouragement and help from the members of the two borough councils and the divisional health committee, and particularly from the chairmen of the two metropolitan borough public health committees and of the divisional health committee. My colleagues in both the borough councils and also the division have added to their extensive knowledge and efficiency (which were never, of course, in doubt) a readiness to co-operate and work together and to give of their best which has been most gratifying.

We look forward to consolidating such success as has so far been attained and a further more detailed report will be made in due course.

APPENDIX A — DEATHS AND SICKNESS IN LONDON IN DECEMBER, 1952.

THE MOST outstanding incident concerning the public health of London in 1952, was the sudden great increase in deaths and sickness which occurred simultaneously with the dense four-day fog at the beginning of December. Some idea of the relative size of this phenomenon is given by considering that in a comparatively short time this increase contributed directly between 0·5 and 1·0 per thousand to the year's general death-rate of 12·0 per thousand ; had no such increase occurred the death-rate would in all probability have been between 11·0 and 11·5 per thousand.

During December the weather had been on the whole slightly worse than might be expected for the time of year, with periods of cold and fog somewhat above the average. The general state of health in the County, as measured by such indices of morbidity as are available, was also a little worse than normal for the season with signs, towards the latter part of the month, of the growth of a moderate 'respiratory' epidemic, which in itself is by no means unusual at this time. Of a true influenza epidemic there were no signs and it was not until the very last week in December that one of the influenza viruses was isolated in South-East England, heralding the spread of influenza in London in January and February, 1953.

The table below shows the weekly values of the main morbidity indices from the beginning of November until the end of the first week in December, together with the weekly averages for these weeks in the preceding three years. In addition to the figures there shown the district nursing associations completed 5,026 cases of all types of home nursing in November as against an average figure of 4,040 for the same month in 1950 and 1951.

Week ended	*8 Nov.*	*15 Nov.*	*22 Nov.*	*29 Nov.*	*6 Dec.*	*Av. of wks. 45–49, in 1949, 1950, 1951.*
Week number	*45*	*46*	*47*	*48*	*49*	
Deaths registered in London A.C. ..	693	747	753	853	945	827
National insurance first certificates of sickness benefit issued in London A.C.*	9,281	9,182	9,099	10,606	11,678	10,623
Removals of in-patients to hospital by ambulance (excluding maternity and accident cases) in London A.C.	2,049	2,071	2,183	2,421	2,493	1,836†
Emergency Bed Service applications (Greater London)	930	1,030	1,070	1,280	1,610	950§

* *The week for sickness benefit certificates ends on Tuesday, i.e., Nov. 4, 11, 18, 25 and Dec. 2.*
† *1951 only.* § *1950 and 1951 only.*

In comparison with previous years both the numbers of persons removed by ambulance to hospital as in-patients in the County, and the number of applications to the Emergency Bed Service in the whole of Greater London were running at an appreciably higher rate throughout November. But it is necessary to use these figures with considerable caution in making comparisons over a period of years. Admissions to hospital depend as much on the availability of beds as on the need for them and the figures from year to year may reflect the former as much as the latter. (Judging by the yardstick of the E.B.S. warning system there was no undue pressure on hospital beds during this month, the first white warning being issued on 8th December). Again, the numbers of applications to the Emergency Bed Service may reflect the amount of use general practitioners choose to make of the service as much as the amount of acute sickness.

District nursing cases completed were appreciably higher than in the previous two years and this was even more marked for those of their cases classified as respiratory, 1,126 in November, 1952, as against a November average of 750 for 1950 and 1951. These respiratory cases form the major part of the *acute* sickness dealt with by the district nursing associations during the winter. Some part of this increase can be accounted for by the fact that the district nursing service in London has been expanding steadily since 1948 but there remains a definite indication of a higher incidence of acute sickness so far as it affected district nursing.

Of the two measures, the deaths registered and the First Certificates for Sickness Benefit, neither would appear, a priori, to be by itself a particularly accurate index of morbidity, the deaths relating only to those whose illnesses have terminated in one particular way and the sickness benefit claims being restricted to the employed (and presumably healthier) section of the community. Both measures, however, are free from the distortion introduced by variations in the availability of services and for comparative purposes depend only on the numbers exposed to risk—in the case of deaths the total population, in the case of sickness benefit claims the employed population. Over the years concerned the total population has remained substantially constant and the employed population in November, 1952, was less than 1 per cent. different from the average in November, 1950 and 1951. Both measures have shown themselves in the last few years particularly sensitive to widespread winter changes in morbidity and during the growth of a considerable epidemic, as for instance an influenza epidemic, they move very closely together. The correlation between the numbers of sickness benefit claims in the week ending on a Tuesday and the number of deaths, registered in the week ending the following Saturday is strikingly high especially during an epidemic period. For this November both measures were running at much the same rate as in the immediately preceding years, but showing a steady increase.

Altogether it is reasonable to say that in November, 1952, there was a slightly higher incidence of sickness generally in London than might have been expected at this time of year from experience of the immediate past, while at the same time the weather was also somewhat worse than normal. There was nothing, however, in any of the morbidity indices on the scale of what is experienced during the growth of an influenza epidemic when the sickness benefit claims rise above 20,000 a week for several weeks in succession.

As December began, this slow steady increase in new sickness continued. The sickness benefit claims were 11,678 in the week up to and including 2nd December, and 12,553 in the week up to and including 9th December. The deaths registered were 945, in the week up to and including 6th December. On the basis of the relationship between the sickness benefit claims to a Tuesday and the deaths to the following Saturday, as experienced in the period 14th October–6th December, 1952, and during the first 8 weeks of the influenza epidemic of early 1951, the 12,553 sickness benefit claims in the week ending 9th December, would be accompanied by an expected number of about 1,100 registered deaths in the week ending 13th December ; or to allow for

some variation in any normal circumstances not less than 890 or more than 1,270.* In fact such expectation was quite confounded ; there were 2,484 deaths registered in the week ending 13th December. The morbidity indices already given for the period up to 6th December, are continued in the table below for the remainder of December :

Week ended	*6 Dec.*	*13 Dec.*	*20 Dec.*	*27 Dec.*
Deaths registered in London A.C.	945	2,484	1,523	1,029
National insurance first certificates of sickness benefit issued in London A.C. §.	11,678	12,553	17,977	9,624
Removals of in-patients to hospital by ambulance (excluding maternity and accident cases) in London A.C.	2,493	3,287	2,594	2,286
Emergency Bed Service applications (Greater London)	1,610	2,510	1,680	1,400

§ *The week for sickness benefit certificate ends on Tuesday, i.e., Dec. 2, Dec. 9, Dec. 16, Dec. 23.*

It is clear that at some time in the latter part of the week ended 6th December, or the early part of the following week, there was a sudden and radical change in the incidence of sickness and deaths, quite unlike anything experienced in a normal winter epidemic however severe. A day-by-day account of certain aspects of the weather and of sickness and deaths in the County of London from 1st December, to 10th December, is as follows :

Monday, 1st December—Weather at Kew—Fine most of the day except for periods in morning and afternoon when fair. Mist in afternoon and evening. Fresh wind 06.40h., 09.30h.–14.40h. (ENE). Frost in morning ; mean air temperature 36·9°F. Atmospheric deposits at County Hall (reading taken at 09.30h. relating to the previous 46 hours)—0·30 mg. of black matter per cubic metre, and 0·090 parts per million of sulphur dioxide. District nurses in London County began treatment of 81 new respiratory cases ; 112 deaths occurred† in the County ; 261 calls were met by the accident ambulance service and the average time the ambulances were out for a call was 44 minutes.

Tuesday, 2nd December—Weather at Kew—Fine until mid-evening, then fair to cloudy. Mist in morning, haze in afternoon, then fog for a time in evening, thick 17.30h.–18.30h.; mist until mid-evening. Frost morning and evening ; mean air temperature 34·2°F. Atmospheric deposits at County Hall (reading taken at 16.30h. relating to the previous 31 hours)—0·49 mg./cubic metre smoke, 0·155 p.p.m. sulphur dioxide. District nurses began treatment of 69 new respiratory cases ; 140 deaths occurred in the County ; and 215 calls were met by the accident ambulance service (average time per call 35 minutes).

Wednesday, 3rd December—Weather at Kew—Cloudy at first then fair till mid-morning, afterwards cloudless. Haze in evening. Fresh wind 02.50h.–15h. (N). Frost morning and evening ; mean air temperature 39·0°F. Atmospheric deposits at County Hall (reading taken at 16.30h. relating to the previous 24 hours)—0·61 mg./cubic metre smoke, 0·220 p.p.m. sulphur dioxide. District nurses began treatment of 71 new respiratory cases ; 143 deaths occurred in the County ; and 248 calls were met by the accident ambulance service (average time per call 43 minutes).

Thursday, 4th December—Weather at Kew—Fine to fair early ; then generally cloudy until mid-evening, afterwards fair to fine. Haze in afternoon and early evening, then fog, thick 19.45h.–20.15h. Frost morning and evening ; mean air temperature 36·5°F.

* *For weeks No. 43–49, 1952 and No. 50, 1950–No. 5, 1951 inclusive, the correlation between the weekly number of sickness benefit claims expressed as a percentage of the mean of the three preceding years and the weekly number of registered deaths similarly expressed is 0·94. The regression of the deaths so expressed on the sickness benefit claims is* $y = 48{\cdot}6 + 0{\cdot}54x$. *The 95 per cent. confidence limits for this regression coefficient are* $0{\cdot}44 < b < 0{\cdot}64$. *The standard error of estimate is 11 as a percentage of the average for previous three years or 96 deaths in the week ended 13th December.*

† *The number of daily deaths occurring are taken from a paper by the Chief Medical Statistician at the General Register Office. Logan, W. P., 'Lancet,' 1953,* **1.** *336.*

Atmospheric deposits at County Hall (reading taken at 16.30h. relating to the previous 24 hours)—0·49 mg./cubic metre smoke, 0·144 p.p.m. sulphur dioxide. District nurses began treatment of 48 new respiratory cases ; 120 deaths occurred in the County ; and 244 calls were met by the accident ambulance service (average time per call 34 minutes).

These first four days of December were normal winter days with nothing unusual in their load of morbidity and mortality. On the Thursday evening the thick fog came down.

Friday, 5th December—Weather at Kew—Fine until mid-morning, then fair, sky becoming obscured by fog afterwards. Fog all day, thick 05h.–08.15h., 11.10h.–24h. Frost all day, rime in morning, mean air temperature 29·5°F. Atmospheric deposits at County Hall (reading taken at 16.30h. relating to the previous 24 hours)—2·64 mg./cubic metre smoke, 0·751 p.p.m. sulphur dioxide. District nurses began treatment of 98 new respiratory cases ; 196 deaths occurred in the County ; and 311 calls were met by the accident ambulance service (average time per call 39 minutes).

Saturday, 6th December—Weather at Kew—Sky obscured by thick fog all day. Frost and rime all day ; mean air temperature 28·9°F. Atmospheric deposits at County Hall (reading taken at 11.30h. relating to the previous 19 hours)—3.45 mg./cubic metre smoke, 0·855 p.p.m. sulphur dioxide. District nurses began treatment of 78 new respiratory cases ; 294 deaths occurred in the County ; and 337 calls were met by the accident ambulance service (average time per call 96 minutes).

Sunday, 7th December—Weather at Kew—Sky obscured by thick fog all day. Frost all day ; mean air temperature 28·9°F. Atmospheric deposits at County Hall*. District nurses began treatment of 42 new respiratory cases ; 513 deaths occured in the County ; and 247 calls were met by the accident ambulance service (average time per call 118 minutes).

Monday, 8th December—Weather at Kew—Sky obscured by fog until morning, then cloudy to fair until late afternoon, afterwards fine. Fog most of day, thick until mid-day, and from 16.45h. Frost morning and evening ; mean air temperature 31·5°F. Atmospheric deposits at County Hall (reading taken at 09.30h. relating to the previous 46 hours)*—4.46 mg./cubic metre smoke ; 1·339 p.p.m. sulphur dioxide. District nurses began treatment of 175 new respiratory cases ; 518 deaths occurred in the County ; and 316 calls were met by the accident ambulance service (average time per call 76 minutes).

Tuesday, 9th December—Weather at Kew—Fine at first becoming fair, then cloudy most of day. Fog in morning, thick until 04.30 h. ; mist in afternoon. Frost in morning; mean air temperature 36·0°F. Atmospheric deposit at County Hall†. District nurses began treatment of 227 new respiratory cases ; 430 deaths occurred in the County ; and 277 calls were met by the accident ambulance service (average time per call 48 minutes).

Wednesday, 10th December—Weather at Kew—Cloudy until early evening, then fair. Intermittent light drizzle and rain morning and afternoon ; light to moderate rain late. Fresh wind 11.05–25h., 12h–14h. (S), 16.15h.–17h. (SSW). Mean air temperature 43·3°F. Atmospheric deposit at County Hall (reading taken at 16.30h. relating to the previous 55 hours)—1·22 mg./cubic metre smoke, 0·472 p.p.m. sulphur dioxide. District nurses began treatment of 184 new respiratory cases ; 274 deaths occurred in the County ; and 273 calls were met by the accident ambulance service (average time per call 41 minutes).

It is apparent from this brief diary of the ten days covering the fog period that the pattern of sickness, accident and death changed abruptly shortly after the fog and cold

** No readings are taken at County Hall on a Sunday, and the figures here given for Sunday and Monday are the averages for the 46 hours since 11.30h. on Saturday.*

† On this particular Tuesday no readings were taken at County Hall ; the figures here given for the Wednesday are the averages for the 55 hours ending at 16.30h. on Wednesday.

began. What is perhaps not immediately obvious is the magnitude of this change ; by the time the fog had lain over London for two days and three nights with the temperature below freezing for almost the whole of that time, the death rate had risen to a height last experienced in this city in the influenza epidemic of 1918 and the deaths continued at this rate for two whole days and fell only slightly on the third. During these three days, December 7th, 8th and 9th, in London Administrative County approximately 440 persons out of every million living died ; in 1918 during the worst three days of the week ending 9th November, approximately 470 persons out of every million living in London died ; and during Monday, Tuesday and Wednesday, September 3rd, 4th and 5th, 1849, approximately 570 persons out of every million living in London died—these were the worst three days in London of the worst cholera epidemic on record. With regard to the extent of sickness, it is not possible to make such clear and chilling comparisons for want of information. But the rise in incidence was as sudden from the level of the previous weeks as was the rise in the deaths ; district nurses took on an average of 67 new respiratory cases a day in the first four days of December ; on December 8th, 9th and 10th they took on 173, 227 and 181 such cases. Dr. Abercrombie in a detailed analysis* of the work of the Emergency Bed Service covering Greater London during this period says :

> 'In 1952, owing to the prevalence of cold weather since early November, the work of the service rose steadily throughout that month with the result that on 1st December, 243 general acute applications were received instead of the normal 130 or so. This rise continued until 6th December, when the fog settled on London, and the number of applications rose very rapidly, reaching an unprecedented peak on 9th December, when 492 were received. Applications continued in abnormally high but diminishing numbers until the 13th, after which a fairly stable state was reached.'

It has already been noted that the Emergency Bed Service applications tend to over-emphasise a rise in acute sickness since general practitioners will make more use of the service under such conditions ; but a rise such as that described by Dr. Abercrombie must very largely represent a real and sudden increase.

In the Administrative County the total number of patients removed to hospital by the ambulance service (excluding maternity and accident patients) was 2,493 in the week, Sunday, 30th November–Saturday, 6th December ; in the following week it was 3,287. The proportion of these removals, for whom arrangements were made through the Emergency Bed Service, had been rising steadily over the preceding weeks ; it was 17 per cent. in the week ending 8th November, 18 per cent. in the two following weeks, 19 per cent. in the next week, 22 per cent. in the week ending 6th December and 24 per cent. in the week ending 13th December. The variation in this proportion can be taken as an indication of the extent to which general practitioners shifted their demands for hospital accommodation from the more usual channels to the E.B.S. Dr. Abercrombie describes also how the demands on the hospitals through the E.B.S. were met and the workings of the E.B.S. warning system :

'When the percentage of admissions to applications, calculated on the moving weekly totals, falls below 85 per cent., a "white" warning is sent to the appropriate hospital authorities' . . . . 'If the percentage falls below 80 per cent. a "yellow" warning is issued, and if below 75 per cent. a "red" warning' . . . . 'On 1st December the admission-rate was 88·5 per cent., and in spite of increasing pressure it was kept above 85 per cent. until Sunday, the 7th, when it fell to 84·9 per cent. ; a "white" warning was issued at 11 a.m. next day. On Tuesday, the 9th, the rate was 79·9 per cent., and the "yellow" warning was issued. The response was such that, despite the high total of applications, the admission-rate fell only a further 1·5 per cent. The "yellow" warning was cancelled on 15th and the "white" on the 17th.'

---

* *Abercrombie, G. F. 'Lancet,' 1953,* **1**. *234.*

A moving weekly total, however, is not a very sensitive measure when the incidence of acute sickness is changing with the rapidity which characterised the period 6th—10th December ; and Dr. Abercrombie shows that on the day when applications for admission were at their maximum, Tuesday, the 9th, the daily admission-rate fell steeply to only just over 71 per cent. On this particular day some 30 new respiratory cases were taken on in the Administrative County by the district nursing associations, either on direct application from hospitals for attention pending admission or where the cases were admitted to hospital within a day or two ; few other cases of this type occurred during November or December. It seems therefore that by this Tuesday, the incidence of new acute sickness had been rising and was still rising so rapidly that for a very short period there was a substantial gap between the demands on the hospitals and the ability to meet these demands immediately. In view of the present efficiency of the system for emergency admission, this gives an indication of how sudden and how great was the rise in acute sickness.

The diagram opposite shows graphically the variation day-by-day from 27th November to 18th December of the atmospheric conditions and of mortality in the County of London ; also the number of new respiratory cases undertaken by District Nurses and the average time per call taken by the accident service ambulances, the former as an index of the variation in morbidity and the latter as an index of the difficulty of traffic movement.

All these measures show a close correspondence in their movements over this period. Dr. Logan, Chief Medical Statistician at the General Register Office,* says of the mortality ' One of the most striking features . . . . was the rapidity at which deaths started to increase . . . . Even on 5th December, the first day of the fog, there was an obvious increase in the number of deaths, and the daily totals mounted rapidly to their highest levels on 7th and 8th December . . . . There was some decline on 9th December, and a still greater decline on 10th December ; but even on 15th December, the daily total was almost twice as high as before the fog began.' The increase on 5th December in new respiratory cases begun by district nurses was almost exactly the same as the increase in the deaths—the deaths increased 52 per cent. over the average of the preceding four days, the new nursing cases 45 per cent. On Saturday, 6th and Sunday, 7th, however, the new respiratory nursing cases declined again before rising sharply on Monday, 8th, and again on Tuesday, 9th, to a peak 240 per cent. above the average of the first four days of December. Normally the number of new nursing treatments falls off on a Saturday and Sunday, due in part no doubt to patients' unwillingness to bother their doctor at the week-end ; a similar drop every Sunday is noticeable in the applications to the Emergency Bed Service and this drop duly took place in the applications on 7th December as compared with 6th December. The true pattern of daily incidence of sickness is thus obscured in the only figures available by the fact that the critical days fell at a week-end ; but it is clear enough that the daily number both of persons needing admission to hospital and of those needing home nursing began to increase with startling rapidity on the first day of the fog simultaneously with the rise in the number of deaths ; and it is a reasonable assumption that the number of persons falling sick, as distinct from the numbers contacting the medical services, continued to increase over the week-end so that their accumulated numbers gave rise in part to the great increase of apparent new sickness on Monday and Tuesday. It is also reasonable to assume that this does not wholly account for the peaks of sickness falling later than the peak of deaths. The maximum deaths were on Sunday and the maxima of applications to E.B.S. and of new respiratory cases begun by district nursing associations were both on Tuesday. If the two latter maxima represented merely the back-log from the week-end they should have fallen on the Monday rather than Tuesday. The figures strongly suggest that there was some difference between the time incidence of deaths and that of acute sickness in relation to the fog ; that whereas the daily number of deaths started

* *Logan, W. P. D. ' Lancet,' 1953,* **1**. *336.*

LONDON ADMINISTRATIVE COUNTY

CERTAIN DAILY MEASURES FROM 27.11.1952 TO 18.12.1952

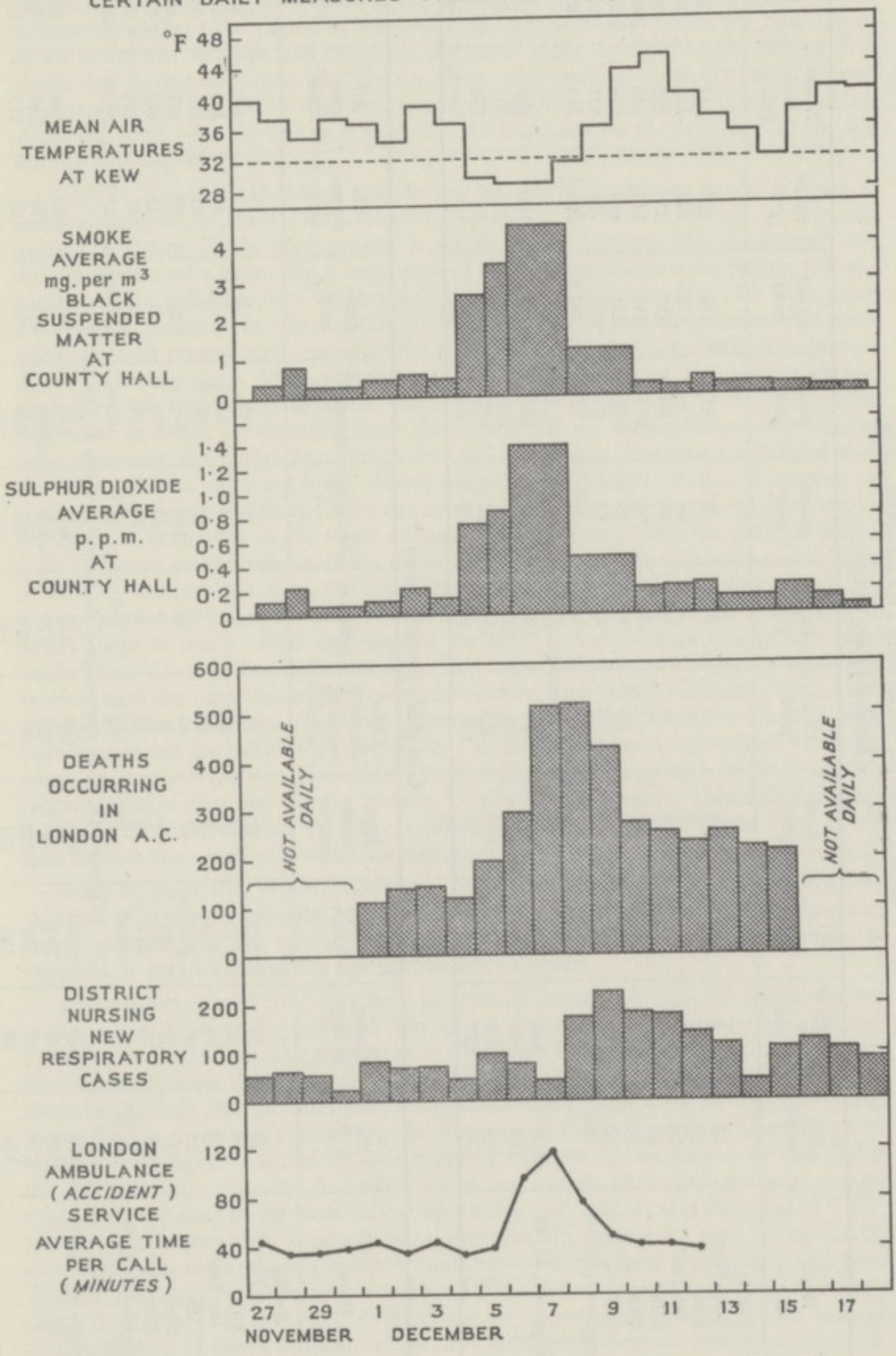


TABLE A

Deaths in the six weeks ended 27th December, 1952

Classified by age groups

Week	0–4 weeks	4 weeks to 1 year	1–4 years	5–14 years	15–24 years	25–34 years	35–44 years	45–54 years	55–64 years	65–74 years	75 and over (years)	All ages
No. Ending												
47 22nd Nov. ..	13	5	11	4	4	14	28	85	118	229	242	753
48 29th „ ..	22	9	5	3	3	7	22	61	152	226	343	853
49 6th Dec. ..	16	12	6	4	9	16	36	80	157	254	355	945
50 13th „ ..	28	26	7	6	7	28	64	204	448	717	949	2,484
51 20th „ ..	19	15	13	6	14	17	29	96	251	444	619	1,523
52 27th „ ..	12	11	7	2	7	11	34	83	167	258	437	1,029
Average—47, 48, 49	17·0	8·7	7·3	3·7	5·3	12·3	28·7	75·3	142·3	236·3	313·3	850·3
Weeks 50, 51, 52 as a percentage of the average for weeks 47, 48 and 49.												
Average—47, 48, 49	100	100	100	100	100	100	100	100	100	100	100	100
50	165	300	96	164	131	227	224	271	315	303	303	292
51	112	173	177	164	263	138	102	127	176	188	198	179
52	71	127	96	55	131	89	119	110	117	109	139	121

Classified by certain causes

Week	Pul. T.B.	Cancer of lung	Heart disease	High blood pressure	Other diseases of circulatory system	Influenza	Pneumonia	Bronchitis	Other resp.	Ill-defined causes	All other causes	All causes
No. Ending												
47 22nd Nov. ..	18	38	225	12	27	1	31	46	10	19	326	753
48 29th „ ..	19	27	272	17	23	7	28	73	8	26	353	853
49 6th Dec. ..	14	45	273	19	26	2	45	76	9	25	411	945
50 13th „ ..	77	69	707	47	46	24	168	704	52	79	511	2,484
51 20th „ ..	37	32	389	36	31	9	125	396	21	35	412	1,523
52 27th „ ..	21	36	272	21	32	6	91	184	13	37	316	1,029
Average—47, 48, 49	17·0	36·7	256·7	16·0	25·3	3·3	34·7	65·0	9·0	23·3	363·3	850·3
Weeks 50, 51, 52 as a percentage of the average for weeks 47, 48 and 49.												
Average—47, 48, 49	100	100	100	100	100	100	100	100	100	100	100	100
50	453	188	275	294	182	720	486	1,083	578	339	140	292
51	218	87	152	225	123	270	362	609	233	150	113	179
52	124	98	106	131	127	180	264	283	144	159	87	121

to increase rapidly as soon as the fog and cold began, and started to decrease as soon as the fog lifted and the temperature rose, the number of people falling seriously ill each day, while starting to increase as rapidly and as soon as the deaths, continued to increase throughout the period of fog and cold, was at its highest on the first day of return to normal weather, and thereafter decreased more slowly than the deaths. This means that during the week *after* the fog there were very considerably more persons lying seriously ill, especially with respiratory complaints, than on any of the four days of the fog itself ; but the numbers of deaths were greatest on the four days of the fog and the day following.

Table A, page 158, shows an analysis of the deaths registered in the County of London each week from 15th November to 27th December, by age groups and by certain causes. There is in general a certain delay between the occurrence and the registration of a death and a large part of the deaths occurring on Friday, 5th and Saturday, 6th, will have been registered in the week ending Saturday, 13th December. The sudden great increase in mortality reflected in the registration during this week although most pronounced among babies and the elderly, was not confined to persons of any particular ages. Among children aged 4 weeks to 1 year and among persons aged over 55, three times as many deaths were registered in the week ending 13th December as could be expected from the figures for the three previous weeks, and among persons of all other ages rather over twice as many. The causes associated with the excess deaths were confined almost entirely to disorders of the circulatory or respiratory systems. Compared with the average per week in the previous three weeks, deaths from bronchitis in the week ending 13th December were ten times as many, from influenza seven times as many, from pneumonia nearly five times as many, from pulmonary tuberculosis four-and-a-half times as many, and from other respiratory diseases nearly six times as many ; from cancer of the lung they rose rather less, to nearly twice as many ; from disorders of the heart and circulatory system they were nearly three times as many. Deaths from any other defined cause show no significant increase with the exception of gastro-enteritis, deaths from which increased considerably among children under one year old ; reference to the certified causes of death in these cases reveals that for half of them there was a parenteral infection shown as an associated cause. At no age were any excess deaths registered from causes which are not normally characteristic of that age during winter. Deaths from influenza, although they rose markedly in the week after the fog, rapidly fell back to a normal winter level and at their highest were well below the numbers to be expected in a developing epidemic.

Table B, page 162, shows day-by-day from 16th December to 31st December, the numbers of nursing treatments begun by the district nursing associations for respiratory causes according to the age of the patient. The age distribution here, as might be expected, is very similar to the age distribution of deaths.

Striking increases in mortality have previously occurred in London in conjunction with periods of intense fog and cold. The last two occasions on which mortality changes thus observed were on a scale as great as in 1952, were in December, 1873, and February, 1880. Extracts from the Registrar-General's returns giving details of the weather at the times of the fogs and the numbers of registered deaths each week by age and certain causes for the seven weeks covering the fog periods for each of these years are given below. These figures refer to an area which is substantially the area now included in the Administrative County. At both times almost exactly the same pattern of changes made itself apparent in the week following the fog and cold as was observed in 1952 ; namely, rises in mortality at all ages but more especially among the very young and the old, these rises being almost entirely confined to deaths from respiratory and heart diseases. (No very direct comparison is possible between the numbers dying of various causes in 1873 or 1880 and 1952, owing to the very considerable changes in the methods of classification of causes of death which have taken place over the intervening period.)

London deaths in period covering fog in 1873

London population 3,356,073

Mean daily temperature		
Tuesday, 9th December,	29·7°	Hoar frost, overcast during middle of day. Fog varying in density, generally very thick.
Wednesday, 10th December,	24·6°	Overcast with exception of a period during afternoon. Very dense fog throughout. Visibility 10 yards.
Thursday, 11th December,	28·3°	Cloudy in morning and at night. Cloudless during mid-day. Dense fog.
Friday, 12th December,	34·6°	Clouds broken, sunshine at times. Fog prevalent but not so dense.
Saturday, 13th December,	35·3°	Overcast and dull. Foggy at times.

Registered deaths by age

Week ended	*All ages*	*Under 1*	*1–4*	*5–19*	*20–39*	*40–59*	*60 and over*
22nd Nov.	1,674 (1,546)	422	318	118	207	264	345
29th Nov.	1,585 (1,537)	352	319	85	226	244	359
6th Dec.	1,484 (1,558)	370	304	101	173	236	300
13th Dec.	1,759 (1,544)	329	333	90	261	331	415
20th Dec.	2,415 (1,487)	409	427	126	304	452	697
27th Dec.	1,540 (1,542)	281	292	84	221	290	372
3rd Jan.	1,842 (1,542)	401	341	96	226	325	453

Registered deaths by certain causes

Week ended	*All causes*	*Phthisis*	*Bronchitis*	*Pneumonia*	*Heart disease*	*Whooping-cough*
22nd Nov.	1,674	152 (172)	262 (226)	128 (117)	85 (75)	46 (39)
29th Nov.	1,585	136 (163)	285 (235)	127 (107)	72 (72)	34 (40)
6th Dec.	1,484	148 (166)	248 (235)	80 (109)	77 (71)	41 (48)
13th Dec.	1,759	201 (159)	364 (231)	102 (113)	94 (68)	42 (52)
20th Dec.	2,415	205 (157)	632 (208)	163 (94)	145 (70)	70 (54)
27th Dec.	1,540	138 (165)	352 (224)	87 (96)	72 (74)	53 (52)
3rd Jan.	1,842	175 (165)	351 (224)	132 (96)	94 (74)	69 (52)

Figures in brackets are the averages in the corresponding week over the previous ten years.

In early 1880 there appears to have been a whooping-cough epidemic in progress and the deaths from this cause showed a marked increase. In 1880 again the rise in deaths from all causes was greater in the week following the fog than in 1873, although the deaths in the preceding weeks had been running at about the same level in both years. In 1880, however, the fog was associated with slightly colder weather than in 1873 or 1952. Below are shown the rates per million inhabitants of the deaths registered in the weeks following the fogs in these three years.

London deaths in period covering fog in 1880

London population 3,769,390

	Mean daily temperature	
Monday, 20th January,	26·1°	Fog and hoar frost in morning ; fine throughout day.
Tuesday, 27th January,	25·9°	Fog and hoar frost in morning ; fine in afternoon ; foggy at night.
Wednesday, 28th January,	23·4°	Fog prevailed all day ; much hoar frost.
Thursday, 29th January,	24·0°	Dense fog prevailed generally. Much hoar frost.
Friday, 30th January,	39·6°	A very fine day ; cloudless throughout. A rapid thaw.
Saturday, 31st January,	36·7°	Fine ; hoar frost in morning ; fog prevalent, very dense in low grounds.

Registered deaths by age

Week ended	*All ages*	*Under 1*	*1–4*	*5–19*	*20–39*	*40–59*	*60 and over*
10th Jan.	1,754 (1,830)	389	385	128	188	291	373
17th Jan.	1,730 (1,760)	396	359	117	180	251	427
24th Jan.	1,900 (1,761)	466	366	109	214	292	453
30th Jan.	2,200 (1,705)	473	434	112	266	382	533
7th Feb.	3,376 (1,718)	546	593	152	404	664	1,017
14th Feb.	2,495 (1,764)	476	493	140	264	451	671
21st Feb.	2,016 (1,791)	502	402	115	208	310	479

Registered deaths by certain causes

Week ended	*All causes*	*Phthisis*	*Bronchitis*	*Pneumonia*	*Heart disease*	*Whooping-cough*
10th Jan.	1,754	148 (175)	301 (322)	108 (110)	79 (101)	120 (63)
17th Jan.	1,730	149 (176)	347 (306)	113 (102)	74 (94)	114 (64)
24th Jan.	1,900	160 (171)	372 (303)	120 (96)	95 (90)	140 (68)
31st Jan.	2,200	207 (178)	531 (273)	149 (91)	111 (96)	193 (72)
7th Feb.	3,376	313 (186)	1,223 (284)	212 (98)	187 (94)	248 (75)
14th Feb.	2,495	212 (190)	760 (308)	171 (101)	105 (94)	197 (74)
21st Feb.	2,016	159 (191)	479 (312)	148 (102)	84 (95)	171 (80)

Figures in brackets are the averages in the corresponding week over the previous 10 years.

Deaths per million inhabitants in London

Week ended	*20th December, 1873*	*7th February, 1880*	*13th December, 1952*
Number of deaths registered during week per million inhabitants	719	896	739

TABLE B

District nursing associations

Respiratory cases begun day by day 16.11.52—31.12.52

Date	Age					All* ages
	Under 1	1–14	15–44	45–64	65+	
1952						
Nov. 16	–	4	5	4	3	16
„ 17	1	6	10	10	9	36
„ 18	2	14	14	13	9	52
„ 19	1	13	13	8	12	47
„ 20	–	16	12	13	12	53
„ 21	3	16	10	13	13	55
„ 22	3	14	11	5	14	47
„ 23	–	6	2	6	3	17
„ 24	–	8	8	17	18	51
„ 25	1	11	14	12	19	57
„ 26	–	13	10	12	21	56
„ 27	1	12	16	9	15	54
„ 28	1	9	13	19	21	63
„ 29	3	15	14	11	13	56
„ 30	1	6	8	2	7	24
Dec. 1	1	16	14	21	29	81
„ 2	3	12	11	22	21	69
„ 3	2	11	12	21	25	71
„ 4	3	10	10	11	14	48
„ 5	2	18	23	28	27	98
„ 6	1	4	19	15	38	78
„ 7	1	7	7	10	17	42
„ 8	2	11	18	51	91	175
„ 9	3	23	23	54	124	227
„ 10	3	16	26	48	90	184
„ 11	6	16	21	51	86	180
„ 12	4	23	18	30	65	141
„ 13	2	15	12	33	55	117
„ 14	1	6	1	18	15	41
„ 15	1	19	11	32	47	110
„ 16	2	19	21	30	53	125
„ 17	2	14	28	25	39	108
„ 18	4	12	17	26	25	84
„ 19	3	23	13	26	33	98
„ 20	1	17	21	27	31	98
„ 21	–	10	13	12	12	48
„ 22	2	9	16	24	37	88
„ 23	3	12	22	14	26	77
„ 24	2	16	13	14	24	69
„ 25	–	4	5	3	7	19
„ 26	1	5	5	8	6	25
„ 27	5	9	15	15	21	66
„ 28	2	5	9	9	6	31
„ 29	2	14	23	19	39	97
„ 30	2	18	21	30	38	109
„ 31	5	5	13	15	22	60

* *The 'all ages' figures exceed the totals of the individual age groups in certain cases where the patient's age was not given.*

It should be borne in mind that in 1873 and 1880 the general level of winter mortality was higher than it is now ; it was about 450 per million inhabitants per week then compared with about 300 per million inhabitants per week now. On the other hand in both 1873 and 1880 the fogs and cold prevailed during the middle of a week and the deaths which occurred simultaneously would have been registered partly in the week of the fog and only partly in the subsequent week, whereas in December 1952 when the fog prevailed at the week-end the concurrent deaths would almost all have been registered in the subsequent week.

In conclusion it is perhaps worthwhile to reproduce from the Registrar-General's weekly returns the numbers of deaths from all causes registered weekly from 15th November to 27th December, 1952, in the eight towns in the South-Eastern Region outside the London conurbation. These eight towns are Brighton, Canterbury, Eastbourne, Gillingham, Hastings, Hove, Maidstone and Worthing. The weather conditions experienced during this period by these towns were not greatly dissimilar from those experienced by London. But these towns do not disgorge into the air so vast a volume of smoke and noxious fumes as does the conurbation of London. The figures are as follows :

Deaths in the eight towns in South-Eastern Region outside Greater London, 1952

Week ended	*22nd Nov.*	*29th Nov.*	*6th Dec.*	*13th Dec.*	*20th Dec.*	*27th Dec.*
Registered Deaths ..	200	215	194	230	220	191

APPENDIX B

POLIOMYELITIS AND INOCULATIONS

A survey relating to the epidemic in 1949

(By B. Benjamin and A. T. Gore, of the statistical section)

DURING AN epidemic of poliomyelitis in Melbourne, Australia, which began in January, 1949, McCloskey (1) reported an apparent association between the site of paralysis involved in poliomyelitis and the limb in which injections had been given in the course of immunisation against diphtheria and whooping-cough. Consequently, attention was directed to a number of cases in which paralysis followed closely upon inoculation and in which the limb paralysed was that inoculated during the course of the epidemic in this country in the summer of 1949. The coincidence was not in itself proof of cause and effect since association in time could and should occur in accordance with the same laws of chance which also determine that a certain number of people are likely to pass over a railway bridge at the same instant as a train passes under it without being suspected of designing the time-table. In addition to taking certain control action, e.g., stopping the use of the antigen most often involved, the London County Council made an immediate local investigation (as did also the Ministry of Health on a national scale) of these cases of paralysis after inoculation. The immediate object was to ascertain whether the frequency of occurrence of such double events (i.e., inoculation and paralysis) was greater than could be accounted for by chance coincidence. The results of this inquiry, which were made public (2), indicated that there was a *prima facie* case for causal association in a proportion of the cases leaving a proportion to be accounted for by chance.

TABLE 1A—*A.P.T. antigen*

Poliomyelitis in the month of:

Immunised in the month of	*No. at risk*	*1949*												*1950*				*Total*	
		Jan.	*Feb.*	*Mar.*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Jan.*	*Feb.*	*Mar.*		*Observed*	*Expected*
January	863	*0·00* —	*0·01* —	*0·01* —	*0·01* —													—	*0·03*
February ..	1,658	—	*0·00* —	*0·02* —	*0·01* —	*0·02*												—	*0·05*
March	1,711			*0·01* —	*0·02* —	*0·02* —	*0·02* —											—	*0·07*
April	1,315				*0·00* —	*0·01* —	*0·01* —	*0·03* —										—	*0·05*
May	1,545					*0·01* —	*0·01* 1	*0·03* —	*0·63* —									1	*0·68*
June	1,385						*0·01* 1	*0·03* 1	*0·56* —	*0·43* —								2	*1·03*
July	1,280							*0·01* 1	*0·52* 2	*0·40* —	*0·62* —							3	*1·55*
August	1,336								*0·27* 1	*0·41* 2	*0·65* —	*0·39* —						3	*1·72*
September ..	1,381									*0·21* 2	*0·67* 2	*0·40* —	*0·13* —					4	*1·41*
October ..	2,947										*0·72* 1	*0·85* —	*0·28* —	*0·09* —				1	*1·94*
November ..	2,517											*0·36* 1	*0·24* —	*0·08* —	*0·08* —			1	*0·76*
December ..	1,598												*0·07* —	*0·05* —	*0·05* —	*0·05* —		—	*0·22*
							Total diagonals observed							*1·67* 7	*2·84* 8	*2·50* —	*2·50* —	15	*9·51*

Figures in italics are the expected cases calculated from the not inoculated group, see text.

TABLE 1B—*Combined diphtheria and whooping-cough antigen*

Poliomyelitis in the month of:

Immunised in the month of	*No. at risk*	*1949*												*1950*				*Total*	
		Jan.	*Feb.*	*Mar.*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Jan.*	*Feb.*	*Mar.*		*Observed*	*Expected*
January	711	*0·00* —	*0·00* —	*0·01* —	*0·00* —													—	*0·01*
February ..	718		*0·00* —	*0·01* —	*0·00* —	*0·01* —												—	*0·02*
March	1,790			*0·01* —	*0·02* —	*0·02* 1	*0·02* —											1	*0·07*
April	1,708				*0·01* —	*0·02* —	*0·02* —	*0·03* —										—	*0·08*
May	2,030					*0·01* —	*0·02* —	*0·04* —	*0·82* —									—	*0·89*
June	1,714						*0·01* —	*0·03* 2	*0·70* 1	*0·53* —								3	*1·27*
July	2,044							*0·02* 2	*0·83* 2	*0·63* 2	*1·00* 1							7	*2·48*
August ..	2,017								*0·41* 3	*0·63* 8	*0·98* 1	*0·58* —						12	*2·60*
September ..	2,224									*0·34* 8	*1·10* 3	*0·64* —	*0·21* —					11	*2·29*
October ..	707										*0·17* 3	*0·21* —	*0·07* —	*0·02* —				3	*0·47*
November ..	517											*0·07* —	*0·05* —	*0·02* —	*0·02* —			—	*0·16*
December ..	290												*0·01* —	*0·01* —	*0·01* —	*0·01* —		—	*0·04*
							Total diagonals observed							*1·06* 16	*2·93* 15	*3·14* 5	*3·25* 1	37	*10·38*

Figures in italics are the expected cases calculated from the not inoculated group, see text.

TABLE 1C.—*All other antigens*

Poliomyelitis in the month of:

Immunised in the month of	*No. at risk*	*1949*												*1950*				*Total*	
		Jan.	*Feb.*	*Mar.*	*April*	*May*	*June*	*July*	*Aug.*	*Sept.*	*Oct.*	*Nov.*	*Dec.*	*Jan.*	*Feb.*	*Mar.*		*Observed*	*Expected*
January	531	*0·00* —	*0·00* —	*0·01* —	*0·01* —													—	*0·02*
February ..	446		*0·00* —	*0·00* —	*0·00* —	*0·01* —												—	*0·01*
March	647			*0·00* —	*0·01* —	*0·01* —	*0·01* —											—	*0·03*
April	536				*0·00* —	*0·00* —	*0·01* —	*0·01* —										—	*0·02*
May	653					*0·00* —	*0·01* —	*0·01* —	*0·27* —									—	*0·29*
June	681						*0·01* —	*0·01* —	*0·28* —	*0·21* —								—	*0·51*
July	620							*0·01* —	*0·25* —	*0·19* —	*0·31* —							—	*0·76*
August	559								*0·11* —	*0·17* —	*0·27* —	*0·16* —						—	*0·71*
September ..	665									*0·10* —	*0·32* —	*0·19* 1	*0·06* —					1	*0·67*
October ..	485										*0·12* —	*0·14* —	*0·05* —	*0·02* —				—	*0·33*
November ..	522											*0·08* —	*0·05* —	*0·02* —	*0·02* —			—	*0·17*
December ..	361												*0·02* 1	*0·01* —	*0·01* —	*0·01* —		1	*0·05*
							Total diagonals observed							*0·45* 1	*0·97* —	*1·05* 1	*1·10* —	2	*3·57*

Figures in italics are the expected cases calculated from the not inoculated group, see text.

Later Bradford Hill and Knowelden (3) made a thorough analysis of national data the results of which may be summarised as follows :

(*a*) In cases of poliomyelitis the distribution of paralysis by site was abnormal in children who had had an injection of antigen in the month preceding onset of illness. In children not so inoculated or without any recent injection paralysis occurred equally in the right and left arms and paralysis in the legs was between two or three times as frequent as paralysis in the arms. In those inoculated within the preceding twenty-eight days paralysis was more frequently observed in the left arm than in the right arm and paralysis in the arms was more frequent than paralysis in the legs.

(*b*) Comparison of poliomyelitis cases with ' controls ' showed that more of the former had been inoculated at some time. Division by time revealed that this excess lay wholly in inoculations given within the month preceding the onset of the attack of poliomyelitis, suggesting that inoculation had brought some children into the paralysed group who would not otherwise have been there.

In reporting the London County Council data (2) which were similar in sort to those referred to in (*b*) above it was stated that ' these figures suggest that in a few cases poliomyelitis has been associated with inoculation with the combined (diphtheria and whooping-cough) antigen, but they do not measure the risk of an inoculated child being attacked by poliomyelitis. To measure this risk would mean comparing the incidence of poliomyelitis in inoculated and uninoculated infants and would not be easy to do because of difficulty in assessing the proportions of these two groups in the population.' Nevertheless it was considered essential that the difficulties should be faced and that the risks should be assessed as accurately as possible. It was therefore decided to survey inoculations carried out during 1949 in London. A total survey was considered impractical and indeed unnecessary since the numbers involved were so large that a random sample was likely to be statistically adequate. In fact, a one in five sample was made of children who had been inoculated.

In Tables 1A, 1B and 1C are shown cases of poliomyelitis aged nine months to two years in the month in which they occurred related to the month of inoculation and up to the third month following inoculation. This has been tabulated for A.P.T. and the combined antigen separately and for all other antigens together (these are a mixture of P.T.A.P., F.T., T.A.F. and the three proprietary brands of pertussis vaccine). The month of inoculation is the month in which the last injection was given ; earlier injections are ignored. This assumes that if the last injection was given, say seventeen days before onset and the earlier injection, say, forty days before onset, the earlier injection did not influence the incidence of poliomyelitis. Thus the cases of poliomyelitis in these Tables are shown once only in relation to the most recent inoculation ; there is no question of duplicate entries. The last injection may have been a first, second or third primary, i.e., they are entered irrespective of order. In Table 2 is a group labelled ' not inoculated group ' being the residue of poliomyelitis cases not inoculated within *three* months of contraction of poliomyelitis. It is assumed that an injection more than three months before onset of the disease could not have exerted any influence thereon. These then form the numerators in the subsequent calculations. The reason for confining this study to the narrow age limits of 9 months to 1 year 11 months is that the sample survey demonstrated that it is within these ages that immunisation very largely took place in 1949. The age of the children throughout this study is reckoned as the age at the date of inoculation.

The ' exposed to risk ' in these tables are the number of children receiving in any given month the final inoculation of a series with stated antigen. This number has been estimated by taking those who completed a course in the stated month together with an allowance for those who had an inoculation (not the last of a complete course) and who did not return for further inoculations. There remains the calculation of the denominators for the ' not inoculated ' group Table 2. In the inoculated groups, cases of

TABLE 2

Not inoculated, or inoculated three or more months before onset of poliomyelitis

Month	*No. at risk*	*No. of cases of poliomyelitis*	*Rate per 1,000 inoculated*
January	58,487	1	
February	59,269	—	
March	57,203	1	mean rate 0·0090
April	54,966	—	
May	52,843	1	
June	52,085	—	
July	52,089	1	0·0192
August	51,736	21	0·4059
September	51,694	16	0·3095
October	51,335	25	0·4870
November	51,723	15	0·2900
December	53,386	5	0·0937
January	53,954	—	
February	53,741	4	mean rate 0·0313
March	52,295	1	

poliomyelitis have been shown as they occurred in the same month and in the first, second and third months following inoculation, i.e., a total period of four months. Therefore, in construction of the 'exposed to risk' for the 'not inoculated' group, children given a final inoculation in the same month and in the preceding three months should be excluded and this has been done in the Table. The number of children inoculated was derived from the one in five sample census of the entire inoculated 'population' in 1949. The numbers inoculated in the last three months of 1948 and the first three months of 1950 have been estimated on the basis of the 1949 figures. The former are required in the calculation of the exposed to risk in January, February and March, 1949, and the latter for the calculation of the exposed to risk in January, February and March, 1950. From these figures attack rates have been calculated month by month.

These attack rates have been applied to the numbers at risk in the inoculated groups to calculate the expected number of cases, shown in italics against the relative observed number (Tables 1A, 1B and 1C). We have, therefore, month by month, the number of cases observed with the expected number on the basis of the experiences of the 'not inoculated' children at the particular seasonal level of prevalence of poliomyelitis. Correction for seasonal fluctuation of risk has thus been fully carried out. The reason for carrying the calculation of the expected rates into January, February and March, 1950, is to apply these rates to those inoculated in the months of October, November and December, 1949, for the first, second and third months of exposure following inoculation. A comparison of the observed number of cases of poliomyelitis with the expected number (based on the experience of the children not inoculated) for the different antigens used month by month is given in Table 3. This is for all intervals following inoculation aggregated together.

TABLE 3

Poliomyelitis cases by different types of antigens by months of the year with the expected number of cases calculated from the not inoculated group.

Month	*A.P.T.*		*Combined*		*All other antigens*	
	Observed	*Expected*	*Observed*	*Expected*	*Observed*	*Expected*
January ..	—	0·03	—	0·01	—	0·02
February ..	—	0·05	—	0·02	—	0·01
March ..	—	0·07	1	0·07	—	0·03
April ..	—	0·05	—	0·08	—	0·02
May ..	1	0·68	—	0·89	—	0·29
June ..	2	1·03	3	1·27	—	0·51
July ..	3	1·55	7	2·48	—	0·76
August ..	3	1·72	12	2·60	—	0·71
September	4	1·41	11	2·29	1	0·67
October ..	1	1·94	3	0·47	—	0·33
November	1	0·76	—	0·16	—	0·17
December ..	—	0·22	—	0·04	1	0·05

In the early months of the year the number of cases of poliomyelitis was sporadic and the use of any kind of rates at all based on such small data may be held to be not justifiable. However, as poliomyelitis became epidemic in the summer months the comparison becomes more realistic.

In the months of June and July the observed number of cases is nearly twice the expected number for A.P.T. and more than twice as great for the combined antigen; in August the observed number exceeds the expected by 70 per cent. for A.P.T., while, for the combined vaccine, the observed cases are more than four times those expected ; in September the observed cases rise to more than double the expected number for A.P.T. and nearly five times the expected number for the combined antigen ; thereafter both the expected number and the number of inoculated poliomyelitis cases fall rapidly.

By adding up the diagonals of Tables 1A, 1B and 1C it is possible to show the observed and expected number in the same month as inoculation and in the three months following inoculation separately and this is done in Table 4. The average period of exposure to risk will be, for the same month—2 weeks ; for the first, second and third month following inoculation—4 weeks each. Allowance has been made for the average period of exposure of two weeks only in the calculation of the expected rates for the cases of poliomyelitis occurring in the same month as inoculation.

It is apparent, that either for the whole year or the three summer months of high epidemic proportions, the excess of observed cases is concentrated in the same month or

TABLE 4

Poliomyelitis cases by different types of antigen with expected number calculated from the not inoculated group according to the month of inoculation.

Same month		*In the following month*		*In the second month following inoculation*		*In the third month following inoculation*		*Total of the four preceding columns* *	
Obs.	*Exptd.*	*Obs.*	*Exptd.*	*Obs.*	*Exptd.*	*Obs.*	*Exptd.*	*Obs.*	*Exptd.*
					For the year 1949				
					A.P.T.				
7	1·67	8	2·84	—	2·50	—	2·50	15	9·51
					Combined				
16	1·06	15	2·93	5	3·14	1	3·25	37	10·38
					All other antigens				
1	0·45	—	0·97	1	1·05	—	1·10	2	3·57
					For the three months July, August and September only				
					A.P.T.				
4	0·49	5	0·96	—	0·99	—	1·09	9	3·53
					Combined				
13	0·77	12	1·49	3	1·37	—	1·38	28	5·01
					All other antigens				
—	0·22	—	0·43	—	0·48	—	0·49	—	1·62

* *This column shows the total experience of observed and expected cases over the same month and three months following inoculation.*

month following injection, i.e., within six weeks of injection. The proportion of observed to expected cases is summarised below :

Period	*In the same month*	*In the following month*	*In the same month and the month following together*	*In the same month and all the three months following inoculation*
		A.P.T.		
Year 1949	Four times ..	Nearly three times	Three times ..	Slightly less than twice.
July—September only	Eight times ..	Five times ..	Six times ..	Three times.
		Combined antigen		
Year 1949	Fifteen times ..	Five times ..	Eight times ..	Nearly four times.
July—September ..	Seventeen times	Eight times ..	Eleven times..	Five times.

Only with the combined antigen does the excess of expected cases in the same month, the month following inoculation and these two together attain statistical significance both for the year and for the three months of July, August and September; the differences in the A.P.T. figures only attain statistical significance in the case of the same month and the month following inoculation taken together though they should not be ignored merely on that account.

The excess of actual over observed cases declines month by month from the time of

TABLE 5

Site of paralysis related to period since last inoculation by antigens.

Period	Same Site		Included site*		Different site		No record of paralysis		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
			A.P.T.							
Same month	—	—	2	28·6	3	42·8	2	28·6	7	100·0
Following month ..	3	37·5	—	—	—	—	5	62·5	8	100·0
Second month following inoculation	—	—	—	—	—	—	—	—	—	—
Third month following inoculation	—	—	—	—	—	—	—	—	—	—
Total	3	20·0	2	13·3	3	20·0	7	46·7	15	100·0
			Combined							
Same month	10	62·5	3	18·7	1	6·3	2	12·5	16	100·0
Following month ..	8	53·3	6	40·0	1	6·7	—	—	15	100·0
Second month following inoculation	—	—	—	—	—	—	5	100·0	5	100·0
Third month following inoculation	—	—	—	—	—	—	1	100·0	1	100·0
Total	18	48·7	9	24·3	2	5·4	8	21·6	37	100·0

* *Included site means that the site of injection was included in the sites of paralysis.*

inoculation. Thus the excess in the same month is followed by a very much smaller excess in the second month until in the third month following inoculation the relationship between observed and expected is reversed. It seems natural to expect that there would be this kind of inverse correlation since an excessive incidence in the first month would remove some of the more susceptible children from those at risk in subsequent months.

Lastly in Table 5 is shown for A.P.T. and the combined antigen separately the association of paralysis with poliomyelitis of the inoculated cases according to whether it was in the inoculated limb alone, or included that limb or excluded it. The proportions shown under the same or included site for the combined antigen are outstanding, 81 per cent. in the same month and 93 per cent. in the month following inoculation had paralysis involving the limb in which the injection was given. The evidence is not nearly so convincing with the A.P.T. prophylactic.

Earlier in this note it was stated that the object was to measure the risk of an inoculated child being attacked by poliomyelitis. The risk of poliomyelitis without the complication of inoculation is, at the outset, small, 91 cases in a population of 50,000, or 1 in 550 children aged 9 months to 2 years in the course of a year in which the disease reached epidemic proportions. The conclusions to be drawn from this investigation are that in the conditions *pertaining in* 1949 and over the whole year there was an increased risk—nearly four times the normal risk in the three months or so following inoculation—of poliomyelitis following inoculation with the combined diphtheria and pertussis vaccine

but that injections with A.P.T. involved a smaller increase in risk, and one to which less statistical confidence could be attached. In July to September the increase of risk for the combined vaccine was five times and even for A.P.T. the risk may have been multiplied three times. The action taken in discontinuing the use of the combined vaccine during September, 1949, was, therefore, fully justified. It does not follow that these considerations would apply in the face of any future epidemic as the newer combined prophylactics may not be subject to the same risks and it is now the practice in many areas to suspend inoculation during epidemic prevalence of poliomyelitis.

We are indebted to Dr. J. Knowelden, of the London School of Hygiene and Tropical Medicine, for much helpful advice during the protracted course of the calculations involved in this investigation.

References :

1. *McCloskey, B.P. (1950), 'Lancet', 1, 659.*
2. *Proc. of Royal Soc. Med. (1950) Vol. XLIII, No. 4.*
3. *Bradford Hill, A. and Knowelden, J., B.M.J. (1950) vol. ii, p. 1.*

APPENDIX C

STATISTICS

TABLE 1—*Population of the Administrative County of London*, 1921–52

Year	Mid-year estimate of population							Average age
	Total	0–4	5–14	15–24	25–44	45–64	65+	
1921 ..	4,484,523	376,055	809,212	796,590	1,365,546	877,145	259,975	31·2
....								
1926 ..	4,605,400	404,800	746,900	826,300	1,380,400	961,300	285,700	31·9
....								
1931 ..	4,374,300	297,700	646,700	827,940	1,330,200	951,000	320,760	33·4
....								
1936 ..	4,141,100	254,400	576,600	729,500	1,306,100	935,700	338,800	34·5
1937 ..	4,094,500	249,300	555,000	721,800	1,296,800	930,000	341,600	34·7
1938 ..	4,062,800	249,300	538,600	709,700	1,291,200	927,300	346,700	34·8
1939 ..	3,800,300	211,900	457,500	3,130,900				
1940 ..	3,236,600	141,300	232,500	2,862,800				
1941 ..	2,507,800	79,200	142,100	2,286,500				
1942 ..	2,634,800	137,700	234,500	2,262,600				
1943 ..	2,794,200	179,500	282,000	2,332,700				
1944 ..	2,753,600	172,000	302,300	2,279,300				
1945 ..	2,906,900	189,720	311,440	2,405,740				
1946 ..	3,272,500	227,470	353,050	2,691,980				
1947 ..	3,409,300	259,000	364,600	2,785,700				
1948 ..	3,397,900	269,900	359,500	2,768,500				
1949 ..	3,389,850	276,200	367,000	2,746,650				
1950 ..	3,389,620	276,200	370,000	1,437,960		1,305,460		
1951 ..	3,358,000	274,000	381,000	419,000	1,101,000	812,000	371,000	36·9
1952 ..	3,363,000	256,000	400,000	416,000	1,091,000	822,000	378,000	37·1

TABLE 2—*Vital statistics for the Metropolitan Boroughs and the Administrative County of London in the year 1952 (b)*

Metropolitan boroughs arranged in divisional order	*Estimated home population mid 1952*	*Live births*	*Death-rate.*											*Notifications of infectious disease*									
			Deaths	*Infant mortality (per 1,000 live births)*	*Heart disease*	*Other circulatory*	*Cerebral vascular lesions*	*Peptic ulcer*	*Pulmonary tuberculosis*	*Pneumonia*	*Other respiratory diseases*	*Cancer*	*Violence*	*Scarlet fever*	*Diphtheria*	*Poliomyelitis*		*Meningococcal infection*	*Acute pneumonia*	*Measles*	*Whooping cough*	*Tuberculosis*	
																Paralytic	*Non Paralytic*					*Pulmonary*	*Non-pulmonary*
Division 1																							
Chelsea	52,140	15·1	12·8	20	3·53	0·90	1·76	0·12	0·23	0·92	0·71	2·55	0·56	1·17	—	0·23	0·02	0·02	0·31	6·81	1·96	1·59	0·15
Fulham	122,800	14·0	11·9	26	3·26	0·55	1·29	0·20	0·27	0·74	1·31	2·28	0·46	1·11	—	0·10	0·02	0·02	0·21	5·86	0·41	1·56	0·24
Hammersmith ..	118,800	15·0	11·4	21	3·38	0·47	1·35	0·13	0·33	0·56	1·09	2·52	0·26	1·75	—	0·06	0·03	0·05	0·72	12·63	1·99	1·51	0·12
Kensington ..	172,800	16·3	11·2	27	3·27	0·50	1·33	0·14	0·17	0·57	0·75	2·20	0·50	0·63	—	0·10	0·02	0·02	0·41	4·86	1·32	1·31	0·14
Division 2																							
Hampstead ..	97,700	14·9	11·2	24	3·46	0·49	1·47	0·14	0·15	0·34	0·75	2·21	0·53	1·15	—	0·07	0·04	0·01	0·38	5·74	1·98	1·06	0·10
Paddington ..	124,800	16·7	11·6	27	3·42	0·68	1·07	0·21	0·26	0·50	1·03	2·16	0·60	0·84	—	0·06	0·02	0·06	0·62	8·75	0·91	1·93	0·21
St. Marylebone ..	74,290	12·5	15·3	25	4·72	1·10	2·13	0·16	0·19	0·63	1·08	2·79	0·61	0·86	—	0·05	0·04	0·01	0·24	6·00	1·51	1·05	0·11
St. Pancras ..	139,600	15·7	11·9	26	3·14	0·55	1·33	0·11	0·31	0·56	1·20	2·53	0·52	1·01	0·02	0·06	0·11	0·03	0·74	8·45	1·80	1·63	0·20
Westminster, City of..	100,800	12·3	10·9	25	2·99	0·56	1·06	0·17	0·46	0·53	0·73	2·43	0·51	0·45	—	0·07	0·03	—	0·31	7·75	2·31	1·37	0·12
Division 3																							
Finsbury	35,740	19·1	13·4	16	3·53	0·64	0·81	0·20	0·53	0·67	1·76	2·74	0·56	2·27	0·03	—	0·03	—	1·23	13·54	2·24	1·90	0·14
Holborn	23,950	12·2	11·5	34	4·01	0·33	0·75	0·25	0·25	0·50	0·67	2·51	0·58	0·75	—	0·25	—	—	0·17	5·55	1·34	1·92	0·08
Islington	235,300	16·6	12·2	23	3·57	0·59	1·29	0·20	0·30	0·68	1·38	2·39	0·37	1·91	—	0·03	0·03	0·03	1·01	11·75	2·07	1·74	0·23
Division 4																							
Hackney	171,000	14·8	11·5	20	3·47	0·45	1·01	0·25	0·25	0·74	1·22	2·37	0·24	2·29	—	0·05	0·04	0·02	0·40	10·22	1·35	0·98	0·09
Shoreditch ..	45,800	18·1	12·2	28	2·97	0·74	0·96	0·24	0·28	0·74	1·79	2·31	0·37	1·86	0·02	0·04	0·04	0·02	0·72	15·55	2·21	1·22	0·13
Stoke Newington	50,610	16·2	11·0	13	2·92	0·45	0·87	0·30	0·24	0·63	1·17	2·41	0·34	2·21	0·02	0·04	0·02	0·04	0·18	11·05	2·17	0·91	0·08
Division 5																							
Bethnal Green ..	57,040	17·4	12·0	29	2·81	0·72	0·88	0·23	0·33	0·68	1·58	2·52	0·37	3·24	0·04	—	0·04	0·02	0·56	9·66	1·67	1·24	0·14
City of London(*a*)	5,220	7·1	11·9	54	3·07	1·15	1·34	—	0·96	0·96	0·38	2·11	0·57	0·38	—	—	—	—	—	6·13	—	1·72	—
Poplar	72,670	16·8	11·9	24	3·11	0·66	1·10	0·21	0·23	0·65	1·61	2·26	0·43	2·86	—	0·01	0·01	0·03	1·17	11·12	2·49	1·25	0·10
Stepney	99,000	19·1	13·8	18	4·10	0·72	1·15	0·19	0·49	1·01	1·61	2·43	0·54	2·09	—	0·06	0·03	0·03	0·65	12·98	1·57	1·38	0·12
Division 6																							
Deptford.. ..	75,910	17·4	12·0	32	3·66	0·70	1·13	0·14	0·36	0·62	1·42	2·13	0·28	1·84	—	0·01	—	0·03	0·18	11·18	1·84	1·77	0·17
Greenwich ..	90,880	14·3	10·5	15	3·16	0·84	1·11	0·14	0·32	0·53	0·94	1·85	0·39	2·33	0·04	0·07	0·01	0·03	0·20	10·10	2·09	1·07	0·18
Woolwich ..	151,800	14·5	11·0	21	3·41	0·44	1·33	0·14	0·24	0·56	1·00	2·13	0·37	1·71	—	0·16	0·03	0·01	0·81	9·33	2·14	1·14	0·14
Division 7																							
Camberwell ..	181,200	16·1	12·2	24	3·68	0·57	1·31	0·20	0·26	0·40	1·54	2·16	0·37	1·46	—	0·03	—	0·01	0·44	9·74	2·03	2·08	0·13
Lewisham ..	227,100	13·9	11·4	23	3·80	0·38	1·32	0·13	0·15	0·45	1·08	2·13	0·35	1·67	—	0·04	0·03	0·02	0·39	9·61	2·25	1·17	0·18
Division 8																							
Bermondsey ..	59,780	16·7	12·2	19	3·56	1·02	0·99	0·20	0·37	0·74	1·44	2·02	0·45	1·37	0·02	0·02	—	0·03	0·42	11·98	0·67	0·99	0·13
Lambeth	230,200	15·8	12·3	25	3·81	0·64	1·31	0·14	0·26	0·65	1·24	2·16	0·31	1·12	—	0·06	0·02	0·03	0·54	10·28	1·32	1·40	0·15
Southwark ..	97,970	17·7	14·1	28	3·89	1·04	1·48	0·17	0·46	0·91	1·86	2·16	0·41	2·98	0·04	0·04	0·04	0·06	0·59	10·15	1·81	1·68	0·20
Division 9																							
Battersea	116,400	15·2	11·9	18	3·76	0·57	1·32	0·21	0·29	0·55	1·33	2·09	0·43	1·05	0·01	0·07	0·05	0·02	0·97	8·65	1·21	1·47	0·15
Wandsworth ..	331,700	13·2	12·6	20	3·83	0·71	1·34	0·16	0·24	0·54	1·20	2·49	0·34	1·61	—	0·06	0·04	0·01	0·67	6·90	1·21	1·15	0·15
London, 1952 ..	3,363,000	15·3	12·0	23	3·55	0·62	1·27	0·17	0·28	0·61	1·21	2·30	0·41	1·56	0·01	0·06	0·03	0·02	0·57	9·23	1·66	1·40	0·15
London, 1951 ..	3,358,000	15·6	12·6	25	3·87	0·46	1·22	0·19	0·34	0·64	1·26	2·27	0·46	1·10	0·01	0·02	0·02	0·03	0·72	14·64	3·11	1·46	0·15

(*a*) *Including Inner and Middle Temple.*

(*b*) *Rates are per 1,000 home population.*

TABLE 3—*Administrative County of London—Principal vital statistics*, 1891–1952

Period	*Annual rate per 1,000 living*			*Annual mortality per 1,000 living* (b)																*Annual mortality per 1,000*			
												Tuberculosis								*Live births*		*Total births* (c)	
	Live births	*Marriages*	*Deaths (all causes)*	*Meningococcal infection*	*Diphtheria*	*Enteric fever*	*Scarlet fever*	*Smallpox*	*Whooping-cough*	*Measles*	*Influenza*	*Pulmonary*	*Non-pulmonary*	*Pneumonia (all forms)*	*Bronchitis*	*Other resp. diseases*	*Heart disease*	*Cancer*	*Diabetes*	*Infants 0—1*	*Diarrhoea and enteritis 0—2*	*Puerperal fever*	*Other child-birth*
1891–95 ..	30·8	17·3	19·8	(a)	0·53	0·13	0·24	0·02	0·52	0·59	0·41	1·83	0·80	1·45	2·45	0·48	(a)	0·80	0·07	156	23·8	2·15	2·22
1896–1900	29·7	18·4	18·5	(a)	0·45	0·14	0·14	0·00	0·47	0·57	0·27	1·75	0·69	1·32	1·80	0·35	(a)	0·92	0·07	162	41·3	1·70	1·74
1901–05 ..	28·6	17·7	16·4	(a)	0·20	0·08	0·11	0·07	0·36	0·45	0·17	1·58	0·57	1·46	1·41	0·26	1·31	1·01	0·08	139	30·4	1·64	1·52
1906–10 ..	26·5	17·4	14·9	(a)	0·14	0·04	0·10	0·00	0·29	0·42	0·22	1·39	0·48	1·49	1·22	0·22	1·26	1·11	0·10	114	23·8	1·46	1·47
1911–15 ..	24·0	20·0	14·8	0·02	0·13	0·03	0·05	0·00	0·22	0·43	0·16	1·39	0·39	1·33	1·29	0·21	1·54	1·16	0·11	108	28·0	1·40	1·57
1916–20 ..	20·0	20·1	15·1	0·04	0·17	0·02	0·03	0·00	0·20	0·28	1·01	1·43	0·34	1·38	1·30	0·19	1·71	1·28	0·09	92	15·4	1·64	1·72
1921–25 ..	19·9	17·9	12·3	0·01	0·17	0·01	0·04	0·00	0·15	0·17	0·32	1·01	0·19	1·14	0·97	0·16	1·66	1·38	0·10	71	11·7	1·36	1·63
1926–30 ..	16·2	18·6	12·3	0·02	0·10	0·01	0·02	0·00	0·11	0·16	0·30	0·90	0·14	1·00	0·72	0·16	2·29	1·52	0·12	64	10·2	1·60	1·63
1931–35 ..	13·8	19·5	12·1	0·03	0·08	0·00	0·02	0·00	0·07	0·09	0·26	0·79	0·11	0·85	0·47	0·14	2·99	1·66	0·14	63	11·6	0·99	1·38
1936–40 ..	13·7	25·4	13·4	0·02	0·04	0·00	0·01	—	0·04	0·04	0·19	0·72	0·09	0·83	0·67	0·13	3·67	1·87	0·16	56	10·9	0·49	0·97 (d)
1941–45 ..	15·4	23·3	16·0	0·02	0·02	0·00	0·00	—	0·04	0·01	0·14	0·90	0·11	0·91	1·14	0·16	3·99	2·38	0·11	48	8·0	0·28	1·08
1946–50 ..	18·6	22·4	11·8	0·01	0·00	0·00	0·00	0·00	0·02	0·01	0·08	0·53	0·06	0·62	0·87	0·13	3·31	2·10	0·07	32	3·0	0·08	0·53
1951 ..	15·6	20·6	12·6	0·01	0·00	0·00	0·00	—	0·01	0·01	0·24	0·34	0·04	0·64	1·14	0·12	3·87	2·27	0·09	25	0·8	0·06	0·39
1952 ..	15·3	19·9	12·0	0·01	0·00	—	0·00	—	0·00	0·00	0·05	0·28	0·03	0·61	1·09	0·12	3·55	2·30	0·08	23	0·8	0·04	0·63

(a) *Comparable figures are not available for this period.*
(b) *Death-rates from 1939 to 1949 relate to the civilian population only. Death-rates for tuberculosis are expressed per 1,000* total *population in Table 10.*
(c) *The rates are per 1,000 total births from 1928 when still births were first registered. Prior to this year the rates are per 1,000 live births, and are estimated to be approx. 0.05 in excess of the rate per 1,000 total births.*
(d) *From 1931 deaths from abortion are excluded.*

TABLE 4—*Administrative County of London—Civilian deaths in 1952 by cause*

Cause	*Sex*	*0—*	*1—*	*5—*	*15—*	*25—*	*45—*	*65—*	*75+*	*Total*	
										1952	*1951*
1. Tuberculosis—respiratory ..	M	–	–	–	10	117	347	161	49	684	826
	F	–	–	–	23	102	72	21	31	249	328
2. Tuberculosis—other.. ..	M	1	6	2	7	12	9	7	1	45	66
	F	1	4	2	3	11	9	3	8	41	59
3. Syphilitic disease	M	–	–	–	–	4	47	64	29	144	152
	F	–	–	–	1	4	27	20	17	69	73
4. Diphtheria	M	–	–	1	–	–	–	–	–	1	1
	F	–	–	–	–	–	1	–	–	1	1
5. Whooping-cough	M	3	2	1	–	–	–	–	–	6	12
	F	1	1	1	–	–	–	–	–	3	9
6. Meningococcal infection ..	M	5	4	2	–	–	1	–	–	12	13
	F	13	2	–	–	–	1	–	1	17	12
7. Acute poliomyelitis	M	1	–	5	3	7	2	–	–	18	1
	F	1	–	1	2	1	–	–	–	5	1
8. Measles	M	–	3	1	–	–	–	–	–	4	14
	F	–	1	3	–	–	–	–	–	4	11
9. Other infective, &c., diseases	M	2	1	2	1	10	13	8	6	43	60
	F	4	1	4	1	7	17	10	9	53	46
10. Malignant neoplasm: Stomach	M	–	–	–	3	30	223	207	130	593	609
	F	–	–	–	1	22	135	159	189	506	492
11. Malignant neoplasm: Lung, bronchus	M	–	–	–	3	73	673	439	141	1,329	1,284
	F	–	–	–	–	19	127	72	65	283	253
12. Malignant neoplasm: Breast	M	–	–	–	–	–	5	2	2	9	7
	F	–	–	–	–	69	320	178	169	736	714
13. Malignant neoplasm: Uterus	F	–	–	–	1	28	137	67	63	296	279
14. Other malignant and lymphatic neoplasms	M	2	11	11	15	129	628	696	575	2,067	2,086
	F	3	7	8	9	111	532	506	552	1,728	1,732
15. Leukemia, aleukemia and Hodgkins disease	M	–	6	6	3	8	31	25	15	94	87
	F	–	2	6	2	14	30	10	21	85	96
16. Diabetes	M	–	–	1	1	4	19	34	25	84	97
	F	–	–	1	2	6	37	73	76	195	213
17. Vascular lesions, nervous system	M	–	1	3	4	40	365	546	710	1,669	1,618
	F	–	–	1	7	36	451	762	1,332	2,589	2,492
18. Coronary disease, angina ..	M	–	–	–	1	97	1,085	1,111	801	3,095	2,857
	F	–	–	1	1	5	292	702	879	1,880	1,757
19. Hypertension with heart disease	M	–	–	–	–	1	82	164	167	414	775
	F	–	–	–	–	3	70	194	288	555	845
20. Other heart disease	M	2	–	3	8	84	360	581	1,350	2,388	2,718
	F	–	–	–	10	106	350	694	2,454	3,614	4,039
21. Other circulatory disease ..	M	–	–	–	3	18	192	300	425	938	722
	F	–	–	1	4	20	151	290	666	1,132	836
22. Influenza	M	1	1	1	1	5	25	23	29	86	356
	F	–	1	–	2	8	13	15	37	76	453
23. Pneumonia	M	82	18	7	4	31	204	294	399	1,039	1,071
	F	75	23	2	4	19	122	210	543	998	1,065
24. Bronchitis	M	28	6	1	1	20	737	819	729	2,341	2,372
	F	15	3	3	–	20	162	378	740	1,321	1,461
25. Other diseases of respiratory system	M	1	4	4	1	21	101	70	65	267	246
	F	–	2	4	2	9	31	40	56	144	150
26. Ulcer of stomach and duodenum	M	1	–	–	3	32	166	141	84	427	465
	F	–	–	–	1	2	32	51	68	154	166
27. Gastritis, enteritis and diarrhoea	M	22	2	–	2	7	10	10	15	68	83
	F	19	–	1	2	10	17	28	36	113	113
28. Nephritis and nephrosis ..	M	–	4	3	4	41	54	39	31	176	197
	F	–	–	3	5	21	64	39	53	185	210
29. Hyperplasia, prostate ..	M	–	–	–	–	–	35	113	218	366	340

TABLE 4 (*contd.*)—*Administrative County of London—Civilian deaths in* 1952 *by cause*

Case	*Sex*	*0—*	*1—*	*5—*	*15—*	*25—*	*45—*	*65—*	*75+*	*Total*	
										1952	*1951*
30. Pregnancy, childb. : abortn.	F	–	–	–	9	39	1	1	–	50	42
31. Congenital malformations ..	M	96	6	8	5	17	11	7	4	154	198
	F	106	9	4	6	20	16	9	10	180	186
32. Other defined and ill defined	M	425	19	25	27	104	328	275	314	1,517	1,535
diseases	F	245	18	13	24	118	343	309	595	1,665	1,802
33. Motor vehicle accidents ..	M	1	4	9	25	55	16	15	14	139	198
	F	–	4	8	4	14	18	12	22	82	84
34. All other accidents	M	16	17	19	18	91	103	60	98	422	405
	F	15	6	6	7	21	41	55	157	308	407
35. Suicide	M	–	–	–	11	60	116	36	25	248	273
	F	–	–	–	2	34	62	34	4	136	149
36. Homicide, operations of war	M	1	–	2	3	6	4	2	1	19	10
	F	1	–	3	1	1	1	2	–	9	8
ALL CAUSES	M	690	115	117	167	1,124	5,992	6,249	6,452	20,906	21,754
	F	499	84	76	136	900	3,682	4,944	9,141	19,462	20,584

TABLE 5—*Administrative County of London, Live births and Still-births,* 1931–52

Year	*Live births*		*Still-births*	
	No.	*Rate per 1,000 total population*	*No.*	*Rate per 1,000 live and still-births*
1931	65,684	14·9	2,205	32·5
1932	62,233	14·3	1,987	30·9
1933	56,743	13·2	1,934	33·0
1934	56,853	13·4	1,844	31·4
1935	55,780	13·3	1,854	32·2
1936	56,273	13·6	1,857	31·9
1937	55,011	13·4	1,864	32·8
1938	54,495	13·4	1,711	30·4
1939	52,366	13·4	1,579	29·3
1940	46,213	14·3	1,405	29·5
1941	33,944	13·5	1,046	29·9
1942	40,654	15·4	1,225	29·3
1943	45,030	16·1	1,137	24·6
1944	44,554	16·2	1,138	24·9
1945	45,532	15·7	1,095	23·5
1946	65,883	20·0	1,598	23·7
1947	71,323	20·9	1,554	21·3
1948	60,934	17·9	1,191	19·2
1949	56,545	16·7	1,134	19·7
1950	53,281	15·7	1,054	19·4
1951	52,387	15·6	1,073	20·1
1952	51,558	15·3	1,008	19·2

TABLE 6—*Administrative County of London—Infant mortality*, 1952

Cause of death		Age at death				Total			Rates per 1,000 live births		
		Under 1 day	1 to 7 days	1 to 4 wks.	4 wks. to 1 yr.	No.	Male	Female	Total	Male	Female
Measles	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Whooping-cough	Leg.	—	—	—	4	4	3	1	0·08	0·11	0·04
	Illeg.	—	—	—							
Influenza	Leg.	—	—	—	1	1	1	—	0·02	0·04	—
	Illeg.	—	—	—							
Tuberculosis	Leg.	—	—	—	2	2	1	1	0·04	0·04	0·04
	Illeg.	—	—	—							
Bronchitis	Leg.	—	2	1	40	43	28	15	0·83	1·06	0·60
	Illeg.	—	—	—							
Pneumonia	Leg.	3	26	23	101	157	82	75	3·05	3·10	2·99
	Illeg.	—	2	2							
Diarrhoea	Leg.	—	—	2	39	41	22	19	0·80	0·83	0·76
	Illeg.	—	—	—							
Premature birth	Leg.	109	65	11	7	216	142	74	4·19	5·37	2·95
	Illeg.	13	11	—							
Congenital malformation	Leg.	32	42	35	84	202	96	106	3·92	3·63	4·22
	Illeg.	4	4	1							
Birth injury	Leg.	68	53	5	4	145	93	52	2·81	3·52	2·07
	Illeg.	8	4	3							
Other diseases of early infancy	Leg.	131	84	12	8	260	155	105	5·04	5·86	4·18
	Illeg.	17	8	—							
Other causes	Leg.	6	6	11	82	118	67	51	2·29	2·53	2·03
	Illeg.	12	1	—							
All causes	Leg. M.	211	172	54	177	1,070	614	456	22·30	24·98	19·48
	F.	138	106	46	166						
	Illeg. M.	34	19	3	20	119	76	43	33·27	40·55	25·25
	F.	20	11	3	9						
TOTAL, 1952		403	308	106	372	1,189	690	499	23·06	26·08	19·87
TOTAL 1951		415	363	129	426	1,333	760	573	25·45	28·37	22·38
1951	Leg. M.	195	209	72	222	1,207	698	509	24·74	27·99	21·34
	F.	161	124	45	179						
	Illeg. M.	23	16	10	13	126	62	64	35·03	33·48	36·66
	F.	36	14	2	12						

TABLE 7—*Administrative County of London—Infant mortality by cause*, 1915–1952

(Rates per 1,000 live births)

Cause of death	1915 to 1918	1919 to 1922	1923 to 1926	1927 to 1930	1931 to 1934	1935 to 1938	1939 to 1942	1943 to 1946	1947	1948	1949	1950	1951	1952
Measles	3·84	1·64	2·02	2·07	1·44	0·95	0·22	0·21	0·11	0·11	0·05	—	0·13	—
Whooping-cough	4·45	2·50	2·60	3·14	2·27	2·01	1·43	1·07	0·76	0·67	0·35	0·39	0·17	0·08
Influenza	1·10	0·81	0·38	0·48	0·40	0·24	0·39	0·29	0·17	0·07	0·27	0·17	0·15	0·02
Tuberculosis	3·20	1·52	1·26	0·89	0·77	0·56	0·63	0·36	0·35	0·28	0·09	0·17	0·08	0·04
Bronchitis	6·72	4·42	2·91	2·30	2·16	1·97	1·81	1·36	0·94	1·03	0·64	0·83	0·95	0·83
Pneumonia	14·96	12·60	11·51	12·10	11·45	10·39	7·64	6·74	5·61	4·37	3·31	2·36	2·41	3·05
Diarrhoea	16·10	12·16	9·36	8·87	10·86	12·10	6·96	6·93	4·30	2·54	1·54	1·16	0·76	0·80
Premature birth	17·42	17·00	14·74	14·17	14·91	13·41	12·51	10·38	7·21	6·76	6·31	4·65	4·71	4·19
Congenital mal., etc.	14·66	11·26	8·39	7·38	7·22	6·35	10·08	11·96	10·75	11·27	11·30	12·33	12·35	11·77
Other causes	20·55	15·09	11·83	12·60	13·52	12·30	8·14	5·83	4·21	3·56	2·97	3·68	3·72	2·29
All causes	103	79	65	64	65	60	50	45	34	31	27	26	25	23

TABLE 8—*Administrative County of London and England and Wales—Maternal mortality (excluding abortion)—1943–52*

(Rates per 1,000 total births)

	1943	*1944*	*1945*	*1946*	*1947*	*1948*	*1949*	*1950*	*1951*	*1952*
Puerperal sepsis :										
London	0·24	0·17	0·26	0·12	0·12	0·13	0·02	—	0·06	0·13
England and Wales ..	0·39	0·28	0·24	0·18	0·16	0·13	0·11	0·12	0·10	0·09
Other causes :										
London	1·06	0·85	1·09	0·80	0·55	0·37	0·38	0·53	0·39	0·53
England and Wales ..	1·44	1·24	1·23	1·06	0·86	0·73	0·71	0·60	0·56	0·50

TABLE 9—*Administrative County of London—Primary notifications of, and deaths from, tuberculosis—1921–52 (a)*

Year	*Pulmonary tuberculosis*				*Non-pulmonary tuberculosis*			
	Formal Primary notifications		*Deaths*		*Formal primary notifications*		*Deaths*	
	No.	*Annual rate per 1,000 living*	*No.*	*Annual rate per 1,000 living*	*No.*	*Annual rate per 1,000 living*	*No.*	*Annual rate per 1,000 living*
1921–25 ..	38,807	1·71	22,980	1·01	10,881	0·48	4,383	0·19
1926–30 ..	34,353	1·53	20,247	0·90	8,971	0·40	3,080	0·14
1931–35 ..	29,569	1·38	17,075	0·79	6,322	0·29	2,354	0·11
1936 ..	5,176	1·25	2,849	0·69	1,056	0·26	363	0·09
1937 ..	5,455	1·33	2,888	0·71	1,014	0·25	351	0·09
1938 .	5,200	1·28	2,590	0·64	982	0·24	347	0·09
1939 ..	4,691	1·24	2,650	0·70	805	0·21	302	0·08
1940 ..	4,326	1·34	2,687	0·83	653	0·20	318	0·10
1941 ..	4·577	1·83	2,552	1·02	675	0·27	343	0·14
1942 ..	4,734	1·80	2,164	0·82	796	0·30	283	0·11
1943 ..	5,066	1·82	2,204	0·79	782	0·28	256	0·09
1944 ..	5,056	1·84	2,073	0·75	673	0·24	237	0·09
1945 ..	4,893	1·68	2,033	0·70	614	0·21	224	0·08
1946 ..	5,137	1·57	1,940	0·59	611	0·19	243	0·07
1947 ..	5,421	1·58	2,044	0·60	662	0·19	252	0·07
1948 ..	5,473	1·61	1,900	0·56	600	0·18	202	0·06
1949 ..	5,699	1·68	1,585	0·47	553	0·16	156	0·05
1950 ..	5,189	1·53	1,225	0·36	529	0·16	122	0·04
1951 ..	4,897	1·46	1,154	0·34	507	0·15	125	0·04
1952 ..	4,713	1·40	933	0·28	518	0·15	86	0·03

(a) *Excluding posthumous cases.*

TABLE 10(*a*)—*Administrative County of London—Primary notification of tuberculosis*, 1952

Form of tuberculosis notified	*Sex*	*Number of formal primary notifications of new cases of tuberculosis*											*Total all ages*
		0–	*1–*	*5–*	*10–*	*15–*	*20–*	*25–*	*35–*	*45–*	*55–*	*65+*	
Pulmonary tuberculosis ..	M.	6	79	72	37	221	276	586	466	427	332	211	2,713
	F.	9	79	70	49	239	377	610	275	155	81	56	2,000
Other forms of tuberculosis..	M.	2	24	34	22	16	23	46	18	14	12	10	221
	F.	1	20	21	13	20	46	81	37	28	15	15	297
All forms of tuberculosis ..	M.	8	103	106	59	237	299	632	484	441	344	221	2,934
	F.	10	99	91	62	259	423	691	312	183	96	71	2,297

TABLE 10(*b*)—*Numbers on the registers*, 1942–52

	1942	*1943*	*1944*	*1945*	*1946*	*1947*	*1948*	*1949*	*1950*	*1951*	**1952*
Cases on the register at the end of the year:											
Pulmonary—											
Males	12,894	13,608	14,340	15,018	15,695	16,374	17,224	18,203	19,090	19,119	17,336
Females	9,441	10,232	10,990	11,496	12,262	12,862	13,549	14,223	15,031	15,556	14,672
Other forms :											
Males	2,785	2,847	2,866	2,813	2,821	2,699	2,889	2,752	2,591	2,520	1,530
Females	2,963	3,074	3,185	3,123	3,099	3,142	3,147	3,015	3,068	2,954	1,850
Total	28,083	29,761	31,381	32,450	33,877	35,077	36,809	38,193	39,780	40,149	35,388
No. per 1,000 of population	11·7	11·9	12·7	12·5	10·9	10·6	11·0	11·3	11·7	12·0	10·5

* *On the chest clinic registers. Prior to 1952 numbers supplied by the metropolitan borough councils under the Tuberculosis Regulations, 1930, now rescinded.*

TABLE 11(*a*)—*Administrative County of London—Primary notification of tuberculosis, 1946–52, by age and sex*

Rates per 1,000 *living*

(i) PULMONARY

Sex	*Age*	*1946*		*1947*		*1948*		*1949*		*1950*		*1951*		*1952*	
		No.	*Rate*	*No.*	*Rate*	*No.*	*Rate*	*No.*	*Rate*	*No.*	*Rate*	*No.*	*Rate*	*No.*	*Rate*
Males ..	0—4	105	0·90	108	0·81	149	1·08	153	1·08	162	1·15	137	0·98	85	0·65
	5—14	175	0·98	187	1·01	158	0·87	153	0·82	141	0·75	143	0·74	109	0·53
	15—44	1,787	2·61	1,809	2·56	1,873	2·66	1,886	2·70	1,711	2·46	1,574	2·18	1,549	2·16
	45+	849	1·45	973	1·61	957	1·60	1,093	1·84	945	1·59	969	1·91	970	1·88
	All males..	2,916	1·87	3,077	1·89	3,137	1·93	3,285	2·03	2,959	1·83	2,823	1·80	2,713	1·73
Females ..	0—4	81	0·73	96	0·76	124	0·94	126	0·94	116	0·86	123	0·92	88	0·70
	5—14	177	1·01	174	0·96	171	0·96	188	1·04	140	0·77	127	0·68	119	0·61
	15—44	1,682	2·32	1,811	2·41	1,797	2·40	1,821	2·45	1,740	2·34	1,582	1·98	1,501	1·90
	45+	281	0·40	263	0·36	244	0·34	279	0·39	234	0·33	242	0·36	292	0·43
	All females	2,221	1·30	2,344	1·32	2,336	1·32	2,414	1·36	2,230	1·26	2,074	1·16	2,000	1·11
Total ..		5,137	1·57	5,421	1·59	5,473	1·61	5,699	1·68	5,189	1·53	4,897	1·46	4,713	1·40

(ii) NON-PULMONARY

Males ..	0—4	43	0·369	69	0·520	55	0·398	39	0·275	34	0·241	29	0·207	26	0·198
	5—14	89	0·499	87	0·472	87	0·479	75	0·404	50	0·265	57	0·294	56	0·275
	15—44	143	0·209	118	0·167	116	0·165	109	0·156	114	0·164	103	0·143	103	0·144
	45+	24	0·041	36	0·060	29	0·048	32	0·054	29	0·049	27	0·053	36	0·070
	All males..	299	0·191	310	0·190	287	0·177	255	0·157	227	0·140	216	0·138	221	0·141
Females ..	0—4	44	0·397	56	0·444	38	0·289	42	0·312	40	0·296	36	0·269	21	0·168
	5—14	96	0·550	71	0·394	69	0·388	68	0·375	49	0·271	48	0·257	34	0·173
	15—44	144	0·198	190	0·253	171	0·229	159	0·214	183	0·247	178	0·223	184	0·233
	45+	28	0·040	35	0·048	35	0·049	29	0·041	30	0·042	29	0·043	58	0·085
	All females	312	0·183	352	0·198	313	0·176	298	0·168	302	0·171	291	0·162	297	0·165
Total ..		611	0·187	662	0·194	600	0·177	553	0·163	529	0·156	507	0·150	518	0·154

TABLE 11(*b*)—*Deaths from tuberculosis by age and sex*

(i) PULMONARY

Males ..	0—4	16	0·14	12	0·09	8	0·06	3	0·02	7	0·05	3	0·02	—	—
	5—14	7	0·04	9	0·05	2	0·01	1	0·01	1	0·01	—	—	—	—
	15—44	484	0·71	495	0·70	463	0·66	323	0·46	236	0·34	196	0·27	127	0·18
	45+	731	1·25	748	1·24	762	1·27	719	1·21	585	0·99	627	1·23	557	1·08
	All males..	1,238	0·79	1,264	0·78	1,235	0·76	1,046	0·65	829	0·51	826	0·53	684	0·44
Females ..	0—4	9	0·08	13	0·10	7	0·05	4	0·03	—	—	3	0·02	—	—
	5—14	5	0·03	8	0·04	6	0·03	4	0·02	2	0·01	3	0·02	—	—
	15—44	498	0·68	527	0·70	487	0·65	342	0·46	238	0·32	171	0·21	125	0·16
	45+	190	0·27	232	0·32	165	0·23	189	0·26	156	0·22	151	0·22	124	0·18
	All females	702	0·41	780	0·44	665	0·37	539	0·30	396	0·22	328	0·18	249	0·14
Total ..		1,940	0·59	2,044	0·60	1,900	0·56	1,585	0·47	1,225	0·36	1,154	0·34	933	0·28

(ii) NON-PULMONARY

Males ..	0—4	31	0·266	30	0·226	26	0·188	13	0·092	6	0·043	10	0·071	7	0·053
	5—14	25	0·140	20	0·109	10	0·055	12	0·065	6	0·032	6	0·031	2	0·010
	15—44	38	0·056	44	0·062	38	0·054	36	0·052	25	0·036	29	0·040	19	0·027
	45+	22	0·048	38	0·063	29	0·048	34	0·057	25	0·042	21	0·041	17	0·033
	All males..	116	0·074	132	0·081	103	0·063	95	0·059	62	0·038	66	0·042	45	0·029
Females ..	0—4	33	0·298	19	0·151	23	0·175	16	0·119	10	0·074	9	0·067	5	0·040
	5—14	20	0·115	16	0·089	11	0·062	7	0·039	7	0·039	9	0·048	2	0·010
	15—44	44	0·061	48	0·064	35	0·047	20	0·027	16	0·022	15	0·019	14	0·018
	45+	30	0·043	37	0·051	30	0·042	18	0·025	27	0·038	26	0·039	20	0·029
	All females	127	0·074	120	0·067	99	0·056	61	0·034	60	0·034	59	0·033	41	0·023
Total ..		243	0·074	252	0·074	202	0·059	156	0·046	122	0·036	125	0·037	86	0·026

TABLE 12—*Administrative County of London—Primary notification of non-pulmonary tuberculosis 1946–51, distribution according to site*

Rates per 1,000 living are shown in parentheses against the number of cases

Age group	Year	Site of tuberculosis lesion					
		Bones and Joints	Abdomen	Peripheral glands	Meninges	Other sites (a)	Total
1. Under 15	1946	58 (0·100)	25 (0·043)	110 (0·189)	44 (0·076)	35 (0·060)	272 (0·468)
	1947	53 (0·085)	26 (0·042)	115 (0·184)	63 (0·101)	26 (0·042)	283 (0·454)
	1948	54 (0·086)	17 (0·027)	97 (0·154)	50 (0·079)	31 (0·049)	249 (0·395)
	1949	56 (0·087)	13 (0·020)	68 (0·106)	63 (0·098)	26 (0·040)	226 (0·351)
	1950	51 (0·079)	15 (0·023)	54 (0·084)	36 (0·056)	17 (0·026)	173 (0·268)
	1951	30 (0·046)	4 (0·006)	62 (0·095)	49 (0·075)	25 (0·038)	170 (0·260)
2. Over 15 years of age.	1946	103 (0·038)	38 (0·014)	83 (0·031)	20 (0·008)	95 (0·035)	339 (0·126)
	1947	110 (0·040)	53 (0·019)	87 (0·031)	15 (0·005)	114 (0·041)	379 (0·136)
	1948	111 (0·040)	36 (0·013)	82 (0·030)	22 (0·008)	100 (0·036)	351 (0·127)
	1949	107 (0·039)	42 (0·015)	77 (0·028)	13 (0·005)	88 (0·032)	327 (0·119)
	1950	94 (0·034)	43 (0·016)	91 (0·033)	22 (0·008)	106 (0·039)	356 (0·130)
	1951	107 (0·040)	37 (0·014)	97 (0·036)	17 (0·006)	98 (0·036)	356 (0·132)

(a) *Includes miliary and genito-urinary.*

Information not available for 1952 owing to change in the regulations governing the notification of tuberculosis.

TABLE 13—*Administrative County of London—Cases of infectious illness reported from schools in 1952 and preceding years*

Year	Chicken-pox	Diphtheria	German measles	Impetigo	Measles	Mumps	Ophthalmia and conjunctivitis	Poliomyelitis	Ringworm	Scabies	Scarlet fever	Whooping-cough
1938 ..	11,018	3,576	2,383	1,018	31,852	4,805	342	—	278	2,718	3,988	4,067
1946 ..	5,602	290	349	381	8,291	5,296	251	5	245	1,488	1,654	2,421
1947 ..	7,423	263	1,571	264	6,684	2,845	233	153	180	650	1,974	3,660
1948 ..	7,745	187	491	243	11,545	9,162	297	34	119	323	2,078	3,691
1949 ..	5,528	135	313	178	7,651	2,113	361	132	71	120	2,359	1,814
1950 ..	7,773	63	312	151	7,495	7,638	275	91	79	106	1,925	4,039
1951 ..	16,756	26	2,193	212	15,045	6,127	1,685	29	138	73	1,811	3,338
1952 ..	14,281	31	16,115	266	13,127	8,391	1,245	70	138	93	3,042	2,028

TABLE 16—*School leavers contra-indications for employment (a)*

Contra-indications	*Boys*		*Girls*	
	No.	*Per cent. of inspected pupils (11,779)*	*No.*	*Per cent. of inspected pupils (11,480)*
Heavy manual work	280	2·4	267	2·3
Sedentary work	24	0·2	22	0·2
Indoor work	8	0·1	16	0·1
Exposure to bad weather	170	1·4	234	2·0
Wide changes of temperature	69	0·6	74	0·6
Work in damp atmosphere	108	0·9	136	1·2
Work in dusty atmosphere	125	1·1	109	0·9
Much stooping	27	0·2	29	0·3
Climbing	84	0·7	87	0·8
Work near moving machinery or moving vehicles	73	0·6	50	0·4
Prolonged standing, much walking or quick movement from place to place	155	1·3	187	1·6
Eye strain	800	6·8	1,192	10·4
Normally acute vision	774	6·6	731	6·4
Normal use of hands	4	(0·03)	10	0·1
Work requiring freedom from damp hands or skin defects	16	0·1	30	0·3
Handling or preparation of food	61	0·5	78	0·7
Normal hearing	53	0·4	45	0·4
Any other work which would be unsuitable	20	0·2	16	0·1
No. of pupils with contra-indications (*b*)	1,716	14·6	1,784	15·5

(a) *Excluding special schools and certain grammar schools at which the leaver contra-indications slip is not in use.*
(b) *The total number of contra-indications is greater than the number of pupils since an individual may be noted for two or more contra-indications.*

TABLE 14.—*Administrative County of London—Notifiable infectious diseases—Annual number of notifications and numbers per 1,000 of population—1933–1952*

Year	Anthrax		Meningococcal infection		Continued fever		Diphtheria		Dysentery		Acute Encephalitis		Enteric fever		Erysipelas		Malaria		Measles		Ophthalmia neonatorum		Pneumonia		Poliomyelitis		Puerperal pyrexia		Scabies		Scarlet fever		Smallpox		Typhus		Whooping-cough		Food poisoning	
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
1933 ..	3	0·0007	216	0·050	5	0·001	9,557	2·23	31	0·007	22	0·005	164	0·038	2,766	0·645	21	0·005	(b)	—	527	(f) 9·31	6,299	1·469	66	0·015	838	(a) 14·28	(b)	—	21,911	5·11	531	0·124	—	—	(b)	—	(b)	—
1934 ..	3	0·0007	137	0·032	4	0·0009	11,782	2·79	58	0·014	29	0·007	109	0·026	2,586	0·613	30	0·007	(b)	—	467	8·24	5,569	1·320	74	0·018	758	12·91	(b)	—	18,238	4·32	144	0·034	—	—	(b)	—	(b)	—
1935 ..	2	0·0005	105	0·025	3	0·0007	9,294	2·23	199	0·048	15	0·004	187	0·045	1,868	0·448	37	0·009	(b)	—	382	6·87	3,707	0·888	85	0·020	652	11·31	(b)	—	10,954	2·63	—	—	—	—	(b)	—	(b)	—
1936 ..	—	—	113	0·027	4	0·001	7,030	1·68	304	0·072	12	0·003	255	0·061	1,815	0·432	35	0·008	(b)	—	462	8·10	4,141	0·986	38	0·009	635	10·92	(b)	—	10,705	2·55	—	—	—	—	(b)	—	(b)	—
1937 ..	3	0·0007	175	0·043	6	0·001	7,810	1·91	916	0·224	8	0·002	216	0·053	1,764	0·432	42	0·010	(b)	—	433	8·26	4,798	1·175	108	0·026	793	13·94	(b)	—	8,455	2·07	—	—	—	—	(b)	—	(b)	—
1938 ..	4	0·001	182	0·045	1	0·0002	7,611	1·88	1,049	0·259	5	0·001	191	0·047	1,829	0·451	16	0·004	282 (c)	0·28	489	9·00	3,962	0·978	134	0·033	853	15·18	(b)	—	8,093	2·00	—	—	—	—	1,891 (c)	1·87	(b)	—
1939 ..	3	0·0008	169	0·045	3	0·0008	3,671	0·974	268	0·071	11	0·003	98	0·026	1,388	0·368	17	0·005	1,303	0·35	408	8·07	3,733	0·990	98	0·026	704	13·05	(b)	—	5,677	1·51	—	—	—	—	10,537	2·80	(b)	—
1940 ..	3	0·001	839	0·274	6	0·002	1,844	0·601	161	0·052	8	0·003	158	0·052	1,076	0·351	16	0·005	5,447	1·78	303	7·10	2,688	0·876	20	0·007	472	10·66	(b)	—	2,498	0·81	—	—	—	—	669	0·218	(b)	—
1941 ..	1	0·0004	706	0·298	2	0·0008	2,179	0·921	610	0·258	10	0·004	210	0·089	1,171	0·495	13	0·005	11,039	4·67	185	6·67	2,518	1·064	41	0·017	340	12·06	(b)	—	2,372	1·00	—	—	—	—	7,944	3·36	(b)	—
1942 ..	1	0·0004	341	0·142	1	0·0004	1,813	0·756	749	0·312	3	0·001	67	0·028	1,034	0·431	16	0·007	19,987	8·33	210	5·18	2,246	0·936	25	0·010	505	12·06	(b)	—	4,416	1·84	2	0·0008	—	—	6,234	2·60	(b)	—
1943 ..	4	0·002	231	0·093	1	0·0004	1,862	0·747	1,103	0·442	4	0·002	47	0·019	1,054	0·423	35	0·014	22,882	9·18	233	5·19	3,159	1·267	43	0·017	471	10·20	9,689 (d)	9·18	9,477	3·80	—	—	—	—	6,661	2·67	(b)	—
1944 (e) ..	—	—	150	0·061	—	—	758	0·308	1,450	0·589	2	0·0008	30	0·012	916	0·372	78	0·032	7,329	2·98	211	4·74	2,292	0·931	17	0·006	399	8·73	16,450	6·70	3,862	1·57	2	0·0008	—	—	7,136	2·90	(b)	—
1945 (e) ..	—	—	145	0·056	1	0·0004	801	0·308	1,867	0·718	3	0·001	28	0·011	818	0·314	93	0·036	23,486	9·03	222	4·88	1,930	0·742	63	0·024	515	11·05	14,753	5·69	4,079	1·57	3	0·001	3	0·001	3,264	1·25	(b)	—
1946 (e) ..	—	—	184	0·059	—	—	747	0·240	845	0·272	6	0·002	44	0·014	844	0·271	168	0·054	22,846	7·35	268	4·08	2,123	0·683	29	0·009	553	8·19	11,892	3·84	4,402	1·42	2	0·0006	—	—	6,887	2·22	(b)	—
1947 (e) ..	2	0·0006	166	0·050	—	—	451	0·136	309	0·093	7	0·002	48	0·015	742	0·224	47	0·014	17,486	5·28	231	3·24	2,110	0·638	702	0·212	441	6·05	5,304	1·60	4,331	1·31	3	0·001	1	0·0003	9,267	2·80	(b)	—
1948 (e) ..	1	0·0003	110	0·033	1	0·0003	335	0·100	704	0·211	1	0·0003	48	0·014	719	0·215	33	0·010	30,608	9·17	224	3·68	1,891	0·566	141	0·042	460	7·40	2,484	0·74	4,568	1·37	—	—	—	—	10,450	3·13	(b)	—
1949 (e) ..	3	0·0009	76	0·023	—	—	221	0·065	440	0·130	4	0·001	58	0·017	583	0·173	21	0·006	28,816	8·54	186	3·29	1,858	0·550	668	0·198	433	7·51	1,311	0·39	4,945	1·46	3	0·001	—	—	5,754	1·70	630	0·19
																									Paralytic		Non-par.													
																									Cases	Rate	Cases	Rate												
1950 (e) ..	2	0·0006	90	0·027	—	—	81	0·024	960	0·283	18	0·005	63	0·019	566	0·167	20	0·006	22,282	6·57	145	2·72	1,691	0·499	267	0·079	163	0·048	371	6·83	823	0·24	4,157	1·23	—	—	—	—	10,875	3·21	863	0·25
1951 (e) ..	1	0·0003	108	0·032	—	—	30	0·009	4,069	1·212	19	0·006	66	0·020	496	0·148	23	0·007	49,148	14·64	93	1·78	2,409	0·717	61	0·018	51	0·015	911	(g) 17·04	572	0·17	3,705	1·10	—	—	1	0·0003	10,448	3·11	787	0·23
1952 (e) ..	—	—	82	0·024	1	0·0003	18	0·005	1,704	0·507	21	0·006	25	0·007	467	0·139	22	0·007	31,055	9·23	202	3·92	1,908	0·567	204	0·061	105	0·031	1,860	35·38	535	0·16	5,263	1·56	—	—	—	—	5,587	1·66	612	0·18

(a) Rate per 1,000 total births. (b) Comparable figures not available for this period. (c) Cases relate to last quarter only—Rates are adjusted on an annual basis. (d) Cases relate to last 22 weeks only—Rates are adjusted on an annual basis. (e) In order to preserve uniformity with published national figures the recently instituted practice of the Registrar-General has been followed in producing this table, namely in taking full account of any known changes in diagnosis after the receipt of the original notification. These corrections were not available prior to 1944. Comparable figures can be obtained by the method given in the footnote to this table in previous annual reports. (f) Rate per 1,000 live births. (g) For cause of increase since 1950 see page 15.

TABLE 15—*Administrative County of London—Notification of certain Infectious Diseases Distribution by age and date of notification—53 weeks commencing week ended 5th January, 1952*

Four weekly periods 1952	*Meningococcal infection*				*Dysentery*				*Measles*				*Pneumonia*				*Poliomyelitis*								*Scarlet fever*				*Whooping-cough*			
																	Paralytic				*Non-paralytic or not stated*											
	Ages				*Ages*				*Ages*				*Ages*				*Ages*				*Ages*				*Ages*				*Ages*			
	0—4	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*	*0—4*	*5—14*	*15+*	*Total*
1— 4 ..	2	4	1	7	60	20	66	150	76	71	14	161	52	20	163	237	3	1	4	8	1	1	—	2	99	202	10	311	220	101	5	327
5— 8 ..	6	2	2	10	128	55	63	249	115	185	34	334	31	21	134	188	1	—	2	3	2	—	1	3	128	339	21	488	271	122	8	402
9—12 ..	6	4	4	14	97	62	66	228	213	537	63	813	23	21	131	176	—	—	—	—	—	1	1	2	116	343	29	492	306	203	6	515
13—16 ..	7	5	2	14	128	40	56	226	347	560	89	998	17	28	129	176	—	—	1	1	1	1	—	2	94	240	16	351	317	180	6	504
17—20 ..	7	2	1	10	54	43	66	163	504	475	63	1,045	16	19	123	159	3	1	—	4	1	—	—	1	75	133	19	229	403	236	10	652
21—24 ..	2	3	—	5	49	27	33	109	967	1,131	29	2,134	8	13	50	71	2	3	—	5	2	3	3	8	76	184	6	266	327	165	10	503
25—28 ..	1	1	1	3	74	27	20	123	1,559	1,172	31	2,765	7	12	47	67	7	2	3	12	6	4	2	12	102	253	10	365	250	171	9	433
29—32 ..	3	—	2	5	25	8	17	50	1,796	1,606	26	3,438	13	8	31	52	14	21	14	49	10	17	6	33	102	229	12	343	251	130	2	391
33—36 ..	2	—	—	2	39	13	26	80	1,447	545	19	2,017	5	8	30	43	9	10	16	35	7	11	16	34	78	92	10	180	260	118	6	385
37—40 ..	5	1	—	6	40	20	26	87	795	616	9	1,422	14	10	46	70	7	8	9	24	4	8	5	17	99	252	9	363	225	95	3	324
41—44 ..	1	2	—	3	28	12	17	57	1,902	2,061	23	3,999	18	18	104	140	5	3	5	13	1	8	2	11	185	428	7	621	163	86	5	254
45—48 ..	4	1	1	6	47	18	28	99	2,469	2,361	38	4,880	34	35	90	161	4	6	9	19	1	4	5	10	212	466	13	692	278	165	4	447
49—52 ..	3	3	—	6	35	16	23	76	2,856	2,768	45	5,683	50	49	234	336	—	2	3	5	1	2	4	7	143	309	15	468	186	146	3	335
53rd week..	4	2	—	6	16	3	8	27	1,382	1,279	22	2,693	37	20	80	138	1	—	—	1	—	—	—	—	33	64	5	102	70	38	1	109
Total .. (53 weeks)	53	30	14	97	820	364	515	1,724	16,428	15,367	505	32,382	325	282	1,392	2,014	56	57	66	179	37	60	45	142	1,542	3,534	182	5,271	3,527	1,956	78	5,581

Note: 1. Where the total figures are in excess of the sum of the age groups, the difference is due to cases 'age not known'.

2. The totals of these figures will not necessarily agree with the total notifications given in Table 14 which relates to the calendar year 1952.

TABLE 17.—*Recommendations made in respect of children referred to determine the need for special educational treatment* (*see page* 129)

(a) Children not attending special schools

Type of case	*Special School for the*																													
	Blind		*Partially-sighted*		*Deaf*		*Partially-deaf*		*Educationally subnormal, day*		*Educationally subnormal, boarding*		*Epileptic, boarding*		*Delicate, day*		*Delicate, boarding*		*Maladjusted, boarding*		*Physically handicapped, day*		*Physically handicapped, boarding*		*Ordinary school*		*Ordinary school with special treatment*		*Decision postponed (pending treatment, etc.)*		*Unsuitable for school (e.g. ineducable)*		*Individual tuition at home or in hospital*	
	B	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*
Vision	14	3	61	51	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	10	5	32	40	1	0	—	—	—	—
Hearing ..	—	—	—	—	31	23	23	19	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	8	9	26	32	8	4	—	—	—	—
Educationally subnormal ..	—	—	—	—	—	—	—	—	379	265	70	43	—	—	—	—	—	—	—	—	—	—	—	—	202	100	475‡	224‡	25	15	82	47	—	—
Maladjusted ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	131	54	—	—	—	—	—	—	130*	30	—	—	—	—	—	—
Epilepsy ..	—	—	—	—	—	—	—	—	3†	3†	—	—	7	3	—	—	—	—	—	—	7	7	—	—	14	14†	—	—	—	1	2	1	—	—
Physically handicapped	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	171*	106*	7*	7*	21*	20*	—	—	—	—	—	—	35	37
Delicate ..	—	—	—	—	—	—	—	—	—	—	—	—	—	—	413	286	739	448	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—

* *Attendance at special classes part-time.* * *See (b) below.*

† *Includes children for whom restrictions on certain physical activities have been prescribed* (e.g. *gymnastics*).

‡ *Represents those children who were recommended to attend ordinary school with special coaching following statutory examination. It does not include children for whom special coaching has been provided by the head teacher on the advice of the Council's educational psychologists, etc.*

TABLE 17—(*b*) *Physically handicapped children*

Morbid condition	*Day P.H. school*			*Boarding P.H. school*			*Total P.H. school*	*Ordinary school*		
	Boys	*Girls*	*Total*	*Boys*	*Girls*	*Total*		*Boys*	*Girls*	*Total*
Infantile paralysis	43	16	59	2	—	2	61	5	3	8
Cerebral palsy	20	13	33	1	—	1	34	—	1	1
Various paralyses	5	1	6	—	—	—	6	1	—	1
T.B. bones and joints	12	11	23	2	1	3	26	—	2	2
Osteomyelitis	—	1	1	—	—	—	1	—	2	2
Perthes disease	13	—	13	—	—	—	13	2	—	2
Congenital deformities	13	9	22	1	1	2	24	2	4	6
Spinal deformities (including scoliosis)	—	1	1	—	—	—	1	1	—	1
Traumata and amputations	9	2	11	—	—	—	11	4	1	5
Non-T.B. arthritis and synovitis	1	—	1	—	1	1	2	—	—	—
Rheumatism and chorea	—	1	1	—	—	—	1	—	—	—
Heart disease, congenital	14	10	24	—	2	2	26	—	5	5
Heart disease, other	13	18	31	—	2	2	33	—	—	—
Other diseases	28	23	51	1	—	1	52	6	2	8
	171	106	277*	7	7	14	291	21	20	41

TABLE 17—(*c*) *Children in special schools*

Recommendation	*Children attending special schools for the*																	
	Blind		*Partially-sighted*		*Deaf*		*Partially-deaf*		*Educationally subnormal*		*Epileptic, boarding*		*Delicate, day*		*Physically handicapped*		*Maladjusted, boarding*	
	B	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*	*B*	*G*
No longer in need of education in a special school	—	—	3	6	2	—	18	9	109	33	2	2	184	117	82	53	57	12
Unsuitable for retention because ineducable, etc.	—	—	—	—	—	—	—	—	49	44	1	—	—	—	—	—	—	—
Transfer from day school to boarding school	—	—	—	4	—	—	—	—	24	7	—	—	25	22	11	5	—	—

In addition 5 pupils at boarding P.H. school were recommended for transfer to day schools for the physically handicapped.

TABLE 17—(*d*) *Other handicapped pupils*

Change of category—vision and hearing cases

Six pupils of schools for the blind were recommended for transfer to schools for the partially-sighted and 6 attending partially-sighted schools for transfer to schools for the blind.

Children recommended for transfer from schools for the deaf to schools for the partially-deaf numbered 10 and from partially-deaf schools to deaf schools 4.

Section 57(5), *Education Act*, 1944

During the year 424 children were recommended for reporting under this section of the Act as requiring supervision after leaving school.

Section 8, *Education* (*Miscellaneous Provisions*) *Act*, 1948

Five children examined under this section of the 1948 Act were found to be suitable to attend schools for the educationally subnormal.

Diabetic children

Four children (two boys and two girls) were found to be diabetic and suitable for residential treatment.

Speech defects

Children in attendance at :		*Recommended for speech therapy because of*	
		Stammer	*Speech defect*
Ordinary school	Boys	164	308
	Girls	47	130
Schools for the educationally subnormal ..	Boys	15	64
	Girls	2	41
Schools for the physically handicapped ..	Boys	11	69
	Girls	—	48
		239	660

Dual Defects

	Boys	*Girls*	*Total*
Recommended for Rayners School (deaf and some other defect)	15	6	21
Recommended for other schools for dual defects	3	3	6
Recommended for home tuition	1	1	2
Found to be blind and ineducable..	—	3	3
Recommended for partially-sighted schools	1	2	3
Recommended for E.S.N. schools	7	11	18
Invalid from school..	1	—	1
	28	26	54

TABLE 18—*Admissions of London children to Queen Mary's Hospital, Carshalton, in 1952.*

Sex	Articular rheumatism							Chorea							Articular rheumatism and chorea						
	No. admitted	Percentage with						No. admitted	Percentage with						No. admitted	Percentage with					
		Carditis	Pericarditis only	Valvular damage			No cardiac involvement		Carditis	Pericarditis only	Valvular damage			No cardiac involvement		Carditis	Pericarditis only	Valvular damage			No cardiac involvement
				Mitral	Mitral and aortic	and peri-carditis					Mitral	Mitral and aortic	and peri-carditis					Mitral	Mitral and aortic	and peri-carditis	
Boys ..	91	18·7	2·2	25·3	5·5	1·1	47·2	17	23·6	—	11·7	—	—	64·7	1	—	—	—	—	—	100·0
Girls ..	77	15·6	—	17·0	1·2	1·2	65·0	26	11·5	—	27·0	—	—	61·5	3	33·3	—	66·7	—	—	—
Total ..	168	17·3	1·2	21·4	3·6	1·2	55·3	43	16·3	—	20·9	—	—	62·8	4	25·0	—	50·0	—	—	25·0

TABLE 19—*Condition on discharge in 1952 of London children treated in Queen Mary's Hospital, Carshalton*

Sex	Fit for ordinary school or ordinary employment		Fit for P.H. school or light employment		Unfit for school or work		Total
	No.	Percentage	No.	Percentage	No.	Percentage	
Boys	56	76·7	15	20·6	2	2·7	73
Girls	75	81·5	14	15·2	3	3·3	92
Total ..	131	79·4	29	17·6	5	3·0	165

TABLE 20—*Treatment of venereal disease at London clinics*

Year	*New cases*						*Total venereal cases*		*Total non-venereal cases*		*Total attendances*	
	Syphilis		*S. Chancre*		*Gonorrhoea*							
	M.	*F.*	*M.*	*F.*	*M.*	*F.*	*M.*	*F.*	*M.*	*F.*	*M.*	*F.*
1918..	3,764	3,002	116	13	4,844	1,940	8,724	4,955	1,345	1,348	169,485	
1928..	3,433	1,837	229	6	8,249	2,647	11,911	4,490	6,369	3,226	544,969	218,566
1938..	1,799	1,065	235	9	7,120	2,151	9,154	3,225	8,249	5,269	588,815	263,908
1939..	1,573	904	164	5	5,982	1,652	7,719	2,561	7,468	5,008	412,067	189,355
1940..	1,493	709	146	9	4,591	1,319	6,230	2,037	5,383	3,515	305,693	131,375
1941..	1,381	773	205	12	3,862	1,425	5,448	2,210	4,675	3,709	224,954	122,492
1942..	1,369	917	148	9	3,082	1,444	4,599	2,370	4,960	5,177	222,864	155,559
1943..	1,362	1,107	104	15	2,839	1,442	4,305	2,564	7,627	8,867	219,014	177,859
1944..	1,176	967	89	13	2,929	1,363	4,194	2,343	6,568	8,234	188.450	155,332
1945..	1,417	1,176	102	3	3,962	1,738	5,481	2,917	9,517	9,849	196,074	160,697
1946..	2,371	1,354	154	11	7,718	1,785	10,243	3,150	17,153	8,654	284,108	161,839
1947..	2,207	1,301	128	6	7,236	1,408	9,571	2,715	13,847	7,132	269,435	147,717
1948..	1,949	1,155	102	6	7,008	1,346	9,059	2,507	16,349	6,821	268,203	148,212
1949..	1,572	790	62	5	6,463	1,207	8,097	2,002	16,140	6,533	245,250	134,897
1950..	1,278	664	90	3	5,740	1,127	7,108	1,794	17,385	6,180	238,986	122,482
1951..	1,077	549	105	6	5,060	1,028	6,242	1,573	16,443	5,648	200,778	101,787
1952..	811	490	91	3	5,625	1,176	6,527	1,669	16,920	5,632	220,871	100,420

TABLE 21—*Statistics of the administrative work carried out by the Metropolitan Borough Councils in* 1952

Borough	*No. of houses in borough*	*Public Health Act*				*Housing Acts, 1936*																	
		No. of houses inspected on account of complaints or illness	*No. of statutory notices served*	*No. of prosecutions*	*No. of houses repaired*	*No. of houses inspected*	*Section 25*		*Section 9 and 10*		*Number of houses demolished*		*Closing Orders*		*Overcrowding*		*No. of dwellings erected for working classes during the year*	*Underground rooms*			*Houses let in lodgings*			
							No. of houses represented	*No. of houses demolished*	*No. of houses repaired*						*No. of families overcrowded*	*No. of families alternative accommodation obtained*		*No. occupied but unfit*	*No. closed or modified occupation approved*	*No. of closing orders determined*	*No. in Borough*	*No. of inspections*	*No. of prosecutions*	*No. of complaints remedied*
									By owner	*By L.A.*	*Section 11*	*Voluntarily*	*No. made*	*No. determined*										
City of London ..	1,100	8	4	—	8	13	—	—	—	—	—	—	—	—	*	*	—	5	—	—	19	21	—	—
Battersea	27,391	4,103	1,466	139	6,800	—	—	—	2	—	—	—	—	—	43	25	—	*	4	—	*	*	*	*
Bermondsey ..	17,018	3,590	1,060	58	3,446	181	45	—	—	—	6	—	5	—	207	47	217	853	—	2	396	15	—	4
Bethnal Green ..	15,939	3,860	1,134	106	2,848	76	140	—	—	—	5	—	3	—	668	72	90	*	4	2	180	314	—	—
Camberwell ..	41,391	6,676	1,616	83	3,442	—	26	—	20	3	3	1	13	2	117	99	191	*	22	16	*	‡	*	—
Chelsea	15,800	1,627	365	15	411	138	—	—	31	—	20	10	1	—	56	9	105	—	—	—	575	‡	—	30
Deptford	16,313	2,859	662	17	1,709	—	—	—	2	—	1	—	4	—	141	47	20	1	1	1	*	—	—	—
Finsbury	9,334	1,694	89	14	877	15	25	—	—	—	—	—	4	—	76	42	24	1,200	9	4	456	—	—	—
Fulham	32,336	4,430	1,973	214	2,851	—	—	—	1	2	—	—	5	—	13	60	216	—	255	—	—	—	—	—
Greenwich ..	22,255	2,378	210	13	1,479	312	26	—	1	—	20	—	—	—	337	65	304	65	3	6	8	24	—	—
Hackney	39,728	6,695	2,332	227	5,429	22	16	—	77	34	5	—	2	—	1,156	136	287	*	9	3	*	*	3	*
Hammersmith ..	25,830	4,623	1,079	125	1,467	—	—	—	—	—	2	—	2	2	187	79	88	*	29	24	9,600	‡	—	‡
Hampstead ..	20,890	2,836	322	10	1,260	236	3	—	14	3	1	—	2	—	588	66	125	489	3	2	1,573	910	—	452
Holborn	6,197	654	34	7	585	2	—	—	—	—	—	1	10	—	158	33	—	488	2	1	300	478	—	20
Islington	44,277	9,401	5,400	316	5,559	1,404	38	—	—	—	1	17	—	—	699	553	272	*	56	—	*	‡	7	—
Kensington ..	37,600	7,346	1,061	122	2,249	347	—	—	32	2	1	—	—	—	208	131	228	3,812	50	60	4,000	‡	—	‡
Lambeth	51,451	12,137	1,888	252	4,778	—	19	—	—	—	8	5	—	4	*	82	78	*	1	3	*	‡	‡	‡
Lewisham	60,420	2,580	700	31	6,576	—	125	—	42	3	5	—	18	1	38	57	262	*	*	—	*	—	—	—
Paddington ..	23,366	4,376	890	55	1,692	—	—	—	37	2	10	—	2	9	411	216	114	*	216	216	5,879	1,095	4	116
Poplar	17,463	3,076	1,046	69	2,732	183	29	—	—	—	6	—	1	—	88	50	90	3,654	13	—	144	12	—	—
St. Marylebone ..	22,904	2,400	233	7	655	11	—	—	—	—	—	21	3	1	175	8	42	2,214	33	8	1,851	4,954	3	55
St. Pancras ..	27,525	5,597	2,437	181	4,286	102	—	—	—	—	—	—	—	—	389	621	289	*	73	13	5,000	‡	49	—
Shoreditch ..	11,200	4,070	397	29	3,378	2,675	48	26	1	1	3	—	6	—	260	258	264	408	24	—	*	*	*	*
Southwark ..	24,571	4,322	1,509	16	2,303	194	55	—	15	—	2	108	6	—	732	125	84	204	142	—	*	*	*	*
Stepney	29,003	5,765	1,236	57	4,173	155	45	7	—	—	2	1	—	—	1,184	104	118	3,640	59	16	1,471	222	—	—
Stoke Newington ..	8,500	5,138	234	21	1,006	54	—	—	39	—	1	—	—	—	40	20	44	—	5	—	10	—	—	—
Wandsworth ..	96,729	9,834	1,041	57	3,875	—	—	—	—	—	—	—	—	—	146	100	343	29	15	2	*	2	—	—
Westminster, City of	23,086	2,437	28	9	1,491	555	—	—	—	—	—	—	—	—	63	76	172	2,477	60	19	3,350	4,299	—	7
Woolwich	39,697	2,643	827	21	1,534	384	27	—	—	—	—	—	—	1	99	42	286	*	26	15	*	—	—	—
Total ..	809,314	127,355	31,273	2,171	78,899	7,059	667	33	314	50	112	164	87	20	8,279	3,223	4,353	19,539	1,114	413	34,812	12,346	66	684

TABLE 21 (*continued*)

Borough	Cow-sheds		Slaughter-houses		Offensive trades		Smoke nuisances				Common lodging houses		Cleansing of persons and rooms				Water supply	Dairies and milk shops		Ice-cream premises		Restaurants and eating houses	
													Persons		Rooms or premises								
	No. licensed	No. of inspections	No. licensed	No. of inspections	No. authorised	No. of inspections	Observations	Intimations	Complaints	Notices	Houses licensed	No. of inspections	Adults	Children	After infectious disease	For vermin	Tenement houses extra supply	No. on register	No. of inspections	No. on register	No. of inspections	No. of places	No. of inspections
City of London	—	—	—	—	3	15	153	7	7	—	1	—	471	3,003	71	133	—	41	30	79	104	671	1,937
Battersea ..	—	—	1	—	2	2	205	2	7	—	—	—	176	1,994	910	257	12	140	297	233	376	200	1,076
Bermondsey ..	—	—	—	—	9	60	442	1	5	1	2	40	189	1,280	12	371	—	110	250	159	160	61	477
Bethnal Green ..	—	—	—	—	5	88	2	—	—	—	1	5	30	8	29	713	—	129	465	151	369	146	359
Camberwell ..	1	—	3	18	5	2	44	—	41	—	1	45	110	1,160	799	1,711	1	206	81	414	346	354	353
Chelsea	—	—	—	—	—	—	14	—	8	—	—	—	457	704	318	249	14	44	73	88	301	225	721
Deptford ..	—	—	—	—	2	6	—	—	—	—	1	7	526	1,165	252	479	—	138	63	212	114	102	98
Finsbury ..	—	—	—	—	3	65	108	—	5	—	1	15	45	1,273	405	454	22	84	321	124	120	496	252
Fulham	—	—	—	—	—	—	1,665	—	31	—	—	—	41	7	206	691	—	121	441	209	169	159	1,056
Greenwich ..	—	—	—	—	—	—	110	2	6	—	—	—	239	582	374	30	—	85	221	216	441	139	567
Hackney ..	—	—	—	—	5	8	1,453	28	14	8	1	6	140	786	1,062	394	3	206	214	328	350	241	447
Hammersmith	—	—	2	—	—	—	58	3	3	—	—	—	502	1,197	104	713	2	81	597	236	649	248	817
Hampstead ..	—	—	—	—	—	—	116	8	41	—	—	—	24	13	264	148	12	42	197	184	274	204	782
Holborn ..	—	—	—	—	—	—	202	1	9	—	2	6	95	—	144	156	12	41	19	83	164	530	1,967
Islington ..	—	—	5	73	13	45	150	3	36	1	—	—	196	610	649	749	47	302	861	506	259	657	2,361
Kensington ..	—	—	—	—	—	—	16	1	6	—	—	—	259	1,444	609	1,640	14	162	39	290	26	217	199
Lambeth ..	—	—	1	2	2	9	51	3	15	1	—	—	258	85	1,008	2,350	4	264	280	626	173	236	815
Lewisham ..	—	—	2	8	—	—	22	—	5	—	—	—	85	900	1,365	390	—	37	253	350	564	260	656
Paddington ..	—	—	—	—	—	—	85	—	6	1	1	3	335	71	226	1,538	62	117	468	193	225	143	605
Poplar	—	—	3	—	1	4	8	—	1	—	2	41	112	8	577	738	—	137	245	173	156	258	207
St. Marylebone	—	—	1	8	—	—	181	4	24	—	2	45	609	507	385	459	18	106	203	169	180	838	1,096
St. Pancras ..	—	—	2	13	—	—	67	—	18	—	—	—	1,062	1,598	750	688	154	286	723	414	639	850	1,708
Shoreditch ..	—	—	—	—	1	4	341	1	3	—	—	—	35	4	200	625	13	85	245	150	328	287	740
Southwark ..	—	—	1	4	2	16	122	—	7	—	6	45	1,585	1,686	462	2,501	—	164	343	209	223	445	1,575
Stepney ..	—	—	—	—	19	136	100	1	52	—	4	45	469	18	448	872	—	235	264	273	238	916	1,141
Stoke Newington	—	—	—	—	—	—	13	—	1	—	—	—	39	437	194	159	—	43	195	86	167	43	145
Wandsworth ..	—	—	3	47	—	—	51	1	14	—	—	—	129	47	1,011	322	—	240	1,544	718	1,611	492	1,352
Westminster, C. of	—	—	—	—	—	—	1,565	11	101	1	3	71	551	256	393	3,405	4	121	198	206	113	3,001	3,714
Woolwich ..	—	—	2	†	2	4	53	—	11	—	2	26	145	1,049	517	603	—	117	267	257	855	282	1,015
Total ..	1	—	26	173	74	464	7,397	77	477	13	30	400	8,964	21,892	13,744	23,538	394	3,884	9,397	7,354	9,694	12,701	28,268

NOTE :—*In the columns above a dash signifies a NIL return ; * information not available ; † daily supervision (one slaughterhouse not in use) ; and ‡ included in inspections under Public Health Act.*

Seamen's Lodging Houses : Total 9—Poplar 3 (31 inspections), Stepney 6 (75 inspections).

Prosecutions : Dairies—Bethnal Green 1, Hammersmith 1, Hampstead 1, Holborn 1, Islington 1, St. Pancras 2 ;
Restaurants : City of London 1, Hackney 2, Hampstead 7, Islington 1, Kensington 1, St. Marylebone 2 ;
Water Supply : Battersea 1, Islington 7, Paddington 1, St. Pancras 9 ; Ice-cream premises—Westminster 1.

APPENDIX D

STAFF OF THE PUBLIC HEALTH DEPARTMENT (AS AT 31st DECEMBER, 1952)

Medical Officer of Health and School Medical Officer	J. A. Scott
Deputy Medical Officer of Health and Deputy School Medical Officer	A. B. Stewart
Senior Principal Medical Officer	M. MacGregor
Principal Medical Officers	
Maternity and child welfare	Dorothy F. Egan
School health	G. D. Pirrie
Epidemiology	I. Taylor
Tuberculosis	W. Hartston
Staff examinations and mental health	C. W. J. Ingham
Chief Dental Officer	W. Ritchie Young
Chief Nursing Officer	Jean M. Calder*
Chemist-in-Chief	C. J. Regan
Chief Inspector	J. Croft
Administrative	
Administrative Officer	C. R. Geere
Establishment Officer	R. H. J. Stronge
Principal Clerks	G. Berridge
	D. J. B. Cooper
	W. H. Joyce
Officer-in-Charge, London Ambulance Service	A. G. Hellman

Senior Officers of the Divisions

Division	*Divisional Medical Officer*	*Divisional Administrative Officer*	*Divisional Nursing Officer*
1.	Violet I. Russell	L. Welsh	Mary Sidebotham
2.	H. L. Oldershaw	H. J. Norton	Evelina Beattie
3.	Bertha E. A. Sharpe	L. Wilkes	Catherine Walsh
4.	S. King	J. C. Minter	Eileen M. Hazel
5.	G. O. Mitchell	A. J. Cridland	Kathleen M. Roe
6.	F. R. Waldron	L. R. T. Coward	Lilian Berry
7.	H. D. Chalke	G. J. Newton	Flora E. Frederick
8.	W. H. S. Wallace	W. H. C. Bishop	Bessie Thom
9.	J. T. R. Lewis	F. E. Willson	Ethel E. K. Woods

* *Resigned 8th August, 1953.*

The following statement shows the number of staff employed in the Public Health Department in December, 1952 (part-time staff being expressed as whole-time equivalents).

Type of staff	*Location*		*Staff employed at other establishments (a)*	*Total*
	Head office staff	*Divisional staff*		
Administrative and clerical (including ambulance control clerks)	206	592	75	873
Medical staff	23	154	(b)	177
Dental staff	1	63	(b)	64
Chemists	19	—	7	26
Inspectors	15	—	—	15
Nursing staff	9	2,235	103	2,347
Medical auxiliaries (c)	25	136	15	176
Social worker grades (including mental health)	33	168	83	284
Supervisory staff (ambulance service)..	3	—	15	18
Manual workers, operative staff (ambulance service), domestic grades, etc. ..	36	2,422	777	3,235
Totals	370	5,770	1,075	7,215

(a) These establishments include residential schools and nurseries, welfare establishments, ambulance stations, occupation centres for mentally defective children, main drainage outfall works, clinics and dispensaries, district offices (mental health), central dental laboratory, etc.

(b) There are 80 visiting medical officers and 9 visiting dental officers employed at residential establishments on a part-time basis whom it is not possible to compute in terms of whole-time units of staff. They have, therefore, been omitted from the table.

(c) Including physiotherapists, chiropodists, speech therapists, play therapists, psycho-therapists, dental attendants, dental hygienists, dental technicians and apprentices.

INDEX

	Page
Accidents in the home	102
Adoption of children	58
Ambulance service	83
Analgesia	64
Appendix	151
Audiometry	123
Births	5
Blind persons	25
Bronchitis	8
Cancer	9
Care of mothers and young children	50
Chemical branch	28
Child guidance	126
Child-minders	56
Child welfare	52
Chronic sick	27
Civil defence	88
Day nurseries	55
Deaths	7
Dental services	131
Diabetes	9, 130
Diarrhœa and enteritis	17
Diphtheria	16, 80
Domestic help service	78
Domiciliary midwifery service	60
Dysentery	16
Emergency obstetric service	63
Enteric fevers	18
Epileptic children	129
Expectant mothers	50
Fertility	5
Finance	138
Fog	151
Food poisoning	19
Foot defects	97
Handicapped children	129
Health centres	48
Health education	99
Health service premises	42
Health visiting	68
Heart disease	8
Home nursing	73
Housing	23
Illegitimacy	7
Immunisation	80
Infant mortality	12
Infectious diseases	16
Infectious diseases in schools	124
Introduction	3
Marriage guidance	55
Mass miniature radiography	94
Maternal mortality	14
Meals for children	119
Measles	19
Medical inspection of school children	116
Medical treatment of school children	120
Mental health services	104
Midwifery service	60
Milk sampling	24
Mortality	7
Nurseries, day	55
Nurseries, residential	58
Nursing home registration	26
Occupation centres	114
Ophthalmia neonatorum	20
Pneumonia	12, 20
Poliomyelitis	20, 163
Population	4
Premature babies	53
Prevention of illness	90
Psychiatry	126
Puerperal pyrexia	15
Recuperative holidays	98
Remedial exercises	129
Reports of Divisional Medical Officers	140
Rheumatism scheme	125
Road accidents	12
Sanitary inspection	25
Scabies	21
Scarlet fever	21
School health service	115
School children under 5 years	130
School meals	119
Smallpox	21
Special investigations	130, 136
Speech therapy	128
Staff	135, 192
Statistical tables	172
Stillbirths	7
Sunday cinema grants	54
Survey of Health Services	35
Tuberculosis	21, 90
Tuberculous milk	24
Unmarried mothers	58
Vaccination	80, 82, 117
Venereal diseases	97
Visitors	139
Vital statistics	4
Voluntary organisations	39
Welfare Committee establishments	27
Whooping cough	23, 82
Woodberry Down Health Centre	48