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

LONDON COUNTY COUNCIL

Report of the County Medical Officer of Health and Principal School Medical Officer for the Year 1958

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Report of the County Medical Officer of Health and Principal School Medical Officer for the Year 1958

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COUNTY MEDICAL OFFICER OF HEALTH AND PRINCIPAL SCHOOL MEDICAL OFFICER

THE COUNTY HALL
WESTMINSTER BRIDGE, S.E.1

CONTENTS

LONDON ADMINISTRATIVE COUNTY

VITAL STATISTICS, 1958

Figures in brackets are for 1957

Population:

Males	1,509,000	3,225,000 (3,254,000)
Females ..	1,716,000	

Area comparability factors:

Births	0·89 (0·89)
Deaths	0·98 (0·99)

Live births:

Legitimate ..	48,809 (48,047)	54,152 (52,733)
Illegitimate ..	5,343 (4,686)	

Live birth rate per 1,000 population: 16·8 (16·2) (adjusted rate 15·0 (14·4))

Still-births:

Legitimate ..	955 (969)	1,102 (1,083)
Illegitimate ..	147 (114)	

Still-birth rate per 1,000 live and still-births: 19·9 (20·1)

Total live and still-births: 55,254 (53,816)

Deaths:

Males	19,280 (19,142)	38,026 (37,078)
Females ..	18,746 (17,936)	

Death rate per 1,000 population: 11·8 (11·4) (adjusted rate 11·6 (11·3))

Deaths of infants:

	Legitimate	*Illegitimate*	*Total*
Under 1 month	786 (743)	115 (116)	901 (859)
1 month to 1 year	291 (268)	26 (33)	317 (301)
Total under 1 year	1,077 (1,011)	141 (149)	1,218 (1,160)
Infant mortality rate: (per 1,000 live births)	22·07 (21·04)	26·39 (31·80)	22·49 (22·00)
Neo-natal mortality rate: (per 1,000 live births)	16·10 (15·46)	21·52 (24·75)	16·64 (16·29)

Illegitimate live births per cent of total live births: 9·9 (8·9)

Number of marriages registered: 32,292 (33,452)

Maternal mortality:

	Post-abortion	*Other pregnancy and childbirth*	*Total*	*Rate per 1,000 live and still-births*
Deaths from sepsis	10 (8)	— (—)	10 (8)	
Deaths from other causes	9 (5)	14 (15)	23 (20)	
Total	19 (13)	14 (15)	33 (28)	0·60 (0·52)

VITAL STATISTICS*

Population

TABLE (i)—*Population (a)*, 1949-58

Year	Mid-year estimate of population by the Registrar General, by age groups							Average age (years)
	Total	0–4	5–14	15–24	25–44	45–64	65+	
1949 ..	3,375,470	276,200	367,000	2,732,270				
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	36·5
1952 ..	3,363,000	256,000	400,000	416,000	1,091,000	822,000	378,000	36·7
1953 ..	3,343,000	244,000	413,000	410,000	1,072,000	826,000	378,000	36·7
1954 ..	3,322,000	234,000	425,000	394,000	1,056,000	827,000	386,000	36·9
1955 ..	3,295,000	230,000	421,000	391,000	1,037,000	829,000	387,000	37·1
1956 ..	3,273,000	229,000	427,000	384,000	1,018,000	829,000	386,000	37·1
1957 ..	3,254,000	230,000	425,000	383,000	974,000	843,000	399,000	37·4
1958 M	1,509,000	119,000	213,000	179,000	468,000	386,000	144,000	35·7
F	*1,716,000*	*112,000*	*205,000*	*208,000*	*481,000*	*457,000*	*253,000*	*39·0*
	3,225,000	**231,000**	**418,000**	**387,000**	**949,000**	**843,000**	**397,000**	**37·5**

(*a*) *1949—Resident civilian population.*

1950—Home population, i.e., resident civilian population, members of the Merchant Navy at home and overseas and members of the Armed Forces stationed in the area.

1951—Home population, i.e., resident civilian population, plus any British, Commonwealth or Foreign Armed Forces stationed in the area.

There was a net loss of 29,000 in the population from the previous year's figure, mostly in the 25-44 years age group.

Fertility

TABLE (ii)—*Live births and still-births*—1949–58

Year	Live births		Still-births	
	No.	Rate per 1,000 population*	No.	Rate per 1,000 total births (live and still)
1949	56,547	16·5	1,129	19·6
1950	53,660	15·8	1,055	19·3
1951	52,387	15·6	1,073	20·1
1952	51,443	15·3	1,000	19·1
1953	50,992	15·3	1,088	20·9
1954	50,745	15·3	1,029	19·9
1955	49,826	15·1	1,034	20·3
1956	52,171	15·9	1,070	20·1
1957	52,733	16·2	1,083	20·1
1958	54,152	16·8	1,102	19·9

* *1949—Total population. 1950—Home population.*

Live births

There were 63,323 live births registered in London in the year ; after correction for residence the final figure of births allocated to London was 54,152, an increase of 1,419 over 1957, giving a birth rate of 16·8 per 1,000 population, compared with 16·2 in 1957 and 15·9 in 1956. The post-war trend in London followed closely that for England and

* *The statistics given are based on the latest information available from the Registrar General: instances have occurred in the past in which figures have been subsequently corrected so that data for a previous year may differ from that published in the Annual Report for that year.*

Wales until 1956 when the rise in the London rate preceded a similar rise in the country as a whole ; in 1957 the two rates were again almost identical, but in 1958 the crude London rate once more exceeded the national rate : the major factor contributing to the increased birth rate, both local and national, appears at present to be the increased proportion of women of childbearing age who are married. The two rates are not however strictly comparable because the proportion of women of child-bearing age in the population is greater in London than in England and Wales ; adjusting for this difference by multiplying the crude rate by the Registrar General's area comparability factor for London births (0·89) the rate becomes 15·0. This factor makes no allowance for the fact that a lesser proportion of women in London are married. The crude birth rate for the past 10 years is shown in Figure 1 below, together with the national rate and the adjusted birth rate: the true comparative fertility of London lies somewhere between the lines for the crude rate and the adjusted rate.

Figure 1

LIVE BIRTH RATE—

LONDON (A.C.) AND ENGLAND & WALES 1949-58

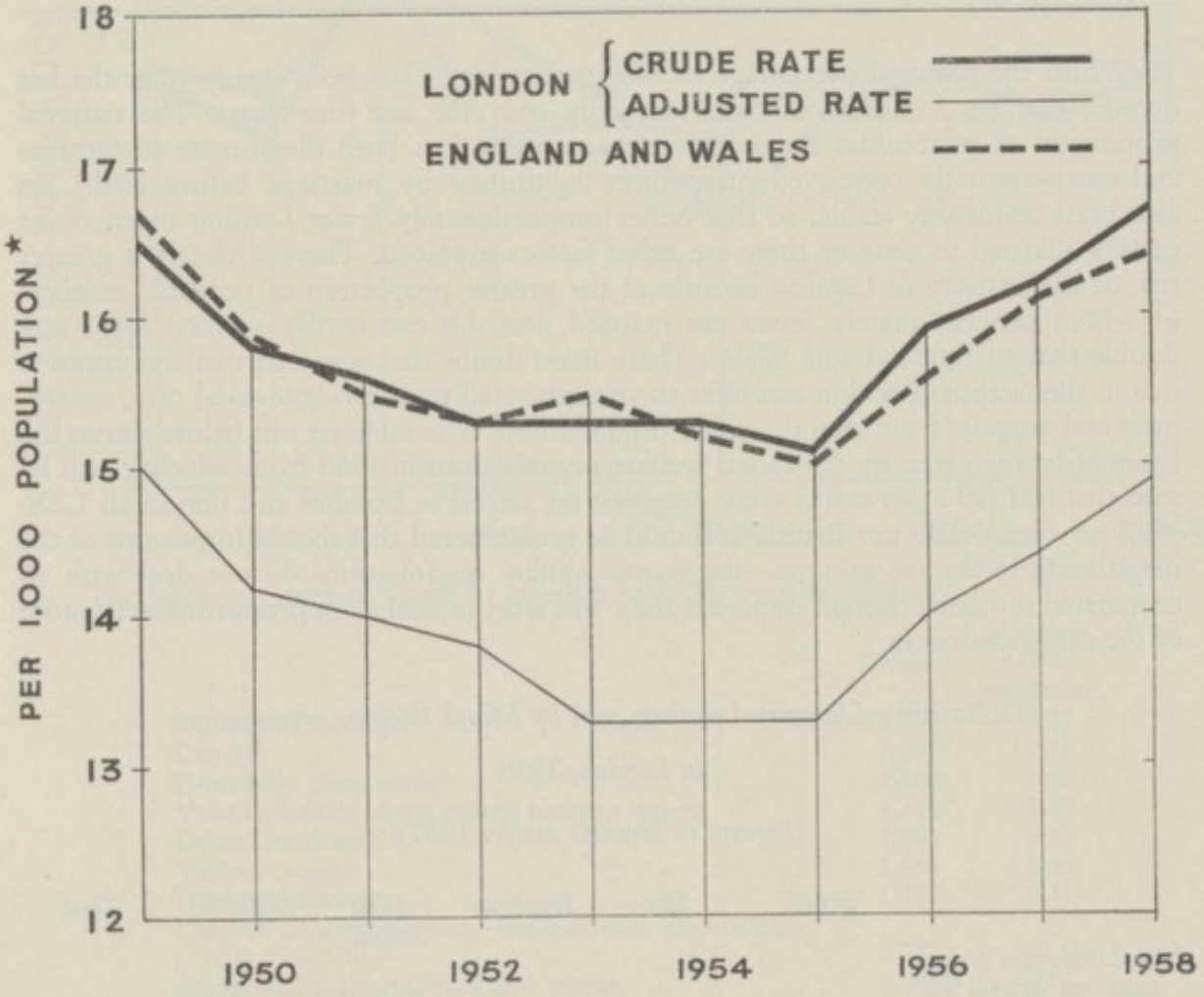


TABLE (iii)—*Illegitimate live births in London (A.C.) and percentages for London and England and Wales*, 1949–58

Year	Illegitimate live births	Illegitimate live births as a percentage of total live births	
		London A.C.	England and Wales
1949	3,899	6·9	5·1
1950	3,752	7·0	5·1
1951	3,597	6·9	4·7
1952	3,607	7·0	4·8
1953	3,645	7·1	4·7
1954	3,615	7·1	4·7
1955	3,827	7·7	4·6
1956	4,434	8·5	4·8
1957	4,686	8·9	4·8
1958	5,343	9·9	4·9

Whilst the national percentage of illegitimate births has been steady over the last decade, that for London has risen markedly over the last four years. The national proportion of maternities conceived extra-maritally (i.e. both illegitimate maternities and extra-maritally conceived maternities legitimised by marriage before birth) has also been reasonably stable, so that either proportionately fewer London mothers are getting married in time or there are other factors involved. There is clearly a greater risk of illegitimacy in London because of the greater proportion of potential mothers of whom proportionately fewer are married, but this can hardly account for a rate double that of England and Wales. There is no doubt that some part of the excess is due to the facilities London can offer to an unmarried mother—ante-natal care, anonymity and support from moral welfare organisations. The table set out below shows the types of women seen by the moral welfare organisations in 1958 from which it will be seen that 693 (23·3 per cent.) were pregnant on arrival in London and that in all 1,236 (41·5 per cent.) were not British. It should be remembered that these components of the illegitimate births are minima—the moral welfare organisations do not deal with all unmarried mothers, though doubtless they will tend to deal with proportionately more of the non-Londoners.

TABLE (iv)—*Unmarried mothers seen by Moral Welfare organisations in London*, 1958

(*Figures in brackets are for* 1957)

	British	Eire	European	West Indian	Other	Total
Non-Londoners pregnant on arrival in London	335 (290)	216 (219)	21 (13)	86 (81)	35 (28)	693 (631)
*Non-Londoners not pregnant on arrival in London ..	104 (78)	103 (83)	13 (21)	50 (67)	8 (6)	278 (255)
Resident in London one year	1,300 (1,142)	364 (330)	52 (59)	242 (225)	46 (42)	2,004 (1,798)
	1,739 (1,510)	683 (632)	86 (93)	378 (373)	89 (76)	2,975 (2,684)

* *Had lived in London less than 12 months before making contact with Moral Welfare Association.*

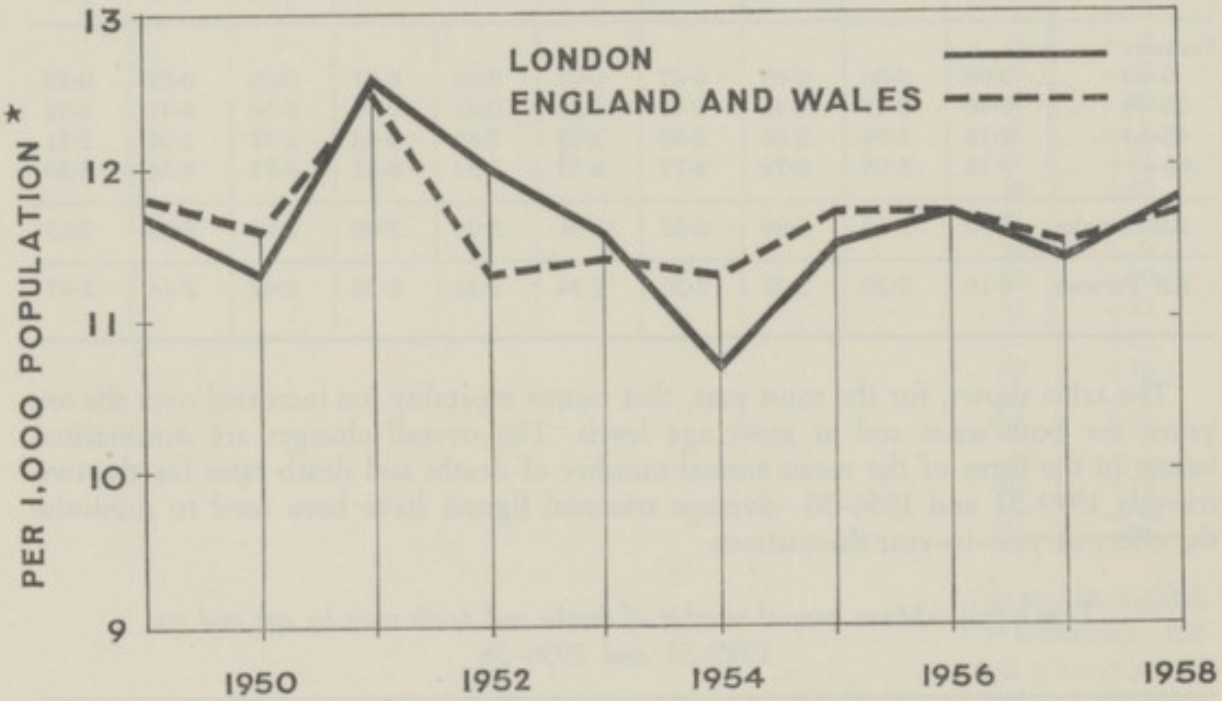
Mortality

The total death rate at 11·8 per 1,000 population, although slightly higher than the previous year (11·4) was about the average post-war level. The death rate in London for the past 10 years, together with that for England and Wales, is shown in Figure 2 below. The area comparability factor for the London death rate (which allows for the differing sex and age structure in the local population to enable comparison to be made with the national rate) was 0·98 for 1958, and has never been far from unity every since its introduction in 1934. The two sets of rates therefore, unlike the birth rate, are reasonably comparable without further adjustment.

Figure 2

DEATH RATE

LONDON (A.C.) AND ENGLAND & WALES, 1949-58



The leading causes of death in London in 1958 were as follows :

Leading causes of death

	Deaths	*Rate per 1,000 population*
Diseases of the heart	11,363	3·52
Cancer	7,981	2·47
Bronchitis, pneumonia*	5,158	1·60
Vascular lesions of the central nervous system	4,154	1·29
Other circulatory	1,905	0·59
Violent causes	1,616	0·50
Digestive diseases	1,332	0·41
Diseases of early infancy (international classification Nos. 760–776)	732	0·27
Congenital malformations, 0–4 weeks	146	
Tuberculosis (all forms)	420	0·13
All other causes	3,219	1·01
Total	38,026	11·79

* *Excluding pneumonia of the new born (under 4 weeks) which is included in ' Diseases of early infancy '.*

The ranking order of the leading causes of death remains unchanged from 1957. Heart disease was discussed in detail in my report for 1956; cancer is the second principal cause, with a rate of 2·47 per 1,000 (the highest ever recorded in peace time).

The cancer death-rate for all ages was 2·47 per 1,000 in 1958—again a slight increase over the previous year. Cancer is, however, largely a disease of the later half of life and in order to eliminate variations, caused by a changing age/sex composition of the population, rates for specific age/sex groups are shown below:

TABLE (v)—*Cancer mortality rates per* 1,000 *living*, 1949–58

Age and Sex	*1949*	*1950*	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*
Males :										
0–24 ..	0·10	0·10	0·09	0·12	0·14	0·12	0·11	0·14	0·11	0·09
25–44 ..	0·39	0·43	0·45	0·45	0·46	0·41	0·40	0·43	0·37	0·42
45–64 ..	4·17	4·45	4·28	4·19	4·28	4·31	4·50	4·51	4·55	4·52
65+ ..	12·97	13·23	15·64	15·50	15·69	15·29	15·73	15·77	15·29	16·01
All Males ..	2·39	2·49	2·60	2·61	2·68	2·64	2·73	2·76	2·77	2·85
Females :										
0–24 ..	0·08	0·06	0·08	0·07	0·07	0·06	0·07	0·09	0·07	0·10
25–44 ..	0·46	0·47	0·46	0·47	0·51	0·43	0·45	0·50	0·47	0·52
45–64 ..	2·76	2·84	2·80	2·85	2·85	2·85	2·93	2·77	2·97	2·71
65+ ..	9·18	8·95	8·79	8·77	8·73	8·39	8·43	8·75	8·34	8·50
All Females	1·96	1·95	1·99	2·02	2·04	2·02	2·08	2·12	2·16	2·15
All Persons	2·16	2·20	2·27	2·30	2·34	2·31	2·39	2·42	2·44	2·47

The table shows, for the most part, that cancer mortality has increased over the ten years, for both sexes and at most age levels. The overall changes are summarised below in the form of the mean annual number of deaths and death rates for the two triennia 1949–51 and 1956–58—average triennial figures have been used to minimise the effect of year-to-year fluctuations.

TABLE (vi)—*Mean annual number of deaths and death rates by age and sex,* 1949–51 *and* 1956–58

Age group	*1949–51*		*1956–58*		*Percentage change in rate*
	No. of deaths	*Rate per 1,000 population*	*No. of deaths*	*Rate per 1,000 population*	
Males :					
0–24 ..	50	0·09	57	0·11	+ 22
25–44 ..	235	0·43	198	0·41	− 5
45–64 ..	1,528	4·18	1,736	4·50	+ 8
65+ ..	2,130	15·00	2,259	15·47	+ 3
Females :					
0–24 ..	43	0·07	45	0·09	+ 29
25–44 ..	259	0·46	247	0·50	+ 9
45–64 ..	1,252	2·81	1,279	2·80	—
65+ ..	1,973	8·61	2,131	8·42	− 2

The biggest proportionate changes are in the youngest age groups but they are based on relatively small death rates; absolutely, the eight per cent. increase in the male rate at ages 45–64 years is of greater importance than the 22 per cent. increase at ages 0–24 years—the former represents an increase of over 200 cancer deaths a year in middle-aged men.

In view of the generally increased mortality from cancer, the following summary sets out the changes in mortality from the principal sites of cancer so that they may be examined to see if the increase is due to any particular form, or forms, of cancer. As with the age group summary triennial periods have been used.

TABLE (vii)—*Mean annual number of deaths and death rates (all ages) by site of cancer, 1949–51 and 1956–58*

Site		1949–51		1956–58		Percentage change in rate
		No. of deaths	Rate per 1,000 population	No. of deaths	Rate per 1,000 population	
Buccal cavity and pharynx ..	M.	140	0·090	106	0·070	−22
	F.	47	0·027	57	0·033	+13
Stomach	M.	595	0·380	563	0·370	− 3
	F.	485	0·270	430	0·248	− 8
Intestines and rectum	M.	608	0·389	473	0·311	−20
	F.	678	0·378	638	0·368	− 3
Lung and bronchus	M.	1,203	0·769	1,670	1·097	+43
	F.	235	0·131	315	0·182	+40
Breast and genito-urinary ..	M.	498	0·318	528	0·347	+ 9
organs	F.	1,378	0·768	1,451	0·838	+ 9
Leukemia and aleukemia ..	M.	84	0·053	96	0·063	+19
	F.	83	0·046	91	0·052	+13
Other lymphatic and	M.	101	0·065	123	0·081	+25
haematopietic tissue	F.	61	0·034	104	0·060	+76
Other sites	M.	705	0·451	691	0·454	+ 1
	F.	552	0·308	616	0·356	+16
TOTAL	M.	3,934	2·515	4,250	2·792	+11
	F.	3,519	1·961	3,702	2·137	+ 9

For males, the greatest proportionate increase was in cancer of the lung and bronchus, followed by cancer of other lymphatic and haematopietic tissue and leukemia: the greatest proportionate decreases were in cancer of the buccal cavity and pharynx and intestines and rectum. For females, the increases were in cancer of the other lymphatic and haematopietic tissue, lung and bronchus, and 'other sites', with decreases in cancer of the stomach, intestines and rectum.

Absolutely, the major change for males was an increased death roll of some 470 from cancer of the lung, whilst for females there was a rise of about 80 in lung cancer, 70 in cancer of the breast and genito-urinary organs and 60 in 'other sites'. For both sexes combined, therefore, the outstanding feature of the table is the great increase in deaths from cancer of the lung—of the same proportionate order—but with male deaths 5–6 times as frequent.

Mortality from leukemia and aleukemia has been shown separately from that of the main group of lymphatic and haematopietic tissue because of the prominence given to the former in recent years in connection with a suggested causal connection between it and radiation, especially the use of X-rays in diagnostic practice and radiotherapeutic treatment. Stewart *et al** are investigating the possibility of a causal connection between irradiation in utero and subsequent malignant disease in children: the increase in deaths from leukemia in London over the past ten years has been mostly in the 65 + years age group.

Of the five causes that make up the total deaths from other lymphatic and haematopietic tissue—lymphosarcoma, Hodgkin's disease, reticulosis, multiple myeloma and mycosis fungoides—the greatest proportionate increase has been in multiple

* *Stewart, A., Webb, J., Giles, D. and Hewitt, D., Lancet (1956) ii, 447.*

myeloma, though the number of deaths from each of the five causes is so small as to make for considerable random fluctuation from year-to-year. The increase in ' other sites ' for females is such a mixture of residuals from the other main sites that it is impossible to be specific about the cause of increase.

Lung cancer

Returning to the main issue, the increase in mortality from cancer of the lung was dealt with extensively in Appendix A to my report for the year 1954. In order to link with the data then produced the following table shows the male and female deaths and death rates for ages 25–44, 45–64 and 65+ years for the ten years 1949–59. Deaths below age 25 years have been excluded because they are very rare.

TABLE (viii)—*Deaths and death rates from cancer of the lung by age and sex*, 1949–1958
(*rates per* 1,000 *population*)

Year	Age					
	25–44		45–64		65+	
	No.	Rate	No.	Rate	No.	Rate
Males :						
1949 ..	57	0·10	601	1·72	457	2·87
1950 ..	71	0·13	693	1·97	474	2·98
1951 ..	63	0·12	696	1·90	523	3·68
1952 ..	73	0·14	673	1·81	580	4·03
1953 ..	81	0·15	734	1·96	614	4·26
1954 ..	64	0·12	773	2·06	625	4·34
1955 ..	62	0·12	810	2·14	651	4·55
1956 ..	65	0·13	853	2·25	718	5·06
1957 ..	37	0·08	891	2·31	723	4·95
1958 ..	52	0·11	883	2·29	786	5·46
Females :						
1949 ..	16	0·03	87	0·19	133	0·62
1950 ..	20	0·04	86	0·19	114	0·53
1951 ..	17	0·03	91	0·20	144	0·63
1952 ..	19	0·03	127	0·28	137	0·59
1953 ..	18	0·03	119	0·26	139	0·59
1954 ..	19	0·04	137	0·30	164	0·68
1955 ..	13	0·02	151	0·33	174	0·71
1956 ..	13	0·03	109	0·24	154	0·63
1957 ..	19	0·04	142	0·31	176	0·70
1958 ..	22	0·05	124	0·27	183	0·72

A true comparison of death rates in the various metropolitan boroughs with that of London and of England and Wales is given in table (ix), which sets out the Standardised Mortality Ratios* for males (calculated on the deaths in the years 1950–53 in relation to the census population), together with the percentage in social classes IV and V, the percentage of the population born in London and two indices of atmospheric pollution. Data for males only has been shown because of their greater mortality from this cause and because one of the factors—social class—is only available in respect of males. As is well known, London has a mortality ratio above average—over half as much again as in the country generally—part of which at any rate is to be expected because of the urbanisation gradient demonstrated by Stocks.†

* *Standardised Mortality Ratios express the actual number of deaths at all ages in each geographical area as a percentage of the ' expected ' number of deaths, i.e., the number that would have occurred in the area if the death rate in each age group had been the same as that of England and Wales. They are drawn from Table 1A of the Registrar General's Decennial Supplement—Area Mortality, 1951, H.M.S.O. 1958.*

† *Stocks, P., Regional and Local Differences in Cancer Death Rates—Studies on Medical and Population Subjects, No. 1. General Register Office (1947).*

TABLE (ix)—*Lung cancer, males only.*
Standardised mortality ratio, social class, percentage born in London, and atmospheric pollution.

Boroughs	*S.M.R. 1950–53 (England and Wales = 100)*	*Percentage of social classes IV and V 1951*	*Percentage born in London 1951*	*Atmospheric pollution 1944–54*	
				Solid deposit (a)	*SO_4 (b)*
Chelsea	164	23	45	653	119
Fulham	147	27	64	1,028	188
Hammersmith	161	30	58	(c)	(c)
Kensington	139	23	39	504	109
Hampstead	155	15	37	(c)	(c)
Paddington	172	27	44	413	400
St. Marylebone	139	22	42	497	114
St. Pancras	203	32	58	516	(c)
Westminster, City of ..	124	27	36	779	122
Finsbury	206	39	74	503	(c)
Holborn	141	30	45	456	(c)
Islington	188	31	70	521	(c)
Hackney	153	26	75	425	98
Shoreditch	193	39	82	(c)	(c)
Stoke Newington ..	154	22	67	374	97
Bethnal Green	222	38	83	(c)	(c)
City of London	100	43	47	637	170
Poplar	167	44	80	982	210
Stepney	163	46	72	496	119
Deptford	162	35	75	(c)	(c)
Greenwich	130	32	69	1,300	240
Woolwich	142	25	59	593	138
Camberwell	152	30	75	378	373
Lewisham	127	22	66	432	104
Bermondsey	176	45	84	(c)	(c)
Lambeth	143	29	65	614	107
Southwark	184	42	76	2,658	188
Battersea	147	30	70	1,145	127
Wandsworth	142	21	60	(c)	(c)
London County	156	29	63	723	168

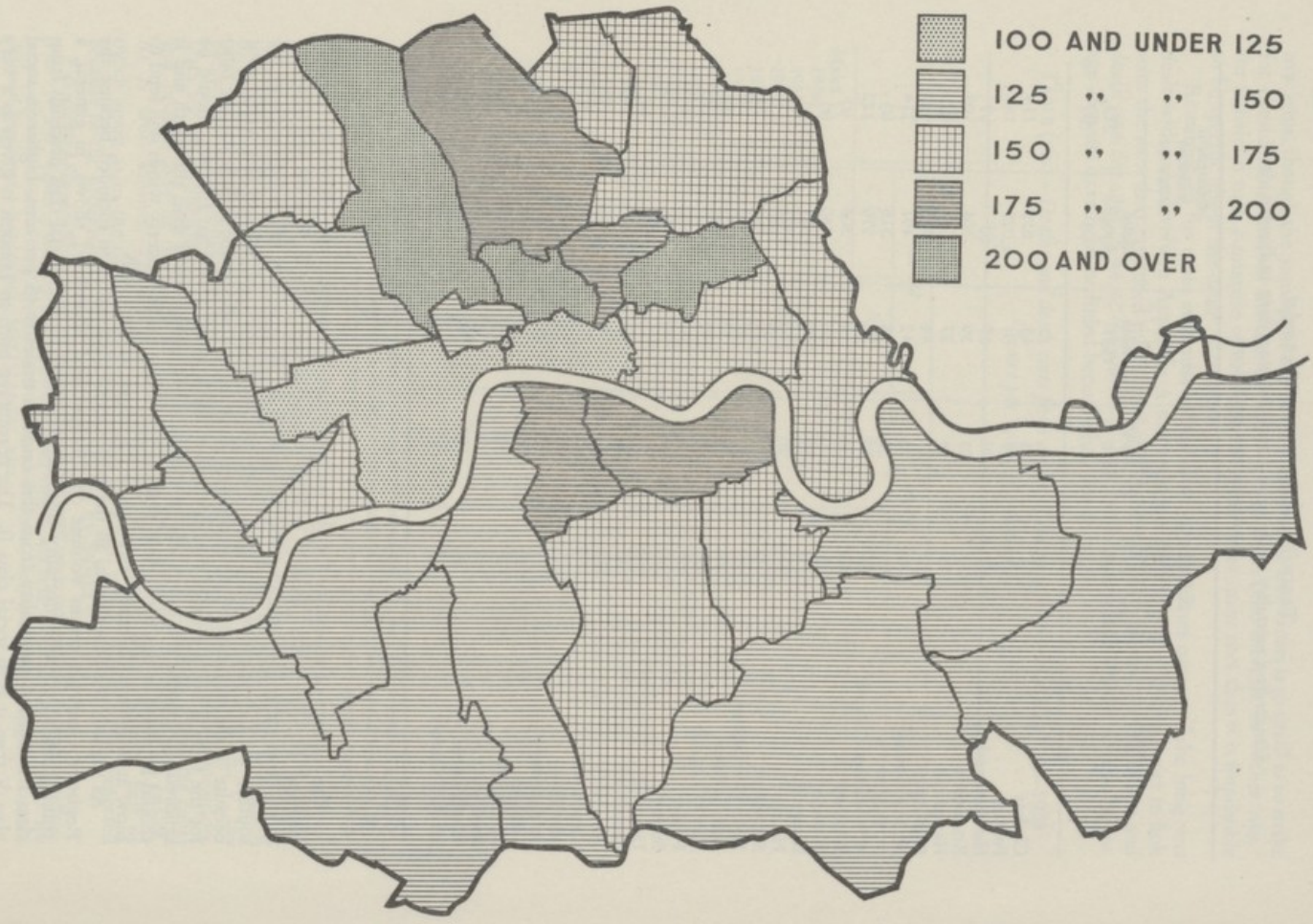
(a) *Total deposited matter, grams per 100 square metres per month, winter months only.*
(b) *Dissolved sulphate ion (SO_4) per 100 square metres per month, winter months only.*
(c) *No deposit gauge.*

The pattern of mortality for the metropolitan boroughs is also shown in Figure 3 on page 12. There is a ' wedge ' of high ratios running from St. Pancras and Islington in the north through Finsbury and Shoreditch to Bermondsey and Southwark in the south ; the City escapes the higher ratios and breaks the continuity of this wedge, but because of the smallness of the experience (only eight deaths in the four years) the ratio for the City is not a reliable measure and in this context and what follows, should be ignored. In general the north side of the river has higher ratios than the south and it should be noted in this connection that the prevailing south-westerly winds will tend to blow atmospheric pollution away from the south to the north.

As regards the other items in the table, social class has been included because the Registrar General's census volume on Occupational Mortality‡ shows, in general, a rising gradient of male mortality from cancer of the lung as social class descends from class I to class V (mortality from this cause in males is 45 per cent. higher in social class V than it is in social class I). The percentage born in London is given as a very

‡ *Registrar General's Decennial Supplement (1951)—Occupational Mortality.*

Figure 3
STANDARDISED MORTALITY RATIOS FROM LUNG CANCER (MALES ONLY)
METROPOLITAN BOROUGHS 1950-1953
(England & Wales = 100)



rough indication of duration of exposure to the London atmosphere and atmospheric pollution because recent works* tend to incriminate a dirty atmosphere as much, or more, than tobacco smoking as a cause of cancer of the lung.

The indices of atmospheric pollution which are taken from the twenty-seventh report of the Department of Scientific and Industrial Research are somewhat unsatisfactory. As I have indicated before (see Appendix B to my annual report for 1956) the readings are from a mixture of instruments sited at different levels and, often, for particular local problems ; to ensure as much homogeneity as possible readings from the more numerous deposit gauge stations have been used—these relate to the ten years ended March, 1954, but only 9 of the 51 stations operated over the whole ten years and 24 of them were in operation for one year only. For these reasons the use of any one station, or group of stations, to give a representative figure for an area as large as a metropolitan borough is of doubtful value, but for what it is worth the stations in a borough have been averaged.

Some indication of the extent of variation from recording stations is given by the following figures taken from one borough, for the winter of 1953-54, viz:—

	Solid deposit	SO_4
	296	105
	556	144
	296	122
	1,222	182
Average	593	138

However, the figures given in table (ix) are the best available and their use should be viewed against the background of the foregoing reservations.

The interaction of these various indices is perhaps best summarised by the calculation of the product-moment correlation coefficient (r) and these are given below for the standardised mortality ratios and the other indices listed (figures for the City of London have been excluded from the calculations).

Correlation coefficients for standardised mortality ratios for cancer of the lung (males only), London boroughs (excluding the City of London) and :

	r
Percentage in social classes IV and V	+0·570
Percentage born in London	+0·476
Solid deposit	+0·106
Sulphate ions (SO_4)	+0·341

The two first are statistically significant ($P<\cdot001$ and $P<\cdot02$ respectively) ; such a highly significant relationship with percentage in social classes IV and V is to be expected because of the known social class gradient of mortality from cancer of the lung. The lower, but nevertheless significant, value for the correlation with percentage born in London conforms with the known increase in mortality from cancer of the lung with increase in the degree of urbanisation, though the index used here is only a crude measure of exposure to the atmosphere of various parts of London and takes no account of movement within the County for work, pleasure or residence, and thus may not be altogether representative of the average environment experienced by the differing populations. The poor correlation with the two indices of atmospheric pollution is not altogether surprising in view of the differing quantity and quality of the measurements.

To summarise, over the past ten years there has been an increase in mortality from cancer of about 14 per cent., attributable, in the main, to men aged 45 and over. In terms of sites for both sexes the greatest absolute increase has been in cancer of the lung.

* *Stocks, P. (1959) British Medical Journal 1, 74.*
Pybus, F. C. (1959) The Medical Press, CCXLI, 122, 149.

Standardised mortality from lung cancer was highest among the boroughs in Bethnal Green, Finsbury, Shoreditch, Islington and St. Pancras in the north and Southwark and Bermondsey in the south. It was also highly correlated with the percentage in social classes IV and V and the percentage born in London, but not with atmospheric pollution as typified by solid deposit or sulphate ion—the limitations of the two last indices are such as not to preclude such an association.

Infant mortality

TABLE (X)—*Infant mortality*—1958

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*
Whooping cough	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Tuberculosis ..	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Measles	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Convulsions ..	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Bronchitis and ..	Leg.	4	25	27	127	**187**	107	*80*	**3·45**	3·85	*3·03*
pneumonia ..	Illeg.	—	3	1							
Gastro enteritis	Leg.	1	—	1	15	**17**	8	*9*	**0·31**	0·29	*0·34*
and diarrhoea ..	Illeg.	—	—	—							
Congenital	Leg.	38	54	41	98	**244**	124	*120*	**4·51**	4·46	*4·55*
malformation	Illeg.	4	6	3							
Immaturity ..	Leg.	122	77	8	7	**254**	145	*109*	**4·69**	5·22	*4·13*
	Illeg.	25	12	3							
Injury at birth ..	Leg.	67	40	2	1	**123**	71	*52*	**2·27**	2·56	*1·97*
	Illeg.	5	6	2							
Post-natal asphyxia	Leg.	124	61	5	2	**221**	139	*82*	**4·08**	5·00	*3·11*
and atelectasis	Illeg.	21	8	—							
Haemolytic disease	Leg.	17	6	—	—	**24**	12	*12*	**0·44**	0·43	*0·45*
	Illeg.	1	—	—							
Accidental	Leg.	—	—	—	6	**7**	3	*4*	**0·13**	0·11	*0·15*
mechanical	Illeg.	1	—	—							
suffocation											
Other causes ..	Leg.	22	31	13	61	**141**	92	*49*	**2·60**	3·31	*1·86*
	Illeg.	8	4	2							
All causes ..	Leg. M.	223	176	56	291	**1,077**	616	*461*	**22·07**	24·61	*19·39*
	F.	*172*	*118*	*41*							
	Illeg. M.	38	21	10	26	**141**	85	*56*	**26·39**	30·94	*21·57*
	F.	*27*	*18*	*1*							
TOTAL, 1958		460	333	108	317	**1,218**	701	*517*	**22·49**	25·24	*19·60*
TOTAL, 1957		438	317	104	301	**1,160**	657	*503*	**22·00**	24·14	*19·71*
	Leg. M.	221	160	40	161	**1,011**	582	*429*	**21·04**	23·44	*18·48*
	F.	*158*	*111*	*53*	*107*						
	Illeg. M.	27	30	4	14	**149**	75	*74*	**31·80**	31·45	*32·16*
	F.	*32*	*16*	*7*	*19*						

The pattern of infant mortality remains much the same as in the previous year. The increase in the total rate from 22·00 in 1957 to 22·49 in 1958 was largely accounted for by an increase in mortality from bronchitis and pneumonia, congenital malformations and immaturity, slightly offset by decreased mortality from injury at birth.

The trend since 1949 is shown below :

TABLE (xi)—*Infant mortality by cause*—1949–58

(*Rates per* 1,000 *live births*)

Cause of death	*1949*	*1950*	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*
Whooping cough ..	0·35	0·39	0·17	0·08	0·27	0·06	0·06	0·04	0·02	—
Tuberculosis	0·09	0·17	0·08	0·04	0·14	0·08	—	—	—	—
Measles	0·05	—	0·13	—	0·06	0·02	0·10	—	—	—
Bronchitis and pneumonia	3·94	4·25	4·47	3·89	4·04	2·70	3·57	3·32	2·88	3·45
Gastro-enteritis ..	1·52	1·14	0·73	0·80	1·27	0·43	0·48	0·35	0·42	0·31
Immaturity	6·31	4·62	4·71	4·20	3·98	3·70	4·67	4·10	4·27	4·69
Congenital malformations ..	4·23	4·14	3·82	3·93	3·41	3·51	3·43	3·70	3·96	4·51
Injury at birth	2·48	2·42	2·98	2·82	2·71	2·34	2·59	2·64	2·98	2·27
Post-natal asphyxia and atelectasis	3·45	3·71	3·82	3·50	3·90	4·06	4·32	3·66	4·17	4·08
Haemolytic disease ..	(*a*)	0·95	0·86	0·72	0·53	0·55	0·58	0·61	0·51	0·44
Convulsions	0·02	—	—	—	—	0·02	—	0·02	—	—
Accidental mechanical suffocation	1·08	0·26	0·25	0·17	0·14	0·12	0·06	0·21	0·23	0·13
Other causes	3·31	3·52	3·42	2·96	3·40	3·04	3·35	2·55	2·56	2·12
All causes	27	26	25	23	24	21	23	21	22	22

(*a*) *Included in other causes.*

Neo-natal mortality

A comparison with England and Wales for both neo-natal (deaths in the first four weeks) and infant mortality (deaths in the first year) is as follows :

Rates per 1,000 live births

Year	*Neo-natal mortality*		*Infant mortality*	
	London	*England and Wales*	*London*	*England and Wales*
1949	17·5	19·3	26·8	32·4
1950	16·9	18·5	25·8	29·6
1951	17·3	18·8	25·4	29·7
1952	15·8	18·3	23·1	27·6
1953	16·1	17·7	23·9	26·8
1954	15·1	17·7	20·7	25·4
1955	16·7	17·3	23·2	24·9
1956	15·9	16·8	21·2	23·8
1957	16·3	16·5	22·0	23·1
1958	16·6	16·2	22·4	22·5

Perinatal mortality

Comparative rates for perinatal mortality (still-births and deaths in the first week of life) per 1,000 *total* births are given below for London and England and Wales.

Year	*London*	*England and Wales*	*Year*	*London*	*England and Wales*
1949	34·2	38·0	1954	32·8	38·1
1950	33·2	37·4	1955	34·8	37·4
1951	34·6	38·2	1956	33·3	36·7
1952	32·6	37·5	1957	34·2	36·3
1953	34·7	36·9	1958	34·3	35·1

The medical conditions causing still-birth cannot be determined since certification of the cause of still-birth is not required in this country although it is in Scotland. Following representations made to the Ministry of Health during 1957 a special inquiry under Ministry auspices is being made into perinatal mortality in certain areas, including London, commencing in 1958. (The National Birthday Trust Fund also made a similar inquiry in March, 1958 and the results are awaited with considerable interest.)

Maternal mortality

TABLE (xii)—*Maternal mortality*, 1949–58

Year	Live births and still-births	Deaths in pregnancy or child-birth excluding abortion	Post-abortion deaths	Total Maternal deaths	
				No.	Rate per 1,000 total births
1949	56,676	20	20	40	0·71
1950	54,715	29	9	38	0·69
1951	53,460	24	18	42	0·79
1952	52,433	35	15	50	0·95
1953	52,080	21	16	37	0·71
1954	51,774	28	6	34	0·66
1955	50,860	31	8	39	0·77
1956	53,241	16	11	27	0·51
1957	53,816	15	13	28	0·52
1958*	55,254	14	19	33	0·60

* *For the third year running none of the deaths in pregnancy or childbirth was due to sepsis ; ten of the 19 post-abortion deaths came under the category of ' abortion with sepsis '.*

Summary tables

Tables summarising the more important of these vital statistics (*a*) by metropolitan boroughs and (*b*) showing the secular trend for the County are to be found on pages 21 and 22.

Atmospheric pollution

In my last two annual reports I have given, in some detail, evidence in support of the hypothesis that when the level of atmospheric pollution reaches about four times the winter average* an ' excess ' of deaths of the order of 3–400 may be expected.

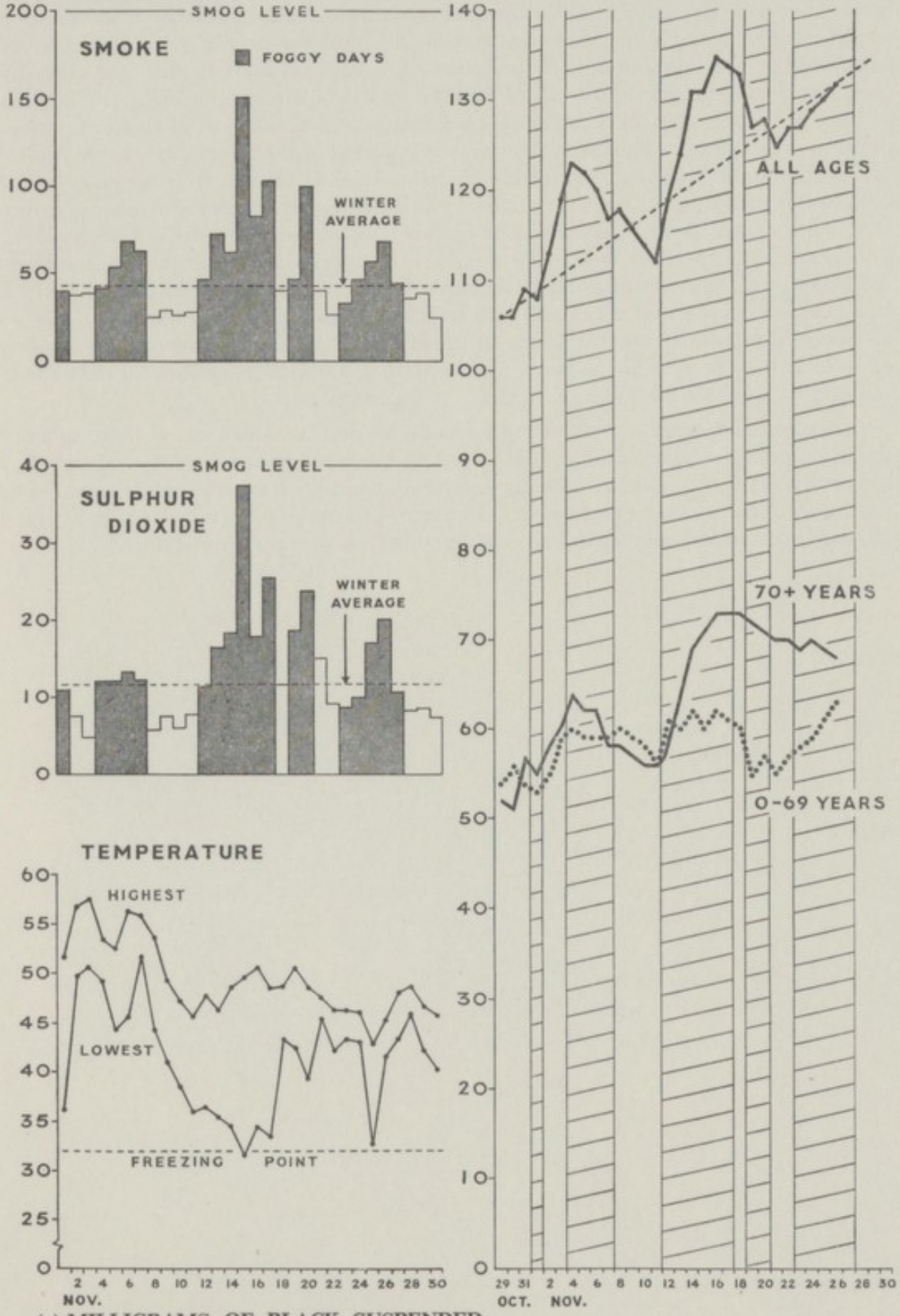
Fortunately in 1958 at no time did pollution reach this apparently critical level but the month of November was marked by persistent fog—fog was mentioned in the meteorological reports of Kew Observatory on 20 days in the month. It was therefore felt advisable to examine the pollution and mortality figures for November in some detail in order to ascertain how the effect, if any, of a fairly persistent pollution below the critical level compared with that of a relatively short period of pollution above it. Figure 4 (p. 17) shows the daily mean concentrations for each day of November—days upon which fog was mentioned are indicated : the highest and lowest daily temperatures recorded at Kew Observatory over the same period are also shown.

The figure shows clearly the fluctuations that occur from day-to-day in the level of pollution and also that the six consecutive days of fog, including the highest level of pollution, corresponded broadly with the days of lowest temperature.

The figure also shows the seven-day moving average of deaths *occurring* in London, for all deaths and for deaths affecting those aged under 70 years of age and 70 years and over. The daily level of mortality fluctuates in the same way as does that of pollution and the production of a moving average is therefore a prerequisite to the estimation of the trend of mortality. Even with this aid the determination of the trend is an extremely hazardous undertaking in a period when mortality is climbing to its seasonal winter level; the estimated trend line for all deaths has been shown by the dotted line. It will be noticed that there were two ' peaks ' above the trend line, the first coinciding with the foggy days from the 4th—7th day, and the second with the period of intermittent fog from the 12th—17th. It is doubtful whether the first peak was in any way a consequence of

* *I.e., a mean daily concentration of 200 milligrams of black suspended matter (' Smoke ') per 100 cubic metres of air and 40 parts of acidic gases (SO_2) per 100 million parts of air.*

FIGURE 4—DAILY CONCENTRATION OF SMOKE (a) AND SULPHUR DIOXIDE (b) AND HIGHEST AND LOWEST DAILY TEMPERATURES (c) IN NOVEMBER 1958. DEATHS, ALL AGES, 0-69 YEARS AND 70 YEARS AND OVER, 29 OCTOBER TO 26 NOVEMBER 1958. SEVEN-DAY MOVING AVERAGES.



(a) MILLIGRAMS OF BLACK SUSPENDED MATTER PER 100 CUBIC METRES OF AIR
(b) PARTS PER 100 MILLION PARTS OF AIR
(c) DEGREES FAHRENHEIT—RECORDINGS FROM KEW OBSERVATORY

atmospheric pollution for the readings were around the normal level until the 12th day : the more likely explanation is that the rise in deaths over this period was the beginning of the intermittent climb to the winter level of mortality—in any case it is in part offset by the following trough. The second incident, when the readings reached the near smog level for sulphur and about three-quarters of this level for smoke, may, however, be considered to be connected with pollution. On the assumption that the peak in mortality during the period 12—21 November was a consequence of smog, the number of ' excess ' deaths contained therein approximates to about 60—all of them in persons of 70+ years of age. However, over the same period of the foggy days, as mentioned earlier, the night-time temperature fell to a low level at or near freezing point and it could be argued that the rise in mortality, particularly as it affected only the aged, was as much, or even more, a consequence of this temperature drop than of atmospheric pollution. It is impossible to say how many of the excess deaths, if in fact excess deaths did occur, were due to smog and how many to cold. So far, in the history of London smogs, there does not seem to have been an incident *causing excess deaths* which has not also been accompanied by low temperatures. Given a sufficient number of these smog episodes it may be possible, in due time, to make a statistical estimation of the relative importance of cold and pollution in their consequences.

To summarise, the protracted fog of mid-November, which never quite attained the smog pollution level, did not lead to excess deaths of the same order as occur when the critical level of pollution is reached. The maximum excess was of the order of 60 deaths, all of them among persons aged 70 years or more. It is thought that some, if not all, the excess deaths may have been attributable to low night temperature.

INFECTIOUS DISEASES

NOTIFICATIONS of infectious diseases for the years 1938–1958 are shown in table V.5, page 25 ; those for certain such diseases by age and sex for the 13 four-weekly periods of the year 1958 are given in table V.6, page 26 ; and deaths from infectious disease are included in table V.3, page 23.

Diarrhœa and enteritis

There were 19 deaths under the age of two years from diarrhœa and enteritis compared with 24 in the previous year. This represents a rate of 0·35 per 1,000 live births and shows a continuation of the low figures of recent years.

Diphtheria

The number of notifications of diphtheria during the year was higher than in 1957. This was largely due to an outbreak in Finsbury, beginning in late September. A boy had a mild sore throat from which a virulent diphtheria bacillus was later grown. Energetic steps were taken locally, particularly in the three schools attended by family contacts. Widespread swabbing was carried out and this was followed by immunisation or re-immunisation of children in these schools. These measures brought to light a number of healthy carriers and these account for most of the notifications. All cases with symptoms had such a mild illness as to give rise to great difficulty in diagnosis. This was fortunately almost entirely a bacteriological epidemic.

Two deaths from diphtheria were registered during the year. One was a girl of 9 years with a history of nephritis, who developed laryngeal diphtheria for which tracheotomy was performed. She was said to have been immunised in infancy, and received a boosting dose of TAF in January, 1956. In view of the circumstances all children given TAF on the same day as this child in 1956 were Schick tested, and all were found to be Schick negative. Swabbing of school contacts of this girl resulted in two healthy carriers being discovered. The other death was that of a woman aged 26 years. Consideration of the circumstances of her fatal illness leaves the diagnosis of diphtheria in much doubt ; all swabs, and also those from contacts, were negative.

Dysentery

There was a marked increase in notifications to 4,502 compared with 2,356 in the previous year although incidence was not so high as in the record epidemic year of 1956. Highest incidence was located mainly in a compact group of boroughs in the east-central part of London. Once more the proportion of notifications in children of school age diminished ; this proportion had reached its highest level during the epidemic of 1956.

Enteric fever

Notifications of enteric fever totalled 42 compared with 47 in 1957. All were sporadic cases, and there were no local outbreaks.

Influenza

After the unusual events of 1957 influenza assumed the more usual seasonal pattern during 1958. Mortality was below average.

Influenza deaths in the last 10 years are shown in the following table :

TABLE (xiii)—*Influenza deaths*, 1949–58

Year	*Influenza deaths*	*Year*	*Influenza deaths*
1949	372	1954	83
1950	256	1955	164
1951	809	1956	120
1952	162	1957	384
1953	514	1958	150

Leptospirosis

For the second consecutive year no cases of leptospirosis were reported among the Council's sewer workers.

Measles

The year 1958 was an inter-epidemic year, and the last period of this year saw the beginning of the 1959 epidemic. The total number of cases in 1958 was higher than in 1956 or 1954 but not unusually high for inter-epidemic years by the standards of previous years.

Ophthalmia neonatorum

There was a slight increase in the number of notifications from 102 in 1957 to 132 in 1958—the rate (per 1,000 live babies registered) changing from 1·69 to 1·99. Cases among children born to London residents totalled 99—vision was unimpaired in 89, nine removed and the remaining infant was still under treatment at the end of the year.

Poliomyelitis

The figure of 107 notifications of poliomyelitis was the lowest since 1946. A point of interest is that the figure was lower than that registered in 1938. In 1958 only 25 per cent. of the notifications were of non-paralytic poliomyelitis, this proportion being much lower than usual. As will be seen in table (xiv) there was a reduction in the proportion of notifications in the 5–14 year age group with a corresponding increase in the proportion under 5 years.

TABLE (xiv)—*Poliomyelitis notifications by age*, 1949–58

Year	*0–4 years*		*5–14 years*		*15 years and over*		*Total*	
	No.	%	*No.*	%	*No.*	%	*No.*	%
1949..	356	53·3	173	25·9	139	20·8	668	100·0
1950..	150	34·9	149	34·6	131	30·5	430	100·0
1951..	27	24·1	45	40·2	40	35·7	112	100·0
1952..	95	30·7	105	34·0	109	35·3	309	100·0
1953..	116	35·0	104	31·3	112	33·7	332	100·0
1954..	42	33·6	41	32·8	42	33·6	125	100·0
1955..	334	34·8	391	40·7	235	24·5	960	100·0
1956..	88	31·5	115	41·2	76	27·3	279	100·0
1957..	103	31·8	131	40·4	90	27·8	324	100·0
1958..	40	37·4	36	33·6	31	29·0	107	100·0

In connection with the poliomyelitis vaccination scheme, detailed enquiries were made of the final diagnosis of all notifications between 1st July and 31st December. During this period the diagnosis of paralytic poliomyelitis was confirmed in 35 children under the age of 15 years, 5 of whom had been vaccinated against poliomyelitis, the remainder being unvaccinated. It was estimated that at the mid-point of the period 294,000 children were vaccinated and 361,000 unvaccinated and if these figures are used as the populations exposed to risk the attack rates are 1·7 per 100,000 in the vaccinated and 8·3 in the unvaccinated. In spite of this evidence of the efficacy of the vaccine in protecting individual children, it would be unwise to assume that the low overall incidence in 1958 was the result of the vaccination campaign. Vaccination may well have been one of the factors responsible, but a much higher level of vaccination must be achieved before the disease can be held in check.

Whooping cough

There were only 1,595 notifications, this being the lowest figure since 1940. For the second successive year only one death from this disease was recorded. Whooping cough is notoriously under-notified and there can be no doubt that the number of cases occurring is much greater than the notifications support. Nevertheless there is no doubt that there has been a marked reduction in incidence during the last two years. The part played by whooping cough immunisation in this reduced incidence and mortality remains enigmatic.

TABLE V.1—*Vital statistics—Metropolitan Boroughs and the Administrative County of London, 1958 (a)*

Metropolitan Boroughs	*Estimated home population mid 1958*	*Live birth rate*		*Death rate (all causes)*		*Infant Mortality (per 1,000 live births)*	*Death rates*							*Notifications of infectious disease*								
							Cancer	*Vascular lesions of C.N.S.*	*Heart disease*	*Other circulatory*	*Pneumonia*	*Other respiratory (including bronchitis)*	*Violence*	*Dysentery*	*Food poisoning*	*Measles*	*Pneumonia*	*Poliomyelitis*		*Scarlet fever*	*Whooping cough*	*Tuberculosis*	
		Crude	*Adjusted*	*Crude*	*Adjusted*													*Paralytic*	*Non-paralytic*			*Pulmonary*	*Non-pulmonary*
Division 1																							
Chelsea	50,190	14·7	11·2	14·5	10·4	33	2·75	1·95	3·91	1·00	0·74	1·06	0·76	2.21	*0·14*	4·32	*0·30*	*0·060*	—	*0·32*	0.40	0·82	*0·14*
Fulham	114,700	15·5	14·9	11·6	11·6	18	2·43	1·33	3·37	0·54	0·57	1·19	0·50	1·94	*0·16*	4·03	0·51	*0·044*	*0·017*	0·44	0·44	0·80	*0·10*
Hammersmith ..	110,200	18·4	17·1	11·3	12·0	24	2·28	1·23	2·92	0·71	0·66	1·26	0·48	1·11	0·33	4·63	0·93	*0·009*	*0·009*	0·44	0·68	1·12	*0·05*
Kensington ..	165,700	18·0	13·0	10·0	10·1	23	2·03	1·15	2·76	0·71	0·51	0·69	0·66	0·71	0·28	3·95	0·42	*0·012*	*0·012*	0·16	0·56	0·96	*0·10*
Division 2																							
Hampstead ..	96,480	15·9	11·9	11·1	11·1	20	2·66	1·23	3·33	0·55	0·55	0·67	0·64	0·62	*0·16*	7·32	0·41	*0·021*	—	0·53	0·22	0·85	*0·13*
Paddington ..	115,700	20·4	16·3	11·5	12·1	22	2·49	1·26	3·28	0·55	0·64	0·77	0·81	0·35	0·91	6·93	0·31	*0·043*	—	0·70	0·83	1·34	*0·13*
St. Marylebone ..	71,410	10·9	8·5	16·4	11·3	33	3·01	2·13	5·95	0·64	0·60	1·34	0·70	0·62	*0·25*	3·44	0·29	—	—	0·28	*0·15*	0·85	*0·13*
St. Pancras ..	130,800	17·6	15·1	10·9	11·3	23	2·45	1·16	2·72	0·50	0·80	1·06	0·57	1·19	0·90	11·51	1·15	*0·015*	—	0·83	0·32	1·45	0·18
Westminster City of ..	95,440	10·7	8·8	11·0	11·4	19	2·63	1·46	3·03	0·67	0·51	0·75	0·62	0·62	*0·17*	5·01	*0·07*	*0·010*	—	0·36	*0·13*	1·33	*0·07*
Division 3																							
Finsbury	34,960	18·2	16·0	9·7	10·1	22	2·06	0·92	2·69	*0·37*	0·63	1·20	*0·43*	9·15	1·32	6·66	2·66	*0·029*	—	1·14	0·83	0·63	*0·14*
Holborn	21,870	9·8	7·0	11·7	12·8	28	2·83	1·33	2·83	*0·50*	*0·87*	*0·73*	0·91	1·37	*0·50*	2·56	*0·09*	*0·137*	*0·046*	*0·41*	*0·14*	1·10	*0·09*
Islington ..	225,800	20·5	18·5	11·5	11·3	23	2·34	1·12	3·41	0·52	0·72	1·13	0·47	3·59	0·75	13·02	0·48	*0·035*	*0·009*	1·19	0·50	1·39	0·09
Division 4																							
Hackney ..	163,400	17·1	15·9	11·0	12·1	20	2·26	1·09	3·42	0·62	0·49	1·11	0·47	1·59	0·34	5·02	0·38	*0·012*	—	1·10	0·48	0·69	*0·04*
Shoreditch ..	43,330	16·5	15·0	10·9	8·8	21	2·52	1·25	2·52	*0·42*	0·76	1·71	*0·28*	2·79	*0·09*	3·05	*0·44*	*0·162*	*0·069*	0·92	*0·39*	0·72	*0·09*
Stoke Newington	50,480	18·7	16·6	10·6	12·0	22	2·08	0·91	3·55	0·81	0·42	0·93	0·48	3·47	*0·06*	7·92	*0·34*	*0·020*	*0·020*	0·85	*0·22*	0·87	*0·06*
Division 5																							
Bethnal Green ..	49,830	17·4	16·2	11·5	11·5	19	2·55	0·98	2·99	0·52	0·92	1·34	0·36	2·49	*0·06*	0·86	*0·08*	*0·080*	—	1·69	*0·24*	0·76	—
City of London(*b*)	5,000	6·4	5·8	11·6	11·8	63	*2·60*	*0·80*	*3·00*	*0·60*	*0·80*	*1·00*	*1·40*	*0·40*	*1·20*	*1·80*	—	—	—	*0·80*	—	*1·20*	—
Poplar	64,780	17·0	16·2	11·2	12·7	34	2·36	1·16	2·93	0·56	0·79	1·08	0·32	0·65	0·43	1·33	1·19	*0·015*	—	1·96	0·34	0·76	*0·12*
Stepney	96,360	18·8	16·5	12·0	13·0	20	2·29	1·33	3·23	0·39	0·87	1·33	0·47	1·50	0·72	2·07	0·93	*0·031*	—	1·01	0·37	1·41	*0·09*
Division 6																							
Deptford	70,220	16·6	15·9	11·9	11·9	28	2·11	1·34	3·94	0·47	0·83	1·22	0·53	1·65	*0·07*	1·74	1·03	—	—	0·84	0·81	1·42	*0·13*
Greenwich ..	89,180	14·8	13·9	10·3	11·7	15	2·04	1·19	3·48	0·37	0·55	0·96	0·36	0·22	0·44	3·43	0·47	*0·011*	*0·011*	1·19	0·62	0·61	*0·06*
Woolwich ..	144,600	13·9	13·9	10·5	11·1	20	2·26	1·16	3·19	0·57	0·81	0·62	0·33	*0·13*	*0·01*	2·89	0·67	—	*0·007*	0·73	0·34	0·64	*0·06*
Division 7																							
Camberwell ..	177,300	17·3	15·9	11·5	11·7	21	2·39	1·31	3·23	0·64	0·84	1·06	0·45	0·45	0·40	3·77	0·28	*0·034*	*0·006*	0·91	0·55	1·00	*0·08*
Lewisham ..	221,000	14·8	14·1	11·0	11·0	24	2·14	1·24	3·48	0·49	0·64	1·09	0·47	1·06	0·16	3·78	0·28	*0·018*	*0·018*	0·95	0·65	0·98	0·09
Division 8																							
Bermondsey ..	54,450	16·4	15·4	11·6	12·6	20	2·72	1·01	3·36	0·68	0·94	0·99	0·46	3·38	0·61	4·92	*0·22*	—	—	0·96	0·59	0·92	*0·17*
Lambeth ..	223,600	20·1	18·1	11·3	11·6	25	2·42	1·44	3·25	0·61	0·67	0·99	0·45	0·57	0·23	2·68	0·51	*0·022*	*0·004*	0·68	0·59	0·85	0·09
Southwark ..	89,920	17·8	15·8	12·8	10·4	27	2·30	1·23	4·25	0·69	0·89	1·11	0·50	2·51	0·42	6·38	0·47	*0·011*	—	1·75	0·71	1·33	*0·10*
Division 9																							
Battersea ..	110,400	17·1	16·2	11·3	11·1	24	2·24	1·57	3·43	0·62	0·67	0·92	0·40	1·77	*0·17*	5·56	0·51	—	—	0·69	0·82	0·61	*0·07*
Wandsworth ..	337,900	15·3	14·7	15·4	10·8	19	3·52	1·45	5·12	0·67	0·87	1·04	0·48	1·00	0·68	5·21	0·64	*0·036*	*0·021*	0·91	0·39	0·69	0·10
London, 1958 ..	3,225,000	16·8	15·0	11·8	11·6	22	2·47	1·29	3·52	0·59	0·70	1·03	0·50	1·40	0·40	5·17	0·54	0·025	0·008	0·84	0·50	0·96	0·10
London, 1957 ..	3,254,000	16·2	14·4	11·4	11·3	22	2·44	1·19	3·34	0·56	0·65	0·93	0·46	0·72	0·37	11·36	0·67	0·062	0·038	0·67	1·22	1·06	0·09

(*a*) *Rates are per 1,000 home population, figures in italics are based upon fewer than 20 births, deaths or notifications.*
(*b*) *Including Inner and Middle Temple.*

TABLE V.2—*Principal vital statistics—Administrative County of London*, 1949–1958

Year	Annual rate per 1,000 living				Annual mortality per 1,000 living (a)													Annual mortality		
	Live births		Deaths (all causes)		Tuberculosis										Violence			Infant (per 1,000 live births)		Maternal (per 1,000 total births)
	Crude rate	Adjusted rate	Crude rate	Adjusted rate	Pulmonary	Non-pulmonary	Cancer	Vascular lesions of C.N.S.	Heart disease	Other circulatory disease	Influenza	Pneumonia (all forms)	Bronchitis	Other resp. diseases	Suicide	Road accidents (b)	Other violence	Infants 0—1	Diarrhœa and enteritis 0—2	
1949 ..	16·7	15·0	11·7	11·8	0·47	0·05	2·10	1·07	3·31	0·65	0·11	0·61	0·90	0·15	0·14	0·08	0·24	27	1·7	0·71
1950 ..	15·7	14·2	11·3	11·4	0·36	0·04	2·20	1·11	3·54	0·45	0·08	0·50	0·78	0·10	0·12	0·08	0·25	26	1·2	0·69
1951 ..	15·6	14·0	12·6	12·7	0·34	0·04	2·27	1·22	3·87	0·46	0·24	0·64	1·14	0·12	0·13	0·09	0·24	25	0·8	0·79
1952 ..	15·3	13·8	12·0	12·1	0·28	0·03	2·30	1·27	3·55	0·62	0·05	0·61	1·09	0·12	0·11	0·07	0·22	23	0·8	0·95
1953 ..	15·3	13·3	11·6	11·5	0·21	0·02	2·34	1·20	3·25	0·59	0·15	0·64	1·07	0·12	0·14	0·08	0·21	24	1·4	0·71
1954 ..	15·2	13·3	10·7	10·6	0·18	0·02	2·31	1·20	3·22	0·60	0·02	0·48	0·66	0·10	0·15	0·08	0·21	21	0·5	0·66
1955 ..	15·1	13·3	11·5	11·4	0·16	0·01	2·39	1·25	3·37	0·61	0·05	0·63	0·88	0·11	0·14	0·10	0·22	23	0·5	0·77
1956 ..	15·9	14·0	11·7	11·7	0·13	0·01	2·42	1·27	3·46	0·59	0·04	0·67	0·96	0·11	0·15	0·10	0·22	21	0·4	0·51
1957 ..	16·2	14·4	11·4	11·3	0·12	0·02	2·45	1·19	3·34	0·56	0·12	0·65	0·83	0·10	0·15	0·09	0·21	22	0·5	0·52
1958 ..	16·8	15·0	11·8	11·6	0·12	0·01	2·47	1·29	3·52	0·59	0·05	0·70	0·92	0·11	0·17	0·11	0·22	22	0·4	0·60

(a) *Death rates in 1949 relate to the civilian population only.*

(b) *Deaths from motor vehicles and other road traffic accidents.*

TABLE V.3—*Deaths by cause—Administrative County of London*, 1958

Cause	Sex	0—	1—	5—	15—	25—	45—	65—	75+	Total 1958	Total 1957
1. Tuberculosis—respiratory ..	M	–	–	2	4	30	112	81	40	**269**	283
	F	–	–	–	*1*	*33*	*31*	*21*	*24*	***110***	*95*
2. Tuberculosis—other	M	–	–	1	–	8	5	6	3	**23**	26
	F	–	–	–	*1*	*2*	*3*	*1*	*11*	***18***	*24*
3. Syphilitic disease	M	–	–	–	–	1	27	28	16	**72**	104
	F	–	–	–	–	*2*	*12*	*16*	*15*	***45***	*42*
4. Diphtheria	M	–	–	–	–	–	–	–	–	—	—
	F	–	–	*1*	–	*1*	–	–	–	***2***	*1*
5. Whooping cough	M	–	*1*	–	–	–	–	–	–	**1**	—
	F	–	–	–	–	–	–	–	–	—	*1*
6. Meningococcal infection ..	M	2	1	–	–	–	1	1	1	**6**	5
	F	*2*	*1*	–	–	–	–	–	–	***3***	*6*
7. Acute poliomyelitis	M	–	1	1	–	4	–	–	–	**6**	10
	F	–	–	–	–	*1*	–	–	–	***1***	*2*
8. Measles	M	–	1	1	–	–	–	–	–	**2**	7
	F	–	*2*	–	–	–	–	–	–	***2***	*4*
9. Other infective, &c., diseases	M	2	2	–	–	5	14	7	3	**33**	38
	F	*1*	*1*	*2*	*4*	–	*15*	*7*	*6*	***36***	*44*
10. Malignant neoplasm: Stomach	M	–	–	–	1	23	213	194	128	**559**	590
	F	–	–	–	–	*18*	*92*	*141*	*171*	***422***	*430*
11. Malignant neoplasm: Lung, bronchus	M	–	–	–	–	52	883	555	231	**1,721**	1,653
	F	–	–	–	–	*22*	*124*	*115*	*68*	***329***	*337*
12. Malignant neoplasm: Breast	M	–	–	–	–	–	5	3	3	**11**	6
	F	–	–	–	–	*80*	*301*	*169*	*166*	***716***	*699*
13. Malignant neoplasm: Uterus	*F*	–	–	–	–	*32*	*122*	*78*	*58*	***290***	*321*
14. Other malignant and lymphatic neoplasms	M	4	9	12	7	109	624	601	561	**1,927**	1,866
	F	–	*8*	*8*	*16*	*83*	*577*	*509*	*628*	***1,829***	*1,867*
15. Leukemia, aleukemia	M	–	2	5	6	14	21	20	10	**78**	108
	F	*1*	*5*	*7*	*5*	*13*	*21*	*22*	*25*	***99***	*79*
16. Diabetes	M	–	–	–	–	2	29	20	26	**77**	67
	F	–	–	–	*1*	*4*	*23*	*65*	*65*	***158***	*156*
17. Vascular lesions of nervous system	M	1	–	–	2	34	340	509	694	**1,580**	1,488
	F	–	–	–	*1*	*36*	*369*	*665*	*1,503*	***2,574***	*2,398*
18. Coronary disease, angina ..	M	–	–	–	–	142	1,298	1,159	973	**3,572**	3,381
	F	–	–	–	–	*13*	*327*	*814*	*1,199*	***2,353***	*2,161*
19. Hypertension with heart disease	M	–	–	–	–	5	58	84	181	**328**	386
	F	–	–	–	–	–	*44*	*132*	*362*	***538***	*563*
20. Other heart disease	M	–	1	1	7	43	233	391	1,100	**1,776**	1,720
	F	*1*	–	–	*3*	*59*	*260*	*435*	*2,038*	***2,796***	*2,653*
21. Other circulatory disease ..	M	1	–	–	2	27	189	232	344	**795**	799
	F	–	–	*1*	–	*20*	*113*	*268*	*708*	***1,110***	*1,030*
22. Influenza	M	–	1	1	2	3	17	25	18	**67**	193
	F	*2*	–	–	*2*	*4*	*8*	*20*	*47*	***83***	*191*
23. Pneumonia	M	83	16	3	1	18	172	263	505	**1,061**	1,062
	F	*65*	*7*	*11*	–	*18*	*108*	*231*	*767*	***1,207***	*1,053*
24. Bronchitis	M	24	7	2	1	18	519	657	715	**1,943**	1,832
	F	*15*	*4*	*2*	–	*13*	*128*	*250*	*595*	***1,007***	*876*
25. Other diseases of respiratory system	M	4	–	3	1	7	93	67	67	**242**	231
	F	*1*	–	*3*	*1*	*5*	*31*	*29*	*47*	***117***	*94*
26. Ulcer of stomach and duodenum	M	–	–	–	–	12	107	111	107	**337**	340
	F	–	–	–	–	*4*	*25*	*44*	*83*	***156***	*159*
27. Gastritis, enteritis and diarrhœa	M	9	2	–	2	6	18	11	17	**65**	68
	F	*9*	–	–	*2*	*3*	*24*	*39*	*47*	***124***	*127*
28. Nephritis and nephrosis ..	M	–	1	–	4	17	52	25	24	**123**	133
	F	–	–	*2*	*1*	*15*	*26*	*25*	*44*	***113***	*105*
29. Hyperplasia, prostate ..	M	–	–	–	–	–	16	58	134	**208**	248
30. Pregnancy, childb. : abortn.	*F*	–	–	–	*10*	*23*	–	–	–	***33***	*28*
31. Congenital malformations ..	M	124	10	9	11	4	20	4	1	**183**	179
	F	*120*	*7*	*6*	*10*	*13*	*15*	*5*	*4*	***180***	*175*
32. Other defined and ill defined diseases	M	433	14	12	12	70	230	198	315	**1,284**	1,401
	F	*287*	*6*	*12*	*14*	*73*	*257*	*296*	*665*	***1,610***	*1,651*

TABLE V.3 (*contd.*)—*Deaths by cause—Administrative County of London*, 1958

Cause	*Sex*	*0—*	*1—*	*5—*	*15—*	*25—*	*45—*	*65—*	*75+*	*Total*	
										1958	*1957*
33. Motor vehicle accidents ..	M	–	3	16	58	39	58	27	30	**231**	216
	F	–	*1*	*4*	*4*	*12*	*22*	*31*	*30*	***104***	*78*
34. All other accidents	M	12	16	21	25	80	99	46	78	**377**	380
	F	*12*	*9*	*6*	*10*	*20*	*35*	*58*	*177*	***327***	*284*
35. Suicide	M	–	–	1	16	100	128	34	26	**305**	310
	F	–	–	–	*13*	*59*	*112*	*41*	*19*	***244***	*188*
36. Homicide, operations of war	M	2	2	1	2	5	5	–	1	**18**	12
	F	*1*	–	–	*1*	*2*	*4*	*1*	*1*	***10***	*14*
ALL CAUSES	M	701	90	92	164	878	5,586	5,417	6,352	**19,280**	19,142
	F	*517*	*51*	*65*	*100*	*683*	*3,229*	*4,528*	*9,573*	***18,746***	*17,936*

TABLE V.4—*Weather during* 1958

(*as recorded at Kew Observatory*)

Month	*Temperature*		*Rainfall*		*Sunshine*	
	Mean (a) °F	*Difference from Average (b)* °F	*Total* ins.	*Difference from Average (b)* ins.	*Total* hrs.	*Difference from Average (c)* hrs.
January	40·6	+0·9	1·91	−0·05	42·9	+1·1
February ..	43·0	+2·7	2·30	+0·75	48·1	−10·3
March .. .	40·3	−2·5	1·02	−0·52	118·8	+12·1
April	46·6	−0·9	1·28	−0·43	156·8	+7·6
May	54·5	+0·9	2·28	+0·53	201·9	+4·4
June	58·8	−0·6	4·13	+2·15	164·5	−36·0
July	62·6	−0·1	2·48	+0·10	210·0	+14·5
August	61·7	−0·1	3·41	+1·17	127·6	−57·4
September.. ..	60·4	+3·0	3·96	+1·97	146·7	+5·8
October	53·2	+2·9	2·04	−0·47	93·6	+0·4
November ..	45·7	+1·5	1·89	−0·45	42·6	−8·6
December ..	42·8	+2·1	2·97	+0·81	33·2	−4·1
Year	50·9	+0·9	29·67	+5·56	1,386·7	−70·5

(*a*) *Average of the daily means of 24 hourly readings.*
(*b*) *Average over the 80 years ended 1950.*
(*c*) *Average over the 70 years ended 1950.*

TABLE V.5—*Notifiable infectious diseases—Annual number of notifications and numbers per 1,000 of population—Administrative County of London, 1938–1958*

Year	Anthrax		Diphtheria		Dysentery		Acute encephalitis		Enteric fever		Erysipelas		Malaria		Measles		Meningococcal infection		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
1938 ..	4	0·001	7,611	1·88	1,049	0·259	5	0·001	191	0·047	1,829	0·451	16	0·004	(d) 282	0·28	182	0·045	489	(a) 7·61	3,962	0·978	134		0·033		853	(b) 15·18	}		8,093	2·00	—	—	—	—	1,891	(d) 1·87	}	
1939 ..	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	169	0·045	408	8·24	3,733	0·990	98		0·026		704	13·05	(c)		5,677	1·51	—	—	—	—	10,537	2·80		
1940 ..	3	0·001	1,844	0·601	161	0·052	8	0·003	158	0·052	1,076	0·351	16	0·005	5,447	1·78	839	0·274	303	7·18	2,688	0·876	20		0·007		472	9·91			2,498	0·81	—	—	—	—	669	0·22		
1941 ..	1	0·0004	2,179	0·921	610	0·258	10	0·004	210	0·089	1,171	0·495	13	0·005	11,039	4·67	706	0·298	185	8·77	2,518	1·064	41		0·017		340	9·88			2,372	1·00	—	—	—	—	7,944	3·36		
1942 ..	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	341	0·142	210	6·23	2,246	0·936	25		0·010		505	12·01			4,416	1·84	2	0·0008	—	—	6,234	2·60		
1943 ..	4	0·002	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	231	0·093	233	5·92	3,159	1·267	43		0·017		471	10·20	9,689	(e) 9·18	9,477	3·80	—	—	—	—	6,661	2·67	} (c)	
1944 (f) ..	—	—	758	0·308	1,450	0·589	2	0·0008	30	0·012	916	0·372	78	0·032	7,329	2·98	150	0·061	211	5·73	2,292	0·931	17		0·006		399	8·68	16,450	6·70	3,862	1·57	2	0·0008	—	—	7,136	2·90		
1945 ..	—	—	801	0·308	1,867	0·718	3	0·001	28	0·011	818	0·314	93	0·036	23,486	9·03	145	0·056	222	5·45	1,930	0·742	63		0·024		515	10·97	14,753	5·69	4,079	1·57	3	0·001	3	0·001	3,264	1·25		
1946 ..	—	—	747	0·240	845	0·272	6	0·002	44	0·014	844	0·271	168	0·054	22,846	7·35	184	0·059	268	4·04	2,125	0·683	29		0·009		553	8·18	11,892	3·84	4,402	1·42	2	0·0006	—	—	6,887	2·22		
1947 ..	2	0·0006	451	0·136	309	0·093	7	0·002	48	0·015	742	0·224	47	0·014	17,486	5·28	166	0·050	231	3·02	2,110	0·638	702		0·212		441	6·11	5,304	1·60	4,331	1·31	3	0·001	1	0·0003	9,267	2·80		
1948 ..	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	110	0·033	224	3·37	1,891	0·566	141		0·042		460	7·42	2,484	0·74	4,568	1·37	—	—	—	—	10,450	3·13		
1949 ..	3	0·0009	221	0·065	440	0·130	4	0·001	58	0·017	383	0·173	21	0·006	28,816	8·54	76	0·023	186	2·99	1,838	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 ..	2	0·0006	81	0·024	960	0·283	18	0·005	63	0·019	566	0·167	20	0·006	22,282	6·57	90	0·027	145	2·40	1,691	0·499	267	0·079	163	0·048	371	6·78	823	0·24	4,157	1·23	—	—	—	—	10,875	3·21	863	0·25
1951 ..	1	0·0003	30	0·009	4,069	1·212	19	0·006	66	0·020	496	0·148	23	0·007	49,148	14·64	108	0·032	93	1·56	2,409	0·717	61	0·018	51	0·015	911	14·96	572	0·17	3,705	1·10	—	—	1	0·0003	10,448	3·11	787	0·23
1952 ..	—	—	18	0·005	1,704	0·507	21	0·006	25	0·007	467	0·139	22	0·007	31,055	9·23	82	0·024	202	3·36	1,908	0·567	204	0·061	105	0·031	1,860	30·38	535	0·16	5,263	1·56	—	—	—	—	5,587	1·66	612	0·18
1953 ..	—	—	11	0·003	2,639	0·789	18	0·005	45	0·013	408	0·122	89	0·027	27,046	8·09	98	0·029	161	2·76	2,434	0·728	235	0·070	97	0·029	1,712	28·72	527	0·16	3,425	1·02	—	—	—	—	11,027	3·30	1,269	0·38
1954 ..	1	0·0003	4	0·001	4,268	1·285	15	0·005	49	0·015	368	0·111	53	0·016	7,445	2·41	86	0·026	112	1·92	1,502	0·452	79	0·024	46	0·013	1,938	32·51	669	0·20	2,444	0·74	—	—	1	0·0003	4,691	1·41	1,060	0·32
1955 ..	—	—	16	0·005	3,019	0·916	20	0·006	111	0·034	361	0·110	40	0·012	49,110	14·90	98	0·030	106	1·85	1,903	0·578	512	0·155	448	0·136	1,584	33·92	660	0·20	2,070	0·63	—	—	—	—	4,709	1·43	1,530	0·46
1956 ..	1	0·0003	11	0·003	6,392	1·953	54	0·016	73	0·022	297	0·091	31	0·009	9,651	2·95	94	0·029	83	1·39	1,633	0·499	183	0·056	96	0·029	1,792	29·49	703	0·21	2,198	0·67	—	—	—	—	5,450	1·67	1,327	0·41
1957 ..	—	—	4	0·001	2,356	0·724	27	0·008	47	0·014	269	0·083	44	0·014	36,952	11·36	70	0·022	102	1·69	2,185	0·672	201	0·062	123	0·038	2,008	32·42	630	0·19	2,177	0·67	—	—	—	—	3,982	1·22	1,189	0·37
1958 ..	—	—	38	0·012	4,302	1·396	38	0·012	42	0·013	257	0·080	10	0·003	16,664	5·17	81	0·025	132	1·99	1,735	0·538	80	0·025	27	0·008	1,680	24·85	635	0·20	2,716	0·84	—	—	—	—	1,595	0·50	1,300	0·40

(a) *Rate per 1,000 live births registered in London.* (b) *Rate per 1,000 total births after correction for London residence 1938–50; from 1951 rate per 1,000 total births registered in London. For cause of increase from this date see page 16 of Annual Report for 1951.* (c) *Comparable figures not available for this period.* (d) *Cases relate to last quarter only—Rates are adjusted on an annual basis.* (e) *Cases relate to last 22 weeks only—Rates are adjusted on an annual basis.* (f) *In order to preserve uniformity with published national figures the 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 the years 1947–51.*

TABLE V.6—*Notification of certain infectious diseases—distribution by age and date of notification—Administrative County of London, 52 weeks commencing 29th December, 1957*

Four-weekly periods 1958		Dysentery				Measles				Meningococcal infection				Pneumonia			
		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
1— 4	M	103	44	35	**190**	49	15	1	**65**	5	1	1	**7**	21	7	163	**191**
	F	*81*	*46*	*75*	***212***	*42*	*15*	—	***57***	*6*	—	*2*	***8***	*25*	*12*	*178*	***216***
5— 8	M	149	136	47	**337**	72	107	1	**180**	3	—	1	**4**	51	18	83	**154**
	F	*126*	*121*	*111*	***362***	*77*	*97*	*4*	***178***	*5*	—	*3*	***8***	*35*	*17*	*113*	***165***
9—12	M	118	95	48	**262**	182	152	10	**344**	3	—	1	**4**	14	9	58	**81**
	F	*86*	*100*	*71*	***257***	*194*	*145*	*8*	***347***	*4*	—	*1*	***5***	*11*	*13*	*59*	***84***
13—16	M	75	73	24	**174**	266	294	20	**581**	2	2	3	**7**	13	11	81	**106**
	F	*73*	*64*	*78*	***217***	*242*	*283*	*23*	***551***	—	—	*1*	***1***	*10*	*7*	*55*	***72***
17—20	M	57	50	27	**137**	364	264	30	**659**	5	—	2	**7**	5	5	59	**69**
	F	*60*	*29*	*48*	***141***	*380*	*298*	*31*	***709***	*1*	—	—	***1***	*4*	*3*	*35*	***42***
21—24	M	43	40	32	**117**	619	469	9	**1,098**	3	—	—	**3**	7	7	26	**41**
	F	*51*	*37*	*48*	***137***	*591*	*467*	*28*	***1,089***	*3*	—	*1*	***4***	*3*	*5*	*26*	***36***
25—28	M	68	79	15	**165**	549	428	8	**992**	1	1	1	**3**	8	3	23	**34**
	F	*61*	*60*	*58*	***179***	*555*	*432*	*21*	***1,009***	—	—	—	***—***	*4*	*6*	*22*	***32***
29—32	M	62	65	39	**166**	544	416	13	**975**	—	1	—	**1**	4	5	29	**38**
	F	*56*	*55*	*62*	***174***	*508*	*354*	*8*	***874***	*1*	—	—	***1***	*1*	*3*	*15*	***19***
33—36	M	43	14	23	**80**	302	112	2	**416**	—	—	—	**—**	2	7	13	**22**
	F	*35*	*20*	*26*	***85***	*282*	*108*	*9*	***400***	*2*	—	*1*	***3***	*2*	*3*	*15*	***20***
37—40	M	44	30	38	**113**	140	78	3	**221**	—	—	1	**1**	4	5	16	**25**
	F	*36*	*22*	*36*	***94***	*128*	*78*	*3*	***209***	*3*	—	—	***3***	*1*	*3*	*20*	***24***
41—44	M	36	41	28	**105**	252	194	1	**448**	—	1	—	**1**	5	7	21	**33**
	F	*37*	*42*	*35*	***115***	*254*	*196*	*7*	***457***	*5*	—	—	***5***	*5*	*5*	*27*	***38***
45—48	M	49	48	32	**130**	374	314	9	**698**	—	—	—	**—**	8	9	49	**68**
	F	*44*	*48*	*45*	***137***	*388*	*324*	*6*	***725***	*1*	—	—	***1***	*4*	*5*	*34*	***44***
49—52	M	64	63	29	**157**	621	647	7	**1,277**	1	—	—	**1**	8	11	52	**71**
	F	*58*	*53*	*47*	***159***	*580*	*608*	*9*	***1,201***	*1*	—	—	***1***	*6*	*8*	*42*	***56***
Total (52 weeks)	M	911	778	417	**2,133**	4,334	3,490	114	**7,954**	23	6	10	**39**	150	104	673	**933**
	F	*805*	*697*	*740*	***2,269***	*4,221*	*3,405*	*157*	***7,806***	*32*	—	*9*	***41***	*111*	*90*	*641*	***848***

Four-weekly periods 1958		Poliomyelitis								Scarlet fever				Whooping cough			
		Paralytic				Non-paralytic or not stated				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
1— 4	M	—	2	1	**3**	1	—	1	**2**	24	57	3	**84**	34	17	—	**51**
	F	—	*2*	*1*	***3***	—	—	—	***—***	*26*	*58*	*3*	***88***	*39*	*26*	*1*	***66***
5— 8	M	1	—	1	**2**	—	—	—	**—**	37	80	4	**121**	33	20	2	**56**
	F	*1*	—	*1*	***2***	—	—	—	***—***	*38*	*73*	*1*	***112***	*49*	*30*	—	***79***
9—12	M	—	—	—	**—**	—	1	1	**2**	31	81	9	**121**	34	19	—	**53**
	F	*1*	—	*1*	***2***	—	—	*1*	***1***	*23*	*90*	*3*	***116***	*34*	*20*	*1*	***55***
13—16	M	—	—	—	**—**	—	—	—	**—**	26	77	4	**108**	36	23	1	**60**
	F	*1*	—	*2*	***3***	—	—	—	***—***	*31*	*61*	*8*	***101***	*29*	*22*	—	***51***
17—20	M	2	—	—	**2**	—	2	—	**2**	20	73	7	**101**	32	18	—	**50**
	F	*1*	*2*	—	***3***	—	*1*	—	***1***	*30*	*64*	*8*	***102***	*36*	*26*	—	***62***
21—24	M	2	1	2	**5**	—	1	—	**1**	22	53	—	**75**	35	24	—	**60**
	F	*2*	*1*	*1*	***4***	—	—	—	***—***	*20*	*82*	*3*	***105***	*41*	*23*	—	***65***
25—28	M	—	1	—	**1**	1	1	—	**2**	22	67	1	**90**	38	30	1	**69**
	F	—	—	*1*	***1***	—	*1*	*1*	***2***	*20*	*90*	*3*	***113***	*34*	*30*	—	***64***
29—32	M	1	2	2	**5**	—	—	—	**—**	28	49	1	**78**	34	30	1	**65**
	F	*1*	*2*	—	***3***	—	—	—	***—***	*25*	*48*	*2*	***75***	*38*	*25*	—	***63***
33—36	M	—	1	1	**2**	1	1	—	**2**	25	21	3	**49**	51	22	3	**76**
	F	*1*	—	*1*	***2***	—	*2*	—	***2***	*26*	*25*	*1*	***52***	*58*	*33*	*5*	***96***
37—40	M	2	1	2	**5**	—	4	1	**5**	25	46	2	**74**	46	16	—	**62**
	F	*2*	—	*1*	***3***	*2*	*1*	—	***3***	*12*	*56*	*2*	***70***	*43*	*27*	*1*	***71***
41—44	M	5	4	3	**12**	—	—	—	**—**	34	84	1	**120**	28	9	—	**37**
	F	*2*	*1*	*1*	***4***	*1*	—	—	***1***	*37*	*83*	*1*	***121***	*39*	*19*	*3*	***62***
45—48	M	2	1	—	**3**	—	1	1	**2**	41	101	—	**144**	30	35	—	**66**
	F	*3*	—	*2*	***5***	*2*	—	—	***2***	*39*	*107*	*5*	***152***	*30*	*26*	*1*	***63***
49—52	M	3	1	1	**5**	—	1	—	**1**	59	106	2	**167**	28	15	1	**44**
	F	*2*	—	*1*	***3***	—	—	—	***—***	*27*	*126*	*4*	***158***	*30*	*15*	—	***45***
Total (52 weeks)	M	18	14	13	**45**	3	12	4	**19**	394	895	37	**1,332**	459	278	9	**749**
	F	*17*	*8*	*13*	***38***	*5*	*5*	*2*	***12***	*354*	*963*	*44*	***1,365***	*500*	*322*	*12*	***842***

Notes: 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 V.5 which relates to the calendar year 1958 and which includes bulk notifications from hospitals not notified individually.

TUBERCULOSIS

Introduction

THE NOTIFICATION rates of tuberculosis were slightly lower than in 1957, and death rates showed the same general trend. Deaths from pulmonary tuberculosis under 25 years of age and all deaths from non-pulmonary tuberculosis are now so few that considerable random fluctuations occur in the rates from year to year. The number of cases on the registers remains practically unchanged, the figure has been about 38,000 for the past four years. The diagram on page 28 shows the trend of notifications, deaths and numbers on the registers of chest clinics over the last decade.

Services provided

The services provided by the Council as local health authority and described in detail in my report for 1955 for the care and after-care of tuberculous patients and the prevention of tuberculosis continued to be available during the year. They are summarised for the years 1953–58 in Table T9 (page 34). A third hostel for 32 homeless infective tuberculous men was opened in July, 1958, at Knight's Hill (Lambeth-Norwood).

Care Committees

The voluntary tuberculosis care committees associated with most of the 29 chest clinics in London continued their valuable work of assisting patients and their families financially or in other ways where help was not available from official sources. The Council's local tuberculosis care organisers act as secretaries to these committees.

B.C.G. vaccination

The numbers of children vaccinated during the year under the Council's schemes for the B.C.G. vaccination of susceptible (tuberculin negative) child contacts of known tuberculous patients, diabetic children and thirteen-year-old school children are shown in Table T12 (page 36).

Preventive measures

In addition to the B.C.G. vaccination schemes other preventive measures arranged by the Council include the chest X-ray of all newly appointed staff who are likely to work in close and frequent contact with children, staff and senior pupils at the Council's occupation centres for mentally deficient persons Table T11 (page 36) and of positive tuberculin reactors discovered among thirteen-year-old school children tested with a view to B.C.G. vaccination.

Epidemiological investigations are made among the contacts of cases of tuberculosis notified from among the children, staff or residents in the Council's establishments. Similar investigations are carried out at secondary schools where the tuberculin positive rates disclosed by tuberculin surveys are significantly higher than the average for secondary schools in the area. (See Table T8, page 33.)

TABLE T1—*Tuberculosis—Statutory notifications and deaths—Administrative County of London*, 1949–58 (*a*)

Year	*Pulmonary tuberculosis*				*Non-pulmonary tuberculosis*			
	Statutory notifications		*Deaths*		*Statutory 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*
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
1953 ..	4,668	1·40	690	0·21	410	0·12	73	0·02
1954 ..	4,231	1·27	596	0·18	410	0·12	62	0·02
1955 ..	3,757	1·14	517	0·16	365	0·11	44	0·01
1956 ..	3,602	1·10	423	0·13	327	0·10	32	0·01
1957 ..	3,460	1·06	378	0·12	294	0·09	50	0·02
1958 ..	3,103	0·96	379	0·12	305	0·10	41	0·01

(*a*) *Excluding posthumous notifications.*

TREND OF TUBERCULOSIS
LONDON A.C. 1949-58

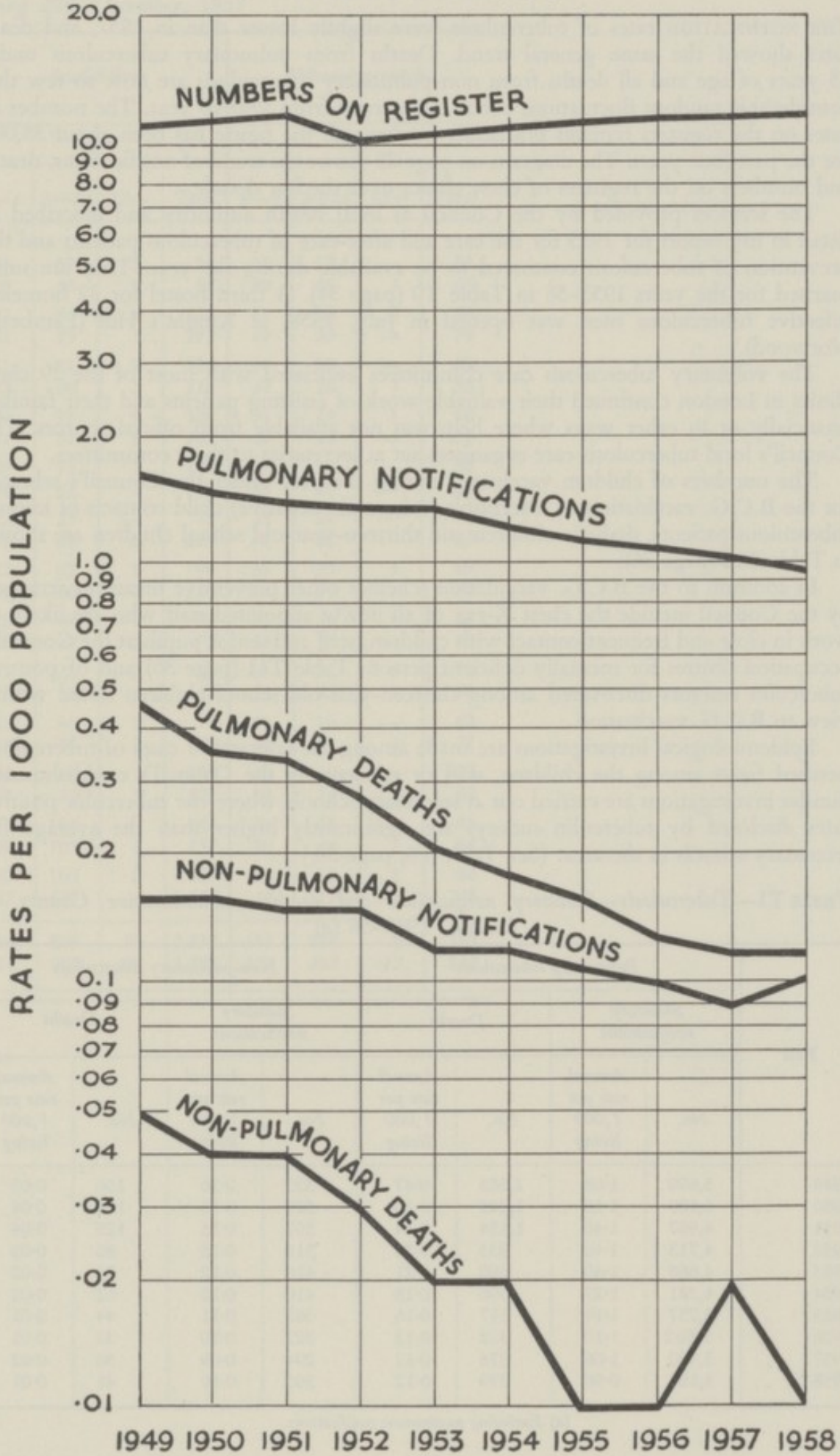


TABLE T2—*Pulmonary tuberculosis—Notification and death rates per* 1,000 *living by age and sex*, 1949–1958

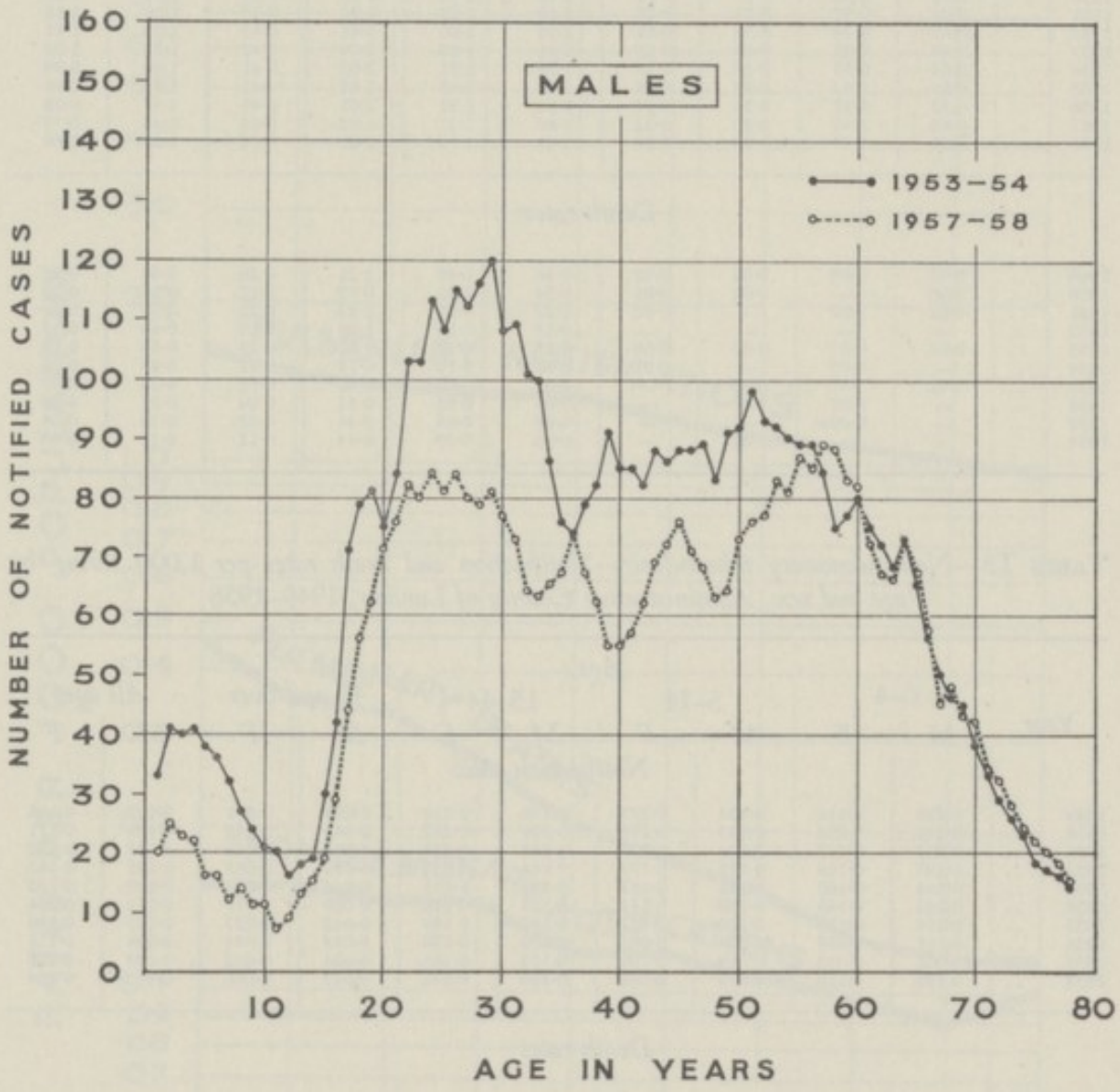
Year	Age 0–4 M	0–4 F	5–14 M	5–14 F	15–44 M	15–44 F	45 and over M	45 and over F	All ages M	All ages F
	Notification rates									
1949 ..	1·08	0·94	0·82	1·04	2·70	2·45	1·84	0·39	2·03	1·36
1950 ..	1·15	0·86	0·75	0·77	2·46	2·34	1·59	0·33	1·83	1·26
1951 ..	0·98	0·92	0·74	0·68	2·18	1·98	1·91	0·36	1·80	1·16
1952 ..	0·65	0·70	0·53	0·61	2·16	1·90	1·88	0·43	1·73	1·11
1953 ..	0·84	0·85	0·69	0·65	2·01	1·80	2·09	0·42	1·76	1·08
1954 ..	0·64	0·55	0·48	0·55	1·79	1·71	2·02	0·41	1·60	0·99
1955 ..	0·56	0·42	0·39	0·48	1·65	1·48	1·82	0·41	1·45	0·86
1956 ..	0·33	0·37	0·31	0·34	1·62	1·31	2·01	0·41	1·47	0·78
1957 ..	0·43	0·40	0·30	0·32	1·60	1·27	1·92	0·38	1·44	0·73
1958 ..	0·39	0·33	0·30	0·27	1·49	1·03	1·89	0·32	1·37	0·60
	Death rates									
1949 ..	0·02	0·03	0·01	0·02	0·46	0·46	1·21	0·26	0·65	0·30
1950 ..	0·05	—	0·01	0·01	0·34	0·32	0·99	0·22	0·51	0·22
1951 ..	0·02	0·02	—	0·02	0·27	0·21	1·23	0·22	0·53	0·18
1952 ..	—	—	—	—	0·18	0·16	1·08	0·18	0·44	0·14
1953 ..	0·02	0·03	0·00	0·00	0·12	0·11	0·81	0·13	0·33	0·10
1954 ..	—	0·03	—	0·01	0·07	0·10	0·74	0·12	0·28	0·09
1955 ..	0·02	—	0·00	—	0·07	0·06	0·66	0·11	0·25	0·07
1956 ..	—	0·02	—	—	0·07	0·05	0·52	0·09	0·21	0·06
1957 ..	—	0·009	—	—	0·06	0·05	0·46	0·08	0·19	0·05
1958 ..	—	—	0·01	—	0·05	0·05	0·44	0·11	0·18	0·06

TABLE T3—*Non-pulmonary tuberculosis—Notification and death rates per* 1,000 *living by age and sex, Administrative County of London*, 1949–1958

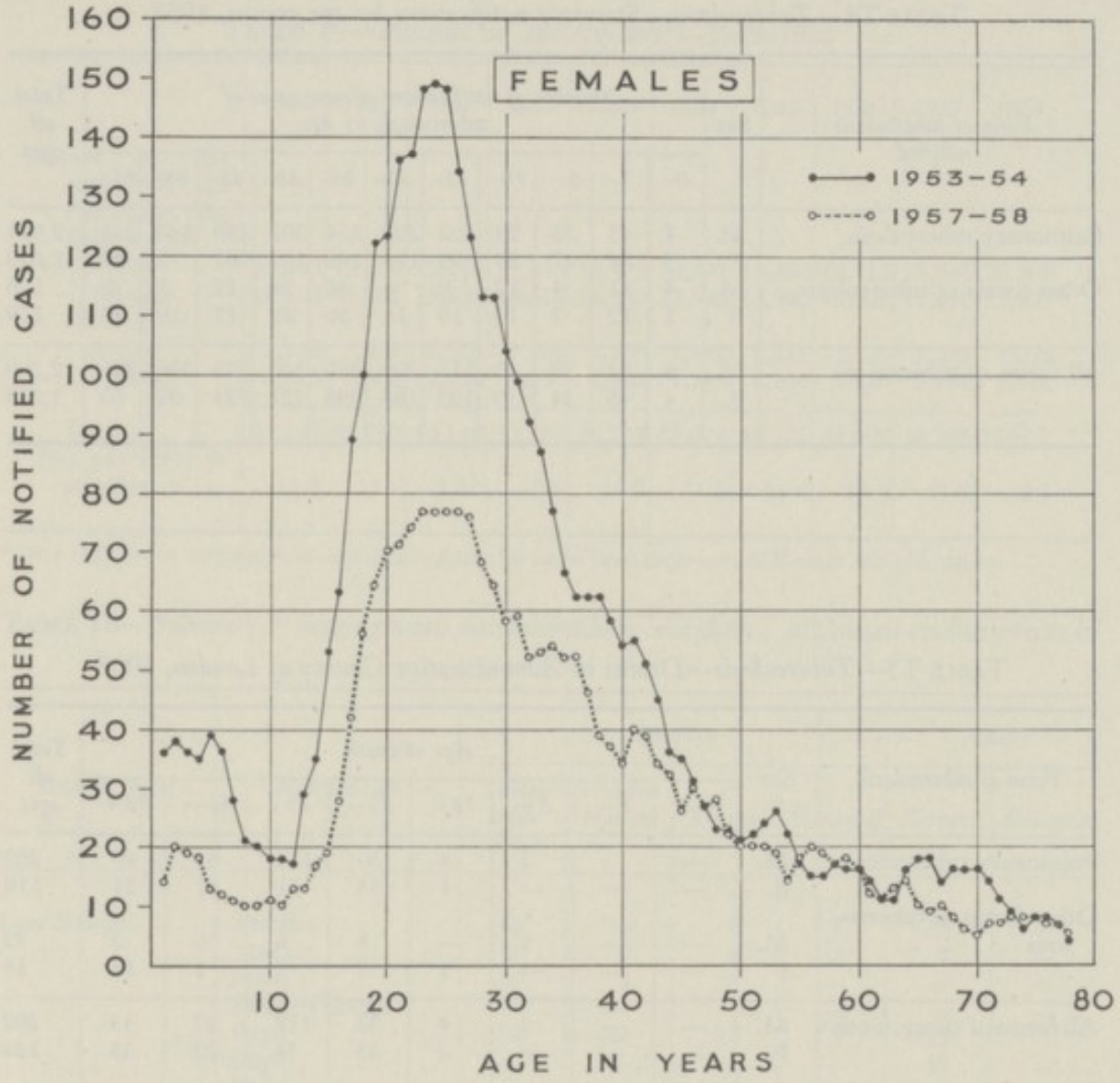
Year	Age 0–4 M	0–4 F	5–14 M	5–14 F	15–44 M	15–44 F	45 and over M	45 and over F	All ages M	All ages F
	Notification rates									
1949 ..	0·275	0·312	0·404	0·375	0·156	0·214	0·054	0·041	0·157	0·168
1950 ..	0·241	0·296	0·265	0·271	0·164	0·247	0·049	0·042	0·140	0·171
1951 ..	0·207	0·269	0·294	0·257	0·143	0·223	0·053	0·043	0·138	0·162
1952 ..	0·198	0·168	0·275	0·173	0·144	0·233	0·070	0·085	0·141	0·165
1953 ..	0·144	0·160	0·152	0·182	0·138	0·175	0·044	0·070	0·109	0·135
1954 ..	0·142	0·149	0·139	0·187	0·128	0·176	0·069	0·071	0·111	0·134
1955 ..	0·110	0·116	0·140	0·121	0·140	0·189	0·042	0·037	0·105	0·116
1956 ..	0·111	0·089	0·078	0·095	0·109	0·176	0·048	0·058	0·084	0·114
1957 ..	0·076	0·063	0·069	0·100	0·105	0·168	0·034	0·052	0·073	0·106
1958 ..	0·126	0·116	0·075	0·083	0·108	0·148	0·047	0·066	0·083	0·104
	Death rates									
1949 ..	0·092	0·119	0·065	0·039	0·052	0·027	0·057	0·025	0·059	0·034
1950 ..	0·043	0·074	0·032	0·039	0·036	0·022	0·042	0·038	0·038	0·034
1951 ..	0·071	0·067	0·031	0·048	0·040	0·019	0·041	0·039	0·042	0·033
1952 ..	0·053	0·040	0·010	0·010	0·027	0·018	0·033	0·029	0·029	0·023
1953 ..	0·024	0·076	0·005	0·010	0·017	0·017	0·025	0·029	0·019	0·025
1954 ..	0·025	0·018	0·005	—	0·016	0·009	0·035	0·029	0·021	0·016
1955 ..	0·008	0·009	0·009	0·005	0·012	0·004	0·021	0·024	0·014	0·013
1956 ..	0·009	—	—	—	0·009	0·004	0·023	0·014	0·012	0·007
1957 ..	0·008	0·009	0·009	0·005	0·011	0·004	0·030	0·027	0·017	0·014
1958 ..	—	—	0·005	—	0·012	0·004	0·026	0·021	0·015	0·010

Natural trends and the effects of B.C.G. vaccination and of recent chemotherapeutic measures on the number of new cases in males and females throughout the various ages of life are demonstrated graphically.

NOTIFICATION OF PULMONARY TUBERCULOSIS, LONDON A.C. 1953-54 AND 1957-58—THREE-YEAR MOVING AVERAGES.



These show by a comparison of figures for 1953-54 with those for 1957-58 how great has been the fall in new notifications of pulmonary tuberculosis between ages 15 and 52 in the case of men and between 13 and 42 in the case of women.



That almost exactly the same numbers of new cases persist at all ages after 42 in women and after 52 in men shows the need for persistent measures to discover cases in these age groups.

TABLE T4—*Tuberculosis—Statutory notifications by age groups*, 1958

Form of tuberculosis notified	*Sex*	*Number of notifications of new cases of tuberculosis by age*											*Total all ages*
		0–	*1–*	*5–*	*10–*	*15–*	*20–*	*25–*	*35–*	*45–*	*55–*	*65+*	
Pulmonary tuberculosis ..	M.	4	43	35	28	102	203	354	302	359	389	255	2,074
	F.	3	34	27	29	93	174	248	193	107	72	49	1,029
Other forms of tuberculosis ..	M.	4	11	4	12	9	6	31	24	12	7	6	126
	F.	1	12	7	10	10	14	50	28	17	10	20	179
All forms of tuberculosis ..	M.	8	54	39	40	111	209	385	326	371	396	261	2,200
	F.	4	46	34	39	103	188	298	221	124	82	69	1,208

TABLE T5—*Tuberculosis—Deaths in Administrative County of London*, 1958

Form of tuberculosis	*Sex*	*Age at death*								*Total all ages*
		0–	*1–*	*5–*	*15–*	*25–*	*45–*	*65–*	*75+*	
Pulmonary tuberculosis	M.	—	—	2	4	30	112	81	40	269
	F.	—	—	—	1	33	31	21	24	110
Other forms of tuberculosis	M.	—	—	1	—	8	5	6	3	23
	F.	—	—	—	1	2	3	1	11	18
All forms of tuberculosis	M.	—	—	3	4	38	117	87	43	292
	F.	—	—	—	2	35	34	22	35	128

TABLE T6—*Statutory notification of non-pulmonary tuberculosis—Distribution according to site and age, Administrative County of London*, 1958

Site of tuberculous lesion	*Numbers of notifications of new cases of non-pulmonary tuberculosis by age*				*Total all ages*
	0–4	*5–14*	*15–24*	*25+*	
Bones and joints	5	13	12	63	93
Abdomen	1	2	5	14	22
Peripheral glands	8	11	16	54	89
Meninges and C.N.S.	9	4	—	4	17
Skin and erythema nodosum	2	2	1	3	8
Genito-urinary	—	—	4	59	63
Other sites	3	1	1	8	13
All sites	28	33	39	205	305

TABLE T7—*Patients on the registers**—1949–1958

	1949	*1950*	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*
Cases on the register at the end of the year										
Pulmonary—										
Males	18,203	19,090	19,119	17,336	18,475	18,897	19,300	19,715	19,946	20,308
Females	14,223	15,031	15,556	14,672	14,930	15,576	15,846	15,928	15,836	15,597
Other forms :										
Males	2,752	2,591	2,520	1,530	1,508	1,442	1,371	1,339	1,274	1,293
Females	3,015	3,068	2,954	1,850	1,820	1,709	1,704	1,710	1,709	1,674
Total	38,193	39,780	40,149	35,388	36,733	37,624	38,221	38,692	38,765	38,872
No. per 1,000 of population	11·3	11·7	12·0	10·5	10·9	11·3	11·6	11·8	11·9	12·1

**Since 1952 figures are taken from chest clinic registers; for earlier years they represent Borough M.O.H. register.*

TABLE T8—*Summary of investigations into tuberculosis ' incidents ' at Council establishments in 1958*

Establishment	*Notified case*	*Children*				*Adults*	
		Tuber-culin tested	*Positive reactors*	*X-rayed*	*Abnormal*	*X-rayed*	*Abnormal*
Day School ..	Teacher	61	10	9	1	15	—
	Teacher	26	2	2	2	7	—
	Pupil	30	2	2	—	—	—
	Kitchen helper ..	—	—	—	—	6	—
	Pupil	116	24	22	1	13	—
	Pupil	—	—	—	—	47	—
	Pupil	—	—	13	—	11	—
	Teacher	27	—	—	—	6	—
	Pupils	140	11	32	1	27	—
	Pupil	—	—	—	—	28	—
	Pupil	—	—	30	—	14	—
Total (11) ..		400	49	110	5	174	—
Residential nursery ..	Assistant nurse ..	15	—	—	—	16	—
Central kitchen ..	Kitchen helper ..	—	—	—	—	8	—
Welfare homes (2)	Resident	—	—	—	—	18	—
	Assistant Class II ..	—	—	—	—	9	—
Grand Total (15)		415	49	110	5	225	—

TABLE T9—*Summary of services provided for tuberculous patients—Administrative County of London 1953–58*

	1953	*1954*	*1955*	*1956*	*1957*	*1958*
Clinic registers						
Total on registers at the end of the year	36,733	37,624	38,221	38,695	38,765	38,872
Work of local tuberculosis care organisers						
Patients assisted for the first time with :—						
Beds and bedding	431	435	291	240	176	165
Clothing or footwear	1,089	1,334	1,014	847	734	571
Patients at the end of the year receiving :—						
Extra nourishment	2,451	2,391	2,285	2,183	1,938	1,875
Home help service	618	729	660	624	528	467
Home care and treatment						
At the end of the year, patients :—						
Awaiting admission to hospital	494	209	71	22	34	16
Under treatment in their own homes	804	930	1,050	334	329	238
Receiving attention by home nurses	466	530	498	405	371	368
Home visiting by tuberculosis health visitors—						
Total visits (including contacts)	94,587	85,439	86,302	83,137	80,302	78,953
Diversional therapy						
At the end of the year, weekly classes at Chest Clinics	Not available			175	147	157
Receiving instruction in their own homes				239	259	262
Rehabilitation						
At the end of the year the Council was financially responsible for rehabilitants at :—						
British Legion Village, Maidstone	25	33	36	33	29	30
Papworth Village Settlement, Cambridge ..	17	23	22	26	19	15
Enham-Alamein Village Centre, Andover ..	21	22	15	10	9	10
Barrowmore Hall, Chester	2	2	2	—	1	1
Correspondence courses arranged through the British Council for Rehabilitation for patients undergoing prolonged treatment at home	113	80	77	33	20	14
At boarding open-air schools						
Children convalescent from tuberculosis :—						
At the beginning of the year	29	34	22	12	8	6
Admitted during the year	27	23	2	3	—	—
At the end of the year	34	22	12	8	6	1
Awaiting admission at end of year	7	1	—	2	—	—
Boarding-out of child contacts						
Children in nurseries and foster homes at the beginning of the year	440	450	365	279	172	136
Placed during the year	562	411	398	272	229	173
Boarded-out at the end of the year	450	365	279	172	136	94
Average number boarded-out at any one time ..	486	417	310	215	164	116
Boarding-out of child contacts for segregation during B.C.G. vaccination						
Children in nurseries and foster homes at the beginning of the year	24	6	11	7	4	3
Placed during the year	38	39	40	28	24	20
Boarded-out at the end of the year	6	11	7	4	3	9
Average number boarded-out at any one time ..	14	10	19	13	7	4
Hostels for homeless infective tuberculous men						
In residence at the beginning of the year	44	59	63	58	69	77
Recommendations approved during the year ..	84	57	49	82	60	81
In residence at the end of the year	59	63	58	69	77	103

TABLE T10—*Principal tuberculosis statistics—Metropolitan Boroughs and the Administrative County of London*, 1958

Metropolitan Boroughs	*Estimated home population mid 1958*	*New notifications*				*New notifications per 1,000 population*	*Deaths from tuberculosis*			*Tuberculosis deaths per 1,000 population*	*Pulmonary tuberculosis deaths per 1,000 population aged 15 and over*	*Number of tuberculosis cases on clinic registers at 31.12.58*		*Cases on register per 1,000 population*
		Pulmonary	*Tuberculosis of Meninges and C.N.S.*	*Other non-pulmonary tuberculosis*	*Total*		*Pulmonary*	*Non-pulmonary tuberculosis*	*Total deaths*			*Total*	*Percentage of pulmonary cases positive during 1958*	
Division 1														
Chelsea	50,190	41	—	7	48	0·96	4	1	5	0·10	0·09	431	4·4	8·6
Fulham	114,700	92	—	11	103	0·90	15	2	17	0·15	0·16	1,312	2·0	11·4
Hammersmith	110,200	123	1	4	128	1·16	13	2	15	0·14	0·15	1,537	2·6	13·9
Kensington	165,700	159	1	16	176	1·06	10	1	11	0·07	0·07	1,592	3·7	9·6
Division 2														
Hampstead	96,480	82	1	12	95	0·98	9	2	11	0·11	0·11	1,100	3·7	11·4
Paddington	115,700	155	1	14	170	1·46	7	1	8	0·07	0·07	1,429	4·7	12·4
St. Marylebone	71,410	61	—	9	70	0·98	7	—	7	0·10	0·11	902	3·3	12·6
St. Pancras	130,800	190	2	21	213	1·63	20	2	22	0·17	0·19	1,440	2·3	11·0
Westminster, City of	95,440	127	—	7	134	1·40	9	1	10	0·10	0·11	950	*	10·0
Division 3														
Finsbury	34,960	22	—	5	27	0·77	6	1	7	0·20	0·22	270	7·1	7·7
Holborn	21,870	24	—	2	26	1·19	3	—	3	0·14	0·16	256	3·3	11·7
Islington	225,800	314	2	19	335	1·48	31	5	36	0·16	0·17	2,735	3·3	12·1
Division 4														
Hackney	163,400	112	1	6	119	0·73	17	1	18	0·11	0·13	1,859	2·4	11·4
Shoreditch	43,330	31	—	4	35	0·81	3	1	4	0·09	0·09	391	5·6	9·0
Stoke Newington	50,480	44	—	3	47	0·93	2	2	4	0·08	0·05	779	1·6	15·4
Division 5														
Bethnal Green	49,830	38	—	—	38	0·76	9	—	9	0·18	0·23	806	2·2	16·2
City of London	5,000	6	—	—	6	1·20	—	—	—	—	—	64	5·1	12·8
Poplar	64,780	49	—	8	57	0·88	7	1	8	0·12	0·14	587	2·7	9·1
Stepney	96,360	136	—	9	145	1·50	15	1	16	0·17	0·20	1,212	2·5	12·6
Division 6														
Deptford	70,220	100	—	9	109	1·55	10	1	11	0·16	0·18	1,121	3·5	16·0
Greenwich	89,180	54	—	5	59	0·66	5	2	7	0·08	0·07	1,078	1·0	12·1
Woolwich	144,600	92	—	9	101	0·70	20	—	20	0·14	0·18	2,034	1·1	14·1
Division 7														
Camberwell	177,300	177	—	14	191	1·08	30	2	32	0·18	0·22	1,698	1·1	9·6
Lewisham	221,000	216	1	19	236	1·07	18	1	19	0·09	0·10	2,780	4·0	12·6
Division 8														
Bermondsey	54,450	50	1	8	59	1·08	6	1	7	0·13	0·14	620	1·0	11·4
Lambeth	223,600	189	2	19	210	0·94	24	2	26	0·12	0·14	3,259	2·1	14·6
Southwark	89,920	120	—	9	129	1·43	19	—	19	0·21	0·27	1,469	2·9	16·3
Division 9														
Battersea	110,400	67	1	7	75	0·68	17	3	20	0·18	0·20	1,087	2·8	9·8
Wandsworth	337,900	232	3	32	267	0·79	43	5	48	0·14	0·16	4,074	2·1	12·1
LONDON	3,225,000	3,103	17	288	3,408	1·06	379	41	420	0·13	0·15	38,872	2·6†	12·1

* *Figures not available.* † *Excluding City of Westminster.*

TABLE T11—*Tuberculosis—Annual chest X-ray examination of mental defectives at senior occupation centres—Administrative County of London—1958*

Division	*Occupation centre* *E.B.—elder boys* *E.G.—elder girls*	*Average roll at time of examination*	*Date of examination*	*No. X-rayed*		*No. of cases of T.B. discovered*
				Under 15	*Over 15*	
1	Hammersmith (E.B.) ..	32	26. 6.58	—	26	—
	N. Kensington (E.G.) ..	28	26. 6.58	—	23	—
3	Archway (E.B.)	40	9.12.58	3	24	—
	Islington (E.G.)	40	10.12.58	1	32	—
4	Clapton (E.G.)	45	19. 3.58	5	30	—
	Dalston (E.B.)	49	19. 3.58	9	32	—
6	Greenwich (E.G.) ..	26	11. 3.58	—	18	—
	Brockley (E.G.) ..	56	11. 3.58	1	45	—
7	Peckham (E.B.)	49	21. 2.58	1	36	—
	Totals	365		20	266	—

Annual X-ray examination of staff at occupation centres, 1958.

No. of existing staff X-rayed .. .. .. 54 All satisfactory.

TABLE T12—*B.C.G. vaccination under L.C.C. schemes in* 1957/58

1. *Day schools—*

1957/58

No. of schools visited 397
No. of 13-year-old children at school *40,899
No. of consents *30,365
No. Mantoux tested.. .. .. *27,742
No. of positive reactors .. .. *3,039=10·9 per cent.
No. given B.C.G. 24,651
No. vaccinated June, 1954, to December, 1958 91,746

Retests in 1958—

No. of consents to retest 4,093
No. of retests 3,768
No. found negative .. .. 58=1·5 per cent.
No. re-vaccinated 52

2. *Residential establishments—*

No. of establishments visited in 1958 6

No. of children tested 185
No. of positive reactors .. .. 36=19·4 per cent.
No. given B.C.G. 149

3. *Notifications of Tuberculosis (all forms) in 14- and 15-year-old children in*

1953 70
1954 82
1955 (first full year after B.C.G.) 45
1956 38
1957 39
1958 38

4. *Tuberculosis contacts—*

No. of contacts given B.C.G. vaccination in London in 1958 5,136
No. of contacts given B.C.G. vaccination in London since inception of scheme in 1950 31,155

5. *Diabetics—*

No. tuberculin tested .. .. No figures available.
No. given B.C.G. in 1958 17
No. given B.C.G. since inception of scheme 68

* *Divisional figures are shown in Table T13*

TABLE T13—*B.C.G. vaccination of school children in Administrative County of London, 1957/58 (fourth year)—Divisional figures*

Division	*No. of 13-year-old school children*	*Total No. of consents*	*Alleged contacts of known cases*	*No. of children tested and read by B.C.G. units*	*Children not dealt with because of refusal of consent or absence*		*Positive reactors (among (4))*		*No. of negative reactors vaccinated by B.C.G. units*	
			Consents included in (2)		*No.*	*Per cent. of (1)*	*No.*	*Per cent.*		
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	
1	4,552	3,379	39	3,239	1,274	28·0	398	12·3	2,841	
2	4,213	3,041	8	2,888	1,317	31·2	391	13·5	2,493	(4 negatives not vaccinated)
3	4,097	2,614	10	2,353	1,734	42·3	275	11·7	2,074	(4 negatives not vaccinated)
4	3,159	2,271	8	2,128	1,023	32·4	231	10·9	1,884	(13 negatives not vaccinated)
5	3,351	2,603	27	2,444	880	23·3	338	13·8	2,105	(1 negative not vaccinated)
6	4,365	3,486	76	3,249	1,040	23·8	333	10·2	2,911	(5 negatives not vaccinated)
7	6,515	5,195	59	4,349	2,107	32·3	363	8·3	3,970	(16 negatives not vaccinated)
8	5,272	3,978	18	3,436	1,818	34·5	376	10·9	3,060	
9	5,375	3,798	26	3,656	1,693	31·5	334	9·1	3,313	(9 negatives not vaccinated)
Totals ..	40,899	30,365	271	27,742	12,886	31·5	3,039	10·9	24,651	

Housing

A LIMITED number of houses was made available for (*a*) families containing tuberculous persons recommended by chest physicians for urgent rehousing, and (*b*) applicants recommended by general practitioners and hospitals as suffering from very serious medical conditions aggravated by housing circumstances. Applications received during the year were dealt with as follows :

(*a*) *Tuberculous persons—*

	1957	*1958*
Recommendations received	421	321
Nominated for rehousing	185	151
Recommendations not qualifying for rehousing	135	132
Under consideration at end of year	101	139

(*b*) *Persons with very severe medical conditions—*

Recommendations received	2,484	2,474
Nominated for rehousing	226	478
Recommendations not qualifying for rehousing	1,904	1,617
Under consideration at end of year	354	733

Slum clearance—

Areas represented as unfit for human habitation	90	77
Houses in such areas	2,409	1,830
Areas surveyed but not represented by the end of the year	81	11
Houses in such areas	2,004	312
Public local inquiries	28	36
Informal hearings	4	2
Orders confirmed—		
(i) after inquiry or hearing	45	33
(ii) without inquiry or hearing (no objections received)	13	14
Orders not confirmed	—	1

Improvement grants—

Surveys following applications to the Council	68	119
Searches following applications to metropolitan borough councils	158	103

Dangerous structures—

Premises scheduled as dangerous structures, searches made	1,094	1,229

Public health laboratory

The facilities available at the Medical Research Council's Public Health Laboratory at the County Hall and the close co-operation with its staff have proved of great value.

Milk Sampling

Designation	Samples examined		T.B. Bacillus isolated		T.B. Bacillus NOT isolated		Test not completed*		Percentage positive of completed tests	
	1957	1958	1957	1958	1957	1958	1957	1958	1957	1958
Ordinary	43	28	—	1	38	24	5	3	—	4·0
Tuberculin tested ..	30	136	—	—	23	130	7	6	—	—
do. (farm bottled)	—	—	—	—	—	—	—	—	—	—
Total	73	164	—	1	61	154	12	9	—	0·64

* *Guinea pigs died before completion of test or milk curdled.*

Milk purchased for use in Council establishments :

	1957	1958
Liquid milk, samples taken by boroughs and county councils ..	1,162	947
Number found to be unsatisfactory	3	7
Dried milk, samples submitted to bacteriological examination ..	4	4

No samples contained more than 100,000 organisms per gramme, nor was staphylococcus aureus isolated.

Sanitary inspection

The public health inspectors dealt with the following matters in Council establishments :

	1957	1958
Reports of infestation by a variety of pests	178	190
Visits and re-inspections involved	294	347
Inspections of school meals centres	420	375
Investigations of illness following consumption of school meals ..	15	12
Occasions when the meal was found to be the cause	2	3

Blind and partially-sighted persons

During the year, 1,637 examinations—148 less than in the previous year—were made in connection with certification under the National Assistance Act, 1948, of blind or partially-sighted persons. 35 persons were found to be neither blind nor partially-sighted. In addition, 451 certificates were accepted from other local authorities, hospitals and private ophthalmologists—117 more than the previous year. The percentage of new registrations recommended to obtain treatment increased from 53·8 per cent. to 59·6 per cent.

The results of examinations of persons newly registered during the year are given in Tables (i) and (ii).

TABLE (i)

Number of new registrations during the year with percentage recommended to obtain treatment

Age	Principal cause of defective vision				Total
	Cataract	Glaucoma	Retrolental fibroplasia	Other conditions	
0–4 years	1	—	—	7	8
5–15 years	—	1	—	1	2
16–64 years	20	17	—	168	205
65–74 years	60	31	—	143	234
75 years and over	181	50	—	312	543
Age not known	2	—	—	—	2
(*a*) Total No. of persons	264	99	—	631	994
(*b*) No. recommended to obtain treatment	177	77	—	338	592
(*b*) as percentage of (*a*)	67·0	77·8	—	53·6	59·6

TABLE (ii)

Number of treatments recommended in respect of newly registered persons

	No. of patients examined	Treatments recommended					Optical	Hospital supervision
		None	Medical	Surgical				
				Early	Later	If general condition permits		
Cataract	264	87	20	40	31	23	15	75
Glaucoma	100	22	22	1	1	—	2	57
Retrolental fibroplasia ..	—	—	—	—	—	—	—	—
Other conditions ..	630	293	72	16	16	10	43	240
TOTAL	994	402	114	57	48	33	60	372

Persons recommended to obtain treatment are re-examined at intervals after the initial registration. The number of persons re-examined for this reason in 1958 is shown in Table (iii).

TABLE (iii)

Re-examination of persons recommended to obtain treatment

	Principal cause of defective vision				Total
	Cataract	Glaucoma	Retrolental fibroplasia	Other conditions	
No. of persons re-examined	207	57	—	263	527
No. found to have had treatment ..	151	43	—	177	371
Percentage treated	72·9	75·4	—	67·3	70·4

As a consequence of successful treatment, 15 persons previously registered as blind were found, on re-examination, to be partially-sighted and 5 persons previously certified as blind or partially-sighted were found to be improved to such an extent as no longer to justify registration.

Figures for ophthalmia neonatorum are given on page 20.

Registration of nursing homes

	1957	*1958*
Registered at beginning of year	39	38
Homes registered—change of keeper	—	1
Registrations cancelled—voluntary closure or change of keeper	1	2
Registered at end of year	38	37
Inspections:		
medical officers	51	41
public health inspectors	96	50
Homes exempted from registration	39	38

The 37 homes registered at 31.12.58 provided the following accommodation:

Number of beds in home	*Number of homes*	*Patients accommodated*		
		Maternity†	*Others**	*Total*
25 or over	10	236	219	455
20 to 24	4	25	62	87
15 to 19	8	30	98	128
10 to 14	7	12	74	86
5 to 9	6	22	23	45
Under 5	2	—	5	5
Total	37	325	481	806

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

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

Welfare Committee establishments

Medical supervision of establishments of all types under the control of the Welfare Committee was continued. In the large homes, in spite of the exchange arrangements for the admission to hospital of chronic sick persons and the reception from hospital of infirm patients ready for discharge, the number of chronic sick residents has not been reduced. There is a reluctance in geriatric units to give beds to patients whose general health cannot improve with medical treatment, although these patients are properly the responsibility of the hospital service. The presence, in large numbers, of persons wholly confined to bed and requiring constant nursing care creates problems in residential homes staffed mainly by care and attention staff. An increasing number of trained nurses is being appointed to the large homes to act in a supervisory capacity in the nursing care and in the distribution and control of drugs needed to alleviate the condition of the chronic sick.

Invalid meals for London

The Council makes a grant-in-aid to Invalid Meals for London, a voluntary body providing meals for invalids and sick persons. Meals are supplied, on the production of a medical certificate, to sick persons including the aged, expectant and nursing mothers, persons discharged from or awaiting admission to hospital, cripples and invalids, e.g., diabetics, requiring special diets. Meals are delivered by motor van to the homes of patients unable to attend the dining rooms attached to five centres.

	1956	*1957*	*1958*
	£	£	£
Grant-in-aid	11,500	11,500	17,500
Meals served	187,578	174,011	167,134

SCIENTIFIC BRANCH

THE SCIENTIFIC BRANCH undertakes analytical and consultative work in chemistry and allied sciences and research on 'domestic' matters for all departments of the Council.

The work of the branch, much of it most important from the point of view of public health, is carried out in three groups of laboratories by a staff numbering 61. At the County Hall headquarters a wide field is covered including air pollution, building and decorative materials, food, fuels, lubricants, laundries, trade effluents, swimming baths, statutory duties, etc. The northern and southern outfall laboratories, situated at Beckton and Crossness respectively, are concerned with obtaining scientific data for the control of the sewage treatment processes and ancillary plant together with research on new methods. Close liaison is maintained with officers in government departments, research organisations, and scientific societies, and the Scientific Adviser and senior officers are members of a number of committees under the auspices of other bodies.

A summary of these activities from the Scientific Adviser's annual report* is given below.

Synopsis of work done

Samples examined during 1958 totalled 36,369, and the following table indicates their main categories. This record of laboratory examinations takes no account of much advisory service, not necessarily associated with analytical work, given by the senior professional officers which is an important function of the branch:

Air from vehicular tunnels	254
Bacteriological, miscellaneous	71
Building materials	590
Chemicals, drugs and medical supplies	268
Clay, sub-soils and borehole waters	4,492
Detergents and soaps	124
Fertilisers and feeding stuffs	96
Foods	499
Floor oils	71
Fuel (coal and coke)	10
Gases from sludge digestion plant	433
Instrument sets (ambulance) for sterilisation	24
Insulating materials for hot water systems	31
Lamps; gas detector	470
Laundry tests	166
Liquor (effluent from Beckton Gas Works)	714
Meals	54
Metals	46
Milk	58
Miscellaneous, numerous categories	237
Oils, lubricating and fuel	87
Paints, varnishes, distempers	1,718
Petroleum and allied samples	38
Rain water (air pollution deposits)	84
Sewage and effluent	2,079
Sludge; primary, digested, activated	3,386
Smoke in air, determinations	3,960
Sulphur gases in air:	
Lead peroxide method	128
Volumetric method	3,953
Water, steam raising plant	1,401
Water, chemical and bacteriological examination:	
Drinking water	954
Swimming baths	1,247
River water	3,570
Water, miscellaneous	86
Trade effluents	2,648
Research and investigation samples	2,349
	36,369

* *A full account of the work of the Scientific Branch is given in the Annual Report of the Scientific Adviser for the Year 1958. The London County Council, price 1s. 3d.*

The following paragraphs relate these activities to the various responsibilities and services of the Council.

River Thames

The condition of London's river is of special concern to the Council. In addition to effluents from the Council's own sewage treatment plants, there are sources of pollution from other sewage works, impure tributaries, trade discharges, and contamination from shipping. To assess the condition of the water under varying conditions of fresh water and tidal flow, and to compare the state between seasons of the year and over periods of years, regular weekly examinations are made involving chemical analysis of water taken from 26 points over a distance of 80 miles. The area examined extends from the upper limit of the tidal reaches at Teddington to the sludge dumping area at Black Deep in the outer estuary.

Dissolved oxygen is continuously being absorbed by oxidisable matter present in the water and the rate of renewal of oxygen from the air depends on the temperature, the wind, and other factors. If the process of absorption requires more oxygen than can be replaced from the air, putrescent conditions arise in which sulphate-reducing bacteria produce hydrogen sulphide from water-soluble sulphate. The summer quarter, July to September, with its higher temperature and normally reduced rainfall is the critical period.

In 1958 the flow of fresh water during the summer quarter was greater than in any year since 1930, and in consequence there was a marked improvement. At no point was the river completely devoid of dissolved oxygen at high tide during this period, and at low tide only off the Southern Outfall Works was dissolved oxygen absent for the whole quarter. Although much of this improvement may be attributed to the increased fresh water flow, the new sedimentation plant at the Northern Outfall Works played a significant part in reducing pollution.

The Scientific Adviser continued to be a member of the Thames Survey Committee of the Department of Scientific and Industrial Research, and of the Heated and Other Effluents Committee of the Ministry of Housing and Local Government. Both committees deal with aspects of the condition of the river and are to make recommendations for its improvement.

Sewage treatment

The treatment of sewage at both outfall works is the joint responsibility of the Chief Engineer and the Medical Officer of Health. Close daily collaboration is maintained between their staffs and weekly conferences are held between the Divisional Engineer (Main Drainage) and the Scientific Adviser, together with their senior officers, to discuss analytical results and operational practice.

The primary sedimentation tanks at the Northern Outfall Works, installed in 1955, continued to reduce the amount of suspended matter leaving this section of the plant by one-half and the oxygen demand by one-third.

The present secondary treatment plant treated up to about 40 million gallons daily. The final effluent from this approached Royal Commission standard for a considerable part of the time. New diffused air plant to extend the capacity for secondary treatment will shortly come into use.

Sludge digestion provided gas at the rate of half a million cubic feet daily.

During the year a considerable programme of research and development work was carried out. Collaboration with the National Chemical Laboratory of the Department of Scientific and Industrial Research in the experimental biological production of sulphur continued. Work on radioactive tracers was extended and problems relating to foam from detergents were investigated. Tests on automatic samplers were continued.

Trade waste discharges

The Council exercises control under the London County Council (General Powers) Act, 1953, over industrial discharges into the London sewerage system ; these have

increased in volume and complexity over recent years. About half of the samples examined were submitted by metropolitan boroughs, and of 2,648 samples examined, 551 were considered to contravene the Act.

Following the examination of unsatisfactory samples, officers of the Scientific Branch and of the Chief Engineer's Department usually visit the premises to discuss with the occupiers the problems involved in treating the discharges. A similar procedure is followed when consideration is given to applications for permission to make new discharges where standards have to be prescribed.

Safety in sewers

Regular examination of inflammable-gas detector lamps of the expanding metal spiral type and those based on selective diffusion is made to ensure that all lamps are in good order and advice is given as required on the use of self-contained oxygen respirators. Experiments have continued on methods of improving sewer ventilation.

Air pollution

The Council has co-operated for many years with the Department of Scientific and Industrial Research in investigating the incidence of air pollution. Regular observations are made at 20 sites, which include seven parks, six ambulance stations, Kew Observatory, and the Science Museum.

The records of air pollution obtained at these sites were again reported to the Fuel Research Station for collation with those of other authorities and publication. They are also being used by the statistical section of this department in a continuing investigation of their relationship with mortality and morbidity.

The average concentration of sulphur dioxide for the year remained at the same level as in previous years, but in the case of smoke the figures show a small decrease of 10 to 20 per cent. during the last two years, both in summer and winter. The reduction in the ratio of smoke to sulphur dioxide may be indicative of a general improvement in the efficiency of fuel consumption and it will be of great interest to see if the trend continues in future years.

By a standing agreement with the Ministries concerned, the Scientific Adviser or his deputy accompanied the Chief Alkali Inspector of the Ministry of Housing and Local Government on visits of inspection to test the efficiency of the flue gas washing plants at Battersea and Bankside Power Stations.

The widespread applications of nuclear science have drawn attention to the risks of environmental contamination by radioactive matter, and during the year further study was made of the techniques of measurement. Such contamination can arise from tests of nuclear explosives, reactor accidents, or unguarded use of the radioisotopes now being widely utilised in hospitals, research laboratories and industry. A continuous record was maintained of the amount of airborne radioactivity, and this indicated the fluctuation in the amount of fall-out resulting from two major periods of testing in the spring and autumn.

The air in the Council's vehicular tunnels under the Thames was examined weekly in order to ensure that forced ventilation gave an adequate dilution of exhaust gases. Carbon monoxide was kept within the specified limit on most occasions at both Blackwall and Rotherhithe tunnels, but the amount of black suspended matter showed a continued tendency to increase in comparison with previous years. This change is attributable to the larger proportion of diesel-engined heavy vehicles now in use, which can be a prolific source of smoke unless carefully maintained and properly driven. The amount of carbon monoxide produced by the diesel engine is, however, relatively low.

Water supplies

Care is taken to ensure that the water supplies to Council establishments are of satisfactory quality. In the majority of cases water is taken from a public supply, but 15 residential schools and other premises draw water from private wells. In these cases the supply is chlorinated before use by means of automatic dosing apparatus and the water supply is regularly examined.

Parks

Although some work was done for this department on fertilisers, soils and other matters of horticultural interest, the major item of work was to ensure efficient water treatment and pleasant bathing at the 16 open-air swimming baths provided for public use. The condition of the water is tested daily by bath attendants and visits are made periodically by officers of the branch.

School Meals, Education and Children's departments

In co-operation with the School Meals and Catering Department, typical meals were analysed for fat, protein, carbohydrate, mineral content and calorific value in order to ascertain that the standards aimed at were being provided by the kitchens. The results showed a good approximation to the requirements of the various nutritional factors for the age groups concerned.

Swimming bath waters at 24 schools and institutions were regularly examined and advice was given on treatment.

Fire Brigade

Much of the work in this field is of a consultative and advisory nature. Investigations were made of cases in which spontaneous ignition was suspected as the cause of fire and where particular materials had caused a fire to spread rapidly. A prototype was developed of a warning device for use by firemen wearing breathing apparatus, and tests were made on other devices in conjunction with a Home Office sub-committee on breathing apparatus.

HEALTH SERVICE PREMISES

As soon as it was known that the Council would become responsible for the personal health services under the National Health Service Act, 1946, a detailed survey was undertaken of the premises which would be transferred to the Council.

This investigation showed that maternity and child welfare centres varied considerably, both in standard and type, and were mainly accommodated in church halls, shops and converted dwelling houses: these were generally sub-standard and in need of replacement. Only a small proportion (about 10 per cent.) of the transferable premises had been specially built for the purpose for which they were used and, while a number of these provided excellent facilities, others, built earlier, were too small to be regarded as adequate by modern standards. Furthermore, an analysis of the distribution of buildings showed that certain areas were not adequately served either by maternity and child welfare centres or day nurseries, partly as a result of alterations in the density of the population within the County which had occurred during and since the war.

It was thus apparent that a radical replanning both of the location of the centres and the type of building required would be necessary in order to place the services on a firm basis.

Health service areas

The preparation of a comprehensive plan for the organisation and future development of the local health services necessitated the sub-division of each of the Council's nine health divisions into a number of smaller planning units for the purpose of assessing both the immediate and long-term needs of individual localities. These smaller units, known as health service areas, were formed by grouping together two or more contiguous Town Planning 'neighbourhood units' included in the County of London Development Plan. Each health service area thus contains a unit of population (about 20,000) forming a socially complete entity, small enough to enable contact to be maintained between the health services and the people for whom they are provided, but sufficiently large to ensure maximum efficiency and economy.

Building programmes

In formulating plans for the development of the newly transferred services it was recognised that prevailing shortages of materials and labour would preclude the erection of many new centres and other health service buildings, and that the rate at which progress could be made would be very largely dependent upon the country's economic position.

Initial building programmes were accordingly designed to secure the completion of building works already begun by the metropolitan borough councils before the 'appointed day' and the provision of additional accommodation, either by improvisation or, where practicable, by new building, in areas where there existed serious deficiencies.

Five-year building programme, 1954–59

Following a reappraisal of the accommodation requirements of the health services, the Health Committee approved a five-year capital building programme for the period 1954–59 prepared with the object of securing that building works should be carried out, as far as practicable, in order of priority and phased so that they might become available at the time they were required. In the light of advice from the Minister of Health, schemes for replacement clinic buildings were excluded from this programme and included in a reserve list of works from which the most urgent could be brought forward if circumstances permitted.

Works completed 1949–58

Although restrictions on capital expenditure have prevented the Council from carrying out much of its five-year health service building programme a substantial number of high priority projects were completed, or nearing completion, by the end of 1958. Particulars of these schemes and of other major building works completed during the first ten years of the National Health Service are set out in Table (i).

Works in hand

Projects in hand at the end of 1958 together with those approved but not commenced at the end of the year are indicated in Table (ii).

The Council's health service capital building programme for 1959–60 included six major schemes costing more than £10,000 and eight minor schemes, details of which are shown in Table (iii). Projects for 1959–60

As part of the long-term development plan, an annual programme of minor building and engineering works for alteration or improvement of existing health service buildings is undertaken: over 250 schemes of this nature, varying in cost between £15 and £250, have been completed during the past five years. In addition, it has been the practice since 1948 for cleaning and painting to be undertaken on the basis of complete external painting and internal redecoration of all health service buildings once in six years supplemented, where necessary, by intermediate washing of interior paintwork. Improvement programmes

Comprehensive health centres

The importance of the role which the comprehensive health centre could play in securing the fullest collaboration between the personal health services provided by the Council and those provided by the hospital and specialist services and by general medical and dental practitioners has long been recognised.

The Council's proposals for carrying out duties under Section 21 of the National Health Service Act envisaged the ultimate provision of a comprehensive health centre for each health service area. It was, however, appreciated that it would not be possible, or desirable, to provide health centres on this scale except over a period of many years, and immediate proposals were limited to the early erection of one specially designed comprehensive health centre on the Woodberry Down estate, Stoke Newington, and the provision of one centre in each of the nine health divisions as and when circumstances permitted. Provision was also made for the acquisition and adaptation of premises to provide accommodation for doctors and dentists who wished to establish a group practice.

Although the Woodberry Down Health Centre* was opened within four years of the inception of the National Health Service long standing restrictions on capital expenditure and, more especially, the unwillingness of local general practitioners to engage in group practice from a health centre, have precluded the provision of further health centres.

The many problems associated with the establishment of health centres have been discussed on numerous occasions with both the London Executive Council and the Ministry of Health, and the Minister finally advised the Council in 1955 that he would be unable to approve of their erection except in areas where existing health services, including general medical services, were inadequate and additional services urgently needed and where, moreover, general practitioners had signified their willingness to work in a health centre.

In view of this advice and the practical difficulties in securing the vital co-operation of general practitioners in the provision of general medical services from health centres, it was decided that it would be unrealistic and, because of the shortage of land in London for housing development, undesirable to continue the policy of long-term reservation of health centre sites. Following consultations with the London Executive Council and the Local Medical Committee the latter suggested that on sites where health centres might be needed later, blocks of flats might be so constructed that ground floor flats could be converted into health centre suites, if required. The Council approved in principle this suggestion and the use in this way, as far as practicable, of sites reserved for health centres. Relinquishment of health centre sites

The future use of each of the 28 sites which had been acquired or reserved for health centres is accordingly being reconsidered in consultation with the London Executive Council, and 14 sites had been released for other development by the end of 1958.

* *A full description of the building and services is contained in a descriptive brochure (No. 3784, price 6d.) published by the Council.*

Group practice accommodation

It is still the Council's policy to assist general practitioners, wherever practicable, to establish group practices, and two schemes have recently been approved whereby specially designed ground floor accommodation in blocks of flats will be leased to local doctors for group practice purposes. Both schemes envisage the eventual provision of maternity and child welfare and school treatment centres in adjoining accommodation.

Diagnostic medical centre for general practitioners

In 1958 the establishment of a diagnostic medical centre in purpose designed accommodation at Queen's Road Centre, Camberwell, in association with the Nuffield Foundation, the Sir Halley Stewart Trust and the South East Metropolitan Regional Hospital Board was approved. The services to be provided for the benefit of local general practitioners will include X-ray and pathological services, a minor operations room, facilities for dressings and other nursing procedures, accommodation for consultants and a common room with a library. Redesigned accommodation will also be provided for the child guidance unit and school specialist clinics at present functioning at the Centre.

Maternity and child welfare and school treatment centres

Short-term development plan

The ultimate aim was, and is, to place the maternity and child welfare and school health services on a firm basis in each health service area in conveniently sited and purpose designed buildings, nevertheless, it was apparent at the outset that many years would elapse before these could be built in sufficient numbers to replace the improvised clinic accommodation to which reference has been made. To safeguard the future of the service it has, therefore, been necessary to obtain, whenever opportunity arose, the freehold or leasehold interest in respect of the more satisfactory existing buildings*, and to carry out works of adaptation and improvement to render them more suitable for health service use. Steps have also been taken to secure improved alternative accommodation to enable centres functioning in very unsuitable premises to be closed. As will be seen in Table (iv), the extent to which the service has to rely on the continued availability of rented buildings has been substantially reduced during the past ten years.

Progress has also been made in providing new or improved accommodation for school health purposes and the opportunity has been taken in suitable cases of incorporating some, or all, of the school health services required for an area in maternity and child welfare centres so as to achieve fuller integration of the two services. (A school minor ailment surgery in a new maternity and welfare centre is shown opposite page 49.)

Provision of new centres

So far as the provision of new purpose designed welfare centres is concerned, financial restrictions have, as already indicated, obliged the Council to defer plans for the erection of replacement buildings and the building of new centres has, of necessity, been largely confined to those areas where expanding population or the development of new housing estates has created a new and urgent demand for services. Deficiencies in existing facilities elsewhere have, in general, been met by the acquisition and conversion of suitable standing property. (A purpose designed welfare centre is shown in the photographic inset.)

More recently, because of the difficulties in the way of building new centres, the Council has approved a number of schemes for the incorporation of purpose designed clinics and day nurseries in ground floor accommodation in blocks of flats to be erected on sites originally reserved for health service purposes. Satisfactory arrangements have also been made for centres to be provided in this way on a number of health service sites which the Council has agreed to release for housing development by metropolitan borough councils. Details of completed and proposed schemes for the provision of centres and nurseries in new housing development are given in Table (v). (Pictures of a day nursery incorporated in a block of flats are shown opposite.)

Planning standards

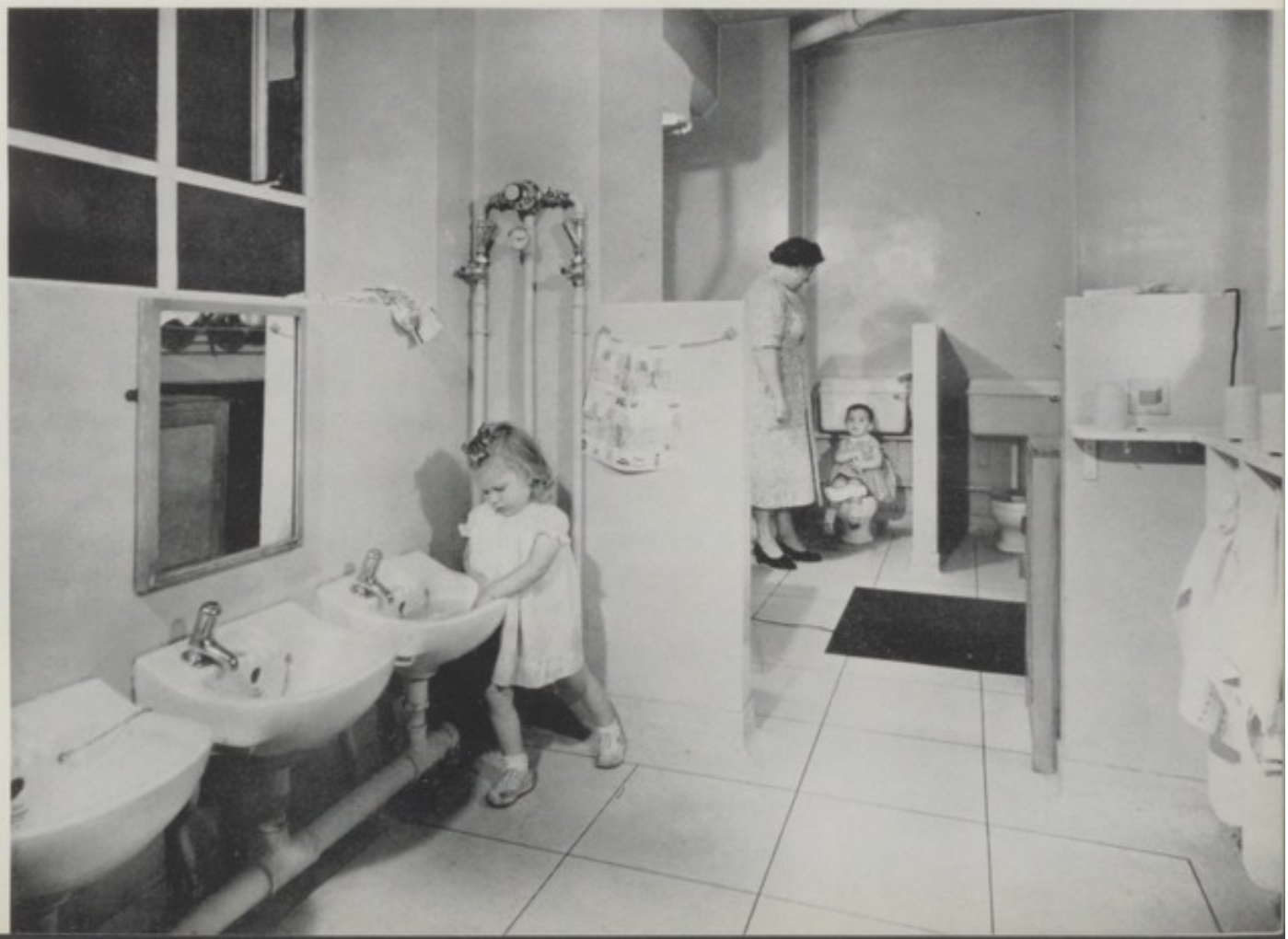
It was decided in 1957 that future maternity and child welfare and school treatment centres should be planned in accordance with standards which had been devised with the object of securing maximum economy in building costs consistent with the provision of properly designed clinic accommodation adequate in all respects to meet the

* *Details of acquisitions and leases of health service premises completed during 1958 are shown in Table (vi).*

Babies room

CHINA WALK DAY NURSERY

Toddlers ablutions



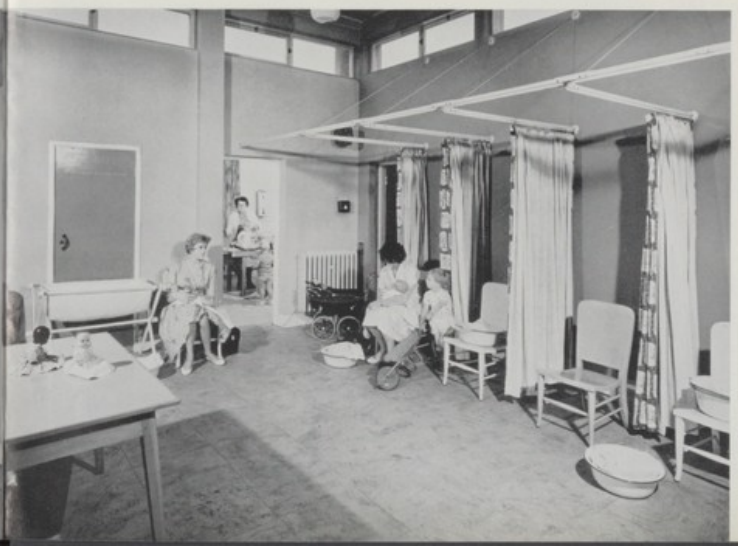
Exterior

Waiting room with demonstration kitchen

ST. QUINTIN WELFARE CENTRE

Vestibule

Preparation room



VICTORIA DRIVE WELFARE CENTRE

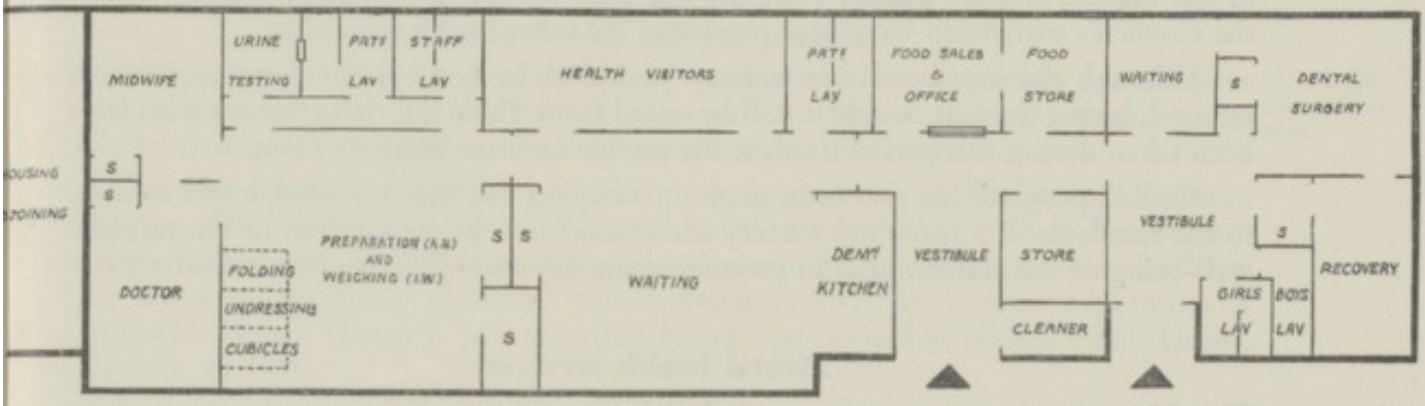
School minor ailments room

School dental surgery

AMBULANCE STATION, Upper Richmond Road

existing and anticipated future needs of the localities which they were intended to serve.

OUTLINE PLAN OF TYPICAL COMBINED MATERNITY AND CHILD WELFARE AND SCHOOL TREATMENT CENTRE FOR INCORPORATION IN A BLOCK OF FLATS



S=storage space.

The standards adopted were formulated in the light of experience already gained in the design of modern clinic buildings in London and elsewhere in the country; they provide a comprehensive code of practice governing such matters as the overall layout of the accommodation required, the sequence and size of rooms necessary to secure their multiple use for various purposes at various times, and the siting of sanitary and other fittings*. In determining standard floor areas for individual rooms special regard was paid to their functional purpose and to the space occupied by essential furniture, fittings and equipment, and in the case of waiting rooms, offices etc., to the maximum number of persons likely to be present in the rooms at any one time. An outline plan of a typical combined centre designed in accordance with planning standards for incorporation in a block of flats is shown above.

The standards are applied so as to allow the greatest possible freedom of design from an architectural point of view and, while minor deviations have been necessary from time to time to meet differing circumstances, no practical difficulties have been experienced in planning new accommodation within the broad limits of the new code.

Day nurseries

The majority of the day nurseries transferred to the Council in 1948 had been established in haste during the war in requisitioned premises or in prefabricated buildings erected on sites which had subsequently been earmarked for housing or education purposes. As the post-war expansion of these services gathered momentum an increasing number of sites on which day nurseries were situated had to be released for permanent development and the nurseries closed before replacement buildings could be provided. At the same time it was necessary to discontinue the use of other premises which were no longer suitable.

While the policy of amalgamating nurseries, where this could be done without causing hardship or inconvenience, and the strict application of a priority system of admission enabled the day nursery service to be maintained without serious difficulty, the extent to which the service depended upon the use of premises held on insecure tenure or under limited requisitioning powers gave rise to concern for several years.

Following a gradual diminution in the demand for places for children in the highest priority groups, the level at which the service would need to be maintained to meet the anticipated future demand was reviewed in 1954 to enable steps to be taken to close

* *The standards adopted are summarised in Table (vii), which shows sizes of room, etc., shown in the outline plan.*

nurseries when they became redundant and to secure, where necessary, the continued availability of those buildings likely to be required to meet a long-term need. As a result of decisions reached at this and subsequent reviews the freehold or leasehold interest in 16 nursery buildings has since been secured while 26 nurseries have been closed by reason of redundancy or because the heavy expenditure involved in their acquisition and renovation could not be justified by the demand for places for children in the highest priority groups*. Of the nurseries closed, six buildings which were in the Council's ownership were later converted for other health service use.

Although the extent of day nursery provision in London has been appreciably reduced during the past decade it will be noted from Table (iv) that effective steps have been taken during this period to place the service on a more secure basis.

Marked progress has also been made in carrying out much needed improvements to the standards of improvised nursery accommodation in the interests of the care and well-being of the children and to promote economy and efficiency in administration.

Mental health services

The 12 occupation centres for mental defective persons living in the community which had been administered by the Council since 1931 were closed during the war years. Although war damage and other difficulties prevented the reopening of centres until the middle of 1948, 21 centres have since been established throughout the County.

While six centres are accommodated in buildings owned by the Council which have been adapted for the purpose, the remainder are housed in hired premises which in many cases are not entirely suitable but are the best obtainable. The poor state of repair and decorative condition of a number of these latter premises has recently given cause for concern and negotiations with the landlords are proceeding with a view to their undertaking, with financial assistance from the Council where necessary, the work essential to provide an improved standard of interior decoration and amenity.

Provision was made in the health service capital building programme, 1954–59, for the erection of three large purpose designed occupation centres, two of which were nearing completion by the end of 1958. Work on the third centre is expected to commence by the middle of 1959.

These new buildings have been so planned that the main hall, which forms the focus of the centre, can be used for assemblies, for physical training and for mid-day meals. To facilitate easy and effective supervision, classrooms have been planned to form self-contained units each with their own cloakrooms and toilet facilities. The accommodation also includes a medical inspection room, staff rooms, a kitchen and servery and a laundry. Both hard and grass play spaces are provided together with a covered court and sand pits. A ground plan of the centre being erected at Highlever Road, Kensington, was included in the Report for 1957 (p. 104).

A further scheme for the conversion of an existing building for use both as an occupation centre and an industrial training centre was included in the building programme for 1959–60. The provision of these centres will permit the closure of improvised sub-standard accommodation.

London Ambulance Service

Despite the limitations placed on capital works, substantial progress has been made in restoring war-damaged buildings and in providing the new ambulance stations needed to meet the greatly increased demand for ambulance transport in London since the inauguration of the National Health Service.

* *Details of closures during 1958 are given in Table (viii).*

Details of major building schemes completed since 1948 are given in Table (i) and in the sections dealing with the ambulance service at page 73 and in Appendix A. (A modern ambulance station is pictured opposite page 49. Other pictures of ambulance stations appear at page 77.)

Numerous minor works of improvement have been undertaken at existing ambulance stations to secure greater operational efficiency.

Other health service premises

Hostels for tuberculous men

In 1950 it was decided to provide special residential accommodation for infective tuberculous men who had reached their maximum degree of improvement under hospital treatment but could not be discharged because they were homeless.

The first hostel was provided in 1951 in a large house at Highbury Quadrant, Islington, which had been adapted. A second hostel was opened in 1953, at Hurlingham Lodge, Fulham, which, after adaptation and redecoration, came into full use a year later. The hostel at Highbury Quadrant was replaced in 1954 by improved premises at Cromwell Lodge, Hornsey, and a further hostel was opened at Knight's Hill House, Lambeth, in 1958.

Each hostel contains ample lounge and dining accommodation and a series of bedrooms, W.C.s, bathrooms and a sputum disposal sluice room. A suite of rooms is allocated to the warden and his family and an equipped consulting room is provided for visiting doctors.

Recuperative holiday homes

The Mayfield Recuperative Holiday Home, Mayfield, Sussex, which was transferred to the Council in 1948, proved to be uneconomical to maintain and was replaced in 1950 by Roland House Holiday Home, Littlehampton, Sussex, which had been acquired and adapted to provide accommodation for 36 children.

In view of difficulties experienced in arranging recuperative holidays for older children the Council entered into an agreement with the trustees of the Surrey Convalescent Home for Children, Cambridge House, Bognor Regis, Sussex, to take over and manage the premises as a holiday home for 44 children. The building was brought into use in 1958 after works of improvement and redecoration had been completed.

TABLE (i)—*Health Service building works completed* 1949–1958

Year of completion	*Health Division*	*Scheme*	*Works completed*
		COMPREHENSIVE HEALTH CENTRE	
1952	4	Woodberry Down health centre, Stoke Newington	New building
		MATERNITY AND CHILD WELFARE	
1949	2	Sumatra Road welfare centre, Hampstead	New building*
	7	Consort Road welfare centre, Camberwell	Conversion of existing building
1950	4	Upper Clapton centre, Hackney	Do.
	6	Rustall Lodge centre, Woolwich	Do.
	7	Downham health centre, Downham, Kent†	Rebuilding of premises demolished by enemy action
1951	9	Earlsfield welfare centre, Wandsworth	Conversion of existing building
1952	7	Amott welfare centre, Camberwell	Extension of existing building
	8	West Norwood welfare centre, Lambeth	Reinstatement of war damage and repairs
1953	6–7	Blackheath Hill welfare centre, Greenwich	New building

* *Scheme initiated prior to 5 July, 1948.*

† *Accommodation also provided for school treatment centre.*

TABLE (i) *continued—Health Service building works completed* 1949–1958.

Year of completion	*Health Division*	*Scheme*	*Works completed*
		MATERNITY AND CHILD WELFARE	
	7	Queen's Road centre, Camberwell	Conversion of existing building
	7	Lordship Lane welfare centre, Camberwell†	Adaptations on acquisition
1954	1	St. Quintin welfare centre, Kensington	New building
	5	Mary Hughes welfare centre, Stepney	Extension of existing building
1955	5	Greenwood welfare centre, Bethnal Green	New building
1956	3	West Islington welfare centre	Major improvements
	5	Rochelle Street welfare centre, Bethnal Green	Conversion of existing building
	5	Wellington Way welfare centre, Stepney	Reinstatement of war damage to provide offices and residential accommodation for nursing staff
	7	Queen's Road centre, Camberwell	Installation of new hot water and heating systems
1957	2	Daleham Gardens welfare centre, Hampstead	New building
	2	Queen's Park welfare centre, Paddington	Conversion of existing building
	6	Lionel Road welfare centre, Woolwich	Adaptations and improvements
	9	Victoria Drive welfare centre, Wandsworth	Completion and adaptation of existing building
1958	2	Parkhill Welfare centre, Hampstead	Conversion of existing building
		SCHOOL HEALTH	
1949	1	St. Dunstan's Road school treatment centre, Fulham	Conversion of existing building
	7	Gordon Road school treatment centre, Camberwell	Do.
	9	Gatton school treatment centre, Wandsworth	New building
1950	5	Whitechapel school treatment centre, Stepney	Conversion of existing building
1951	5	East India Dock Road centre, Poplar	Do.
	5	Bethnal Green school treatment centre	Do.
	8	Brixton child guidance unit, Lambeth	Adaptations on acquisition
1953	2	Westminster school treatment centre	Conversion of existing building
1955	9	Tooting school treatment centre, Wandsworth	Do.
1956	8	West Norwood welfare centre, Lambeth	Adaptations to provide school treatment centre
		DAY NURSERY	
1949	4	Wetherell Road day nursery, Hackney	New building*
	5	Christian Street day nursery, Stepney	New building*
1950	1	Mulgrave day nursery, Fulham	Conversion of existing building
	2	Ampthill Square day nursery, St. Pancras	Do.
1951	2	Katherine Bruce day nursery, Paddington	New building
1952	3	Springdale day nursery, Stoke Newington	Do.
	4	St. John's day nursery, Hackney	Do.
	4	Woodberry Down day nursery, Stoke Newington	Do.

* *Scheme initiated prior to 5 July, 1948.*

† *Accommodation also provided for school treatment centre.*

TABLE (i) *continued—Health Service building works completed* 1949–1958.

Year of completion	*Health Division*	*Scheme*	*Works completed*
		DAY NURSERY	
1953	2	St. Stephen's day nursery, Paddington	Completion of building
	5	University House day nursery, Bethnal Green	Extension of existing building
1954	6	Amersham Road health centre, Deptford	Conversion of existing building
1956	2	Carlton Hill day nursery, St. Marylebone	Adaptations on acquisition
	4	Clifton Lodge day nursery, Hackney	Major improvements
1957	2	Camden Road day nursery, St. Pancras	Do.
	9	Sisters Avenue day nursery, Battersea	Do.
		LONDON AMBULANCE SERVICE	
1953	–	Eastern ambulance station, Hackney	Adaptations and improvements
	–	Fulham ambulance station	Major improvements
	–	South Western ambulance station, Lambeth	Extension of existing building
	–	West Smithfield ambulance station, City of London	New building
1954	–	Hampstead ambulance station	Do.
1955	–	Headquarters, Lambeth	Conversion of existing building
	–	Pear Place ambulance station, Lambeth	Major improvements
	–	Brook ambulance station, Woolwich	Reinstatement of war damage
	–	Mottingham ambulance station, Woolwich	New building
1956	–	South Western ambulance station, Lambeth	Reinstatement of war damage and repairs
	–	Upper Richmond Road ambulance station, Wandsworth	New building
		MENTAL HEALTH	
		(*a*) OCCUPATION CENTRES	
1954	–	Fulham occupation centre	Conversion of existing building
	–	Wandsworth occupation centre	Do.
1955	–	Stepney industrial training centre	Do.
1956	–	Bethnal Green occupation centre	Do.
1957	–	Balham occupation centre, Wandsworth	Do.
1958	–	Shoreditch occupation centre	Do.
		(*b*) HOSTEL FOR GIRLS	
1955	–	Dover Lodge, Lewisham	Do.
		TUBERCULOSIS—HOSTELS FOR MEN	
1951	3	Highbury Quadrant Hostel, Islington‡	Conversion of existing building
1954	1	Hurlingham Lodge, Fulham	Do.
	–	Cromwell Lodge, Hornsey	Adaptations on acquisition
1958	8	Knight's Hill House, Lambeth	Conversion of existing building
		RECUPERATIVE HOLIDAYS—HOLIDAY HOMES	
1952	–	Roland House, Littlehampton, Sussex	Conversion of existing building
1958	–	Cambridge House, Bognor Regis, Sussex	Adaptations on acquisition of lease

‡ *Closed in 1954.*

Summary

Service	*Type of scheme*						
	New building	*Completion of existing building*	*Conversion of existing building*	*Extension of existing building*	*Adaptation on acquisition*	*Reinstatement of major war damage*	*Major improvements*
Comprehensive Health Centre	1	–	–	–	–	–	–
Maternity and Child Welfare	5	1	8	2	1	3	3
School Health ..	1	–	8	–	1	–	–
Day Nursery	6	1	3	1	1	–	3
London Ambulance Service	4	–	1	1	–	2	3
Mental Health ..	–	–	7	–	–	–	–
Tuberculosis	–	–	3	–	1	–	–
Recuperative Holidays	–	–	1	–	1	–	–
	17	2	31	4	5	5	9

TABLE (ii)

*(a) Works in hand**

Div.	*Premises*	*Service*	*Work involved*
6	Abbey Wood Estate, Woolwich	Maternity and child welfare	Adaptation of shop to provide temporary clinic accommodation
7	Lewisham school treatment centre	School health	Extension of premises to provide recovery room to dental suite
1	Uxbridge Road day nursery, Hammersmith	Day nursery	Installation of sluices
8	Coldharbour Lane day nursery, Lambeth	Do.	Major repairs
—	Wallingford Avenue, Kensington	Occupation centre	Erection of new building
—	Perry Rise, Lewisham	Do.	Do.

*(b) Works approved but not commenced at end of 1958**

Div.	*Premises*	*Service*	*Work involved*
2	Portman day nursery, St. Marylebone	Day nursery	Provision of new fencing and tar-paving of enlarged play space
3	Canonbury Place day nursery, Islington	Do.	Improvements to water services and provision of additional toilet facilities
9	Putney day nursery, Wandsworth	Do.	Resiting of boiler and provision of improved toilet facilities

* *See also Table (v)*

Table (iii)

Health Service Capital Building Programme, 1959–60

(i) *Schemes costing over £10,000*

Premises	*Work proposed*
42 Clapham Manor Street, Wandsworth ..	Adaptation of premises to provide an occupation centre and an industrial training centre
Queen's Road Centre, Camberwell.. ..	Major adaptations to provide a diagnostic medical centre and improved accommodation for existing child guidance unit
Stormont Road, Battersea	New maternity and child welfare centre to replace unsatisfactory temporary premises
Galbraith Street, Poplar	Adaptation of premises to provide new maternity and child welfare and school treatment centre
Battersea accident ambulance station ..	Replacement of building destroyed by enemy action
South Eastern ambulance station ..	Extension of existing premises to provide additional accommodation for vehicles and other improvements
Iceni occupation centre, Hackney ..	New occupation centre to replace unsatisfactory temporary accommodation and to provide additional places

(ii) *Other Schemes**

Div.	*Premises*	*Service*	*Work involved*
3	Scholefield Road, Stoke Newington	Day nursery	Conversion of boilers
—	Headquarters, London ambulance service, Lambeth	London ambulance service	Provision of additional workshop and storage accommodation and other improvements
—	Brook ambulance station, Woolwich		Improvements of office accommodation
—	Canonbury accident ambulance station, Islington		Resiting of boiler and improvement to coke storage
—	Eastern ambulance station, Hackney		Improvement of staff quarters
—	Fulham ambulance station		Reinstatement of petrol pump
—	Streatham ambulance station Wandsworth		Adaptations to provide staff locker room
—	Upper Richmond Road accident ambulance station, Wandsworth		Improvement of water services

* *Additional to minor works programmes approved by Divisional Health Committees.*

TABLE (iv)

Analysis of the tenure of maternity and child welfare centre and day nursery premises, 1948–1958

Tenure	Welfare centres		Day nurseries	
	5.7.48	*31.12.58*	*5.7.48*	*31.12.58*
Freehold	34	67*	8	43
Leasehold	15	26	13	24
Rented	103	60	36	6
Requisitioned	5	—	54	3
In joint use with other authorities ..	46	9	9	—

* *Includes 19 centres provided in housing accommodation owned by the Council.*

TABLE (v)

Purpose designed health service accommodation incorporated in blocks of flats

Year	*Service*	*Health Div.*	*Scheme*	*Authority responsible for housing development*
	(i) *Works completed*			
1955	Maternity and child welfare	8	Rose McAndrew welfare centre, Lambeth	London County Council
1956		5	Will Crooks welfare centre, Poplar	Do.
1956	Day nursery	8	China Walk day nursery, Lambeth	Do.
	(ii) *Works in hand*			
	Maternity and child welfare	2	St. Alban's Villas, St. Pancras	St. Pancras Metropolitan Borough Council
		9	*William Harvey welfare centre, Ashburton Estate, Wandsworth	London County Council
	Day nursery	8	†Coral day nursery, Windmill Walk, Lambeth	Do.
	(iii) *Works approved but not commenced by end of 1958*			
	Maternity and child welfare	2	*Hallfield Estate, Paddington	Paddington Metropolitan Borough Council
		6	Burney Street, Greenwich	Greenwich Metropolitan Borough Council
		8	*Keeton's Road, Bermondsey	London County Council
		9	*Plough Road, Battersea	Battersea Metropolitan Borough Council

* *Includes school treatment centre.* † *A plan is shown opposite page 62.*

TABLE (vi)

Acquisitions and leases completed in 1958

Div.	*Property*	*Interest obtained*	*Service*
9	37 Riggindale Road, Wandsworth ..	Leasehold	Maternity and child welfare
1	25 Stratford Road, Kensington ..	Leasehold	School health
1	Dalling Road day nursery, Hammersmith	Freehold	Day nursery
1	Grove House day nursery, Fulham ..	Leasehold	Day nursery
3	Lloyd Square day nursery, Finsbury	Leasehold	Day nursery
7	Dog Kennel Hill day nursery, Camberwell	Leasehold	Day nursery
	South Eastern ambulance station, Deptford—land adjoining	Freehold	London ambulance service
	South Western ambulance station, Lambeth—land adjoining	Freehold	London ambulance service
	Surrey Convalescent Home, Cambridge House, Bognor Regis, Sussex	Leasehold	Recuperative holiday home
9	42 Fairfield Street, Wandsworth ..	Leasehold	Home help office

TABLE (vii)

Maternity and child welfare and school treatment centres planning standards

Room (1)	*Standard floor area s.f.* (2)	*Minimum fittings, furniture and equipment to be accommodated* (3)	*Special requirements* (4)
Vestibule	90 (maximum)	—	Two sets of doors to be provided to exclude draughts and sufficient space allowed to enable welfare foods to be obtained without entering main clinic accommodation.
Welfare food sales office	80	Small table Chair Built-in cupboard and shelving beneath service counter Filing cabinet	To open off vestibule and adjoin welfare food store. Hatch giving access to vestibule for sales purposes.
Welfare food store	See col. 4	Built-in shelving	Access from vestibule through sales office. Natural lighting and ventilation by means of high guarded window. Floor area to vary according to estimated turnover of welfare foods on the basis of one month's supply being stored, viz.:

	Dried milk	*Cod-liver oil*	*Orange juice*	*Floor area s.f.*
Number of cartons to be stored	80	8	75	110
	60	6	56	80
	45	5	42	65

Other storage needs	See col. 4	—	Variable size according to local needs or preference for built-in cupboard space in waiting hall and other clinic rooms.
Cleaner's store	20	Sink	To open off vestibule, if practicable.
Toilets	35–45	Lavatory basin	*For patients* (2)—One opening off waiting room or vestibule and one combined with urine test room. *For staff* (1)—To be centrally situated.
Main waiting room	See col. 4	Stackable chairs to facilitate re-arrangement of seating	Waiting room should: (*a*) provide adequate seating space; (*b*) permit free movement of staff and mothers and children entering and leaving adjoining rooms; (*c*) be capable of use for demonstration purposes during sessions and at other times; (*d*) be warm, well-lighted and ventilated, and free from draughts. Windows to be capable of being darkened at reasonable cost to facilitate use of film strips and projector.
			Floor area to be based upon space required for seating maximum number of mothers and children likely to be present at any one time having regard to the highest estimated average sessional attendance, viz.:—

Highest estimated sessional attendance	*Number of chairs required**	*Floor area s.f.*	*Convenient dimensions*
Up to 40	25	320	21 ft. × 15 ft.
50	30	375	25 ft. × 15 ft.
55	33	415	25 ft. × 16½ ft.
60	36	450	25 ft. × 18 ft.
65	39	490	26 ft. × 19 ft.

Special attention to be paid to choice of colour schemes, furniture and soft furnishings (when provided).

Demonstration kitchen	60	Sink with double draining boards Ascot water heater Cooker Demonstration table Cupboard for crockery and utensils Swinging wall blackboard	To open off waiting room and to be capable of being closed off by removable screens when desired. To be sited near health visitors' office so that it may be used by staff for preparation of light meals when necessary.
Health Visitors' office	50 per person (55 per person where only 2 health visitors are to be accommodated)	For each health visitor— Typist—type table Chair Wardrobe or locker 4-drawer steel filing cabinet One visitor's chair for every two health visitors	To be sited off waiting room as near as possible to demonstration kitchen.
Preparation room— Advising (*ante-natal sessions*) Undressing (*infant welfare sessions*) Waiting room, vision testing, special clinics (*school health sessions*)	See Col. 4	Folding cot and table for demonstration purposes Undressing cubicles formed by curtains hanging from ceiling rail Stackable chairs (adults and toddlers)	To have direct access to doctor's, midwife's and urine test rooms. Adequate space required for equipment, circulation and for demonstration purposes. Floor area to be calculated according to highest estimated sessional attendance, viz.:

Highest estimated sessional attendance	*Estimated number present in centre at any one time*	*Number of undressing cubicles (15 s.f. each)*	*Floor area*
Up to 35	21	2	300
35–55	21–33	3	340
Over 55	Over 33	3 or 4	400

Note: In small centres a separate weighing room (infant welfare session) may be omitted in which event the floor area of the preparation room should be increased by 40 s.f.

* *Based on 60 per cent. of estimated attendance allowing 12½ sq. ft. per chair.*

TABLE (vii)—*continued*

Maternity and child welfare and school treatment centres planning standards

Room (1)	*Standard floor area s.f.* (2)	*Minimum fittings, furniture and equipment to be accommodated* (3)	*Special requirements* (4)
Urine Test room	75	Lavatory basin Sink Working bench	To be entered from preparation room. Hatch with shelf to be provided between W.C. compartment and test room.
Doctor's room (*all sessions*) ..	130	Lavatory basin with shelf for steriliser Table or desk Swivel-type armchair Examination couch Instrument trolley Filing cabinet, if required Wardrobe or locker Patients' chair(s)	To be entered from preparation room with access within to midwife's room. Room to be not less than 10 feet wide. Inexpensive sound-proofing of doors where necessary.
Midwife's room (*ante-natal sessions*) Waiting room (*infant welfare sessions*) Nurse's room (*school health sessions*)	110	Lavatory basin with draining board Table or desk Armchair Examination couch Cupboard Patients' chair(s)	To be entered from preparation room with access within to doctor's room. To be not less than 9 ft. wide. *Note:* A separate school health minor ailments, etc., room may be provided in large and exceptionally busy centres. (See below.)
Weighing room (*infant welfare sessions*) Waiting room (*ante-natal sessions*)	110	Lavatory basin Well-type table Scales for babies Upright weighing scales Chairs (3 to 4) for patients and staff	To be entered from preparation room. *Note:* May be omitted in small centres where weighing may be carried out in preparation room.

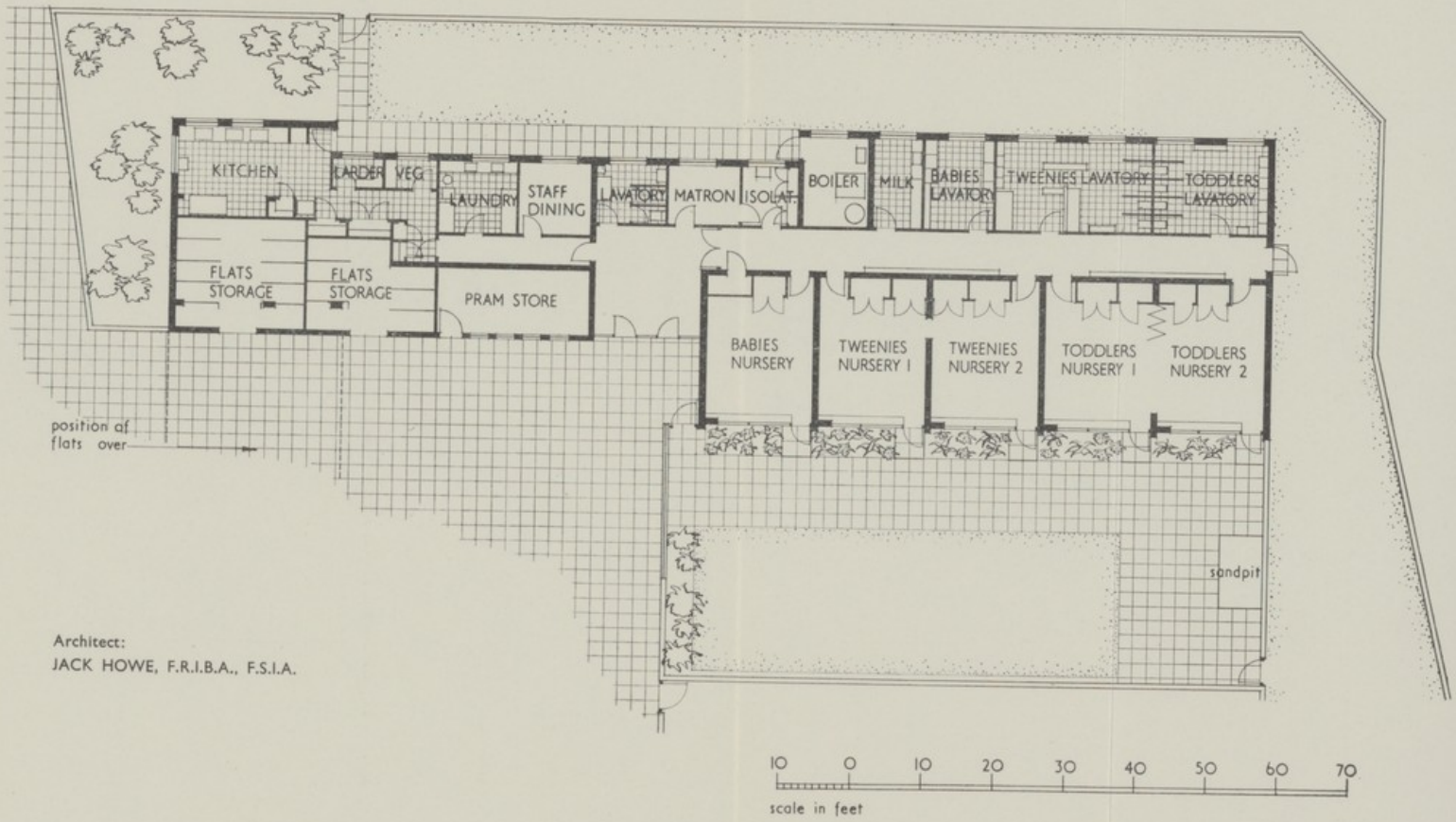
Minor ailments, etc., room (*School health sessions*)	90–110	Lavatory basin/sink (or both) with draining board Steriliser Table Chair(s) for patients and staff Store cupboard(s) Dark cubicle for vision testing, if required	To be provided only in large and busy centres. In small centres midwife's room (q.v.) to be used for this purpose.
Dental Suite— Surgery	144	Dental unit and chair Lavatory basin Sink with draining board Shelf for steriliser Formica-top working bench Instrument cabinet Built-in cupboards	Main windows facing north wherever practicable. Where twin surgeries are provided both to have direct access to recovery room.
Recovery room	96	Sink Rinsing trough Couch	To be sited next to surgery and as near as possible to separate entrance to dental suite, so that children may leave without being seen by those still waiting.
Waiting room	65	6–8 chairs	Waiting space to be provided either in a small room or as part of a corridor. Additional waiting space required for gas sessions to be met by use of main waiting hall.
Toilets (for children) ..	30–40	Lavatory basin	To be provided for both sexes.
Exterior— Pram shelter	13 per pram	—	To be sited as near as possible to entrance to maternity and child welfare centre. Provision of shelter as part of clinic building to be avoided wherever possible on grounds of cost.

TABLE (viii)

Day nurseries closed during 1958

Div.	*Nursery*	*Date of closure*
4	Clifton Lodge day nursery, Hackney	30.5.58
7	North Lewisham day nursery, Lewisham	8.8.58
8	Crossway day nursery, Southwark	9.5.58
8	Fulford Street day nursery, Bermondsey	10.2.58
8	Gipsy Hill day nursery, Lambeth	20.6.58

CORAL DAY NURSERY



Architect:
JACK HOWE, F.R.I.B.A., F.S.I.A.

10 0 10 20 30 40 50 60 70

scale in feet

CARE OF MOTHERS AND YOUNG CHILDREN

THE MAIN features of the Council's services for care of mothers and young children remained as in previous years. Day-to-day administration of the services is the responsibility of the nine divisional health committees, and the reports of the individual divisional medical officers are given in the section which begins on page 124. Details of changes in centres during the year will be found in the section on health service premises, page 46.

Maternity and child welfare

Particulars of sessions and attendances are given in the following table :

TABLE (i)—*Clinics for mothers and young children*

	1949	*1955*	*1956*	*1957*	*1958*
Ante-natal, post-natal and combined clinics :					
Number at end of year	*148*	118	116	118	112
Sessions per month	*1,220*	846	805	786	799
Ante-natal :					
First attendances	*29,917*	22,231	23,379	23,918	25,673
Total attendances	*184,018*	116,042	122,662	121,579	134,684
Percentage of pregnant women attending an ante-natal clinic ..	*52*	43	44	44	45
Post-natal :					
Number of women attending during the year	*5,839*	4,258	4,543	3,887	3,714
Child welfare clinics :					
Number at end of year	*165*	176	178	178	179
Sessions per month	*1,784*	1,939	1,953	1,990	1,991
Attendances under a year :					
First	*48,489*	43,068	44,910	46,387	49,229
Total	*683,089*	587,143	595,690	613,147	611,057
Attendances over 1 year	*282,202*	193,273	189,388	183,538	177,283
Attendances at special toddlers clinics	*35,500*	41,268	41,055	40,848	38,940
Percentage of infants attending a centre at least once in the first year of life	*86*	86	86	86	88

Family planning

Advice on family planning is provided for married women for whom further pregnancy would be detrimental to health. The number of women attending for advice was :

	1957	*1958*
At sessions provided by Council	4,092	4,392
Referred by Council to Family Planning Association	688	702

National welfare foods

Average weekly issues

	1956	*1957*	*1958*
National dried milk (tins)	25,413	19,839	15,791
Cod-liver oil (bottles)	6,156	5,191	3,620
Vitamin tablets (packets)	2,952	2,788	2,736
Orange juice (bottles)	48,163	48,925	31,360

Day accommodation for children

TABLE (ii)—*Day nurseries and child minders*

	At 31st December				
	1949	*1955*	*1956*	*1957*	*1958*
DAY NURSERIES					
Maintained	*113*	94	86	81	76
Grant-aided	*6*	5	5	5	5
Total	*119*	99	91	86	81
Places 0–2	*2,591*	1,903	1,775	1,747	1,690
Places 2–5	*3,958*	3,677	3,368	2,988	2,631
Total places	*6,549*	5,580	5,143	4,735	4,321
COUNCIL'S CHILD MINDER SCHEME (Voluntary registration) :					
Child minders registered	*584*	743	777	838	824
Children minded	*579*	851	886	954	973
NURSERIES & CHILD MINDERS REGULATION ACT, 1948 :					
Private day nurseries registered .. (including part-time nurseries)	*28*	56	58	60	59
Places	*972*	1,640	1,646	1,701	1,742
Child minders registered	*73*	106	102	132	141
No. of children authorised to be minded	*501*	649	611	699	781

Occasional crèches

After the costs relating to children with free places in crèches because their mothers were taking part in a welfare centre activity were disregarded, practically the whole cost of the occasional crèche service was recovered in charges. Subject to this remaining true, the intention is that the service will continue substantially at its present level, but in future children will not be restricted to two attendances a week. At 31 July, 1958, 17 crèches provided 280 places.

Residential establishments for young children

Residential establishments under the direction of the Children's Committee are visited regularly by the Council's medical officers. The care of children suffering from physical handicap or mental retardation, whether due to innate defect or emotional disturbance is carefully reviewed. A register is also kept and reviewed periodically by a medical officer so that constructive plans for the future of these handicapped children can be made. New problems are arising as a result of early diagnosis of congenital handicaps such as deafness and children must often be moved into the County so that they may attend auditory training centres.

Adoption and boarding out

Every child whom it is proposed to board out with a view to adoption is given a full medical examination by his doctor and the opinion of the Medical Officer of Health is sought on the suitability of the child for adoption on medical grounds.

The opinions on the children referred by the Children's Officer in 1958 and two previous years were as follows :

	1956		1957		1958	
1. Considered unfit for either adoption or boarding out		4		3		3
2. Referred for adoption :						
(*a*) Fit for adoption	147		178		167	
(*b*) Fit for adoption subject to certain conditions	7		8		2	
(*c*) Unfit for adoption but fit for boarding out	15		7		17	
(*d*) Withdrawn by Children's Officer	1		8		3	
(*e*) Still under consideration ..	3		4		1	
		173		205		190
3. Referred for boarding out :						
(*a*) Fit for boarding out	324		310		320	
(*b*) Withdrawn by Children's Officer	2		7		3	
(*c*) Still under consideration ..	—		5		1	
		326		322		324
TOTAL		503		530		517

Care of the Unmarried Mother and her Child

Mother and baby homes

One mother and baby home is managed by the Welfare Committee together with two units in larger establishments. Other homes are provided by voluntary organisations supported by grants in aid from the Council.

	1956	1957	1958
Number of voluntary homes receiving grant at 31 December.	18	17	16
Number of expectant and nursing mothers admitted	1,306	1,141	1,191
Total grants	£10,758	£11,360	£10,476

Moral Welfare Associations

Financial assistance to the five large moral welfare associations of the major religious denominations was continued.

	1956	1957	1958
Total grants	£9,625	£9,625	£12,531
Number of expectant and nursing mothers advised ..	2,908	2,684	2,975

The increase in the grants for 1958 was mainly due to the payment by the associations of higher salaries to their moral welfare workers.

The following statistical tables relate only to cases dealt with by the five Moral Welfare Associations (London Diocesan Council, Southwark Diocesan Association, Westminster Catholic Social Welfare Committee (Crusade of Rescue), Southwark Catholic Rescue, Jewish Board of Guardians).

TABLE (i)—*Mothers seen for the first time in* 1958

Age of mother	*No.*	%
Under 18 years	249	8·4
18–24 years	1,788	60·1
25–34 years	771	25·9
Over 35 years	163	5·5
Not known	4	0·1
	2,975	100·0

TABLE (ii)—*Referring Agency*

	No.	*%*
Hospital	1,115	37·5
National Council for the Unmarried Mother and her Child and other Voluntary Agencies	571	19·2
Health, Welfare and other Local Authority departments	544	18·3
Clergy, church workers	334	11·2
Employers, friends	134	4·5
Personal application	98	3·3
National Assistance Board, Employment Exchanges, etc.	19	0·6
Any other	160	5·4
	2,975	100·0

TABLE (iii)—*Nationality—Normal residence*

	London (Admin. County)	*Elsewhere*	*Total*
British	1,300	439	1,739
Eire	364	319	683
West Indian	242	136	378
European	52	34	86
Other	46	43	89
	2,004	971*	2,975

* *693 were pregnant on arrival in London.*

TABLE (iv)—*Care of babies three months after birth*
(Babies born between 1.10.57 and 30.9.58)

	No.	*%*
Actually in mother's care	1,095	51·0
Adopted or placed for adoption	507	23·7
Mother responsible for and has access to child	362	16·8
Mother and child moved away	82	3·8
In care of local authority	46	2·1
Died	34	1·6
Miscellaneous	22	1·0
	2,148	100·0

These babies resulted from the pregnancies of 2,760 women—in the case of 522 the result of pregnancy was unknown, and in the remainder the result was a miscarriage, or still-birth. Of the 2,760 women, 1,137 (about 41 per cent) were reported as admitted to mother and baby homes before birth of their babies.

The total number of illegitimate births in London (Administrative County) during 1958 was 5,343 and the number reported as admitted to Mother and Baby Homes represents about 21 per cent of this total.

Child life protection

By arrangement with the Children's Officer responsibility for the visiting of foster children and the inspection of premises in which the children are living, under Part XIII of the Public Health (London) Act, 1936, as amended by Part V of the Children Act, 1948, was undertaken by health visitors designated as ' child protection visitors '.

The number of children so supervised on 31 March was 703, an increase of 44 on 1957.

Marriage Guidance

Grants totalling £6,500 for the year ending 31 March, 1959, were made to the London Marriage Guidance Council, the Catholic Marriage Advisory Council and the Family Discussion Bureau.

DOMICILIARY MIDWIFERY SERVICE

THE DUTY to provide an adequate domiciliary midwifery service is discharged through the Council's own midwives and those employed by district nursing associations and hospitals.

TABLE (i) *Staff*

District Midwives employed by ;	*1956*	*1957*	*1958*
The Council	92	87	87
District Nursing Associations (including supervisory staff)	46	44	48
Hospitals	44	39	40

TABLE (ii)—*Domiciliary confinements attended*

Year	*Number of confinements*						*Number of confinements*						*Grand Total*
	Doctor not booked						*Doctor booked*						
	L.C.C.		*District Nursing Association*		*Hospital*		*L.C.C.*		*District Nursing Association*		*Hospital*		
	Doctor present	*Doctor not present*	*Doctor present*	*Doctor not present*	*Doctor present*	*Doctor not present*	*Doctor present*	*Doctor not present*	*Doctor present*	*Doctor not present*	*Doctor present*	*Doctor not present*	
1956 ..	193	3,500	68	1,790	25	1,944	847	1,293	134	197	103	148	10,242
1957 ..	172	3,325	68	1,624	29	1,711	996	1,548	152	294	68	196	10,183
1958 ..	201	2,899	75	1,577	23	1,693	1,135	1,966	182	389	144	225	10,509

83 per cent of all the domiciliary confinements in 1958 were conducted without the attendance of a doctor. This figure compares with 85 per cent in 1957 and 87 per cent in 1956.

TABLE (iii)

	1956		*1957*		*1958*	
Premature babies born	509		501		482	
Still-births per 1,000 total births ..	8·8		8·5		8·4	
Inhalation analgesia administered—						
Gas and air	70%	84%	35%	87%	17%	88%
Trilene	14%		52%		71%	

Portable trilene inhalers were introduced into the Council's service in 1955 and by the end of 1957 each of the Council's midwives had been equipped with an inhaler and trained in its use. In consequence there has been a marked reduction in the use of the more cumbersome gas and air apparatus which, nevertheless, is still delivered by the London Ambulance Service on a midwife's request for use when labour is prolonged.

Midwives Act, 1951

Notifications received of intention to practise :

	1956	*1957*	*1958*
As midwives	1,164	1,193	1,160
As maternity nurses ..	144	137	121

Fees to medical practitioners called in by midwives in emergency :

	1956	*1957*	*1958*
Number of claims	2,554	2,479	2,626

HEALTH VISITING

Home visits	*1949*	*1955*	*1956*	*1957*	*1958*
Expectant mothers :					
First	*29,011*	22,999	23,143	23,482	24,131
Revisit	*20,649*	19,436	21,422	21,994	23,213
Percentage of notified live and still-births	*50*	45	44	43	42
Still-births	*1,586*	1,032	1,173	1,080	979
Children under 1 :					
First	*54,562*	48,225	51,960	52,171	53,557
Revisit	*171,288*	174,864	173,774	169,760	176,428
*Percentage of live births	*96*	97	100	98	96
Children 1–5	*361,313*	362,764	357,215	354,643	368,845
Care of old people }	*76,280*	77,014	12,842	12,465	13,331
Miscellaneous }			66,823	74,513	80,978
Unsuccessful	*113,985*	110,149	103,600	100,250	100,648
	828,674	816,483	811,952	810,358	842,110

** The true percentage may be somewhat less, but it is not practicable to exclude from the year's figures a small number of immigrants and of children visited in the year but born in the previous year.*

HOME NURSING SERVICE

DETAILS of the work done by the 26 voluntary grant-aided district nursing associations who acted as agents for the Council are given below :

TABLE (i)—*Staff*

	1949	*1954*	*1955*	*1956*	*1957*	*1958*
Total number of nurses employed at end of year	*410*	558	572	584	614	540
Full time equivalent of nurses employed ..	*361*	508	512	538	567	496
Number of trained district nurses	*Not*	Not	321	327	389	468
Number of state enrolled assistant nurses ..	*re-*	re-	36	35	30	31
Number of male nurses	*corded*	corded	49	38	40	41

TABLE (ii)—*Types of case nursed and visits paid*

Type of case	*Number of patients nursed*	*Percentage of total*	*Average number of visits to each patient*	*Total visits*
Medical	52,222	84·1	30	1,563,599
Surgical	5,937	9·6	36	211,261
Infectious diseases	142	0·2	6	907
Tuberculous	1,395	2·2	51	71,012
Maternal complications ..	862	1·4	8	6,710
Others	1,558	2·5	26	40,064
	62,116	100·0	30	1,893,553

The total visits for 1957 and 1956 were 1,991,621 and 1,962,733 respectively.

TABLE (iii)—*Visits for general treatment and for injections*

Visits for	*At patients' homes*	*Elsewhere (e.g., Nurses' Homes)*	*Percentage of total visits*
Injections only	856,840	33,923	47
Injections plus other treatment	111,555	259	6
Other treatment only	890,540	436	47
	1,858,935	34,618	100

During 1958 visits for injections only fell by 3% compared with 1957 and for other treatments rose correspondingly.

TABLE (iv)—*Long term cases (i.e., those visited more than 24 times during the year)*

Number	*Percentage of total patients nursed*
11,769	18·9

Percentage of long term cases shows a reduction from 21·7 for 1957.

TABLE (v)—*Age distribution of patients*

Age	*Number of patients*	*Percentage of total*
0–5 years	2,576	4
5–64 years	27,164	44
65 years and over ..	32,394	52
	62,116	100

Percentage of aged rose slightly compared with 1957.

TABLE (vi)—*Nursing treatments completed, cases on books and average case load per nurse*

	1949	*1954*	*1955*	*1956*	*1957*	*1958*
No. of completed treatments..	*37,855*	61,352	64,256	60,772	56,395	53,359
No. of patients being nursed at end of year	*(Not recorded)*	11,792	12,535	12,806	13,749	12,099
Average case load per nurse at end of year	*16·5*	23	24	24	27	24

HOME HELP SERVICE

STATISTICS of the service given follow :

	1949	*1954*	*1955*	*1956*	*1957*	*1958*
Cases assisted	*25,933*	32,503	34,785	34,557	35,737	34,600
Applications deferred or refused because home helps were not available	*3,500*	161	61	76	25	25
Hours worked	*2,783,000*	4,601,168	4,660,600	4,779,600	4,896,000	4,651,500
Home helps employed at end of year	*2,310*	3,124	3,148	3,326	3,388	3,529
Equivalent of whole-time staff	*1,265*	1,992	2,029	2,089	2,116	2,033
Night helps for chronic sick patients*—						
Applications met ..	—	65	48	37	44	55
No. of new families assisted*—						
Child help (resident) ..	—	12(34)	5(16)	5(20)	4(20)	6(20)
Early morning and evening help	—	185	205	180	153	197

* *These are included in total cases assisted. Figures in brackets denote numbers of children involved. These extensions of the service were introduced in 1953.*

The pattern of cases assisted remained constant, four-fifths being aged and chronic sick.

Specially trained home helps

There are now 118 specially trained home helps in the Council's service and during 1958 special home help was provided for 119 problem families. The scheme is now an integral part of the home help service, and experience to date is encouraging.

IMMUNISATION AND VACCINATION

THE NUMBER of children immunised against diphtheria and tetanus and vaccinated against whooping cough during the last five years is set out in Table (i) below with, where appropriate, corresponding figures for 1949.

TABLE (i)

	1949	*1954*	*1955*	*1956*	*1957*	*1958*
Diphtheria						
Primary course—						
Under 1 year ..		22,292	18,555	23,927	24,325	23,385
Age 1–4		16,533	11,078	13,907	12,643	10,560
Total under 5 ..	*42,392*	38,825	29,633	37,834	36,968	33,945
Age 5–14	*13,638*	8,796	4,896	6,403	5,856	4,742
Reinforcing doses ..	*38,312*	45,802	30,850	43,866	39,268	38,725
Percentage of age group 1–4 immunised at 5 years of age ..	*66·2**	66·4	66·5	68·4	70·4	69·9
Tetanus†	—	—	—	—	12,405	15,092
Whooping Cough	*24,805*	37,434	27,941	36,556	35,648	34,133

* *Estimated.* † *Started January, 1957.*

On 4th July, 1957, the Ministry of Health issued Circular 8/57 on the use of combined antigens and recommended that, where a local authority considered it expedient to use non-alum containing combined diphtheria and whooping cough antigens, they should pay special regard to the prevalence of poliomyelitis in the locality and to the period of highest risk of provocation as demonstrated in the report of the Medical Research Council. As the period of highest risk of provocation shown by the report was April-June the use of combined prophylactic in the county of London was suspended from 1st April, 1958. The low incidence of poliomyelitis in London permitted the resumption of the use of the combined prophylactic in August, 1958.

The use of single prophylactics during this period tended towards a reduced number of children receiving primary immunisation against diphtheria and whooping cough as parents failed to complete the long course of injections necessitated by the use of single prophylactics.

The degree of reduction varied from area to area and was as high as 50 per cent. in some places and insignificant in others. As whooping cough vaccine is given earlier than diphtheria immunisation the effect was greatest on the latter.

The number of children receiving multiple antigens is shown in the following table.

TABLE (ii)

	1956	*1957*	*1958*
Combined diphtheria/whooping cough ..	32,091	19,464	7,623
Diphtheria/whooping cough/tetanus ..	—	12,405	15,092

TABLE (iii)

Vaccination against smallpox

	1949	*1954*	*1955*	*1956*	*1957*	*1958*
Number vaccinated under 1 year ..	13,896	24,995	24,649	25,734	29,677	30,865
Per cent of live births	25	49	50	49	56	55

Two mild cases of generalised vaccinia were reported during the year.

Vaccination against poliomyelitis

The scheme for vaccination against poliomyelitis was extended in 1958 to persons born in the years 1933 to 1942 inclusive, hospital staff coming into contact with patients, medical students at hospitals, and families of the two latter groups. The extended scheme also provided for third injections to be offered to those who had already received two injections.

The inclusion of persons born in the years 1933 to 1942 brought in about 380,000 young people who, except for those still at school or receiving some form of further education, were nearly all in employment. The normal clinic facilities available for vaccination were not thought likely to be convenient for people at work during the day. Some additional clinics were arranged for the early evening, but generally these were not made use of to any extent. It became clear that if any impact was to be made on this group, it would have to be through their place of employment, or where they met socially in groups. Business houses, factories, etc., were approached for their co-operation in publicising to their staffs the facilities available for vaccination, including mid-day clinics in areas where there were large concentrations of workers. Where practicable, vaccination teams consisting of a medical officer, nurse and clerk were sent to places of employment to do the vaccinations. In some cases employers offered to undertake the vaccinations through their own medical staff, and vaccine and records only were supplied. Similar approaches were made to further educational establishments, including constituent colleges of the University of London. Still further sources of contact have yet to be explored.

It was appreciated that a large proportion of persons who were likely to apply at the mid-day clinics in central London would not be London residents. All eligible applicants were accepted regardless of residence with a view to getting as many vaccinated as possible.

In accordance with the suggestion of the Ministry of Health, priority was given to persons who had not received primary vaccination, and organised arrangements and publicity for third injections was deferred until 1959. Divisional medical officers were advised, however, not to refuse a third injection to any eligible applicant.

The number of persons who have received protection against poliomyelitis is as follows :

TABLE (iv)

	Persons who have received two injections		*Persons who have had a third injection*
	In 1958	*Since the commencement of the scheme*	
Born in			
1953–58	78,114	108,286	2,723
1943–52	151,954	227,667	4,876
1933–42			
Londoners	8,254	8,254	28
Others	4,126	4,126	1
Expectant mothers			
Londoners	9,417	9,424	41
Others	143	143	1
Others	3,293	3,293	131
Total	255,301	361,193*	7,801*
* *Given by general medical practitioners*		*60,892*	*1,958*

LONDON AMBULANCE SERVICE

Introduction

A FULL ACCOUNT of the origins of the London Ambulance Service was given in my report for 1949 (page 63). Briefly ambulances were originally devised to serve military purposes and their use in civil life was a later development. An ambulance service as such in London dates back only to the latter part of the last century when the Metropolitan Asylums Board in 1879 established the first horse-drawn ambulance service in London for the purpose of conveying fever patients to hospitals. Origins and early development

The Council's own ambulance service did not begin until 1915 when an accident ambulance service was introduced under the control of the Chief Officer of the Fire Brigade. This Service, which, during the first year, established six ambulance stations with 50 men and 9 ambulances, had grown by 1929 to 14 ambulance stations in commission with 20 ambulances and a total staff of 165.

The Local Government Act, 1929, transferred to the Council the ambulance services previously maintained by the Metropolitan Asylums Board and the 25 Boards of Guardians. Six large ambulance stations, 107 vehicles and a staff of about 270 were taken over by the Council and the general section of the London Ambulance Service, as distinct from the accident section, came into being, both sections then being administered through the Public Health department.

At the outbreak of war in 1939 there were 6 general ambulance stations, 16 accident ambulance stations, some 200 vehicles and a total staff of 422. The London Ambulance Service formed the nucleus of the London Auxiliary Ambulance Service created to deal with the conveyance of air-raid casualties, 48,709 of whom were transported to hospitals or first-aid posts. The six general stations were supplemented by some 112 auxiliary stations and in 1940 there were in commission about 900 ambulances and 700 motor cars for 'sitting' cases with a staff of some 7,000, later to be increased to 8,500.

After the war and the disbanding of the Auxiliary Ambulance Service, developments in the regular service prior to 1948 included the conveyance of analgesia apparatus for use by midwives in home confinements, emergency obstetric units to deal with complications arising during child birth at home and resuscitation ('iron lung') apparatus for use in cases of emergency.

Section 27 of the National Health Service Act, 1946, made mandatory upon the Council, as Local Health Authority, the provision of a *free* ambulance service in London. It had already been the Council's policy to extend from time to time the range of facilities which were provided by the ambulance service without charge to the public and, in fact, in 1947 (the year before the National Health Service came into operation) no less than 95 per cent. of all removals undertaken were carried out without charge. National Health Service Act, 1946

The tremendous growth in the demand for ambulance transport since the inception of the National Health Service is shown in table (i) and is referred to in detail in the paragraphs which follow. In 1947, 243,342 patients were conveyed over a distance of 2,131,430 miles. Each year since 1948 has shown an increase in the volume of the work undertaken so that in 1958 the total number of patients had risen to nearly 1,200,000 and the miles travelled to over 6,000,000.

General description of the Service

The Service meets the need for ambulance transport in the Administrative County of London, which covers 117 square miles, with a day-time population of over four million, and is controlled and administered from Headquarters at 150 Waterloo Road, S.E.1. It is under the immediate direction of the Officer-in-Charge, who is responsible to the Medical Officer of Health, and is divided, for operational purposes, into two sections—Accident and General. The central control system ensures that each section can assist the other in times of pressure. The service is supplemented by the assistance of certain voluntary organisations whose work is described later.

Accident Section

The Accident section is organised through a Headquarters Superintendent and 20 accident ambulance stations, each in charge of a station officer, and undertakes the conveyance of (*a*) persons suffering from accidental injury (wherever occurring), sudden illness in the streets, public places or places of employment, (*b*) cases of serious illness at home (provided that a doctor certifies that the case is of top priority), (*c*) urgent mental cases, (*d*) maternity cases (*e*) analgesia apparatus for use by domiciliary midwives and (*f*) mobile obstetric units.

In 1958 an average of 272 calls a day for these emergency services were received in the Headquarters control room and 69 per cent. of these calls were made by members of the public.

Upon receipt of an emergency call, the necessary instructions are passed immediately by direct telephone line from the control room to the nearest accident ambulance station at which an ambulance and crew are available. These ambulance stations are so situated that no station is more than about two miles from the scene of an emergency and the average time taken for an ambulance to reach the scene of an emergency call in 1958 was 6·5 minutes.

Peak demand periods tend to follow a definite pattern. 1958 conformed to type with Friday as the busiest day of the week, averaging about 300 calls, and December as the busiest month.

At Christmas and New Year and on other special occasions the Accident section is augmented to meet the anticipated increase in emergency calls and during the period from 2 p.m. on Christmas Eve 1958 to 2 a.m. on Christmas morning, no less than 411 emergency calls were received, i.e. an average of one call every 105 seconds.

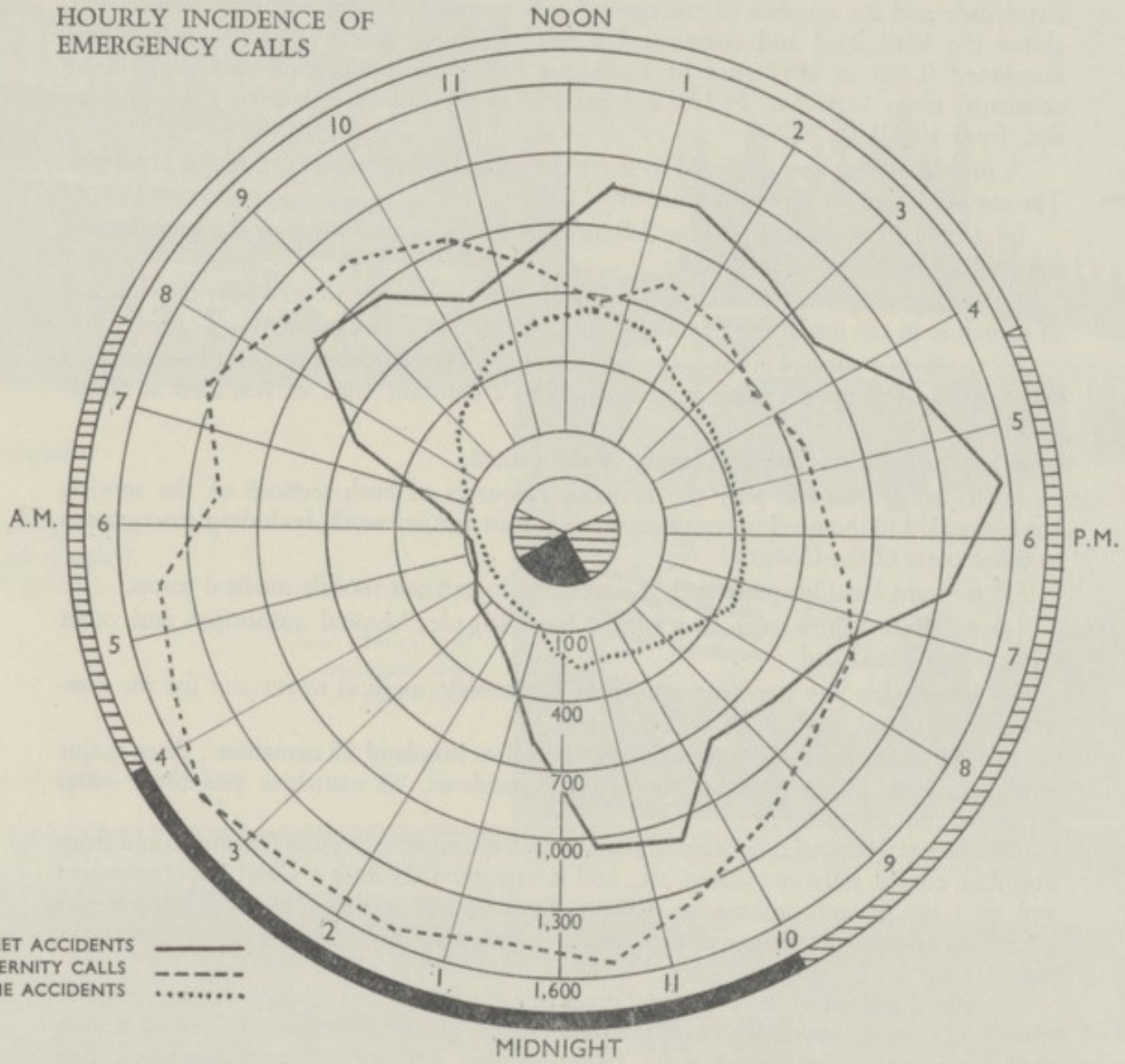
Table (ii) shows an analysis of the various categories of emergency calls received in 1958 and indicates that the highest incidence of such calls was from 10 a.m. to 7 p.m. and from 10 p.m. to midnight. The most dangerous periods for street accidents were between 5 p.m. and 6 p.m. and for home accidents between the hours of 11 a.m. and 3 p.m.

Calls for the removal of maternity cases constitute the greatest single category of emergency demand but the pressure which these calls would otherwise put upon the resources of the Accident section is to some extent offset by the fact that the majority of them occur at night. 27,248 calls were received in 1958, amounting to 26·5 per cent of the total emergency calls. In 198 cases the babies were born before the arrival of the ambulance, 120 babies were born after the arrival of the ambulance but before the doctor or midwife could be summoned, 42 were born in the ambulance on the way to hospital without the assistance of a midwife and 18 on the way to hospital with the assistance of a midwife.

In spite of the increasing volume of emergency work and the increased traffic congestion there has been a steady improvement in the times taken to reach the scene of an emergency and to reach hospital. The average time of arrival has been reduced from 8·1 minutes in 1948 to 6·5 minutes in 1958 and the average time taken to reach hospital from 21·7 minutes to 20·3 minutes, these times intervals being calculated from the time of receipt of the original call.

The average of the times taken to reach the scenes of street accidents, to which there were 16,690 calls, involving 19,182 patients in 1958, was six minutes and the casualties were admitted to one or other of 61 hospitals in the county, which are prepared to admit casualties at any time of the day or night, within an average of 17·8 minutes from the time the initial call for assistance was received.

The diagram below affords a comparison between the periods of peak demand for home and road accident cases and maternity admissions.



The Accident section is operational throughout the 24 hours every day. At 18 of the accident ambulance stations, in addition to one ambulance reserved for emergency calls, there are either one or two supplementary vehicles operating for 16 hours each day. These vehicles are fully equipped for emergency work but can be deployed to assist the General section by undertaking any removals which the general station ambulances are unable to deal with as promptly as the circumstances require. This arrangement reduces 'stand by' periods to a minimum. The increase since 1948 in the number of emergency calls has been met by increasing the number of accident ambulance stations from 16 in 1947 to 20 in 1958 and by placing at certain of these stations additional ambulances. The fleet of ambulances attached to the accident section was thereby increased from 32 in 1947 to 47 in 1958. Even so, an analysis of calls during one week in 1958 showed that 25 per cent of all calls received could not be responded to by the nearest Accident ambulance station because the vehicles and crews at those stations were already engaged on other urgent work and that at certain 'peak' periods this figure rose to 43 per cent. The full complement of drivers attendants and vehicles attached to the Accident section is 350 men and 49 ambulances which are controlled and deployed from headquarters. In 1958 they dealt with 99,188 emergencies and undertook 100,047 General removals.

The growth of the demand on the Accident section of the service, whilst not so dramatic as that on the General section, has shown a steady annual expansion during the last decade and the number of emergency calls received in 1958 was over 50 per cent. above the 1947 level and constituted a record figure. Street accident cases, which numbered 9,329 in 1947 rose to 19,182 in 1958; other accidents (including home accidents) from 11,430 to 19,779 and cases of urgent illness in streets, public places, etc., from 10,205 to 20,769.

Major accidents

A procedure has been evolved to meet the special circumstances of major accidents. The essential aims of this procedure are:

(*a*) to obtain as soon as possible full information as to the extent of the accident and the probable number of casualties,

(*b*) to deploy quickly an adequate number of ambulances and crews for the removal of casualties in the initial stages and to build up reserves at the incident,

(*c*) to set up a control point as soon as practicable. For this purpose a radio-controlled and specially equipped vehicle is maintained in a constant state of readiness at Headquarters,

(*d*) to provide an adequate supply of equipment,

(*e*) to bring into full play the available resources of both sections of the service, having regard to the need to continue dealing with normal work, including emergencies in other parts of the County,

(*f*) to warn local hospitals and, if necessary, to call out mobile medical teams,

(*g*) to effect liaison with the Police, Fire Brigade, hospital authorities and other services concerned and

(*h*) to provide any necessary transport for mobile medical teams and for the conveyance of blood, plasma, etc.

In 1958 there were 18 large incidents. Ten fires involved 22 casualties ; three major road accidents, 13 casualties ; two railway accidents, 45 casualties and three other incidents, nine casualties.

General Section

The General section is concerned mainly with the removal of sick persons to and from hospitals, clinics, railway stations, etc., and is organised through a Chief Superintendent and six large general ambulance stations. Each station is staffed by a resident superintendent, an assistant superintendent and an average of seven ambulance control clerks and 70 men.

40–50 vehicles of various sizes and types suitable for the conveyance of recumbent or sitting patients are attached to each station. Orders for the provision of General section ambulances are normally received from hospital authorities, the Emergency Bed Service or general practitioners. About 100 of the larger hospitals and clinics at present pass their transport requests, other than those for journeys of more than 25 miles from the ' pick up ' point, railway journeys or requests for the removal of infectious or mentally ill patients, directly to the appropriate local general ambulance station, the remaining orders being received and dealt with through the Headquarters control. At some 60 of the larger hospitals in London, in order to simplify the procedure and to reduce dead mileage and unproductive time, one or more ambulances are stationed for varying periods on week days to convey patients to and from those hospitals under the direction of transport officers appointed by the hospital authorities.

In 1947 (the year preceding the inauguration of the National Health Service) the General section dealt with the removal of 182,206 patients. Since that time there have been gradual but substantial increases in demand year by year (table (i)) and by 1958 this figure had risen to 966,877. The volume of work in 1958 was inflated to some extent by the bus strike which inevitably led to increased demands for special transport during the months of May and June but, even so, it is estimated that there was a ' normal ' increase of about 7 per cent as compared with the previous year and a five-fold increase over the 1947 level.

Headquarters

LONDON
AMBULANCE
SERVICE

New standard type ambulance with plastic body

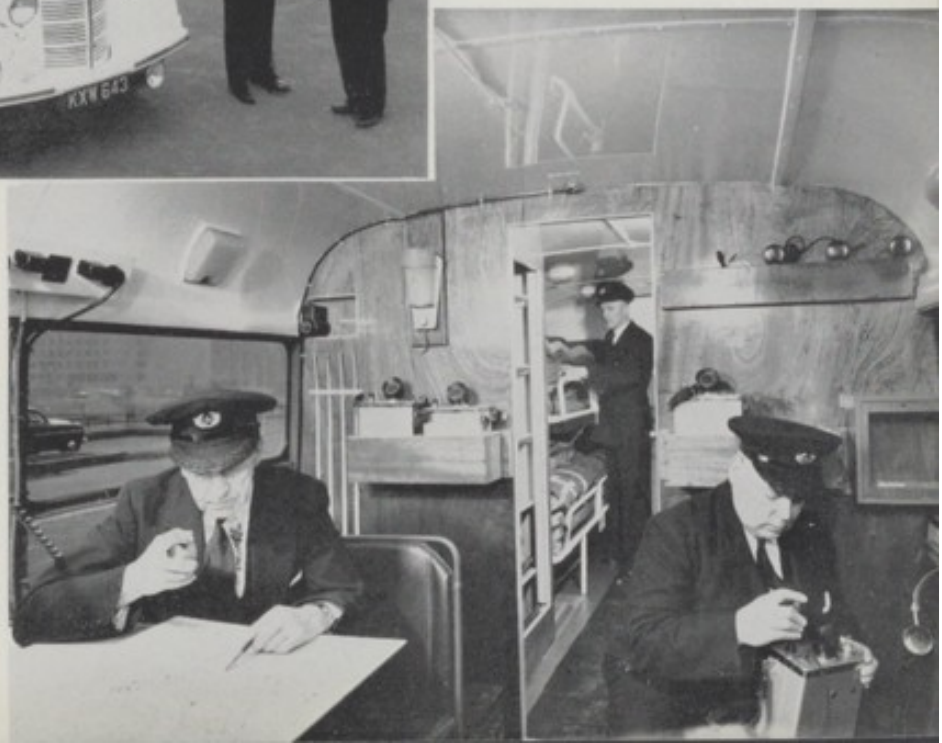
Headquarters Control Room

Top—Accident Station Watchroom

Centre—Suburban street accident
(Photo by "Mercury" Photos)

Bottom—Interior of new standard type ambulance

Major road accident in Central London
(Photo by Pathé News)



The Mobile Control Unit

An accident section station

Removal by train on special stretcher

A general section station

In order to cope with the continuing increase in the volume of work, constant vigilance has had to be exercised and the best use of available resources carefully planned. The results of these efforts are indicated in table (iii).

By far the greatest single category of users of the Service are out-patients attending hospital departments and clinics and in 1958 they accounted for about 80 per cent of the whole of the work of the Service. Taking into account the various schemes now in hand or in contemplation for the re-building or extension of hospitals within the London area, the increasing average age of the population and the policy of the Ministry of Health in encouraging out-patient as distinct from in-patient treatment by the provision of day hospitals and geriatric, rehabilitation and chiropody services, it is not unreasonable to expect a continuing increase in the volume of out-patient treatment in the future and a corresponding increase in the demand for ambulance transport.

Headquarters station

The special functions of the Headquarters station are to supply relief staff and ambulances to other stations, to provide a battery and tyre service for the Accident section ambulances and, when necessary, to deal with vehicle breakdowns on the road. A mobile servicing unit makes a regular circuit of accident ambulance stations to carry out routine servicing and inspection and a fully equipped ambulance is provided by the Headquarters station to accompany this unit and to stand in for each ambulance as it is temporarily taken out of commission.

Removals by train

When a patient has to travel a long distance, arrangements have continued to be made, with the co-operation of the present hospital administrations and their medical officers and of the railway authorities, for the major portion of the removal to be carried out by train when the condition of the patient permits and rail transport would be quicker and more comfortable than a long journey by road. Reserved accommodation is arranged on the train and ambulance transport is provided as necessary at each end of the rail journey. These arrangements help to achieve an appreciable shortening of the time taken for the overall journey and not only is this a significant factor in minimising the fatigue occasioned to the patient but the saving gained in vehicles and man-power affords valuable relief to the ambulance service.

Patients coming into London by rail from out-county areas are also met at the various railway stations and arrangements made to enable them to continue their onward journeys.

It is estimated that about 24,000 patients are being taken by ambulance transport to and from the eleven London railway termini in the course of a year. The Council pays the rail fare of a patient who, in the opinion of the hospital or doctor concerned, cannot be regarded as travelling as an ordinary passenger and the number of such patients for whom railway fares were paid by the Council in 1958 was 1,622.

Agency and supplementary services

The Ambulance Department of the Joint Committee of the Order of St. John of Jerusalem and British Red Cross Society and the County of London Hospital Car Service render valuable assistance in relieving the directly provided service of a large volume of work.

The Ambulance Department of the Joint Committee carries out removals at an agreed rate of reimbursement and undertakes much of the conveyance of patients who need to travel by ambulance to out-county areas. A summary of the work carried out by this organisation since 1948 is given in table (i), from which it will be noted that 17,151 patients were conveyed in 1958 over a distance of 394,145 miles.

The Hospital Car Service is a voluntary organisation administered jointly by the Order of St. John of Jerusalem, the British Red Cross Society and the Women's Voluntary Services. This service supplements the Council's own services by undertaking the conveyance by motor car of certain patients who do not need an ambulance but who, nevertheless, are unable to travel by ordinary means of public transport. In order that the combined resources of the Hospital Car Service and the Council's own service may be deployed with the maximum efficiency and economy, all demands for Hospital Car Service transport are made through the Council's control organisation.

About 200 volunteer drivers are enrolled in the service and the Council pays these drivers at an agreed rate per mile and reimburses the Hospital Car Service for the whole of its administrative and overhead expenditure. Figures relating to the work of this service since 1948 are also given in table (i) and it will be noted that in 1958, 112,558 patients were conveyed over a distance of 1,224,817 miles.

Agency arrangements also exist with the West Ham County Borough Council whereby the ambulance service of that authority undertakes the removal of patients in the two parts of the Metropolitan Borough of Woolwich which lie north of the Thames and are separated from the rest of the administrative county by the river or by that borough. 409 patients were dealt with under this arrangement in 1958 (table (i)).

Special services

Analgesia apparatus—Analgesia apparatus is located at accident ambulance stations and, upon receipt of a call from a domiciliary midwife, a set can be delivered within a few minutes to any address in the County.

Emergency obstetric units—A number of hospitals maintain emergency obstetric units in a constant state of readiness to deal with complications arising during childbirth at home and in London an arrangement exists by which any general medical practitioner or midwife, who finds it necessary to call for the help of one of these units, simply has to put through an emergency call to the ambulance service headquarters control and an ambulance is despatched at once to pick up the nearest available unit, convey it to the patient's address and, if necessary, stand by to remove the patient to hospital.

Premature baby units.—When the removal of a premature baby to hospital becomes urgently necessary the service undertakes, if required, to collect a premature baby unit from the hospital, take it to the patient's address and carry out the removal.

Transport of blood, drugs, 'iron lungs' etc.—In emergency the service undertakes the transport, on behalf of hospitals etc., of blood, drugs, 'iron lungs' or other such items.

Smallpox and typhus.—Special arrangements have been made for the removal of patients suffering from smallpox or typhus and for the conveyance of consultants in emergency to examine patients suffering or suspected to be suffering from these diseases. Staff who have been successfully vaccinated and trained in the use of special clothing and other precautions are employed and provision made for the disinfection of vehicles and equipment. These services have been made available to neighbouring local health authorities.

System of communications

With the exception of calls made directly to general ambulance stations by hospitals under the decentralised arrangements already described, all calls for ambulances are received in the control room at Headquarters. The Control Room staff receive requests for general removals either by telephone or in writing and all telephoned emergency calls upon the Accident section, decide which ambulance station shall carry out a particular removal and transmit thereto the necessary instructions.

A specially designed telephone switchboard with 40 direct and 31 Exchange lines gives direct communication with all the Council's ambulance stations. The exchange lines are routed through six different telephone exchanges as a safeguard against failure of the communications system. The calls come in either directly from hospitals, doctors, midwives, police etc. or are relayed to the control room by telephone exchanges which have received them as '999' calls. This central control enables the resources of the entire service to be used to the best advantage by the diversion of work from one station to another according to the fluctuating pressure. The control room is manned throughout the day and night by a total staff of 32 working on a shift rota.

The maximum number of staff on duty at any one time is 16 to cope with the peak period between 9.30 a.m. and 4 p.m. From 8 p.m. to 8 a.m. three ambulance control clerks are on duty and on Sunday the staff is reduced to two shifts of three control clerks, each between the hours of 8 a.m. and 8 p.m.

In the event of a power failure on the Post Office telephone lines an auxiliary supply is automatically switched into circuit and an auxiliary lighting system is brought into use should the normal supply of electricity fail.

The movement of vehicles at accident stations is controlled from the Headquarters control room and, from reports received from the crews, the availability of these vehicles at any time is known and is indicated on an electrically operated indicator board which shows at any moment whether any particular accident ambulance is in its station, on the way to a call or returning to its station. The control room officer concerned is thus able to follow from minute to minute the movements of the entire fleet of accident ambulances and thus is able to ensure that emergency calls are answered with the minimum of delay.

A half-hourly ' state ' of the General section, i.e., the number of vehicles and men available and the number of cases waiting, is maintained from information obtained from these stations.

In addition to being in direct telephonic communication with the headquarters control room, each general ambulance station has three or four exchange telephone lines and each accident station one line through the local exchange for administrative use and as a stand-by in case of breakdown of the direct line.

Radio-telephony also is being increasingly used in the Accident and General sections of the service, the accident ambulances remaining under direct headquarters control while the general ambulances are controlled from their own stations.

Methods of calling an ambulance are given in Annex A.

Staff

The following table shows the staff establishment of the London Ambulance Service on 31 December, 1958 :—

	Staff numbers
Administrative Staff	
Officer-in-Charge	1
Assistant Officer-in-Charge	1
Administrative and clerical Officers	27
Supervisor (Headquarters Control Room)	1
Assistant Supervisor (Headquarters Control Room)	1
Ambulance Control Clerks :	
(*a*) at Headquarters	32
(*b*) at Ambulance Stations	42
	105
Uniformed Staff	
Chief Superintendent	1
Deputy Chief Superintendent and Civil Defence Superintendent	1
Headquarters Superintendent	1
Superintendents at General Stations	6
Assistant Superintendents at Headquarters and at General Stations	7
Assistant Superintendent for Civil Defence	1
Duty Station Officers (Headquarters)	3
Station Officers at Accident Stations	19
Station Officers for Civil Defence	3
Leading Drivers at General Stations	12
Leading Drivers at Headquarters Station	4
Drivers/Attendants at General Stations	408
Drivers/Attendants at Accident Stations	346
Total	812

Staff qualifications

All the operative staff are qualified to act either as drivers or as attendants Applicants for appointment are required to be competent to drive a motor car and to pass an examination held by the Council in their ability to drive an ambulance. They are also required to hold, or to obtain before the expiration of 6 months probationary service, a recognised first-aid certificate.

A driver and an attendant are sent on all journeys except when it is clear that only a driver is needed.

Awards to staff

During 1958 the London Ambulance Service silver medal for meritorious conduct was presented for only the second time since its introduction by the Council in 1938. Driver P. S. W. Poole, together with a Police Constable, in the course of his duty grappled with a man of unsound mind who was brandishing two knives and uttering threats against their lives. The man was eventually disarmed but in the course of the struggle Driver Poole was injured in the hand. He continued with his duties until the patient had been admitted to hospital before seeking first-aid for his injury. His action was considered by the Council to merit the award of the silver medal and this was presented to Driver Poole by the Chairman of the Council at a Council Meeting on 18 March, 1958.

One station officer and four drivers in the Accident section of the Service were awarded the Royal Humane Society's Resuscitation Certificate during the year.

Of 763 drivers who were entered in the National Safe Driving Competition held by the Royal Society for the Prevention of Accidents in 1957, 80 per cent gained awards. Only 7 per cent were disqualified, the remaining 13 per cent being accounted for by resignations and by exemptions owing to prolonged illness. One driver received a 35 years' medal, the highest award yet gained in the Service, and it is gratifying to record that four drivers hold awards for over 30 years safe driving and nine for 25 years or more.

Vehicles

The total operational vehicle strength at the end of 1958 was 335 comprising 230 ambulances, 62 single stretcher ambulances mainly used for sitting patients, 34 sitting-case cars, 6 ambulance buses, two tenders and a mobile control unit for use at major accidents.

Equipment

Each of the ambulances operating in the Accident section carries, in addition to the normal first-aid equipment, a comprehensive range of special equipment and appliances, including oxygen resuscitation apparatus, sterile surgical instruments, drugs, a carrying-chair, a hack-saw, rope and special apparatus for raising and lowering injured persons from positions difficult of access. A full list of equipment is given in Annex B.

The ambulances attached to the general stations are provided with first-aid kits to enable crews to treat any injured persons they may encounter while engaged on their normal duties of sick removal.

Replacement programme

In formulating a vehicle replacement programme, the growing demand from hospital out-patient departments, with the consequent need for a higher proportion of sitting-case vehicles, has been taken into account. To meet this need and to secure more economical running and maintenance, the large ambulances at present in use will be replaced by a new and more economical type of ambulance or by smaller dual-purpose vehicles. Most of the motor cars, also, which are less economical of accommodation, will be replaced by more suitable vehicles.

The new type ambulance has been designed and produced in the Mechanical Works Division of the Council's Supplies Department to the special requirements of the service and this vehicle, whilst preserving the same low loading level and accommodation for patients as in the existing large ambulance, is smaller in over-all dimensions, lighter in weight and more economical in operation. The chassis can be fitted with either petrol or diesel engine and the body is made of glass-reinforced polyester resin. Nine of these vehicles were in operation at the end of 1958.

The Chief Officer of Supplies is responsible for the maintenance and repair of all ambulance vehicles. The work is undertaken in the Mechanical Works Division of the Supplies Department at the central repair depot at Wandsworth. Periodically, all vehicles are taken into the central repair depot for overhaul but subsidiary repair workshops for the more minor repairs and servicing are located at each of the six general stations. The mechanics employed in these workshops are under the direction of the central repair depot. As mentioned above, ambulances stationed at the accident ambulance stations are serviced on the site by a mobile unit based on the central repair depot. Maintenance and repairs

Finance

The total cost of ambulance services in London has risen from £320,619 in 1947/48 (the last financial year before the commencement of the National Health Service) to £1,063,819 in 1957/58, including £102,162 for the agency and supplementary services. This very marked increase in costs is due partly to increases in wages and in the cost of materials and supplies but is largely due to the increased amount of ambulance work.

The following table shows a percentage analysis of costs (1957/58) relating to the directly provided service :

	Percentage of total	£
Operative staff	59·6	571,969
Running and maintenance of vehicles ..	18·5	177,416
Provision of vehicles	7·2	68,905
Maintenance of buildings, furniture, etc. ..	4·0	38,352
Provision of land and buildings (notional annual expenditure)..	1·5	14,407
Other expenditure	9·2	88,299
	100·0	959,348

The following is a summary of the actual costs incurred during the financial year 1957/58 relating to the directly provided, agency and supplementary services :

	Miles	*Patients*	*Total cost*	*Cost per mile*	*Cost per patient*
			£	s. d.	s. d.
Directly provided Service					
(*a*) by road	4,255,608	1,015,649	959,348	4 6	18 10
(*b*) by rail	126,811	1,678	2,632	5	31 4
Hospital Car Service ..	1,168,266	144,305	48,806	10	5 0
Joint Committe of St. John and British Red Cross..	428,860	24,786	52,710	2 5	42 6
West Ham County Borough Council ..	4,735	531	323	1 4	12 2
Whole Service ..	5,984,280	1,239,949	£1,063,819	3 7	17 2

NOTE.—The above table is based upon the Ministry of Health's definition of a 'patient' for statistical purposes, i.e., one person carried once in one direction.

Civil Defence

In peace-time, the responsibilities of the Council under the Civil Defence Regulations of 1949 and 1954 are :

(*a*) to make plans for the expansion in the event of war of their ambulance services ;

(*b*) to train members of the ambulance and casualty collecting section of the Civil Defence Corps, and also peace-time ambulance staff, in Civil Defence ambulance duties and

(*c*) to make plans for the provision of a service for the collection and removal of casualties and for the maintenance of that service in conjunction with the ambulance service.

In war-time, the ambulance service will have three functions :

(*a*) the conveyance of the ordinary sick and injured to and from hospital

(*b*) the conveyance of casualties caused by enemy action to hospital and, when required, to assist in the transfer of patients from one hospital to another and

(*c*) the rendering of first-aid to casualties and conveying them to ambulance loading points.

The responsibility for the collection and carriage of casualties over the debris to the waiting ambulances led to the name of the section being altered to the Ambulance and Casualty Collecting Section in 1954.

The section enrols both men and women volunteers, irrespective of whether they can drive or not. In London there were 1,623 volunteers at the end of 1958 of whom women were in a majority.

Training is given at a number of ambulance stations with suitable lecture room facilities in London and also at a social and training centre at the South Bank, S.E.1. The following subjects are included :

(*a*) defence against the various forms of attack that might be used in any future war

(*b*) first-aid

(*c*) blanketing of stretchers, carriage of patients, ambulance loading etc.

(*d*) map reading

(*e*) duties of the peace-time service

(*f*) practical exercises with the aid of faked casualties and simulated war-time conditions

(*g*) vehicle maintenance

(*h*) driving practice for those holding driving licences

(*i*) driving tuition for those who do not hold current licences. Tuition is dependent on reaching a certain stage of training and also displaying a reasonable aptitude for learning to drive during the early tuition lessons. There is no charge to the individual volunteer for tuition nor for the licence or driving test fees. If successful in passing the driving test, volunteers continue with driving practice

(*j*) elementary rescue

(*k*) a special revision course for the selection of potential officers.

Training is given by officers and staff of the London Ambulance Service, many of whom qualified as Civil Defence instructors at the Home Office Technical Training School at Falfield, Gloucestershire. Sixty-five training courses in various subjects were held in 1958.

TABLE (i)—*Work performed by the directly provided service and by the agency and supplementary services*

	1947	*1949*	*1950*	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*
Patients :											
Accident Section	*61,136*	65,989	73,853	77,661	78,692	81,800	82850	87,164	88,608	91,801	94,079
General Section	*182,206*	362,963	480,048	550,621	660,206	721,334	797,937	851,997	881,006	886,839	966,877
Total—directly provided service ..	*243,342*	428,952	553,901	628,282	738,898	803,134	880,787	939,161	969,614	978,640	1,060,956
Joint Committee	—	9,557	7,966	10,111	13,682	15,272	17,493	21,539	24,358	25,090	17,151
Hospital Car Service	—	107,667	144,669	149,046	135,523	131,763	125,352	127,938	120,122	112,028	112,558
West Ham C.B.C.	—	113	246	208	591	457	434	416	378	499	409
Total—agency and supplementary services	—	117,337	152,881	159,365	149,796	147,492	143,279	149,893	144,858	137,617	130,118
Total patients	*243,342*	546,289	706,782	787,647	888,694	950,626	1,024,066	1,089,054	1,114,472	1,116,257	1,191,074
Journeys :											
Accident Section	*64,560*	75,901	83,791	87,012	87,691	90,896	92,401	96,661	97,823	97,535	99,188
General Section	*155,122*	279,600	340,876	361,664	410,469	428,755	448,004	462,615	463,158	457,976	482,863
Total—directly provided service ..	*219,682*	355,501	424,667	448,676	498,160	519,651	540,405	559,276	560,981	555,511	582,051
Joint Committee	—	5,716	4,785	5,499	6,886	7,628	8,848	10,118	10,837	11,745	9,710
Hospital Car Service	—	84,306	109,860	99,947	89,633	83,561	78,447	82,652	76,756	71,556	70,724
West Ham C.B.C.	—	113	246	199	583	454	433	414	378	494	403
Total—agency and supplementary services	—	90,135	114,891	105,645	97,102	91,643	87,728	93,184	87,971	83,795	80,837
Total journeys	*219,682*	445,636	539,558	554,321	595,262	611,294	628,133	652,459	648,952	639,306	662,888
Mileage :											
Accident Section	*362,880*	410,917	437,416	443,683	442,268	458,602	466,415	488,292	491,929	485,431	495,913
General Section	*1,768,550*	2,808,550	3,041,569	3,092,902	3,470,442	3,625,430	3,804,544	3,856,850	3,736,550	3,687,353	3,982,374
Total—directly provided service ..	*2,131,430*	3,219,467	3,478,985	3,536,585	3,912,710	4,084,032	4,270,959	4,345,142	4,228,479	4,172,784	4,478,287
Joint Committee	—	376,564	281,223	263,087	285,075	319,869	371,372	429,980	436,927	430,373	394,145
Hospital Car Service	—	1,496,090	1,787,434	1,740,930	1,504,138	1,424,788	1,320,582	1,425,624	1,399,355	1,292,177	1,224,817
West Ham C.B.C.	—	1,468	4,373	3,338	7,806	5,358	5,008	4,621	4,152	5,052	4,953
Total—agency and supplementary services	—	1,874,122	2,073,030	2,007,355	1,797,019	1,750,015	1,696,962	1,860,225	1,840,434	1,727,602	1,623,915
Total mileage	*2,131,430*	5,093,589	5,552,015	5,543,940	5,709,729	5,834,047	5,967,921	6,205,367	6,068,913	5,900,386	6,102,202

TABLE (ii)—*Analysis by hours of the day, of numbers of patients conveyed and of journeys' without patients—1958.*

Hours	Street accidents	Home accidents	Maternity removals	*Other	Total
A.M.					
12–1	562	147	1,455	1,509	3,673
1–2	249	83	1,564	928	2,824
2–3	167	52	1,519	669	2,407
3–4	113	31	1,602	509	2,255
4–5	87	35	1,492	395	2,009
5–6	89	42	1,422	338	1,891
6–7	186	46	1,174	493	1,899
7–8	658	102	1,330	885	2,975
8–9	1,020	215	1,183	1,668	4,086
9–10	984	373	1,145	2,377	4,879
10–11	739	494	1,019	2,905	5,157
11–12	883	580	819	3,367	5,649
P.M.					
12–1	1,171	640	693	3,262	5,766
1–2	1,199	603	827	3,036	5,665
2–3	1,093	498	799	3,000	5,390
3–4	1,058	448	698	3,423	5,627
4–5	1,302	436	750	3,155	5,643
5–6	1,593	426	785	2,899	5,693
6–7	1,372	471	901	2,483	5,227
7–8	987	476	1,003	2,185	4,651
8–9	831	379	1,037	2,210	4,457
9–10	739	281	1,190	2,066	4,276
10–11	1,092	272	1,301	2,439	5,104
11–12	1,008	251	1,540	2,627	5,426
Total	19,182	7,381	27,248	48,863	102,674
Percentage	18·7	7·2	26·5	47·6	100·0

* *Includes accidents (other than home and street accidents) (12·1 per cent.) ; assault (3·1 per cent.) ; attempted suicide (1·8 per cent.) ; urgent illness (21·9 per cent.) ; non-patient carrying journeys (1·2 per cent) ; ambulance not required (7·5 per cent.).*

TABLE (iii)—*General Section*

	1949	*1950*	*1951*	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*
Average mileage per patient	*7·74*	6·34	5·62	5·26	5·03	4·77	4·53	4·24	4·16	4·12
Average mileage per journey	*10·05*	8·92	8·55	8·45	8·45	8·49	8·34	8·07	8·05	8·25
Patients carried per 100 journeys	*130*	141	152	161	169	178	184	190	194	200
Percentage of lost journeys	*4·2%*	3·2%	2·8%	2·6%	2·5%	2·4%	2·2%	2·1%	1·9%	1·9%
Delays at hospitals of over half hour's duration	N/A	N/A	N/A	N/A	2,996	1,813	1,372	745	334	283

ANNEX A

METHODS OF CALLING AN AMBULANCE

(1) *Accidents (wherever occurring) and sudden illness (in the streets, public places or places of employment).*—For the conveyance to hospital of persons meeting with accidents (in the home or elsewhere) or suffering from sudden illness (in the streets, public places or places of employment) within the County of London. The ambulance may be called by private, public or police telephone ; full instructions are given in every telephone box. Where the dialling system is in operation '999' should be dialled and the operator asked for 'Ambulance'. No charge is made for the use of the telephone if the call is made from a public call-box.

(2) *Very urgent illness at home.*—For the conveyance of sick persons from their homes to hospital, provided a doctor certifies that the case is one of top priority and that arrangements have been made with a hospital for the patient's admission. Application should be made to one of the following telephone numbers :—WATerloo 6000, NEW Cross 2645, RELiance 3622, CENtral 6301 or REGent 4000.

(3) *Maternity cases.*—For the removal of maternity cases to hospitals etc. Normally, if the expectant mother has booked a bed at a hospital or nursing home, she is in possession of a white card (Form L.A.S. 23) confirming the booking arrangements and giving full instructions for summoning the ambulance. Where no previous arrangements have been made, however, the London Ambulance Service cannot accept direct applications for removal to hospital except in the case of emergencies occurring in the street or other public place, when the procedure as in (1) above should be followed. In all other cases application should be made *by a doctor or midwife* to the Emergency Bed Service, telephone No. HOP 7181.

(4) *Other illness.*—For the removal to and from hospitals etc. of sick persons, provided the ambulance is ordered by the hospital authority, by the Emergency Bed Service or, in certain circumstances, by a private doctor. Application should be made in writing or by telephoning WATerloo 3311.

(5) *Analgesia apparatus.*—For the delivery to addresses within the County of London of analgesia apparatus. Orders for this service are normally accepted only from the Council's domiciliary midwives.

(6) *Arrangements in North Woolwich.*—The West Ham Ambulance Service undertakes, on behalf of the London County Council, ambulance work in the two parts of the Borough of Woolwich, which lie north of the River Thames and the procedure for obtaining ambulance service in these areas is as follows :—

For accidents (wherever occurring) and for sudden illness (in the streets, public places or places of employment)—As in (1) above.

For booked maternity cases and very urgent illness in the home—Telephone GRAngewood 9621.

For all other removals.—Telephone GRAngewood 4477.

ANNEX B

Equipment carried by each Accident Ambulance

Beds, Rubber (2)
Blankets, red (6)
Blanket, cot (1) in canvas envelope
Bowls, kidney, small (2)
Bowl, kidney, large (1)
Bowls, round (2)
Coats, crew's protective (2)
Carrying chair (1)
Carrying sheet (1)
Dressings case (1)
Drinking water bottle (1)
Drugs case (1)
Feeding cup (1)
Fracture board (1)
Gloves, rubber, elect., pair (1)
Guide lines (2 by 12 yds.)
Hacksaw (1)
Hacksaw blades (6)
Hot-water bottle, rubber (1)
Hot-water bottle, cover (1)
Lamp, electric, hand (1)
Lamp, electric, red (1)
Mats, rubber (4)
Oxygen apparatus (1)
Pillows, rubber (2)
Rope, 40 ft. length (1)
Rubber Sheet, 8 ft. (1)
Satchel, first-aid (1)
Splints, set of 16 (1)
Splint, back leg, 18 in. (1)
Stretcher canvases (6)
Stretcher poles, wooden, pair (1)
Stretcher poles, duralumin, pair (1)
Stretchers, rigid (2)
Stretcher, Neil Robertson, or Barnes attachment or manifold harness (1)
Towelling square (1) for use with cot blanket
Traverse irons, pairs (2)

Contents of Drugs Case

Calcis saccharatus, liq., oz. (6)
Dettol, oz. (4)
Epsom salts, saturated solution, oz. (6)
Iodine, ampoules (4)
Labels, casualty (6)
Magnesium oxide, oz. (2)
Measure, 4 oz. (1)
Measure, 2 oz. (1)
Mustard, oz. (2)
Olive oil, oz. (6)
Sal volatile, oz. (4)
Skin pencils (2)
Soda, Bi-carb., oz. (2)
Tannic acid, solution, oz. (6)
Teaspoon (1)
Vaseline, tube (1)
Vinegar, oz. (6)

and the following items TO BE USED ONLY BY MEDICAL PRACTITIONER

*Adrenaline tartrate, ampoules (6)
Amyl nitrate, ampoules (12)
Chloroform, oz. (2)
*Nikethamide (coramine) ampoules (6)
Surgical needles and sutures, sterile, in tube (3)
Swabs (2)
Syphon, stomach (1)
Syringe, sterile, hypodermic (with three needles) (1)
†*Morphine (OMNOPON) in ampoule-syringes (6)

†*CARRIED IN SPECIAL LOCKED CUPBOARD CONTAINING ALSO 6 CASUALTY LABELS AND 1 SKIN PENCIL.*

* For hypodermic injection.

Contents of Dressings Case

Bandages, Asepto, No. 0 (6)
Bandages, Asepto, No. 1 (6)
Bandages, Asepto, No. 2 (6)
Bandages, Asepto, No. 3 (6)
Bandages, Asepto, No. 4 (6)
Bandages roller, 1 inch (6)
Bandages roller, 2 inch (6)
Bandages roller, 3 inch (6)
Bandages, triangular (12)
Cotton wool, 4 oz. packet (1)
Gag (1)
Gloves, surgical, pair (1)
Lint, 4 oz. packets (2)
Lint, boric, packet (1)
Mask, Schimmelbusch (1)
Mouth cloths (3)
Pins, safety (12)
Plaster, adhesive, roll, 1 inch (1)
Plaster, adhesive, roll, 2 inch (1)
Scissors, dressing, pair (1)

Surgical Instruments contained in holdall, sterile cellophane wrapping and plastic outer envelope

Forceps, artery (4)
Forceps, dissecting (1)
Forceps, Treves (1)
Gauze, white, roll (1)
Knife, amputation (1)
Probe (1)
Saw (1)
Scalpels (2)
Scissors, dressing, pair (1)
Tracheotomy tubes, adult (1)
Tracheotomy tubes, child (1)

Contents of First-Aid Satchel

Bandages, Azoic, No. 0 (1)
Bandages, Azoic, No. 1 (6)
Bandages, Azoic, No. 2 (6)
Bandages, Azoic, No. 3 (4)
Bandages, Azoic, No. 4 (2)
Bandages, roller, 1 inch (6)
Bandages, roller, 2 inch (6)
Bandages, triangular (6)
Cotton wool, oz. (1)
Iodine, ampoules (4)
Lint, oz. (1)
Mouth cloth (1)
Sal volatile, 4 oz. (1)
Tourniquet (Esmarch)
Tongue depressors, wooden 6

PREVENTION OF ILLNESS: CARE AND AFTER-CARE

Foot clinics

Particulars of new cases and attendances

Year	New cases	Attendances	Staff at the end of the year (in terms of whole units)
1949	*9,446*	*129,682*	*35*
1950	10,165	153,687	44
1951	10,348	162,163	43·5
1952	10,828	169,598	43·2
1953	11,374	180,588	43·5
1954	10,143	185,614	44·8
1955	9,089	184,628	43·8
1956	7,362	170,855	41·8
1957	8,149	166,987	44·2
1958	6,994	172,005	44·2

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

Recuperative holidays

Admissions to recuperative holiday homes

	1949	*1955*	*1956*	*1957*	*1958*
Expectant and nursing mothers ..	*379*	153	141	138	111
Other adults	*2,779*	2,784	2,590	2,510	2,289
Children under 5 not at school ..	*5,309*	746	602	660	575
School and nursery school children ..		2,865	2,842	2,852	2,507
	8,467	6,548	6,175	6,160	5,482

The Council maintains a recuperative holiday home at Littlehampton, Sussex, for 36 boys and girls from 3 to 8 years of age. For some years older children have been sent under annual contract to a small private hotel at Deal, Kent, and to a home at Aldeburgh, Suffolk, maintained by the Women's Voluntary Services for children nominated by the Council. Children who could not be accommodated in these three homes, and all adults, have been placed in homes under private ownership or maintained by voluntary organisations.

In October, 1958, the Council opened a children's recuperative holiday home in premises at Bognor Regis, leased on generous terms by the trustees of the Surrey Convalescent Homes. Cambridge House, as it is called, was designed as a children's convalescent home and accommodates 44 children from 8 to 15 years old. The opportunity to have a home suitable for use all the year round and within easy reach of London in an ideal situation was greatly welcomed, even though it meant severing the connection with the W.V.S. at Aldeburgh besides terminating the use of the hotel at Deal. Tribute is due to the W.V.S. for the services provided over a long period which included escorting children between Aldeburgh and London.

Venereal disease

Treatment of venereal disease at London out-patient clinics

Year	New cases										Total attendances	
	Syphilis		S. Chancre		Gonorrhoea		Total venereal cases		Total non-venereal cases			
	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
1953..	720	401	88	4	6,103	1,546	6,911	1,951	17,615	6,121	220,316	102,365
1954..	651	340	64	2	5,816	1,422	6,531	1,764	17,875	6,304	219,258	100,554
1955..	625	400	77	6	5,916	1,457	6,618	1,863	18,735	7,056	221,381	103,815
1956..	691	493	72	4	7,468	1,718	8,231	2,215	19,802	7,468	222,695	101,034
1957..	701	562	78	2	8,943	2,003	9,722	2,567	20,554	8,102	223,821	97,149
1958..	733	490	66	3	10,619	2,307	11,418	2,800	21,906	8,857	215,934	89,407

	1957	*1958*
Percentage of patients resident in County of London	81	82
Number of patients completing treatment and of defaulters—		
Syphilis—patients completing treatment—		
Males	828	631
Females	627	554
patients not completing treatment—		
Males	675	870
Females	294	292
Gonorrhoea—patients completing treatment—		
Males	4,938	5,237
Females	985	1,165
patients not completing treatment—		
Males	3,501	4,128
Females	900	1,161

Tracing of contacts of patients

Analysis of work undertaken by Council's male and female welfare officers

Contacts referred by hospitals, medical services of the Armed Forces and by local health authorities	384	297
Insufficient information for following-up	276	191
Contacts brought to treatment	27	43
Contacts traced but not brought to treatment ..	14	3
Contacts not traced	67	60

In addition the female welfare officers attended clinics at St. Paul's Hospital, St. Mary's Hospital and H.M. Prison, Holloway and followed-up persons defaulting in attendance at these clinics.

Health Education

Health education covers a very wide field and it is only possible to deal with aspects which were outstanding during the year.

Diphtheria immunisation

A diphtheria immunisation campaign was held in January and an improvement in the acceptance rate of primary injections was noted.

Major campaigns

The timing of this campaign and of the 'Safety in the Home' week were given careful consideration. So that a course of injections might have a better chance of completion before the season closes for the use of triple or combined antigens it was decided that in future diphtheria immunisation campaigns should be held in the early autumn, but the timing of the 'Safety in the Home' week should be unchanged. To avoid a gap of over a year and a half before the next diphtheria immunisation campaign a second campaign was held in the two weeks commencing 6th October. The home safety campaign followed early in November. The difficulty of running two major campaigns so close together was increased by the receipt of Ministry of Health Circular 20/58 extending the age groups for whom vaccination against poliomyelitis was available. It was important that this form of protection should be made widely available to the extended age group and arrangements were made for additional clinics to be provided from 8th November. A great deal of publicity had to be arranged including preparation and display of posters, distribution of leaflets and the organisation of publicity in the local and evening newspapers. This, together with work that was being carried out to make effective the safety in the home campaign which began on 2nd November, imposed a very heavy burden on divisional and central office staff and indicated that, unless circumstances made it impossible to do so, the coincidence or near coincidence of major health education efforts should be avoided in the future.

Home Safety

Ministry of Health Circular 6/58 expressed concern at the number of casualties arising from home accidents, stressed the need for co-ordinating the efforts of the large number of organisations involved in any area, and suggested the setting up of local committees as an effective method of doing so. It also intimated that hospital authorities had been asked to assist by supplying information about the incidence of serious home accidents. As mentioned in my report of 1957 metropolitan borough councils had received co-extensive powers with this Council in the home accident field and generally the orders of reference of their existing road safety committees were enlarged to include this new responsibility. Arrangements were made where this was desired by the council concerned for representation on these committees by divisional medical officers, who already had a close liaison with borough colleagues. Arrangements were also made for provision of information about patients treated in London hospitals as a result of home accidents occurring in homes within the Administrative County, the inquiry to continue for a period of six months and include out-patients as well as in-patient admissions. The memorandum on burns and scalds and their avoidance, which accompanied the Minister's Circular, was made widely available to the Council's staff and was brought to the notice of the London Local Medical Committee with the suggestion that it should be provided for all general practitioners.

'Guard that Fire'

Home Office Circular 58/1958 intimated that the Home Secretary hoped to launch personally a campaign to impress upon householders and other responsible persons the need to provide and use efficient fireguards. As this coincided with arrangements for the Council's fifth home safety campaign, which would cover the whole range of home accident prevention, the Council's campaign was made to include the placing of special emphasis upon the need for the provision of adequately fixed fireguards of British standard pattern and thus to support the Home Secretary.

As part of the campaign an exhibition on this theme presented at County Hall was opened by the Home Secretary, who used the opportunity as an official occasion to launch his nationwide campaign. Mr. Butler stressed the importance of the co-operation of local authorities, the press, the broadcasting authorities, voluntary organisations, industries and traders in running a successful campaign. He said :—

"I hope many people will come to see or hear of this exhibition and will be shocked into taking some action to safeguard themselves and their households . . . The much loved British open coal fire is a serious danger spot in our homes. For one thing, it is not practicable to fit a permanent fireguard and, what is more difficult to combat, there is reluctance to use fireguards at all—safety is sacrificed to convenience, or 'cosiness', or merely to forgetfulness in putting this in position. A guard is not simply something to put around the fire when the house is unoccupied. It should be in position whenever there are people about, particularly when the room is being used by children or old people. Every home which has an open coal fire should have a fireguard ; and it should be in use, not gathering dust in the cupboard under the stairs . . . in the last resort it rests with the individual to take those precautions on which the safety of himself and those for whom he is responsible may depend."

A number of inquiries were received from local authorities who wished to borrow the exhibition for use in their areas.

Cancer education

The Council's leaflet 'A Guide to your Health', which gave prominence to the causal connection between cigarette smoking and lung cancer and had, for some time, been distributed to school-leavers from the London schools, attracted some attention on the part of other authorities. As a result, in January, permission was given to the Central Council for Health Education to reproduce it from the original blocks and to make it widely available.

Notes on the prevalence of lung cancer were prepared and circulated to divisional medical officers for use by their staff, who were asked to take every opportunity of health education in this field and to give every help to parents and teachers who might wish for it. In reply to Ministry of Health Circular 17/58 which asked for a report of the action taken since the receipt of Circular 7/58 in the previous year, the Minister was informed that it was the Council's opinion that a firmer lead must be received from the Government. This lead might take the form of :

(*a*) Alerting of leaders to the problem and the effect of personal examples. An approach might be made to leaders of industry, the services, doctors, teachers, youth leaders, etc. through their professional bodies to call attention to their responsibilities in the matter.

(*b*) An entry into the advertising sphere, by way of broadcasting, to give a nationwide lead to the need for a reduction in the consumption of tobacco.

(*c*) Financial help to local authorities through the media of the press as in the similar field of diphtheria immunisation.

(*d*) Governmental research into the possibility of production of 'clean' tobacco.

A suggestion was made that the Council should campaign publicly against smoking in places of public entertainment. As smoking is a social habit the modification of which will undoubtedly be a slow process, until public opinion generally is more strongly opposed to it, direct propaganda in relation to places of entertainment seems unlikely to be effective and would undoubtedly antagonise commercial interests. To attempt direct prohibition might be equally objectionable, as it would be regarded by the entertainment industry and public alike as restrictive, and it cannot be argued that tobacco smoking constitutes cancer risk other than to the smoker. The fire risk was not regarded as sufficient to justify a prohibition.

Staff competition

Seventy-four entries were received for the third competition for health education media designed by staff. These entries fell into two classes and prizes were awarded as follows to exhibits : posters: first—Division 4 ; second—Division 2 ; third—Divisions 9 and 3 ; three dimensional teaching aids : first—Division 8 ; second—(two of equal merit) Divisions 8 and 5. In addition seven entries from staff at Divisions 5, 6, 7, 8 and the County Hall were commended.

B.C.G. vaccination

The Cinematograph Exhibitors' Association kindly agreed that the Council's film 'B.C.G. Vaccination' might again be shown for a week at each cinema at the discretion of their members in London. It was agreed that the necessary arrangements might be made direct between divisional medical officers and managers of cinemas, so that its showing would occur at the most effective time, having regard to the arrangements for the B.C.G. vaccination of schoolchildren in the locality.

Films and film Strips

One hundred and eighty-seven shows were arranged, most of them at maternity and child welfare centres, during which three hundred and twenty-five films on health topics were shown and four hundred and forty-six film strips were used from the central library of Film Strips.

Dysentery

A leaflet was prepared for distribution to heads of schools and to schoolkeepers on methods of preventing and controlling outbreaks of dysentery.

Talks

Health education talks on a wide range of subjects are organised at welfare centres by the centre superintendents and health visitors and, in addition to the planned programmes, every opportunity is taken for an informal talk and discussion. Day and evening talks are also given by medical and nursing staff to school children, students and to voluntary and other organisations.

The following tables analyse talks given during 1958 in eight of the nine health divisions, but do not include some 3,000 talks given in schools to school girls on personal hygiene and mothercraft. In the remaining division a similar programme was followed, but no figures are available. Talks have varied from the short and relatively informal approach to quite a small audience to the more formal address to a larger gathering. Visual presentation of all kinds has been used by speakers.

TABLE (i)—*Summary of speakers*

	No. of talks
Medical officers	13
Senior nursing officers	8
Health visitors and school nursing sisters	4,327
Domiciliary midwives	33
Public Health Inspectors	2
London school teachers	131
Fire Brigade officers	4
Youth Employment Officer	1
Lecturers from outside the Council's service—	
Nursing	2
Other	95
	4,616

TABLE (ii)—*Audience groups*

Audience	*No. of talks*
Ante-natal mothers	2,983
Mothers, Mothers' Clubs	1,389
Parent/Teacher Associations	8
Day Continuation Classes	203
Voluntary organisations	26
Activities with young people	7
	4,616

TABLE (iii) *Subjects of talks and attendances*

Subject	*No. of talks*	*Attendances*
Family health		
Mother and young children	2,831	26,542
Other children	557	5,806
General	664	9,007
Environmental hygiene	30	278
Special problems (including prevention of accidents, first aid, smoking and lung cancer)	317	4,091
Health services and how to use them	217	4,833
	4,616	50,557

Although the health education activities evidenced are considerable, particularly when it is remembered that the staff most concerned are those taking a large part in giving talks to and supervising visits of experience for student nurses and other students, of which details are given at page 123, the position is not one for complacency. Notwithstanding the obvious advantages that parent/teacher associations present as audiences the number of occasions on which it has been possible to put on programmes for them has been quite small, whilst some subjects, and notably cancer education with the connection between heavy smoking and cancer of the lung, have so far only received sparse attention. Many of the 217 talks on the health services have been general but such specific services as the work of the health visitor, district nurse, domiciliary midwife and home helps have been included.

MENTAL HEALTH SERVICES

A COMPREHENSIVE review of the Mental Health Services appeared as a part of a special feature in my last annual report.

Lunacy and Mental Treatment Acts

The following statistical tables relate to persons alleged to be suffering from mental illness referred to the Council's mental welfare officers. Care and treatment for the mentally ill

TABLE (i) *Persons referred in the year*

	1957	*1958*
Once	5,005	4,755
Twice	797	721
Three times	169	166
Four times	46	43
Five or more times	27	26
Total	6,044	5,711*
Number of separate investigations	7,439	7,016

* *453 of these persons were first referred to mental welfare officers in 1957, 279 in 1956 and 961 in earlier years : thus 4,018 were new cases in 1958.*

The total includes 397 persons normally resident outside the County but some two-thirds of these were in hospital in London at the time of referral.

TABLE (ii) *Referring agency*

	1957		*1958*	
	No.	*%*	*No.*	*%*
General practitioner	3,261	43·8	3,227	46·0
Psychiatrist*	841	11·3	609	8·7
Hospital ward	704	9·5	712	10·1
Hospital casualty department	680	9·1	605	8·6
Non-medical	1,953	26·3	1,863	26·6
	7,439	100·0	7,016	100·0

* *These numbers exclude cases referred for a psychiatrist's advice by the mental welfare officer after seeing the patient and before taking action.*

TABLE (iii) *Initial action*

(*a*) *All cases*

	1957		*1958*	
	No.	*%*	*No.*	*%*
None possible or necessary	1,691	22·7	1,547	22·0
Referred for continued care*(other than at mental hospital)	63	0·8	51	0·7
Admitted to mental hospital—				
(*a*) as voluntary patient	235	3·2	286	4·1
(*b*) as non-statutory patient	41	0·6	69	1·0
(*c*) under urgency order, temporary certificate, Magistrates' Court Act, or as returned escapee	51	0·8	68	1·0
Referred to psychiatrist	138	1·9	193†	2·8
Removed to observation ward	3,924	52·6	3,738	53·2
Referred to Justice of the Peace other than at observation ward	1,296	17·4	1,064	15·2
	7,439	100·0	7,016	100·0

* *Referral to welfare department, sanitary authority, psychiatric social worker, back to general practitioner for possible help on general medical grounds, etc.*

† *122 were later admitted to mental hospital but only 4 were certified (Sections 14/16); 13 others were treated at out-patient clinics.*

(*b*) *'Action' cases only*

	1957 %	*1958* %
Independent action by mental welfare officer	6·8	8·7
Referred to psychiatrist	2·4	3·5
Removed to observation ward	68·3	68·3
Referred to Justice of the Peace	22·5	19·5
	100·0	100·0

These percentages indicate a continuing trend towards procedures designed to help patients without recourse to direct reference to Justices of the Peace.

(*c*) *By age group*
(*1957 percentages in brackets*)

	Age group				*Total*	
	Under 65		*65 and over*			
	No.	%	*No.*	%	*No.*	%
Removed to observation ward	3,290	80·7 (79·5)	444	32·1 (32·9)	3,734*	68·3 (68·3)
Brought before a Justice of the Peace	369	9·0 (11·6)	695	50·2 (56·9)	1,064	19·5 (22·5)
Other action	422	10·3 (8·9)	245	17·7 (10·2)	667	12·2 (9·2)
Total investigations where action was taken ..	4,081	100·0	1,384	100·0	5,465	100·0
No action	1,152	—	392	—	1,544†	—
Total investigations ..	5,233	—	1,776	—	7,009	—

* *Age not stated in four cases.* † *Age not stated in three cases.*

It is apparent from the table that persons aged 65 or over accounted for about a quarter of the total investigations and of 'action' cases. In 1958, however, proportionately more of these cases were dealt with independently by mental welfare officers (or via psychiatrists) than in 1957 with a resultant reduction in the proportion brought before a Justice of the Peace.

TABLE (iv) *Closure*

(*a*) *All cases*

	1957		*1958*	
	No.	%	*No.*	%
No action possible or necessary	1,988	26·8	1,770	25·1
Discharged by medical officer at observation ward ..	1,317	17·7	1,299	18·5
Transferred to general hospital	65	0·9	74	1·1
Other continued care including section 22	158	2·1	102	1·5
Out-patient (psychiatric) and miscellaneous action recommended by psychiatrist	46	0·6	60	0·8
Admitted to mental hospital—				
(*a*) as voluntary patient	1,928	25·9	1,885	26·8
(*b*) as non-statutory patient :				
(i) Tooting Bec hospital	279	3·8	306	4·4
(ii) other hospital	83	1·1	125	1·8

TABLE (iv)—*continued.*

	1957		1958	
	No.	%	*No.*	%
(*c*) on temporary certificate	48	0·6	39	0·6
(*d*) on urgency order	42	0·6	47	0·7
(*e*) as returned escapee or under Magistrates' Courts Act	7	—	26	0·4
(*f*) certified (sections 14/16)	1,414	19·0	1,214	17·3
Died	56	0·8	69	1·0
Miscellaneous	8	0·1	—	—
	7,439	100·0	7,016	100·0

The overall picture is that of a reduction in the proportion of cases certified and an increase in voluntary and non-statutory patients. Over the two year period since 1956, the proportion of patients entering mental hospital who have been certified has shown a marked reduction particularly in the older age groups : reductions are for the under 65s, 21·0 per cent., aged 65–79, 34·2 per cent. and aged 80 and over, 43·2 per cent. As in previous years, cases referred from casualty departments showed the lowest percentage of admissions to mental hospital.

(*b*) *Observation ward cases*

	1957		1958	
	No.	%	*No.*	%
Discharged by medical officer	1,317	33·5	1,296	34·7
Transferred to general ward	65	1·7	65	1·7
Admitted to mental hospital—				
(*a*) as voluntary patient	1,477	37·7	1,358	36·4
(*b*) as non-statutory patient :				
(i) to Tooting Bec	66	1·7	74	2·0
(ii) other hospitals	68	1·7	106	2·8
(*c*) with temporary certificate or as returned escapee	45	1·1	41	1·1
(*d*) certified (sections 14/16)	826	21·0	729	19·5
Died	56	1·4	56	1·5
Miscellaneous	8	0·2	13	0·3
	3,928	100·0	3,738	100·0

There was a marginal reduction in the proportion of observation ward cases admitted to mental hospitals—voluntary patients and certifications both fell but this was offset to some extent by an increased proportion of non-statutory patients. Only 11·9 per cent. of the observation ward cases were aged 65 or more.

There were differences in the proportion of various disposals from the five major observation wards (A to E) and from a group of small units based at mental hospitals (F). These are as follows :

	A	*B*	*C*	*D*	*E*	*F*
	%	%	%	%	%	%
Discharged by medical officer	52·6	32·2	46·6	26·1	31·1	9·9
Admitted to mental hospital—						
(i) as voluntary or non-statutory patient	17·0	48·1	33·6	40·1	38·3	71·3
(ii) with temporary certificate	0·4	0·8	1·2	—	4·3	0·2
(iii) certified (sections 14/16)	25·7	16·2	15·4	23·5	24·4	16·4
Percentage certified of those admitted to mental hospital—1957	57·1	21·6	36·7	44·0	44·4	22·5
1958	59·6	24·8	30·7	37·0	36·4	18·6

The highest discharge rates, as in previous years, occurred in cases referred from hospitals—46·0 per cent. among cases referred from casualty departments and 40·8 per cent. from general wards compared with an average of 32·6 per cent. from other sources. Also, as formerly, the highest certification rate (43·0 per cent.) for those admitted to mental hospital was among cases referred from non-medical sources.

(c) Cases referred to Justices of the Peace other than at an observation ward

	1957		1958	
	No.	%	No.	%
No (further) action	282	21·8	228	21·4
Other continued care including section 22 and referred to psychiatrist	87	6·7	47	4·4
Admitted to mental hospital—				
(i) as voluntary patient	155	12·0	131	12·3
(ii) as non-statutory patient	184	14·2	177	16·6
(iii) with temporary certificate	1	0·1	—	—
(iv) certified (sections 14/16)	587	45·2	481	45·3
	1,296	100·0	1,064	100·0

The proportion entering a mental hospital (74·2 per cent.) and the proportion of these certified (61·0 per cent.) was still much higher than the corresponding proportion of cases dealt with in observation wards—61·8 per cent. and 31·6 per cent. respectively.

Community care and after care

Psychiatric social workers

Authority was given for the employment of an additional psychiatric social worker, making the establishment one senior psychiatric social worker and four psychiatric social workers. Unfortunately it did not prove possible to fill the vacancy or a further vacancy which arose and for the latter half of the year only the senior and two other workers were employed.

The number of cases dealt with by the depleted staff during 1958 was 594 (compared with 500 during 1957). In 374 of these cases, the referring agency was enabled to continue to deal with the case after advice and help from the Council's psychiatric social workers. The remaining 220 cases, involving 2,159 interviews (as against 269 and 2,099, respectively, in 1957) were dealt with directly by the Council's workers.

Five per cent. of the cases were referred by mental hospitals, 20 per cent. by psychiatric departments of other hospitals, including out-patient clinics associated with mental hospitals, and the remainder by non-psychiatric agencies. Twelve per cent. of those referred from non-psychiatric sources had previously been in a mental hospital.

Long-term care

One hundred and seventy-six chronic and senile cases (compared with 124 during 1957) were maintained by the Council during the year, 156 at homes owned or sponsored by the Mental After Care Association, 10 at a Jewish Board of Guardians' hostel, five at Parnham House run by the National Association for Mental Health and five at other establishments.

Recuperative holidays and rehabilitation

During the year 75 persons recovering from mild psychiatric illness were granted recuperative holidays of two to three weeks in general recuperative holiday homes ; 13 who had more serious breakdowns were sent for similar periods to homes owned or sponsored by the Mental After Care Association, and 13 were accommodated for periods up to 12 weeks or longer when necessary at the Mental After Care Association homes at Dartford, Kent ; Cheam, Surrey ; and Chiswick, Middlesex, which provide specially for the rehabilitation of younger patients capable of work. The total of 101 compares with 179 in 1957. The fall in numbers was largely due to the drop in the number of applications received.

Forty-two London patients commenced attendance at the rehabilitation centre run by the Institute of Social Psychiatry at Blackfriars during the year: of these, and 12 others who began attendance in 1957, 10 were discharged to return to work and 26 were discharged as unsuitable or unlikely to derive further benefit or because of non-attendance or admission to a mental hospital. Seventeen chronic cases continued to attend the centre from previous years : of these three were discharged during 1958. A total of 32 London patients were attending the centre at the end of the year.

National Association for Mental Health

The annual grant made by the Council to the National Association for Mental Health in recognition of their general services to the community and to local health authorities in the field of mental health was increased from £200 to £300 a year subject to review at the end of three years.

Mental Deficiency Acts

The following table shows the sources from which cases were brought to notice under the Mental Deficiency Acts and the action taken thereon, references unless otherwise specified are to the Mental Deficiency Act, 1913 : Statistics

	1957		1958	
Source of information—Local education authority—				
Reported under Section 57 of the Education Act, 1944	415		440	
Not reported, referred for voluntary supervision	133		141	
	—	548	—	581
Police authority (Section 8)		12		11
Home Office (Section 9)—				
from prison	1		—	
from approved school	3		—	
	—	4	—	—
From hospitals, residential nurseries, etc.		66		101
Miscellaneous		139		188
Total		769		881

The position as at 31st December, 1958, is shown below, together with comparable figures for 1957.

	1957		1958	
Under guardianship—				
Personal guardianship of council's social workers	49		52	
Nominees of the Guardianship Society, Brighton	60		60	
Guardianship of relatives and friends	59		28	
Guardianship of superintendents of small homes and institutions	26		21	
In institutions awaiting decision as to their future	2		—	
In mental hospitals	1		—	
	—	197	—	161
In hostels without orders under the Mental Deficiency Acts		6		11
Under statutory supervision		5,061		4,772
Under voluntary supervision		1,494		1,461
In institutions on orders under the Mental Deficiency Acts	7,399		4,163	
In institutions without orders	2		3,119	
	—	7,401	—	7,282
In hospitals, residential nurseries, etc., awaiting institutional care		33		25
Still under consideration		26		21
Total		14,218		13,733

The following is a summary of the cases dealt with during the year together with comparable figures for 1957.

	1957		1958	
Placed in institutions—				
On an informal basis	—		211	
Under section 3	127		22	
Under section 6	93		43	
Under section 8	37		42	
Under section 9	6		—	
	—	263	—	318
Placed under guardianship		14		25
Varying orders—				
from guardianship to guardianship	40		23	
from guardianship to institution	13		7	
from institution to guardianship	4		4	
	—	57	—	34

	1957		1958	
Placed in hostels without order		10		17
Placed in places of safety		3		—
Placed under statutory supervision (including licence cases)		714		764
Placed under voluntary supervision		313		398
Discharged—				
from institutions	300		325	
from guardianship	18		51	
		318		376
Removed to mental hospitals		15		5
Withdrawn from supervision		469		1,073
Withdrawn from voluntary supervision		148		431
Removed from London		70		73
Died		170		137
No action		22		40
Cases still awaiting institution care		149		180
Cases dealt with by way of short term care—				
In Mental Deficiency hospitals	176		227	
In approved homes and private homes	68		75	
		244		302

Occupation centres

The accommodation available at the Council's occupation and training centres for the mentally defective at the end of December, 1958, was as follows :

Centres for children	*Accommodation*
Bethnal Green	90
Clifton	60
Finsbury	45
Fulham	75
Greenwich	60
Herne Hill	60
North Kensington (including a class of elder girls)	80
Peckham	45
Shoreditch	80
Wandsworth	90

Centres for elder girls	*Accommodation*
Brockley	60
Clapton	60
Earlsfield	60
Greenwich	35
Islington	40
Centres for elder boys	
Archway	40
Balham	60
Dalston	60
Hammersmith	35
Peckham	60
Industrial training centre (elder boys)	
Stepney	20
Total	1,215

Articles made in the occupation centres realised the following amounts :

	£	£
Junior centres	68	
Elder girls' centres	189	
Elder boys' centres	985	1,262
Stepney I.T. centre :		
(*a*) sales	20	
(*b*) value of orders executed for Supplies Department		877
Total		£2,139

Informal admissions

In conformity with Ministry of Health Circulars (of 15 January, 1958) 2/58 to local health authorities and (58)5 to mental deficiency hospitals and institutions recommending the informal admission of patients to mental deficiency hospitals and institutions in appropriate circumstances, the Council, with the co-operation of the hospitals, has arranged the informal admission of all suitable patients ; up to the end of 1958 211 patients were so admitted.

Circular 2/58 also requested local health authorities to review all cases under guardianship under the Mental Deficiency Acts and to recommend the Board of Control to discharge the orders in those cases where supervision would be sufficient, bearing in mind the financial help which could be given by the National Assistance Board. By the end of 1958, 32 cases had been discharged by the Board on the recommendation of the Council and financial responsibility for the maintenance of 55 patients had been transferred from the Council to the National Assistance Board. The review is continuing.

Allowances for pocket-money, etc.

At the end of the year pocket-money allowances to mentally deficient persons under guardianship, etc. were increased to the following rates :

Up to	10s.	a week at age	16
,,	12s.	,,	17
,,	15s.	,,	18 or over
,,	17s. 6d.	,,	21 ,,

In addition, recreation allowances up to 50s. a head a year in respect of mentally deficient persons under guardianship or in care informally in a hostel or similar establishments were authorised to enable such persons to be given occasional outings and treats, and authority was given for the payment by the Council of the travelling expenses in excess of 10s. a week of any girl at Dover Lodge to and from her place of employment.

Occupation centres

In November an additional centre for eighty children was opened in a former school building at Shoreditch. This enabled the number of children attending the centre held in rented premises at Finsbury to be reduced. Building work on the new Kensington and Lewisham centres was well advanced in December, 1958.

Speech therapy

Authority was given in July, 1958 for speech therapy sessions, which during 1957 had been provided at two junior occupation centres, to be extended to include all junior occupation centres.

Stepney industrial centre

An increase in the *ex gratia* payment made to each of the boys and men attending the Stepney industrial centre from 1s. to 1s. 6d. a day was authorised from 1 September, 1958.

Home teaching

A second home teacher was appointed during the year and 35 persons are receiving tuition, the majority by weekly sessions.

SCHOOL HEALTH SERVICE

Pupils on school rolls

In September, 1958, there was a total of 438,301 pupils on the day school roll ; 245,126 attending primary schools ; 184,495 at secondary schools ; 1,821 at nursery schools and 6,859 children in day special schools.

Ministry of Education returns

The annual returns to the Ministry of Education have been revised and medical inspection results are now analysed according to the pupils' years of birth. To enable comparisons to be made with previous annual reports where ' age groups ' are recorded, the following paragraphs include, in addition to the new tabulations, comparative tables in which years of birth have been grouped to approximate to the age-group categories previously used.

Medical inspections

During 1958 a total of 363,018 medical inspections were carried out, and 172,271 of these inspections, equivalent to 39·4 per cent. of the children on the rolls, were general medical inspections :

Age groups inspected (by year of birth)	*Age (year of examination less year of birth)*	*Number of pupils inspected*
1954 and later	4 and under	7,690
1953	5	29,514
1952	6	6,508
1951	7	30,775
1950	8	5,086
1949	9	1,709
1948	10	2,455
1947	11	44,635
1946	12	6,126
1945	13	1,930
1944	14	8,812
1943 and earlier	15 and over	27,031
		172,271

In the following comparative table, the 1958 figures have been grouped on the basis that ' nursery ' = years of birth 1954 or later ; ' entrants '= 1953 and 1952 ; '7-year-old '= 1951 and 1950 ; ' 11-year-old '= 1947 and 1946 ; ' leavers '= 1943 or earlier. Part of the differences from previous years, particularly as regards the ' other ages ' group, must be attributed to this arbitrary grouping. In addition medical inspections carried out in special schools are now included in the appropriate age group.

		1956	*1957*	*1958*
General medical inspections	Entrants ..	37,423	37,610	36,022
	7 years old ..	34,259	31,459	35,861
	11 years old ..	34,033	42,923	50,761
	Leavers	25,650	29,272	27,031
	Total	131,365	141,264	149,675
	Nursery	8,632	8,018	7,690
	Other ages ..	23,492	21,322	14,906
	Special schools ..	2,450	2,322	—
	Total general inspections ..	166,095	172,926	172,271

			1956	1957	1958
Other inspections	Special inspections	Secondary schools annual surveys	11,811	11,941	8,934
		'Urgents' and 'Specials' (a) ..	23,256	20,564	17,677
		Employment certificates ..	5,377	4,985	4,266
		School journeys	25,220	24,270	20,261
		Miscellaneous (b)	6,549	6,775	6,041
		Total	60,402	56,594	48,245
	Re-inspections	Nutrition cases (c)	64,565	56,304	46,293
		Other	96,186	90,060	87,275
		Total other inspections ..	221,153	202,958	181,813
		Total inspections	399,059	387,825	363,018

NOTES :

(a) *Pupils referred by parents, heads, school health visitor, care committee, etc.*

(b) *Handicapped pupils for their special defect ; candidates for nautical school ; children engaged in theatrical employment, etc.*

(c) *Pupils receiving vitamin capsules on the recommendation of the school doctor.*

Pupils found to require treatment at general medical inspections (excluding dental and infestation)

Age groups inspected (by year of birth)	*Age (year of examination less year of birth)*	*For defective vision (excluding squint)*	*For other conditions*	*Total individual pupils*
1954 and later	4 and under	19	669	683
1953	5	101	2,729	2,818
1952	6	74	725	790
1951	7	2,066	2,721	4,541
1950	8	399	456	805
1949	9	155	162	295
1948	10	247	201	433
1947	11	3,673	2,823	6,255
1946	12	559	415	942
1945	13	208	132	331
1944	14	825	328	1,119
1943 and earlier	15 and over	2,512	990	3,404
	Total	10,838	12,351	22,416

Pupils referred for treatment

(Referrals for infestation and teeth are not included)

Age group and sex		1956 %	1957 %	1958 %
Nursery	Boys ..	10·9	8·6	9·6
	Girls ..	8·2	8·5	8·1
Entrants	Boys ..	11·5	10·7	10·9
	Girls ..	9·7	9·3	9·1
7 years old	Boys ..	15·3	15·0	15·6
	Girls ..	14·0	14·2	14·2
11 years old	Boys ..	13·7	13·1	13·8
	Girls ..	14·2	14·9	14·6
Leavers	Boys ..	10·4	11·6	12·1
	Girls ..	13·4	12·6	13·2
Other ages	Boys ..	14·4	15·7	14·2
	Girls ..	15·7	17·0	15·0
All pupils		12·9	12·9	13·0

The principal defects noted, and referred for treatment or observation, expressed as percentages, with comparable figures for previous years, were as follows :

	1956	*1957*	*1958*
	%	%	%
Skin diseases	1·10	1·16	1·19
External eye diseases	0·57	0·55	0·48
Defective hearing	0·60	0·64	0·77
Otitis media	0·66	0·60	0·57
Enlarged tonsils and adenoids	5·88	4·84	4·91
Defective speech	0·77	0·80	0·81
Enlarged cervical glands	1·22	0·97	0·95
Heart and circulation	0·74	0·75	0·75
Lung disease (not T.B.)	1·35	1·32	1·25
Orthopaedic defects	4·41	4·06	4·12
Defects of nervous system	0·34	0·41	0·40
Psychological defects	0·94	0·86	0·93
Anaemia	0·13	0·11	0·10
Enuresis	1·62	1·54	1·59

Physical condition of pupils

The physical condition of pupils inspected at periodic general medical inspections was recorded as satisfactory for over 98 per cent. of the children. The percentages recorded as *un*satisfactory in each age group were as follows :

Age group inspected (by year of birth)	*Age (year of examination) less year of birth)*	*Physical condition unsatisfactory* %
1954 and later	4 and under	2·1
1953	5	2·0
1952	6	3·3
1951	7	2·4
1950	8	3·9
1949	9	3·7
1948	10	3·0
1947	11	1·7
1946	12	1·4
1945	13	1·5
1944	14	1·1
1943 and earlier	15 and over	1·0

The table below shows the overall classification of physical condition 1956–58, together with the percentages referred for treatment or observation of nutrition defects :

		1956	*1957*	*1958*
		%	%	%
Classification	Satisfactory	95·0	97·3	98·1
	Unsatisfactory	5·0	2·7	1·9
Referred for	Treatment	0·9	0·6	0·5
	Observation	0·9	0·6	0·6
	Total	1·8	1·2	1·1

Nutrition re-inspections

Pupils receiving vitamin capsules on the recommendation of the school doctor are re-inspected each term. During 1958 the number of such re-inspections was 46,293. The classification of general condition recorded at these ' nutrition ' re-inspections, with comparable figures for previous years, was as follows :

	1956	*1957*	*1958*
	%	%	%
Good	17·5	19·2	19·0
Fair	70·3	69·1	70·3
Poor	12·2	11·7	10·7

School meals, milk and vitamin supplements

A return to the Ministry of Education for a day in September, 1958, showed that 230,557 pupils, 58·2 per cent. of the number present, were provided with school dinners ; of these 18,591 received dinners free of charge. On the same day, 345,337 children had school milk. Vitamin capsules were supplied daily without charge to children recommended for them by a school medical officer ; other children whose parents so desired received capsules on payment of 1s. a term. (Issues of capsules at schools were discontinued from 1.1.59 (see p. 110).)

Vision

Visual acuity standards, expressed as percentages of children inspected, are contained in the table below :

		Visual acuity (with glasses, if worn)			*Percentage wearing glasses*
		6/6	*6/9*	*6/12 or worse*	
		%	%	%	
7-year-old	Boys ..	78·6	14·0	7·4	3·3
	Girls ..	77·9	14·7	7·4	3·6
11-year-old	Boys ..	83·8	8·1	8·1	8·3
	Girls ..	82·0	9·5	8·5	8·9
Leavers	Boys ..	83·1	8·1	8·8	12·5
	Girls ..	80·3	10·0	9·7	13·8
Other ages	Boys ..	82·9	8·2	8·9	8·8
	Girls ..	79·8	10·1	10·1	10·3

The incidence of defective vision and the percentage of pupils referred for treatment of defective vision was similar to preceding years : as usual the recorded incidence of defective vision was greater among girls than boys.

24,478 pupils were noted for defective vision, of whom 5,544 (27·1%) were already wearing glasses : comparable figures for leavers were 4,233 and 1,918 (45·3%).

Consideration is being given to the possibility of introducing routine examinations for visual acuity of school entrants. The number of pupils found at the ' leavers ' examination to need glasses suggests that more tests for visual acuity during adolescence would also be valuable.

Squint was most prevalent in the entrant group, falling to a very low level in the leaver group. The overall figure of pupils referred for treatment of squint (0·6%) was the same as in 1957.

Hygiene inspections and the cleansing scheme

The number of pupils found to be ' verminous ' continued to decline, although at a slower rate than has been the experience since the war.

TABLE (i)—*Hygiene inspections*

	1954	*1955*	*1956*	*1957*	*1958*
No. of pupils on school rolls	442,129	442,917	445,870	443,612	438,301
No. of inspections	1,299,358	1,252,375	1,199,100	1,128,034	1,100,292
No. of *occasions* pupils found to be verminous*	21,872	16,965	15,165	14,090	13,933
Percentage found to be verminous ..	*1·7*	*1·4*	*1·3*	*1·2*	*1·3*
No. of *individuals* found to be verminous	11,801	9,613	8,238	7,772	7,096
Percentage of pupils on school rolls found to be verminous	*2·7*	*2·2*	*1·8*	*1·7*	*1·6*

* *' Verminous ', in this context, includes cases with only one ' nit ' (ovum), as well as cases with live vermin present.*

The steady decrease in the total number of inspections is the result of an increased emphasis on selective examinations.

The percentage of verminous children as between boys, girls and infants has remained roughly static with the highest incidence amongst girls.

TABLE (ii)—*Cleansing Scheme*

	1954	*1955*	*1956*	*1957*	*1958*
Advice cards issued	13,135	10,483	9,614	8,830	8,054
Percentage of number examined ..	*1·0*	*0·8*	*0·8*	*0·8*	*0·7*
Families involved	5,225	4,581	3,836	3,448	3,085
Pupils returning to school clean after issue of advice card	2,228	1,176	1,690	1,559	1,468
Percentage returning clean	*16·9*	*11·2*	*17·5*	*17·6*	*18·2*
Pupils attending bathing centre voluntarily after issue of advice card ..	8,827	7,001	6,452	6,183	5,527
Percentage attending voluntarily ..	*67·2*	*66·7*	*67·1*	*70·0*	*68·6*
Statutory cleansing notices issued ..	1,839	1,532	1,223	998	964
Pupils cleansed after serving of statutory notice—					
(i) Voluntarily	632	459	325	243	240
(ii) Compulsorily	1,123	977	853	704	628
Total	1,745	1,436	1,178	947	868

Review of medical inspection arrangements

My report for 1956 (page 99) mentioned that a departmental committee was reviewing the whole field of school medical inspection. Their report was received by the Education Committee in October, 1958, and a number of changes were approved to become effective on 1 January, 1959. The major recommendations were as follows :

(*a*) At least four general medical inspections should be carried out during a pupil's school life.

(*b*) Inspections should take place on entry to each new school or department.

(*c*) All pupils should be inspected in the term before their 15th birthday and before leaving school.

(*d*) Personal hygiene inspections should be replaced by ' health surveys '.

(*e*) All pupils should receive an annual comprehensive health survey.

(*f*) Selective health surveys, at the discretion of the divisional medical officer, should replace the routine hygiene inspection of all pupils once a term.

(*g*) Vision should be tested at each periodic inspection after the ' entrant to infants ' inspection, and also at age 7. If and when vision testing at age 5 years is introduced, the test at age 7 should be discontinued.

(*h*) The 13-year-old vision test by school health visitors should be discontinued.

(*i*) Routine weighing and measuring should be discontinued.

(*j*) Annual secondary school medical surveys should be discontinued.

(*k*) Whilst inspections of school journey parties covered by insurance policies will need to be continued, parties going to Marchants Hill and Sayers Croft should be seen only by a school health visitor prior to departure.

(*l*) The separate procedure for the automatic re-inspection each term of certain pupils receiving milk, meals or vitamins should be discontinued.

(*m*) Tuberculosis contacts should not be automatically re-inspected by the schoo doctor.

The following extracts from the report summarise the grounds upon which the recommendations were based :—

(*a*), (*b*), (*c*) and (*j*)—*Medical inspections*

" We feel that the question of the frequency of periodic inspections can only be answered in the light of what alternative could be substituted. Fundamentally all substitute schemes depend on special medical inspection of cases specially picked out by teacher, parent, school health visitor, etc. We feel that whilst such special inspections are a very important part of a school health service and should be encouraged, they should be additional to, and not in substitution for, periodic inspections. Such special references would probably tend to become something in the nature of child guidance consultations, and as such are to be welcomed, but reliance on special references only (without any period inspections) would probably mean that asymptomatic and minor physical conditions would remain undetected.

" The view was expressed that the general medical inspection of the healthy, whether for insurance, armed forces or school health purposes, was probably the most difficult task the clinician was asked to tackle, compared, for example, with diagnosis of the sick patient. Obviously, therefore, complete reliance could not be placed on the comprehensive health surveys done by school health visitors.

" Considering all the relevant data, particularly the results of the findings at the four periodic inspections and the percentage of parents attending at such inspections, and noting that an ' age-group ' amounted to less than 10 per cent. of the total of all inspections, we unanimously recommend that at least four age group inspections should be carried out. The alternative of two inspections, entrants and leavers only, with special references in between, we rejected because we are not satisfied that any system of special references is an adequate substitute for general medical inspections.

" Prior to 1933 periodical inspections were held at entry, 8 years, 12 years and on leaving. The intermediate inspections were then altered to 7 and 11 years. The change from 8 to 7 years was associated with the provisions under the 1921 Act whereby pupils were not compelled to attend special schools until the age of 7 years ; and the change from 12 to 11 years was associated with an economy whereby *ad hoc* inspections of junior county scholars at age 11 years prior to transfer to secondary schools were avoided.

" The reasons for these changes, which were cogent in 1933, are no longer relevant, and we now recommend that inspections should take place after entry to each new school or department, and should be linked to the transfer, and not to age, since the actual age of transfer is, to some extent, flexible.

" The age groups suggested are :—

(i) Entrants to infants' schools (the examination to be held even if the child had been medically examined whilst attending at a nursery school or class).

(ii) Entrants to junior schools (age not to be specified, since Heads are permitted to transfer before 7, or hold back for two terms after 8 years).

(iii) Entrants to secondary schools (age not to be specified).

(iv) All pupils in the term before their 15th birthday.

(v) ' Leavers ' (this will coincide with (iv) for pupils leaving at age 15 years).

" The scheme of annual medical surveys of pupils attending grammar schools was originated many years ago to provide a substitute follow-up precedure at those grammar schools where the normal care committee, re-inspection, and follow-up systems did not operate. The desirability of dropping these inspections was accepted a few years ago, and the fall in the numbers of inspections carried out reflects the implementation of this decision at a number of schools. However, it is understood that, at some of the voluntary aided grammar schools the school authorities have, so far, been reluctant to agree to the abandonment of these annual inspections.

" We consider that, in the light of our recommendations as to the ages at which inspections should be held in all secondary schools, the annual surveys still carried out should be given up.

" Although we consider that periodic inspections should be continued, nevertheless, we feel that within the framework of the Council's divisional organisation there is room for experimentation in small areas."

(d), (e) and (f)—Health surveys

" It is clear that the nature of the school health visitor's inspections has changed from earlier years when the emphasis was, necessarily, on personal hygiene. Quite apart from the introduction of comprehensive surveys of general health, discretion has already been given to divisional medical officers to drop personal hygiene inspections at senior boys' schools.

" We suggest that these changes should be recognised (i) by a change in terminology from ' hygiene inspection ' to ' health survey ' and (ii) whilst retaining an annual comprehensive health survey for all pupils, by giving divisional medical officers complete discretion as to the frequency of intervening health surveys. For example, whilst, at some schools, no regular, termly, health surveys may be necessary, at other schools some, or all, of the pupils may need to be seen more often than once a term. We consider that, in the context of the reduced incidence of defective hygiene the routine inspection of all pupils once a term is unnecessary, and that the school health visitor's time would be much better utilised through such a system of selective health surveys. "

(g) and (h)—Vision testing

" Ideally the school health service arrangements should ensure, by vision testing, that every child needing spectacles has them as soon as possible ; that the spectacles are changed whenever necessary during growth ; and that the children leave school wearing correct glasses. The follow-up and re-inspection procedures appear to ensure satisfactorily that once a child has had glasses the necessary changes are made, but we have given special attention to the vision testing arrangements.

" A child is normally now first tested for vision after reaching the age of 7 years but the suggestion has been made in several quarters that it is desirable for routine vision testing to be carried out for all 5-year-old entrants to school. It cannot be denied that there are young children whose defective eyesight could be aided by spectacles, but the questions that arise are (i) the practicability of testing all entrants each year to discover such cases ; (ii) the necessity for testing all entrants, when doubtful cases can always be referred for special inspection ; and (iii) whether any harm, medical or educational, accrues in those cases who are not discovered until the age of 7 years.

" In view of the great practical difficulties of testing young children, who do not know their letters, by subjective methods, such as picture charts, some authorities have engaged ophthalmologists to test by objective methods. In London, with 50,000 entrants a year, this would be extremely expensive, even if the specialist staff were available. Even subjective methods, using special charts, require two persons to carry out the test, and a considerable amount of time on each case so that the possible additional nursing staff requirements would be very large.

" Since reasonable doubts exist as to whether, in fact, any medical or educational harm is suffered by those few children who, not having been picked out for special medical examination, wait until 7 years of age before receiving spectacles, we consider that a decision on the introduction of testing at a younger age should await the results of special field studies.

" We consider that the ages at which vision is tested need not automatically be the same as those at which periodic inspections are carried out and that vision testing can be associated at whatever ages necessary with the annual school health visitors' comprehensive health surveys. However, we consider that vision testing should remain, as indeed it must, a part of each general medical inspection.

" This being so, and in view of the recommendations we are making as to the ages at which periodic inspections should be carried out, we recommend that (i) vision testing should also be carried out, either as part of the comprehensive health survey, or at an *ad hoc* session at age 7 years ; and (ii) the 13-year-old vision test by school health visitors should be discontinued.

" In the future, should the results of the field trials establish it to be both desirable and practicable to test all 5-year-old entrants' vision, and a scheme for this be introduced,

then the test at age 7 could be omitted. Meanwhile vision should be tested in the infants' schools at age 7, and also as part of the second ('entry to junior school') periodic inspection."

(i) Weighing and measuring

"Height and weight recording at present takes place as a routine four times during each child's school life, at the times of the periodic inspections. Special cases are, of course, when necessary, measured more frequently. The periodic special biometric surveys are always *ad hoc* enquiries, unrelated to the routine measurements, so that the latter can be considered on their merits. We consider that the height and weight data, in the majority of cases, is of doubtful value to the school medical officer conducting a periodic medical inspection, and that the practice of routine weighing and measuring could be discontinued. The necessary apparatus should remain in the schools, and the school medical officer could always refer for measuring any pupils for whom he especially required the data."

(k)—School journeys

"The medical and nursing inspection of parties of children about to proceed on school journeys is a practice of many years' standing. Whilst it is clear that, years ago, this was a very necessary precautionary procedure, the question naturally arises whether today, in the context of the present greatly reduced incidence of infection and infestation, the expenditure of such a large amount of professional manpower is justified by the remote possibility of detecting overt cases of infection. We consider that today there are no longer any valid medical reasons for continuing the inspection of school journey parties, but discussions held with the London School Journey Association have disclosed that, in those cases where insurance policies are involved, it is necessary to have a medical certificate before travelling and, in fact, numbers of such certificates are being obtained from family doctors, when the Council is not able to arrange for the inspection.

"Accordingly, it would appear to be necessary for the present practice to continue, the principles being that, as early as possible, particularly for strenuous tours, the Head should consult with the school health visitor about the pupils proposing to travel so that the school medical officer could be referred to in doubtful cases, and any necessary treatment arranged, before the start of the journey. This would be followed by a medical and nursing inspection prior to departure, the medical inspection needing only to be a superficial F.F.I., and the nursing inspection confined to personal hygiene.

"With regard to pupils travelling throughout most of the year to Marchants Hill and Sayers Croft, at which there are resident nurses, we consider that the medical inspection prior to departure should be waived, but that the nursing inspection should be continued."

(l)—'Nutrition' re-inspections

"Pupils receiving milk, meals or vitamins on the recommendation of the school doctor, head master or mistress, or Care Committee are re-inspected each term. It is clear that this continuation of long established practices amounts to carrying out a large number of inspections not for medical reasons but in order to give 'cover' to the issue of free welfare facilities. We suggest that a clear distinction needs to be made between the doctor's advice to the parent about nutrients given at an inspection at the school and medical treatment which is given at a clinic. That is to say that a 'recommendation' at an inspection for nutrients, whether meals, milk or vitamins, is not a 'prescription', which must automatically be 'dispensed' by the Head free of charge, but advice which if accepted (as it should be) will involve payment of the standard charge. Abatement of the standard charge is a matter for the Care Committee, and has no relevance to the need, if any, for medical re-inspection. The school doctor will use the normal re-inspection procedure for bringing forward, any cases needing to be seen again on medical grounds.

"Summarising, our suggestions are as follows :—

(i) *Milk*—Since all pupils receive 1/3rd pint of milk free of charge there is no point in 'recommendations' for milk being made at medical inspections at ordinary schools.

(ii) *Meals*—Assessment is a matter for the Care Committee, and there is no need for pupils receiving free meals to be presented by the Care Committee to the doctor to obtain medical 'cover' to the free assessment.

(iii) *Vitamins*—All pupils should pay for these 'nutrients' in school. A need on medical grounds is met by a free issue of medicaments from a treatment centre. Advice at a medical inspection to take vitamin supplements, like advice to take school meals, is not a 'prescription' which the Head must 'dispense' free of charge". (The Education Committee decided that the issue of capsules from school should be discontinued from 1.1.59.)

In concluding their report the departmental committee said :

" In view of our terms of reference, this report has necessarily been concerned mainly with the present practices in the field of medical inspections, and therefore there remain many aspects of the work of the school health service which either we have not considered, or about which we did not feel it was appropriate to make recommendations. Some of these, such as the duties of health visitors, are matters which are being discussed elsewhere, whilst others, such as developments in the fields of health education, and mental health education are matters in which the future, and the not too far distant future at that, may bring great changes. Accordingly therefore some of what has been said in this report may well need to be reconsidered in the light of any change of emphasis or direction which the future may bring in the activities of the school health service."

Scabies, impetigo and ringworm

	1956	*1957*	*1958*
Scabies			
Pupils treated	762	697	768
Verminous			
Pupils treated ..	9,669	8,175	7,473
Treatments needed ..	14,770	13,787	13,647
Impetigo			
Pupils treated ..	2,776	2,433	1,478
Ringworm			
New cases	—	17	22

Employment of school children

4,266 medical examinations were carried out locally with a view to the issue of employment certificates and 311 medical examinations of children were carried out in respect of employment under licence in public entertainments.

Choice of employment

Pupils advised, at their 'school leavers' general medical inspection, against particular forms of employment formed 13·6 per cent. of all leavers examined. The following table gives the main contra-indications disclosed :

Contra-indications	*Boys*	*Girls*
Occupations involving :		
Heavy manual work	282	143
Sedentary work	13	7
Indoor work	2	5
Exposure to bad weather	150	121
Wide changes of temperature	86	59
Work in damp atmosphere	125	95
Work in dusty atmosphere	140	74
Much stooping	42	43
Climbing	90	60
Work near moving machinery or moving vehicles	73	65

Contra-indications	*Boys*	*Girls*
Prolonged standing, much walking or quick movement from place to place	127	145
Eye strain	692	802
Normal vision	878	599
Normal colour vision	412	7
Normal use of hands	24	14
Exposure of hands to moisture, chemicals, etc.	27	2
Handling or preparation of food	125	111
Normal hearing	94	51

The total number of contra-indications is greater than the number of pupils with contra-indications (2,132 boys and 1,507 girls) since an individual may be noted for two or more contra-indications.

School treatment centres

The number of school treatment centres remained unchanged at 113 but 9 previously run by voluntary committees were transferred to the Council so that, at the end of the year 102 were run directly by the Council and 11 by voluntary committees.

Treatment statistics, including sessions which are held in hospital premises

Type of clinic	*Sessions*	*New cases*	*Attendances*
*Vision	4,960	34,273	87,249
*Orthoptic	2,031	1,362	8,499
*Ear, nose and throat	790	3,981	10,273
Audiology	305	1,193	2,997
Minor ailments (doctor)	2,647	40,124	582,306
Minor ailments (nurse)	24,349	75,110	
Dental	34,705	97,300	298,342
*Rheumatism (supervisory)	404	304	2,646
*Enuresis	331	393	2,222
Special investigation	2,014	1,903	13,712

* *Hospital and specialist services provided by boards of governors or regional hospital boards.*

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 head of the school notifies the divisional medical officer and the borough medical officer of health.

These notifications are uncorrected for diagnosis, but form the best available index of the trend of infectious disease in the school community and are the only figures available in respect of diseases which are not statutorily notifiable.

When the number of cases of infectious disease reported from a particular school indicates the possibility of an outbreak, special visits are made by a school health visitor and, if necessary, by a school doctor, in order to investigate the situation and take whatever control action is considered desirable.

The numbers of cases of infectious diseases reported during 1958 and the preceding years are given below :

	1956	*1957*	*1958*
Chicken pox	8,424	4,496	8,901
Dysentery or diarrhoea	1,458	414	1,170
German measles	1,775	2,081	2,549
Impetigo	354	301	265
Jaundice	123	75	11
Measles	2,903	13,039	5,045
Mumps	6,059	5,509	2,778
Ophthalmia and conjunctivitis	280	291	319
Poliomyelitis	66	41	17
Ringworm	49	63	51
Scabies	53	61	61
Scarlet fever	1,020	1,037	1,251
Sore throat or tonsillitis	897	864	994
Whooping cough	1,857	1,372	485

Handicapped pupils

At the end of 1958 special educational treatment was being provided for approximately 11,000 pupils. The following table shows the main categories of handicap and numbers of pupils receiving full-time special educational treatment :

TABLE (iii)

	Day special schools	*Boarding special schools*	*Hospitals*	*Non-Council boarding schools, hostels, foster-homes*	*Total*
Blind	—	60	—	57	117
Partially sighted	270	—	—	8	278
Deaf and partially sighted	294*	33	—	111	438
Physically handicapped	1,015	72	376	67	1,530
Delicate	1,467	205	—	110	1,782
Educationally sub-normal	3,477	613	—	30	4,120
Epileptic†	—	—	—	39	39
Maladjusted	123	279	54	458	914
	6,646	1,262	430	880	9,218

* *Includes 78 pupils in partially deaf units.*

† *A number of epileptic children (apart from those in ordinary school) are placed in schools for the delicate, physically handicapped or educational sub-normal.*

In addition, part-time special educational treatment at day special classes was provided for 312 maladjusted pupils and 2,169 pupils with speech defects.

During the year the numbers of new formal ascertainments were as follows :

	Day	*Boarding*
Blind	—	17
Partially sighted	39	1
Deaf and partially deaf	48	11
Delicate	413	466*
E.S.N.	790	101
Epileptic	—	1
Maladjusted	201	278
Physically handicapped	220	9
Speech defect	1,212	71†
Dual defect	—	72

* *Including diabetic and E.S.N./Delicate.*

† *Including pupils attending boarding schools for other defects.*

Educationally sub-normal pupils

Section 57 of the Education Act, 1944, deals with the examination and reporting to the local health authority of children considered incapable of receiving education at school, of children whom it is considered inexpedient to educate with other children and of children needing supervision under the enactments relating to mental health after leaving school. Details of the numbers reported under this section are given below :

	1956	*1957*	*1958*
Section 57(3) Incapable of receiving education :			
Children not in any school	97	57	118
Children in normal schools	1	3	9
Children in special schools	102	75	83
Children receiving home tuition	—	—	2
	200	135	212
Section 57(3) and (4)—Inexpedient to educate with other children	4	4	3
Section 57(5)—School leavers	351	322	305

In 1958 another 118 school leavers were in need of voluntary supervision only.

The special article on pages 166 to 180 reviews the provision made, over the years, for the special educational treatment of the educationally sub-normal.

Speech therapy

During the year there were two developments in the field of speech therapy. First, the good results obtained over recent years in schools for the educationally sub-normal had led to the hope that speech therapy would also be profitable in the occupation centres for the mentally handicapped (see page 101). A pilot experiment in two centres was conducted in 1957 and in 1958 the work was expanded and regular speech therapy made available at four centres. In December, 1958, 72 children were receiving treatment there. Secondly, a start was made in the provision of portable tape recorders. One of the problems facing the speech therapist is that of bringing the patient to an appreciation of his own speech defect. This is readily achieved by playing back a sound recording. The difficulty has always been that the provision of a recording machine at each establishment—over 90—visited by speech therapists would have been prohibitively expensive, as well as uneconomic in that each machine would have been used for part only of each week. The obvious solution was to provide at each clinic or school visited by a speech therapist a ' library ' of spools of tape relating to the patients at that centre, together with a number of portable machines, which the therapists could readily carry from place to place, using ordinary public transport. The machines have proved to be of very great assistance, not only for the reason stated above, but also in demonstrating to patients, and their parents, the changes and progress that occur under treatment.

At the end of the year 137 speech therapy sessions were held at 46 clinics. In addition 48 sessions were held in 27 day schools for the educationally sub-normal, 27 sessions in day schools for the physically handicapped and 20 sessions in boarding special schools. During the year 1,282 pupils (including 224 in special schools) were formally ascertained as requiring speech therapy, 503 (including 69 in special schools) were discharged as either cured or improved, and 269 (including 71 in special schools), most of whom showed some improvement, ceased to receive treatment for various reasons, e.g., removal. The number of pupils under treatment at the end of the year was 2,181, whilst 322 remained on the waiting list. At the end of the year the total staff employed was the whole time equivalent of 23 8/11.

Audiometry

1958 was the first complete year during which the 'rapid pure tone sweep' method of audiometry was carried out in all divisions. The ' sweep test ' apparatus is essentially a simplified pure tone audiometer easily transported from school to school, which is used for the testing of school entrants.

The numbers of tests conducted were as follows :

' Sweep ' tests	55,889
Full pure tone tests	3,135
Pupils referred to otologist	1,322

It is always the intention to discover cases of congenital deafness within the first 18 months of life, but there will always be a number of children who are deaf or partially deaf in one or both ears found for the first time on admission to school.

Short courses have been arranged by the Council in the detection of deafness in young children, and opportunities have been given for all full-time and a number of part-time medical officers to attend.

Maladjusted pupils

Divisional case conferences

In each division a case conference is held regularly to consider problem children. The education district inspector, the divisional medical officer, the education divisional officer and the district organiser of children's care work (education) are members : whenever possible an educational psychologist also attends and headteachers are invited for discussion of children from their schools. Many of the children discussed at these conferences are referred to child guidance clinics.

Child guidance

In London child guidance facilities, at over 30 clinics, are provided mainly by hospitals, although there are also some voluntary and local authority clinics.

Early in 1958 the Council opened a new child guidance unit at Peckham, bringing the number of directly provided units up to five. The work done at these units during the year is summarised in the following table :

TABLE (iv)

	Battersea	*Brixton*	*Earls Court*	*Wood-berry Down*	*Peckham*	*Total*
No. of applications received	124	175	108	225	127	759
No. awaiting first interview at 31st December	23	44	28	37	27	159
No. interviewed and awaiting treatment	11	7	10	16	9	53
Number of patients						
In treatment at 1st January	55	140	44	162	—	401
New cases treated ..	69	146	81	165	70	531
Total	124	286	125	327	70	932
In treatment at 31st December	48	123	76	238	36	511
Discharged	76	163	49	99	34	421
No. of home visits by staff	10	9	22	118*	9	168
No. of school visits by staff	84	22	70	63	48	287

* *Includes visits by students*

All the child guidance units administered by the Council maintain close liaison with local schools and child welfare centres. The Tavistock Clinic and the Child Guidance Training Centre administered by the North West Metropolitan Regional Hospital Board have also developed special schemes for co-operation with local schools.

Day special classes

In addition to the full time provision indicated in Table (iii), page 112, part-time special educational treatment is provided at 19 day special classes for 312 maladjusted pupils.

A third day school for the maladjusted, the North Croft School at Hammersmith, was opened in 1958.

Severely disturbed children

One problem which caused concern throughout the year was the difficulty in securing in-patient treatment for severely disturbed children. The National Association for Mental Health continued its efforts to find a solution to this problem and the Council made strong representations to the hospital authorities concerned.

DENTAL SERVICES

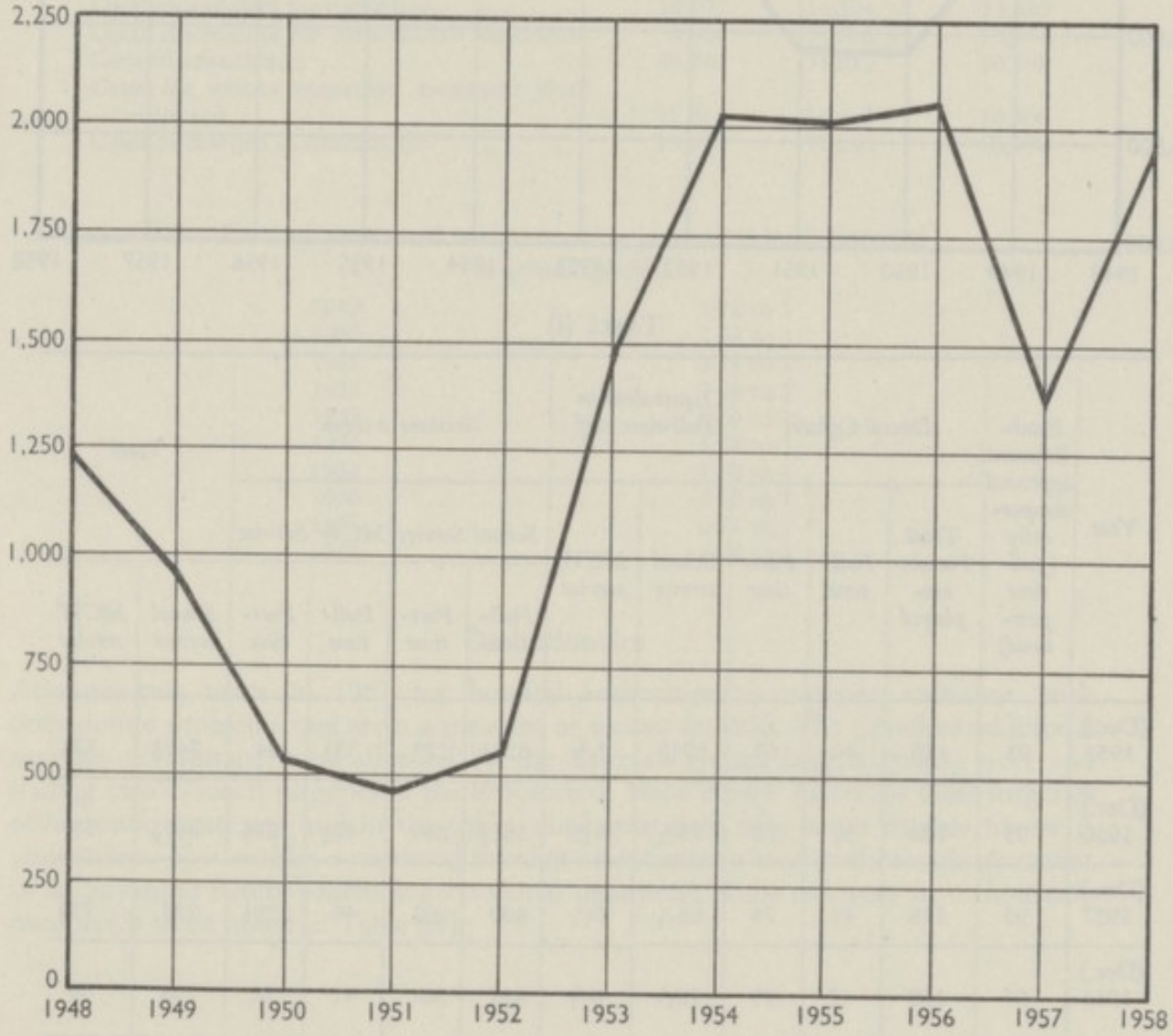
The Chief Dental Officer and Principal School Dental Officer reports as follows :

During 1958 the services available again met the demand rather than the need for treatment. At dental inspections three out of every four school children were found to require treatment but it was possible to carry out these inspections for less than half the total school population. Only 97,300 or just over half the 180,117 school children found on examination to need treatment received it at the Council's surgeries. Many parents expressed the intention of having their children treated " privately " but there is no evidence that their intentions were always implemented. Systematic revisional treatment for children rendered " dentally fit " was impossible and the policy of spread-over treatment for the greatest number was continued. (It should be noted that some of the 97,300 patients treated in 1958 were " unofficial " revisional treatment patients, and thus the number of *children* treated in the year was *less* than 97,300.)

Graphs of the number of inspection sessions and of treatment sessions are shown below. Reference was made last year to an experiment to obtain more treatment sessions by curtailing dental inspection sessions.

SCHOOL DENTAL SERVICE

NUMBER OF INSPECTION SESSIONS AT SCHOOLS



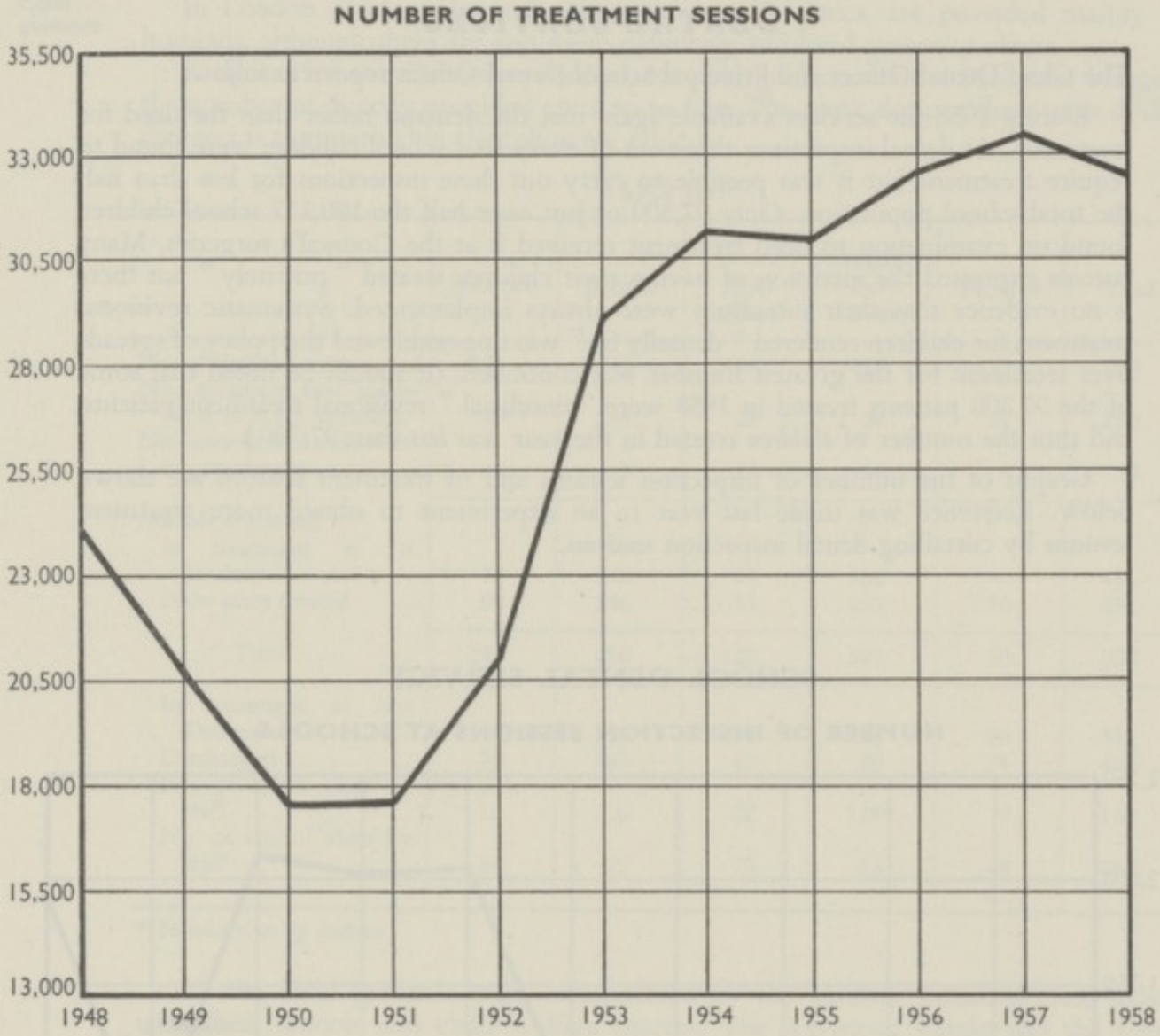


TABLE (i)

Year	Establishment approved temporarily (full-time positions)	Dental Officers			Equivalent in Full-time staff		Sessions a week				Total	
							School Service		MCW Service			
		Total Number employed	Full-time	Part-time	School service	MCW service	Full-time	Part-time	Full-time	Part-time	School service	MCW service
(Dec.) 1955	93	116	49	67	$67\frac{10}{11}$	$5\frac{3}{11}$	527½	220	33½	24	747½	57½
(Dec.) 1956	95	122	52	70	$73\frac{4}{11}$	$6\frac{4}{11}$	561½	246	42½	27½	807½	70
(Dec.) 1957	95	118	44	74	$65\frac{8}{11}$	$6\frac{9}{11}$	460	263	46	29½	723	75½
(Dec.) 1958	95	139	42	97	$72\frac{6}{11}$	$6\frac{8}{11}$	437	361	41	28	798	69

School dental service

The high incidence of dental disease continued to give cause for concern (73·5 per cent. of children inspected) and—in Table (iii)—the further decline in ratio of permanent teeth restored to extracted is regrettable.

TABLE (ii)

	1956	*1957*	*1958*
Number of inspection sessions held at schools	2,111	1,354	1,952
Number of children inspected at schools by dental officers	213,957	120,440	196,573
Number found to require treatment	163,414	91,868	144,050
Percentage requiring treatment	76·4%	76·3%	73·5%
Additional number inspected at centres	44,078	56,598	36,067
Total number found to require treatment	207,492	148,466	180,117
Total cases treated	115,587	102,568	97,300
Attendances	332,785	308,862	298,342
Ordinary treatment sessions	31,257	31,841	31,322
General anaesthetic sessions	1,708	1,594	1,431
Temporary teeth extracted	83,341	69,247	58,223
Permanent teeth extracted	19,992	18,273	19,342
Temporary teeth restored by fillings	43,474	45,509	40,994
Permanent teeth restored by fillings	129,931	117,148	122,558
Fillings in temporary teeth	46,088	48,477	43,176
Fillings in permanent teeth	144,746	131,071	136,811
Other operations :—			
temporary teeth	58,808	58,021	54,884
permanent teeth	68,972	64,675	64,995
Local anaesthetics for extraction	16,195	14,404	13,320
Local anaesthetics for conservative treatment	9,494	10,718	13,964
General anaesthetics	38,740	34,019	30,861
Cases for whom immediate treatment was completed	11,614	10,415	10,566
Cases discharged as dentally fit	79,994	71,260	66,990

TABLE (iii)—*Ratio of permanent teeth restored to permanent teeth extracted in school children*

1949	3·72 to 1
1950	3·29 to 1
1951	3·43 to 1
1952	3·86 to 1
1953	4·69 to 1
1954	5·32 to 1
1955	7·39 to 1
1956	6·50 to 1
1957	6·41 to 1
1958	6·34 to 1

Orthodontics

Arrangements made in 1957 for hospital authorities to increase assistance with orthodontic problems met with a measure of success in 1958. The principal additional measure of assistance was afforded by the Eastman Dental hospital taking over and staffing two Council surgeries in the Province of Natal centre. In one of these surgeries orthodontic treatment and in the other allied treatment of a more routine nature is undertaken. This enables a restricted number of patients to receive thorough treatment of an advanced nature—including revisional treatment. Some recovery in orthodontic numbers is to be noted in Table (iv).

TABLE (iv)

	1955	*1956*	*1957*	*1958*
Number of special orthodontic sessions	185	290	321	282
Number accepted at special orthodontic sessions ..	195	252	108	199
Number accepted at routine sessions	432	427	403	474
Number referred to hospitals	59	182	158	186
Total number of patients accepted	686	861	669	859

Maternity and child welfare dental service

During 1958 there was no improvement in this service which continued to represent approximately 10 per cent. of the total dental effort. As far as is known, however, "demand" was met but continuing shortage of staff prohibited any effort to assess need of the total population of expectant and nursing mothers and of pre-school children.

TABLE (v)—*Attendances and treatments of maternity and child welfare patients*

	1949	*1955*	*1956*	*1957*	*1958*
Number of sessions	*3,046*	3,220	3,169	3,293	3,135
Number of appointments offered ..	*31,338*	35,854	36,711	36,636	34,740
Attendances—by appointment	*24,861*	26,430	27,640	26,006	24,691
—other	*5,392*	1,526	1,799	1,717	1,539
Silver nitrate treatment	*2,938*	5,058	4,716	5,423	5,065
Fillings	*8,564*	13,212	13,465	11,310	11,491
Extractions	*16,560*	9,177	9,561	7,809	5,873
Dentures supplied—new full	*652*	572	538	508	422
—new partial	*795*	686	778	820	685
Number made dentally fit	*5,283*	7,117	7,492	6,010	5,014

Dental services in boarding schools and residential establishments

There was little or no change in these services in 1958.

STAFF

THE following statement shows the number of staff employed in the Public Health Department at the end of the year (part-time staff are expressed as whole-time equivalents). (The principal officers of the department are shown in Appendix D on page 182.)

Types of staff	*Location*			*Total (1949 figures in brackets)*
	Head office	*Divisions*	*Other establishments (a)*	
Administrative and clerical (including ambulance control clerks)	217	628	74	919 (881)
Medical officers (*b*)	30	158	(*b*)	188 (179)
Dental officers (*b*)	2	76	(*b*)	78 (66)
Scientific Branch staff	26	—	14	40 (23)
Inspectors	16	—	—	16 (15)
Nursing staff	10	1,837	176	2,023(3,066)
Medical auxiliaries (*c*)	23	155	20	198 (144)
Social worker grades (including mental health)	32	96	125	253 (254)
Ambulance service operational staff ..	3	—	783	786 (625)
Home help organising staff, wardens, manual workers, home helps, domestic grades, etc.	11	2,900	125	3,036 (2,038)
Totals	370	5,850	1,317	7,537 (7,291)

(*a*) *These establishments include residential schools and nurseries, welfare establishments, ambulance stations, occupation centres for mentally deficient persons, main drainage outfall works, clinics and dispensaries, district offices (mental health), central dental laboratory, etc.*

(*b*) *There are 100 visiting medical officers and 7 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, occupational therapists, psychotherapists, dental attendants and dental technicians.*

Training of staff

The Council appointed 49 student health visitors for training in 1957–58 under its standing arrangements. Theoretical training was provided by the University of London Institute of Education (39 students), the Battersea College of Technology (6 students) and the Royal College of Nursing (4 students), arrangements for practical instruction in the department's divisional establishments being arranged and co-ordinated with the theoretical training under the direction of the Council's principal health visitor tutor. All the students completed the course, 49 sat for the examination and 48 were successful.

It is of interest that no fewer than 123 of the students trained since the inception in 1948 of the Council's training schemes were still in the service as health visitors on 30 September, 1958, two of them having been trained on the original (1948–49) course. This represented over a third of the total number of students trained.

Domiciliary midwifery service

Two developments worthy of note took place in connection with the domiciliary midwifery service. The Council authorised the grant of loans to selected grades of staff to assist them to purchase motor vehicles for use for official purposes in accordance with an approved scheme. Domiciliary midwives were the first grade to be granted such facilities. Also, the provision of furnished flats was authorised for two newly-qualified young midwives ; hitherto there had been no demand for other than unfurnished accommodation.

Medical examinations

Numbers of staff medically examined for various purposes, with the result of the examination, follow:

	1957	*1958*		*1957*	*1958*
Candidates fit for appointment	6,286	7,531	Eligibility for spouse pensions	26	24
Candidates unfit for permanent appointment ..	285	401	Staff casualties	240	315
Referrals (ill-health) ..	7,268	6,719	Candidates for out-county authorities..	65	100
Permanently unfit to carry out their ordinary duties ..	245	323	Candidates examined for the Council by out-county medical officers of health	77	138
Advice given (without examination)	1,378	1,621			

Food handlers

During the year 403 food handlers were referred for investigation because they had been in contact with or had suffered from certain infectious diseases. Bacteriological examination was arranged where appropriate.

	1957	*1958*
Contacts	107	137
Ill	270	266
Allowed to resume work after examination	360	388
Resigned	—	9
Excluded from work and referred to own doctor for treatment	17	6

The six cases excluded from duty were found to have the following micro-organisms:

Condition	*Organism isolated*
Scarlatina contact	*Strep. pyogenes*
Diarrhoea contact	*Shigella sonne*
Gastro-enteritis contact	*Shigella flexner*
Gastro-enteritis convalescent ..	*Shigella sonne*
Vomiting convalescent	*Shigella flexner*
Diarrhoea and vomiting convalescent	*Salmonella typhimurium*

Retirements, etc.

In September, 1958, Dr. A. Smyth, M.R.C.S., L.R.C.P., D.P.H., LL.B., who had been Deputy Divisional Medical Officer of Division 8 since February, 1955, and had previous service in Division 2 and with St. Pancras Metropolitan Borough Council, resigned her appointment and was succeeded by Dr. J. A. Linden, M.R.C.S., L.R.C.P., D.P.H.

On 31 March, 1958, Miss A. M. Sidebotham retired from the position of Divisional Nursing Officer of Division 1. Miss Sidebotham joined the Council's service as a school nurse in 1928. She was called up for duty with the Q.A.I.M.N.S. on 1 September, 1939, and on her return was promoted superintendent school nurse. In 1948 Miss Sidebotham was appointed divisional nursing officer to Division 1. She has been succeeded by Miss Joan A. Surr, who was promoted from the rank of assistant divisional nursing officer.

In April, 1958, Miss Catherine Walsh, Divisional Nursing Officer of Division 3 since its inception in 1948, resigned her appointment. She held various appointments between 1930 and 1936 in hospitals administered by the Council, followed by health visitors' posts with Middlesex County Council and with Hammersmith and St. Marylebone Borough Councils, before being transferred to the Council's service again

in 1948. Miss Walsh had been seconded to work with the World Health Organisation and at the end of this period decided to remain with that body. Miss M. D. Butler, who had acted as Divisional Nursing Officer was appointed to succeed her.

In December, 1958, Mr. E. M. Power, L.D.S., R.C.S., who had acted as Assistant Chief Dental Officer since July, 1953 and had given in all over 36 years to the public dental service, retired at the age of 65 years.

FINANCE

Capital

THE TOTAL capital expenditure on the health services of the Council in the year ended 31st March, 1958, was £18,498, details of which are as follows:

	£
Ambulance service:	
Stations—erection and adaptation	2,566
Day nurseries—erection and acquisition	318
Maternity and child welfare centres—acquisition, erection, equipment, adaptation	11,380
Occupation centres—adaptation and erection ..	1,791
Queen's Road health centre—adaptation	2,443
	£18,498

Maintenance

The gross cost of the various services in 1957–58—including central administrative and debt charges—and the contributions recovered from recipients of the services were:

Service	*Cost*	*Amount recovered in charges*
	£	£
Ambulance service	1,071,946	—
Day nurseries	1,023,893	184,203
Domiciliary midwifery service	221,467	—
General health services (including £212,972 contribution to Metropolitan Borough Councils for salaries of sanitary officers)	261,723	—
Health centres	38,415	—
Health visiting	277,572	—
Maternity and child welfare	842,690	58,583
Mental health	268,957	1,012
Prevention of illness—		
Home nursing	469,510	—
Domestic help	1,022,562	54,180
Other preventive services	562,133	31,858
School health	950,548	5,796
	£7,011,416	£335,632

The net cost of the services after allowing for Government grant, expressed in terms of rate in the £ was 8·65d.

VISITORS TO THE DEPARTMENT

VISITORS for whom talks with senior officers and visits to the Council's establishments were arranged through the central office numbered 333, and in addition a number of visitors were received at the divisional health offices. Programmes covered varying periods from one day to four weeks. Of these visitors 175 came from abroad :

Argentina	2	Greece	3	Portugal	2
Australia	10	Holland	5	Qatar	1
Austria	1	Hong Kong	2	Rhodesia & Nyasaland	3
Belgium	1	India	7	Singapore	1
Burma	2	Indonesia	4	South Africa	7
Canada	3	Iraq	2	Sudan	2
Ceylon	7	Iran	4	Sweden	8
Chile	2	Israel	3	Switzerland	8
Denmark	5	Italy	1	Syria	1
Eire	2	Japan	7	Thailand	4
Egypt	1	Kenya	3	Turkey	5
Finland	4	Morocco	1	U.S.A.	15
France	1	New Zealand	2	U.S.S.R.	1
Germany	7	Norway	1	Vietnam	2
Ghana	5	Pakistan	2	Yugoslavia	9
Goa	1	Poland	5		

They included 2 members of governments, 82 doctors, 25 nurses, 3 students, 23 social workers, 27 central and local government administrative officers and 13 teachers.

A number of these visitors included in their programme a visit to Woodberry Down Health Centre, where 1,441 visitors were received during the year; to the London ambulance service, 174 visitors ; to occupation centres for the mentally defective, 621 visitors including 436 students, and the laboratories of the scientific branch.

In addition to the individual visitors mentioned above, several groups were received including 31 medical officers of the World Health Organisation travelling seminar, 35 German social workers, 20 teachers from Chile and 13 local government officers from Israel.

Facilities were given for medical, nursing and social science students to study the health services and a number of talks by members of the staff, single visits or periods of attachment were arranged as seemed most suitable.

4,139 hospital student nurses and some 80/90 students of speech therapy from the Central School of Speech and Drama, the Kingdon-Ward School of Speech Therapy, the Speech Therapy Training School of the West End Hospital for Neurology and Neurosurgery and the Oldrey-Fleming School of Speech Therapy were attached to the Council's clinics for varying periods up to 12 months. In addition students were received from the following training centres :

Health Visitor Students

Battersea College of Technology
Queen's Institute of District Nursing
Royal College of Nursing
South East Essex Technical College
Surrey County Council

Other Students (medical, nursing and social studies)

Battersea Training College of Domestic Science
Bedford College
Herts and Essex General Hospital
King Edward's Hospital Fund for London
London School of Economics and Political Science
Ministry of Labour and National Service
National Training College of Domestic Subjects
Queen Elizabeth College
Royal College of Nursing
University House
University of London Institute of Education

REPORTS BY THE DIVISIONAL MEDICAL OFFICERS

DIVISION 1, comprising the boroughs of Chelsea, Fulham, Hammersmith and Kensington.

Dr. B. E. A. Sharpe reports:

Mental health education

Two case conference groups were started during the year. The groups met fortnightly, one under the leadership of Dr. Felix Brown, Medical Director of the Earl's Court Child Guidance Unit and the other under Dr. Erskine, Psychiatrist, West London Hospital. The groups consisted of psychiatric social workers, medical officers and health visitors. In addition, arrangements with Dr. Felix Brown were completed by the end of the year for the establishment at Sir John Lillie School of a fortnightly educational group which will consist of the psychiatrist, educational psychologist, teaching staff, school doctor, school nursing sister, school care committee workers and a divisional health office representative. The group will discuss problems relating to children referred by the head master. This association outside the child guidance clinic should enable the psychiatrist to appreciate the work done by other workers with children's problems, enable the group to understand the work of the child guidance unit, and learn when to manage cases themselves and when to refer them to the clinic.

Centre for spastic children, Cheyne Walk, S.W.3

By arrangement with Dr. John Foley, the Medical Director of the Centre for Spastic Children, Cheyne Walk, S.W.3, health visitors in whose districts spastic children lived, visited the centre with the parents to see the children receive treatment. The unanimous opinion of the health visitors concerned was that the visits to the centre were most helpful and constructive.

Neglect and ill-treatment of children

Regular meetings of the divisional co-ordinating committee have continued. Home helps specially trained to assist the mother in all aspects of home management and child care were supplied to eight families.

Mothercraft and home-making courses

The two mothercraft and home-making courses for selected mothers held at the Westway welfare centre in North Hammersmith and the Raymede welfare centre in North Kensington arranged by the respective voluntary home advice groups were continued. Average attendance was higher at both courses in 1958 than in the previous year.

Liaison with other bodies

Professor McClure Browne continued to hold monthly perinatal mortality conferences at Hammersmith Hospital and in addition he held two meetings at the hospital for medical officers engaged in ante-natal work at the maternity and child welfare centres. A meeting of hospital almoners, health visitors, Divisional Directors of the British Red Cross Society, home help organisers, tuberculosis care organisers and divisional staff was held early in the year and a useful exchange of views took place.

Poliomyelitis vaccination

Since August monthly vaccination clinics have been held on Saturday mornings at Queen Charlotte's Hospital for expectant mothers attending the hospital for ante-natal care. The clinic is staffed by a visiting team of Council officers. In November vaccination against poliomyelitis was extended by offering it to young people born in the years 1933–42 (inclusive). In addition to general publicity an individual approach was made to some 600 local firms and arrangements were made to hold clinics on business premises, in further education establishments and in the evenings and on Saturday mornings at health service establishments for young people who found it difficult to attend a clinic during their working hours. General practitioners co-operated in giving poliomyelitis inoculations, and out of a total of 21,812 vaccinated with two injections 6,292 received them from their family doctors. At the end of the year a start was made on giving third injections to children who had received their first two injections in 1956.

Lancaster Road Infant Welfare Centre Voluntary Committee

The Lancaster Road Infant Welfare Centre Voluntary Committee, which was responsible for founding the infant welfare centre and day nursery at 63 Lancaster Road, W.11 and, had been in existence since the 1914–1918 war ceased to function in July. It had administered these establishments until 1938 when they were taken over by the Kensington Borough Council. (The day nursery closed at the end of 1939.) The

Committee thereafter continued to provide comforts and amenities on a voluntary basis. Two members of the Committee continued to be available at the centre after July, 1958.

Day nurseries

A reduction in the number of approved places and adjustments of accommodation for the various age groups were effected at Cheyne Hospital, Violet Melchett, Mulgrave and Brook Green day nurseries, but daily attendances were higher than in the previous year.

Staff

Arrangements were made in September to transfer the health visitors working in the Fulham area from the Town Hall to Council premises which in the main were the centres from which the health visitors were working. The public have expressed their appreciation of the new arrangements which save them time and expense in travelling.

Divisional statistics for 1958

(corresponding figures for 1957 are shown in brackets)

Vital statistics

Total births	7,743	(7,231)
Live birth rate	16·2	(15·9)
Total deaths	5,050	(4,916)

Welfare of mothers and children

Attendances at ante-natal sessions	21,109	(15,973)
Attendances at child welfare sessions	89,163	(89,330)

Health visiting

Total visits	100,833	(94,837)

Day nurseries

Number of nurseries	12	(12)
Number of approved places	624	(673)
Average daily attendances	568	(542)

Child-minders

	Number		*No. of children minded*	
Statutorily registered child-minders	22	(30)	77	(132)
Statutorily registered private day nurseries	17	(15)	550	(455)
Voluntarily registered child-minders	168	(173)	201	(208)

Vaccination and immunisation

Total primary vaccinations against smallpox	4,877	(4,989)
Total primary diphtheria immunisations	5,193	(5,832)
Total poliomyelitis inoculations (2 doses)	21,812	(10,438)

Home help service

Total number of households attended	4,490	(4,609)
(Early morning and evening home help was provided for 30 families and a night help in 8 cases.)		

Home nursing

Total visits	238,737	(242,214)

Chiropody

Total attendances	19,840	(19,353)

Occasional crèches

Total attendances	1,788	(1,762)

DIVISION 2, comprising the boroughs of Hampstead, Paddington, St. Marylebone, St. Pancras and City of Westminster.

Dr. H. L. Oldershaw reports:

Welfare centres and health visiting

At the end of 1958 the maternity and child welfare centre at 230 Haverstock Hill, N.W.3, was closed, and a replacement centre opened in adapted premises at Parkhill Road, N.W.3, leaving unaltered the total of 25 Council centres and one voluntary grant-aided centre. The combined results of all the centres' work and other divisional activities during the year may be summarised as follows:

Out of a total of some 8,500 expectant mothers 6,266 attended ante-natal clinics. Comparable attendances in 1957 were 5,570.

Of 17,982 children under five brought to the clinics, 7,755 were under one year at the time of their first attendance : the numbers for the previous year were 18,189 and 7,281.

Altogether 89,031 visits were made to a total of 24,464 children under five by the health visitors. Visits were made to 8,257 expectant mothers during the year, as against 7,383 in 1957. The number of families visited amounted to 21,611 (24,156 in 1957), and a total of 12,911 visits were made to other cases (12,929 in 1957). 2,128 visits were made to tuberculous households during 1958, in addition to the visits made by tuberculosis visitors.

Home help

The number of families needing home help rose by 389, service was provided in 4,867 instances : the number of chronic sick, aged and infirm cases needing help rose from 3,550 to 4,066 which was 80 per cent. of the total as in the previous year.

Day nurseries and child-minders

The overall number of approved places provided at the 18 maintained and one grant-aided day nurseries was reduced by 111 to 995 in order to relate them more closely to the actual attendances. The number of children on the registers at the end of the year included 90 children resident in adjacent divisions :

	31.12.58	*31.12.57*
Places 0–2	431	433
Places 2–5	691	693
Total	1,122	1,126

Greater flexibility as between age groups resulted in a more economical use of the places provided and in assessing the priority of applications particular care is taken in regard to children whose health might suffer through adverse environmental conditions.

The number of private day nurseries registered under the Nurseries and Child-Minders Regulation Act, 1948, totalled 21 (representing 543 places) at the end of 1958, an increase of 26 places over the previous year's figure. There has been no change in the number of child-minders statutorily registered, the total at the end of the year being 19 (119 places).

Prophylaxis

A small decrease is recorded in the number of children immunised against diphtheria. As against 5,598 primary courses completed in 1957, the figure for 1958 was 5,260, of which 53 per cent. were given to children born in 1957 and 23 per cent. to those born in 1958; of this year's figure 67 per cent. were given in the form of the combined diphtheria and whooping cough immunisation. An increase was, however, shown in the number of reinforcing injections given—6,144 compared with 5,707 in 1957: the bulk of this year's total was made up from children of the 4–11 age-group, and 94 per cent. of the overall number received a reinforcing dose against diphtheria only.

There was a decrease in the number of primary vaccinations for smallpox—5,290 (5,388 in 1957) of which 87 per cent. were under one year at the time of vaccination. 65 children under 15 were re-vaccinated, which again is less than the number recorded for 1957 (249), and of those 95 per cent. were between the ages of 5 and 14

inclusive. One reason for the decline in the number of children recorded as vaccinated and immunised during the year is the continuing movement of families away from the division.

The poliomyelitis vaccination programme was extended in the autumn of 1958 to include all young people born in the years 1933–43. In order to inoculate persons in this age group, teams have visited many of the larger business premises and further educational establishments. In addition, regular open sessions where inoculation is given without need for prior appointment were established at seven centres.

During the year 26,353 persons were inoculated with two injections under the Council's arrangements and 5,736 inoculations were performed by general medical practitioners.

Tests for B.C.G. vaccination were made on 2,920 13-year-old children out of a total of 3,041 (72 per cent. of those eligible) whose parents had agreed to their being tested: of this number, 2,493 showed a negative reaction and were given vaccination (2,513 in 1957). 391 reacted positively and 355 of these were X-rayed (364 X-rayed in 1957) of whom only one was found to have an abnormal chest condition. Of the children given vaccination in 1957, a group of 613 was selected for re-testing in 1958, to which the parents of 578 agreed, and 530 were actually tested again: 10 were found to need further vaccination.

Home nursing equipment

The demand for home nursing equipment continued to grow in 1958. Of 201 requests received, 141 patients were supplied with a total of 157 items of equipment, including commodes (most in demand), hospital beds, foam rubber mattresses, wheel-chairs, hoists, etc.

Health education

A campaign highlighting a particular aspect of health education continues to be launched each month from the divisional office. Visual aids and displays made by staff are shown at all centres with suitable facilities. Material relating to the topic of the month is sent to the editor of a local newspaper group who has co-operated by producing short articles designed to interest and influence the public.

Film strips on health topics were arranged by staff for mothers attending welfare centres and for school children when requested. Staff also gave talks on appropriate aspects of health to outside bodies, e.g., home safety to old people's associations.

School health service

None of the school treatment centres had seriously long waiting lists. Additional sessions were held to supplement regular vision clinics, and evening dental sessions were provided as necessary, chiefly for the older children as well as for expectant and nursing mothers.

Problem families

The divisional co-ordinating committee under the chairmanship of the deputy divisional medical officer and with the divisional treatment organiser as secretary, met on 23 occasions during the year and dealt with the case-work on a total of 57 families.

In addition to the class already provided at Beauchamp Lodge, a second mothercraft and home-making class for selected mothers at the Queen's Park welfare centre was started in 1958: the class is run by a voluntary committee in association with the Paddington Council of Social Service. Both classes are grant aided by the Council to the extent of £60 a year each.

DIVISION 3, comprising the boroughs of Finsbury, Holborn and Islington.

Dr. W. G. Harding reports:

Diphtheria

On 30 September, 1958, a throat swab from a non-immunised 7-year-old boy who attended Compton School revealed *c. diphtheriae*. Positive swabs were also produced from his brother who attended the same school, a play contact and her younger sister who attended St. Catherine Labouré school.

A girl (aged 7½ years) had attended Moreland school for two days with a mild sore throat. On the third day (3.10.58) clinical diphtheria was diagnosed and she and a child (aged 6) in the infant department of the same school produced a positive swab.

Throat and nose swabs were taken from all children in the classes concerned and, in view of the extremely congested site, from the entire infant, junior and senior departments of St. Catherine Labouré school. Close contacts were inspected daily. Children with infection of the upper respiratory tract were swabbed and excluded from school, absentees followed up and parents' permission sought for immunisation. Children whose parents gave consent in the classes affected at the Compton and Moreland schools, and in the whole of St. Catherine Labouré school were immunised, and those who had not previously been immunised also received anti-diphtheritic serum, special care being taken with children with an allergic history who received test doses in the first instance.

On 10 November, 1958, and 12 November, 1958, two children of two years were diagnosed as cases of clinical diphtheria. Family contacts were swabbed and, as one aged 4½ years who attended St. Catherine Labouré school produced a positive swab, swabbing of class contacts and the class of a sibling contact were carried out.

No direct connection was found between the cases in the first and second phases, but it may be that one of the adult healthy carriers who lived in the same block dwelling as the clinical cases initiated the second phase and was the missing link.

In the first phase 34 and in the second phase 14 positive swabs were obtained but only 2 of each were considered to be mild clinical diphtheria. Of these 4 cases one had not been immunised; there was no record of another being immunised, one had received, in September, 1958, the first injection only of a primary immunisation course, and another had had primary immunisation in 1957 and a booster injection in October, 1958.

Letters were written to parents of children in the affected schools, who required primary or booster injections, using the incident as an illustration of the need to have their children fully protected. Immunisation activities in other schools were pressed ahead as far as possible.

Poliomyelitis

The extension of the offer of protection against poliomyelitis to everyone born in 1933 or later necessitated the provision of special facilities for adolescents and young adults who did not opt to go to their family doctor, viz.:

(i) Sessions at the place of work by a visiting team from the division, or a doctor employed by a firm; 5 sessions, 237 attendances;
(ii) sessions at further education establishments by a divisional team: preliminary arrangements made at 14 establishments, first session on 12 January, 1959;
(iii) evening sessions; 36 sessions, 765 attendances;
(iv) Saturday morning sessions; 7 sessions, 26 attendances;
(v) lunch time sessions (held at Holborn Town Hall with the co-operation of the Metropolitan Borough of Holborn); 6 sessions, 1,513 attendances.

The most successful methods were (v) and (i)—415 persons attended one lunch time session. Attendances at (iii) and (iv) were generally few.

Initial publicity for these facilities included the sending of letters to 2,628 firms in the division. Of these 15 asked for the divisional team to visit and 5 firms made their own arrangements with some assistance from the divisional staff. Many more asked for publicity material.

Problem families

'Field' and intermediate case conferences continued to be held and the divisional co-ordinating committee met regularly. Co-ordinating conferences were run on the principle of elasticity with the aim to secure the attendance of all who had personal knowledge of any particular case. Family doctors are now always consulted before

families on their lists are discussed and frequently attend themselves or, alternatively provide full information. A conference of all statutory and voluntary agencies working in this field within the division, including the churches, was held in October ; 70 representatives attended. One object was to stimulate the referral of cases by non-statutory bodies for co-ordinating action, for in the past, although these agencies have invariably co-operated closely when invited to co-ordinating conferences, the number of cases actually referred by them has been low.

School health service

The school treatment centre in Clifton Terrace was transferred to more suitable accommodation made available by the Voluntary Committee of the North Islington infant welfare centre. Thus the integration of the maternity and child welfare service and the school health service was carried a step further.

Arrangements were completed between the Eastman Dental hospital, the Institute of Child Health and the Council for the establishment of an annexe of the hospital at the Province of Natal Centre to provide a consultant orthodontic service for school children. The initial equipment was provided by the Institute of Child Health from the balance of the fund provided by the Province of Natal, and the Council undertook to bear the greater part of the maintenance costs.

Mental health education

As part of in-service training activities, case conference discussions between child psychiatrists, psychiatric social workers, centre doctors and health visitors, which are also attended by senior divisional staff, continued to be held in the Province of Natal and East Islington welfare centres. Staff of the Child Guidance Training Centre visit the latter and the increasingly close contact is found of great help by psychiatric and public health staff alike.

Statistics of Services during 1958

(corresponding figures for 1957 are shown in brackets)

Clinics

	No. of centres	*Average No. of sessions per month*	*No. of patients attending*	*Total attendances in the year*
Ante- and post-natal clinics	7 (7)	80 (84)	4,667 (3,632)	17,123 (16,766)
Child welfare centres	14 (15)	192 (185)	12,128 (10,295)	76,843 (76,965)

Health visiting

Children under 5		*Visits to expectant mothers*	*T.B. households*	*Other cases*	*Total households visited*
Visited	*Total No. of visits*				
17,607 (17,104)	56,220 (51,011)	4,493 (3,841)	850 (690)	10,630 (8,262)	15,956 (14,925)

Home nursing

No. of visits made—139,610 (138,162).

National welfare food distribution

Points at the end of the year—14 (15).

Day nurseries

No.	*Approved places*	*No. on registers at end of the year*	*Average daily attendances*
6 (6)	346 (338)	364 (323)	294 (370)

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Child minders

	Registered at end of the year	*No. of children minded*
Statutory ..	8 (7)	29 (26)
Voluntary ..	142 (140)	133 (131)

Home help service

Three areas employed the equivalent of 141 whole time home helps.

No. of cases receiving service at end of the year—1,621 (1,634).

Foot clinics

Three centres provided 3,207 sessions in the year. Attendances—23,642 (23,208).

Prophylaxis

	Primary	*Re-vaccinations*
Vaccination	4,144 (4,277)	250 (704)

	Primary courses	*Reinforcing injections*
Whooping Cough ..	3,082 (3,492)	202 (357)
Diphtheria	3,665 (3,898)	2,862 (4,989)
Poliomyelitis	Persons given two injections—19,093 (6,605)	

School health service

Type of session	*No. of sessions a year*	*No. of new cases*	*No. of attendances*
Vision	830	5,270 (5,703)	14,208 (13,472)
E.N.T.	31	137 (134)	282 (300)
Audiology	47	234 (211)	374 (334)
Special Investigation ..	341	367 (282)	2,809 (2,551)
Minor Ailments doctor ..	241	3,274 (4,287)	34,638 (48,013)

School medical inspections

(i) *No. of children examined:*

Routine	26,700 (16,113)	Special	12,280 (12,574)
Re-inspections	9,632 (8,942)	Nurses hygiene	98,500 (113,092)

(ii) *Audiometry*

No. of children given:

Sweep test	9,626 (—)	Pure tone test	561 (937)

Tuberculosis

Patients receiving diversional therapy at home 40 (48)

DIVISION 4, comprising the boroughs of Hackney, Shoreditch and Stoke Newington.

Dr. S. King reports:

Woodberry Down health centre

The services provided at the health centre have been maintained during the year, apart from a reduction of 11 general dental sessions owing to the withdrawal by the London Executive Council of their second dental officer in March, 1958, and the departure of the dental hygienist at the end of 1957.

One additional ophthalmologist's session was established during the year and four additional dental sessions for schoolchildren.

The total number of sessions held each week had dropped to 224 by the end of the year with an average weekly attendance of 2,087 persons. Of these 52 were general medical sessions (average attendance 10) and 11 were general dental sessions (average attendance 7).

The occasional crèche was open for nine sessions a week and was much used.

Medical staff committee meetings have continued to be held regularly and included a discussion on intra-articular use of hydro-cortisone under the leadership of Dr. J. H. Glyn.

Health education work continued to play a prominent part in the Centre's work during the year; at the end of October an 'Any Questions' evening was held on the subject of 'smoke abatement' in preparation for the designation of the surrounding area as a smokeless zone. A two-day education course for staff was arranged in November.

Maternity and child welfare

There were 7,664 ante-natal and 220 post-natal attendances and 4,254 first attendances of infants under one year of age (equal to 94 per cent. of children born during 1958) at the Council's clinics.

Day nurseries and child-minders

During the year one of the Council's day nurseries (Clifton Lodge) was closed and this, together with a reduction in the number accommodated at another nursery, resulted in the total authorised accommodation at the end of 1958 being 379 compared with 439 in the previous year.

Two private day nurseries provided accommodation for 93 children and nine statutorily registered child-minders cared for 34 children. In addition there were at the end of the year 62 daily child-minders approved under the arrangements for voluntary registration.

Health education

Health education continued in accordance with the planned programme and a committee of officers in the various grades concerned with these activities met at regular intervals to co-ordinate the work and to plan further developments. Educational work in the welfare centres is continuing steadily as the following figures show:

	Sessions	*Attendances*
1953	288	5,421
1954	414	6,494
1955	564	5,775
1956	698	6,402
1957	624	6,629
1958	557	6,649

Recuperative holidays

Holidays were provided for 868 patients comprising 72 children under school age, 349 schoolchildren, 11 expectant and nursing mothers and 436 other adults. These figures include twelve cases in which the holidays were arranged to prevent physical or mental breakdown.

Home help service

This service continues to expand year by year and help was again given up to the limit of available workers. The recruitment of home helps continued throughout the year and the organisers are continually faced with the problem of selecting the applicants in most urgent need of help and spreading the help as widely as possible. There is constant need for more workers suitable and willing to attend tuberculous households. During the year help was given to 4,213 cases.

Problem families and help for children

The divisional co-ordinating committee concerned with the special needs of problem families has considered 22 new cases and reviewed 57 cases. The specially trained home helps are continuing to make a valuable contribution to the work of holding together families in danger of breaking up. Two social case workers appointed in the previous autumn for intensive work with selected problem families developed their work during the year. In most cases an improvement in the homes of the families referred to them

has resulted and deterioration has been arrested in others, but further experience is necessary, particularly in the more difficult cases, before the permanence of these results can be assessed.

Handicapped children

A physiotherapist from the London Hospital continued to attend daily to tend the physically handicapped children attending the Geffrye primary school.

Chiropody

Seventy-seven chiropody sessions are held in the division each week and a satisfactory level of attendance is maintained. A chiropody session for elderly persons is run by the Stoke Newington Old People's Welfare Committee at Woodberry Down health centre on Saturday mornings and at Barton House welfare centre on Monday mornings.

Prophylaxis

During the year 3,559 children completed a primary course of immunisation against diphtheria and 5,084 received re-inforcing injections, while 2,983 were immunised against whooping cough and 1,227 against tetanus. The number of persons vaccinated against smallpox was 3,221. The scheme for immunisation against poliomyelitis was extended during 1958 to cover a larger age range. 22,355 cases completed a course of two injections and 3,679 were given a third (booster) injection. At the end of the year 1,894 had received one injection.

During 1958 all 13-year-old schoolchildren in the division were offered B.C.G. vaccination and positive reactors to the skin test (236) were given appointments for a chest X-ray.

DIVISION 5, comprising the boroughs of Bethnal Green, Poplar, Stepney and the City of London.

Dr. G. O. Mitchell reports:

Premises

In September, 1958, the maternity and child welfare activities which had been carried on in premises at 39 Duckett Street were transferred to the Council's premises at 35 Stepney Green.

Chiropody

During the latter part of the year two additional chiropody sessions were held each week, bringing the total weekly number of chiropody sessions to six.

Quadruplets

Special arrangements were necessary to assist with the home care of quadruplets born in the East End Maternity hospital on 14 December, 1957. The mother and children were sent home in January, 1958, and since that date both home help and nursing assistance have been given. On their discharge a nurse was seconded from the hospital for four weeks day duty, while a deputy matron from one of our day nurseries carried out night duty, transferring to day duty at the end of February when it was felt that a night nurse was no longer needed. Shortly after this the family was rehoused by the Stepney Borough Council. In July it was found possible to replace the deputy matron by a staff nursery nurse. The position remained unchanged at the end of the year, when the home help was giving 18 hours' assistance weekly and the parents managing at nights and during the week-ends. The children have made steady and satisfactory progress, and were duly vaccinated against smallpox, immunised against diphtheria and whooping cough, and inoculated against poliomyelitis.

Prophylaxis

The incidence of poliomyelitis during the year was low and the routine work of immunisation against diphtheria and whooping cough continued without curtailment. The inoculation of the priority groups against poliomyelitis continued throughout the year, but the inclusion in these groups of young adults born in 1933 and later made necessary a considerable increase in activity. The good offices of the Medical Officer of Health of the Corporation of London made it possible to establish a lunch-time clinic in the Guildhall on the first three days in each week in mid-November. Evening clinics were arranged at selected centres. Wide publicity was given to these arrangements which were brought to the attention of all large firms in the division, but except in the City the response generally was disappointing. In the City arrangements were made

with 32 firms for a team to vaccinate staff on their premises, but elsewhere in the division only three firms co-operated in this way. By the end of the year 7,150 injections had been given at the Guildhall clinic, where the peak passed the 500 mark in a 2-hour session on several occasions, and 3,310 injections on the premises of City firms. These autumn activities threw considerable strain upon the divisional staff. In addition to the foregoing, about 32,500 anti-polio injections were given during the year in clinics and schools, and records were received from general practitioners in respect of nearly 8,000 such injections given by them.

Mothercraft and home-making

A special class to train selected mothers in mothercraft and home-making was started during the year at St. Katharine's Foundation, Butcher Row. A committee was set up and a leader appointed, and with the co-operation of the health visitors a small group of mothers was got together. These mothers attended the class weekly and showed sustained interest. While a slow start has been made, the field workers are convinced that there are reasonable grounds for optimism about the future of the scheme.

Health education

Talks on mothercraft were given in several schools by the health visitor or school nursing sister and a talk on ' Children's Fears ' was given by special request to a Young Wives' Club. A group of nine students on a training course for work in connection with Dr. Barnardo's Homes was shown over divisional establishments and was given two talks on the local health authority's place in the national health service and the work of the health visitor. This was their first introduction to public health work and they expressed both their interest and enjoyment.

Cookery demonstrations, by request, especially of meals for toddlers, were given during the year at 12 infant welfare centres by the London Electricity Board. Prevention of accidents in the home, particularly burns and scalds, was stressed at the same time.

Home helps

Two transportable vacuum cleaners are now used by home helps. During the year the number of households attended per 1,000 of the population was consistently the second highest among the nine divisions.

Home nursing

The number of home visits per head of population by district nurses remained highest in this division throughout the year.

DIVISION 6, comprising the boroughs of Deptford, Greenwich and Woolwich.

Dr. F. R. Waldron reports:

Smallpox, diphtheria and whooping cough

Special immunisation sessions were conducted at eight centres; in addition the service was available at a further eight infant welfare clinics to ensure that all districts were covered; an average of 15 sessions was held each week. ' Booster ' sessions were held at schools.

During the year 3,580 children under 15 completed courses of immunisation against diphtheria and 3,403 received ' booster ' doses, compared with 3,788 and 2,423 in 1957. Smallpox vaccination was carried out successfully in 2,927 cases and there were 335 re-vaccinations. The corresponding figures for 1957 were 3,144 and 450. 3,126 children were inoculated against whooping cough and 312 received reinforcing injections.

B.C.G. vaccination

The Council's central B.C.G. unit operating south of the Thames concluded in February their fourth visit to division 6 for the vaccination of 13-year-old school-children. Of the parents of the 4,365 children in the age group (4,183 in 1957) approximately 79·7 per cent. (77·8 per cent. in 1957) consented to their children taking part in the scheme.

Divisional arrangements for operating the scheme were made during the summer. It was decided that the commitment in future would be spread over the school year and in September the campaign for 1958–59 commenced. By December 31, 1,623 children had been dealt with under the new plan.

Poliomyelitis inoculations

The extension of the scheme to cover additional age and priority groups provided many administrative and clinical problems which were overcome by the enthusiastic co-operation of all concerned. The following table shows the position at the end of the year. It will be seen that it has been possible to make a start on third or booster doses. A pleasing by-product of the operation has been increased liaison with hospitals, general practitioners, factories, schools, etc.

Persons	*Born since 1942*	*Born 1933–1942*	*Other priority groups*	*Total*
No. who completed a course of two injections during the year	27,365	2,512	2,435	32,312
No. who received a third injection ..	348	3	133	484

No. who completed a course of two injections since commencement of scheme in 1956, 45,310.

Maternity and child welfare

A film illustrating the stringent tests to which Salk vaccine is subjected was shown and invitations were extended to those in the division concerned with the promotion of health.

Ante-natal clinics were held at 19 centres with an average of 25 sessions a week. Relaxation, mothercraft and parentcraft classes were held at varying intervals at seven centres.

For the fourth successive year courses of parentcraft for husbands were held at three centres, one in each borough. Evening meetings were held on the same days as the afternoon courses on mothercraft and relaxation for expectant mothers. The meetings were as popular and successful as before and attracted considerable attention through the press and television services. Chest X-ray examinations were arranged during the year for expectant mothers.

Over 50 separate or combined infant welfare and toddlers' sessions were held weekly. A new centre was opened at Avery Hill, Woolwich. Attendances totalled 85,058; the corresponding figure for 1957 was 84,490. The total number of children born during 1958 to mothers resident in the area was 4,531 compared with 4,320 during 1957.

Plumstead Housewives' Club

A club sponsored by the Woolwich Council of Social Service started in April and met weekly at the Garland Road welfare centre. Activities include cookery, dress-making demonstrations, talks and films; the Divisional Health Committee authorised a grant to assist towards expenses.

Preventive mental health

In October a group of health visitors and doctors under the leadership of a child psychiatrist started meeting one evening each week. It is hoped that discussions may lead to the gaining of insight as to factors bearing on problems in this field.

The Divisional Health Committee sponsored the showing of six films bearing on this and the question of Mental Health generally. The meetings were well attended by members of the staff of Council departments and voluntary bodies, doctors, heads of schools, almoners, etc. and useful discussions took place.

Backward children

The special welfare clinic for mentally retarded children under five years of age, at which parents are able to discuss their special difficulties with a doctor experienced both in this field and that of maternity and child welfare was continued. Mothers attended with their children by appointment.

Child-minders

The number of statutorily and voluntarily registered child-minders at 31 December, 1958, was 98, compared with 100 at 31 December, 1957. Approximately 250 children were minded each week-day.

Voluntary workers

About ten voluntary workers assisted each week at various infant welfare sessions; I am most pleased to acknowledge their generous service.

Charlton and Blackheath district nursing association, the Nursing Sisters of St. John the Divine, Ranyard Nurses and Woolwich and Plumstead nursing association continued to render valuable service, the work of the latter association being particularly helpful in that part of the division lying north of the river. District nursing

National welfare foods were distributed at 95 sessions every week at 28 establishments throughout the division. Arrangements were made for sales on the new Abbey Wood Estate. The Women's Voluntary Services conducted 18 sessions weekly at their own centres; their assistance was greatly appreciated. Welfare foods

The distribution figures were:

National dried milk (tins)	*Cod liver oil (bottles)*	*Orange juice (bottles)*	*Vitamin A and D (tablets)*
64,899	13,984	151,248	14,310

Shortage of chiropodists and other restrictions on the service limited its scope but some homebound old people and invalids in need are treated with the assistance of the Council's ambulance service and special arrangements with the British Red Cross Society and Woolwich Council of Social Service who help in transport problems. In addition to the Council's service there are some facilities available through local voluntary bodies and institutes. Chiropody

At foot clinics 150 sessions a week were provided and 59,475 treatments were given. A foot clinic was re-opened at Fairfield House welfare centre to provide better coverage for Greenwich.

At the end of the year 321 part-time home helps, equivalent to 155 full-time helps, were employed. The demand for help continues to increase. Five home helps attended special courses of training to fit them to assist mothers with household management, cooking and budgeting. These helps and a number of others trained earlier were successfully employed in several households. Home help service

Useful meetings were held with representatives of all services inter-related with the home help service.

The co-ordinating committee met regularly to consider policy and subjects of common concern in addition to measures to help particular families, the allocation of social case workers and of specially trained home helps. Problem families

Of the 55 families discussed, many had been referred after intermediate case conferences which were held when required at convenient locations in the division. At these conferences 56 families were discussed and all departments of the Council and the majority of other statutory and voluntary agencies in the area were involved to a greater or lesser degree. Health visitors and others are involved in day to day supervision of the large group of potential problem families, of which relatively few reach the level of the special conferences.

Two social case workers undertake intensive work with suitable families and they were fully occupied during the year. The work in this field, especially intensive case work, is particularly trying and long drawn out and great credit is due to the individual field workers whose efforts so often meet set backs but who nevertheless battle on.

In the autumn a scheme was introduced to provide fireguards on loan to necessitous elderly or handicapped persons, or householders with children under twelve, and a small number of applications was met. Fireguards

DIVISION 7, comprising the boroughs of Camberwell and Lewisham.

Dr. E. A. Mower White reports:

Maternity and child welfare

The full range of maternity and child welfare has been maintained.

Routine weighing of babies at child welfare sessions has been discouraged. Regular weighing is carried out at the first visit, and repeated after four weeks and at six months of age. Foster children and children placed for adoption are weighed at every visit. Children are weighed at other times if required. The reaction of staff and mothers to this change will be watched and the experiment will be reviewed.

Day nurseries and occasional crèches

The fall in attendances at the North Lewisham day nursery led to its closure in August and the transfer of the children to Rushey Green day nursery, where the indoor accommodation and the playground were extended by adaptations. The crèche in Camberwell was closed in May owing to insufficient use; that at Lewisham continues to be well attended.

School health service

Approval was given to the building at a small extension to the Lewisham school treatment centre to provide a dental recovery room for the two surgeries in the premises.

A new development is the provision at Queen's Road Centre, Peckham, of a child guidance unit.

The divisional treatment organiser's staff was concentrated at the divisional office, and the separate office at Lewisham was discontinued.

Prophylaxis

The number of sessions was kept under constant review and three extra vaccination sessions were held at one centre to deal with an exceptional increase in attendances owing to a local smallpox ' scare '.

Poliomyelitis vaccination sessions have been held in centres, schools and business premises. By the end of the year, 50,000 persons had had the complete primary course of two injections.

The B.C.G. inoculation of schoolchildren aged 13–14 years has continued, the work being carried out by a divisional team.

Home help service

A third home help office was opened to serve the southern part of the division.

Home safety

Among the many aspects of health education in the centre and in the home, the prevention of accidents takes a consistently important place. A valuable contribution in this field has been the scheme for providing fireguards for necessitous families, where old people or children are in danger of burns.

Co-operation

Consultation has taken place at all levels, and the value of the consultations has been reflected in the subsequent action. Of special interest was the issue of a periodical bulletin to the general practitioners in the division, dealing with matters of common interest. The demand for special nursing equipment in the home continues to grow and is met either by the division, or by arrangement with the welfare and hospital services.

Review of first ten years

As the division has completed 10 years' of life, it is interesting to note the principal changes that have occurred since its inception in 1948.

During the period, 12 new welfare centres have been opened, in rented or adapted premises, to serve new areas or to replace unsatisfactory accommodation often in church halls. Seven new school treatment centres have been started. Of the ten voluntary committees who ran centres in 1948, seven still continue. The number of day nurseries has fallen from eight (with 439 places) to six (with 294 places), and the average daily attendance from over 350 to 225. Associated with this decline in the day nurseries is an increase in child-minding from 103 children minded by 39 minders in 1948 to 329 children minded by 133 minders in 1958.

The home help service has responded to the national policy of using it as an ancillary to the other medical and hospital services for confinement cases and for chronic sick persons. The full-time equivalent number of helps employed has grown from 185 to 380, and the number of households served from 1,160 to 3,075.

Among the new activities undertaken have been the sale of government welfare foods at child welfare clinics, B.C.G. and polio vaccination, the detection of signs of mental ill-health and physical disabilities in very young children and priority dental services. Progress has been made towards the integration of the health visiting and school nursing services and, whereas in the early days the staff in these grades were divided almost equally into two self-contained groups, now, half of the full-time staff are doing combined duties.

There have been several well-marked trends since 1948. A fall in attendances at ante-natal and child welfare sessions reflects the fall in the birth-rate, but may also owe something to the increased activity of family doctors, especially during the latter part of the period, when the birth rate has somewhat rallied. In school treatment centres, although the number of new cases at vision sessions has grown by over a thousand, the number of attendances has dropped: this may be due to the use of hyoscine for the refraction of older pupils which reduces the number of attendances per child. At bathing centres the sharp fall in attendances is attributable to higher standards of cleanliness and improved cleansing methods. There has been an appreciable decline in cases and attendances at minor ailment centres, but the special investigation of pupils referred from school medical inspections has grown considerably. The most noticeable fall has been in cases and attendances at rheumatism supervisory clinics; and, although this may be partly offset by a diversion of cases to special investigation clinics or to hospital departments, it undoubtedly reflects a decrease in the overall number of cases, which in turn may be associated with the greatly increased use of ear, nose and throat sessions over the same period.

A well-defined pattern of co-operation has evolved with other branches of the National Health Services, with other local authority services and public bodies. These efforts have been made to meet the needs of special classes in the community, in the care of expectant mothers, of problem families and maladjusted children, of old persons, in the prevention and control of infectious disease, and in health education and the avoidance of accidents.

DIVISION 8, comprising the boroughs of Bermondsey, Lambeth and Southwark.

Dr. W. H. S. Wallace reports:

Maternity and child welfare

The work of the clinics has been well maintained. Attendances have been slightly more than in previous years as a result of the higher birth rate and the number of immigrants who have come from overseas, chiefly to the Brixton area of the division. Increased births have led to an increased demand for beds for hospital confinement, which has not been satisfactorily met. Many women whose homes have been unsuitable for confinement have had difficulty in booking a hospital bed in advance and arrangements for admission have had to be made through the Emergency Bed Service.

Prophylaxis

The work of inoculation of children against diseases from which protection can now be offered has been increasing. The following table shows the number of children afforded protection in 1958 compared with the number in 1957:

	Diphtheria primary	*Diphtheria booster*	*Whooping cough*	*Tetanus*	*Polio*	*B.C.G.*
1957 ..	5,607	4,074	4,837	1,903	10,797	2,608
1958 ..	5,463	5,885	4,599	2,780	30,233	3,060

The fall in the number immunised against whooping cough was due to the fact that combined immunisation against whooping cough and diphtheria had to be stopped from April to July and precedence was given to diphtheria immunisation.

There was a very substantial increase in the number receiving poliomyelitis vaccination because of the greater availability of vaccine and the increased number becoming eligible. The number receiving B.C.G. has also increased. The work of B.C.G. vaccination of 13-year-old school children was taken over by the medical officers of the division during the year.

Day nurseries

The demand for day nursery accommodation again diminished during the year. The average daily attendance at day nurseries in the division was 658, compared with 699 in 1957. Three day nurseries were closed during the year. The Fulford Street nursery was closed in February, Crossways nursery was closed in May and Gipsy Hill nursery in June.

Hostel for tuberculous men

Knight's Hill House was opened in June as a hostel for 32 homeless infective tuberculous men.

School health service

The health of the school children has been well maintained. Owing to the continued fall in the number of children suffering from either rheumatic or nutritional conditions, sessions confined to these categories ceased during the year and special investigation clinics were substituted throughout the division. These clinics deal chiefly with dietetic problems, obesity, enuresis and minor behaviour disorders.

There has been a further fall in the number of children treated for minor ailments. During the year the Cutten Memorial clinic was closed, as the numbers attending in both the minor ailments and dental departments no longer justified continuing to provide facilities so near to St. George's dispensary, where they are also available. Figures comparing attendances for minor ailments in 1957 and 1958 are shown in the following table:

	Minor Ailments	*Ear Infections*	*Eye infections*
1957	3,978	83	282
1958	3,727	50	149

The general condition of the children has much improved and it is now so rare for the first detection of social problems to be made at minor ailment sessions that treatment organisers have been withdrawn from all sessions except that at the Southwark health services department.

Co-ordinating committee

The work of the co-ordinating committee has continued actively throughout the year and 33 case conferences on problem families were called. The chief difficulty has been the shortage of housing accommodation for the large families. The South London Family Service Unit began work in the northern part of the division in September, and although not yet fully established, is already dealing with 13 problem families. Special mothercraft and home-making classes have been arranged in conjunction with the London Council of Social Service at Sutherland House and North Brixton welfare centre. These classes have been well attended and should prove of great benefit and help to prevent many families sliding into the category of problem families.

Health education

Health education has been carried on mainly by health visitors. A subject is chosen each month and posters and pamphlets dealing with it are shown at clinics, whilst lectures and demonstrations are given and a special display is put in the shop window at a sub-office in Brixton. Subjects dealt with during the year included the care of old people, smoking and lung cancer, summer clothing, mental health, feet and posture and accidents in the home.

DIVISION 9, comprising the boroughs of Wandsworth and Battersea.

Dr. J. T. R. Lewis reports :

Premises

From June the new clubroom at the Wandsworth Borough Council's Putney Vale estate was used for one child welfare session weekly.

Housing development justified the opening in November of a child welfare centre in the new clubroom at Poynders Gardens Estate, Clapham. Two infant welfare sessions are held weekly and a toddlers' session monthly.

At the request of the voluntary committee the Council assumed full responsibility from 1 August for the Putney Children's health centre which provides a comprehensive range of maternity, child welfare and school treatment services. In the past the Council has allocated certain staff thereto and has paid an annual grant towards other running costs. Thus terminated a half century of voluntary endeavour by Miss Eileen Lecky, M.B.E., and her associates in a fruitful partnership with the County Council and, in former years, with the Wandsworth Borough Council.

Maternity and child welfare

The services available at the Victoria Drive centre, were developed and now comprise infant welfare (including a special session for backward children), ante-natal, toddlers', mothercraft sessions and the following provision for schoolchildren : minor ailments treatment, special investigation clinic, ear, nose and throat clinic, physiotherapy sessions and speech therapy.

Another study group for medical and nursing staff began under the guidance of a psychiatrist. A smaller group elsewhere was revived with fresh members but under the leadership of the same psychiatrist.

In October there was introduced at St. Peter's welfare centre, Clapham, a second mothercraft class designed to meet the needs of mothers of problem families and other mothers requiring special guidance and help. Associated with this class has been an occasional crèche transferred from Fairfield welfare centre, which has proved both more successful and more useful in the new venue.

Prophylaxis

The results of an investigation by the Medical Research Council in collaboration with senior officers of the division and in other areas into the efficacy of a combined prophylactic against diphtheria and whooping cough have now been published. Approximately half of some 5,000 children were given plain whooping cough vaccine and the remainder the mixed vaccine, of which the whooping cough component was from the same batch as the plain vaccine. Children given the plain vaccine were later immunised against diphtheria with two doses of ordinary diphtheria prophylactic. The survey showed that the protective action induced by the whooping cough vaccine mixed with the diphtheria prophylactic (formol toxoid) were similar to that induced by the same whooping cough vaccine alone.

From September, in place of antigens giving protection separately against diphtheria and whooping cough, the standard in the division's welfare centres became either combined antigens (diphtheria and whooping cough) or triple antigens (diphtheria, whooping cough and tetanus).

The poliomyelitis vaccination programme concentrated on protecting school-children before the summer holidays.

The annual B.C.G. campaign for the protection of 13-year-old children against tuberculosis was carried out for the first time by teams of divisional staff.

Home help service

The continued extension of this service necessitated the separation of the division into three sub-areas instead of two.

Prevention of break-up of families

The equivalent of one and a half social caseworkers were employed on intensive work amongst problem families. After 12 months working, the wholetime officer had a case load of 16 families. The service has worked very smoothly, a notable feature

being the ready acceptance of it by other field workers who have welcomed the relief afforded by the transfer of some almost intractable cases, thus permitting them to concentrate on other work. In many instances the families aided have shown some degree of improvement.

Divisional services during 1958

(Corresponding figures for 1957 are shown in brackets)

Day nurseries

Total number of places	413 (*413*)
Number of nurseries	9, with 7 classified as training nurseries (*9*, *7*).

Child-minders

	Number	*Total places authorised*
Statutorily registered child-minders	20 (*17*)	145 (*122*)
Statutorily registered day nurseries	9 (*8*)	205 (*183*)

Recuperative holidays

405 (*473*) persons received recuperative holidays.

B.C.G. inoculation of school children carried out in autumn

1. Number of school children eligible for B.C.G. vaccination	3,798	(*4,740*)
2. Number tested	3,726	(*3,820*)
3. Number from whom results read	3,656	(*3,779*)
4. Number given B.C.G. vaccination	3,313	(*3,342*)
5. Number of positive reactors	334	(*422*)
6. Number given X-ray	320	(*403*)

Home help service

At the end of December, 1958, 2,443 (*2,240*) cases were being given service.

Poliomyelitis inoculation

Number of courses of two injections completed.

1. By L.C.C.	26,227	
2. By general practitioners	8,876	
Total	35,103	

Foot clinics

Number of attendances	5,397	(*4,008*)

APPENDIX A

REVIEW OF THE LOCAL HEALTH SERVICES

SINCE THE INCEPTION of the National Health Service in 1948 my annual reports have included detailed accounts of one or more aspects of the local health services administered by the Council. This present comprehensive review of the first ten years of the local health services is undertaken in accordance with Ministry of Health circular 22/58 and necessarily deals in rather broader outline with the development of the Council's services since 1948 and the manner in which these services have functioned within the wider setting of the National Health Service.

The services transferred from the City of London and the 28 metropolitan borough councils varied considerably in scope and much of the early work was therefore concerned with creating a comprehensive service of a uniform standard throughout London and integrated with other Council services in the field. At the same time there has been constant endeavour towards co-operation with other branches of the National Health Service in London.

While general policy is a matter for central decision, the oversight of the day to day administration of the council's health services has been delegated to Divisional Health Committees. This has enabled the general service to be adapted to local needs and to be administered by officers intimately acquainted with the localities and their special problems.

To assist in a comparison of the services provided under the National Health Service Act, 1946, in the earliest stage and now, figures for 1949 have, wherever possible, been inserted in tables appearing in the relevant sections of this report. The year 1949 has been chosen as the first complete year of service. An ambulance service was provided by the Council before 1948 and so that the full effect upon this service can be seen, figures for 1947 have been inserted in addition to those for 1949.

Following the publication of the report of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency the Council's mental health services were made the subject of a special feature in my Annual Report for 1957. This contained a comprehensive review of these services which in the circumstances have not been included in this review. Brief references to decisions and developments during 1958 and statistics for that year appear in the section beginning on page 95.

Health Centres

The situation in connection with health centres in London, together with the provision of health service premises generally in the period under review, is dealt with fully on page 47.

It is appropriate here to comment on certain developments at Woodberry Down health centre, the first purpose-built health centre to have plans approved by the Ministry of Health. Experience has shown that some of the accommodation provided has not been much used. The minor operations theatre has been discontinued and the accommodation is now used by officers of the Council's children's department. The second of the Executive Council dental surgeries has also been discontinued after a period of full-time occupancy by a health service dental surgeon, whilst the dental workshops, apart from casual use by dental surgeons on the premises, have not so far been required. A number of other services at the centre have developed in addition to the introduction of the children's services already mentioned ; the Care Committee organisation (education department) have an office on the premises and a tutorial class for maladjusted children is held in accommodation originally designed as a health service ophthalmic room. Pathological services for general practitioners practising within a two-mile radius of the centre are provided under the direction of the pathologist at a nearby hospital and are available to the medical staff of the Council at the centre.

Similarly, under the direction of the specialist in physical medicine at the same hospital, a physiotherapist treats health service patients in addition to mothers and children for the local health authority. A psychiatric social worker uses the premises for interviewing persons in need of assistance under the Council's after-care scheme. An antenatal clinic is held for expectant mothers expecting to be confined in a local hospital as well as for mothers who will be attended by one of the Council's domiciliary midwives. The Family Planning Association hold a clinic on the premises. Speech therapy sessions, which started in 1954, have now developed so that six sessions are held in each week and in the autumn of 1956 sessions commenced for the auditory training of very young deaf children.

Care of mothers and young children

In 1948 many clinics were housed in premises held on short tenancies or in requisitioned buildings, often in church halls or shops. There has been a gradual improvement in centre and day nursery accommodation (page 48) and a building up of health visiting services. Woodberry Down comprehensive health centre was completed in 1952, six new maternity and child welfare centres have been built and a further 12 opened in premises which were converted for the purpose. Some 20 voluntary organisations which had run maternity and child welfare centres with financial help from the metropolitan borough councils continued their work with financial assistance from the Council. The divisional medical officers and the Council's representatives who have been members of the voluntary committees managing these centres have integrated the work of these voluntary organisations with the other personal health services. Some voluntary hospitals also provided maternity and child welfare services by arrangement with metropolitan borough councils and as the hospital authorities no longer had powers to provide these services this work was taken over by the Council from the regional hospital boards. Teaching hospitals, however, were able to arrange for committees of medical schools to act as voluntary bodies for this purpose and in this way four hospitals have continued to provide a service, grant-aided by the Council. Altogether there are now well over 150 maternity and child welfare centres in the County.

Despite the continued shortage of health visitors, the introduction of selective visiting and the recruitment of clinic nurses, who have taken over some of the clinical duties, have enabled the percentage of first visits to babies born in the County to be maintained at around 96 per cent. during the last 10 years. 88 per cent. of all babies attend child welfare clinics in the first year of life. Breast feeding sessions have been merged almost entirely into normal child welfare clinic sessions—ultra-violet light and massage sessions have been reduced by more than half while mothercraft training sessions have been doubled. A steady flow of new health education material for use in the centres —posters, pamphlets, film strips and films—has been maintained by a committee of officers meeting regularly at County Hall. The interest of health visitors in the use of these materials has been stimulated by an annual competition of original work in the field of health education and mothercraft open to the whole of the Council's staff for which prizes are awarded for the best entries. All of the entries submitted are subsequently exhibited so that the staff have an opportunity of seeing them.

Day nurseries—The demand for day nursery places has declined. In 1949 there were 6,549 places which by 1958 had been reduced to 4,321 by the closure of a number of nurseries. Admission to day nurseries has been made according to the following scheme of priorities:

1. The first priority for admission is given equally, subject to the other rules, to the children (including adopted children) of :

(*a*) 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 ;

(*b*) parents when the mother is in ill-health and cannot care adequately for the children, or during the mother's confinement ;

(*c*) 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

(*d*) widowers or fathers when the mother has left the home.

2. The second priority for admission is given, subject to other rules, to children whose mothers are compelled to go to work as an economic necessity because the father is unemployed or his net income (i.e., his gross income less rent and an allowance of £1 for each child after the first and, at discretion, any unavoidable expenses of an exceptional kind) does not exceed £7 a week, provided that the mother is employed for at least 35 hours a week, including meal times.

3. Vacancies not required for children in the first and second priority classes are offered to other children in a third priority class whose parents are both working provided that the mother is employed for at least 35 hours a week, including meal times

4. The divisional medical officer, with the approval of the Chairman of the Divisional Health Committee, is authorised, at his discretion, to admit, in appropriate cases, the children of mothers working fewer than 35 hours.

5. The divisional medical officer has overriding discretion to admit any other cases presenting special features.

Charges for admission have risen considerably but have remained abatable according to means; 27 per cent. of children in day nurseries attended without charge in 1958. The number of children minded by voluntarily registered child minders has nearly doubled in number (from 579 in 1949 to 974 in 1959). These child minders, who are not required to register under the Nurseries and Child-Minders Regulation Act, 1948, have been paid a fee of 6s. per week for voluntary registration, and the acceptance of regular supervision by health visitors. They are required to take precautions against accidents and the spread of infection, to ensure that the child is kept clean and well fed and to take children to the Council welfare centre once a fortnight if under one year of age or once a month if older.

The number of private day nurseries and of child minders registered under the Nurseries and Child-Minders Regulation Act, 1948, has also doubled since 1949.

Marriage guidance—The Council has made financial grants for case work to the London Marriage Guidance Council, the Catholic Marriage Advisory Council and the Family Discussion Bureau, formerly a branch of the Family Welfare Association but since 1950 associated with the Department of Human Relations, Tavistock Clinic. Total grants paid to the three organisations in 1958 amounted to £6,500. The London Marriage Guidance Council holds some of its weekly counselling sessions in Council maternity and child welfare centres. Monthly talks are given to groups of engaged or newly married couples. The Catholic Marriage Advisory Council holds weekly sessions mainly at its own headquarters. The Family Discussion Bureau works in premises in central London and case workers are supported by case conferences with consultant psychiatrists from the Tavistock Clinic*

Moral Welfare Associations—The social work of Moral Welfare Associations for the care of the unmarried mother and her child is grant-aided by the Council. The amount of annual grant paid has increased from £7,200 in 1949 to £12,531 in 1958, not only to meet the increased salaries of social workers, but also because of increased demand for the services of these organisations. A number of Conferences of Moral Welfare workers with

* *A report of the research work into the value of these methods and into factors associated with marriage breakdown was published in 1955. Social Casework in Marital Problems. Tavistock Publications Ltd.*

officers of the public health, welfare and children's departments of the Council have been held at County Hall.

Mother and Baby Homes—With the exception of one mother and baby home, under the direct control of the welfare department, homes have been run by voluntary organisations which received annual deficiency grants from the Council. Expectant mothers are admitted two months before and may remain for two months after confinement. The post-natal period has, in many cases, become shorter than this following a change in public opinion which has led to girls being received back more frequently into the parental home. Demand for places in mother and baby homes has declined with increased national maternity grants and allowances despite a rise in the proportion of illegitimate live births in the County from 6·9 per cent. to 9·9 per cent. of total live births. The number of homes in the County has fallen from 24 at the beginning of 1949 to 16 at the end of 1958; in terms of accommodation provision for mothers has fallen from about 460 to 300 and for babies from 300 to 190.

The provision of adequate ante-natal care for unmarried mothers has remained a problem. Many young expectant mothers have their first real ante-natal care after admission to these homes in spite of pressure by moral welfare workers. It is difficult for the unmarried mother, booked for hospital confinement, to attend out-patient departments for ante-natal care during the day when she must be working. Because of this in some divisions ante-natal clinics for working mothers have been held in the evenings. One voluntary home has helped almost exclusively young mothers under 18 years of age. Visiting teachers have been provided for this home by the education department.

Health visitors call regularly at mother and baby homes. Mothers from some voluntary homes who intend to keep the baby may attend child welfare centres in the final weeks of their stay.

Experience in the last ten years has shown that on an average about 50 per cent. of babies from mother and baby homes are offered for adoption. Until some five years ago every effort was made by moral welfare workers to keep mother and child together at all costs, but it has become clear that this policy is not necessarily in the best interests of the baby in every case. The welfare department of the Council in 1948 opened a hostel for unmarried mothers in work. Mothers are admitted to the hostel on leaving the mother and baby home and remain there for a maximum period of 18 months, by which time it is expected that the individual mother will have overcome her difficulties. In the hostel babies are cared for by resident and non-resident staff while the mother is at work. This hostel was considerably enlarged in 1955 and now provides accommodation for 29 mothers and babies.

A second hostel run on similar lines was opened in 1953. The main difference between the two hostels has been in the care of the children. At the second hostel the mother has been expected to take her baby to a local day nursery. She has assumed at once full responsibility for her baby and has been introduced early to the pattern of living which in the future she must adopt if she is to keep the child.

In these hostels the mother has the opportunity to try out her own strength and will to face the hardships which a decision to bring up her child herself must entail.

There is little doubt that improved maternity benefits, together with a change in public opinion, have reduced the demand for accommodation for first cases. The problem of the care of mother in her second or subsequent pregnancy yet remains to be tackled realistically by those voluntary organisations which undertake the residential care of the unmarried mother and her child.

So far the day-to-day services for the care of mothers and young children have been discussed. A number of special problems have also received attention and are discussed below.

(*a*) *Problem families*—In 1955 a survey was carried out to estimate the number of problem families in London, which was reported in my annual report of 1956 and in the

medical press. The percentage incidence of problem families in the nine divisions ranged from 0·52 to 2·28 per cent. of all families with a child or children under five.

A disproportionate amount of the time of health visitors as well as of many other care workers, both statutory and voluntary, was being taken up by socially handicapped families. Their tendency to gravitate to the poorer housing areas has produced a gross disproportion in the case load of individual health visitors—for as the survey has shown, as many as 30 such families may live in the area of one health visitor while only one or two, or perhaps none, may live in the area of another. The situation presented an administrative problem which has not been easy to solve. The introduction of the practice of grouping health visitors in teams, each team serving an area, has helped to a limited extent to spread the case load. In addition, the Council in 1957 decided to appoint for an experimental period four full-time and two part-time social case workers in the public health department to work with problem families in three divisions of the county. These social case workers are the key workers in the field work concerning certain problem families selected by the divisional co-ordinating committees. The function of these case workers is not necessarily to replace other statutory or voluntary workers who may be concerned, but to co-operate with them and to know and consider any major proposals that may affect the family. In the light of experience gained similar appointments will be made in all divisions in the near future.

Family Service Units have carried out their invaluable work in several parts of the County, namely, Kensington and Paddington ; Islington, Finsbury and Holborn ; Stepney, Poplar and Bethnal Green ; Southwark and the northern parts of Lambeth and Bermondsey. In 1956 the Council provided a training course of two weeks for selected home helps who were willing to undertake such arduous duties with problem families under the direction of the health visitor.

Problem family mothers with their children under five years of age have been sent for periods of two months to rehabilitation homes. From 1951 to 1954, 23 families were sent to Spofforth Hall, or the Brentwood or Mayflower homes. The results obtained have on the whole been disappointing for, in spite of constant support on their return by health visitors and other social workers, many families tended to slip back quickly. This has happened more especially if the father himself is unstable, if housing conditions are intolerable, or if another pregnancy increases the stress on the family. The inevitable, if temporary, break-up of the family was often in itself an adverse factor. The mother, with or without reason, tended to become anxious about the use her husband might make of his new-found freedom or the husband became intolerant of his wife's absence. It became clear if families were to be sent away from their own environment that they must be carefully selected for this purpose.

(*b*) *Mental health*—Child psychiatrists in the child guidance clinics set up to deal with the maladjusted school child have pointed out that some emotional disturbances might have been prevented or minimised had the case been seen earlier. A study group, under the chairmanship of Dr. J. Bowlby of the Tavistock Clinic, was formed in 1953 to consider how mental health work might be brought into the maternity and child welfare field. The group's conclusions were published in my annual report for 1954 and in the medical press. The Council accepted their recommendation that case conferences of medical officers and health visitors with a child psychiatrist and psychiatric social worker would provide a training for maternity and child welfare staff and at the same time give an indirect service to mothers and children. Case conference groups were formed in a number of divisions and are being continued. The relationship which has arisen between maternity and child welfare and child guidance staffs has proved of great value to both services. On the one hand, there is a better insight into mental health problems which manifest themselves in the abnormal behaviour of young children; on the other, psychiatrists have been brought into constant touch with behaviour problems of more children younger than those normally brought to the child guidance centre. It is possible that the original view of the study group that a succession of medical officers

and health visitors would become trained to a point where they would no longer need to work with the support of a child psychiatrist, may need to be modified and a continuous service through permanent case conferences may take its place.

(*c*) *Early diagnosis of congenital deafness*—Medical officers working in child welfare clinics see 88 per cent. of infants born in the County (page 142 above), and thus have a unique opportunity to screen babies for congenital handicaps. This is perhaps peculiarly true of congenital deafness. In 1957 Mr. J. C. Ballantyne, F.R.C.S., consultant otologist to the Council, and Dr. Mary Sheridan, M.D., D.C.H., medical officer, Ministry of Health, were invited to train medical officers in screening tests of the hearing of young children. Some 30 medical officers have attended these courses and by the end of 1959 it is expected that all medical officers in the Council's service will have had the opportunity of studying these techniques. The importance of the standardisation of tests has not been overlooked. Every maternity and child welfare centre has been equipped with the ' Stycar ' testing set designed by Dr. Sheridan. Medical officers have been asked to train health visitors not only to refer babies known to be at risk but also to help to carry out screening tests at the centre. All cases of suspected deafness are being referred to the divisional otologist or to Mr. Ballantyne. The youngest child for whom a hearing aid and auditory training have so far been prescribed was four months of age.

In the 10 years under review the infant mortality rate in the County has fallen from 31 per 1,000 in 1948 to 23 per 1,000 in 1958. This figure compares favourably with the national figure of 26 per 1,000. Much work however remains to be done. The application of the newly discovered tests for errors of metabolism may help us to tackle the problem of hereditary and familial diseases. Screening tests for the early diagnosis of congenital handicaps are being developed to meet the needs of the handicapped child under two years of age. In the field of preventive mental health only the first steps have been taken. Peri-natal mortality remains a challenge.

Domiciliary midwifery

The domiciliary midwifery 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 Council had employed salaried midwives since 1938 and had entered into agreements with hospitals and district nursing associations to continue district practice. This structure of the service has been maintained through the last ten years and remains centrally administered.

In 1949 there were 16,090 home confinements—5,573 more than in 1958. The number reached its lowest level in 1955. The decline in the general birth rate up to and including 1955 relieved the pressure on hospital beds and the proportion of domiciliary confinements fell, staff being reduced accordingly: from 1956 onwards the birth rate has risen but although there has been an absolute increase in domiciliary confinements these still represent a smaller proportion of total births. In 1949 the Council's 140 directly employed midwives carried a case-load of 58. In 1957, in spite of new responsibilities in ante-natal care 87 midwives carried a case-load of 71. The lower case-load in 1949 is perhaps explained by the fact that the Council's policy then was to offer an alternative choice of midwife to each mother so that Council midwives practised in the same areas as midwives employed in district nursing associations and hospital districts. Shortage of woman power now makes this policy impracticable

Ante-natal services

The main changes brought about by the Act have been the closer integration of the domiciliary midwifery services with the maternity and child welfare, home help and other health services; with the general practitioner service through the maternity medical services and with the hospital maternity and paediatric units. All midwives, including most of those employed in District Nursing Associations, now do their ante-natal work in the centres. There are the obvious advantages of the better facilities than could be provided formerly in the home of the midwife and the fact that the midwife is brought

into constant contact with her colleagues, the clinic doctor and the health visitor, in a way almost impossible prior to 1948. A progressive programme of mother-craft and health education has thereby been developed on a team basis. Varied exhibits, posters and demonstrations are provided by health visitors to stimulate the interest of expectant mothers. Health education for individual mothers as well as group teaching with modern visual aids are given, in which doctor, midwife and health visitor each take their share. All midwives have attended courses in relaxation for expectant mothers, including relaxation by suggestion. Classes are arranged by midwife, health visitor or physiotherapist according to convenience in any particular centre.

Inhalation analgesia

Mothers can be taught in the ante-natal clinic to accept without apprehension, inhalational analgesia which all midwives offer to the mother having her baby at home. In 1948 only gas and air was available and the Minnitt apparatus was carried by the ambulance service to the home on the request of the midwife. 63 per cent. of mothers confined at home had inhalational analgesia in 1949. By 1958 this figure had reached 88 per cent. which is probably near the maximum acceptance rate for the county as a whole, as there will always be mothers who do not want it or whose delivery is too rapid for it to be given. In 1954 the Central Midwives Board permitted midwives to administer Trilene on their own responsibility. The midwives, some of whom had taken part in the trials, were sent for training. By 1957 all midwives were provided with approved inhalers. Their use had a striking effect on the ambulance service whose mileage run by vehicles for this purpose was reduced from 50,000 miles in 1949 to approximately 3,000 miles in 1958. Gas and air, however, is still available and the choice of analgesia is left to the clinical judgment of the midwife. In 1958, 17 per cent. of mothers confined at home had gas and air and 71 per cent. had Trilene. The use of analgesia by inhalation and the introduction of legislation in 1953 to permit midwives to order pethedine have given to the mother having her baby at home the same possibilities for the relief of pain which are given to the mother in hospital.

Blood testing, etc.

Routine medical examinations are made by the clinic doctor unless a booked doctor is giving ante-natal care himself. Measures are taken for the early recognition of toxaemia through weight records and blood pressure readings. The full range of blood tests are given, the Rhesus factor determined and tests for antibodies are carried out in appropriate cases. In most parts of the County cord blood is taken for Coomb's tests from all babies born at home of Rhesus-negative mothers.

Maternity medical services

The integration of 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 has progressed steadily. Regular consultations are held with the London Local Medical Committee and there have been full discussions on new proposals to promote better co-operation in the interests of the patient. In 1948 a regional obstetric committee was set up in each of the Metropolitan Regional Hospital Board areas and in 1950 the Medical Officer of Health became the Chairman of the combined London Obstetric Committee.

The increasing co-operation between doctors and midwives can perhaps be best illustrated by a comparison of the number of midwives' patients for whom a doctor was booked in 1949 with the figures for 1958.

	1949			*1958*		
	Not booked for M.M.S.	*Booked for M.M.S*		*Not booked for M.M.S*	*Booked for M.M.S*	
L.C.C. midwives	7,831	749	8·7%	3,100	3,101	50%
D.N.A. midwives	2,581	285	9·9%	1,652	571	25·7%
Hospital district midwives ..	4,532	112	2·4%	1,716	369	17·7%

The increase in maternity medical services is reflected in the decline in medical aid fees paid by the Council from £15,829 in 1949 to £7,739 in 1958.

A number of general practitioners have always been employed sessionally in the Council's ante-natal clinics but the peculiar structure of general practice in London makes it necessary often to place a doctor in a clinic out of his area, thereby defeating the objective of continuity of care of the mother in pregnancy and labour, which is attained in other parts of the country.

General practitioners giving maternity medical services are able to use clinic facilities for tests and for health education, whether the mother has her intermediate ante-natal care at the centre or not. Since 1948 arrangements have been made for the interchange of records between the general practitioner and midwife at booking and at the 36th week of pregnancy. It became clear, however, that these arrangements did not cover all contingencies and a personal ante-natal record card to be carried by the mother herself was introduced in 1958. This card, designed to give full details of pregnancy, is available at each visit to doctor or midwife and serves as an appointment card for the patient. Through its use the midwife can be given more readily an opportunity to participate fully in the ante-natal care while working under the guidance of the general practitioner. In addition 13 midwives regularly attend ante-natal sessions in the surgeries of general practitioners.

By the end of 1958 all midwives were trained in the use of intra-gastric oxygen for the resuscitation of new born babies and each midwife now carries the apparatus with her. This has already proved a valuable measure as the work of resuscitation can be begun at once before the arrival of the doctor. The attention of midwives has been directed to the syndrome of neo-natal cold injury and its predisposing causes ; low reading clinical thermometers and room thermometers are provided as part of standard equipment.

The acceptance rate of post-natal examinations by mothers has not yet reached a satisfactory level. In 1948 separate sessions were held for post-natal examinations, but gradually these sessions have been merged with ante-natal work. By 1955 combined clinics had been established throughout the County, and in home confinements the responsibility for securing the attendance of the mother and the follow-up of the defaulter has been laid on the midwife.

Co-operation with hospital services

Co-operation between the domiciliary midwifery and hospital services is most dramatically represented by the work of the Emergency Obstetric Units. Since 1938, when University College Hospital established the first unit, eleven other hospitals then under the control of the Council had also given this assistance, transport being provided by the ambulance service. When the National Health Service came into operation the service continued unchanged and in 1955 two other units were added. Only the name was changed as the use of the term ' flying squad ' provoked confusion with calls for the police. The Emergency Obstetric Unit is called out by midwives in an emergency without waiting for medical aid. The Units have given aid not only in cases of haemorrhage or obstetric shock but also for malpresentations, uterine inertia and, occasionally, for resuscitation of the baby.

The hospital service provides six premature baby units in addition to many beds for babies in paediatric wards. Midwives are advised to transfer their cases to hospital if possible, when it seems likely that the baby will be born prematurely. All multiple births, if diagnosed during pregnancy, are referred to hospital for delivery. About 500 premature births occur annually at home. There is a working rule that babies born at home weighing less than 4 lbs. should be transferred to a premature baby unit. A nurse and special cot are brought to the home by the ambulance service or in less urgent cases the midwife takes the baby in a heated cot by ambulance. In 1948, premature baby sets, containing everything required to nurse a baby in the home, were available in the divisions on loan. Experience has shown that with the increasing use of hospital facilities the demand for these packs is declining rapidly.

Home visits are made by health visitors or midwives, at the request of maternity hospitals to patients seeking a maternity bed on social grounds. There has been a varying practice among obstetricians in seeking the co-operation of the Council. This lack of uniformity of practice has created a serious problem especially in the north-west area of the County where there is a large community of immigrant peoples. Despite the fact that the provision of maternity beds in London is one of the highest in the country—over 80 per cent.—it has proved very difficult to book maternity beds in that area for women who require beds on social grounds or on grounds of age and parity if they apply after the 20th week of pregnancy. Attempts are made at the Council's clinics to book beds for these women in advance. When it becomes apparent that a booking is unlikely to be obtained a letter is sent to the family doctor asking him to arrange admission through the Emergency Bed Service when labour starts. If the general practitioner does not agree the patient is referred to a general practitioner obstetrician. If he also is unable to make the arrangements the domiciliary midwife must take this responsibility. This procedure, which has been adopted of necessity in the last few years, can only be regarded as an unsatisfactory improvisation. The patient is left in a state of anxiety and uncertainty and an unnecessary burden is placed on doctors and midwives. Delay in admission is inevitable, as a bed has to be found and the mother must be visited by a doctor or midwife before the Emergency Bed Service can act. If maternity hospitals have no area responsibility—and no provision is made for this in the recommendations of the Cranbrook Committee—it is difficult to see how the obstetrician can arrive at a decision that all priority cases have been booked and a ' first come, first served ' policy applied. Arrangements that have been in operation since 1951, for the allocation of a certain number of beds to the Council's clinics each month, have broken down in the peak season for births. No difficulty has been experienced in obtaining the admission to hospital of any patient showing early signs of toxaemia or one who has any other obstetric or medical grounds for admission. This seems to indicate that the provision of ante-natal beds in London is adequate. Since the meetings of the professional representatives of the three parts of the national health service on ante-natal care relating to toxaemia of pregnancy in 1956, health visitors make home visits on request by maternity hospitals to non-attenders at hospital ante-natal clinics.

Ten teaching hospitals and two hospitals of the regional hospital boards still undertake district midwifery practice under agreements with the Council. The Royal Free hospital and the Elizabeth Garrett Anderson hospital discontinued in 1952 and 1956 respectively. The Royal Northern Hospital Maternity Nursing Association's work was transferred in 1954 to the Council's domiciliary midwifery service. Charing Cross hospital have sent medical students to district cases with midwives of the Metropolitan District Nursing Association since 1953. There has, however, been a marked fall in the number of confinements attended in the home by the hospitals from 4,644 in 1949 to 2,085 in 1958. A decline in domiciliary midwifery has of course been the general picture in the last ten years but loss of cases on district must present a serious problem to those responsible for the training of medical students. Although the number of cases dealt with by hospital district midwives has declined during the decade reviewed, the proportion of such cases booked with general practitioners for maternity medical services has risen from 2·4 per cent. to 17·7 per cent.—a three fold increase in numbers. A few hospitals, particularly those with an exclusive area of practice, have accepted in principle that if the hospital is to act as the agent of the Council in providing midwives and maternity nurses to meet the needs of the area, they must take calls from doctors giving maternity medical services. Most hospitals with district practice, however, have not agreed to do so and coverage of the area has had to be made through midwives of district nursing associations or the Council's midwives. This procedure necessarily reduces the number of cases available to hospitals on their districts.

The Council provides facilities for the district training of Part II midwifery pupils **Staff**

through its domiciliary midwifery service. The majority of pupils reside with the midwife during district training, but a few remain resident at their Part II training home.

Non-medical supervisors of midwifery attend, in turn, refresher courses for teachers arranged by the Royal College of Midwives and the Association of non-medical supervisors. Midwives have attended residential courses arranged by the College since 1948. In addition until 1957, the Council in conjunction with the County Councils of Middlesex and Surrey held annual courses at the County Hall for all midwives who notified their intention to practise. The Council has continued these lecture demonstration courses for midwives in its own area.

The general shortage of midwives has not seriously affected the staffing of the domiciliary service. Since 1948 accommodation has been offered to midwives and more encouragement has been given them in the past few years to accept such accommodation in order to give more elasticity to the service, as areas have now more frequently to be changed owing to the decline in home confinements. A small district home was opened in 1954 in North Islington in Council property staffed by a superintendent midwife and four midwives with four pupil midwives. This has proved a most useful venture as it gives newly qualified midwives experience in running district practice under supervision before taking over an area of their own. A mileage allowance has always been paid to midwives using their own cars. Some form of motorised transport for all midwives is becoming more necessary because of the increasing load of equipment which midwives must carry. The Council is helping to meet this need by the introduction in 1958 of a loan scheme.

Dental services

The coming into force of the National Health Service Act in 1948 brought about the transference of the Council's quite substantial maternity and child welfare dental service (in hospitals) to the regional hospital boards. By the same Act the Council absorbed the various dental services formerly run by the metropolitan borough councils a proportion of which was for maternity and child welfare patients. The equivalent of six whole-time dental officers on maternity and child welfare work was taken over.

The service given was about one eleventh of the then total dental effort (school service and maternity and child welfare service) and, on the advice and with the agreement of the two Ministries concerned, this proportion has been maintained to date. Direct demand to the Council for treatment is met and it is known that, in addition, a number of mothers seek treatment from general dental service sources, or elsewhere.

Health visiting

It has been the Council's policy to expand the functions of health visitors to cover the whole range of duties envisaged in section 24 of the Act. Apart from the national shortage of health visitors, development was handicapped by the statutory separation in London, until 5 July, 1948, of the health visiting and school nursing services. This resulted in the Council having in the service a large number of school nursing sisters, who, lacking the qualification specified in the National Health Service (Qualification of Health Visitors and Tuberculosis Visitors) Regulations, 1948, could not play their part in the health visiting service. Since the Handicapped Pupils and School Health Service Regulations, 1945, which required school nursing sisters to possess the health visitor's certificate, came into force, efforts have been made to encourage existing school nursing sisters to secure the qualification. Special intensive courses were arranged with the approval of the Ministry and leave without pay granted in approved cases to those wishing to take other courses of training to qualify as health visitors. The majority of the school nursing sisters, however, were unable to secure the qualification as they are not accepted, because of age, for the normal training courses.

Considerable progress has, nevertheless, been made in integrating the health visiting and school nursing services and in extending the function of health visitors to cover the care and welfare of the family as a whole and the process continues. Shortage of staff has been met by redeployment, to ensure that the health visitor is able to use her special skills to the greatest advantage, while selective visiting has enabled her to allocate more time

to the families most in need of the help and support which she can give. Group working has enabled problems to be shared, language and religious difficulties to be met more easily and has provided continuity of staff during sickness and leave.

For over fifty years most of the home visiting and medical follow-up of children attending the Council's schools has been undertaken by voluntary children's care committee workers, trained and organised by social workers employed by the education and public health departments. A continuing aim is the association of the health visitor with the voluntary worker in the care of the school child.

Besides increased co-operation between health visitor, general practitioner and voluntary and statutory organisations serving the family there have been experiments in integrating the preventive and curative services. As there are only some 400 health visitors and over 2,200 general practitioners the amount of effective help is necessarily limited. Co-operation is very fruitful in dealing with medico-social problems of families when difficulties have not come singly and in some districts it has been possible to allocate health visitors to work with general practitioners in group practices and with specialists at paediatric hospital clinics.

In addition to meeting the growing demand for teaching in child welfare centres and schools, health visitors assist in Day Colleges, Polytechnics and Institutes at training courses and refresher courses for nursery matrons, nursery nurses, wardens and house mothers and in school pre-nursing courses.

Home nursing

History

Home nursing in London before 1948 was provided by 32 voluntary nursing associations. Twenty associations were affiliated to the Queen's Institute of District Nursing ; the Ranyard Nursing Association covered a large area in south London with affiliated associations in Roehampton and Stoke Newington ; the Nursing Sisters of St. John the Divine provided district midwifery and general nursing services in Deptford and Poplar and the Catholic Nursing Institute did general nursing in Lambeth. In addition, several very small associations worked in London and in the neighbouring counties of Kent, Essex and Surrey.

Finance

When the Council became responsible for home nursing in 1948, the district nursing associations continued, but as agents for the Council, which made grants-in-aid based on 90 per cent. of their approved expenditure. The Central Council for District Nursing in London continued to act as a liaison and advisory body to the district associations and distributed the Council's grant to the associations. The Catholic Nursing Institute, however, remained outside the arrangement, and received instead a direct grant based on the number of people nursed annually. The grant to the district nursing associations was increased to 92 per cent. of approved expenditure in 1952 and to 93 per cent. in 1954. The total annual grant increased from £168,371 in 1948 to £485,000 in 1958. In addition, an *ex-gratia* payment of £12,000 was made to the Central Council for District Nursing in 1958 to help reduce the accumulated deficits of the associations which had experienced increasing difficulty in raising the seven per cent. of their expenditure which remained for them to find from voluntary sources.

Organisation

The Silvertown and North Woolwich District Nursing Association closed in 1955 because the work was insufficient for the maintenance of an economical service in this industrialized part of the county, cut off as it is entirely by the river and by the County Borough of West Ham from the rest of the administrative county lying south and west of it. District nursing for North Woolwich was taken over by the Woolwich and Plumstead District Nursing Association which operates south of the river, and the County Borough of West Ham undertook district midwifery on an agency basis.

Co-operation between the home nursing service and other local health authority services has been promoted at all levels. Divisional medical officers have been members of voluntary committees of district nursing associations and divisional home nursing voluntary committees. In the field, direct contact between health visitors and district nurses has been encouraged and informal meetings, talks and demonstrations are held.

The nursing work has increased steadily throughout the past ten years, from 44,000 patients treated in 1949 to 62,000 in 1958. It is not unreasonable to assume that many of these additional patients might otherwise have had to be admitted to hospital. The character of the treatments given has undergone considerable change with the increasing use of antibiotics, of mercurial diuretics for cardiac cases and the tendency to get patients out of bed much earlier. This is reflected in an increase in the average case-load of the nurse from 16-17 in 1949 to 24 in 1958. During 1958 the number of visits to give insulin to elderly diabetic patients was substantially reduced by the introduction of oral therapy.

In 1949 52 per cent. of all patients treated by the home nursing service were over 60 years of age. This large proportion of elderly patients has tended to increase during the last ten years. 75 per cent. of all patients are referred by general practitioners.

Staff

There is among all nurses a natural desire to live in homes of their own. This preference has increased very much in the last ten years ; in 1948, except for the Ranyard nurses, almost all district nurses lived in homes provided by the associations. In 1958 only 70 out of some 550 nurses were willing to do so, in addition to 67 midwives and pupil midwives. Some district homes have closed, e.g., Charlton, Stoke Newington and Shoreditch, and have been replaced by district rooms and offices, and others are running half empty. This trend is likely to continue in spite of considerable capital grants paid by the Council for rebuilding or structural improvement of district homes.

The total number of nurses employed, excluding students, has increased from 307 whole-time and 103 part-time nurses in 1949 to 451 whole-time and 88 part-time in 1958. The employment of state-enrolled assistant nurses has relieved the district nurse of some of her more routine duties, but a few organizations have shown reluctance to use them. Male nurses have proved their worth and have become indispensable in most parts of the county.

The bicycle is still the form of transport most widely used by district nurses in London, but motor scooters are coming into greater use. Mileage allowance for these vehicles is paid on demand. In 1952 the Council provided cars on loan to associations doing midwifery, and has since extended the provision to most of the district nursing associations for supervisory duties as well as for transport of Minnitt apparatus and midwifery duties. The Council licenses, insures, and maintains the cars, but running costs are paid by the associations and rank as approved expenditure. Nurses may be permitted to use privately owned cars for district duties, but a mileage allowance is paid only when circumstances warrant, and this applies principally in the case of male nurses who cover particularly wide areas.

Lighter nursing bags were introduced in 1952 and these replaced existing bags as necessary.

In 1955 one of the non-medical supervisors of midwives was appointed to undertake certain advisory and liaison duties in connection with the home nursing service for an experimental period of one year. The appointment proved most valuable to the Council, the Central Council, and the nursing associations, and has been continued.

Training and refresher courses

In the same year the Council, which had recognized as approved expenditure the fees paid by associations for nurses to attend residential refresher courses, decided to offer all district nurses the opportunity of attending a non-residential refresher course every five years. The Council itself organised the first non-resident course of two days' duration, and has since extended such courses to five days. Non-resident courses organized by the Queen's Institute of District Nursing, Ranyard Nurses, and the Royal College of Nursing are also attended by district nurses. Student nurses from hospitals visit district homes and obtain district experience with home nursing staff.

The training of district nurses is undertaken by Ranyard Nurses and by some district nursing associations approved for the purpose by the Queen's Institute.

A four-year course of nurse training, which includes syllabuses of the General Nursing Council for general registration, part I of the C.M.B., health visitor course, and district nurse training, was begun at Hammersmith Hospital Post-graduate Medical School and Battersea College of Technology in association with the South London Hospital for Women. The results of this integrated scheme of nurse training are awaited with great interest.

Loan equipment

A loan equipment service, which is a useful adjunct to the district nursing service, has been provided by the medical loan depots of the British Red Cross Society, who receive a block grant from the Council. District nursing associations also make similar provision for their own patients. It has, however, become increasingly difficult for the associations to provide, store, and maintain the large and expensive equipment which has been coming increasingly into use during the last few years. Since 1953 the Council has taken upon itself the responsibility for providing lifting apparatus, wheel chairs, beds, and other large items of equipment.

Home help

The Council's scheme (under section 29 of the National Health Service Act) provided *inter alia* for the continuation of the former borough service but for organisation on a divisional basis to secure a greater measure of uniformity and to facilitate extension and development where necessary (and for the recovery of charges assessed according to means for services provided).

The position before the 5th July, 1948, was that all the metropolitan boroughs (but not the City of London) operated home help schemes for maternity cases and that all the boroughs (except one) and the City had schemes for assisting sick and infirm persons. The extent of the provision varied widely from borough to borough—in all 7,389 cases were attended in 1947 and at the end of that year 826 home helps were employed. Section 29 somewhat amended the category of household to which help could be given making it turn on the presence " of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age. . . . "

The Council's scheme having been agreed, there was, as can be seen from the table on page 70, a rapid increase in numbers of home helps and cases assisted.

After a year's experience of the service the Health Committee agreed to the following order of priority for dealing with applications for home help:

(i) confinement cases ;
(ii) acute or chronic illness ;
(iii) aged and infirm, and the blind ;
(iv) households with a mental defective, or large families of children not over school age.

The distribution of service has remained fairly constant. The aged and chronic sick constitute 75 to 80 per cent. of the patients receiving home help ; 4 to 6 per cent. are maternity cases; 3 or 4 per cent. are tuberculous; and the remainder miscellaneous.

Extension of the service

There have been four extensions of the service.

(i) *Night helps*—introduced in 1953 (after an amendment to the scheme) provided for the chronic sick in their own home so that relatives can get one or two nights' undisturbed sleep a week. Demand has been small, possibly because it is supplementary to voluntary assistance.

(ii) *Child helps*—also introduced in 1953—provided for children in their own homes who are temporarily deprived of both parents and have no other adult to care for them. Again demand has been small but the service may render it unnecessary to receive children into care.

(iii) *Morning and evening helps*—introduced in 1954—provided for children who have to be cared for in the day time, hours being adjusted to parents' hours of work, day nursery and school hours.

(iv) *Problem families*—introduced in 1956—provided by specially trained home helps for families in danger of breaking up—the home helps teach the rudiments of housekeeping to the mothers of such families in an attempt to keep the home together and prevent the children coming into care: 118 of the helps are now trained.

Organisation

The service was reviewed by a working party in 1957 and a number of improvements in procedure and organisation resulted. In 1958 there were 31 home help districts in the nine divisions staffed by an organiser, one or more assistant organisers and clerks, together with varying numbers of home helps : the latter work an average of 25 hours a week and provide an average of 4 hours service weekly for each case.

Immunisation and vaccination

A detailed review of the first ten years of the immunisation and vaccination services provided under section 26 of the National Health Service Act appeared in my report for 1957 (page 64). During 1958 the only new developments were in poliomyelitis vaccination. Arrangements were made for giving a third dose of poliomyelitis vaccine to those who had received two doses more than seven months previously. The age range of those eligible for this vaccine was also extended to include adolescents and young adults born in the years 1933 to 1942.

London ambulance service

There was a large and immediate increase in requests for ambulance transport on the introduction of the National Health Service in July, 1948, and demands rose steadily during the remainder of that year so that by the end of 1948 the number of patients removed daily was 35 per cent. more than at the beginning of the year. During the last decade there have been continuing and substantial increases in demand year by year (table (i), page 83) and in 1958 the service as a whole (including the services of the Hospital Car Service and the Joint Committee of the Order of St. John of Jerusalem and British Red Cross Society, with whom agreements were made to provide supplementary and agency services from the 'appointed day') dealt with 1,096,586 sick removals and responded to 99,188 emergency calls.

Out-patients attending hospital departments and clinics are by far the most numerous users of the service and their demands accounted for over 80 per cent. of the whole. It seems unlikely that this category of patient will diminish in numbers in future years and, taking into account the various schemes now in hand for the re-building or extension of hospitals within the London area, the policy of the Ministry of Health to encourage out-patient as distinct from in-patient treatment by the provision of day hospitals and the increasing average age of the population, it is not unreasonable to forecast a continuing increase in the volume of out-patient treatments in the future.

The growth in the demand on the accident section, while not so dramatic as that on the general section, has nevertheless shown a steady annual expansion since 1948 and the number of emergency calls received in 1958 reached a record level about 60 per cent. above that for 1947.

A measure of the results of the efforts made to cope with these annual increases in the volume of work is indicated in table (iii), page 85. However, in spite of increasing efficiency in the deployment of men and vehicles to meet the growing demand, it became apparent by the end of 1958 that some additional resources of men and vehicles would be required to prevent any deterioration in the standard of service in terms of delays in the transport of non-priority patients. The growing volume of out-patient transport and the increasing number of patients in the priority groups, e.g., urgent illness, specialist and consultant appointments, radio-therapy treatments, removals by

ambulance-train-ambulance, etc., have resulted in delays to less urgent cases and during 1958 four per cent. of the journeys undertaken by the general section of the service were delayed for over an hour because of the pressure of total demand and the over-riding need to deal promptly with urgent removals. Hospital authorities, realising the heavy and fluctuating demand upon the ambulance service, have been most co-operative in accepting some delay in the conveyance of non-priority patients as being sometimes inevitable. It is nevertheless disturbing that delays on this scale should occur to the inconvenience and distress of patients and the disruption of hospital appointment systems. The Council has accordingly authorised an expansion of the fleet by ten ambulances and an extension of the radio-telephony control system,

General section—For every 100 patients transported by the general section of the service in 1947, 531 were removed in 1958. Of the 966,877 patients conveyed in 1958, 810,867 (84 per cent.) were out-patients taken to and from hospitals, 148,213 (15 per cent.) were admitted to or discharged from hospitals and the remaining 7,797 (1 per cent.) were transported on other journeys.

The task of coping with the annual increases in the volume of work since 1948 has called for careful planning to ensure the fullest use of available resources. During the past ten years the average mileage per patient carried by the general section of the service has been reduced from 7·74 to 4·12, the average mileage per journey from 10·05 to 8·25 and wasted journeys from 4·2 per cent. to 1·9 per cent.

The existence of many specialist hospitals in the London area has meant that a considerable number of orders are received from other local health authorities for patients to be met at railway termini and conveyed to these hospitals and it is estimated that about 24,000 patients are now being taken by ambulances to and from the eleven main London railway stations each year.

Accident section—The work of this section is fully surveyed on page 74. Since 1948 the average daily number of patients conveyed and journeys without patients as a result of emergency calls received has risen from 185 to 280, and the following table compares the daily average number of emergency calls received in 1948 with similar figures for 1958 :

	1948	*1958*
Street accidents	26	53
Other accidents	32	54
Urgent illness in public places, etc.	30	57
Maternity removals	63	75
Assaults and attempted suicides ..	5	14
Miscellaneous emergencies ..	18	6
Ambulances not required	11	21

The general public were responsible for 69 per cent. of all emergency calls received in 1958 as compared with 63 per cent. in 1948.

Consultations were held in 1955 with the metropolitan regional hospital boards and with certain teaching hospitals and police and fire services to formulate schemes for dealing with major accidents. Some features of these schemes were subsequently modified and improved in the light of the experience gained on the occasion of the railway disaster at Lewisham in December, 1957.

Relationship with other services

(*a*) *Hospitals*—A close liaison has been developed since 1948 with the London hospitals' staffs at medical, administrative and operative levels. Efforts have been directed in particular towards ensuring that transport is not ordered unnecessarily, that routine reviews are made at frequent intervals of all patients receiving regular transport, that wasted journeys are reduced to a minimum and that there is a quick release of ambulances from hospitals. Hospital staffs have responded well and it is encouraging to note (table iii, page 85) that during the last ten years the percentage of wasted

journeys has been reduced by more than half and that delays of ambulances at hospitals of over half an hour's duration have been reduced from 2,996 in 1953 to 283 in 1958.

An immediate effect of the National Health Service was a large increase in orders for transport. Some measure of decentralisation was necessary and in consequence arrangements were introduced for certain hospitals to place their orders directly with the appropriate general ambulance station instead of centrally. This system was extended year by year and called for a high degree of co-operation between the hospital authorities and the ambulance service. At the end of 1949, some 30 hospitals had been brought within the ambit of these arrangements and steps had also been taken at 14 of these hospitals to station ambulances there during day-time for the purpose of conveying out-patients to and fro under the direction of hospital transport officers. By the end of 1958 the number of hospitals and clinics decentralised to local general ambulance stations had risen to 100 and at about 60 of the larger hospitals some 80-90 vehicles and crews were stationed daily to work directly under the instructions of the hospital transport officers.

(*b*) *General medical practitioners*—Many emergency calls are received at headquarters in circumstances where it is clear that what is required is not an ambulance but medical attention for a person ill at home. In such a case the caller is advised to call in the patient's own doctor or is given particulars of other general practitioners in the locality.

(*c*) *Other ambulance authorities*—The Council has fostered co-operation with other ambulance authorities and a number of reciprocal arrangements, both operational and financial, have been made in the interests of mutual economy and efficiency.

Agreements on standard charges were reached with sixteen neighbouring authorities for work done by one authority on behalf of another in the conveyance of patients between the various county areas and, to avoid unnecessary clerical and accounting work, the settlement of financial claims and counter claims between London and Middlesex, Surrey and Kent, is effected on a basis of compounded payments.

To reduce as much as possible the period before the arrival of an ambulance, arrangements were made in 1948 with all neighbouring local ambulance authorities for emergency calls near the common boundary to be answered by the nearest available ambulance and crew, irrespective of whether or not the parent ambulance station is controlled by the authority in whose area the incident has occurred. During 1958 no fewer than 1,014 emergency calls were dealt with under these arrangements.

The special facilities provided by the Council for the removal of patients suffering from smallpox or typhus and for the conveyance of consultants in emergency to examine patients suffering or suspected to be suffering from these diseases have now been made available to seven county councils and four county borough councils.

When long road journeys are made, the practice has been developed of notifying the distant authorities as a routine so that use can be made of vehicles which would otherwise be returning empty.

(*d*) *Agency services*—Valuable supplementary work has been done on behalf of the Council since the inception of the National Health Service by the Hospital Car Service and by the Ambulance Department of the Joint Committee of the Order of St. John of Jerusalem and British Red Cross Society; the former undertakes the conveyance, by motor cars manned by volunteer drivers, of patients who do not need an ambulance but who are unable to travel by ordinary means of public transport and the latter deal primarily with the removal of patients by ambulance from places within the county to places outside the county. Details of the work done by these agencies are shown in table (i), page 83. In 1949 these two organisations transported 117,224 patients ; the corresponding figure in 1958 was 129,709.

Close co-operation between the Hospital Car Service and the directly provided service was achieved soon after the inauguration of the National Health Service by

providing accommodation for the area officers of the Hospital Car Service at the general ambulance stations, thus establishing direct liaison with the superintendents at those stations. With a view to integrating the two services still more closely and utilizing their combined resources with greater efficiency and less duplication of effort, all requests for transport since 1 October, 1957, have been made, in the first instance, through the Council's own control organisation.

Vehicles—By 1948 many of the Council's ambulance vehicles had been in use for many years, since replacement during the war was not practicable. About 40 per cent. of the fleet of vehicles was under repair at any one time. The purchase of replacements was an urgent necessity and during the four years 1948-51, 291 new vehicles were brought into commission.

Replacement programmes authorised by the Council in recent years have had regard to the increasing demand for the conveyance of out-patients and the consequent need for a higher proportion of vehicles capable of being used for the dual purpose of accommodating either patients able to walk and sit or those who are recumbent.

The following gives a comparison of the vehicle strength at the end of 1948 and that at the end of 1958 and shows the types of vehicle in service:

	1948	*1958*
Large ambulances	260	230*
Dual purpose vehicles (i.e., single stretcher/sitting-case ambulances)	—	70
Sitting-case cars	33	31
Ambulance buses	20	6
Tenders	2	2
	315	339

* 25 adaptable for sitting-cases.

During 1956-58 a prototype ambulance body was designed, in conjunction with a modified commercial vehicle chassis, and produced in the mechanical works division of the Council's supplies department to the special requirements of the London Ambulance Service. Ambulances of this type will serve as a replacement for those purchased in 1949 and subsequent years as they reach the end of their economic life (further details are available on page 80).

Radio-telephony—A pilot scheme of radio-telephony control was introduced in 1956 by equipping six ambulances and a staff car for two-way radio communication and by installing at headquarters control apparatus connected by land line with a main transmitter at Hampstead. Even this limited experiment showed that radio control offered scope for improvement in the co-ordination, deployment and flexibility of the resources of the service, that it was essential as a means of controlling operations at a major incident with maximum efficiency, and that it enabled a much closer liaison to be established between crews and Headquarters. In 1958 the Council authorised an extension of the system to include up to a maximum of 41 radio controlled vehicles and during the year the opportunity was taken also to equip 20 vehicles at the North Western general ambulance station with radio in addition to supplementing the radio network of the accident section.

Premises—The Council's approved proposals for carrying out its functions as an ambulance authority under the National Health Service Act, 1946, contemplated the building of three new accident ambulance stations at Hampstead, Mottingham and Wandsworth; the building of a permanent ambulance station to replace a temporary structure in West Smithfield; the transfer of Headquarters station from temporary premises in Lambeth Palace Road to permanent premises; the re-accommodation of the Brook general ambulance station, which was housed in temporary premises following enemy action; and the extension and improvement of the Eastern, South Eastern, Brook

and South Western general ambulance stations to provide for additional staff and vehicles. With the exception of the extension and improvement of the South Eastern ambulance station, which were authorised to commence in 1959, these proposals were implemented between 1948 and 1956 (further details are given on page 50).

Apart from the foregoing projects, which formed part of the Council's development programme, other works of improvement have been carried out since 1956 and further schemes have been formulated and approved for early completion as follows :

Dalston accident ambulance station—improvement of the staff accommodation.

Fulham accident ambulance station—reinstatement of war damage.

Kingsland Road accident ambulance station—widening of the entrance.

Streatham Accident ambulance station—provision of additional covered accommodation for ambulances.

(The foregoing works were completed during 1957 and 1958.)

Battersea accident ambulance station—replacement of a temporary building which had served until 1956 when the station was closed.

Eastern general ambulance station—provision of additional covered space for vehicles.

North Western general ambulance station—provision of a new entrance and reinstatement of war damage.

South Eastern general ambulance station—provision of additional sanitary accommodation and the re-allocation of accommodation.

Western general ambulance station—provision of improved office accommodation for clerical staff and improved mess-room accommodation for operative staff.

Western general ambulance station—provision of additional vehicle washing space.

North Western ambulance station—erection of soundproof compartment for radio operations.

Brook general ambulance station—re-allocation of accommodation.

Fulham accident ambulance station—provision of new petrol pump and tank.

Headquarters—provision of additional storage and office accommodation and improvements to stores hoist arrangements.

(The above schemes were approved for commencement or completion during 1959.)

Tuberculosis

The Council became responsible as a local health authority for services for the prevention of tuberculosis and the care and after-care of tuberculous persons. Most of these services had previously been included in the Council's comprehensive scheme for the diagnosis and treatment of tuberculosis but some had been performed by the metropolitan borough councils with grant aid from the Council and the Ministry of Health.

Chest clinics—Although responsibility for the diagnostic and treatment services passed to the hospital authorities on 5 July, 1948, the close link which existed between this work and the preventive, care and after-care services, mainly through the 31 tuberculosis dispensaries (later renamed ' chest clinics '), was maintained.

The Council rents from the hospital management committees accommodation at the chest clinics for its own staff, i.e., tuberculosis visitors, tuberculosis care organisers and their clerks and, in some cases, handicraft instructors and it reimburses the Metropolitan Regional Hospital Boards three-elevenths of the salaries paid to the chest physicians to cover work done for the local health authority.

Contacts—A scheme in operation for over 20 years, whereby the Council arranges for the boarding-out of children to protect them from infection by tuberculosis in their own homes or to enable their parents to undertake treatment in hospital, was continued. The Invalid Children's Aid Association, acting as the Council's agents, places the children with suitable foster parents or in private nurseries. The scheme has been

widened to meet the occasional need to segregate children from infectious homes during B.C.G. vaccination.

The average number of children boarded-out at any one time rose from 257 in 1948 to a peak of 500 (including 14 for B.C.G. segregation) in 1953 since when it has fallen annually to a figure of 120 (including 4 for B.C.G. segregation) in 1958.

Strenuous efforts are made to find some alternative form of care for these child contacts, e.g., use of a Council day nursery, child minder or home help service, before resorting to boarding away from home.

B.C.G. vaccination—The most important development in the Council's services in the preventive field was a B.C.G. vaccination scheme for children of consenting parents initiated:

(*a*) in September, 1950, for susceptible (tuberculin negative) contacts of *known* tuberculous patients ; vaccinations are carried out by the chest physicians and 31,155 contacts had been vaccinated by the end of 1958,

(*b*) in 1953 for diabetic children in the Council's schools. 68 children had been given B.C.G. vaccination by the end of 1958, and

(*c*) in June, 1954, for tuberculin negative 13-year-old children attending London schools; these vaccinations are carried out in the schools by the Council's own medical officers; 91,746 children had been vaccinated by the end of 1958.

The 14 per cent. of children tuberculin tested and found to be reactors have been mass X-rayed and among these 1·2 per cent. have revealed active lung lesions meriting treatment or close surveillance. In schools showing an abnormally high tuberculin reactor rate among the children special X-ray examination of adult staff members has been pressed.

Mass X-ray—The mass radiography units provide facilities for the examination on entry and periodic examination of the Council's staff working with children, and of staff and senior pupils at its occupation centres for mentally handicapped persons.

Special epidemiological investigations are undertaken on contacts at schools, nurseries, welfare department homes and other establishments of the Council involving children and adults whenever a case of tuberculosis is ascertained in an adult working there.

Home care—In addition to assisting the chest physicians with clinic work the Council's tuberculosis visitors see patients in their homes to advise on diet, hygiene, etc., to ascertain home conditions and needs and to persuade contacts to attend the clinic. The total number of visits in 1958 was 78,953. Home nurses are provided under the domiciliary nursing service to give patients nursing attention under the direction of the family doctor or chest physician, and nursing equipment, e.g., back rests, bedpans etc., is made available on loan where necessary. 368 patients were receiving attention by home nurses at the end of 1958. Patients unable to make their own way to the local chest clinic for consultation or treatment are conveyed by ambulance or sitting-case car provided through the Council's ambulance service.

Home helps are employed in the homes of bed-fast patients and to care for children of mothers undergoing treatment. 467 patients were receiving this service at the end of 1958. Extra nourishment (milk, butter, eggs) is provided for necessitous patients on the recommendation of chest physicians and patients are also helped to obtain extra nourishment by the voluntary care committees. The total number of patients receiving extra nourishment at the end of 1958 was 1,875.

Hostels—Another important development has been the establishment of hostels for homeless infective tuberculous men who have completed hospital treatment and who, if a hostel were not available, would live in lodging houses where they might be an infective risk to other residents. Details of these hostels, the first of which was opened in 1951, are given on page 51.

At the end of 1958, 103 men were in residence in three London hostels and in accommodation provided at the British Legion Village, Preston Hall, Maidstone, Kent. Most of the residents are middle-aged or elderly men severely handicapped by their tuberculous disease, often complicated by some other disabling condition (e.g., arthritis, diabetes, amputation, bronchitis, gastric ulcer, amyloidosis): of 284 residents, who between them spent 387 periods in hostel accommodation from 1951 to the end of 1958, 157 (55 per cent.) were aged 45 to 64 years on the date of admission and 61 (21 per cent.) were aged 65 years or over.

Instruction is given in handicrafts to those residents who can be interested in such activities and they receive profits on the sale of articles completed. Residents who are fit to do so take on jobs at the hostels during times of staff shortage and receive payment of up to 5s. a ' task ' for such work.

Industrial rehabilitation—Selected patients recommended by chest physicians are sent to village settlements where they undergo courses of instruction in work suited to their capacity and temperament. The Council has agreed with the regional hospital boards that a patient comes within the Council's after-care scheme for rehabilitation when he is fit to work at the settlement for five hours a day. Maintenance charges then become the Council's financial responsibility until the patient returns home or becomes a settler.

The number of patients at these settlements for whom the Council was financially responsible at the end of 1948 was 31. The number rose to 80 (76 men, four women) at the end of 1954 and fell to 56 (men) at the end of 1958.

The disablement resettlement officers of the Ministry of Labour try to place in suitable employment registered disabled patients unable to return to their former employment. Where necessary training is arranged at a Government or other recognised training centre, sometimes after preliminary assessment at a Ministry of Labour industrial rehabilitation unit.

Diversional therapy—Diversional therapy classes, mostly organised by the voluntary tuberculosis care committees, are held at many chest clinics for patients able to travel. The instructors are provided and paid by the education department as part of the Council's evening institute teaching arrangements.

A service for home-bound patients, started experimentally in 1953 in north west London, was extended in 1955 to other parts of London where the need for such a service was apparent. In the last week of December, 1958, 262 patients were receiving instruction in their own homes from the Council's occupational therapists.

Among the crafts in which patients are instructed are basketry, book-binding, dressmaking, leather work, rug and toy making, and weaving. The finished articles are purchased by the patients or their relatives or friends or disposed of at market stalls or annual sales of work. The articles are, of course, disinfected before display for sale.

Voluntary care committees—A voluntary tuberculosis care committee operates in association with most of the chest clinics under a constitution, prescribed by the Council, which includes representation of the metropolitan borough councils and other bodies interested in the welfare of tuberculous persons and their families. The Council's tuberculosis care organiser usually acts as secretary to the care committee.

These committees help patients with money or other benefits not available to them from official sources. Their funds are obtained from voluntary contributions, sales of work, Christmas seal sales, Council grants from Sunday cinema profits, etc.

Prevention of illness : care and after care

Foot clinics—The Council has continued to operate the 26 foot clinics established by some of the metropolitan borough councils before 5 July, 1948. The demand for foot treatment continues to be unsatisfied and applications were made to the Minister of

Health on three occasions for approval to an expansion of the service. The Minister was unable, on financial grounds, to agree to the opening of any new clinics but in 1956 agreed to a more even geographical distribution throughout the County of existing sessions provided that attendance at the re-allocated sessions was restricted to expectant mothers and to elderly persons. Particulars of new cases and attendances are shown in the table on page 89.

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. For infirm, aged and housebound patients unable to reach a clinic in any other way, transport has been provided.

In some divisions it has been possible, by grouping chiropodists into larger units so that three or four work simultaneously at one session, to make it economical to provide clerical assistance to relieve the chiropodists of clerical work.

Recuperative holidays—The demand for recuperative holidays for adults, mothers and children, and unaccompanied children has declined since 1950. Doctors in child welfare centres and general practitioners who, together, have made the majority of recommendations, no longer refer very young children, especially those under two years of age, for recuperative holidays unless the circumstances are quite exceptional. This has been one major factor in the fall in demand for places. The services of the Invalid Children's Aid Association have not been used for placing unaccompanied children since 1953. The Women's Voluntary Service, who in 1948 had a holiday home at Aldeburgh where children with non-tuberculous chest infections had holidays up to three months, were compelled because of rising costs to offer ordinary recuperative holidays from 1949 to 1958, when the home closed altogether. Many parties of children from 8-15 years of age under the care of an organiser and his staff, have been given a fortnight's holiday at a private hotel on the Kent coast. This scheme was transferred in 1958 to Cambridge House, Bognor Regis, run entirely by the Council. Children from 3-8 years have been placed at Roland House, Littlehampton, which the Council has also acquired as a recuperative holiday home.

Risk of infection among babies has always been a problem in placing mothers with very young children. The risk has been minimised by the use of private accommodation obtained through advertisements in the press inviting householders to take one or a maximum of two mothers with young children for a recuperative holiday. All applicants are visited by a medical officer of the department and minimum requirements for facilities for making bottle feeds and for napkin washing have been made.

Venereal disease—Arrangements initiated during the second world war for the tracing of contacts and the following-up of defaulting patients have been continued under section 28 of the National Health Service Act, 1946. Welfare officers undertake the tracing of contacts of patients, details of whom have been provided by hospitals, medical services of the British, Commonwealth and United States Armed Forces, and local health authorities, and assist clinics in case of difficulty in following-up patients who have defaulted.

One female welfare officer works part-time at St. Paul's hospital following-up defaulters from the clinic and part-time on the tracing of contacts. Visiting of male contacts or defaulters is undertaken by one of the Council's male public health inspectors.

In 1950, at the request of the Prison Commissioners, the part-time services of a female welfare officer were made available for attendance at the clinic at Holloway Prison and for following-up contacts and prisoners on discharge. In 1952 the appointment was made full-time. Despite the many difficulties encountered, good results continue to be achieved in overcoming the reluctance of prisoners to attend out-patient clinics on discharge or, where necessary, to complete treatment in hospitals. 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 Probationer Officers and other social workers engaged in this field.

In April, 1958, at the request of the Governors of St. Mary's hospital, a full-time female welfare officer was appointed to attend the clinic and to follow-up defaulters and contacts. Good results in securing attendance at the clinic have been obtained.

Health education—Over the past ten years there has been a considerable development in health education. Its most important single constituent during the whole of this period has certainly been the direct approach made to individual members of the public by the staff of the department in the course of their duties and, of course, the health visitor in this respect, as in so many others, is the mainspring of activity. Reference has already been made elsewhere in this review to her activities and to the support that she receives by the provision of health education material suitable to the occasion.

Some general and a number of particular aspects of health education should be considered.

As part of its proposals under section 28 of the National Health Service Act, 1946, the Council submitted a proposal to develop " a comprehensive educational programme in physical and mental health " and to seek the co-operation of the borough councils and to utilise the services of the Central Council for Health Education and other appropriate bodies.

In furtherance of this objective, in 1952 the existing arrangements for health education were reviewed and, concurrently, working parties studied educational activities in maternity and child welfare centres and the prevention of accidents in the home.

The review indicated that the metropolitan borough councils concentrated on propaganda in connection with the services remaining under their control and the Council on the personal health services. It was recognised that the most efficacious approach was through informal talks and discussions by the health visitor and that the expansion of activities in the welfare centres should receive every encouragement. It was decided that a concentrated annual campaign should be carried out in an endeavour to bring home to Londoners the need to prevent the heavy toll of health and life caused by accidents in the home.

Advisory panel

Questions of policy in this field have always been decided by the Health Committee of the Council. In 1954 a health education advisory panel was set up inside the department which represents the main professional points of view, both central and divisional, and which for some two years, because of the very great importance of health education in schools, has had the assistance of the head of a large secondary modern school. The panel sits regularly and the principal medical officers responsible respectively for school health and maternity and child care act as chairman and vice-chairman. Other persons inside and outside the Council's service are invited to join its deliberations as appropriate. A small committee of field workers under the chairmanship of a senior nursing officer, who is also a member of the advisory panel, acts as a permanent health education working team.

Divisional medical officers are responsible for the day to day arrangements for health education in their own divisions. A very wide selection of subjects are covered and there were in 1958 3,499 educational sessions in welfare centres with attendances of 40,597 as against 1,601 and 21,779 in 1949.

Annual campaigns

Centrally organised county-wide campaigns to encourage diphtheria immunisation have been held annually throughout the whole of the period and generally they have been followed by an increase in the acceptances for primary inoculations. It is considered essential to keep this important matter before the public.

The prevention of accidents in the home has formed the subject of a similar campaign which has been held in the autumn of each year since 1954. It is appreciated that a considerable and well sustained effort in this field will be necessary before any obvious improvement is likely.

The home safety campaigns, which take the form of ' Safety in the Home ' week held in the autumn of the year at a time when people are, because of the onset of winter, spending more time indoors, has gradually become accepted over a much wider area than London and has assumed a national aspect. This has been due to a very large extent to the efforts of the Royal Society for the Prevention of Accidents.

Campaigns are widely supported and, in addition to the co-operation of the metropolitan boroughs which has been forthcoming on a generous scale as the Council's proposals forecast, the press, both local and national, hospital authorities, general practitioners, voluntary organisations, cinema exhibitors and a large number of business and commercial organisations in the administrative County have shown a marked willingness to assist. In 1957 the Councils of the metropolitan boroughs received co-extensive powers with the Council in this important field.

Since May, 1956, the scheme for vaccination against poliomyelitis with its periodical extension to new age groups has necessitated continuous efforts by way of press releases and advertisements, posters and leaflets to keep the public informed and persuade them to submit themselves for vaccination. The means used are described elsewhere in this annual report.

Exhibitions

The Council has always been very willing to take part in exhibitions and throughout this period it has joined in a large number promoted by metropolitan borough councils and other organisations as opportunities occurred. It has departed from this practice in connection with home safety. In 1957, in association with the Royal Society for the Prevention of Accidents, a ' Danger at Home ' exhibition was presented at Charing Cross underground railway station as a focus for the home safety campaign of that year, and in 1958 a ' Guard that Fire ' exhibition was presented at County Hall at which the Home Secretary took the opportunity of launching his nation-wide campaign. Generally, however, the Council is satisfied that its policy of taking part in exhibitions as the opportunity arises rather than itself promoting large exhibitions specially for health education purposes is the right one.

Displays in welfare centres, at divisional offices and similar establishments throughout London are a regular health education feature. These are arranged by nursing staff and form part of divisional programmes initiated, except in the case of diphtheria immunisation and home safety, by divisional medical officers at their discretion. Generally divisional programmes deal with one subject throughout the whole division for a period of four weeks at a time.

A portable exhibition, which could be used as a comprehensive whole while being capable of use in sections in premises of various sizes, has been carefully considered but the disadvantages involved have indicated that it is better to augment the central pool of material available for divisional use. This has the added advantage that it does nothing to discourage initiative locally.

Health education material

The Council's policy generally is to make use of material available from official and voluntary sources rather than provide its own pamphlets, posters, etc. It has, however, departed from this practice recently in a number of cases. It has had a short film made dealing with B.C.G. vaccination which has been exhibited widely in London cinemas and is still being used, and two film strips dealing with the school health service and vaccination. Its own officers have made a film strip dealing with the development of the senses in the young and it has provided a pamphlet for school leavers in the form of a guide to health which gives prominence to the causal connection between smoking and cancer of the lung.

Facilities have been given for the distribution of a home safety handbook published by an independent firm of publishers : a separate edition was prepared for each metropolitan borough which, in addition to home and other safety material, gave full details of the Council's health and other services in the locality.

Cancer education, particularly cancer of the lung with its connection with excessive smoking, has received increasing attention in the last five years. Full consultation has

taken place with representatives of the medical authorities concerned and it was considered that it could best be dealt with in the general context of health education. As a result, the leaflet for school leavers already mentioned has been prepared and a set of notes was provided for the use of staff of the department as a basis for talks, etc. By the end of 1958, when a number of other projects were under consideration, the general attitude appeared to have changed to one favouring some aspects of specific cancer education.

A handbook has been prepared and is issued to general practitioners in London, social workers and to other persons who need to have a comprehensive reference to the Council's health services. It consists of a section giving general information about the centrally and divisionally organised services which are common to the whole of London with an appendix, giving details of actual clinics, etc., for each of the nine administrative divisions.

Opportunities are taken of obtaining general publicity by putting out releases to the press on subjects which it is thought likely will prove of interest and which should be brought widely to the notice of the London public. Releases dealing with the business transacted are sent to the editors of newspapers circulating in their locality following the meeting of divisional health committees.

In-service training

A suggested series of one day training courses for nursing staff on home accidents has not been pursued, because it has been necessary to give in-service training a broader basis as the time that can be given to any one aspect is limited. In-service training has been arranged over the whole period of review to assist health department staff in their health education assignments. Some courses have been organised and carried out by the Council's staff and others have been provided with outside assistance. Over the last five years a large number of courses have been run by the Central Council for Health Education on a wide variety of subjects under its in-service training programme for local authorities. The Medical Director and his colleagues have held courses centrally and at divisional establishments, benefiting considerably the staff who have attended. Members of the medical, nursing and lay staff have also been sent to conferences, seminars and summer schools promoted by voluntary organisations concerned with the various aspects of health education.

There has been an increase both in the scope of health education generally and in those aspects requiring special attention. Whilst much has been done to meet the situation, it is faced by a number of problems of particular difficulty which will continue to claim the attention and tax the ingenuity of the staff concerned.

Invalid Meals for London—With the approval of the Minister of Health the Council since 1950 has made an annual grant to the Invalid Meals for London, a voluntary organisation providing meals for invalids and sick people in the whole or part of 14 of the metropolitan boroughs. The meals, which are supplied only on the production of a medical certificate, are served at dining rooms attached to the five kitchens or delivered by motor van to the homes of patients unable to attend. (See page 41 for details of service provided in 1958.)

School health service

The administrative changes brought about by the National Health Service had little effect on the school health service except that, in the early days after July, 1948, as result of the offer of services free of charge formerly paid for by the patient, there was for example delay in the provision of glasses for school children.

Section 48 of the Education Act, 1944, placed upon the education authority the duty of ensuring that a fully comprehensive *free* medical treatment service was available for school pupils. Treatment was available not only at school treatment centres but at the Council's wide range of hospitals and at the large number of voluntary hospitals, clinics and dispensaries which had contractual arrangements with the Council. Thus for over three years before the National Health Service Act came into operation hearing aids,

artificial limbs and appliances, spectacles, dentures, insulin, convalescence, etc., had all been available free and without delay, through the school health service.

After July, 1948 a number of specialist services which the Council had itself been providing became the responsibility of the hospital authorities. The Ministry of Education in circular 179 suggested that the regional hospital boards should plan future organisation and development of specialist services for school pupils in consultation and agreement with local education authorities. The four metropolitan regional hospital boards were concerned in these consultations with the Council as were a large number of boards of governors of teaching hospitals. Considering the expansion of the specialist services generally since 1948 remarkably little restriction of the expansion of the specialist services for school children has been encountered and in the field of child guidance co-operation with the hospital authorities has been notably successful.

The effect of the National Health Service on priority dental services for the school child has been difficult to estimate. There has undoubtedly been a reduction by about one-third in the dental treatment provided by the Council, but against this must be set the availability of free dentistry provided under Part IV of the Act. The extent to which general dental practitioners treat school children is difficult to estimate.

The basis of the school health service—systematic medical inspection—has continued unimpaired ; and thanks to the various social worker services, including the voluntary care workers, defects discovered by the school doctor are in general followed up to ensure that suitable treatment is obtained. It must be pointed out, however, that owing to the multiplicity of authorities now providing that treatment the task of ensuring the health of the school child is a good deal more complex than it was before July, 1948.

APPENDIX B

THE ASCERTAINMENT, CARE, EDUCATION AND TRAINING OF EDUCABLE MENTALLY HANDICAPPED CHILDREN

Introduction

THE EARLIEST statutory recognition of mental deficiency as a separate mental disability from mental illness was in the Idiots Act of 1886 which differentiated between 'idiots and imbeciles' and 'lunatics', as the mentally ill were then called, made provision for the reception of the former into hospitals etc., licensed by the Commissioners in Lunacy (The Board of Control) and required that suitable registers be kept, and notices of admission, discharge and death be sent to the Commissioners.

Section 24 of the Lunacy Act, 1890, gave power for 'lunatics', which by definition still included idiots, to be kept in workhouses in special circumstances. In London some mentally defective children were accordingly placed in the institutions, legally workhouses, provided by the Metropolitan Asylums Board.

In 1911 the Metropolitan Asylums (Mentally Defective Persons) Order, 1911 provided that persons under 21 years of age who were not certified as lunatics but were incapable of receiving proper benefit or training in schools, protecting themselves from injury, improper usage or treatment, or of maintaining themselves by work, could be admitted to a workhouse for care. A disadvantage of the Order was that young persons admitted under it (in London, generally to Darenth training colony, one of the institutions mentioned above) remained there indefinitely, in many cases without subsequent re-examination to determine whether they should be discharged. Systematic reconsideration of these cases was not undertaken until after the Local Government Act, 1929, had transferred these institutions to the control of the Council.

The Order, intended to provide for care and protection for low grade and obviously ineducable persons, did not contemplate anything in the nature of education or training.

Following the recommendation of a Royal Commission* the London School Board, which had strongly urged the setting up of the Commission and had already formed a statistical committee to deal with problems, decided in 1891 to provide special centres for the training of physically and mentally afflicted children who could not be taught in ordinary schools or by ordinary methods and combined centres were set up for this purpose in the following year. This was the first step towards the provision of regular schooling for mentally defective children. School activities typical of this period are illustrated opposite page 174.

Provision of special schools

The Elementary Education (Defective and Epileptic Children) Act, 1899 empowered school boards to maintain special schools for mentally and physically defective children from the age of 7 to 16 years and laid down, where this was done, that medical officers should certify the children. In 1914 the provision of education for mentally defective children became mandatory.†

The Mental Deficiency Act, 1913, which came into operation in the following year, dealt comprehensively with all classes of mentally defective persons. Grades of mental defect were defined and one of the grounds for dealing with a child under the Act was that a child was over seven years of age and had been notified by the education authority as incapable of benefiting from education in a special class or school or who could not be so educated without detriment to the other children. Those about to leave special schools could be notified as requiring care or supervision after leaving school where the education authority considered that this would be to their benefit.

**Report of the Royal Commission on the Blind, the Deaf, the Dumb etc., of the United Kingdom, 1889.*

†Elementary Education (Defective and Epileptic Children) Act, 1914.

The Education Act, 1921

The Education Act, 1921, was passed shortly after the end of the first world war and was the first statute to deal comprehensively with the whole field of public education for children, including arrangements for the education of mentally defective children as an integral part of its provision.

The Act required local education authorities to make arrangements to ascertain which children between the ages of 5 and 14 years were, by reason of mental defect, incapable of profiting from education in any ordinary school and to provide compulsory special education in a special school for those between the age of 7 and 16 mentally capable of receiving it. In these early days the problem confronting the school medical officer was confined almost entirely to satisfying the education authority as to the backward child's position having regard to these requirements and, additionally, whether his behaviour was detrimental to the children with whom he associated in school. Once the school medical officer had certified that a child was mentally defective it was the local education authority's duty to arrange admission to a special school for the mentally defective for so long as this was appropriate.

Referral

Headteachers referred children for investigation for special education almost entirely upon their ability to progress by ordinary means of education and little notice was taken of emotional maladjustment as a possible cause. Although obvious mental defectiveness of low grade was noted before compulsory school age, unless the parent desired custodial action, full investigation was deferred even in such cases until the time came for admission to school when it was dealt with when educability was determined. It was usual to arrange admission to an infant school and to leave it to the headmistress to refer the child for ascertainment if she felt that he was mentally unable to benefit from normal education. Severely defective children, whose admission to school was obviously undesirable, were referred direct; generally by the education officer but also by other persons.

Preliminary action

Once a child was referred the school medical officer had to obtain family and early history. In London, a child already at school was referred direct by the headmistress to the school medical officer whose duty it was to make certain that no physical or social condition existed to prevent normal development and initiate action to remedy any such condition. This pre-statutory examination was valuable in discovering conditions that could be remedied, thus often obviating unnecessary mental examination and anxiety on the part of parents concerned about their child's mental condition.

If the preliminary examination disclosed no physical abnormality or if after correction of abnormality no improvement in educational progress resulted the school medical officer recommended a statutory medical examination.

A Board of Education form (41D) completed by the headteacher provided a detailed report for the use of the examining medical officer on the educational and social career of the child, his ability and aptitudes and his home life so far as known, with a factual record of school attendance. Where the child did not attend school a social worker visited the home and reported. Any other medical records in existence were made available.

Ascertainment

Statutory medical examination was carried out under section 55 by medical officers of the local authority specially approved for the purpose by the Board (later Ministry) of Education, to determine whether or not the child was certifiable as a mental defective and incapable of receiving education in an ordinary school and if so to certify him as such. These medical officers accordingly became known as 'certifying officers'. The Council's school medical service was divided into five areas staffed by a number of 'certifying officers' according to population. Each area had a 'special education section' which was responsible for statutory examinations, staffed by medical officers who had specialised in mental deficiency practice. These were generally held at the special school to which the child would go if certified as in need of special education, thus the experience of the headteacher in dealing with defective children and their

parents was available and the parents were able to see something of the school and the children attending it.

The training of the certifying officer for approval by the Board of Education was left to the various local authorities and in London courses of lectures, demonstrations and observation classes were held at regular intervals by the senior medical officer in charge of mental deficiency work throughout the County. Other authorities arranged for some of their medical staff to attend these courses and many such doctors attended the training and refresher courses and demonstrations given yearly by the Council's specialist medical staff.

A simple notification to the parent was sufficient notice to bring the child for examination under penalty of a fine if he failed to do so without good reason. There was no obligation to allow the parent to be present, although certifying officers were reluctant to exclude parents, and a standard form of record was only compulsory when cases had to be referred to the Board of Education. This form provided for a comprehensive medical picture but was designed to indicate the presence or absence of signs or characteristics of mental deficiency; only under a heading 'temperamental condition' was any information required which today would indicate emotional maladjustment or juvenile psychosis.

The I.Q. in diagnosis

The main diagnostic point was the estimate of intelligence as shown by the intelligence quotient estimated by the Binet Simon system and, later, the Stamford and London revisions. Unless strong complicating or alternative conditions appeared, an I.Q. above 70 indicated retention in an ordinary elementary school, below 70 but above 50 education in a special M.D. school, below 50 reference to the local mental deficiency authority as ineducable. Because the minimum age for attending at a special school was seven years, children put forward for examination between five and seven years and unsuitable for retention at an ordinary elementary school were invalided until their seventh birthday and then re-examined. Psychometric testing at this time is shown opposite page 174.

A difficulty arose because a child, mentally defective for the purpose of the Education Act, 1921, on the grounds of low I.Q. and inability to absorb education, might also be regarded as 'feeble-minded' within the meaning of the Mental Deficiency Act, 1913. The first Act aimed at the provision of special education, the second at the provision of care and control because of social inefficiency. Certifying officers were loth to certify as ineducable and feeble-minded for the purpose of the Mental Deficiency Act, 1913, any child who appeared to show more intelligence than the apparent I.Q. warranted or whose temperamental make-up gave rise to a suspicion that the child did not give a true showing of its ability under test. As a result, many children remained in school although they made little or no educational progress.

Enforcement of attendance

Once it had been determined that a child was mentally defective but educable in a special school, it became the duty of the local education authority to consult with the parent as to the form of education the child was to receive and, if the parent was not providing suitable schooling or making adequate arrangements for education, he could be required to send the child to a 'certified special school'. If he failed so to do without reasonable excuse the authority could apply to a petty sessional court for an order to enforce attendance.

The most common excuse advanced by the parents was that they were not convinced that their child was mentally defective and they could contest the findings of the certifying medical officer in a petty sessional court. Section 55(6) provided that where doubt existed as to whether the child was or was not mentally defective, the decision rested with the Board of Education. However, the making of an attendance order and deciding whether there was an excuse for non-attendance remained with the court, as did the imposition of a fine for non-compliance with any order made and making an order for attendance at a residential school. No order could be made to send a child to a school not within reach of his residence, or to a boarding-school, without the consent

of the parents in writing unless it could be shown that the withholding of such consent was unreasonable, and consent was not deemed to be withheld unreasonably if withheld with the *bona fide* intention, of which the court was the judge, of benefiting the child.

An order to attend a residential school did not authorize school attendance officers to take a child forcibly from his home to either a day or a residential school. In the event of non-attendance, the parent was summoned for non-compliance with the order or an application was made for an order to send the child to an industrial school of a type suitable for mental defectives. The court had power to award to the parent costs which could include compensation for expense, trouble and loss of time incidental to attendance if it refused to make an order so that, apart from considerations of equity, there was a strong practical incentive to the adequate preparation of cases.

Provision of special education

Special education for educable mentally defective children was provided in special day and residential M.D. schools and there was little possibility of backward children receiving special educational aid if they remained in ordinary elementary schools. A medical officer might suggest special coaching in certain subjects but in most instances it was possible to give little practical effect to such a recommendation.

Day special schools—Special M.D. day schools generally consisted of small single storey buildings in a corner of the playground of ordinary elementary schools and, although within the curtilage of the ordinary schools, they were completely isolated from contact with them. They had separate entrances and all connecting doors into the main school were locked so that only in emergencies was there contact of any kind between the pupils of the two kinds of school. These schools were divided into junior (boys and girls to 11 years) and elder boys' schools and elder girls' schools (11 to 16 years).

It began to be recognised that this system of somewhat modest buildings hidden away in the corners of school playgrounds was detrimental to the morale of the school and caused resentment and opposition from parents who objected to their children being sent to what was so obviously an ' abnormal ' school instead of attending the big school with their neighbour's children. As time went on the Council allocated larger premises to special education, of which a practical aspect is shown in the inset.

Residential special schools—The need for residential special schools before the second world war was not very great and the Council's residential M.D. school provision consisted only of one school and accommodation in two children's residential homes for a number of children who attended M.D. day schools. These establishments admitted children who showed a tendency towards delinquency or truancy or who were out of the control of their parents or who could not be cared for at home for some other reason. The total residential accommodation in 1939 was 459.

In addition, provision was made for children specially recommended to be maintained in boarding schools run by religious bodies, other local authorities or voluntary organisations.

Medical supervision of children at special schools

The Act provided that all pupils should be re-examined, mentally and physically, to ascertain whether any pupil had improved sufficiently to return to an ordinary school or deteriorated so much that he was unfit to be retained in school.

In addition to this periodic review the Board of Education directed that any parent could demand re-examination at any time after six months from the date of the last examination. In London examinations were carried out at roughly nine-monthly intervals by the certifying officer attached to each school. They were informal, parents were not invited to attend nor were they informed of the result unless they had asked for reconsideration, the examination resulted in a change of category, or there was some other reason to do so.

Notification on leaving school

At about the age of 15½ special consideration was given to all mentally defective children in attendance at special schools to decide whether there was a need for further special care or supervision after leaving. Such further care could only be provided under the Mental Deficiency Act, 1913, and if necessary, it meant that the child would have to be notified to the mental deficiency authority (the Council) as likely to benefit by or

to be in need of supervision, guardianship or institutional care. Consideration in this instance took place from the adult angle and the determining factor was the apparent ability of the young person to fend for himself with little or no supervision. It involved the important decision by the school medical officer, whether the child could and should be certified as a feeble-minded person. This special medical examination was carried out within six months of the date on which the child was due to leave school. Should he decide on notification, the certifying medical officer completed a certificate that the child was feeble-minded within the meaning of the Mental Deficiency Act, 1913.

Experience of the new special teaching given to M.D. children convinced medical officers specialising in mental deficiency that many children, whose intellectual development was little below average, were yet unable to profit to any extent by education in ordinary elementary schools. That basic mental development was not the main cause of their inability to learn was evident from the fact that the I.Q. was not constant. One examination might reveal an I.Q. of almost imbecile rate and the next approach the border-line of normality whilst the individual test result showed an unusually large year range which was later described as ' scattering '. Some factor in the child's mental or emotional make-up was inhibiting, not the actual development of the brain, but the child's ability to use the brain development in the normal way.

From this it followed naturally that it was wrong to label a child mentally defective because it could not profit by education in an ordinary elementary school when special medical testing (later termed psychiatric and psychometric) proved that the cause was due not to non-development of the brain but to abnormal emotional impulses or neuropathic manifestations rendering the child incapable of applying himself in school or work in a normal manner. Psychiatry had begun to develop as a medical speciality and to be interested in the problem that this presented. Specialised approved medical officers of the local authority began to refer cases for further psychiatric investigation when they considered that lack of progress was caused by emotional and neurotic traits rather than genuine mental defect. The first child guidance clinics began to take shape and only those cases which failed to respond to psychiatric or child guidance treatment were referred back to be dealt with as educable mental defectives.

Public opinion began to make itself felt in support of many parents of special school children who objected to their children being called mentally defective and relegated to attend establishments known as special M.D. Schools, situated in apparently inferior premises to those of ordinary schools. In London the term ' Silly School ' was quickly coined and parental resentment became more and more marked.

This was the position in 1939 when the whole school situation in London was disrupted by the second world war.

Education Act, 1944

The Education Act, 1944, which came into operation in April, 1945, made revolutionary changes in the nomenclature, ascertainment and education of mentally handicapped children.

The offensive and often wrongly applied term ' mental defective ', with the stigma popularly attaching to it, was eliminated. No longer could a child of school age who had not been deemed totally incapable of receiving education be called a mental defective. Two new terms were introduced ; ' educationally subnormal ' (E.S.N.) for children whose inability to progress was primarily due to intellectual failure, and ' maladjusted ' for those whose inability to progress was due to abnormal conduct and/or gross emotional or neurotic impulse.

To make public and parents alike realise that the new schools for the educationally subnormal were not just schools of the old type under another name, the definition of the term E.S.N. was made to include children who were unable to profit by education in an ordinary school by reason of mental subnormality or any other cause. Thus the local authority could provide education for children better developed intellectually

than those previously accepted as it was no longer necessary for the school medical officer to certify them as mentally defective. Indeed this widening of the legal concept made it possible for children to be admitted to E.S.N. schools even if their educational subnormality was due to causes other than intellectual failure. This interpretation of the legal definition was rarely used except at the parents' request but it did mean that special schools began to receive children with I.Q.'s ranging up to 80—85 (provided they were functioning educationally at E.S.N. level). This was welcomed by teachers in E.S.N. schools as among other things it enabled them to obtain far better results, thus setting higher standards and encouraging them to introduce more modern methods of education. With this raising of the upper intelligence level of educationally subnormal children there was a tendency in some instances to raise also the lower I.Q. level, below which a child could be considered ineducable in any school and suitable only for occupation centre training under the Mental Deficiency Acts. The Ministry of Education, however, very rightly make it clear that local education authorities should give a trial to any child who had not had any school experience unless the child was obviously completely unsuitable.

This improvement in the I.Q. range of special school children resulted inevitably in an apparently steady rise in the number of children receiving special E.S.N. education, either in special schools or the newly created special E.S.N. classes in ordinary schools. Close investigation showed, however, that so far as mental deficiency and genuine intellectual retardation was concerned there was very little basic change from the figure issued in the Wood Report of 1929.*

The enlarged scope of the special E.S.N. school increased its attractiveness for young teachers as a career. Finally the subject attracted so much attention that in 1950 the Institute of Education of the University of London instituted a Diploma in Special Education awarded by examination after a year's course in the subject which is now recognised as a qualification in E.S.N. teaching.

The fundamental change was that the age at which education could be provided for any handicapped child was two years if the parents wished. Few, if any, local education authorities had any nursery school provision for educationally subnormal children under five years and the majority of school medical officers foresaw great difficulty in coming to a firm conclusion as to the educability of a mentally retarded child of two years. This last point was of particular importance as the new Act provided no method of revoking a report that a child was ineducable once made. Representations resulted in the issue of Circular 146† which recommended that the local education authorities should not issue reports in respect of children alleged to be educationally subnormal and under five years of age. Section 8 of the Education (Miscellaneous Provisions) Act, 1948, enabled a local education authority to cancel a report that a child was ineducable and to provide education suitable to its ability and aptitudes. This relieved the school medical officer of the heavy burden of deciding to recommend a report with the knowledge that if he was wrong in his diagnosis and prognosis the decision was irrevocable and the child would be deprived of any further education. As the Act had originally been interpreted, if a child had been reported as ineducable by one local education authority, no other local education authority could admit to school unless the authority that had issued the report recommended its withdrawal. In most of the small number of cases of this kind some delay was the only disadvantage which resulted but in the last ten years in three cases which occurred in London the local education authority concerned required much persuasion before agreeing to withdraw the report and in one case it refused to do so. About two years ago the Ministry took a different interpretation which allowed one authority's report to be withdrawn by another authority to whose area the child had removed subsequent to the issue of the report.

**Report of the Special Committee appointed to consider the problems presented by Mental Deficiency among children of school age, 1929.*

†*Ministry of Education Circular 146 (30th June, 1947).*

Referral

The number of sources from which children were being referred for possible ascertainment, apart from primary schools, increased.

Widening the scope of the definition to educational subnormality and the fact that children aged five years must (and some children below this age may) be provided with special education contributed to this increase. In addition psychiatrists and child guidance clinics were dealing with maladjusted or behaviour cases daily and were referring a proportion of their cases. In spite of the increase in possible sources of reference, however, the majority of ascertainment examinations still result from headteachers' reports that a child has failed to respond to ordinary teaching in primary school.

The procedure remained similar to that already instituted as a result of the Act of 1921 whereby a child was first seen by the school medical officer.

Documentation

In essentials the material required for the information of the administrative medical officer who advised on the need for a formal statutory examination and the approved medical officer who conducted it remained the same—information from anybody who had reliable knowledge of early history, habits, rate of progress and behaviour. In some cases a dossier of relevant information, including medical reports, is available and up to date reports from any doctor, whether general practitioner or specialist, under whose care the child had been are essential. On this information the administrative medical officer decided whether to obtain consultant opinion before recommending an examination.

In the case of children already in attendance at an ordinary school the report of the headteacher recorded on Ministry of Education Form 3 H.P. constitutes a statutory part of the procedure and is most important. This gives a complete picture of school life, the teacher's estimate of educational age and rate of progress and opinions about parental character, co-operation and supervision. Headteachers understand that, in addition, any other information, written or verbal, will be welcome and fully considered.

In 1948 the administrative picture was altered slightly as a result of the National Health Service Act, 1946. Nine administrative divisions were set up for all health service purposes each with a divisional medical officer who became responsible for the school health service in his division. Thus the five school health service areas already mentioned were replaced and the divisional medical officer in the first instance undertook the administrative decisions relating to educationally subnormal children and immediate responsibility for the examination of children in his division.

Ascertainment

The Education Act, 1944, differentiates sharply between the procedure for ascertaining children in need of special education and capable of benefiting by it and that used in the case of children incapable of education in any school because of ineducability or conduct detrimental to other children. In the first case, subsections 1 and 2 of section 34 lay down the action to be taken, in the second, subsections 3 and 4 of section 57. The provisions are so strict that if a child is examined under one procedure but proves on examination to be suitable for action under the other, the medical examination is invalid and, even though the parent may agree with the action proposed, another has to be arranged. The administrative medical officer's first responsibility therefore is to assess whether the child is of very low grade and thus likely to be ineducable or whether mentally he is likely to be in the E.S.N. range of intelligence so that a notice to the parent can be issued under the right section of the Act, thus avoiding the risk that a second examination might be necessary.

When the principal school medical officer has informed the education officer that he is prepared to examine a child under section 34 (subsections 1 or 2) the authorised officer of the local education authority delivers a notice of ' intention to examine ' to the parent. This tells the parent what is proposed and why and the penalty for failing to produce the child for examination. Section 34 (3) stipulates that the local education authority must itself give the parent notice of the time and place of the examination. This is done by placing the child's name before the appropriate sub-committee of the

Education Committee whose Chairman's (or Vice-Chairman's) signature indicates the local education authority's formal sanction for the notice to be issued to the parent. This legal duplication of the notice to the parent does not appear to safeguard the child, parent or the local education authority's officers.

Examination

The examination is more thorough than was the case under the earlier Act. The regulations issued under the Education Act, 1944 rule that all medical officers must be approved by the Ministry of Education for the purpose and it is further required that they must have undergone specified training and had experience beforehand.* In London the training regarded as a minimum for this purpose is that which would be regarded as necessary for a qualifying diploma, but a medical officer would only be regarded as fit to undertake this work with a further period of additional observation and practical experience after the training course. For this purpose medical officers whenever possible are initially employed under the personal supervision of the principal medical officer responsible for this work throughout the county.

Notwithstanding any physical or sensory defects apparent from the records which might account for or complicate the alleged intellectual failure, the examining medical officer must satisfy himself personally on this point. The form of examination is prescribed in Ministry of Education Form 2 H.P. An accurate assessment of the intellectual state must be made by detailed psychometric examination using a universally accepted system of testing, usually the Terman and Merrill revision of the Stanford Binet. This—recorded on Part II of the form—may be carried out by an educational psychologist instead of the medical officer responsible for the remainder of the examination, although it is obviously better both clinically and legally for the entire examination to be carried out where practicable by one examiner at one time. The examining medical officer must also investigate the child psychiatrically to be sure that there is no emotional orpsychotic abnormality which might indicate a school for maladjusted children or even deeper psychiatric investigation or treatment. The result is recorded on Form 2 H.P., proper completion of which demands answers in every sphere of examination and thus eliminates the possibility of inadequate investigation.

Form 2 H.P. provides for three alternative conclusions about the child examined.

He may be (1) not educationally subnormal and fit for normal education,

(2) educationally subnormal but capable of receiving education at school, or

(3) unfit for education in any school and suitable for report to the local health authority as ineducable.

The examining medical officer, if his examination reveals a condition which justifies it, may recommend that a decision be deferred until after further inquiry or treatment.

The Act provides that the local education authority must give the parent notice of the result of the examination and of any action proposed. For this reason the medical officer should not tell the parent what he finds or intends to recommend, as it is for the local education authority to decide what is to be done on the medical officer's advice. For a medical officer, however, not to discuss the mental condition of the child with an interested and often anxious parent would be embarrassing and might well antagonise the latter whilst it is difficult in any case to see what would be gained. In London it is considered that the legal position is adequately safeguarded if the examining medical officer uses his discretion in discussing the child's condition, providing he makes it clear that he cannot anticipate the recommendation that the principal school medical officer will make and that the local education authority will decide the action to be taken as a result.

Subsequent action by the local education authority depends on the recommendation of the principal school medical officer. In the first case the child remains at school and no notification to the parent is necessary. The last case involves commencing the

* *S.R. & O. 1945 No. 1076. Regulations 52 and 53.*

whole process of ascertainment anew under another section of the Act with its own strict procedure and again the parents need not be told of the result of the examination under section 34.

In the second case the local education authority informs the parent in writing of the intention to provide special education and, normally, names the school proposed. The parent must be told that he can appeal against the proposal to the Ministry of Education if he disagrees with it. Usually he is asked if he proposes to do so. As a result, a parent intending to appeal usually writes to the education officer who refers the matter to the principal school medical officer with a copy of the parent's letter.

The senior medical officer in charge of this work throughout the county considers each of these appeals personally. Experience shows that many appeals are based on a misapprehension of what special education really is, whilst others show a genuine belief that a mistake has been made. The parent may be invited to submit the child to a further examination by one of the specialised medical officers, sometimes in association with a consultant in another branch. Where further examination would be a waste of time an interview with the parent may be arranged to give him an opportunity of stating his objections and having the position explained to him.

As a result of this informal appeal procedure most parents do not proceed with appeals to the Minister and now very few are made.

Should the parent wish to proceed, the medical officer who conducted the examination completes the statutory certificate that the child needs special education (1 H.P.) and the complete dossier is sent to the Ministry of Education for decision.

Enforcement of attendance

The Act, in keeping with the principle of parental determination, gives under section 37 (2) the parent an opportunity of choosing a school. Generally an ordinary school is chosen and the local education authority then has to prove to the Ministry that the school would be incapable of providing suitable education. If the Minister decides that the local education authority is right he directs the parent to present the child at the special school when, if the parent persists in his refusal, the aid of the court may be invoked.

Exclusion from school

The decision of the local education authority itself is necessary before the principal school medical officer can proceed with examination arrangements under section 57 (3 and 4) which may result in exclusion from school.

Once the local education authority has decided upon this course the principal school medical officer arranges for the examination and the education officer arranges for a letter of notification, which also explains what is proposed, to be delivered to the parent, usually by hand. The child must be physically within the local education authority's area at the time notice is served on the parent. This point seems of little real value but has a high nuisance value to the larger authorities with large boarding schools outside their boundaries.

Once the details of notification have been successfully completed, the examination is similar to that under section 34 (1), the only differences being the use of a recognised system of performances and that testing must be recorded. A variety of performance systems is used according to the age and ability of the child (Drever Collins, Alexander, Porteous Maze) and, if detrimental conduct has to be considered under section 57 (4), a psychiatrist's report must be available. In examinations under both sections 34 and 57 different adaptations of recognised test systems are used when a child is physically as well as mentally handicapped; for deafness—Drever Collins; blindness or severe partial sightedness—Langham's adaptation of the Binet Simon.

The result of such an examination can only be that the child is, or is not, incapable of education in any school.

In London, however, should the examination under section 57 (3 and 4) indicate that the child may be educable in a special school for E.S.N. or maladjusted children, the parent is told and, if he agrees that the child should have a trial in a special school, requisite action is taken under section 34 (1) but if he is not in agreement a fresh examination must be arranged under the appropriate section to satisfy the legal requirement.

Early primary school

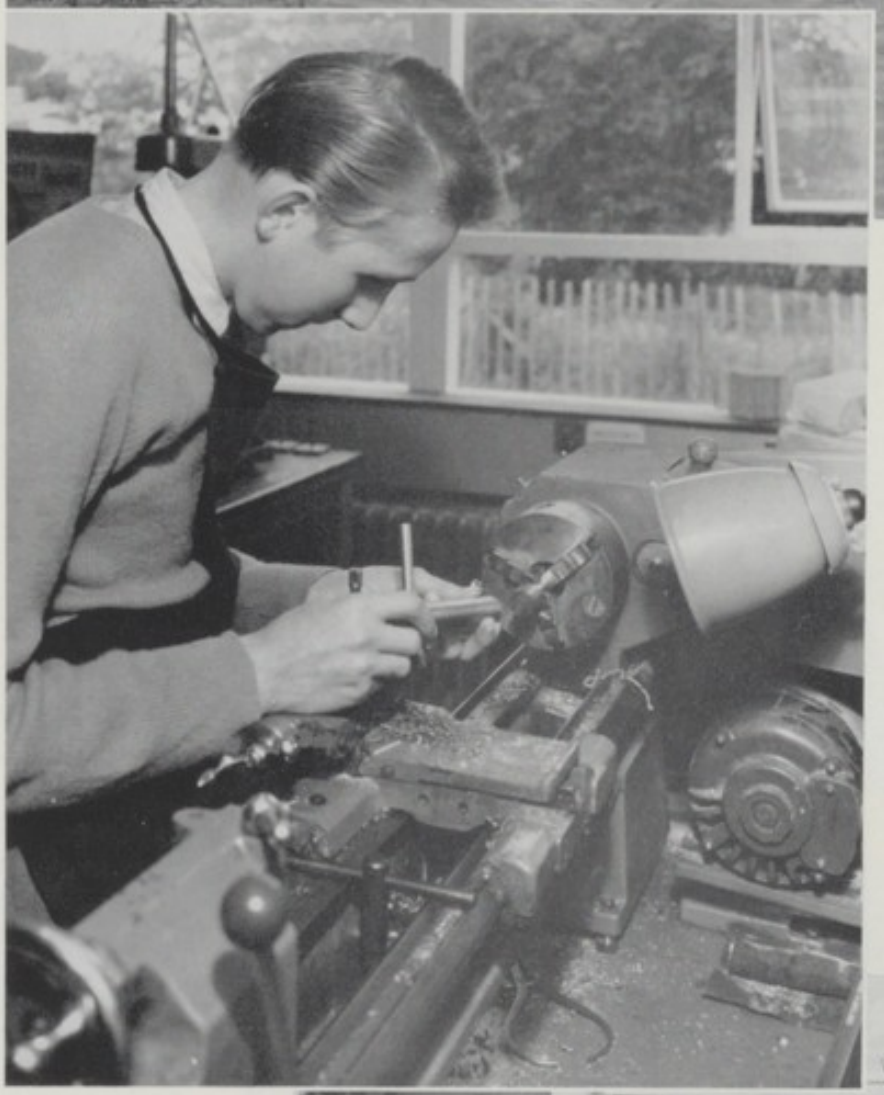
A shoe-making class in the 'twenties

Psychometric testing

Learning to read

Arithmetic activity in a primary school

Summer at a country camp



A modern all-age mixed school

A boarding school in a private country house

The "Ark Royal"

Photo by "Beds and Bucks Observer"

Should the child prove ineducable, the recommendation of the principal school medical officer is sent to the local education authority who informs the parent of the decision and indicates that the latter has a right of appeal to the Minister, provided he does so within 14 days of the notification. Because of this time limit and the fact that so many parents fail to understand the position properly, the notification is taken by an experienced social worker of the health department who explains fully the implications of what is proposed and, if the parent is obviously in disagreement, the letter is not delivered to the parent until the senior medical officer in charge of this work throughout the County has seen the papers and decided whether or not further examination of the child or discussion with the parent would serve a useful purpose. If it is decided that no further action on these lines would be of any use the official letter is sent to the parent by registered post so that the official 14 days' grace only begins after all discussions are over and the parent thus has the full statutory period in which to appeal to the Ministry of Education against the local education authority's decision.

In such a case no further action is taken by the local authority until the Minister's decision is known, except that if the child's presence in the school is a source of danger to himself or the other pupils the headmaster may order his temporary exclusion.

The special education provision for educationally subnormal children

The Education Act, 1944, subdivides the provision of special education for educationally subnormal children into three types.

Special E.S.N. classes in ordinary schools—These are for children who although educationally subnormal were not sufficiently retarded to warrant removal to a special school, or in whose case the cause of the retardation was in doubt and there was a chance that with tuition in small classes the child would improve sufficiently to maintain himself in ordinary school environment.

Experience indicated that E.S.N. classes housed in ordinary schools did not fulfil their purpose. Two reasons for this became apparent. In borderline cases where a diagnosis of educational subnormality was in doubt both the parents and the medical officer were opposed to labelling a child E.S.N. for it to receive some unspecified special education in its normal school. The classes themselves were difficult to control because the amount and type of extra help given was not uniform and varied widely in different schools.

A conference was arranged between senior officers of the public health and education departments and medical and lay officers of the Ministry of Education. As a result the abolition of the special E.S.N. classes in the County was sanctioned and a system of special educational help which could be given to retarded children in their own school on the advice of the principal school medical officer replaced them.

Children receiving this form of special educational help are not classed as E.S.N. but are recommended by the principal school medical officer as fit for education in an ordinary school with special educational help.

This is not an ideal solution to the problem of providing a uniform system of special education by specialised teachers within the ambit of the ordinary school but it does away with labelling a retarded child as E.S.N. within the meaning of the Education Act unnecessarily. In practice it has the advantage that with the widening of the I.Q. range for admission to special school, children really in need of prolonged special education are more quickly received into special school instead of tending to spend a longer period of trial in a special class with consequent late entry into their proper educational environment should the trial fail.

Day Special E.S.N. Schools—London has day school accommodation for 3,608 pupils comprising eleven primary day schools, five secondary girls' schools, eight secondary boys' schools and two secondary girls' schools which also admit a number of children of primary school age of both sexes.

Rose Cottage School at Welton Road, S.E.18, opened in 1958, accommodates 160 pupils of all ages and both sexes. This ' all age mixed school ' does away with the necessity of moving educationally subnormal children from primary to secondary special schools,

which often resulted in a psychiatric setback and caused resentment on the part of both parents and children.

Rose Cottage is in semi-rural surroundings on the Kent county border. The playground is partly asphalt and partly grass, whilst there is a greenhouse for educational purposes. For those of primary school age, the experiment of having washing, water closet and cloakroom accommodation immediately adjoining each classroom has proved most successful. The secondary block is of two storeys, with woodwork, metal-work and housecraft rooms, the last having a dining alcove and needlework section. A large assembly hall provides a good stage and all ground floor rooms open directly on to the playground.

Although the number of day E.S.N. schools has decreased from 29 in 1939, the number of pupils in that year was 3,464, as against 3,553 on roll at the end of 1958. The slight change in relativity is due to improved accommodation in bigger, though often old schools, whilst two new schools have been built since the war.

Other school buildings and facilities provided follow the same pattern as ordinary schools, with similar slow improvement in siting and accommodation. The provision of adequate playground space in the congested area of London is a persistent problem. In the inset are shown class activity in a typical primary school and practical workshops in a mixed all age school.

Boarding Special E.S.N. Schools—Eight boarding schools accommodate 635 pupils and, in addition 20 pupils are maintained in boarding schools most of which are run by Roman Catholic orders or other local education authorities. Numbers of children admitted to boarding schools have shown a large increase since the end of the war.

Year	*No. of schools*	*No. of children*
1939	1 (plus 2 homes)	459
1946	3	393
1952	6	561
1958	8	635 including 15 out-county pupils

Evacuation showed that the children appeared to develop better both mentally and physically in a rural or sea-side environment. Some of the school premises used during the evacuation were retained or replaced by new boarding schools situated in similar surroundings. This experiment proved highly satisfactory and accounts for the disproportionately large increase in the number of children in residential accommodation.

At the end of 1958 eight boarding E.S.N. schools were so situated :

Bowden House	Seaford, Sussex	Primary Boys
Bradstow	Broadstairs, Kent	Primary and Secondary Girls and Boys 5–9 years
Burrow Hill	Frimley, Surrey	Primary Boys
Ditton Place	Balcombe, Sussex	Secondary Girls
Grafham Grange	Bramley, nr. Guildford, Surrey	Primary Mixed
Great Stony	Chipping Ongar, Essex	Secondary Boys
Stockgrove Park	nr. Leighton Buzzard, Bedfordshire	Secondary Boys
Gorseway	Hayling Island, Hampshire	Nursery, 2–7 years

Scenes at Ditton Place appear opposite page 175.

In addition there are certain schools for pupils with special handicaps, where the proportion of E.S.N. pupils with the additional disability for which the school is appropriate is high.

Rayners, Penn, Buckinghamshire is designed for deaf children with a second handicap and in slightly more than 80 per cent. of the pupils this is educational subnormality. The premises, a Victoria mansion house with 22 acres of grounds in pleasant surroundings, have certain defects as a school and a major project is now in hand to bring them into line with modern requirements and to provide additional places. New classrooms, a gymnasium and a housecraft room are being built together with additional dormitories, staff accommodation and new sick bays.

Penbury Grove, Penn, Buckinghamshire, is intended for children with more than one handicap, other than deafness. A high proportion of the pupils have educationally subnormality as one of their handicaps.

A similar situation applies at Hatchford Park, Cobham, Surrey and at Staplefield Place, Haywards Heath, Sussex, where a percentage of pupils are educationally subnormal as well as being physically handicapped.

The Wainwright Annexe of Wanstead House Boarding Open-Air School, Broadstairs, Kent, provides short-term placements (one or two terms) for pupils from day E.S.N. schools who are also delicate.

Despite the wide range of boarding school accommodation the demand for places remains high and a waiting list is inevitable for many of the schools ; however, this is generally not more than one term.

Gorseway deserves special mention as it is the only boarding special E.S.N. nursery school in the country. It is designed to take children of both sexes from two (although children under three have not been placed there so far) to seven years of age of the higher E.S.N. grade who have shown conduct or other difficulties, either in their own homes or Council nurseries. The majority quickly become suitable for primary boarding or day E.S.N. schools, whilst a minority become capable of ordinary school education.

It is housed in a modern mansion, standing in its own grounds of approximately 8½ acres, facing the sea-front. The healthy situation is evidenced by the almost complete absence of minor ailments and by progressive weight and growth charts.

It is considered that this experiment has been completely justified but it is essential that children for admission should be carefully selected, not only having regard to their mental and emotional development but to the environment from which they are to be transferred.

An indication of the changed attitude towards the training of mentally handicapped children is a recent activity of the boys at Stockgrove Park School. Under the supervision of the headmaster and other members of the staff, a 70 ft. canal barge which had been acquired for the purpose was converted into a houseboat with living accommodation for 16 boys and cabins for two adults, together with an efficient galley and a saloon capable of seating 30 people. The enormous amount of work involved was undertaken by the boys themselves of whom some 78 took part altogether under the supervision of school staff. In July a party of the boys travelled with the boat from a point near the school down the Grand Union Canal to Brentford and thence, with the aid of a tug, to the Royal Festival Hall Pier. The ' Ark Royal ', as the barge was named, in transit on a reach of the Grand Union Canal, is shown opposite page 175.

Medical supervision of children in special schools

Medical officers approved under Regulation 53 are appointed to visit one or more day E.S.N. school so that each pupil in the school is mentally examined approximately every 9 months, but in any case at least once a year. In addition any special school pupil will be specially considered at any time on request of the headteacher of the school or the parent, provided the requests are not made with unreasonable frequency, e.g. within six months of the last routine or special examination. Each child has a complete physical examination yearly as routine school health service procedure.

All boarding E.S.N. schools are visited regularly by one of the Council's medical officers specialised in mental deficiency practice who not only conducts the yearly mental review of every child in the school but deals with all special queries and examinations at the request of the headteacher, parents or officer of the children's

department in the case of children in the care of the Council. In addition he makes a comprehensive inspection of the school each year and completes a full report to the principal school medical officer on hygiene, equipment and diet in addition to the physical and mental health of the pupils and the general running of the school.

Day to day medical care is provided by a local general practitioner who holds the appointment of visiting medical officer. He undertakes National Health responsibilities and has all the children and most of the members of the staff on his list. He has regular days for visiting and visits cases of casual illness as required : in addition he carries out a routine physical examination of each child at least once a year.

Nursing care is available at all boarding schools and some of the larger schools for young children have a whole time nurse. In the majority of cases a local nurse is engaged to visit daily and carry out minor ailment and other nursing duties in the school.

All ancillary medical services, i.e., dental, ophthalmic, and orthopaedic inspection and treatment, speech therapy and psychiatric investigation are provided at each school, in some cases directly by the Council, but at most schools through the school health service of the local authority of the area in which the school is.

School leaving procedure

To meet the requirements of section 57 (5) of the Education Act, 1944, each child suffering from a disability of mind who is about to leave school is examined to determine whether or not he requires supervision after he has left. Unlike the school leaving procedure under the 1921 Act, there is no reference to mental deficiency. The duty laid on the medical officer is simply to advise whether or not the child should be reported to the local health authority as in need of supervision after leaving school. The further question whether or not the child may subsequently require statutory action or eventual certification under the Mental Deficiency Act, 1913, does not arise at this stage. The date of the medical examination may not be earlier than six months from the date of the issue of any subsequent report under section 57 (6) and such a report must be issued not later than the last day of the term in which the child's 16th birthday occurs. The local education authority has a discretion in arranging a school leaving examination for children who, although backward, are still in ordinary school. When the headteacher of a secondary modern school considers the child's mentality is such that he will require further supervision after leaving school, similar statutory procedure is followed as for a leaver from a special E.S.N. school but it takes place at the age of 14½ instead of 15½ years.

The local education authority is not required to inform the parent of the date and place of examination, the intention to examine or even the result. No right of appeal exists and whether a report is issued to the local health authority is purely a matter for decision by the local education authority.

When the approved medical officer recommends that a child should be reported under section 57 (5) the social worker of the health department experienced in mental health visits the parent and enquiries into the home circumstances of the family. A full report is made on the social aspect of the case, with special reference to the type of home in which the child will live, the ability of the parents to provide care and supervision adequate for the type of mentality the child has and the parents' wishes as to the child's future care. Although co-operation by the parent is not essential to any action under section 57 (5), this last duty is most important because the consent of the parent or nearest relative, which may require to be given formally in writing, may well be necessary before any action can be taken under the Mental Deficiency Acts as a result of a report under section 57 (5).

This social report is added to the child's school health and education records and the complete dossier of the child's school life is then considered by the senior medical officer in charge of this work throughout the County, who has to decide whether to recommend that a report to the local health authority be issued, and to indicate to the local health authority the form of care which may be provided if this is done. This medical officer is the better able to recommend a report or otherwise as he is also responsible for the immediate medical oversight of the Council's work under the Mental Deficiency Acts.

School leaving procedure is carried out, especially in boarding schools, as early as possible after the child has come within the statutory age limit so that where a report is necessary the form of care to be provided after leaving school can be settled at the earliest reasonable moment to prepare the child for the life ahead. As part of the assessment of the needs of the case a social worker from the public health department visits the child at the school. Where a child who has no home or whose home is unsuitable has to be admitted to a hostel or placed under guardianship, as part of the effort to accustom the child to the decision he is introduced to the proposed guardian or a visit to the hostel is arranged. Instead of wondering, and in some cases worrying, as to what the future holds in store he will now know and learn to look forward to the new life after school in which it is hoped he will learn to adjust himself to industrial conditions and, eventually, earn his living like any other citizen.

The National Health Service Act, 1946

This Act, of which the objective was the promotion of the nation's health, was almost entirely concerned with the prevention and treatment of physical and mental illness and abnormality. Whilst the provisions of the Education Act, 1944, regarding special education remained unaltered the National Health Service Act provided a number of local health authority, hospital and specialist and general medical services which are available to educationally subnormal children and their parents as to other members of the community and thus lightened the burden of caring for them.

The Mental Health Bill*

The recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency may be divided into two classes, those requiring new legislation before they could be put into effect and recommendations which can become effective as soon as administratively convenient, under existing powers. Whilst the Mental Health Bill deals, *inter alia*, with the duty and power to provide voluntary or compulsory care and treatment for mentally ill persons, both in their own interest and in the interest of the public, few of its recommendations are concerned specifically with the education of children. These few, however, are of vital importance. The most important concerns the future of children who have not shown ability to profit by education, even in special E.S.N. schools. It is proposed, in the new Bill, that section 57 of the Education Act, 1944, should be repealed and replaced by a new section which would remove the statutory duty to report to the local health authority the name of any child about to leave any school who is found by the local education authority to require further care and supervision.

The proposed new section 57 stipulates that the local education authority shall record the decision that the ineducable child is suffering from a disability of mind of such a nature as renders him unsuitable for education in school, and shall forward a report of the decision to the local health authority (2nd Schedule—57 (4)). It will, however, give the parent the right (2nd Schedule—57A (1) (*a*)) to demand a review of the decision after a year's interval from the recording of the decision and once in any subsequent year. In addition to this parental right the 2nd Schedule— (section 57A (1) (*b*)) implies that the local health authority should also review ' reported ' children at regular intervals. If these proposals become law, it is likely that in London all such children will be reviewed yearly. In the event of a child having improved sufficiently to return to special school the local health authority shall inform the local education authority of the position.

It is of interest in this connection that under the new legislation it will not be necessary for the local education authority which recorded the decision that the child was ineducable officially to rescind its decision if the child is no longer in its area, but the authority recommending the child's re-admission to school would notify the previous local education authority of its decision to rescind the notification of unfitness to attend school.

**The Bill received royal assent on 29th July, 1959 and section 57 of the Education Act, 1944 was re-enacted in the form envisaged.*

The proposed new section would still give the parent the right to disagree with the local education authority's finding that the child is no longer able to profit by school education, either by reason of ineducability or detrimental conduct, and to appeal to the Ministry of Education. In addition it is hoped the new Act will provide a simpler procedure for notifying the parent of the intention of carrying out a medical examination than the strict compulsory requirements under section 34 (1) and 57 (3) of the Education Act, 1944.

The statutory report now made under section 57 (5) in the case of the school leaving child is not specifically replaced by a clause in the Mental Health Bill, but in practice there is little need for such provision. In London the principal school medical officer will continue to carry out the present special medical examination of all children attending special E.S.N. school and others specially recommended as possibly in need of further care after leaving school, and will recommend to the education officer that the local health authority should be notified when appropriate. The education officer will notify the medical officer of health of the names of the children, the only practical difference between the old and the new procedure being that the formal statutory reports will no longer be necessary.

The Royal Commission rightly pointed out that a large number of improvements could be made in the informal care of mentally retarded children and that some of the care and supervision now being carried out under the provisions of the Mental Deficiency Act could well be provided informally by means of powers already existing under section 28 of the National Health Service Act, 1946, or in some instances the Children and Young Persons Act, 1933, or National Assistance Act, 1948. Action on these lines may well be of service to local health authorities in providing for the care of sub-normal children excluded from or leaving schools. It is anticipated that the proposed Mental Health Act will give local authorities greater freedom to organise services—including child care services—as may be appropriate.

It will be seen from the brief history of the various Acts and Regulations to which reference has been made that the welfare of educable mentally handicapped children has received much consideration during the past sixty or seventy years. It must be a source of satisfaction to the Council to know that many of the conditions and improvements which are now operative were suggested by the Council and were put into effect in London at as early a date as was practicable. A great deal of progress has been made in the period under review but there is much still to be done and the new legislation together with the spirit of enterprise which has succeeded the years of inactivity in this field augurs well for the future.

APPENDIX C

Statistics of the administrative work carried out by the Metropolitan Borough Councils in 1958.

Borough	DWELLINGS: Erected by Borough Council	DWELLINGS: Erected by other persons	DWELLINGS: Total number in the Borough	CLEARANCE AREAS: Unfit Houses: Demolished	CLEARANCE AREAS: Unfit Houses: Persons displaced	CLEARANCE AREAS: Other Houses: Demolished	CLEARANCE AREAS: Other Houses: Persons displaced	DWELLING HOUSES: Inspections: On complaint	Inspections: On notification of illness	Inspections: House-to-house	Inspections: Other reasons	Represented on a result of informal action	Defects remedied after service of formal notice: Public Health (London) Act 1936: By owners	Public Health (London) Act 1936: By local authority	Housing Act, 1957: By owners	Housing Act, 1957: By local authority	Housing Act, 1957: Made fit for occupation by displaced persons accommodated	Housing Act, 1957: Outstanding closed	Demolished: Number	Demolished: Persons displaced	Closed by undertaking: Number	Closed by undertaking: Persons displaced	Closing Orders determined	Rooms closed: Underground rooms: Number	Rooms closed: Underground rooms: Persons displaced	Rooms closed: Other rooms: Number	Rooms closed: Other rooms: Persons displaced	Undertakings accepted: Underground rooms: Number	Undertakings accepted: Underground rooms: Persons displaced	Undertakings accepted: Other rooms: Number	Undertakings accepted: Other rooms: Persons displaced	Water supply provided to tenanted houses	AIR POLLUTION: Complaints	AIR POLLUTION: Observations	AIR POLLUTION: Defective notices served	AIR POLLUTION: Nuisance notices served	AIR POLLUTION: Smoke control orders confirmed	CLEANSING AND DISINFECTION: Adults cleansed: At home	CLEANSING AND DISINFECTION: Adults cleansed: At cleansing station	CLEANSING AND DISINFECTION: Children cleansed	CLEANSING AND DISINFECTION: Premises disinfected	CLEANSING AND DISINFECTION: Premises disinfested	LICENSED OR REGISTERED PREMISES: Licensed slaughterhouses	LICENSED OR REGISTERED PREMISES: Other effective intakes	LICENSED OR REGISTERED PREMISES: Dairies and milk shops	LICENSED OR REGISTERED PREMISES: Ice cream premises	LICENSED OR REGISTERED PREMISES: Common Lodging Houses	Restaurants, eating houses and canteens	PUBLIC HEALTH INSPECTORS: Employed at end of year: Established	Employed at end of year: Male	Employed at end of year: Female	Employed at end of year: Total	Assistants employed at end of year: Male	Assistants employed at end of year: Female	Assistants employed at end of year: Total
Division 1																																																					
Chelsea	21	31	13,920	—	—	—	—	597	652	—	78	197	95	1	18	1	—	—	4	12	—	—	—	—	—	—	—	—	—	—	13	43	69	—	—	—	216	257	319	376	—	—	31	123	—	191	9	6	2	8	—	—	—
Fulham	123	—	30,702	—	11	—	—	1,962	75	74	485	645	1,086	24	1	—	—	2	1	1	—	—	2	—	—	11	—	—	—	—	1	16	1,380	—	—	1	59	9	111	480	—	—	130	480	—	142	16	14	1	15	1	—	1
Hammersmith	91	5	28,211	—	—	—	—	3,467	292	—	1,464	770	304	38	—	—	1	—	—	—	—	—	20	—	—	1	4	—	—	—	4	25	107	—	—	—	397	710	14	260	2	—	120	299	—	339	13	9	1	10	—	—	—
Kensington	168	116	39,021	60	398	2	13	2,347	1,365	1,494	4,604	833	613	4	1	—	—	1	239	1	4	1	7	2	63	15	1	3	9	—	—	—	13	20	48	—	—	—	207	985	200	547	—	—	225	312	—	255	19	14	—	14	2	—	2
Division 2																																																					
Hampstead	72	148	23,028	—	—	—	—	1,016	5	53	861	606	61	—	—	—	—	—	—	—	—	—	—	—	6	17	2	4	—	—	—	—	9	32	196	—	—	1	—	18	94	144	136	—	—	55	239	—	175	12	11	1	12	3	—	3
Paddington	50	135	39,889	—	—	—	—	3,256	†	708	1,195	863	196	3	23	—	—	—	—	—	—	—	—	—	1,300	136	126	—	—	—	—	13	3	31	3	—	—	42	146	36	120	752	—	—	142	207	1	140	17	11	1	12	2	1	3
St. Marylebone	66	66	24,412	10	56	2	—	853	615	163	238	297	141	—	—	—	—	•	2	3	—	—	6	11	2	19	6	3	—	—	—	1	156	65	3	2	2	—	1,160	235	38	276	1	—	88	224	2	739	14	11	3	14	2	—	2
St. Pancras	402	—	28,323	23	158	—	—	3,566	441	239	2,458	1,335	1,075	19	—	—	—	—	—	—	—	—	32	22	—	6	—	—	—	—	10	36	133	—	—	—	—	1,119	692	354	437	—	—	229	352	—	680	22	21	1	22	—	—	—
Westminster, City of	92	293	27,703	—	3	—	—	713	167	4	2,569	234	4	1	—	—	—	—	8	—	—	—	7	1	2	—	—	—	—	—	1	67	625	9	—	1	—	362	12	159	313	—	—	117	265	2	3,103	26	18	—	18	3	—	3
Division 3																																																				
Finsbury	219	8	9,857	174	119	3	—	1,520	†	—	692	589	129	34	—	—	—	—	16	18	—	—	4	21	—	1	—	—	—	—	6	34	586	6	2	—	—	152	788	233	358	—	1	136	130	1	412	9	9	—	9	1	—	1
Holborn	23	1	6,319	—	—	—	—	197	141	228	583	88	10	—	—	—	—	—	1	—	—	—	—	3	—	—	—	—	—	—	—	38	374	—	—	1	—	23	—	52	76	—	5	71	123	2	532	5	3	—	3	—	—	—
Islington	352	85	44,314	2	24	—	—	3,443	†	341	—	1,801	1,158	57	—	—	1	—	—	3	85	—	—	4	74	108	20	34	—	—	1	3	14	29	568	5	—	—	113	311	461	421	418	1	11	301	518	—	860	34	24	2	26	3	—	3
Division 4																																																				
Hackney	148	303	41,510	—	42	—	—	3,845	137	—	1,185	190	2,027	28	6	—	—	2	7	6	22	—	—	6	33	11	12	11	—	—	—	—	134	1,845	37	6	1	55	156	291	301	358	—	5	222	410	1	205	24	22	—	22	3	—	3
Shoreditch	303	145	11,791	—	73	—	—	1,811	326	238	4,398	928	154	—	—	—	—	—	—	3	13	3	16	—	13	—	61	38	—	—	—	—	14	412	12	—	1	—	13	7	73	306	—	1	91	116	—	219	9	8	—	8	3	—	3
Stoke Newington	298	7	11,865	—	—	—	—	1,137	184	—	—	197	176	4	—	—	—	—	—	—	—	—	2	9	1	1	3	12	—	—	—	—	28	—	1	—	1	—	23	16	65	191	—	—	49	106	—	44	7	6	—	6	1	—	1
Division 5																																																				
Bethnal Green	139	482	15,301	59	368	—	—	1,869	497	64	104	803	427	45	—	—	—	—	3	—	—	—	4	—	—	4	—	1	—	—	—	—	33	69	—	—	—	30	48	17	3	349	—	3	112	151	—	145	9	5	—	5	1	—	1
City of London	—	9	1,106	—	—	—	—	4	3	25	8	8	2	—	1	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	15	—	—	—	1	—	651	—	3	22	—	—	35	81	1	982	20	19	—	19	—	—	—
Poplar	32	236	16,321	—	—	—	—	1,574	33	—	165	900	249	—	—	—	—	—	—	—	—	—	3	—	—	—	—	—	—	—	—	52	54	—	—	—	—	69	9	297	960	—	1	157	189	1	267	8	4	—	4	2	—	2
Stepney	73	221	25,601	99	16	—	—	2,909	184	—	1,586	1,541	487	24	—	—	—	—	—	4	12	—	—	20	8	4	6	—	—	—	—	31	60	1	—	—	76	368	17	37	642	—	19	258	309	3	1,060	18	14	—	14	—	—	—
Division 6																																																				
Deptford	74	164	17,650	—	—	—	—	1,434	139	—	2,370	599	333	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	2	11	—	—	—	219	1,064	51	138	2	—	91	192	1	138	8	7	—	7	—	—	—
Greenwich	197	194	24,288	5	17	1	3	1,358	216	—	544	761	183	—	—	—	—	—	—	7	24	—	—	2	—	—	—	—	—	—	—	16	17	—	—	—	224	709	205	157	394	—	—	120	197	—	176	10	9	1	10	—	—	—
Woolwich	247	656	42,448	47	235	22	29	1,834	667	257	3,439	903	393	—	1	—	—	—	6	6	18	—	—	6	2	6	—	—	—	—	—	—	19	218	6	2	4	30	188	974	147	73	2	—	129	321	1	279	19	18	1	19	—	—	—
Division 7																																																				
Camberwell	214	142	44,002	2	5	—	—	3,196	348	—	2,363	268	1,723	4	22	3	—	—	5	—	—	—	—	3	—	—	41	22	—	—	—	—	70	33	2	1	—	—	99	460	259	797	—	5	221	307	1	336	21	17	—	17	1	—	1
Lewisham	223	218	63,370	4	125	—	—	2,442	46	—	3,814	285	352	32	29	3	—	—	—	4	7	—	—	7	—	—	3	14	—	—	—	—	6	—	—	—	1	—	33	162	295	117	1	—	112	279	—	230	23	18	—	18	4	—	4
Division 8																																																				
Bermondsey	102	187	15,236	81	268	6	23	1,854	631	14	2,836	663	499	3	—	—	—	—	—	2	3	—	—	2	—	19	—	—	—	—	—	—	213	—	—	12	36	14	—	238	—	8	134	201	2	266	11	10	—	10	2	—	2
Lambeth	340	556	55,810	—	—	—	—	2,961	339	—	1,589	1,055	1,094	97	—	—	1	—	—	6	9	2	3	2	9	21	1	3	1	4	—	—	5	23	—	—	—	—	161	49	534	298	—	2	271	367	—	233	21	16	1	17	1	—	1
Southwark	113	165	24,483	83	371	4	16	2,996	392	411	1,320	892	306	30	—	—	—	—	—	42	49	—	—	—	132	293	111	82	—	—	—	—	19	245	12	—	—	—	1,258	1,580	281	1,099	—	3	132	264	6	413	20	17	1	18	2	—	2
Division 9																																																				
Battersea	79	—	29,649	2	15	2	5	3,011	592	—	2,014	680	600	19	5	—	—	—	—	1	—	—	—	3	32	40	5	3	—	—	1	32	83	—	—	—	—	288	1,596	762	207	—	2	135	264	—	223	16	9	2	11	1	—	1
Wandsworth	58	1,413	117,287	52	142	—	—	6,150	1,372	—	8,736	1,267	520	1	—	—	—	—	—	2	7	5	27	2	3	2	23	25	1	—	—	1	23	255	2	—	1	—	34	30	360	162	—	—	258	626	—	536	23	18	—	18	2	—	2
LONDON	4,381	6,008	834,417	703	2,440	42	89	65,234	10,059	4,273	54,140	20,256	14,397	488	109	7	7	7	288	112	269	15	53	111	1,762	662	471	278	28	4	1	3	67	1,042	7,632	99	13	15	582	8,541	10,930	5,771	11,190	9	66	4,214	8,272	27	12,855	457	370	16	388	40	1	41

† Included in previous columns. * Not available. § The whole of the City of London is a Smokeless Zone under the City of London (Various Powers) Act, 1954.

Notes :—(1) Closing Orders : *Orders were made in respect of individual unfit houses by Islington—154 houses (330 persons displaced) and Battersea—30 houses (172 persons displaced). Houses were closed in pursuance of an undertaking given by the owners and still in force in Islington (one house, 11 persons displaced) and Lambeth (one house).*
Closing Orders were revoked and Demolition Orders made in Islington (3), Hackney (1) and Woolwich (1). (2) Licensed Conveyors : *Camberwell*—1. (3) Shared's Lodging Houses : *Poplar*—2, *Stepney*—6. (4) Prosecutions : Inadequate Water Supply to Tenement Houses : *St. Pancras*—5 (5 convictions). *Islington*—5 (4 convictions). *Lambeth*—1 (1 conviction).
Dairies and Milk Shops : *Islington*—1 (1 conviction). *Bethnal Green*—7 (5 convictions). Restaurants, Eating Houses and Canteens : *St. Marylebone*—1. *Westminster*—44 (26 convictions). *Islington*—3 (3 convictions). *City of London*—1 (1 conviction). *Bermondsey*—10 (9 convictions). *Wandsworth*—1 (1 conviction).

APPENDIX D

STAFF OF THE PUBLIC HEALTH DEPARTMENT

Medical Officer of Health and Principal School Medical Officer	J. A. Scott
Deputy Medical Officer of Health and Deputy Principal School Medical Officer	A. B. Stewart
Senior Principal Medical Officer	M. MacGregor
Administrative Officer	C. R. Geere

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 deficiency	C. W. J. Ingham
Chief Dental Officer and Principal School Dental Officer	W. Ritchie Young
Chief Nursing Officer	Evelyn Robinson
Scientific Adviser	S. G. Burgess
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
Statistician	C. W. Shaddick
Chief Inspector	J. C. Clancey
Principal Organiser of Children's Care Work	Frances C. K. Gregson
Senior Organiser, Mental Deficiency	Olive K. Bowtell

Senior Officers of the Divisions

Division	*Divisional Medical Officer*	*Divisional Administrative Officer*	*Divisional Nursing Officer*
1.	Bertha E. A. Sharpe	G. J. Newton	Mary Sidebotham (retired 31/3/58.) Joan A. Surr (from 23/5/58.)
2.	H. L. Oldershaw	H. J. Norton	Eveline Beattie
3.	W. G. Harding	N. B. Chapman	Catherine Walsh (seconded to World Health Organisation.) Margery D. Butler (from 15/3/56.)
4.	S. King	J. C. Minter	Ellen M. Hazell (seconded to World Health Organisation.) Lilian E. Arrow (from 28/11/58.)
5.	G. O. Mitchell	A. J. Cridland	Katherine M. Roe
6.	F. R. Waldron	T. A. Stone	Lilian Berry
7.	Evelyn A. Mower White	F. L. Clark	Kathleen L. Sewell
8.	W. H. S. Wallace	D. E. Armstrong	Bessie Thom
9.	J. T. R. Lewis	R. E. Haymes	Winifred M. Winch

INDEX

References to local activities in the sphere of health education, mental health education, home making courses, problem families, vaccination against poliomyelitis, etc., will be found in the divisional medical officers' reports, pages 124–140.

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ADDENDUM

Page 70 - Home help service statistics:

Cases assisted 1949-1957:	Number of times assistance given.
1958:	Number of households assisted.
Equivalent of whole-time staff:	1958 excludes staff on annual and sick leave.

Corrigendum

Page 184 - Sunday cinema grants should read page 160.