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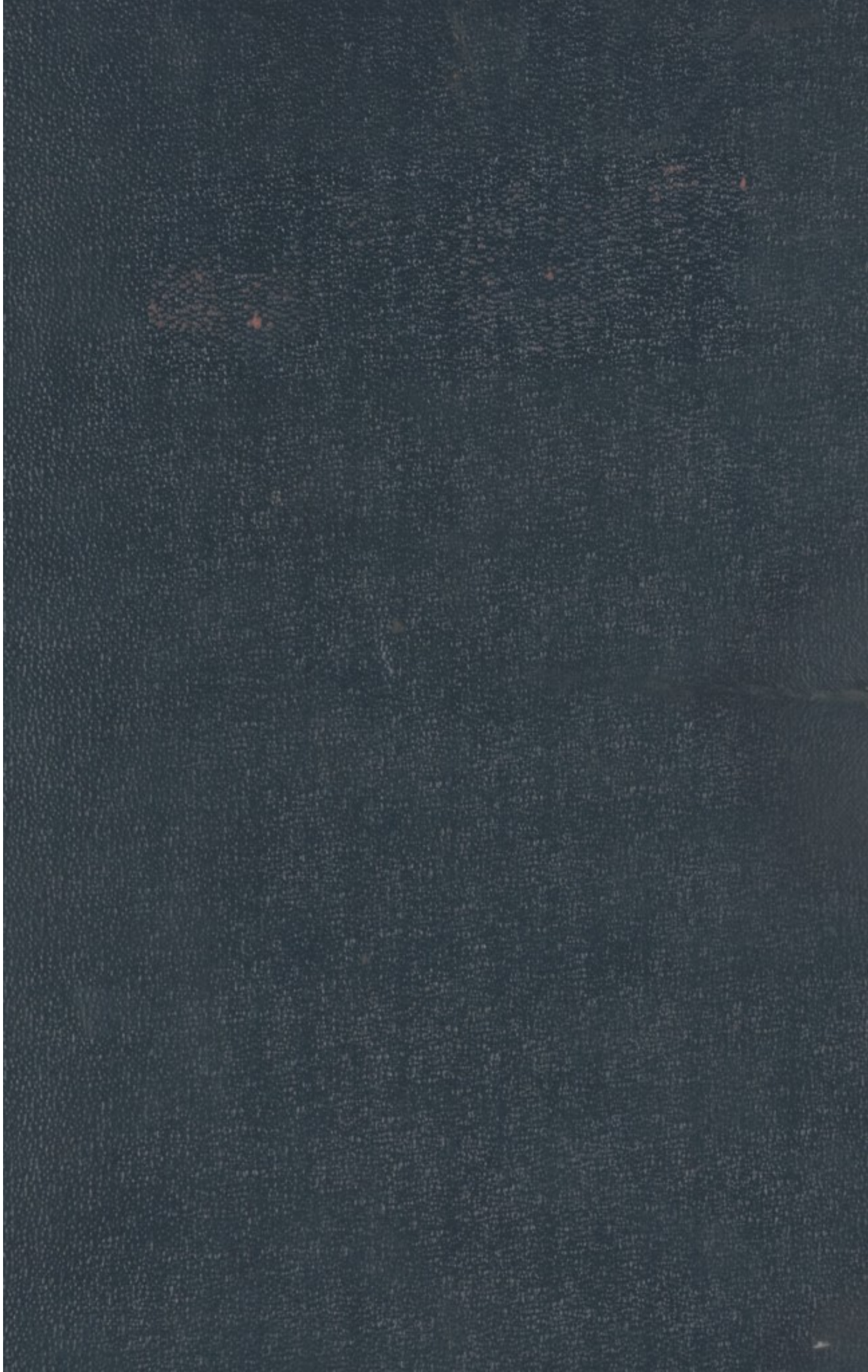
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LONDON COUNTY COUNCIL

Report of the
County Medical Officer of Health
and Principal School Medical Officer
for the Year 1959

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

COUNTY MEDICAL OFFICER OF HEALTH AND PRINCIPAL SCHOOL
MEDICAL OFFICER



LONDON COUNTY COUNCIL

THE COUNTY HALL
WESTMINSTER BRIDGE, S.E.1

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LONDON ADMINISTRATIVE COUNTY

VITAL STATISTICS, 1959

Figures in brackets are for 1958

<i>Population:</i>				<i>Area comparability factors:</i>			
Males	..	..	1,500,000	}	Births	..	.. 0.90 (0.89)
Females	..	..	1,704,000		Deaths	..	.. 0.98 (0.98)
					3,204,000 (3,225,000)		

Number of marriages registered: 32,356 (32,292)

<i>Live births:</i>				<i>Illegitimate live births</i>			
Legitimate	..	49,426	(48,809)	}	55,191	(54,152)	<i>per cent. of total live births:</i> 10.4 (9.9)
Illegitimate	..	5,765	(5,343)				

Live birth rate per 1,000 population: 17.2 (16.8) (adjusted rate 15.5 (15.0))

<i>Still-births:</i>			
Legitimate	..	918	(955)
Illegitimate	..	167	(147)
}			
1,085 (1,102)			

Still-birth rate per 1,000 live and still-births: 19.3 (19.9)

Total live and still-births: 56,276 (55,254)

<i>Deaths:</i>			
Males	..	..	19,471 (19,280)
Females	..	..	18,756 (18,746)
}			
38,227 (38,026)			

Death rate per 1,000 population: 11.9 (11.8) (adjusted rate 11.7 (11.6))

Deaths of infants:

					<i>Legitimate</i>	<i>Illegitimate</i>	<i>Total</i>
Under 1 month	..	..	..	..	750 (786)	116 (115)	866 (901)
1 month to 1 year	..	..	..	..	337 (291)	35 (26)	372 (317)
Total under 1 year	..	..	..	..	1,087 (1,077)	151 (141)	1,238 (1,218)

Infant mortality rate: .. (per 1,000 live births) 22.00 (22.07) 26.19 (26.39) 22.43 (22.49)

Neo-natal mortality rate: .. " " " " 13.59 (16.10) 21.02 (21.52) 15.69 (16.64)

Early neo-natal mortality rate: .. " " " " 13.21 (14.12) 17.52 (19.46) 13.66 (14.64)

Peri-natal mortality rate: .. (per 1,000 total births) 31.21 (33.04) 45.18 (45.72) 32.68 (34.30)

Maternal mortality:

					<i>Rate per 1,000</i>
		<i>Post-abortion</i>	<i>Other pregnancy and childbirth</i>	<i>Total</i>	<i>live and still-births</i>
Deaths from sepsis	..	8 (10)	— (—)	8 (10)	
Deaths from other causes	..	4 (9)	22 (14)	26 (23)	
Total	..	12 (19)	22 (14)	34 (33)	0.60 (0.60)

VITAL STATISTICS*

Population

TABLE (i)—Population (a), 1950-59

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+	
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	3,225,000	231,000	418,000	387,000	949,000	843,000	397,000	37.5
1959	M 1,500,000	121,000	208,000	184,000	457,000	387,000	143,000	35.7
	F 1,704,000	115,000	201,000	210,000	468,000	455,000	255,000	39.1
	3,204,000	236,000	409,000	394,000	925,000	842,000	398,000	37.5

(a) 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 21,000 in the population from the previous year's figure; the major fall was again in the 25-44 years age group, followed by the 5-14, with further increases at ages 15-24 and under 5 years.

Fertility

TABLE (ii)—Live births and still-births—1950-59

Year	Live births		Still-births	
	No.	Rate per 1,000 population	No.	Rate per 1,000 total births (live and still)
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
1959.. ..	55,191	17.2	1,085	19.3

* 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.

Live births—There were 63,728 live births registered in London in the year; after correction for residence the final figure of births allocated to London was 55,191, an increase of 1,039 over 1958 giving a birth rate of 17.2 per 1,000 population, compared with 16.8 in 1958 and 16.2 in 1957. The post-war trend in London followed closely that for England and 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 since then 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 child-bearing 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 (0.90) the rate becomes 15.5. This factor makes no allowance for the fact that proportionately fewer 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, 1950-59

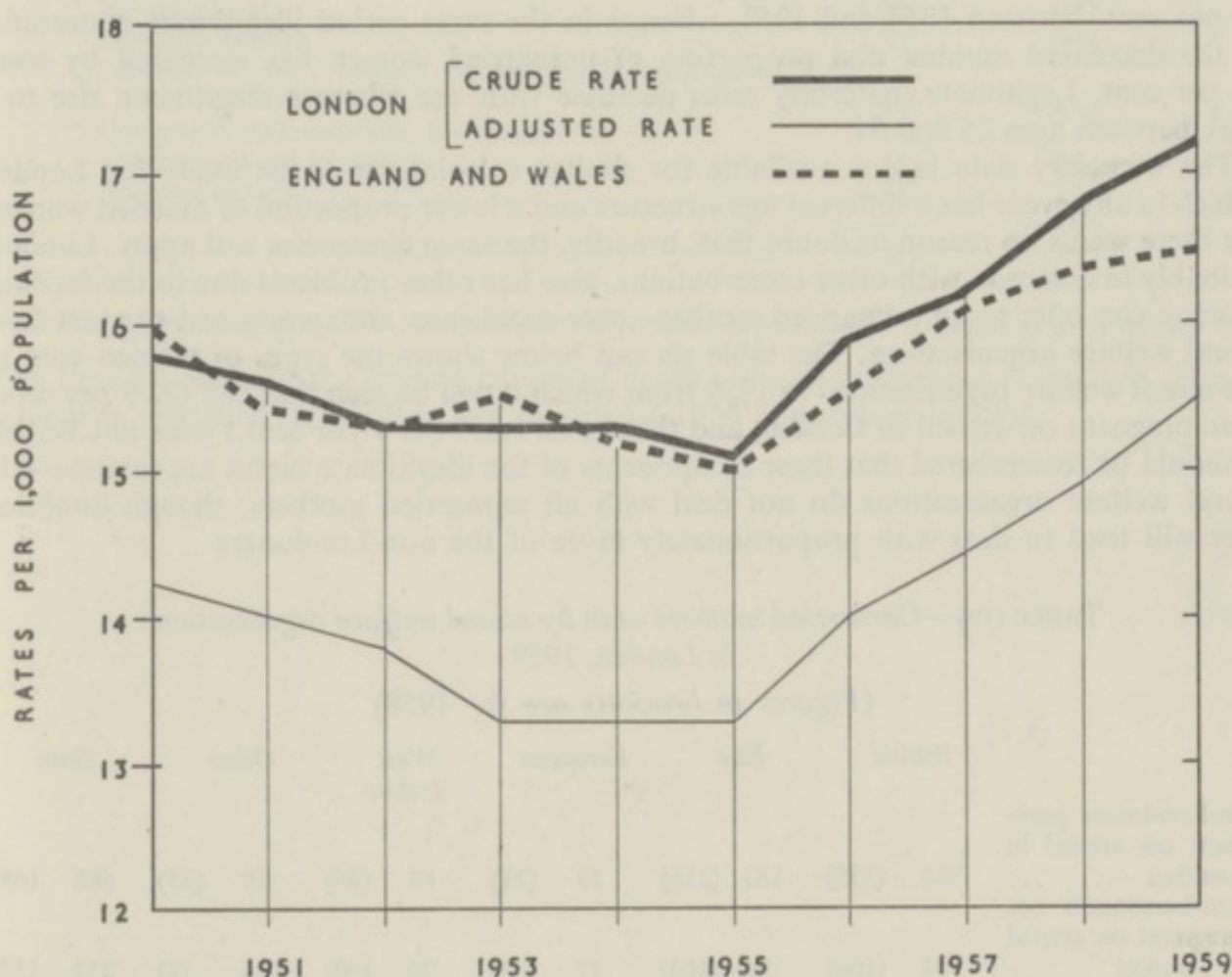


TABLE (iii)—*Illegitimate live births in London (A.C.)
and percentages for London and England and Wales, 1950-59*

Year	Illegitimate live births	Illegitimate live births as a percentage of total live births	
		London A.C.	England and Wales
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
1959	5,765	10.4	5.1

The percentage of illegitimate births in London has shown a marked upward movement over the last five years whilst nationally there has been a relatively slight increase. The national percentages, however, mask the fact that the relatively constant proportion of illegitimate births derives from a decreasing proportion of women—on the assumption that all unmarried women are equally exposed to such a risk. Overall, legitimate maternities to the increased numbers and proportion of married women have increased by some 10 per cent. between 1954 and 1958, whereas in the same period illegitimate maternities in the decreased number and proportion of unmarried women has increased by some 24 per cent. Legitimate maternity rates decrease with age whereas illegitimate rise to a peak between ages 25 and 34.

The necessary data is not available for similar calculations to be made for London (which in any event has a different age structure and a lower proportion of married women) but there seems no reason to doubt that, broadly, the same tendencies will apply. London, probably in common with other conurbations, also has other problems 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 1959 from which it will be seen that 688 (22.9 per cent.) were pregnant on arrival in London and that in all 1,259 (41.9 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, 1959*

(*Figures in brackets are for 1958*)

	British		Eire		European		West Indian		Other		Total	
Non-Londoners preg- nant on arrival in London	383	(335)	183	(216)	39	(21)	64	(86)	19	(35)	688	(693)
*Non-Londoners not pregnant on arrival in London ..	93	(104)	96	(103)	17	(13)	20	(50)	6	(8)	232	(278)
Resident in London one year	1,270	(1,300)	455	(364)	85	(52)	236	(242)	39	(46)	2,085	(2,004)
	1,746	(1,739)	734	(683)	141	(86)	320	(378)	64	(89)	3,005	(2,975)

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

Mortality

The total death rate at 11·9 per 1,000 population, although slightly higher than the previous year (11·8), was about the average of the last decade. In detail, however, deaths differed in pattern from the normal. Figure 2 shows the weekly deaths registered in London in 1959 (before correction for residence although this is a fairly constant factor week by week) together with the average for the previous five years. It will be seen that mortality was much higher than usual in the early weeks of the year but that this excess was compensated for, to some extent, by a lower mortality during the remainder of the year. This high mortality in the first quarter was due to a combination of cold weather in January and an epidemic of influenza in February and early March, with the attendant respiratory complications of pneumonia and bronchitis. In the week ended 21st February registered deaths totalled 1,815 (147 from influenza, 259 from pneumonia, 326 from bronchitis), which apart from the aftermath of the smog in December, 1952, and the war years, was the highest weekly figure since January, 1937 (the population was 28 per cent. higher in that year).

Leading causes of death—The leading causes of death in London in 1959 were as follows:

	<i>Deaths</i>	<i>Rate per 1,000 population</i>
Diseases of the heart	11,011	3·44
Cancer	7,693	2·40
Bronchitis, pneumonia*	5,800	1·81
Vascular lesions of the central nervous system	3,958	1·24
Other circulatory	1,901	0·59
Violent causes	1,654	0·52
Digestive diseases	1,302	0·41
Diseases of early infancy (international classification Nos. 760-776)	685	0·26
Congenital malformations, 0-4 weeks	148	
Tuberculosis (all forms)	343	0·11
All other causes	3,732	1·16
Total	38,227	11·93

* *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 1958. Heart disease was discussed in detail in my report for 1956 and cancer in 1958.

Cancer—The cancer death-rate for all ages was 2.40 per 1,000 in 1959—a slight decrease 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, 1950-59*

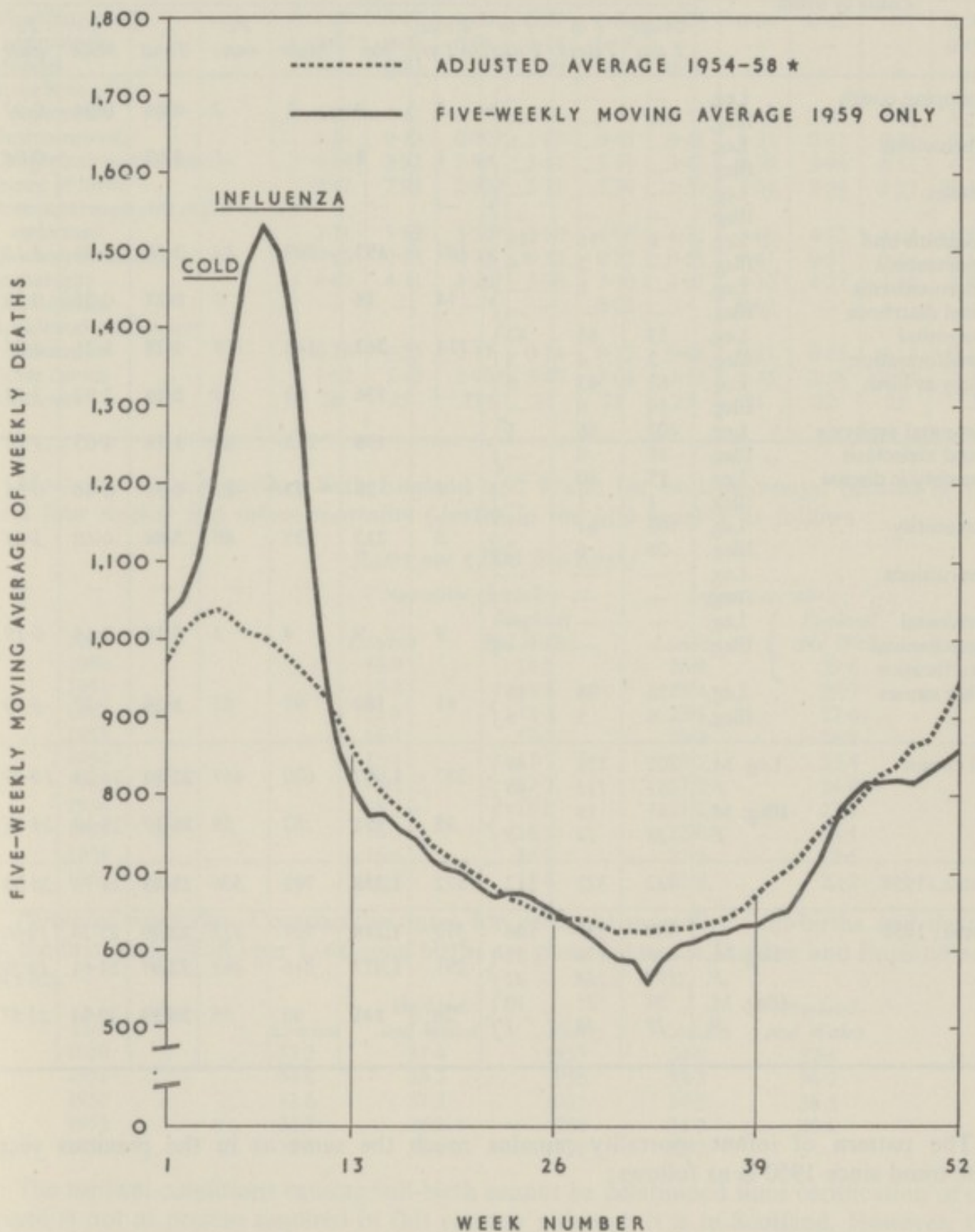
<i>Age and Sex</i>	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959
Males:										
0-24	0.10	0.09	0.12	0.14	0.12	0.11	0.14	0.11	0.09	0.10
25-44	0.43	0.45	0.45	0.46	0.41	0.40	0.43	0.37	0.42	0.40
45-64	4.45	4.28	4.19	4.28	4.31	4.50	4.51	4.55	4.52	4.46
65+	13.23	15.64	15.50	15.69	15.29	15.73	15.77	15.29	16.01	15.20
All Males ..	2.49	2.60	2.61	2.68	2.64	2.73	2.76	2.77	2.85	2.76
Females :										
0-24	0.06	0.08	0.07	0.07	0.06	0.07	0.09	0.07	0.10	0.07
25-44	0.47	0.46	0.47	0.51	0.43	0.45	0.50	0.47	0.52	0.51
45-64	2.84	2.80	2.85	2.85	2.85	2.93	2.77	2.97	2.71	2.63
65+	8.95	8.79	8.77	8.73	8.39	8.43	8.75	8.34	8.50	8.18
All Females ..	1.95	1.99	2.02	2.04	2.02	2.08	2.12	2.16	2.15	2.09
All Persons ..	2.20	2.27	2.30	2.34	2.31	2.39	2.42	2.44	2.47	2.40

Lung Cancer—As was demonstrated in my report last year, the lung has become the principal site for cancer in males and the table below shows, for three age groups, the steep rise that has occurred in the last decade together with, for comparison, the corresponding figures for females.

TABLE (vi)—*Deaths and death rates from cancer of the lung by age and sex, 1950-59*
(rates per 1,000 population)

<i>Year</i>	<i>Age</i>					
	<i>25-44</i>		<i>45-64</i>		<i>65+</i>	
	<i>No.</i>	<i>Rate</i>	<i>No.</i>	<i>Rate</i>	<i>No.</i>	<i>Rate</i>
Males:						
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
1959 ..	61	0.13	907	2.34	788	5.51
Females:						
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
1959 ..	22	0.05	134	0.29	157	0.62

Figure 2
WEEKLY REGISTERED DEATHS—LONDON (A.C.),
1954-58 AND 1959



* Calculated by taking the number of deaths in the corresponding weeks of five previous years, eliminating the highest and lowest figures and then computing a five-week moving average of the arithmetic means of the remaining three weekly figures.

Infant mortality

TABLE (vii)—*Infant mortality—1959*

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.	—	—	—	3	3	1	2	0.05	0.04	0.07
		Illeg.	—	—	—							
Tuberculosis	..	Leg.	—	—	—	1	1	—	1	0.02	—	0.04
		Illeg.	—	—	—							
Measles	..	Leg.	—	—	—	—	—	—	—	—	—	—
		Illeg.	—	—	—							
Bronchitis and pneumonia	..	Leg.	6	16	18	147	193	109	84	3.50	3.84	3.13
		Illeg.	—	2	4							
Gastro-enteritis and diarrhoea	..	Leg.	—	1	—	14	15	7	8	0.27	0.25	0.30
		Illeg.	—	—	—							
Congenital malformation	..	Leg.	37	55	47	114	262	148	114	4.75	5.21	4.25
		Illeg.	2	4	3							
Injury at birth	..	Leg.	65	43	6	—	136	83	53	2.46	2.92	1.98
		Illeg.	14	8	—							
Post-natal asphyxia and atelectasis	..	Leg.	107	66	1	—	198	115	83	3.59	4.05	3.10
		Illeg.	18	6	—							
Haemolytic disease	..	Leg.	15	10	—	1	28	13	15	0.51	0.46	0.56
		Illeg.	1	1	—							
Immaturity	..	Leg.	107	61	7	2	213	125	88	3.86	4.40	3.28
		Illeg.	28	6	2							
Convulsions	..	Leg.	—	—	—	—	—	—	—	—	—	—
		Illeg.	—	—	—							
Accidental mechanical suffocation		Leg.	—	—	—	9	9	4	5	0.16	0.14	0.19
		Illeg.	—	—	—							
Other causes	..	Leg.	26	38	18	81	180	97	83	3.26	3.42	3.10
		Illeg.	6	5	6							
All causes	..	Leg. M.	202	179	49	337	1,087	620	467	22.00	24.34	19.49
		F.	161	111	48							
		Illeg. M.	41	18	7	35	151	82	69	26.19	28.10	24.24
		F.	28	14	8							
TOTAL, 1959	..	..	432	322	112	372	1,238	702	536	22.43	24.73	20.00
TOTAL, 1958	..	..	460	333	108	317	1,218	701	517	22.49	25.24	19.60
		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							

The pattern of infant mortality remains much the same as in the previous year. The trend since 1950 is as follows:

TABLE (viii)—*Infant mortality by cause—1950-59*
(Rates per 1,000 live births)

<i>Cause of death</i>	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959
Whooping cough	0.39	0.17	0.08	0.27	0.06	0.06	0.04	0.02	—	0.05
Tuberculosis	0.17	0.08	0.04	0.14	0.08	—	—	—	—	0.02
Measles	—	0.13	—	0.06	0.02	0.10	—	—	—	—
Bronchitis and pneumonia	4.25	4.47	3.89	4.04	2.70	3.57	3.32	2.88	3.45	3.50
Gastro-enteritis	1.14	0.73	0.80	1.27	0.43	0.48	0.35	0.42	0.31	0.27
Congenital malformations	4.14	3.82	3.93	3.41	3.51	3.43	3.70	3.96	4.51	4.27
Injury at birth	2.42	2.98	2.82	2.71	2.34	2.59	2.64	2.98	2.27	2.46
Post-natal asphyxia and atelectasis	3.71	3.82	3.50	3.90	4.06	4.32	3.66	4.17	4.08	3.59
Haemolytic disease	0.95	0.86	0.72	0.53	0.55	0.58	0.61	0.51	0.44	0.51
Immaturity	4.62	4.71	4.20	3.98	3.70	4.67	4.10	4.27	4.69	3.86
Convulsions	—	—	—	—	0.02	—	0.02	—	—	—
Accidental mechanical suffocation	0.26	0.25	0.17	0.14	0.12	0.06	0.21	0.23	0.13	0.16
Other causes	3.52	3.42	2.96	3.40	3.04	3.35	2.55	2.56	2.12	2.83
All causes	26	25	23	24	21	23	21	22	22	22

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

<i>Year</i>	<i>Neo-natal mortality</i>		<i>Infant mortality</i>	
	<i>London</i>	<i>England and Wales</i>	<i>London</i>	<i>England and Wales</i>
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	22.5	22.5
1959	15.7	15.8	22.4	22.2

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.

<i>Year</i>	<i>London</i>	<i>England and Wales</i>	<i>Year</i>	<i>London</i>	<i>England and Wales</i>
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
1954	32.8	38.1	1959	32.7	—

The medical conditions causing still-birth cannot be determined since certification of the cause is not at present required in this country although it is in Scotland. However, the Population (Statistics) Bill* will bring the law in England and Wales into line with that in Scotland by requiring the certificate to state the cause of death. A special enquiry, under Ministry auspices, into peri-natal mortality was made in 1958-59, and the National Birthday Trust Fund also made a similar enquiry in March, 1958; the results of both enquiries are still awaited.

* The Bill received Royal Assent on 2nd June, 1960.

TABLE (ix)—*Maternal mortality, 1950-59*

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
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
1959*	56,276	22	12	34	0.60

* For the fourth year running none of the deaths in pregnancy or childbirth was due to sepsis; eight of the 12 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 19 and 20.

Air pollution

In previous reports I have given, in some detail, evidence in support of the hypothesis that when the mean daily level of air pollution reaches 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, an 'excess' of deaths may be expected.

The winter of 1958-59 was notable for the large number of foggy days although on no one day was the concentration referred to above attained by both constituents of pollution, though they came very close to it. On two occasions, once in January, and again in February, 1959, the critical level for 'sulphur dioxide' alone was exceeded. Neither of these two near 'smogs' appeared to have any serious effect on mortality, though on the latter occasion the situation was complicated by the prevalence of the influenza epidemic. A full report on these episodes was given in a paper published in 'The Medical Officer' on 16 October, 1959.

There were two foggy incidents later in the year, in mid-November and early December, but in neither of these two instances was the critical level more than three-quarters attained.

Comparisons are now available for the past six winters of the average levels of pollution based on the seven recording stations described in appendix B to my report for 1956.

Winter averages (a) of air pollution

Winter	'Smoke' (b)	'Sulphur dioxide' (c)	Ratio smoke/ SO_2
1954-1955	49	11.1	4.41
1955-1956	52	11.8	4.40
1956-1957	45	10.2	4.41
1957-1958	41	11.5	3.57
1958-1959	43	11.9	3.61
1959-1960	32	9.6	3.33

(a) Average daily readings of seven volumetric recording stations.

(b) Milligrams of black suspended matter per 100 cubic metres of air.

(c) Acidic gases in parts per 100 million parts of air.

It will be seen that whereas the amount of 'sulphur dioxide' has remained relatively constant there has been a downward trend in smoke since 1955-1956. The end column shows a change in the ratio of smoke to 'sulphur dioxide' during the past three winters. This reduction in smoke, both absolute and relative, appears to have been the accompaniment of a reduction in the consumption of coal, particularly by residential users. If the reduction is a consequence of the implementation of the Clean Air Act, it is perhaps a pity that 'sulphur dioxide' is not similarly reduced but, as stated by the Minister of Housing and Local Government in the House of Commons on 28 July, 1959, the designation of sulphur-oxide-free zones is rendered impracticable by 'the present state of scientific and technical knowledge.' In fact, from previous work (1), (2), (3), smoke appears, in relation to mortality, to be more injurious to health.

(1) *Appendix B to Annual Report, M.O.H., L.C.C. (1956).*

(2) *Scott, J. A. (1959) Medical Officer 102, 191-193.*

(3) *Burgess, S. G. and Shaddick, C. W. (1959) Jnl. Roy. Soc. Hlth. 79, 10.*

INFECTIOUS DISEASES

Notifications of infectious diseases for the years 1950–1959 are shown in table V.5, page 23; those for certain such diseases by age and sex for the 13 four-weekly periods of the year 1959 are given in table V.6, page 24; and deaths from infectious disease are included in table V.3, page 21.

Diarrhoea and enteritis—There were 19 deaths under the age of two years from diarrhoea and enteritis, the same as in the previous year. This represents a rate of 0.34 per 1,000 live births and shows a continuation of the low figures of recent years.

Diphtheria—Once again there was a rise in the number of notifications of diphtheria. Mention was made in the report for 1958 of a carrier outbreak in Finsbury. In June, 1959 a positive throat swab was reported in a child attending one of the schools involved the previous year. In the next few weeks 60 children in this school were found to have positive swabs. Most of these were carriers, but in view of the extremely mild nature of the symptoms in those presenting them, any clear differentiation between cases and carriers was impossible. Shortly afterwards eight carriers were discovered in a neighbouring school and later positive swabs were reported in children in other schools. Altogether 106 swab-positive schoolchildren were discovered in ten schools in this neighbourhood during the year, and a number of positive swabs were also found in home contacts of these cases.

In November, 1959 an episode occurred in Camberwell having many similarities to that in Finsbury. There were six cases with symptoms, all mild, and 76 symptomless positives, mostly discovered in the school contacts in two schools and in home contacts of known positives.

The policy adopted in dealing with these incidents was elimination (rather than control) of the infection. Widespread and repeated swabbing of all contacts in school and home was carried out, and all infected persons were admitted to hospital. At the same time steps were taken to bring immunisation up to date in all contacts in school or home.

Dysentery—There was a decline in the incidence of dysentery from 4,502 in 1958 to 3,571 in 1959. Once again more cases occurred in pre-schoolchildren than in schoolchildren. This year there was an increase in the proportion of cases in those over 15 years of age.

Enteric fever—There was a rise to 84 in the number of notifications of enteric fever. Part of this rise was explained by an outbreak in Southwark of 15 cases of paratyphoid arising from the consumption of infected cream-filled confectionery. Apart from this limited group, all reported cases were single sporadic events.

Influenza—There was a considerable outbreak of influenza during the month of February, 1959. The epidemic, therefore, occurred at the customary season, and the seasonal incidence of the disease appears to have resumed its usual rhythm after the unique autumn epidemic of 1957. It is difficult to estimate how the incidence of influenza in 1959 compares with that in previous epidemics. Judged by mortality, however, the 1959 epidemic ranks as one of the most severe of recent years, there being 580 deaths from influenza. In the last 20 years there have been only three other years in which there were more than 500 deaths from influenza; these were 1943, 1951 and 1953 when there were 726, 809 and 514 deaths respectively.

Leptospirosis—For the third successive year there were no reported cases of leptospirosis among the Council's sewer workers.

Measles—The beginning of the year saw the main part of the biennial measles epidemic which came to its peak in the week ending 21 February. The epidemic was rather smaller than the two preceding epidemics. The disease continues to be generally mild and there is no sign of return to its former virulence.

Ophthalmia neonatorum—There was an increase in the number of notifications from 132 in 1958 to 161 in 1959—the rate (per 1,000 registered live births) changing from 1.99 to 2.53. Cases among children born to London residents totalled 99—the same as in the previous year: in 83 vision was unimpaired, 12 removed and the remaining four were still under treatment at the end of the year.

Poliomyelitis—There was an increase in the number of notifications of poliomyelitis from 107 in 1958 to 210 in 1959. Of the total, 59 (38 paralytic) were notified in Islington giving that borough a level of incidence higher than that experienced generally in London in the great epidemic of 1947. This is a salutary warning to those who may be tempted to claim too soon that poliomyelitis has been conquered.

An unexpected finding was the relatively high proportion of cases occurring in the 0–4 age group. As may be seen from table (x), in 1959 this was 51.4 per cent. whereas in recent years it has tended to be between 30 and 40 per cent. Only once before has it risen to 50 per cent.—in 1949. The explanation of this sudden change in 1959 and 1949 is obscure, but in 1959 it does not appear to have been due to any difference between the level of vaccination in this age group and other age groups.

TABLE (x)—*Poliomyelitis notifications by age, 1949–59*

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
1950	150	34.9	149	34.6	131	30.5	430
1951	27	24.1	45	40.2	40	35.7	112
1952	95	30.7	105	34.0	109	35.3	309
1953	116	35.0	104	31.3	112	33.7	332
1954	42	33.6	41	32.8	42	33.6	125
1955	334	34.8	391	40.7	235	24.5	960
1956	88	31.5	115	41.2	76	27.3	279
1957	103	31.8	131	40.4	90	27.8	324
1958	40	37.4	36	33.6	31	29.0	107
1959	108	51.4	66	31.4	36	17.2	210

Every notification in respect of London residents in 1959 was followed up in two directions. First, the divisional medical officer provided details of the past history of poliomyelitis vaccination and of recent inoculations with other prophylactics. Secondly, the hospitals provided details of the clinical history and of virological examinations.

Table (xii) gives the results of virological examinations in hospitals excluding four out-county notifications. It will be seen that virological examination was part of the diagnostic routine at all but one of the main receiving hospitals. With one exception all the polio virus findings were of type I. The exception was a case with encephalitic illness from which poliomyelitis virus type III was isolated: other viruses isolated included Echo 4 (two cases) and Cocksackie B.4 (one case).

TABLE (xi)—Notifications of poliomyelitis—virology at hospitals
(Figures in brackets represent cases subsequently diagnosed as not poliomyelitis.)

Paralytic notifications									Non-paralytic notifications								
Hospital	Age	Number of original notifications	Virology done		Result of virological test				Hospital	Age	Number of original notifications	Virology done		Result of virological test			
			No	Yes	Negative	Polio virus	Other virus	Not known				No	Yes	Negative	Polio virus	Other virus	Not known
A	0-4	22	—	22	3	19	—	—	A	0-4	3 (2)	—	3 (2)	— (2)	3	—	—
	5-9	3	—	3	1	2	—	—		5-9	2 (3)	— (1)	2 (2)	— (2)	2	—	—
	10-14	3	—	3	—	3	—	—		10-14	1	—	1	— (1)	1	—	—
	15+	5	1	4	1	3	—	—		15+	— (3)	— (1)	— (2)	— (1)	—	— (1)*	—
		33	1	32	5	27	—	—			6 (8)	— (2)	6 (6)	— (5)	6	— (1)*	—
B	0-4	6	6	—	—	—	—	—	B	0-4	—	—	—	—	—	—	—
	5-9	2 (2)	2 (2)	—	—	—	—	—		5-9	— (1)	— (1)	—	—	—	—	—
	10-14	1	1	—	—	—	—	—		10-14	1	—	1	—	1	—	—
	15+	2	2	—	—	—	—	—		15+	—	—	—	—	—	—	—
		11 (2)	11 (2)	—	—	—	—	—			1 (1)	— (1)	1	—	1	—	—
C	0-4	16	—	16	—	16	—	—	C	0-4	6	—	6	1	5	—	—
	5-9	2	1	1	—	1	—	—		5-9	3	—	3	—	3	—	—
	10-14	2	—	2	1	1	—	—		10-14	—	—	—	—	—	—	—
	15+	6	—	6	4	2	—	—		15+	—	—	—	—	—	—	—
		26	1	25	5	20	—	—			9	—	9	1	8	—	—
D	0-4	7 (1)	—	7 (1)	1 (1)	6	—	—	D	0-4	— (1)	—	— (1)	— (1)	—	—	—
	5-9	1	—	1	—	1	—	—		5-9	2 (2)	—	2 (2)	— (2)	2	—	—
	10-14	—	—	—	—	—	—	—		10-14	—	—	—	—	—	—	—
	15+	1	—	1	—	1	—	—		15+	1 (1)	—	1 (1)	— (1)	1	—	—
		9 (1)	—	9 (1)	1 (1)	8	—	—			3 (4)	—	3 (4)	— (4)	3	—	—
E	0-4	10	—	10	1	9	—	—	E	0-4	3	—	3	—	3	—	—
	5-9	6	—	6	—	6	—	—		5-9	6	—	6	—	6	—	—
	10-14	—	—	—	—	—	—	—		10-14	— (2)	—	— (2)	— (2)	—	—	—
	15+	3	—	3	—	3	—	—		15+	1 (1)	—	1 (1)	1 (1)	—	—	—
		19	—	19	1	18	—	—			10 (3)	—	10 (3)	1 (3)	9	—	—
F	0-4	5	—	5	1	4	—	—	F	0-4	—	—	—	—	—	—	—
	5-9	2	—	2	—	2	—	—		5-9	3	—	3	—	3	—	—
	10-14	—	—	—	—	—	—	—		10-14	—	—	—	—	—	—	—
	15+	5 (1)	1 (1)	4	4	—	—	—		15+	—	—	—	—	—	—	—
		12 (1)	1 (1)	11	5	6	—	—			3	—	3	—	3	—	—
Other	0-4	14	2	12	—	11	—	1	Other	0-4	6 (3)	1	5 (3)	— (2)	5	—	— (1)
	5-9	3	—	3	—	3	—	—		5-9	3 (4)	—	3 (4)	— (2)	3	—	— (1)
	10-14	1	—	1	—	1	—	—		10-14	1	—	1	—	1	—	— (1)†
	15+	6	1	5	1	4	—	—		15+	1 (1)	—	1 (1)	1	—	— (1)†	—
		24	3	21	1	19	—	1			11 (8)	1	10 (8)	1 (4)	9	— (2)†	— (2)
All hospitals . . .		134 (4)	17 (3)	117 (1)	18 (1)	98 (—)	—	1 (—)	All hospitals . . .		43 (24)	1 (3)	42 (21)	3 (16)	39 (—)	— (3)	— (2)
Total		138	20	118	19	98	—	1	Total		67	4	63	19	39	3	2

One other case age 7/12 notified paralytic (not vaccinated) no further details.

* Coxsackie B4

† Echo 4

As a result of scrutiny of the clinical and virological findings, a final diagnosis was made in respect of each notification. The diagnosis of paralytic poliomyelitis was made on clinical grounds, although virological confirmation was present in the majority of cases. A diagnosis of non-paralytic poliomyelitis was made only in cases in which poliomyelitis virus was present in the stool, or when serological evidence supported the diagnosis. Table (xii) gives an analysis of the original notifications according to the final diagnosis.

TABLE (xii)—*Final diagnosis of poliomyelitis notifications, 1959*

Final diagnosis	Notified as paralytic				Notified as non-paralytic				Total (all ages)
	0-4 years	5-14 years	15+ years	Total	0-4 years	5-14 years	15+ years	Total	
Paralytic ..	78	26	27	131	3	6	1	10	141
Non-paralytic ..	2	1	—	3	15	16	2	33	36
Not poliomyelitis (or not known)	2	2	1	5*	6	12	6	24	29*
Total ..	82	29	28	139	24	34	9	67	206

* includes 1 case, diagnosis not known

It will be seen that out of 139 cases notified as paralytic eight proved to be non-paralytic or not poliomyelitis (including one case where the true diagnosis was not known) and that, out of the 67 cases notified as non-paralytic, ten proved to be of the paralytic form and 24 were not poliomyelitis. Thus, on balance, the original notifications slightly understated the extent of the paralytic form—139 against 141—and there were 29 cases which proved to be not poliomyelitis (including the one not known). The vaccinal state of the 141 cases finally diagnosed as paralytic poliomyelitis and the 36 non-paralytic cases is set out in table (xiii).

TABLE (xiii)—*Vaccinal state of confirmed cases of poliomyelitis, 1959*

Age				Vaccinated *		Not vaccinated		Total
				No.	%	No.	%	No.
(a) Paralytic cases								
0-4 years				18	22	63	78	81
5-14 "				6	19	26	81	32
15+ "				2	7	26	93	28
Total				26	18	115	82	141
(b) Non-paralytic cases								
0-4 years				3	18	14	82	17
5-14 "				3	18	14	82	17
15+ "				—	—	2	100	2
Total				6	17	30	83	36

* One, two or three injections

It is estimated that at 30 June, 1959—about midway point of the poliomyelitis season in 1959—66 per cent. of children aged 0–16 years had received two injections of poliomyelitis vaccine. Applying this percentage to the child population at risk gives the following incidence rates for the paralytic form of the disease:

	<i>Population 0–14 years</i>	<i>Cases</i>	<i>Cases per 1,000 population at risk</i>
Vaccinated	426,000	24	0.056
Not vaccinated ..	219,000	89	0.406

Thus the incidence rate in the unvaccinated children was about seven times that in the vaccinated. This is probably an understatement of the difference because among the vaccinated cases there were five who had received only one injection and can therefore be regarded as incompletely vaccinated.

In a similar analysis for the last six months of 1958, when approximately 45 per cent. of the child population had been vaccinated, the corresponding differential between the incidence rates in the unvaccinated and vaccinated was five times. The improvement in 1959 may be linked with the fact that by the end of that year slightly over one-half of the vaccinated child population had received a third injection of vaccine.

It was not thought worthwhile to extend this analysis to the older age groups because of the difficulty in arriving at an estimate of the 'exposed to risk' population of vaccinated persons, as it is not known how many London adult residents have been vaccinated outside the county.

Whooping Cough—There was a slight rise in the number of notifications of whooping cough from 1,595 in 1958 to 1,607 in 1959. The figures for the last two years are considerably lower than in the preceding years. Although it is known that whooping cough is grossly under-reported, there is no reason to assume that the degree of under-notification has suddenly changed, and one is therefore led to believe that the incidence of the disease has in fact declined. It would not be unreasonable to associate this decline in some degree with whooping cough immunisation, in view of the fact that during the last few years about two-thirds of infants under the age of one year have been given a course of whooping cough vaccine.

Metropolitan Boroughs	Estimated home population mid 1959	Live birth rate		Death rate (all causes)		Infant Mortality (per 1,000 live births)	Death rates							Notifications of infectious disease									
		Crude	Adju- sted	Crude	Adju- sted		Cancer	Vascu- lar lesions of C.N.S.	Heart disease	Other circula- tory	Pneu- monia	Other respi- ratory (exclud- ing tuber- culosis)	Vio- lence	Dysen- tery	Food poison- ing	Measles	Pneu- monia	Poliomyelitis		Scarlet fever	Whoop- ing cough	Tuberculosis	
																		Para- lytic	Non- para- lytic			Pulmo- nary	Non- pulmo- nary
Division 1																							
Chelsea	49,520	14.6	11.1	14.7	11.0	17	2.69	1.64	4.42	1.19	1.35	1.15	0.65	1.25	0.10	8.40	0.36	0.040	0.020	0.63	0.67	0.73	0.06
Fulham	113,300	15.8	15.3	12.2	12.1	22	2.65	1.41	3.20	0.76	0.63	1.54	0.42	0.62	0.17	7.93	0.40	0.018	0.009	0.36	0.61	0.73	0.05
Hammersmith ..	108,900	18.3	17.2	11.4	12.0	28	2.41	1.27	2.99	0.55	0.62	1.23	0.53	1.36	2.92	7.58	0.84	0.018	—	0.93	0.54	1.24	0.07
Kensington ..	166,500	18.2	13.1	9.9	10.0	25	2.12	1.15	2.49	0.66	0.65	0.88	0.60	0.66	0.39	4.43	0.36	0.042	0.006	0.32	0.50	1.03	0.13
Division 2																							
Hampstead ..	96,810	16.4	12.3	10.9	10.9	23	2.31	0.92	3.34	0.49	0.53	0.96	0.57	0.82	0.27	3.55	0.49	0.020	0.031	0.38	0.38	0.92	0.06
Paddington ..	113,400	20.0	16.0	10.8	11.1	22	2.48	1.03	2.73	0.58	0.64	0.89	0.80	0.22	0.77	3.42	0.33	0.026	0.009	0.33	0.43	1.28	0.12
St. Marylebone ..	70,430	9.7	7.6	16.2	11.3	16	3.08	2.19	5.31	0.78	0.75	1.66	0.64	0.65	0.14	3.55	0.09	0.014	—	0.27	0.07	0.81	0.01
St. Pancras ..	128,700	18.0	15.7	11.0	11.3	26	2.43	1.10	2.64	0.44	1.06	1.06	0.59	1.05	0.90	4.63	1.12	0.070	0.047	0.47	0.36	1.47	0.09
Westminster, City of ..	94,640	10.0	8.2	10.7	11.1	20	2.40	1.00	3.01	0.61	0.59	1.10	0.68	0.22	0.15	4.70	0.20	0.011	—	0.31	0.15	0.90	0.06
Division 3																							
Finsbury	34,030	18.3	16.3	11.0	11.2	16	2.29	0.76	2.85	0.44	0.85	1.59	0.85	1.32	0.85	17.20	2.20	0.059	0.029	2.03	0.50	0.73	0.03
Holborn	21,370	10.0	7.1	11.7	12.5	66	2.48	1.08	2.99	0.47	0.98	1.12	0.61	1.31	0.89	6.50	0.28	0.094	—	0.33	0.19	1.26	—
Islington	223,400	22.1	20.1	11.5	11.2	22	2.32	1.13	3.10	0.65	0.79	1.44	0.56	1.41	0.71	6.19	0.48	0.170	0.094	1.08	0.71	1.14	0.06
Division 4																							
Hackney	163,200	19.2	17.9	11.7	12.6	21	2.48	1.15	3.56	0.48	0.70	1.37	0.41	1.03	0.31	9.75	0.32	0.037	0.012	1.02	0.22	0.60	0.12
Shoreditch ..	43,330	13.8	12.6	12.7	11.8	27	2.42	0.67	2.95	0.74	1.48	2.05	0.46	1.29	0.05	10.27	0.51	0.046	0.023	1.11	0.07	0.81	0.12
Stoke Newington ..	50,200	21.1	18.8	11.2	12.7	18	2.55	1.10	3.15	0.54	0.60	1.12	0.50	0.66	0.32	10.40	0.36	0.040	—	1.55	0.56	0.90	0.08
Division 5																							
Bethnal Green ..	48,960	16.9	15.9	11.6	11.5	23	2.41	1.23	2.49	0.51	0.88	1.86	0.43	0.71	0.10	14.89	0.25	0.123	0.041	1.00	0.06	0.80	0.06
City of London(b) ..	4,900	5.7	5.1	9.2	9.4	—	2.65	0.20	2.24	1.02	0.82	0.82	0.20	0.20	0.82	4.29	0.20	—	—	0.20	—	0.82	0.20
Poplar	63,540	17.7	17.0	11.8	13.0	19	2.47	1.07	2.80	0.46	1.05	1.72	0.39	0.98	0.85	18.35	1.04	0.016	—	1.23	0.24	0.90	0.09
Stepney	94,900	18.9	16.8	13.1	14.0	25	2.55	1.37	3.42	0.58	0.94	1.79	0.57	0.92	0.08	14.16	1.38	0.063	0.011	0.62	0.80	1.42	0.15
Division 6																							
Deptford	69,660	17.7	17.2	11.9	12.0	19	2.63	1.11	3.65	0.53	0.85	1.22	0.42	1.64	—	11.56	0.62	0.014	—	0.92	2.07	1.31	0.10
Greenwich	88,970	15.0	14.1	9.9	11.2	18	1.98	1.02	3.12	0.39	0.85	0.93	0.33	2.80	0.48	7.16	0.22	0.022	—	0.76	0.38	0.46	0.02
Woolwich	144,800	13.5	13.4	10.6	11.2	21	2.09	1.30	3.45	0.55	0.88	0.77	0.41	0.52	0.10	12.44	0.97	—	0.007	0.70	0.24	0.55	0.06
Division 7																							
Camberwell ..	176,100	17.7	16.5	11.4	11.3	27	2.50	1.14	2.82	0.62	1.07	1.24	0.43	0.63	0.61	7.51	0.33	—	—	0.81	0.52	0.81	0.09
Lewisham	221,000	15.7	14.9	11.8	11.8	18	2.41	1.48	3.76	0.53	0.82	1.05	0.38	1.24	0.30	11.82	0.49	0.054	0.018	1.37	1.04	0.57	0.08
Division 8																							
Bermondsey ..	54,120	15.9	15.1	11.4	12.3	20	2.20	0.98	2.96	0.59	0.83	1.88	0.54	1.87	0.87	11.73	0.85	—	—	1.16	0.26	0.89	0.04
Lambeth	223,300	20.9	19.0	11.1	11.3	25	2.17	1.17	3.22	0.47	0.76	1.14	0.50	0.94	0.18	10.71	0.50	0.036	0.036	0.79	0.54	0.69	0.07
Southwark	88,720	16.9	15.2	13.6	11.6	29	2.29	1.35	4.17	0.72	1.15	1.80	0.50	3.84	0.30	11.60	0.90	0.056	0.022	1.09	0.68	1.04	0.07
Division 9																							
Battersea	108,500	18.7	18.0	12.2	11.6	22	2.29	1.47	3.75	0.54	0.82	1.47	0.42	1.54	0.23	6.47	0.76	0.101	0.018	0.65	0.29	0.65	0.05
Wandsworth ..	338,800	15.8	15.2	14.8	10.5	19	2.59	1.41	4.98	0.71	1.06	1.35	0.59	1.19	0.77	9.48	0.79	0.038	0.018	0.97	0.33	0.71	0.06
London, 1959 ..	3,204,000	17.2	15.5	11.9	11.7	22	2.40	1.24	3.44	0.59	0.85	1.27	0.52	1.12	0.51	8.73	0.60	0.046	0.020	0.82	0.50	0.87	0.08
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

(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, 1950-59

Year	Annual rate per 1,000 living				Annual mortality per 1,000 living														Annual mortality—		
	Live births		Deaths (all causes)																Infant (per 1,000 live births)	Maternal (per 1,000 total births)	
	Crude rate	Adjusted rate	Crude rate	Adjusted rate	Tuberculosis		Cancer	Vascular lesions of C.N.S.	Heart disease	Other circulatory disease	Influenza	Pneumonia (all forms)	Bronchitis	Other resp. diseases	Violence			Infants 0—1	Diarrhoea and enteritis 0—2		
					Pulmonary	Non-pulmonary									Suicide	Road accidents (a)	Other violence				
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	
1959..	17.2	15.5	11.9	11.7	0.10	0.01	2.40	1.24	3.44	0.59	0.18	0.85	0.98	0.11	0.17	0.12	0.23	22	0.3	0.60	

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

TABLE V.3—Deaths by cause—Administrative County of London, 1959

Cause	Sex	0—	1—	5—	15—	25—	45—	65—	75+	Total	
										1959	1958
1. Tuberculosis—respiratory ..	M	—	2	—	—	18	101	71	47	239	269
	F	1	—	—	—	22	24	16	11	74	110
2. Tuberculosis—other	M	—	3	1	—	6	4	1	1	16	23
	F	—	1	—	—	1	7	3	2	14	18
3. Syphilitic disease	M	—	—	—	—	4	25	16	18	63	72
	F	—	—	—	—	—	11	12	13	36	45
4. Diphtheria	M	—	—	—	—	—	—	—	—	—	—
	F	—	—	—	—	—	—	—	—	—	2
5. Whooping cough	M	1	—	—	—	—	—	—	—	1	1
	F	2	—	—	—	—	—	—	—	2	—
6. Meningococcal infection ..	M	3	2	—	—	1	1	—	—	7	6
	F	2	—	4	1	—	—	1	—	8	3
7. Acute poliomyelitis	M	—	1	2	3	4	—	—	—	10	6
	F	—	2	1	1	2	—	—	—	6	1
8. Measles	M	2	1	—	—	—	—	—	—	3	2
	F	—	1	—	—	—	—	—	—	1	2
9. Other infective, &c., diseases	M	3	1	1	3	6	10	3	5	32	33
	F	1	2	1	1	9	13	7	7	41	36
10. Malignant neoplasm: Stomach	M	—	—	—	—	16	212	167	121	516	559
	F	—	—	—	—	14	87	151	183	435	422
11. Malignant neoplasm: Lung, bronchus	M	—	—	—	1	61	907	545	243	1,757	1,721
	F	—	—	—	—	22	134	87	70	313	329
12. Malignant neoplasm: Breast	M	—	—	—	—	—	3	—	1	4	11
	F	—	—	—	—	71	299	155	169	694	716
13. Malignant neoplasm: Uterus	F	—	—	1	—	31	134	73	54	293	290
14. Other malignant and lymphatic neoplasms	M	2	6	8	15	100	578	552	510	1,771	1,927
	F	2	3	7	9	89	517	516	586	1,729	1,829
15. Leukemia, aleukemia ..	M	—	6	6	7	8	27	19	15	88	78
	F	—	10	4	1	11	24	25	18	93	99
16. Diabetes	M	—	—	—	1	6	18	19	14	58	77
	F	—	—	—	—	1	28	51	68	148	158
17. Vascular lesions of nervous system	M	—	—	—	3	42	365	449	674	1,533	1,580
	F	1	—	1	1	30	345	570	1,477	2,425	2,574
18. Coronary disease, angina ..	M	—	—	—	1	134	1,332	1,169	963	3,599	3,572
	F	—	—	—	—	14	351	806	1,286	2,458	2,353
19. Hypertension with heart disease	M	—	—	—	—	1	63	77	148	289	328
	F	—	—	—	—	2	38	137	287	464	538
20. Other heart disease	M	1	1	—	6	61	229	324	934	1,556	1,776
	F	3	—	2	6	53	236	404	1,942	2,645	2,796
21. Other circulatory disease ..	M	—	—	—	6	28	187	239	322	782	795
	F	1	—	—	5	12	115	250	736	1,119	1,110
22. Influenza	M	1	—	—	5	14	73	80	88	261	67
	F	3	—	2	2	9	58	82	163	319	83
23. Pneumonia	M	83	9	5	11	25	242	339	643	1,357	1,061
	F	66	11	5	2	20	95	258	903	1,360	1,207
24. Bronchitis	M	26	7	3	3	18	592	689	771	2,109	1,943
	F	18	1	—	1	11	128	262	596	1,017	1,007
25. Other diseases of respiratory system	M	4	1	3	3	10	82	68	73	244	242
	F	1	1	1	2	6	31	32	46	120	117
26. Ulcer of stomach and duodenum	M	1	—	—	1	8	98	93	91	292	337
	F	—	—	—	—	2	31	39	92	164	156
27. Gastritis, enteritis and diarrhoea	M	7	4	—	2	2	20	16	20	71	65
	F	8	1	1	—	2	27	32	54	125	124
28. Nephritis and nephrosis ..	M	4	3	—	9	21	31	23	22	113	123
	F	—	2	3	1	11	29	31	38	115	113
29. Hyperplasia, prostate ..	M	—	—	—	—	—	12	51	162	225	208
30. Pregnancy, childb.: abortn.	F	—	—	—	8	26	—	—	—	34	33
31. Congenital malformations ..	M	148	22	13	7	10	13	11	1	225	183
	F	114	10	10	3	12	24	7	5	185	180
32. Other defined and ill defined diseases	M	407	11	21	16	70	246	217	306	1,294	1,284
	F	298	8	7	14	76	251	290	677	1,621	1,610

TABLE V.3 (contd.)—Deaths by cause—Administrative County of London, 1959

Cause	Sex	0—	1—	5—	15—	25—	45—	65—	75+	Total	
										1959	1958
33. Motor vehicle accidents ..	M	1	6	9	67	55	56	36	24	254	231
	F	—	2	—	12	12	27	32	44	129	104
34. All other accidents ..	M	8	17	20	23	66	93	52	86	365	377
	F	13	12	4	6	20	46	53	185	339	327
35. Suicide ..	M	—	—	—	13	93	138	50	24	318	305
	F	—	—	—	9	50	97	41	14	211	244
36. Homicide, operations of war	M	2	3	—	1	9	1	1	2	19	18
	F	2	—	2	4	5	3	2	1	19	10
ALL CAUSES ..	M	702	107	93	207	897	5,759	5,377	6,329	19,471	19,280
	F	536	67	56	89	646	3,210	4,425	9,727	18,756	18,746

TABLE V.4—Weather during 1959
(as recorded at Kew Observatory)

Month	Temperature		Rainfall		Sunshine	
	Mean (a)	Difference from Average (b)	Total	Difference from Average (b)	Total	Difference from Average (c)
	°F	°F	ins.	ins.	hrs.	hrs.
January ..	37.0	−2.7	2.13	+0.17	80.1	+38.3
February ..	40.3	0.0	0.09	−1.46	58.5	+0.1
March ..	46.4	+3.6	1.57	+0.03	108.8	+2.1
April ..	50.5	+3.0	2.04	+0.33	138.9	−10.3
May ..	56.1	+2.5	0.53	−1.22	230.3	+32.8
June ..	61.5	+2.1	0.60	−1.38	239.7	+39.2
July ..	66.0	+3.3	1.57	−0.81	290.4	+94.9
August ..	65.8	+4.0	1.13	−1.11	239.9	+54.9
September ..	61.3	+3.9	0.10	−1.89	212.1	+71.2
October ..	56.1	+5.8	1.87	−0.64	159.6	+66.4
November ..	46.0	+1.8	2.36	+0.02	58.1	+6.9
December ..	44.8	+4.1	3.07	+0.91	35.9	−1.4
Year ..	52.7	+2.6	17.06	−7.05	1,852.3	+395.1

(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, 1950-1959

Year	Anthrax		Diphtheria		Dysentery		Acute encephalitis		Enteric fever		Erysipelas		Malaria		Measles		Meningo-coccal infection		Ophthalmia neonatorum		Pneumonia		Polio-myelitis				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	Paralytic		Non-par.		Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate		
																							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	(a) 2.40	1,691	0.499	267	0.079	163	0.048	371	(b) 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	1,984	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	4,502	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
1959	—	—	75	0.023	3,571	1.115	31	0.010	84	0.026	240	0.075	4	0.001	27,970	8.73	69	0.022	161	2.53	1,914	0.597	146	0.046	64	0.020	1,666	25.64	544	0.17	2,621	0.82	—	—	—	—	1,607	0.50	1,639	0.51

(a) Rate per 1,000 live births registered in London. (b) Rate per 1,000 total births after correction for London residence 1950; 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.

TABLE V.6—Notification of certain infectious diseases—distribution by age and date of notification—Administrative County of London, 52 weeks commencing 5th January, 1959

Four-weekly periods 1959		TABLE VII.—Incidence of certain communicable diseases, and mortality by age and cause of registration																															
		Dysentery				Measles				Meningococcal infection				Pneumonia				Polio-myelitis								Scarlet fever				Whooping cough			
																		Paralytic				Non-paralytic											
		Ages				Ages				Ages				Ages				Ages				Ages				Ages							
0-4	5-14	15+	Total	0-4	5-14	15+	Total	0-4	5-14	15+	Total	0-4	5-14	15+	Total	0-4	5-14	15+	Total	0-4	5-14	15+	Total	0-4	5-14	15+	Total	0-4	5-14	15+	Total		
1-4	M	49	54	35	138	1,280	914	20	2,220	—	—	—	—	13	16	78	107	1	1	—	2	—	—	—	—	37	93	3	133	22	23	—	45
	F	49	44	52	145	1,179	895	34	2,117	2	—	—	2	10	14	62	86	—	—	2	—	—	—	—	—	46	89	4	140	24	15	1	40
5-8	M	52	67	36	155	1,442	1,423	26	2,893	5	1	—	6	30	25	337	398	—	—	—	—	—	—	—	—	34	81	10	127	28	13	—	42
	F	48	43	48	143	1,412	1,469	36	2,923	3	3	3	9	31	29	308	371	1	—	—	1	—	—	—	—	33	85	5	123	34	21	1	57
9-12	M	73	76	53	204	1,581	1,261	18	2,865	2	—	1	3	10	13	148	172	—	—	3	3	—	—	—	—	33	67	4	105	24	10	—	34
	F	57	67	86	211	1,447	1,156	20	2,627	2	1	1	4	22	11	143	177	2	—	—	2	1	—	—	—	34	100	3	137	37	12	1	50
13-16	M	92	59	33	185	1,427	788	23	2,247	7	1	1	9	9	6	50	65	1	—	1	2	—	1	1	2	28	33	2	63	26	13	—	39
	F	80	55	76	212	1,345	778	24	2,150	1	—	—	1	8	5	43	57	1	—	—	1	—	—	—	—	33	55	6	96	28	15	1	44
17-20	M	62	54	31	147	769	573	7	1,353	6	1	—	7	5	3	25	33	3	2	2	7	1	2	1	4	86	17	3	108	42	9	1	52
	F	54	53	63	172	784	550	17	1,353	1	1	—	2	6	7	11	25	4	—	1	5	1	—	2	3	87	12	1	100	35	24	—	59
21-24	M	85	45	40	170	678	476	5	1,161	1	—	—	1	1	3	21	25	11	7	1	19	5	1	1	7	27	63	4	94	25	30	—	55
	F	55	55	56	167	645	446	10	1,104	1	1	—	2	3	1	6	11	10	4	—	14	1	1	1	3	31	77	3	112	27	23	—	50
25-28	M	54	33	37	125	397	219	2	620	4	2	—	6	3	4	12	19	4	5	—	9	—	1	—	1	24	71	5	101	33	20	—	53
	F	39	31	41	112	360	242	5	608	—	1	—	1	4	2	9	15	7	8	3	18	2	—	1	3	28	83	3	114	33	23	2	58
29-32	M	31	16	27	74	205	78	5	289	—	2	2	4	4	1	15	20	6	—	2	8	3	3	1	7	14	38	1	53	36	27	1	64
	F	27	18	36	82	174	83	2	259	—	—	—	—	4	4	9	17	3	1	1	5	—	4	2	6	20	31	1	52	33	22	3	59
33-36	M	33	27	17	77	99	20	—	109	—	3	—	3	2	3	7	13	8	1	2	11	3	1	1	5	22	18	—	40	42	26	1	69
	F	23	6	25	55	98	23	—	121	—	1	—	1	—	—	10	10	—	—	—	1	5	—	6	15	19	1	35	60	37	1	98	
37-40	M	36	21	29	86	36	7	1	44	1	2	—	3	2	6	23	31	1	—	3	4	1	2	—	3	35	48	—	83	49	14	—	63
	F	25	15	52	92	51	12	2	65	—	—	—	—	3	4	14	21	4	1	4	9	—	1	1	2	30	51	4	85	44	23	1	68
41-44	M	34	20	26	80	35	14	—	49	—	1	—	1	3	1	26	30	3	—	1	4	—	2	—	2	30	63	4	97	36	13	1	50
	F	28	15	36	79	30	9	—	39	—	—	—	—	2	2	19	24	1	—	2	1	—	—	1	32	69	3	104	37	33	4	75	
45-48	M	48	53	32	137	32	9	2	43	4	—	—	4	2	3	25	30	4	1	2	7	2	3	—	5	49	110	6	166	60	35	—	98
	F	44	42	46	134	30	6	—	38	1	—	—	1	2	2	28	32	3	2	1	6	—	—	—	35	96	4	136	68	48	3	119	
49-52	M	75	60	41	177	32	8	2	42	—	—	—	—	8	6	27	41	2	—	—	2	—	—	—	—	44	59	1	105	48	27	—	75
	F	72	61	89	226	18	17	1	36	2	1	—	3	5	9	42	57	—	1	—	1	—	—	—	1	28	79	5	112	57	31	—	88
Total	M	724	585	437	1,756	8,003	5,790	111	13,935	30	13	4	47	92	90	794	984	44	17	17	78	15	16	5	36	463	761	43	1,275	471	260	4	736
	F	601	505	706	1,833	7,573	5,686	151	13,440	13	9	4	26	100	90	704	903	36	18	12	66	7	12	7	26	453	846	43	1,346	517	327	18	865

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 1959.

TUBERCULOSIS

Notification rates of tuberculosis were slightly lower than in 1958, and the death rate followed the same general trend. Deaths from pulmonary tuberculosis under 25 years of age and 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 is now 37,124. The diagram on page 26 shows the trend of notifications, deaths and numbers on the registers of chest clinics over the last decade. Tuberculosis is still a serious infectious disease. It accounted this year for more cases than were notified of *any* other notifiable infectious disease in adults. The 344 deaths from tuberculosis compare with 452 from all other notifiable infectious diseases.

Services provided—The services provided by the Council as local health authority for the care and after-care of tuberculous patients and the prevention of tuberculosis are summarised in table T.10.

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, thirteen-year-old school children and students at further education establishments are shown in table T.13.

Preventive measures—In addition to the B.C.G. vaccination schemes other preventive measures 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 T.12) and of tuberculin reactors discovered among thirteen-year-old school children and students tested with a view to B.C.G. vaccination.

Epidemiological investigations are made among the contacts of cases of tuberculosis notified in children, staff or residents in the Council's establishments. Similar investigations are carried out at secondary schools where the reactor rates disclosed by tuberculin surveys are significantly higher than the average for secondary schools in the area (table T.9).

TABLE T.1—*Tuberculosis—Statutory notifications and deaths—Administrative County of London, 1950–59 (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
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
1959 ..	2,794	0.87	313	0.10	244	0.08	30	0.01

(a) *Excluding posthumous notifications.*

TREND OF TUBERCULOSIS LONDON A.C. 1950-59

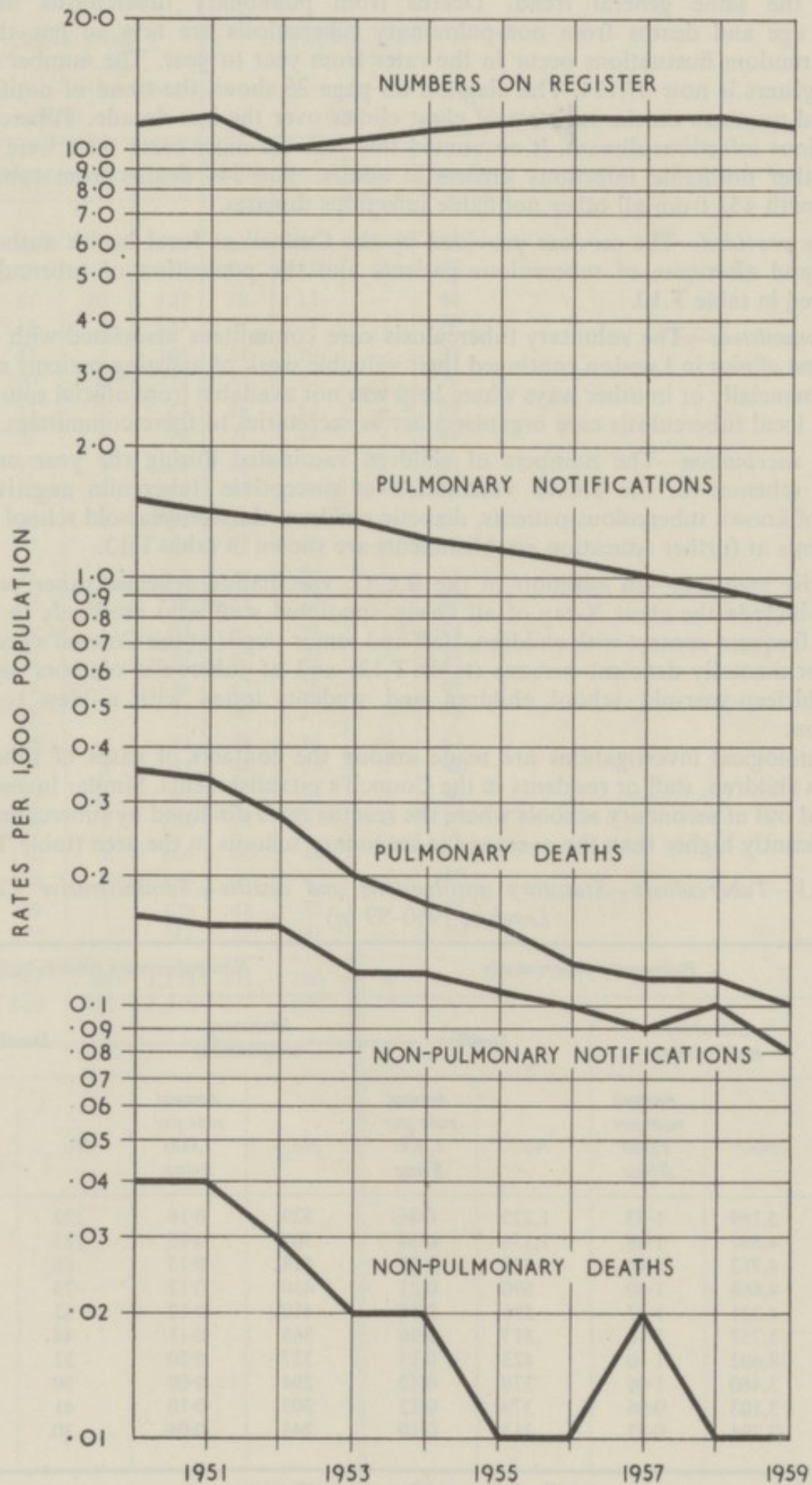


TABLE T.2—*Pulmonary tuberculosis—Notification and death rates per 1,000 living by age and sex—Administrative County of London, 1950–1959*

Year	Age									
	0–4		5–14		15–44		45 and over		All ages	
	M	F	M	F	M	F	M	F	M	F
<i>Notification rates</i>										
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
1959 ...	0.47	0.43	0.24	0.28	1.30	0.95	1.66	0.32	1.21	0.57
<i>Death rates</i>										
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
1959 ...	0.02	0.009	—	—	0.03	0.03	0.41	0.07	0.16	0.04

TABLE T.3—*Non-pulmonary tuberculosis—Notification and death rates per 1,000 living by age and sex, Administrative County of London, 1950–59*

Year	Age									
	0–4		5–14		15–44		45 and over		All ages	
	M	F	M	F	M	F	M	F	M	F
<i>Notification rates</i>										
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
1959 ...	0.050	0.043	0.063	0.040	0.103	0.130	0.055	0.041	0.076	0.076
<i>Death rates</i>										
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 ...	0.008	—	—	—	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
1959 ...	0.025	0.009	0.005	—	0.009	0.001	0.011	0.017	0.011	0.008

TABLE T.4—*Tuberculosis—Statutory notifications by age groups, Administrative County of London, 1959*

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-	75+		
Pulmonary tuberculosis ..	M.	7	50	27	23	59	173	319	283	300	359	162	60	1,822	
	F.	9	40	30	26	76	177	246	143	104	69	38	14	972	
Other forms of tuberculosis ..	M.	—	6	10	3	7	14	27	18	16	6	5	2	114	
	F.	1	4	3	5	8	19	40	21	8	11	4	6	130	
All forms of tuberculosis ..	M.	7	56	37	26	66	187	346	301	316	365	167	62	1,936	
	F.	10	44	33	31	84	196	286	164	112	80	42	20	1,102	

TABLE T.5—*Tuberculosis—Deaths in Administrative County of London, 1959*

Form of tuberculosis	Sex	Age at death								Total all ages
		0—	1—	5—	15—	25—	45—	65—	75+	
Pulmonary tuberculosis ..	M.	—	2	—	—	18	101	71	47	239
	F.	1	—	—	—	22	24	16	11	74
Other forms of tuberculosis ..	M.	—	3	1	—	6	4	1	1	16
	F.	—	1	—	—	1	7	3	2	14
All forms of tuberculosis ..	M.	—	5	1	—	24	105	72	48	255
	F.	1	1	—	—	23	31	19	13	88

TABLE T.6—*Statutory notification of non-pulmonary tuberculosis—Distribution according to site and age, Administrative County of London, 1959*

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	4	8	13	57	82
Abdomen	—	1	8	4	13
Peripheral glands	3	9	12	51	75
Meninges and C.N.S.	4	1	2	8	15
Skin and erythema nodosum	—	—	—	2	2
Genito-urinary	—	2	13	36	51
Other sites	—	—	1	5	6
All sites	11	21	49	163	244

TABLE T.7—*Tuberculosis—Statutory notifications by occupations—London Administrative County, 1959*

<i>Registrar General's short classification of employment</i>	<i>Population Census 1951</i>		<i>Notifications (a)</i>			
	<i>Males</i>	<i>Females</i>	<i>Males</i>		<i>Females</i>	
			<i>No.</i>	<i>Rate per 1,000 population (b)</i>	<i>No.</i>	<i>Rate per 1,000 population (b)</i>
1. Fishermen	15	—	— (—)	—	— (—)	—
2. Agriculture, horticulture, etc.	3,829	283	— (—)	—	— (—)	—
3. Mining, quarrying occupations	137	—	— (—)	—	— (—)	—
4. Non-metalliferous mining products	4,471	1,559	— (—)	—	— (—)	—
5. Coal, gas, coke, chemical workers	5,347	896	3 (—)	0.6	— (—)	—
6. Metalwork, engineering ..	137,927	13,178	126 (11)	0.9	4 (2)	0.3
7. Textile workers	896	2,142	1 (—)	1.1	— (—)	—
8. Tanners, leatherworkers, etc.	8,435	4,750	12 (—)	1.4	3 (—)	0.6
9. Textile goods and dressmakers	26,475	71,908	27 (3)	1.0	37 (4)	0.5
10. Food, drinks, tobacco makers	13,070	7,596	15 (—)	1.1	2 (—)	0.3
11. Wood, cane, corkworkers ..	35,998	1,206	39 (3)	1.1	— (—)	—
12. Papermakers, bookbinders, printers	21,803	11,709	28 (—)	1.3	3 (—)	0.3
13. Other products (plastics, etc.)	7,876	4,485	9 (—)	1.1	— (—)	—
14. Builders and contractors ..	68,838	39	40 (2)	0.6	1 (1)	25.6
15. Painters and decorators ..	34,964	1,023	36 (2)	1.0	2 (—)	2.0
16. Administrators, directors, managers	31,075	7,958	12 (—)	0.4	— (—)	—
17. Transport and communications	162,138	18,140	251 (8)	1.5	7 (—)	0.4
18. Finance, insurance, commerce	103,875	58,813	91 (6)	0.9	41 (6)	0.7
19. Professional and technical ..	60,573	53,959	62 (4)	1.0	56 (11)	1.0
20. Defence services	38,934	1,173	21 (—)	0.5	2 (—)	1.7
21. Entertainment and sport ..	12,417	5,549	13 (—)	1.0	3 (—)	0.5
22. Personal services (hotels, etc.)	72,919	195,271	156 (5)	2.1	115 (7)	0.6
23. Clerks, typists, etc.	96,115	167,721	137 (6)	1.4	132 (18)	0.8
24. Packers, warehousemen, etc.	40,674	21,317	58 (6)	1.4	5 (1)	0.2
25. Stationary engine drivers, stokers	12,176	83	15 (3)	1.2	— (—)	—
26. Unskilled workers (not elsewhere specified)	79,229	31,703	195 (10)	2.5	35 (7)	1.1
27. Other and undefined workers	13,806	4,197	20 (—)	1.4	3 (—)	0.7
Total (1-27)	1,094,012	686,658	1,367 (69)	1.2	451 (57)	0.7
Students	25,941	19,470	42 (5)	1.6	15 (3)	0.8
Children under 15	334,401	320,134	126 (20)	0.4	119 (14)	0.4
Occupation outside U.K. ..	6,458	1,720	4 (—)	0.6	— (—)	—
Retired	78,906	27,678	136 (5)	1.7	14 (1)	0.5
Unemployed or no occupation stated	26,170	726,434	263 (16)	(c)	141 (21)	(c)
Housewives	—	—	— (—)	—	374 (43)	(c)

(a) *Notifications are based on weekly (uncorrected) notifications and therefore differ by 14 from the corrected totals (table T.1); numbers in brackets are non-pulmonary cases included in the total figure.*

(b) *Figures in italics are based on fewer than 20 notifications.*

(c) *Rates cannot be quoted because of different uses of the terms unemployed, no occupation and housewives, in the context of census classification of employment and notifications.*

TABLE T.8—*Patients on the registers*—1950–59*

<i>At 31st Dec.</i>	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959
Cases on the register										
<i>Pulmonary:</i>										
Males ..	19,090	19,119	17,336	18,475	18,897	19,300	19,715	19,946	20,308	19,553
Females ..	15,031	15,556	14,672	14,930	15,576	15,846	15,928	15,836	15,597	14,858
<i>Other forms:</i>										
Males ..	2,591	2,520	1,530	1,508	1,442	1,371	1,339	1,274	1,293	1,158
Females ..	3,068	2,954	1,850	1,820	1,709	1,704	1,710	1,709	1,674	1,555
Total ..	39,780	40,149	35,388	36,733	37,624	38,221	38,692	38,765	38,872	37,124
No. per 1,000 of population ..	11.7	12.0	10.5	10.9	11.3	11.6	11.8	11.9	12.1	11.6

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

TABLE T.9—*Summary of investigations into tuberculosis ' incidents ' at Council establishments in 1959*

<i>Establishment</i>	<i>Notified case</i>	<i>Children</i>				<i>Adults</i>	
		<i>Tuber- culin tested</i>	<i>Positive reactors</i>	<i>X-rayed</i>	<i>Abnormal</i>	<i>X-rayed</i>	<i>Abnormal</i>
Day School ..	Teacher	167	22	22	—	16	—
	Teacher	140	6	6	—	—	—
	Teacher	32	—	—	—	4	—
	Pupils	140	11	11	1	27	—
	Teacher	66	39	12	—	—	—
	Teacher	70	11	11	—	11	—
	Pupil	254	104	96	—	17	—
	Pupil	15	1	1	—	2	—
	Teacher	407	47	47	—	117	—
	Pupil	29	3	—	—	8	1
	Teacher	—	—	1,408	4	128	1
	Pupil	221	41	41	—	—	—
	Pupil	—	—	—	—	11	1
	Pupil	53	21	17	—	32	1
	Kitchen helper ..	—	—	—	—	13	—
	Teacher	36	7	7	2	12	—
	Pupil	5	2	—	—	—	—
	Kitchen helper ..	—	—	—	—	5	5
	Pupil	59	—	—	—	9	—
	Pupil	—	—	—	—	27	—
Total (20) ..		1,694	315	1,679	7	439	9
Residential nursery ..	Assistant nurse ..	9	—	—	—	—	—
Dining centre ..	Kitchen helper ..	135	9	9	—	11	—
Welfare home ..	Resident	—	—	—	—	75	8
Grand Total (23)		1,838	324	1,688	7	525	17

TABLE T.10—Summary of services provided for tuberculous patients—Administrative County of London 1955–59

	1955	1956	1957	1958	1959
<i>Clinic registers</i>					
Total on registers at the end of the year	38,221	38,695	38,765	38,872	37,124
<i>Work of local tuberculosis care organisers</i>					
Patients assisted for the first time with:					
Beds and bedding	291	240	176	165	210
Clothing or footwear	1,014	847	734	571	558
Patients at the end of the year receiving:					
Extra nourishment	2,285	2,183	1,938	1,875	1,714
Home help service	660	624	528	467	465
<i>Home care and treatment</i>					
At the end of the year, patients:					
Awaiting admission to hospital	71	22	34	16	16
Under treatment in their own homes	1,050	334	329	238	143
Receiving attention by home nurses	498	405	371	368	331
Home visiting by tuberculosis health visitors—					
Total visits (including contacts)	86,302	83,137	80,302	78,953	86,680
<i>Diversional therapy</i>					
At the end of the year, weekly classes at Chest Clinics	N/A	175	147	157	131
Receiving instruction in their own homes		239	259	262	200
<i>Rehabilitation</i>					
At the end of the year the Council was financially responsible for rehabilitants at:					
British Legion Village, Maidstone	36	33	29	30	19
Papworth Village Settlement, Cambridge	22	26	19	15	10
Enham-Alamein Village Centre, Andover	15	10	9	10	5
Barrowmore Hall, Chester	2	—	1	1	1
Correspondence courses arranged through the British Council for Rehabilitation for patients undergoing prolonged treatment at home	77	33	20	14	10
<i>At boarding open-air schools</i>					
Children convalescent from tuberculosis:					
At the beginning of the year	22	12	8	6	1
Admitted during the year	2	3	—	—	—
At the end of the year	12	8	6	1	—
Awaiting admission at end of year	—	2	—	—	—
<i>Boarding-out of child contacts</i>					
Children in nurseries and foster homes at the beginning of the year	365	279	172	136	94
Placed during the year	398	272	229	173	154
Boarded-out at the end of the year	279	172	136	94	79
Average number boarded-out at any one time	310	215	164	116	100
<i>Boarding-out of child contacts for segregation during B.C.G. vaccination</i>					
Children in nurseries and foster homes at the beginning of the year	11	7	4	3	9
Placed during the year	40	28	24	20	35
Boarded-out at the end of the year	7	4	3	9	3
Average number boarded-out at any one time	19	13	7	4	8
<i>Hostels for homeless infective tuberculous men</i>					
In residence at the beginning of the year	63	58	69	77	103
Recommendations approved during the year	49	82	60	81	63
In residence at the end of the year	58	69	77	103	101

TABLE T.11—Principal tuberculosis statistics—Metropolitan Boroughs and the Administrative County of London, 1959

Metropolitan Boroughs	Estimated home population mid 1959	New notifications				New notifi- cations per 1,000 popula- tion	Deaths from tuberculosis			Tuber- culosis deaths per 1,000 popula- tion	Pulmonary tuber- culosis deaths per 1,000 popula- tion aged 15 and over	Number of tuberculosis cases on clinic registers at 31.12.59		Cases on register per 1,000 popula- tion
		Pulmonary	Tuber- culosis of Meninges and C.N.S.	Other non- pulmonary tuber- culosis	Total		Pulmonary	Non- pulmonary tuber- culosis	Total deaths			Total	Percentage of pulmonary cases positive during 1959	
Division 1														
Chelsea	49,520	36	—	3	39	0.79	3	—	3	0.06	0.07	411	4.0	8.3
Fulham	113,300	83	—	6	89	0.79	14	—	14	0.12	0.15	1,262	1.0	11.1
Hammersmith ..	108,900	135	1	7	143	1.31	8	—	8	0.07	0.09	1,581	1.4	14.5
Kensington	166,500	172	—	21	193	1.16	9	1	10	0.06	0.06	1,633	1.7	10.0
Division 2														
Hampstead	96,810	89	—	6	95	0.98	7	1	8	0.08	0.09	1,144	3.9	11.8
Paddington	113,400	145	—	14	159	1.40	11	2	13	0.11	0.12	1,396	2.0	12.3
St. Marylebone ..	70,430	57	—	1	58	0.82	10	1	11	0.16	0.16	927	1.9	13.2
St. Pancras	128,700	189	—	12	201	1.56	12	1	13	0.10	0.11	1,234	1.9	9.6
Westminster, City of	94,640	85	—	6	91	0.96	13	2	15	0.16	0.16	615	4.7	6.5
Division 3														
Finsbury	34,030	25	—	1	26	0.76	1	—	1	0.03	0.04	269	4.3	7.9
Holborn	21,370	27	—	—	27	1.26	5	—	5	0.23	0.27	269	2.8	12.6
Islington	223,400	254	—	14	268	1.20	23	2	25	0.11	0.13	2,564	2.1	11.5
Division 4														
Hackney	163,200	98	2	17	117	0.72	18	1	19	0.12	0.14	1,836	2.2	11.3
Shoreditch	43,330	35	—	5	40	0.92	4	—	4	0.09	0.12	377	5.5	8.7
Stoke Newington ..	50,200	45	1	3	49	0.98	4	—	4	0.08	0.10	817	1.3	16.3
Division 5														
Bethnal Green ..	48,960	39	1	2	42	0.86	3	—	3	0.06	0.08	776	2.6	15.8
City of London ..	4,900	4	—	1	5	1.02	—	—	—	—	—	60	3.5	12.2
Poplar	63,540	57	—	6	63	0.99	9	—	9	0.14	0.19	560	1.6	8.8
Stepney	94,900	135	1	13	149	1.57	17	—	17	0.18	0.23	1,253	2.8	13.2
Division 6														
Deptford	69,660	91	—	7	98	1.41	13	2	15	0.22	0.24	1,117	2.5	16.0
Greenwich	88,970	41	—	2	43	0.48	13	1	14	0.16	0.19	1,080	1.7	12.1
Woolwich	144,800	80	—	8	88	0.61	12	2	14	0.10	0.11	1,742	1.2	12.0
Division 7														
Camberwell	176,100	142	—	15	157	0.89	12	2	14	0.08	0.09	1,190	1.4	6.8
Lewisham	221,000	126	1	17	144	0.65	11	1	12	0.05	0.06	2,754	1.6	12.5
Division 8														
Bermondsey	54,120	48	—	2	50	0.92	4	—	4	0.07	0.09	641	1.3	11.8
Lambeth	223,300	155	3	13	171	0.77	27	2	29	0.13	0.15	3,318	*	14.9
Southwark	88,720	92	—	6	98	1.10	11	2	13	0.15	0.16	1,451	2.2	16.4
Division 9														
Battersea	108,500	70	1	4	75	0.69	7	1	8	0.07	0.08	1,156	2.7	10.7
Wandsworth	338,800	239	4	17	260	0.77	32	6	38	0.11	0.12	3,691	2.9	10.9
LONDON	3,204,000	2,794	15	229	3,038	0.95	313	30	343	0.11	0.12	37,124	2.0†	11.6

* Figures not available.

† Excluding Borough of Lambeth.

TABLE T.12—*Tuberculosis—Annual chest X-ray examination of mental defectives at senior occupation centres—Administrative County of London, 1959*

Division	Occupation centre E.B.—elder boys E.G.—elder girls	Average roll at time of examina- tion	Date of examina- tion	No. X-rayed		No. of cases of T.B. dis- covered
				Under 15	Over 15	
1	Hammersmith (E.B.)	32	22. 7.59	—	30	—
	N. Kensington (E.G.)	43	15.10.59	—	36	—
4	Clapton (E.G.)	53	20. 3.59	2	40	—
	Dalston (E.B.)	52	20. 3.59	5	42	—
5	Stepney (E.B.)	19	14. 1.59	—	14	—
6	Greenwich (E.G.)	35	12. 6.59	—	30	—
	Brockley (E.G.)	61	12. 6.59	3	43	—
7	Peckham (E.B.)	59	16. 3.59	1	30	—
9	Balham (E.B.)	48	13. 2.59	—	30	—
	Earlsfield (E.B.)	58	13. 2.59	—	30	1
	Totals	460		11	325	1

Annual X-ray examination of staff at occupation centres, 1959.
No. of existing staff X-rayed 77 All satisfactory.

TABLE T.13—*B.C.G. vaccination under L.C.C. schemes in 1958/59*

1. *Day schools—*

1958/59

No. of schools visited	350
No. of 13-year-old children at school	*35,659
No. of consents	*26,371
No. tuberculin tested	*23,847
No. of reactors	*2,036=8.5 per cent.
No. given B.C.G.	21,798
No. vaccinated June, 1954, to December, 1959	115,830

2. *Further education establishments (colleges, etc.)*

No. of establishments visited during 1959	26
No. tested	4,136
No. of reactors	2,014
No. given B.C.G.	2,106

3. *Residential establishments—*

No. of establishments visited in 1959	2
No. of children tested	75
No. of reactors	6=8.0 per cent.
No. given B.C.G.	69

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

1953	70
1954	82
1955 (first full year after starting B.C.G.)	45
1958	38
1959	20

5. *Tuberculosis contacts—*

No. of contacts given B.C.G. vaccination in London in 1959	5,172
No. of contacts given B.C.G. vaccination in London since inception of scheme in 1950	36,327

6. *Diabetics—*

No. tuberculin tested	—
No. given B.C.G. in 1959	—
No. given B.C.G. since inception of scheme	68

* Divisional figures are shown in Table T.14

TABLE T.14—B.C.G. vaccination of school children in Administrative County of London, 1958/59 (fifth 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	4,484	3,115	18	2,891	1,575	35.1	344	11.9	2,545 (2 negatives not vaccinated)
2*	1,011	693	1	572	438	43.3	63	11.0	509
3	2,609	1,668	4	1,503	1,102	42.2	144	9.6	1,358 (1 negative not vaccinated)
4	3,415	2,527	11	2,315	1,089	31.9	164	7.1	2,151
5	2,974	1,943	20	1,812	1,142	38.4	214	11.8	1,596 (2 negatives not vaccinated)
6	4,116	3,124	32	2,881	1,203	30.0	221	7.7	2,659 (1 negative not vaccinated)
7	6,249	5,347	45	4,544	1,660	26.6	339	7.5	4,203 (2 negatives not vaccinated)
8	4,574	3,126	22	2,922	1,630	35.6	249	8.5	2,673
9	6,227	4,828	9	4,407	1,811	29.1	298	6.8	4,104 (5 negatives not vaccinated)
Totals . .	35,659	26,371	162	23,847	11,650	32.7	2,036	8.5	21,798

* Programme not completed.

GENERAL PUBLIC HEALTH

Housing

This subject is treated at length at the end of this section.

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	1959	1957	1958	1959	1957	1958	1959	1957	1958	1959	1957	1958	1959
Ordinary ..	43	28	27	—	1	—	38	24	27	5	3	—	—	4.0	—
Tuberculin tested ..	30	136	107	—	—	—	23	130	100	7	6	7	—	—	—
Total ..	73	164	134	—	1	—	61	154	127	12	9	7	—	0.64	—

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

Milk purchased for use in Council establishments:

	1957	1958	1959
Liquid milk, samples taken by boroughs and county councils ..	1,162	947	910
Number found to be unsatisfactory	3	7	11
Dried milk, samples submitted to bacteriological examination..	4	4	4
<i>No samples contained more than 100,000 organisms per gramme, nor was staphylococcus aureus isolated.</i>			

Sanitary inspection

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

	1957	1958	1959
Reports of infestation by a variety of pests	178	190	207
Visits and re-inspections involved	294	347	472
Inspections of school meals centres	420	375	362
Investigations of illness following consumption of school meals	15	12	7
Occasions when the meal was found to be the cause	2	3	2

Blind and partially-sighted persons

During the year, 1,741 examinations—104 more than in the previous year—were made in connection with certification under the National Assistance Act, 1948, of blind or partially-sighted persons and 48 persons were found to be neither blind nor partially-sighted. In addition, 370 certificates were accepted from other local authorities, hospitals and private ophthalmologists—81 less than the previous year. The percentage of new registrations recommended to obtain treatment was 57.0 per cent. compared with 59.6 per cent. in 1958.

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	2	—	2	12	16
5-15 years	—	—	—	7	7
16-64 years	24	14	—	191	229
65-74 years	65	23	—	157	245
75 years and over	161	41	—	332	534
Age not known	—	1	—	4	5
(a) Total No. of persons	252	79	2	703	1,036
(b) No. recommended to obtain treatment	180	58	1	352	591
(b) as percentage of (a)	71.4	73.4	50.0	50.1	57.0

TABLE (ii)

Number of treatments recommended in respect of newly registered persons

	<i>No. of patients examined</i>	<i>Treatments recommended</i>						<i>Optical</i>	<i>Hospital supervision</i>
		<i>None</i>	<i>Medical</i>	<i>Surgical</i>					
				<i>Early</i>	<i>Later</i>	<i>If general condition permits</i>			
Cataract	252	72	18	58	21	18	4	94	
Glaucoma	79	21	13	1	3	1	3	49	
Retrolental fibroplasia ..	2	1	—	—	—	—	—	1	
Other conditions ..	703	351	60	19	23	9	36	262	
Total	1,036	445	91	78	47	28	43	406	

Persons recommended to obtain treatment are re-examined at intervals after the initial registration. The number of persons re-examined for this reason in 1959 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	183	55	—	339	577
No. found to have had treatment	146	51	—	185	382
Percentage treated	79.8	92.7	—	54.6	66.2

As a consequence of successful treatment, 15 persons previously registered as blind were found, on re-examination, to be partially-sighted and 15 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 23.

Registration of nursing homes

	1955	1956	1957	1958	1959
Registered at beginning of year	42	41	39	38	37
New homes registered	—	1	—	—	1
Homes registered on change of keeper	1	—	—	1	2
Registrations cancelled—voluntary closure or change of keeper	2	3	1	2	6
Registered at end of year	41	39	38	37	34
Inspections:					
medical officers	53	60	51	41	42
public health inspectors	93	102	96	50	63
Homes exempted from registration	39	37	39	38	38

The 34 homes registered at 31 December, 1959 provided the following accommodation:

Number of beds in homes	Number of homes	Number of beds provided		
		Maternity*	Others†	Total
25 or over	10	234	219	453
20 to 24	4	25	62	87
15 to 19	8	21	114	135
10 to 14	6	12	65	77
5 to 9	5	15	23	38
Under 5	1	—	4	4
Total	34	307	487	794

* 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 continued. Hospital geriatric units are still reluctant to give beds to patients whose general health cannot improve with medical treatment, although such patients are properly the responsibility of the hospital service. The number of chronic sick residents in the Council's welfare homes consequently remains at a high level. These residents in the main have to be concentrated in the large homes because the small ones, particularly those provided by adaptation, have very limited facilities for the nursing of sick persons: the small purpose-built homes were, however, used increasingly for the elderly infirm because of the special amenities provided in their design for the frail but ambulant patient.

It is doubtful, on humanitarian grounds, whether pressing for the transfer of residents who have spent many years in welfare homes could be justified solely because they have become chronic sick. However, 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 has to be appointed to the large homes to act in a supervisory capacity in caring for them.

Care of the aged

In association with the welfare department, discussions have been held with representatives of the metropolitan regional hospital boards and the Local Medical Committee on the care of old people and the chronic sick in Part III accommodation. The home nursing of old people, physiotherapy, chiropody and home help services were among the subjects

discussed with a view to ensuring that hospital, local authority and general practitioner services co-operated as fully as possible towards postponing infirmity and ill health in old people and, wherever possible, they are given any necessary treatment and care in their own homes.

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.

				1955/6	1956/7	1957/8	1958/9	1959/60
				£	£	£	£	£
Grant-in-aid	..	..	..	8,000	11,500	11,500	17,500	18,664
Meals served	..	..	..	182,399	187,578	174,011	167,134	172,637

HOUSING

Slum Clearance

Legislation—Even before the first Public Health Act was passed in 1848 the maintenance of good sanitary conditions in a healthy environment, together with the abatement and prevention of overcrowding, had been regarded by the discerning few as of first importance to the health and well-being of the community.

The law relating specifically to housing has been said to have originated in Lord Shaftesbury's Acts of 1851 (the Common Lodging Houses Act and the Labouring Classes Lodging Houses Act); which, for the first time, authorised the provision and regular inspection of lodging houses. The Acts of 1868 and 1879 (Torrens)*, enabling individual insanitary houses to be dealt with, and of 1875 and 1879 (Cross)†, empowering local authorities, including the Metropolitan Board of Works, to clear and reconstruct unhealthy areas, were, however, of greater importance.

The Council succeeded the Metropolitan Board of Works in 1889. A review of the sanitary circumstances of the county led the Council to make representations to the Government for statutory powers to enable it more adequately to deal with the situation. These representations followed the report of the Royal Commission‡ which had sat in 1884–5. The Housing of the Working Classes Act was enacted in 1890. This Act was a milestone in local authority housing administration; it was well founded and it remained as the principal Act until July, 1925 when it was repealed by the Housing Act of that year. In spite of great difficulties, largely of a financial nature, the Council had undertaken thirteen clearance schemes, involving the rehousing of 15,644 persons, up to the end of 1912.

The problems produced by the First World War of high interest rates, serious shortages of accommodation and scarcity of labour and materials demanded new legislation and the Act of 1919, known as Addison's Act**, introduced for the first time the payment from central funds of a subsidy for housing. Various amending Acts followed until the general law relating to housing was consolidated in the Housing Act, 1925.

The Housing Act, 1930, made better provision for the clearance of unhealthy areas and introduced a method of dealing with aggregations of unfit houses, known as 'improvement areas', in which conditions were not so bad as to justify total clearance. This Act also required the submission to the Minister of Health of programmes of housing measures to be carried out by local authorities, normally over a five-year period. The Council's programme envisaged the expenditure of £21,825,000 for the provision of some 34,670 houses and flats including 6,200 for rehousing persons displaced from clearance and improvement areas. In 1933 financial conditions improved and the Minister of Health made a special appeal to all local authorities for a concerted effort to ensure a speedier end to the evil of bad housing. The Council responded with a programme to cover a ten-year period involving the displacement of 250,000 persons at an estimated cost of £35,000,000.

The Housing Act, 1935, was designed specifically to deal with the abatement and prevention of overcrowding; it introduced measures for dealing with 'redevelopment areas' and repealed those in the Act of 1930 relating to 'improvement areas.' Consolidation followed in the Housing Act, 1936.

The Housing Act, 1949, made provision for the improvement and conversion of dwellings with aid from public funds; this hitherto was a facility which had been restricted to rural areas. The principal Act of 1936, like the earlier Acts, was concerned with the housing of the working classes and all but a few of its provisions were confined to this class of the

* *The Artizans' and Labourers' Dwellings Act, 1868.*

The Artizans' and Labourers' Dwellings Act (1868) Amendment Act, 1879.

† *The Artizans' and Labourers' Dwellings Improvement Act, 1875.*

The Artizans' and Labourers' Dwellings Improvement Act, 1879.

‡ *First Report of Her Majesty's Commissioners for Inquiring into the Housing of the Working Classes, 1885.*

** *Housing, Town planning, etc., Act, 1919.*

community. The Act of 1949, with a very few exceptions, removed the expression 'working classes' from housing legislation, the social revolution of the first half of this century having made the term inappropriate.

The Housing Repairs and Rents Act, 1954 reflected the view of the Government that the time had arrived for more attention to be given to the stock of existing houses. Once again local authorities were required to submit returns to the Minister indicating the extent of unfit houses in their areas, including proposals for dealing with them by means of phased programmes. The Act also promulgated a new basis on which fitness for habitation was to be assessed. It introduced new powers to enable local authorities to retain unfit houses 'for the time being' so long as they were 'patched'. (The Act also made provision for increases in rents in certain cases).

In 1957 the law relating to housing was consolidated yet again and the Housing Act of that year is the authority from which the Council derives its present powers.

Implementation of 'clearance' legislation—Every large city has its peculiar housing problems depending largely on its social and industrial evolution; to this rule London is no exception. Some thousands of unfit houses have already been demolished as a result of the slum clearance operations of the Council and the councils of the metropolitan boroughs. At the present time there still remain many thousands of houses which are unfit for habitation to such an extent as to justify similar action. Many are in the region of 100 years old and thus were built before bye-law or town planning control. In most instances they were not designed for occupation by more than one family.

The Council has concurrent powers with the metropolitan borough councils in the matter of slum clearance and is responsible for co-ordinating these operations. It is the normal practice for the Council, preparatory to the formulation of any programme of slum clearance, to invite the metropolitan borough councils to review the sanitary circumstances in their areas and to submit their views. Differences of opinion revealed by these proposals are resolved by discussion. The bulk of the detail work in this matter falls on the borough medical officers of health and their staffs and I here acknowledge the assistance which has always been afforded to me in this important field.

Each authority having accepted its share of the programme the necessary work of implementation follows. So far as this department is concerned representations of clearance areas to the Council are related to demolitions at a rate of about 3,000 houses each year.

Two methods are available to a local authority in dealing with a clearance area, compulsory purchase order or clearance order. The essential difference is that in the first case the local authority acquires the property, demolishes the buildings and itself re-develops or disposes of the site and in the second case the site is left in the possession of the owners, who are themselves required to demolish the insanitary building standing thereon.

Of the various procedures which lead up to the demolition of a clearance area it suffices to say they are defined by statute and great care is essential at every stage to ensure that the statutory requirements are met, as failure so to do may well result in a nullification of the Council's Order. The conditions precedent to the declaration of a clearance area by a local authority have, in principle, remained unchanged since originally laid down in the Housing Act, 1930. A clearance area must contain at least two houses and all the houses within the area must be:

- (a) unfit for human habitation, or
- (b) dangerous or injurious to the health of the inhabitants of the area by reason of their bad arrangement, or the bad arrangement or narrowness of the streets.

Further, the most satisfactory method of dealing with conditions in the area must be by the demolition of all the buildings in the area.

When these conditions obtain the area may be declared by the Council to be a clearance area provided the Council is satisfied that:

(a) in so far as suitable accommodation available for the persons to be displaced by the clearance of the area does not already exist they can provide, or secure the provision of, such accommodation in advance of the displacements which will from time to time become necessary as the demolition of buildings in the area proceeds; and

(b) the resources of the authority are sufficient for the purpose of carrying the resolution into effect.

The Council's 1933-43 ten year programme was interrupted by the outbreak of war and slum clearance work came to a standstill. In 1949 the Council decided that steps should be taken to resume clearance operations on a modified scale, and accordingly resolved to deal with six areas which had been declared to be clearance areas prior to 1939 but on which work had been stopped by the outbreak of war. These areas contained some 1,500 houses. Concurrently with this action steps were taken to consult with the metropolitan borough councils with a view to the general resumption of clearance activities in 1950. A five-year programme was drawn up covering some 10,000 unfit houses. On the expiry of that programme a further time-table for dealing with 7,000 houses in the period 1956-60 was compiled and at the time of writing all the areas contained in those two programmes for which the Council has accepted responsibility have been reported upon.

Fitness for habitation—Until the Housing Repairs and Rents Act, 1954, became law fitness for human habitation was determined, according to the terms of statute, on the amount of disrepair and sanitary defects which existed. 'Sanitary defects' were defined as 'including lack of air space or of ventilation, darkness, dampness, absence of adequate and readily accessible water supply or sanitary accommodation or of other conveniences and inadequate paving or drainage of courts, yards or passages'. This, of course, was not a positive standard and opinions varied from district to district as to what was meant by 'unfit for habitation'. In a 'Manual on Unfit Houses' published by the Ministry of Health in 1919 a standard for a fit house was, in fact, prescribed but since no steps were taken to incorporate it in any legislation it remained only of academic interest.

In 1946 a sub-committee of the Central Housing Advisory Committee (the Mitchell Committee) after deliberation on this subject, reported that a more positive standard by which to judge fitness for habitation was desirable, and recommended that the old 1919 standard should be made mandatory. The Housing Repairs and Rents Act of 1954 repealed the 'disrepair and sanitary defects' rule and in its place provided an alternative method for determining when a house is unfit for habitation.

A house is to be considered unfit for habitation if, and only if, it is so far defective in one or more of certain matters that it is not reasonably suitable for occupation in that condition. The matters to which regard shall be had are repair, stability, freedom from damp, natural lighting, ventilation, water supply, drainage and sanitary conveniences, facilities for the preparation, storage and cooking of food and for the disposal of waste water. This list is exclusive and no other circumstances may be considered. It will be noted that this is not a positive standard and the test remains a qualitative one; in practice, so far as houses included in clearance areas are concerned, it may be said that there is little or no difference between the old rule and the 1954 directions. This is to be expected as houses included in a clearance area have reached the end of their useful lives and on any standard would be deemed to be unfit for human habitation.

Over the years there has been little change in London in the type of houses included in clearance areas. Two storey cottages, two storey mews type dwellings over garages, three storey and four storey houses in multiple occupation and block tenement dwellings continue to figure in reports to the Council. Examples are shown in the inset.

These houses have numerous defects. Dampness rising from the ground through absence of proper damp proof courses is perhaps the most common and is also the most difficult and expensive to remedy. Instability is not common, except in some areas of the county where houses with inadequate foundations have been built on made-up ground. Almost every 'clearance area' house contains one or more inadequately lighted and ventilated

rooms, of which the most usual is the dark and badly ventilated ground floor back room of the two storey cottage; such rooms are usually the principal living rooms of the houses. Water supplies are frequently inadequate, particularly in the houses in multiple occupation; it is difficult for the tenant of top floor rooms to traverse three or four flights of stairs in order to obtain water from a tap in the basement scullery or even in the yard. Sanitary accommodation is nearly always externally situated, sometimes a considerable distance from the house. Food storage facilities are nearly always inadequate and a properly ventilated food cupboard is rare in the type of house which is included in clearance areas. By far the most variable factor is disrepair. In some houses this is so extensive as to render the house un-inhabitable whilst in other properties of identical type much time, money and effort have been expended, commonly by the tenant, in order to make the best of his indifferent accommodation.

Summary of action taken—Since the resumption of slum clearance after the end of the war 426 areas containing 16,882 houses unfit for human habitation have been represented to the Council.

In 111 areas, comprising 1,557 houses, no objections were made to the Council's proposals and the Orders were confirmed by the Minister of Housing and Local Government. In 203 areas containing 11,958 houses the Council's Orders were confirmed, in some instances with very minor modifications, after the holding of Public Local Inquiries.

In two areas comprising 10 houses the Minister of Housing and Local Government was not satisfied that demolition was the best method of dealing with conditions; although he accepted that the houses were properly designated unfit for human habitation.

In six areas, made up of 76 houses, the Minister decided that clearance orders should have been made instead of the compulsory purchase orders submitted to him for confirmation. In these cases the Minister invited the Council to submit Orders under section 50 of the Housing Act, 1957.

At the end of the year the Minister's decision in respect of the remaining areas was awaited.

Detailed figures in respect of work done during the last five years follow:

	1955	1956	1957	1958	1959
Areas represented as unfit for human habitation..	52	70	90	77	27
Houses in such areas	2,642	3,436	2,409	1,830	660
Areas surveyed but not represented by the end of the year	46	111	81	11	13
Houses in such areas	2,292	3,255	2,004	312	641
Public local inquiries	20	37	28	36	37
Informal hearings	7	4	4	2	1
Orders confirmed					
(i) after inquiry or hearing	14	28	45	33	42
(ii) without inquiry or hearing (no objection received)	4	9	13	14	28
Orders not confirmed	—	1	1	1	3

Present problems—Without question a great deal of progress has been achieved towards the abolition of the unhealthy area in the county and it is true to say that nearly all the large aggregations of unfit houses have now been cleared; there are no longer any back-to-back houses in existence although there are many dwellings which are deficient in through ventilation.

As is frequently the case, however, new problems are presenting themselves.

(a) *The block tenement dwelling*—Block tenement dwellings exist in large numbers and, indeed, some of them were built by the social reformers of 90/100 years ago; they were strongly built and structurally they shew little defect. Some of the better types are capable of improvement and conversion with the aid of a grant but many of the smaller blocks which stand on very restricted sites cannot be brought up to modern standards.



*Two-storey
houses*





Three-storey houses in multiple occupation





*Block tenement
dwellings*



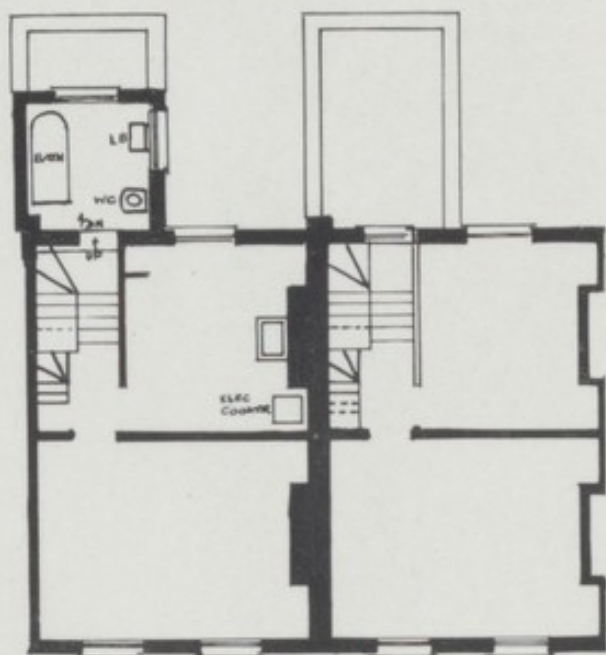


Houses rehabilitated

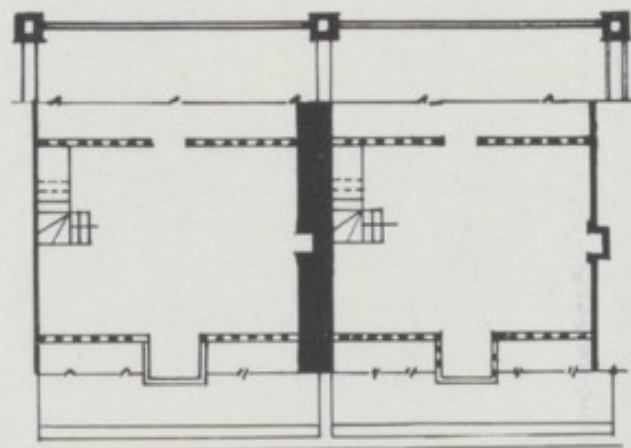
*Elevations and
interior of houses
before rehabilitation*



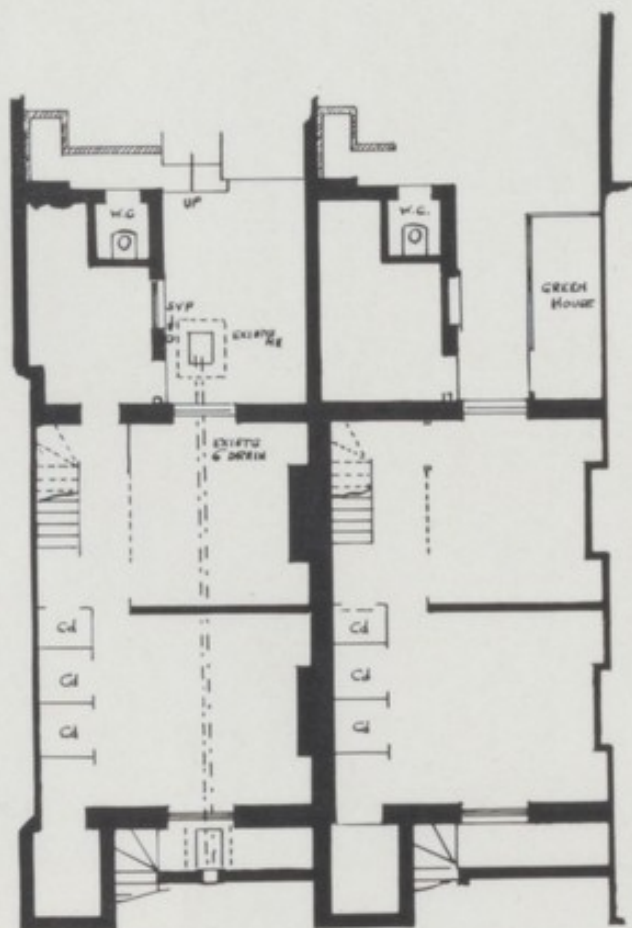
*Plan of semi-basement house with three floors above
before rehabilitation*



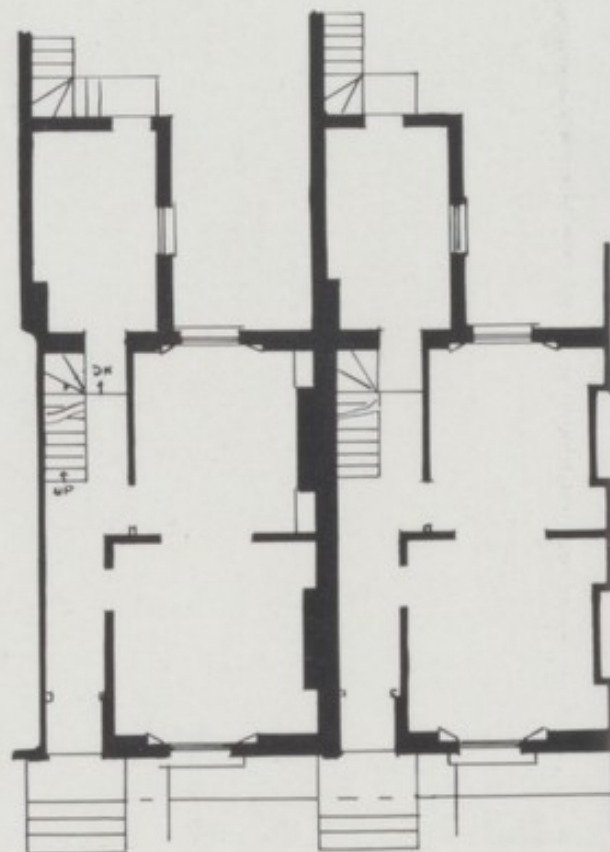
FIRST FLOOR



ATTIC FLOOR

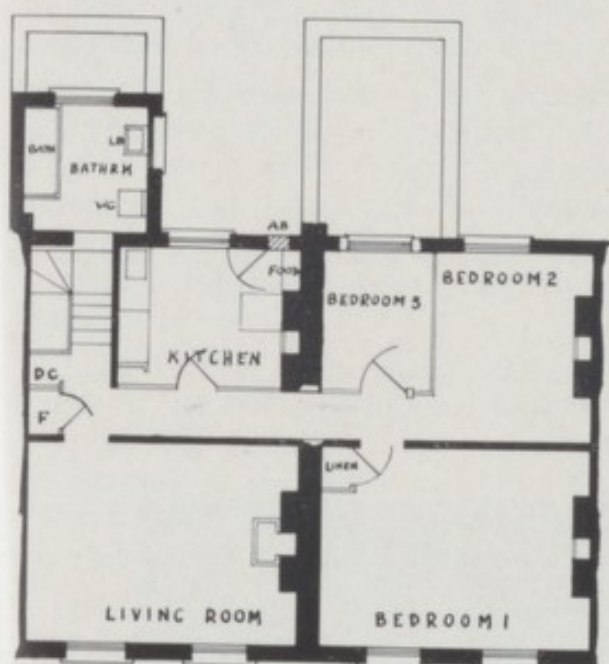


LOWER GROUND FLOOR

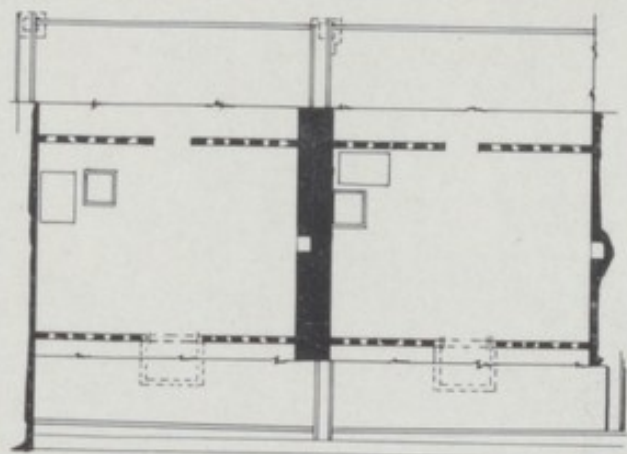


GROUND FLOOR

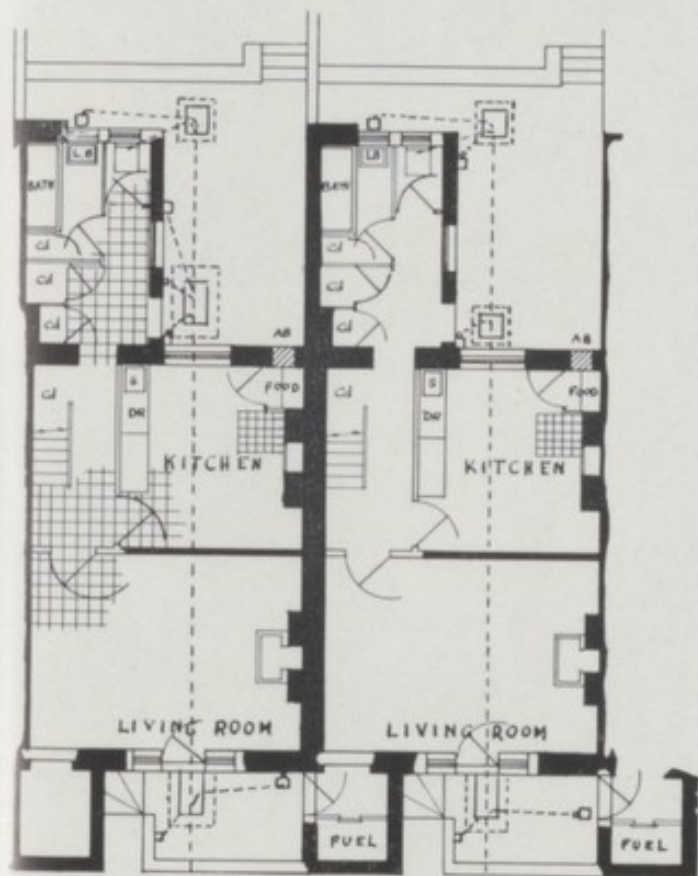
*Plan of semi-basement house with three floors above
after rehabilitation*



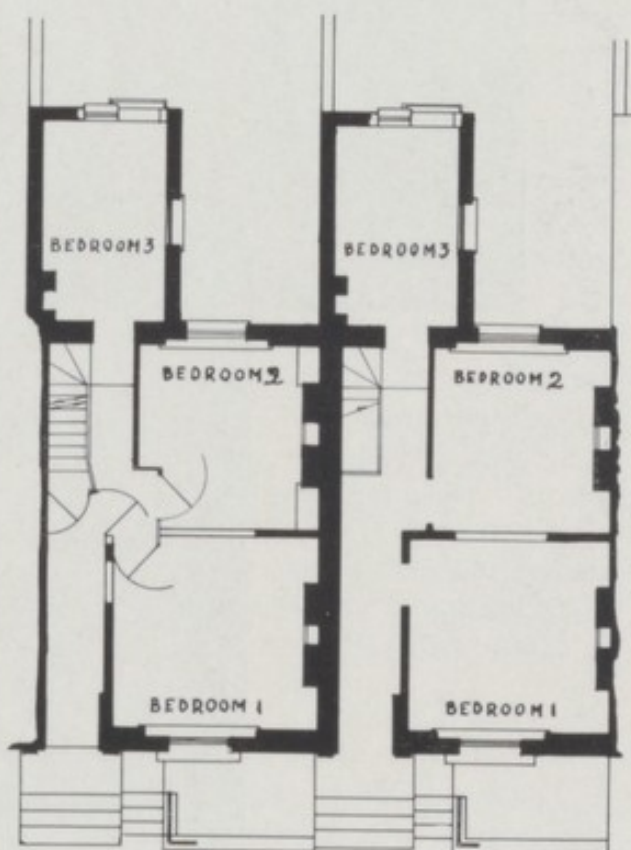
FIRST FLOOR



ATTICS



LOWER GROUND FLOOR



GROUND FLOOR

*Elevation
and interiors of houses
after rehabilitation*



As living accommodation they are poor; amenities are deficient, shared sanitary accommodation and water supplies leave much to be desired, rooms generally are dark and ill-ventilated whilst general maintenance costs are excessively high. Many such blocks are fast falling into the slum clearance category and each one will present a serious problem for the rehousing authority as in most instances the site is unsuitable for redevelopment and the overspill reaches a very high figure indeed.

(b) *The tenement house*—The second problem centres around the tenement house; it is not a new one to the staffs of public health departments in London. The type of house to which I refer is well known; it is generally three or four storeys in height and often has a basement storey below street level as well. These, too, are about 90/100 years old and were originally built for single family occupation. Today, they provide accommodation for a family on each floor of two or three rooms; the lettings are not self-contained and amenities are shared.

As in the case of the block tenement dwellings the heavy wear and tear of multiple use shews in the extent of internal disrepair. Sharing of sanitary accommodation and water supplies frequently leads to friction between tenants; hot water supplies and baths are found only in the rarest instances. The multiple occupation, lack of proper means of escape and the fact that the lower floors are often used for businesses, sometimes with catering, give rise to an increased risk of fire and dangers to life and health.

In 1953, the last year during which a return was made, there were 45,000 such houses known to the metropolitan sanitary authorities, of which 9,581 had been inspected during the year. An intimate knowledge of the county leads one to conclude that this number of 45,000 has not been reduced but on the contrary has been increased and it may not be unreasonable to estimate that there are some 50,000 houses in the county in multiple occupation and which should be brought under closer supervision by the sanitary authorities.

Prior to 1954, houses of this type were maintained in a reasonable sanitary state by means of bye-laws but these and the power to make them were repealed by the Housing Repairs and Rents Act, 1954, which provides that a local authority may by notice require an owner to provide adequate amenities for the use of the families residing in the house. As an alternative to compliance with the notice the owner is, however, at liberty to reduce the number of occupants to accord with the amenities already in existence and to give effect to such a course any security of tenure under the Rent Acts may be overridden.

These provisions, which are now included in the Housing Act, 1957, do not meet the needs of London. That the legislation has failed to provide a remedy in this matter is evidenced by the fact that in the whole of the county during 1959 only eight houses were made fit for occupation by the number of families accommodated. It is clear that this situation requires urgent consideration if new clearance areas are not to be created.

Conclusion—The Council has, since 1930, secured the demolition of 28,527 unfit houses involving the rehousing of more than 134,000 persons. This has been achieved as a result of phased programmes generally covering five year periods. In a vast conurbation like London there will be unfit houses for many years to come; houses like many other things wear out and must be replaced. The legislation provides the machinery and the Council has unique experience in its operation. At the time of writing a programme of clearance to cover the quinquennium 1961/65 is in course of preparation for which the final figures are not yet available, but it is thought that a further 10,000 houses which are unfit for habitation will be reported upon to the Council with a recommendation that they be demolished.

Improvement grants

The year 1949 marked an important stage in the housing programme. From the end of the war, effort had been concentrated primarily on the repair of war damage and the provision of homes for families who were without separate homes of their own. In England

and Wales nearly 900,000 war damaged houses had been repaired and 867,598 new homes provided. With the output of dwellings by new buildings firmly established, it was intended that encouragement should be given to modernising existing accommodation. Estimates indicated that something like one-third of the houses in England and Wales were over 65 years old and most of these lacked the amenities regarded today as essential. The Housing Act, 1949, empowered local authorities to make grants to assist owners to modernise their houses, and to obtain assistance in modernising their own houses where required. Similar powers, with regard to certain rural houses, were already contained in the Housing (Rural Workers) Acts, 1926–31. The Standards of Fitness for Habitation Sub-Committee of the Central Housing Advisory Committee had, in 1946, recommended a standard for a 'satisfactory house' which was more severe than their definition of a 'fit house' and this was adopted for a dwelling in respect of which assistance could be given. In order to be eligible for grant the expenses estimated to be incurred to provide a satisfactory house must fall within certain limits (then £100 and £600, but amended subsequently) and the amount of the grant could be up to half of the sum expended on approved works, excluding works of repair unless occasioned by the improvement. In London (excluding the City of London) both the London County Council and the councils of the metropolitan boroughs had concurrent powers. The response from persons having control of property was less than was hoped for and the 1949 Act was amended by the Housing Repairs and Rents Act, 1954, and again by the Housing (Financial Provisions) Act, 1958, with the object of making the grants more attractive. Unfortunately the response, when compared with the need, continued to be disappointing and in the House Purchase and Housing Act, 1959, a simpler form of 'standard' grant was introduced. Details of the two kinds of grant now available are summarized briefly.

Standard grants—These grants must be made by the local authority if certain simple conditions are satisfied. The grant, up to a maximum of £155, is half the cost of installing five basic improvements—a bath (or shower), a wash-hand basin, a water closet, a hot water system and a food store.

Discretionary grants—These grants are made at the local authority's discretion and are designed to cover extensive works of improvement to houses and conversion of large houses into flats. The expenses must fall within the limits of £100 and £800 for each dwelling and up to half the estimated approved expenses rank for grant. The property must normally have a life of 30 years after improvement, but this period may be reduced to 15 years if the local authority in all the circumstances considers it expedient, which is usual. After improvement houses must be in a good state of repair and substantially free from damp, have each room properly lighted and ventilated, have an adequate supply of wholesome water laid on inside the dwelling, be provided with efficient and adequate means of supplying hot water for domestic purposes, have an internal or otherwise readily accessible water closet, have a fixed bath or shower in a separate room, be provided with a sink or sinks and with suitable arrangements for the disposal of waste water, have a proper drainage system, be provided in each room with adequate points for gas or electric lighting (where reasonably available), be provided with adequate facilities for heating, have satisfactory facilities for storing, preparing and cooking food, and have proper provision for the storage of fuel, where required.

The number of grants made in the period since the Housing Act, 1949, came into operation to the end of 1959 are shown below:

<i>Discretionary grants—</i>								<i>Total grants</i>
England and Wales	..	..	..	..	..	..	..	205,804
London—								
Metropolitan borough councils	..	..	..	..	..	..	..	3,842
London County Council	..	..	..	..	..	..	..	385

Standard grants (from 14 June, 1959)—

England and Wales	33,061
London—	
Metropolitan borough councils	257
London County Council	5
<i>Houses improved by local authorities with financial assistance—</i>	<i>Total houses</i>
England and Wales	28,944
London—	
Metropolitan borough councils	1,010
London County Council	764

Brandon Estate—The following is an example of the operation by the Council of the improvement grants scheme for reviving houses which still have a useful life before them.

In 1951 the Council resolved to acquire by agreement a declining estate of about 56 acres, consisting mainly of residential property, with a view to preparing a phased programme of rehabilitation and redevelopment. In the area suitable for rehabilitation were 182 two- to five-storey houses. These were without bathrooms, the sanitary arrangements were inadequate, the kitchens and fireplaces antiquated and, although they were in multiple occupation, no conversions into self-contained flats had taken place. The treatment undertaken produced 328 self-contained dwellings, each with its own bathroom and usual amenities.

The two-storey houses were modernised (*a*) by providing a bathroom with a separate internal water closet on the ground floor and a dining-kitchen, or (*b*) by providing a bathroom and a separate water closet on the first floor and a small kitchen adjacent to a dining-room on the ground floor, or (*c*) by conversion into self-contained flats on the ground and first floors.

Houses with semi-basements and two floors above were converted into maisonettes on semi-basement and ground floors and flats on the first floors, each flat extending over two houses.

Of the houses with semi-basements and three floors above, six were converted into five maisonettes with seven flats over; others (where the attic floor had insufficient room height to be habitable) were converted to contain maisonettes on semi-basement and ground floors, and flats on the first floors, each flat extending over two houses; and the remainder were converted into maisonettes on semi-basement and ground floors with self-contained flats on first and second floors, each flat extending over two houses.

The houses with semi-basements and four floors above (the attics not being habitable) were converted into maisonettes on semi-basement and ground floors and self-contained flats on the first and second floors, each flat extending over two houses.

Photographs and plans which illustrate a typical scheme for the conversion of a three-storey and basement house on the Brandon Estate are shown in the inset.

Rehousing on medical grounds

Background—Since the Council commenced to provide housing many applicants for such accommodation have submitted medical certificates in an attempt to gain preference. In 1939 about 1,000 applications with medical certificates were received; in 1945 the figure was only 450 but by 1950 it was no less than 44,000. While an analysis of 1,000 applications for rehousing supported by medical certificates in 1947 revealed that 20 per cent. were of a genuinely urgent nature, 40 per cent. were less urgent and the remaining 40 per cent. were not considered worthy of a recommendation; a similar sample in 1948 produced percentages of 10, 35 and 55, respectively. It became obvious that the medical certificate had become debased and that medical practitioners were under various pressures to supply them.

The Council, like other housing authorities, at that time had a scheme whereby points were awarded. The Council scheme, as revised in 1955, contained 15 different categories, as well as further awards for length of time registered. The scheme provided for the award of a large number of points to cases of infective tuberculosis and this usually resulted in a tuberculous case qualifying very quickly for rehousing. It was a feature of points schemes, however, that other factors apart from health such as, for example, the length of time registered and of residence in the district, operate against the intention to rehouse on purely medical grounds.

A review of the housing position in 1955 showed that most of the larger areas for building in London had been used, and that there was bound to be a slowing-up owing to lack of sites within the county. Moreover slum clearance and other redevelopment required about 7,000 houses per year. The Council took a realistic view of the position and decided to tackle slum clearance as a first priority but nevertheless decided to put aside a proportion of the accommodation for rehousing on purely medical grounds.

Present position—In November, 1956 all applicants on the waiting list were informed that between 1945 and 1955 the Council had rehoused 75,000 families and that in future priority was to be given to slum clearance. In the following month a letter explaining the position was sent to all general practitioners and to hospitals telling them that in future there would be only a small allocation of accommodation to rehouse families on purely medical grounds. Doctors were requested not to submit medical certificates, but to send a personal letter to me in each individual case where they considered that there was a very serious medical condition which would benefit from rehousing. In the first three months 1,400 personal letters were received and although this number has abated somewhat, letters are still being received at a steady rate of 40 to 50 a week. The practitioners concerned agree that the present system is greatly to be preferred to the widespread granting of medical certificates, as the responsibility is entirely with the doctor and the patient rarely handles the letter.

Investigation of cases—The present method of investigation is that on receipt of the doctor's recommendation, the background is filled in by a health visitor and, where considered desirable, by a public health inspector's report on the premises. This work is carried out at divisional and borough level and a medical officer in each division assesses and decides whether the case is worthy of consideration. The most worthy cases from each division are then dealt with centrally and I or my deputy make the final decision as to which families are to be nominated for accommodation. It cannot be stressed too strongly that the vast majority of doctor's letters do draw attention to serious medical conditions, but in view of the housing shortage the choice has to be between those which on the evidence available seem most urgent. The rejection of a case does not reflect on the doctor making the recommendation. It is simply that the very worst must be taken first. A small number may be held over from one period to the next and reconsidered as borderline cases.

In a great number of the cases overcrowding is a factor. Overcrowding in itself is not regarded as a reason for rehousing. It is defined statutorily, and is a matter which is dealt with independently. Only when associated with medical factors is it taken into account in considering rehousing.

A case selected for nomination is submitted to the Housing Committee, which before giving final approval considers the particulars gathered by the housing department in anticipation of rehousing. During the preliminary inquiries a number of cases are rejected for very sound reasons. The main reason for this is suppression by the applicant of material facts, such as residence for only a few months in the country and, more frequently, false statements regarding the accommodation already occupied.

The following table shows the cases dealt with in the three years the scheme has been in operation:

				1957	1958	1959
(a) <i>Tuberculous persons</i>						
Recommendations received	..	..	..	421	321	275
Nominated for rehousing	..	..	..	185	151	185
Recommendations not qualifying for rehousing				135	132	114
Under consideration at end of year	..	..		101	139	115
(b) <i>Persons with severe medical conditions</i>						
Recommendations received	..	..	..	2,484	2,474	2,689
Nominated for rehousing	..	..	..	226	478	418
Recommendations not qualifying for rehousing				1,904	1,617	1,951
Under consideration at end of year	..	..		354	733	1,053

Types of case—Referrals to the public health department cover a very wide variety of medical conditions. In the three years 521 cases have been recommended for rehousing because of pulmonary tuberculosis and 1,122 because of other medical conditions. A very large number, over 50 per cent. of all the cases, request accommodation on the ground floor. This the Housing Committee have been unable to provide in every case. Only the modern blocks have lifts, and rehousing in the older buildings depends on vacancies on the ground floor. Experience has shown that the best to be hoped for is accommodation on the ground or first floors. Of the first 600 non-tuberculous cases nominated no fewer than 174 had locomotor troubles of one kind or another and wished to avoid stairs: 30 living on high floors had had amputations and were recommended for accommodation on a low floor, 41 had arthritis of various types, 40 were patients with paresis of the lower limbs following poliomyelitis, and 31 were cases of disseminated sclerosis. Another group of 164 requiring accommodation on the ground floor suffered from cardiac conditions: more than 40 had coronary disease, and 89 had valvular disease (12 of the cases of valvular disease had had valvotomy with partial relief). This group was not always easy to deal with. Cardiologists and almoners sometimes pressed for ground-floor accommodation for a patient and when enquiry showed that the nearest council accommodation was a considerable distance from the place of work, the exertion of climbing to the third or fourth floor to a flat within easy reach had to be weighed against the provision of a ground-floor flat and a long journey to and from the place of work.

Another group consisted of 50 cases suffering from intestinal or urinary trouble and living in accommodation with an outside lavatory or with one lavatory shared by several families. In this group 26 colostomies and 13 ileostomies were rehoused in accommodation with bathrooms. Respiratory troubles accounted for 78 cases, including 46 cases of asthma alone or associated with bronchitis and emphysema, and 18 lobectomies or pneumonectomies and mental illness 75 cases, but selection for rehousing within this group is far from easy.

A large number of persons suffering from rarer conditions was rehoused for a variety of reasons including four cases of muscular dystrophy, one of fragilitas ossium, one of syringomyelia and one of myasthenia gravis.

In rehousing people with cardiac conditions priority has been given to those who are still in work and to young mothers bringing up a family. There were several families who had multiple claims for rehousing. One family had a sputum positive case of pulmonary tuberculosis, another member with paresis of the lower limbs following poliomyelitis, while the husband had hemiplegia and the wife was crippled after a motor accident. This family was living on the fourth floor. In another family the husband had a peptic ulcer, the wife mental illness, one child had chorea with a heart involvement and another had a rheumatic heart and otitis media. In yet another family both parents were partially sighted, the mother had colitis and there was a mentally retarded child. One patient who was rehoused had a colostomy, was wearing a spinal jacket for a fractured vertebrae, and also had spondylitis.

The choosing of cases for rehousing is no easy task and it is difficult to lay down any rational set of rules for guidance. It would perhaps be best described as an exercise in the art of medicine rather than a scientific process. Some of the patients rehoused will probably not benefit greatly themselves, but one can imagine the improvement in a family where, say, an ileostomy case has been given proper accommodation after having to share accommodation with other families. There seems to be no limit to the surprises to be experienced in carrying out an assessment. Some of the cases which apparently were the most deserving and were recommended for rehousing were not rehoused. Enquiry showed that offers of rehousing had been rejected. In one case of disseminated sclerosis three different premises were offered and all turned down. There seem to be several factors which cause these patients to turn down offers. One is the higher rent which may be charged for more adequate premises, another is disappointment at not being offered completely new premises. Much of the accommodation which the Council has to offer is pre-war and many prospective tenants are disappointed if the offer is of anything other than entirely new premises. A further important factor is that not only do people need to be rehoused for the reasons indicated but they need to be rehoused in specific localities where their personal connections will not be broken.

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. Much of the work of the branch, which is carried out in three groups of laboratories by a staff of 64, has a special importance, however, from the point of view of public health. At the County Hall headquarters a wide field is covered including air pollution, building and decorative materials, food, laundries, trade effluents, swimming baths, and statutory duties. 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 other senior officers are members of a number of committees under the auspices of other bodies.

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

Synopsis of work done

During 1959 35,286 samples were examined and their main categories are indicated in the following table. The figures of examinations exclude much advice, not necessarily associated with analytical work, which is an important function of the branch and is given by the senior professional officers.

Air from vehicular tunnels	260
Bacteriological, miscellaneous	123
Building materials	1,037
Chemicals, drugs and medical supplies	132
Clays, sub-soils and borehole waters	3,302
Detergents and soaps	190
Fertilisers and feeding stuffs	93
Foods	570
Gases from sludge digestion plant	304
Instrument sets (ambulance) for sterilisation	172
Lamps; gas detector	505
Laundry tests	97
Liquor (effluent from Beckton Gas Works)	720
Meals	54
Milk	53
Miscellaneous, numerous categories	621
Oils; lubricating and fuel	74
Paints, varnishes, distempers	1,830
Petroleum and allied samples	29
Rain water (air pollution deposits)	80
Sewage and effluent	2,458
Sludge; primary, digested, activated	2,823
Smoke in air, determinations	3,791
Sulphur gases in air:	
Lead dioxide method	118
Volumetric method	3,780
Trade effluents	2,243
Water, steam raising plant	1,335
Water, chemical and bacteriological examination:	
Drinking water	840
Swimming baths	1,929
River water	2,798
Water, miscellaneous	179
Research and investigation samples	2,746
	35,286

* A full account of the work of the Scientific branch is given in the Annual Report of the Scientific Adviser for the Year 1959, The London County Council, price 1s. 3d.

The following paragraphs relate these activities to the various responsibilities and services of the Council with special reference to matters specifically related to public health.

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 reduced upland flow is normally the critical period, and in both these respects 1959 was exceptional. The average daily fresh-water flow over Teddington Weir during this quarter was less than half that of the comparable quarter of the previous year; early in September it was reduced to the statutory minimum of 170 million gallons daily, which condition prevailed for seven weeks. The average temperature of the water measured off the outfall works was the highest yet recorded. These adverse circumstances were associated with a deterioration in the state of the river as compared with the previous year, although the position was less unfavourable when comparison was made with 1957 which was a year of normal fresh-water flow. There was some evidence of improvement in the condition of the river at high tide off the Northern Outfall Works.

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.

Secondary treatment of 40 million gallons daily was given in the paddle-type activated sludge plant. In mid-September the first steps were taken to build up activated sludge in a new diffused air plant, and the plant was officially opened by His Royal Highness the Duke of Edinburgh on 22 October. Units treating 20 million gallons daily were operating at the end of the year and units for a further 40 m.g.d. were waiting to be put into service. From the initial operation there was every sign that the new plant would effect a substantial reduction in the oxygen demand of the effluent.

Sludge digestion provided gas at the rate of half a million cubic feet daily from the reservoir plant which was shut down at the end of the year. During the last quarter of 1959 gas production commenced in a new plant, the initial performance of which was very satisfactory.

A considerable programme of research and development work was carried out during the year.

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 2,243 samples examined were submitted by metropolitan boroughs.

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 respirators.

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. Observations were made at 21 sites, which were reported to the Warren Spring Laboratory for collation with those of other authorities and publication. They are also being used by the department generally in a continuing statistical investigation of their relationship with mortality.

A progressive tendency for improvement in the smoke content of London air has been observed since the inception of the Clean Air Act and the measurements indicated a further reduction of 7 per cent. during the year. Part of the improvement was due to the mild weather in December with consequent reduction in fuel consumption.

Regular visits were made in company with the Alkali Inspector of the Ministry of Housing and Local Government to test the efficiency of the flue gas washing plants at Battersea and Bankside electricity generating stations.

The widespread applications of nuclear science have drawn attention to the risks of environmental contamination by radioactive matter; 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. Analysis of air-borne dust provides a sensitive and early indication of any change in conditions, and for this reason continuous monitoring of the atmosphere was again maintained throughout the year. During the first four months of 1959 the results indicated delayed contamination of the atmosphere by large-scale tests which took place in the previous autumn. There had been no subsequent tests and the residue of air-borne contamination decreased rapidly during the second half of the year.

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 was unpleasantly high. This was mainly attributable to the diesel-engined heavy vehicles 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 relatively low.

School meals

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.

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.

Swimming baths

The Council has under its control 13 swimming baths for public use and 26 swimming baths situated at schools and institutions. Of these 19 are sited outdoors and 20 indoors. 30 of the baths are equipped with complete purification plant, two with plant for gas chlorination and circulation only, and seven are chemically treated by hand. It is the Council's policy to equip all baths with complete purification plants and during the past year two further complete purification plants were installed.

As an example of the efficiency of treatment, the figures obtained during the five months summer season from 13 fully equipped public baths may be quoted. These baths are filled with water from the Metropolitan Water Board mains and are emptied and refilled only once a year. The weather during the summer of 1959 was very good, and the baths were extensively used. During this period about 1,750,000 people used the baths, and on several occasions bathing loads at a single bath reached 7,000 per day. The minimum recorded clarity was 12 feet, whilst the maximum was 161 feet.

Open air swimming baths in London Parks (1959)

Summary of bacteriological examinations

<i>Standards</i>	<i>Agar count 1 ml. 37°C. 48 hours</i>			<i>Presumptive coliform pollution without faecal</i>	<i>Faecal coliform pollution</i>
	<i>0-10</i>	<i>11-100</i>	<i>Over 100</i>		
Numbers of samples ..	117	17	3	Nil	3

The incidence of coliform pollution was about 2 per cent. and was due to temporary features such as plant breakdown which were speedily rectified. The results obtained are considered satisfactory, particularly for the conditions appertaining during the summer of 1959.

HEALTH SERVICE PREMISES

Building programme

Programme for 1960-65—The Council approved a health service building programme, subject to annual review, for the five years 1960 to 1965 providing for estimated expenditure amounting to £1,666,000. Details of the schemes for the 1960-61 programme are given in table (i).

Mental health service—Of the proposed expenditure for 1960-65, about £950,000 relates to schemes for the expansion and improvement of the mental health services, including the provision of hostel accommodation for mental patients and new training centres for the mentally handicapped to meet increased need and to replace accommodation in church halls.

General

The Council has decided that consideration should be given to including housing accommodation in new premises erected for health service purposes and this policy is being applied.

Details of works completed during the year, works in hand and works approved but not yet commenced are set out in tables (ii), (iii) and (iv). During the year freehold or leasehold interests in some properties were acquired; details are shown in table (v).

TABLE (i)—*Health Service building programme 1960-61*

<i>Health Division</i>	<i>Premises</i>	<i>Works proposed</i>
1	Cheyne Hospital day nursery, Chelsea	Replacement nursery if lease cannot be renewed.
1	Eridge House day nursery, Fulham ..	Resurfacing of play space.
1	Hurlingham Lodge hostel for tuberculous men, Fulham	Provision of additional accommodation.
1	St. Quintin day nursery, Kensington	Extension to existing building to provide additional places.
3	Basire Street, Islington	New junior occupation centre.
3	Cromwell Lodge hostel for tuberculous men, Hornsey	Provision of new boilers and small annexe for occupational therapy.
3	Scholefield Road day nursery, Islington	Conversion of boilers to oil firing.
4	Morning Lane, Hackney	New elder boys' occupation centre to replace an unsatisfactory centre.
5	Old Church Road day nursery, Stepney	Replacement nursery.
6	Blackwall Lane, Greenwich	Adaptation of existing building as an additional elder boys' occupation centre.
6	Maze Hill, Greenwich	New junior occupation centre to replace an unsatisfactory centre.
7	Brockley Rise, Lewisham	New mental health hostel.
7	Peckham Park Road, Camberwell ..	New mental health hostel.
—	Oval ambulance station, Lambeth ..	Extension to accommodate additional ambulances.

TABLE (ii)—*Works completed*

<i>Health Division</i>	<i>Premises</i>	<i>Work involved</i>
MATERNITY AND CHILD WELFARE		
6	Abbey Wood Estate, Woolwich ..	Adaptation of flat to provide temporary clinic accommodation.
9	William Harvey welfare centre, Ashburton Estate, Wandsworth.	New welfare centre incorporated in block of flats.

<i>Health Division</i>	<i>Premises</i>	<i>Work involved</i>
SCHOOL HEALTH		
7	78 Lewisham Park, Lewisham ..	Extension of premises to provide recovery room to dental suite.
DAY NURSERY		
1	Uxbridge Road, Hammersmith ..	Installation of sluices.
2	Portman, St. Marylebone	Provision of new fencing and tarpaving of enlarged play space.
3	Canonbury, Islington	Improvements to water services and provision of additional toilet facilities.
8	Bishop's House, Lambeth	Improvement to grounds.
8	Coldharbour Lane, Lambeth	Major repairs.
8	Coral, Lambeth	Replacement day nursery incorporated in block of flats.
9	Putney, Wandsworth	Resiting of boiler and provision of improved toilet facilities.
LONDON AMBULANCE SERVICE		
-	Eastern ambulance station, Hackney ..	Roofing of station yard.
-	Headquarters ambulance station, Lambeth	Provision of additional storage space and office accommodation and installation of stores hoist.
-	North Western ambulance station, Hampstead	Reinstatement of war damage and alteration to office accommodation.
-	South Eastern ambulance station, Deptford	Extension of garage accommodation and improvements to entrance and offices.
-	Western ambulance station, Chelsea ..	Provision of additional vehicle washing plant.
OCCUPATION CENTRES		
1	Kensington, Wallingford Avenue, Kensington	Erection of new building.
7	Lewisham, Perry Rise, Lewisham ..	Erection of new building.

TABLE (iii)—*Works in hand*

<i>Health Division</i>	<i>Premises</i>	<i>Works involved</i>
MATERNITY AND CHILD WELFARE		
2	St. Alban's Villas, St. Pancras ..	Provision of centre in ground floor of block of flats (being built by St. Pancras Metropolitan Borough Council).
4	St. Barnabas Church Hall, Evering Road, Hackney	The church authorities are erecting a new church hall which this Council will rent.
7	Bellingham Green, Lewisham ..	Adaptations to tenants' clubroom for use for infant welfare sessions.
8	Keeton's Road, Bermondsey	Replacement welfare centre in block of flats.
9	Welcome Mission Hall, Austin Road, Battersea	New hall being built by Shaftesbury Society incorporating accommodation for health service purposes.
LONDON AMBULANCE SERVICE		
-	Brook ambulance station, Woolwich ..	Improvement of superintendent's accommodation and re-arrangement of quarters.
-	Fulham ambulance station, Fulham ..	Adaptation of unused portion of Civil Defence quarters to provide additional accommodation for staff.
-	Western ambulance station, Chelsea ..	Enlargement of office accommodation.
MENTAL HEALTH		
3	Camden Road Congregational Church Hall, Islington	Church hall being built to incorporate Council's requirements for use as an occupation centre for elder girls.
4	Clifton Lodge, 96 Dalston Lane, Hackney	Conversion of former day nursery into a day centre for the mentally ill.

TABLE (iv)—Works approved but not yet commenced at end of 1959

Health Division	Premises	Works involved
MATERNITY AND CHILD WELFARE		
2	Hallfield Estate, Paddington	Provision of maternity and child welfare and school treatment centre in ground floor of block of flats (to be built by Paddington Metropolitan Borough Council).
6	Burney Street, Greenwich	Provision of maternity and child welfare centre in ground floor of block of flats (to be built by Greenwich Metropolitan Borough Council).
9	Plough Road, Battersea	Provision of maternity and child welfare and school treatment centre in ground floor of block of flats (to be built by Battersea Metropolitan Borough Council).
9	Stormont Road, Battersea	New maternity and child welfare and school treatment centre to replace unsatisfactory temporary premises.
SCHOOL HEALTH		
3	6 Clephane Road, Islington	Conversion of basement of South Islington welfare centre to form school health centre.
DAY NURSERY		
1	Ladbroke, Kensington	Additional toilets and new heating and hot water systems.
LONDON AMBULANCE SERVICE		
—	Battersea ambulance station, Battersea	Replacement of building destroyed by enemy action.
MENTAL HEALTH		
1	Letchford Gardens, Hammersmith ..	Adaptation of former maternity and child welfare centre to form an occupation centre for elder girls.
4	Iceni Sports Ground, Hackney ..	New junior occupation centre.
9	42 Clapham Manor Street, Wandsworth	Adaptation of premises to form an occupation and industrial training centre.
DIAGNOSTIC MEDICAL CENTRE AND CHILD GUIDANCE UNIT		
7	Queen's Road Centre, Camberwell ..	Major adaptations to third floor to provide general practitioners centre and improved accommodation for existing child guidance unit.

TABLE (v)—Acquisitions and leases completed

Health Division	Property	Interest obtained
MATERNITY AND CHILD WELFARE		
6	Merton Place, S.E.10	Freehold.
6	William Barefoot Drive, S.E.9 ..	Freehold.
9	Southlands, Shuttleworth Road, S.W.11	Freehold.
SCHOOL HEALTH		
9	55 Lewin Road, S.W.16	Leasehold.
DAY NURSERY		
1	1 Ladbroke Square, W.11	Leasehold.
2	Katherine Bruce, Queen's Park Court, Ilbert Street, W.10	Freehold.
3	Lloyd Square (day nursery garden), W.C.1	Leasehold.
3	1 and 3 Mitford Road, N.19	Freehold.
7	Dog Kennel Hill, S.E.22	Hutted buildings.
8	Tenda Road, S.E.1	Freehold and hutted buildings.
8	Whitstable Street, S.E.1	Freehold and hutted buildings.
9	95 Lacy Road, S.W.15	Leasehold.
9	56 Nightingale Lane, S.W.12 ..	Leasehold.
9	Summerley Street, S.W.18	Freehold.
MENTAL HEALTH		
3	Basire Street, N.1	Freehold.
9	42 Clapham Manor Street, S.W.4 ..	Leasehold.

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 details are given in the reports of the individual divisional medical officers. Details of changes in centres during the year will be found in the section on health service premises.

Maternity services committee

The Council decided to adopt the principles laid down in the report of the Maternity Services (Cranbrook) Committee for improving co-ordination, co-operation and exchange of information between the three branches of the maternity service.

The Council already provides premises and facilities, without charge, to general practitioner obstetricians and hospital medical staff holding outlying hospital clinics, and health education and mothercraft instruction in the Council's clinics has long been available to the booked maternity patients of general practitioners and general practitioner obstetricians. There will be the fullest co-operation with hospital authorities in extending arrangements for following-up mothers who fail to attend hospital ante-natal clinics; providing health education and mothercraft instruction to expectant mothers booked for hospital confinement at the Council's clinics or at hospitals; and assessing the home circumstances of a patient before she is booked for hospital confinement on social grounds.

Officers of the Council will serve on local maternity liaison committees and attend local clinical meetings and will thus have opportunities of advocating the views and recommendations of the Cranbrook Committee on such matters as the selection of patients for domiciliary and for hospital confinement, and the adequate allocation of beds both for the priority groups and for emergency admissions.

The Council approved in principle the introduction of an appointments system in the Council's ante-natal clinics where attendances and other considerations justify such arrangements, and the inclusion of the domiciliary midwifery service in any proposals which may eventually be agreed by the hospital authorities for the publication of clinical reports.

Providing no greater difficulty arises in obtaining maternity beds for patients needing hospital confinement on medical or social grounds and patients remain in hospital for the normal period of ten days, the Council will make no objection to the proposal for the provision of general practitioner maternity beds. The Council has urged that hospital authorities should consult the Council in advance before any general plan for the discharge of maternity patients before the tenth day is adopted, should notify all routine discharges of maternity patients from hospitals daily and consult the appropriate officers of the Council in relation to exceptional cases being discharged before the tenth day.

The Council confirmed the opinion expressed in its evidence to the Cranbrook Committee that there should be a stricter standard for admission to the general practitioner obstetrician list and that every general practitioner obstetrician should have as a deputy another general practitioner obstetrician.

Maternity and child welfare

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

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

	1955	1956	1957	1958	1959
Ante-natal, post-natal and combined clinics:					
Number at end of year	118	116	118	112	111
Sessions per month	846	805	786	799	797
Ante-natal:					
First attendances	22,231	23,379	23,918	25,673	23,905
Total attendances	116,042	122,662	121,579	134,684	129,731
Percentage of pregnant women attending an ante-natal clinic	43	44	44	45	42
Post-natal:					
Number of women attending during the year	4,258	4,543	3,887	3,714	3,524
Child welfare clinics:					
Number at end of year	176	178	178	179	179
Sessions per month	1,939	1,953	1,990	1,991	1,957
Attendances under a year:					
First	43,068	44,910	46,387	49,229	49,610
Total	587,143	595,690	613,147	611,057	606,042
Attendances over 1 year	193,273	189,388	183,538	177,283	152,627
Attendances at special toddlers clinics ..	41,268	41,055	40,848	38,940	38,361
Percentage of infants attending a centre at least once in the first year of life ..	86	86	86	88	89

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	1959
At sessions provided by Council	4,092	4,392	4,260
Referred by Council to Family Planning Association	688	702	705

National welfare foods

	<i>Average weekly issues</i>				
	1955	1956	1957	1958	1959
National dried milk (tins)	26,515	25,413	19,839	15,791	15,328
Cod-liver oil (bottles) ..	7,100	6,156	5,191	3,620	3,469
Vitamin tablets (packets)	2,877	2,952	2,788	2,736	2,775
Orange juice (bottles) ..	45,838	48,163	48,925	31,360	30,412

Day accommodation for children

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

	At 31st December				
	1955	1956	1957	1958	1959
DAY NURSERIES:					
Maintained	94	86	81	76	75
Grant-aided	5	5	5	5	4
Total	99	91	86	81	79
Places 0-2	1,903	1,775	1,747	1,690	1,693
Places 2-5	3,677	3,368	2,988	2,631	2,499
Total places	5,580	5,143	4,735	4,321	4,192
COUNCIL'S CHILD MINDER SCHEME (Voluntary registration):					
Child minders registered	743	777	838	824	875
Children minded	851	886	954	973	1,039
NURSERIES & CHILD MINDERS REGULATION ACT, 1948:					
Private day nurseries registered (including part-time nurseries)	56	58	60	59	60
Places	1,640	1,646	1,701	1,742	1,620
Child minders registered	106	102	132	141	167
No. of children authorised to be minded	649	611	699	781	939

Occasional crèches—At 31 December, 1959, 17 crèches provided 280 places. This service was substantially self-supporting, except for the free admission of children during the time their mothers were attending clinic and health education sessions.

Prevention of break-up of families

Following a review of the work done by the five social case workers appointed to temporary positions in three divisions, the Council decided to increase the number of social case workers to fifteen. The Council also authorised an experiment in arranging for selected assistant organisers of children's care work to undertake the support and intensive care of one or two problem families each. Recruitment and selection of staff continued during the year, with the aim of extending this service to all divisions, and by 31 December, 1959 eight full-time and one part-time social case workers and three assistant organisers were undertaking intensive work with problem families in five divisions.

Home-making courses for selected mothers

Since 1954 the Council has been associated with a few special home-making courses for selected mothers. Some of these have been organised by voluntary committees under the auspices of the London Council of Social Service, with financial assistance from the Council; others are run entirely by the Council's own staff. The courses provide for regular weekly meetings of a small group of mothers known to have problems, including some mothers of 'problem families'. They receive instruction and advice in simple housecraft, child management, household budgeting and similar subjects; many of the groups also arrange social activities in which their members with their husbands and children may share. Each group has a leader who arranges the activities and if necessary encourages the mothers to attend regularly. There were 11 such groups meeting regularly at the end of 1959, eight of them with voluntary committees.

Experience has been that the mothers gain not only from the instruction given but also from friendly association with other members of the group. The Council is now co-operating with the Advisory Group on Home-making, set up by the London Council of Social Service under the chairmanship of Sir Allen Daley, in an enquiry into the progress made by mothers attending the courses.

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 the 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 and children are often moved into the county so that they may more easily obtain appropriate special educational treatment.

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 Medical Officer of Health is asked for his observations on the proposal.

The number of children referred by the Children's Officer in 1959 and the two previous years was as follows:

<i>Observations of M.O.H., etc.</i>	1957		1958		1959	
1. Unsuitable for either adoption or boarding out ..		3		3		1
2. Adoption cases:						
Suitable for adoption	178		167		228	
Suitable for adoption subject to certain conditions ..	8		2		1	
Unsuitable for adoption but suitable for boarding out	7		17		5	
Withdrawn by Children's Officer	8		3		2	
Under consideration at 31 December	4		1		2	
		205		190		238
3. Boarding out cases:						
Suitable for boarding out	310		320		290	
Withdrawn by Children's Officer	7		3		3	
Under consideration at 31 December	5		1		3	
		322		324		296
TOTAL		530		517		535

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.

	1955	1956	1957	1958	1959
Number of voluntary homes receiving grant at 31 December	20	18	17	16	15
Number of expectant and nursing mothers admitted ..	1,171	1,306	1,141	1,191	1,072
Total grants	£11,048	£10,758	£11,360	£10,476	£10,237

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

	1955	1956	1957	1958	1959
Total grants	£9,525	£9,625	£9,625	£12,531	£13,555
Number of expectant and nursing mothers advised ..	2,429	2,908	2,684	2,975	3,005

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).

Unmarried mothers—

TABLE (i)—*Mothers seen for the first time in 1959 by age*

	No.	%
Under 18	285	9.5
18-19	533	17.7
20-24	1,261	41.9
25-34	748	24.9
35 and over	167	5.6
Not known	11	0.4
	3,005	100.0

The percentage of mothers seen for the first time in 1954 who were under 18 years of age was 7.2.

TABLE (ii)—*Nationality by normal residence*

	London (Administrative County)	Elsewhere	Total
British (United Kingdom)	1,270	476	1,746
Eire	455	279	734
West Indian	236	84	320
European	85	56	141
Any other	39	25	64
	2,085	920*	3,005

*688 were pregnant on arrival in London.

Approximately half the mothers interviewed by Catholic moral welfare associations for the first time in 1959 came from Eire and about a quarter of these mothers were pregnant on arrival in England.

The moral welfare associations report an increasing awareness of this problem by the appropriate authorities in Eire. Closer relationship has been established with the Irish moral welfare organisations and about half the girls who were pregnant on arrival in this country during 1959 were helped by moral welfare associations in both countries to return to Eire for confinement. The problem is being carefully watched by the moral welfare associations and it is hoped that, with the wider and improved services now being offered to such mothers in Eire, particularly in regard to adoption, for which the waiting period has been reduced from two years to two months, the number of pregnant girls coming to England will be greatly reduced.

Efforts are also being made by Church authorities to keep close contact with young girl immigrants from Eire who have taken up work in London.

Illegitimate babies—

TABLE (iii)—*Care of babies three months after birth*

	No.	%
(a) <i>Living with mother</i>		
Mother married to putative father or another man	108	4.7
Mother cohabiting with putative father	126	5.5
In grandparents' home, lodgings, residential post, mother and baby home, etc.	961	42.1
	1,195	52.3
(b) <i>Separated from mother</i>		
Adopted or placed for adoption	564	24.7
With foster parents or in residential nursery	359	15.7
In care of local authority	60	2.6
	983	43.0
(c) <i>Miscellaneous</i>		
Mother and child moved away, etc.	108	4.7
	2,286	100.0

These babies resulted from the pregnancies of 3,023 women—in 652 cases the result of pregnancy was unknown, and 99 resulted in miscarriages or stillbirths; 1,352 women (45 per cent.) were reported as admitted to mother and baby homes before their babies were born.

The total number of illegitimate births in London (Administrative County) during 1959 was 5,765 and the number of women reported as admitted to mother and baby homes represents about 23 per cent. of this total.

Enquiries made by three of the five associations, which deal with about 85 per cent. of all cases, into the background of girls whose babies were born during the period 1 January, 1957, to 30 September, 1958, showed that 90 per cent. of the mothers had been brought up by their own parents.

Information about putative fathers is unreliable but from evidence available it appears that only about six per cent. were under 20.

Child protection

By arrangement with the Children's Officer the visiting of foster children and the inspection of the premises in which the children are living continues to be undertaken by health visitors designated as 'Child Life Protection' visitors. Until 31 March, 1959, these duties were carried out in accordance with Part XIII of the Public Health (London) Act, 1936, as amended by Part V of the Children Act, 1948. The Children Act, 1958, which repealed existing legislation and re-enacted with modifications the child protection code came into force on 1 April. The expression 'child life protection' has been dropped and is replaced by the expression 'child protection.' Under the new Act, a child is not a 'foster child' unless there is an undertaking to care for and maintain him for reward for a period exceeding one month. Also excluded from the definition of a foster child is a child who is in the care of any person in any premises in which a parent, adult relative or guardian is for the time being residing, or a child whose welfare is already the responsibility of specified competent authorities. The Act now extends child protection to certain school children who remain at school during the school holidays for a period of more than one month unless the school is one maintained by a local education authority. Whilst the former child protection code was in force, the number of foster children to be kept in each new foster home was fixed by the local authority. Under the Children Act, 1958, the power to limit the number of children to be kept in a foster home applies only to premises which are 'wholly or mainly' used for the keeping of foster children. Where the premises are so used, the local authority may also impose other requirements.

The number of children supervised by Child Protection visitors on 31 March, 1959, was 626, a decrease of 77 compared with 1958.

Marriage guidance

Grants totalling £6,500 for the year ending 31 March, 1960, were made to the London Marriage Guidance Council, the Catholic Marriage Advisory Council and the Family Discussion Bureau.

DOMICILIARY MIDWIFERY

The duty to provide 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

	1955	1956	1957	1958	1959
The Council	96	92	87	87	89
District Nursing Associations (including supervisory staff)	34	46	44	48	45
Hospitals	44	44	39	40	46
	<u>174</u>	<u>182</u>	<u>170</u>	<u>175</u>	<u>180</u>

TABLE (ii)—*Domiciliary confinements attended*

	1955		1956		1957		1958		1959			
	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	
									No.	%	No.	%
(a) Doctor not booked												
L.C.C.	245	3,729	193	3,500	172	3,325	201	2,899	232	2.1	2,761	25.3
D.N.A.	54	1,745	68	1,790	68	1,624	75	1,577	58	0.5	1,360	12.5
Hospital district	22	1,776	25	1,944	29	1,711	23	1,693	41	0.4	1,574	14.4
	<u>321</u>	<u>7,250</u>	<u>286</u>	<u>7,234</u>	<u>269</u>	<u>6,660</u>	<u>299</u>	<u>6,169</u>	<u>331</u>	<u>3.0</u>	<u>5,695</u>	<u>52.2</u>
		7,571		7,520		6,929		6,468		6,026		55.2
(b) Doctor booked												
L.C.C.	759	1,042	847	1,293	996	1,548	1,135	1,966	1,340	12.3	2,405	22.0
D.N.A.	138	157	134	197	152	294	182	389	194	1.8	505	4.6
Hospital district	98	133	103	148	68	196	144	225	132	1.2	313	2.9
	<u>995</u>	<u>1,332</u>	<u>1,084</u>	<u>1,638</u>	<u>1,216</u>	<u>2,038</u>	<u>1,461</u>	<u>2,580</u>	<u>1,666</u>	<u>15.3</u>	<u>3,223</u>	<u>29.5</u>
		2,327		2,722		3,254		4,041		4,889		44.8
Total		9,898		10,242		10,183		10,509		10,915		100.0

During the past five years there has been a marked increase in the number of home confinements in which a doctor has been booked for maternity medical services, the 1959 total of such cases, 4,889 (45 per cent.) being proportionately nearly double that of 1955 when the number was 2,327 (24 per cent.) If hospital district practice is excluded, the figure for 1959 is 50 per cent.

TABLE (iii)

	1955	1956	1957	1958	1959
Still-births per 1,000 total births	8.8	8.8	8.5	8.4	9.2
Premature babies	479	509	501	482	555
Per cent. of live births.. ..	4.8	5.0	5.0	4.6	5.1

The corresponding rates for domiciliary confinements for England and Wales in the year 1958 (the latest available) were for prematurity, 4.5 per cent., and for still-births, 10.9 per 1,000 total births.

The still-birth rate in the domiciliary midwifery service compares favourably with the rate for domiciliary confinements in England and Wales as a whole. This is to be expected as although obstetric and medical abnormalities in pregnancy are admitted to hospital for confinement in both cases the proportion of hospital confinements in London is 81 per cent. compared with 64 per cent. in England and Wales; nevertheless it is an encouraging indication of the effect of good ante-natal care.

TABLE (iv)—*Inhalation analgesia administered*

		1955	1956	1957	1958	1959
Gas and air	..	N.A.	70%	35%	17%	9%
Trilene	..	..	14%	52%	71%	78%
			84%	87%	88%	87%

Each of the Council's midwives had been equipped with a portable trilene inhaler by the end of 1957. A marked reduction has resulted 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 in her, or a doctor's, clinical judgment it is required.

Midwives Act, 1951

Notifications received of intention to practise:

				1955	1956	1957	1958	1959
As midwives	..	..	..	1,193	1,164	1,193	1,160	1,285
As maternity nurses	..	..	..	150	144	137	121	110

In accordance with Section G.1 of Rules of the Central Midwives Board, 136 midwives in the county attended a refresher course during the year.

Fees to medical practitioners called in by midwives in emergency:

				1955	1956	1957	1958	1959
Number of claims	..	..	..	2,682	2,554	2,479	2,626	2,653

HEALTH VISITING

<i>Home visits</i>	<i>1955</i>	<i>1956</i>	<i>1957</i>	<i>1958</i>	<i>1959</i>
Expectant mothers:					
First	22,999	23,143	23,482	24,131	22,940
Revisit	19,436	21,422	21,994	23,213	23,161
Percentage of notified live and still-births..	45	44	43	42	40
Still-births	1,032	1,173	1,080	979	960
Children under 1:					
First	48,225	51,960	52,171	53,557	53,224
Revisit	174,864	173,774	169,760	176,428	173,932
*Percentage of live births	97	100	98	96	95
Children 1-5	362,764	357,215	354,643	368,845	372,622
Care of old people }	77,014	12,842	12,465	13,331	14,366
Miscellaneous }		66,823	74,513	80,978	80,948
Unsuccessful	110,149	103,600	100,250	100,648	101,503
TOTAL	816,483	811,952	810,358	842,110	843,656

* 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

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 (numbers employed at 31 December)**

	1955	1956	1957	1958	1959
State registered nurses ..	490	491	533	506	512
State enrolled assistant nurses ..	36	42	30	33	34
Total number of nurses employed ..	526	533	563	539	546
Male nurses (included above) ..	41	38	41	41	39
Full time equivalent of nurses employed	478	487	522	496	507
Students	68	75	52	65	78
Male students (included above) ..	6	8	4	6	6

* *Exclusive of administrative and supervisory staff.*

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	47,464	82.7	30	1,427,302
Surgical	5,928	10.4	37	218,895
Infectious diseases	214	0.4	8	1,766
Tuberculous	1,269	2.2	55	69,309
Maternal complications	982	1.7	8	7,461
Others	1,511	2.6	26	38,563
	57,368	100.0	31	1,763,296

The total visits for 1958 and 1957 were 1,893,553 and 1,991,621 respectively.

TABLE (iii)—*Types of treatment and location*

Visits for	At patient's home	Elsewhere (e.g., Nurses' Homes)	Percentage of total visits
Injections only	718,335	36,542	42
Injections plus other treatment	102,037	487	6
Other treatment only	904,752	1,143	52
	1,725,124	38,172	100

During 1959 the proportion of visits for 'Other treatment only' rose by 5 per cent. compared with 1958, whilst visits for 'Injections only' fell by the same amount. The latter was due largely to the increasing use of oral treatment for diabetes, to more selective use of antibiotics and to a decrease in the number of tuberculous cases requiring streptomycin.

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

Number	Percentage of total patients nursed
11,225	19.6

The percentage of long term cases increased from 18.9 in 1958.

TABLE (v)—Age distribution of patients

Age	Number of patients	Percentage of total
0-5 years	2,554	4
5-64 years	25,225	44
65 years and over	29,589	52
	57,368	100

The number of patients was smaller than in 1958 (62,116) but the age distribution was the same.

TABLE (vi)—Nursing treatments and case load

	1956	1957	1958	1959
Number of completed treatments ..	60,772	56,395	53,359	49,299
Number of patients being nursed at end of year	12,806	13,749	12,099	11,352
Average case load per nurse at end of year	24	27	24	23

HOME HELP

Introduction

In London, prior to 1948, all the metropolitan boroughs (but not the City of London) had schemes for providing home helps for maternity cases and (except Bethnal Green and the City of London) had schemes for the provision of help for sick or infirm persons not themselves able to provide such assistance. The extent of the provision and the nature of the staff employed, however, varied considerably from borough to borough.

The Council has administered a home help service since 5 July, 1948 when the National Health Service Act, 1946, came into force. The service provides assistance where such help is required because of the presence in the household of a sick person, a lying-in or expectant mother, a mentally subnormal person, an aged person or a child under school-leaving age. The home help service has been developed to meet these varied circumstances and special types of help made available to deal with differing social problems and circumstances.

Organisation

The service is organised in each of the nine health divisions. Each division has three or four home help organisers whose areas coincide in many cases with those of the metropolitan boroughs which provided the service before 1948. Each organiser has a conveniently situated office, generally at one of the Council's welfare centres. Whilst of necessity much of her time is spent there on such work as preparing visiting schedules for her staff and discussing problems with them, she and her assistant (one or two) are occupied for a considerable part of their time in visiting households in their area. A visit is paid to each applicant for help to ascertain what kind of assistance is needed, whether home help can be provided and how many hours' service is necessary to meet the specific need. The organiser or her assistant may pay several subsequent visits to supervise the service. A departmental working party examined all aspects of the home help service in 1956, made certain recommendations designed to bring about a greater measure of uniformity in the administration of the service and concluded that organisers should not be hampered by responsibility for unduly large areas where, although the clerical work involved could be provided for by additional clerical staff, the organiser and her assistant might find it impossible to maintain a satisfactory standard of home visiting. It is accordingly the general aim that a district shall be of a size which will yield not more than 1,000 and not fewer than 500 cases.

Charges

The charge to the recipient of home help of any kind is three shillings an hour.* In cases of hardship this may be abated in the light of the family income and expenses of maintaining the household, in accordance with the Council's assessment scale and, in many cases, particularly among old age pensioners and those in receipt of National Assistance, the service is therefore provided free.

Staff training

Formal training is not generally given to home helps engaged on routine cases but those who have obtained the Diploma of the National Institute of Houseworkers receive an additional payment of a penny an hour. In-service training is, in the main, confined to selected home helps who from time to time attend a short course, organised by one or other of the divisions, to enable them to undertake work with problem families. Organised on a divisional basis, home helps from two or three divisions may attend together to hear talks given by speakers such as a divisional nursing officer, a welfare centre superintendent and a health visitor. The syllabus for the course provides for talks and discussion on

**The charge was increased in 1960.*

the basic requirements of children if they are to develop fully; the importance of gaining the family's co-operation and getting them to play an active and responsible part in running the household; and the maternity and child welfare services. Attention is also given to practical domestic subjects such as the use of household materials, making the best of poor equipment and facilities, and teaching mothers to plan menus and budget. Practical demonstrations, films and film-strips are used as part of the course, which is designed to show home helps how they can recognise and deal with a mother's inadequacies in household management and encourage her to improve her standards of home care so that eventually the family will be able to maintain reasonable standards in the home without outside help.

Four courses were held in 1959, but unfortunately the generally high staff turnover among home helps was reflected in the number of specially trained home helps, notwithstanding that only those who seem likely to remain in the service are selected for training. Thus the number of these home helps at the end of the year, 118, was no higher than at the end of 1958. Trained helps receive an additional fourpence an hour for time spent in working with problem families.

Assistant home help organisers—Post-entry training for assistant home help organisers is provided through occasional centrally-run refresher courses. It was originally intended that a course should be spread over some three weeks, but it has been found preferable to compress it into four days. Each session takes the form of a discussion group whose leaders are drawn from divisional medical and nursing staff, social workers, home help organisers, and divisional and central office administrative officers. Subjects include the history and development of the service and its counterparts abroad; the place of the service in the public health department and its administration; financial aspects of the service such as assessment of charges and collection of debts; office methods—records and statistics; staff management, including recruitment and discipline; home visiting; the special problems of various types of patient; child care; and other social services.

Assistant home help organisers have usually had up to two years' experience of the work before they attend a course and they have therefore a considerable amount of practical knowledge which they can pool for their mutual benefit. Their grounding in fieldwork enables them to take a full part in discussion at a well-informed level which is of greater interest and value than an earlier briefing in more elementary aspects of their work.

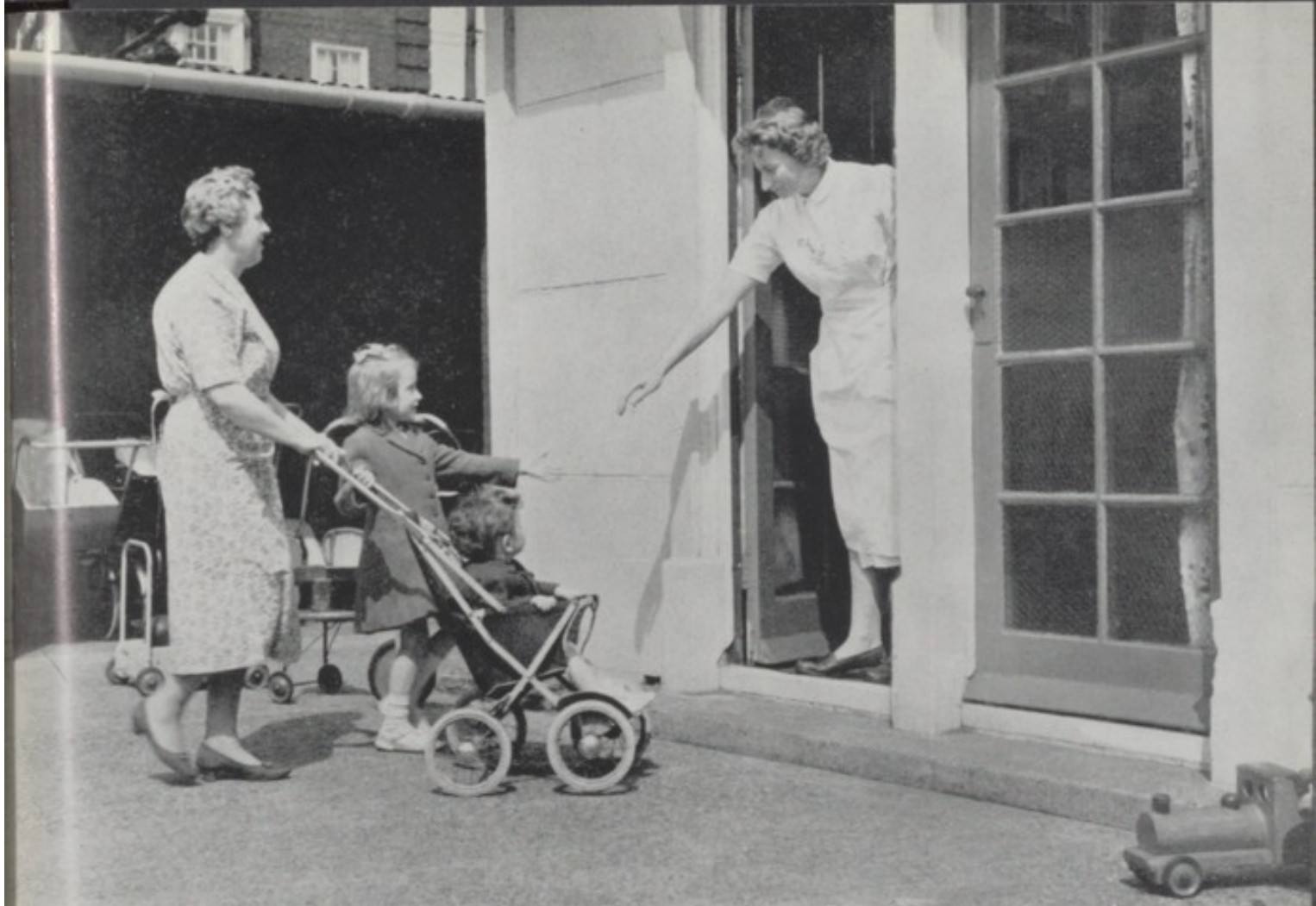
One course attended by nine assistant home help organisers was held in 1959.

Conferences of home help organisers

Where a service has to meet such varied demands and where the recruitment and servicing problems of the more prosperous residential areas may be quite different from those of the densely populated and perhaps more neighbourly districts, consultation among those responsible for the service in different parts of the county is valuable. It can stimulate ideas and suggest improvements and also ensures that the advantages of local control and special knowledge of local conditions do not lead at the same time to discrepancies and undesirable local variations in the administration of the service. Home help organisers are therefore brought together about twice a year to meet for an afternoon at County Hall, and subjects for discussion range from the suggested revision of forms used in the service to the best way to deal with specially difficult types of case.

Services provided

The work of the service consists in most cases of help so far as is necessary with housework, caring for children—taking them to school or nursery perhaps—shopping, cooking, washing, ironing, mending: all the tasks which in fact are normally undertaken by the housewife. Demand for home help still sometimes exceeds the supply of assistance available, although only 13 applications were deferred or refused for this reason in 1959.



HELP WHEN MOTHER IS ILL

*Children are taken to a day nursery
Lunch for mother in bed*





*Service for
a blind and
deaf person*

*Shaving time—
A male home help
at work*



*The night help
watches*

Priority is given to applications for help in the following order:

- (i) Maternity cases.
- (ii) Cases of acute or chronic illness.
- (iii) Aged, infirm or blind persons.
- (iv) Households where there is a mentally subnormal person or a large number of children under compulsory school-leaving age.

The majority of requests for assistance come from general practitioners and hospital almoners.

Patients' relatives who give up paid employment to look after them are allowed, in exceptional circumstances and at the divisional medical officer's discretion, to act as home helps if an official home help cannot be provided. They are paid for this service in accordance with the home help organiser's assessment of the needs of the case. This arrangement can be particularly useful when the patient is tuberculous and it is difficult to obtain a volunteer from the ordinary staff to work in the household.

Old people—The great majority of the cases provided with home help are the aged and chronic sick (83 per cent. in 1959). Many of these old people require simply a helping hand to enable them to maintain their independence but others are in the care of a doctor and perhaps a home nurse.

In some cases failing physical and mental powers may create a more difficult situation, as they have done with Miss P., an old lady living in the basement of a four-storied building, formerly the family house but now empty and dilapidated. A borough council health inspector appealed to the home help service to see whether anything could be done for Miss P. who, it had been suggested, might have to be removed under a court order. Miss P. was visited and her home found to be covered in cobwebs and littered with accumulated rubbish. She was sleeping in an old armchair because her bed had two mattresses on it and she could not climb up. After some persuasion she consented to accept some help. It has not, unfortunately, been possible to break the hoarding habits of the old lady, who is adamant in refusing to throw away any article however old and dirty and useless; every empty tin and bottle is retained and she even manages to collect other rubbish, going out with a push-chair to collect the discarded ashes from a local school. She is a pleasant old soul, however, determined to stay in her own home and is causing no nuisance to anyone. Although little visible progress has been made, her bed has been adapted for use and she now occupies it on most nights, and she looks forward to the visits of the home help who comes three times each week to do the little sweeping and tidying which Miss P. will permit her to carry out.

Tuberculous cases—Home helps who attend tuberculous patients have all been Mantoux tested and X-rayed before being allowed to take on the work, and a regular X-ray check is maintained thereafter. In addition to these precautions a special leaflet is issued to home helps working with tuberculous patients advising them on cleaning and ventilation, laundering the patient's linen and other points which can eliminate any unnecessary risk of infection.

Uniform and protective clothing—Home helps do not wear uniform but they are provided with cotton floral overalls for wear when doing housework on duty; the home helps who appear in the photographs facing page 68 are wearing these. Hand-towels are also issued and rubber gloves and aprons can be supplied on loan where necessary. Stocks of cleaning materials and household utensils are kept at home help offices for use where proper equipment is not available in the patient's home.

Specialised services

Although specialised services are needed in only a small proportion of the total households helped, the part played by these services in ensuring that individual needs are met makes them indispensable if a complete home help service is to be provided for those in need in the community as a whole.

Night helps—Introduced in 1953, they provide service for one or two nights a week, generally from about 11 p.m.-7 a.m., in households where old or sick patients may require constant attention; the rest of the family are given some relief from broken nights when a help can sit up with the patient and attend to his needs.

The case of Mrs. N. is an example; she lived with her widowed daughter, who had also her own son and another young man, both of whom were blind, to care for. Mrs. N. took to wandering at night, when she would go down the road in her nightdress or turn on and light the gas on her cooker, thus endangering herself and the home, and so a home help was sent twice weekly to give her daughter some respite. Applications for this sort of assistance were met in 40 cases in 1959.

Child help—The child help service was also introduced in 1953 with the object of avoiding wherever possible the necessity for receiving children into care when they are temporarily left on their own, for example, because both parents are in hospital. Child helps work in the children's own homes, run the household and sleep in. Demand for this service has been small but new families assisted in this way in 1959 numbered 20; two households continued to receive help commenced before 1959. The service has to be adapted to meet the needs of individual cases. The V. family illustrates one rather unorthodox way in which this has been done: Mrs. V. who suffers from steadily worsening disseminated sclerosis, was obliged at last to enter a home; at the same time as she was admitted her husband had to go into hospital for three weeks leaving two children, aged six and three, without friends or relatives to care for them. The home help who had undertaken the household duties over the last four years offered to take the children to stay with her in her own home, and she was allowed for this the two hours daily which she had spent in the family's home with an additional two hours of paid time in order that she might look after them; she wanted no other remuneration for this work. The older child attended school while the younger was placed in a day nursery. In this way it was made possible for them to be looked after temporarily by somebody they knew and trusted.

Early morning and evening help—Where children need care during the day-time only, help is supplied outside the normal hours starting, if necessary, as early as 7 a.m. and resuming in the evenings to continue until 7 p.m., so that children can be sent to school or day nursery in the morning and be given tea and cared for on their return until the parent is back from work.

Such a case is that of Mr. G., a widower with two sons aged nine and eleven. After his wife's death a home help was provided from 8.30 to 10.30 in the morning to get the boys ready for school and help generally in the home. The father, who is capable, is thus enabled to keep his home together and follow his usual occupation. In school holidays help is continued and the boys go to their grandmother for the day.

200 new applications for assistance of this sort were met in 1959 and service continued for 49 additional families from the previous year.

Special help—Problem families may be supplied not only with normal home help but also with the service of a special home help. As already indicated, selected helps undergo a short training course on problem family work; their function is not merely to do the domestic chores but to encourage the mother to undertake them herself and teach her proper home and financial management. The special home help must gain the family's friendship and confidence and plays in this way an important part in their social rehabilitation. There is close co-operation with the health visitor or social case-worker.

Typical of the problem families assisted by the service of a special home help is the S. family where the mother seemed unable to cope with running the home and the care of her five children. Little was achieved by the first special home help provided who tended to treat Mrs. S. like a naughty child. The home help organiser and the social case-worker therefore took the opportunity when she was on sick leave to change to another help. Considerable improvement in the routine and management of the home has resulted, the

mother has started to make clothes for herself and the children and, when two of their rooms had been cleared of the accumulated rubbish of years, the father, who hitherto had taken little interest in the home, volunteered to decorate them during his summer holidays.

Mrs. S., who has been very aggressive to outsiders, now feels that her difficulties are appreciated and understood, and the marked change in her behaviour has been reflected in the children: the two eldest, both formerly enuretic, who had been attending a special investigation clinic, were virtually cured in six months, and this rapid progress must be attributed in part to the calmer home atmosphere.

There is still much to be done in the home and the mother will need support for some time further as there has been a rapid deterioration whenever the special home help has been on holiday or sick leave. Both parents have high ideals of how a home should be run, but having a large family in a short time the mother found the situation so overwhelming that she gave up trying. It is only since she had the support of someone who could help her towards attaining her own high standards that she has made any effort at all. It has been possible, however, to reduce the service provided from four hours every day to two hours on weekdays.

Periodic discussions are held between the home help organiser, social case-worker and special home help to consider the direction and way in which further efforts to help the family should be made.

During 1959 110 problem families received special home help, and the number being attended at the end of the year was 63.

Male helps—Among the home helps employed are a small number of male home helps whose service is most valuable where it is not possible or advisable to send a woman to help a male patient; they provide all the usual household and personal assistance for their cases. At the end of 1959 there were 21 of these helps in the Council's service.

Amount of service given

Statistics of the service provided during the last five years are shown in the following table.

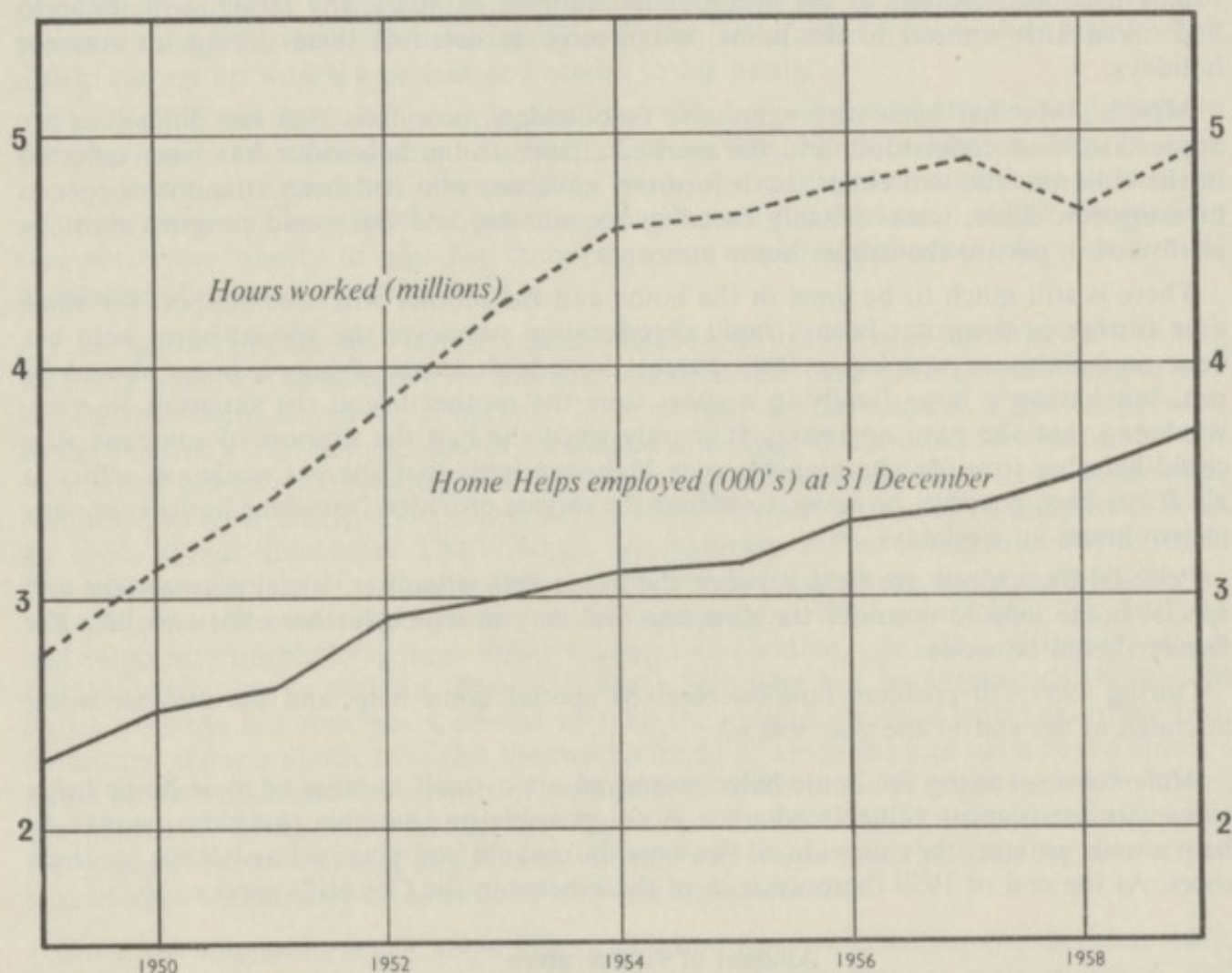
	1955	1956	1957	1958	1959
Cases assisted*	34,785	34,557	35,737	34,600	36,056
Applications deferred or refused because home helps were not available	61	76	25	25	13
Hours worked	4,660,600	4,779,600	4,896,000	4,651,500	4,919,200
Home helps employed at end of year ..	3,148	3,326	3,388	3,529	3,706
Equivalent of whole-time staff†	2,029	2,089	2,116	2,033	2,150
Night helps for chronic sick patients‡—					
Applications met	48	37	44	55	40
No. of new families assisted‡—					
Child help (resident)	5	5	4	6	20
Early morning and evening help	205	180	153	197	200

* 1955–1957, number of times assistance given; from 1958, number of households assisted.

† From 1958 excludes staff on annual and sick leave.

‡ These are included in total cases assisted.

HOURS WORKED AND NUMBERS OF HOME HELPS EMPLOYED 1949-1959.



Liaison arrangements

Apart from the opportunity given by the conferences referred to earlier for co-ordination and co-operation within the service, the work is also closely co-ordinated with that of the other personal health services to ensure that care given is adequate. For this purpose there is close liaison and regular meetings between home help organisers and divisional medical, administrative and nursing officers, and day-to-day contact is maintained with health visitors, domiciliary midwives, home nurses and social case-workers, to whose duties the home help service is often complementary. Special attention is given to ensure adequate co-operation between the various services concerned with problem families and for this purpose home help organisers attend meetings of divisional co-ordinating committees when any families in which they have a particular interest are under discussion. These families are also the subject of consultations between the home help organiser, the special home help, the health visitor and the social case-worker as the need arises.

It is the function of the service to enable the household service to continue in difficult circumstances to maintain the home as a viable entity and, where this cannot be done without assistance, to create an ordered, organised household. A sound basis is thus provided for any further care which may be needed. The home help service is in many cases a necessary adjunct to social and nursing care as well as a service in its own right.

IMMUNISATION AND VACCINATION

Diphtheria, tetanus, whooping cough—

TABLE (i)

	1955	1956	1957	1958	1959
<i>Diphtheria immunisation:</i>					
Primary course—					
Under 1 year	18,555	23,927	24,325	23,385	29,534
Age 1-4	11,078	13,907	12,643	10,560	10,693
Total under 5	29,633	37,834	36,968	33,945	40,227
Age 5-14	4,896	6,403	5,856	4,742	5,022
Reinforcing doses	30,850	43,866	39,268	38,725	33,237
Immunity Index 1-4 years	66.5	68.4	70.4	69.9	70.6
<i>Tetanus immunisation*</i>	—	—	12,405	15,092	32,531
<i>Whooping cough vaccination</i>	27,941	36,556	35,648	34,133	38,917

* Started January, 1957.

The number of children referred to in table (i) who received multiple antigens is as follows:

TABLE (ii)

	1956	1957	1958	1959
Diphtheria/whooping cough	32,091	19,464	7,623	4,925
Diphtheria/whooping cough/tetanus	—	12,405	15,092	32,382
Diphtheria/tetanus*	—	—	—	42

* Started 1959.

During the year it was decided to introduce a standard schedule of infant immunisation in all divisions as follows:

Age (approx.)	Immunisation against
2 months ..	Diphtheria/tetanus/whooping cough (triple vaccine)
3 ..	Diphtheria/tetanus/whooping cough (triple vaccine)
4 ..	Diphtheria/tetanus/whooping cough (triple vaccine)
5 ..	Smallpox
7 ..	Poliomyelitis
8 ..	Poliomyelitis
15 ..	Diphtheria/tetanus/whooping cough (triple vaccine)
15 ..	Poliomyelitis
5 years ..	Diphtheria/tetanus

It is hoped that by presenting the schedule of inoculations as a concerted programme there will be uniformity in the acceptance rates of the different forms of immunisation. One immediate result of the introduction of this new schedule, with emphasis on triple vaccine, was that the number of children immunised against tetanus was more than doubled. The substantial number of children so immunised made it necessary to consider the introduction of some form of personal record for retention by the parents. A record of this type has been brought into use. It is intended to be used by doctor or health visitor as a basis for discussion of immunisation with the parents, and thereafter as an appointment card and as a personal record card.

During the year it was decided that a separately sterilized syringe and needle should be used for each immunising injection, and arrangements were made to implement this policy early in 1960.

TABLE (iii)

	1955	1956	1957	1958	1959
Number vaccinated under 1 year ..	24,649	25,734	29,677	30,865	30,489
Percentage of live births	50	49	56	55	55

One case of generalised vaccinia was reported during the year.

Poliomyelitis—As mentioned in my report last year, although provision had been made for third injections, priority was given to increasing the number of primary vaccinations. Organised arrangements and publicity for third injections were put into force in 1959 and during the year some 360,000 such injections were given—this number was sufficient to cover those who at the end of 1958 had had primary vaccinations only and deal with a number of persons so vaccinated in the early part of 1959 for whom the necessary seven months delay period had elapsed.

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

TABLE (iv)

							<i>Number of persons who have received</i>		
							<i>Two injections</i>		<i>A third injection (cumulative total)</i>
							<i>In 1959</i>	<i>Since the commencement of the scheme</i>	
Born in:									
1953-59	..	..	..	..	..	..	76,962	184,677	91,090
1943-52	..	..	..	..	..	..	82,366	307,900	185,140
1933-42:									
Londoners	..	..	..	..	..	..	155,014	163,268	51,735
Others	..	..	..	..	..	..	48,120	52,246	22,307
Expectant mothers:									
Londoners	..	..	..	..	..	..	18,676	28,100	8,207
Others	..	..	..	..	..	..	419	562	146
Other priority groups	..	..	..	..	..	..	15,786	19,079	6,945
TOTALS	..	..	..	..	..	..	397,343	755,832	365,570
<i>Given by general practitioners and hospital doctors and included in the total above</i>							125,012	183,381	76,921

LONDON AMBULANCE SERVICE

A comprehensive account of the history and work of the ambulance service was given in my report for 1958.

Some aspects of the work of the service during 1959 and comparisons with earlier years are shown in the tables below. The steady increase in the numbers of patients carried and journeys performed is apparent from table (i).

The policy of developing out-patient treatment and day hospitals appears to offer every prospect of a continuing increase in demand for ambulance transport. The pressure on the ambulance service is already severe, despite the most careful planning and some increase in resources, and any further substantial growth of demand will require the provision of more vehicles and more men.

The general section covers the great bulk of the work and includes all journeys apart from the conveyance of accident and emergency cases.

General section patients conveyed include some 25,000 patients travelling long distances, partly by train, who were taken to and from railway stations. Most of these patients were conveyed at the request of other authorities, but this service initiated arrangements for about 5,000 of these 'ambulance-train-ambulance' journeys.

TABLE (i)—*Work performed by the directly provided service and by the agency and supplementary services, including both General and Accident Section work*

	1947	1949	1955	1956	1957	1958	1959
<i>Patients:</i>							
Accident Section	61,136	65,989	87,164	88,608	91,801	94,079	99,834
General Section	182,206	362,963	878,118	905,089	911,303	991,263	1,009,128
Total—directly provided service	243,342	428,952	965,282	993,697	1,003,104	1,085,342	1,108,962
Joint Committee	—	9,557	21,539	24,358	25,090	24,382	26,582
Hospital Car Service	—	107,667	225,959	217,527	201,436	201,161	193,523
West Ham C.B.C.	—	113	416	378	499	409	496
Total—agency and supplementary services	—	117,337	247,914	242,263	227,025	225,952	220,601
Total patients	243,342	546,289	1,213,196*	1,235,960*	1,230,129*	1,311,294*	1,329,563*
<i>Journeys:</i>							
Accident Section	64,560	75,901	96,661	97,823	97,535	99,188	104,983
General Section	155,122	279,600	462,615	463,158	457,976	482,863	488,336
Total—directly provided service	219,682	355,501	559,276	560,981	555,511	582,051	593,319
Joint Committee	—	5,716	10,118	10,837	11,745	9,710	10,250
Hospital Car Service	—	84,306	82,652	76,756	71,556	70,724	69,672
West Ham C.B.C.	—	113	414	378	494	403	489
Total—agency and supplementary services	—	90,135	93,184	87,971	83,795	80,837	80,411
Total journeys	219,682	445,636	652,459	648,952	639,306	662,888	673,730
<i>Mileage:</i>							
Accident Section	362,880	410,917	488,292	491,929	485,431	495,913	524,009
General Section	1,768,550	2,808,550	3,856,850	3,736,550	3,687,353	3,982,374	3,980,327
Total—directly provided service	2,131,430	3,219,467	4,345,142	4,228,479	4,173,784	4,478,287	4,504,336
Joint Committee	—	376,564	429,980	436,927	430,373	394,145	411,823
Hospital Car Service	—	1,496,090	1,425,624	1,399,355	1,292,177	1,224,817	1,212,580
West Ham C.B.C.	—	1,468	4,621	4,152	5,052	4,953	5,121
Total—agency and supplementary services	—	1,874,122	1,860,225	1,840,434	1,727,602	1,623,915	1,629,524
Total mileage	2,131,430	5,093,589	6,205,367	6,068,913	5,900,386	6,102,202	6,133,860

* For 1955 onwards the figures of patients conveyed are based on the Ministry of Health definition of a 'patient', which differs somewhat from that formerly applied by the Council. Totals for general section work by the directly provided service and Joint Committee are therefore some 3 per cent. higher and the total for Hospital Car Service some 80 per cent. higher than totals based on the Council's definition, which is used for all earlier years and in previous reports.

The following tables give a cross-section of the work of the general and accident sections in 1959 and some comparisons with earlier years. Table (ii) shows, *inter alia*, that the increased mileage has not been commensurate with the increase in patients or journeys, with a consequent reduction in the average mileage per patient and journey.

TABLE (ii)—General Section

	1947	1949	1955	1956	1957	1958	1959
Average mileage per patient* ..	9.71	7.74	4.39	4.12	4.04	4.02	3.94
Average mileage per journey ..	11.40	10.05	8.34	8.07	8.05	8.25	8.15
Patients carried per 100 journeys ..	117	130	189	195	198	205	207
Percentage of lost journeys† ..	N/A	4.2	2.2	2.1	1.9	1.9	1.87
Delays to ambulances at hospitals of over half an hour's duration ..	N/A	N/A	1,372	745	334	283	336

* For 1955 onwards the numbers of patients conveyed are based on the Ministry of Health definition of 'a patient' which differs somewhat from that formerly applied by the Council.

† A 'lost journey' occurs when for any reason the patient is not conveyed.

TABLE (iii)—Accident Section

Year	Number of calls received	Ambulance not required	Average time to incident (in minutes)	Average time from incident to hospital (in minutes)
1947	64,560	3,757	8.3	6.9
1949	75,901	4,281	8.3	6.0
1955	96,661	6,747	7.4	6.3
1956	97,823	7,106	6.7	5.8
1957	97,535	7,213	6.4	6.0
1958	99,188	7,746	6.5	5.7
1959	104,983	8,640	6.6	6.2

NOTES—1. These numbers include some urgent parturition cases and patients removed by general section ambulances when passing the scene of an accident.

2. Some accident calls are answered by vehicles from general stations, usually when an ambulance from the nearest accident station is not available.

TABLE (iv)—Accident Section—Source of calls

	1947	1949	1955	1956	1957	1958	1959
Public and L.C.C. staff ..	41,355	47,505	63,346	64,647	66,039	68,134	72,793
Police	13,117	13,539	14,554	14,707	15,546	15,468	16,430
Midwives*	1,409	7,116	5,347	4,621	1,564	714	420
Doctors	1,193	2,739	6,430	6,734	6,781	6,815	7,092
Hospitals	5,733	2,540	1,991	1,887	1,917	2,032	2,021
Railway officials ..	734	1,176	2,370	2,535	2,775	3,030	2,931
Local calls†	527	802	918	930	892	870	923
London Fire Brigade ..	356	437	886	827	841	928	1,067
Out county	136	47	819	935	1,180	1,206	1,306
Total calls	64,560	75,901	96,661	97,823	97,535	99,188	104,983

* Fewer calls for gas-and-air analgesia apparatus because of the introduction of trilene apparatus which is portable by midwives.

† Made personally at ambulance stations.

Radio-telephony—1959 saw a continuing extension of radio-telephony communication in the Service. Only one channel was in use but plans were laid to provide a second channel, with 'talk-through' facilities available on both channels, which will increase the effectiveness of the system considerably.

Operational—The general section, particularly north of the river, remained hard-pressed and the Council authorised the provision of ten additional radio-equipped ambulances. These were allocated to the Fulham ambulance station. They are fully equipped for accident work if required, but normally operate on general work over a wide area of the county north of the Thames and as they are under radio control they provide a very flexible service. The three original accident section vehicles at the Fulham station continue to provide the usual accident service in that area.

Vehicles—Production of the new-type Austin ambulances continued at a modest rate in 1959.

The authorised operational vehicle strength for the year 1959/60 was:

Large ambulances	252
Single-stretcher, sitting-case ambulances ..	62
Sitting-case cars	24
Ambulance buses	4
Tenders	2
	344

Staff—The service is under the supervision of an Officer-in-Charge and is staffed by 28 administrative and clerical staff, 74 ambulance control clerks and 843 operative staff.

An additional position of Station Officer was authorised in 1959 for duty at Headquarters. With the expansion of Fulham ambulance station, the position of Station Officer at that station was upgraded to Assistant Superintendent and the staff establishment increased by two leading drivers and eighteen men.

Award of resuscitation certificates—Two drivers in the accident section of the service were awarded the Royal Humane Society's resuscitation certificate during the year.

Safe Driving—Of 765 drivers entered in the National Safe Driving Competition held by the Royal Society for the Prevention of Accidents in 1958, 70 per cent. gained awards. Of the remainder 16 per cent. were disqualified and 14 per cent. were accounted for by resignations and by exemption owing to prolonged sickness.

Civil Defence

In the course of the year the strength of the Ambulance and Casualty Collecting Section fell slightly from 1,623 to 1,600. The drop is attributable to the cancellation of the usual autumn recruiting campaign because of the general election.

During the year, 295 persons were enrolled but 318 persons resigned.

The following courses were held during 1959:

Introductory	2
First-aid	7
Ambulance section—part (1)	9
Ambulance section—part (2)	10
Driving and maintenance	11
Officer selection	4
First-aid practical revision	5

After a total of 1,300 hours' instruction by the British School of Motoring 44 volunteers passed the Ministry of Transport driving test.

A total of 3,737 hours' driving practice on various types of ambulance was put in by volunteers holding driving licences and 371 tests were passed on such vehicles.

Volunteers visit the Council's accident ambulance stations to see casualty work at first hand and the number of such attendances in 1959 was 639 covering 1,582 hours.

Members of the Section took part in many exercises and displays, including the National Competition organised by the Home Office. In addition an internal competition between teams of the Ambulance & Casualty Collecting Section of the County of London division was organised.

PREVENTION OF ILLNESS: CARE AND AFTER-CARE

Foot clinics

Following the receipt of Ministry of Health Circular 11/59, when the existing services in the county were reviewed, it was ascertained that in addition to the services provided by the Council, more than 19,000 treatments a year were provided by voluntary organisations for the welfare of old people.

Precise information as to the extent of the unsatisfied needs of the priority classes (the elderly, the physically handicapped and expectant mothers) referred to in the Ministry's circular was difficult to obtain. It was, however, estimated that some 350 additional sessions might be required and the Council decided, subject to the Minister approving an amendment of its proposals under Section 28 of the National Health Service Act, 1946, to increase the service by 100 sessions a week as soon as practicable and by a further 100 in April, 1960 and to subsidise the voluntary organisations as necessary to enable them to maintain their existing services.

The amendment to the Council's proposals (which was approved by the Minister) was as follows:

The Council proposes to extend its chiropody service as may be necessary, priority being given to the needs of old people, of the physically handicapped and of expectant mothers. The service will be provided at foot clinics established by the Council and/or at surgeries of private chiropodists, by means of a domiciliary service and/or by utilising on a grant-aided basis the services of approved voluntary organisations.

It is not proposed at present to exercise the power to provide a domiciliary service or to use the surgeries of private chiropodists. The following tables show the attendances at the clinics, with an analysis according to age groups for the years 1958 and 1959:

New cases and attendances

	1955	1956	1957	1958	1959
New cases	9,089	7,362	8,149	6,994	7,074
Attendances	184,628	170,855	166,987	172,005	169,847
Staff at 31 December (in terms of whole units) ..	43.8	41.8	44.2	44.2	46.2

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.

Analysis in age groups of treatment given at clinics

Group	1958	1959
Children 0-4 years	100	137
5-14 years	6,381	6,390
Males 15-64 years	14,805	14,442
65 years and over	15,435	15,410
Females 15-59 years	59,217	56,581
60 years and over	76,067	76,887
Total	172,005	169,847

Recuperative holidays *Admissions to recuperative holiday homes*

	1955	1956	1957	1958	1959
Expectant and nursing mothers	153	141	138	111	123
Other adults	2,784	2,590	2,510	2,289	2,457
Children under 5 not at school	746	602	660	575	571
School and nursery school children ..	2,865	2,842	2,852	2,507	2,597
	6,548	6,175	6,160	5,482	5,748

The Council maintains a recuperative holiday home at Littlehampton, Sussex, for 36 children from 3 to 8 years of age, and leases another home at Bognor Regis, Sussex, for 44 children from 8 to 15 years old. Children who could not be accommodated in these homes, and all adults, have been placed in homes under private ownership or maintained by voluntary organisations.

The generally accepted view that it is often not in the best interests of the child to place him alone, away from his own family environment, has led to a marked decline in the number of unaccompanied children placed for recuperative holiday, e.g. for children under five the numbers, even between 1955 and 1959, fell by half from 403 to 203.

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.
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
1959 ..	799	493	93	—	11,722	2,599	12,614	3,092	24,013	9,179	229,368	88,232

	1955	1956	1957	1958	1959
Percentage of patients resident in County of London	77	79	81	82	83

Number of patients completing treatment and of defaulters—

Syphilis—patients completing treatment—

Males	595	818	828	631	579
Females	678	645	627	554	508

patients not completing treatment—

Males	718	639	675	870	672
Females	348	326	294	292	336

Gonorrhoea—patients completing treatment—

Males	3,042	3,663	4,938	5,237	4,941
Females	715	780	985	1,165	1,199

patients not completing treatment—

Males	2,555	3,172	3,501	4,128	4,900
Females	692	801	900	1,161	1,312

Tracing of contacts of patients—

Analysis of work undertaken by Council's welfare officers

	1955	1956	1957	1958	1959
Contacts referred by hospitals, medical services of the Armed Forces and by local health authorities	418	370	384	297	246
Insufficient information for following-up ..	338	277	276	191	102
Contacts brought to treatment	30	44	27	43	57
Contacts traced but not brought to treatment ..	10	6	14	3	7
Contacts not traced	40	43	67	60	80

In addition the female welfare officers attended clinics at St. Paul's Hospital and H.M. Prison, Holloway, and since 1958 at St. Mary's Hospital and followed-up persons defaulting in attendance at these clinics.

Health education

The pattern of health education in London in recent years was reviewed in my report for 1958 (page 162). The work in the past year has followed similar lines—the direct approach to individuals being supported and supplemented by divisionally arranged group lectures and centrally organised exhibitions and campaigns.

Lectures and discussions—While special exhibitions and campaigns have an important place in health education, it is the day to day contacts with individual members of the public and the regular series of talks and discussions held mainly at welfare centres, which form the basis of what is being done in this field. The following tables give an indication of the volume of this work under the direction of the divisional medical officers, and the variety of subject and audience. Most of the work falls naturally to the health visitor.

Health education talks

TABLE (i)—*Speakers*

	Divisions									Total
	1	2	3	4	5	6	7	8	9	
Medical officers	—	47	8	—	—	—	1	—	4	60
Nursing officers	4	—	—	—	—	—	1	—	—	5
Health visitors and school nursing sisters	642	1,127	145	352	367	792	382	176	357	4,340
Domiciliary midwives	2	10	7	1	4	—	17	—	—	41
Public health inspectors	—	—	—	1	—	—	—	—	—	1
School teachers	—	12	17	138	36	—	12	—	—	215
Parks department officer	—	—	—	1	—	—	—	—	—	1
Senior child care officer	—	—	—	1	—	—	—	—	—	1
Physiotherapists	—	7	—	—	—	—	—	—	—	7
Lecturers from outside the Council's service—Nursing	—	—	—	—	—	—	6	—	—	6
Other	128	33	2	46	3	—	50	3	11	276
Total	776	1,236	179	540	410	792	469	179	372	4,953

TABLE (ii)—*Audience groups*

	Divisions									Total
	1	2	3	4	5	6	7	8	9	
Expectant mothers	440	665	37	282	312	761	256	153	113	3,019
Mothers, mothers clubs, etc.	331	534	55	218	97	28	194	14	252	1,723
Parent/teacher associations	—	—	—	—	—	3	5	4	—	12
Schools*	—	—	4	—	—	—	—	—	—	4
Day continuation classes	—	37	83	30	—	—	—	2	—	152
Voluntary organisations	5	—	—	10	1	—	14	6	7	43
Total	776	1,236	179	540	410	792	469	179	372	4,953

* Lectures by medical officers.

TABLE (iii)—Subjects of talks and attendances

	Divisions																			
	1		2		3		4		5		6		7		8		9		Total	
	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances	Talks	Attendances
Care of mothers and young children..	529	4,544	934	7,808	114	1,942	217	1,889	301	2,008	781	9,273	241	2,540	139	781	187	1,616	3,443	32,401
Care of older children	24	180	—	—	6	54	10	156	21	198	—	—	48	467	2	70	23	321	134	1,446
General family health topics	26	258	124	963	11	180	14	176	7	55	—	—	16	288	3	317	53	567	254	2,804
Environmental hygiene	3	34	14	118	2	13	19	48	—	—	—	—	1	9	—	—	2	13	41	235
Infectious diseases and prophylaxis ..	90	820	99	597	4	34	20	288	19	184	—	—	30	522	5	67	27	546	294	3,058
Prevention of accidents	15	178	57	395	2	28	12	128	15	116	6	178	20	426	5	59	13	147	145	1,655
Smoking and lung cancer	10	64	—	—	4	938	—	—	—	—	—	—	2	10	—	—	—	—	16	1,012
Cancer education (other than above)..	2	13	1	10	—	—	—	—	—	—	—	—	1	3	5	173	—	—	9	199
Mental health	1	50	2	38	1	16	1	14	—	—	—	—	—	—	—	—	—	—	5	118
First aid	3	47	5	40	—	—	1	8	4	32	—	—	3	17	4	40	4	41	24	225
Other	73	843	—	—	35	587	246	3,925	43	465	5	30	107	1,835	16	305	63	813	588	8,803
Total	776	7,031	1,236	9,969	179	3,792	540	6,632	410	3,058	792	9,481	469	6,117	179	1,812	372	4,064	4,953	51,956

These tables exclude talks of less than ten minutes duration to groups or talks of whatever duration to individuals.

In addition, nearly 4,000 talks were given to schoolgirls on personal hygiene and mothercraft; series of lectures were given in connection with the National Nursery Examination Board certificate and the Home Office Senior Child Care Reserve course, and talks to hospital student nurses and medical students.

Films and filmstrips—There is a constant demand for films and filmstrips in the presentation of talks and discussions. A total of 231 film shows was arranged. The department's own library, which was increased during the year by the purchase of three films, provided 55 of the 364 films shown. There were also 406 filmstrip shows using 977 filmstrips. The use of both types of visual aid showed marked increases on previous years.

Special campaigns and exhibitions—To mark the first decade of the National Health Service a Nursing and Health exhibition was held at County Hall for two weeks in March. Organised by the Council and the metropolitan regional hospital boards, in association with the London Executive Council and the metropolitan borough councils, it not only showed comprehensively what is now done for the health of the Londoner but the opportunities open to young people for interesting and worthwhile careers in this field. Although attendances were generally disappointing a large proportion of those who did attend were senior school children.

The annual diphtheria immunisation campaign, which was planned for October had to be postponed until December to avoid clashing with the autumn general election campaign. It followed customary lines; an intensification of divisional health education supplemented by extensive advertising through posters, leaflets, in local newspapers and in cinemas. The subject of prophylaxis was featured in a display window at County Hall. This was to have supported the campaign, but had to take place in October as planned, because it could not be postponed.

The annual 'Safety in the Home' campaign throughout the county was given additional publicity through a successful three week exhibition in October, arranged by the Council and the Royal Society for the Prevention of Accidents in the ticket hall at Charing Cross underground station. The exhibition covered home accident prevention, prevention of fire in dwellings and means of escape; it was most attractively mounted and was visited by some 22,000 people. An interesting feature was the large number of visitors who came on weekday evenings and on Saturdays. Home safety week in the divisions dealt principally with the prevention of falls and a follow up of the 1955 'Guard that fire' campaign. The amount of publicity material used, 30,000 posters, 177,000 leaflets and 111,000 bookmarks, is some indication of the intensive work undertaken locally.

Special publications—A pamphlet, 'The care of your health', a development of the guide to health mentioned in my report for 1957 (which is still being issued to leavers from the Council's schools), was prepared for use in connection with instruction on health and hygiene by teachers in secondary schools.

The department collaborated with the College of Physical Education in the preparation of a pamphlet on foot health, which is available to the parents of every child receiving foot remedial exercises and for general use.

Staff visual aids competition—For the first time since the inception of the competition, entries were restricted to a set subject—care of expectant mothers with emphasis on diet. This no doubt accounted for the smaller number of entries, 37 in all. In the poster section two entries from health visitors in division 5 were placed equal first; similarly in the teaching aid section entries by health visitors from divisions 4 and 6 were placed equal first.

Health education in ante-natal clinics—As will be apparent from table (ii), a wide and comprehensive health education service is provided for expectant mothers at the Council's clinics, using such methods as films, film strips, flannelgraphs and posters. Inhalational analgesia is demonstrated by midwives so that mothers become quite familiar with the type of apparatus they will use whether their confinement is at home or in hospital. Relaxation classes are taken by health visitors, midwives or physiotherapists; there are also sewing classes and mothercraft sessions. Fathers and mothers are given the opportunity to attend discussion groups in the evening.

In a few instances, health visitors in London attend ante-natal clinics held in doctors' surgeries or hospitals to give health education and mothercraft instruction. It is not likely to be possible to expand these very limited arrangements while the present shortage of health visitors exists, but the possibility is being examined. Some hospitals run mothercraft classes of their own and others refer patients booked for hospital confinement to the Council's clinics for mothercraft and health education (i.e. apart from patients who are referred for routine intermediate ante-natal care).

MENTAL HEALTH SERVICES

Mental Health Act, 1959.—The only provisions in the Act brought into operation during the year (on 6 October) related to the informal admission of mentally ill patients to certain kinds of hospital.

(As regards the mentally subnormal, it will be noted from the table on page 90 that 262 out of a total of 340 hospital admissions during the year were informal. These admissions were arranged in conformity with Ministry of Health Circulars 2/58 to local health authorities and 58/5 to mental deficiency hospitals, which became operative in February, 1958).

The Council decided that during the initial stages of implementing the new Act and the recommendations of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency, whilst important policy considerations would be involved, all matters dealing with mental health should be reserved to the Health committee. In consequence, the Mental Health sub-committee was not re-appointed. The Council also decided that, so far as practicable, the day-to-day administration of its mental health services should, at the appropriate time, be decentralised to the nine divisional health committees which already administer other personal health services of the Council. Proposals for this and for the development of the services were in course of preparation at the end of the year for submission to the Minister of Health early in 1960.

Lunacy and Mental Treatment Acts, 1890-1930 and Mental Health Act, 1959

The following statistical tables relate to persons alleged to be suffering from mental illness referred to the Council's mental welfare officers. References to sections are to the Lunacy Act, 1890, unless otherwise indicated.

TABLE (i) *Persons referred in the year*

	1958	1959
Once	4,755	4,600
Twice	721	758
Three times	166	158
Four times	43	39
Five or more times	26	23
Total	5,711	5,578*
Number of separate investigations	7,016	6,880

* 511 of these persons were first referred to mental welfare officers in 1958, 259 in 1957 and 1,104 in earlier years: thus 3,704 were new cases in 1959.

The total includes 378 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*

	1958		1959	
	No.	%	No.	%
General practitioner	3,227	46.0	3,137	45.6
Psychiatrist*	609	8.7	613	8.9
Hospital ward	712	10.1	620	9.0
Hospital casualty department	605	8.6	686	10.0
Non-medical	1,863	26.6	1,824	26.5
	7,016	100.0	6,880	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*

	1958		1959	
	No.	%	No.	%
None possible or necessary	1,547	22.0	1,583	23.0
Referred for continued care* (other than at mental hospital)	51	0.7	53	0.8
Admitted to mental hospital—				
(a) as voluntary or informal patient	355	5.1	501	7.3
(b) under urgency order, temporary certificate, Magistrates' Courts Act, 1952, or as returned after escape	68	1.0	78	1.1
Referred to psychiatrist	193	2.8	271†	3.9
Removed to observation ward	3,738	53.2	3,476	50.6
Referred to Justice of the Peace other than at observation ward	1,064	15.2	918	13.3
	7,016	100.0	6,880	100.0

* Referral to welfare department, sanitary authority, psychiatric social worker, general hospital, etc.

† 162 were later admitted to mental hospital but only 3 were certified (sections 14/16); 15 others were treated at out-patient clinics.

(b) *'Action' cases only*

	1958	1959
	%	%
Independent action by mental welfare officer	8.7	11.9
Referred to psychiatrist	3.5	5.1
Removed to observation ward	68.3	65.7
Referred to Justice of the Peace	19.5	17.3
	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*

(1958 percentages in brackets)

	Age group				Total	
	Under 65		65 and over		No.	%
	No.	%	No.	%		
Removed to observation ward ..	3,115	75.4 (80.7)	361	31.0 (32.1)	3,476	65.7 (68.3)
Brought before a Justice of the Peace	418	10.1 (9.0)	500	43.0 (50.2)	918	17.3 (19.5)
Other action	600	14.5 (10.3)	302	26.0 (17.7)	903*	17.0 (12.2)
Total investigations where action was taken	4,133	100.0	1,163	100.0	5,297	100.0
No action	1,206	—	370	—	1,583†	—
Total investigations	5,339	—	1,533	—	6,880	—

* Includes one case, age not stated. † Includes seven cases, age not stated.

TABLE (iv) *Closure*(a) *All cases*

	1958		1959	
	No.	%	No.	%
No action possible or necessary	1,770	25.1	1,807	26.3
Discharged by medical officer at observation ward	1,299	18.5	1,222	17.8
Transferred to general hospital.. .. .	74	1.1	71	1.0
Other continued care including section 22	102	1.5	90	1.3
Out-patient (psychiatric) and miscellaneous action recommended by psychiatrist	60	0.8	103	1.5
Admitted to mental hospital—				
(a) as voluntary or informal patient	2,316	33.0	2,307	33.5
(b) on temporary certificate	39	0.6	25	0.4
(c) on urgency order	47	0.7	66	1.0
(d) as returned after escape or under Magistrates' Courts Act, 1952	26	0.4	17	0.2
(e) certified (sections 14/16)	1,214	17.3	1,121	16.3
Died	69	1.0	51	0.7
	<u>7,016</u>	<u>100.0</u>	<u>6,880</u>	<u>100.0</u>

(b) *Observation ward cases*

	1958		1959	
	No.	%	No.	%
Discharged by medical officer	1,296	34.7	1,220	35.1
Transferred to general ward	65	1.7	62	1.8
Admitted to mental hospital—				
(a) as voluntary or informal patient	1,538	41.2	1,468	42.2
(b) with temporary certificate, as returned after escape or under Magistrates' Courts Act, 1952	41	1.1	27	0.8
(c) certified (sections 14/16)	729	19.5	642	18.5
Died	56	1.5	45	1.3
Miscellaneous	13	0.3	12	0.3
	<u>3,738</u>	<u>100.0</u>	<u>3,476</u>	<u>100.0</u>

Only 10.4 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	51.7	29.6	55.8	31.9	37.2	12.4
Admitted to mental hospital—						
(i) as voluntary or informal patient	21.7	48.0	32.7	37.0	29.9	71.2
(ii) with temporary certificate, as returned after escape or under Magistrates' Courts Act, 1952	0.6	0.7	1.0	0.3	3.0	0.4
(iii) certified (sections 14/16)	22.5	19.5	8.5	20.8	26.9	12.8
Percentage certified of those admitted to mental hospital—						
1959	50.2	28.6	20.1	35.9	44.9	15.2
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—48.5 per cent. among cases referred from casualty departments and 41.7 per cent. from general wards compared with an average of 32.6 per cent. from other sources. Also, as formerly, the highest certification rate (39.7 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

	1958		1959	
	No.	%	No.	%
No (further) action	228	21.4	227	24.7
Other continued care, including section 22 and referred to psychiatrist	47	4.4	33	3.6
Admitted to mental hospital—				
(i) as voluntary or informal patient	308	28.9	179	19.5
(ii) with temporary certificate or urgency order	—	—	3	0.3
(iii) certified (sections 14/16)	481	45.3	476	51.9
	1,064	100.0	918	100.0

The percentage entering a mental hospital (71.7) and the percentage of these certified (72.3) was still much higher than the corresponding percentage of cases dealt with in observation wards—61.5 and 30.0 respectively.

Community care and after care

Psychiatric social workers—The psychiatric social workers dealt with 361 cases during 1959, compared with 594 in 1958. This reduction was due to a shortage of psychiatric social workers. It was not until November that the full complement of five psychiatric social workers became available; previously not more than three could be obtained. In 120 cases the referring agency was able to continue to deal with the patient after receiving advice and help from the psychiatric social workers, who dealt directly with the remaining 241.

Long term care—During the year 181 chronic and senile cases (compared with 176 during 1958) were maintained by the Council; 161 at homes owned or sponsored by the Mental After Care Association, 10 at hostels of the Jewish Board of Guardians, six at Parnham House run by the National Association for Mental Health, and four at other establishments.

Recuperative holidays and rehabilitation—During the year 136 persons recovering from mild psychiatric illness were granted recuperative holidays of two to three weeks in general recuperative holiday homes; 12 who had had more serious breakdowns were sent for similar periods to homes owned or sponsored by the Mental After Care Association and 16 were accommodated for periods up to twelve weeks, or longer when necessary, at the Mental After Care Association homes at Dartford, Kent; Cheam, Surrey; and Chiswick, Middlesex; which provide especially for the rehabilitation of younger patients capable of work. The total of 164 compares with 101 in 1958.

Fifty-one London patients commenced attendance at the rehabilitation centre run by the Institute of Social Psychiatry at Blackfriars during the year: of these, and 33 others already attending at the end of 1958, 11 were discharged to work, one to further training and 34 were discharged as unsuitable, or because of non-attendance or admission to a mental hospital. At the end of the year 38 London patients were attending the centre.

During the year the Council approved the establishment of its first directly run day centre, to provide occupation and training for up to 40 mental patients of either sex. This centre, to be accommodated in premises at 96 Dalston Lane, Hackney, formerly a day nursery, is intended for patients suffering from residual mental disturbance after an acute mental illness and as a preventive service for those who do not need hospital treatment. Activities will depend on the needs and interests of the patients, but it is expected that training in carpentry, gardening and cookery will be included.

The Council also decided to participate in a scheme for the establishment of a day hospital at St. Olave's hospital, Bermondsey in association with Cane Hill hospital, in whose catchment area the former hospital is, and with the Bermondsey and Southwark Hospital Management Committee. The Council will bear the cost of occupational therapy provided for the patients, and make available the services of one of its psychiatric social workers. It is expected that the establishment of this unit will also facilitate the operation of the hospital admission procedures under the Mental Health Act, in which both the hospital medical staff and the Council's mental welfare officers will be concerned.

National Association for Mental Health—In recognition of its general services to the community and to local health authorities a grant of £300 was again paid to the National Association for Mental Health.

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:

	1958	1959
<i>Source of information—Local education authority—</i>		
Reported under section 57 of the Education Act, 1944	440	396
Not reported, referred for voluntary supervision ..	141	176
	—	—
Police authority (section 8)	581	572
	11	24
From hospitals, residential nurseries, etc.	101	80
Miscellaneous	188	193
	—	—
Total	881	869
	—	—

The position as at 31st December, 1959, is shown below, together with comparable figures for 1958.

	1958	1959
<i>Under guardianship—</i>		
Personal guardianship of council's social workers ..	52	57
Nominees of the Guardianship Society, Brighton ..	60	52
Guardianship of relatives and friends	28	11
Guardianship of superintendents of small homes and institutions	21	18
	—	—
	161	138
In hostels without orders under the Mental Deficiency Acts	11	31
Under statutory supervision	4,772	4,648
Under voluntary supervision	1,461	1,668
In institutions on orders under the Mental Deficiency Acts	4,163	2,332
In institutions without orders	3,119	4,887
	—	—
	7,282	7,219
In hospitals, residential nurseries, etc., awaiting institutional care	25	71
Still under consideration	21	26
	—	—
Total	13,733	13,801
	—	—

The following is a summary of the cases dealt with during the year together with comparable figures for 1958:

	1958	1959
Placed in institutions—		
On an informal basis	211	262
Under section 3	22	1
Under section 6	43	28
Under section 8	42	48
Under section 9	—	1
	318	340
Placed under guardianship	25	10
Varying orders—		
from guardianship to guardianship	23	22
from guardianship to institution	7	—
from institution to guardianship	4	—
	34	22
Placed in hostels without order	17	30
Placed in places of safety	—	1
Placed under statutory supervision (including licence cases)	764	750
Placed under voluntary supervision	398	412
Discharged—		
from institutions	325	281
from guardianship	51	26
	376	307
Removed to mental hospitals	5	6
Withdrawn from supervision	1,073	569
Withdrawn from voluntary supervision	431	69
Removed from London	73	82
Died	137	171
No action	40	25
Cases still awaiting institution care	180	247
Cases dealt with by way of short term care—		
In mental deficiency hospitals	227	219
In approved homes and private homes	75	157
	302	376

Occupation centres—At the beginning of September the first of the Council's purpose-built junior occupation centres were opened, one in Lewisham and one in Kensington, with places for 120 and 100 children respectively. The opening of these centres enabled the use of unsatisfactory rented premises in Finsbury and Peckham to be discontinued. During 1959 tenders were invited for a third purpose built junior centre, which is expected to be ready for occupation early in 1961, and plans were approved for the adaptation of premises to provide a combined occupation centre and industrial training centre for 120 male adults, and an occupation centre for 35 female adults. The opening of these centres will also enable unsuitable rented accommodation to be given up. During the year 19 adults attending the Council's centres—eight of them at the industrial training centre—were placed in employment and five children were found to be suitable for transfer to special schools.

At the end of the year there were nine occupation centres accommodating 705 children, six accommodating 295 older girls and women and five accommodating 255 older boys and men for whom there was also an industrial training centre with 20 places, a total of 1,275 places, an increase over the previous year of 60.

Articles made in the four types of centres and sold to the public during the year realised £40, £182, £1,060 and £35 respectively. In addition, the industrial training centre produced goods valued at £1,053 for use in the Council's Service.

Home teaching—At the end of 1959 tuition was being provided for 41 persons who were unable through physical handicap to attend occupation centres.

Dover Lodge hostel—Evening classes—Authority was given for the payment by the Council of fees for attendance of girls from Dover Lodge at evening classes and also a social club at the New Cross Institute.

Guardianship—The review of guardianship cases made in accordance with Ministry of Health Circular 2/58 resulted in the discharge from order of a further 14 patients formerly under the statutory guardianship of relatives and friends, financial responsibility being assumed in each case by the National Assistance Board.

Medical inspection

Since 1958 routine medical inspections have been arranged by year in parts to coincide with Ministry of Education requirements. The following annual comparisons for the year 61 have been placed into "age" for inspection year of birth (not year of inspection) in the tables throughout the section of the report.

On 1 January 1959 the Council's records showed for the medical inspection of school children some 100,000 children aged 5 to 15. Of this total 10% were aged 5 to 6, 30% aged 7 to 8, 30% aged 9 to 10, 20% aged 11 to 12, 10% aged 13 to 14, and 10% aged 15 to 16.

Another effect was the abolition of routine inspection. In 1958 the number of girls mainly during the first quarter and there were four inspections. The number of ordinary inspections increased by almost 1 per cent which suggests that the school medical officers are continuing to see more children who were previously "withheld" cases.

Inspection of secondary school children were less than a third of the 1958 figure. The number of children seen at routine medical inspections was 11.4 per cent in the school roll compared with 39.4 per cent in 1958 and 39.0 per cent in 1957.

Age group		Number of children		Percentage of total	
Year	1958	Year	1957	Year	1956
5-6	10,000	10,000	10,000	10.0	10.0
7-8	30,000	30,000	30,000	30.0	30.0
9-10	30,000	30,000	30,000	30.0	30.0
11-12	20,000	20,000	20,000	20.0	20.0
13-14	10,000	10,000	10,000	10.0	10.0
15-16	10,000	10,000	10,000	10.0	10.0
Total	100,000	100,000	100,000	100.0	100.0

SCHOOL HEALTH SERVICE

Pupils on school rolls—In January, 1960 there was a total of 433,415 pupils on the day school roll; 238,931 attending primary schools, 184,066 at secondary schools, 1,800 at nursery schools and 8,618 at day special schools. In January, 1959 there were 437,076 pupils on roll.

Ministry of Education circulars—Circular 352 superseded circular 269 and dealt with the changes brought about by the series of new regulations (S.I's (1959) Nos. 336, 362, 363, 365, 366) which took the place of the School Health Service and Handicapped Pupils Regulations, 1953. The main effect of the new regulations is to relax central control over details of the service; in particular the frequency of inspections is no longer prescribed by regulation.

Circulars 347 and 348 dealing with child guidance and maladjusted pupils are mentioned on page 106.

Medical inspections

Since 1958 routine medical inspections have been analysed by year of birth to conform with Ministry of Education requirements. To facilitate annual comparisons the year of birth has been turned into 'age' (by subtracting year of birth from year of inspection) in the tables throughout this section of the report.

On 1 January, 1959 the Council's revised scheme for the medical inspection of school children came into operation (see pages 106–110 of my report for 1958). One effect of this was to make the intermediate inspections a year later in the child's school life and, consequently, fewer of these inspections were made during 1959 than in 1958.

Another effect was the abolition of nutrition re-inspections. In 1959 only 3,622 took place, mainly during the first quarter and these were final inspections. The number of ordinary re-inspections increased by almost 12 per cent. which suggests that the school medical officers are continuing to see some children who were previously 'nutrition' cases. Reviews of secondary school children were less than a third of the 1958 figure.

The number of children seen at routine medical inspections was 31.4 per cent. of the school roll compared with 39.4 per cent. in 1958 and 39.0 per cent. in 1957.

Routine medical inspections

<i>Age groups</i>	<i>1958</i>		<i>1959</i>	
	<i>No.</i>	<i>%</i>	<i>No.</i>	<i>%</i>
4 and less	7,690	4.5	7,660	5.6
5	29,514	17.1	29,317	21.6
6	6,508	3.8	7,069	5.2
7	30,775	17.9	13,278	9.7
8	5,086	3.0	8,540	6.3
9	1,709	1.0	3,128	2.3
10	2,455	1.4	1,817	1.3
11	44,635	25.9	15,424	11.3
12	6,126	3.5	8,744	6.4
13	1,930	1.1	2,896	2.1
14	8,812	5.1	8,204	6.0
15 and over	27,031	15.7	30,186	22.2
	172,271	100.0	136,263	100.0

Non-routine medical inspections

	1955	1956	1957	1958	1959
Special inspections (a) ..	57,511	60,402	56,594	48,245	47,924
Secondary school reviews	13,978	11,811	11,941	8,934	2,771
Re-inspections—nutrition	68,051	64,565	56,304	46,293	3,622
Re-inspections—other ..	101,278	96,186	90,060	87,275	97,401
Total	240,818	232,964	214,899	190,747	151,718
Total inspections..	429,150	399,059	387,825	363,018	287,981

(a) These are inspections of pupils specially brought to the attention of the school doctor for employment certificates, for school journeys and holiday camps, admission to special schools, etc.

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

Age groups inspected	For defective vision (excluding squint)	For other conditions	Total individual pupils
4 and less	29	707	730
5	165	2,495	2,625
6	85	795	867
7	978	1,177	2,057
8	621	652	1,229
9	244	238	464
10	157	170	309
11	1,409	1,021	2,324
12	690	468	1,107
13	271	208	461
14	757	296	1,020
15 and over	2,840	1,033	3,761
	8,246	9,260	16,954

Defects noted at routine medical inspections—The overall percentage of children referred for treatment of a defect fell from 13.0 per cent. in 1958 to 12.4 per cent. This can probably be attributed to the fewer intermediate inspections where a higher rate of referral for treatment is usual.

Percentage of children noted for treatment

Age and sex				All defects		Vision defect	Defects other than vision
				1958	1959	1959	1959
4 and less	Boys	..	..	9.6	10.1	0.4	9.8
	Girls	..	..	8.1	8.9	0.4	8.6
5	Boys	..	..	10.4	9.6	0.6	9.1
	Girls	..	..	8.6	8.3	0.5	7.9
6	Boys	..	..	12.9	13.2	1.3	12.1
	Girls	..	..	11.3	11.2	1.0	10.3
7	Boys	..	..	15.4	15.7	7.2	9.2
	Girls	..	..	14.1	15.3	7.5	8.5
8	Boys	..	..	16.8	14.8	6.9	8.5
	Girls	..	..	14.7	14.0	7.7	6.8
9	Boys	..	..	16.8	15.5	7.2	9.0
	Girls	..	..	17.8	14.1	8.4	6.1
10	Boys	..	..	18.0	17.2	8.6	10.0
	Girls	..	..	17.3	16.8	8.7	8.6
11	Boys	..	..	13.7	14.1	8.5	6.2
	Girls	..	..	14.3	16.1	9.8	7.0
12	Boys	..	..	14.3	11.6	7.1	5.0
	Girls	..	..	16.4	13.9	8.8	5.8
13	Boys	..	..	17.1	14.9	9.1	6.5
	Girls	..	..	17.2	17.1	9.7	8.0
14	Boys	..	..	12.0	12.0	9.1	3.2
	Girls	..	..	13.4	12.9	9.3	4.0
15 and over	Boys	..	..	12.1	11.9	9.0	3.2
	Girls	..	..	13.2	13.0	9.8	3.6
Total	Boys	..	..	13.1	12.4	5.8	7.0
	Girls	..	..	12.8	12.5	6.3	6.6

NOTE: A child can be noted as requiring treatment of vision and another defect, hence the percentage requiring vision treatment plus the percentage requiring treatment of other defects exceeds the percentage referred for treatment of all defects.

The following table shows the percentage of children of all ages noted for treatment or observation of the defects listed for the years 1955 to 1959. These percentages remain fairly stable over the period except for defects of hearing and speech, which show a slight but steady yearly increase, and enlarged cervical glands which show a slight but steady yearly decrease. The increases may be due to improved case finding but in the case of cervical glands the trend was observed in the preceding four years (1951-1954).

	1955	1956	1957	1958	1959
Numbers examined	176,637	163,489	170,604	172,271	136,263
	<i>Percentages</i>				
Skin diseases	1.35	1.10	1.16	1.19	1.22
External eye diseases	0.58	0.57	0.55	0.48	0.55
Defective hearing	0.59	0.60	0.64	0.77	0.91
Otitis media	0.66	0.66	0.60	0.57	0.67
Enlarged tonsils and adenoids	5.97	5.88	4.84	4.91	5.11
Defective speech	0.75	0.77	0.80	0.81	0.93
Enlarged cervical glands	1.30	1.22	0.97	0.95	0.89
Heart and circulation	0.79	0.74	0.75	0.75	0.88
Lung disease (not T.B.)	1.41	1.35	1.32	1.25	1.49
Orthopaedic defects	4.82	4.41	4.06	4.12	4.16
Defects of nervous system	0.39	0.34	0.41	0.40	0.39
Psychological defects	0.97	0.94	0.86	0.93	0.93
Anaemia	0.14	0.13	0.11	0.10	0.17
Enuresis	1.57	1.62	1.54	1.59	1.75

Physical condition of pupils

In accordance with the requirements of the Ministry of Education, school medical officers, at periodic medical inspections, are asked to classify the 'physical condition' of pupils according to a two-point scale, 'satisfactory' or 'unsatisfactory'. Such assessments are, of course, purely subjective, and no criteria or definitions can be laid down. Nevertheless it may be accepted that the experienced school physician can, and does, classify on a meaningful basis, so that valid year by year comparisons can be made. In 1959 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 unsatisfactory in each age group were as follows:

Age (year of examination less year of birth)	Physical condition unsatisfactory %
4 and less	1.4
5	1.4
6	2.4
7	1.4
8	1.2
9	2.0
10	2.9
11	1.2
12	1.3
13	1.3
14	0.9
15 and over	0.6

The percentage of pupils whose condition was classified as satisfactory and unsatisfactory, and the percentage who were noted as requiring treatment or observation on account of poor nutrition, are set out below. This table indicates a continuous improvement over the four years.

		<i>Physical Condition</i>		<i>Nutrition defect noted for</i>	
		<i>Satisfactory</i>	<i>Unsatisfactory</i>	<i>Treatment</i>	<i>Observation</i>
		%	%	%	%
1956		95.0	5.0	0.9	0.9
1957		97.3	2.7	0.6	0.6
1958		98.1	1.9	0.5	0.6
1959		98.8	1.2	0.2	0.5

The new basis of tabulation by years of age shows that sufficiently large numbers of pupils are inspected at each age to make each group a reasonably large enough statistical sample to justify certain comparisons not previously possible. For example, it will be of interest to compare the findings of 'physical condition' by 'year of birth', i.e., to compare samples of the same group of children, from year to year, on the analogy of a 'follow-up' survey. The first two years' figures are as follows:

<i>Percentage unsatisfactory physical condition</i>					<i>Year of examination</i>	
<i>Year of birth</i>					1958	1959
1943 and earlier	..	..	..	..	1.0	—
1944	..	..	..	..	1.1	0.6
1945	..	..	..	..	1.5	0.9
1946	..	..	..	..	1.4	1.3
1947	..	..	..	..	1.7	1.3
1948	..	..	..	..	3.0	1.2
1949	..	..	..	..	3.7	2.9
1950	..	..	..	..	3.9	2.0
1951	..	..	..	..	2.4	1.2
1952	..	..	..	..	3.3	1.4
1953	..	..	..	..	2.0	2.4
1954	..	..	..	..	2.1	1.4
1955 and later	..	..	..	..	—	1.4

Anthropometric survey—During 1959 the quinquennial anthropometric survey was carried out. In addition to heights and weights a number of other measurements were taken, i.e., subcutaneous fat, using skin-fold calipers. The results were still under statistical analysis at the end of the year and will be the subject of a separate publication.

School meals and milk

A return has been sent to the Ministry of Education giving for a typical day in September, 1959 the numbers of day-school children who had school dinners and of those who had school milk. The figures for school meals are set out below with the corresponding figures in brackets for a similar day in September, 1958:

<i>Type of school</i>	<i>Number of children present</i>			<i>Number who took school dinners</i>			<i>%</i>
				<i>On payment</i>	<i>Free</i>	<i>Total</i>	
Secondary..	..	..	175,991	107,078	7,068	114,146	64.85
			(168,953)	(105,533)	(6,587)	(112,120)	(66.36)
Primary ..	..	..	213,110	101,842	11,766	113,608	53.31
			(220,628)	(100,807)	(10,941)	(111,748)	(50.65)
Special ..	..	..	5,728	4,647	1,023	5,670	98.98
			(5,713)	(4,703)	(974)	(5,677)	(99.37)
Nursery ..	..	..	1,551	982	106	1,088	97.84*
			(1,560)	(923)	(89)	(1,012)	(98.63)
			396,380	214,549	19,963	234,512	59.22
			(396,854)	(211,966)	(18,591)	(230,557)	(58.18)

* Percentage of 1,112 children as 439 children attend half time and do not have school dinners.

On the selected day 337,825 children in schools maintained by the Council took milk as compared with 345,337 in 1958. Of 31,926 children present in non-maintained schools 24,465 had milk under the scheme. The percentages for the several types of school were:

	1959	1958
Secondary ..	69.23	71.45
Primary ..	96.82	97.52
Day special ..	98.83	98.44
Nursery ..	98.64	98.78
Boarding ..	98.12	98.78
Non-maintained ..	76.67	77.10

Vision

The visual acuity standards expressed as percentages of children tested are set out in the following table.

The vision of children under seven years of age is not tested as a routine and therefore this age group is a select sample with a high rate of referral for treatment. Related to the total number of children seen at this age the incidence is much lower—the true incidence of defective vision in children under seven years of age is therefore somewhere between these two figures.

It appears that the percentage of boys requiring treatment for vision rises until age 13 when it levels off, but for girls this levelling off occurs earlier at age 11. At all ages proportionately fewer girls than boys have 6/6 vision without glasses and therefore proportionately more girls are referred for treatment. The highest rate of referral for treatment occurs at age 10 for both boys and girls not wearing spectacles, after which it declines slightly; for children wearing glasses the rate increases with age.

Of the children inspected 0.6 per cent. were noted for treatment of squint as in 1958. This percentage was 2.9 in the entrant group, falling to 0.1 in the school leaver group.

Age group	6/6		6/9		6/12 or worse		Referred for treatment	
	Boys %	Girls %	Boys %	Girls %	Boys %	Girls %	Boys %	Girls %
<i>Not wearing spectacles</i>								
Under 7	76.2	75.9	12.6	14.6	8.6	7.8	14.3	13.5
7	76.4	75.2	13.4	14.3	6.7	6.7	6.0	6.7
8	81.2	79.9	8.7	9.4	4.7	5.5	5.1	5.6
9	81.9	79.4	7.6	8.5	5.4	5.5	5.8	5.9
10	81.6	77.8	7.6	9.4	6.4	7.0	6.9	7.0
11	80.3	77.0	5.5	7.2	5.6	6.0	5.6	6.7
12	79.9	77.7	5.2	6.2	4.5	5.3	4.4	5.8
13	79.7	78.8	4.2	5.4	5.6	4.3	5.6	6.2
14	79.9	76.9	4.8	5.6	5.2	6.3	5.1	6.1
15 and over	77.5	75.4	4.6	5.2	5.2	5.5	5.1	5.3
Total	78.7	76.7	6.7	7.7	5.5	5.8	5.6	6.1
<i>Wearing spectacles</i>								
Under 7	0.3	1.0	1.1	0.4	1.2	0.3	0.6	0.2
7	1.0	1.1	0.9	1.1	1.6	1.6	1.2	1.3
8	2.2	1.4	1.3	1.6	1.9	2.2	1.9	2.3
9	1.4	2.1	1.2	2.1	2.5	2.4	1.6	2.8
10	1.5	3.1	1.6	1.2	1.3	1.5	2.0	1.9
11	3.9	4.3	2.4	2.7	2.3	2.8	3.0	3.2
12	5.4	4.6	2.8	3.3	2.2	2.9	2.8	3.1
13	5.3	5.1	2.4	3.1	2.8	3.3	3.6	3.6
14	5.2	5.2	2.5	3.0	2.4	3.0	4.0	3.3
15 and over	6.4	6.1	3.0	4.1	3.3	3.7	3.9	4.6
Total	4.3	4.2	2.3	2.8	2.5	2.8	2.9	3.2

NOTE: The percentages of children referred for treatment differ slightly from those quoted in the defects for treatment table on page 93 in which the percentages were based on the number of children medically inspected.

Personal hygiene

Health surveys—From 1 January, 1959 the hygiene inspection of each child once a term was replaced by an annual comprehensive health survey of each pupil, plus such additional health surveys as may be thought necessary or desirable in selected individual schools or departments. Details of the findings at these surveys follow:

		No. examined	No. of verminous heads	No. with nits only	Other verminous cases	Total No. of pupils found to be verminous No.	% of No. examined
<i>Annual comprehensive health surveys</i>							
Boys ..	..	125,520	369	292	—	661	0.53
Girls ..	..	139,114	1,294	1,317	—	2,611	1.88
Infants ..	..	95,081	584	642	—	1,226	1.29
Total ..	..	359,715	2,247	2,251	—	4,498	1.25
<i>Additional health surveys</i>							
Boys ..	..	148,236	624	446	—	1,070	0.72
Girls ..	..	174,906	1,952	1,871	2	3,825	2.19
Infants ..	..	150,152	1,076	1,017	—	2,093	1.39
Total ..	..	473,294	3,652	3,334	2	6,988	1.48

To assess the comparative level of infestation amongst school children, only the findings for comprehensive health surveys (each child seen once a year) can be compared with the former hygiene inspections (each child seen once a term). As will be seen in the following table, the percentage found to be verminous at comprehensive surveys in 1959 is very much the same as that found at hygiene inspections in recent years.

Percentage found to be verminous

				<i>Hygiene inspections</i>			<i>Comprehensive health surveys</i>	
				1955	1956	1957	1958	1959
Boys ..	..	..	..	0.67	0.61	0.55	0.55	0.53
Girls ..	..	..	..	2.13	1.79	1.80	1.84	1.88
Infants ..	..	..	..	1.20	1.30	1.32	1.33	1.29
All pupils ..	..	..	..	1.35	1.26	1.25	1.27	1.25

Review of the cleansing scheme—There has been no general review of the Council's scheme for the inspection of personal hygiene and cleansing of school pupils for many years. A scheme was approved by the Education Committee in 1909, under which the cleansing procedure has continued with slight modifications. The current arrangements were approved in 1946.

When a child is found on inspection to be verminous (in the context of the cleansing scheme the word 'verminous' has a special meaning, in that it includes children with only one 'nit', i.e., ovum, as well as children with live vermin present) the parent is sent an advice card, drawing attention to the condition, and giving advice on the steps which should be taken to remedy it. In more serious cases, or if on re-inspection the condition is again found, a second advice card is issued, giving similar advice and offering an appointment at a bathing centre. Only if this advice is not taken does the scheme provide for the exercise of the statutory procedure of formal notice, and, if necessary compulsory cleansing.

Over the years there has been a radical improvement in the condition of school pupils as regards general well being and in particular cleanliness; one of the principal factors which has contributed to this improvement has been the effect of the cleansing scheme in raising the parental consciousness of the need for keeping children clean.

The problem of the control of head lice has always been dominated by two factors, the need to maintain such a concentration of insecticide that the young louse was killed either before or just after hatching, and the removal of the nit from the hair. The louse cements its nit to the hair with a substance which is more resistant than the hair itself, thus chemicals which would dissolve the cement would either be depilatories or harmful to the skin or both. For this reason the only treatment for heavy infestation was at one time the complete cropping of the hair. In the early 1920's the necessity for this was removed by the invention of a special metal comb (Sacker) with extremely fine teeth, triangular in section, which removes nits from wet hair.

Since the war much research has gone into the development of chemical preparations based on modern insecticides, such as D.D.T. and B.H.C., which would be lethal not only to the louse, but also to the hatching nymph. Within the last few years Imperial Chemical Industries, Limited have produced a preparation of gamma B.H.C. in the form of a cream hair shampoo known as Lorexane No. 3, packaged in small tubes containing enough for eight shampoos, which is quite attractive in use. This preparation has been given extensive field trials, notably in Salford, the success of which have been widely reported upon in the medical press.

In London a trial in division 2 began in the spring term, 1959. The trial was not concerned with the efficacy of Lorexane as a parasiticide but with the feasibility of extending the established principle of helping parents to keep their children clean themselves. Instead of the issue of the traditional advice card, with its offer of cleansing station facilities, parents were to be encouraged to clean their children themselves by the issue of a tube of Lorexane No. 3 shampoo, with instructions for its use.

The Divisional Medical Officer reported in December, 1959:

'... The general opinion of the school health visitors is that the shampoo is reaching and being used by the other members of the family as well as the child in whom infestation was found and numerous instances have been quoted showing that the availability of the shampoo has been welcomed by families and the individual members are eager to use it. Success in reducing infestation and re-infestation has been reported in families in which previously little progress had been made. Nevertheless, there are parents who make little or no effort to cleanse their children and home visits continue to be necessary in these cases.'

Accordingly it was decided that, with effect from 1 January, 1960, the trial of the issue of Lorexane for use at home would be extended to the whole of the County of London. A problem raised by the introduction of the shampoo is the re-education of the families who have been encouraged over past years into the habit of making voluntary bathing centre attendances. Health visitors have now to re-educate these families into the alternative habit of asking for a tube of Lorexane instead.

Cleansing scheme

	1955	1956	1957	1958	1959
Advice cards issued	10,483	9,614	8,830	8,054	6,723
Families involved	4,581	3,836	3,448	3,085	3,183
Pupils returning to school clean after issue of advice card	1,176	1,690	1,559	1,468	1,277
Pupils attending bathing centre voluntarily after issue of advice card	7,001	6,452	6,183	5,527	4,552
Statutory cleansing notices issued	1,532	1,223	998	964	764
Pupils cleansed after serving of statutory notice—					
(i) Voluntarily	459	325	243	240	259
(ii) Compulsorily	977	853	704	628	458
Total	1,436	1,178	947	868	717

Bathing centre and cleansing station facilities—In 1958 the Council had the use of 16 cleansing stations and bathing centres in the 48 square miles of London north of the river and only 9 in the 67 square miles south of the river. As there have never been any representations to the effect that south London was inadequately served, or that parents and children have had to travel excessive distances, the review concentrated on north London. At a number of the Council's bathing centres no other activities take place and in most areas the total volume of work carried out no longer justifies staff standing-by at such centres. These centres will therefore be closed as opportunities occur and cleansing facilities will be provided at centres at which the nursing and bathing attendant staff can be usefully employed on other activities.

In the light of the review arrangements were made to terminate, with effect from 31 March, 1960 the agreements with five of the metropolitan borough councils under which pupils were sent for cleansing to the borough cleansing station. In addition three of the Council's bathing centres were closed during 1959.

Scabies, impetigo and ringworm

	1955	1956	1957	1958	1959
<i>Scabies</i>					
Pupils treated	961	762	697	768	660
<i>Verminous</i>					
Pupils treated	9,867	9,669	8,175	7,473	7,025
Treatments needed	15,756	14,770	13,787	13,647	11,799
<i>Impetigo</i>					
Pupils treated	3,749	2,776	2,433	1,478	1,187
<i>Ringworm</i>					
New cases	9	—	17	22	20

Employment of school children

Medical examinations were carried out divisionally of 3,750 children with a view to the issue of employment certificates, and 462 medical examinations were carried out at the County Hall in respect of employment under licence in public entertainments.

Choice of employment

The percentage of school leavers advised against particular forms of employment was 13·8 per cent. of those inspected compared with 13·6 per cent. in 1958. For boys the figure rose from 15·0 per cent. in 1958 to 15·5 per cent. and for girls it decreased from 12·0 per cent. to 11·9 per cent. As in recent years, normally acute vision and eye strain headed the list of contra-indications followed by colour vision (boys only) and heavy manual work:

	Boys	Girls
<i>Contra-indications</i>		
Occupations involving:		
Heavy manual work	260	134
Sedentary work	18	9
Indoor work	5	5
Exposure to bad weather	153	100
Wide changes of temperature	100	56
Work in damp atmosphere	131	92
Work in dusty atmosphere	168	70
Much stooping	52	32
Climbing	102	51
Work near moving machinery or moving vehicles	103	77
Prolonged standing, much walking or quick movement from place to place	127	127
Eye strain	703	755
Normal vision	986	575
Normal colour vision	419	—
Normal use of hands	29	16
Exposure of hands to moisture, chemicals, etc.	36	26
Handling or preparation of food	104	102
Normal hearing	80	51

NOTE: The total number of contra-indications is greater than the number of pupils with contra-indications (2,381 boys and 1,563 girls) since an individual may be noted for two or more contra-indications.

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 necessary.

The numbers of cases of infectious diseases reported during 1959 and the preceding years are given below:

	1955	1956	1957	1958	1959
Chicken-pox	8,366	8,424	4,496	8,901	5,399
Dysentery, diarrhoea or enteritis ..	446	1,458	414	1,170	1,148
German measles	639	1,775	2,081	2,549	1,325
Impetigo	522	354	301	265	192
Jaundice	133	132	75	11	19
Measles	16,724	2,903	13,039	5,045	9,326
Mumps	1,982	6,059	5,509	2,778	3,788
Ophthalmia and conjunctivitis ..	271	280	291	319	264
Ringworm (scalp)	} 80 {	5	8	13	13
Ringworm (body)		44	55	38	46
Scabies	72	53	61	61	57
Scarlet fever	984	1,020	1,037	1,251	1,264
Sore throat and tonsilitis	937	897	864	994	1,299
Whooping cough	1,614	1,857	1,372	485	508

Prophylaxis—The new system of recording medical inspection findings by years of birth permits an analysis of the percentage of school pupils, according to age, who have received prophylaxis, based on the findings at periodic general medical inspections. These figures may be compared with the separate estimates, prepared for the Ministry of Health, given on pages 73 and 74 which also contain details of poliomyelitis vaccination of school pupils:

Age Group (year of examination minus year of birth)	Number of pupils examined	% Vaccinated	% Immunised against Diphtheria	% Immunised against Whooping cough
4 or less	7,660	54.6	82.0	73.1
5	29,317	53.2	78.8	67.5
6	7,069	48.9	72.9	58.9
7	13,278	52.4	85.3	59.9
8	8,540	51.1	82.4	53.9
9	3,128	50.3	74.9	45.2
10	1,817	46.8	70.6	39.7
11	15,424	49.6	87.3	46.5
12	8,744	60.1	87.5	41.7
13	2,896	60.6	84.0	31.3
14	8,204	53.3	83.6	26.6
15 and over	30,186	54.6	86.8	24.2

'Outbreak' at a school due to excessive dust—The following account of an 'outbreak' at a school in Kensington is of interest as an illustration of how effective action can be taken by the public health inspectorate following notification by a school of cases of absence due to illness:

On 18 September, 1959 cases of sore throat, vomiting and diarrhoea were reported, together with a complaint of nuisance from dust caused by demolition and rebuilding work in progress at the school. Children, staff and parents had complained of dust affecting their throats and making them feel sick. The number of cases was increasing and children on the ground floor, where the concentration of dust was most severe, were the greatest sufferers. Of some 60 children who had been affected only two had come from classrooms on the first floor.

The following remedial measures were immediately taken:

- (a) damping down by hose spraying;
- (b) removal of rubbish from the site;
- (c) wherever possible screens used to stop dust falling;
- (d) all windows kept closed;
- (e) children's bottles of milk and drinking straws specially covered;
- (f) special arrangements to protect meals and utensils in the school meals kitchen.

By 28 September the headmaster reported that the number of illnesses probably connected with dust was now very few and continuing to fall daily, and that the recommended precautions were being maintained. No further action was subsequently found to be necessary.

School treatment centres

At the end of the year there were 111 school treatment centres, of which 8 were run by voluntary committees.

Treatment of enuresis: electric alarm bell apparatus—During recent years increasing publicity has been given to electric alarm bell apparatus in the treatment of enuresis. The devices consist simply of an electric bell with a battery and two pads, and there are several makes on the market. Whilst the idea is by no means new, in earlier years it was subject to severe criticism on psychiatric grounds. Today the pendulum has swung the other way and such devices are being recommended by some psychiatrists. Divisional medical officers were informed, in 1959, that there was no objection to the issue of such apparatus from special investigation clinics, if the clinician responsible wished to try it for a particular patient.

Treatment statistics—The number of sessions, new cases and total attendances at school children's clinics during 1959 (including sessions held in hospital premises) were as follows:

Type of clinic	Sessions	New cases	Attendances
Minor ailments (nurse)	23,435	75,017	513,333
Minor ailments (doctor)	2,610	35,123	
Special investigation	2,124	1,931	13,935
Dental	30,817	82,448	267,781
Vision	4,959	31,841	81,324
Orthoptic	1,927	1,143	7,651
Ear, nose and throat	745	3,507	8,800
Audiology	325	1,279	3,153
Rheumatism (supervisory)	350	176	2,142
Enuresis	321	284	1,929

Handicapped pupils

At the end of 1959 special educational treatment was being provided for approximately 12,000 pupils. The following table shows the main categories of handicap and numbers of pupils receiving full-time special educational treatment:

	Day special schools	Boarding special schools	Non-council boarding schools, hostels, foster-homes hospitals, etc.	Total
Blind	—	66	51	117
Partially sighted	258	—	10	268
Deaf and partially deaf	273*	33	113	419
Physically handicapped	974	61	439	1,474
Delicate	1,470	178	103	1,751
Educationally sub-normal	3,386	600	39	4,025
Epileptic†	—	—	35	35
Maladjusted	133	271	539	943
	6,494	1,209	1,329	9,032

* Includes 75 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 educationally sub-normal.

In addition, part-time special educational treatment at day special classes was provided for 358 maladjusted pupils and 2,558 pupils with speech defects.

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

	Day	Boarding
Blind	—	15
Partially sighted	33	2
Deaf and partially deaf	44	9
Delicate	361	399*
E.S.N.	627	88
Epileptic	—	1
Maladjusted	250	269
Physically handicapped	186	19
Speech defect	1,235	79†
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:

	1955	1956	1957	1958	1959
Section 57(3)-Incapable of receiving education:					
Children not in any school	94	97	57	118	86
Children in normal schools	9	1	3	9	6
Children in special schools	90	102	75	83	97
Children receiving home tuition	1	—	—	2	1
	194	200	135	212	190
Section 57(3) and (4)—					
Inexpedient to educate with other children ..	6	4	4	3	3
Section 57(5)—School leavers	348	351	322	305	272

In 1959 another 154 school leavers were in need of voluntary supervision only.

Section 8 of the Education (Miscellaneous Provisions) Act, 1948 provides for a review in the case of any child reported to the local health authority under section 57(3) of the

Education Act, 1944 and authorises the cancellation of the report where the child on re-examination is found to be educable. During 1959 four reports were cancelled and the children admitted to special schools.

Home and hospital tuition—Section 56 of the Education Act, 1944 authorises education 'otherwise than at school', and covers teaching at home and in hospital. At the end of 1959 a special analysis was made of the morbid condition of the 63 pupils then in receipt of home tuition. In many of the cases there were multiple defects, and only the major condition is quoted in the following analysis:

Tuberculosis	2	Heart disease	2
Post-poliomyelitis	3	Ulcerative colitis	1
Ganglioneuroma	1	Fibrocystic pancreas	4
Cerebral dysthymia	1	Nephritis	6
Obesity	1	Osteochondritis	1
Haemophilia	1	Muscular dystrophy	3
E.S.N.	4	Spina bifida	3
Maladjusted	11	Ectopic bladder	2
Cerebral palsy	2	Fragilitis ossium	1
Epilepsy	1	Fractured leg	2
Blindness	9		
Rheumatic fever	2	Total	63

Hospital tuition falls into three categories; hospital schools, permanent teaching groups in hospitals, individual hospital tuition. Without special enquiries directed to a large number of hospitals, both in and out county, it would not be possible to give a full analysis of the children concerned; but the following estimates have been made of the average number of London children receiving hospital tuition:

London hospitals	230
Surrey hospitals	200
Kent hospitals	70
Middlesex hospitals	50
Essex hospitals	40
Other area hospitals	40
Voluntary hospital schools	30
Total	660

In addition, at any one time, there will be a number of children in hospitals without permanent teaching arrangements, whose stay is too short to warrant individual tuition being arranged.

During December an analysis was made of the children who were known to have been 'out of school' for three months or more. These children form part of the group discussed above, and the analysis gives an indication of the conditions necessitating long absence from school due to illness:

Tuberculosis (all forms)	35
Post-poliomyelitis	9
Other infectious diseases	5
Anaemia	3
Diseases of the nervous system	38
Eye diseases	6
Ear, nose and throat conditions	13
Lung disease (not T.B.)	21
Rheumatism, chorea and rheumatic heart disease	53
Other heart diseases	8
Orthopaedic conditions	30
Skin diseases	12
All other conditions (including traumatic and not known)	107
Total	340

High tone deafness—About one pupil in a thousand receives special educational treatment as deaf or partially deaf, in day or boarding special schools, or in partially deaf units in ordinary schools. Nowadays virtually all pupils requiring such special schooling are detected at an early age and it is most unusual for a child who is seriously handicapped by deafness to be first brought to notice in an ordinary school.

It is most important that deafness should be detected at as early an age as possible, certainly before the age of two years, so that, with suitable training and treatment, the child learns to detect and distinguish normal sounds. The modern development of the miniature transistorised hearing aid has enabled babies of under one year to be fitted with aids, so that, like the normal child, they learn to listen in their cradles. The doctors and health visitors in maternity and child welfare clinics have, in recent years, been receiving special training in the somewhat difficult task of testing young children for suspected deafness and all doubtful cases are referred to a consultant otologist. Therefore, by the time a child starts school, most cases of congenital deafness should already have been detected and appropriately dealt with. However, there are some children who suffer from unilateral deafness or from high tone deafness, whose disability may not be at all obvious and may never even have been suspected.

The routine audiometer tests, now carried out soon after children start school, should pick up such cases but for some years there will be a number of children in school who have never had such a test. Teachers can, of course, always refer any child about whom they have a doubt to the school doctor but, as was stated above, high tone deafness is not necessarily obvious and the only symptom presenting itself in class may be some degree or other of backwardness or of defective consonantal speech.

In fact it has been not uncommon in the absence of a reliable audiogram for cases of high tone deafness to be confused with educational retardation. But the emotional difficulties caused by this type of hearing loss often make it impossible for any but the most experienced tester to obtain an audiogram and then only by using special techniques.

The confusion and insecurity of living in a world where all sound may be likened to a poor telephone line often causes behaviour problems at both ends of the intelligence scale. Thus abnormal aggressiveness or withdrawal, in many cases coupled with a speech defect, could be an indication of impaired hearing for higher frequencies. The speech defect is present because the child repeats what he hears and probably has no idea that his speech is different from that of his fellows. The sounds which are made on the higher frequencies include: t, p, k, th, sh, f, ch, x and wh. Ee also contains some high frequency components. Obviously confusion of these sounds can lead to backwardness in reading and other subjects.

Survey of deaf children—In September, 1959 a special count was made of children known to be receiving special educational treatment for defective hearing. The survey excluded children in ordinary schools who were not specifically receiving special treatment (other than 'sit near the front') and thus does not represent the total incidence of impaired hearing, but only those cases warranting special treatment. The results were as follows:

Day schools for the deaf	203	
Non-L.C.C. boarding schools (deaf)	71	
Rayner's school (deaf)	18	
Total deaf	292	
Day partially deaf units	73	
Non-L.C.C. boarding schools (partially deaf)	36	
Rayner's school (partially deaf)	14	
Total partially deaf	123	
Children attending auditory training centres—		
(a) under 2 years of age	5	60
2-3	17	
3-5	38	
(b) over 5 years of age	166	
Children 'followed-up' by peripatetic teachers	62	
Total under peripatetic teachers	288	
Total	703	

The 288 children under care of the peripatetic teachers of the deaf attend (if old enough) ordinary schools, nursery schools, day nurseries, or special schools for other handicaps. An analysis of the placement of the 228 children over 5 years of age is as follows:

Ordinary schools	183
Schools for the blind or partially sighted	5
Schools for the E.S.N.	22
Schools for the physically handicapped	13
Schools for the maladjusted	1
Schools for the delicate	4
Total	228

Auditory training centres—The first two auditory training centres were opened in 1955 with one peripatetic teacher of the deaf responsible for the work at both centres. Two more centres were opened in 1956 and a second teacher appointed to work at them. A further three centres were opened in 1957 when a third teacher was appointed.

During 1959 a fourth peripatetic teacher of the deaf was appointed, and at the end of the year auditory training sessions were held at five of the Council's audiology clinics and at two hospitals—Belgrave and Lewisham.

When the proposal to establish the centres was first put forward it was envisaged that the greater part of the teachers' time would be spent on the auditory training of young deaf children and that the proportion of time spent with children in ordinary schools and on the follow-up of children discharged from the units for the partially deaf would be comparatively small. In practice the reverse has been the case and the greater part of the teachers' time has been taken up with the older children.

The age distribution of the children on the rolls of the auditory training centres at the end of the year is shown in the table on page 104.

Routine audiometer testing—All pupils are given a routine audiometer test as soon after entry to school as possible. The tests are carried out by the school health visitors, using small portable audiometers, by means of the 'rapid-sweep' technique. Pupils who fail to pass this 'screening' test are referred for a further full pure tone test, and those that fail this are referred to the otologist at the divisional audiology clinic. The numbers of pupils tested during 1959, and the results of the tests, are as follows:

Pupils given screening tests	52,556
Pupils given pure tone tests	3,427
Pupils referred to otologists	1,200
Percentage of pupils failing screening test	6.5%
Percentage of pupils referred to otologists	2.3%

Speech therapy—During the year the provision of portable magnetic tape recorders, described on page 113 of my report for 1958, was extended by the purchase of further machines.

At the end of the year 162 speech therapy sessions were held each week in 52 clinics. In addition, 50 sessions were held in day schools for the educationally sub-normal; 28 sessions in day schools for the physically handicapped; and 24 sessions in boarding special schools. At the end of the year the total staff employed was the whole time equivalent of 28 4/11.

During the year 1,320 pupils (including 226 in special schools) were formally ascertained as requiring speech therapy; 630 (including 86 in special schools) were discharged as either cured or improved; and 303 (including 53 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 2,527, whilst 272 remained on the waiting list.

Telescopic visual aids for partially sighted pupils—During recent years an important development in the care of the partially sighted has been the introduction of telescopic visual aids. During 1959 arrangements were made for the inventor and manufacturer (Mr. Keeler) to visit the day schools for the partially sighted and, in conjunction with the Council's consultant ophthalmologist who visits the schools (Miss Irene Gregory, F.R.C.S.), to select those pupils who might benefit therefrom to receive a trial with telescopic devices. The Ministry of Health have agreed that the provision of such appliances falls within the responsibility of the regional hospital boards as part of their hospital eye service arrangements for school children.

Maladjusted pupils

A special article, Appendix B, reviews the growth and development of child psychological services.

During 1959 consideration was given to Ministry of Education circulars 347 and 348, and Ministry of Health circulars 3/59 and H.M. (59) 23, which implemented certain of the recommendations of the report of the Underwood Committee on Maladjusted Children. It was decided, in principle, that new child guidance clinics were needed in certain areas of London and, in accordance with the circulars, negotiations were opened with the metropolitan regional hospital boards on the question of future planning in this field.

Details of the work done during 1959 at the five child guidance clinics maintained by the Council follow:

	<i>Battersea</i>	<i>Brixton</i>	<i>Earl's Court</i>	<i>Peckham</i>	<i>Woodberry Down</i>	<i>Total</i>
<i>Patients</i>						
At 1 January, 1959						
On waiting list	34	44	38	36	53	205
In attendance	48	124	76	24	250	522
During 1959						
Applications received	114	247	174	83	247	865
Applications withdrawn	28	39	17	37	54	175
Cases closed	57	175	60	40	160	492
At 31 December, 1959						
On waiting list	41	40	67	12	98	258
In attendance	70	161	144	54	238	667
<i>Visits</i>						
During 1959						
No. of home visits by staff ..	6	9	46	22	181*	264
No. of school visits by staff ..	121	28	128	51	74*	402

*includes visits by students.

Research and investigation

Dr. W. J. Israelsohn, of the Institute of Child Health, was given permission to visit the day schools for educationally subnormal boys, to take buccal mucosal smears which were to be examined at the Hospital for Sick Children for chromatin positive cells, with a view to detecting cases of Klinefelter's syndrome at an early age before the appearance of the post-pubertal overt symptoms.

DENTAL SERVICES

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

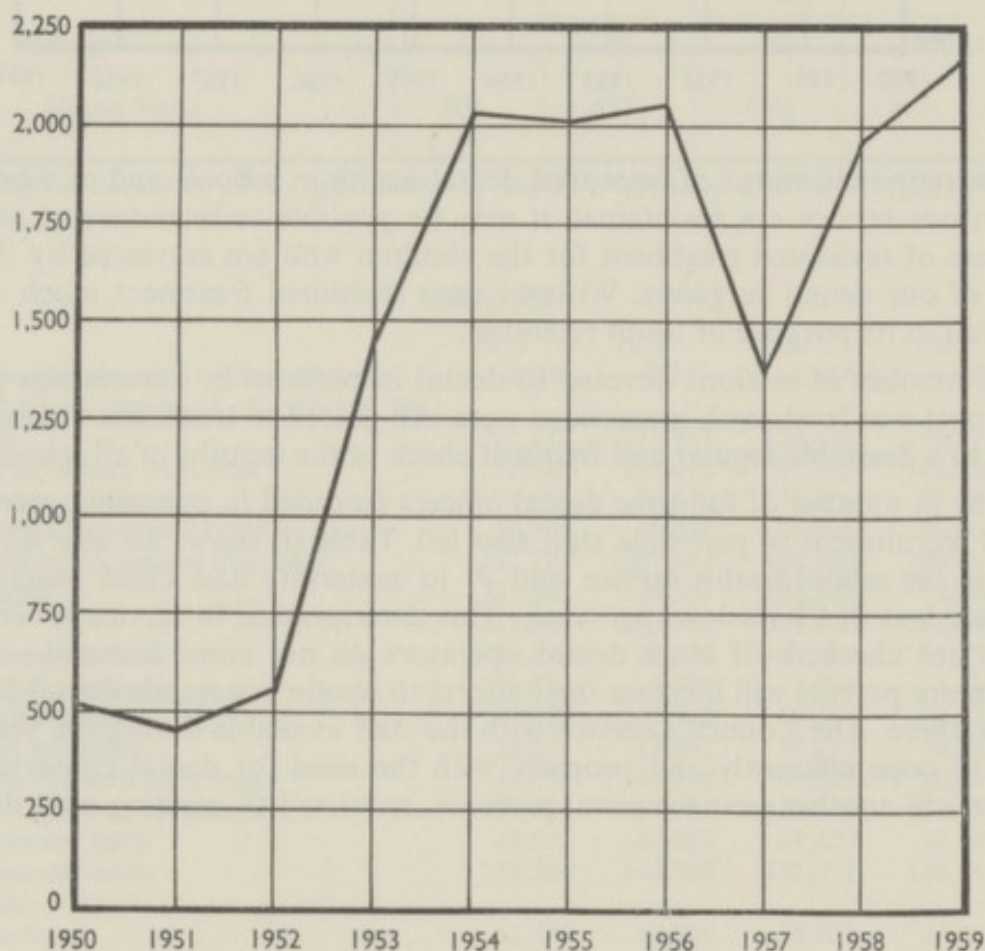
School dental service

In 1959, 215,637 children (49·8 per cent. of the school population) were inspected at schools by dental officers and the percentage found to require treatment again fell by 3 per cent. (to 70·5 per cent.) compared with that of the preceding year (table (ii)).

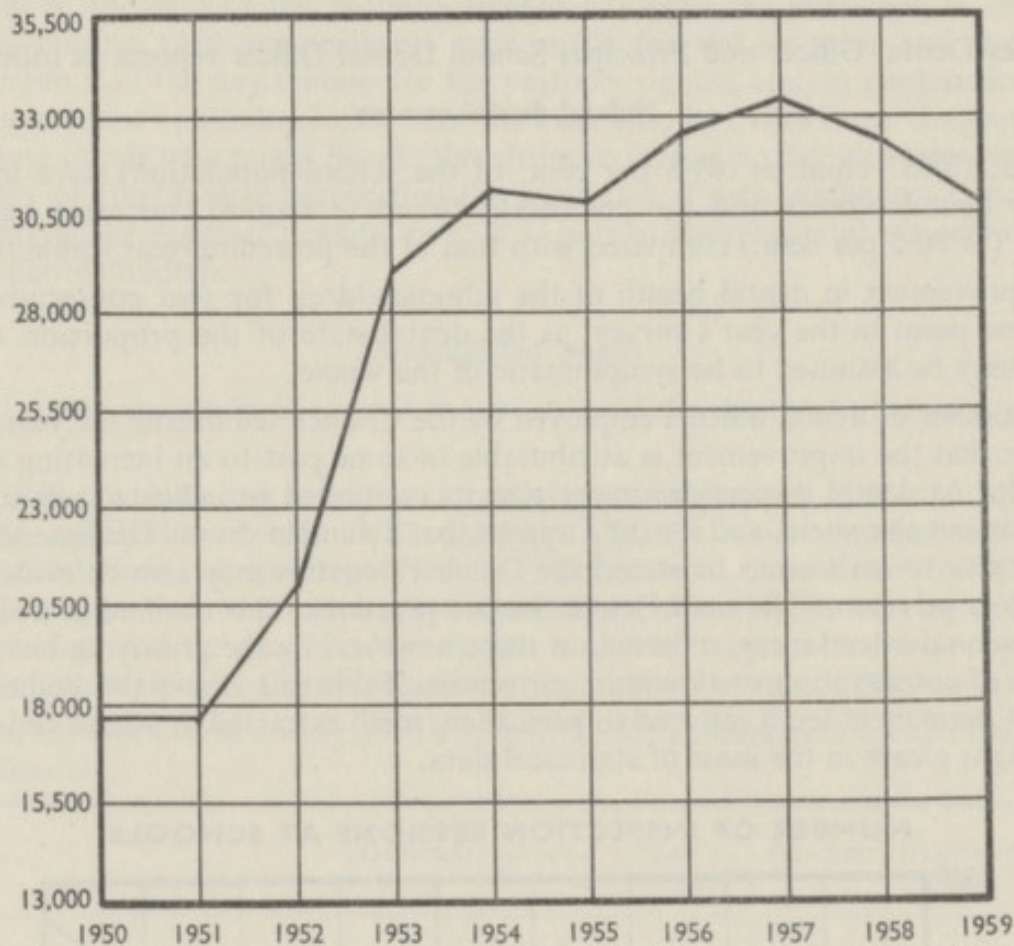
This improvement in dental health of the schoolchildren for two consecutive years is the brightest point in the year's survey, as the dental state of the proportion of children examined may be assumed to be symptomatic of the whole.

As the number of dental officers employed by the Council fell during the year, it is a fair assumption that the improvement is attributable in some part to an increasing measure of outside help. At dental inspections many parents continued to indicate their intention to obtain treatment elsewhere, and it would appear that a number do so. The lessened response during the year to invitations to attend the Council's centres may also be evidence of this trend towards private or National Health Service practices. This resulted in a slight fall in average sessional attendances, reflected, in turn, however, by the gratifying increase in the proportion of conservation work within our service. Table (iii) shows the highest ratio yet obtained of permanent teeth restored to permanent teeth extracted in school children and is another bright gleam in the mass of statistical data.

NUMBER OF INSPECTION SESSIONS AT SCHOOLS



NUMBER OF TREATMENT SESSIONS



If the foregoing indications of improved dental health in schools and of a better type of treatment in our service are maintained it may be possible to introduce at an early date some measure of revisional treatment for the children who are entrusted by their parents to the care of our dental surgeons. Without such revisional treatment much of the work done must fail in its purpose of tooth retention.

While the number of sessions devoted to dental inspections in schools was increased to the highest post-war level, such inspections were still geared to treatment facilities available rather than to a desirable regular and frequent check of the mouths of all schoolchildren.

The decline in number of full-time dental officers recorded in preceding years continued in 1959 and recruitment of part-time staff also fell. Table (i) shows an over-all loss of $8\frac{2}{3}$ in the year in the school health service and $\frac{8}{3}$ in maternity and child welfare service—a total service loss of 93 sessions per week. This deterioration in service is serious and, if the trend is not checked—if more dental operators do not come forward—it should be hoped that more parents will increase their efforts to obtain systematic dental care for their children elsewhere. The Council's service with the staff available during the year was quite inadequate to cope efficiently and properly with the need for dental conservation in the schools. For still another year we were, perforce, restricted to meeting only demand.

TABLE (i)

	1955	1956	1957	1958	1959
<i>Dental officers</i>					
Number employed (i) full-time	49	52	44	42	35½*
(ii) part-time	67	70	74	97	94
Total	116	122	118	139	129½
<i>Full-time equivalent</i>					
(i) School service	67½	73½	65½	72½	64½
(ii) M & CW service	5½	6½	6½	6½	6
Total	73½	79½	72½	78½	70½
Establishment (temporary)	93	95	95	95	95
<i>Weekly sessions</i>					
<i>School service</i>					
(i) by full-time dental officers	527½	561½	460	437	364
(ii) by part-time dental officers	220	246	263	361	355½
Total	747½	807½	723	798	719½
<i>M & CW service</i>					
(i) by full-time dental officers	33½	42½	46	41	29
(ii) by part-time dental officers	24	27½	29½	28	37½
Total	57½	70	75½	69	66½
Grand Total	805	877½	798½	867	786

* '½' full-time officer accounted for by appointment of half-time Assistant Chief Dental Officer

TABLE (ii)

	1955	1956	1957	1958	1959
Number of inspection sessions held at schools ..	2,008	2,111	1,354	1,952	2,177
Number of children inspected at schools by dental officers	202,242	213,957	120,440	196,573	215,637
Number found to require treatment	151,326	163,414	91,868	144,050	152,131
Percentage requiring treatment	74.8%	76.4%	76.3%	73.5%	70.5%
Additional number inspected at centres	50,887	44,078	56,598	36,067	27,576
Total number found to require treatment ..	202,213	207,492	148,466	180,117	179,707
Total cases treated	121,362	115,587	102,568	97,300	82,448
Attendances	317,684	332,785	308,862	298,342	267,781
Ordinary treatment sessions	29,698	31,257	31,841	31,322	29,637
General anaesthetic sessions	1,578	1,708	1,594	1,431	1,180
Temporary teeth extracted	83,539	83,341	69,247	58,223	46,461
Permanent teeth extracted	16,527	19,992	18,273	19,342	14,973
Temporary teeth restored by fillings	45,256	43,474	45,509	40,994	39,861
Permanent teeth restored by fillings	122,097	129,931	117,148	122,558	110,934
Fillings in temporary teeth	48,075	46,088	48,477	43,176	42,656
Fillings in permanent teeth	135,384	144,746	131,071	136,811	125,053
<i>Other operations:</i>					
temporary teeth	62,496	58,808	58,021	54,884	49,109
permanent teeth	65,811	68,972	64,675	64,995	61,835
Local anaesthetics for extraction	17,341	16,195	14,404	13,320	12,354
Local anaesthetics for conservative treatment ..	7,130	9,494	10,718	13,964	11,667
General anaesthetics	36,099	38,740	34,019	30,861	24,367
Cases for whom immediate treatment was completed	13,744	11,614	10,415	10,566	9,414
Cases discharged as dentally fit	80,964	79,994	71,260	66,990	54,474

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

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
1959	..	..	..	..	7.41 to 1

Orthodontics

Table (iv) shows a slight increase in the number of patients received at all treatment sources but many patients had still to go by default. Many patients continued to be treated at our own routine clinic sessions but the time so spent interferes seriously with other work. I would register appreciation of the help given by the Eastman Dental, King's College, University College and St. Alfege's hospitals.

TABLE (iv)

	1955	1956	1957	1958	1959
Number of special orthodontic sessions	185	290	321	282	229
Number accepted at special orthodontic sessions	195	252	108	199	138
Number accepted at routine sessions	432	427	403	474	371
Number referred to hospitals	59	182	158	186	279
Total number of patients accepted or referred ..	686	861	669	859	788

Maternity and child welfare dental service

This section of the dental work (the 'priority service' (Part III) of the National Health Service) continued for another year to be exceedingly meagre. The equivalent of only six full-time officers was utilised. No 'inspections' by dental officers were held at maternity welfare centres and only the requests by a relatively small number of mothers for attention were met.

As with the schoolchildren, it is believed that a number of patients receive attention elsewhere but with the paucity of dental staff it was deemed inadvisable, during the year, to attempt to develop this branch of the dental service.

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

	1955	1956	1957	1958	1959
Number of sessions	3,220	3,169	3,293	3,135	2,764
Number of appointments offered	35,854	36,711	36,636	34,740	30,456
Attendances—by appointment	26,430	27,640	26,006	24,691	21,995
—other	1,526	1,799	1,717	1,539	1,122
Silver nitrate treatment	5,058	4,716	5,423	5,065	4,415
Fillings	13,212	13,465	11,310	11,491	10,031
Extractions	9,177	9,561	7,809	5,873	5,114
Dentures supplied—new full	572	538	508	422	380
—new partial	686	778	820	685	649
Number made dentally fit	7,117	7,492	6,010	5,014	4,784

Dental service in boarding schools and residential establishments

Recruitment of visiting (local) dental surgeons continued to prove disappointing and in some instances full-time school dental officers had to be deployed from their routine work to supply visits to outlying establishments—an increased drain on an already attenuated school service, but resulting in more satisfactory services in some residential establishments.

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.)

<i>Types of staff</i>	<i>Location</i>			<i>Total</i>
	<i>Head office</i>	<i>Divisions</i>	<i>Other establishments (a)</i>	
Administrative and clerical (including ambulance control clerks)	216	629	75	920
Medical officers (b)	32	159	(b)	191
Dental officers (b)	2	71	(b)	73
Scientific branch staff	31	—	14	45
Inspectors	14	—	—	14
Nursing staff	10	1,808	195	2,013
Medical auxiliaries (c)	28	148	21	197
Social worker grades (including mental health); home help organising staff; wardens	33	183	144	360
Ambulance service operational staff	3	—	811	814
Manual workers, home helps, domestic grades, etc.	12	2,925	139	3,076
Totals	381	5,923	1,399	7,703

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

(b) There are 103 visiting medical officers and seven 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 health visitors—The Council appointed 45 student health visitors for training in 1958-59 under its standing arrangements. Theoretical training was provided by the University of London Institute of Education (35 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 and sat for the examination and 43 were successful.

Nursing staff—Following a recommendation of the Nurses and Midwives Whitley Council, the hours of duty of nursing staff in the Council's residential establishments were reduced from 96 to 88 hours a fortnight with effect from 1 April, 1959.

Psychotherapists: qualification for appointment—Psychotherapists are employed by the Council at child guidance units and at schools for maladjusted children. In November, 1959 the qualifications of applicants for posts in this grade were reviewed. It was decided that future candidates for appointment as psychotherapist shall have undertaken specialised training in psychotherapy, including analysis with children. They shall possess either an honours degree in psychology or its equivalent; or other university degree which, if it does not include an approved basic training in psychology or scientific study of human relations, is coupled with an approved post-graduate diploma in psychology or the certificate in mental health; or other appropriate academic qualification or experience.

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

	1957	1958	1959		1957	1958	1959
Candidates fit for appointment	6,286	7,531	7,399	Eligibility for spouse pensions	26	24	29
Candidates unfit for permanent appointment .. .	285	401	343	Staff casualties	240	315	309
Referrals (ill-health)	7,268	6,719	7,252	Candidates for out-county authorities	65	100	111
Permanently unfit to carry out their ordinary duties .. .	245	323	331	Candidates examined for the Council by out-county medical officers of health	77	138	111
Advice given (without examination)	1,378	1,621	1,595				

Food handlers—During the year 469 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	1959
Contacts	107	137	167
Ill	270	266	302
Allowed to resume work after examination or fixed period of exclusion	360	388	451
Resigned	—	9	8
Excluded from work and referred to own doctor for treatment ..	17	6	10

The 10 cases referred to their doctor had been found to have the following micro-organisms:

Condition	Organism isolated
Diarrhoea convalescent	<i>Shigella sonne</i>
Dysentery convalescent	" "
Dysentery contacts (2)	" "
Food poisoning contact	<i>Salmonella enteridis</i>
Gastro-enteritis convalescent	<i>Shigella sonne</i>
Gastro-enteritis contacts (2)	" "
Gastro-enteritis contact	<i>Salmonella paratyphi B</i>
Scarlet fever contact	<i>Streptococcus pyogenes</i>

Retirements, etc.—My predecessor's report for the year 1950 mentioned the retirement, at the age of 66, of Dr. Verner Wiley, who had been in charge of staff medical examinations and of work under the Mental Deficiency Acts since 1935 and had served with the Council from 1920. Formal retirement, however, did not sever Dr. Wiley's connection with the Council and its staff and he continued to undertake staff medical examination work on a part-time basis until October, 1959, when ill health compelled him to give up. Dr. Wiley had always put his wealth of experience and sound advice freely at the disposal of his colleagues, to the great benefit of the service.

On 13 April, 1959 Mr. H. E. Beresford Mash, a dental officer in the Council's service, was appointed as Assistant to the Chief Dental Officer on a half time basis, the remainder of his time being devoted to orthodontic clinical work.

I report with regret the death of Mr. G. J. Newton, Divisional Administrative Officer, Division 1, at the age of 56 years. Mr. T. A. Stone, Divisional Administrative Officer, Division 6, was transferred to take his place and Mr. L. M. Longhurst was appointed Divisional Administrative Officer, Division 6.

On 14 August, 1959 Mr. H. J. Norton, M.B.E., Divisional Administrative Officer, Division 2, since July, 1948 retired after nearly 48 years in the Council's service and his place was taken by Mr. N. A. Woodruff.

On 31 July, 1959 Miss K. M. Roe, Divisional Nursing Officer, Division 5, retired. She was transferred to the Council's service in July, 1948 from the Royal Borough of Kensington where she had been Superintendent Health Visitor since 1938.

FINANCE

Capital—The total capital expenditure on the health services of the Council in the year ended 31 March, 1959 was £68,927, details of which are as follows:

Ambulance service:	£
Stations—erection and adaptation	417
Day nurseries—erection and acquisition ..	1,410
Maternity and child welfare centres—acquisition, erection, equipment, adaptation	4,109
Occupation centres—adaptation and erection ..	62,052
Queen's Road health centre—adaptation ..	939
	£68,927

Maintenance—The gross cost of the various services in 1958–59—including central administrative and debt charges—and the contributions recovered from recipients of the services were:

<i>Service</i>	<i>Cost £</i>	<i>Amount recovered in charges £</i>
Ambulance service	1,097,549	—
Day nurseries	992,711	158,656
Domiciliary midwifery service	247,477	—
General health services (including £198,617 contribution to metropolitan borough councils for salaries of medical officers and inspectors)	254,429	—
Health centres	36,285	—
Health visiting	277,664	—
Maternity and child welfare	866,711	65,884
Mental health	285,159	1,113
Prevention of illness—		
Home nursing	514,689	—
Home help	1,091,079	57,317
Other preventive services	640,130	33,388
School health	973,104	3,315
	£7,276,987	£319,673

The net cost of the services after allowing for Government grant, expressed in terms of rate in the £ was 9.03d.

VISITORS TO THE DEPARTMENT

During the year 416 visitors, including 307 from overseas, were received through the central office—an increase of 73 on the previous year. Programmes of talks with senior officers and visits to the Council's establishments, varying in duration from one day to several weeks, were arranged as necessary.

Parties included one of 22 health workers, teachers and instructors and another of 40 doctors and health workers from Germany, 40 Froebel students from Denmark, 12 African child care workers from Ghana, Nigeria, Rhodesia and Kenya and a number of wives and friends of delegates to the Atlantic Congress (N.A.T.O.). Visitors were received from 51 countries and included 15 members of governments, 72 doctors (including 2 psychiatrists) 29 health visitors and nurses, 4 students, 16 social workers, 5 teachers, 4 journalists, 27 central and local government administrative officers, 3 architects, 2 speech therapists and 4 dental officers. In addition a number of visitors were received at divisional health offices.

Woodberry Down Health Centre was visited by 1,353 people, 282 (including 124 students) from overseas and 1,071 (923 students) from the United Kingdom. The London ambulance service headquarters received 166 visitors and occupation centres 618 visitors (462 students).

Facilities were again provided for medical, nursing and social science students to study the health services. Courses of ten or twenty visits of observation and talks were arranged for 107 post-graduate students preparing for the Diploma in Child Health. Members of the department's nursing staff gave talks to student nurses at hospitals and programmes were arranged to enable 4,005 of these students to gain practical experience. Talks by members of the staff and/or visits of observation and periods of attachment were also arranged for students from the following training centres:

Health visitor students

Battersea College of Technology
Royal College of Nursing
South East Essex Technical College
Surrey County Council
The University, Southampton

Speech therapy students

Central School of Speech and Drama
Kingdon-Ward School of Speech Therapy
Oldrey-Fleming School of Speech Therapy
Speech Therapy Training School of the
West End Hospital for Neurology
and Neurosurgery

Other students (medical, nursing, teaching and social science)

Avery Hill Training College
Battersea Training College of Domestic Science
King Edward's Hospital Fund for London
Queen Alexandra Military Hospital
Royal College of Nursing
Royal Institute of Public Health and Hygiene
University of London
Bedford College
London School of Economics and Political
Science
Queen Elizabeth College
Royal Free Hospital School of Medicine
West Ham College of Technology
Women Public Health Officers' Association

REPORTS BY THE DIVISIONAL MEDICAL OFFICERS

(A statistical summary of work done in the divisions will be found at the end of this section.)

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

Dr. B. E. A. Sharpe reports:

Health education—In line with the recommendations made by the Maternity Services Committee, five parentcraft and relaxation classes were added during the year to the three already held at welfare centres. General practitioners, maternity hospitals and maternity departments of hospitals were informed of these activities, and attendances and results are encouraging.

Health education in the Council's schools has increased and one health visitor undertakes part-time teaching in health education at a large modern secondary school. A course of four lectures given at a day college was followed by a request for regular talks. Health visitors also gave talks to home helps, family advice groups and hospital tutors in training.

Nursing staff continued to assist in training girls at a large industrial concern for the Duke of Edinburgh award, and have now become associated with their youth group. Lecturers in child care were provided for a few private schools. Medical and nursing staff took part in school discussion groups and brains trusts, and medical officers have given lectures on smoking and lung cancer.

Mental health education—The two discussion groups, one based on maternity and child welfare centres in South Kensington and led by Dr. Felix Brown, Medical Director of the Earls Court child guidance unit, and the other serving the North Kensington area and led by Dr. Erskine, psychiatrist, West London hospital, continued to function. Maternity and child welfare doctors, full-time and sessional, and health visitors have found attendances at the groups stimulating and beneficial.

As these training groups had by then been functioning for three years and one year respectively, proposals were in hand at the end of the year for both groups to be discontinued; the close links established with the child guidance unit, Dr. Felix Brown and Dr. Erskine being continued by consultations whenever necessary.

A replacement training group in the Fulham area is to become effective on the closure of the South Kensington group and further developments in this field are under consideration.

Chiropody—The foot clinic previously held on the second floor at Greyhound Road welfare centre, Fulham, was transferred in September to ground floor accommodation at the divisional health office for the benefit of the old people using the clinic.

As part of the Council's interim extension of the chiropody service, 11 additional chiropody sessions allocated to the division for the treatment of the elderly, the physically handicapped and expectant mothers were started during October and November.

School health service—Special investigation clinics were increased by two a month to 16. One of the main concerns of the doctors at these clinics is the problem of the obese child.

Orthoptic sessions were reduced by one a week to six.

Prophylaxis—Protection against whooping cough, diphtheria, tetanus and smallpox was made available at infant welfare sessions in North Kensington and Fulham, in addition to the *ad hoc* prophylaxis sessions held at the centres.

These arrangements will be extended to other centres as more mothers accept the offer of protective immunisation and vaccination for their children when this can be given at the infant welfare session.

Vaccination against poliomyelitis—In common with other parts of the county, wide publicity and public interest just before Easter caused an unprecedented demand for vaccination against poliomyelitis, particularly from teenagers and young persons aged 20–25 years.

Three Football League clubs in the division, Chelsea, Fulham and Queens Park Rangers, were most helpful and not only arranged for their players to be vaccinated but also readily agreed to give publicity to this service during matches played over the Easter holidays.

Attendances at open clinics and postal applications rose sharply. A special week of open sessions each evening and on Saturday morning was held at the divisional health office to meet this demand. Posters at divisional health establishments, borough council sites, football grounds, coffee bars, London Transport underground stations, shop windows, letters to some 600 firms in the area, broadcast announcements at Hammersmith Palais dance hall, and articles and letters in the local Press were all used to give added publicity. Total attendance at the open sessions during the special week was 4,250.

During the year a quarter of all the injections were given by general practitioners.

Mothercraft and homemaking classes—The two mothercraft and homemaking classes for selected mothers in North Hammersmith and North Kensington respectively, arranged by voluntary home advice groups, continued throughout the year and, following an application from the Hammersmith group, a second class was started in that area in May.

Prevention of break-up of families—There were five policy meetings of the divisional co-ordinating committee and 16 intermediate case conferences at which 49 families were considered.

One full-time and two part-time social case workers were appointed to the division, the second part-time social case worker to start work in January, 1960.

Home help—Home helps specially trained to assist mothers in all aspects of home management and child care were supplied to 12 families and resident child helps were provided in seven instances during the temporary absence of the mother, where there was no other adult in the family, to look after the children and sleep in the home at night.

Day nurseries—The improvement noted in daily attendances at day nurseries in 1958 was maintained. Apart from minor variations in percentage weighting of registers no alteration to the approved accommodation was made during the year.

Occasional crèches—An additional occasional crèche session was instituted at Lancaster Road welfare centre, North Kensington (making three sessions in all), from 7 September particularly for the convenience of mothers attending the mothercraft class at the centre and those attending St. Charles hospital for treatment. The other two occasional crèche sessions at Glenthorne Road welfare centre continued.

Liaison with other bodies—In accordance with the recommendations of the Maternity Services Committee a local maternity liaison committee for the Chelsea and the Fulham and Kensington hospital groups was convened in December. The Council is represented on the committee by the divisional medical officer, divisional nursing officer and the supervisor of midwives for the division.

To improve the co-operation between Hammersmith hospital, the medical officers at welfare centres and general practitioners, Professor McClure Browne held two meetings at the hospital for local general practitioners and the Council's ante-natal medical officers working in the division. One of the main topics of discussion was the selection of patients for confinement at the hospital with special reference to late bookings.

A meeting of hospital almoners, health visitors, superintendents of district nursing associations, tuberculosis care organisers, home help organisers and divisional staff was held. Useful discussions took place on a variety of subjects, including the admission to

school of children under five years of age, the use of the personal health services in preventing children being received into care and the co-operation between almoners and the care committee organisation.

Staff—At the end of September the health visitors in the Hammersmith area were transferred from the Town Hall to Council premises which were for the most part the welfare centres from which they worked.

The home help office for the Hammersmith area was transferred from Hammersmith Town Hall to the Glenthorne Road welfare centre premises.

All 10 day nursery students who entered for the 1959 examination of the National Nursery Examination Board passed.

DIVISION 2, comprising the boroughs of Hampstead, Paddington, St. Marylebone, St. Pancras and the City of Westminster

Dr. H. L. Oldershaw reports:

Maternity and child welfare—A small decrease in the number of births, 8,113 against 8,401 in the previous year, is reflected in the work done in the maternity and child welfare centres.

Health visiting—The fall in the number of births and a continuing process of more selective visiting are factors in the reduction of home visits by 11,754 compared with 1958.

Home help—There was a reduction of 239 households assisted as compared with the previous year. Four-fifths of the service continues to be provided for the aged and chronic sick.

Day nurseries—An outstanding feature of the day nursery service has been the unusually high attendance rates. A special review in September showed that no less than 97 per cent. of the places available in the division were being taken up. Small variations in the numbers of approved places and the closure of a grant-aided part-time day nursery resulted in an overall reduction of approved places by 25 to 970. The number of children on the registers at the end of the year, 1,071 (including 70 children resident in neighbouring divisions), indicates the continuing need of the service at present levels.

City of Westminster Health Society—The grant-aided part-time day nursery mentioned in the foregoing paragraph was provided at Marsham Street, S.W.1, by the City of Westminster Health Society, which has a notable record of voluntary service for the improvement of health in Westminster since its formation in 1903. As the demand for nursery care in Westminster could be met by the two day nurseries provided by the Council in the locality, agreement was reached with the Society for the closure of their part-time day nursery. The Council's grant for the maternity and child welfare services provided by the Society continues, subject to review.

Prophylaxis—The inoculation of children against disease continues as an important and integral part of the activities of the child welfare and school health services.

The programme of poliomyelitis vaccination for the 1933 to 1942 groups and third injections, which began towards the end of 1958, continued with only modest results into the early months of 1959. This was transformed in April, when sudden public interest throughout the country produced a heavy increase in attendances. During the peak of this period people were receiving vaccination at the rate of about 8,600 a week at seven centres providing 'open' sessions, at special sessions for further education establishments and on the premises of industrial and commercial concerns. In one 2½-hour lunch-time session 1,959 persons attended the clinic temporarily established at the Caxton Hall, Westminster. Towards the end of the summer public interest in these 'open' clinics was upheld by various methods, including public address equipment which toured the neighbourhood of clinics whilst sessions were in progress. The year's work resulted in no less than 171,139 separate attendances at clinics arranged by the Council and general practitioners' surgeries.

Home nursing equipment—There has been a steady growth in the demand for home nursing equipment which includes commodes, hospital beds, foam rubber mattresses, wheelchairs and hoists and during the year 160 patients were supplied with 178 items.

Prevention of break-up of families—The divisional co-ordinating committee met nineteen times during the year under the chairmanship of Dr. M. T. Paterson, the deputy divisional medical officer, to discuss general policy affecting the work of official and statutory agencies in the area and to direct and co-ordinate casework. Fifty-three new families engaged the attention of the committee and reviews were undertaken of eleven others which had been before the committee previously.

Central syringe service—In co-operation with the Paddington Group Hospital Management Committee, a scheme was started as an experiment by which their central syringe service supplies syringes and needles for clinics in the division. The service provides for the delivery and collection of sterile needles and syringes in sealed containers. A fresh syringe and needle is used for each person.

DIVISION 3, comprising the boroughs of Finsbury, Holborn and Islington

Dr. W. G. Harding reports:

Diphtheria—In last year's report I referred to the detection of a number of carriers of *C. diphtheriae mitis* and of some mild cases in three schools in the division. In June, 1959 a positive throat swab was obtained in a boy who visited a local hospital on account of an injury and also complained of a sore throat. This boy attended Moreland school, one of the three schools involved in 1958. Further swabbing between June and September revealed sixty children at that school with positive throat and nose swabs. Almost all were admitted to hospital, a number of them with clinical involvement of throat or nose, or with a past history of this, but in view of the extremely mild clinical condition of most of the children in whom any signs appeared at all any rigid differentiation between 'cases' and 'carriers' on the old pattern appears impossible. It seemed likely that the infection had been kept smouldering by carriers with unhealthy throats and noses and also septic skins. Special attention was therefore focused in that school on the discovery of such children by daily visits by the school nursing sister and frequent visits by the medical staff.

In order to discover whether there was any widespread incidence of carriers in the schools, throat and nose swabs were taken in three classes each of two junior schools in the same district, but all produced negative findings. However, in October two children attending an infant school less than a mile away were found to have sore throats and the same organism was again isolated. Altogether eight children were found to carry the organism in this and another school which used the same premises. Shortly afterwards a positive throat swab was returned from a child with tonsillitis from another junior school and later in the year two further children from that school were found to carry this germ. In yet another junior school there was a similar incident affecting altogether 31 children, and there were isolated occurrences in five schools involving nine children, some of them family contacts of children affected in the earlier incidents.

Altogether 106 swab-positive school children were discovered in ten schools in the course of the year; no definite link could be established between the schools except in some of the last-mentioned sporadic incidents.

Following the reappearance of cases in Moreland school a procedure was agreed with the borough medical officers of health and the director of the Public Health laboratory service laboratory, designed to minimise the risk of infections gaining a foothold in the schools. This involved the swabbing of all children in the school (or school department), if, following the discovery of a positive swab, class swabbing revealed one or more further cases. Absentees and home contacts were followed up rigorously and on discharge from hospital—or in very rare instances from treatment at home—a further independent negative swabbing was required before exclusion from school was lifted.

Alongside these activities efforts were made to improve the immunisation state in the affected schools. Subject to parental consent, combined active and passive immunisation was given to unprotected children, and booster injections to all who had had a primary course but had not been protected during the previous 12 months. In several schools the immunity state had been regrettably low; thus in Moreland school only 31 per cent. in the infants and 44 per cent. in the junior department were fully protected in May. Thanks to the incident itself and to vigorous efforts made by the teaching staff and ourselves this had risen by November to 100 per cent. in both departments and similar results were obtained in other affected schools.

It is hoped to follow this up by an intensive campaign aimed to raise the immunisation state in the primary schools throughout the division by the autumn of 1960.

Poliomyelitis—The response of the public to three different incentives to accept vaccination against poliomyelitis was interesting. During the year the numbers of first injections given each week ranged from 113 to 3,079. The death of Jeff Hall, the footballer, was announced in the press on 6 April, when the weekly number of first injections was 269. During the next three weeks the number of adolescents seeking vaccination rose progressively, until in the week ended 25 April, 3,079 first injections were given in the Council's clinics, and in one lunch-time session 1,112 persons were injected in two hours. Thereafter the demand dropped and four weeks later only 693 first injections were given.

The second stimulus was a local poliomyelitis outbreak which occurred in some parts of Islington from early May to October and mainly affected school children. There were 63 confirmed cases; of these 56 were children below the age of 15 years, 47 of whom had not been immunised, 8 were children previously immunised with two primary and one also with a booster injection. One adult and four children died, none of whom had been immunised.

Joint press statements were issued by Dr. V. Freeman, Medical Officer of Health, Islington and myself in which the number of notified cases was given and the public urged to seek vaccination. The first Press statement was released on 2 June, 1959. The weekly number of first injections then was 800; for two weeks it rose to a peak of 1,458 during one week; thereafter there was a steady fall for 4 weeks until in the week ended 11 July only 540 persons sought protection notwithstanding the occurrence of further cases of poliomyelitis. The stimulus to obtain protection was effective in this instance for some six weeks, and thereafter the number of persons seeking first injections dropped to about 290 a week.

Following this local outbreak and with a view to raise the immunity state within the community, an intensive publicity campaign was started in mid-September—the third of the incentives mentioned above. 7,000 firms and organisations were approached in writing; 871 responded and 2,300 posters, 2,500 window and car stickers, 22,200 leaflets, 23,100 slips for wage packets were issued. There were advertisements in the local Press, cinemas played propaganda records and short films were shown. The results of the campaign were disappointing; the weekly number of persons seeking vaccination continued to waver around the 300 mark until the end of October, when the numbers dropped to about 135 first injections weekly and continued at that level up to the end of the year. Although this campaign did not produce the results hoped for it seems to have maintained the level of take-up for rather longer than in some parts of the county where no campaign was held.

A mobile immunisation clinic was designed in the division and constructed in the Supplies department, by converting an obsolete type of school bus. This is intended to be used primarily for vaccination of small groups of workers in factories and offices against poliomyelitis. It had been found impracticable to make *ad hoc* arrangements for vaccination for many of these small groups on constricted or otherwise unsuitable office or workshop premises. The mobile unit is also useful for immunisation and vaccination of small groups of school children. In order to underline its primary role as a means of taking vaccination against poliomyelitis to adults at work in industrial and commercial premises, the mobile

clinic was brought into use on 28 September with a ceremony held at the premises of Messrs. Cossors in Highbury. From the end of the year onwards the clinic was placed on a site adjoining the Arsenal Stadium on match Saturday afternoons, so that adolescents and young adults, whose attention was drawn to this facility in the club programmes and, at half-time, over the public address system, could obtain vaccination immediately on leaving the stadium.

Up to the end of the year the mobile immunisation clinic had carried out the following work:

Number of visits made to:

Factories and offices	42	Youth centres	6
Further education establishments and schools	15	Arsenal Stadium	5

Total number of injections given — 1,594

Premises—The Newington Green school treatment centre, which had been housed in a church hall, was closed and its activities transferred to the South Islington welfare centre, Clephane Road, where better accommodation could be provided for the service and the integration of the maternity and child welfare service and the school health service carried a step further.

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 were maintained and there was little change in the level of general medical and dental work.

In April an ante-natal clinic was established in co-operation with the Bearsted Memorial hospital, the Council providing a medical officer and the premises, while supervision is provided by the hospital's consultant obstetricians. The usual ante-natal facilities at the centre are available to these mothers. This is a noteworthy step towards the full co-operation in maternity services urged in the report of the Cranbrook Committee.

Extra accommodation was provided for the child guidance unit and a second educational psychologist was employed.

The pathological service available to general practitioners within a two mile radius from the health centre, suspended for eight months following the resignation of the technician, was resumed in October.

A mental health seminar was held in June. In the same month a local office of the Children's department was established in the health centre.

Prophylaxis—The marked increase in the number of persons given two injections against poliomyelitis was due partly to the extension of the inoculation scheme to persons born not earlier than 1933 and partly to public reaction following the death of a professional footballer. An intensive local publicity campaign was launched in September in conjunction with Division 3 but the response was small.

Co-operation with other organisations—Blood donor sessions were held at Woodberry Down and Shoreditch health centres. Co-operation with hospitals in the division, particularly in the inoculation against poliomyelitis of expectant mothers, has been very good. An information bulletin for distribution at quarterly intervals to all general practitioners offering services in the division was introduced early in 1959. Chiropody sessions for elderly persons are run by the Stoke Newington Old People's Welfare Committee at Woodberry Down health centre and at Barton House.

DIVISION 5, comprising the boroughs of Bethnal Green, Poplar, Stepney and the City of London

Dr. G. O. Mitchell reports:

Premises—The minor ailments sessions held at the St. Cecilia's school treatment centre, Commercial Road, E.1, ceased at the end of the Christmas term 1959 when the premises reverted to the voluntary committee. Sincere thanks are tendered to the St. Cecilia's Voluntary Committee for their enthusiastic co-operation for so many years. It is proposed to re-establish this school treatment centre early in 1960 in the adjacent Marion Richardson school.

Chiropody—From November, 1959 two additional chiropody sessions have been held each week.

Quadruplets—These children, arrangements for whose early home care were described last year, continued to make satisfactory progress, with a home help and a nursery nurse assisting the mother.

Prophylaxis—The poliomyelitis vaccination clinic at the Guildhall continued to attract large numbers of young people and attendances during April reached a peak of more than 1,300 a session on several occasions. Sessions were then being held four days weekly to meet the greatly increased demand.

The scheme launched in the autumn of 1958 for sending an inoculation team to City business houses continued with mounting activity throughout the early months of the year. It was followed by a large scale programme for the inoculation of school children, which with the active co-operation of the teaching staffs, was centred mainly on the schools. The numbers coming forward for first injections fell off appreciably during the autumn, allowing more freedom to deal with the peak period of third injections.

Considerable success attended these efforts to inoculate a substantial proportion of the young City workers; the results of similar efforts in the three East London boroughs, in spite of continued and well directed publicity and the setting up of evening clinics (which had to be abandoned after several weeks owing to lack of support), were disappointing.

Mothercraft and home-making—The class mentioned rather hopefully last year foundered in July, 1959 owing to lack of support. Hopes of inaugurating another such class in another part of the division have not been abandoned.

Health education—Increasing health education activities during the year led to a gratifying increase in numbers attending the sessions. A weekly evening mothercraft class has been held at the Wellington Way centre for over a year, and is well attended by expectant mothers who have booked at hospitals and who are out at work during the day. A number of husbands also attend with their wives. Talks to student nurses and medical students continued to be given, and there were occasional talks to outside bodies. The sisters from the London hospital asked to see something of the work of the local health authority and arrangements were made for two parties of approximately 40 each to spend an afternoon with the health visitors, school nursing sisters and at day nurseries; a new and encouraging sign of liaison.

Prevention of break-up of families—The divisional co-ordinating committee and its intermediate case conference met on 18 occasions during the year and dealt with 41 families, the services of specially trained home helps being supplied to seven families to assist the mother with budgeting, cooking and general household management. Successes are not spectacular, but are sufficiently encouraging to warrant continuing the efforts.

Home nursing equipment—During 1959, 128 items of equipment were loaned to 115 households. These included commodes, foam rubber mattresses, Penryn and other hoists, wheelchairs, etc. At the end of the year, 125 articles were still on loan to 103 households.

DIVISION 6, comprising the boroughs of Deptford, Greenwich and Woolwich

Dr. F. R. Waldron reports:

B.C.G. vaccination—Divisional arrangements for operating the scheme for the B.C.G. vaccination of 13-year-old schoolchildren throughout the school year were continued, and by the end of December 2,811 children had been dealt with. In February the scheme had been extended to training colleges and 444 students at five colleges in the division were dealt with in the course of the year.

Backward children—The special welfare clinic for mentally retarded children under five years of age, at which parents are able to discuss their particular difficulties with a doctor experienced in this field and that of maternity and child welfare, was continued. Attendance is by appointment and mothers have appreciated not only the opportunity of obtaining professional help and guidance but also of meeting other parents with similar problems.

Chiropody—As part of the interim expansion of the chiropody service throughout London seven additional weekly sessions were allocated to the division towards the end of the year. The additional sessions were distributed among centres serving localities where an unsatisfied demand for the service among persons in the priority classes was known to exist. Homebound elderly people and invalids continued to be conveyed to centres by ambulance.

In addition to the Council's services, some facilities are available through local voluntary organisations.

Home help—The demand for the home help service continued to have an upward trend in all areas of the division. Ten home helps attended special courses of training to fit them to assist mothers in household management, cooking and budgeting. These and other specially trained helps were employed with success in a number of households.

Useful meetings were held with representatives of all services inter-related with the home help service.

Health education—This is conducted as an integral part of the day to day activity of each welfare centre. Group discussions and demonstrations with film strips and other media were a regular feature of the programmes arranged at the larger centres. Much of the material used for health education purposes is produced by the health visitors who continued to show ingenuity and skill in this field.

Parentcraft classes for husbands were held for the fifth successive year at three welfare centres, one in each borough. These evening meetings, which were as popular and successful as before, were held on the same days as the afternoon courses on mothercraft and relaxation for expectant mothers.

Housewives' clubs—A second club sponsored by the Woolwich Council of Social Service, for Eltham housewives, was inaugurated in October and met weekly at New Market Green community centre, Eltham. The Divisional Health Committee authorised grants to assist towards the expenses of the new club and those of the existing Plumstead Housewives' club held weekly at the Garland Road welfare centre. The activities at both clubs include cookery, dress-making demonstrations, talks and films.

Prevention of break-up of families—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.

Of the 67 families discussed, many had been referred after intermediate case conferences held as required at convenient locations in the division. At these conferences 59 families were discussed and all departments of the Council and the majority of other statutory and voluntary agencies in the area took part 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 were concerned with 33 families during the year. The work in this field, especially that of the intensive case worker, calls for much patience, perseverance and understanding and great credit is due to the individual field workers who continue their task with energy and enthusiasm despite frequent setbacks.

Fireguards—Fifteen applications were met under the scheme for the loan of fireguards to necessitous elderly or handicapped persons, or householders with children under 12 years of age.

Voluntary workers—About nine voluntary workers assisted each week at various infant welfare sessions; I am most pleased to acknowledge their generous service.

DIVISION 7, comprising the boroughs of Camberwell and Lewisham

Dr. Ann Mower White reports:

Maternity and child welfare—New child welfare clinics have been established on the Bellingham and the Sydenham Hill Estates, both in new community centres serving self-contained neighbourhoods some distance from existing centres.

At most child welfare sessions routine weighing of each baby at each attendance has been discontinued in favour of more selective weighing. Discussion groups and demonstrations are favoured as a means of inducing mothers to attend consistently.

Day nurseries—Average daily attendances in day nurseries have increased and more use was made of them by the lone or deserted parent, the expectant or sick mother, and the family living in an adverse environment.

Home-making course—The home-making course for inexperienced mothers of actual or potential problem families is now held in a centre close to one of the Council's welfare homes and the health visitors who give the instruction at the centre are those who visit the families in the home.

Chiropody—The expansion for the county as a whole of the chiropody service for old people, expectant mothers and handicapped persons has resulted in an increase of 32 sessions in the division which are being allocated to meet the needs of various areas, having regard to the similar sessions provided by the local Old People's Welfare Associations.

Home help—Home helps selected to work with problem families have been given special training, whilst for the remaining home helps talks on the care of old people have been given by the local geriatric consultant and the borough Medical Officer of Health.

Health education—The usual wide range of subjects has been covered by talks at centres and by visits to schools, clubs and other community groups. As a special effort to bring home the dangers of smoking to adolescents, talks at which a film has been shown have been given by a medical officer at senior schools.

Special investigation clinics—There has been a marked increase in the number of children referred by school doctors—2,073 compared with 1,829 in 1958. This increase may be due partly to the withdrawal of the issue of cod-liver oil and malt and halibut oil capsules from the schools. The number of obese children referred for treatment was marked and the schools have been most helpful by arranging for them to have as little starchy food as possible.

Two additional weekly clinics were started and there are now seven special investigation clinics held each week. Each centre has an enuretic alarm apparatus. The popularity of these clinics is due to the fact that there is no time limit and doctor and parent can discuss the child's problems in a quiet atmosphere.

Diphtheria—There was an outbreak of diphtheria localised in the north-west corner of Camberwell occurring in mid-November. By the end of the year, five cases had been notified and 67 positive carriers found and treated. A large-scale exercise in preventive medicine was undertaken.

Immediately a case was notified to the borough council all contacts at home or at school were listed and arrangements made for them to be swabbed. Those found to be positive (i.e. carrying the organism) were referred to their general practitioner for admission to hospital. Those found to be negative (i.e. free from the organism) were followed up until regarded as 'clear', usually as the result of two negative swabs. In many instances, mainly with adults, follow-up and clearance was undertaken by the general practitioner. After discharge from hospital, each child returned to school only after a further negative swab result had been obtained. The first case, a girl aged 9, was admitted to hospital on 21 November. Her family were swabbed and found to be clear. Her class at St. Joseph's school was swabbed twice, on 23 and 25 November, and all pupils were clear. No further action was called for.

The other four cases were all pupils of St. George's primary school—a boy aged 5 admitted to hospital on 21 November and a girl aged 11, her brother aged 8, and a boy aged 5 admitted to hospital originally as carriers and subsequently notified from there as having developed diphtheria. Two of these children had been immunised, the last dates being in 1953 and 1954 respectively.

The home contacts of the diphtheria cases were swabbed and in due course were found to be clear. Commencing on 24 November all pupils at St. George's school, including absentees, were systematically swabbed. The first two visits yielded 25 carriers, including a teacher and a kitchen worker. The contacts of these carriers were then sought out for swabbing and clearance. A 'chain-reaction' was established and a further 15 carriers resulted. Children from St. Michael's, Brunswick Park and Gloucester Grove schools were involved, and their classes were duly swabbed. Special immunisation sessions were held at St. George's and St. Michael's schools for children found to be swab negative and there were increased attendances by adults and children at all the immunisation sessions at centres in the borough. This outbreak called for a concentration of effort by the Council's staff and close co-operation with other workers in the public health field. Daily association with the Borough Medical Officer of Health was maintained and family doctors were brought in as their patients were affected, either as cases or carriers, with excellent results. Frequent consultation took place with the county medical officer of health, the director of the bacteriological laboratory, and the heads of the schools concerned.

DIVISION 8, comprising the boroughs of Bermondsey, Lambeth and Southwark

Dr. W. H. S. Wallace reports:

Maternity and child welfare—Attendances at the maternity and child welfare clinics have been approximately the same as in 1958 and the birth rate has remained steady. Some re-arrangement of districts has made it possible to discontinue some smaller infant welfare sessions held in unsatisfactory premises. The sessions closed were at Crossway Mission and Bermondsey Gospel Mission.

Hospital beds for mothers whose homes are unsuitable for confinement have become much more readily obtainable, although some difficulty still remains. Lambeth hospital maternity unit has been particularly helpful in making provision for nearly all mothers in need of a hospital bed on social grounds.

Day nurseries—The demand for day nursery accommodation has continued to diminish. The average daily attendance at nurseries in the division during the year was 594, compared with 658 in 1958. The Coral Street nursery has been transferred from an old prefabricated building to a new permanent building only a short distance away and re-named 'The Coral Nursery.'

The Sutherland House play centre, situated near the new Brandon Estate, has continued to provide a most useful service and has been administered as an occasional crèche since April.

Prophylaxis—The work of inoculation of children against diseases from which protection can now be offered has been well maintained. Public response to wide publicity resulted in a substantial increase in the number receiving poliomyelitis vaccination.

To meet the great demand for inoculation during the summer months a special weekly session for young people was arranged during lunch time at the Royal Festival Hall, where 2,159 received two inoculations during July, August and September.

Hostel for tuberculous men—An extension to Knight's Hill House hostel for homeless infective tuberculous men was completed during the year and arrangements made for the provision of diversional therapy classes for the residents.

School health service—Both the health and the hygiene of the schoolchildren continue to improve. Whereas in 1939 seven full-time bathing centres were operating in the three boroughs, by 1959 only one part-time bathing centre was needed.

Attendances at minor ailment clinics have again decreased this year, the nature of the ailments treated becoming progressively more minor. As a result it has been possible to withdraw the care organiser from the one remaining session attended by organising staff last year.

Attendances at special investigation clinics, on the other hand, show a slight increase from 525 in 1958 to 600 in 1959; many of these children are suffering from minor behaviour difficulties. The attendance at the one hospital clinic (All Saints) confined solely to enuresis has dropped from 896 last year to 782.

It is now, fortunately, rare to find a really sick child through the school health service.

The new Elm Court school provides every facility for delicate children and has been particularly valuable for children with chest complaints.

Prevention of break-up of families—During the year 35 intermediate case conferences were held. All recommendations and results were reviewed at the co-ordinating committee's quarterly meetings. It was evident that inter-departmental co-operation was excellent, not least in those cases where family breakdown proved unavoidable.

The South London Family Service Unit has done valuable work in holding together 15 families, nine of them with a total of 48 children referred by the co-ordinating committee. On 30 December, 1959 the co-ordinating committee had a waiting list of five families for Family Service Unit service when staffing permits.

The mothercraft classes started at Sutherland House last year have been most successful, partly because the premises are in the centre of the section of the population served; the classes at North Brixton welfare centre, which is less favourably situated, had to be closed until more suitable premises can be found.

The special home help service has been well used and is undoubtedly of great value in these disorganised and socially sub-standard families.

In a large majority of the families rehoused following nomination by the co-ordinating committee definite social improvement has occurred, though regularity of rent paying has not always resulted.

Home safety—Health education to achieve a higher standard of safety in the home has been carried on by the health visitors. The need for fireguards in homes with children and old people has been particularly stressed. The scheme for the loan of fireguards to necessitous families has been very successful and 62 fireguards were provided during the year.

DIVISION 9, comprising the boroughs of Wandsworth and Battersea

Dr. J. T. R. Lewis reports:

Additional premises—In July the purpose-built William Harvey centre was opened on the Council's Ashburton Estate at Roehampton. It provides a full range of maternity, child welfare and school treatment services for some 6,000 persons in new housing developments in the area and about 11,000 others in older housing accommodation, and includes a B.C.G. clinic taken by the chest physician, Wandsworth chest clinic, for contacts of tuberculosis. The centre, although designed on traditional lines with rooms designated for a particular use, is well suited to cater for future development.

It is a curious fact that hitherto no hospital or clinic has borne the name of 'William Harvey.' There is, however, a special reason why this particular centre should be so named: during the last seven years of his life Harvey lived in a house in Roehampton not very far away and he died there on 3 June, 1657.

Day nurseries—By the selective adjustment of places the service has been kept in balance with the local need. At the end of the year there were nine day nurseries providing 388 places, and in addition a voluntary grant-aided nursery providing 49 places.

Vaccination against poliomyelitis—To meet the sudden increase in the demand in April for vaccination against poliomyelitis, especially from the 15–25 age group, teams comprising doctor, nurse and clerk visited the Locarno Ballroom, Streatham and other halls. In all, 924 young people were inoculated at dance halls. At one session alone, some of the young people had come from as far afield as Stoke Newington, Woolwich, Canvey Island and from Yorkshire.

B.C.G. vaccination—Skin tests, B.C.G. vaccinations and inspection of reactions have been carried out by teams of divisional staff. In addition to the annual quota of nearly four thousand schoolchildren, over a thousand students at further education establishments, municipal and voluntary, were dealt with.

Home help—This continued to grow, 216 more households receiving service at the end of December, 1959 than a year earlier.

Safety in the Home—In association with Battersea and Wandsworth Borough Councils, a 'Guard that Fire' exhibition was displayed for one week at Battersea Central Library and for another week at Earlsfield Library.

Statistical summary 1959—health divisions

Health division	1	2	3	4	5	6	7	8	9	Total	Health division	1	2	3	4	5	6	7	8	9	Total
Estimated population—mid 1959 ..	438,220	503,980	278,800	256,730	212,300	303,430	397,100	366,140	447,300	3,204,000	Foot clinics										
Births and associated mortality											Sessions	2,855	361	3,099	3,772	296	7,482	1,642	3,445	865	23,817
Live births	7,442	8,113	5,777	4,995	3,791	4,456	6,516	7,090	7,654	55,834	Total attendances	20,219	2,450	22,516	27,829	1,838	57,076	10,010	22,489	5,420	169,847
Rate per 1,000 population	17.0	16.1	20.7	19.5	17.9	14.7	16.4	19.4	17.1	17.4	Day nurseries										
Deaths under 1 month	134	130	82	75	57	61	106	116	109	870	Number of places	624	1,000	346	379	358	55	294	729	428	4,213
Rate per 1,000 live births	18.0	16.0	14.2	15.0	15.0	13.7	16.3	16.4	14.2	15.6	Total attendances	141,211	230,273	82,452	86,176	68,094	13,021	61,511	151,504	91,888	926,130
Deaths registered											Child minders										
All ages	5,284	7,136	3,163	2,939	2,587	3,784	4,642	4,140	6,239	39,914	Statutorily registered 31 Dec. ..	21	15	15	14	5	34	35	1	27	167
Rate per 1,000 population	12.1	14.2	11.3	11.4	12.2	12.5	11.7	11.3	13.9	12.5	Children minded	82	103	51	47	14	214	175	12	219	917
Health visiting											Voluntarily registered 31 Dec. ..	143	138	124	86	76	84	113	92	19	875
Effective visits	113,360	100,473	61,211	62,107	75,058	70,259	78,952	110,645	70,088	742,153	Children minded	188	158	142	94	90	95	139	109	24	1,039
Staff at 31 Dec. W/T equivalents ..	47	60	37	31	35	35	44	51	50	390	Home help										
Welfare Centres											Total households attended ..	4,532	4,672	2,653	4,233	2,992	3,202	5,103	4,484	4,235	36,056
Children—											Households attended per 1,000 population	10.3	9.3	9.5	16.5	14.1	10.6	12.9	12.1	9.5	11.3
Sessions	2,323	3,571	1,992	1,562	1,768	2,547	2,283	2,544	2,201	20,791	Home nursing										
Age 0-1—First attendances % of live births	84	91	91	88	85	96	93	85	89	89	Total visits	217,108	246,304	145,347	147,577	158,542	193,959	217,074	234,618	202,067	1,763,296
Total attendances	72,346	88,101	59,239	52,137	42,014	60,696	74,289	75,922	81,298	606,042	Visits per 1,000 population ..	495	489	523	575	747	639	547	641	452	550
Expectant mothers—											School health service										
Sessions	1,595	1,631	1,142	352	414	2,189	1,540	711	759	10,324	Medical inspection, routine, special, reinspection	37,188	29,450	27,320	19,244	30,981	34,654	37,990	28,183	41,880	286,890
First attendances	4,359	5,135	3,488	1,360	607	2,867	1,855	2,549	2,628	24,848	Health surveys	118,815	121,837	85,385	42,788	75,371	81,714	134,479	71,948	100,672	833,009
% of live and still-births	57.5	62.3	59.3	26.6	15.7	63.0	27.9	35.3	33.7	43.7	Hospital/specialist clinics—										
Total attendances	19,161	23,569	17,212	5,908	4,443	18,638	11,417	11,968	12,328	124,644	New cases	3,919	4,262	4,838	3,155	4,333	3,711	4,333	3,777	4,623	36,951
Prophylaxis											Total attendances	10,212	12,986	14,587	7,495	8,917	9,937	10,612	11,596	15,504	101,846
Polio myelitis—											Dental services										
Two injections											Schools—New cases	8,722	11,110	6,394	11,061	7,761	7,824	7,811	9,364	9,967	80,214
born 1953-59	9,223	9,162	8,977	7,422	6,038	7,119	9,107	9,952	9,962	76,962	New cases per 1,000 population age 5-14	188	249	184	316	253	177	132	188	158	196
born 1943-52	9,376	7,908	8,909	8,299	7,574	8,251	11,423	9,467	11,159	82,366	Attendances	31,789	35,875	20,830	33,839	25,145	24,266	26,440	32,849	33,576	264,609
born 1933-42	19,151	40,778	25,496	14,026	35,478	13,486	15,526	19,658	19,535	203,134	M. & CW—First treatment ..	710	810	365	1,377	401	393	361	529	282	5,228
Expectant mothers and others ..	2,863	7,916	2,651	3,907	3,711	2,879	2,711	5,515	2,728	34,881	Total attendances	4,146	3,428	3,666	5,168	1,523	1,525	841	1,866	1,023	23,186
Total	40,613	65,764	46,033	33,654	52,801	31,735	38,767	44,592	43,384	397,343											
Third injections	42,814	39,702	33,188	32,438	45,522	39,543	44,046	50,489	30,027	357,769											
Smallpox—Vaccination	4,869	4,813	3,519	3,704	1,985	2,822	4,220	3,983	5,083	34,998											
Re-vaccination	233	676	196	366	326	340	351	259	377	3,124											
Diphtheria—Primary course ..	6,488	6,515	4,064	3,879	3,920	3,644	5,120	5,624	5,995	45,249											
Reinforcing injection	4,906	4,500	3,489	3,888	2,989	2,580	3,500	5,579	2,125	33,556											
Whooping cough—Primary course ..	5,334	5,612	3,348	3,539	2,899	3,226	4,758	5,001	5,200	38,917											
Reinforcing injection	159	321	208	828	42	386	510	316	326	3,096											
Tetanus—Primary course	4,909	3,392	2,664	3,398	2,569	3,072	4,378	4,033	4,116	32,531											
Reinforcing injection	139	221	148	89	—	286	331	174	200	1,588											

APPENDIX A

SOCIAL WORKERS AND THE HEALTH VISITING SERVICE

The Report of the Working Party on Social Workers in the Local Authority and Welfare Services (The Younghusband Report), was published in 1959. The terms of reference were the proper field of work, training and recruitment of social workers at all levels in the local authorities' health and welfare services under the National Health Service and National Assistance Acts, and in particular whether there was a place for a general purpose social worker with an in-service training as a basic grade. Although the report was primarily concerned with the functions of social workers in the health and welfare services, the working party recognised that the work of other professional staff, such as doctors and health visitors, also had a social content and that other services such as those of the children's, education and housing departments, as well as those of voluntary agencies, also contributed social services which helped to resolve the personal problems of people who were unable to meet their difficulties without such help. If, therefore, social work was to be fully effective and the best use to be made of the resources available, there must be a broader and more flexible grouping of functions, which took account of the range of need of individuals or families with problems and of the fluctuations to which these needs are subject from time to time.

The range of need was broadly divided in the report into three categories:

- (i) people with straightforward or obvious needs who require material help, some simple service or a periodic visit;
- (ii) people with more complex problems who require systematic help from trained social workers; and
- (iii) people with problems of special difficulty requiring skilled help by professionally trained and experienced social workers.

It was recommended that the needs of individuals or families in these categories could be met by the appointment of social workers at three levels, all of whom must have had adequate training:

- (i) welfare assistants, with a short but systematically planned in-service training, to do the simpler and more straight-forward work under supervision;
- (ii) social workers with a common general training in social work to deal with the main range of the work; and
- (iii) professionally trained or experienced social workers to deal with the most difficult cases and to act as consultants and supervisors.

No precise pattern for the grouping of functions was laid down, for these must vary according to local circumstances; but five main fields of employment for social workers were distinguished in the health and welfare services, apart from the home help service:

- (i) mental health services;
- (ii) services for the care and after-care of the sick;
- (iii) social work with families, including homeless families, problem families and unmarried mothers;
- (iv) domiciliary and residential care of the elderly;
- (v) services for the handicapped, including blind, deaf and general classes of handicapped persons.

The working party regarded the home help service as complementary to the health and welfare services, and considered that social workers should be eligible for appointment as organisers or deputies, but that appointment as organiser need not necessarily be made from social workers.

These five main fields represent natural groupings which in the Council's services are already broadly covered by existing administrative arrangements. In this section of my report the deployment of social workers in the health services is considered, but each field must be regarded, not as a separate or self-contained service, but as one in which the public health department is mainly concerned. In social work with families, the welfare, children's, education and housing departments are all concerned and the work has to be closely co-ordinated interdepartmentally.

Functions of social workers

This Council was probably the first local authority in the country to employ trained social workers. The first appointments were made in 1908 in the education department to work with the voluntary workers of the children's care committees, which were then appointed to help with the implementation of the Education (Provision of Meals) Act, 1906; in 1917 the public health department appointed five trained social workers to organise the medical treatment and follow-up of children in the London schools. Approximately 190 social workers are now employed in the public health department; they include divisional treatment organisers, assistant organisers of children's care and social case-workers working under the supervision of a principal organiser of children's care at County Hall, organisers in the tuberculosis and mental deficiency services, social workers dealing with problems connected with venereal diseases, and psychiatric social workers in the school health and mental health services. Furthermore a number of social workers is employed by voluntary bodies which carry out work for and are financially assisted by the Council.

Mental health services—In my report for 1957 I gave a comprehensive account of the Council's mental health services. In that year the Royal Commission on the Law relating to Mental Illness and Mental Deficiency had issued its report, and many of its recommendations have now been implemented in the Mental Health Act, 1959. I reported then that the proposed pattern of services already existed in London.

In the field of mental deficiency, or subnormality as it is now termed, social workers have been employed ever since the Mental Deficiency Act, 1913 came into operation. Inquiries associated with the ascertainment of new cases were made by social workers employed by the Council. Supervision of defectives living in the community was undertaken by social workers of the London Association for Mental Welfare, until that organisation was taken over by the Council in 1931. Since then social case work for subnormal persons has been carried out by social workers based on four district officers, each under the control of a local organiser. A senior organiser who is on the central staff has exercised general supervision of this work and also, with part-time assistance, carried out the social work at the Council's residential hostel for mentally deficient girls in work, some of whom are under her guardianship. The duties of the social workers include inquiries necessary for the ascertainment of new cases, visits in connection with statutory and voluntary supervision, guardianship cases and those on licence from hospitals; they assess the urgency of cases awaiting admission to institutions and act as a link between home and the occupation (now training) centres. Most of the workers in this field possess a university social science qualification. These social workers work under the general direction of a principal medical officer, who is immediately responsible for all matters relating to mental subnormality. Special welfare clinics for backward children under five years of age have been held regularly in all divisions by medical officers experienced in both mental subnormality and child welfare, assisted by mental deficiency social workers and health visitors. There is a whole time organiser who exercises general supervision over the Council's nine junior occupation centres and twelve adult training centres.

The important role played by the social worker in the care and treatment of the mentally ill was early recognised by the Council, and psychiatric social workers were employed at the Maudsley hospital in 1929, and subsequently in the mental observation wards of the

Council's general hospitals and in the county mental hospitals. When the National Health Service Act, 1946 came into operation the community after-care services for the mentally ill in London were at first carried out by the National Association for Mental Health and the Mental After-Care Association; but in 1953 the service was undertaken directly by the Council. Five qualified psychiatric social workers, working under the general direction of a consultant psychiatrist, the Council's adviser in mental health, are employed in this work.

The work of taking the initial proceedings in providing care and treatment for persons suffering from mental illness is at present carried out by a separate group of mental welfare officers (duly authorised officers). These officers will be integrated into the divisional mental health teams under the proposed new arrangements. Unfortunately, there is no nationally organised course of training for persons undertaking these responsible duties. When these duties were first placed under the direction of the Medical Officer of Health in 1948 relieving officers with experience in the work were transferred to form the nucleus of the staff. Since then trained social workers, mental and general trained nurses, and others with suitable experience and character have been appointed to fill the vacancies that have arisen and in-service training has been given to new entrants.

Services for the care and after care of the sick—

Tuberculosis—The Council provides for the care of tuberculous patients after discharge from hospital and while they are being treated at home. The tuberculosis care organiser, who is a trained social worker, has the duty at each chest clinic to advise on the social needs of the tuberculous patient and his family. As a matter of course all new cases are referred to the care organiser, for so often social problems which may profoundly affect the course of the patient's illness may only reveal themselves with skilled and patient interviewing. Case discussions are also held regularly between chest physician, care organiser and tuberculosis health visitor. The tuberculosis care organiser maintains contact with many voluntary agencies, with the housing departments, National Assistance Board and other statutory organisations. The social care of residents at the Council's tuberculosis hostels is another of her duties. She acts as the secretary of the local tuberculosis care committee, which includes representatives of the metropolitan borough councils and other bodies interested in the welfare of tuberculous persons and their families.

Venereal diseases—Work in this field was initiated during the last war as a result of Defence Regulation 33b, which provided for compulsory treatment in certain circumstances. The Council employed a number of welfare officers whose duty it was to trace contacts, to ensure that they attended clinics for examination and treatment, and to follow-up cases who defaulted in attendance. Under the National Health Service Act, 1946 the venereal disease clinics became the responsibility of the hospital service and the policy now is to encourage patients to persuade the contacts to attend a clinic. If however a home visit is necessary for this purpose it is carried out by a social worker or an inspector employed by the Council. Not all hospital venereal disease clinics avail themselves of this service. Four social workers are employed on this work. Three undertake part-time duties in the hospital clinics and one worker, at the request of the Prison Commissioners, is attached full-time to Holloway Prison for women and undertakes the follow-up of prisoners on discharge.

Social work with families, including problem families and unmarried mothers—

Divisional co-ordinating committees, set up since 1952 under the chairmanship of divisional medical officers with the object of bringing together all interests and activities deployed to help families with difficult or intractable problems, have gained most valuable experience in the intervening years. In each division the divisional treatment organiser, an experienced and trained social worker, was appointed to act as secretary to the co-ordinating committee and this further strengthened the link between the social agencies in the area, both voluntary and statutory. Increasingly the children's, education, housing and welfare departments, as well as other statutory and voluntary agencies and individuals,

have referred families for consideration to these committees. Family and hospital doctors seek help with their cases and often give active support to the co-ordinating committee.

In 1956, I reported on an enquiry made in 1955 into the number of families in the county who required help on the lines suggested in Ministry of Health circular 27/54, which dealt with the prevention of break-up of families. An approximate estimate of the number and distribution of hard-core problem families was made. The survey revealed that there was good co-operation between the health visiting service and other statutory and voluntary bodies, but the distribution of problem families, who tend to be found in or drift to areas of poorer housing, had resulted in some health visitors bearing a disproportionate case-load.

There was considerable evidence that the health visitor was well placed to recognise the early stages of family breakdown and that her continued support of the family was essential when her special skills were needed to cope with health problems. On the other hand, it appeared wrong to divert the health visitor from her normal duties to carry out intensive time-consuming casework with these families. When four full-time and two part-time social workers were appointed on an experimental basis in 1957 to do family casework in some of the divisions, the divisional treatment organisers also acted as their consultants and supervisors.

Families are selected for this intensive casework by the divisional co-ordinating committees. Broadly the families fall into two main groups:

(a) those in which there is some inherent and permanent disability such as severe sub-normality, mental illness or low mentality which limits the extent to which the family is able to carry on without support ;

(b) those where it can be assumed that, given intensive support, the family will in time be enabled to become independent of the social caseworker, although still needing support from the ordinary social services.

Early in 1959 an attempt was made to assess the work of the social caseworkers. Clearly no exact method could be devised to measure its effectiveness, but the points system introduced for the 1955 survey was employed for periodic assessment of the families under review. It appeared that more than half the families referred to social caseworkers had shown some definite improvement.

This pilot scheme showed that selected social workers with sufficient time for intensive casework with these families could achieve encouraging results. Although the work was difficult and demanding, social workers attached to the public health department were able to tolerate the inevitable frustration and disappointment without undue strain. This was important, as the link with a family might have to extend over a period of years if lasting results were to be achieved. It was decided, therefore, to make the scheme permanent and to extend it by the appointment of further workers to bring the total staff up to fifteen in due course. By the end of the year there were eight full-time social workers and one part-time worker in five of the nine divisions. Moreover, five of the children's care organisers had been selected to do similar work on a part-time basis, working with two or three families and continuing their former duties for the rest of the time.

Unmarried mothers—Social work for unmarried mothers is carried out by five moral welfare associations which receive grants from the Council. The two Church of England associations employ between them 28 moral welfare workers to cover the county. The two Roman Catholic associations have four social workers but use the Council's health visiting service or sometimes moral welfare workers of Church of England associations to undertake visiting for them. The Jewish Board of Guardians employs two moral welfare workers.

Unmarried expectant mothers are referred to these associations by the National Council for the Unmarried Mother and her Child, by the public health, welfare and children's departments, by doctors and hospital almoners, clergy and church workers, voluntary organisations and members of the public. About 40 per cent. of the mothers are admitted to the fifteen voluntary mother and baby homes in the county.

Recruitment and training

Recruitment—The working party drew attention to the serious shortage of social workers of all kinds. Their proposals for recruitment included a national publicity campaign, emphasising the scope and challenge of a career in social work, as soon as a training programme has been well established. Training was considered essential for social workers of all levels. In the country as a whole, only a minority of social workers at present have a social work qualification and 89 per cent. of social workers in local authority health and welfare services have qualification neither in social science nor in professional social work.

Training—The working party recommended that there should be three types of training for the three levels of social workers:

(i) systematic in-service training for welfare assistants; this would include a planned introduction to the different aspects of local authority work, practical work with a small case-load and opportunities for discussion of cases, and talks on the special needs of the elderly and the handicapped; courses would be of six to eight weeks' duration.

(ii) a new general training outside the universities, for a National Certificate in Social Work:

(a) full-time study for two years (Parts I and II) for new recruits and some present officers.

(b) part-time study for two or three years by day-release on one or more days a week, with full-time residential or non-residential periods, and a lightened case-load—Part I; this course to be followed by full-time study for one year—Part II.

In addition, for a limited period of five years, it is proposed to award the full certificate to certain social workers at present without formal training, who successfully complete a full-time course of one year.

(iii) University social science course followed by a professional course of one year on the lines of those which at present exist for psychiatric social workers, almoners and generic caseworkers.

Furthermore, the working party recommended that a National Council for Social Work Training should be set up as a representative body to sponsor and promote training. This body, although responsible for recognising courses for the national qualification, would not itself provide the general training courses. These, it was suggested, would be arranged at a national training centre or staff college which might be set up for the purpose. It is clear that local authorities will be expected to take an active part in the provision of field training.

The Council, while it welcomes these proposals in the main, questions the need to establish a staff college. Once the National Council for Social Work Training has propounded a syllabus, the London further education service could make an effective contribution to the speedy initial organisation of courses for the national certificate.

In the health and welfare services of the Council there is a higher percentage of trained social workers than that given in the Report for the country as a whole. The percentage of social workers without formal training in London was at the end of June, 1959:

Welfare department 78; public health department 49 (mental health 53, problem families 33, care and after care 42).

In spite of this comparatively favourable position, major difficulties will need to be overcome. The new concept, which shifts the responsibility and emphasis from the hospital care of the mentally ill and the severely subnormal to community care, which is the theme of the new Mental Health Act, will require a rapid expansion of social worker services. Already, while this report is being written, a date by which local authorities must produce schemes has been fixed by the Minister. Moreover a substantial number of social workers, both trained and untrained, must be expected to retire from the various sections of the

public health department during the next ten years and they will have to be replaced (table (ii)). We must look to the recruitment and training arrangements proposed in the Younghusband Report to provide new recruits, who it is hoped will in the main be social workers envisaged as of the middle tier. Some of the new recruits, however, must of necessity be untrained. This very difficulty was faced during the recent expansion of the social caseworker service for problem families, when some of the newly appointed workers were trained social workers already in the Council's services, and others came from the health visiting service, while a few had had no formal training, but were persons with suitable experience and aptitudes.

Although the working party envisaged that new recruits to the services will ultimately all be trained before appointment or will enter as welfare assistants and go on later to take a full-time course for the national certificate, it is optimistic to expect that this position will be reached in London within seven years. We have to make up a back-log of training for a large number of workers already in the service who have had no formal training, and provide training for new recruits who must be employed to keep pace with the rapidly expanding services. This must involve a considerable sacrifice of work time to permit the day release of workers for the two to three year part-time courses which will allow them to enter for Part I national certificate, as well as release of a few to take the full-time one year emergency course for the full certificate. In addition, substitutes must be provided for these workers. Because of these difficulties the Council intends to concentrate on a programme for releasing workers for full-time courses for Part II.

We must also ensure that a sufficient number of social workers who have a social science diploma and who are already in the service, or may be recruited to the service, will receive a further professional training which will qualify them for promotion to senior consultant and advisory posts as they become vacant. Unless this is done the time may come when new recruits, who enter the service at the professional level, may be dissatisfied if they have to work under senior workers without this qualification.

Over the next ten years in the public health department, if these priorities are given, possibly some twelve social workers may have to be released for professional courses and probably at least twenty for either part-time Part I courses or full-time emergency courses.

Career structure—The working party stressed the need for career prospects for men and women in social work, with an adequate proportion of senior posts especially in the mental health services. Table (i) shows that in the Council's health and welfare services such a career structure, which offers scope for promotion, already broadly exists. The whole structure of social work in the public health department is now coming under review to ascertain what place, if any, there may be for welfare assistants, and whether the supervisory and consultant service should be expanded and strengthened.

Future trends

Mental health—The comprehensive programme for the development of community care services for the mentally ill and the severely subnormal in London will necessitate considerable changes in the existing organisation of the services. Already plans are being formulated for the delegation of day to day responsibility for mental health services to divisional health committees, which are now responsible for most of the personal health services, although special types of service will of necessity remain on a county basis. Under such a scheme a mental health social worker team will be set up in each division, under the immediate direction of a divisional mental welfare officer responsible to the divisional medical officer. A principal mental welfare officer will be appointed to the central staff at County Hall to supervise and co-ordinate all mental health social work.

In-service training of social workers is likely to be extended and some staff will be selected for further training in general and advanced courses.

In my report for 1957 reference was made to the link with the hospital service which had already been established at the Bexley and Cane Hill hospitals, and to the intention to try to extend this to other distant mental hospitals which serve London. There have as yet been no formal arrangements through joint committees with the hospital and general practitioner services, but preliminary meetings have established a general understanding of the lines along which it is hoped to develop liaison between all three branches of the health service. As hospital schemes for the provision of day hospitals are gradually extended, consideration will be given by the Council to provision of the services of psychiatric social workers and occupational therapists at these hospitals.

Relationship with the health visiting service—In some spheres of public health, such as the tuberculosis service, the social worker/health visitor relationship has long been firmly established. Although the functions of the tuberculosis care organiser and the health visitor are not clearly demarcated and at times inevitably must overlap, recognition of the place of each in a common service to the tuberculous patient and his family is understood and accepted by social worker and health visitor alike.

In other spheres (such as the mental health service, which has been almost exclusively the province of the social worker) new relationships must be developed. Already, through the case conference groups set up since 1954, psychiatric social workers and health visitors meet regularly for discussions, and consultants in child psychiatry now call with confidence for reports from visitors who have been members of such a group. The health visitor is frequently the first to know of the subnormal baby in a family and therefore introduce the mental welfare worker into the home, or bring mother and baby to the special clinic where she and the mental welfare officer meet. The school nurse must be increasingly alive to the ill effects on young children which may arise from the presence in the home of a mentally ill parent. Both health visitor and school nurse must be alert to detect early signs, such as behaviour disturbances in children, which might indicate a failure of adjustment of the parent or mental cruelty to the child. In such a case she would discuss the situation with the psychiatric social worker or mental welfare officer. It is likely that the changes in organisation proposed in the mental health services in London will provide further scope for integration.

The health visiting service is not of course directly concerned in the control of venereal disease and takes no part in London in tracing contacts of these diseases, except in those cases where the patient, as an expectant mother, is already visited by the health visitor. In April, 1959 the Minister informed local authorities of his concern at the increasing incidence of gonorrhoea and reference was made in Circular 6/59 to the value of publicity and health education. The health visitor may be called upon in London to give talks on venereal diseases to mothercraft classes and parent associations. Opportunities can be taken to answer questions on this subject in discussion groups on sex education in schools. It must be remembered too that with the cessation of National Service in the near future, a valuable opportunity for health education of young men may be lost and ways should be found to fill this gap.

The social worker has not been introduced into the general field of public health in London during the last few years in order to replace the health visitor, who is and must remain the key figure in the care of mothers and children, but to give a complementary service. It is the health visitor who is best placed to recognise the medical and social needs of the families and to initiate action when necessary. No single worker or single service can however take over all aspects of the more difficult problem family, for personnel from both statutory and voluntary services may necessarily be involved. One of the functions of the co-ordinating committees is to prevent avoidable overlapping in such cases and, when a family requires extra help for their profound social need, to bring in a social worker to give support to the family and to relieve the health visitor of some of her burden.

It is clear that in London in the public health field the foundations for partnership between health visitors and social workers have already been laid and that we can look forward to the future with confidence.

TABLE (i)—Chart to show how the Council's establishment of social workers falls within the main fields and levels indicated by the Younghusband working party

MAIN FIELDS	HEALTH AND WELFARE SERVICES COVERED BY THE WORKING PARTY'S TERMS OF REFERENCE											OTHER SERVICES					
	Social work with families			Services for elderly		Services for the handicapped		Care and after care of the sick		Mental health services			Children's department	Children's care organisation		Housing management	School inquiry
Existing specialisations	(a) Problem families	(b) Homeless	(c) Unmarried mothers	(a) Admitting	(b) Large homes	(a) Blind	(b) Others	(a) T.B.	(b) V.D.	(a) Certification and removal	(b) Mental deficiency	(c) Care and after-care	9 ACWO (I)	(a) P.H.	(b) E.Os.		
ASSNT. LEVEL				(16) Social worker general assistant (I)													
MAIN OPERATIONAL LEVEL(S)	15 SCW (III)	44 WO (II)	34 WO (II)	18 (15) WO (II)	7 WO (II)	49 (39) HV (II)	33 (30) HV (II)	24 LO (II+)	3 WO (II+)	7 AMWO (III)	28 ALO (II)	4 PSW*	145 CWO (III) 28 CWO/SD (III)	58 AO (II)	35 AO (II)	28 HWO (II)	181 SIO (II)
		DSWO (III)				2 APO (II)	3 LO (III)				3 LO (III)	4 SALO (III)		SPSW*	21 SAO (III) 4 CCW/SD (III)	18 SIO/SD (III)	
CONSULTANT AND SUPERVISORY LEVELS	9 [DTO (IV)] *	SWO (IV)					SO (IV)			18 MWO (IV)	4 LO (IV)		35 SCWO (IV) 9 ACO (V+) 4 Inspector (VI)	9 DTO (IV) APO (IV)	10 DO (IV)		
										SMWO (V)					SO (V)		
	* See under Child care organisation WO=Welfare officer SCW=Social caseworker DSWO=Deputy superintendent and superintendent, welfare office for the homeless SWO }			WO=Welfare officer		HV=Home visitor LO=Local organiser, services for the blind and other handicapped APO=Assistant placement officer PO=Placement officer PTO=Pastimes organiser SO=Senior organiser services for the blind, etc.		LO=Local T.B. care organiser WO=Welfare officer		AMWO=Asst. mental welfare officer MWO=Mental welfare officer SMWO=Senior mental welfare officer ALO=Assistant local organiser mental health services SALO=Senior assistant local organiser mental health services LO=Local organiser mental health services SO=Senior organiser mental health services PSW=Psychiatric social worker SPSW=Senior psychiatric social worker		ACWO=Asst. child welfare officer CWO=Child welfare officer CWO/SD=Child welfare officer special duties SCWO=Senior child welfare officer ACO=Area children's officer	AO=Asst. organiser of children's care work SAO=Senior asst. organiser of children's care work CCW/SD=Children's careworker special duties DTO=Divisional treatment organiser DO=District organiser of children's care work APO=Assistant principal organiser of children's care work PO=Principal organiser of children's care work		HWO=Housing welfare officer	SIO=School inquiry officer SIO/SD=School inquiry officer special duties	

(Roman numerals indicate gradings within the Council's social worker grading scheme).
* Whitley grades.

TABLE (ii)—*The Council's social workers—Actual numbers (mid 1959) in the various training categories suggested in the Younghusband Report*

	Present numbers	Over 50 or with 15 or more years' experience	Over 40 or with more than 5 years' experience		Under 40 and with less than 5 years' experience		Possible recruitment in next 10 years to meet	
			(a) With Social Science qualification	(b) Without Social Science qualification	(a) With Social Science qualification	(b) Without Social Science qualification	(a) Wastage	(b) Expansion
HEALTH AND WELFARE SERVICES								
WELFARE DEPARTMENT								
Blind, handicapped, elderly homeless families, unmarried mothers	114	50	10	16	15	23	100	90
PUBLIC HEALTH DEPARTMENT								
Mental health services ...	60	14	17	14	11	4	100	50
Problem families	6	1	3	1	1	—	10	34
Care and after-care ...	26	10	10	—	5	1	30	10
OTHER SERVICES								
CHILDREN'S DEPARTMENT	193	36	62	34	49	12	238	40
CHILDREN'S CARE ORGANISATION								
Public Health department ...	62	13	24	2	22	1	100	—
Education Officer's department	69	11	29	5	19	5	94	4
HOUSING MANAGEMENT DEPARTMENT	27	6	5	11	1	4	30	50
SCHOOL INQUIRY ...	195	53	4	118	—	20	125	—

APPENDIX B

PSYCHOLOGICAL SERVICES FOR CHILDREN IN LONDON— FROM BURT TO UNDERWOOD

I—Introduction

The year 1959, which saw the Mental Health Act and Ministry of Health and Ministry of Education Circulars implementing recommendations of the 'Underwood Committee,' affords an opportunity to review the growth and development of aspects of the mental health services for children which were not covered by the article on 'The ascertainment, care, education and training of educable mentally handicapped children' in my report for 1958.

Psychology, in the widest sense of the term, now extends to a number of fields in which the Council has an interest. These may be classed broadly as child guidance services; special educational provision; school psychological service; advisory services to juvenile courts, residential establishments and the maternity and child welfare service. Whilst most of the developments are of recent growth, the beginnings can now be clearly seen to have occurred nearly forty years ago.

II—Child guidance services

(a) *Early beginnings*—As an organised movement, and in the particular sense that the words are now used, child guidance was introduced into this country in the mid-twenties, mainly through the generosity of the Commonwealth Fund of America. The Child Guidance Council was established in 1927 as the central voluntary organisation 'to encourage the provision of skilled treatment of children showing behaviour disturbances and early symptoms of disorder'. This body approached the London County Council to obtain its support for the establishment in London of a child guidance clinic of the kind widely established in the United States of America and Canada. As a result two officers of the Council were included in a group of social and other workers which visited America, at the expense of the Commonwealth Fund, to report on the methods followed there.

In 1928, after consideration of the reports of the team which had visited America, the London County Council accepted the offer of the Child Guidance Council to open a clinic in London:

- (a) for the investigation of difficult, maladjusted or delinquent children;
- (b) to treat symptoms so as to prevent further trouble;
- and (c) to establish harmony between the child and his environment, home life, school and play.

An important part of the reports of the visiting team had been concerned with staff training, and four assistant organisers of children's care work spent a year in America, again at the expense of the Commonwealth Fund of America, in order to take a course of training as psychiatric social workers.

The London Child Guidance Clinic was opened in 1929 at Canonbury with Dr. William Moodie as medical director. (It is now called the London Child Guidance Training Centre.) One of the assistant organisers who had taken the course of training in America was appointed chief psychiatric social worker. A course in mental welfare was arranged at the London School of Economics for the training of psychiatric social workers, the London Clinic being used for demonstration and practice. Four of the Council's organisers of children's care work were sent on this course. The whole expense of these developments was borne by the Commonwealth Fund, which continued to finance the movement on a generous, but gradually diminishing scale, until the outbreak of war in 1939.

(b) *Work done at the London Child Guidance Clinic, 1930-1931*—The following quotation from the report of the clinic on its activities up to 31 March, 1931, gives a picture of the type of work carried out in the early days of the child guidance movement in London:

"The total number of children referred during the period was 582, of whom 323 were attending London County Council schools. The remaining 259 comprised a group of pre-school children ; children who had left school ; children from private schools in London ; and children from areas outside London.

"The following analysis refers to the 323 children attending L.C.C. schools. 143 were referred through the office of the School Medical Officer ; 6 direct by the school doctor ; 34 direct to the Clinic by teachers ; 7 direct to the Clinic by Care Committee workers ; and 64 were referred by parents.

"A larger proportion of the problems arose in the home life of the child, and not in the school . . .

"In boys the largest numbers were referred at the age of six, eight, and thirteen. In the case of girls, there was a small group at six, a large group at ten, and a large group at thirteen.

"The problems for which cases were referred were, in order of incidence : backwardness, stealing, lying, being unmanageable, temper, nervousness, stammering. . .

"Only children do not form the majority of cases, their number being greatly exceeded by those who are one of a family of two. But from two upwards the bigger the family the less the incidence of behaviour difficulties.

"In about one third of the cases the family was incomplete one or both parents being absent . . .

"Serious physical conditions were only infrequently discovered . . . Less than three per cent of the children were discovered to be mentally abnormal, and to require direct treatment. About one-fourth of the children were found to have an academic difficulty.

"It has been necessary in an extremely small proportion of cases to place the children away from home, but this has been done only with the consent of the parents . . . The principle of the Clinic is so to work that the child shall, if possible, remain at home during treatment.

"A considerable number of patients have been sent for a short period of convalescence to improve physical health, or to tide over times of stress in the home.

"The Medical Director attends all the sessions of the Islington Juvenile Court, and examines any child referred to him by the Bench. It has been found possible to arrange for the referral of numerous Court cases for Clinic treatment—frequently with beneficial results".

(c) *Developments up to 1939*—Gradually a number of child guidance clinics were started both in hospitals and by voluntary organisations, but, following a directive from the Board of Education issued in 1933, no financial grants were made by the Council as local education authority, although payment was made to the London Clinic for the psychological examination of children and young persons in the remand home and for the supply of special reports required by juvenile courts. This work had previously been carried out by the Council's own psychologist, Sir Cyril Burt, who had been appointed on a part-time basis in 1913 and had not been replaced when he resigned in 1932.

In 1936 the Council reviewed the child guidance movement, and had regard particularly to the work of the various clinics at which attendance was officially 'recognised' for the purposes of school attendance.

The following quotation from the Education Committee report clearly illustrates the view then taken :

"We have given careful consideration to the question of the value of the work done by child guidance clinics.

"We understand that it is claimed that 45 per cent of the cases referred to the London Child Guidance Clinic for treatment were dealt with successfully, i.e., the symptoms complained of cleared up and the patient's mental state became as good as it was ever likely to be.

"We are of opinion that, in a limited number of cases, a great deal of good is done by the special methods of investigation and treatment known as child guidance. Among the 45 per cent claimed as successes we think, however, that there are undoubtedly instances where an accurate diagnosis of the root of the trouble could have been reached without the elaborate technique of child guidance. We think, however, that for carefully selected cases child guidance is a useful and beneficial part of a school medical service. In certain cases, child guidance treatment given in time may often prevent the appearance of a child in a juvenile court'.

As a result of this review a grant for one year of £400 was made to the London Clinic in recognition of its services, and because it was proposed to terminate the arrangements for the remand home work upon the appointment of the Council's own medico-psychologist for this work.

In the years 1937, 1938, and 1939 the grant of £400 to the London Clinic was continued, and small grants—£50 and £100—were made to five other clinics. These grants, which bore no relation to the costs of treatment, could not be regarded as anything more than tokens of the Council's formal recognition of the clinics as school treatment centres.

It will be apparent that whilst the Council co-operated with the Child Guidance Council from the inception of the movement, its policy up to 1939 had been marked by extreme caution. Child guidance had been imported with very little modification from America, and it was questioned whether its range and technique fitted in as well as in some parts of that country with the other provisions for children which had already been made here, both by local authorities and voluntary bodies.

(d) *References for child guidance in 1938*—As an illustration of the numbers and types of cases which were referred officially by the Council for child guidance before the war, the following table gives an analysis of the reasons for which children were referred to clinics during 1938 :

Behaviour difficulties	..	..	230	Speech difficulties	..	..	56
Nervousness	..	..	190	Temper tantrums	..	..	45
Backwardness	..	..	156	Truancy	..	..	37
Stealing	..	..	127	Sex difficulties	..	..	49
Enuresis	..	..	113	Fits	..	..	35
Night terrors and fears	..	..	61	Other reasons	..	..	90
Intelligence testing	..	..	58				
				Total	..	..	1,247

It is noteworthy that the backwardness and stealing that headed the list in 1931 have been replaced by behaviour difficulties and nervousness. The very wide range of difficulties with which the pre-war clinics concerned themselves is also reflected. Many of these cases would, today, be dealt with in other ways.

(e) *The 'Feversham' Report*—As early as 1934 the Child Guidance Council and the National Council for Mental Hygiene had agreed to explore the possibility of a closer co-ordination between the various bodies engaged in voluntary mental health work. In the event, with the help of the Commonwealth Fund, a joint committee of five of the principal societies was founded under the lay chairmanship of Lord Feversham. This Committee undertook to review the provisions of mental health services and to make suggestions for eventually bringing together all the voluntary services concerned in the United Kingdom. The Committee issued a comprehensive and valuable report in 1939, in which a scheme was formulated for the amalgamation of the principal voluntary societies.

They remarked that at first the child guidance clinics had dealt with every type of behaviour difficulty in children. This they attributed to the aptness generally of the supporters of any new school of therapeutics to be overenthusiastic, and particularly to take too seriously every minor abnormality in a child's reactions. There was a danger lest incursion into the normal provinces of the teacher and the family doctor might bring the child guidance movement into disrepute, and they called attention to the difficulty of estimating the results of child guidance methods so long as clinics dealt with children who were fundamentally normal.

These views led the Committee to the concept of a more careful selection of cases referred for child guidance treatment, which would probably encourage teachers and others to bring to notice children who had presented problems of abnormality in behaviour or educability. Some of these cases would merely constitute problems of simple training or discipline and the kind of guidance required for these cases was, in the opinion of the Feversham Committee, part and parcel of the education system, and a matter for an educational psychologist. The Committee recommended that every local education authority should, when possible, appoint a psychologist to advise them on their educational

programme, to examine and advise on the treatment of backward children and those presenting difficult problems of behaviour and education, and to refer suitable cases to a child guidance clinic for further advice and treatment.

(f) *Divisional case conferences*—Arising out of a review carried out in 1943 which took cognisance of the 'Feversham' recommendations the Council decided to set up in each education division a small standing conference, colloquially known as the 'problem' case conference.

Each conference meets at regular intervals, either fortnightly or monthly. It consists of the District Inspector of Schools, who acts as chairman, the Divisional (Education) Officer, the Divisional Medical Officer, and the District Organiser of Children's Care Work, who acts as secretary. Others who may attend, either regularly or for specific cases, are psychiatrists, educational psychologists, representatives of voluntary care committees etc., while headteachers are welcomed for discussion on children from their schools. Teachers of children who present problems from the educational or behaviour angle and others are free to seek the help of the conference, whether or not medical considerations appear to be involved. The need of children for special schooling may be in question, whilst others may have difficulties in their homes.

The conferences have the advantage of working as a team—the foundation underlying so much child guidance work—and the fact that the secretary is the District Organiser of Children's Care, who is responsible for the general organisation of social work for pupils and their parents ensures the proper co-ordination of all aspects of case-work carried out by the education authority.

Some twenty years ago, when most of the school medical treatment under the Education Act of 1921 was done by voluntary bodies, who were paid only nominal sums by the Council, the relatively high cost of child guidance led inevitably to the concept of 'screening' and pre-selection of cases, in order to ensure that no problems were referred to clinics which could be solved in other ways and thus to reduce the cost to the Council. These considerations are no longer overriding, but the work done by the conferences, apart from selection of cases for referral to clinics, is of such value and is so welcomed by teachers, amongst others, that the system continues to operate successfully in London.

Table (i) shows how the work of the 'problem' case conferences increased from their inception in April, 1944 to a peak about five years ago, since when the number of new cases dealt with has averaged rather more than 1,800 a year and that, allowing for cases 'kept on the books', there are about 3,800 children, less than one per cent of the total school roll, being dealt with in a year.

The conferences have disposed of the cases brought to their notice in four main ways—reference to child guidance clinics ; to me for medical action ; to the education officer for 'educational action' such as reference to an educational psychologist, change of school, special remedial class, enforcement of attendance, etc., and for 'other action' such as reference to a moral welfare agency, dealt with by juvenile court, received into care, etc.

The major method of disposal has been the reference to a child guidance clinic and the steadily increasing percentage of the cases so disposed of, from only 50 per cent in the early years to 80 per cent in the later years, has been shown in the table. The need in the earlier years for such a 'screening' procedure is apparent and the figures illustrate how over the years the referring sources have themselves, by a better appreciation of what child guidance can do, become more selective. Nevertheless the value of the conferences should not be measured by this alone and, as has been said earlier, they continue because they serve a useful function in the wider educational organisation.

TABLE (i)—Summary of divisional case conferences 1944–1959

			NEW CASES Referred by			Totals	Cases from previous years	Total cases dealt with	Percentage of school population	Percentage of new cases referred to C.G.C.
			Council services	C.G.C.	Other sources					
1944–45..	..	..	289	111	79	479	N.A.	N.A.	N.A.	51·1
1945–46..	..	..	471	185	166	822	N.A.	N.A.	N.A.	54·5
1946–47..	..	..	850	429	302	1,581	772	2,353	·66	62·0
1947–48..	..	..	761	314	307	1,382	1,051	2,433	·67	73·0
1948–49..	..	..	854	328	384	1,566	973	2,539	·68	70·7
1949–50..	..	..	843	441	274	1,558	1,306	2,864	·78	65·9
1950–51..	..	..	790	501	228	1,519	1,662	3,181	·83	73·1
1951–52..	..	..	987	574	249	1,810	1,699	3,509	·87	76·4
1952–53..	..	..	997	523	288	1,808	1,888	3,696	·88	77·2
1953–54..	..	..	1,078	609	256	1,943	1,898	3,841	·89	81·4
1954–55..	..	..	1,031	488	244	1,763	2,134	3,897	·89	80·3
1955–56..	..	..	1,045	449	302	1,796	1,842	3,638	·83	73·3
1956–57..	..	..	1,066	483	257	1,808	1,994	3,802	·86	76·2
1957–58..	..	..	1,116	485	212	1,813	1,997	3,810	·87	77·8
1959–60*	..	..	1,269	496	214	1,979	1,986	3,965	·91	76·1

* Biennial return.

(g) *Education Act, 1944*—The major changes introduced by the Education Act, 1944, inasmuch as they concerned maladjusted children, are mentioned in part III. In 1945, however, the Association of Education Committees appointed a committee 'to consider and report upon the full content of the psychological functions of local education authorities in association with the discharge of their statutory duties . . .' This committee, in a lengthy report, expressed the view that the child guidance clinic should be replaced by a child guidance service incorporating a psychological service, all of which should be a part of the education service, and that its organisation should rest with the educational psychologist.

The Council did not accept this view, and did not consider that the circumstances in London and the position reached since 1929 called for the considerable re-orientation advocated.

(h) *Developments from 1945 to 1948*—Whereas up to as late as 1945 the Council was still proceeding cautiously in the field of child guidance, by 1948 the picture had changed completely. Payments to clinics were progressively raised; the position of educational psychologist, vacant since 1932, was filled; the establishment of Council child guidance clinics and centres was authorised; and in 1948 the Council took over full administrative and financial responsibility for one voluntary clinic and opened a part-time clinic in a school treatment centre.

(i) *National Health Service Act, 1946 and Circular 179 of 4 August, 1948*—Ministry of Education circular 179, which dealt with the overall relationship between the pre-existing school health service of free medical treatment and the newly formed national health service, and which broadly allocated 'specialist' work to the N.H.S. and 'non-specialist' work to the school treatment service, attempted to apply this concept of divided responsibility to child guidance.

Paragraph 18 of the circular was as follows :

"Child guidance work of the type at present undertaken by local education authorities is in the main an educational service closely linked with the school and home. Thus the needs of most of the children who are maladjusted, whether to a degree which calls for their ascertainment as handicapped pupils or to a lesser degree, can be met by social and educational adjustments. Much of the work is carried out at the schools in co-operation with the parents and teachers by the educational psychologists and specially qualified social workers appointed by the (local education) authorities. The educational, physical and psychiatric aspects of the work are, however, inseparable and at the child guidance centres established by (local education) authorities the team of workers includes a psychiatrist and also, as a rule, a pædiatrist. Some of the children may be found to need psychiatric treatment; the Minister (of Education) in agreement with the Minister of Health, considers that these children should normally be referred by the (local education) authority to the clinics which will be provided in due course by the regional hospital boards and which in some instances are already available; similarly these clinics will refer appropriate cases to the child guidance centres".

This attempt to distinguish between 'clinics' and 'centres' (which was not withdrawn until circular 347 was issued in 1959) led to protracted negotiations over the next few years, which cannot but have hampered development.

In 1948 the Council took the view that the main difficulty lies in deciding at what point a child was in need of psychiatric treatment as opposed to social and educational adjustment and that it was questionable whether it was good for a child under investigation or treatment to be transferred from one team of workers to another after initial investigation or during the course of his or her treatment.

Independently, in the same year, my predecessor headed a deputation to the Ministry of Education from the School Health Group of the Society of Medical Officers of Health, stated the objections to the separation of child guidance work into diagnosis and treatment and its division between the hospital and the local education authority and said that it would be preferable to do the work of both child guidance 'centres' and 'clinics' in *ad-hoc* 'units' administered by the local education authority.

However, as already stated, it was nearly twelve years before circular 347 withdrew the official directive, quoted above, given in circular 179.

At a meeting with the senior administrative medical officers of the metropolitan regional hospital boards in November, 1948, there was general agreement that it was undesirable and uneconomic for parallel 'centres' and 'clinics' to be established, the one by the education authority and the other by the hospitals. The same staff should work in the same building and be responsible for both diagnosis and treatment.

In January, 1949 the position was further discussed with the regional psychiatrists of the hospital boards. General agreement was reached that 'clinics' should not be separated from 'centres'; it would be too complicated to work out, for allocation of costs, how much time was spent on diagnosis and how much on treatment and that as an alternative the psychiatrists should be appointed and paid by the regional boards; the psychologists and the psychiatric social workers should be appointed and remain on the staff of the education authorities; the premises should be provided and maintained by the regional boards, if they were in hospitals; or by the education authority, if they were in *ad hoc* premises.

(j) *Developments 1950-1958*—In 1950 the Council's two clinics were removed to new premises and became the Earls Court and Battersea units.

The first entirely new unit to be provided by the Council after the inception of the national health service was opened at Brixton in 1951. The organisation of this unit is unique since the medical director has been seconded by the Institute of Psychiatry (Maudsley Hospital) and is assisted by a senior registrar plus five to seven registrars pursuing studies in child psychiatry who work at the unit for six months at a time. Experience has shown that the stimulus of working with a post-graduate teaching hospital—and the need to train more child psychiatrists—has more than outweighed any disadvantages arising from changes of staff.

A fourth child guidance unit was opened at Woodberry Down health centre in 1952, and the fifth at Peckham early in 1958.

(k) *Work done at the Council's units 1952-1959*—A quantitative account of the activities of the five Council units is given in tables (ii) to (v).

Table (ii) shows the number of new patients treated each year; it should perhaps be mentioned that on average about 14 per cent of the so-called 'new patients' had a record of previous attendance at the same or another child guidance unit.

The remaining tables analyse the patients 'discharged' (except for five who left school). Tables (iii) and (iv) show respectively the types of problem and service given; both complicated by the fact that an individual often comes under more than one heading. About half the children had two or more problems, behaviour being the most common, similarly two or more types of service were given in many cases and whilst individual child therapy was most common, case work with parents was not far behind. Table (v) shows the reasons for closure and the distressingly high proportion of cases in which attendance ceased before completion or treatment was refused.

TABLE (ii)—*Number of new patients treated 1952–1959*

<i>Unit*</i>	1952	1953	1954	1955	1956	1957	1958	1959
Battersea	68	58	47	58	54	60	69	79
Brixton	199	187	159	136	141	141	147	212
Earls Court	97	96	95	73	59	53	81	128
Peckham	—	—	—	—	—	—	70	70
Woodberry Down ..	9	46	91	156	117	133	165	148
All units	373	387	392	423	371	387	532	637

*Brixton opened October, 1951. Peckham opened, February, 1958. Woodberry Down opened October, 1952.

TABLE (iii)—*Problem of patients 'discharged' 1952–1959*
(the number of times each type of problem was mentioned)

<i>Type of problem*</i>	1952		1953		1954		1955		1956		1957		1958		1959	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Nervous	91	35.7	133	36.5	169	43.3	182	48.1	221	54.4	174	45.4	188	44.8	246	50.0
Intellectual	57	22.4	68	18.7	74	19.0	77	20.4	99	24.4	91	23.8	96	22.9	122	24.8
Behaviour	166	65.1	249	68.4	233	59.7	225	59.5	254	62.6	254	66.3	276	65.7	337	68.5
Psycho-somatic ..	60	23.5	64	17.6	68	17.4	91	24.1	88	21.7	85	22.2	88	21.0	99	20.1
Other	9	3.5	9	2.5	10	2.6	6	1.6	10	2.5	19	5.0	19	4.5	16	3.3
	383		523		554		581		672		623		667		820	

* Many children had multiple problems.

TABLE (iv)—*Service given to patients 'discharged' 1952-1959*
(including service given, where necessary, to parents)

Service given*	1952		1953		1954		1955		1956		1957		1958		1959	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Diagnosis only ..	85	33.3	90	24.7	135	34.6	110	29.1	131	32.3	142	37.1	155	36.9	179	36.4
Supervision only—child	26	10.2	40	11.0	39	10.0	59	15.6	64	15.6	43	11.2	57	13.6	90	18.3
Supervision only—parent	†		†		†		†		†		†		51	12.1	27	5.5
Child therapy—group	6	2.4	18	4.9	9	2.3	7	1.9	9	2.2	28	7.3	14	3.3	14	2.8
Child therapy—individual	137	53.7	202	55.5	198	50.8	194	51.3	189	46.5	164	42.8	192	45.7	178	36.2
Child therapy—educational.. ..	14	5.5	25	6.9	23	5.9	19	5.0	19	4.7	24	6.3	21	5.0	35	7.1
Casework with parent	Not recorded		63	17.3	101	25.9	124	32.8	105	25.9	124	32.4	178	42.4	222	45.1
	268		438		505		513		517		525		668		745	

* More than one type of service was given in many cases.

† First recorded in 1958. No details available for earlier years.

TABLE (v)—*'Discharges'—Reasons for closure 1952-1959*

Reason for closure	1952		1953		1954		1955		1956		1957		1958		1959	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Service complete ..	109	42.7	168	46.2	175	44.9	152	40.2	173	42.7	174	45.4	165	39.4	208	42.4
Transferred to other treatment	30	11.8	41	11.3	36	9.2	23	6.1	24	5.9	20	5.2	30	7.1	28	5.7
Placed as maladjusted or placing recommended	3	1.2	13	3.5	24	6.2	12	3.2	26	6.4	29	7.5	45	10.7	46	9.3
Received into care ..			3	0.8	2	0.5	7	1.9	5	1.2	6	1.6	9	2.1	12	2.4
Further attendance impossible	28	11.0	44	12.1	48	12.3	44	11.6	41	10.1	42	11.0	36	8.6	46	9.3
Ceased attendance before completion	77	30.2	95	26.1	105	26.9	140	37.0	137	33.7	68	17.8	95	22.6	116	23.6
Treatment refused ..											44	11.5	40	9.5	36	7.3
Not known	8	3.1	—		—		—		—		—		—		—	
Total children ..	255		364		390		378		406		383		420		492	

(l) *Progress in London in relation to national development since 1948*—Tables (ii) to (v) relate only to the five units maintained by the Council, while the figures given in table (i) of references for treatment by the problem case conferences, do not include cases referred direct to hospital clinics by family doctors, parents, etc. It is impossible to give a picture of the total child guidance activity in London, since no separate hospital statistics are available for London residents only.

The Ministry of Education reports, however, give the number of clinics provided by local education authorities, and the number of cases known to have been treated. This latter figure will include some, but not all, of the cases treated in hospital clinics, as well as those treated in education premises :

Year					Clinics	Cases Treated
1949	..	..	..	..	153	21,149
1950	..	..	..	..	162	22,379
1951	..	..	..	..	185	25,123
1952	..	..	..	..	202	26,859
1953	..	..	..	..	202	28,458
1954	..	..	..	..	204	29,889
1955	..	..	..	..	211	30,994
1956	..	..	..	..	220	31,067
1957	..	..	..	..	229	32,010
1958	..	..	..	..	236	34,594
1959	..	..	..	..	253	36,281

Since the London school roll is about one-fifteenth of the national school roll, a proportionate scaling down of the above figures would lead to an expected figure of something over 2,000 cases treated a year in London for each of the past few years. Over the same period the conferences have referred some 1,400 new cases a year for treatment, and when allowance is made for direct referrals to hospital and also the cases carried forward at the beginning of each year, it is clear that the number of cases treated in London must be of the same order as the 2,000 which would be expected from the national figures, i.e. the suggestion is that the statistical data support the view that London is no worse off than the country as a whole in the facilities available for child guidance.

(m) *Report of the Committee on Maladjusted Children ('Underwood')*—The report of the Underwood Committee, which had been appointed in 1950, was published in 1955 although another four years were to elapse before ministerial circulars were issued implementing certain of the Committee's recommendations. (The membership of the Committee included the Headmaster of Bredinghurst, one of the Council's boarding schools for the maladjusted; the Council submitted written evidence, and oral evidence was given by officers of both the Education and Public Health departments.)

The terms of reference of the Committee were : ' To enquire into and report upon the medical, educational and social problems relating to maladjusted children with reference to their treatment within the educational system '. The report dealt comprehensively with the whole field of child guidance, special education, after-care, training of staff, and future planning. References will be found, where appropriate in subsequent paragraphs of this review.

So far as child guidance services are concerned, the report recommended that the troublesome paragraph 18 of circular 179, should be withdrawn and that :

" The pattern of provision most likely to lead to an effective and well integrated child guidance service is for the local education authority to provide the clinic and to employ the educational psychologists and psychiatric social workers, and for the regional hospital board to provide and pay for the psychiatrist "

This is the pattern which had been adopted in London, by agreement between the Council and the metropolitan regional hospital boards.

The Minister of Education, in circular 347, withdrew circular 179, accepted the pattern advocated by the Underwood Committee for the organisation of child guidance clinics and asked local education authorities to consult with hospital authorities and to furnish a progress report by June, 1960.

Consequently the Council has reviewed the provision of child guidance facilities in London and formulated provisional plans for future development, which were still under discussion with the boards at the end of 1959.

(n) *Summary of present provision in London*—The main emphasis in the foregoing account has, necessarily, been concerned with the activities of the Council. However, over the past thirty years child guidance facilities have been introduced at many of the teaching hospitals in London, and a number of special establishments have been developed. In 1948 most of the latter were incorporated in the national health service, with the regional hospital boards accepting responsibility. A few clinics remain independent, being run on a voluntary basis, with assistance from the regional boards, in specific cases, on a contractual basis.

It is not easy to give a complete picture of the aggregate facilities available to London children, since not in all cases does a 'clinic' provide the full team facilities which are the essential framework of child guidance; some of the 'clinics' listed in directories consist merely of an out-patient psychiatric clinic once a week. With this proviso there were at the end of 1959 some 30 child guidance clinics in London; half of these were provided by teaching hospitals; one-third by the regional hospital boards; and the remainder by the Council, together with a few independent clinics.

III.—Special educational treatment

(a) *Early beginnings*—From the earliest days of the child guidance movement it was clear that the solution to some children's problems lie purely in the educational sphere. The report of the London Clinic for the period ended 31 March, 1931 (quotations from which have been given earlier) also contained the following reference:

"In cases where an educational difficulty is present, the educational advisers of the Clinic are often able to point out its cause, and to indicate necessary modifications of the school curriculum. Coaching is also given, but only with the assent of the teacher. A speech training class is held twice a week for the treatment of stammer and other speech defects".

This same report also referred to the placement of some children away from home, so that thirty years ago we have a picture of the child guidance clinic itself, *faute de mieux*, engaging in special educational action.

(b) *Review of 1943*—The review carried out in London following upon the report of the Feversham Committee, which led to the setting up of the problem case conferences, still accepted the view that the Council should not use boarding placement for maladjusted children, as the following quotation shows:

"Under the Evacuation Scheme many hostels have been opened by local billeting authorities for 'difficult' children, sometimes designated 'maladjusted'. There have been a few cases of evacuated London children who have been admitted to voluntary schools for maladjusted children at the instigation of the local authority of the reception area . . .

While we believe that many unstable and troublesome children would be improved if not cured by going to boarding schools run by capable and understanding teachers, we have grave doubts whether the bringing together of several 'maladjusted' children in the same small school or hostel does not defeat its object. The experience of one headmaster who has conducted an efficient and happy boarding school under the Evacuation Scheme is that he can cope successfully with superficially bad boys so long as they do not exceed about ten per cent of the roll.

We do not think there is any occasion for the Council to change its policy not to agree generally to sending children as a matter of medical treatment to voluntary schools or hostels set up solely for maladjusted children.

Until such times as the Council may be given new powers to provide boarding schools for children who are not destitute or not delinquent or not physically or mentally defective we think the Council might express their willingness to co-operate with any parent who finds his child beyond control for reasons of temperament by accepting the care of that child under the Children and Young Persons Act, 1933".

This quotation is of great interest as it indicates how boarding placement in schools or hostels had been developed as a solution to the 'problems' of evacuees ; and also in that it foreshadowed powers which were to come under the Education Act, 1944.

(c) *Effect on developments of the problem case conferences*—The problem case conferences played an important part in the early days in putting forward recommendations to the Education Committee for the provision of new services for the maladjusted child. The conferences' first annual report, for the year 1944/45, contained the following suggestions :

(i) there is a need for good foster-homes and residential schools for children with behaviour difficulties caused by maladjustment to home surroundings ;

(ii) special classes for dull and backward children are required, and also facilities for giving special coaching to individual children retarded through long absence from school.

Similarly the conferences' annual report for 1946/47 recommended :

(i) more residential accommodation in the form of hostels or foster-homes is urgently required for maladjusted children to obviate delay in placing the children ;

(ii) more boarding accommodation (not grammar) is required for children with unsuitable home conditions ;

(iii) backward children recommended for child guidance treatment should have at least one term in a special class or special coaching before such treatment is begun, and

(iv) a residential unit should be established for observation of difficult cases and to which children can also be sent for a change of environment.

The first day special classes for maladjusted pupils were set up in division 5 in June, 1944, on the direct initiative of the local 'problem' case conference.

In 1946 the division 8 conference, concerned about the influence of the parental factor in some cases, invited representatives of care workers, N.S.P.C.C., child guidance, teachers, housing managers, etc., to discuss the problem of contact with the non co-operative parent.

These examples are illustrative of the point already made that the value of the case conference procedure extended far beyond its function of a 'screening' device for selecting children for treatment in clinics.

(d) *Education Act, 1944*—

(i) A fundamental step forward in the attitude towards the treatment of the maladjusted child came with the Education Act, 1944, one of the basic principles of which is that every child is to be educated in accordance with his age, ability and aptitude. Some children require special educational treatment either in ordinary or in special schools because they suffer from disabilities of body or mind including emotional or psychological troubles, and the Regulations issued under the Act included 'maladjusted' as one of the several categories of pupils for whom special educational treatment was to be provided. All subsequent developments derive from powers conferred on local education authorities under this Act.

(ii) In 1946 the Ministry of Education issued Pamphlet No. 5 entitled 'Special Educational Treatment', which was

"intended for the guidance of local education authorities and teachers in the discharge of a difficult and important duty, which has the dual claim of succour to the afflicted and practical value to the community".

This pamphlet was an important and stimulating document and, in its paragraphs dealing with the maladjusted child, gives a clear indication of the several ways in which special education could be provided. It discussed remedial teaching, day special schools, boarding out, boarding homes and boarding schools, as well as action taken by the teachers of the child's own school, or transfer of the child from his own school to another, all of which are methods which have been subject to development in the ensuing years.

(e) *Summary of subsequent developments*—In the period immediately after the inception of the Act of 1944 the only facilities available for maladjusted children, apart from treatment at a clinic, were the few special classes initiated by the 'problem' conferences, or boarding placement in voluntary schools or hostels. In 1947 there were five special classes, each taking six or seven pupils at a time, and some 80–90 pupils were placed in non-Council establishments.

The following years have seen a development along the lines indicated in Pamphlet No. 5, but the programme of expansion has necessarily been dependent upon factors such as difficulties of securing suitable premises, shortage of suitably qualified staff, and governmental financial limitations.

At all times the facilities available have lagged behind the number of recommendations received from the child guidance clinics and the 'problem' case conferences, so that there have always been a number of pupils, formally ascertained as maladjusted, who have been awaiting placement. Because of the shortage of directly provided accommodation the Council has been obliged to make use of voluntary and independent establishments scattered all over the country. The number of such establishments used, which was about 70 in 1950, grew to over 90 in 1952 and is now about 100. The widespread location of pupils in this way raises considerable problems of supervision and inspection for the Education Officer's department.

By 1959 there was 22 day special classes, eight boarding schools and three day special schools, whilst about 500 pupils were placed in non-Council establishments. These services are discussed in greater detail below.

(f) *Day special classes*—The first day special class in London and, for that matter, in the country was started in June, 1944 and the following extract from the annual report for 1944/45 of the 'problem' case conference for division 5 tells the story :

"The London Hospital approached us in June, asking if there were any facilities for helping children whose behaviour problems were aggravated by their backwardness in school. Mrs. Davids, one of our infants' headmistresses . . . , expressed her interest in this work and a large room was found for her . . . She quickly obtained toys and educational apparatus, and took over some of the children from the London hospital, and some others who had been referred to us".

Mrs. Davids wrote at the time a detailed report on her work, of which the following extracts are of special interest in that they indicate clearly how from the very start of the scheme the concept was along lines which are still followed :

"The children recommended for inclusion in this scheme lack determination and have poor powers of concentration ; are inhibited and react markedly to the influence of their environment, . . . in their classroom they lose interest in their work if they are unable to maintain the standard of attainment of their class-mates. They have a sense of inferiority and try to conceal the extent of retardation. In any emergency they become inhibited . . . Hence, when submitting to a mental test they rarely show their actual ability . . .

The child's backwardness is often a result of unfavourable environment, e.g., repression at home, loss of parents, shelter dwelling, unsavoury association with bad companions, neglect, mental shock, scolding, over-anxious parents . . .

Aims—to diagnose the cause of backwardness and treat by coaching, free play, or relaxation, in order that the child may, if possible, be enabled to return to his normal class in school. That he may feel that he *belongs* to his school and can take a really useful part in the running of that school.

Each child attending the centre has to put in at least six sessions weekly in his own school—he attends the centre for a maximum of four sessions weekly, and stress is laid on the fact that he is an active member of his *own* school"

Table (vii) on page 153 shows how the number of children attending these classes has grown over the years, as the provision has been increased to a total of 22 classes by the end of 1959.

(g) *Day special schools*—The first day special school for the maladjusted in London was opened in 1954. One of the reasons which led to the provision of a day school in addition to the classes was that teachers of the classes had sometimes expressed a wish

that individual children should come to classes for a greater proportion of their sessions ; in addition it was desired to provide for some children whose behaviour difficulties made it necessary for them to be completely detached from their ordinary schools, though they did not need to leave home for a boarding school.

Originally it was thought that the children would be attending local child guidance clinics which would be responsible for psychiatric supervision. In fact some children were not attending clinics and, in contrast to children attending the Council's own child guidance units, there was little or no home visiting from non-Council clinics. It was therefore decided in 1955 to attach a part-time psychiatric social worker to the school to undertake this necessary work.

It was also found that some of the pupils who were not receiving clinic treatment raised a problem which could only be solved by the teachers attempting the role of therapists, to the detriment of their educational duties—a few children having to be given a disproportionate amount of class time. A part-time psychotherapist was therefore appointed to the school and she took up her duties at the beginning of 1959. At the same time the frequency of psychiatrist's visits was increased, one a month, to one a week.

A second day school for the maladjusted was opened in 1956 and a third in 1958, but so far the purely psychiatric services at these newer schools have not developed so extensively.

(h) *Boarding special schools*—Boarding placement for maladjusted children has been the practice for many years, with the Council making, and still continuing to make, considerable use of voluntary and independent establishments, as the data in table (vii), page 153, shows. The Council's first directly maintained boarding school, Bredinghurst, was opened in 1948. Regular visits by a psychiatrist began early in 1949 and later that year a psychotherapist was appointed, whilst a psychiatric social worker was added to the team in 1950.

Another boarding school was opened in 1950, two in 1951, one in 1953, two in 1954, and an eighth in 1957 ; two of the schools are in the metropolitan area, and the other six are all outside the county, in converted country houses with large grounds.

These schools are also hostels, in that pupils who make reasonable educational progress go out to local day schools as a step towards their eventual 'complete personal, social and educational readjustment'.

(i) *Placing of maladjusted children in boarding establishments*—In placing a maladjusted child in a boarding school or home the following general points have to be taken into account :

- (i) age and sex.
- (ii) level of intelligence and attainment.
- (iii) type of maladjustment, e.g., whether aggressive, difficult and out of control or withdrawn, inhibited and depressed.
- (iv) social background, family relationships, whether parents (if any) will co-operate.
- (v) religion.
- (vi) problems in school (not always present).
- (vii) whether psychiatric treatment is required.

The placing of each child is considered individually to ensure that the child is placed in a school best suited to his or her needs. The Ministry of Education require that wherever possible a child should be placed in a boarding *special* school or home approved by the Ministry for the special educational treatment of maladjusted pupils. There are, however, insufficient places available in establishments recognised by the Ministry, and considerable use has to be made of independent schools and homes. For certain types of children, such as the disturbed grammar school child and the pre-psychotic, placing in an independent school may be more appropriate.

In addition to the eight Council boarding special schools, which provide 312 places for boys and girls of all ages and which cater for most types of maladjustment, there were approximately 100 non-Council schools and homes in use for the placing of London maladjusted children in 1959. The numbers so placed in December, 1959 were as follows :

<i>Type of establishment</i>	<i>No. of establishments</i>	<i>No. of children</i>
Voluntary boarding special schools recognised by the Ministry	11	72
Voluntary boarding homes recognised by the Ministry ..	3	13
Boarding schools maintained by other L.E.As.	2	7
Boarding homes maintained by other L.E.As.	4	4
Independent boarding schools	65	329
Independent boarding homes	14	65
Foster homes	2	2
	101	492

Some factors associated with maladjustment add to the problem of placing. Examples are :

- (i) borderline E.S.N./maladjusted children.
- (ii) the adolescent girl with sex problems.
- (iii) the adolescent boy who is aggressive, out of control.
- (iv) children who need psychiatric treatment—as so few schools have facilities for treatment.
- (v) children who soil persistently.
- (vi) psychotic children—very few schools will even consider psychotic children.

The time taken to find a vacancy for a maladjusted child varies considerably. A child not at the top of the waiting list often has to be given priority for reasons such as exclusion or threat of exclusion from day school, persistent truancing from day school or intolerable home circumstances. There is usually a hard core of about six to ten boys for whom vacancies are difficult to obtain and where placement is delayed in consequence : these boys are generally in the 13–15 year old age group, very backward and of low intelligence and with poor social backgrounds—many of them have strong delinquent tendencies and have been involved in court proceedings. An added complication is often that of epilepsy ; other factors which may cause delay in making suitable placements are persistent soiling, diurnal enuresis, and psychotic symptoms. With regard to girls, the demand is much smaller, and apart from the occasional cases where sexual misdemeanours have taken place the difficulties in obtaining suitable placements are more easily overcome.

One of the Council's boarding special schools, Anerley school, is used as a short-stay assessment centre where maladjusted boys and girls go for a period of investigation and/or treatment. The children admitted to Anerley are generally those about whom little information is available at the time of ascertainment to guide the selection of boarding school.

After a short stay at Anerley, a recommendation is made as to the type of boarding school or hostel most suitable for permanent placement. In some cases, after a short stay at the school, the children are able to return home.

(j) *Hospital placements*—There is one particular group of severely disturbed children who may find their way to schools for the maladjusted, but who are no better placed there than in any other school. These children, some of whom are psychotic, are few but each one creates a large problem for his family, his medical attendants, the hospital and local authorities. The children cannot be educated in schools and there are only very few hospital units where they can receive the treatment that they need, and which will enable some of them to return to school or to employment. Hospital treatment is often prolonged, so

that it is difficult to free hospital beds. The National Association for Mental Health set up a committee to investigate the nature of this problem, the metropolitan regional hospital boards have made increased provision and the children's and adolescent departments of the Maudsley-Bethlem hospital makes a special contribution ; nevertheless, when such a boy or girl is received in a school or one of the Children's Officers' establishments it is often exceedingly difficult to find any hospital to receive the child, who has sometimes to be placed more or less permanently in a ward for adults in a mental hospital.

Another small group difficult to place correctly in their education setting is that of those children who have sustained a permanent brain damage, whether as the result of encephalitis or meningitis in early life or of injury. The bizarre and unpredictable behaviour, the occurrence of major epilepsy, the normal intelligence with defects of spatial or sensory perception and crossed laterality, make it difficult for them to be accepted in a school for the physically handicapped, for example, while the less rigid more loosely structured organization of a school for the maladjusted is in no better position to help them.

Unfortunately, as the toll of infectious diseases declines the number of accidents tends, if anything, to rise, and it would seem that experiments in the education of these children, who share some of their problems with the children with cerebral palsy, would be justified.

(k) *The 'Underwood' Report 1955*—The report of the 'Underwood' Committee on Maladjusted Children contained nothing which called for reorientation in the Council's policies towards the special educational treatment of maladjusted children. On the contrary, London's unique system of special classes was commended for general adoption throughout the country. In Circular 348 of 10 March, 1959 the Minister of Education asked local education authorities to consider the provision of day schools and classes ; to arrange for boarding schools to specialise in pupils ; to send children out from boarding schools to local day schools ; all of which had been the Council's practice over the past years.

(l) *Growth of special educational provision 1951-59*—Tables (vi) and (vii) give a numerical picture of the development of special educational provision for the maladjusted in London over the past decade.

Table (vi) gives the annual numbers of formal ascertainments under section 34 of the Education Act, 1944 of pupils requiring treatment as maladjusted, and illustrates how there has been a steady growth in the numbers dealt with, despite some inexplicable year to year fluctuations. In particular this table shows the increasing proportion of pupils put forward for placement at day schools or classes, as opposed to residential placement.

Table (vii) shows the numbers of pupils actually in receipt of special education on stated dates, analysed according to the type of school attended ; it also shows numbers on the waiting lists on the given dates, thus demonstrating the point that the facilities available have always fallen short of the recommendations received, and that the demand for day placement has outgrown the provision available, whilst at the same time, extra boarding provision has reduced the waiting lists for residential placements.

TABLE (vi)—*New ascertainments as maladjusted 1948-1959*

Year	Recommended for		Total ascertainments	Percentage 'Day'
	Day placement	Boarding placement		
1950	103	254	357	29
1951	144	293	437	33
1952	140	191	331	42
1953	75	263	338	22
1954	158	218	376	42
1955	121	169	290	42
1956	107	205	312	34
1957	147	255	402	37
1958	201	278	479	42
1959	250	269	519	48

TABLE (vii)—*Provision of special education for maladjusted pupils 1951–1959*

Date		Pupils in day special schools	Pupils attending day special classes	Pupils in Council boarding schools	Non-Council boarding schools, hostels, foster homes, etc.	Waiting lists	
						Day schools classes	Boarding schools
1951 ..	September ..	First day school opened in 1954	178	93	369	24	165
1952 ..	October ..		235	140	355	49	103
1953 ..	October ..		209	140	409	44	101
1954 ..	September ..	27	239	209	334	40	111
1955 ..	September ..	48	284	208	288	43	92
1956 ..	September ..	28	290	211	277	63	109
1957 ..	September ..	74	311	237	333	103	75
1958 ..	September ..	104	275	266	417	77	82
1959 ..	September ..	127	302	249	501	112	67

(m) *Future developments*—During 1959 plans were formulated for the opening of another boarding school, two more day schools and a further tutorial class ; together with the first directly administered hostel, from which children would attend local schools.

At the same time plans were being made, under the provisions of the Mental Health Act, 1959, for ensuring that school-leavers from maladjusted schools received any necessary community care, including residential accommodation, if required.

IV.—School psychological service

(a) *Early history*—In 1913 the London County Council “ took the unprecedented step of appointing a (half-time) psychologist, Mr. (later Sir) Cyril Burt ”. The initial appointment was for a period of three years, and after a subsequent extension was made permanent in 1919. According to the reports of the Underwood Committee it was not until 1932 that another school psychologist was appointed, by Leicester. By an odd coincidence it was also in 1932 that Burt resigned his Council appointment.

In the preface to the second edition of his ‘ Mental and Scholastic Tests ’, dated 1946, Sir Cyril has given the following account of the early days :

“ The appointment in 1913 of a psychologist to work in the Education Department of the L.C.C. was the first of its kind ; and the duties had therefore largely to be defined by the psychologist himself in the light of his own growing experience. My formal instructions were to ‘ assist teachers by developing means both for the examination or ascertainment, and for the education or training, of various types of children needing special provision or attention.’ This referred primarily to the study of sub-normal pupils (the mentally deficient, the dull and backward, the delinquent, and the nervous), but was also intended to cover the super-normal (i.e. children suitable for transfer to secondary schools, trade schools, art schools, central schools, and the like, on the ground of higher or specialized ability) and particularly the junior county scholarship examination. In the case of both sub-normal and super-normal the problem was envisaged as one of detection and training rather than of diagnosis and treatment ; that is, it was expressly considered to be a task for an educational psychologist rather than for a school medical officer or psychiatrist. That view, indeed, was shared in those days by the majority of medical officers themselves, who were still a little sceptical about the feasibility of introducing what would nowadays be called child guidance. The social aspects of the work proved to be of great importance ; the medical aspect, though not to be neglected, of less significance. For inquiries in these directions the Council’s psychologist was able to rely on the generous aid of the school doctors and social workers (care committee visitors) as well as on that of teachers and voluntary assistants. His office thus developed into the earliest official child guidance centre in this country ; and a special tribute of thanks is due to the Education Officer, Sir Robert Blair, and to the Chief Inspector, Dr. C. W. Kimmins, for their early and effective support of such a scheme.”

(b) *Burt's 'Memoranda'*—During the first decade of his work for the Council, Sir Cyril Burt wrote a series of reports to the Education Committee in the form of 'Memoranda' dealing with a wide range of fundamental aspects of educational psychology. Most of these reports were considered to be of such importance and widespread general interest that they were published in book form by the Council—a far-sighted step, which Burt (1946, *loc. cit.*) has described as follows :

"I should like to record the deep indebtedness of all educational psychologists to the Council itself for its generosity in publishing at its own expense the results of these numerous researches, and that at a time when mental testing and educational psychology were a novel, and, in the view of many, a transient, development, and when the printing of test-materials and long tables of results would have been far too costly for an author to undertake in his private capacity. In this country psychological and educational journals have always depended for financial support on lay subscribers who are easily repelled by formulae and figures ; and consequently their editors have rightly been chary of publishing articles of a statistical or technical nature. As a result, the tables of frequency-distributions and of percentages for various age-groups to be found in this volume are still almost the only examples available for those who wish to re-examine such data from various points of view. From time to time they have been used by American writers like Courtis and Thurstone for illustrating and testing formulae for growth-curves, and more recently by students and research-workers who wished to try out fresh modes of analysis. If I may judge from the many requests I have received, they are still in demand for such purposes, as well as for the purpose of comparison in subsequent surveys."

Amongst the many published works of Sir Cyril Burt the following were based mainly on work carried out during his period with the Council :

- The Distribution and Relations of Educational Abilities (1917).
- Mental and Scholastic Tests (1921).
- Handbook of Tests for Use in Schools (1923).
- The Young Delinquent (1925).

(c) *Period from 1932 to 1939*—After Sir Cyril Burt resigned in 1932, (to take up his appointment as Professor of Psychology in the University of London), 'temporary' arrangements were made, which lasted for 15 years, for carrying on the school psychological work within the framework of the education inspectorate.

It was during this period that the Council published in 1937 the Report of a Committee of Inspectors on Backwardness in Elementary Schools, the second such survey to have been made in London, the first having been carried out in 1915-1917—*vide* Burt's 'Distribution and Relations of Educational Abilities'.

It was also during this period, at the October, 1935 examination for junior county scholarships (11-plus selection), that the Council first used 'intelligence tests' of the type now quite well known and in common use (e.g. 'Moray House' tests).

(d) *Report of the Feversham Committee*—As mentioned on page 139, the Feversham Committee recommended, *inter alia*, that every local education authority should appoint a psychologist to advise them on their educational programme and to examine and advise on the treatment of backward children. In the report on the subsequent comprehensive review carried out in 1943 there is a paragraph which laments, albeit obliquely, that the post of educational psychologist to the Council had not been filled since 1932 :

"We think it would be an advantage if the Council could take a more active part in shaping the sphere of psychology in statutory educational provision. It was in the years immediately after the resignation of Dr. Burt that the Council had to determine its policy in regard to an ambitious voluntary service of child guidance. We surmise that, if during that period the Council had had a ready means of focusing the advice of its own officers and teachers who were qualified to speak on this subject, it might have been more easy to define the types of children for whom treatment by the methods of the child guidance clinic was suitable and also those types for which the necessary provision could be found within the Council's own educational or medical or mental health services."

In the event an appointment of this kind was not made, and the setting up of the problem case conferences was achieved with psychological advice from psychiatrists of the health department.

(e) *Review of 1946*—By the time of the next general review, in 1946, the position had materially changed. The Education Act, 1944 had come into operation; the work of the problem case conferences had established the needs; the report of the Committee of the Association of Education Committees had been issued. Accordingly it was decided that the post of educational psychologist be converted into a full-time one, that steps be taken to fill the vacancy, and that the duties should include:

- (i) assisting teachers to carry out and interpret the results of mental and scholastic tests,
- (ii) advising generally on the psychological aspects of education especially for sub-normal and other handicapped children and for exceptionally able children,
- (iii) giving advice on the problems of selecting pupils for different kinds of secondary education,
- (iv) co-operating with divisional case conferences,
- (v) assisting in the running of special classes for problem and maladjusted children,
- (vi) furnishing psychological reports on individual pupils as required.

The vacancy was filled in 1947.

(f) *Developments after 1947*—In 1949 the Education Committee considered the future development of the school psychological service in the light of the fact that the Council was maintaining its own child guidance units. It was considered that educational psychologists attached to the child guidance units should also work for part of their time in the school psychological service. (This conclusion was later reinforced by one of the recommendations of the Underwood Committee accepted by the Ministry of Education in Circular 347.) It was also considered that psychologists not attached to Council child guidance units should undertake liaison work with the non-Council child guidance clinics, since the clinical psychologists working for the hospital clinics were not in a position to work on the 'school' side. This has not been possible, except that in 1950 one of the Council's educational psychologists was attached part-time to St. Alfege's hospital child guidance clinic.

Apart from the increase arising from the opening of child guidance units, two other educational psychologists were appointed in 1950, two in 1957 and by 1959 there were a total of 13, including one senior position. In addition psychologists were employed at specific schools, such as Anerley boarding special school (see page 151).

(g) *Backwardness*—In his classic work, 'The Distribution and Relations of Educational Abilities,' Sir Cyril Burt, to quote the words in its preface by Sir Robert Blair, then Education Officer, "put an approximate measure (40,000) on a well known problem," i.e. backwardness. Sir Cyril showed that intelligence, like other biometric attributes, followed the same laws of statistical mathematics that Galton and Karl Pearson had earlier demonstrated for other mensurables. Within a few years the publication by the Council of Burt's 'Mental and Scholastic Tests' provided the tools with which an attempt could be made to solve the problem with which the Wild Boy of Aveyron had confronted the French Academicians 120 years before, i.e. was a child 'backward' because he was 'dull,' or because he was 'retarded.'

The publication, some 20 years later, of the Report of a Committee of Inspectors on Backwardness in Elementary Schools confirmed Burt's findings, restated the problem, and placed the number of backward pupils at 35,000.

In 1946 in Ministry of Education pamphlet No. 5 on special education treatment, it was suggested that the category of 'educationally sub-normal' was so defined that it covered 10 per cent. of the school rolls, i.e. that 'backward' children should be dealt with as educationally subnormal. However, as was explained in my report for 1958 (page 175), this concept did not work out satisfactorily in practice, and proposals for the provision of special classes for backward children in ordinary schools were abandoned in 1952.

In 1955 the Council decided to establish remedial classes for backward children. The classes were intended for children of average ability whose backwardness was particularly recalcitrant, who showed no signs of improvement under ordinary school conditions. The children were to be selected by the educational psychologists, and were not to be 'ascertained,' although they were to be specially medically examined to exclude the possibility of physical reasons for their educational retardation.

Nearly twenty years after the Inspectors' report, and forty years after Burt's work, the Education Committee gave consideration to a third report on backwardness, prepared by the Council's educational psychologists. This report, although using different criteria from the earlier ones, confirmed the nature and extent of the problem, and suggested that the incidence of backwardness was a little higher than it had been in pre-war years. It estimated that there were 24,000 pupils of junior school age who would benefit from special help, apart from those in secondary schools. The report suggested that the Council should establish a Remedial Education centre, at which teachers could attend, on a part-time basis, courses in the teaching of backward children; that specially selected teachers should be trained to administer, to those children who present educational problems in their own schools, group tests of intelligence and attainment, under the supervision of the Council's educational psychologists, and that such an establishment would provide a centre to which teachers could turn for advice on individual problems.

These recommendations were accepted by the Council, and the centre was opened in 1957 with two concurrent courses of 40 teachers attending one day a week for 10 weeks. The work occupies the time of the equivalent of two full-time educational psychologists.

(h) *Summary of the present position and future outlook*—The schools' psychological service is primarily concerned with the promotion and maintenance of mental health among school children generally. The core of its work is essentially the assessment of the needs and difficulties of individual children. The close liaison between the Council's psychologists enables them to detect children early who need child guidance treatment or some other form of specialized help. Further, it enables them to advise teachers on how to deal with children who have behaviour problems and/or learning difficulties. Educational psychologists are also responsible for the dissemination of knowledge about recent research into matters concerning the mental health of children. This is done partly through the organisation of teachers' courses, and lectures to parent-teacher associations, care committee workers, etc., and partly through discussions about individual cases.

In London the varied and extensive provision for special educational treatment provides a fruitful field of work for educational psychologists. Individual testing of handicapped children provides not only data upon which to base their educational programme but also information about the general problems of special groups of handicapped pupils. Certain psychologists are already specializing in the testing of blind, deaf and physically handicapped children. It is hoped gradually to extend this specialisation to all groups of handicapped pupils.

V—Juvenile delinquency, remand homes and approved schools

(a) *Historical notes*—The Children Act, 1908, which established the Juvenile Courts, made it compulsory for the Council to arrange for all children taken into custody within the metropolitan area to be accommodated in remand homes, a duty previously vested in the Metropolitan Asylums Board. The remand homes in the possession of that authority were transferred to the Council in April, 1911 and placed under the direction of the Education Committee. In 1949, following upon the Children Act of 1948, they became the immediate responsibility of the Children's Committee.

From the beginning the Council had appointed a medical officer to the remand homes, although in the earliest days his reports to the Courts were confined to the question of a child's medical fitness for committal to an 'industrial' school.

The slow growth of the 'psychiatric' outlook led to the practice of the Juvenile Courts requesting special psychological reports on particular cases.

(Burt's 'The Young Delinquent' was based on a careful long-term study of the case histories of nearly 200 London children. In 1926 the Council published a report entitled 'Juvenile Delinquency in London', in which the results were given of an investigation of every London child reported as an industrial school case during the two years ended 31 March, 1923.)

My predecessor's report for 1924 included a long report by Dr. Shrubsall on the work of the North American juvenile courts he had visited, in which it was recommended, *inter alia*, that a medical officer experienced in mental testing should be allocated to the remand homes. This was done in 1929, when a full-time medical officer was placed in charge of the work. As previously mentioned, in the early 30's an arrangement was also made under which the London Child Guidance Clinic undertook the psychometric testing of cases on remand, and the provision of special psychiatric reports requested by the Courts.

In 1935 the large increase in the numbers of London children and young persons appearing before the Juvenile Courts led to speculation whether the increase was real or due to increased vigilance on the part of the social workers and the police and a greater readiness on the part of the public to bring charges. The findings of a conference of teachers and other officers in the Education Officer's department, published by the Council in February, 1937, were that the increase in juvenile delinquency was more apparent than real, being accounted for in part by such factors as the high post-war birth rates, an alteration of police procedure in 1932 and increased vigilance with a consequential increase in the number of charges.

The fluctuating numbers of children and young persons admitted to the Council's remand homes in this period is shown below. Quite apart from what was said about the 'increase' in delinquency in the preceding paragraph, the reasons for admission have varied over the years and the numbers in earlier years also included children remanded from out-county Courts. For example, 2,608 children admitted in 1936 included 659 from ten out-county Courts as far away as Hertfordshire and Southend, whilst most of the fall of about 10 per cent. between 1936 and 1937 was due to the opening in the autumn of that year of the Middlesex County Council remand home. Nevertheless the figures show the work done by the Council over the years in providing accommodation for children in the hands of the police.

No. of admissions to L.C.C. remand homes			No. of admissions to L.C.C. remand homes		
1912	..	2,932	1927	..	835
1913	..	2,781	1928	..	832
1914	..	2,391	1929	..	726
1915	..	3,034	1930	..	785
1916	..	3,732	1931	..	866
1917	..	3,364	1932	..	1,052
1918	..	2,975	1933	..	1,328
1921	..	1,206	1934	..	2,057
1922	..	1,190	1935	..	2,420
1923	..	1,174	1936	..	2,608
1924	..	1,012	1937	..	2,331
1925	..	910	1938	..	2,188
1926	..	1,006			

Admissions for 1919 and 1920 not available.

(b) 1936 to 1946—In January, 1936 the Council's remand home was transferred to its present premises at Stamford House and in July of that year Dr. John D. W. Pearce was appointed as medico-psychologist.* This appointment, coupled with the termination of the arrangement with the London Child Guidance Clinic, resulted in a co-ordination of the methods of investigation which Dr. Pearce described as follows:

"The medico-psychologist examines physically every child or young person not later than the day following admission. At a later date psychometric tests are carried out on every case on remand. Combined

* Dr. Pearce's book, 'Juvenile Delinquency,' published in 1952, was based mainly on his clinical experience whilst working for the Council at Stamford House.

with, or following, the mental testing an examination of a psychiatric type is made. This is of the nature of a discussion with a view to ascertaining the state of mind of the child or young person and the underlying causation of the delinquency. While the child is on remand at the home, reports are received in many cases from the probation officers and from the local education authority. It is only after reaching a definite opinion that a final report on a special case is submitted to the Court. In some cases in which it is not possible to make a diagnosis without further information full investigation at a child guidance clinic is recommended."

(c) *Developments from 1946 to 1951—*

(i) By June, 1946 the demand from the Courts for psychological reports on cases passing through the remand homes proved to be beyond the resources of the medico-psychologist, so arrangements were made for part of the work, consisting largely of mental and scholastic testing, to be handled by an educational psychologist. Dr. Pearce resigned in that year and there was an interim period of two years during which several differing temporary arrangements were made for the psychiatric work at the remand homes, which were described in the annual reports for 1946 and 1947 of my immediate predecessor, Sir Allen Daley.

In 1948 Dr. Peter Scott was appointed as psychiatrist to the remand home, and the psychiatric team was completed by the appointment of a psychiatric social worker.*

(ii) In Circular 38/51, of 10th September, 1951 the Ministry of Health advised that:

"the Minister . . . has had under consideration . . . ' the question whether the provision of psychiatric services for remand homes is the duty of the local authority which provides the home or of the National Health consultant service. While the question itself is not free from doubt it has been decided on practical grounds that services of this kind should be provided by regional hospital boards without charge ".

Accordingly discussions were held with the appropriate hospital authorities as a result of which it was agreed that the work in London should be taken over by the Institute of Psychiatry and Maudsley hospital, for whom Dr. Peter Scott was also already working as a consultant.

(d) *Circular on juvenile delinquency of 20 July, 1953—*In a joint circular of 20 July, 1953 on juvenile delinquency (Home Office No. 99/53, Ministry of Education No. 265/53), the Secretary of State and the Minister of Education suggested that the local committees on juvenile delinquency, formed in the light of a memorandum issued in April, 1949 by the Home Office and Ministry of Education on the problems of juvenile delinquency, be kept in being, that full use be made of the opportunities that they gave for consultation, and that it might be convenient for the committees to form part of the co-ordinating procedure for dealing with children neglected in their own homes. In London this has been carried out through the medium of the divisional co-ordinating committees, the introduction of which was described on pages 57/58 of my annual report for 1952.

(e) *Stamford House Remand Home, 1950 to 1959—*Stamford House is the largest remand home in the country, having room for 105 boys. During the past ten years the number of annual admissions has ranged from between 1,284 (in 1954) to 1,859 (in 1950) and has averaged 1,528 a year. The following table shows the number of cases remanded to Stamford House by the Courts since 1950, the number of psychiatric reports requested, and the number of 'conduct' (i.e. Superintendent's) reports. (Total admissions, which include those from the police pending a court hearing, lodgers, etc., exceed in number those for whom reports are requested by the Courts.)

*A full account of the work of the psychiatric team is given in Sir Allen Daley's annual report for 1949, pages 94-97.

Year	No. of boys remanded	Psychiatric reports requested %	Conduct reports requested
1950	1,246	720 57.9	110
1951	1,323	870 65.7	266
1952	996	752 75.5	277
1953	1,042	918 88.1	364
1954	1,028	803 78.1	234
1955	1,036	846 81.7	244
1956	1,103	793 71.9	303
1957	899	844 93.9	414
1958	1,182	961 81.3	688
1959	1,226	978* 79.8	905

*In addition, there were 131 'comprehensive' reports which include psychiatric, conduct and other reports.

The table shows clearly how the proportion of cases in which the Courts call for special reports has increased over the period, in continuance of the trend which started in 1936 when the percentage of such cases was only 11.6.

(f) *London classifying centre*—Since January, 1958 Stamford House has been functioning as a classifying centre as well as a remand home. Until then boys committed to approved schools by London courts had been unable to have the benefit of the classifying system, which operated in the rest of England and Wales for non-Roman Catholic boys. Under that system boys committed outside London to approved schools went to one of four classifying approved schools so that the most suitable training school for the particular boy could be assessed. Stamford House now does this work for boys committed by London courts and during 1959 dealt with approximately 400 boys. The approved school most suited to the boy is selected and its name is submitted to the court for approval. The classifying procedure is designed to be a continuation and reorientation of the remand procedure rather than a discreet process. Thus the information already collected is expanded and used in an attempt to decide what conditions, atmosphere and case-work would be advisable for each particular boy in the approved school. The staff involved in the classifying work are, therefore, the same as those who take part in the remand work. A notable development was the agreement that from July, 1958 Stamford House should undertake the assessment and allocation of all Roman Catholic boys committed by the London courts: these boys are not so classified outside London. The agreement was made by the Church authorities, the Home Office and the Council, and contained safeguards to ensure that Roman Catholic boys should, save in exceptional circumstances, be allocated to Roman Catholic schools, that Stamford House should have Roman Catholic representatives on its managing committee, and that a member of the staff of that faith should take part in the classifying procedure.

(g) *Cumberlow Lodge Remand Home for Girls*—Only about ten per cent. of the children and young persons appearing before the Juvenile Courts are girls, so that when the total numbers were low, as they were a quarter of a century ago, separate accommodation for girls was not justified by the small numbers involved. Since 1949, however, the Council has maintained at Cumberlow Lodge a separate remand home for girls. In addition to a full psychiatric team, similar to that at Stamford House, Cumberlow Lodge has the services of a consultant venereologist, who provides any necessary 'special' reports to the Courts. During 1959 plans were being drawn up for the future development at Cumberlow Lodge of a classifying centre for girls, similar to that at Stamford House for boys.

(h) *Psychiatric services at approved schools*—During the past ten years there has been the gradual development of psychiatric services at the approved schools maintained by the Council. At the outset the arrangements were simply that one of the Council's psychia-

trists paid regular visits to the schools, solely for the purpose of advising the staff on the management of the children in their care. However, as it became known to the Courts that certain approved schools were visited by a psychiatrist, the practice grew up of committing to these schools an increasing proportion of children who were considered in the light of the remand reports to be in need of psychiatric treatment. Consequently, it became necessary to make arrangements for a far greater provision of psychiatric services to the approved schools than the purely advisory visits originally contemplated. Since it was considered that a psychiatrist's visits to an approved school were for the purposes of treatment or diagnosis with a view to treatment, arrangements were made for the specialist work to be taken over by the National Health Service, whilst the Council provided the psychiatric social workers.

While the opinion of the psychiatrist and that of the psychiatric social workers is needed on the difficult problems posed by particular children and young persons, it is perhaps in the education and help of the staff through the discussion of these problems that the main contribution is made, and the staff encouraged to provide the atmosphere that the child needs. The differences between 'delinquency' and 'maladjustment' are indeed fine-drawn but as Dr. John Bowlby has said, it is not conceivable that we shall ever have sufficient psychiatrists to treat all the psychological illnesses of the community, so that everyone concerned with child-care has to feel able to play a part in the prevention, or indeed in the treatment, of mental ill-health in these manifestations.

VI.—Mental health education

(a) *Introduction*—There is no doubt that mental health education will become increasingly important in the future of public health. The problems before medical officers of health in this direction were firmly put to them by Lord Adrian in his centenary oration, delivered to their Society in May, 1956. The following paragraphs describe some of the ways in which in London these problems of mental health education are being investigated.

(b) *Maternity and child welfare services*—In my annual report for 1954, Appendix B, will be found the report of a study group, which was set up in 1953 under the leadership of Dr. John Bowlby, of the Tavistock Clinic, to investigate the possibility of increasing preventive mental health work in the maternity and child welfare service.

The proposals of the study group were accepted by the Council, and by the end of 1959 there were 10 case conference groups meeting regularly at which medical and nursing staff of the child welfare centres received training and guidance from the psychiatrists and other professional staff of local child guidance clinics.

Originally the conferences were intended to be part of a training course which was expected to last about two years. It was anticipated that at the end of that period the child welfare staff would feel competent to cope with mental health problems without specialist advice. Experience has shown however that the disturbances in family relationships which are manifest in behaviour disorders in young children have been very complex and often serious, and that there is need for a continuous consultative service. At the end of the year plans were being formulated for the scheme for consultation through case conferences to be put on a permanent basis, and extended as far as the availability of child psychiatrists permitted.

(c) *Residential establishments*—At any one time the Council accommodates, in various boarding and residential establishments, about 12,000 children. The psychiatric services for children in boarding special schools for the maladjusted and for children in remand homes and approved schools have been dealt with earlier. There remains to be considered a very wide range of other establishments, boarding schools, children's homes, residential nurseries, etc.

The principle underlying the scheme of visits by psychiatrists to the residential establishments for children is that of mental health education of the staff, as the following extract from a report to the Education and Children's Committees in 1952 makes quite clear:

"It is also becoming increasingly clear that one of the major factors in juvenile delinquency is deprivation of a stable and secure home life. It follows that it is very important that the Council should do all it can to provide the best possible environment for those children in its care, who are deprived of a normal home life for any length of time, both in the interest of the child and in the interest of the community. Staff in daily charge of children should have knowledge which will assist them in preventing emotional disturbance and, to secure this, modern psychological knowledge and advice should be available, not only to the officers-in-charge but to the staff who are in daily contact with the children. Staff can then discuss the handling of children and any psychiatric problems which may arise in individual children. This will help to prevent children becoming maladjusted, and to ensure that any early symptoms of maladjustment will be detected, so that treatment can be obtained in the early stages."

Arrangements now exist under which regular or occasional visits are made according to needs, by psychiatrists to the majority of the establishments, under both the Children's and Education Committees, at which children reside. More important, perhaps, is the fact that the staff at the establishments concerned are aware that the services of a psychiatrist or an educational psychologist are available on request.

Enuresis has always been a problem in residential establishments for children and to assist houseparents and other child-care staff to understand the nature of the problem, a leaflet on the subject written by one of the Council's psychiatrists has been very widely distributed amongst the staff concerned.

(d) *Tavistock Clinic 'Neighbourhood Project'*—During the past few years the concept of a 'neighbourhood project' has been taking shape in the district around the Tavistock Clinic in north-west London. A number of local schools are taking part in the experiment under which the Clinic offers to each school the services of a team composed of psychiatrist, psychologist and psychiatric social worker. The head of the school acts as convenor and chairman of case conferences in his own school, and has access to the psychiatrist for discussion of general problems.

Although it is too early to see how this idea will develop, it is already clear that the most intractable problem is that of time. School-based case conferences and individual discussions involve the expenditure of time by all concerned, yet it is clearly essential for the success of the project that sufficient time should be available for everyone to attend. This will undoubtedly be difficult for some members and calls for administrative readjustments and flexibility if full participation is to be possible and full benefit derived.

Other child guidance clinics are working out similar schemes, which will establish a 'link' with local schools and centres.

(e) *Staff training*—Quite apart from the question of mental health education and psychiatric 're-orientation' of staff of all grades, which has been discussed above, there remains the problem of the national shortage of trained psychiatric staff. The Council has always been ready to help to train students, post-graduate and under-graduate, provided the interests of the children were not thereby prejudiced. This training is a direct stimulant to the activities of the service, and provides a reciprocal benefit both to students and to the staff concerned.

Brixton child guidance unit provides facilities for the training of doctors; the unit at Woodberry Down undertakes the practical training of psychiatric social workers; whilst Froebel student teachers visit that at Earls Court. Students working for qualifications in educational psychology, or teaching qualifications for schools for the maladjusted, attend all of the Council's child guidance units. Registrars, and other medically qualified psychiatrists in training from the Institute of Psychiatry, Maudsley hospital, attend the remand homes, to work with and assist the responsible psychiatrists.

(f) *General health education*—It should not be forgotten that mental health education is only one aspect of health education, and that all the media used, posters, films, lectures, etc., have a 'psychiatric' aspect. Perhaps the most successful are those in which the 'psychology' is so implicit as not to be apparent, and it is therefore acceptable as 'common-sense'. An example which comes to mind is the popular Central Council for Health Education leaflet, 'Toys for Teresa and Timothy', which was based on a design by a group of London health visitors and incorporates in advice to parents on everyday matters some of the teachings of the early pioneers in the field of the psychological development of children which are now generally accepted.

VII—Conclusion

In the preceding pages it has been convenient to treat the child psychological services in separate sections. The services described are not in fact separate entities; on the contrary the constant aim is their integration.

It is perhaps too early yet to attempt to assess with any accuracy the value of all the educational and medical work with maladjusted children and their families which has been described.

An apparently growing number of children do not fit happily into the normal social pattern and it is important that every effort be made to enable them to do so, because failure involves a heavy cost to society and unhappiness to their parents and friends. The cost is no less great because much of it will fall upon the next generation, who will be affected by their inability to make permanently satisfactory relationships as spouses or parents or workers. This cost, though incalculable, must be far more than that of these services. Nevertheless, there is a duty to determine what success is achieved and how best the limited efforts available can be employed, but the evaluation of such work is immensely difficult. Some attempts have been and are being made and the Education Committee has asked the National Foundation for Educational Research to consider how to further this assessment. No doubt all children (and adults too) are at times maladjusted with reference to the society around them, but few are maladjusted all the time. Deaf children, educationally subnormal children and those with other handicaps are more often maladjusted than children without handicaps. There are never likely to be sufficient psychiatrists, psychologists and social workers to treat all the mentally sick in the community, and the chief hope therefore must always lie in the education of the nursing, teaching and medical professions, and indeed of the whole community, in the prevention of emotional maladjustment and mental ill health.

APPENDIX C

Statistics of the administrative work carried out by the Metropolitan Borough Councils in 1955.

Borough	DWELLING HOUSES										AIR POLLUTION										CLEANING AND REPAIRS				LICENSED OR REGISTERED PREMISES				PUBLIC HEALTH INSPECTORS																																																																																																																																																																																																																																																																																													
	DWELLINGS		CLEARANCE AREAS		DISPOSITIONS		DEFECTS REMOVED AFTER SERVICE OF JOURNAL NOTICE						ROOFS CLOSED		UNDERDRAUGHTS ACCEPTED		AIR POLLUTION		CLEANING AND REPAIRS		LICENSED OR REGISTERED PREMISES		PUBLIC HEALTH INSPECTORS																																																																																																																																																																																																																																																																																																			
	Divided by Borough Council	Divided by other persons	Total number in the Borough	Discontinued	Premises demolished	Premises demolished	On completion	On completion of others	Borough Council	Other persons	Reported as a result of informal action	Defects remedied after service of Journal Notice						By owners	By local authority	By private undertakers	Made fit for use by persons other than the owners	Overseas	Other persons	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By owners	By local authority	By private undertakers	By 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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

<i>Division</i>	<i>Divisional Medical Officer</i>	<i>Divisional Administrative Officer</i>	<i>Divisional Nursing Officer</i>
1.	BERTHA E. A. SHARPE	G. J. NEWTON (died 25/6/59) T. A. STONE (from 31/8/59)	JOAN A. SURR
2.	H. L. OLDERSHAW	H. J. NORTON (retired 14/8/59) N. A. WOODRUFF (from 31/8/59)	EVELINE BEATTIE
3.	W. G. HARDING	N. B. CHAPMAN	MARGERY D. BUTLER
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	KATHARINE M. ROE (retired 31/7/59) ELIZABETH J. EARLY (from 1/8/59)
6.	F. R. WALDRON	T. A. STONE (transferred 31/8/59) L. M. LONGHURST (from 31/8/59)	LILIAN BERRY
7.	ANN 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

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References to local activities in the sphere of chiropody, health education, mental health education, home making courses, problem families, vaccination against poliomyelitis, etc., will be found in the divisional medical officers' reports, pages 115–126.