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LONDON COUNTY COUNCIL

Report of the County Medical Officer of Health and Principal School Medical Officer for the Year 1961

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Page 164, table (ii) - Work in various departments:
For "electrocephalograms" read "electrocardiograms"

Page 166, Diagnostic Group table:
The classification is a modification of the International Classification, designed by the College of General Practitioners.

Symptoms and ill-defined conditions:
Para. 2, line 3 - for "electric cardiograms" read "electrocardiograms"

Page 167, Diseases of the blood and blood forming:
Line 3 - delete "hypochronic;
line 9 - for "60" read "65"

LONDON COUNTY COUNCIL

Report of the County Medical Officer of Health and Principal School Medical Officer for the Year 1961

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

COUNTY MEDICAL OFFICER OF HEALTH AND PRINCIPAL SCHOOL MEDICAL OFFICER

THE COUNTY HALL
WESTMINSTER BRIDGE, S.E.1

CONTENTS

LONDON ADMINISTRATIVE COUNTY
VITAL STATISTICS, 1961

Figures in brackets are for 1960

Population:
Males 1,494,000
Females 1,686,000
} 3,180,000 (3,194,000)

Area comparability factors:
Births .. .. .. 0·90 (0·90)
Deaths .. .. .. 0·96 (0·98)

Number of marriages registered: 33,579 (32,677)

Live births:
Legitimate .. 52,420 (50,838)
Illegitimate .. 7,632 (6,530)
} 60,052 (57,368)

Illegitimate live births per cent. of total live births: 12·7 (11·4)

Live birth rate per 1,000 population: 18·9 (18·0) (adjusted rate 17·0 (16·2))

Stillbirths:
Legitimate .. 913 (911)
Illegitimate .. 190 (141)
} 1,103 (1,052)

Stillbirth rate per 1,000 live and stillbirths: 18·0 (18·0)

Total live and stillbirths: 61,155 (58,420)

Deaths:
Males 19,108 (18,534)
Females 18,807 (17,987)
} 37,915 (36,521)

Death rate per 1,000 population: 11·9 (11·4) (adjusted rate 11·4 (11·2))

Deaths of infants:

	Legitimate	*Illegitimate*	*Total*
Under 1 month	799 (761)	154 (125)	953 (886)
1 month to 1 year	295 (307)	34 (39)	329 (346)
Total under 1 year	1,094 (1,068)	188 (164)	1,282 (1,232)

Infant mortality rate: .. *(per 1,000 live births)*	20·87 (21·01)	24·63 (25·11)	21·35 (21·48)
Neo-natal mortality rate: .. „ „ „ „	15·24 (14·97)	20·18 (19·14)	15·87 (15·44)
Early neo-natal mortality rate: „ „ „ „	13·66 (13·04)	18·34 (16·39)	14·25 (13·42)
Perinatal mortality rate: .. *(per 1,000 total births)*	30·54 (30·42)	42·19 (37·18)	32·03 (31·19)

Maternal mortality:

	Post-abortion	*Other pregnancy and childbirth*	*Total*	*Rate per 1,000 live and stillbirths*
Deaths from sepsis	14 (9)	— (—)	14 (9)	
Deaths from other causes ..	4 (2)	27 (15)	31 (17)	
Total ..	18 (11)	27 (15)	45 (26)	0·74 (0·45)

VITAL STATISTICS*

Population

TABLE (i)—*Home population* (*a*), 1952–61

(*Figures in thousands*)

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+	
1952	3,363	256	400	416	1,091	822	378	36·7
1953	3,343	244	413	410	1,072	826	378	36·7
1954	3,322	234	425	394	1,056	827	386	36·9
1955	3,295	230	421	391	1,037	829	387	37·1
1956	3,273	229	427	384	1,018	829	386	37·1
1957	3,254	230	425	383	974	843	399	37·4
1958	3,225	231	418	387	949	843	397	37·5
1959	3,204	236	409	394	925	842	398	37·5
1960	3,194	241	403	398	905	846	401	37·6
1961 .. M	1,494	127	202	190	444	388	143	35·7
F	*1,686*	*120*	*194*	*214*	*449*	*451*	*258*	*39·2*
	3,180	247	396	404	893	839	401	37·5

(*a*) *Resident civilian population, plus any British, Commonwealth or Foreign Armed Forces stationed in the area.*

There was a net loss of 14,000 in the population from the previous year's figure; in detail there was a rise of 6,000 at ages 0–4, a fall of 7,000 at ages 5–14, a rise of 6,000 at ages 15–24, falls of 12,000 and 7,000 at ages 25–44 and 45–64 respectively, whilst the population aged 65 and over remained constant.

The rise in the number of pre-school children stems from the increased birth rate—see table (ii) below; the changes at ages 5–14 and 15–24 are linked with the movement out of the former age group of children born in the years of high fertility following the war—migration of young people into London also affects the 15-24 age group. The losses at ages 25–64 are probably due in the main to outward migration and the net effect of this loss in conjunction with the increased birth rate has been a marginal change towards a younger population—the average age having fallen by 0·1 year.

Fertility

TABLE (ii)—*Live births and stillbirths*, 1952–61

Year	Live births		Stillbirths	
	No.	Rate per 1,000 population	No.	Rate per 1,000 total births (live and still)
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
1960..	57,368	18·0	1,052	18·0
1961..	60,052	18·9	1,103	18·0

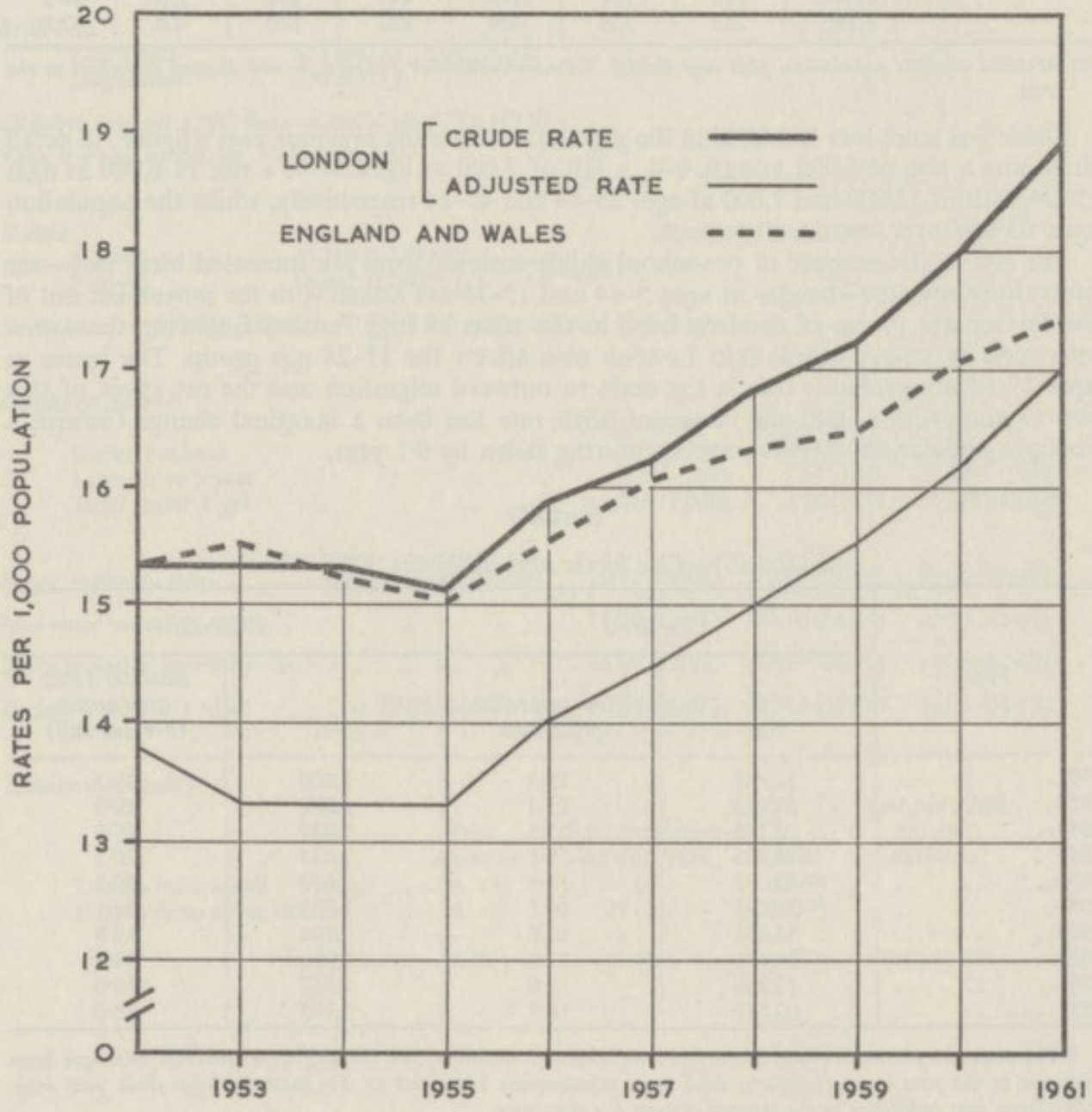
* *The statistics given are based on the latest information available from the Registrar General: instances have occurred in the past in which figures have been subsequently corrected so that data for a previous year may differ from that published in the Annual Report for that year.*

Live births—There were 68,619 live births registered in London in the year; after correction for residence the final figure of births allocated to London was 60,052, an increase of 2,684 over 1960, giving a birth rate of 18·9 per 1,000 population compared with 18·0 in 1960 and 17·2 in 1959. 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 has continued to exceed 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 17·0. 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.

Figure 1

LIVE BIRTH RATE—

LONDON (A.C.) AND ENGLAND & WALES, 1952-61



Illegitimacy—

TABLE (iii)—*Illegitimate live births in London (A.C.) and percentages for London and England and Wales*, 1952-61

Year	Illegitimate live births	Illegitimate live births as a percentage of total live births	
		London A.C.	England and Wales
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
1960	6,530	11·4	5·4
1961	7,632	12·7	6·3

The percentage of illegitimate births in London has increased year by year for the past six years—one in every eight babies born in 1961 was illegitimate. Boroughs with notably high percentages were, in the West, Paddington (21·5) and Kensington (18·2), in the South, Lambeth (15·8) and in the North and East, Stoke Newington (16·4), Hackney (15·8) and Stepney (15·3). Nationally the rise in illegitimacy has been much slower than in London; the national percentage is now about half that for London.

A complex of factors probably accounts for the phenomenal rise in London—proportionately more single women, a continuous influx of unmarried women, many of whom are already pregnant and the facilities which London can offer to an unmarried mother in the way of anonymity, ante-natal care and support from moral welfare organisations. Information as to the extent of some of these factors will only become reliably known when the results of the 1961 census are available.

The table below gives details of women seen by the moral welfare organisations in the twelve months ended September 1961, from which it will be seen that 991 (30·1 per cent.) were pregnant on arrival in London and that in all 1,450 (44·1 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 associations in London, 1st October, 1960–30th September, 1961.*

(Figures in brackets are for 1959–60)

	British (U.K.)		*Eire*		*European*		*West Indian*		*Other*		*Total*	
Non-Londoners pregnant on arrival in London	468	(424)	308	(272)	49	(50)	137	(85)	29	(33)	991	(864)
*Non-Londoners not pregnant on arrival in London ..	64	(71)	49	(87)	8	(8)	40	(33)	8	(3)	169	(202)
Resident in London one year or more..	1,306	(1,371)	434	(454)	92	(76)	260	(267)	36	(58)	2,128	(2,085)
	1,838	(1,866)	791	(813)	149	(134)	437	(385)	73	(94)	3,288	(3,292)

* *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 was higher than the previous year (11·4) and slightly above the average of the last decade.

Leading causes of death—The leading causes of death in London in 1961 were as follows:

	Deaths	*Rate per 1,000 population*
Diseases of the heart	11,509	3·62
Cancer	7,782	2·45
Bronchitis, pneumonia*	5,155	1·62
Vascular lesions of the central nervous system	3,965	1·25
Other circulatory	2,027	0·64
Violent causes	1,701	0·53
Digestive diseases	1,224	0·38
Diseases of early infancy (international classification Nos. 760–776)	765	0·29
Congenital malformations (0–4 weeks)	152	
Tuberculosis (all forms)	318	0·10
All other causes	3,317	1·04
Total	37,915	11·92

* *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 1960. Heart disease was discussed in detail in my report for 1956, cancer in 1958 and bronchitis and pneumonia in 1960.

Cancer—The cancer death-rate for all ages was 2·45 per 1,000 in 1961—a slight decrease from 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*, 1952–61

Age and Sex	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*
Males:										
0–24	0·12	0·14	0·12	0·11	0·14	0·11	0·09	0·10	0·12	0·11
25–44	0·45	0·46	0·41	0·40	0·43	0·37	0·42	0·40	0·38	0·37
45–64	4·19	4·28	4·31	4·50	4·51	4·55	4·52	4·46	4·75	4·52
65+	15·50	15·69	15·29	15·73	15·77	15·29	16·01	15·20	15·74	15·72
All Males ..	2·61	2·68	2·64	2·73	2·76	2·77	2·85	2·76	2·90	2·83
Females:										
0–24	0·07	0·07	0·06	0·07	0·09	0·07	0·10	0·07	0·07	0·07
25–44	0·47	0·51	0·43	0·45	0·50	0·47	0·52	0·51	0·52	0·50
45–64	2·85	2·85	2·85	2·93	2·77	2·97	2·71	2·63	2·82	2·72
65+	8·77	8·73	8·39	8·43	8·75	8·34	8·50	8·18	8·44	8·02
All Females ..	2·02	2·04	2·02	2·08	2·12	2·16	2·15	2·09	2·20	2·11
All Persons ..	2·30	2·34	2·31	2·39	2·42	2·44	2·47	2·40	2·53	2·45

Lung cancer—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*, 1952–61

(*Rates per* 1,000 *population*)

Year	*Age*					
	25–44		*45–64*		*65+*	
	No.	*Rate*	*No.*	*Rate*	*No.*	*Rate*
Males:						
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
1960 ..	55	0·12	958	2·46	857	5·99
1961 ..	44	0·10	883	2·28	832	5·82
Females:						
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
1960 ..	26	0·06	157	0·34	190	0·74
1961 ..	24	0·05	151	0·33	184	0·71

The rates for males in 1961 are slightly below those of the previous year and for females they are about the same. Whilst these figures are encouraging it is too soon to read into them a halt in the upward trend of lung cancer.

TABLE (vii)—*Infant mortality*, 1961

Cause of death		*Age at death*				*Total*			*Rates per 1,000 live births*		
		Under 1 day	*1 to 7 days*	*1 to 4 wks.*	*4 wks. to 1 yr.*	*No.*	*Male*	*Female*	*Total*	*Male*	*Female*
Whooping cough	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Tuberculosis	Leg.	—	—	—	2	**2**	1	*1*	**0·03**	0·03	*0·03*
	Illeg.	—	—	—							
Measles	Leg.	—	—	1	1	**2**	2	—	**0·03**	0·06	—
	Illeg.	—	—	—							
Bronchitis and pneumonia	Leg.	5	16	11	150	**191**	112	*79*	**3·18**	3·63	*2·70*
	Illeg.	2	3	4							
Gastro-enteritis and diarrhoea	Leg.	—	—	2	15	**18**	9	*9*	**0·30**	0·29	*0·31*
	Illeg.	—	—	1							
Congenital malformation	Leg.	56	47	38	84	**236**	95	*141*	**3·94**	3·08	*4·82*
	Illeg.	3	4	4							
Injury at birth	Leg.	75	66	—	—	**169**	102	*67*	**2·81**	3·31	*2·29*
	Illeg.	20	7	1							
Post-natal asphyxia and atelectasis	Leg.	114	60	2	1	**217**	130	*87*	**3·61**	4·22	*3·00*
	Illeg.	29	10	1							
Haemolytic disease	Leg.	13	8	—	—	**22**	11	*11*	**0·37**	0·36	*0·38*
	Illeg.	1	—	—							
Immaturity	Leg.	128	48	8	2	**231**	126	*105*	**3·85**	4·09	*3·58*
	Illeg.	29	14	2							
Convulsions	Leg.	—	—	—	—	—	—	—	—	—	—
	Illeg.	—	—	—							
Accidental mechanical suffocation	Leg.	—	—	1	6	**8**	3	*5*	**0·13**	0·10	*0·17*
	Illeg.	—	—	1							
Other causes	Leg.	35	45	20	68	**186**	120	*66*	**3·10**	3·89	*2·26*
	Illeg.	15	3	—							
All causes	Leg. M.	245	172	34	295	**1,094**	617	*477*	**20·87**	22·88	*18·74*
	F.	*181*	*118*	*49*							
	Illeg. M.	50	22	4	34	**188**	94	*94*	**24·63**	24·35	*24·92*
	F.	*49*	*19*	*10*							
TOTAL, 1961		525	331	97	329	**1,282**	711	*571*	**21·35**	23·06	*19·54*
TOTAL, 1960		467	303	116	346	**1,232**	711	*521*	**21·48**	24·20	*18·61*
	Leg. M.	228	163	56	307	**1,068**	614	*454*	**21·01**	23·58	*18·31*
	F.	*167*	*105*	*42*							
	Illeg. M.	44	24	9	39	**164**	97	*67*	**25·11**	29·05	*21·00*
	F.	*28*	*11*	*9*							

The pattern of infant mortality remains much the same as in the previous year. The trend since 1952 is as follows:

TABLE (viii)—*Infant mortality by cause*, 1952-61

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

Cause of death	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*
Whooping cough	0·08	0·27	0·06	0·06	0·04	0·02	—	0·05	0·05	—
Tuberculosis	0·04	0·14	0·08	—	—	—	—	0·02	0·03	0·03
Measles	—	0·06	0·02	0·10	—	—	—	—	—	0·03
Bronchitis and pneumonia	3·89	4·04	2·70	3·57	3·32	2·88	3·45	3·50	3·63	3·18
Gastro-enteritis	0·80	1·27	0·43	0·48	0·35	0·42	0·31	0·27	0·16	0·30
Congenital malformations ..	3·93	3·41	3·51	3·43	3·70	3·96	4·51	4·75	4·32	3·94
Injury at birth	2·82	2·71	2·34	2·59	2·64	2·98	2·27	2·46	2·55	2·81
Post-natal asphyxia and atelectasis	3·50	3·90	4·06	4·32	3·66	4·17	4·08	3·59	3·63	3·61
Haemolytic disease	0·72	0·53	0·55	0·58	0·61	0·51	0·44	0·51	0·54	0·37
Immaturity	4·20	3·98	3·70	4·67	4·10	4·27	4·69	3·86	3·71	3·85
Convulsions	—	—	0·02	—	0·02	—	—	—	—	—
Accidental mechanical suffocation	0·17	0·14	0·12	0·06	0·21	0·23	0·13	0·16	0·09	0·13
Other causes	2·96	3·40	3·04	3·35	2·55	2·56	2·60	3·26	2·77	3·10
All causes	23	24	21	23	21	22	22	22	21	21

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*)

	Neo-natal mortality		*Infant mortality*	
Year	*London*	*England and Wales*	*London*	*England and Wales*
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
1960	15·4	15·6	21·5	21·7
1961	15·9	15·5	21·4	21·6

As regards neo-natal mortality there were 953 deaths in London; of this number 597 occurred in premature infants. An analysis of the total number of premature births by birth weight and mortality is shown in the following table. Corresponding figures of domiciliary confinements are shown in the section on domiciliary midwifery on page 53.

TABLE (ix)—*Prematurity and mortality by birth weight*, 1961.

Weight	*Number*	*Proportion per 100 live premature infants*	*Died within 24 hours*		*Survived 28 days*	
			Number	*Per 100 live premature infants*	*Number*	*Per 100 live premature infants*
3 lb. 4 oz. or less	614	13.3	235	38·3	271	44·1
3 lb. 5 oz. to 4 lb. 6 oz. ..	811	17·5	73	9·0	671	82·7
4 lb. 7 oz. to 4 lb. 15 oz. ..	945	20·4	20	2·1	896	94·8
5 lb. 0 oz. to 5 lb. 8 oz. ..	2,263	48·8	24	1·1	2,198	97·1
All premature babies ..	4,633	100·0	352	7·6	4,036	87·1

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

Year	*London*	*England and Wales*	*Year*	*London*	*England and Wales*
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	34·2
1955	34·8	37·4	1960	31·2	32·9
1956	33·3	36·7	1961	32·0	32·2

The causes of death in the first seven days of life are shown in table (vii) on page 10. It will be apparent from the preceding section that premature babies provided the major share. The cause of stillbirth, the other component of perinatal mortality, was not known until certification was introduced on 1 October, 1960 under the Population (Statistics) Bill, 1960. The following table gives the causes for 1961, but on the basis of the 1960 certificates only about two-thirds of them were certified by medical practitioners.

TABLE (x)—*Causes of stillbirth*, 1961.

*Code No.**	*Cause*	*Male*		*Female*	
		Number	*Per cent.*	*Number*	*Per cent.*
Y.30	Chronic disease in mother	23	3·9	17	3·3
Y.31	Acute disease in mother	3	0·5	1	0·2
Y.32	Diseases and conditions of pregnancy and childbirth:				
	(1) Ectopic gestation	1	0·2	—	—
	(2) Haemorrhage	52	8·8	37	7·3
	(3 and 4) Toxaemia	79	13·3	69	13·6
	(5) Infection	2	0·3	1	0·2
Y.34	Difficulties in labour..	57	9·6	39	7·7
Y.35	Other causes in mother	5	0·8	3	0·6
Y.36	Placental and cord conditions	151	25·4	110	21·5
Y.37	Birth injury	14	2·4	11	2·2
Y.38	Congenital malformation of foetus ..	59	9·9	80	15·7
Y.39	Diseases of foetus and ill-defined causes:				
	(0–3) Diseases of foetus	20	3·4	27	5·3
	(4–6) Other ill-defined or unspecified cause	128	21·5	114	22·4
	Total	594	100·0	509	100·0

* *International classification of causes of stillbirth.*

Maternal mortality—

TABLE (xi)—*Maternal mortality*, 1952-61

Year	Live births and stillbirths	Deaths in pregnancy or childbirth excluding abortion	Post-abortion deaths	Total maternal deaths	
				No.	Rate per 1,000 total births
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
1960	58,420	15	11	26	0·45
1961*	61,155	27	18	45	0·74

** For the sixth year running none of the deaths in pregnancy or childbirth was due to sepsis; 14 of the 18 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 17 and 18.

Air pollution

There were no particular foggy incidents in 1961. The table below shows for the past eight winters the average levels of pollution based on the seven recording stations described in appendix B to my report for 1956.

Winter averages of air pollution

Average daily readings of seven volumetric recording stations

Winter	'Smoke'		'Sulphur dioxide'		Ratio smoke/SO_2	
	(*a*)	(*c*)	(*b*)	(*c*)	(*a*:*b*)	(*c*:*c*)
1954–1955	49		11·1		4·4	
1955–1956	52		11·8		4·4	
1956–1957	45		10·2		4·4	
1957–1958	41		11·5		3·6	
1958–1959	43	309	11·9	340	3·6	0·9
1959–1960	32	206	9·6	275	3·3	0·7
1960–1961	24	200	9·7	277	2·5	0·7
1961–1962		182		302		0·6

(*a*) *Milligrams of black suspended matter per 100 cubic metres of air.*
(*b*) *Acidic gases in parts per 100 million parts of air.*
(*c*) *Micrograms per cubic metre.*

From 1 October, 1961 the estimation of smoke and sulphur dioxide was changed to a common unit, micrograms per cubic metre, to accord with the new system introduced by the Department of Scientific and Industrial Research. In order to provide a link with the figures quoted in previous reports the pollution data has been recalculated on the revised basis for the three preceding years and both sets of figures are shown.

INFECTIOUS DISEASES

Notifications of infectious diseases for the years 1952–1961 are shown in table V.5, page 21, those for certain such diseases by age and sex for the 13 four-weekly periods of the year 1961 are given in table V.6, page 22 and deaths from infectious diseases are included in table V.3, page 19.

Diarrhoea and enteritis—There were 20 deaths under the age of two years from diarrhoea and enteritis, compared with 16 in the previous year. This represents a rate of 0·33 per 1,000 live births and shows a continuation of the low figures of recent years.

Diphtheria—There was a slight rise in notifications in 1961, from sixteen in 1960 to twenty-eight. Localised outbreaks occurred in Camberwell, Battersea, Kensington, Bermondsey and Deptford. Each of these episodes centred on a primary school (that in Kensington in a junior training centre for subnormal children). The pattern was that after the recognition of a single case of diphtheria widespread swabbing among the school and home contacts brought to light a variable number of infected persons, most of whom were carriers without symptoms. The intensive search for infected persons and the isolation of any cases or carriers enabled the infection to be eliminated from the area in each instance. There were three deaths from diphtheria and there was no evidence that any of these children had been immunised in the past. The fact that it has been possible to limit these outbreaks by the rapid institution of energetic measures has been due to the willing co-operation of the staff of the Public Health Laboratory at County Hall, who shared with the divisional staff a great deal of additional work while the outbreaks were in progress.

Nothing that occurred during the year cast any doubt on the value of immunisation. The risk of contracting diphtheria is four or five times greater in the unimmunised than in the immunised and there was a tragic demonstration that diphtheria can still be a very serious disease in unimmunised children. The events described above have somewhat diverted attention from the continued improvement in the proportion of young children given their primary course of immunisation. Figures for infant immunisation in 1961 given elsewhere in this report give cause for some satisfaction. The local outbreaks during the year lead to a general determined effort to increase the number of boosting doses given to children in primary schools.

Dysentery—During the year dysentery notifications fell to 1,812—the lowest figure for ten years. Whereas in recent years the number of cases occurring in children of school age has been roughly equal to that in the much smaller numbers of pre-school children, in 1961 the cases in school children were fewer in number than those in the age group 0 to 4 years.

Enteric fever—Incidence continued at a low level; no notable outbreaks occurred. Most cases in recent years have been of the sporadic kind.

Influenza—There was a rise in the number of deaths from influenza but incidence of the disease was not above the average.

Leptospirosis—For the fifth successive year there was no case of leptospirosis reported among the Council's sewer workers.

Measles—The customary biennial epidemic culminated in the early part of the year. Mortality remains at a low level.

Trials of a new vaccine were carried out during the year. Although it gives substantial protection against the disease, its administration is followed in a high proportion of those receiving the vaccine by side effects (fever and skin eruption). These reactions make it most unlikely that the vaccine in its present form will become popular in this country while natural measles remains as mild a disease as it now is. The vaccine may have a place in the health programme of countries in which measles still has a high mortality.

Ophthalmia neonatorum—There was an increase in the number of notifications from 89 in 1960 to 100 in 1961, the rate (per 1,000 registered live births) changing from 1·36 to 1·46. Cases among children born to London residents totalled 70, a fall of three compared with the previous year; in 61 vision was unimpaired, five removed and four were still under treatment at the end of the year.

Poliomyelitis—There was a considerable reduction in the number of notifications of poliomyelitis in 1961.

Once again a marked feature of the epidemiological picture was the high proportion of cases found in the age group 0–4 years. This was 50·0 per cent. of all cases.

TABLE (xii)—*Poliomyelitis notifications by age*, 1949–61

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
1960	52	59·8	17	19·5	18	20·7	87
1961	22	50·0	12	27·3	10	22·7	44

It will be seen from table (xii) that a high proportion of cases in the 0–4 years age group has been recorded previously in 1949, 1959 and 1960. Cases were spread throughout the age group. The higher rate of incidence in the under-fives does not appear to be related to any difference between vaccination rates in this age group and the over-fives. The reason for the high proportion of cases in young children remains uncertain.

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 on the stool, or when serological evidence supported the diagnosis. Table (xiii) gives an analysis of the original notifications according to the final diagnosis.

TABLE (xiii)—*Final diagnosis of poliomyelitis notifications*, 1961

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 ..	19	2	6	27	—	—	—	—	27
Non-paralytic ..	—	—	—	—	2	4	2	8	8
Not poliomyelitis (or not known)	1	3	2	6	—	3	—	3	9
Total ..	20	5	8	33	2	7	2	11	44

TABLE (xiv)—*Vaccinal state of confirmed cases of poliomyelitis*, 1961

Age	Vaccinated*		Not vaccinated		Not known		Total	
	No.	%	No.	%	No.	%	No.	%
(*a*) Paralytic cases								
0–4 years	3	16	16	84	—	—	19	100
5–14 „	—	—	2	100	—	—	2	100
15+ „	1	17	4	66	1	17	6	100
Total	4	15	22	81	1	4	27	100
(*b*) Non-paralytic cases								
0–4 years	1	50	1	50	—	—	2	100
5–14 „	2	50	2	50	—	—	4	100
15+ „	1	50	—	—	1	50	2	100
Total	4	50	3	38	1	12	8	100

* *One, two or three injections.*

Of the four vaccinated cases with the paralytic form of the disease, one had received one injection and three (the children aged 0–4 years) had had two injections; none of the four had received a third injection. In the non-paralytic cases two had received three injections and the remaining two vaccinated cases two injections.

It is estimated that by the end of the year 75 per cent. of children aged 0–14 years had received two injections of poliomyelitis vaccine, 56 per cent. three injections and 25 per cent. of the schoolchildren had had a fourth injection. Applying the figure of 75 per cent. to the child population at risk gives the following incidence rates for the paralytic form of the disease:

	Population 0–14 years	*Cases*	*Cases per million population at risk*
Vaccinated	482,700	3	6·2
Not vaccinated	160,900	18	111·9

Thus the incidence rate in the unvaccinated children was about 18 times that in the vaccinated; in 1960 when the percentage vaccinated with two injections was 70 per cent. it was 13 or 18 times*.

Smallpox—There was one case notified during the year in St. Pancras; this was in respect of a visitor to this country. Fortunately no secondary cases resulted.

Whooping cough—After the increase in 1960 the figures for whooping cough returned to a low level in 1961, being the lowest yet recorded. For the first time no death from whooping cough was reported.

* *These alternative ratios were according to whether two cases whose vaccinal state was not known were included or excluded.*

TABLE V.1—*Vital statistics—Metropolitan Boroughs and the Administrative County of London, 1961 (a)*

Metropolitan Boroughs	*Estimated home population mid 1961*	*Live birth rate*		*Death rate (all causes)*		*Infant mortality (per 1,000 live births)*	*Death rates*							*Notifications of infectious disease*								
		Crude	*Adjusted*	*Crude*	*Adjusted*		*Cancer*	*Vascular lesions of C.N.S.*	*Heart disease*	*Other circulatory*	*Pneumonia*	*Other respiratory (excluding tuberculosis)*	*Violence*	*Dysentery*	*Food poisoning*	*Measles*	*Pneumonia*	*Poliomyelitis*		*Scarlet fever*	*Whooping cough*	*Tuberculosis*	
																		Paralytic	*Non-paralytic*			*Pulmonary*	*Non-pulmonary*
Division 1																							
Chelsea	48,490	13·5	10·3	15·0	10·8	24	2·80	1·84	4·39	0·99	0·76	0·95	0·78	0·80	*0·02*	11·63	*0·16*	*0·021*	—	*0·08*	0·49	*0·39*	*0·04*
Fulham	111,500	16·8	16·5	11·3	11·0	19	2·68	1·06	3·43	0·64	0·48	1·09	0·51	*0·05*	0·18	12·27	*0·14*	*0·027*	*0·009*	*0·14*	0·22	0·57	*0·05*
Hammersmith ..	108,010	21·3	20·2	11·5	11·8	17	2·56	1·20	3·59	0·57	0·55	0·98	0·60	1·06	0·37	10·99	0·41	—	*0·009*	0·23	0·19	0·81	*0·14*
Kensington ..	169,080	19·6	14·1	10·2	10·2	21	2·11	1·15	2·87	0·66	0·66	0·72	0·65	0·59	0·25	8·83	0·14	*0·035*	*0·006*	0·18	0·20	0·99	0·16
Division 2																							
Hampstead ..	96,990	17·8	13·5	10·1	10·0	16	2·31	1·05	3·20	0·55	0·63	0·62	0·53	*0·16*	*0·13*	11·27	*0·20*	*0·041*	*0·031*	0·39	0·26	0·56	*0·16*
Paddington ..	113,980	21·9	17·7	11·0	11·2	22	2·24	1·09	2·88	0·61	0·70	0·89	0·82	0·34	0·59	7·35	0·26	*0·018*	—	0·22	0·25	1·30	*0·12*
St. Marylebone ..	67,690	11·2	8·8	16·4	12·1	26	3·28	2·17	5·64	0·90	0·66	1·27	0·49	*0·13*	*0·12*	6·23	*0·04*	—	—	*0·19*	*0·16*	0·59	*0·03*
St. Pancras ..	125,340	18·5	16·3	11·2	11·1	24	2·49	1·08	2·95	0·62	0·80	0·99	0·69	1·07	0·32	12·94	0·39	—	—	0·42	0·31	1·09	*0·08*
Westminster, City of ..	86,680	11·9	10·0	11·2	11·1	22	2·58	0·90	3·43	0·76	0·61	0·78	0·72	0·31	0·23	9·17	*0·05*	—	—	*0·14*	*0·06*	0·84	*0·01*
Division 3																							
Finsbury ..	33,020	18·8	17·1	10·7	10·6	31	2·70	0·94	3·24	*0·30*	*0·42*	1·15	*0·42*	2·45	0·85	12·51	1·61	—	—	2·21	0·85	1·03	*0·09*
Holborn	20,520	10·5	7·5	11·8	12·4	46	2·68	1·12	3·36	*0·63*	0·97	*0·58*	*0·63*	*0·10*	*0·19*	5·95	*0·10*	*0·049*	—	*0·24*	*0·34*	1·07	*0·10*
Islington ..	227,170	24·0	21·8	11·4	11·1	21	2·32	1·13	2·93	0·72	0·87	1·32	0·53	1·10	0·49	14·55	0·19	*0·004*	—	0·67	0·29	1·05	0·10
Division 4																							
Hackney ..	163,180	22·4	21·1	11·8	12·6	23	2·59	1·13	3·58	0·66	0·55	1·24	0·38	0·32	0·17	15·39	0·29	*0·006*	—	0·57	0·21	0·61	*0·07*
Shoreditch ..	40,530	16·7	15·7	12·7	11·4	27	1·92	1·73	3·23	0·67	1·11	1·85	0·54	*0·17*	*0·12*	16·01	*0·35*	—	—	0·59	*0·30*	0·64	*0·02*
Stoke Newington	52,180	24·9	22·2	10·9	12·5	27	2·20	1·19	2·99	0·54	0·57	1·11	0·54	0·67	*0·29*	17·50	*0·21*	—	*0·019*	0·38	*0·29*	0·88	*0·06*
Division 5																							
Bethnal Green ..	46,490	17·7	17·0	12·2	11·5	19	2·43	1·18	3·27	0·45	1·05	1·53	*0·41*	*0·22*	*0·04*	20·0	*0·34*	—	—	0·77	*0·28*	0·71	*0·09*
City of London(*b*)	4,600	5·9	5·4	12·4	12·2	37	*3·26*	*1·09*	*4·13*	*0·43*	*1·30*	*0·43*	*0·65*	*0·43*	—	5·0	*0·22*	*0·217*	—	*0·43*	*0·43*	*1·09*	—
Poplar	65,850	20·7	19·7	10·8	12·2	28	2·07	1·12	3·01	0·56	0·64	1·23	0·56	0·35	0·46	20·24	1·02	*0·030*	—	0·91	*0·23*	0·61	*0·11*
Stepney	91,710	20·4	18·6	13·1	13·4	22	2·56	1·06	4·00	0·56	1·06	1·56	0·60	0·52	0·26	20·70	1·28	—	—	0·58	0·34	1·08	*0·10*
Division 6																							
Deptford	68,220	20·3	19·9	11·6	11·7	22	2·46	0·86	3·78	0·44	1·07	1·13	0·53	0·34	*0·12*	20·52	0·34	—	—	0·51	0·67	1·42	*0·04*
Greenwich ..	85,240	15·4	14·8	10·9	11·9	23	2·43	1·06	3·48	0·42	0·77	0·87	0·46	0·41	0·26	21·35	*0·06*	—	—	0·35	0·31	0·38	*0·05*
Woolwich ..	146,850	14·8	14·8	11·0	11·7	17	2·38	1·07	3·51	0·59	0·93	0·84	0·33	*0·03*	*0·02*	20·82	0·52	*0·007*	—	0·31	0·33	0·36	*0·02*
Division 7																							
Camberwell ..	173,980	19·4	18·2	11·8	11·6	19	2·41	1·40	3·39	0·69	0·74	1·10	0·53	0·17	0·18	15·74	0·20	—	—	0·28	0·54	0·85	*0·10*
Lewisham ..	220,910	17·2	16·5	11·7	11·2	19	2·18	1·43	3·94	0·56	0·64	1·07	0·45	0·58	0·14	19·37	0·28	*0·009*	*0·005*	0·43	0·29	0·51	*0·05*
Division 8																							
Bermondsey ..	51,770	17·6	17·1	11·7	12·2	20	2·34	1·35	3·30	0·99	0·62	1·08	0·46	1·45	0·91	17·00	*0·31*	—	—	0·66	*0·37*	0·70	*0·06*
Lambeth ..	221,960	22·1	20·1	11·6	11·6	22	2·61	1·18	3·23	0·55	0·81	1·09	0·52	0·57	*0·07*	15·60	0·28	*0·009*	—	0·52	0·54	0·57	*0·08*
Southwark ..	86,270	19·7	17·9	14·5	12·2	22	2·69	1·45	4·76	0·77	1·10	1·41	0·53	3·13	0·28	19·38	0·78	—	*0·012*	0·92	0·46	0·93	*0·08*
Division 9																							
Battersea	104,980	19·6	19·2	11·7	10·9	21	2·43	1·39	3·54	0·57	0·57	0·99	0·57	0·30	*0·11*	18·16	0·41	*0·010*	*0·010*	0·35	0·60	0·56	*0·05*
Wandsworth ..	346,790	17·1	16·4	14·0	10·5	20	2·53	1·50	4·91	0·72	0·94	0·95	0·50	0·27	0·26	14·21	0·62	*0·003*	*0·003*	0·31	0·55	0·49	0·06
London, 1961 ..	3,179,980	18·9	17·0	11·9	11·4	21	2·45	1·25	3·62	0·64	0·76	1·06	0·53	0·57	0·25	15·00	0·37	0·009	*0·003*	0·43	0·36	0·74	0·08
London, 1960 ..	3,194,480	18·0	16·2	11·4	11·2	21	2·53	1·28	3·51	0·57	0·65	0·83	0·49	1·62	0·38	2·68	0·28	0·020	0·007	0·47	1·50	0·79	0·08

(*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*, 1952-61

Year	Annual rate per 1,000 living				Annual mortality per 1,000 living													Annual mortality—		
	Live births		Deaths (all causes)		Tuberculosis										Violence			Infant (per 1,000 live births)		Maternal (per 1,000 total births)
	Crude rate	Adjusted rate	Crude rate	Adjusted rate	Pulmonary	Non-pulmonary	Cancer	Vascular lesions of C.N.S.	Heart disease	Other circulatory disease	Influenza	Pneumonia (all forms)	Bronchitis	Other resp. diseases	Suicide	Road accidents (a)	Other violence	Infants 0—1	Diarrhoea and enteritis 0—2	
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
1960.. ..	18·0	16·2	11·4	11·2	0·07	0·01	2·53	1·28	3·51	0·57	0·01	0·65	0·70	0·11	0·16	0·14	0·20	21	0·3	0·45
1961.. ..	18·9	17·0	11·9	11·4	0·09	0·01	2·45	1·25	3·62	0·64	0·08	0·76	0·87	1·06	0·16	0·13	0·24	21	0·3	0·74

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

TABLE V.3—*Deaths by cause—Administrative County of London*, 1961

Cause	*Sex*	*0–*	*1–*	*5–*	*15–*	*25–*	*45–*	*65–*	*75+*	*Total*	
										1961	*1960*
1. Tuberculosis—respiratory ..	M	–	–	1	–	17	92	74	44	**228**	176
	F	–	–	–	–	*13*	*23*	*11*	*19*	***66***	*59*
2. Tuberculosis—other	M	1	–	–	–	1	3	3	2	**10**	9
	F	*1*	*1*	*1*	–	*2*	*6*	*2*	*1*	***14***	*25*
3. Syphilitic disease	M	–	–	–	–	2	24	26	13	**65**	62
	F	–	–	–	–	*2*	*7*	*16*	*22*	***47***	*36*
4. Diphtheria	M	–	–	–	–	–	–	–	–	–	–
	F	–	–	*3*	*1*	–	–	–	–	***4***	–
5. Whooping cough	M	–	–	–	–	–	–	–	–	–	2
	F	–	–	–	–	–	–	–	–	–	*1*
6. Meningococcal infection ..	M	–	2	–	–	–	1	1	–	**4**	4
	F	*2*	*3*	*1*	–	–	–	–	–	***6***	*5*
7. Acute poliomyelitis	M	–	–	–	–	–	–	–	–	–	2
	F	–	–	–	–	*1*	–	–	–	***1***	–
8. Measles	M	2	3	1	–	–	–	–	–	**6**	1
	F	–	*3*	*1*	–	*1*	–	–	–	***5***	–
9. Other infective, &c., diseases	M	–	1	2	1	3	13	6	5	**31**	45
	F	*1*	*1*	*4*	*2*	*5*	*13*	*4*	*7*	***37***	*27*
10. Malignant neoplasm: Stomach	M	–	–	–	–	15	206	156	133	**510**	497
	F	–	–	–	–	*8*	*102*	*144*	*186*	***440***	*424*
11. Malignant neoplasm: Lung, bronchus	M	–	–	–	2	44	883	568	264	**1,761**	1,870
	F	–	–	–	–	*24*	*151*	*99*	*85*	***359***	*373*
12. Malignant neoplasm: Breast	M	–	–	–	–	–	4	–	–	**4**	8
	F	–	–	–	–	*53*	*286*	*168*	*180*	***687***	*703*
13. Malignant neoplasm: Uterus	*F*	–	–	–	*1*	*34*	*133*	*76*	*52*	***296***	*309*
14. Other malignant and lymphatic neoplasms	M	–	6	8	21	89	629	544	552	**1,849**	1,850
	F	*2*	*3*	*4*	*16*	*99*	*525*	*470*	*565*	***1,684***	*1,837*
15. Leukemia, aleukemia ..	M	3	8	6	5	15	32	19	12	**100**	112
	F	–	*2*	*6*	*3*	*7*	*29*	*17*	*28*	***92***	*96*
16. Diabetes	M	–	–	1	1	3	15	27	26	**73**	72
	F	–	–	*1*	–	*3*	*30*	*61*	*80*	***175***	*145*
17. Vascular lesions of nervous system	M	2	–	2	5	31	342	471	684	**1,537**	1,600
	F	–	*1*	–	*1*	*26*	*310*	*577*	*1,513*	***2,428***	*2,485*
18. Coronary disease, angina ..	M	–	–	–	–	120	1,471	1,146	1,073	**3,810**	3,857
	F	–	–	–	–	*12*	*373*	*860*	*1,475*	***2,720***	*2,611*
19. Hypertension with heart disease	M	–	–	–	–	1	54	80	115	**250**	254
	F	–	–	–	–	–	*39*	*90*	*289*	***418***	*396*
20. Other heart disease	M	1	–	1	6	63	236	322	926	**1,555**	1,504
	F	–	–	–	*4*	*58*	*255*	*428*	*2,011*	***2,756***	*2,583*
21. Other circulatory disease ..	M	1	–	1	–	20	207	245	357	**831**	738
	F	–	*1*	–	*2*	*19*	*153*	*254*	*767*	***1,196***	*1,095*
22. Influenza	M	2	3	–	2	3	29	32	40	**111**	21
	F	*1*	*1*	–	*1*	*2*	*17*	*30*	*83*	***135***	*25*
23. Pneumonia	M	92	15	5	3	23	166	258	546	**1,108**	986
	F	*68*	*10*	*3*	*3*	*16*	*84*	*218*	*917*	***1,319***	*1,091*
24. Bronchitis	M	20	7	1	1	9	464	627	764	**1,893**	1,520
	F	*11*	*7*	–	*1*	*7*	*91*	*221*	*536*	***874***	*727*
25. Other diseases of respiratory system	M	3	2	1	5	13	66	66	65	**221**	252
	F	*4*	*3*	*1*	*1*	*2*	*35*	*32*	*59*	***137***	*100*
26. Ulcer of stomach and duodenum	M	–	–	–	–	7	84	78	85	**254**	282
	F	–	–	*1*	–	*2*	*24*	*39*	*70*	***136***	*146*
27. Gastritis, enteritis and diarrhoea	M	9	3	1	1	5	24	20	22	**85**	65
	F	*9*	–	–	–	*2*	*17*	*35*	*63*	***126***	*124*
28. Nephritis and nephrosis ..	M	–	1	2	4	10	50	13	25	**105**	119
	F	–	–	*1*	*5*	*6*	*28*	*23*	*28*	***91***	*105*
29. Hyperplasia, prostate ..	M	–	–	–	–	–	12	44	129	**185**	175
30. Pregnancy, childb., abortn.	*F*	–	–	–	*11*	*33*	*1*	–	–	***45***	*26*
31. Congenital malformations ..	M	95	15	11	6	7	21	8	2	**165**	196
	F	*141*	*13*	*1*	*4*	*16*	*15*	*4*	*2*	***196***	*200*
32. Other defined and ill-defined diseases	M	467	11	12	22	77	269	188	301	**1,347**	1,270
	F	*317*	*10*	*9*	*18*	*55*	*244*	*292*	*681*	***1,626***	*1,638*

TABLE V.3 (*contd.*)—*Deaths by cause—Administrative County of London*, 1961

Cause	*Sex*	*0–*	*1–*	*5–*	*15–*	*25–*	*45–*	*65–*	*75+*	*Total*	
										1961	*1960*
33. Motor vehicle accidents ..	M	1	7	14	66	64	49	37	43	**281**	307
	F	–	*4*	*3*	*13*	*22*	*27*	*29*	*35*	***133***	*140*
34. All other accidents	M	11	17	25	37	90	115	53	63	**411**	359
	F	*14*	*16*	*5*	*9*	*15*	*45*	*59*	*162*	***325***	*247*
35. Suicide	M	–	–	–	22	99	120	34	23	**298**	303
	F	–	–	–	*10*	*61*	*100*	*30*	*23*	***224***	*199*
36. Homicide, operations of war	M	1	1	2	4	6	5	1	–	**20**	16
	F	–	–	–	*1*	*4*	*2*	–	*2*	***9***	*9*
ALL CAUSES	M	711	102	97	214	837	5,686	5,147	6,314	**19,108**	18,534
	F	*571*	*79*	*45*	*107*	*610*	*3,165*	*4,289*	*9,941*	***18,807***	*17,987*

TABLE V.4—*Weather during* 1961
(*as recorded at Kew Observatory*)

Month	*Temperature*		*Rainfall*		*Sunshine*	
	Mean (a) °F	*Difference from Average (b)* °F	*Total* ins.	*Difference from Average (b)* ins.	*Total* hrs.	*Difference from Average (c)* hrs.
January	40·8	+1·1	2·45	+0·49	53·5	+11·7
February	46·2	+5·9	2·15	+0·60	66·0	+7·6
March	47·5	+4·7	0·16	−1·38	171·3	+64·6
April	52·0	+4·5	2·06	+0·35	101·7	−47·5
May	53·8	+0·2	0·95	−0·80	232·6	+35·1
June	61·2	+1·8	1·39	−0·59	241·5	+41·0
July	62·4	−0·3	1·20	−1·18	202·9	+7·4
August	62·1	+0·3	2·29	+0·05	166·9	−18·1
September ..	60·8	+3·4	2·14	+0·15	130·3	−10·6
October	53·1	+2·8	2·11	−0·40	123·1	+29·9
November	45·3	+1·1	1·82	−0·52	63·3	+12·1
December	39·6	−1·1	3·44	+1·28	54·4	+17·1
Year	52·1	+2·1	22·16	−1·95	1,607·5	+150·3

(*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, 1952–1961*

Year	Anthrax		Diphtheria		Dysentery		Acute encephalitis		Enteric fever		Erysipelas		Malaria		Measles		Meningo-coccal infection		Ophthalmia neonatorum		Pneumonia		Poliomyelitis				Puerperal pyrexia		Scabies		Scarlet fever		Smallpox		Typhus		Whooping cough		Food poisoning	
																							Paralytic		Non-par.															
	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate	Cases	Rate
																			(a)								(b)													
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
1960 ..	—	—	16	0·005	5,161	1·616	23	0·007	51	0·016	229	0·072	10	0·003	8,561	2·68	71	0·022	89	1·36	882	0·276	64	0·020	23	0·007	1,416	21·20	498	0·16	1,500	0·47	1	0·0003	—	—	4,794	1·50	1,229	0·38
1961 ..	—	—	28	0·009	1,812	0·570	18	0·006	32	0·010	204	0·064	26	0·008	47,620	15·00	67	0·021	100	1·46	1,174	0·369	29	0·009	11	0·003	1,486	21·27	463	0·15	1,361	0·43	1	0·0003	—	—	1,146	0·36	783	0·25

(a) *Rate per 1,000 live births registered in London.* (b) *Rate per 1,000 total births registered in London.*

TABLE V.6—*Notification of certain infectious diseases—distribution by age and date of notification—Administrative County of London, 52 weeks commencing 2 January, 1961*

Four-weekly periods 1961		Dysentery				Measles				Meningococcal infection				Pneumonia				Poliomyelitis								Scarlet fever				Whooping cough			
																		Paralytic				Non-paralytic											
		Ages				Ages				Ages				Ages				Ages				Ages				Ages				Ages			
		0—4	5—14	15+	Total	0—4	5—14	15+	Total	0—4	5—14	15+	Total	0—4	5—14	15+	Total	0—4	5—14	15+	Total	0—4	5—14	15+	Total	0—4	5—14	15+	Total	0—4	5—14	15+	Total
1— 4	M	25	16	16	**57**	1,621	1,130	16	**2,775**	1	1	1	**3**	20	4	64	**88**	—	—	—	—	—	—	—	—	13	34	5	**52**	52	37	2	**92**
	F	*23*	*11*	*21*	***56***	*1,492*	*1,035*	*46*	***2,578***	*3*	*1*	*1*	***5***	*10*	*5*	*75*	***90***	*1*	—	*1*	***2***	—	—	—	—	*21*	*31*	*4*	***56***	*68*	*34*	*2*	***104***
5— 8	M	40	24	20	**84**	2,839	2,794	43	**5,686**	4	—	1	**5**	12	8	172	**193**	2	—	—	**2**	—	—	—	—	20	42	7	**69**	45	18	—	**63**
	F	*38*	*15*	*34*	***87***	*2,713*	*2,864*	*55*	***5,639***	*4*	*1*	—	***5***	*15*	*8*	*156*	***179***	—	—	—	—	—	—	—	—	*22*	*46*	*13*	***81***	*71*	*16*	*2*	***89***
9—12	M	34	48	24	**106**	3,544	2,397	52	**6,008**	2	—	2	**4**	6	9	34	**49**	—	—	—	—	—	—	—	—	17	47	1	**65**	28	15	1	**44**
	F	*38*	*44*	*31*	***114***	*3,463*	*2,367*	*70*	***5,909***	*1*	—	—	***1***	*6*	*4*	*51*	***61***	—	—	—	—	—	—	—	—	*14*	*41*	*2*	***57***	*51*	*31*	*4*	***86***
13—16	M	47	31	10	**89**	3,016	1,753	65	**4,840**	1	5	—	**6**	6	7	39	**52**	1	—	—	**1**	—	—	—	—	22	27	3	**52**	15	15	—	**30**
	F	*43*	*19*	*30*	***93***	*2,922*	*1,779*	*96*	***4,806***	—	*1*	*1*	***2***	*5*	*3*	*33*	***41***	—	—	—	—	—	—	—	—	*29*	*44*	*3*	***77***	*25*	*21*	*1*	***47***
17—20	M	56	17	13	**86**	1,364	610	44	**2,024**	3	—	1	**4**	4	4	14	**22**	1	—	—	**1**	—	1	—	**1**	26	30	7	**63**	20	18	1	**39**
	F	*32*	*24*	*33*	***89***	*1,454*	*574*	*76*	***2,106***	*1*	*1*	—	***2***	*5*	*5*	*18*	***28***	—	—	—	—	—	—	—	—	*24*	*43*	*4*	***71***	*28*	*12*	*2*	***42***
21—24	M	41	25	17	**83**	784	386	27	**1,197**	1	1	—	**2**	8	4	26	**38**	—	—	—	—	—	—	—	—	18	27	5	**50**	24	11	—	**35**
	F	*51*	*16*	*40*	***107***	*772*	*431*	*36*	***1,239***	—	*1*	—	***1***	*3*	*4*	*21*	***28***	—	—	—	—	—	—	—	—	*16*	*29*	*3*	***49***	*18*	*14*	—	***33***
25—28	M	25	24	27	**77**	402	210	16	**629**	—	—	—	—	4	6	18	**28**	—	—	—	—	—	—	—	—	16	32	2	**50**	22	9	—	**31**
	F	*27*	*15*	*31*	***75***	*399*	*223*	*18*	***641***	*3*	—	*3*	***6***	*1*	*2*	*13*	***16***	*1*	—	—	***1***	*1*	—	—	***1***	*13*	*31*	*2*	***46***	*17*	*9*	*1*	***27***
29—32	M	57	15	13	**85**	210	93	4	**308**	3	—	1	**4**	4	4	13	**21**	—	—	—	—	—	—	—	—	9	20	—	**29**	18	9	1	**28**
	F	*47*	*15*	*39*	***101***	*213*	*109*	*7*	***329***	—	—	*1*	***1***	*2*	—	*12*	***14***	*2*	—	—	***2***	—	—	—	—	*9*	*29*	*1*	***39***	*27*	*10*	*2*	***39***
33—36	M	53	13	14	**80**	114	37	7	**158**	—	—	—	—	1	2	13	**16**	—	—	2	**2**	—	—	—	—	14	9	1	**24**	15	8	—	**23**
	F	*47*	*10*	*31*	***88***	*123*	*32*	*6*	***161***	—	—	*3*	***3***	*1*	*1*	*12*	***14***	*1*	—	—	***1***	—	—	*1*	***1***	*12*	*9*	*4*	***25***	*22*	*13*	—	***35***
37—40	M	20	4	11	**35**	58	15	—	**73**	1	—	2	**3**	4	—	8	**12**	—	1	—	**1**	1	1	—	**2**	12	17	1	**30**	27	10	—	**38**
	F	*20*	*9*	*15*	***45***	*63*	*21*	*4*	***88***	—	—	—	—	—	*1*	*11*	***12***	*1*	*1*	*1*	***3***	—	*1*	—	***1***	*7*	*24*	*2*	***33***	*30*	*8*	—	***38***
41—44	M	37	9	8	**54**	50	26	3	**79**	1	2	—	**3**	7	3	13	**23**	—	—	2	**2**	—	—	—	—	22	31	1	**54**	17	12	—	**29**
	F	*20*	*15*	*19*	***56***	*66*	*26*	*3*	***95***	*1*	*1*	—	***2***	*2*	—	*11*	***13***	*2*	—	—	***2***	—	—	—	—	*14*	*32*	*2*	***48***	*18*	*15*	*1*	***34***
45—48	M	17	14	15	**46**	48	13	1	**62**	2	—	—	**2**	—	4	33	**37**	3	2	1	**6**	1	1	—	**2**	31	37	—	**68**	23	7	—	**30**
	F	*17*	*12*	*27*	***56***	*56*	*22*	*2*	***80***	—	—	*1*	***1***	*1*	*2*	*19*	***22***	*2*	—	*2*	***4***	—	*1*	—	***1***	*27*	*37*	*3*	***68***	*36*	*15*	—	***51***
49—52	M	21	13	4	**38**	35	17	2	**55**	2	—	—	**2**	4	3	35	**42**	—	—	—	—	—	1	1	**2**	16	26	2	**44**	9	5	—	**14**
	F	*20*	*11*	*12*	***43***	*34*	*15*	—	***49***	*2*	—	—	***2***	*4*	*5*	*36*	***45***	—	—	—	—	—	—	—	—	*22*	*30*	*4*	***56***	*15*	*6*	—	***21***
Total	M	473	253	192	**920**	14,119	9,481	280	**23,894**	21	9	8	**38**	80	58	482	**621**	7	3	5	**15**	2	4	1	**7**	236	379	35	**650**	315	174	5	**496**
	F	*423*	*216*	*363*	***1,010***	*13,770*	*9,498*	*419*	***23,720***	*15*	*6*	*10*	***31***	*55*	*40*	*468*	***563***	*10*	*1*	*4*	***15***	*1*	*2*	*1*	***4***	*230*	*426*	*47*	***706***	*426*	*204*	*15*	***646***

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 1961.

TUBERCULOSIS

Notification rates of pulmonary tuberculosis were slightly lower than in 1960 and the death rate followed the same general trend. The diagram on page 24 shows the trend of notifications, deaths and numbers on the registers of chest clinics over the last decade. Deaths from non-pulmonary tuberculosis are now so few that considerable random fluctuations occur in the rates from year to year and therefore are not shown in the diagram. The number of cases on the registers is now 35,208. Tuberculosis is still a serious infectious disease. This year, in adults it accounted for more cases than were notified of *any* other notifiable infectious disease. The 318 deaths from tuberculosis (all forms both sexes) include 210 deaths from pulmonary disease in men aged 45 years and over.

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.9.

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 (now renamed chest clinic welfare officers) 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 schoolchildren, students at further education establishments and mentally subnormal persons at training centres are shown in table T.11.

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 at the Council's training centres for mentally subnormal persons and of tuberculin reactors discovered among thirteen-year-old schoolchildren, students and others 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.8).

Tuberculosis contact scheme—In view of the small number of child contacts now needing to be boarded away from home, the placing of such children was taken over, as from 1 April 1961, by the Council from the Invalid Children's Aid Association, which had undertaken this work on the Council's behalf for over thirty years.

TREND OF TUBERCULOSIS
LONDON A.C. 1952–61

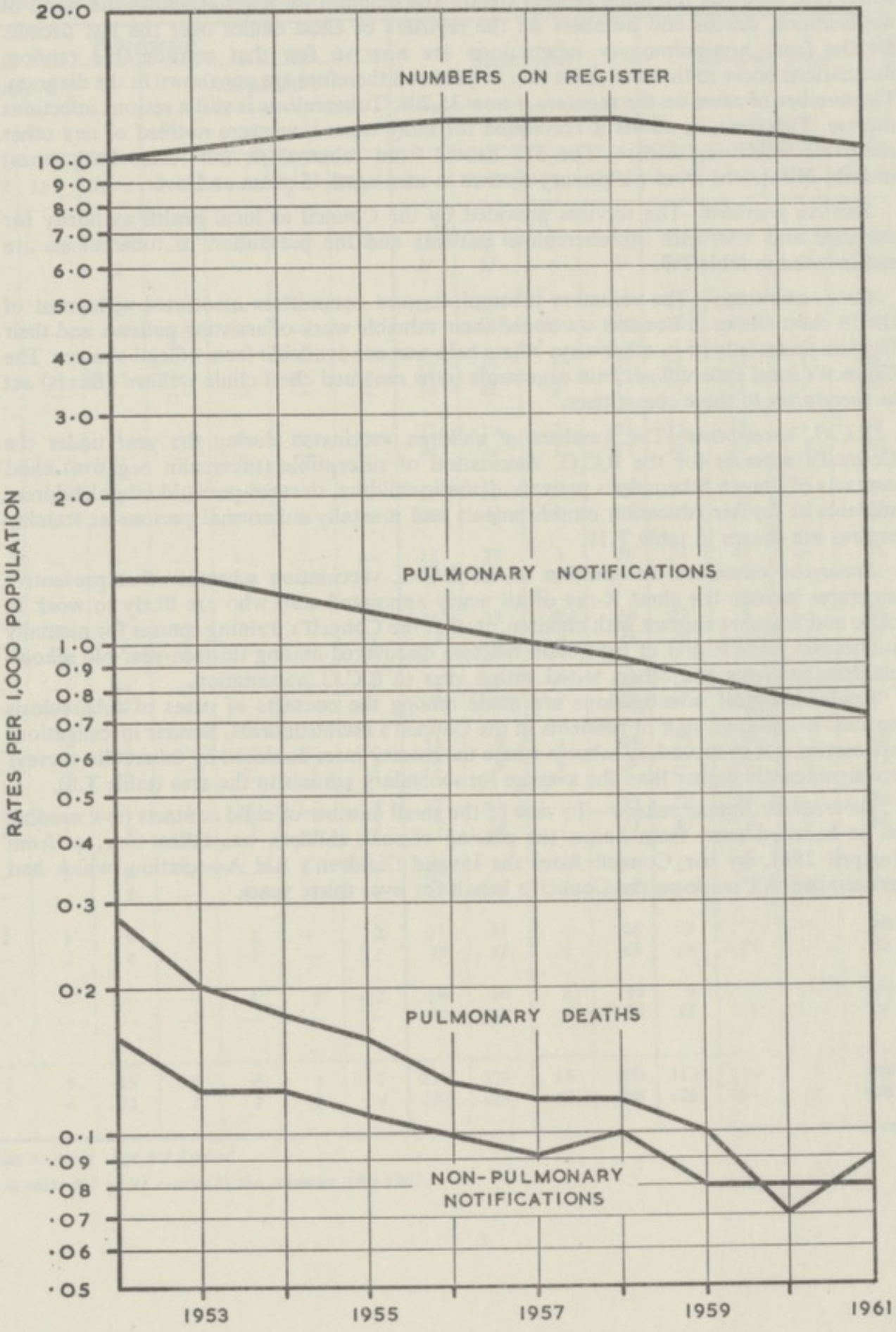


TABLE T.1—*Tuberculosis—Statutory notifications and deaths, Administrative County of London, 1952–1961 (a)*

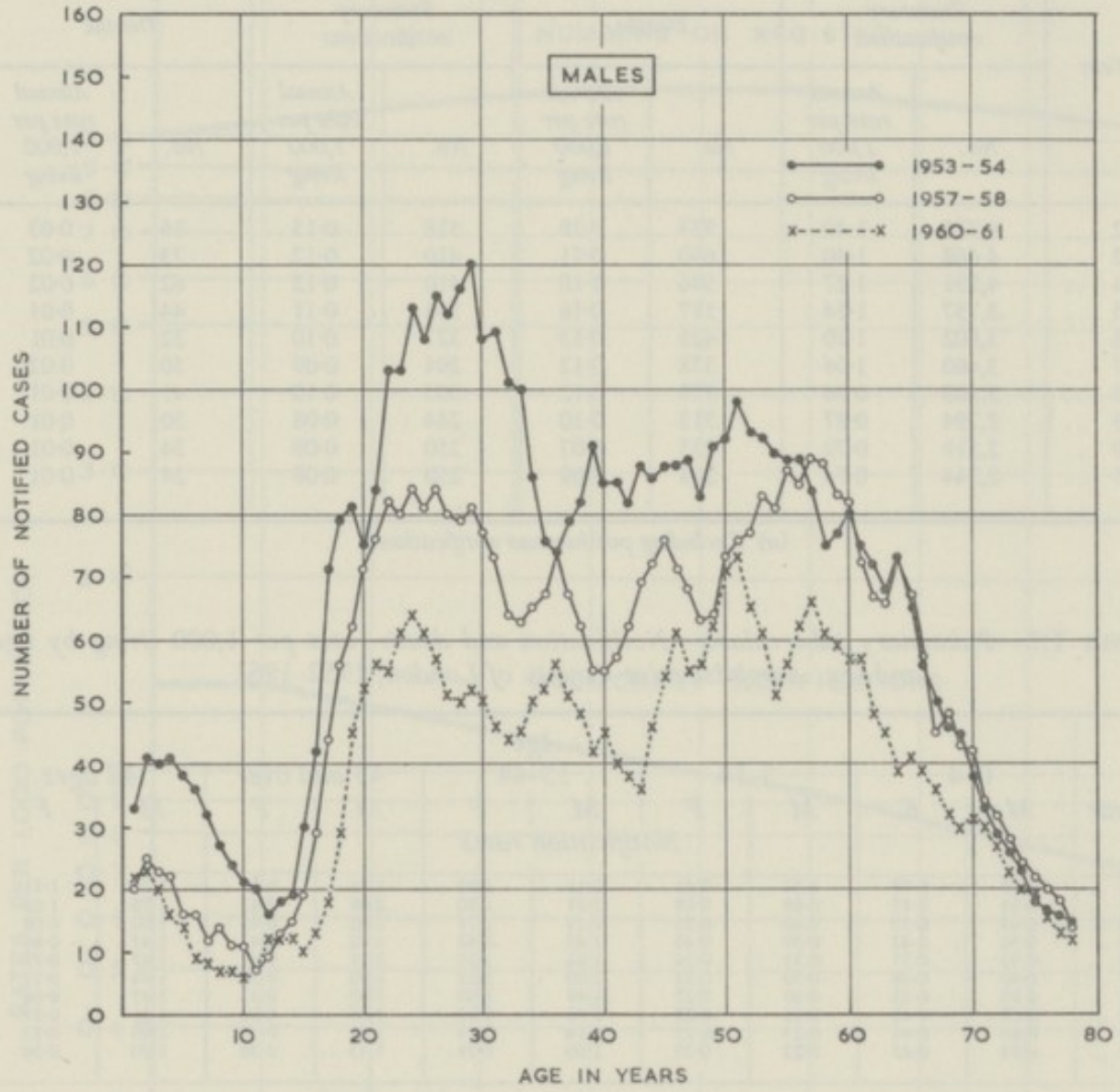
Year	Pulmonary tuberculosis				Non-pulmonary tuberculosis			
	Statutory notifications		Deaths		Statutory notifications		Deaths	
	No.	Annual rate per 1,000 living	No.	Annual rate per 1,000 living	No.	Annual rate per 1,000 living	No.	Annual rate per 1,000 living
1952 ..	4,713	1·40	933	0·28	518	0·15	86	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
1960 ..	2,519	0·79	235	0·07	250	0·08	34	0·01
1961 ..	2,344	0·74	294	0·09	250	0·08	24	0·01

(a) *Excluding posthumous notifications.*

TABLE T.2—*Pulmonary tuberculosis—Notification and death rates per* 1,000 *living by age and sex, Administrative County of London,* 1952–1961

Year	Age 0–4		5–14		15–44		45 and over		All ages	
	M	F	M	F	M	F	M	F	M	F
	Notification rates									
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
1960 ...	0·46	0·44	0·23	0·25	1·14	0·83	1·49	0·33	1·08	0·53
1961 ...	0·34	0·45	0·23	0·29	1·00	0·79	1·45	0·30	1·00	0·50
	Death rates									
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
1960 ...	—	0·03	—	—	0·03	0·02	0·29	0·06	0·12	0·03
1961 ...	—	—	0·005	—	0·03	0·02	0·40	0·07	0·15	0·04

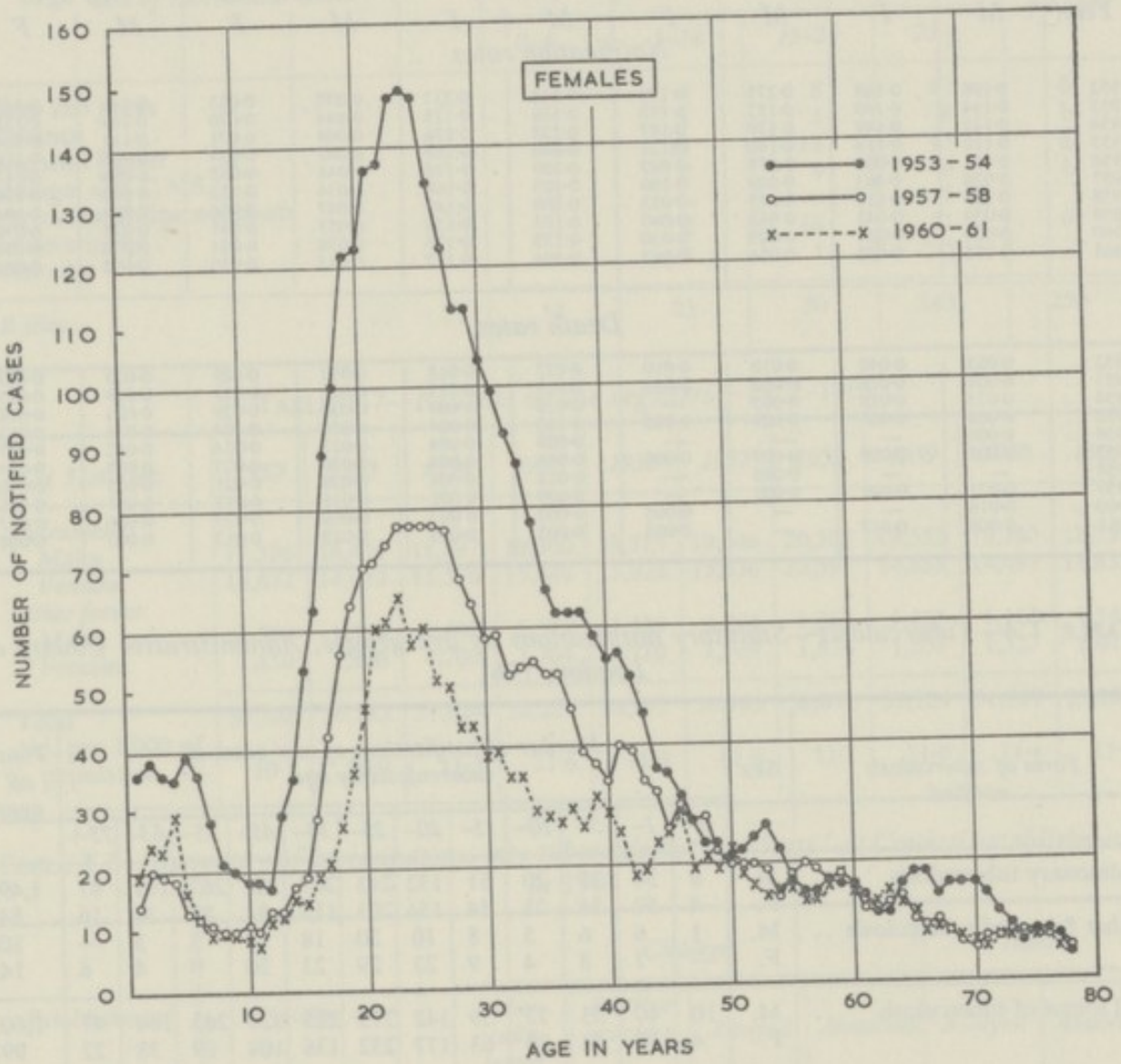
Figure 2



Figures 2 and 3 show a continuing fall during the last two years in the number of new notifications of pulmonary tuberculosis at ages up to 70 in men and in ages 15 to 45 in

TUBERCULOSIS, LONDON A.C.
—THREE-YEAR MOVING AVERAGES

Figure 3



women. In earlier years females showed a fall in all years up to age 55. The considerable improvement in the position as it affects older men is a very gratifying feature of current tuberculosis trends.

TABLE T.3—*Non-pulmonary tuberculosis—Notification and death rates per* 1,000 *living by age and sex, Administrative County of London,* 1952–1961

Year	Age 0–4 M	0–4 F	5–14 M	5–14 F	15–44 M	15–44 F	45 and over M	45 and over F	All ages M	All ages F
	Notification rates									
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
1960 ...	0·065	0·051	0·029	0·030	0·133	0·136	0·038	0·041	0·079	0·078
1961 ...	0·055	0·058	0·054	0·062	0·104	0·127	0·045	0·055	0·072	0·084
	Death rates									
1952 ...	0·053	0·040	0·010	0·010	0·027	0·018	0·033	0·029	0·029	0·023
1953 ...	0·024	0·076	0·005	0·010	0·017	0·017	0·025	0·029	0·019	0·025
1954 ...	0·025	0·018	0·005	—	0·016	0·009	0·035	0·029	0·021	0·016
1955 ...	0·008	0·009	0·009	0·005	0·012	0·004	0·021	0·024	0·014	0·013
1956 ...	0·009	—	—	—	0·009	0·004	0·023	0·014	0·012	0·007
1957 ...	0·008	0·009	0·009	0·005	0·011	0·004	0·030	0·027	0·017	0·014
1958 ...	—	—	0·005	—	0·012	0·004	0·026	0·021	0·015	0·010
1959 ...	0·025	0·009	0·005	—	0·009	0·001	0·011	0·017	0·011	0·008
1960 ...	0·016	—	—	0·005	0·003	0 007	0·009	0·027	0·006	0·015
1961 ...	0·008	0·017	—	0·005	0·002	0·003	0·015	0·013	0·007	0·008

TABLE T.4—*Tuberculosis—Statutory notifications by age groups, Administrative County of London,* 1961

Form of tuberculosis notified	Sex	Number of notifications of new cases of tuberculosis by age 0–	1–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75+	Total all ages
Pulmonary tuberculosis ..	M.	9	34	27	20	51	132	243	207	302	262	161	47	1,495
	F.	4	50	36	21	54	154	203	113	84	80	34	16	849
Other forms of tuberculosis ..	M.	1	6	6	5	8	10	30	18	18	3	3	—	108
	F.	—	7	8	4	9	23	29	23	20	9	4	6	142
All forms of tuberculosis ..	M.	10	40	33	25	59	142	273	225	320	265	164	47	1,603
	F.	4	57	44	25	63	177	232	136	104	89	38	22	991

TABLE T.5—*Tuberculosis—Deaths in Administrative County of London,* 1961

Form of tuberculosis	Sex	Age at death 0—	1—	5—	15—	25—	45—	65—	75+	Total all ages
Pulmonary tuberculosis ..	M.	—	—	1	—	17	92	74	44	228
	F.	—	—	—	—	13	23	11	19	66
Other forms of tuberculosis ..	M.	1	—	—	—	1	3	3	2	10
	F.	1	1	1	—	2	6	2	1	14
All forms of tuberculosis ..	M.	1	—	1	—	18	95	77	46	238
	F.	1	1	1	—	15	29	13	20	80

TABLE T.6—*Statutory notification of non-pulmonary tuberculosis—Distribution according to site and age, Administrative County of London*, 1961

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	2	4	8	47	61
Abdomen	2	1	3	8	14
Peripheral glands	6	11	18	47	82
Meninges and C.N.S.	2	2	4	4	12
Skin and erythema nodosum	2	—	—	1	3
Genito-urinary	—	2	16	51	69
Other sites	—	3	1	5	9
All sites	14	23	50	163	250

TABLE T.7—*Patients on the registers*—1952–1961

At 31st Dec.	*1952*	*1953*	*1954*	*1955*	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*
Pulmonary:										
Males ..	17,336	18,475	18,897	19,300	19,715	19,946	20,308	19,553	19,380	18,759
Females ..	14,672	14,930	15,576	15,846	15,928	15,836	15,597	14,858	14,497	13,833
Other forms:										
Males ..	1,530	1,508	1,442	1,371	1,339	1,274	1,293	1,158	1,163	1,143
Females ..	1,850	1,820	1,709	1,704	1,710	1,709	1,674	1,555	1,527	1,473
Total ..	35,388	36,733	37,624	38,221	38,692	38,765	38,872	37,124	36,567	35,208
No. per 1,000 of population ..	10·5	10·9	11·3	11·6	11·8	11·9	12·1	11·6	11·4	11·1

TABLE T.8—*Summary of investigations into tuberculosis 'incidents' at Council establishments in* 1961

Establishment	*Notified case*	*Children*				*Adults*	
		Tuberculin tested	*Positive reactors*	*X-rayed*	*Abnormal*	*X-rayed*	*Abnormal*
Day school ..	Pupil	28	—	—	—	1	—
	Teacher	132	7	7	—	—	—
	Pupil	280	22	22	—	2	—
	Pupil	16	5	5	—	—	—
	Secretary	17	4	4	—	—	—
	Pupil	—	—	—	—	1	—
	Teacher	23	4	4	—	16	—
	Pupil	—	—	—	—	134	2
	Pupil	118	74	74	—	—	—
	Pupil	—	—	—	—	45	—
	Secretary	197	2	2	—	6	—
Total (11) ..		811	118	118	—	205	2
Training centre	Trainee	52	4	4	—	—	—
College	Lab. Technician ..	—	—	—	—	4	—
Grand Total (13)		863	122	122	—	209	2

TABLE T.9—*Summary of services provided for tuberculous patients, Administrative County of London* 1957–1961

	1957	*1958*	*1959*	*1960*	*1961*
Clinic registers					
Total on registers at the end of the year	38,765	38,872	37,124	36,567	35,208
Work of local tuberculosis care organisers					
Patients assisted for the first time with:					
Beds and bedding	176	165	210	123	164
Clothing or footwear	734	571	558	500	421
Patients at the end of the year receiving:					
Extra nourishment	1,938	1,875	1,714	1,558	1,417
Home help service	528	467	465	462	412
Home care and treatment					
At the end of the year, patients:					
Awaiting admission to hospital	34	16	16	14	18
Under treatment in their own homes	329	238	143	140	123
Receiving attention by home nurses	371	368	331	283	244
Home visiting by tuberculosis health visitors—					
Total visits (including contacts)	80,302	78,953	86,680	77,861	83,585
Diversional therapy					
At the end of the year, attending classes at chest clinics	147	157	131	110	101
Receiving instruction in their own homes	259	262	200	180	150
Rehabilitation					
At the end of the year the Council was financially responsible for rehabilitants at:					
British Legion Village, Maidstone	29	30	19	11	13
Papworth Village Settlement, Cambridge	19	15	10	6	4
Enham-Alamein Village Centre, Andover	9	10	5	4	—
Barrowmore Hall, Chester	1	1	1	1	1
Correspondence courses arranged through the British Council for Rehabilitation for patients undergoing prolonged treatment at home	20	14	10	9	6
At boarding open-air schools					
Children convalescent from tuberculosis:					
At the beginning of the year	8	6	1	—	2
Admitted during the year	—	—	—	2	2
At the end of the year	6	1	—	2	3
Awaiting admission at end of year	—	—	—	1	—
Boarding-out of child contacts					
Children in nurseries and foster homes at the beginning of the year	172	136	94	79	53
Placed during the year	229	173	154	152	111
Boarded-out at the end of the year	136	94	79	53	34
Average number boarded-out at any one time ..	164	116	100	76	47
Boarding-out of child contacts for segregation during B.C.G. vaccination					
Children in nurseries and foster homes at the beginning of the year	4	3	9	3	2
Placed during the year	24	20	35	22	9
Boarded-out at the end of the year	3	9	3	2	2
Average number boarded-out at any one time ..	7	4	8	6	3
Hostels for homeless infective tuberculous men					
In residence at the beginning of the year	69	77	103	101	107
Recommendations approved during the year ..	60	81	63	74	51
In residence at the end of the year	77	103	101	107	103

TABLE T.10—*Principal tuberculosis statistics—Metropolitan Boroughs and the Administrative County of London*, 1961

Metropolitan Boroughs	*Estimated home population mid* 1961	*New notifications*				*New notifications per* 1,000 *population*	*Deaths from tuberculosis*			*Tuberculosis deaths per* 1,000 *population*	*Pulmonary tuberculosis deaths per* 1,000 *population aged* 15 *and over*	*Number of tuberculosis cases on clinic registers at* 31.12.61		*Cases on register per* 1,000 *population*
		Pulmonary	*Tuberculosis of Meninges and C.N.S.*	*Other non-pulmonary tuberculosis*	*Total*		*Pulmonary*	*Non-pulmonary tuberculosis*	*Total deaths*			*Total*	*Percentage of pulmonary cases positive during* 1961	
Division 1														
Chelsea	48,490	19	1	1	21	0·43	9	1	10	0·21	0·23	359	3·6	7·4
Fulham	111,500	63	1	5	69	0·62	3	1	4	0·04	0·03	1,206	1·1	10·8
Hammersmith ..	108,010	87	—	15	102	0·94	4	1	5	0·05	0·05	1,456	1·8	13·5
Kensington .. .	169,080	168	2	25	195	1·15	16	1	17	0·10	0·11	1,315	1·9	7·8
Division 2														
Hampstead .	96,990	54	—	16	70	0·72	1	—	1	0·01	0·01	979	4·0	10·1
Paddington .. .	113,980	148	—	14	162	1·42	14	1	15	0·13	0·15	1,320	2·6	11·6
St. Marylebone ..	67,690	40	—	2	42	0·62	8	1	9	0·13	0·13	877	1·7	13·0
St. Pancras .	125,340	137	1	9	147	1·17	9	—	9	0·07	0·09	1,119	2·1	8·9
Westminster, City of	86,680	73	—	1	74	0·85	7	—	7	0·08	0·09	844	6·0	9·7
Division 3														
Finsbury .. .	33,020	34	—	3	37	1·12	1	1	2	0·06	0·04	276	5·8	8·4
Holborn .. .	20,520	22	—	2	24	1·17	1	1	2	0·10	0·06	262	3·3	12·8
Islington .. .	227,170	238	1	22	261	1·15	22	1	23	0·10	0·12	2,450	1·5	10·8
Division 4														
Hackney .. .	163,180	100	1	11	112	0·69	12	2	14	0·09	0·09	1,736	2·1	10·6
Shoreditch .. .	40,530	26	—	1	27	0·67	11	1	12	0·30	0·04	330	7·9	8·1
Stoke Newington	52,180	46	—	3	49	0·94	6	—	6	0·11	0·15	775	0·7	14·9
Division 5														
Bethnal Green .	46,490	33	—	4	37	0·80	4	—	4	0·09	0·11	737	1·7	15·9
City of London .	4,600	5	—	—	5	1·09	—	—	—	—	—	69	4·6	15·0
Poplar .. .	65,850	40	—	7	47	0·71	10	—	10	0·15	0·20	591	2·4	9·0
Stepney .. .	91,710	99	—	9	108	1·18	11	—	11	0·12	0·16	1,298	1·5	14·2
Division 6														
Deptford .. .	68,220	97	—	3	100	1·47	5	—	5	0·07	0·09	1,058	2·5	15·5
Greenwich .. .	85,240	32	—	4	36	0·42	6	1	7	0·08	0·09	1,046	1·2	12·3
Woolwich .. .	146,850	53	—	3	56	0·38	19	—	19	0·13	0·17	1,634	1·4	11·1
Division 7														
Camberwell .	173,980	148	2	15	165	0·95	19	1	20	0·11	0·14	987	1·1	5·7
Lewisham .. .	220,910	112	—	11	123	0·56	18	1	19	0·09	0·10	2,473	0·7	11·2
Division 8														
Bermondsey .	51,770	36	—	3	39	0·75	5	—	5	0·10	0·12	654	1·6	12·6
Lambeth .. .	221,960	126	1	17	144	0·65	27	2	29	0·13	0·16	3,134	2·0	14·1
Southwark .. .	86,270	80	—	7	87	1·01	9	1	10	0·12	0·14	1,461	2·1	16·9
Division 9														
Battersea	104,980	59	—	5	64	0·61	12	1	13	0·12	0·15	1,050	2·1	10·0
Wandsworth ..	346,790	169	2	20	191	0·55	25	5	30	0·09	0·09	3,712	1·7	10·7
LONDON	3,179,980	2,344	12	238	2,594	0·82	294	24	318	0·10	0·12	35,208	1·9	11·1

TABLE T.11—*B.C.G. vaccination under L.C.C. schemes in* 1960/61

1. *Day schools*—	
No. of schools visited 1960/61 (to 31.12.61)	371
No. of 13-year-old children at school	*57,099
No. of consents	*43,975
No. tuberculin tested	*38,521
No. of reactors	*3,377=8·8 per cent.
No. given B.C.G.	*35,050
No. vaccinated June, 1954 to December, 1961	177,690
2. *Further education establishments* (*colleges, etc.*)	
No. of establishments visited during 1961	35
No. tested	3,639
No. of reactors	2,138
No. given B.C.G.	1,489
3. *Residential establishments*—	
No. of establishments visited during 1961	3
No. of children tested	120
No. of reactors	20=16·6 per cent.
No. given B.C.G.	99
4. *Training centres*—	
No. tested	150
No. of reactors	24
No. given B.C.G.	126
5. *Notifications of tuberculosis* (*all forms*) *in 14- and 15-year-old children in*	
1954	82
1955 (first full year after starting B.C.G.)	45
1958	38
1959	20
1960	31
1961	26
6. *Tuberculosis contacts*—	
No. of contacts given B.C.G. vaccination in London in 1961	5,084
No. of contacts given B.C.G. vaccination in London since inception of scheme in 1950	46,572
7. *Diabetics*—	
No. given B.C.G. in 1961	11
No. given B.C.G. since inception of scheme	79

* *Divisional figures are shown in Table T.12*

TABLE T.12—*B.C.G. vaccination of schoolchildren in Administrative County of London*, 1960/61 (*seventh year*)—*Divisional figures to* 31.12.61

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	8,603	6,684	52	6,024	2,527	29·4	712	11·8	5,300	(12 negatives not vaccinated)
2	5,278	4,041	10	3,572	1,696	32·1	529	14·8	3,026	(17 negatives not vaccinated)
3	3,421	2,413	3	2,102	1,316	38·5	269	12·8	1,832	(1 negative not vaccinated)
4	4,892	3,903	105	3,323	1,464	29·9	296	8·9	3,018	(9 negatives not vaccinated)
5	6,897	5,153	27	4,403	2,467	35·8	445	10·1	3,950	(8 negatives not vaccinated)
6	8,384	6,953	119	6,177	2,088	25·0	294	4·7	5,881	(2 negatives not vaccinated)
7	8,054	5,807	161	5,013	2,880	35·7	291	5·8	4,700	(22 negatives not vaccinated)
8	5,756	4,248	111	3,841	1,804	31·3	230	6·0	3,611	
9	5,814	4,773	54	4,066	1,694	29·1	311	7·6	3,732	(23 negatives not vaccinated)
Totals ..	57,099	43,975	642	38,521	17,936	31·4	3,377	8·8	35,050	

Housing

The Council has set aside a small number of dwellings for the rehousing of families on purely medical grounds.The following table shows the cases dealt with in the five years the scheme has been in operation in its present form:

	1957	*1958*	*1959*	*1960*	*1961*
Tuberculous persons					
Recommendations received	421	321	275	232	224
Nominated for rehousing	185	151	185	209	139
Recommendations not qualifying for rehousing	135	132	114	93	20
Under consideration at end of year	101	139	115	45	110
Persons with severe medical conditions					
Recommendations received	2,484	2,474	2,689	3,357	2,570
Nominated for rehousing	226	478	418	607	164
Recommendations not qualifying for rehousing	1,904	1,617	1,951	2,503	1,791
Under consideration at end of year	354	733	1,053	1,300	1,915

Work in connection with unfit houses during the past five years is summarised below:

	1957	*1958*	*1959*	*1960*	*1961*
Slum clearance					
Areas represented as unfit for human habitation	90	77	27	48	34
Houses in such areas	2,409	1,830	660	1,356	932
Areas surveyed but not represented by the end of the year	81	11	13	39	90
Houses in such areas	2,004	312	641	1,291	2,869
Public local inquiries	28	36	37	42	12
Informal hearings	4	2	1	1	4
Orders confirmed					
(i) after inquiry or hearing	45	33	42	41	27
(ii) without inquiry or hearing (no objection received)	13	14	28	15	2
Orders not confirmed by Minister	1	1	3	1	—
Confirmed order quashed on appeal to High Court	—	—	—	—	1
Improvement grants					
Surveys following applications to the Council	68	119	160	1,178	309
Searches following applications to metropolitan borough councils	158	103	346	572	595
Dangerous structures					
Premises scheduled as dangerous—searches made	1,094	1,229	1,013	*	*

* *The functions with regard to dangerous structures were, by the London County Council (General Powers) Act, 1958, transferred to the metropolitan borough councils as from 1 January, 1960.*

Public Health Laboratory

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

Milk sampling

The following table shows the results of tests during the year on samples taken of milk arriving in London (the figures in brackets are those for 1960):

Designation	*Samples examined*	*T.B. bacillus isolated*	*T.B. bacillus NOT isolated*	*Passed phosphatase test*	*Tests not completed**
Tuberculin tested (Farm bottled)	34 (49)	— (—)	34 (47)	N/A	— (2)
Tuberculin tested†	4 (4)	— (—)	4 (4)	N/A	— (—)
Pasteurised	17 (20)	N/A	N/A	17 (20)	— (—)
Total	55 (73)	— (—)	38 (51)	17 (20)	— (2)

* *Milk curdled or guinea pigs died before completion of test.*
† *Samples from a residential school which has its own farm.*

Milk purchased for use in Council establishments:

	1957	*1958*	*1959*	*1960*	*1961*
Liquid milk: samples taken by boroughs and county councils	1,162	947	910	589	306
number found to be unsatisfactory	3	7	11	—	—
Dried milk: samples submitted to bacteriological examination	4	4	4	3	24*

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

Sanitary inspection

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

	1957	*1958*	*1959*	*1960*	*1961*
Reports of infestation by a variety of pests ..	178	190	207	274	221
Visits and re-inspections involved	294	347	472	506	409
Inspections of school meals centres	420	375	362	341	208
Investigations of illness following consumption of school meals	15	12	7	8	11
Occasions when the meal was found to be the cause	2	3	2	2	—

Blind and partially-sighted persons

During the year, 1,560 examinations—198 fewer than in the previous year—were made in connection with certification under the National Assistance Act, 1948, of blind or partially-sighted persons and 45 persons were found to be neither blind nor partially-sighted. In addition, 349 certificates were accepted from other local authorities, hospitals and private ophthalmologists—90 fewer than in the previous year. The percentage of new registrations recommended to obtain treatment was 53·9 per cent. compared with 57·7 per cent. in 1960.

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

* *Increased sampling was due to co-operation in the formulation of a British Standard for dried milk.*

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	3	—	—	6	9
5–15 years	—	—	—	5	5
16–64 years	35	23	—	127	185
65–74 years	68	33	—	102	203
75 years and over	220	52	—	242	514
Age not known	3	—	—	11	14
(*a*) Total no. of persons	329	108	—	493	930
(*b*) No. recommended to obtain treatment	205	89	—	207	501
(*b*) as percentage of (*a*)	62·3	82·4	—	42·0	53·9

TABLE (ii)

*Number of treatments recommended in respect of newly registered persons**

	No. of patients examined	Treatments recommended					Optical	Hospital supervision
		None	Medical	Surgical				
				Early	Later	If general condition permits		
Cataract	329	124	16	37	30	25	23	125
Glaucoma	108	19	21	3	8	2	3	77
Other conditions	493	286	53	6	7	4	25	148
Total	930	429	90	46	45	31	51	350

* *Includes cases recommended more than one form of treatment.*

Persons recommended to obtain treatment are re-examined at intervals after the initial registration. The number of persons re-examined for this reason in 1961 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	168	42	1	293	504
No. found to have had treatment	136	42	—	157	335
Percentage treated	81·0	100·0	—	53·6	66·5

As a consequence of successful treatment eight persons previously registered as blind were found, on re-examination, to be partially-sighted and nine 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 21.

Registration of nursing homes

TABLE (i)—*Registration and inspection of nursing homes*

	1957	*1958*	*1959*	*1960*	*1961*
Registered at beginning of year	39	38	37	34	33
New homes registered	—	—	1	—	5
Homes registered on change of keeper ..	—	1	2	3	1
Registrations cancelled—voluntary closure or change of keeper	1	2	6	4	3
Registered at end of year	38	37	34	33	36
Inspections:					
medical officers	51	41	42	35	46
public health inspectors	96	50	63	84	122
Homes exempted from registration	39	38	38	40	37

TABLE (ii)—*Accommodation in registered nursing homes at* 31 *December*, 1961

Number of beds in homes	*Number of homes*	*Number of beds provided*			
		*Maternity**	*Others†*	*Mentally disordered*	*Total*
25 or over	11	216	212	162	590
20 to 24	6	25	83	22	130
15 to 19	8	17	100	17	134
10 to 14	7	12	75	—	87
5 to 9	2	9	6	—	15
Under 5	2	—	6	—	6
Total	36	279	482	201	962

** 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.

Mental nursing homes—When Part III of the Mental Health Act, 1959 came into operation on 1 November, 1960, the Council became responsible for the registration and inspection of mental nursing homes and of residential homes for mentally disordered persons. (Residential homes are registered by the Welfare department.)

Eleven establishments formerly supervised by the Board of Control were notified to this department as likely to be affected by the provisions of the Act. All the establishments were inspected and after discussion with the keepers the following decisions were taken:

Licensed house (Lunacy Act, 1890—Part VIII)—2: Both premises registered as mental nursing homes; one for patients liable to detention under the Act and the other for informal patients only.

Certified institution (Mental Deficiency Act, 1913—sec. 36)—2: One institution registered as a mental nursing home for informal patients; the other establishment was not registrable under the Act.

Approved home (Mental Deficiency Act, 1913—sec. 50)—1: This home was not registrable as a mental nursing home; it is being considered for registration as a residential home.

Person having charge of a certified single patient (Lunacy and Mental Treatment Acts, 1890–1930)—1: Registration as a mental home was not appropriate; the patient remains in the person's charge in ' community care '.

Person having care and control of mental defectives (Mental Deficiency Act, 1913—sec. 51)—5: One establishment registered as a mental nursing home to accommodate patients detained under the Act; in another the sole patient remains under the person's care in ' community care '. In the other three establishments the patients had left and no other mentally disordered patients were accommodated.

Welfare Committee establishments

Medical supervision of homes under the control of the Welfare Committee was continued. These homes include large and small homes for the aged and infirm, accommodation for mothers and babies, and homeless families units.

The medical problems arising in large and small homes for the aged and infirm was the subject of discussion at a conference of visiting medical officers held at County Hall in October under my chairmanship. The conference was attended by some twenty general medical practitioners who act as visiting medical officers of the homes. The Chief Officer of the Welfare department spoke of the overall increase in the numbers of old people resident in the Council's welfare homes and of the greater infirmity because of the rise in their average age. The number of people designated as chronic sick had also increased, in spite of the active liaison between visiting medical officers and the local geriatric units for the interchange of residents and patients as appropriate. Moreover, it was recognised that it was not humane to transfer an old person who had spent many years in a welfare home to hospital, even if there were sufficient beds available in hospitals in London. Nevertheless, their nursing care created staffing problems; the Public Health department had had some difficulty in recruiting ward sisters to supervise the nursing care and administration of drugs and there was an acute shortage of welfare assistants. The Principal Medical Officer (Tuberculosis) spoke of pulmonary tuberculosis among the elderly, in whom the incidence of the disease had not fallen as had been the case in the age groups under fifty-five years. He emphasised the value and ease of sputum examination and advocated an extension of arrangements for the routine examination of sputum of newly-admitted residents with a productive cough and of other residents with winter sputum. These arrangements have since been put into effect.

There are units for lone women with a new-born baby in two of the large welfare homes, where mothers may be resident for periods up to three months. The size of one of these units has been doubled in the past year. Carisbrooke House is a mother-and-baby home for single girls, who are admitted for six weeks before and six to eight weeks after delivery. Outbreaks of infectious disease have not been a problem in these homes except at the peak periods for confinements during March and April. The Welfare Committee also have a hostel for mothers-in-work with a baby. Mothers are admitted when the baby is six weeks old and may stay until the baby reaches the age of eighteen months. Three welfare assistants have been replaced during the year by nursery nurses appointed by the Public Health department.

The sharp increase in the number of homeless families received by the Welfare department necessitated the setting up of further homeless families units within the large homes for old people, in addition to Newington Lodge and Morning Lane reception centre. The Public Health department advised on the adaptation of the accommodation for this purpose and on the steps to be taken to limit the spread of infectious disease, particularly Sonné dysentery and gastro-enteritis due to *E. Coli*. Many children had subsequently to be taken into care by the Children's Officer and were segregated in special units for short periods until free from infection. Three negative rectal swabs were required for each child, or the period of incubation of disease outlived, before transfer to residential nurseries or children's homes. It was found that 27 per cent. of children under five years of age had developed one or other of the diseases with which they had been in contact compared with only four per cent. among children over that age. It seemed likely in the light of experience that children over five years of age may be received directly into children's homes without undue risk, provided that reasonable observation by trained staff is maintained.

Invalid Meals for London

The Council for many years made an annual grant under section 28 of the National Health Service Act, 1946 to Invalid Meals for London, a voluntary body providing meals

for invalids and sick persons. Meals were supplied to those suffering from diseases which necessitated special diets which the recipients could not provide themselves nor obtain in an ordinary restaurant. In the great majority of cases the recipients of the meals were housebound and meals were delivered to them at their homes (in eighteen boroughs) by a transport fleet of 20 vehicles specially fitted with heated food-conveyors. Invalids living near and able to walk to the kitchens with dining-rooms attached (four out of the five) were served with meals at the restaurants.

Towards the end of 1959 the Chairman of the voluntary body informed the Council that he felt unable to continue to be responsible for the work. His Executive Committee had authorised him to ask the Council to take over the service as soon as possible and, pending the completion of the necessary formalities, to make interim arrangements for the continuance of the service. The Council approved in principle the taking over of the service and, to enable the service to be maintained, approved the provision of financial and administrative assistance to Invalid Meals for London. The legal formalities were unexpectedly protracted and it was not until December, 1961 that the service was transferred to the Council.

In the meantime, at the request of the metropolitan borough councils, provision had been included in the London County Council (General Powers) Act, 1961, to enable the borough councils to provide an invalid meals service or to make grants to voluntary bodies providing such a service. At the end of the year discussions were taking place with the Metropolitan Boroughs' Standing Joint Committee on the future running of the service.

Details of the service provided is shown by the following figures:

	1957/8	*1958/9*	*1959/60*	*1960/1*	*1961/2*
Meals served	174,011	167,134	172,637	180,291	196,695

SCIENTIFIC BRANCH

The Scientific branch provides an advisory service to all departments of the Council on matters involving chemistry, physics and allied sciences. Similar service is provided, as required, to the metropolitan borough councils. In addition to statutory duties, the branch has important functions relating to health, safety and amenity. It is responsible for giving guidance on the efficient and economical use of material of all types used in the Council's service for construction, maintenance and consumption.

The work is carried out in three groups of laboratories by a staff of 73. The headquarters laboratories at the County Hall cover the following main subject headings:

(i) Air pollution, environmental radioactivity, ventilation.
(ii) Noise and acoustics, fire precautions and investigations, industrial matters.
(iii) Building materials and development work, floor maintenance, insecticides and fungicides, plastics, metals.
(iv) Paint and decorative materials.
(v) Fuel and boiler plant technology, heat insulation materials, drinking water, trade wastes.
(vi) Detergents, laundries, swimming baths.
(vii) Statutory, food, drugs, medical and general supplies.

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 process and ancillary plant together with research on projects potentially useful to the main drainage service.

Samples totalling 63,187 were examined during 1961 in the course of analytical, experimental and research work. This record of samples does not include much of the consultative service given by the senior professional officers, which was not necessarily associated with laboratory work.

A summary of the activities of the branch which have a direct or indirect application to the field of public health is given below. Full particulars are given in the annual report of the Scientific Adviser.*

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 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. The results are communicated to the Port of London Authority.

The middle and lower reaches of the river showed general improvement when compared with conditions during the previous ten years, although low upland flow due to lack of rain during the late summer of 1961 caused deterioration in the upper reaches of the tidal river for a time. Improvement in the condition of the river off the Northern Outfall Works was attributable to operation of new plant at this works, which includes diffused air activated sludge units.

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

* *Annual Report of the Scientific Adviser for the Year 1961, the London County Council, price 1s. 3d.*

our staffs and weekly conferences are held between the Scientific Adviser and the Divisional Engineer (Main Drainage), together with their senior officers, to discuss analytical results, operational practice and research projects.

In addition to laboratory work undertaken to obtain the best efficiency from the treatment plant, full attention was given to matters of safety. For example, the utilisation of sludge gas involved daily safety tests at all potentially hazardous points in the digestion plant, power house and domestic boiler room.

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 discharges have increased in volume and complexity over recent years and continuous control is needed to exclude substances which would be hazardous or damage the fabric of the sewers.

Detailed laboratory examinations were made on 2,795 samples of trade waste discharges, about one-third of this number being submitted by twelve metropolitan boroughs. In consequence of these examinations, officers of the Scientific branch and of the Chief Engineer's department visited many premises to discuss with the occupiers the problems involved in treating the discharges and to give advice.

During the year a working party of the Council and of representatives of the metropolitan boroughs considered what further steps might be necessary to exercise a closer control on trade waste discharges in the county. The results of their deliberations were embodied in the London County Council (General Powers) Bill, 1962.

Drinking water

To ensure that the water supplies to Council establishments are of satisfactory quality, the Scientific branch carries out regular monthly inspections and samplings at those establishments where supplies are drawn from private wells. The water from these wells is chlorinated before use by means of automatic dosing plant. Samples of both the raw well waters and the treated waters are taken for bacteriological and chemical examination. If pollution is suspected check samples are taken at frequent intervals.

At the request of the hospital management committees, the well supplies at some of the hospitals formerly under the control of the Council have continued to be regularly examined.

Because of the excellent system of drinking water examination by the Metropolitan Water Board, samples are not examined direct from mains supplies but water from storage tanks is tested in many institutions to check the internal system and to ensure that tanks are periodically cleaned.

Air pollution

The Council continued its long-standing co-operation with the Department of Scientific and Industrial Research in investigating the incidence of air pollution, by maintaining regular observation of the degree of pollution of the atmosphere over the county. In recent years these measurements have acquired a special significance in reflecting progress in the implementation of the Clean Air Act of 1956.

Results obtained by the daily volumetric method indicated a further reduction in the average pollution of the air during the year, as compared with the previous year, to the extent of about seven per cent. in smoke and four per cent. in sulphur dioxide, despite the occurrence in November and December of foggy periods which caused the average pollution during these months to be worse. Except perhaps in local pockets, the concentration of either of the two main pollutants never reached the level which would be regarded as ' smog ' ; the smoke concentrations, in particular, during fog reached little more than half the level which has frequently been exceeded in fogs of the past.

Environmental radioactivity

For some years the branch has undertaken experimental studies to obtain reference data on environmental levels of ionising radiation and to determine the extent of any additions arising from the numerous applications of nuclear science.

Matters dealt with during the year included radiological safety in the Council's dental clinics; the safe use of radio-isotopes and X-ray apparatus in colleges; the safety of the public at exhibitions; advice to the London Fire Brigade in assessing hazards at fires involving radioactive matter. Several applications were made by hospital, industrial and laboratory users of radio-isotopes for the discharge of wastes to the sewers and suitable provisions were made.

Swimming baths

The Council has under its control 23 outdoor baths, many for public use, and 24 indoor baths situated in schools and institutions. A number of baths are equipped with complete purification plant and all receive some form of chlorination treatment. Regular visits are made to these baths by officers of the branch for inspection and testing; samples are taken for bacteriological and chemical examination.

As an example of the efficiency of treatment, the following were the figures obtained from 13 fully equipped public baths during the five months summer season, in which time about 850,000 people used the baths. The minimum measured clarity was 18 feet and the maximum was 160 feet. These baths vary from 100,000 to 1,000,000 gallons capacity and are emptied and refilled with mains water only once a year.

Noise and acoustics

There was an increase in the amount of work done under this heading, due largely to the growing awareness of the significance of noise in town planning.

Measurement of the existing background noise levels was completed at two-thirds of the 500 sites selected for the London Noise Survey, which is being made in collaboration with the Building Research Station of the Department of Scientific and Industrial Research and the Town Planning division of the Architect's department. The Scientific branch made measurements at an additional 80 points to obtain information about sound effects from helicopters.

In connection with the Council's extensive road building schemes the noise of fast moving traffic was studied; measurements were made at sites near fly-overs, inclines, roundabouts and junctions, and where shielding has been given by shrubbery. Estimates were made of the alteration in noise level to be expected through road widening. The extent to which traffic noise is attenuated in high buildings was studied.

Acoustics measurements were made to test sound insulation methods in blocks of flats and also in connection with the design of ventilating systems for the new concert hall and art gallery to be built on the South Bank.

HEALTH SERVICE PREMISES

Building programme

Programme for 1962–63—As a result of the usual annual review of the five-year building programme, the Council approved a programme for 1962–63 providing for estimated expenditure amounting to £395,780, including acquisition of sites. Details of the schemes in the programme are given in table (i).

General

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 1962–63*

Health Division	*Premises*	*Works proposed*
1	Additional day nursery in North Kensington area.	Conversion of standing property if acquired.
2	Sumatra Road welfare centre, Hampstead.	Extension to existing building to provide additional facilities.
3	Additional day nursery in South West Islington area.	Conversion of standing property if acquired.
3	Cromwell Lodge Hostel for tuberculous men, Hornsey.	Annexe for occupational therapy.
4	Shoreditch Health Centre, Shoreditch	Improvements to provide additional dental surgery accommodation.
4	Sun Babies day nursery, Shoreditch ..	Improvements to heating and sanitary facilities.
4	Morning Lane, Hackney	New elder boys' training centre to replace an unsatisfactory centre.
4	Additional child guidance unit in Hackney area.	Conversion of standing property if acquired.
8	Loughborough Estate, Lambeth ..	New maternity and child welfare and school treatment centre to replace unsatisfactory premises.
9	Sisters Avenue day nursery, Battersea	Replacement nursery.
9	Additional child guidance unit in Putney/Wandsworth area.	Conversion of standing property if acquired.
–	Conversion of two premises for mental health hostels.	Premises being sought.
–	Oval accident ambulance station, Lambeth.	Rebuilding to accommodate additional ambulances.
–	South Western general ambulance station, Lambeth.	Provision of workshops and extra garage space.
–	South Eastern general ambulance station, Deptford.	Improvements to access, service bay and lighting.
–	Russell Square accident ambulance station, Holborn.	Adaptation and reconstruction.

TABLE (ii)—*Works completed in 1961*

Health Division	*Premises*	*Work involved*
	MATERNITY AND CHILD WELFARE	
2	Hallfield Estate, Paddington	Provision of maternity and child welfare and school treatment centre in ground floor of housing block (built by Paddington Metropolitan Borough Council).

TABLE (ii)—*Works completed in 1961—continued*

Health Division	*Premises*	*Work involved*
	DAY NURSERY	
1	Ladbroke, Kensington	Additional toilets and new heating and hot water systems.
1	Eridge House, Fulham	Resurfacing of play space.
3	Scholefield Road, Islington	Conversion of boilers to oil firing.
	MENTAL HEALTH	
1	College Park training centre (elder girls), Letchford Gardens, Hammersmith.	Adaptation of former maternity and child welfare centre.
4	Hackney training centre, Iceni Sports ground, Hackney.	New junior training centre.
9	Clapham training centre, Clapham Manor Street, Wandsworth	Adaptation of premises to form an industrial training centre.
	PREVENTION OF ILLNESS—TUBERCULOSIS	
3	Cromwell Lodge hostel for tuberculous men, Hornsey.	Provision of new boilers.
	GENERAL PRACTITIONERS' CENTRE AND CHILD GUIDANCE UNIT	
7	South East London General Practitioners' Centre and Peckham Child Guidance unit, St. Mary's Road, Camberwell.	Major adaptations to third floor to provide general practitioners' centre and improved accommodation for existing child guidance unit.
	LONDON AMBULANCE SERVICE	
–	Eastern general ambulance station, Hackney.	Improvement and re-allocation of accommodation and improvements to entrance.

TABLE (iii)—*Works in hand*

Health Division	*Premises*	*Work involved*
	MATERNITY AND CHILD WELFARE	
6	Abbey Estate, Woolwich	New maternity and child welfare and school treatment centre in housing block to replace temporary welfare centre on L.C.C. estate.
6	Burney Street, Greenwich	Provision of maternity and child welfare centre in ground floor of housing block (being built by Greenwich Metropolitan Borough Council).
8	Keeton's Road, St. Crispin's Estate, Bermondsey.	Provision of maternity and child welfare and school treatment centre in ground floor of L.C.C. housing block.
9	Plough Road, Battersea	Provision of maternity and child welfare and school treatment centre in ground floor of housing block (being built by Battersea Metropolitan Borough Council).
	MENTAL HEALTH	
6	Blackwall Lane, Greenwich	Adaptation of existing building as an additional industrial training centre.
9	Putney Hill, Wandsworth	Adaptation of premises as a mental health hostel.
	LONDON AMBULANCE SERVICE	
–	Battersea accident ambulance station, Battersea	Replacement of building destroyed by enemy action.

TABLE (iv)—*Works approved but not yet commenced at end of 1961*

Health Division	*Premises*	*Work involved*
	MATERNITY AND CHILD WELFARE	
3	Barnsbury Estate, Islington	New maternity and child welfare and school treatment centre in L.C.C. housing block to replace unsatisfactory premises.
9	Stormont Road, Battersea	New maternity and child welfare and school treatment centre to replace unsatisfactory premises.
	DAY NURSERY	
1	St. Quintin, Kensington	Extension to existing building to provide additional places.
9	Upper Tulse Hill, Lambeth	New day nursery in L.C.C. housing block to replace unsatisfactory premises.
	MENTAL HEALTH	
3	Basire Street, Islington	New junior training centre.
6	Maze Hill, Greenwich	New junior training centre to replace unsatisfactory premises.
7	Brockley Rise, Lewisham	New mental health hostel.
8	Draper Street, Southwark	New day centre for the mentally ill to be constructed in L.C.C. housing development.

TABLE (v)—*Acquisitions and leases completed*

Health Division	*Property*	*Interest obtained*
	MATERNITY AND CHILD WELFARE	
9	5 Stormont Road, Battersea, S.W.11 ..	Freehold.
	DAY NURSERY	
8	Coral day nursery, Windmill Walk, Lambeth, S.E.1.	Indefinite tenancy (from Housing Committee).
9	23, Summerley Street, Wandsworth, S.W.18.	Freehold.
	MENTAL HEALTH	
6	33 Blackwall Lane, Greenwich, S.E.10	Freehold.
8	The Grange Tannery, The Grange, Bermondsey, S.E.1.	Freehold.
	PREVENTION OF ILLNESS—INVALID MEALS	
3	65 Essex Road, Islington, N.1 ..	Freehold.
4	159 Lower Clapton Road, Hackney, E.5	Leasehold.
–	124 Churchfield Road, Acton, W.3 ..	Leasehold.
	LONDON AMBULANCE SERVICE	
–	Auckland Road, Battersea, S.W.11 ..	Freehold.

South East London General Practitioners' Centre—This centre, which opened early in 1961, provides family doctors in the neighbourhood with facilities, which they do not possess in their own surgeries, for the diagnosis and treatment of conditions not requiring full hospital investigation and treatment. It has an operations room where the general practitioner can perform minor surgery on his own patients, a well-equipped pathological laboratory, X-ray, dark- and viewing-rooms and two consulting rooms. Nursing staff

carry out treatment on the doctors' instructions and there is co-operation with health visitors and other social workers. A common-room is available where there are books and other information for reference and where conferences, film shows and informal discussions take place. The centre is the first of its kind in the country to provide so wide a service to local general practitioners and has been established by the Council in collaboration with the South East Metropolitan Regional Hospital Board, the Camberwell Hospital Management Committee, the Nuffield Foundation and the Sir Halley Stewart Trust. An account of the first year's working of the centre is given in Appendix D.

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; details are given in the reports of the divisional medical officers. Changes in centres during the year are reported in the section on health service premises.

Maternity and child welfare

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

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

	1957	*1958*	*1959*	*1960*	*1961*
Ante-natal, post-natal and combined clinics:					
Number at end of year	118	112	111	109	109
Sessions per month	786	799	797	793	787
Ante-natal:					
First attendances	23,918	25,673	23,905	25,455	27,560
Total attendances	121,579	134,684	129,731	133,062	140,790
Percentage of pregnant women attending an ante-natal clinic	44	45	42	43	45
Post-natal:					
Number of women attending during the year	3,887	3,714	3,524	3,369	2,859
Child welfare clinics:					
Number at end of year	178	179	179	179	178
Sessions per month	1,990	1,991	1,957	2,034	2,057
Attendances under 1 year					
First	46,387	49,229	49,610	50,202	54,393
Total	613,147	611,057	606,042	578,250	599,930
Attendances over 1 year	183,538	177,283	152,627	163,845	169,023
Attendances at special toddlers clinics (not included in above)	40,848	38,940	38,361	37,533	38,203
Percentage of infants attending a centre at least once in the first year of life	86	88	89	88	90

Family planning—Advice on family planning is provided for married women for whom further pregnancy would be detrimental to health.

	1958	*1959*	*1960*	*1961*
Attendances at sessions provided by the Council				
First	1,011	975	945	899
Total	4,392	4,260	4,337	4,226
Women referred by the Council to Family Planning Association	702	705	741	641

National welfare foods

Average weekly issues

	1957	*1958*	*1959*	*1960*	*1961*
National dried milk (tins)	19,839	15,791	15,328	13,817	11,647
Cod-liver oil (bottles) ..	5,191	3,620	3,469	3,442	2,623
Vitamin tablets (packets)	2,788	2,736	2,775	2,837	2,109
Orange juice (bottles) ..	48,925	31,360	30,412	28,864	18,514

Day accommodation for children

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

	At 31 December				
	1957	*1958*	*1959*	*1960*	*1961*
DAY NURSERIES:					
Maintained	81	76	75	74	73
Grant-aided	5	5	4	4	4
Total	86	81	79	78	77
Places under 2	1,747	1,690	1,693	1,649	1,623
2–5	2,988	2,631	2,499	2,420	2,394
Total	4,735	4,321	4,192	4,069	4,017
COUNCIL'S CHILD MINDER SCHEME (Voluntary registration):					
Child minders registered	838	824	875	989	861
Children minded	954	973	1,039	1,187	993
NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948:					
Private day nurseries registered (including part-time nurseries)	60	59	60	59	69
Places	1,701	1,742	1,620	1,595	1,840
Child minders registered	132	141	167	202	210
No. of children authorised to be minded	699	781	939	1,023	1,088

Occasional crèches—These crèches provide for the children of mothers attending a clinic or class on the premises and also give occasional relief to mothers who, for various reasons such as visits to hospitals, shopping, laundering and other domestic duties, wish to be relieved of their young children for two or three hours during the day; they also present an opportunity for an only child to associate with other children of similar age. At 31 December a total of 88 sessions a week was being held, providing for 1,610 child-attendances weekly.

Prevention of break-up of families

It was possible during the year to provide caseworkers to undertake the support and intensive care of problem families in two more divisions, leaving only one without such workers. By 31 December nine full time social caseworkers were undertaking this work in the county and thirteen assistant organisers were working with one or two families each.

As in previous years, the Council made a grant to Family Service Units in London towards the cost of their work with families in difficulty. The amount of the grant for the financial year 1961/62 (divided equally between the Health and Children's committees) was £12,715. During the year the Council agreed to make an annual grant for three years to the Family Welfare Association as a contribution towards their work with families with problems. The grant for 1961/62 was £1,000.

Admission to maternity beds

The shortage of maternity beds, especially in North West London, continued to cause anxiety throughout the year and the attention of the Ministry of Health was drawn to a continued increase in the number of women who had to be admitted to hospital in labour through the Emergency Bed Service because they had been unable to book a bed. Discussions on the subject took place with representatives of the Ministry, the North West Metropolitan regional hospital board and the teaching hospitals in the area. The Ministry

intimated that there were prospects of additional maternity beds being provided in North West London in the near future. In the meanwhile the Ministry asked the teaching hospitals to reserve 20 per cent. of their beds for emergencies and late-comers and not to book women, other than those needing hospital confinement on medical grounds in accordance with the criteria laid down in the Cranbrook Report, unless the local health authority had advised that there was a need on social grounds for hospital confinement. The Ministry also proposed that for this latter type of case hospitals or groups of hospitals should accept responsibility for all such cases from a defined area, it being left to local maternity liaison committees to agree on the allocation of areas of responsibility and the machinery for booking. A draft plan of catchment areas for the whole county is being drawn up for presentation to local maternity liaison committees.

Detection of children suffering from phenylketonuria

Following the pilot survey on the practicability of routine testing described by the divisional medical officer for division 3 in his report, arrangements have been made throughout the county for mass screening tests of babies to detect phenylketonuria, a rare inborn metabolic disorder which can give rise to mental defects. In addition more extensive tests will be made of children thought to be at special risk.

Young children handicapped by impaired hearing

In recent years certain factors which may arise during pregnancy, labour and early childhood have become recognised as potentially dangerous sources of deafness. In view of the vital importance of early detection, an index of children subject to a risk of deafness is kept in each of the nine divisional health offices. Arrangements have been made for hearing tests to be carried out in the maternity and child welfare service and for all new entrants to school to receive an audiometer test. General practitioners and hospitals have been asked to bring to the notice of the Council any children considered to be at risk.

In September a joint circular on ' Young children handicapped by impaired hearing ' was issued by the Ministry of Health (Circular 23/61) and the Ministry of Education (Circular 14/61). The services provided by the Council were already on the lines recommended in the circular and therefore discussions with metropolitan regional hospital boards and teaching hospitals were on the question of future planning in this field.

Arrangements were in hand at the end of the year for consultation with the London local medical committee and the hospital authorities on the early ascertainment and follow-up of young children at risk of deafness.

Mental health education

In further development of the arrangements made for intensive training of medical officers and health visitors in mental health education, six additional case conference groups were set up for medical and nursing staff of the child welfare centres to receive training and guidance from psychiatrists and other professional workers attached to child guidance clinics. The co-operation of the hospital authorities in these groups has been a very great help. The aim is gradually to bring all child welfare medical officers and health visitors into the groups and to develop the case conference groups into a permanent consultative service under the leadership of the psychiatrist from the local child guidance unit.

Residential establishments for young children

Private residential establishments and those under the management of the Children's Committee are visited regularly by the Council's medical officers, who advise on hygiene and child health. A register is maintained of physically and mentally handicapped children and is reviewed periodically by a senior medical officer so that a handicapped child's special needs for medical or educational treatment can be anticipated.

Adoption and boarding out

Children in care who are being considered by the Children's Committee for adoption or boarding out are given a full examination by a general medical practitioner. These medical reports are scrutinised by a medical officer of the Public Health department. Should these reports reveal a medical defect or handicap in the child, or a history of inheritable illness in the natural parents, the Children's Officer is advised whether the child is medically fit for adoption or boarding out. In some cases, before the Children's Officer is given this advice, the prospective adopters are interviewed by the medical officer and an explanation is given of the implications of the child's defect or illness, or the probability of inheritance of disease from his parents. A report may be sent in some cases to the prospective adopters' family doctor. The number of children referred by the Children's Officer is shown below:

	1957	*1958*	*1959*	*1960*	*1961*
1. Adoption cases:					
Suitable for adoption	178	167	228	267	257
Suitable for adoption subject to certain conditions	8	2	1	2	32
Unsuitable for adoption but suitable for boarding out	7	17	5	21	13
Withdrawn by Children's Officer	8	3	2	1	9
Under consideration at 31 December	4	1	2	5	4
	205	190	238	296	315
2. Boarding out cases:					
Suitable for boarding out	310	320	290	447	438
Withdrawn by Children's Officer	7	3	3	6	5
Under consideration at 31 December	5	1	3	7	7
	322	324	296	460	450
3. Unsuitable for either adoption or boarding out	3	3	1	—	1
TOTAL	530	517	535	756	765

Care of the unmarried mother and her child

Moral welfare associations—Financial assistance is given to the five large moral welfare associations of the major religious denominations (London Diocesan Council, Southwark Diocesan Association, Westminster Catholic Social Welfare Committee (Crusade of Rescue), Southwark Catholic Rescue Society, Jewish Board of Guardians).

	1957	*1958*	*1959*	*1960*	*1961*
Total grants	£9,625	£12,531	£13,555	£12,800	£13,250
Number of expectant and nursing mothers advised	2,684	2,975	3,005	3,292	3,288

Nationality of mothers by normal residence

	London (Administrative County)	*Elsewhere*	*Total*
British (United Kingdom)	1,306	532	1,838
Eire	434	357	791
West Indian	260	177	437
European	92	57	149
Other	36	37	73
	2,128	1,160*	3,288

**991 were pregnant on arrival in London.*

Nearly one quarter of the total cases helped by the associations are girls from Eire.

Mother and baby homes—Voluntary organisations provide most of the mother and baby homes in London, supported by grants in aid from the Council under the National Health Service Act, 1946. One mother and baby home is maintained by the Welfare department together with two other units within their larger homes.

	1957	*1958*	*1959*	*1960*	*1961*
Total grants	£11,360	£10,476	£10,237	£8,865	£9,998
Number of voluntary homes receiving grant at 31 December	17	16	15	15	15
Number of expectant and nursing mothers admitted	1,141	1,191	1,072	1,136	1,171

A marked upward trend in the percentage of illegitimate births in London over the last five years has been commented on in this report (see page 7). There has also been an increase in the number of illegitimate pregnancies among girls under school-leaving age and girls still receiving full-time education. Although this increase must cause concern, it should be kept in perspective. The overall number of pregnancies in girls 13 and 14 years of age for England and Wales is not a large one (111 in 1960, the latest available figure) but the care of these young mothers presents special problems.

I reported last year that, following a conference of departments and voluntary bodies concerned, it was arranged for a mother and baby home in South London administered by the Church Army to be made available for the sole use of young expectant mothers in receipt of full-time education, who would be referred by the Children's Officer.

The home was opened on 1 April, 1961. A grant was made by the Health Committee for the adaptation of a room for use as a schoolroom and a full-time teacher was provided by the Education Committee. A special per capita maintenance rate was agreed by the Children's department, which maintains close co-operation with the staff of the home.

An obstetrician in the maternity unit of a local hospital has undertaken the full maternity care of the girls admitted to this home and they are all admitted to the hospital for delivery.

During the year 24 girls under 16 years of age were admitted to the home, one of whom left before the baby was born. The majority had entered the home at about the fourth month of pregnancy. Twelve babies were born during the year, of which five were taken into care and five went for adoption; one mother kept her baby and one baby was still in the home in 1962. Although the stay in the home can be prolonged post-natally, in practice most mothers have left at six to eight weeks after delivery.

It is, perhaps, too soon to assess, in all its aspects, the value of this experiment in the care of young unmarried mothers having full-time school education in a home designed to meet their needs. Undoubtedly various modifications of the initial arrangements will be made in the light of experience, but a review of the work achieved in the first eight months is most encouraging.

Child protection

The visiting of foster children under the Children Act, 1958, and the inspection of the premises in which these children are living is undertaken for the Children's Officer by health visitors, who are designated as 'child protection visitors'. During 1960 the Children's Officer assumed direct control of the work in health divisions 5 and 8; in 1961 he assumed control additionally in health division 2. In the remaining divisions the number of children supervised by child protection visitors on 31 March, 1961 was 487.

The Health Committee assumed the powers formerly exercised by the Public Control Committee in respect of sec. 11 of the Children and Young Persons Act, 1933, relating to the death or serious injury of children under the age of 12 years involving an insufficiently protected fire or heating appliance. Responsibility will be exercised by divisional health committees and divisional medical officers within the scope of the department's child welfare functions.

Marriage guidance

Grants totalling £6,900 for the year ending 31 March, 1962 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

	1957	*1958*	*1959*	*1960*	*1961*
The Council	87	87	89	94	94
District Nursing Associations (including supervisory staff)	44	48	45	46	43
Hospitals	39	40	46	43	40
	170	175	180	183	177

TABLE (ii)—*Domiciliary confinements attended*

	1957		*1958*		*1959*		*1960*		*1961*	
	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*
(*a*) Doctor not booked										
L.C.C. ..	172	3,325	201	2,899	232	2,761	178	2,197	83	1,069
D.N.A. ..	68	1,624	75	1,577	58	1,360	47	1,193	39	716
Hospital district	29	1,711	23	1,693	41	1,574	—	—	—	—
	269	6,660	299	6,169	331	5,695	225	3,390	122	1,785
	6,929		6,468		6,026		3,615		1,907	
(*b*) Doctor booked										
L.C.C. ..	996	1,548	1,135	1,966	1,340	2,405	1,563	2,848	2,237	3,759
D.N.A. ..	152	294	182	389	194	505	280	692	339	1,010
Hospital district	68	196	144	225	132	313	202	1,745	302	1,666
	1,216	2,038	1,461	2,580	1,666	3,223	2,045	5,285	2,878	6,435
	3,254		4,041		4,889		7,330		9,313	
	10,183		10,509		10,915		10,945		11,220	

All hospital district cases are now shown as 'doctor booked', because all such cases are ante-natally under the direct care of a hospital doctor and medical aid during labour and the puerperium is available to them on call to the hospital.

The difference in recording only partially accounts for the marked increase in the number of home confinements in which a doctor was booked for maternity medical services. The total increase was from 4,889 (45 per cent.) in 1959 to 9,313 (83 per cent.) in 1961, while the corresponding figures for 1956 were 2,722 (27 per cent.). Taking only those cases attended by London County Council and District Nursing Association midwives, the increase was from 4,444 (51 per cent.) in 1959 to 7,346 (79 per cent.) in 1961.

TABLE (iii)

	1957	*1958*	*1959*	*1960*	*1961*
Premature babies:					
Number	501	482	555	517	525
Per cent. of live births ..	5·0	4·6	5·1	4·7	4·7
Stillbirths:					
Number	87	89	100	79	85
Per 1,000 total births	8·5	8·4	9·2	7·2	7·6

The corresponding rates for domiciliary confinements for England and Wales in the year 1960 (the latest available) were for prematurity, 4·1 per cent., and for stillbirths, 8·7 per 1,000 total births.

Particulars of domiciliary premature live births are set out below. The difference between the total (559) shown in this table and the number (525) quoted above represents the number of cases attended by doctors and midwives independently of the Council's domiciliary midwifery service.

TABLE (iv)

Weight	*Number*	*Proportion per 100 live premature infants*	*Deaths in 24 hours*		*Survivors at 28 days*	
			Number	*Per 100 live premature infants*	*Number*	*Per 100 live premature infants*
3 lb. 4 oz. or less	33	5·9	14	42·4	13	39·4
3 lb. 5 oz. to 4 lb. 6 oz. ..	68	12·2	4	5·9	62	91·2
4 lb. 7 oz. to 4 lb. 15 oz.	84	15·0	1	1·2	80	95·2
5 lb. to 5 lb. 8 oz. ..	374	66·9	4	1·1	368	98·4
All cases	559	100	23	4·1	523	93·6

These figures, especially those relating to infants surviving at 28 days, compare favourably with those for all live premature infants born in the administrative county during 1961, (see table (ix), page 11).

TABLE (v)—*Inhalation analgesia administered*

	1957	*1958*	*1959*	*1960*	*1961*
	%	%	%	%	%
Gas and air ..	35 } 87	17 } 88	9 } 87	8 } 86	7 } 84
Trilene ..	52 }	71 }	78 }	78 }	77 }

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:

	1957	*1958*	*1959*	*1960*	*1961*
As midwives	1,193	1,160	1,285	1,404	1,447
As maternity nurses ..	137	121	110	25	—

As a result of amendments to the Rules of the Central Midwives Board, which became effective on 1 July 1960, the distinction between practising as a midwife and acting as a maternity nurse has been removed. In the past a midwife who acted only as a maternity nurse was required to notify her intention to practise as a maternity nurse but was not required to attend compulsory refresher courses. The meaning of the term ' practising midwife ' has been altered to include the former maternity nurse and, as a consequence of this change in definition, any midwife who wishes to attend maternity cases must notify her intention to practise as a midwife and attend compulsory refresher courses required by the Central Midwives Board.

In accordance with section G of Rules of the Central Midwives Board, 149 midwives in the county attended a refresher course during the year.

Fees to medical practitioners called in by midwives in emergency:

	1957	*1958*	*1959*	*1960*	*1961*
Number of claims	2,479	2,626	2,653	2,350	2,603

HEALTH VISITING

Home visits	*1957*	*1958*	*1959*	*1960*	*1961*
Expectant mothers:					
First	23,482	24,131	22,940	24,013	26,531
Revisit	21,994	23,213	23,161	22,546	23,934
Percentage of notified live and still-births..	*43*	*42*	*40*	*41*	*43*
Stillbirths	1,080	979	960	1,024	849
Children under 1:					
First	52,171	53,557	53,224	55,226	60,995
Revisit	169,760	176,428	173,932	168,669	172,964
*Percentage of notified live births	*98*	*96*	*95*	*96*	*101*
Children 1–5	354,643	368,845	372,622	369,122	379,793
Care of old people	12,465	13,331	14,366	14,350	14,772
Miscellaneous	74,513	80,978	80,948	80,026	86,971
Unsuccessful	100,250	100,648	101,503	104,014	111,958
TOTAL	810,358	842,110	843,656	838,990	878,767

* *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

(A special article, Appendix B, reviews the home nursing service in London since 1931.)

Details of the work done by the 25 voluntary grant-aided district nursing associations who acted as agents for the Council are given below:

TABLE (i)—*Staff (numbers employed at 31 December)**

	1957	*1958*	*1959*	*1960*	*1961*
State registered nurses	533	506	512	517	495
State enrolled assistant nurses	30	33	34	34	35
Total number of nurses employed	563	539	546	551	530
Male nurses (included above)	41	41	39	39	38
Full-time equivalent of nurses employed	522	496	507	508	492
Students	52	65	78	27	64
Male students (included above)	4	6	6	—	2

* *Exclusive of 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	39,756	81·0	32	1,281,293
Surgical	5,434	11·1	41	221,543
Infectious diseases	220	0·4	12	2,536
Tuberculous	997	2·0	51	51,000
Maternal complications	1,396	2·8	6	8,547
Others	1,334	2·7	28	36,941
	49,137	100·0	33	1,601,860

The total visits for 1959 and 1960 were 1,763,296 and 1,690,084 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	546,959	26,383	36
Injections plus other treatment	89,358	2,538	6
Other treatment only	930,413	6,209	58
	1,566,730	35,130	100

The proportion of visits for 'injection only' fell during the year by two per cent., compared with reductions in the previous three years of four, five, and three per cent. respectively. Over the four year period there has been a fall of 14 per cent.

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

Number	*Percentage of total patients nursed*
10,236	20·8

The percentage of long-term cases shows an increase of two per cent. on the previous year.

TABLE (v)—*Age distribution of patients*

Age	*No. of patients*	*Percentage of total*
0–5 years	2,236	5
5–64 years	19,256	39
65 years and over	27,645	56
	49,137	100

There were fewer patients than in 1960 (51,325) and the proportion of patients 65 years and over increased by two per cent.

TABLE (vi)—*Nursing treatments and case load*

	1957	*1958*	*1959*	*1960*	*1961*
Number of completed treatments	56,395	53,359	49,299	43,118	41,010
Number of patients being nursed at end of year	13,749	12,099	11,352	11,118	10,898
Average case load per equivalent whole-time effective* nurse at end of year	27	24	23	24	22

**Allowing for holidays and sickness.*

HOME HELP

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

	1957	*1958*	*1959*	*1960*	*1961*
Cases assisted*	35,737	34,600	36,056	38,031	38,546
Applications deferred or refused because home helps were not available	25	25	13	23	18
Hours worked	4,896,000	4,651,500	4,919,200	5,129,000	5,069,064
Home helps employed at end of year ..	3,388	3,529	3,706	3,830	3,896
Equivalent of whole-time staff†	2,116	2,033	2,150	2,242	2,164
Night helps for chronic sick patients‡					
Applications met	44	55	40	28	17
No. of new families assisted‡					
Child help (resident)	4	6	20	8	24
Early morning and evening help.. ..	153	197	200	244	257
Special help (problem families)			110	116	112

* *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.*

In the scheme for free home help service to women suffering from toxaemia of pregnancy, assistance was given to 107 cases, amounting to 6,977 hours of service.

IMMUNISATION AND VACCINATION

During 1961 more children received a primary course of immunisation against diphtheria, pertussis and tetanus than in any year since the National Health Service came into being. These good results were offset to some extent by a decline in the number receiving a primary course of poliomyelitis vaccine caused, at least in part, by the shortage of vaccine supplies during the year. The number of infants vaccinated against smallpox in 1961 rose somewhat from the total of the previous year, although the figure was lower than the record level of 1959. The reasons for the decline in smallpox vaccination during the last two years are still somewhat obscure; a slight and temporary decline was to be expected when the new schedule of immunisations was introduced, but thereafter one might have expected a rise to a level substantially higher than ever before. The reasons for this continued unpopularity of smallpox vaccination require further study.

The personal record card introduced in 1959 continues to be popular with both parents and staff. During reprinting the opportunity was taken to incorporate a section in which allergies and other personal idiosyncrasies can be noted for the benefit of those carrying out further inoculations. Space is also provided for a record of active and passive immunisation against tetanus alone.

A separate sterile syringe and needle are provided for each injection. The arrangements for sterilization remained unchanged during the year.

Diphtheria, tetanus, whooping cough—

TABLE (i)

	1957	*1958*	*1959*	*1960*	*1961*
Diphtheria immunisation:					
Primary course—					
Born in same year	8,281	10,644	14,102	20,203	20,990
Born in previous four years ..	28,687	23,301	26,125	28,980	32,276
Total under 5	36,968	33,945	40,227	49,183	53,266
Age 5–14	5,856	4,742	5,022	7,648	14,490
Reinforcing doses	39,268	38,725	33,237	40,511	87,758
Immunity Index 1–4 years	70·4	69·9	70·6	74·1	82·2
Tetanus immunisation	12,705	15,092	32,531	48,605	60,298
Whooping cough vaccination	35,648	34,133	38,917	48,539	54,064

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

TABLE (ii)

	1957	*1958*	*1959*	*1960*	*1961*
Diphtheria/whooping cough	19,464	7,623	4,925	1,536	722
Diphtheria/whooping cough/tetanus ..	12,405	15,092	32,382	46,650	52,927
Diphtheria/tetanus	—	—	42	1,734	5,860

The number of reinforcing doses of diphtheria toxoid given to children during the year was very much higher than during any recent year. This was the result of a deliberate attempt to improve the level of recent diphtheria immunisation in the children of primary school age following outbreaks of carrier infection in certain schools.

The number of recall doses of diphtheria toxoid given to children at the age of 15–18 months is well below the level that is desirable. To some extent this has been due to the fact that this activity is timed to take place at about the same time as the third dose of Salk poliomyelitis vaccine, which had to be curtailed during the year because of shortage of vaccine. It is to be hoped that the number of doses of diphtheria toxoid (in the form of the triple prophylactic) given at this stage will increase in the current year, so that a sufficient level of protection against diphtheria can be carried over until the age of school entry.

Smallpox—

TABLE (iii)

	1957	*1958*	*1959*	*1960*	*1961*
Number vaccinated under 1 year ..	29,677	30,865	30,489	23,057	30,482
Percentage of live births	56	55	55	40	51

The fact that infant vaccination, in spite of a rise on the previous year, remains at a lower level than in 1959 has already been mentioned. The acceptance rate for infant vaccination is about 51 per cent. This level is about twice that of 1949 and present levels have been attained by a fairly steady improvement since compulsion was abolished by the National Health Service Act. In spite of this improvement, the acceptance rate for smallpox vaccination remains substantially lower than that for diphtheria and whooping cough immunisation. The reason for this must be found and steps taken to remedy it. Although the situation is much more favourable than it was ten years ago one must view with some concern the fact that half our children are growing up without being vaccinated. One of the disadvantages of such a situation was shown very clearly in the early weeks of 1962, when, as a result of importation of smallpox into the country, there was a huge public demand for vaccination. This resulted in large numbers of persons being vaccinated for the first time in adolescence and adult life, when the complications of primary vaccination are relatively common. Had they been vaccinated in infancy, their re-vaccination could have been carried out during the smallpox epidemic without discomfort or danger.

One child, aged three years, developed generalised vaccinia six days after successful primary vaccination. The eruption developed at the sites of quiescent lichenified eczema and the child made a good recovery.

A child who was vaccinated at the age of five months became ill seven days later. At the time of admission to hospital four days later there was a typical primary response, but the child was severely ill with signs of encephalitis from which he died within 24 hours of admission. At the post-mortem examination the diagnosis of encephalitis was confirmed.

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

TABLE (iv)

	Number of persons who have received			
	Two injections		*A third injection (cumulative total)*	*A fourth injection (age 5–14 years)*
	In 1961	*Since the commencement of the scheme*		
Born in:				
1957–61	48,164	618,501	463,518	
1943–56	22,741			
1933–42:				
Londoners	24,150	226,841	174,614	
Others	2,150	58,887	47,395	
1932 or earlier (under 40):				
Londoners	39,083	112,594	70,200	
Others	4,929	21,067	15,827	
Other priority groups (over 40) ..	2,306	24,324	14,146	
TOTALS	143,523	1,062,214	785,700	98,809
Given by general practitioners and hospital doctors and included in the total above	52,940	288,963	218,430	16,199

Plans for poliomyelitis vaccination had to be curtailed during the latter part of the year because of the national shortage of Salk vaccine.

During the year a fourth injection was given to a large number of children between the ages of five and 14 who had previously received the course of three injections of the Salk vaccine. The routine administration of the primary course of three injections to infants continued. There is an interval of at least seven months between the second and third injections and it is a matter for some concern that about a quarter of those receiving the first two doses do not return for the third. Figures given elsewhere in this report show that the additional immunity arising from the third or fourth doses is very considerable.

Towards the end of the year thoughts turned to the possible use of the Sabin live poliomyelitis vaccine, which consists of attenuated strains of the three antigenic types of poliomyelitis vaccine and is given by mouth. It is known to be effective in giving a good antibody response. It has the advantage of not requiring injections. If given on a community basis to a high proportion of those under the age of 15 years, it not only provides individual protection but also stops the circulation of the virus in the community and thus reduces the risk of infection to the unvaccinated as well as the vaccinated. A decision was made to begin the routine use of the Sabin vaccine in the Council's clinics early in 1962. It is regrettable that the Ministry of Health has so far limited its use to those in the priority groups who have not received a full course of Salk vaccine. Its use as a measure of community protection is thus not possible.

A new quadruple prophylactic is now being produced in this country, in which inactivated poliomyelitis vaccine is incorporated into the triple (diphtheria/tetanus/pertussis) prophylactic. Hitherto such an idea was not very attractive because it was known that early in life, when one would wish to give the triple prophylactic in order to protect against whooping cough, the response to poliomyelitis vaccine, particularly to Type I, is diminished. The new quadruple prophylactic has a fortified Type I poliomyelitis component in the hope that this difficulty will be overcome and its use will be studied with interest.

Yellow fever vaccination—At the invitation of the Ministry of Health a yellow fever vaccination service is provided. This is operated by arrangement with the authorities of the centres mentioned below, who give vaccination and issue the appropriate international certificates. No charge is made to the public for this service.

The numbers of persons vaccinated were:

		1961	*1960*
Clinic No. 1.	(Hospital for Tropical Diseases)	9,297	10,571
	(Shipping Federation Clinic, King George V Dock) ..	2,762	809
Clinic No. 2.	(Unilever House)	1,173	1,249
Clinic No. 3.	(West London Centre)	3,682	4,031
		16,914	16,660

LONDON AMBULANCE SERVICE

The tables below show some aspects of the work of this Service and of its agency and supplementary services in 1961.

Table (i) indicates that the number of emergency calls dealt with by the accident section, 4,738 more than in 1960, continue to increase; that 25,370 fewer patients were carried by the general section and 7,005 fewer by the agency and supplementary services. The decrease in the total number of patients carried is only two and a half per cent. or, on average, less than one patient per hospital per day.

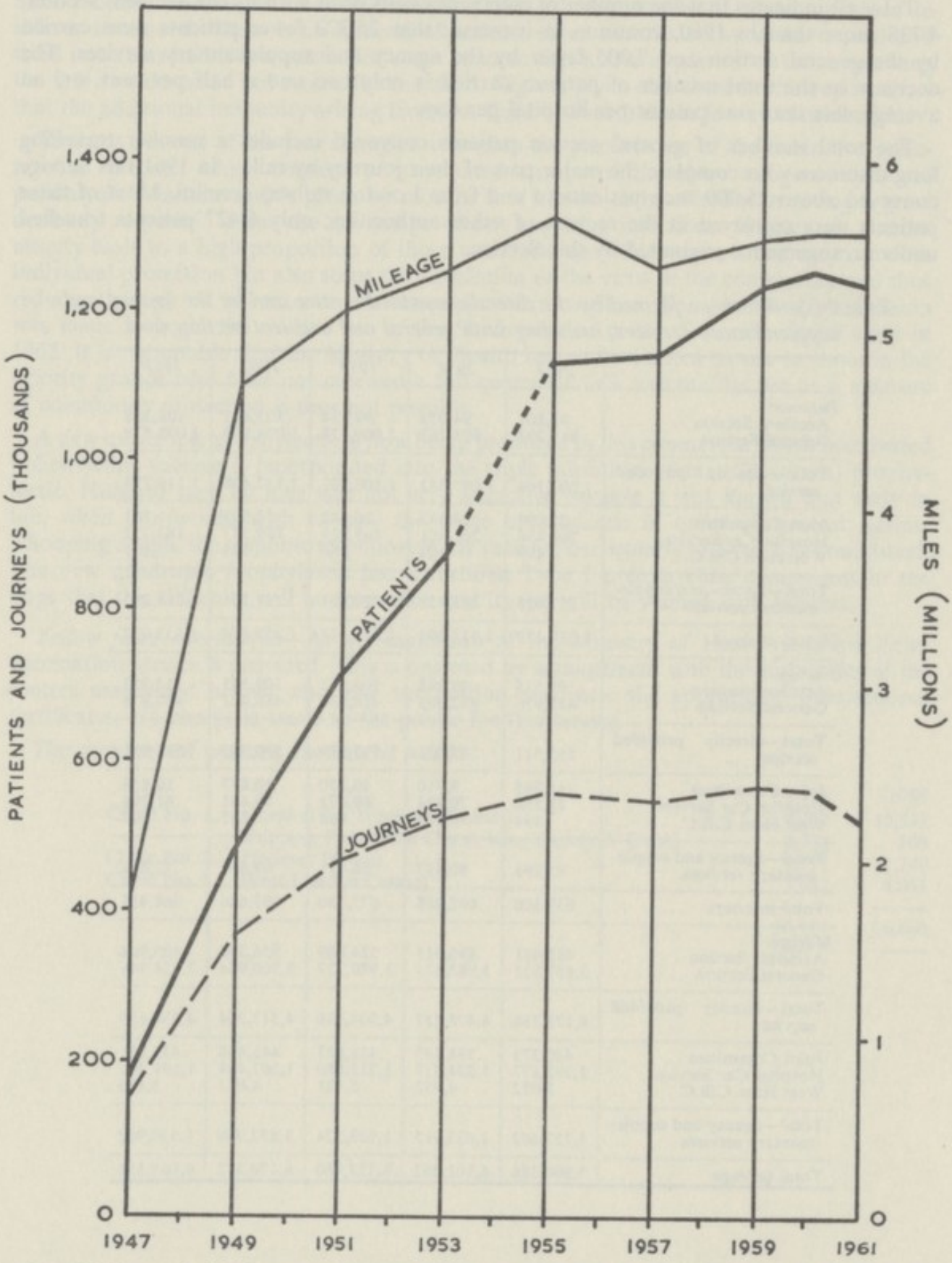
The total number of general section patients conveyed includes a number travelling long distances who complete the major part of their journey by rail. In 1961 this Service conveyed about 25,000 such patients to and from London railway termini. Most of these patients were conveyed at the request of other authorities; only 6,427 patients travelled under arrangements originated by this Service.

TABLE (i)—*Work performed by the directly provided service and by the agency and supplementary services, including both general and accident section work*

	1957	*1958*	*1959*	*1960*	*1961*
Patients:					
Accident Section	91,801	94,079	99,834	103,497	108,235
General Section	911,303	991,263	1,009,128	1,033,909	1,008,539
Total—directly provided service	1,003,104	1,085,342	1,108,962	1,137,406	1,116,774
Joint Committee	25,090	24,382	26,582	32,593	31,701
Hospital Car Service	201,436	201,161	193,523	189,337	183,231
West Ham C.B.C.	499	409	496	338	331
Total—agency and supplementary services	227,025	225,952	220,601	222,268	215,263
Total patients	1,230,129	1,311,294	1,329,563	1,359,674	1,332,037
Journeys:					
Accident Section	97,535	99,188	104,983	109,551	114,953
General Section	457,976	482,863	488,336	488,422	480,978
Total—directly provided service	555,511	582,051	593,319	597,973	595,931
Joint Committee	11,745	9,710	10,250	10,877	10,858
Hospital Car Service	71,556	70,724	69,672	58,441	61,294
West Ham C.B.C.	494	403	489	335	329
Total—agency and supplementary services	83,795	80,837	80,411	69,653	72,481
Total journeys	639,306	662,888	673,730	667,626	668,412
Mileage:					
Accident Section	485,431	495,913	524,009	556,390	605,904
General Section	3,687,353	3,982,374	3,980,327	3,960,964	3,928,746
Total—directly provided service	4,173,784	4,478,287	4,504,336	4,517,354	4,534,650
Joint Committee	430,373	394,145	411,823	441,468	435,851
Hospital Car Service	1,292,177	1,224,817	1,212,580	1,207,439	1,191,201
West Ham C.B.C.	5,052	4,953	5,121	4,061	3,850
Total—agency and supplementary services	1,727,602	1,623,915	1,629,524	1,652,968	1,630,902
Total mileage	5,900,386	6,102,202	6,133,860	6,170,322	6,165,552

LONDON AMBULANCE SERVICE, 1947–61

GENERAL SECTION, INCLUDING AGENCY AND SUPPLEMENTARY SERVICES



From 1955 onwards the figures of patients conveyed are based on the Ministry of Health definition of a 'patient', which differs somewhat from that formerly used by the Council.

Perhaps the most important influence on the work of the Service resulted from a conference of representatives of members and staff of the Council, the four Metropolitan Regional Hospital Boards, the London Executive Council and the Teaching Hospitals Association. Meetings at hospital group level followed so that, with the close co-operation of hospital transport officers and of specially appointed uniformed visiting officers, there might be a more economic movement of ambulances and some reduction in the calls upon the Service.

While it is gratifying to note that these co-operative efforts have met with some success in controlling the demand for ambulance transport, there is no reason to expect a general decline in the volume of work falling upon the Service. Indeed, the continuing development of out-patient treatment and of day hospitals and geriatric units, the increasing age of the population and the quickening turnover of hospital beds are all likely to result in the need for more and more ambulance transport.

TABLE (ii)—*General section*

	1957	*1958*	*1959*	*1960*	*1961*
Average mileage per patient	4·04	4·02	3·94	3·83	3·89
Average mileage per journey.. ..	8·05	8·25	8·15	8·11	8·17
Patients carried per 100 journeys ..	198	205	207	212	210

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)*
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
1960	109,551	9,644	6·8	6·4
1961	114,935	10,350	7·0	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*

	1957	*1958*	*1959*	*1960*	*1961*
Public and L.C.C. staff ..	66,039	68,134	72,793	76,705	81,755
Police	15,546	15,468	16,430	16,505	16,753
Midwives*	1,564	714	420	326	339
Doctors	6,781	6,815	7,092	7,522	7,964
Hospitals	1,917	2,032	2,021	2,186	2,045
Railway officials	2,775	3,030	2,931	2,896	2,868
Local calls†	892	870	923	893	788
London Fire Brigade ..	841	928	1,067	1,055	789
Out county	1,180	1,206	1,306	1,463	1,634
Total calls	97,535	99,188	104,983	109,551	114,935

** 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.

Vehicles—By the end of the year 136 of the new type Austin ambulances were in service in replacement of Daimlers. Many modifications and improvements to the original prototype were carried out and research continued into the possibility of further improvement.

The vehicle strength at 31.12.61 was:

Large ambulances	249
Single stretcher, sitting case ambulances	62
Sitting case cars	30*
Ambulance coaches	6
Mobile control unit for major accidents	1
Tenders	2
	350

** Including four cars for the use of visiting officers.*

Staff—The service is under the supervision of an Officer-in-Charge and is staffed by 28 administrative and clerical staff, 77 ambulance control clerks and 859 uniformed supervisory and operative staff. Recruitment improved during 1961 and 185 new entrants successfully completed the three weeks induction course at the London Ambulance Service training school. However, wastage remained high and resulted in a deficiency of 40 ambulance driver/attendants at the end of the year.

Award of resuscitation certificates—Three drivers were awarded the Royal Humane Society's resuscitation certificate during the year.

First aid and diagnosis competition—An international competition, organised by the Casualties Union, was won by the London Ambulance Service team. The competition was in two parts, a first aid test and a diagnosis test; two cups, the Buxton International Trophy and the Dawson Cup, were awarded.

Safe driving—66 per cent. of the 779 drivers who entered the National Safe Driving Competition held by the Royal Society for the Prevention of Accidents in 1960 gained awards, 20 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 First Aid Section increased from 1,678 to 1,895—539 persons were enrolled but 322 persons resigned.

The following courses were held during 1961:

New entrants	6
First aid	3
Ambulance section—part 1	9
Ambulance section—part 2	8
Driving and maintenance	12
Officer selection	6
First aid practical revision	4

After a total of 991 hours' instruction by the British School of Motoring 34 volunteers passed the Ministry of Transport driving test. A total of 2,726 hours' driving practice on various types of ambulance was put in by volunteers holding driving licences and 222 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 1961 was 544, covering 1,088 hours.

Members of the Section took part in a number of exercises and displays: in addition, an internal competition between teams of the Ambulance and First Aid Section of the County of London Division proved of great value.

Chiropody

A detailed account of the growth of this service was given in my report for 1960 (pages 78-82).

The following tables show the attendances at the Council's foot clinics since 1957, with an analysis according to age groups for the last four years:

New cases and attendances

Year	*New cases*	*Attendances*	*Staff at the end of the year (in terms of whole units)*
1957	8,149	166,987	44·2
1958	6,994	172,005	44·2
1959	7,074	169,847	46·2
1960	9,405	186,735	57·7
1961	10,379	196,788	55·6

Analysis in age groups of treatment given at clinics

Group	*1958*	*1959*	*1960*	*1961*
Children 0–4 years	100	137	129	117
5–14 years	6,381	6,390	7,062	6,599
Males 15–64 years	14,805	14,442	14,766	14,076
65 years and over	15,435	15,410	17,613	19,675
Females 15–59 years	59,217	56,581	57,980	55,237
60 years and over	76,067	76,887	89,185	101,084
Total	172,005	169,847	186,735	196,788

Recuperative holidays

Admissions to recuperative holiday homes

	1957	*1958*	*1959*	*1960*	*1961*
Expectant and nursing mothers ..	138	111	123	109	95
Other adults	2,510	2,289	2,457	2,175	2,183
Children under 5 not at school ..	660	575	571	512	479
School and nursery school children	2,852	2,507	2,597	2,357	2,138
	6,160	5,482	5,748	5,153	4,895

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.

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.
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
1960 ..	908	410	68	2	13,077	2,905	14,053	3,317	26,494	10,647	240,303	96,113
1961 ..	1,067	563	47	—	13,573	2,906	14,687	3,469	28,081	11,824	253,806	93,398

	1957	1958	1959	1960	1961
Percentage of patients resident in County of London	81	82	83	81	83
Number of patients completing treatment and of defaulters—					
Syphilis—patients completing treatment—					
Males	828	631	579	526	572
Females	627	554	508	434	362
patients not completing treatment—					
Males	675	870	672	677	776
Females	294	292	336	431	390
Gonorrhoea—patients completing treatment—					
Males	4,938	5,237	4,941	5,700	7,800
Females	985	1,165	1,199	1,334	1,269
patients not completing treatment—					
Males	3,501	4,128	4,900	6,536	8,085
Females	900	1,161	1,312	1,485	1,550

Tracing of contacts of patients—

Analysis of work undertaken by Council's welfare officers

	1957	1958	1959	1960	1961
Contacts referred by hospitals, medical services of the Armed Forces and by local health authorities	384	297	246	282	188
Insufficient information for following-up ..	276	191	102	91	33
Contacts brought to treatment	27	43	57	72	67
Contacts traced but not brought to treatment ..	14	3	7	13	15
Contacts not traced	67	60	80	106	73

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

Health education

During the year the Council was invited to submit evidence to a Joint Committee of the English and Scottish Health Service Councils (the Cohen Committee). This committee was set up to consider fresh fields for health education, having regard to recent developments in medicine; how far it is possible to assess the results of health education in the

past and what methods are likely to be most effective in future. As the Council's evidence was in the nature of a review of the department's activities in this field in recent years, the substance of the statement is reproduced here, with the addition of statistics for 1961, in place of the more usual limited annual review.

As both a local health and education authority, the Council aims to provide a comprehensive educational programme in physical and mental health. It has been active in some degree in the field of health education since the inception of the school health service in 1905.

What is health education—Health education may be defined as attempting to:

(*a*) teach some of the underlying facts that will enable people to understand something of modern medicine and the function of their own bodies;

(*b*) help people to appreciate the effects of heredity and environment on the community, their family and themselves;

(*c*) help people to accept responsibility and to modify their attitudes towards health, disease and injury;

(*d*) explain the health services to people in terms which they can understand, so that they are able to accept help in a rational manner.

The emphasis of health education has changed over the years and can be thought of in three groups, inevitably mixed but still broadly separate:

Environmental hygiene—sewage disposal, safe water, etc. The education of small and influential groups for a short time, i.e. till the service was created.

Preventive medicine—the control of communicable diseases by immunisation and medical treatment. The need for quite large numbers of people, e.g. parents, to modify their attitudes for long enough to allow their children or themselves to be immunised.

Positive health—the education of groups of people to modify their attitudes permanently, e.g. to change their diet, the way of rearing children, to give up smoking, in order to attain higher standards of physical and mental health.

Co-operation in health education—Broadly, since 5 July, 1948 the Council has left health education on environmental hygiene to the metropolitan borough councils and has itself concentrated on the personal health services. There is the fullest co-operation with the metropolitan boroughs, e.g. the Council has provided stands and stewards for borough home safety exhibitions. In addition, there is a close link with the numerous bodies which have an interest, direct or indirect, in health education such as the Central Council for Health Education, Borough Safety Committees, the Royal Society for the Prevention of Accidents, the British Standards Institution, the National Association for Mental Health and the National Marriage Guidance Council. Financial assistance given by the Council in 1960/61 included:

Central Council for Health Education	£1,925
Royal Society for the Prevention of Accidents (Training Centre) ..	£2,400

The Council looks to the voluntary bodies as the main source of posters and pamphlets.

An executive committee to co-ordinate health education projects of common interest was formed early in 1961 by the liaison committee of medical officers of health of London and the Home Counties.* Its chairman and secretary are respectively chairman and secretary of the Council's Health Education Advisory Panel; the Medical Director of the Central Council for Health Education is also a member. Plans for a joint campaign to publicise polio vaccination, based on a poster display at London Transport Executive and British Railway stations in the area of the authorities, were rendered abortive by difficulties over the availability of vaccine and it was decided to postpone the campaign indefinitely.

* *Bedfordshire, Brighton, Buckinghamshire, Canterbury, Croydon, Eastbourne, East Ham, East Sussex, Essex, Hastings, Hertfordshire, Kent, London, Middlesex, Southend, Surrey and West Ham.*

Organisation—Overall policy is decided by the Health Committee.

There is a central Health Education Advisory Panel representing the main professional points of view both central and divisional, which also has the assistance of a senior teacher of a large secondary school. This panel deals with broad planning matters, particularly in relation to exhibitions, campaigns, media and the timing thereof. Matters for detailed consideration are referred to a working team of health visitors, under the chairmanship of a divisional nursing officer who is a member of the central panel. This team undertakes the appraisal of films and filmstrips, preparation and revision of lists of approved mothercraft equipment and practical steps for the preparation of visual aids. Each of the nine divisional medical officers is responsible for the day-to-day direction of health education activities and he is assisted by a representative panel of his staff.

At the central office there is a small executive section which undertakes the co-ordination of departmental health education activities, liaison with interested bodies, press publicity, campaigns and exhibitions, the supply of equipment, films, filmstrips, literature and other aids, and the maintenance of a photographic and a general library on health subjects.

Health education activities—These may be regarded as falling under three heads:

(i) Day-to-day health education by medical officers, health visitors, etc. in the home or at clinics, on mothercraft, the need for prophylaxis, etc.

(ii) Health education in schools in cleanliness, hygiene, biology, mothercraft, etc. This is the responsibility of head teachers but the school doctors and health visitors/school nurses afford any help requested.

(iii) Individual campaigns or exhibitions which are in general centrally organised.

These three aspects of the work are explained in detail below.

The work of the field staff—Health education may be deemed to form part of almost any contact between field staff and the public, e.g. there are, each year, some 900,000 attendances at maternity and child welfare clinics, 1,750,000 visits by home nurses, 750,000 home visits by health visitors, 300,000 school medical examinations and possibly another 750,000–1,000,000 visits to the homes of schoolchildren by the 70 trained social workers and over 2,500 voluntary workers of the children's care committees (a service unique to London) to follow up findings at medical inspections, non-attendance for diphtheria immunisation, cases of problem children and mental health and moral welfare cases. Apart from this day-to-day contact with the public, a regular series of talks and discussions held mainly at welfare centres is the basis of field work. The variety and volume of the talks, arranged under the direction of divisional medical officers, is shown in the following tables.

Health education talks—1961

TABLE (i)—*Speakers*

	Divisions									
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*Total*
Medical officers	2	50	2	—	—	—	5	—	2	61
Nursing officers	—	—	—	—	—	—	1	—	—	1
Health visitors and school nursing sisters	596	1,278	323	290	417	941	696	151	351	5,043
Domiciliary midwives ..	2	14	3	1	4	—	20	—	—	44
Teachers/instructors	129	—	—	110	53	—	20	—	—	312
Fire prevention officer (L.F.B.)	—	—	—	1	—	—	—	1	—	2
Lecturers from outside the Council's service—Nursing	—	9	—	4	—	—	—	1	—	14
Other	16	47	15	5	—	—	68	3	—	154
Total ..	745	1,398	343	411	474	941	810	156	353	5,631

TABLE (ii)—*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	631	4,749	831	6,791	303	1,810	237	1,900	348	3,056	941	9,924	443	4,989	128	913	275	2,045	4,137	36,177
Care of older children	6	50	66	576	7	62	3	63	13	65	—	—	48	673	1	100	7	42	151	1,631
General family health topics ..	5	35	184	1,663	2	22	3	57	15	127	—	—	42	475	—	—	28	208	279	2,587
Environmental hygiene	7	52	22	200	—	—	—	—	1	6	—	—	5	58	1	10	3	29	39	355
Infectious diseases and prophylaxis	23	243	72	540	3	15	3	17	25	219	—	—	37	473	10	110	14	99	187	1,716
Prevention of accidents	16	139	48	408	2	33	1	19	10	85	—	—	17	197	3	31	9	63	106	975
Smoking and lung cancer	—	—	6	27	—	—	—	—	—	—	—	—	5	274	—	—	—	—	11	301
Cancer education (other than above)	—	—	—	—	—	—	—	—	—	—	—	—	1	8	—	—	—	—	1	8
Mental health	—	—	21	104	—	—	—	—	—	—	—	—	—	—	—	—	1	8	22	112
First aid	5	45	13	153	10	60	2	39	2	20	—	—	6	54	8	80	1	8	47	459
Other	52	489	135	1,103	16	98	162	3,131	60	412	—	—	206	2,959	5	68	15	136	651	8,396
Total	745	5,802	1,398	11,565	343	2,100	411	5,226	474	3,990	941	9,924	810	10,160	156	1,312	353	2,638	5,631	52,717

TABLE (iii)—*Audience groups*

	Divisions									
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*Total*
Expectant mothers	574	817	266	275	322	941	452	130	233	4,010
Mothers, mothers' clubs, etc.	167	500	77	136	152	—	343	10	117	1,502
Parent/teacher associations	—	—	—	—	—	—	5	1	—	6
Schools*	—	—	—	—	—	—	4	—	—	4
Day continuation classes ..	—	80	—	—	—	—	—	—	—	80
Voluntary organisations ..	4	1	—	—	—	—	6	15	3	29
Total ..	745	1,398	343	411	474	941	810	156	353	5,631

* *Lectures by medical officers.*

Health education in schools—This is the responsibility of head teachers. The services of divisional staff are, however, always available for advice and help in planning health education in schools and for giving special talks.

Whilst a variety of discussions, talks and demonstrations are offered by the public health department and many schools do a great deal on their own, much more is needed, especially in boys' schools. The key to the whole matter, it is thought, lies in the emphasis given to health education in the training of teachers.

Talks given by school health visitors at the invitation of head teachers range over a variety of subjects and numbered over 4,000 in 1961.

Campaigns and exhibitions—Normally county-wide home safety and diphtheria campaigns are held annually, sustained for one and two weeks respectively. These campaigns have involved press advertisements in thirty-eight local newspapers, exhibition of films and filmstrips at welfare centres, etc. and films or slides at local cinemas, press, radio and television publicity, special shop window displays and printed slogans on correspondence envelopes used by the Council. Other campaigns are undertaken in response to requirements, e.g. poliomyelitis vaccination and mental health.

In 1957 and 1959 exhibitions, in conjunction with the Royal Society for the Prevention of Accidents, were arranged at Charing Cross underground station on the themes of ' Danger at home ' and ' Home, safe home ', attendances being some 27,000 and 23,000 respectively. In co-operation with the Architect's department, special exhibits on home safety were also provided at the Ideal Home Exhibition at Olympia in 1960 and 1961. Displays on a number of health education subjects have been provided in the Council's own display centre at County Hall and in 1960 a 60-second film was made, in conjunction with local authorities in the Home Counties, which was shown on independent television networks.

In 1959 an exhibition was held at County Hall to show what was being done after ten years of the National Health Service for the health of the people of London and the opportunities for young people in the health services for interesting and worthwhile careers in nursing and allied professions. The exhibition was presented by the Council and the four metropolitan regional hospital boards, in association with the London Executive Council and the Metropolitan Boroughs' Standing Joint Committee.

As already indicated, the Council has participated in various exhibitions run by metropolitan borough councils.

Displays on health education topics designed and executed by health visitors are a feature at welfare centres, in particular at three centres which have a shop window front and can therefore attract a wider public than those who would be attending the centres.

Health education material—As already mentioned, the Council mostly draws on other agencies for literature, but it has itself produced leaflets on such topics as lung cancer, oil heaters and general guidance to school leavers. To a limited extent some written material has been produced in foreign languages, i.e. Arabic, Bengali, French, German, Greek, Hungarian, Italian, Polish, Russian, Spanish, Turkish and Urdu, to meet local needs.

The central office distributes over 400 different leaflets and booklets and some 250 posters and wall charts produced by related organisations. Over 900,000 leaflets, 90,000 bookmarks and 24,000 posters are used annually.

Local distribution is mainly through the Council's own channels but the co-operation of the metropolitan borough councils is sought and obtained as regards their libraries, notice boards, etc.

In addition to the large central library previously mentioned, smaller libraries are maintained at the nine divisional offices.

There has been an increasing demand for films and filmstrips in the presentation of talks and discussions, as indicated in the following table of requests received from divisions:

	1957	*1958*	*1959*	*1960*	*1961*
Films	270	325	364	473	675
Filmstrips	477	446	977	1,094	955

The department's own library provided films on 199 occasions and all the filmstrips. In addition to those supplied centrally, divisions hold a number of filmstrips for exclusive local use.

Assessment of results—In the day-to-day teaching and publicity, a most effective method has been the personal approach by talks to the individual or to small groups of people to whom the particular subject is of immediate interest, the lectures being supplemented as appropriate by posters, leaflets, flannelgraphs, films, filmstrips, etc. Though it is extremely difficult to assess the impact made on the particular public to which health education is directed, an attempt was made when a polio campaign was held in the Spring of 1960. An enquiry showed that of a sample of 2,116 who attended clinics for immunisation, the greatest response attributed to an advertising medium was due to posters and press advertisements.

Results of the survey are shown in percentages* in the table below:

Age group	*Medium*					
	T.V. or radio	*Posters*	*Press adverts*	*Leaflets*	*Bookmarks*	*None*
All ages..	6·3	21·2	21·2	14·1	3·6	45·6
Born after 1942	6·2	15·2	15·2	8·9	2·1	64·5
1933–1942	6·3	22·2	22·2	19·5	4·0	40·1
Before 1933 and aged over 40 ..	6·2	22·6	22·6	14·3	3·9	41·8

* *In total these exceed 100 per cent. because some were influenced by more than one medium.*

A number of those who did not admit to having seen any publicity were influenced by spouses, parents or friends, who may themselves have been influenced by the publicity campaign.

A further difficulty that cannot readily be resolved is the assessment of results. Though in the case cited above a demand for vaccination was provoked by publicity and some measure of its effect could be gauged, in many cases, such as in home safety campaigns, no immediate effect is apparent to judge from relevant statistics. There is, however, an indirect effect produced by such publicity by the Council in influencing the contents of television programmes and popular magazines, which have a wider and more direct appeal to the public.

Training of staff in health education—An account of in-service training of staff will be found in the staff section of the main report.

The future—Health education has in the past been concerned largely with physical problems connected with nutrition, grooming, general care and protection from common dangers, particularly in relation to the young and the elderly. Current problems of adolescent promiscuity, rising incidence of venereal disease, lung cancer and smoking, immunisation, dental health of children, accident prevention, and emotional development and mental health spotlight the changing pattern of social needs which in turn will necessitate a change of emphasis in health education.

Attention has been focussed recently on the subject of smoking and lung cancer, following the publication of a report by the Royal College of Physicians of London; the problems of achieving more effective health education in this field for children and adults are being actively probed in co-operation with representatives of the education service and my medical colleagues of the Home Counties.

Personal approach, to individuals or groups, has been found to produce the most hopeful results within the limitations of the means of publicity which are available to local authorities. In contrast with advertising appropriations of commercial enterprises, the money spent on health education by local authorities is insignificant; the cost of production of films, television advertising and large-scale publicity by use of poster hoardings are in the main beyond their financial resources. Future intensification of health education activities will necessarily depend on the amount of money allocated and the availability of trained health educators.

Pupils on school rolls—In January, 1962 there was a total of 422,622 pupils on the day school roll; 230,134 in primary schools, 182,248 in secondary schools, 1,790 in nursery schools and 8,450 in special schools. In January, 1961 there were 428,591 pupils on the roll.

Ministry of Education circular 14/61 *and Ministry of Health circular* 23/61—These administrative circulars, relating to young children handicapped by impaired hearing, in which local authorities were asked to review their existing services in consultation with Local Medical Committees and hospital authorities, are referred to on page 49.

Medical inspection

Details of medical inspections during 1961 are summarised and compared with those for earlier years in the tables below. Since 1958 periodic general medical inspections have been analysed by year of birth to conform with Ministry of Education requirements, but 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.

The Council's revised scheme for the medical inspection of schoolchildren came into operation on 1 January, 1959 and one effect was to make the intermediate periodic inspections a year later in the child's school life. Consequently fewer inspections were carried out during 1959 than in 1960; in 1960 the normal pattern was resumed, but on the new time-table. It will be seen from the following table that intermediate inspections now are each spread over two age-groups because the school year begins in September. The number of children seen at periodic general medical inspections in 1961 was 38·7 per cent. of the school roll, compared with 35·2 per cent. in 1960 and 31·4 per cent. in 1959.

Another effect of the revised scheme was to abolish nutrition reinspections and none is now recorded. Ordinary reinspections showed a fall of almost 7 per cent. from the 1960 figure and fewer ' special ' inspections were carried out. It is of interest that of the 11,837 special inspections, half were requested by head teachers, nearly a quarter by school health visitors and one-eighth by parents.

Periodic general medical inspections

Age groups	*1959*		*1960*		*1961*	
	No.	*%*	*No.*	*%*	*No.*	*%*
4 and less	7,660	5·6	7,674	5·1	7,939	4·9
5	29,317	21·6	27,435	18·2	28,558	17·4
6	7,069	5·2	7,511	5·0	8,314	5·1
7	13,278	9·7	9,744	6·5	9,356	5·7
8	8,540	6·3	19,322	12·8	20,684	12·6
9	3,128	2·3	3,227	2·1	4,204	2·6
10	1,817	1·3	1,897	1·3	2,078	1·3
11	15,424	11·3	10,549	7·0	10,096	6·2
12	8,744	6·4	19,634	13·0	20,148	12·3
13	2,896	2·1	4,884	3·2	6,103	3·7
14	8,204	6·0	9,418	6·2	10,277	6·3
15 and over	30,186	22·2	29,495	19·6	35,841	21·9
	136,263	100·0	150,790	100·0	163,598	100·0

Non-routine medical inspections

	1959	*1960*	*1961*
Reinspections—nutrition	3,622	—	—
Reinspections—other	97,401	80,631	74,618
Secondary school reviewals	2,771	1,785	1,908
Other non-routine inspections (see next table)	47,924	50,648	48,380
Total	151,718	133,064	124,906
Total inspections	287,981	283,854	288,504

Analysis of non-routine medical inspections

Nature of inspection	*Number inspected*	
Bathing centre inspections—scabies	28	
Bathing centre inspections—other	128	
Employment certificates	5,264	
Licences for theatrical employment	468	
School journeys	21,409	
Recuperative holidays—prior to holiday	1,075	
Recuperative holidays—on return	53	
Candidates for higher awards	34	
Nautical school entrants	149	
Outward Bound and Adventure courses	159	
T.B. contacts	30	
Boarding schools for the delicate—		
Pre-departure inspections	130	
On return	45	
Other handicapped pupils—		
Statutory examination	1,072	
Periodic special defect examination	5,126	
Research investigations and enquiries	186	
		35,356
Specials, at request of:		
Head teacher—special book	1,618	
Head teacher—others	4,585	
School nurse—after health survey	1,208	
School nurse—others	1,401	
Divisional officer (Education)	895	
District care organiser or care committee	642	
Parent	1,488	
		11,837
All other non-routine inspections		1,187
Total		48,380

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

Age groups inspected	*For defective vision (excluding squint)*	*For other conditions*	*Total individual pupils*
4 and less	32	647	672
5	163	2,172	2,313
6	117	783	884
7	665	762	1,369
8	1,496	1,328	2,721
9	319	301	589
10	190	137	309
11	1,008	514	1,469
12	1,934	1,086	2,897
13	587	270	823
14	1,029	392	1,358
15 and over	3,807	1,121	4,748
	11,347	9,513	20,152

Defects noted at routine medical inspections—The overall percentage of children referred for treatment of a defect was 12·3 in 1961 compared with 12·5 in 1960 and the comparative percentages for sex and age are shown in the following table. The percentage referred for vision defects has increased from 6·1 in 1959 and 6·6 in 1960 to 6·9 in 1961; for other defects it has decreased from 6·8 in 1959, 6·3 in 1960, to 5·8 in 1961; the increase in vision defect was of the same order for both boys and girls, but the decline in the percentages for other defects was greater for girls than for boys. Vision defects are dealt with in more detail in a later paragraph.

For all defects in the age groups containing the largest numbers (viz., 5, 8, 12 and 15) boys aged 15 showed a marked increase over the 1960 figures and boys aged 12 also showed an increase, but to a lesser extent, both increases being accounted for almost entirely by the increase in vision defect. For girls there was no appreciable change.

Percentage of children noted for treatment

Age and sex		*All defects*			*Vision defects*			*Defects other than vision*		
		1959	*1960*	*1961*	*1959*	*1960*	*1961*	*1959*	*1960*	*1961*
4 and less	Boys	10·1	9·6	9·3	0·4	0·5	0·4	9·8	9·3	9·0
	Girls	8·9	8·3	7·6	0·4	0·3	0·4	8·6	8·0	7·3
5	Boys	9·6	9·2	8·6	0·6	0·5	0·5	9·1	8·7	8·2
	Girls	8·3	7·9	7·5	0·5	0·7	0·7	7·9	7·3	6·9
6	Boys	13·2	12·5	11·8	1·3	2·1	1·3	12·1	10·8	10·8
	Girls	11·2	10·7	9·4	1·0	2·0	1·5	10·3	9·0	7·9
7	Boys	15·7	15·2	15·4	7·2	6·6	7·0	9·2	9·2	9·0
	Girls	15·3	15·0	13·9	7·5	7·6	7·2	8·5	8·2	7·2
8	Boys	14·8	14·0	13·5	6·9	7·2	7·0	8·5	7·5	7·0
	Girls	14·0	13·5	12·8	7·7	7·3	7·5	6·8	6·7	5·9
9	Boys	15·5	13·7	14·0	7·2	7·3	7·1	9·0	7·1	7·9
	Girls	14·1	13·3	14·0	8·4	7·5	8·1	6·1	6·2	6·3
10	Boys	17·2	16·0	15·5	8·6	8·7	8·9	10·0	7·8	7·4
	Girls	16·8	15·5	14·2	8·7	9·0	9·4	8·6	7·4	5·7
11	Boys	14·1	13·3	12·8	8·5	9·1	8·4	6·2	4·6	4·8
	Girls	16·1	17·3	16·4	9·8	11·3	11·6	7·0	6·9	5·4
12	Boys	11·6	13·0	13·4	7·1	8·3	8·8	5·0	5·2	5·1
	Girls	13·9	15·3	15·4	8·8	9·8	10·4	5·8	6·2	5·8
13	Boys	14·9	13·4	12·0	9·1	8·7	8·5	6·5	5·2	3·9
	Girls	17·1	16·3	15·0	9·7	11·0	10·7	8·0	6·2	4·9
14	Boys	12·0	12·1	12·1	9·1	8·9	9·4	3·2	3·5	3·1
	Girls	12·9	13·2	14·5	9·3	10·2	10·7	4·0	3·7	4·6
15 and over	Boys	11·9	11·4	12·2	9·0	8·9	9·7	3·2	2·8	2·9
	Girls	13·0	14·3	14·3	9·8	10·7	11·6	3·6	4·2	3·3
Total	Boys	12·4	12·1	12·0	5·8	6·1	6·4	7·0	6·3	6·0
	Girls	12·5	12·9	12·6	6·3	7·1	7·5	6·6	6·4	5·6
Total	Both sexes	12·4	12·5	12·3	6·1	6·6	6·9	6·8	6·3	5·8

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 1959 to 1961. These percentages remain fairly stable over the period. The slight but steady decrease in the incidence of enlarged cervical glands continues. Enlarged tonsils and adenoids, lung disease and orthopaedic defects all show a continued decline since 1959, psychological defects an upward trend.

	1959	1960	1961
Numbers examined	136,263	150,790	163,598
		Percentages	
Skin diseases	1·22	1·22	1·19
External eye diseases	0·55	0·56	0·54
Defective hearing	0·91	0·85	0·90
Otitis media	0·67	0·56	0·51
Enlarged tonsils and adenoids ..	5·11	4·28	3·95
Defective speech	0·93	0·88	0·87
Enlarged cervical glands	0·89	0·68	0·63
Heart and circulation	0·88	0·83	0·87
Lung disease (not T.B.)	1·49	1·38	1·21
Orthopaedic defects	4·16	3·93	3·52
Defects of nervous system	0·39	0·43	0·43
Psychological defects	0·93	1·02	1·08
Anaemia	0·17	0·12	0·12
Enuresis	1·75	1·80	1·77

A child can be noted for more than one defect.

A new method of recording, introduced on 1 January 1960, permits new defects discovered at special medical inspections to be related to the source of reference. The following table shows clearly how certain types of defect are most often brought to notice through a particular source of reference.

Defects found at special medical inspections—1961

	Referred by:				
	Head teacher	*School health visitor*	*Divisional officer (Education)*	*Care committee*	*Parent*
Number of pupils seen	6,203	2,609	895	642	1,488
Number of defects found	2,827	1,424	269	201	832
Number of defects per 1,000 pupils:					
Skin diseases	30	63	7	8	16
Defective vision	109	575	15	31	75
External eye diseases	21	40	3	8	29
E.N.T. conditions	92	102	27	30	126
Orthopaedic defects	51	57	16	12	33
Defects of nervous system	32	11	11	2	15
Psychological defects	291	24	35	40	52
Enuresis	17	29	1	28	46
Speech defects	53	23	—	2	25
Nutritional defects	15	31	8	19	22
All other defects	170	140	179	134	121

Attendance of parents and care committee representatives at periodic inspections—As in previous years the percentage of medical inspections at which a parent is present decreases as children get older. The overall percentage was 48·6, slightly lower than in 1960 when it it was 50·6 per cent.

Care committee representatives attended 86·9 per cent. of all periodic general inspections. In the infant and junior school age groups the figure was over 90 per cent. but only about 80 per cent. in the secondary school age groups. This was due, no doubt, to the fact that care committees do not function in all secondary schools.

Attendance of parents and care committee representatives

Age Group	*Number of pupils inspected*	*Parent present*	*Care committee representatives present at inspection*
		%	%
4 or less	7,939	90·9	82·3
5	28,558	87·7	94·6
6	8,314	79·1	95·8
7	9,356	71·8	94·4
8	20,684	70·1	96·4
9	4,204	59·2	96·3
10	2,078	51·9	95·2
11	10,096	37·7	75·8
12	20,148	31·8	82·9
13	6,103	24·7	79·9
14	10,277	10·3	82·1
15 and over	35,841	8·5	78·8

Physical condition of pupils

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 nutrition during 1961 are set out below, with similar figures for the four preceding years. This table suggests a continuous improvement over the five years, but the steadying of the percentage noted with a nutrition defect may mean that the end of this improvement is near.

	Physical condition		*Nutrition defect noted for*	
	Satisfactory	*Unsatisfactory*	*Treatment*	*Observation*
	%	%	%	%
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
1960	99·0	1·0	0·2	0·5
1961	99·2	0·8	0·2	0·4

As indicated in my report for 1959, the newly introduced basis of tabulation by years of birth permits the comparison of samples of children of the same age group and is analogous to a ' follow-up ' survey. The last three years' figures are:

Percentage unsatisfactory physical condition

Year of birth	*Year of examination*		
	1959	*1960*	*1961*
1944	0·6	—	—
1945	0·9	0·4	—
1946	1·3	0·6	0·4
1947	1·3	0·8	0·4
1948	1·2	0·9	0·6
1949	2·9	0·9	0·6
1950	2·0	2·2	0·6
1951	1·2	1·6	1·7
1952	1·4	1·1	1·5
1953	2·4	1·8	1·0
1954	1·4	1·8	1·2
1955	1·4	1·2	1·8
1956	—	1·0	0·7
1957 and later	—	—	0·8

School meals and milk

The Ministry of Education asked for a return for a typical day of the total number of (i) day school children who had school dinners and (ii) children who had school milk. The day selected for the census was 26 September or the nearest normal school day thereto. The figures are set out below with those for 1960 in brackets.

Type of school	*Number of children present*	*Number who took school dinners*			
		On payment	*Free*	*Total*	*%*
Secondary	173,329 (*173,092*)	103,139 (*105,855*)	7,470 (*7,237*)	110,609 (*113,092*)	63·81 (*65·34*)
Primary	205,994 (*202,240*)	109,150 (*103,145*)	12,382 (*11,880*)	121,532 (*115,025*)	59·00 (*56·88*)
Special	5,585 (*5,545*)	4,411 (*4,473*)	1,098 (*1,011*)	5,509 (*5,484*)	98·64 (*98·90*)
Nursery	1,509 (*1,480*)	870 (*933*)	87 (*95*)	957 (*1,028*)	99·17 (*98·66**)
	386,417 (*382,357*)	217,570 (*214,406*)	21,037 (*20,223*)	238,607 (*234,629*)	61·75 (*61·37*)

* *Percentage of 965 children, as 544 children attended half time and did not have school dinners.*

The Ministry was informed that 316,826 children in Council maintained schools took milk on the selected day(s) compared with 318,678 in September 1960. Of 28,891 children present in independent schools, 22,438 had milk under the scheme.

The percentages for the several types of school for the corresponding days were:

	1960	*1961*
Secondary	66·05	63·12
Primary	96·32	96·51
Day special	98·47	99·18
Nursery	98·51	98·67
Boarding	98·51	97·52
Independent	74·60	77·66

Vision

Visual acuity standards expressed as percentages of the numbers of children whose eyes were *tested* are set out in the following table.

For children not wearing spectacles the highest rate of referral for treatment is at age under 7 (entrants), but this is because vision testing at this young age is not general and tends to be confined to those in whom there is a suspicion of defective vision. In general, the referral rate for treatment is fairly consistent throughout the age range, i.e., development of defective vision is progressive with age, since those found to have defective vision at earlier examination and provided with spectacles will be excluded from this side of the table at subsequent examinations.

For children already wearing spectacles the proportions referred for treatment increase with age, doubtless for correction of refraction.

Of the children medically inspected 0·6 per cent. were noted for treatment of squint, the same as in 1958, 1959 and 1960. The percentage ranged from 1·3 in the entrant group to 0·1 in the leaver group.

Age group	Boys							
	Not wearing spectacles				*Wearing spectacles*			
	6/6	*6/9*	*6/12 or worse*	*Referred for treatment*	*6/6*	*6/9*	*6/12 or worse*	*Referred for treatment*
Under 7	82·0	11·0	5·3	7·8	0·6	0·5	0·7	0·3
7	78·2	12·0	6·2	6·4	1·1	1·0	1·6	1·3
8	80·9	9·5	5·7	5·7	1·4	1·0	1·5	1·4
9	80·7	8·7	6·3	6·0	1·8	1·3	1·3	1·3
10	80·9	5·9	8·2	7·5	1·7	1·0	2·3	1·8
11	80·9	5·3	6·2	6·0	3·5	2·1	1·9	2·5
12	80·3	5·1	6·2	6·0	4·3	2·1	2·1	2·9
13	80·4	5·2	6·1	6·2	4·7	2·0	1·7	2·3
14	80·5	4·0	5·8	5·5	5·0	2·3	2·3	3·9
15 and over	78·2	4·3	5·9	5·7	6·3	2·7	2·5	4·0
Total	79·8	6·3	6·0	5·9	3·9	1·9	2·0	2·7

Age group	Girls							
	Not wearing spectacles				*Wearing spectacles*			
	6/6	*6/9*	*6/12 or worse*	*Referred for treatment*	*6/6*	*6/9*	*6/12 or worse*	*Referred for treatment*
Under 7	78·8	12·2	6·5	9·1	1·1	0·6	0·8	0·6
7	76·4	13·1	6·5	6·6	1·1	1·3	1·5	1·3
8	79·2	10·6	5·5	5·9	1·4	1·5	1·7	1·7
9	77·2	11·2	7·0	6·9	1·2	1·5	1·9	1·4
10	79·4	6·5	7·5	7·2	2·3	1·7	2·5	2·4
11	75·7	6·6	7·4	8·0	4·4	3·3	2·6	3·7
12	77·6	6·5	6·5	7·0	4·5	2·6	2·3	3·4
13	77·2	6·0	6·9	7·5	4·5	2·7	2·6	3·2
14	77·1	6·1	6·6	6·6	5·8	2·9	2·5	4·1
15 and over	74·3	5·3	6·0	6·5	7·5	3·8	3·0	5·1
Total	76·7	7·5	6·3	6·8	4·5	2·7	2·7	3·4

NOTE: *The percentages of children referred for treatment differ slightly from those quoted in the defects for treatment table on page 75 in which the percentages were based on the number of children medically inspected.*

Personal hygiene

As stated last year, the hygiene inspection of each child once a term was replaced in January, 1959 by an annual comprehensive health survey of each pupil, plus such additional health surveys as may be thought necessary or desirable at selected individual schools or departments. Also, from January, 1960 the use of Lorexane No. 3 shampoo was brought into use throughout the county under a revised cleansing scheme. However, since the type of action to be taken in any particular case is at the discretion of the school nurse/health visitor concerned, in the light of her knowledge of the family, it was decided that from 1 January, 1961 no attempt need be made to distinguish between 'first' and 'second' notices and that the distinction between 'verminous heads', 'nits only', and 'other verminous cases' be also discontinued. In consequence, the details of the findings at the 1961 surveys and the work done under the cleansing scheme are presented in a slightly different form from that used in 1960.

Health surveys—The number of comprehensive health surveys conducted in 1961 was only slightly less than that conducted in 1960, but there was a decrease of 56 per cent. in the number of selective health surveys. This is explained in large part by the fact that in 1960 examinations of children for athlete's foot, plantar warts and other communicable disease were included; whereas in 1961 they have been excluded from this figure and are shown separately later in the same table.

	No. examined	*No. found verminous*	*Pupils found to be verminous % of No. examined*
Annual comprehensive health surveys* ..	323,800	2,899	0·90
	(326,372)	*(3,028)*	*(0·93)*
Additional health surveys*	189,216	3,327	1·76
	(435,166)	*(5,413)*	*(1·24)*

* *1960* figures in brackets.

To assess the comparative level of infestation amongst schoolchildren, 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 fell considerably between 1959 and 1960 but has now stabilised at about the level of the latter year.

Percentage found to be verminous

Hygiene inspections				*Comprehensive health surveys*		
1955	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*
1·35	1·26	1·25	1·27	1·25	0·93	0·90

The number of individual children found to be verminous in 1961 was 4,127, a reduction of 743 from the number in 1960. The average annual reduction from 1955 to 1959 was 450. Comparison with the earlier years of these figures and those of the percentage found verminous, tabled above, throws into relief the dramatic change brought about by the use of Lorexane.

Details of the work done under the cleansing scheme are shown below. The new cleansing scheme itself is, of course, fundamentally different from past practice in its emphasis on children being cleansed at home by the parents and makes comparison with past years very difficult. It appears, however, that of the number found verminous at comprehensive and selective health surveys more than seven out of every ten were given a tube of Lorexane and the number of statutory notices issued showed a drop from 320 in 1960 to 62 in 1961.

Cleansing scheme

	1957	*1958*	*1959*	*1960*	*1961*
Advice notice only issued	N/A	N/A	N/A	2,381	575
Advice notice with Lorexane No. 3	N/A	N/A	N/A	6,552	4,488
Number of pupils referred for further action	N/A	N/A	N/A	N/A	1,204
Pupils attending bathing centre voluntarily	6,183	5,527	4,552	1,628	735
Statutory cleansing notices issued	998	964	764	320	62
Pupils cleansed after service of statutory notice:					
voluntarily	243	240	259	84	18
compulsorily	704	628	458	197	37
Total	947	868	717	281	55

Bathing centres—The number of cases of infestation with vermin treated at bathing centres showed a reduction of 34 per cent. compared with 1960 and the number of treatments a reduction of 36 per cent. There can be little doubt that these reductions are directly attributable to the introduction of Lorexane.

	1957	1958	1959	1960	1961
Scabies					
Pupils treated	697	768	660	637	514
Vermin					
Pupils treated	8,175	7,473	7,025	3,441	2,265
Treatments needed	13,787	13,647	11,799	4,345	2,764
Impetigo					
Pupils treated	2,433	1,478	1,187	1,020	1,033
Ringworm					
New cases	17	22	20	10	7

Employment of schoolchildren

Medical examinations were carried out divisionally of 5,264 children with a view to the issue of employment certificates and 468 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 13·3 per cent. of those inspected, compared with 12·9 per cent. in 1960. For boys the figure fell from 14·6 per cent. in 1960 to 14·2 per cent. but for girls it rose from 11·1 per cent. to 12·3 per cent. As in recent years, normally acute vision headed the list of contra-indications followed by colour vision (boys only) and heavy manual work:

Contra-indications	*Boys*	*Girls*
Occupations involving:		
Heavy manual work	289	210
Sedentary work	10	32
Indoor work	3	8
Exposure to bad weather	141	140
Wide changes of temperature	107	83
Work in damp atmosphere	152	134
Work in dusty atmosphere	189	118
Much stooping	60	61
Work near moving machinery	101	103
Prolonged standing, much walking or quick movement from place to place	256	256
Normally acute vision	2,031	2,027
Normal colour vision	511	5
Normal use of hands	25	13
Work requiring freedom from damp hands and skin defects	47	38
Handling or preparation of food	70	56
Normal hearing	78	57

NOTE: *The total number of contra-indications is greater than the number of pupils with contra-indications 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; they 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 1961 and the preceding years are given below:

	1957	*1958*	*1959*	*1960*	*1961*
Chicken-pox	4,496	8,901	5,399	8,357	5,895
Dysentery, diarrhoea or enteritis	414	1,170	1,148	1,557	669
German measles	2,081	2,549	1,325	631	3,891
Impetigo	301	265	192	194	187
Influenza	N/A	N/A	N/A	229	127
Jaundice	75	11	19	253	493
Measles	13,039	5,045	9,326	2,544	14,343
Mumps	5,509	2,778	3,788	8,783	2,338
Ophthalmia and conjunctivitis	291	319	264	299	536
Ringworm (scalp)	8	13	13	8	10
Ringworm (body)	55	38	46	51	26
Scabies	61	61	57	76	78
Scarlet fever	1,037	1,251	1,264	721	634
Sore throat and tonsillitis	864	994	1,299	905	1,416
Whooping cough	1,372	485	508	1,454	395

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 58 and 59:

Age group	*Number of pupils inspected*	% *vaccinated against smallpox*	% *immunised against diphtheria*	% *immunised against whooping cough*	% *vaccinated against poliomyelitis*
4 or less	7,939	63·0	88·4	82·1	81·2
5	28,558	59·2	85·9	75·8	78·7
6	8,314	52·8	77·8	64·7	67·8
7	9,356	53·0	86·2	67·9	74·8
8	20,684	52·9	89·2	67·7	76·2
9	4,204	50·0	79·9	58·3	65·6
10	2,078	51·7	71·8	48·3	59·9
11	10,096	52·4	88·2	47·0	77·6
12	20,148	46·5	88·7	46·1	74·6
13	6,103	44·7	84·9	44·0	70·1
14	10,277	55·5	87·4	39·2	74·0
15 and over	35,841	53·0	88·2	36·4	79·7

Medical treatment of schoolchildren

Treatment statistics—The number of sessions, new cases and total attendances at schoolchildren's clinics during 1961 (including sessions held in hospital premises) were as follows:

Type of clinic	*Sessions*	*New cases*	*Attendances*
Minor ailments (nurse)	17,567	40,374	399,998
Minor ailments (doctor)	2,325	24,843	
Special investigation	2,184	2,108	14,745
Dental	28,982	69,470	237,411
Vision	4,709	27,464	72,546
Orthoptic	2,014	1,348	7,641
Ear, nose and throat	604	2,673	6,376
Audiology	308	1,292	2,848
Rheumatism (supervisory)	135	75	880
Enuresis	186	169	889

Handicapped pupils

New ascertainments—During 1961 the numbers of new ascertainments of pupils for special educational treatment were as follows:

	Day	*Boarding*
Blind	—	5
Partially sighted	36	—
Deaf and partially deaf	52	4
Delicate	455	246*
E.S.N.	798	92
Epileptic	—	1
Maladjusted	267	262
Physically handicapped	159	14
Speech defect	1,179†	30†
Dual defect	—	65

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

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

Special educational provision—At the end of 1961 special educational treatment was being provided for over 12,000 pupils. The following table shows the main categories of handicap and numbers of pupils receiving full-time special education:

	Day special schools	*Boarding special schools*	*Non-council boarding schools, hostels, foster-homes hospitals, etc.*	*Total*
Blind	—	66	36	102
Partially sighted	252	—	12	264
Deaf and partially deaf	254*	33	117	404
Physically handicapped	855	68	406	1,329
Delicate	1,374	135	123	1,632
Educationally subnormal	3,385	606	95	4,086
Epileptic†	—	—	26	26
Maladjusted	198	321	516	1,035
	6,318	1,229	1,331	8,878

* *Includes 82 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 subnormal.*

Educationally subnormal pupils—Section 57 of the Education Act, 1944 (as amended by the Mental Health Act, 1959) deals with the examination and reporting to the local health authority of children who are considered unsuitable for education at school, the review of cases previously reported to the local health authority and the cancellation of the report where the child on re-examination is found to be suitable for education at school. Details of the number of children dealt with under this section are as follows:

Section 57 (as amended)—Unsuitable for education at school:

	1959	*1960*	*1961*
Children not in any school	86	84	100
Children in ordinary schools	6	—	3
Children in special schools	97	57	68
Children receiving home tuition under section 56 of the Education Act, 1944	1	—	1
	190	141	172

Section 57/A—Review of cases:

Number reviewed	20
Still considered unsuitable for education at school	16
Cancellation of report	4

Children with impaired hearing—During 1961 a sixth peripatetic teacher of the deaf was appointed for work in audiology and auditory training centres, thus passing the half-way mark towards the approved establishment of ten.

Routine audiometer testing—The numbers of children given 'rapid-sweep' audiometer tests during 1961 are as follows:

Pupils given screening tests	50,332
Pupils failing screening tests given pure tone tests	3,749
Pupils failing pure tone tests referred to otologists	1,513

Speech therapy—By the end of the year 288 sessions a week were being held, 188 in 59 clinics and 100 in special schools. During the year 1,207 pupils were ascertained as requiring speech therapy, whilst 566 were discharged from treatment and 289 ceased to attend. The number of pupils under treatment at the end of the year was 3,536, whilst 179 were on the waiting list.

A special article (Appendix C) reviews the history, growth and development of services for children suffering from speech defects over the past 50 years.

Maladjusted pupils—At one of the Council's day schools for maladjusted children an experimental psycho-drama therapy group is being conducted. Although the experiment is in its infancy, the results so far are sufficiently encouraging for the continuance of the group, since some of the participants are already showing signs of a greater sense of reality and of using their intelligence more constructively.

Child guidance units—Details of the work done during 1961 at the child guidance units maintained by the Council follow:

Patients

At 1 January, 1961		*At 31 December, 1961*	
On waiting list:		On waiting list:	
(*a*) awaiting first interview ..	218	(*a*) awaiting first interview ..	165
(*b*) interviewed and awaiting treatment	69	(*b*) interviewed and awaiting treatment	78
In attendance:		In attendance:	
(*a*) active	410	(*a*) active	392
(*b*) under review*	425	(*b*) under review*	429
During 1961		*During 1961*	
Applications received	862	Applications withdrawn	280
		Cases closed	640
	1,984		1,984

** Some cases are kept 'under review' for a time after active treatment has ceased; others are closed as soon as active treatment has ceased, any further visits, etc., being regarded as 'follow up'. During the year 165 closed cases were followed up.*

Student health scheme

The experimental student health service, which was started at Barrett Street technical college at the beginning of the 1960/61 session (see page 112 of my report for 1960), was reviewed in July, 1961. There was no doubt that the students and staff valued the service and advice given by the doctor and that local contacts made (e.g. with hospitals, mass X-ray unit) were beneficial. In view of this satisfactory report, it was decided to extend the scheme to the City of Westminster and Brixton day colleges, although at the latter college the scheme was not fully implemented until the beginning of 1962.

The general conclusions reached, so far, by the medical officers and the college principals concerned indicate that the service is making a useful contribution to college life, particularly in the case of students from overseas and from other parts of the country, who seem to encounter difficulties in fitting into life in London. There is every reason for satisfaction in the way the service is developing.

The following table gives statistics of the work done in 1961:

	Barrett Street College (Three terms)		*City of Westminster College (One term)*	
No. of new students under 19 years returning questionnaires ..		198		147
No. invited for interview after scrutiny of completed questionnaire ..		83		36
No. of students seen by doctor:				
(*a*) following invitation—first attendances	55		31	
—subsequent attendances	1		8	
(*b*) voluntary—first attendances	89		17	
—subsequent attendances	71		6	
	—	216	—	62
No. of students referred for treatment		78		17
No. of doctor's sessions		30		11
No. vaccinated against poliomyelitis		103		37

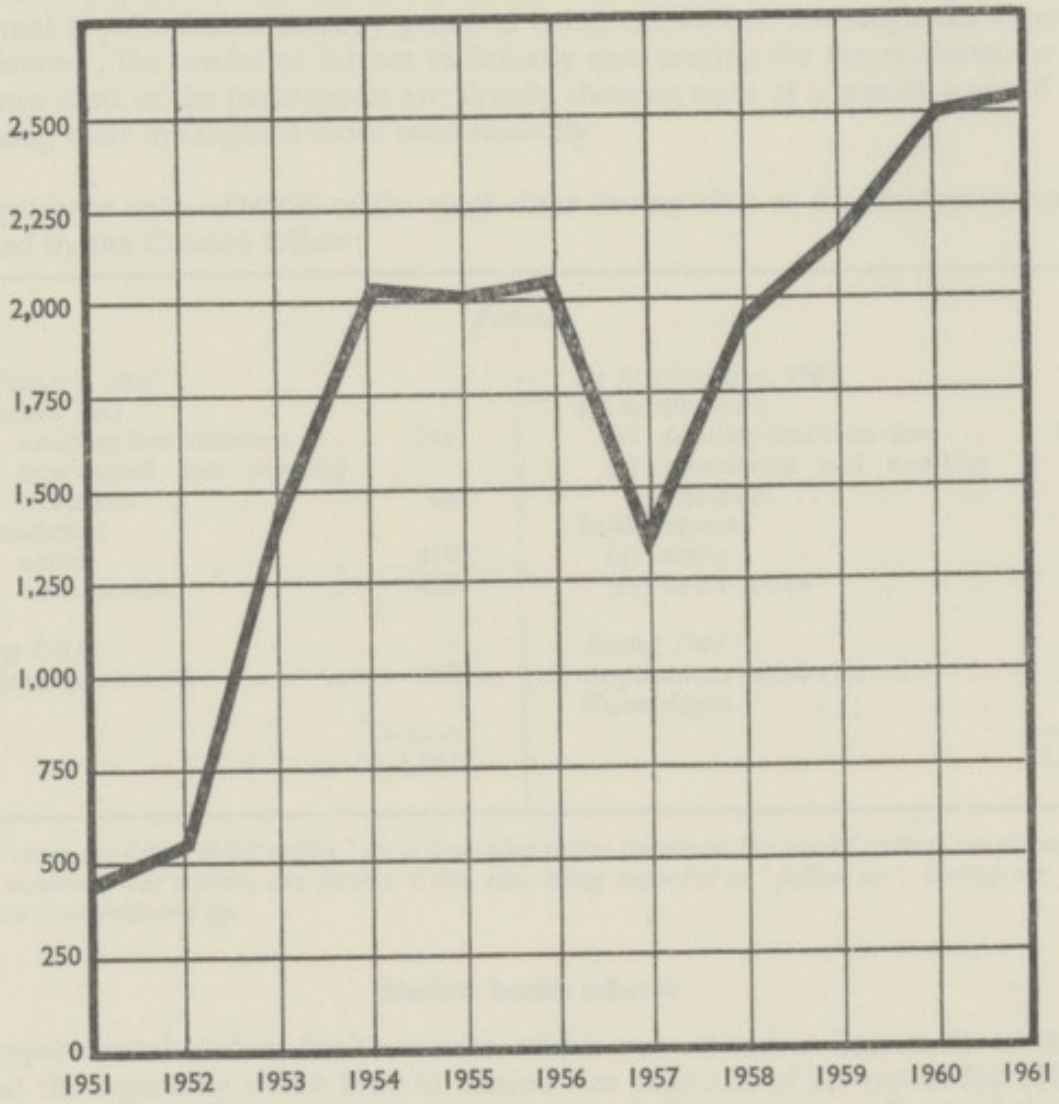
DENTAL SERVICES

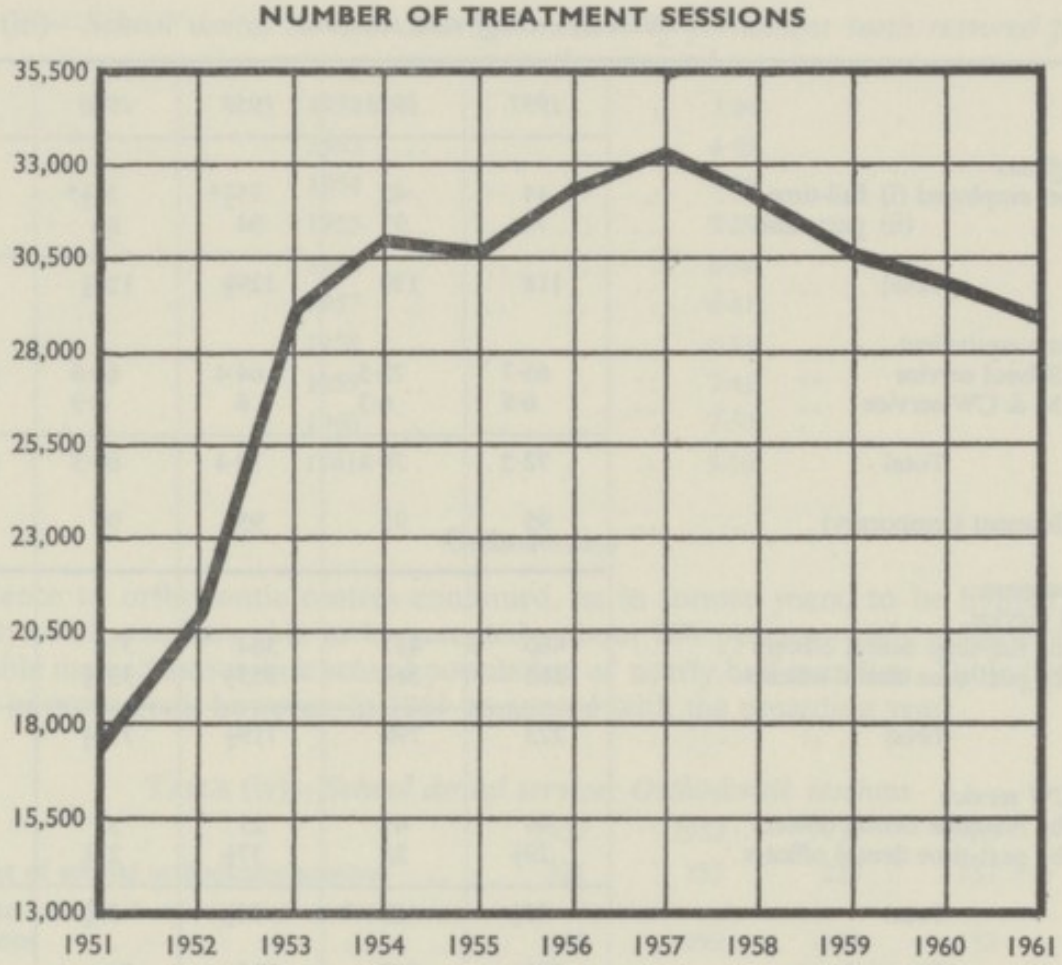
The Chief Dental Officer and Principal School Dental Officer reports as follows:

School dental service

In comparing results with those in 1960 not much change is observed. There were the equivalent of four fewer full-time dentists and 42 fewer treatment sessions a week. There was a slight increase, however, in the number of sessions devoted to dental inspections in schools. The number of children found at these school inspections to require treatment fell (for the fifth successive year) to 65·3 per cent.—a considerable improvement from the 1957 figure of 76·3 per cent. There is little doubt that this improvement indicates that more children than formerly are receiving dental attention of a reparative type, rather than a preponderance of extractions for pain relief. The indication is underlined if one looks at table (ii) ' additional number inspected at centres '. These patients are known to be mainly toothache and pain relief cases and the demands by such patients at our treatment centres has steadily fallen from 56,598 cases in 1957 to 19,778 cases in 1961.

NUMBER OF INSPECTION SESSIONS AT SCHOOLS





The reduction in staff produced a corresponding reduction in the totals of individual dental operations and in patients discharged, but it is gratifying to note in table (iii) a continued improvement in the number of permanent teeth conserved to those extracted. In the past ten years this ratio has improved from 3·86 to 9·10. General clinical observation throughout the year confirms the belief that children who attend the Council's treatment centres are now receiving a better service than formerly and it is expected that early official recognition of the necessity for revisional treatment will soon raise the standard still further. In 1961 it was still necessary to use a spread-over policy for dental attention throughout the school population but during the year increasing expressions on the part of parents of preference for ' private ' treatment gave hopes for the possibility of routine revisional work for children who continue to attend our centres. It is a matter of concern that many parents who state their wish to have their children treated by their ' private ' dentist do not see that the treatment is obtained; at subsequent inspections two out of every three children are still found to be in need of treatment. It is difficult to approach parents and urge provision of ' private ' treatment. During 1961 much thought was given to exploring schemes for ' contracting in ' or ' contracting out ' of the Council's dental services by parents and means of improving the service for those who might ' contract in '.

As far as possible, treatment sessions were held out of school hours to meet the wishes of teachers to prevent disruption of school instruction but staff response was low. With the same object in view, treatment centres were kept open during school holidays but attendance was lower than for school time sessions.

TABLE (i)—*Staff and sessions*

	1957	*1958*	*1959*	*1960*	*1961*
Dental officers					
Number employed (i) full-time	44	42	35½*	36½*	36½*
(ii) part-time	74	97	94	84	72
Total	118	139	129½	120½	108½
Full-time equivalent					
(i) School service	65·7	72·5	64·4	64·6	60·9
(ii) M & CW service	6·8	6·3	6	4·9	4·8
Total	72·5	78·8	70·4	69·5	65·7
Establishment (temporary)	95	95	95	95	95
Weekly sessions					
School service					
(i) by full-time dental officers	460	437	364	373	361
(ii) by part-time dental officers	263	361	355½	337½	308½
Total	723	798	719½	710½	669½
M & CW service					
(i) by full-time dental officers	46	41	29	31	32
(ii) by part-time dental officers	29½	28	37½	22½	20½
Total	75½	69	66½	53½	52½
Grand Total	798½	867	786	764	722

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

TABLE (ii)—*School dental service: Attendances and treatments*

	1957	*1958*	*1959*	*1960*	*1961*
Number of inspection sessions held at schools ..	1,354	1,952	2,177	2,473	2,514
Number of children inspected at schools by dental officers	120,440	196,573	215,637	244,630	246,803
Number found to require treatment	91,868	144,050	152,131	165,439	161,277
Percentage requiring treatment	76·3%	73·5%	70·5%	67·6%	65·3%
Additional number inspected at centres	56,598	36,067	27,576	23,229	19,778
Total number found to require treatment ..	148,466	180,117	179,707	188,668	181,055
Total cases treated	102,568	97,300	82,448	77,781	69,470
Attendances	308,862	298,342	267,781	256,983	237,411
Ordinary treatment sessions	31,841	31,322	29,637	29,006	28,060
General anaesthetic sessions	1,594	1,431	1,180	1,049	922
Temporary teeth extracted	69,247	58,223	46,461	42,343	35,286
Permanent teeth extracted	18,273	19,342	14,973	14,467	11,072
Temporary teeth restored by fillings	45,509	40,994	39,861	38,164	37,533
Permanent teeth restored by fillings	117,148	122,558	110,934	109,586	100,755
Fillings in temporary teeth	48,477	43,176	42,656	40,996	40,350
Fillings in permanent teeth	131,071	136,811	125,053	124,821	115,294
Other operations:					
temporary teeth	58,021	54,884	49,109	43,889	38,682
permanent teeth	64,675	64,995	61,835	63,835	57,641
Local anaesthetics for extraction	14,404	13,320	12,354	12,165	9,919
Local anaesthetics for conservative treatment ..	10,718	13,964	11,667	13,082	12,844
General anaesthetics	34,019	30,861	24,367	21,753	18,101
Cases for whom immediate treatment was completed	10,415	10,566	9,414	8,407	5,317
Cases discharged as dentally fit	71,260	66,990	54,474	50,584	45,003

TABLE (iii)—*School dental service: Average number of permanent teeth restored for each permanent tooth extracted*

1952	3·86
1953	4·69
1954	5·32
1955	7·39
1956	6·50
1957	6·41
1958	6·34
1959	7·41
1960	7·57
1961	9·10

Orthodontics

Reference to orthodontic centres continued, as in former years, to be limited by the relatively small numbers able to be accepted—about 800 patients—only a fraction of the discernible malocclusions in a school population of nearly half a million. Table (iv) shows a slight improvement, however, in 1961 compared with the preceding year.

TABLE (iv)—*School dental service: Orthodontic sessions*

	1957	*1958*	*1959*	*1960*	*1961*
Number of special orthodontic sessions	321	282	229	237	254
Number accepted at special orthodontic sessions	108	199	138	152	171
Number accepted at routine sessions	403	474	371	401	470
Number referred to hospitals	158	186	279	154	154
Total number of patients accepted or referred	669	859	788	707	795

Maternity and child welfare dental service

For another year this service was kept at about 10 per cent. of the total dental services available. During the year new legislation, the National Health Service Act, 1961, exempted expectant and nursing mothers from the standard National Health Service charges for dental appliances. The local health authorities' dental service, under Part III of the Act of 1946, thereby ceased to be the only ' free ' source of treatment for these patients and in consequence attendances fell. Many mothers also express preference for ' private ' treatment. Staff fell by the equivalent of one full-time dental officer.

Tables (v) and (vi) show the work done during the year.

TABLE (v)—*Maternity and child welfare patients: Attendances and treatments*

	1957	*1958*	*1959*	*1960*	*1961*
Number of sessions	3,293	3,135	2,764	2,592	2,300
Number of appointments offered	36,636	34,740	30,456	27,368	23,864
Attendances—by appointment	26,006	24,691	21,995	19,651	16,500
—other	1,717	1,539	1,122	1,060	894
Silver nitrate treatment	5,423	5,065	4,415	5,858	5,718
Fillings	11,310	11,491	10,031	8,716	7,399
Extractions	7,809	5,873	5,114	4,513	3,624
Dentures supplied—new full	508	422	380	351	327
—new partial	820	685	649	468	485
Number made dentally fit	6,010	5,014	4,784	4,165	3,255

TABLE (vi)—*Breakdown of table* (v) *separating nursing or expectant mothers from children under five*—1961

	Total	*Nursing or expectant mothers*	*Children (under 5)*
Number of sessions	2,300	—	—
Number of appointments	23,864	14,036	9,828
Attendances—by appointment	16,500	9,231	7,269
—other	894	313	581
Silver nitrate treatment	5,718	832	4,886
Fillings	7,399	3,941	3,458
Extractions	3,624	2,650	974
Dentures supplied—new full	327	327	—
—new partial ..	485	485	—
Number made dentally fit	3,255	1,279	1,976

Dental service in boarding schools and residential establishments

There was little change in this field and it is still not possible to provide the level of service desired at these establishments. At all, however, some form of dental supervision and treatment was continued. Heads have authority to employ the services of local practitioners in cases of urgency.

School for dental auxiliaries

In 1960 a development of some importance was the establishment of a training school for dental auxiliaries conducted under the aegis of the General Dental Council. The Council is co-operating in this experiment. During the year some 25,000 children attending schools in the neighbourhood of the School for Dental Auxiliaries, New Cross were available for inspection by dental officers of the training school. The parents of children found to need dental treatment at these inspections had the choice of making ' private ' arrangements, sending their children to the children's clinic at the School for Dental Auxiliaries or to one of the Council's dental surgeries. The nature of the treatment that can be given by dental auxiliaries is limited under the Dental Auxiliaries Regulations, 1961 and the Council seconded a full-time dental officer appointed to the Council's service for duty at the School for Dental Auxiliaries to undertake dental work beyond that permitted to the trainee dental auxiliaries.

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 at that date are shown in Appendix F.

Types of staff	*Location*			*Total*
	Central office	*Divisional offices and establishments (a)*	*Other establishments (b)*	
Administrative and clerical (including ambulance control clerks)	232	640	78	950
Medical officers (*c*)	32	158	—	190
Dental officers	2	64	—	66
Scientific branch staff	34	—	18	52
Inspectors	14	—	—	14
Medical auxiliaries (*d*)	41	154	18	213
Social worker grades (*e*)	24	350	11	385
Nursing and midwifery staff	10	1,763	242	2,015
Ambulance service operational staff	—	—	857	857
Manual workers, home helps, domestic grades, telephonists, etc.	9	3,305	21	3,335
Totals	398	6,434	1,245	8,077

(*a*) *Including divisional health offices, home help offices, welfare centres, school treatment centres, training centres for the mentally sub-normal, etc.*

(*b*) *Including residential schools and nurseries, Welfare department homes, recuperative holiday homes, ambulance stations, outfall works laboratories, central dental laboratory.*

(*c*) *There are 132 visiting medical officers employed at residential establishments on a part-time basis whom it is not possible to compute in terms of whole-time staff. They have therefore been omitted from the table.*

(*d*) *Including physiotherapists, speech therapists, dental surgery assistants, dental technicians.*

(*e*) *Including psychiatric social workers, mental welfare officers, local tuberculosis care organisers, child care organising staff, etc., and workers in allied fields (e.g. home help organisers).*

Appointments and retirements—On 31 July, Mr. C. R. Geere, Administrative Officer of the department since 1947, retired after 41 years' service, his place being taken by Mr. D. J. B. Cooper, who had been Principal Clerk of Division B of the department. Mr. G. M. Howes was appointed to the latter position on 2 October, on transfer from the Clerk of the Council's department.

On 3 March, Mr. A. G. Hellman, Officer-in-Charge, London Ambulance Service, retired on reaching the age of 65, his place being taken by Mr. F. A. Richardson, previously Assistant Officer-in-Charge.

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

	1957	*1958*	*1959*	*1960*	*1961*
Candidates fit for appointment	6,286	7,531	7,399	8,252	11,106
Candidates unfit for permanent appointment	285	401	343	250	560
Referrals (ill-health)	7,268	6,719	7,252	8,032	8,156
Permanently unfit to carry out their ordinary duties	245	323	331	418	641
Advice given (without examination)	1,378	1,621	1,595	1,034	1,386
Eligibility for spouse pensions	26	24	29	66	87
Staff casualties	240	315	309	289	863
Candidates for out-county authorities	65	100	111	84	121
Candidates examined for the Council by out-county medical officers of health	77	138	111	102	72

Food handlers—During the year 425 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*	*1960*	*1961*
Contacts	107	137	167	205	118
Ill	270	266	302	419	307
Allowed to resume work after examination or fixed period of exclusion	360	388	451	578	406
Resigned	—	9	8	23	16
Excluded from work and referred to own doctor for treatment	17	6	10	23	3

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

Condition	*Organism isolated*
Dysentery convalescent	*Shigella sonnei*
Gastric influenza with diarrhoea and vomiting convalescent	*Salmonella typhimurium*
Gastro-enteritis contact	,, ,,

Staff training

A feature of the year 1961 has been a marked expansion in volume and variety of the department's provision of training facilities for its professional staff. These facilities may be grouped as follows:

Short courses and conferences—Some 450 professional staff of the department, from a wide range of services, attended 66 short courses and conferences arranged by outside representative organisations. These figures do not include the attendance of senior staff at conferences as official representatives of the Council. Because of the changes brought about by the Mental Health Act, 1959 and the fact that many new staff were recruited in this field, there was a particular demand for courses on various aspects of mental health.

Refresher courses for medical and nursery staff—Regular refresher training, on the basis of attendance at a course of from one to two weeks' duration every five years for medical, health visitor, school nursing and midwifery staff, has continued to be provided through professional bodies such as the Society of Medical Officers of Health, the British Post-graduate Medical Federation, the Royal College of Nursing, the Women Public Health Officers' Association and the Royal College of Midwives. Refresher courses for day nursery staff continued to be provided at the North Western Polytechnic.

Training for qualifications—In July, five of the department's social workers completed one-year university professional courses for which they had been granted leave with pay and in September a further five proceeded on leave for the same purpose. In addition, two senior mental welfare officers were granted leave with pay for a pioneer two-year course in general social work at the North Western Polytechnic, set up following the recommendations of the Younghusband Report.

The University of London Institute of Education, Battersea College of Technology and the Royal College of Nursing continued to provide theoretical instruction for the Council's health visitor students, 49 of whom were undergoing training at the end of the year. Approximately 40 per cent. (i.e., 198) of the health visitor students successfully trained since 1948 and appointed to the Council's service as health visitors were still in the service at the end of the year.

The Council's day nursery students, 190 of whom were undergoing training at the end of the year, continued to receive their theoretical instruction at Wandsworth Technical College, the Borough Polytechnic or the North Western Polytechnic.

Evening institute classes—The Council pays the fees for attendance of officers at evening classes when it appears in its interest to do so. During the year 42 health visitors attended courses providing instruction in the care and use of slide, film-strip and cinematograph projectors (which apparatus is in use for health education purposes in child welfare centres) at Goldsmiths' College and Wandsworth Technical College and 99 health visitors attended courses in teaching techniques at Garnett College. An evening institute course of one year's duration leading to the examination for the Certificate of the Examining Board for Dental Nurses and Assistants was completed by 12 dental surgery assistants and a further ten assistants commenced a similar course in September.

In-service training—For large numbers of professional officers, training needs can sometimes be met more precisely and at less cost to the Council by courses arranged within the department. During the year this policy has been followed extensively as the following summary shows:

A course on recent developments in mental health, consisting of ten evening lectures supplemented by visits to hospitals for the mentally disordered was provided. The course was repeated twice to permit the attendance of most health visitors, social and family case workers and junior mental welfare officers in the department. Altogether, approximately 600 officers (including some social workers from the Education and Children's Officers' departments) attended one of these courses.

An advanced course of ten weekly sessions in ' discussion methods ' was arranged for 18 selected health visitors.

A three-day residential refresher course for 51 day nursery matrons was held in country surroundings outside the county.

A course for medical officers in current techniques for the early detection of deafness in young children was provided at the Province of Natal centre on two consecutive Saturday mornings.

A four-day course for assistant home help organisers was arranged, talks followed by discussion being given by nine of the department's professional and administrative officers, with a further general session devoted to summing up the course.

Short courses for 27 day nursery cooks were arranged at the North Western Polytechnic.

' Post-entry ' training for members of the administrative and clerical staff, pursuant to the Council's policy in this respect for all departments, has continued during the year.

FINANCE

Capital—The total capital expenditure on the health services of the Council in the year ended 31 March, 1961 was £206,739, details of which are as follows:

	£
Ambulance stations—erection	3,249
Health centres—adaptation and equipment	25,719
Maternity and child welfare centres—acquisition and erection	695
Hostels and training centres—acquisition, adaptation, erection, etc.	177,076
	£206,739

Maintenance—The gross cost of the various services in 1960-61—including central administrative and debt charges—and the contributions recovered from recipients of the services were:

Service	*Cost* £	*Amount recovered in contributions* £
Ambulance service	1,234,655	—
Day nurseries	1,056,074	150,053
Domiciliary midwifery service	269,397	—
Foot clinics	84,698*	16,813
General health services (including health education)	66,458	—
Health centres	34,279	—
Health visiting	410,089	—
Home nursing	546,651	—
Home help	1,291,517	68,843
Maternity and child welfare	894,413	75,630
Mental health	445,295	16,603
Prevention of illness, including care and after-care of tuberculosis	407,289	10,402
School health	1,079,118	—
Vaccination and immunisation	199,907	—
	8,019,840	338,344

**Excluding central administration.*

The net cost of the services, before allowing for Government grant, expressed in terms of rate in the £ was 17d.

VISITORS TO THE DEPARTMENT

During the year 634 visitors were received through the central office—of whom 426 came from overseas.

Individual overseas visitors included the Speaker of the Federal Assembly of Nigeria, a member of the Malayan Parliament, the Ministers of Health for Mali, the Western Province of Nigeria, and Yugoslavia, the Minister of Social Service for the Leeward Islands, the Deputy Director of Health for Western Australia and 56 doctors, two dental officers, nine members of central and local governments, 14 central and local government officers, 35 social workers, 15 nurses, one university lecturer, five teachers, eight journalists, seven speech therapists, one architect, three hospital administrators and 17 students.

Parties included delegates from eight countries to a World Health Organisation seminar in medical rehabilitation, a civic party from Zehlendorf, West Berlin, a group of youth leaders from Guinea, 100 delegates to the European Congress of the European League of Societies for the Mentally Handicapped and members of the Fourth Japanese Medical Survey Tour. Altogether visitors were received from 56 overseas countries.

Other visitors were received at divisional offices, Woodberry Down health centre, the London Ambulance Service headquarters and the Council's training centres for mentally subnormal children. The health centre was visited by 1,216 people, 211 (including 84 students) from overseas and 1,005 (905 students) from the United Kingdom; the Ambulance Service headquarters received 188 visitors and training centres 767 visitors, including 536 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 104 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 3,892 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
Surrey County Council
University of Southampton

Speech therapy students

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

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

Battersea College of Technology
Battersea Training College of Domestic Science
King Edward's Hospital Fund for London—Course for Overseas Hospital Administrators
National Association for Mental Health
North-Western Polytechnic
Queen's Institute for District Nursing
Royal College of Nursing
Royal Institute of Public Health and Hygiene
University of London—
- Bedford College
- Institute of Education
- London School of Economics and Political Science
- London School of Hygiene and Tropical Medicine
- Queen Elizabeth College

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. Bertha E. A. Sharpe reports:

Diphtheria—Early in the year there was an outbreak of diphtheria involving the Kensington training centre, with places for 100 mentally handicapped children aged from 5 to 15. Although the number of children is relatively small, the centre is attended by severely subnormal children from a large part of North London.

On 7 February one of the children was diagnosed as suffering from diphtheria. A medical team immediately examined and swabbed all those attending or visiting the centre, including all staff, meals service personnel and other close or likely contacts. About 60 per cent. of the children had been immunised in the past and were given a booster dose of diphtheria prophylactic. Those not immunised were given a protective dose of anti-toxin and the first of a course of immunising injections. Swabbing was extended to absentees, to all family contacts of those attending the centre, to the older girls attending North Kensington training centre, some of whom shared transport with children from the Kensington centre, and to the classmates of siblings of positive cases. The search for possibly infected children included certain parties and social groups known to have been attended by infected children during the period in which the infection might have been transmitted. Swabbing of the children at the centre continued at 48-hourly intervals.

There were 16 clinical cases in all; six in Islington, five in St. Pancras, two in Hammersmith and one each in Paddington, Kensington and Westminster. Unfortunately there were three deaths (all children from Kensington training centre); four clinical cases and nine carriers received hospital treatment, of these one clinical case and two carriers lived in this division.

As usual, there was the closest co-operation both with the borough medical officers concerned and with other divisional medical officers, who were notified daily of centre absentees living in their areas.

Because of the wide area from which the centre was attended the County Medical Officer of Health informed all general medical practitioners in London of the outbreak.

As a result of the publicity which accrued there were increased attendances at immunisation sessions and additional facilities were provided in divisional establishments. During the last two weeks of February 2,412 persons were immunised, as compared with 657 in the corresponding fortnight of 1960.

In the course of the investigation health-visiting staff in the division visited some 200 homes and took more than 500 swabs; some 700 swabs were taken in the training centre and about 3,000 were taken throughout the division.

Vaccination against poliomyelitis—Instruction was received early in the year that a fourth injection was to be offered to parents for children entering school between their fifth and twelfth birthdays. It was decided that as far as practicable the whole age group eligible should be vaccinated before the summer season when the risk of contracting poliomyelitis is greatest. With the co-operation of heads of schools two vaccination teams visited each school in the division and by the end of the summer term 10,458 fourth injections had been given.

Maternity and child welfare services—The mothercraft and home-making classes for North Hammersmith (two) and North Kensington (one) continued their useful function. Attendances were small at one of the Hammersmith classes held in a church hall; there was a marked improvement, however, when this class was transferred to Glenthorne Road welfare centre.

Chiropody—An additional fourteen sessions for the priority classes were authorised but it was not possible to utilise all of these before the end of the year, when 93 weekly sessions were being provided.

Day nurseries—Following the annual review of day-nursery accommodation it was decided to reduce the number of approved places at Dalling Road nursery by seven to 55 places. The percentage weighting on the register of two other nurseries was increased with the object of securing fuller attendance.

Additional crèche sessions were instituted at Glenthorne Road, Lancaster Road and St. Quintin welfare centres.

School health service—An experiment in holding clinics out of school hours began this year. One special investigation clinic is held every five weeks on a Saturday morning and a vision clinic is held weekly in the evening. Average attendances at the Saturday clinic are not yet as high as those at the morning and afternoon clinics at the same centre (53·7 per cent. as against 70·1 per cent.) but the experiment has been under way for only five months. The average attendance at the vision clinic is 48·3 per cent. as against 59·6 per cent. at morning clinics at the same centre. The evening sessions have only been held since September. These sessions are used mainly for children of secondary school age and are particularly useful for those who are working for examinations.

During the year the withdrawal of organisers from vision clinics in school treatment centres was completed. The work is now done by the sister at the clinic and a clerk, the overall supervisory responsibility remaining in the divisional social workers' office.

Physiotherapy—On the retirement of the whole-time physiotherapist the Divisional Health Committee decided to discontinue physiotherapy sessions, in view of the alternative facilities available for treatment and a continuing decrease in demand.

Mental health—Good attendance at a meeting of general practitioners and social workers, held as part of the divisional activities connected with World Mental Health Year in 1960, encouraged the holding of a meeting in May, 1961 arranged jointly with the Kensington and Hammersmith branches of the British Medical Association. It was held by courtesy of the Physician-Superintendent at St. Charles' hospital, Kensington and eighty-seven people attended, including general practitioners, hospital medical officers and consultants, and psychiatric and other social workers from Banstead and Springfield hospitals and the Earl's Court child guidance unit. Talks by the Superintendent of Downview and Banstead hospitals, a general practitioner and the divisional mental welfare officer on their experience of the working of the new Act and on recent developments were followed by a keen and informed discussion.

The meeting provided an excellent opportunity for establishing closer contacts and exchanging views, and it was encouraging to hear that representatives of services and professions so closely concerned with the working of the Act were alert to the difficulties that arose and had so clear an idea of the intentions of the Act and how they might be effected.

The part-time services of an occupational therapist, who had previously been employed solely on work with tuberculous patients, were utilised to give instruction and occupation to a house-bound mentally ill person. Although this patient had to return to hospital at the end of the year, two other patients were being given these services with good results.

As part of an experimental scheme for the reception of groups of severely subnormal infants, specially chosen as being likely to benefit from attendance at a day nursery, arrangements were made to set up a unit to accommodate not more than nine such infants at Grove House day nursery. Notwithstanding some difficulty in recruiting suitable nursing staff, the first children were received in October. Difficulty was also experienced in arranging for attendance because of lack of suitable public transport, but it was found possible to give some assistance in this respect and at the end of the year there were eight children on the register, with a daily attendance of four.

A rearrangement of the accommodation for the training centres for the severely subnormal in the division was effected. The elder girls, formerly at Branstone Street, North Kensington, moved into the premises at College Park, North Hammersmith, a former welfare centre specially converted for them, whilst the elder boys' centre housed in a church hall was moved to the Branstone Street premises. As a result, each of these centres now has very much better facilities for its work.

During the year the girls at College Park training centre took part in a scheme for carrying out suitable work for industrial firms and received the first payment for the work they had done before the Christmas holiday.

Liaison with other bodies—The Council continued to be represented on the maternity liaison committee for the Chelsea, Fulham and Kensington hospital groups. Professor McClure Browne of the Obstetric and Gynaecological department of Hammersmith hospital has continued to hold meetings for local general practitioners and the Council's ante-natal medical officers working in the division. Dr. C. W. Kesson, consultant paediatrician of St. George's hospital, has arranged talks for health visitors and for medical officers. The two discussion groups led by Dr. Felix Brown, Medical Director of the Earl's Court child guidance unit, and Dr. Erskine, psychiatrist of the West London Hospital, continue to be well attended by child welfare doctors and health visitors. A meeting of hospital almoners, health visitors, superintendents of district nursing associations, tuberculosis care organisers, home-help organisers, and divisional staff was held; much useful discussion took place on the services provided by the Council which can be of use to persons attending or being discharged from hospitals. Regular meetings were held with the medical officers of health of the metropolitan boroughs in the division.

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—The birth rate in the division continues to increase although it is below the county average.

A high proportion of all live-born infants are brought to the infant welfare centre in their first year of life and the percentage of expectant mothers in the division who receive ante-natal care at the Council's clinics is above the county average. Three evening sessions are held for expectant mothers at work who find it difficult to attend sessions during the day.

Ampthill Square maternity and child welfare centre, St. Pancras, closed at the end of the year on the expiry of the lease. The clinic activities were transferred to Somers Town and other nearby welfare centres.

Day nurseries—The demand for places has continued at about the same level for several years and the level of occupation remains high.

Prophylaxis—To ensure that immunisation is completed an intensive follow-up procedure has been instituted and reminder letters are sent to mothers.

Following the experimental use of the Paddington hospital syringe service, disposable syringes were introduced during the year and have proved satisfactory.

Health visiting—Great demands are still made on the time of the health visitor and the pressure has increased because recruitment has not kept pace with resignations and retirements.

Health education—This has formed a feature of the work and is reflected in the high attendance at ante-natal and other educational classes for mothers at the centres.

Mental Health—Co-operation with the Tavistock Clinic and welfare centres has been maintained and three mental health education discussion groups are held in the division. These are attended by psychiatrists, psychiatric social workers, doctors and health visitors.

The first year of the working of the decentralised mental health services has shown the new organisation has worked well and integration with the other services provided by the division continues.

The division has a very substantial share of all referrals in the county under the Mental Health Act, 1959, with a high proportion of cases referred for compulsory admission. Despite the pressure that this branch of work imposes on the mental health team, developments in other fields have taken place. Every chance is seized of contacting other social worker and public health agencies and opportunities for informal case discussions are made available whenever required. The community care service in the subnormal field has been well maintained.

A new special clinic for diagnostic as well as supportive work is held by Dr. Alexander at the Harrow Road welfare centre. This clinic has become well established and enables the service to cover far more of the division than was formerly the case. Some expansion of the community care of the mentally ill has been undertaken. In addition to the work of the psychiatric social worker, the visiting of mentally ill patients in their homes is being undertaken by mental welfare officers and it is in this field that future developments are anticipated. A good liaison has been established with the psychiatric clinics of local hospitals and the out-patients' departments of the catchment area hospitals. The importance of the patient's private doctor in matters relating to mental health is clearly recognised in the new Act and divisionalisation has enabled local practitioners to get closer to the mental welfare officers. Many doctors now know the divisional staff personally and are able to use their services freely on an informal as well as a formal basis.

Prevention of break-up of families—The work in connection with the prevention of neglect and ill-treatment of children in their own homes has increased greatly. During the year sixty-three families came before the divisional co-ordinating machinery as presenting particularly difficult problems. In addition twenty-seven families have been reviewed on one or more occasions. These conferences are very well attended and many people, both from statutory and voluntary organisations, speak of their value.

There are now two full-time family case workers in the division and one social worker is doing part-time case work.

The largest number of referrals come from health visitors. More cases, however, are now being referred by outside agencies—including borough council housing departments.

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

Dr. W. G. Harding reports:

Phenylketonuria—A pilot survey was conducted to establish the practicability of routine testing of all infants for phenylketonuria and the amount of extra effort by health visiting staff which would be required. The survey was based on two child welfare centres, the Province of Natal, Holborn and East Islington.

The children tested were those born during a six months period to mothers resident in the areas of the two welfare centres or who moved into the areas. Testing was by application of paper strips impregnated with reagents (' Phenistix ') made available by the manufacturer. Two tests were carried out; the first as early as possible after the tenth day of life and the second about five weeks after the first. Health visitors were told to carry out the tests as far as possible during the course of their normal contact with mother and child at home or in the clinic. Arrangements were made for urine showing a doubtful test result to be retested in a hospital biochemical laboratory.

Of 582 births referred to the two centres, tests were carried out on 530 infants. In the Province of Natal centre area 90 per cent. of the first tests were completed by the end of the third week of life and in the East Islington area, a larger and more difficult one, the corresponding figure was 75 per cent. Overall, 36 babies (6·8 per cent.) could not be tested until they were at least seven weeks old and no second test was arranged for them; others left the area after the first test and 458 were available for the second test.

Only three doubtful results were found, but on retesting the urines were found to be normal. The majority of the tests were carried out without difficulty, either at home or in the centres, but special arrangements for additional home visits or centre appointments had to be made in some instances. For the first tests 222 special home visits were made and for the second tests 169.

Altogether 129 infants out of 530 needed one or more special home visits for the first test and 107 out of 458 needed at least one special visit for the second test, a total of 391 extra visits. A hard core of 85 infants—well below 10 per cent. of all—required between two and eight special visits, amounting to a total of 239. The most frequent reasons for special visits were the absence of a wet napkin or failure to keep an appointment. It was estimated that if all infants born in the county were to be tested once only some 17,000 additional visits would be necessary, equivalent to the time of approximately two whole-time health visitors. With an incidence of phenylketonuria as low as between one in 25,000 to 50,000 and bearing in mind the many other important tasks performed by health visitors, it could be argued that special visits should not be devoted to this sole purpose. Equally it could be argued that, because the consequences of non-detection are so serious, every effort should be made to ensure that no case is missed.

A more economical case-finding routine would be the follow-up of families of known cases, comprising not only the testing of live siblings of diagnosed cases but also blood tests of any further siblings shortly after birth. The search on these lines should be extended into the next generation and as far as first cousins. Such selective testing would need a national register of all ' high risk ' families, with the attendant problems of exchange of information between authorities concerned.

A full account of this pilot screening survey was published in ' The Medical Officer ' of 21 June, 1961 (*CVI, 51–53*).

Maternity beds—The difficulties in obtaining maternity beds, especially for patients in social need of hospital confinement, continued throughout 1961 and in many instances beds were secured only through the Emergency Bed Service when labour commenced. Fortunately, the helpful arrangement described in last year's report, whereby the Royal Free hospital allocated ten beds directly to our welfare centres for cases in urgent social need, continued.

Mothercraft and home-making class—Since 1957 the Divisional Health Committee had explored the possibility of establishing a mothercraft and home-making class for selected mothers who would benefit from this instruction, but the problem of finding social agencies who could spend time on liaison work in persuading mothers to make regular attendances and to keep the instructor in touch with developments with families could not be resolved, although all the voluntary organisations interested were in favour of the scheme in principle.

In 1961, however, the Islington Family Service Unit offered to provide accommodation for a class of about six mothers and to undertake the necessary liaison work. Owing to limited space it was not possible to provide a crèche on the premises to mind children of mothers attending the class, but the Health Committee agreed that such children could be looked after free of charge during the training sessions in the nearby Canonbury Place day nursery. The class commenced on 21 November. Mothers attending have all been recommended by intensive caseworkers who introduce mothers to the class at their first attendance, and, when possible, attend with them for the first few visits. The mothers need continuous encouragement to attend and voluntary helpers who collect most mothers in their own cars make an important contribution to the running of the group. Attendances at the sessions varied between six and three mothers.

Health education for expectant mothers—The attention of hospitals with maternity units was drawn to health education facilities for expectant mothers available in the Council's welfare centres and an invitation was issued for hospital-booked expectant mothers to attend. A more definite link between the hospital service and welfare centres was developed between the Royal Free hospital and the West Islington and Leage Street welfare centres. A pamphlet setting out the regular mothercraft and relaxation exercise classes in the welfare centres in the division and inviting mothers attending the ante-natal clinic at the hospital to attend the centre nearest their home was issued over the names of the obstetrician and myself. At Leage Street welfare centre a weekly evening session for relaxation exercises and parent-craft teaching was arranged for both welfare centre and hospital patients. Short talks and discussions on understanding childbirth, or relaxation exercises, are followed after a break for tea by parent craft discussions or films and fathers have been invited to take part in some of the latter together with their wives.

Attachment of a health visitor to a group practice—From 30 October a health visitor was attached to a group practice in Central Islington. This practice is run by three doctors in purpose-adapted premises. The arrangement is an experimental one and the intention is that the health visitor will be available for home visiting, advice to and health education of all families with children under five years of age on the list of the group practice. All these families are given the option of continuing to attend their welfare centre. The doctors concerned run ante-natal and child welfare sessions and record their findings on the Council's forms. The health visitor assists with these sessions exactly in the same way as in the Council's own centres and also runs a relaxation and mothercraft class on the practice premises.

First impressions of the experiment have been encouraging; attendances at clinic sessions have been good and many mothers have expressed satisfaction with the scheme which is likely to strengthen co-operation between the general practitioner and local health authority services.

Employment of coloured home helps—The number of coloured residents in the division has been increasing for some years and they now represent a significant proportion of the total. During 1961 a special effort was made to encourage the employment of coloured home helps. They have proved to be able workers and have been found to be popular, both with the households they visit and with the other home helps. In the future, it may be expected that they will contribute in greater numbers to the flow of recruits needed for the home help service.

Remedial foot classes—Four remedial foot classes for schoolchildren were started in 1951 and under the direction of Dr. W. K. Steel and with the co-operation of head teachers they had increased to 20 in 1961. They are held three or four times weekly, lasting 15–20 minutes for 12 to 16 children. Teachers who volunteer to conduct these classes attend a course of lectures and demonstrations held by Dr. D. M. Baker at the Physical Education College, Nottingham Place, and Dr. Baker visits the classes at least once a term. A remedial gymnast also visits to help the teachers with any difficulties. Children are usually recommended for the classes by school doctors, but some referrals come from general practitioners. The defects chiefly found are flat feet and valgus ankles, the wrong type of footwear has also to be dealt with, parents being advised on this matter. One term of classes may be sufficient with some children but two or three terms may be required in bad cases. During 1961 the number of children attending the classes was 617; of these 395 were newly admitted to the classes.

DIVISION 4, comprising the boroughs of Hackney, Shoreditch and Stoke Newington.

Dr. S. King reports:

Woodberry Down health centre—Still further developments in the use of accommodation at the health centre occurred during the year. There are now seven general practitioners practising at the centre, one of the six original practitioners having been joined by a partner. The psychiatric social club now meets weekly instead of fortnightly and provides a varied programme of discussions, films and social activities.

The area Children's Office was moved to the centre in March, occupying the accommodation of the former sub-office together with an additional room which was needed to house the increase in staff.

The Welfare department's class for the rehabilitation of physically handicapped persons now meets four times a week instead of twice, thus enabling a larger number to attend this popular class. Another activity of the Welfare department, the training class for the young blind, was moved during the summer to a more convenient location in South London.

Mental health—The mental health officers' first full year of operations on a divisional basis was completed without untoward incident. The team has settled well and established a good relationship with general practitioners, hospitals and the various social agencies in the area.

Nearly 600 cases of mental illness were dealt with during the year and the community care service was developed as fully as possible having regard to the day-to-day pressure of work upon the staff.

A new training centre, purpose-built, was opened in Ickburgh Road, Hackney in June to accommodate 120 subnormal children between the ages of 5 and 16 years.

Clifton Lodge, a day centre for the rehabilitation of patients recovering from mental illness which accommodates 40 patients, was opened in July, 1960. Initially conventional occupational therapy was undertaken at this centre, but since the beginning of June, 1961 industrial work has been undertaken with the willing co-operation of local firms. This has proved an incentive for regular attendance, as the patients undertaking the work gain financially by the payment of an allowance up to a maximum of three shillings a day.

Health education—Meetings of staff involved in health education continued to be held to discuss and co-ordinate the work in this field and to select topics for monthly publicity efforts.

Local maternity liaison committees—These were established in 1960 by both hospital management committees of the hospitals providing maternity beds in the division. A health visitor attends the Bearsted Memorial hospital weekly to see the mothers during the lying-in period and some of the patients who are confined at this hospital attend the Woodberry

Down health centre for ante-natal care and mothercraft instruction. There have been four meetings during 1961 of the Hackney Group liaison committee.

Chiropody—The shortage of chiropodists limited the number of sessions held during the year to an average of approximately 71 a week.

The number of sessions held at the Salvation Army Goodwill Centre in New North Road was increased from two to four weekly.

Occasional crèches—These continued to be held at six centres.

Premises—Facilities at Hoxton school treatment centre, other than the dental service, were transferred to the Shoreditch health centre in preparation for the conversion of the building for use as a child guidance clinic.

In June, the Hackney training centre in Ickburgh Road was opened and in December the Clapton training centre closed, the girls being transferred to the Bethnal Green training centre.

Prevention of break-up of families—There were five meetings of the divisional co-ordinating committee and fourteen intermediate case conferences at which 47 families were discussed. As in 1960 the largest number of requests for discussion of families came from the Housing department which referred 25 cases, 24 of these on account of rent arrears which might lead to eviction.

Special investigation clinics—New attendances decreased very slightly as compared with 1960. The number of obese children referred was approximately 17 per cent. of the total. The ring-a-bell alarm apparatus for cases of enuresis continues in use.

Loan of equipment—The demand for home nursing equipment continues and during the year under review 138 commodes and wheelchairs were issued on loan, in addition to various other items such as mattresses, hospital beds, quadruped walking sticks, etc. A further eight fireguards were also loaned to necessitous households, making a total of 22 fireguards on loan at the end of the year.

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

Dr. G. O. Mitchell reports:

Divisional co-ordinating committee—Four meetings of the committee and twenty-four intermediate case conferences were held during the year; the latter included two meetings held for a review of families with children under five years of age visited currently by the N.S.P.C.C.

Nearly eighty cases were considered, the largest group (20) being those referred for persistent non-payment of rent; four of these were referred by a metropolitan borough and 16 by the Council's Housing department.

Eight new families were referred to the case workers in the division and five of these, in addition to 11 families referred in 1960, were visited regularly. A further seven new cases were referred by the committee to the Family Service Unit and their case workers visited these.

Mental health—The divisional special advisory clinic for mentally-backward children under five years of age was attended by 38 children, of whom 13 were present for the first time.

During the year 633 patients were referred to the mental welfare officers for investigation, of these 343 were admitted to psychiatric hospitals, 63 being over 70 years of age. Arrangements for a number of informal admissions were made by general practitioners direct with the hospitals concerned; for patients admitted under certificate there was a satisfactory liaison between the general practitioner, the consultant and the mental welfare officer.

Aged patients continued to present the greatest problem as so many of them were in a physically bad condition as well as being mentally ill.

The psychiatric social worker gave intensive case work to 69 patients.

Educationally subnormal children, particularly school leavers, were encouraged to join clubs and recreational institutes.

Six children visited the home at Seaford opened recently by the 'Buckets and Spades' Society; no charge was made to the Council and the children were given every possible care by the matron of the home and the voluntary helpers from the Society.

Recuperative holidays were arranged for many patients who were mentally ill.

The Bethnal Green training centre closed on 9 June, 1961, in order that the premises could be adapted for an elder girls' training centre together with a special care unit for junior children. The new centre was due to open early in 1962.

Prophylaxis—In May a fourth poliomyelitis injection was introduced for children about to enter school and for schoolchildren between the ages of five and eleven years. All eligible children living or attending school in the division were offered the fourth injection during June and July; all seventy-six primary schools in the area were visited by poliomyelitis teams during the last six weeks of the summer term.

Health education—At two welfare centres film shows were held during the evenings, for which special invitations were sent to expectant mothers and their husbands. The response was gratifying and the highest attendance on any one evening was 46.

Ante-natal services—In order to improve liaison, arrangements were made for a member of the health visiting staff to attend the weekly ante-natal booking clinic held at St. Andrew's hospital. This arrangement has worked very successfully.

Day nurseries—In December, Old Church Road day nursery, Stepney, was closed. The premises are again to be used as a nursery school. The parents of children accommodated in the day nursery were offered alternative placings in other nurseries in the division.

Bathing centres—The sole remaining *ad hoc* bathing centre was closed on 30 March and bathing facilities on a reduced scale were provided elsewhere. The number of schoolchildren needing cleansing at bathing centres continued to fall considerably; in 1961 there were 217 cases compared with 673 in the previous year.

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

Dr. F. R. Waldron reports:

Accommodation—As an addition to divisional headquarters, premises at 74 Deptford High Street were occupied in February. These house the divisional mental health team, the Deptford home help office and a food sales point. The 'shop window' is used for topical displays by health visitors who form the divisional health education group.

Maternity services—Despite co-operative efforts in applying priorities, the demand for maternity beds increased during the year, especially in the Greenwich and Deptford districts. Inevitably, some cases were referred to the Emergency Bed Service. Both maternity liaison committees in the division have discussed this problem at their meetings.

Fifteen general practitioner obstetricians in the Woolwich and Greenwich district continued to attend ante-natal centres. In December steps were being taken to offer similar facilities to doctors in Deptford and to extend the facilities in the Greenwich, Eltham and

Woolwich areas. Although the formation of such schemes is not without difficulty, it is evident that they form the best available basis for team work in the supervision and care of the maternity case.

Mental health—It became possible in February to accommodate the mental health team close to divisional headquarters. Although staff shortages have, until recently, slowed down expected progress, great strides have nevertheless been taken. The increasing number of persons coming under community care reflects in some measure the case work dealt with. In addition, excellent contact has been made with family doctors, consultants, and statutory and voluntary social workers in the area. The team has integrated at all levels with the existing divisional staff.

Special ' mental health ' groups were established at the beginning of the year in Woolwich, Eltham, Greenwich and Deptford. Each was composed of health visitors, social workers and doctors under the leadership of a consultant psychiatrist. They met periodically to discuss problems arising in the mental health field with emphasis on community care and prevention.

Poliomyelitis vaccination—A great effort on the part of divisional health staff and colleagues in the education service resulted in the majority of the 5–11 years old age group receiving their fourth injection before the summer holidays.

Diphtheria—A case living in Camberwell and attending a Deptford school was found just before the summer holidays. Fifteen carriers were discovered and removed to hospital. In September it was found that the carrier state had recurred in one child and further treatment was required.

It is felt that the fact that no overt case resulted could be attributed to the high degree of immunity in the local child population. The intensive investigation required by this incident reflects great credit on the school medical and nursing staff and the district health visitors. Every co-operation was given, as usual, by the heads and staffs of the schools involved and the borough health department. The Devonport and Public Health laboratories had to deal with and report upon up to 600 swabs on several occasions at short notice.

Chiropody—Considerable difficulty was experienced during the year in maintaining the divisional chiropody service in the face of an acute shortage of chiropodists. While every effort was made to deploy available staff in such a way as to secure an even geographical spread of the service throughout the division, some reduction in the number of weekly sessions was inescapable. Although the temporary suspension of sessions at certain centres inevitably resulted in increased waiting lists, the staff continued to make every effort to meet the special needs of persons in the priority classes.

Occasional crèche—In response to what appeared to be a reasonably strong local demand, an occasional crèche was opened on 19 April at the Creek Road welfare centre, Greenwich. Attendances at the crèche have, however, been much lower than anticipated and efforts continue to be made to stimulate mothers living in the locality to take advantage of the facilities available.

Prevention of break-up of families—The co-ordinating committee continued to meet regularly to consider policy and subjects of common concern as well as measures to help particular families, the allocation of social case workers and of specially trained home helps. In addition, 28 intermediate case conferences were held, at which a number of departments of the Council and the majority of other statutory and voluntary agencies in the area took part to a greater or lesser degree.

Voluntary workers—On average 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:

Premises—The South East London General Practitioners' Centre was opened officially on 16 February, 1961, in adapted premises in part of the Queen's Road Centre, St. Mary's Road, S.E.15.

The Bellingham welfare centre, opened in September, 1960 in the Estate Community Centre, Bellingham Green, S.E.6, attained some publicity in the local press. Initial attendances were poor and the possibility of its discontinuance was raised in the Divisional Health Committee early in the year. Representations for its retention were made in the local press and by the end of the year attendances had sufficiently improved to justify continuing the centre.

It was regrettable to note an appreciable increase in unauthorised entries to centres and day nurseries. Such entries used to be frequent in the early post war years, when short supply foodstuffs were an attraction; of late they had become rare. During the year there were ten entries, mainly into nurseries. There were minor thefts, probably the work of juveniles, and in two instances wanton damage of foodstuffs and materials. The police investigated each entry.

Diphtheria—An outbreak of diphtheria centred in a school in North Camberwell had commenced in mid-December, 1960, as described in my report for that year. Home swabbings had been carried out for the pupils of the two classes affected; in the New Year swabbings were extended to cover other pupils from the school and special immunisation sessions were held at the school during the holidays. When the school reopened, swabbing and immunisation was continued systematically, over 950 injections being given. Further positive carriers were discovered and their contacts were followed up in conjunction with the borough medical officer of health. Two other schools were involved through contacts but they produced only one further positive swabbing, which was non-toxic. Precautions were taken with all pupils discharged from hospital to ensure that they showed a further negative swab result before returning to school. In all, 37 children were admitted to hospital, of whom 13 were clinical cases. As previously reported, the organism (*C. diphtheria mitis*) that caused this outbreak produced some severe attacks of the classical type, and one little girl aged seven years died on 7 January, 1961; she was unimmunised. The outbreak received much publicity in the press, radio and television news; as a result attendances at immunisation sessions throughout the division increased considerably.

There was a further mild outbreak among the pupils in the nursery class and infants department of the same school, which lasted from 1–24 July, 1961. The divisional staff carried out swabbings and immunisation at the school and the borough council took similar action with home contacts.

A further outbreak caused by a different type of organism made itself known early in May, 1961 in a school in the Dulwich area of Camberwell, the same routine of swabbing and follow-up was operated as in the previous outbreak. Because of a home contact, a class at a senior girls school in Peckham was also swabbed. Five cases of diphtheria were reported—two pupils at the original school, one senior girl contact, one parent contact and one pre-school child contact. None proved serious. There were also 14 carriers. The incident was closed early in June, 1961 when all swabbings had produced two negative results.

Day nurseries—The number of places at Shaftesbury House day nursery was reduced from 50 to 35. The upper floor was thus released for use by young subnormal children, as described below. At the other nurseries there has been a consistently high level of occupation. The pressure has been felt particularly in the four Camberwell nurseries and proposals are in hand to increase their accommodation, as part of the replacement schemes for Peckham Park Road and Wyndham Road nurseries.

Occasional crèches—There has been a steady growth in this service and good use has been made of the sessions provided. Eleven sessions are held in six premises, three of which are rented. One new crèche was opened during the year.

Chiropody—Growth of the service has been limited by the supply of chiropodists. Although the full establishment of 66 sessions was not attained, there was sufficient recruitment to enable an experimental re-arrangement of sessions to be introduced at the end of the year at the Sangley Road foot clinic, Catford on the following lines:

Old	*New*
9.30 a.m.—12.30 p.m.	8 a.m.—11 a.m.
2 p.m.—5 p.m.	11.30 a.m.—2.30 p.m.
5.30 p.m.—8.30 p.m.	3 p.m.—6 p.m.
	6.30 p.m.—9.30 p.m.

The object is to enable more sessions to be worked at each clinic. Enquiries from the public suggest that there are many who welcome the earlier morning and lunch-time sessions, which fit in with their shopping and other activities.

Health education—A planned programme of health education activities was carried out at centres and schools, and talks and lectures were given to interested bodies, e.g. parent-teacher associations. A small exhibition was staged at the divisional office to stress the causes of home accidents and means of prevention. The exhibits were prepared by the divisional health education team, supplemented by material loaned by the Gas Board and an insurance company. About 200 people attended.

Prevention of break-up of families—The work of the divisional co-ordinating committee increased during the year, as did the number of families referred to the intermediate committee. The families with heavy arrears of rent provided the greatest number of those referred; these had been notified both from the London County Council and borough council housing departments. Two full-time and one part-time case workers were allocated to the division in November; between them they undertook intensive work with 17 families.

Mental health—The services which devolved on the division late in 1960 continued to be absorbed and much development took place, both in the emergency arrangements for the mentally ill and in the community care for the subnormal and mentally ill.

A mental welfare officer attends the psychiatric day hospital, St. Olave's hospital, Bermondsey, to assist in the co-ordination of the hospital and local authority social work for patients who attend from Camberwell and Lewisham.

Dover Lodge hostel for mentally subnormal girls was closed from May until July owing to the resignation of the warden. The six resident girls were dispersed to residential work, other hostels and lodgings. With the appointment of a new warden, a new intake of girls was admitted gradually. All are in employment. Their leisure is well organised to include attendance at local evening institute and church activities, where they participate in dress-making, ' keep-fit ', dancing and badminton.

Special features of the training centres for subnormal pupils were the opening of an experimental holiday play centre at the Lewisham centre, at which permission was also given for the holding of a weekly evening club for 20 young persons under the aegis of the Lewisham Society for Mentally Handicapped Children. The friendly interest of local residents in the pupils manifested itself in a number of gifts of money to be used for outings and special equipment.

The division co-operated in the Health Committee's experiment to provide, in association with a day nursery, for the care of severely subnormal infants under five years of age. A vacant floor was brought into use at Shaftesbury House day nursery, for up to nine infants. These were specially selected by a medical officer from the County Hall mental health section, on the recommendation of the divisional medical officer after consultation with the health visitors and mental welfare social workers. Eight children were admitted for a six months' experimental period. The early weeks of the scheme showed promise that it was meeting a real need of the parents and that the children themselves were responding to the care provided.

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

Dr. W. H. S. Wallace reports:

Maternity and child welfare—The maternity and child welfare clinics have continued to be well attended. Increasing demands for help from families with social and domestic problems have thrown a heavy burden on health visiting staff. The rising birth rate and the increase in the number of immigrants have resulted in much extra work for the centres and a greatly increased demand for maternity beds. The home conditions of the immigrant population in particular are frequently poor and home confinements are not possible. The hospitals have been most helpful and, in spite of heavy pressure, have managed to find beds for all mothers requiring hospital confinement on medical or social grounds.

Day nurseries—The demand for day nursery accommodation remains about the same as last year. There has, however, been a considerable increase in the demand for the occasional crèches that have been provided at some of the welfare centres. Additional sessions were provided at the Barley Mow and St. Anne's centres and a new crèche was opened at the Rose McAndrew centre during the year.

Infectious diseases—Three cases of diphtheria occurred in schoolchildren in Bermondsey during the year. Bacteriological tests were carried out on all the children in the schools concerned and the immunisation campaign was carried on intensively. No further cases were traced.

School health service—The health of schoolchildren has remained good and the incidence of minor ailments has continued to decline. A further decline has taken place in the incidence of rheumatism. Attendances at rheumatism supervisory sessions have been dropping steadily in the division for some years and during 1961 only one new case was seen. As it was no longer necessary to maintain a supervisory session, as such, at St. Thomas' hospital the session is now working as a general investigation session, on the lines of special investigation clinics in other parts of the division.

Special efforts have been made to ensure that all children with any defect of hearing are discovered and that every provision is made for them. There are at present 124 children on the deaf register and these cases are regularly reviewed. A treatment organiser attends the hearing aid distribution centre at St. Thomas' hospital.

Mental health—The mental health team has made a satisfactory start in the development of services for the mentally disabled, though progress has been tempered to the staffing position for much of the year. There has been a steady rise in the number of people referred and the 3,778 visits and interviews undertaken indicate the effort made by a small staff to meet the needs of the community.

A psychiatric social worker joined the team for three months and this enabled the division to start a closer working relationship with the day hospital at St. Olave's hospital.

The mental welfare officers have been much encouraged by the helpful co-operation they have received from general practitioners and the medical staff of the area mental hospitals and out-patient clinics.

The Institute of Social Psychiatry opened another rehabilitation centre in the division, Crossways, and the West London Mission opened St. Luke's Hostel, Wincott Street, S.E.11 for the after-care of alcoholic patients.

Co-ordinating committee—The co-ordinating committee continued to do valuable work. The number of case conferences continues to increase annually, reaching a total of 57 during 1961. These conferences have proved most valuable in co-ordinating the work of those visiting the homes and agreement on the designation of a key worker has frequently helped to eliminate multiple visiting.

DIVISION 9, comprising the boroughs of Wandsworth and Battersea

Dr. J. T. R. Lewis reports:

The work of the division has proceeded normally throughout the year and we seem to have been as busy as ever. My colleagues and I never seem to be short of problems but it is difficult to convey accurately the extent, variety, and not seldom the complexity of the work. The following somewhat bare recital instances some, but by no means all, of the non-routine matters dealt with in 1961.

Premises—In conjunction with the modernisation by Battersea Borough Council of Chatham Hall, a separate annexe was built to provide a doctor's room and waiting room for the welfare centre conducted from the main hall. This has improved the facilities at this busy centre.

Diphtheria—Shortly after the commencement of the Easter holidays, a boy from Falconbrook Infants' school, Battersea, was diagnosed as suffering from diphtheria. A second case and 37 carriers were discovered later. The process of swabbing all contacts was made much more difficult because of the school holidays, but nevertheless was successfully carried out from six schools. On one of the peak days over 500 children and adults each had two swabs taken and 363 persons received either a primary or booster injection of diphtheria antigen.

Prophylaxis—To enable eligible children aged 5–11 years to receive a fourth injection of anti-poliomyelitis vaccine before the summer holidays a special programme was organised and 7,524 children were inoculated.

Maternity and child welfare—An occasional crèche was opened for one session a week at William Harvey centre on the Ashburton Estate, Roehampton.

Bathing centres—Due to the general improvement in the standards of health education and hygiene and the issue of Lorexane shampoo for use in the home, the number of attendances for cleansing at the two bathing centres in the division dropped from 2,147 in 1959 to 1,123 in 1960; in consequence cleansing sessions were reduced by five a week.

Mental health services—In the first full year's working since the Mental Health Act, 1959 came into operation, community care began to expand in a variety of ways.

In April, a social club on one evening a week was opened for psychiatric patients either discharged from a mental hospital or who might, with sufficient domiciliary support, be discharged. The meetings give opportunities of discussing difficulties in an informal, friendly atmosphere with a psychiatrist and one of the Council's social workers. The success of this venture has been outstanding and it undoubtedly is a pioneering effort which may well prove to be one of the most fruitful ways of helping the mentally disordered in the community.

A scheme was started in February with the object of giving occupation and instruction in their own homes to mentally ill persons. To some younger patients this can be a step to a psychiatric club or rehabilitation centre and then possibly to employment. The more elderly patient has been helped towards a more normal life in the community. This small incipient service, consisting of three sessions a week, has been welcomed by hospital doctors and general practitioners.

Clapham industrial training centre was opened in April with accommodation for over 100 men and boys. Balham training centre, vacated by the older boys who were transferred to the Clapham centre, was modified and improved to provide occupation and training for 60 older girls and women formerly using a centre held in a church hall.

Liaison with general practitioners and hospitals—Close association has been fostered in all aspects including case work and two specific measures of co-operation may be instanced. A session in the programme of the local division of the British Medical Association, held at a welfare centre, was devoted to the community care of the mentally disordered. About 50 general practitioners and consultants met members of the divisional health team. Secondly, arrangements were made for the Council's social workers to attend the fortnightly clinical conferences held at Tooting Bec hospital.

A weekly clinic conducted by a psychiatrist from Tooting Bec hospital for out-patient treatment of the mentally ill was started at Putney health centre in January.

Staff—Dr. T. A. Plumley joined the division in March as deputy divisional medical officer.

Statistical summary 1961—health divisions

Health division	1	2	3	4	5	6	7	8	9	Total
Estimated population—mid 1961	437,080	490,680	280,710	255,890	208,650	300,310	394,890	360,000	451,770	3,179,980
Births and associated mortality										
Live births	8,147	8,349	6,292	5,631	4,082	4,877	7,176	7,519	7,979	60,052
Rate per 1,000 population	18·6	17·0	22·4	22·0	19·6	16·2	18·2	20·9	17·7	18·9
Deaths under 1 month	118	140	106	97	75	75	99	117	126	953
Rate per 1,000 live births	14·5	16·8	16·8	17·2	18·4	15·4	13·8	15·6	15·8	15·9
Deaths										
All ages	4,964	5,707	3,185	3,004	2,542	3,337	4,640	4,438	6,098	37,915
Rate per 1,000 population	11·4	11·6	11·3	11·7	12·2	11·1	11·8	12·3	13·5	11·9
Health visiting										
Effective visits	108,197	117,810	67,381	58,848	59,477	76,634	93,645	108,367	76,450	766,809
Staff at 31 Dec. W/T equivalents	47	57	39	43	31	38	53	51	54	413
Welfare centres										
Children—										
Sessions	2,787	3,899	2,740	1,737	2,063	2,874	2,987	3,151	2,591	24,829
Total attendances	88,341	121,968	80,804	66,125	59,431	83,503	96,747	98,637	111,600	807,156
Age 0–1: first attendances % of live births	86	92	91	88	86	96	92	88	97	91
Expectant mothers—										
Sessions	1,587	1,614	1,200	368	330	1,373	1,650	644	749	9,515
First attendances	4,377	5,266	4,287	1,794	648	3,107	3,107	2,703	2,271	27,560
% of live and still-births	53	62	67	31	16	63	43	35	28	45
Total attendances	21,112	22,954	19,659	8,629	4,993	20,113	17,406	13,361	12,563	140,790
Prophylaxis										
Poliomyelitis—										
Two injections										
born 1957–61	6,519	6,747	4,879	4,277	3,058	4,293	6,303	6,077	6,011	48,164
born 1943–56	2,592	3,069	2,256	3,165	1,428	1,746	2,696	3,015	2,774	22,741
born 1933–42	4,069	5,454	2,709	1,973	2,675	2,012	2,533	2,536	2,339	26,300
born 1932 or earlier and under 40 years	5,013	7,597	3,821	3,203	5,372	3,884	5,254	5,208	4,660	44,012
over 40 years	224	815	134	161	43	344	374	67	144	2,306
Total	18,417	23,682	13,799	12,779	12,576	12,279	17,160	16,903	15,928	143,523
Third injections	13,060	24,289	14,992	11,726	13,759	12,218	16,617	13,538	19,432	139,631
Fourth ,,	10,458	9,989	9,589	10,831	11,101	14,080	13,898	10,945	9,805	98,809
Smallpox—Vaccinations	4,877	5,597	4,395	3,590	2,010	3,585	5,245	4,280	4,966	38,545
Re-vaccinations	328	861	319	505	181	401	465	351	448	3,859
Diphtheria—Primary course	8,861	8,374	7,113	5,315	4,492	5,906	9,288	9,627	8,882	67,858
Reinforcing injections	11,278	11,265	4,571	5,824	6,811	9,689	11,814	17,548	9,292	88,092
Whooping cough—Primary course	6,749	6,790	5,857	4,595	3,406	4,913	7,524	7,092	7,138	54,064
Reinforcing injections	3,726	2,707	2,225	2,120	1,570	3,650	4,713	2,624	3,576	26,911
Tetanus—Primary course	8,269	7,306	6,330	5,084	4,187	5,423	8,194	7,877	7,628	60,298
Reinforcing injections	4,431	2,948	2,766	2,345	1,974	4,356	5,025	3,470	3,910	31,225

Health division	1	2	3	4	5	6	7	8	9	Total
Foot clinics										
Sessions	4,238	1,040	4,022	3,671	291	6,586	2,526	3,965	1,866	28,205
Total attendances	30,690	6,622	27,466	26,789	2,022	51,203	15,097	24,481	12,418	196,788
Day nurseries										
Number of places at 31 Dec.	634	975	349	379	275	55	279	634	437	4,017
Total attendances	133,151	219,866	79,380	86,209	56,467	12,349	62,466	146,786	89,889	886,563
Child minders										
Statutorily registered 31 Dec.	37	13	21	15	7	48	40	2	27	210
Children minded (authorised no.)	127	81	99	58	18	276	213	18	198	1,088
Voluntarily registered 31 Dec.	143	143	105	71	50	120	124	90	15	861
Children minded	183	146	127	87	55	139	127	106	23	993
Home help										
Households attended	4,392	4,793	3,040	4,478	3,036	3,661	5,686	4,666	4,794	38,546
Households attended per 1,000 population	10·0	9·8	10·8	17·5	14·6	12·2	14·4	13·0	10·6	12·1
Home nursing										
Total visits	212,902	229,666	135,698	127,226	117,802	190,461	199,685	206,582	181,838	1,601,860
Visits per 1,000 population	487	468	483	497	565	634	506	574	403	504
School health service										
Medical inspection, routine, special, reinspection	35,536	30,231	29,031	20,713	27,062	34,585	38,165	29,503	42,169	286,995
Health surveys	75,890	104,081	50,578	34,017	39,804	98,155	72,766	48,286	86,228	609,805
Hospital/specialist clinics—										
New cases	3,913	3,844	3,838	2,697	3,188	3,493	3,834	2,490	4,432	31,729
Total attendances	8,244	11,088	13,225	6,714	7,363	8,610	9,323	9,087	14,678	88,332
Dental services										
Schools—										
New cases	7,247	8,451	6,566	11,254	7,502	5,794	6,673	7,934	8,003	69,424
New cases per 1,000 population age 5–14	167	195	190	333	249	131	118	158	133	175
Total attendances	26,326	32,517	20,549	33,881	23,348	18,125	22,315	28,802	28,238	234,101
Maternity and child welfare—										
First treatment	656	483	393	948	215	291	190	295	220	3,691
Total attendances	2,957	2,649	3,387	3,858	1,186	1,157	553	853	821	17,421

APPENDIX A.

MENTAL HEALTH IN LONDON IN 1961 AND THE IMPLEMENTATION OF THE MENTAL HEALTH ACT, 1959

Introduction

In that part of my Annual Report for 1957 which dealt with the mental health services, particular emphasis was given to the findings of the Royal Commission on the Law relating to Mental Illness and Mental Deficiency which were welcomed by the Council as providing an imaginative charter for a comprehensive mental health service. There was no doubt that the former legislation no longer reflected modern attitudes towards persons suffering from mental disorders and the drastic revision of the whole legislative structure introduced by the Mental Health Act, 1959, which came into operation on 1 November, 1960, underlined the concepts now accepted by many of the general public, as well as by those who are directly concerned with the care of mentally disordered patients, that mental illness and mental subnormality should be regarded in the same way as physical illness and physical disability.

The main principles upon which the new Act were based were:

(*a*) that as much treatment as possible, both in hospital and outside, should be given on a voluntary and informal basis;

(*b*) that proper provision should be made for the residual category of care where compulsion is necessary, either in the interests of the patient or of society;

(*c*) that the emphasis in mental care should be shifted, so far as possible, from hospital care to care within the community.

The Act provides for the establishment of a comprehensive community care service by local health authorities to meet the needs of all types of mentally disordered persons not requiring hospital treatment. This includes—

(*a*) provision of residential accommodation;

(*b*) provision of centres for training and occupation;

(*c*) exercise of functions relating to persons placed under guardianship;

(*d*) provision of day centres, social clubs, recuperative holidays and short-term care; and

(*e*) visiting and general welfare of patients in the community.

In common with other local health authorities, the Council was required, in accordance with Ministry of Health circular 28/59, to submit its proposals for implementing the new legislation. The account which follows gives specific details of these proposals and indicates to what extent it has been found possible, up to the end of 1961, to put them into effect.

The present mental health services are also described in relation to the progress which has been made in recent years and reference is made to the tasks which still face the Council.

Historical developments

Services for subnormal and severely subnormal persons—Social work for persons now classified under the Mental Health Act, 1959, as ' subnormal ' or ' severely subnormal ' has continued in London since the Mental Deficiency Act, 1913 came into operation, when social workers employed by the London Association for Mental Welfare undertook the supervision of such persons living in the community on behalf of the Council. A nucleus of officers designated as Mental Deficiency Act ' Inspectors ' was appointed directly by the Council and was based at the County Hall to carry out initial enquiries for the ascertainment of new cases; to exercise compulsory powers; and to be responsible for the supervision of, and general social work for, persons placed under guardianship.

The work of the London Association for Mental Welfare was taken over by the Council in 1930 and the social workers continued to operate from four local offices. The work of the inspectors remained separate and centralised until 1955; these officers were then allocated to the local offices with the object of integrating the social work in this field and a senior organiser with over-all responsibility was appointed. This arrangement, whereby a group of social workers was engaged exclusively on mental deficiency work, continued until the mental health services were re-organised in 1960.

The Council recognised that the provision of centres for the training and occupation of mentally defective children and adults living in the community afforded the means of achieving their fullest possible development and social adaptation. Occupation centres (now referred to as training centres) were first provided by the London Association for Mental Welfare, with financial assistance from the Council, in 1923. The Council took over the running of these centres in 1931, when there were 18 small centres providing accommodation for about 300 persons, although only three of these operated on a full-time basis. By the outbreak of war in 1939, when the centres had to close, about the same number of persons were being accommodated in 12 larger centres. It was not possible to start re-opening the centres until 1948 and most of the centres then had to be accommodated in hired premises which it was realised were far from satisfactory. The period since 1948 has been one of rapid expansion to meet an increasing demand for places, as well as planning to improve the standard of accommodation in use. By the time the Council's proposals under the Mental Health Act, 1959 were formulated, although much remained to be done, the training centre service had been expanded to provide places for 1,250 persons in 21 centres (including one industrial centre); some of the least satisfactory hired premises had been replaced; some specially adapted Council-owned premises had been brought into use and the first two specially designed centres had been opened.

Services for mentally ill persons—Social workers for the mentally ill were employed by the Council in its mental hospitals before the first mental health course for the training of psychiatric social workers was instituted in 1929, following which fully trained social workers were employed in the mental observation wards at the Council's general hospitals and subsequently at the county mental hospitals. When the hospitals were transferred to the Ministry of Health in 1948, under the National Health Service Act, 1946, these social workers were retained in the hospital service.

Community care services for the mentally ill were started in 1943, at the request of the Ministry of Health, by the National Association for Mental Health for ex-service personnel who had been discharged on psychiatric grounds. Responsibility for this work, which from 1948 was extended to civilians, was assumed by the Council under section 28 of the National Health Service Act, 1946; the work at first was carried out by the National Association for Mental Health and the Mental After Care Association acting jointly as agents for the Council. In 1953 the Council took over direct responsibility and in 1960, when the mental health services were re-organised, there were five psychiatric social workers, including one senior, working from the County Hall under the general direction of the consultant psychiatrist employed by the Council as its adviser in mental health.

Mental welfare officers—The emergency removal of mentally ill persons to observation wards and hospitals was for many years the responsibility of the Boards of Guardians. This work, which was taken over by the Council in 1930, was first performed in the newly-constituted Public Assistance department; in 1948 it was transferred to the Public Health department, the relieving officers so employed being re-designated as duly authorised officers and transferred to the department to form the nucleus of the staff of mental welfare officers. From then until 1960, these officers were employed almost exclusively on the work of taking the initial proceedings in providing care and treatment for persons suffering from mental illness. Whilst these workers did not come within the category of social worker and although the organisation and nature of their duties precluded continuity of

contact with the mentally ill and their relatives, the work called for a high standard of integrity, tact and sympathetic understanding. This work, unrelieved by other duties, made great demands both physically and mentally on the officers concerned.

Organisation and staffing

Before the Mental Health Act, 1959 came into operation, the responsibility for the Council's mental health services rested with the Health Committee and the services were administered centrally from the County Hall. Mental welfare officers, employed as duly authorised officers under the Lunacy and Mental Treatment Acts, and psychiatric social workers for community care work with the mentally ill were based at the central office under the supervision and guidance of the part-time consultant in mental health. The medical work arising from the operation of the Mental Deficiency Acts was carried out by medical officers on the central staff and the bulk of the social work in this sphere was carried out from four district offices each under the control of a local organiser with the general supervision centrally of a senior organiser.

Decentralisation of staff and services—As from October, 1960, the bulk of responsibility for the day-to-day operation of the mental health services was delegated to the nine divisional health committees and the staff of the services then existing were allocated to the divisions. The three categories of mental health worker were thus brought together and a mental health social worker team was set up in each division under the immediate direction of a Divisional Mental Welfare Officer responsible to the Divisional Medical Officer for the day-to-day operation of the local services. A Principal Mental Welfare Officer was appointed to the central staff to supervise and co-ordinate all mental health social work and to act as the chief professional adviser to the department in this field. The remaining members of the team included a deputy to the Principal Mental Welfare Officer, deputy divisional mental welfare officers, senior mental welfare officers, mental welfare officers, assistant mental welfare officers and psychiatric social workers. The background, training and experience of the members of the divisional teams varied widely. A number were qualified psychiatric nurses, others held social science qualifications, some were recruited from other fields of social work and included recruits from other departments of the Council. The bringing together and pooling of this varied knowledge and experience has been invaluable.

The Council had been considering for some time the desirability of extending the work of mental welfare officers to include community care. The opportunity was therefore taken to reduce specialisation in the various branches of the mental health services by giving the staff the opportunity to widen the scope of their duties beyond those in which they had particular experience, the ultimate aim being to weld an integrated organisation of social workers within the mental health field.

Certain aspects of the work were retained under direct central control where it was clear that provision on a wholly self-contained basis for each division would be uneconomical, e.g. the provision of hostels and day centres. Similarly, a number of medical examinations of mentally subnormal and severely subnormal persons continue to be dealt with centrally, either because they required the services of a particularly experienced medical officer or because they did not fall to be dealt with by a particular division. Responsibility for giving medical evidence to courts in respect of subnormal and severely subnormal or psychopathic patients, for the submission of evidence required by Mental Health Tribunals and for obtaining hospital beds for subnormal and severely subnormal persons was also retained at the centre.

As part of the general devolution of responsibilities for the mental health services to Divisional Health Committees, responsibility for the day-to-day administration of training centres, including the maintenance of premises, supplies, the arranging of visits, centre functions and general staff administration passed to the divisional medical officers at the

end of 1960. Planning and the formulation of policy, the supervision of training, general control over admissions, the exclusion and transfer of trainees, the allocation of industrial work to centres and the arranging of transport and home teaching were retained as central responsibilities.

Under the guidance of a principal medical officer, the training centre service is supervised centrally by the Organiser of Training Centres. The Industrial Manager, whose responsibilities include the obtaining and allocation of industrial work to adult centres, is also based at the County Hall. Supervisory staff at the centres are appointed and allocated centrally, whilst the engagement of subordinate staff and general day-to-day administration is handled divisionally.

Staff establishment—In 1961 the Health Committee reviewed the divisional staffing structure which had been agreed consequent upon the reorganisation of the service. It became evident that the staff had been working under extreme pressure as a result of increasing demands. Considerable credit is due to the divisional mental welfare officers and their deputies for the leadership which they showed and to all the staff engaged in this work for their conscientiousness during the difficult time of transition to the requirements of the new legislation and the change-over from a centralised to a locally run service. The Committee agreed (subject to a further review before 1 April, 1963) to increase the establishment by 18 additional positions. The total approved divisional establishment at the end of 1961 was 95; which comprised nine divisional mental welfare officers, nine deputy divisional mental welfare officers, 24 senior mental welfare officers, 15 mental welfare officers (redesignated mental welfare officers, Grade I), 27 assistant mental welfare officers (redesignated mental welfare officers, Grade II), nine psychiatric social workers and two escorts.

Recruitment to the grade of psychiatric social worker proved difficult and at the end of the year although there were 11 qualified psychiatric social workers on the staff only four were engaged solely on case work, the remaining seven occupying more senior positions.

In 1959 the staffing of training centres followed a formula fixed several years before, namely a supervisor and one assistant supervisor for each 15 (or substantial part of 15) trainees except the first 15, with attendants as necessary, subject to the proviso that the over-all ratio of staff (supervisory and attendants) should not exceed one to ten. A slight strengthening of the supervisory staffing of the larger centres has since been found desirable and in 1960 an additional assistant supervisor for each centre with 100 or more trainees and an extra assistant supervisor for each older girls' centre were authorised.

The number of staff employed in the training centre service at the end of 1961 was 134, comprising the Organiser of Training Centres, the Industrial Manager, 22 supervisors, 71 assistant supervisors, 36 attendants and three home teachers.

Staff training—The Council's proposals to the Ministry envisaged an extension of arrangements for in-service training, both basic and refresher, for social workers in the mental health services, in conjunction with the recognised training bodies where appropriate and otherwise as necessary. The main object was to broaden the field of interest and activities of the staff in the various aspects of mental disorder and to keep their knowledge up to date. It was also proposed that there should be increasing participation by suitable social workers in general and advanced courses of full-time study.

The pressure on available staff in maintaining an expanding service and, in particular, the need to provide sufficient senior officers for duty at the County Hall outside normal office hours to deal with emergency work hampered the efforts made to provide training facilities.

Nevertheless, selected mental welfare officers attended all or some part of a series of lectures on mental health organised at the County Hall for health visitors; others attended a

week's intensive course arranged especially for them at Bexley, the Maudsley and Springfield psychiatric hospitals respectively. Weekly conferences held at some of the hospitals afforded good training facilities for staff who could be spared from their normal duties. There was also a number of organised visits of observation to various hospitals.

Arrangements were made for some of the more senior officers to attend conferences and residential week-end schools. Three officers attended a three-week course for mental welfare officers and four others attended a special course for social workers for a half day each week extending over a period of about six months.

About 24 officers attended evening courses during the year, the Council paying the fees, on such subjects as abnormal psychology, human relations, marriage guidance, casework principles and problems of old age.

The policy of seconding suitable officers to full-time courses was continued and during 1961 one officer so seconded completed the Mental Health Course and another commenced. Two officers were also seconded to take the first two-year 'Younghusband' course.

Much remains to be done in promoting the further training of social workers in the mental health services so as to equip them to apply constructive casework principles to their work and to give them every opportunity of keeping abreast with new and changing ideas.

The continuance of in-service training of the training centre supervisory staff for a recognised qualification and a possible cadet training scheme for school leavers were suggested in the Council's proposals relating to the training centre service, but no action had been taken at the end of the year to vary existing staff training arrangements pending the publication of the report of a sub-committee of the standing Mental Health Advisory Committee on the Training of Staff of Training Centres for the mentally subnormal. Eight members of the supervisory staff successfully completed the two-year part-time course for the diploma of the National Association for Mental Health for teachers of the mentally handicapped which ended in 1961. Thirty-five members of the staff held the diploma at the end of the year.

Medical and diagnostic services

Since the inception of the Mental Health Act, 1959, the medical services concerned with the diagnosis, supervision and care of the mentally disordered have continued to expand. The increased responsibilities placed on the Local Health Authority, the varying legal procedures to be adopted according to the type of mental disorder from which a patient suffers and the abolition of the Board of Control laid emphasis on the need for accurate diagnosis and specialised medical supervision by doctors specially experienced in this branch of medical practice. The Council maintains a team of medical officers, working full time under a principal medical officer, which specialises in the field of mental subnormality. These specialist medical officers are based centrally at the County Hall and are responsible for the more difficult and complicated clinical work arising from the Local Health Authority's duties under the Act. At the request of the divisional medical officers, they are also available for carrying out diagnostic examinations in the divisions, where the routine medical examinations for mental subnormality and the medical supervision of children and adults at training centres are now carried out.

The central medical staff also have responsibilities for carrying out special examinations at the request of the Courts or the Prison Medical Service; for exercising any necessary medical supervision in relation to subnormal persons under guardianship or receiving community care and for undertaking special examinations in difficult cases involving very young children or multiple handicaps.

The initial diagnosis of mental illness in adults remains largely in the hands of general practitioners, with the usual facilities for reference to hospital consultants when desirable.

The Council's mental health social workers, however, are available to general practitioners for visiting persons suffering from mental disorder and, if necessary, for making arrangements for their admission to hospital, either under compulsory procedures or informally.

In my report for 1959 I gave a comprehensive account of the psychological services for children in London, in which references were made to the child guidance services and to preventive mental health work in the maternity and child welfare services. Further reference to these subjects will be found on pages 84 and 49 respectively in this report.

Diagnostic clinics—The Royal Commission on the Law relating to Mental Illness and Mental Deficiency urged the need for a diagnostic service for severely subnormal and psychopathic patients and indicated that the initiative in organising such a service should generally lie with local health authorities.

Diagnostic clinics have been set up in all divisions in London where parents and relatives of mentally subnormal children can obtain advice and help. These clinics were primarily designed to cater for children under the age of five years, rather in the nature of special maternity and child welfare clinics for parents who, because of their child's obvious mental abnormality, were unwilling to bring them to the ordinary clinic. It was soon evident, however, that the clinics were filling a real need and their number and scope were extended until at present they offer a very similar service to the out-patient department of a hospital, where a patient can not only be diagnosed and the nature and severity of mental disorder explained to the parent but where 'follow-up' examinations can be arranged and the various facilities available for the care, education and training suitable for each individual case indicated and necessary arrangements made. These diagnostic clinics are staffed by specialist medical officers, all of whom are approved under section 28 (2) of the Act as having special experience in the diagnosis or treatment of mental disorder, and are also attended by mental health social workers and health visitors. Facilities for consultation with the senior consultant staff at the County Hall are readily available and consultation with other specialists can also be arranged.

Admission to hospital and guardianship

The Council's mental welfare officers provide a continuous service, available through the 24 hours of each day, to receive and act upon calls received from general practitioners, hospitals, police, the public, etc. During office hours such calls are received and dealt with divisionally, but outside normal office hours a nucleus of staff is maintained on duty at the County Hall to deal with any emergency arising in the London area.

During 1961, 5,750 persons who were alleged to be mentally ill and in urgent need of care and control were referred to the Council's mental welfare officers for investigation, of whom 4,141 were removed to hospital. About one-tenth (550) of the cases were referred between the hours of 9 p.m. and 9.15 a.m., which was less than half of the number referred during those same hours in 1957, when the proportion was about one-sixth of the total cases referred. Not all these cases were so urgent as to require a visit the same night, but of 467 cases visited 346 were admitted to hospital; no immediate action was found to be necessary in the remaining 121 cases.

Hospitals serving the area—Only two of the nine psychiatric hospitals which admit mentally ill patients from London are within the county area, i.e. Springfield hospital, Tooting and Tooting Bec hospital. The remaining seven are Bexley hospital, Bexley; Banstead hospital, Sutton; Cane Hill hospital, Coulsdon; Horton hospital, Epsom; Long Grove hospital, Epsom; West Park hospital, Epsom; and Friern hospital, New Southgate. In addition five of the London general hospitals, i.e. St. Clements, St. John's, St. Francis, St. Pancras and Fulham, provide emergency wards for the admission of patients for observation. At the end of the year 210 beds were provided at these general hospitals for such cases and mental welfare officers arranged the admission of 1,442 patients to these wards during 1961.

There are 21 hospitals which admit subnormal and severely subnormal persons from the county area; two in London and 19 out-county. The Council continues to act as the normal channel for applications for admission to these hospitals, to assist in the assessment of priorities and in the provision of medical and social reports. Such patients are normally received in hospital on an informal basis.

Difficulties persisted throughout the year in obtaining beds, particularly for children. The position was aggravated by the closing in July of the Fountain hospital to all children except those living within the area of the South West Metropolitan regional hospital board, although the hospital continued to accept children from other regions of London for short term care.

During the year 234 subnormal or severely subnormal patients were admitted to hospital and at the end of the year 148 children under 16 and 47 patients over this age were awaiting admission, of whom 34 were regarded as being in urgent need. The comparative numbers of patients awaiting admission at the end of 1959 were 193 children under 16 and 50 patients over 16, of whom 87 were in urgent need.

Informal admission to hospital—Hospital care under the Mental Health Act, 1959 is now available to all mentally disordered persons who are willing to receive it, with no more restriction of liberty or legal formality than applies to persons who need such care because of other types of illness or disability. Patients can be admitted to hospital informally providing they are not unwilling and can be treated suitably without powers of detention.

The Council's mental welfare officers are not, of course, concerned with the large majority of informal admissions of mentally ill persons to psychiatric hospitals, but in 1961 about one-fifth of all removals of such patients dealt with by mental welfare officers were arranged informally.

Compulsory admissions to hospital—The Act embodies a new code for compulsory admission to hospital of mentally disordered patients; it makes provision for applying compulsion only in the case of such patients who cannot be persuaded to enter hospital voluntarily but for whom hospital care is essential. It is necessary for an application for compulsory admission to hospital under the provisions of section 25 (admission for observation) or section 26 (admission for treatment) to be completed by a mental welfare officer or the nearest relative supported by two medical recommendations. In the case of an emergency admission under section 29, a mental welfare officer or any relative may make the application and only one medical recommendation (made if practicable by a practitioner who has previous acquaintance with the patient) is required in the first instance.

During 1961, 903 persons were admitted to hospital for observation under section 25, 116 for treatment under section 26 and 1,841 were the subject of emergency admissions for observation under section 29.

The police alone retain the power to remove to a place of safety without a medical certificate any person who appears to be mentally disordered and in immediate need of care or control in a place to which the public have access. Such a person may be detained for not more than 72 hours for the purpose of enabling him to be examined by a medical practitioner and to be seen by a mental welfare officer and of making any necessary arrangements for treatment or care. During 1961 mental welfare officers were concerned in the compulsory removal to hospital of 232 such cases.

Power is given to the Courts to make orders for the compulsory admission to hospital or guardianship in respect of certain offenders or children or young persons found to be in need of care or protection or beyond control; provided that the court is satisfied, on the evidence of two doctors, that the offender or child or young person is suffering from mental disorder of a nature or degree which warrants his detention in hospital for medical treatment or his reception into guardianship and that in the circumstances the making of such an order is the most suitable method of disposing of the case. The Council's central medical staff are concerned in the examination and submission of evidence in relation to such

persons who are suffering from subnormality or severe subnormality and any necessary reports on the patient's home and social conditions are furnished by the mental welfare officer. During 1961 the Council's staff were called upon to give evidence in the case of 56 adults and 11 children and young persons and were concerned in the compulsory removal to hospital of 167 persons as the result of Court orders.

Guardianship—Guardianship of mentally subnormal persons under the Mental Health Act, 1959 replaced (with some differences) the provisions for guardianship under the former Mental Deficiency Acts. A local health authority can now itself act as guardian and guardianship may now also be used as a form of control over mentally ill and psychopathic patients who do not need to be in hospital. Up to the end of 1961 this form of control for mentally ill or psychopathic persons had, however, not been used. In most cases it is possible for mentally disordered persons to receive community care without being subject to the legal control of guardianship over their place of residence and everyday life, but a small number of patients in the community still require control for their own welfare or for the protection of others.

The procedure for placement under guardianship follows the same lines as that for securing compulsory admission of a patient to hospital. Applications to the Council for securing care under guardianship are made by the nearest relative or by mental welfare officers and must be accompanied by two medical recommendations (as in applications for admission to hospital), but in these applications reasons must be given why the patient cannot appropriately be cared for without powers of guardianship. The powers conferred are those which would be possessed by the guardian if the authority or the person concerned were the patient's father and the patient was under the age of 14. Guardianship in relation to subnormality or psychopathic disorder is limited to persons under the age of 21 years, but there is no such age limit in the case of severe subnormality or mental illness or in relation to patients who are the subject of court orders.

The guardian is required in general, so far as is practicable, to make arrangements for the occupation, training or employment of the patient and for his recreation and general welfare and to ensure that everything practicable is done for the promotion of his physical and mental health.

Under the new Act a ' responsible medical officer ' was required to review all persons remaining under guardianship on 1 November, 1960, in order to classify under the Act the form of mental disorder from which they were suffering and to decide whether it was necessary for them to remain under guardianship. There were 92 London cases under guardianship on 1 November, 1960, of whom 51 were discharged from guardianship and continued in community care on an informal basis, three were admitted to hospital and 38 were continued under compulsory guardianship.

It was decided that, save in exceptional circumstances, the Council should itself seek to undertake the function of guardian in all cases where this form of control was appropriate for mentally disordered persons under its care and that the Council's whole-time medical staff who have been approved for the purposes of section 28 of the Act should be authorised as ' responsible medical officers ' in relation to these functions. Such officers act for the Council under the provisions of regulation 24 (1) of the Mental Health (Hospital and Guardianship) Regulations, 1960. Six members of the Health committee were appointed to exercise the power to order the discharge of a patient from guardianship, a power which is also given to the nearest relative.

Approval of medical practitioners for the purpose of compulsory removals and guardianship—One of the two medical recommendations required for the compulsory admission of a mentally disordered person to hospital or reception into guardianship must be given by a practitioner approved by a local health authority as having special experience in the diagnosis or treatment of mental disorder; the other certificate is normally given by the patient's general practitioner. Before approving a medical practitioner a local health authority must consult a professional advisory panel for its area (appointed by regional

hospital boards); any two members so consulted must be satisfied that the medical practitioner possesses the necessary special experience before the local health authority approves him. Approval of a medical practitioner is for five years only and may be renewed only after compliance with the foregoing procedure. A doctor so approved may act in any part of England and Wales.

The advisory panel in London consists of 23 members who, up to the end of 1961, had considered 268 applications of which 246 (including 12 from doctors in general practice) had been approved.

Residential accommodation

The provision of residential accommodation for certain mentally disordered patients now in hospital and for others who need to be admitted to hospital in the absence of such provision is potentially the most onerous task which the Council faces in developing its mental health services. Whilst recognising its ultimate obligation under the new Act to provide such accommodation for a very large number of persons for whom the special facilities of the hospital services are not essential, the Council decided to proceed with the provision of hostels on a broad basis of priority for certain classes, for whom the need was considered to be particularly marked. An initial programme was formulated on the principle that one hostel of each of a number of types for which a prima facie need existed should be provided; the need for further hostels of each type was to be examined in the light of experience.

Considerable assistance in the provision of residential accommodation for elderly mentally infirm persons and for mentally disordered children in care is given by the Welfare Committee (in accommodation provided under Part III of the National Assistance Act) and by the Children's Committee (in homes provided under the Children Act, 1948) respectively.

The categories of persons for whom hostel provision is being made in the initial stages through the health services and the progress made by the end of the year towards the implementation of the programme are shown below:

(*i*) Persons discharged from psychiatric hospitals and considered likely to benefit from rehabilitation; other persons needing a period of hostel care to avoid admission to hospital.

A large residential property in Putney has been acquired to accommodate 23 persons; the necessary adaptations were in progress at the end of the year with a view to occupation in mid-1962. Work on a similar purpose-built hostel for 60 residents for which a site has been acquired in Lewisham, is expected to start at the beginning of 1963.

(*ii*) Young persons of both sexes leaving residential schools for the maladjusted and needing extra care and guidance.

A search for suitable sites, or buildings for adaptation was proceeding at the end of 1961.

(*iii*) Subnormal and severely subnormal children requiring short-term care to avoid hospital admission at times of particular domestic difficulty.

Accommodation is to be incorporated in a purpose-built junior training centre for which a site has been acquired in Bermondsey.

(*iv*) Employable subnormal male persons requiring long-term care.

Negotiations were in progress at the end of the year for the acquisition of a site in Paddington.

(*v*) Mentally disordered children requiring long-term care but not needing specialist medical treatment or training or continual nursing attention.

A search for a suitable site, or building for adaptation, was proceeding at the end of the year.

Dover Lodge hostel—The Council established the first hostel of its kind in the country at Dover Lodge, Wood Vale, S.E.23 in 1955. This hostel accommodates up to 13 mentally subnormal girls who, normally, have no homes or whose home background is unsatisfactory. The girls are usually leavers from schools for the educationally subnormal and the hostel serves a useful purpose in training the girls to become self supporting members of the community. Suitable employment is found for them in the locality. During 1961, 18 girls were resident at the hostel and eight remained in residence at the end of the year. Three girls were placed in lodgings during the year; three in resident employment; two in other hostels; one absconded and one returned home.

Voluntary organisations—In addition to the direct provision of hostels the Council intends to continue and, where necessary, extend the placing and maintenance of suitable mentally disordered persons in hostels and homes under the control of voluntary associations and with private persons. Use has been made of homes maintained by such voluntary organisations (principally the Mental After-care Association) for the long term and short term care of persons suffering from mental illness. At the end of 1961, 136 such persons were being maintained at homes owned or sponsored by the Mental After-care Association, seven at hostels of the Jewish Board of Guardians, five at Parnham House (National Association for Mental Health) and two at Winston House, Cambridge (S.O.S. Society). Patients at these homes are maintained by the Council and contribute towards the cost according to their means.

With regard to the placing of mentally subnormal persons, the practice was continued of using private homes and hostels run by voluntary associations where this form of care was considered appropriate, including placings in convents and other training establishments run by religious communities and placings through the Guardianship Society, Brighton. Use was also made of two hostels (one for boys and one for girls) established by the National Association for Mental Health, where mentally subnormal children are trained to undertake paid employment and to fit them for life in the community. At the end of the year 139 mentally subnormal persons were being maintained by the Council under these and other similar arrangements.

Short term care—The provision of short term care for mentally subnormal persons in hospitals or private homes approved by the Council's medical staff has grown considerably since it was first authorised by Ministry of Health circular 5/52. During 1961, 427 persons were placed under these arrangements for periods normally not exceeding eight weeks (compared with 376 in 1959). These facilities have been greatly appreciated by parents and relatives of children and adults, many of whom, while not willing to place them in hospital or elsewhere on a long term basis, have been relieved without cost for short periods from the strain of home care.

The Guardianship Society, Brighton has nominated a number of foster mothers who are willing to care for mentally subnormal persons for a short period and so give them a holiday at the seaside which, in many cases, would not otherwise have been possible.

Hostel for alcoholics—The Council contributes 90 per cent. of the net cost of maintenance towards the running, by the West London Mission, of a hostel in Lambeth for the after-care of alcoholics. This hostel, which was opened on 1 July, 1961, provides after-care for a maximum of 40 patients who have received psychiatric treatment and who are under the continued supervision of psychiatrists. During the first six months, to the end of 1961, 66 men had been admitted to the hostel and 30 discharged; 16 of those discharged were considered to be failures because of short-stay or refusal to co-operate, the remaining 14 had made reasonable progress so far as is known. There has been close co-operation with the agencies referring the cases. Twenty men were admitted from Pentonville Prison psychotherapy group, the majority of whom did not return to drink. As complete rehabilitation is, to a large extent, dependent upon the availability of support and supervision after active treatment, the provision of this hostel meets a real need, particularly for those who have no homes of their own to go to after treatment.

Recuperative holidays—Recuperative holidays are provided for persons recovering from mental illness. During 1961, 143 persons were given holidays for two to three weeks in recuperative holiday homes compared with 128 in 1960.

Training for mentally subnormal and severely subnormal persons

Proposals for future development—In 1960, when the Council submitted to the Ministry of Health its proposals for the development of the mental health services, 21 centres were provided for the training of mentally subnormal and severely subnormal persons, with places for 700 children of school age, 295 for older girls and women, and 275 for youths and men—a total of 1,270 places. Of the nine junior training centres, two were purpose-built, four were in adapted premises and the remaining three were accommodated in church halls. Only three of the twelve adult centres were in buildings owned or leased exclusively by the Council.

The proposals envisaged the following future developments in the training services for these categories of mentally disordered persons:

(*i*) replacement of centres in church halls and other unsuitable premises by purpose-built centres or by premises specially adapted for the purpose and the provision of additional centres to cater for the increasing demand from both children and adults;

(*ii*) provision of special care units for children who require extra attention because of physical handicap or other difficulty;

(*iii*) reduction in the general admission age of children to training centres from five to three years;

(*iv*) provision of some form of holiday minding service or the opening of centres for longer periods, to afford additional relief for parents of children attending the centres;

(*v*) introduction of sheltered industrial work for both men and women attending adult training centres; the expansion of industrial training centres; and the introduction of a system of payments for work done;

(*vi*) provision of a part-time service at adult training centres, or otherwise, for older handicapped persons who are unable, unwilling, or unsuitable to attend a full-time training centre; and

(*vii*) an increase in the number of home teachers and the frequency of their visits.

Premises—Developments towards the replacement of unsatisfactory training centre premises and the provision of additional places, which have already taken place since the Council's proposals were formulated, include the opening in Hackney of a third purpose-built junior centre with places for 120 children; the opening in Wandsworth of a second industrial training centre with 100 places, including workshop accommodation for 40 trainees; the opening of an additional adult centre in Islington with 40 places for older girls and women; and the replacement of an adult training centre for females in specially adapted premises in Hammersmith. As a result of these changes it was possible to discontinue the use of three unsatisfactory church halls for training centre purposes and at the end of 1961 the number of centres had been increased to 22 and the total number of places available by 135 to 1,405.

The provision of new premises has been hampered to some extent by difficulties in acquiring suitable sites, but at the end of 1961 the following projects were in hand—

(*i*) the adaptation of premises in Greenwich to provide an additional industrial centre for 36 males;

(*ii*) the erection of two new junior centres, each with 112 places, in Greenwich and Islington respectively;

(*iii*) the provision of a new building in Hackney to provide an industrial training centre for 120 males;

The Training Centre Service

Special coaches bring juniors and older girls to the centres.

A new junior training centre opened in Hackney during the year.

Juniors at work and play at the new Hackney centre.

Laundry work and cookery play a prominent part in the training of the older girls.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In the new industrial training centre for older boys and men in Wandsworth, training includes woodwork, using power tools, and the chopping and packaging of firewood.

Simple paid industrial work being carried out in adult training centres.

(*iv*) the acquisition of a site in Bermondsey on which to provide a new junior centre with 112 places, an adult training centre for females and one for males (with provision for industrial training and also residential accommodation for severely subnormal children).

In addition, special attention was being given to the possibility of obtaining more satisfactory premises to replace an adult centre for females in south-east London and to acquiring suitable premises for an additional such centre in south-west London. This programme, which it is hoped will be completed within five years, will enable more unsatisfactory premises to be vacated and more places to be provided.

Training of children—Training for children between the ages of five and sixteen is provided in nine junior training centres which are open during ordinary school hours and are run as closely as possible on the lines of schools.

Pending the opening of new and larger centres, lack of places has precluded any general lowering of the minimum age for admission, i.e. five years. As a first step, however, towards the ultimate aim of accepting children from the age of three years, it has been possible to lower to four years the admission age at two centres serving west and south-west London, whilst children of this age may be admitted to other centres in special circumstances.

In furtherance of the Council's intention to provide training for subnormal children at an early age, specially staffed and equipped units have been set up for this purpose on an experimental basis in two of the Council's day nurseries. The units were opened towards the end of 1961 and the results of the experiment are awaited with interest.

Powers are given under the new Act to compel the attendance at training centres of children of school age who are unsuitable for education at school. The great majority of parents welcome the opportunity of sending such children to the centres and up to the end of 1961 it had not been found necessary to resort to legal action to enforce attendance.

Provision has been made in the design of each new junior centre planned for the future for a special unit for 12 mentally disordered children who suffer from an additional handicap or have behaviour difficulties which would otherwise render them unsuitable for training centre attendance. Although it will be some time before the first of these specially designed units is ready for occupation, it has been possible to adapt vacant accommodation, at one of the older girls' centres in north-east London, to provide a unit for 12 handicapped children which was to be opened early in 1962.

Since 1960 a special grant has been made by the Council towards the cost of staffing a unit for severely subnormal spastic children run by a spastic centre in west London, which is attended by some London children.

Following the Council's proposal to afford additional relief to the parents of children attending junior centres, as an experiment four junior centres were kept open as play centres for four weeks of the 1961 summer holiday period. Although attendances were somewhat disappointing, this additional service was much appreciated by those who were able to take advantage of it and it has been decided to continue with the scheme during the summer holidays in future years. It was not considered practicable to provide special transport to the play centres and it is clear that difficulty in travelling to such centres prevented many children from attending. Special attention will accordingly be given, in future, to the selection of centres as play centres which are easily reached by public transport.

Training of adults—Adult centres provide accommodation for persons from the age of sixteen, the social training given in the junior centres being continued; the trainees are encouraged to make the most of their limited capabilities and to achieve a measure of independence. There is more emphasis on the production of useful articles, carpentry and other crafts being taught to the older boys and the older girls receiving instruction in domestic crafts such as cookery, laundry and needlework. On one afternoon a week the trainees hold their own clubs, in which the activities include table tennis, billiards, playing their own gramophone records and—for the girls—dancing. Regular sports activities are also arranged at the boys' centres.

To stimulate industrial activity, an industrial manager was appointed in 1961 to negotiate orders for, and generally supervise, industrial work. Until that time this work had been confined to the single industrial centre, where woodwork articles, mainly for the Council's Supplies department, were produced; industrial activities have now been extended to other adult centres, so that as many as possible of the trainees have an opportunity of doing work for which they receive a proportionate share of the income received by the Council. There is no doubt that this development has been welcomed by the trainees who have shown themselves capable of quite a wide variety of simple work.

It has been particularly gratifying that very severely subnormal adults who were previously considered quite unemployable have been able, as a result of the careful planning of jobs and their breakdown into simple stages, to play a useful part from which they derive an obvious satisfaction. So far work has been provided for seven centres and has included the assembly of lamp holders and brush and comb sets, sewing gas mantles and the stuffing of soft toys.

The opening in 1961 of the second industrial training centre, with workshop accommodation for 40 trainees, was a significant step in the expansion of the arrangements for industrial training. Considerable power-driven machinery was installed and it is hoped to be able to produce a wide range of woodwork articles both for the Council's own use and for outside sale. The range of goods so far attempted includes tidy boxes, wooden toy bricks, toy blackboards and easels, ironing boards, swing seats and duckboards.

Since autumn 1961, the two industrial centres have been kept open for a slightly longer day to bring them more into line with industry; for the same reason, instead of being open only for the periods of the school terms, they are now closed for only four weeks a year. At the end of 1961 each trainee at an industrial centre was receiving a daily payment of two shillings, a figure calculated on the annual profits at that time.

Medical and ancillary services—All persons attending junior and adult training centres receive an annual medical examination and chest x-ray (subject to parental consent); annual mental re-examinations by medical officers experienced in mental subnormality are being introduced. Dental treatment and speech therapy are provided as necessary for children attending the junior centres. Trainees age 12 and over receive a B.C.G. examination.

Meals—Mid-day meals are supplied cheaply (free in necessitous cases) at all centres by the School Meals Service, the food being conveyed to the centres in containers from conveniently situated school kitchens. It has recently been decided that in all new centres with 100 or more places meals shall be cooked on the premises and special provision for kitchen accommodation has accordingly been incorporated in the design of the centres for which plans have been completed. Free mid-morning milk is supplied to all trainees up to the age of sixteen.

Transport—Special coach transport is provided for all junior and older girls' centres, twenty-seven coaches being in use at the end of 1961. In the case of the older boys, the making of their own way to the centres, by public transport if necessary, is felt to be an important part of their training for community life and for this reason they are not provided with coach transport. Where older boys are incapable of making their own way to their centres unescorted, guides are provided for them. Individual transport has recently been authorised for a small number of older boys who suffer an additional physical handicap which would prevent their travelling by public transport; at the end of 1961 four boys were being conveyed to and from their centres under this authority.

Special activities—A seaside holiday for about 200 trainees at a holiday camp on the south-east coast has continued to be a popular feature. Trainees attending the camp are supervised by volunteer members of the centre supervisory staffs under the direction of the Organiser of Training Centres. The holiday is provided free of charge or at a reduced cost for those trainees who are in need. Day outings to the seaside and other places of interest

are organised during the summer out of amenity funds and transport is provided for regular outings to London parks for trainees attending centres which have no open space within easy reach.

Home teaching—At the time of the Council's proposals under the Act, two home teachers were employed to give instruction and occupation to mentally handicapped persons who were prevented by an additional physical handicap from attending training centres. About 40 persons were being visited in 1959. A third teacher was appointed in 1960 and although the number of persons receiving teaching remains roughly the same, it has been possible to increase the amount of attention devoted to each one. There was a small waiting list for home teaching at the end of 1961, but the transfer of some home teaching cases to special care units should mean that the present staff will shortly be able to satisfy the needs for this service.

General comment—Although the full implementation of the Council's proposals must await the bringing into use of new premises providing extra places—and the availability of some of these is still some way off—nevertheless, the period since 1959 has been one of steady development. In the case of every proposal except that for the special daytime care of older subnormal persons—the need for which is now becoming more evident although, hitherto, it has not been regarded as a first priority—solid progress has been made towards the ultimate goal.

Rehabilitation, training and occupation of mentally ill persons

In its proposals for the development of day centres for mentally ill persons the Council placed emphasis on rehabilitation rather than occupation and proposed to provide such centres as may be necessary and practicable, both directly and through approved voluntary bodies on a grant-aided basis. Similarly, it proposed to give support to the running of social clubs by voluntary bodies and to make such direct provision as may be necessary. With regard to psychiatric day hospitals, the intention was to participate in the provision of such units as were considered appropriate within the limits of its statutory functions, generally by making available the services of occupational therapists and social workers.

Clifton Lodge day centre—The Council's first day rehabilitation centre, at Clifton Lodge, Hackney, was opened in July, 1960. The centre is intended primarily to cater for the rehabilitation of persons who have been suffering from some form of mental illness, with a view to their ultimate return to full community life. The provision of occupation for persons with a permanent psychiatric disablement is secondary to this.

During the first twelve months only traditional occupational therapy was available but by June, 1961 a start was made on industrial work obtained through the co-operation of local firms. Originally, the majority of patients were referred from the main psychiatric hospital serving the area but increasing numbers of referrals are now being received from other sources.

The centre, which provides accommodation for both sexes, can accommodate up to 40 persons. There were 56 admissions during 1961 and 26 remained on the register at the end of the year.

In the latter half of the year most patients were engaged in groups on remunerative work, including folding Christmas cards, thonging moccasin shoes, fixing ornamental beading to dressing tables, machining sleeve linings, assembling jewellery and stripping down meters and light engineering parts to recover materials.

A system of ex-gratia payments at fixed rates was introduced on 1 July, 1961, which had regard to the net income. No payment is made for the first month, 2s. a day is paid for the second month and 3s. a day thereafter. These payments, which are kept under review, have proved an incentive to the patients to attend regularly and to undertake, quite readily, many different kinds of work.

The following table analyses the discharges during the year; 10 of the persons leaving were admitted in 1960 and 33 in 1961.

Obtained outside employment	4
Admitted to Government training centre ..	2
Admitted to hospital	7
Left the district	1
Unsuitable for further attendance	9
*Self-discharged..	20
Total ..	43

* About half of these patients took their discharge within two days; the remainder within two weeks.

The relative number of persons discharged to work or for further training is, of course, governed by the type of case referred and, as the centre has only undertaken industrial work for a comparatively short time, it is too early to assess results. Large numbers of patients do, of course, receive rehabilitation whilst in hospital and the potential demand for rehabilitation centres for patients only requiring out-patient treatment or treatment from their general practitioners may not necessarily be high. Patients whose mental state does not enable them to undertake individual work, even under sheltered conditions, are not normally accepted for admission to Clifton Lodge, but there may well prove to be many who can continue to do useful work at the centre but who cannot go the further stage and work under ordinary factory conditions.

Steps are taken to prevent deterioration in the condition of the patients by ensuring that they take any tablets prescribed whilst attending the centre and regular visits are made by one of the Council's psychiatric social workers, working in close liaison with the supervisor.

The Council plans to open a further centre in the Elephant and Castle area during 1963.

Institute of Social Psychiatry day centres—Since 1949 the Institute of Social Psychiatry has provided a centre, the Blackfriars rehabilitation centre, for the rehabilitation of mentally ill patients and the Council has contributed 90 per cent. of the approved cost of attendance of London patients. It was considered unfortunate that, because there was only one centre, it was necessary for long-term patients to be treated in association with those who were recoverable. In May, 1961, however, the Institute opened a second centre, Crossway rehabilitation centre, which was also grant-aided by the Council on the same basis as Blackfriars. This centre has been adapted to cater for recoverable patients who are capable of simple industrial work and there is special emphasis on work routine and work tolerance, with a view to the patients' eventual rehabilitation in the community. All patients taking part in the work programme at the centre are paid by the hour at a uniform rate, the rate varying according to the income to the centre from the remunerative work being done at the time.

At the Blackfriars centre, which caters for the more withdrawn, long-term patients, the emphasis is on group activities and resocialisation in the group, thus encouraging the patients to live a fuller life outside the centre.

During 1961, 66 persons resident in the London area were admitted to these two centres. At the end of the year there were 50 London patients on the registers, 42 having been discharged during the year, 15 to take up employment or to attend government training centres; 10 were admitted to hospital, 12 were self-discharged and five were discharged for other reasons.

Social clubs—Since 1948 the Council has contributed 90 per cent. of the approved cost of attendance of London patients at the psycho-therapeutic social clubs run by the Institute of Social Psychiatry, of which at the end of 1961 there were nine in London, including a drama group and a youth club. The average weekly attendance at these clubs was 18. The clubs meet one evening a week under the guidance of a psychiatrist and a social therapist.

In addition, the Council gives financial assistance towards the cost of two clubs run by psychiatric hospitals for patients in their catchment areas (average weekly attendance at these is approximately 18) and to a club run by the psychiatric department of one of the London teaching hospitals, which has a weekly attendance of 40 and above. Another psychiatric hospital holds its club in one of the Council's health centres, free of charge. St. Olave's psychiatric day hospital, which is run in conjunction with the Council, has its own associated social club with an average weekly attendance of 30.

The Council runs two social clubs of its own, at each of which the average weekly attendance is about 15. One is in division 9 where there is no other club, the other is run in association with the Council's rehabilitation centre at Clifton Lodge.

The existing clubs are well attended and, although they are all able to accommodate more patients, there would appear to be scope for new clubs in areas where, as yet, no clubs exist. The present clubs can cater for a maximum of 695 patients weekly.

Psychiatric day hospitals—The Council co-operated with the South-East Metropolitan regional hospital board, the Bermondsey and Southwark hospitals group and the Cane Hill hospital management committee in the establishment, from 1 July, 1960, of a psychiatric day hospital at St. Olave's hospital. The Council assumed responsibility for the provision of occupational therapy for those patients in the day hospital who would benefit from it. This entailed the appointment of an occupational therapist, the provision of equipment and materials and the attendance of a social worker. The occupational activities were organised on a wide basis to include, among other things, handicrafts, group discussions and music appreciation. In addition, the Council makes an annual grant towards recreational activities of the patients, such as tennis, net-ball and ballroom dancing, which are considered to be of a therapeutic nature.

It is reported that experience of the working of the day hospital has been very encouraging. It has been possible to treat all types of psychiatric illness in patients who have been able to travel daily from home and it has been found that a number of patients, who would otherwise have needed in-patient treatment, have been catered for satisfactorily as day patients.

A further day hospital for psychiatric patients was established at St. Clement's hospital, towards the running of which the Council's services have contributed.

Experimental scheme of rehabilitation—In 1960 the Council agreed to give substantial financial support to the Institute for Group and Society Development, to undertake a limited experiment in health division 4 in establishing community care services for patients discharged from Long Grove hospital. This experimental scheme consisted of preparing patients in hospital against the time of their discharge and in preparing their relatives and other members of the community to receive them back. Group sessions with patients and relatives, at which hospital staff (medical, social worker and nursing) joined in, were held initially at the hospital and later at a centre in the catchment area. Rehabilitated ex-patients and their relatives were enlisted to help in the scheme by providing temporary foster homes, acting as escorts, joining in social activities etc. The experimental scheme proved to be of great value in pointing the way in which group therapy could be developed as an aid in the rehabilitation of hospital patients. Towards the end of 1961 it was decided, however, that it would not be right to continue the inevitable overlapping of functions with the Council's own divisional mental health team which the scheme entailed. It was therefore agreed that from 1 June, 1962 the development of the scheme would be carried on within the framework of the Council's divisional mental health services.

Occupation and instruction at home—A limited experiment has been conducted for some time in division 9, utilising the part-time services of an occupational therapist who had previously been employed solely on work with tuberculous patients. The therapist devoted three sessions a week to the home teaching and occupation of mentally ill patients and has reported progress with chronic patients. The experiment is reported to have fulfilled much

of its promise and the scheme has been welcomed by hospital doctors and general practitioners. The experiment was later extended to division 1. Thirteen persons were benefiting from this service at the end of the year and consideration was being given to an extension of the arrangements to include other divisions.

Social work in the mental health service

The Principal Mental Welfare Officer reports :

The mentally ill—As applied to mental illness, preventive care in a broad sense covers a very wide field in which all public health and other social services are involved, from the maternity and child welfare clinics to the old people's welfare committees, from the school to the housing office. It is usual to distinguish between preventive and after-care work, but this is often an artificial distinction, for the mental health social worker concerned with community care, as with all after-care, aims at preventing a relapse.

It must be emphasised that the community care service for both the mentally ill and the subnormal is a permissive one, in that the person concerned and/or the relatives have a right to refuse to accept it: there is no question of a power to enforce, even where this may seem very desirable. The only exception to this rule is where the patient is the subject of a compulsory order, which may be during a period of up to six months on leave of absence from hospital or where a guardianship order is in existence, but these together represent a very minute proportion of those receiving community care. It follows that for the service to be effective the mental health worker must aim at securing the goodwill and maximum co-operation of all concerned. This calls for qualities of sympathy and understanding coupled, of course, with the right degree of detachment. It requires the capacity not only to listen but to withdraw at the right moment and also the willingness to work as hard as is required at any given moment. The work is therefore physically and emotionally demanding. The mental health team bears the brunt of this but other social workers in the department are inevitably confronted by mental health problems with which they must deal, not least the Council's health visitors who do a great deal of therapeutic value in the course of their work.

Referrals to the service come from many quarters and the numbers are, as might be expected, steadily increasing. The community has, of course, always carried a heavy burden of mental illness but until comparatively recently the load was lightened by long term incarceration, sometimes for a lifetime. With changed attitudes and—more important—modern methods of treatment (including the use of new drugs), and the decrease in the use of compulsory powers, the average stay in psychiatric hospitals is now very short. On return from hospital, many, although ' cured ', do require the supportive help of somebody who understands without judging and with whom they can make a good relationship; this of course frequently applies to the relatives as well as to the patients. In most cases the sense of stigma attached to hospital admission is still very real and the social worker is able to play a part in offsetting this.

In some cases community care involves frequent and lengthy visits over a period; sometimes long supportive telephone conversations in times of crisis. So far as possible those cases requiring special skills are dealt with by the psychiatric social workers but the bulk of the work inevitably falls to the mental welfare officers. Where there is a psychiatric social worker employed as such, he or she is available for consultation if mental welfare officers so wish in cases of special difficulty. In four divisions the divisional mental welfare officer is a qualified psychiatric social worker. Any possible steps to prevent further breakdown or to assist rehabilitation are taken. These may include persuasion to attend a day centre, an out-patient clinic, a day hospital or perhaps an evening club; it may mean arranging a recuperative holiday or making special contact with the employment exchange or the National Assistance Board or any other assisting agency. It may also include finding a hostel vacancy. The social worker is frequently in a position to recognise early signs of

potential breakdown (which may be due to failure to continue drug treatment or increase of family stress or any other factor) and may, by timely liaison with the general practitioner or out-patient clinic, be able to avert the necessity for in-patient treatment.

One effect of the new Act, with the consequential expansion of the community care service, is that inevitably a great variety of people with mental health problems are referred from many sources. For a number of these no very constructive help is possible but it is nevertheless impossible to shelve responsibility entirely, except in a very limited number of 'hopeless' cases. For the remainder, time and energy is often spent fruitlessly but unavoidably.

A number of mentally ill (also subnormal) adults find their way into London from the provinces; some of these have spent earlier years in psychiatric hospitals. Before the establishment of a community care service, many floated more or less happily from lodging house to lodging house, only coming to the notice of the authorities if they appeared before the Courts; a number are now referred to the mental welfare officer. In some cases it is possible to help constructively but many have well established wandering habits and have become unemployable. Frequently they are not sufficiently ill mentally to be made the subject of compulsory orders and there is a tendency to wander in and out of hospital voluntarily. This is also the pattern of life of many of the mentally disordered who are Londoners and the burden is shared by all agencies, voluntary or otherwise, concerned with the homeless and destitute, including of course the Council's Welfare department. Bodies such as the Salvation Army and the Church Army provide temporary and sometimes permanent havens for them and co-operate with the mental health workers in efforts at rehabilitation.

The severely subnormal—Mental welfare officers remain in close touch with all severely subnormal children and also the small number of children who are not severely subnormal but are reported under sec. 57 of the Education Act, 1944 (as amended by the Mental Health Act). By visits to the homes they are in a position to assess the situation and to recommend short term care in times of crisis or when the family need a rest from the demanding care of such children. It is also the function of the officers to explain more permanent hospital care to enquiring parents and to help them to come to terms with the problem whilst awaiting a hospital vacancy—frequently a very long wait.

They play an active part in explaining the value of training-centre training and in persuading any reluctant parent to agree to the child attending. They also attend medical examinations at the centres and in most cases arrange for any necessary treatment. A number of officers attend centre open days; these affording valuable opportunity for fostering good relationships with the family and liaison with centre staff.

Closeness of contact is usually maintained by mental welfare officers through the adolescent and adult years of the severely subnormal person, when the problems frequently become accentuated by the illness and increasing age of the parents.

The subnormal—The majority of cases coming within this category are those who have attended schools for the educationally subnormal, leaving at 16 years of age. Most of these boys and girls are capable of unskilled or semi-skilled employment and the majority live at home. An after-care service is offered to the parent, just prior to the boy or girl leaving school; if accepted, visits are paid to the home at fairly regular intervals or as the need arises, until the mental welfare officer, the parent, or perhaps the boy or girl feels that this is no longer necessary. The amount of help required depends as much, if not more, upon the degree of stability of temperament as of that of subnormality. The service is partly advisory and the social worker may have to deal with any general or specific matters affecting the young people's welfare. This covers a wide range, from pocket money to income tax, from matters affecting employment or recreational activities to how to deal with potential delinquency. More concrete help is given as the need arises; this may take the form of limited financial help, arranging holidays or attendance at clubs, sometimes making alternative living arrangements when the home situation breaks down.

Although friendly supervision is discontinued at about the age of 18 (unless active assistance is still required), a number come to notice again at a later stage, sometimes some years later, when further help is required. This may arise from such factors as homelessness following the death of a parent, appearance before the courts, illegitimate pregnancy or sometimes problems following on marriage. In all such cases, any possible help or guidance is given. This also applies to those subnormal persons returning to the community after a period of hospital care, when efforts are made to assist rehabilitation.

The maladjusted school-leaver—After-care of the children leaving the schools for the maladjusted is now the responsibility of the public health department. Some of these children require little if any follow-up, having made a good adjustment during the last months at school; others require help in varying degrees from placing in suitable lodgings to arranging attendance at a psychiatric clinic or admission to hospital. The service includes giving supportive help to the family, landlady or hostel staff as the case may be. With children who are in the Council's care there is liaison between the mental health social worker and the child care officer as and when the need arises, the mental welfare officer taking over normally at the age of 18 if continuing help is required. This applies also to the subnormal.

Hostel placing : Dover Lodge—The main bulk of the social work connected with this hostel for up to 13 sub-normal girls in work falls mainly on the division in which it is situated, although mental welfare officers from other divisions play their part where they have a special relationship with the girls or their families. Close contact is maintained with the hostel and it falls to the lot of the social worker to find alternative placement when girls are ready to leave or are found unsuitable for retention there. The role of the social worker includes close co-operation with the Youth Employment service, child care officers and, of course, the staff of the hostel on anything concerning the general well-being of the girls; this includes employment conditions, recreational activities, holiday arrangements and general social training. The girls admitted to Dover Lodge are almost invariably those with either no home or homes into which they cannot fit satisfactorily. They are often lacking in a sense of security and sometimes with consequent delinquent tendencies. As a result, what may appear *prima facie* to be a disproportionate amount of the social workers' time and effort has to be spent on work at this hostel. This will probably apply also to future hostels, whether for the mentally ill or the subnormal.

Hostels of voluntary bodies—The foregoing applies, to a lesser extent, to those boys and girls maintained in hostels run by bodies such as the National Association for Mental Health, the Church Army, etc; while the mental welfare officer is not quite so involved during the stay at the hostel, there is usually a great deal of community care work to be done subsequently, sometimes for many years on any one particular case. One such lad, since leaving the hostel, has been placed by the mental welfare officer concerned four times in lodgings, once in resident employment, three times in other employment and twice in other hostels. Each of these placings represents much time-consuming effort on the part of the social worker and this pattern seems likely to continue.

The educational role of the mental health team—One valuable effect of divisionalisation of the service has been the closer contact and liaison with general practitioners, out-patient clinics, day hospitals, health visitors and other social workers, and the various social agencies, with the resultant exchange of ideas and information and improved mutual understanding. The mental welfare officers have actively participated in the meetings held at divisional level to which general practitioners and others were invited. During the year the Principal Mental Welfare Officer, her deputy and the divisional mental welfare officers (in some cases their deputies or the psychiatric social worker) have given talks on mental health to various local groups, including health visitors and other social workers, mothers' meetings, branches of the Society for the Mentally Handicapped, Rotary clubs and groups concerned with old people's welfare, etc.

In the wider field talks have been given to the mental health students at the London School of Economics; to students at the Royal College of Nursing; at the course for training centre teachers and regularly at the nurses school of the Maudsley Hospital. During the year officers have met various interested visitors from abroad to explain and discuss with them the Council's mental health service.

It can be said that the educational role of the mental welfare worker is an important one in view of the need to promote a greater understanding and acceptance of mental disorder; this is fully appreciated by the mental welfare staff.

Statistics

Statistical tables detailing the work of the mental health services during 1961 are set out below. Various salient features of this work are discussed and certain comparisons made with 1959 (the last complete year before the operation of the Mental Health Act, 1959).

Total number of referrals—The total number of mentally disordered persons referred to the mental health social workers during 1961 was 8,258, of which 7,158 were referred as ' mentally ill ' and 1,100 as ' subnormal ' or ' severely subnormal '. In 1959, persons so referred numbered 8,110, including 7,241 ' mentally ill ' and 869 ' subnormal ' or ' severely subnormal '.

Sources of referrals—Table (i) gives a detailed analysis of the sources of referrals in relation to (*a*) mentally ill persons (other than those specifically referred for community care), (*b*) mentally ill patients referred specifically for community care and (*c*) mentally subnormal and severely subnormal patients. About 40 per cent. of the referrals under (*a*) were received from general practitioners, 12·9 per cent. from police or courts, 14·8 per cent. from psychiatric sources (compared with 8·9 per cent. in 1959). The proportion of such referrals from hospital wards and casualty departments without prior referral to psychiatrists fell from 19 per cent. in 1959 to 10·8 per cent. in 1961. Of mentally ill patients referred specifically for community care about one third were referred from hospitals, one fourth from other Council services and one tenth from general practitioners.

TABLE (i)—*Sources of referral of all cases*

	Mentally ill				*Subnormal and severely subnormal*		*Total*	
	With a view to hospital admission		*Community care*					
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Psychiatric hospital or ward	467	8·1	398	28·3	104	9·5	969	11·7
Psychiatric out-patient clinic or day hospital ..	147	2·6	67	4·8	7	0·6	221	2·7
Psychiatrist at general ward, casualty dept., etc. ..	236	4·1	—	—	—	—	236	2·9
Non-psychiatric referrals from hospitals ..	619	10·8	38	2·7	65	5·9	722	8·8
General practitioner ..	2,312	40·2	140	9·9	16	1·5	2,468	29·9
Police or Court	741	12·9	7	0·5	29	2·6	777	9·4
Other medical sources ..	77	1·3	28	2·0	111	10·1	216	2·6
Non-medical sources:								
Patients' relatives, neighbours, etc.	1,151	20·0	173	12·3	—	—	2,649	32·0
Education Service ..			107	7·6	570	51·8		
Other Council services			224	15·9				
Government agencies ..			51	3·5				
Voluntary organisations			110	7·9				
Miscellaneous			65	4·6	198	18·0		
	5,750	100·0	1,408	100·0	1,100	100·0	8,258	100·0

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Applications with a view to removal to hospital of mentally ill persons—Mental welfare officers received 5,750 applications for visits to persons alleged to be suffering from mental illness, with a view to arranging admission to hospital. The applications concerned 4,839 persons, 581 being referred on two occasions and 145 on three or more occasions; 58 per cent. of the applications related to females and 42 per cent. to males. These numbers show a reduction of 1,130 applications (739 individuals) compared with 1959. Table (ii) gives details of the initial action taken on these applications and also the final disposal. No further action was found to be necessary in 21·9 per cent. of all cases investigated, compared with 23 per cent. in 1959.

TABLE (ii)—*Initial action and final disposal of mentally ill persons referred to mental welfare officers with a view to removal to hospital*

	Initial action		*Final disposal*	
	No.	*%*	*No.*	*%*
Informal admission	899	15·6	2,306	40·1
Compulsory admission:				
For observation (sec. 25)	903	15·7	—	—
Emergency admission for observation (sec. 29)	1,841	31·9	—	—
For treatment (sec. 26)	116	2·0	497	8·6
By police (sec. 136)	232	4·0	—	—
Court order	147	2·6	156	2·7
Absent from hospital without leave (sec. 40)	3	0·1	5	0·1
Psychiatric out-patient clinic or day hospital	170	3·0	170	3·0
General ward for physical care	43	0·8	66	1·2
Community care from general practitioner, Welfare dept., etc.	109	1·9	110	1·9
No further action	1,258	21·9	2,285*	39·7
Other action	29	0·5	29	0·5
Not known	—	—	126	2·2
	5,750	100·0	5,750	100·0

* *Includes 933 discharged after a period of observation, 68 deaths and 25 withdrawn or absconded.*

Admission to hospital of mentally ill persons—Arising from the applications referred to in the preceding section, 4,141 mentally ill persons (71·9 per cent. of the total number referred) were admitted to hospital. Table (ii) analyses the numbers of patients removed compulsorily to hospital under the various sections of the Mental Health Act, 1959 and shows the number of formal admissions.

The proportion of compulsory removals for observation (the majority) or for treatment was high and much use was made of sec. 29 of the Mental Health Act. A further analysis in table (iii) shows the position for the two age groups—under 65 years and 65 years and over.

TABLE (iii)—*Hospital admissions dealt with by mental welfare officers informally or under secs. 25, 26 and 29 of the Mental Health Act, 1959*

	Initial disposal to hospital						*Final disposal to hospital*					
	Under 65 years		*Over 65 years*		*Total*		*Under 65 years*		*Over 65 years*		*Total*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Informal admission	668	22·0	229	32·4	897	23·9	1,783	80·0	515	91·3	2,298	82·2
Compulsory admission:												
For observation (sec. 25)..	685	22·5	215	30·5	900	24·0	—	—	—	—	—	—
Emergency admission (sec. 29) ..	1,583	52·1	250	35·4	1,833	49·0	—	—	—	—	—	—
For treatment (sec. 26) ..	103	3·4	12	1·7	115	3·1	447	20·0	49	8·7	496	17·8
Total ..	3,039	100·0	706	100·0	3,745	100·0	2,230	100·0	564	100·0	2,794	100·0

It will be noted that the major use of sec. 29 was in relation to those under 65 years of age but that about two-thirds of the ' 65 and over ' age group who appeared to need psychiatric hospital care, even temporarily, were removed compulsorily. Prior to the full introduction of the Mental Health Act, 1959 there were voluntary patients and some informal admissions, whilst others were admitted under three-day orders, urgency orders, temporary certificates or sec. 14/16 of the Lunacy Act. Voluntary patients are now referred to as informal patients and sections 29, 25 and 26 replace the various orders and certificates stated above.

Although, in the case of patients under 65 referred to mental welfare officers, there was a reduction in the proportion of compulsory admissions, i.e., from 89·4 per cent. of total cases removed in 1959 to 78 per cent. in 1961, the reverse took place in the age group ' 65 and over ', i.e., a rise from 63 per cent. to 67·6 per cent. Reasons for this require further investigation, bearing in mind also that whereas the proportion of total cases seen by mental welfare officers which resulted initially in informal or compulsory admission to hospital was the same for the under 65's in 1959 and 1961, it rose from 60·9 per cent. in 1959 to 65 per cent. in 1961 for the elderly group.

Bearing in mind the comments on initial disposal, particularly with regard to the elderly, the comparative percentages for patients retained in hospital under compulsion (table iii) were as follows:

	Under 65	*65 and over*
	%	*%*
1959	31·9	31·2
1961	20·0	8·7

These comparisons show that in 1961 there was a major reduction in the percentage of elderly persons retained in hospital compared with the increased initial compulsory rate already referred to. These factors will be taken into account in carrying out the further investigation referred to above.

Admissions to the five emergency wards in general hospitals within the county area fell from 2,977 in 1959 to 1,442 in 1961. The increase in the statutory period of observation from 17 to 28 days introduced by the new Act and the numbers of patients now admitted informally to these wards with no restriction on their period of stay have affected the position, in that increasing numbers of patients are now being admitted for observation to psychiatric hospitals outside the area, often remote from their residences. There were 1,750 patients so admitted in 1961.

Community care—Persons suffering or suspected to be suffering from mental illness referred specifically for community care through the mental health services during 1961 totalled 1,408, compared with 361 such persons in 1959. Table (iv) shows the action taken relating to these referrals.

TABLE (iv)—*Disposal of cases suffering or suspected to be suffering from mental illness referred specifically for community care during* 1961

	No.	*%*
Hospital care:		
Informal admission	32	2·3
Compulsory admission	6	0·4
Psychiatric out-patient clinic or day hospital	20	1·4
Community care of mental health service ..	1,113	79·1
Other community care, e.g., Welfare or Children's dept., general practitioner, probation officer, etc.	61	4·3
No further action	176	12·5
No. of persons involved..	1,408	100·0

At the end of 1961, 1,321 mentally ill persons and 4,732 mentally subnormal or severely subnormal were receiving some form of community care. Table (v) analyses the various types of care being given, from which it will be seen that 5,724 persons were being visited by mental health social workers, 304 were being provided with residential accommodation and 1,430 were receiving training at day centres or in their own homes.

TABLE (v)—*Persons receiving community care at* 31.12.61

Type of care received	*Mentally ill*	*Mentally subnormal or severely subnormal*						*Grand total*
		Under 16 years		*Over 16 years*		*All ages*		
		No.	*%*	*No.*	*%*	*No.*	*%*	
Residential home, hostel, convent, etc.	165	15	1·1	57	1·7	72	1·5	237
Boarded out	—	4	0·3	63	1·8	67	1·4	67
Home training	13	18	1·4	22	0·6	40	0·8	53
Attendance at day centres for mentally ill	85	—	—	—	—	—	—	85
Attendance at social clubs for mentally ill* ..	67	—	—	—	—	—	—	67
Training centres for subnormal and severely subnormal	—	719	55·1	573	16·7	1,292	27·3	1,292
Receiving visits from m.w.o. or p.s.w. ..	1,132	1,267	97·0	3,325	97·1	4,592	97·0	5,724
Other types of community care	12	23	1·8	29	0·8	52	1·1	64
No. of persons involved ..	1,321	1,306	100·0	3,426	100·0	4,732	100·0	6,053

* *Some patients who are not included were attending clubs which receive financial or other help from the Council.*

Referrals of mentally subnormal and severely subnormal persons—Of the 1,100 mentally subnormal and severely subnormal persons referred to the mental health services during the year (table (vi)), 127 (11·6 per cent) related to children who had been found unsuitable for education at school and 443 (40·2 per cent) were school-leavers. Residential accom-

modation was provided in 36 cases and in 102 cases arrangements were made for attendance at a training centre. At the end of the year 1,267 children under 16 years and 3,325 persons over 16 were being visited by the mental health social workers.

TABLE (vi)—*Mentally subnormal and severely subnormal persons referred during* 1961

Disposal of cases			*No.*	%
Hospital care			49	4·5
Community care of mental health service:				
Residential home, hostel, convent, etc.	36			
Attendance at training centre	102			
Receiving visits from mental welfare officer	904		926	84·1
Other types of community care	30			
Other community care, e.g., Welfare or Children's depts., general practitioner, probation officer, etc.			22	2·0
No further action			86	7·8
Miscellaneous			17	1·6
			1,100	100·0

Conclusion

From the foregoing paragraphs it will be apparent that the Council has given very careful consideration to the duties placed on local health authorities by the Mental Health Act, 1959; that real progress has been achieved in improving and expanding the services for the care and training of mentally disordered persons in the community; and that the implementation of future proposals, already planned, will go some way towards meeting the recommendations of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency.

As the number of mentally disordered persons living in the community increases, however, the demand for the facilities provided by the Council will inevitably grow and the development of the mental health services to meet this demand will place increasing responsibilities on the Council. In the immediate future it will not be possible, for various reasons, e.g. shortage of staff and difficulties in obtaining sites and buildings, for the Committee to meet all its obligations under the Mental Health Act, 1959.

As already stated, one of the most onerous tasks facing the Council is the provision of residential accommodation. It is unlikely that sufficient accommodation can be provided for some years to come to permit of appropriate care being given for the large numbers of persons, both in hospital and in the community, for whom the special facilities of the hospital services are not essential. In the meantime, it is hoped that hospital authorities will be forbearing in avoiding too rigid an interpretation of the duties now placed on local health authorities in this regard.

There is no doubt that the efficiency of a local health authority's mental health services depends upon close co-operation both within the authority's own services and with outside agencies. Mutual consultation and exchange of information and ideas are essential if the fullest development is to be achieved. In London arrangements have been made for the divisional medical officers to establish links with the psychiatric hospitals and general practitioners serving their areas, by means of visits by medical staff and social workers to the hospitals and of local meetings of general practitioners to which the physician superintendents of the hospitals have been invited. Achievement of the maximum degree of personal contact with hospital staffs has been hampered to some extent by the location of the psychiatric hospitals, most of which are a long way from their London catchment areas. The future provision of psychiatric beds in general hospitals would not only be of benefit to relatives in avoiding long journeys to visit patients in out-county hospitals but would also have the great advantage of fostering closer relations between the staff of hospitals and the

Council's mental health social workers. Nevertheless, a good understanding between the two sides has been established and as more trained social workers become available it is hoped to foster closer relations with the hospitals.

An informal joint advisory committee of officers, whose members are drawn from the various hospital, consultant and general practitioner interests, was set up in 1960 to advise on the development of the mental health services, including co-operation with other bodies concerned and has served a very useful purpose. The co-operation of voluntary agencies concerned in the field of mental health has also been invaluable in the developments so far achieved and it is the Council's intention in its future planning to foster further co-operation with and assistance from these agencies.

The Council's plans for the future provide for a continued expansion in the community care of mentally disordered persons for whom such care is appropriate, with the ultimate aim that all such persons should receive the necessary care and supervision in their own homes or in day or residential establishments according to their particular need.

APPENDIX B

THE HOME NURSING SERVICE IN LONDON

Introduction—It is exactly thirty years since Dr. Margaret Hogarth produced her comprehensive report on home nursing in London*—thirty years which have seen far-reaching advances in the practice of medicine, a shift in the age distribution of the population and vast improvements in the living and working conditions of the people. Another major change has been the development of the personal health services as well as the availability of free medical and nursing service to all, with specialist consultation when necessary. These changes have completely altered the pattern of district nursing.

When the National Health Service Act, 1946 came into force the structure of the home nursing service in London remained the same and in 1961 the service was still provided by voluntary associations. The work of these associations is co-ordinated by the Central Council for District Nursing in London, which was set up in 1914 for this purpose. From 1948, when the Council became responsible for the service, the Central Council has acted as the Council's intermediary with the associations. Except in the case of the Catholic Nursing Institute, the Council since 1948 has paid an increasing proportion of the approved expenditure of the district nursing associations; since 1954 this has amounted to 93 per cent. The total grant disbursed through the Central Council for District Nursing in 1960/61 was £531,786; in addition the Council made a deficiency grant of £7,000 to the associations.

The home nursing service in London is provided by 25 district nursing associations, which in the main still base their work on residential staff homes; 20 are affiliated to the Queen's Institute of District Nursing. The Ranyard Nurses, together with an affiliated association (Norwood) cover a large part of London and have traditionally employed nurses working from their own homes in the areas of practice. Two other associations not affiliated to the Queen's Institute are the Nursing Sisters of St. John the Divine, who work in the areas of Poplar and Deptford, and the Catholic Nursing Institute in Southwark, which receives from the Council an *ad hoc* grant of £900 a year. Both these associations work from residential homes. A further independent association, Stoke Newington, is non-residential. A detailed list of the associations will be found at the end of this article.

Staff—

Staff employed by district nursing associations at 31st December, 1961

	Whole-time	*Part-time*	*Total*
Superintendents	25	—	25
Assistant superintendents	18	10	28
Senior nurses	2	—	2
State registered nurses—			
district trained	334	32	366
not district trained	93	36	129
	427	68	495
Male nurses (included above)	38	—	38
State-enrolled nurses	22	13	35
Nursing auxiliaries	—	2	2

Since the National Health Service Act, 1946 came into force, one of the changes in staffing has been the entry into the domiciliary nursing field of the male nurse and the state-enrolled nurse, both of whom are now well established as highly valued members of the staff. The Council's view is that the ratio of one state-enrolled nurse to five state-registered nurses might ultimately be reached—the present ratio is one to 14.

* *Survey of District Nursing in the Administrative County of London.*

There has also been a considerable change in the attitude of the nurse herself towards her work, which she now tends to regard more as a professional career than a vocation. Hence the nurse with a private life of her own no longer looks to the district nursing associations to provide accommodation in a residential home. By the end of 1961, excluding superintendents and midwives, only 81 nurses (16·6 per cent.) were living in district homes.

The bicycle has remained the normal means of transport of the home nurse in London but cars have been made available by the Council, in the first instance to associations undertaking midwifery and later also to other associations for the use of superintendents and other staff. In some cases where local conditions warranted or when unusually large areas had to be covered, as is often the case with the male nurse, car allowances have been paid to nurses who have used their own cars. Mileage allowances are paid to any nurse who uses her own scooter and crash helmets provided by the associations have ranked for grant.

Midwifery and maternity nursing—Ten district nursing associations undertake domiciliary midwifery as agents of the Council, employing 43 midwives for the purpose. This number includes the supervisory staff who do relief work for the practising midwives within the association. Reciprocal relief is also supplied by the Council's own midwives.

In 1931 four teaching hospitals in London arranged for district nursing associations to nurse midwifery cases after home delivery by medical students. These arrangements have long since disappeared, although since 1960 the Metropolitan District Nursing Association has again taken medical students from Charing Cross hospital to their patients on the district. The nursing organisations were also called upon thirty years ago to nurse cases of puerperal fever and maternity complications referred from the domiciliary midwifery service. Only the occasional pyrexia of unknown origin is now referred from the domiciliary midwifery service.

On the other hand, there has been a growing tendency for maternity hospitals to discharge patients 48 hours after delivery because of the tremendous demand for beds; in London this is far in excess of the 70 per cent. recommended by the Cranbrook Committee. It has for long been the practice for hospitals to refer patients discharged before the tenth day to the superintendents of district nursing associations, as each has some staff with the qualification of the Central Midwives Board who can be deployed to nurse these cases under the guidance of the general practitioner.

With ever-increasing pressure from the maternity hospitals the Council, having in mind the necessity for the pre-selection of cases for early discharge, has tried out pilot schemes with Hammersmith, St. Mary's and Lewisham hospitals of acceptance of cases for maternity nursing by the Council's own midwives. By the end of 1961 it was decided to recruit part-time relief midwives to the Council's staff, in the proportion of one to six full-time midwives. These part-time midwives will provide relief to cover the extended holiday period awarded by Whitley Council and the week-end off-duty period for each midwife once per month proposed by the Council, and will take over the nursing of maternity patients discharged before the tenth day from maternity hospitals. When the full number of part-time midwives has been recruited, the district nursing associations not undertaking midwifery will be relieved of the duty to take maternity nursings.

Training—The Queen's Institute of District Nursing at 12 district homes and the Ranyard Nurses have provided general district nurse training for many years. The Council has now adopted the shortened courses recommended in the majority report of the Working Party on the Training of District Nurses, 1953. In this connection it is perhaps interesting to reflect that Dr. Hogarth in her report in 1931 said ' six months seems a long period of training for a nurse who has completed three years' hospital training, and more often than not has in addition taken her C.M.B. certificate involving another period of six months'. In 1961 the Queen's Institute of District Nursing and the Ranyard Nurses combined to give a joint theoretical training at two district homes, the nurses taking their practical course on the district as before; 64 nurses had district nurse training during 1961.

Ten district nursing associations, nine of which are affiliated to the Queen's Institute of District Nursing, provide three months' district experience for pupil midwives taking Part II midwifery training. Two of these associations, the Camberwell District Nursing Association and the independent Nursing Sisters of St. John the Divine, are approved Part II training schools and for the present have been able to give their pupils six months' district experience.

The Council has authorised the attendance of superintendents and of home nurses at appropriate refresher courses run by the Queen's Institute of District Nursing, the Ranyard Nurses and the Royal College of Nursing each year. Since 1955 the Council itself has run a two-day course and subsequently five-day courses for home nurses in London, alternating with Ranyard Nurses for this purpose.

Statistics—The associations make quarterly statistical returns to the Council. There has been a steady decline in the last few years in the number of patients nursed and in the visits paid. The following table shows the work done in the last five years.

Work done by district nursing associations in London, 1957–1961

	1957	*1958*	*1959*	*1960*	*1961*
Staff—					
Total number of nurses employed	563	539	546	551	530
State-enrolled assistant nurses (included above)	30	33	34	34	35
Whole-time equivalent	522	496	507	508	492
Visits—					
Type of case—					
Medical	1,647,319	1,563,599	1,427,302	1,351,815	1,281,293
Surgical	210,477	211,261	218,895	232,988	221,543
Infectious diseases	1,807	907	1,766	1,506	2,536
Tuberculosis	82,620	71,012	69,309	59,415	51,000
Maternity complications	5,441	6,710	7,461	7,626	8,547
Other	43,957	40,064	38,563	36,734	36,941
Total	1,991,621	1,893,553	1,763,296	1,690,084	1,601,860
To patients' homes for—					
Injections only	968,506	856,840	718,335	614,053	546,959
Injections and other treatment	108,715	111,555	102,037	85,571	89,358
Other treatments only	880,504	890,540	904,752	953,950	930,413
Average number of visits—					
To each patient	30	30	31	33	33
By each nurse	3,815	3,818	3,478	3,327	3,256
Patients—					
Types of care—					
Medical	56,091	52,222	47,464	41,914	39,756
Surgical	6,126	5,937	5,928	5,735	5,434
Infectious diseases	276	142	214	144	220
Tuberculosis	1,742	1,395	1,269	1,134	997
Maternity complications	714	862	982	1,047	1,396
Other	2,220	1,558	1,511	1,351	1,334
Total	67,169	62,116	57,368	51,325	49,137
Average case load per equivalent whole-time effective* nurse at end of year	27	24	23	24	22
Completed treatments	56,395	53,359	49,299	43,118	41,010
Long-term cases†—					
Number	14,598	11,769	11,225	9,628	10,236
Percentage of total patients nursed	21·7	18·9	19·6	18·8	20·8

* *Allowing for holidays and sickness.*

† *Visited more than 24 times during the year.*

Interchange of information between general practitioners and the home nursing service—There are two entirely distinct but equally important aspects of the interchange of information between these two services. One relates to the availability of local health authority services and how they can be obtained. This is covered by the issue from time to time of an information booklet to, among others, all general practitioners in the county, with a local appendix which gives details about the services in each division. In the same way and in the same format the Welfare department issues information on the welfare services for the handicapped.

The other aspect covers the means of direct communication between the family doctor and the nurse on individual cases. Here the traditional pattern persists. The doctor establishes communication by telephone with the nurse at the district home or office and leaves written instructions on the case at the patient's house. The nurse enters her report on the same sheet. The old method of leaving notes in local shops has, however, completely disappeared.

In all associations every case must be nursed under the care of a general practitioner and not more than two visits of observation may be paid before a doctor is called in.

Each nurse is now responsible for her own case records on standard cards, which were designed in 1957 by the Public Health department in consultation with the Central Council for District Nursing.

The changing pattern of home nursing—What are the salient changes in the work of the home nurse during the last thirty years? In the first place she now serves all sections of the community, in contrast to her predecessor in 1931 who provided nursing mainly for the sick poor—' and only in exceptional circumstances, as when a doctor made a very special request for the services of a certain district nurse, did a district nurse attend a patient able to pay the usual five shillings a visit for a private nurse '. Another important change brought about by the National Health Service Act, 1946 has been the gradual breaking down of the isolation of the home nurse and the recognition of her place with the health visitor, the midwife and the home help in the local authority team. This integration has been helped by the fact that the divisional medical officer is a member of the committees of the district nursing associations in his area and by the setting up of divisional home nursing committees. In 1955 the Council also appointed a supervisor of midwives with special liaison duties in connection with the home nursing service. A principal medical officer and the Chief Nursing Officer sit as observers on the executive committee of the Central Council for District Nursing in London.

In a service so largely financed from public funds the home nurse has been able to draw readily on up-to-date equipment, unlike her predecessor in 1931 who often spent hours on the improvisation of containers, making of bags, etc. In the past, too, the home nurse had to depend solely on voluntary resources for many essential needs of her patients. In an era of full employment, patients are better housed and in the main are able to provide for themselves the linen, blankets and even food which once the home nurse had to try to bring to them. However, the demand for specialised nursing equipment to be used in the patient's own home has, if anything, increased with the growing complexity of medical and nursing procedures. The Council makes grants for this purpose to the British Red Cross Society, which maintains medical loan depots in certain parts of London. At the request of the family doctor, the Council also supplies hoists and other lifting aids, wheel-chairs, cardiac beds, walking aids, etc., free of charge. A nominal deposit (returnable) is required for each article borrowed.

A permanent exhibition of gadgets and other aids for the handicapped is maintained by the Welfare department of the Council and is open to all general practitioners, Council's staff or relatives of handicapped persons for advice and guidance on the supply or making of these aids. In addition, adaptations and special fittings have been installed in patients' homes by the Welfare department.

District nursing associations have co-operated with the Council in the experimental use of disposable syringes and incontinence pads. It is not possible to estimate from small scale experiments how much staff time and work could be saved by the introduction of disposable equipment on a large scale, but it is evident that over a long period some saving is to be expected.

The introduction of sulphonamide therapy and antibiotics have replaced the long treatments for abscesses, whitlows or excision of carbuncles which were once the daily task of the home nurse—and puerperal fever, then the commonest cause of maternal death, is now almost unknown on the district. In 1961, of 1,566,730 home visits paid by home nurses in the county, 546,959 (35 per cent.) were for injections only; a further six per cent. were for injections and other treatment. These included injections of mersalyl which have banished the water-bed which had to be refilled every two weeks, the treatments by paracentesis and the care of pressure points to prevent the bed-sores, to which the oedematous patient with chronic nephritis or cardiac failure was so prone. Pneumonia in 1931 meant poultices, steam kettles and the anxiety of the ' crisis '. The treatment of diabetes, too, is becoming less exacting of the nurse's time. Many new patients, including children, now learn to give their own injections and some older patients can be satisfactorily maintained on oral treatments, so that the nurse in these cases takes on a supervisory role.

The most striking change, however, in the day-to-day work of the home nurse has been the shift in the age range of her patients.

Age distribution of patients nursed at home

	1931	*1961*
	%	%
0– 5 years	19·5	5
5–14 years	20	39
15–65 years	42	
Over 65 years	18·5	56

The general improvement in the hygiene and health of children brought about by the maternity and child welfare and school health services is reflected in the marked decline in 1961 in the number of children who have needed nursing care at home. One reads, almost with incredulity, that in 1931 home nurses gave many rubbing treatments to children with rickets, having received special training in this technique at Guy's hospital. Modern drug therapy for worms has replaced the enemata of infusions of quassia. The infectious diseases of childhood have been largely brought under control by immunisation programmes, so that the severe complications which were then treated by inhalations, steam kettles and poultices have almost disappeared from district practice. There were, too, babies suffering from ophthalmic infections or pemphigus referred from the domiciliary midwifery service. Otorrhoea was commonplace and home nurses in London attended school treatment centres each morning to treat these cases, a daily attendance of 70 children at one centre—mostly with otorrhoea and some eye affections and sores—having been recorded. The London County Council in 1931 maintained centres throughout the county for the operative treatment of tonsils and adenoids, where children were retained for two nights before being sent home for nursing care by the district nursing associations. In addition, many children had operative treatment in hospitals outside the Council's scheme and these children were sent home the same day for nursing care at home.

In 1961 these centres for tonsillectomy, like the special hospitals for severe cases of ophthalmia neonatorum or bone tuberculosis, had long since disappeared. The 2,236 children under five years of age treated by the home nursing service in 1961 represent only 5·4 per cent. of the total case load.

Children treated by the Metropolitan District Nursing Association in 1961

Disease	*Children under five years of age*		*Schoolchildren*	
	No.	*Injections only*	*No.*	*Injections only*
Diarrhoea and enteritis	1	—	—	—
Other diseases of digestive system	5	—	—	—
Boils, abscess cellulitis, other skin infections	3	—	2	1
Diseases of bones and organs of movement	1	—	—	—
Circumcision	6	—	—	—
Burns and scalds	4	—	—	—
Inflammatory C.N.S.	1	1	—	—
Infectious diseases	5	—	1	—
Otitis media	16	4	7	3
Other ear	9 (25)	1	1 (8)	
Pneumonia	4	1	—	—
Bronchitis	9	6	1	1
Tonsillitis	11	6	2	—
Pharyngitis	1 (37)	—	— (4)	—
Enlarged glands	2	1	1	—
Other respiratory	10	6	—	—
Total	88	26	15	5

Age analysis—			
Under 1 year	18	Age 5	14
1 year	19	6	1
2 to 4 years	51		
Total	88		15

It is interesting to note that cases treated were almost all acute illness.

If the home nursing service is no longer concerned to any great extent with paediatric nursing, this is more than offset by the rise in the demand for home nursing of the elderly. In 1931 there were 321,000 persons over 65 years of age living in London; by 1961 this number had increased by 25 per cent. to 401,000. However, prolonged expectation of life has brought an increasing liability with advancing age to degenerative diseases and associated deformities. While there was no real evidence that families were less willing to look after their old people in 1961 than they were thirty years ago, smaller families have meant fewer young people to look after them and economic opportunity has taken the young away from home. It is recognised that it is the home nurse, with her colleague the home help, who has made it possible for many old people, who would otherwise have had to go into residential homes, to remain much longer in the community. In her daily work with the elderly sick the home nurse gets the patient up as early as possible, tries to preserve function however limited this may be and helps the patient to do whatever he is capable of doing. Comprehensive statutory and voluntary services have been made available throughout the county for the rehabilitation of the elderly sick, to counteract loneliness and to bring colour and interest into the patient's life. The home nurse has worked closely with the health visitor to bring these services to the patient.

In other age groups the home nurse has attended mainly acute illness and has been especially helpful to the general practitioner in carrying out diagnostic procedures in the early stages of illness. Nursing visits to the home traditionally have had an educational value, for the occurrence of illness brings to the relatives a ready receptiveness of the means of prevention, teaches them to take temperatures and carry out other simple nursing procedures and to observe the signs of change. Relationships within the family are no less important and the home nurse may have to use her influence to prevent over-coddling, to calm the patient who has to be isolated of his fear of loss of affection, or to give relatives

some basic knowledge of the disease so that they can understand the patient's special needs. Terminal cancer has often been nursed at home and in these cases the home nurse has had not only to help the patient but also to support the relatives in their distress and allay their fears. A special branch of the home help service was set up in 1952 to provide sitters-in for two nights each week, to allow relatives the opportunity to sleep. The demand has been surprisingly low, only 17 home helps were provided under this scheme in 1961. The Marie Curie Foundation also provides sitters-in for these cases on the request of the family doctor.

The shift of emphasis from hospital to the community care of mentally disordered patients, since the Mental Health Act, 1959 came into force, has already had some repercussions on the home nursing service. Senility was commonly a reason for repeated visits by the nurse. Home nurses, too, have been called in to supervise the administration of drugs to mentally ill patients discharged to their own homes, particularly in the first weeks when relatives have not been able to cope or have gone out to work. Clearly the responsibility for the care of mentally ill patients on discharge from hospital is laid on the general practitioner, but it is still an open question whether he should call on the new divisional mental welfare officers or the home nurse to help him in this task.

Conclusion—Undoubtedly the home nurse of today has a different but no less valuable role than her predecessor of thirty years ago. The standard of nursing is high and health education, always an essential part of every home visit, has become increasingly important. The home nursing service has always been closely integrated with the general practitioner service. Today the home nurse in London is also firmly established as a member of the local health authority team and has co-operated at field level with the hospital service in the continuity of care of patients discharged early to the general practitioner and home nursing services. This close integration, so well begun, deserves the highest praise, for we have now moved from the concept of limited services for the few to a vast network of community services for all. No service can any longer work effectively in isolation.

DISTRICT NURSING ASSOCIATIONS IN LONDON

(*a*) *Affiliated to Queen's Institute of District Nursing*

Brixton
47 Tulse Hill, S.W.2.

Camberwell
Halsemere Road, S.E.5.

*Charlton & Blackheath
50 Vanbrugh Park, S.E.3.

East London Nursing Society
7–9 Stainsby Road, E.14.

Fulham
56 Harwood Road, S.W.6.

Hackney
6 Lower Clapton Road, E.5

†Hammersmith
141 Uxbridge Road, W.12.

Hampstead
3 Pond Street, N.W.3.

Kensington
14 Holland Park, W.11.

‡Kilburn & West Hampstead
20 Dennington Park Road, N.W.6.

Metropolitan
18–20 Montague Street, W.C.1.

North London
6–7 Canonbury Place, N.1.

Paddington & St. Marylebone
117 Sutherland Avenue, W.9.

*Putney
15 Earldom Road, S.W.15.

St. Olave's (Bermondsey & Rotherhithe)
13 Cherry Garden Street, S.E.16.

Shoreditch & Bethnal Green
210 Kingsland Road, E.2.

*South London
109 North Side, Clapham Common, S.W.4.

Southwark, Newington & Walworth
65 Sancroft Street, S.E.11.

Westminster & Chelsea
73 Cadogan Gardens, S.W.3.

Woolwich & Plumstead
22 Nightingale Place, S.E.18.

(*b*) *Ranyard Nurses and affiliated association*

Ranyard Nurses
*St. Mark's Church
Kennington Park Road, S.E.11.

*Norwood
40 Hitherfield Road, Streatham, S.W.16.

(*c*) *Independent associations*

Catholic Nursing Institute
60 Lambeth Road, S.E.1.

Nursing Sisters of St. John the Divine
St. John's Home, Watson Street, Deptford, S.E.8.

*Stoke Newington
Barton House Annexe,
235 Albion Road, N.16.

* *Non-residential.*

† *Superintendent only in residence.*

‡ *Superintendent and Assistant Superintendent only in residence.*

APPENDIX C

SPEECH THERAPY IN L.C.C. SCHOOLS

Introduction—Speech is not an automatic development, it is something learned by the child; to attain such a power the child must have a pattern to follow and the ability both to recognise this pattern and to follow it. A child who for various reasons (for example deafness or no speech in the environment) never hears speech used is unable to make speech sounds. Given hearing and the presence of speech, there must be some power of concentration and some intelligence before profitable progress can be made in developing speech. This development can be retarded by emotional problems and even if hearing is normal there may be difficulty in interpreting sounds and reproducing them as useful speech.

The ability to communicate is a necessity to the human race if not indeed to all animals; speech, amongst those using the same language, is the simplest method. Education without speech and an understanding of speech becomes very difficult and life in the community is full of frustrations.

It can be accepted then that, where speech is inadequate, there is a place for speech therapy in the work of the school health service. The reason for the inadequacy of speech is usually to be found amongst the conditions noted above, but in many cases it is not clear how they operate.

More children are recommended for speech therapy now than formerly and there is a general impression that there is more poor speech amongst children in the younger, pre-school and infant school age groups. There is no obvious cause for this, but it may have relation to the amount of time that radio and television is left on in the home. Instead of talking, telling stories and reading at close range in quietness, there is an overlay of noise from the radio and fewer stories are told by parents; there is less accent on the value of the story read by the fireside and indeed on the relating of the day's doings amongst the family. The pattern of speech seen, heard and felt by the small child sitting close to the speaker is lost in these circumstances and lost with it is the stimulation of speech necessary to small children. There can be no objection to radio, but its indiscriminate use may well be harmful. Harmful too is the need for keeping children quiet in flats lest the people below or above object. There is need to experiment in speech just as in walking. Shouting and crying are useful as are whistling and laughing.

The child needs to have someone to listen to and to talk to and nothing so far has replaced home companionship as the best way to achieve this. The speech clinic is able to help children to attain normal speech and language by correcting incorrect sounds and exercising the child in the development of new sounds necessary for language but not yet within the competence of the child; work done at home by the parents guided by the speech therapist is a useful supplement, and in the case of a school where there is good contact between the school and clinic and parents the situation is still better.

The start—The need for some special provision to be made for children with some disorder of speech was becoming apparent in London by 1912. Before this year a few children ' suffering from stammering, idioglossia and cleft palate ' were ' recommended for a course of instruction in articulation ' in a deaf school.

Mr. Yearsley, the Council's otologist at that time, reported that this was not satisfactory and drew attention to the needs of children with disorders of speech requiring treatment, for whom no arrangements had been made. The annual report of the School Medical Officer for 1912 recommended the provision of centres for their treatment and emphasised that instruction must be by an expert.

The following year's annual report gave some details of the size of the problem and a first classification of the disorders:

	Total	*Boys*	*Girls*
Stammering	625	473	152
Other defect of speech ..	1,939	1,135	804

The children were grouped by ages (infants, intermediates and leavers) and it was noticed that in both sexes stammering was most frequently found in the oldest age group, leavers (0·88 per cent. boys and 0·24 per cent. girls). The number of children recommended for treatment for stammering was 14 boys and five girls and for treatment for other defects 25 boys and 14 girls. A note in the 1913 annual report states that seven children seen by the otologist were physically defective, ' mostly cases of cleft palate requiring lessons in articulation '. The need for some special provision for these children was being made clear and by 1914 plans began to take shape. Much thought was being given to the question at this time and the following extract from the 1914 annual report is a summary of the state of affairs then:

> ' From time to time attention has been drawn to the need for special educational treatment for children suffering from stammering and schemes have been drawn up for the opening of experimental classes, but up to the present none of the schemes has reached maturity.'

The first advance came in this year when the Council arranged for students in training colleges to have some teaching in the theory and practice of speech. It was St. Thomas' hospital which made the first practical advance in the field of speech therapy for schoolchildren, for at this time the hospital ' established a speech clinic for the treatment of schoolchildren suffering from defective speech, including stammering, post adenoid conditions, respiratory defects and general nervous conditions '. This clinic was conducted by Miss Fogerty. The number of children reported as stammering was 559 and the proportion of boys to girls was about three to one (419 boys and 140 girls).

Cautious experiment—In the latter part of 1915 the Council decided to add articulation for stammerers to the list of subjects which might be taught in evening classes and two classes were opened in the autumn term. These two classes for adult stammerers, taken by teachers of the deaf using oral methods, proved to be successful and it was decided that they should be kept going, but as a result of the experience gained it was thought that more effective work would be done if treatment were started at an earlier age. A suggestion was made that one or two visiting teachers should be appointed to attend in each district once or twice a week and give instruction to children who would attend at an elementary school in the district; this would be in addition to the clinic at St. Thomas' hospital which continued to treat schoolchildren.

A survey of leavers from the ordinary schools was made in 1916. This showed that 0·5 per cent. of boy leavers stammered and 0·5 per cent. had other defects of speech; in girls 0·2 per cent. stammered and 0·4 per cent. had other defects of speech. Speech defects were noted as being more common amongst the children in the special schools for the ' mentally defective ', 4·5 per cent. of whom had some defect of articulation.

First development—Arrangements were made in 1917 for an experimental class in remedial exercises for stammering children from elementary schools. This class was conducted under the auspices of the Westminster Health Society. The class was very successful and was continued, with growing success, in 1918. As a result of this class the Council decided in 1919 to start a number of classes itself. It was estimated that about 1,000 children would need treatment in the proportion of three boys to one girl. Teachers were asked to report on the nature of the speech disorder and to classify each case as acute, moderate, or slight; 914 children were notified, 682 boys and 232 girls. The age distribution is of interest:

Age	Number	Boys	Girls
7	15	12	3
8	73	54	19
9	123	89	34
10	146	105	41
11	154	121	33
12	187	150	37
13	197	137	60
14+	19	14	5

The number of children actually having treatment in 1919 was 105. A revised estimate the following year showed that 1,200 children needed treatment, the proportion of boys to girls remaining the same.

The proposed system for treatment was that five classes were to be established, with 20 children in each class, the whole to be under the general supervision of a medical officer. The effect of this scheme was good and 34 children were discharged at the end of the first term. As a result of this experience stammering children were classified in the following groups:

(i) Children who started to stammer as they developed speech.

(ii) Those in whom stammering came on at a later date and after the development of normal speech.

It was noted that successful treatment of the first group was difficult. This work done in 1920 suggested some reasons for the onset of stammer of the second group and noted that air raids during 1914–1918 were associated, causing frights, nightmares and night terrors. Poor physique and spasmodic breathing were often found in these children, many of whom looked strained and anxious. Treatment was directed towards improving the general condition and relaxation.

The first speech clinic organised and conducted entirely by the Council was opened this year in Brixton; experience with this class showed that 20 children was too large a number and 12 more satisfactory. At this time, 1920, it was thought that a total accommodation of 144 places would meet the need and a scheme was drawn up for the treatment of about 300 children each year. It seemed likely that the arrears of work would be overtaken and younger children admitted to the class. It was realised that there would be difficulties in getting the younger children to the centres—this problem is still with us. The plan provided for a gradual movement of centres from the central area towards the periphery of the county, so that vacancies occurring then could be offered to children from neighbouring authorities which might not have centres of their own.

First expansion—Centres were opened in six schools in 1921. Two groups of 12 children attended twice weekly ' for treatment and advice from special instructresses in speech training '. A total of 330 children passed into the centres and ' a number of the more chronic patients were sent to Margate and Bushey Park Camp schools with beneficial results '. Until this time the classes had been for boys and girls separately, but in 1921 the number of girls requiring treatment fell and the experiment of putting the younger boys with the girls was made. This proved a happy experiment and since then mixed groups have been quite usual.

The term ' treatment centre ' came into use in 1922 and has been in current use since. Of 350 children treated for stammering in 1922 the greater part was made up of older boys; 95 out of the total of 350 were noted as provisionally cured. This term was used for children whose speech was quite clear or so nearly so that the standard of speech was readily acceptable. The six centres were continued throughout 1923 and as experience was gained more information about stammering children became available. It was noted in a report that after a period of treatment there was sometimes a period of standstill and in some cases this was an indication for a rest from treatment; after such a rest more progress was made on return to the centre. An attempt was made to define criteria on which to make a prognosis and it was thought that the main factors were the teacher, the time between onset and treatment, the intelligence of the child and the physical condition of the child.

A development in 1924 was the opening of a clinic in the Jews' Free School in Shoreditch, which replaced one in Lombard Wall and was for the treatment of Jewish children in the school. In the following year ' very beneficial results ' were noted in three children who had cleft palates.

No new centres were opened in 1926. The Headmaster reported that the centre in the Jews' Free School was producing good results.

In 1927 an attempt was made to discover, a year after discharge, how permanent was the cure or improvement of children who had been treated for stammering—

Remaining cured after a year	.. ..	24
Much improved	.. ..	19
Relapsed	.. ..	5
Worse	.. ..	1
		49 (boys 43, girls 6)

Experience in the centres and in the Jews' Free School centre was showing the great value of a close connection between the speech therapist and the school. It had proved very helpful in the Jews' Free School, so in 1928 one session a week was devoted to school visiting. The need for this has not diminished through the years and much useful work has grown out of school visits by therapists to heads and class teachers.

A new centre was opened in Lewisham in 1929. The number of children reported in need of treatment had been growing slowly as facilities increased and in this year over 300 passed through the centres. In the following year another centre was opened, in Paddington, making eight in all and again there was an increase in the number needing treatment. The plan of treatment had been that each child attended twice a week for one-and-a-half hours, but in 1931 it was decided that instead of 12 children there would be nine in each group and that the period of treatment would be 50 minutes twice a week. Pressure on the centres was increasing and in 1933 the experiment of using student-assistants was begun. These were persons who, after they had observed the work of the clinic for some time, were given experience in the clinical work and could then obtain posts with other local authorities. By the end of the year there had been so many applications from students for places in the centres that it became necessary to regulate the attendances and to charge a small fee. This fee was charged until 1953. Students who attended for a year were given a certificate of attendance which, while not in any way a diploma, was evidence of practical experience. The requests from students for places in the centres increased and it became obvious that systematic training was required as well as clinical experience. Such a course was started for six students in 1934 by Dr. Boome and Miss Richardson. After a short time this venture was absorbed by one of the training schools.

The annual report of the School Medical Officer for 1933 records that of 455 children who stammered, 273 were found to have another stammerer in their immediate family circle and 174 more had a near relative who stammered.

Pressure was building up on the centres as more children were recommended for treatment and in 1935 the number of centres was increased by five: two for children attending primary and secondary schools were opened in June in Kennington and Hackney; two more, intended to serve children in secondary (now grammar) schools, were opened in November, at the North Western Polytechnic and at Henry Thornton School, Clapham and worked on Saturday mornings; another new centre was opened at Salter's Hill School to serve children in the Council's residential homes and schools. There were now 13 centres to serve school children; they continued through the following year and over 500 children were treated in 1936. An attempt to follow up some children who had left school five years or more ago after treatment gave the following result:

Regular employment	..	29	No speech defect ..	.. 13
Not employed	.. ..	1	Slight speech defect	.. 15
Still studying	.. ..	1	Severe speech defect	.. 3
		31		31

The term 'speech therapists' was first used in the School Medical Officer's reports in 1937. The therapists employed by the Council had started monthly meetings in 1934 and had continued them regularly. In 1937, therapists living and working out of London were invited to attend these meetings which were held on Saturday afternoons. They were well attended and therapists were in this way helped to keep in touch with their colleagues.

The 13 centres continued to operate through 1938; over 500 children attended, 403 from elementary schools, 51 from secondary schools and 48 from residential homes. One therapist noted the following in 100 consecutive cases of stammering:

Onset of stammering related to age.

Only child	.. .. ..	6	
First „	.. .. ..	31	
Second „	.. .. ..	25	
Third „	.. .. ..	16	
Fourth „	.. .. ..	8	
Fifth „	.. .. ..	7	
Sixth „	.. .. ..	6	
Seventh „	.. .. ..	1	
At start of speech	..	16	
2 years	.. .. ..	2	
3 „	.. .. ..	12	
4 „	.. .. ..	14	
5 „	.. .. ..	19	
6 „	.. .. ..	7	
7 „	.. .. ..	3	
8 „	.. .. ..	5	
9 „	.. .. ..	1	
10 „	.. .. ..	7	
11 „	.. .. ..	6	
12 „	.. .. ..	2	
Uncertain	.. ..	6	

In five cases the child was one of twins.

War and contraction of field of work—The mass evacuation in September, 1939 so scattered the school population that school medical work in clinics in London was brought to an end. All the speech clinics were closed and later the therapists visited the reception areas. Where it was possible they continued treatment. Despite the number moved from London many children remained or returned and by December some clinical services were restarted and part-time school commenced. The story in 1940 was of more evacuation, the estimated number of children in London was then 85,000; this increased in 1941 as people began to drift back and by December reached 150,000. It was not until the autumn of 1942 that five centres for speech therapy, which could accommodate 144 children, were reopened. The drift back to London continued and by the end of 1943 there were 250,000 in the schools and two more centres had been opened, giving places for 180 children. Progress continued in 1944: two more centres, now nine in all, were operating, despite the number of school children beginning to fall as evacuation became more intense. Records show that 439 children attended speech therapy in 1944.

The Education Act, 1944 recognised children suffering from speech disorders as being in need of special educational treatment and it became necessary for a legal process of ascertainment by the Chairman of the Education Committee to be completed before treatment could be commenced.

The nine centres continued in 1945 and had places for 260 children. All that year the number of children in schools in London continued to increase, so that in December it reached 277,359 and a total of 361 children were treated in the year. The number of school children continued to increase in 1946 to 334,784 by December and the speech clinics were increased to twelve. All the centres were staffed by part-time therapists who worked under the general supervision of a principal assistant medical officer.

Second period of development—The second period of growth commenced in 1947 when the school population had grown to 352,570. The 12 centres had 536 attendances. It had become plain that expansion of the speech therapy services was necessary and in 1948 the number of clinics was increased to 16, with 645 attendances. Two more centres were opened in 1949 and 670 children attended. It was in 1950 that two advances were made;

one more centre for ordinary schools was opened, one was started at the Children's department residential establishment at Banstead and one experimental clinic was started in a day school for educationally subnormal children. At this time the speech therapy staff consisted of one senior therapist (whole-time), one whole-time assistant therapist and four part-time therapists; a senior medical officer was charged with general supervision.

Expansion of the service was rapid from then on, 23 centres in 1951 and three more whole-time therapists, with 536 children under treatment at the end of the year and a waiting list of 296.

The experiment of conducting clinics in the schools for educationally subnormal children proved to be useful, time was saved, escorts were not needed and closer contact between school and therapists was possible. In general, progress was found to be slower than in normal clinics, but progress was made and these clinics in special schools have continued. These centres in special schools treated 205 children. In this year the service was extended to some severely handicapped children confined to their homes and having home tuition. There has never been a large number of such cases, but each year has produced two or three.

The day schools for physically handicapped children had always had a number of children in need of speech therapy and in 1952 arrangements were made for a therapist to visit regularly 16 such schools. A start was made in some of the boarding special schools, too. Throughout the years difficulty has been experienced in keeping the boarding schools supplied and some schools have had long gaps when there has been no therapist. In particular those at a distance from London have been unfortunate. A therapist living nearby is wanted but this ideal state usually does not exist and some schools are supplied by a therapist travelling from London.

There were 28 remedial clinics for day schools and 22 educationally subnormal day school clinics in 1952. There had been 778 new admissions and the total of children under treatment reached 1,059.

During the next two years there was further expansion. In December, 1954 there were 1,135 children having tuition in 38 normal centres and 1,483 under treatment in 26 day educationally subnormal, 17 day physically handicapped and five residential schools. The staff had grown to one senior speech therapist, 12 full-time, three part-time and seven sessional therapists. It was about this time that the issue of free-paid bus tickets for children attending various types of clinics came under consideration and it was decided to stop the use of these tickets. This apparently simple decision caused much despondency amongst stammering children, who could not always bring themselves to ask the school teacher for the fare, much less ask for their ticket on the bus. It was clear too that difficulty would be caused in cases of severe dyslalia and dysphasia, because of the difficulty in being understood. It was decided that tickets for special clinics would continue to be available and the easing of tension could almost be felt.

Speech therapy was extended in 1957 to two occupation centres, now junior training centres, for an experimental period of one year. In 1957 the number of children under treatment exceeded 2,000, with 270 on the waiting list in December; 124 sessions had been worked each week in 41 centres for children from ordinary schools and 78 sessions each week in 41 day special schools. Authority to start speech therapy in all junior occupation centres was given in 1958. In December, 72 children in the occupation centres were having treatment. In the same year a number of portable tape recorders were supplied for use in the clinics, following a period of experiment with one recorder kept in one clinic. Therapists can take these light machines from centre to centre themselves and keep a supply of tapes in each centre as may be required. The waiting list increased and stood at 322 at the end of 1958. An increase in staff the following year enabled more sessions to be worked and the waiting list to be reduced to 272.

Stewart Headlam special classes—Over the years several children had been admitted to speech clinics who suffered from various degrees of dysphasia. Some of these children were found to be unsuitable for Moor House, a boarding school which takes children with this defect. The usual weekly or twice weekly attendance in a speech clinic was found to give insufficient treatment and progress in school was very slow. Dysphasic children may have difficulty in the comprehension of spoken language or in the production of language or both; they need, therefore, much more help than can be given in an ordinary speech clinic. There is need of stimulus to speech, encouragement to practice and understanding guidance in both school and clinic. The support given by the family circle and regular contact with much normal speech are also of valuable assistance.

A regime in which the child spends part time in normal school, part time in the speech clinic, part time in a special class and in the meantime lives at home and maintains normal contacts with family and friends would seem to be as good as possible. This is the scheme worked at the Stewart Headlam special class, where speech therapy and special educational arrangements are available four days each week. Children attend as frequently as can be arranged and spend the rest of the time in their ordinary school. This venture was started in November, 1959 in conjunction with the Education Officer and has been found to be of real value in helping these rather awkward children. Here they can be helped as individuals and also work as a community, they gain strength by discovering that they are not alone in their disability.

The children in this group take part in very varied activities, some of which are handicrafts such as painting, modelling and woodwork, some more academic such as reading and writing and mathematics; they make visits, go swimming and have visitors—one memorable visitor was a mounted policeman, an inspector. All sorts of ways are used to enable normal contacts to be made and all sorts of people have been of great help; the teacher and speech therapist, of course, but also the schoolkeeper and the cook.

Progress is apparently good at first, then seems to slow down and it is as yet uncertain how long children should attend; about two years is the expected minimum and some will need longer. The degree of difficulty experienced by the children varies greatly, some have a severe defect of expression, some have little language and in some there is an associated problem of the understanding of written symbols.

The greatest difficulty in keeping the group in being has been that of attendance; escorts are necessary for most children and they have not been easy to find. The area from which the children attend is large, anywhere within the county and rarely can one escort bring two children. One boy from out-county was sent and fetched by car each day the group operated. This boy, at one time unable to speak with anyone, distinguished himself by ringing up a headmaster to enquire the whereabouts of his friend due in the group and who had not turned up. His message was understood and gave all concerned much satisfaction. Not so another occasion on which a message to be given to the teacher was taken by a boy and distorted from ' your visitors will not be able to come today ' into ' you have two new children coming tomorrow '.

Most of the schools from which these children come find some degree of improvement in a short time, at first in the reaction of the child to the staff and children and later in academic achievement. In one school a boy made such advances as to win an award for having made more progress than any other pupil. For the presentation of the award by the Lord Mayor he went with the school to the Guildhall. Alas, a mistake was made and this boy's name was not called. He took the disappointment bravely but was still very upset next day. The teacher in the special class made sure that the Lord Mayor heard of the error with the result that the boy was asked to meet the Lord Mayor and had a very special presentation on his own. He was more thrilled because the Lord Mayor of London was robed.

Present state—That speech therapy is filling a useful place is clear from statements by teachers and parents, but there is still a waiting list and still fields of work only touched. More needs to be done in the boarding schools, but there are still insufficient therapists. It is interesting to see that in several day schools enough work exists to make it necessary to allot sessions to these schools; in the day special schools the demand fluctuates but remains relatively constant in the infant and junior schools; the senior children, it may be, are showing the result of work done when they were in the junior school.

The staff at present consists of one head therapist, 22 full-time, eight part-time and 11 sessional therapists.

The number of sessions held each week is as follows:

In school treatment and M. & C. W. centres ..	175
Ordinary schools	10
Special schools:	
E.S.N.—	
Day	54
Boarding	12
Physically handicapped—	
Day	26
Boarding	6
Partially sighted	6
Blind	1
Children's department establishments	7
Training centres	18

The 1961 survey—The original intention of this survey was to obtain information on every child who attended a centre between 1 June, 1960 and 31 May, 1961. Eventually, completed forms in respect of 3,290 children were received and it is estimated that reports on some 500 children were not completed. Staffing problems, particularly in the boarding schools, made a complete census impracticable.

The numbers of children in the survey admitted, attending and discharged during the period are set out in table (i). Boys outnumbered girls by three to one.

TABLE (i)—*Children included in the survey*

	Total		*Boys*		*Girls*	
Admitted before 1.6.60		2,140		1,519		621
Admitted after 1.6.60		1,142		812		330
Date of admission not recorded		8		6		2
Total children in survey		3,290		2,337		953
Discharged by 31.5.61	586		400		186	
Transferred before 31.5.61	45		29		16	
Left school before 31.5.61	35		30		5	
Lapsed before 31.5.61	148		114		34	
Refused treatment	54		35		19	
Died	3		2		1	
	—	871	—	610	—	261
Remaining in attendance		2,419		1,727		692

Table (ii) shows the total number of defects for which these children required treatment. As 454 children suffered from more than one defect, the total number of defects is greater than the total number of children. Proportionately within the sexes, the incidence of stammer in boys is twice that of girls but the incidence of dysarthria and dyslalia is greater in girls.

Details of children suffering from more than one defect are shown in table (ii) *a*.

TABLE (ii)—*Number and type of speech defects reported*

Nature of defect	*All children*		*Boys*		*Girls*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Stammer	880	23·3	721	26·8	159	14·6
Dysphasia	68	1·8	42	1·6	26	2·4
Sub-mucous cleft	7	0·2	4	0·1	3	0·3
Cleft palate	71	1·9	39	1·4	32	2·9
Alalia	74	1·9	50	1·9	24	2·2
Dysarthria	174	4·6	105	3·9	69	6·3
Dyslalia—simple	868	23·0	570	21·2	298	27·5
—multiple	986	26·1	720	26·7	266	24·4
—general	444	11·7	302	11·2	142	13·0
Dysphonia	209	5·5	139	5·2	70	6·4
Total defects	3,781	100·0	2,692	100·0	1,089	100·0
Total children	3,290		2,337		953	

TABLE (ii) *a—Multiple defects (main defect and associated defects)*

Main defect	*Sex*	*Total cases*	*Number with one other speech defect*	*Number with two other speech defects*	*Associated speech defects*							
					Dysphasia	*Cleft palate*	*Alalia*	*Dysarthria*	*Dyslalia simple*	*Dyslalia multiple*	*Dyslalia general*	*Dysphonia*
Stammer ..	B	721	178	15	6	3	1	10	70	78	21	19
	G	*159*	*43*	*4*	*1*	*1*	*1*	*3*	*23*	*15*	*5*	*2*
Dysphasia ..	B	36	21	4	—	—	2	7	4	10	4	2
	G	*25*	*8*	*3*	—	—	—	*4*	—	*2*	*7*	*1*
Sub-mucous cleft ..	B	4	1	—	—	—	—	—	—	—	1	—
	G	*3*	*2*	—	—	—	—	—	—	*2*	—	—
Cleft palate ..	B	36	9	2	—	—	—	1	2	4	2	4
	G	*31*	*6*	—	—	—	—	—	*3*	—	*2*	*1*
Alalia ..	B	47	2	1	—	—	—	2	—	—	—	2
	G	*23*	—	—	—	—	—	—	—	—	—	—
Dysarthria ..	B	85	27	1	—	—	—	—	1	12	5	11
	G	*62*	*20*	*7*	—	—	—	—	—	*12*	*5*	*17*
Dyslalia simple	B	493	27	—	—	—	—	—	—	—	—	27
	G	*272*	*6*	—	—	—	—	—	—	—	—	*6*
Dyslalia multiple	B	616	32	—	—	—	—	—	—	—	—	32
	G	*235*	*16*	—	—	—	—	—	—	—	—	*16*
Dyslalia general	B	269	12	—	—	—	—	—	—	—	—	12
	G	*123*	*7*	—	—	—	—	—	—	—	—	*7*
Dysphonia ..	B	30	—	—	—	—	—	—	—	—	—	—
	G	*20*	—	—	—	—	—	—	—	—	—	—
All	B	2,337	309	23	6	3	3	20	77	104	33	109
	G	*953*	*108*	*14*	*1*	*1*	*1*	*7*	*26*	*31*	*19*	*50*

Therapists were asked to classify each case according to severity and defect with the following criteria:

1. Severe—complete breakdown in the process of communication.
2. Moderate—difficulty in communicating in some or all special situations.
3. Slight—variable or constant, not interfering with fluency.

Their assessments are summarised in table (iii).

TABLE (iii)—*Severity of defect*

	All children		*Boys*		*Girls*	
	No.	*%*	*No.*	*%*	*No.*	*%*
Severe	290	8·8	200	8·6	90	9·4
Moderate	1,564	47·5	1,158	49·6	406	42·6
Slight..	1,436	43·6	979	41·9	457	48·0
	3,290	100·0	2,337	100·0	953	100·0

The type of school the children attended is shown in table (iv).

TABLE (iv)—*Type of school, etc. attended*

	All children		*Boys*	*Girls*
	No.	*%*	*No.*	*%*
Open air	45	1·4	30	15
Maladjusted	18	0·5	15	3
Partially sighted	30	0·9	24	6
Physically handicapped	210	6·4	127	83
Educationally sub-normal	560	17·0	407	153
Secondary	461	14·0	339	122
Junior	993	30·2	717	276
Infants	753	22·9	546	207
Pre-school	67	2·0	38	29
Home tuition	2	0·06	1	1
Training centre	151	4·6	93	58
	3,290	100·0	2,337	953

It is interesting to note that nearly a third of these children are receiving education in one or other type of special school. This is an under-estimate as the sample is known to be deficient in this type of child.

Table (v) shows the age of admission by main type of defect, each child counted once only.

TABLE (v)—*Age* at admission according to type of defect and sex*

Defect	*Sex*	*Total cases*	*Approximate age* in years at admission*														
			Under 5	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	*N.R.*
Stammer	B	717	25	41	87	97	97	74	77	71	60	35	27	20	4	2	4
	G	*158*	*7*	*11*	*18*	*18*	*21*	*15*	*18*	*11*	*16*	*11*	*4*	*5*	*2*	*1*	*1*
Dysphasia	B	36	—	2	9	3	4	8	1	2	3	—	2	2	—	—	—
	G	*25*	*3*	*7*	*5*	*1*	*1*	*2*	*1*	—	*2*	*1*	*2*	—	—	—	—
Sub-mucous cleft	B	4	—	1	1	—	—	1	1	—	—	—	—	—	—	—	—
	G	*3*	—	*1*	*2*	—	—	—	—	—	—	—	—	—	—	—	—
Cleft palate	B	36	3	5	8	6	4	3	1	2	3	—	—	1	—	—	—
	G	*31*	*6*	*7*	*4*	*5*	*4*	—	*1*	*1*	—	*2*	*1*	—	—	—	—
Alalia ..	B	47	9	11	8	4	6	1	4	2	—	1	1	—	—	—	—
	G	*23*	*6*	*6*	*2*	*3*	*2*	*2*	*1*	—	—	*1*	—	—	—	—	—
Dysarthria	B	85	2	15	7	13	10	5	5	9	3	6	5	5	—	—	—
	G	*60*	*3*	*5*	*9*	*10*	*8*	*3*	*5*	*4*	*2*	*6*	*2*	*2*	*1*	—	*2*
Dyslalia simple	B	492	12	40	79	86	88	42	39	42	29	14	9	8	2	2	1
	G	*271*	*8*	*21*	*42*	*35*	*48*	*32*	*27*	*15*	*18*	*13*	*9*	*2*	*1*	—	*1*
Dyslalia multiple	B	614	32	103	164	134	82	35	18	22	11	8	4	1	—	—	2
	G	*235*	*13*	*29*	*72*	*46*	*30*	*13*	*12*	*6*	*10*	*1*	*3*	—	—	—	—
Dyslalia general	B	269	29	53	91	41	21	12	7	8	3	3	1	—	—	—	—
	G	*123*	*24*	*22*	*26*	*21*	*14*	*7*	*3*	*4*	*1*	*1*	—	—	—	—	—
Dysphonia	B	30	—	3	2	2	4	6	3	2	3	1	2	2	—	—	—
	G	*20*	—	*1*	*1*	3	*2*	*5*	*1*	*2*	*1*	*3*	—	—	*1*	—	—
All ..	B	2,330	112	274	456	386	316	187	156	160	115	68	51	39	6	4	7
	G	*949*	*70*	*110*	*181*	*142*	*130*	*79*	*69*	*43*	*50*	*39*	*21*	*9*	*5*	*1*	*4*
	Both	3,279	182	384	637	528	446	266	225	203	165	107	72	48	11	5	11

* *Age was calculated by deducting year of birth from year of admission.*

Those children suffering from alalia in the older age group were attending training centres.

No marked modal age is demonstrated for stammering but there is a peak at 7–8 years old. The modal ages show for dyslalia at 6–8 years and a lesser peak at 11. This probably reflects the result of routine school medical inspections.

Tables (vi) B and G show, for boys and girls separately by type of defect, the position in the family of these children.

TABLE (vi) B—*Position in family according to type of defect—BOYS*

(*a*) *Position in family of children with defect.* (*b*) *Percentage of* (*a*) *to total children in family positions.*

Defect		*No. of children with defect*	*Only children*	*Position in family*									
				1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9 or more*	*Not recorded*
Stammer	(*a*)	721	102	192	199	118	52	20	18	4	4	5	7
	(*b*)	—	—	*31*	*33*	*29*	*22*	*17*	*24*	*7*	*7*	*28*	—
Dysphasia	(*a*)	36	8	5	10	6	4	2	—	—	—	1	—
	(*b*)	—	—	*18*	*36*	*33*	*33*	*25*	—	—	—	*100*	—
Sub-mucous cleft	(*a*)	4	—	1	1	1	—	—	1	—	—	—	—
	(*b*)	—	—	*25*	*25*	*25*	—	—	*100*	—	—	—	—
Cleft palate	(*a*)	36	7	9	10	3	6	—	—	—	—	1	—
	(*b*)	—	—	*31*	*34*	*17*	*50*	—	—	—	—	*100*	—
Alalia ..	(*a*)	47	7	11	15	5	4	1	1	—	—	2	1
	(*b*)	—	—	*28*	*38*	*22*	*31*	*11*	*33*	—	—	*100*	—
Dysarthria	(*a*)	85	20	22	19	14	2	2	3	—	1	1	1
	(*b*)	—	—	*34*	*30*	*42*	*10*	*14*	*43*	—	*50*	*50*	—
Dyslalia simple	(*a*)	493	52	84	159	97	40	21	11	6	7	3	13
	(*b*)	—	—	*20*	*37*	*32*	*21*	*18*	*15*	*14*	*30*	*27*	—
Dyslalia multiple	(*a*)	616	51	94	218	109	64	33	17	9	6	8	7
	(*b*)	—	—	*17*	*39*	*28*	*26*	*20*	*19*	*16*	*19*	*42*	—
Dyslalia general	(*a*)	269	25	37	78	56	39	15	7	4	3	2	3
	(*b*)	—	—	*15*	*32*	*31*	*36*	*20*	*21*	*18*	*33*	*40*	—
Dysphonia	(*a*)	30	5	7	14	2	1	—	—	—	—	—	1
	(*b*)	—	—	*29*	*58*	*17*	*12*	—	—	—	—	—	—
Total ..	(*a*)	2,337	277	462	723	411	212	94	58	23	21	23	33
	(*b*)	—	—	*23*	*36*	*30*	*25*	*18*	*20*	*12*	*20*	*39*	—

TABLE (vi) G—*Position in family according to type of defect—GIRLS*

(*a*) *Position in family.* (*b*) *Percentage of* (*a*) *to the children in family positions.*

Defect		*No. of children with defect*	*Only children*	*Position in family*									
				1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*Not recorded*
Stammer	(*a*)	159	26	48	50	23	1	5	2	—	—	1	3
	(*b*)	—	—	*37*	*39*	*33*	*3*	*22*	*13*	—	—	*100*	—
Dysphasia	(*a*)	25	3	8	8	3	3	—	—	—	—	—	—
	(*b*)	—	—	*36*	*36*	*33*	*60*	—	—	—	—	—	—
Sub-mucous cleft	(*a*)	3	—	1	—	—	—	—	1	1	—	—	—
	(*b*)	—	—	*33*	—	—	—	—	*50*	*50*	—	—	—
Cleft palate	(*a*)	31	4	7	11	4	1	2	—	—	2	—	—
	(*b*)	—	—	*26*	*41*	*25*	*20*	*50*	—	—	*100*	—	—
Alalia	(*a*)	23	4	3	5	7	2	1	—	—	—	1	—
	(*b*)	—	—	*16*	*26*	*50*	*25*	*25*	—	—	—	*100*	—
Dysarthria	(*a*)	62	13	14	14	11	4	1	2	—	2	—	1
	(*b*)	—	—	*29*	*29*	*37*	*22*	*10*	*33*	—	*100*	—	—
Dyslalia simple	(*a*)	272	26	51	79	50	30	9	8	8	1	4	6
	(*b*)	—	—	*21*	*33*	*29*	*27*	*12*	*17*	*26*	*5*	*31*	—
Dyslalia multiple	(*a*)	235	12	37	77	55	27	11	4	3	3	3	3
	(*b*)	—	—	*17*	*35*	*36*	*28*	*19*	*12*	*13*	*21*	*30*	—
Dyslalia general	(*a*)	123	10	20	41	25	13	4	3	3	1	2	1
	(*b*)	—	—	*18*	*37*	*31*	*30*	*17*	*27*	*38*	*17*	*33*	—
Dysphonia	(*a*)	20	1	4	6	2	3	2	2	—	—	—	—
	(*b*)	—	—	*21*	*32*	*18*	*38*	*29*	*67*	—	—	—	—
Total ..	(*a*)	953	99	193	291	180	84	35	22	15	9	11	14
	(*b*)	—	—	*23*	*35*	*32*	*25*	*17*	*17*	*18*	*17*	*33*	—

Only children are shown separately because order of position in family does not arise in their case. The proportion of only children in the survey was 12 per cent. for boys and 10 per cent. for girls; for both sexes these percentages were higher for the defects of stammer (14 per cent. boys, 16 per cent. girls) and dysarthria (23 per cent. boys, 20 per cent. girls).

In a self-selected sample of families having children with a specific defect, there will invariably be an over-representation of the larger families. If, for example, the incidence of the defect was ten per cent., every ten-child family would be statistically likely to be represented but only half the five-child ones and one-fifth of the two-child families. Hence, if it is desired to see whether the position in the family has any bearing on the presence or absence of a particular defect, it is difficult to arrive at a population against which to test such a hypothesis. Practical alternatives are to assume that in, say, five-child families the theoretical distribution of defective children would be 20 per cent. for each position; or to relate the incidence to the numbers of children in each position to the numbers of children contained in all the families in the sample. There are complications with either course—for example, bearing in mind that this was a survey of schoolchildren, there is the risk that, in the larger families in particular, some of the children would be under or over the school age range and might not have been included. Fortunately, whichever method is used the results are of the same order and line (*b*) shows the children with defects (line (*a*)) as a percentage of the total children in the families occupying the respective positions.

Overall, for children with more than one child in the family, second and third children have a higher incidence of defective speech than do first and later children; this applies to both boys and girls. With boys this tendency towards second and third children is particularly noticeable with dyslalia, extending to the fourth child for general dyslalia; for stammer the higher incidence extends to first, second or third children. A similar pattern obtains for girls, though the numbers are smaller and do not have the same significance.

Table (vii) shows age at admission by severity of selected defect. The sexes are shown separately.

TABLE (vii)—*Age* at admission according to severity of selected defects and sex*

Defect	*Degree of severity*	*Sex*	*Approximate age* at admission*														*Total children*
			Under 5	*5*	*6*	*7*	*8*	*9*	*10*	*11*	*12*	*13*	*14*	*15*	*16*	*17*	
Stammer	Severe	B	3	4	7	7	5	5	2	5	4	3	2	8	—	—	48
		G	—	*1*	*1*	*1*	*3*	*1*	*1*	*2*	*2*	—	—	*1*	—	—	*13*
	Moderate	B	11	23	56	64	66	48	42	41	34	19	16	14	4	1	439
		G	*5*	*4*	*13*	*11*	*12*	*9*	*8*	*5*	*9*	*9*	*2*	*3*	*1*	—	*91*
	Slight	B	47	26	26	21	28	25	29	13	9	5	—	—	—	—	230
		G	*2*	*6*	*4*	*6*	*6*	*5*	*9*	*4*	*5*	*2*	*2*	*1*	*1*	*1*	*54*
Dyslalia simple	Moderate	B	—	1	5	4	4	7	3	1	2	1	1	—	—	—	29
		G	*1*	*3*	*1*	*4*	*2*	*1*	—	—	*2*	—	—	—	—	—	*14*
	Slight	B	12	39	74	82	62	57	36	41	27	13	8	8	2	2	463
		G	*6*	*18*	*41*	*31*	*46*	*31*	*26*	*15*	*16*	*13*	*9*	*2*	*1*	—	*255*
Dyslalia multiple	Severe	B	1	7	5	5	2	1	—	1	—	—	—	—	—	—	22
		G	—	*3*	*5*	—	—	—	—	—	*1*	—	—	—	—	—	*9*
	Moderate	B	19	72	119	94	45	25	10	13	6	4	1	—	—	—	408
		G	*8*	*16*	*48*	*27*	*20*	*6*	*4*	*2*	*5*	—	*1*	—	—	—	*137*
	Slight	B	12	24	40	35	35	9	8	8	5	4	3	1	—	—	184
		G	*5*	*11*	*18*	*19*	*10*	*7*	*8*	*4*	*4*	*1*	*2*	—	—	—	*89*
Dyslalia general	Severe	B	10	16	13	5	3	1	2	1	1	1	—	—	—	—	53
		G	*6*	*4*	*3*	*3*	*1*	*1*	—	—	—	—	—	—	—	—	*18*
	Moderate	B	17	34	66	29	11	7	5	6	1	2	1	—	—	—	179
		G	*14*	*15*	*16*	*13*	*11*	*5*	*3*	*3*	*1*	*1*	—	—	—	—	*82*
	Slight	B	2	3	12	7	7	4	—	1	1	—	—	—	—	—	37
		G	*4*	*3*	*7*	*5*	*2*	*1*	—	*1*	—	—	—	—	—	—	*23*
Total	Severe	B	14	27	25	17	10	7	4	7	5	4	2	1	—	—	123
	Moderate	B	47	130	246	191	126	87	60	61	13	26	19	14	4	1	1,055
	Slight	B	73	92	152	145	132	95	73	63	42	22	11	9	2	2	914
	Severe	G	*6*	*8*	*9*	*4*	*4*	*2*	*1*	*2*	*3*	—	—	*1*	—	—	*40*
	Moderate	G	*28*	*38*	*78*	*55*	*45*	*21*	*15*	*10*	*17*	*10*	*3*	*3*	*1*	—	*324*
	Slight	G	*17*	*38*	*70*	*61*	*64*	*44*	*43*	*24*	*25*	*16*	*13*	*3*	*2*	*1*	*421*
	Severe	Both	20	35	34	21	14	9	5	9	8	4	2	1	—	—	163
	Moderate	Both	75	168	324	246	171	108	75	71	30	36	22	17	5	1	1,379
	Slight	Both	90	130	222	206	196	139	116	87	67	38	24	12	4	3	1,335

* *Age was calculated by deducting year of birth from year of admission.*

Table (viii) shows other members of the family reported to have defective speech. It will be seen that children who stammer have the highest incidence of defective speech in the family.

TABLE (viii) B—*Speech defect in other members of the child's family according to child's defect—BOYS*

Child's defect	*Number of children*	*Members of family with defective speech*								
		None	*Father*	*Mother*	*Brother*	*Sister*	*Twin*	*Father's near relation*	*Mother's near relation*	*More remote*
Stammer ..	721	409	94	68	75	31	11	42	71	13
Dysphasia ..	36	28	—	1	4	2	—	1	1	1
Sub-mucous cleft ..	4	3	—	1	1	—	—	—	—	—
Cleft palate	36	30	2	1	2	1	—	—	3	1
Alalia ..	47	40	—	2	6	2	—	—	1	—
Dysarthria ..	85	77	1	—	3	3	2	1	—	—
Dyslalia—										
simple ..	493	372	19	16	51	32	4	7	17	4
multiple ..	616	406	33	26	76	43	5	22	32	13
general ..	269	176	13	19	42	20	6	3	19	1
Dysphonia ..	30	26	—	1	—	1	1	—	1	—
All ..	2,337	1,567	162	135	260	135	29	76	145	33

TABLE (viii) G—*Speech defect in other members of the child's family according to child's defect—GIRLS*

Child's defect	*Number of children*	*Members of family with defective speech*								
		None	*Father*	*Mother*	*Brother*	*Sister*	*Twin*	*Father's near relation*	*Mother's near relation*	*More remote*
Stammer ..	159	83	25	16	9	14	1	8	15	2
Dysphasia ..	25	21	3	1	—	1	—	1	—	—
Sub-mucous cleft ..	3	3	—	—	—	—	—	—	—	—
Cleft palate	31	24	—	1	1	2	—	—	3	1
Alalia ..	23	20	—	1	—	1	—	—	2	1
Dysarthria ..	62	59	1	—	2	—	—	—	1	—
Dyslalia—										
simple ..	272	190	5	11	33	23	5	6	12	1
multiple ..	235	146	10	6	35	26	3	10	19	5
general ..	123	89	7	2	12	13	4	2	5	1
Dysphonia ..	20	18	—	1	—	1	—	—	1	—
All ..	953	653	51	39	92	81	13	27	58	11

Conclusions—As a result of this survey little that is new has come to light but some impressions have been confirmed, such as the excess of boys over girls particularly in stammering and that on the whole boys are more severely affected than girls.

Left-handedness was included in the survey but has not been shown to be associated with stammer. A small number of children was reported as having been changed from left-hand to right-hand and analysis suggests that such a change of laterality increases the child's chances of stammering. An odd sidelight would seem to indicate that in the E.S.N. schools a greater percentage of girls having speech therapy are left-handed than in ordinary schools.

No evidence was found to suggest that children with parents, or one parent, of foreign origin, i.e. non-English speaking, were more likely to suffer from speech defect. Language difficulties exist, of course, in those children who normally speak some language other than English at home; in some special schools the speech therapist is able to assist these children to attain adequacy of English speech more rapidly than would otherwise have been possible.

An attempt to gather information about the home background was not successful, mainly it would seem because only a limited number of questions was asked, each covering too wide a field. It is still thought that there is valuable information to be obtained about the relationships between a child's home background and speech, but it would need to be the subject of a specially planned enquiry.

APPENDIX D

SOUTH EAST LONDON GENERAL PRACTITIONERS' CENTRE
St. Mary's Road, S.E.15

(Medical Director, Brigadier H. L. Glyn Hughes, C.B.E., D.S.O., M.C., M.R.C.S., L.R.C.P.)

The following abbreviated account of the activities of the South East London General Practitioners' Centre during the first twelve months of its existence is based on the Director's report to the House Committee.

Introduction

The South East London General Practitioners' Centre, which was officially opened on 16 February, 1961 by Lord Cohen of Birkenhead, provides general practitioners with facilities for diagnosis, treatment and minor operations which they do not possess in their own surgeries and with a range of subsidiary services, including organised discussion groups, lectures and a well-equipped common room.

The Centre was established by the London County Council, who provided, adapted and maintains the premises, supplied the furniture and non-specialist equipment, the nursing, health visiting and secretarial staff and appointed the Director. Generous financial assistance was given by the Nuffield Foundation towards the cost of adaptations and equipment and by the Sir Halley Stewart Trust in respect of the Director's salary and expenses. The South East Metropolitan Regional Hospital Board and the Camberwell Hospital Management Committee provided the specialist equipment, staff and consultants for the radiological and pathological departments. (See table (v) for financial statement.) The College of General Practitioners has supported the project throughout and invaluable advice and assistance has been given by local general practitioners, both in the planning stage and since the Centre has been open.

The general management of the Centre is the responsibility of a House Committee consisting of members of the London County Council, representatives of general practitioners and of all the organisations associated with the establishment of the Centre. A Medical Staff Committee of general practitioners and the Centre consultants acts in an advisory capacity to the Director on existing and projected activities of the Centre.

Background

The Centre is in part of the former Pioneer Health Centre, where the 'Peckham Experiment' was carried out. This was pioneer research work into human health and the biological observation of the family as a unit, and the building was equipped for both medical and recreational activities, including a swimming bath.

When the Pioneer Health Centre closed and the premises were purchased by the London County Council in 1951, various health and education activities were accommodated there and a committee was set up by the Council to consider the possibility of continuing some form of medico-sociological work in the building. In discussions with interested organisations the need emerged for a diagnostic centre for general practitioners and for a centre where senior medical students could obtain instruction in general practice, and support for such a project was promised. This need was confirmed at meetings of local general practitioners, whose support was immediately demonstrated by the election of representatives to form an advisory committee. In 1958, the approval of the Ministry of Health having been obtained to the Centre being set up under section 21 of the National Health Service Act, detailed planning began.

Planning and construction

The building which houses the Centre was one of the first in this country to be built entirely in reinforced concrete. Part of the second floor, which it was proposed to adapt, had not been used for some time and required considerable alterations, the scope for which was severely limited because it was impracticable to pull down, alter or adapt any structural walls. The planning of the various rooms had to take into account the reinforced columns and beams and it was necessary to fit around these the operational parts of the Centre in a relationship which could not easily be changed.

To simplify the layout, it was decided to build a separate entrance vestibule, staircase and lift block, connected by a bridge to the building at second floor level. The entrance to the lift and staircase was designed both for pedestrians and for patients arriving by ambulance; stretcher patients may be lifted direct from the ambulance into the lift under cover. A car park with turning space for ambulances was an essential part of the scheme and it has been surrounded by gardens. Within the Centre is a pathological laboratory, an X-ray suite with dark- and viewing-rooms, two consulting rooms, a nursing treatment and minor operations suite, a common room and office accommodation. There was already on the same floor a child guidance unit and it was necessary to reorganise this accommodation as part of the whole scheme.

Special finishes were required to meet the high standards necessary in a centre of this sort; it was also thought that to some degree the Centre would provide an opportunity to demonstrate to general practitioners types of wall and floor finishes and other amenities which require little maintenance and which might be suitable for their surgeries. Cement glaze was used on the walls and ceilings of the minor operations and nursing treatment rooms and those rooms have anti-static earthed vinyl plastic floors. The walls of the X-ray room were plastered with a barium based plaster and the doors reinforced with lead sheet to prevent the penetration of radiation. Vinyl plastic fabric of various designs and colours was used for other rooms with vinyl plastic floor tiles.

The cost of adaptations is given in table (v) but it will be appreciated that this figure is no guide to the cost of setting up a similar centre in different circumstances.

Services provided at the Centre

The facilities of the Centre are available to any general practitioner who wishes to use them and 106 local doctors have done so during the first year, sending 3,450 patients to the Centre in respect of whom 6,081 investigations, etc., have been carried out (see table (1). No doctors practise from the Centre.

Diagnostic facilities—The diagnostic facilities which are provided enable general practitioners to investigate more fully those patients who do not necessarily require a specialist opinion, to follow-up patients who need repeated investigations to record their progress and to make a single check on patients after certain illnesses; all without having to make what may be thought at times to be an unnecessary use of busy hospital facilities. This should be an incentive to better practice and there are other advantages for the patients in the non-institutional atmosphere of the Centre and the fact that they do not have to repeat their history to a strange doctor.

It is not part of the concept of the Centre to have consultant clinics but specialist opinion is available to general practitioners when required from the part-time consultants who supervise each department and the clinical reports which emanate therefrom.

The pathological laboratory provides services within the following range: haematology, urine examinations, bacteriology and bone marrow aspirations—but certain investigations such as blood grouping, tests for tubercle and diphtheria bacilli, etc., are referred to other laboratories. During the year 1,886 investigations were carried out and a further 329 requests were referred elsewhere (table iii).

The radiological department has, up to now, been mainly restricted to investigations to bones and joints, chests and sinuses. A larger X-ray machine is about to be installed and the range of examinations will be extended; 1,800 were carried out during the year (table iv).

An electrocardiography service has been started during the year and to date 277 requests have been dealt with. The investigations are carried out by the radiographer and the results interpreted by the consultant physician.

The allergy service is also one which has been started during the year and 125 patients have so far been investigated. Skin sensitisation tests are very time consuming, taking anything up to one hour to carry out and this service should be of assistance to busy general practitioners.

Other facilities—In addition to diagnostic facilities, the Centre provides specially designed and fully equipped rooms in which general practitioners can carry out minor operations or intensive investigations to their own patients with the assistance of trained nursing staff; 133 operations have been carried out during the year.

Nursing treatments, dressings and injections ordered by the general practitioner are carried out for him by the nursing staff. 280 patients were dealt with during the year, many of them attending a number of times, the total number of treatments given being 1,208.

An important feature of the Centre is the Common Room, where doctors can meet, study the wide range of medical periodicals and consult the reference library and information service which is being built up. Many large medical conferences have been held here and lunchtime meetings for general practitioners, which are held every six weeks or so, have proved to be very popular, with an average attendance of over 50 each time. A tape recording on a subject of medical interest to family doctors is played, followed by a discussion led by a specialist in the subject; these have included discussions on cardiac emergencies, the coroner and the general practitioner, and speech disorders in neurological disease.

Liaison with local health authority services is maintained by the health visitor for the immediate area, who works from an office in the Centre; 28 requests for assistance have been made to her during the year. It is hoped that her work in the Centre will increase and will stimulate closer contact between family doctors and local health authority staff in the area.

Other activities of the Centre

Research—A few research projects have been started and others are in the planning stage, but the first year has mainly been used to gain experience on which to assess what might be the potential of the Centre in this field and all clinical and statistical records have been designed with the possibility of research in mind. Some subjects for research suggest themselves from the ordinary routine work of the Centre. There are, for example, a number of Africans and West Indians living in the area and special records are being kept of those who attend the Centre, which it is hoped may be of use in studying morbidity in those groups. The Centre is also able to collect information for other organisations undertaking research, such as the recording for the purposes of a survey being carried out by the College of General Practitioners of persons who have had measles.

Undergraduate education—In the first year it was not practicable to start a formal scheme for undergraduate education but consideration has been given to the ways in which the Centre can participate in the instruction of senior medical students in the art and performance of general practice. It seems probable that this would consist of co-ordinating schemes involving students and local general practitioners and of organising lectures and case conferences at the Centre in which students, general practitioners, social workers and nursing officers could take part.

Appraisal of first year

Tables are given at the end of this report which show the extent to which the Centre has been used and they indicate the continuing support of the local doctors and a steady growth of work. In the appendix are shown the classification of patients attending the Centre with more detail about certain of the groups.

The value of the Centre, however, cannot be demonstrated in statistical terms. Some of the services provided have not hitherto been available to general practitioners and the only measure of the need is the use made of them. Radiological and pathological services were already available at eight large hospitals in the area and the opening of the Centre will not be reflected to any significant extent in the outpatient figures of any one of them. Similarly, no conclusive evidence is available that the Centre contributes towards earlier detection of disease, although it has been observed that a number of patients were sent to the Centre whose symptoms were so slight that they might not normally have been referred to a chest clinic or hospital and that in some of these abnormal conditions were found.

The Centre is still in the experimental stage and it may not be until the third or fourth year that it becomes stabilised. During the first year it was important not to be too ambitious and not to start any project in so big a way that there was a risk of it not being carried through to completion. For this is essentially the general practitioners' Centre and, notwithstanding the part played by the London County Council and the other organisations concerned, its pattern, growth and success depend to a very large extent on the needs and continued enthusiasm of the local doctors and on their ability to add to their busy lives. It will be interesting to see how it develops.

TABLE (i)—*Use of Centre*

	1.3.61 to 31.5.61	*1.6.61 to 31.8.61*	*1.9.61 to 30.11.61*	*1.12.61 to 28.2.62*	*Total*
Doctors using Centre ..	62	83	97	106	106
New patients	825	843	821	961	3,450
Patients seen	1,043	1,193	1,281	1,413	4,930
No. of investigations, etc. ..	1,268	1,481	1,592	1,842	6,183

TABLE (ii)—*Work in various departments*

	1.3.61 to 31.5.61	*1.6.61 to 31.8.61*	*1.9.61 to 30.11.61*	*1.12.61 to 28.2.62*	*Total*
Pathology investigations ..	488	517	584	677	2,266
Radiology investigations ..	451	454	441	677	2,023
Electrocephalograms	68	91	72	91	322
Allergy tests	16	52	42	19	129
Nursing treatments	187	306	385	330	1,208
Minor operations	33	36	42	22	133
Research investigations ..	25	25	26	26	102
	1,268	1,481	1,592	1,842	6,183

TABLE (iii)—*Pathology*

No. of requests received	2,215
No. of resulting investigations	2,216

Requests dealt with entirely at Centre	
Bacteriology ..	382
Chemical pathology	53
Haematology ..	1,451
	1,886

Requests dealt with in conjunction with other laboratories	
Bacteriology ..	45
Chemical pathology	87
Haematology ..	32
Histology	26
Miscellaneous ..	139
	329

TABLE (iv)—*Radiology*

No. of requests received		1,800
No. of resulting investigations:		
Chest	1,067	
Spine	172	
Skull	71	
Bones and joints	468	
Other	22	
		2,023

TABLE (v)—*Cost of setting up the Centre*

	£
Net expenditure by London County Council	19,700
Contribution by Nuffield Foundation	12,000
Expenditure by S.E. Metropolitan Regional Hospital Board	4,300
	£36,000

Details of expenditure

	£
Building works	15,850
Lift and staircase	7,200
Heating, water, electrical works and telephone	4,950
Furniture and non-specialist equipment	2,050
Layout of garden	550
Contract particulars	1,100
X-ray equipment	3,350
Pathological equipment	950
	£36,000

TABLE (vi)—*Cost of running Centre for first year*

	£
Net expenditure by London County Council	6,515
Expenditure by S.E. Metropolitan Regional Hospital Board	1,025
Expenditure by Camberwell Hospital Management Committee	3,060
Contribution from Sir Halley Stewart Trust	2,815
	£13,415

Details of expenditure

	£
L.C.C.:	
Salaries and wages of—	
nursing staff (3)	1,890
secretarial staff (2)	1,475
cleaner (1)	255
Provision and repair of equipment	225
Medical requisites	125
Printing, stationery, postage and telephones	980
Maintenance of building and grounds	500
Alterations and improvements to building	215
Heating, lighting, rates, transfer rent, etc.	540
Miscellaneous running expenses	310
L.C.C. reimbursed by Sir Halley Stewart Trust:	
Salary, etc., of Director	2,815
South East Metropolitan Regional Hospital Board:	
Salaries, etc., of two part-time consultants	1,025
Camberwell Hospital Management Committee:	
Salaries and wages of radiographers and laboratory technicians	1,580
Medical and surgical appliances and equipment	1,480

APPENDIX

The pattern of morbidity

The classification of all patients attending the Centre has made it possible to demonstrate the requirements of the doctors and to produce a pattern of the diseases and conditions which are thought to require investigation in making a diagnosis.

The requests by the practitioners, classified according to results in order of frequency, were:

Diagnostic Group	%
1. Symptoms and ill-defined conditions	20·4
2. Diseases of respiratory system	14·3
3. Diseases of blood and blood forming organs	13·0
4. Diseases of bones and organs of movement	10·6
5. Accidents and violence	10·3
6. Diseases of genito-urinary system	6.5
7. Diseases of circulatory system	4·5
8. Allergic, endocrine system, metabolic and nutritional diseases	4·3
9. Communicable diseases	3·4
10. Complications of pregnancy, childbirth and the puerperium	3·3
11. Diseases of skin and cellular tissue	3·2
12. Prophylactic procedures	2·2
13. Diseases of the digestive system	1·2
14. Mental, psychoneurotic and personality disorders	0·8
15. Neoplasms	0·7
16. Congenital malformations	0·7
17. Diseases of the nervous system and sense organs	0·6
18. Certain diseases of early infancy	—
	100·0

A few of these are examined here in a little more detail. Further particulars can be supplied on request to the Director.

Symptoms and ill-defined conditions—This was the largest group, containing a majority of results which were within normal limits. When related to the clinical details supplied the requests were all justified. In most cases either the tests were asked for as a precautionary measure or in checking the progress of a patient following an acute incident. Accidents, chest cases and possible anaemias figure largely in this number. Females greatly exceeded males in the group study. It is of some interest that an appreciable number of patients in this group had normal results apart from high sedimentation rates; this may be worthy of follow up.

			Age groups					
Patients	*Male*	*Female*	*20/29*	*30/39*	*40/49*	*X-ray*	*Pathology*	*ECG*
512	195	317	110	77	99	284	205	56

The age distribution was mainly in the mid-range, 286 patients between the ages of 20 and 49. X-ray investigations (284) were largely chests, bones and joints, pathology (205) chiefly haematology. The age groups of the patients referred for electric cardiograms with normal results are of some interest when compared with the table for diseases of the circulatory system which records abnormals.

		Age groups						
Male	*Female*	*16/19*	*20/29*	*30/39*	*40/49*	*50/59*	*60/69*	*70+*
40	16	1	4	5	16	18	11	1

Diseases of the respiratory system—In this case men slightly exceeded women and the commonest conditions investigated were acute and chronic bronchitis (246), pneumonia pneumonitis (128), upper respiratory tract invections (57), sinusitis (47), tonsillitis (26). There were seven spontaneous pneumothoraces, all between the ages of 16 and 30.

Diseases of the blood and blood-forming organs—These were mainly anaemias. Including only those outside the lowest recognised normal limits gave men (86) and women (367) suffering from hypochronic anaemia. The males were either very young or elderly. The women were mainly of child-bearing age, 42 of them being pregnant.

It is hoped to study anaemia in the age group 60 years and above in relation to malignant disease of the gastro-intestinal tract.

Diseases of bone and organs of movement—There were largely osteoarthritic and disc lesions including 266 women and 148 men. The remainder were mainly forms of arthritis, muscular rheumatism and fibrositis.

Accidents and violence—These were equally distributed between male and female, nearly all in the young, and many of them injuries connected with sport and recreation.

Diseases of the genito-urinary system—The great preponderance were women and almost all investigations were connected with cystitis and pyelonephritis.

Diseases of circulatory system—These were equally divided between men (90) and women (85). They were mainly cases of arteriosclerotic heart disease and coronary thrombosis. As would be expected, the cases of arteriosclerosis were mainly in the higher age range. There were a proportion of cases of hypertension and functional heart disease.

Patients with evidence of:	*Male*	*Female*	*Age groups* 5/15	16/19	20/29	30/39	40/49	50/59	60/69	70+
Arteriosclerosis and coronary disease ..	40	18	—	—	2	2	7	15	27	5
Other cardiac conditions	19	19	1	—	2	1	5	15	12	3

Of those with definite evidence of ischaemic heart disease, 11 were known to have had previous attacks. It is assumed that of the remainder the majority were first attacks. In all types 59 of the patients were working, 37 were not.

Diseases of allergic origin, metabolic, nutritional and endocrine diseases—These were nearly all associated with the allergy service and skin sensitisation tests. The distribution related to the presenting symptoms was asthma (35), hay fever (53), dermatoses (23), other allergic disorders (26), thyroid disorders (8), myxoedema (3), gout (7).

Allergic conditions tested

Patients		*Age groups*								
Male	*Female*	0/4	5/15	16/19	20/29	30/39	40/49	50/59	60/69	70+
61	69	3	25	14	28	25	24	10	1	—

Of these patients, 15 had previously been tested and eight treated; five with substantial improvement and three were free for two years. It is not known how many of those tested at the Centre have been treated but it is intended to carry out a follow-up check.

The lowest age group comprised two cases of asthma and one of eczema.

Communicable diseases—The figures of male (61), female (72) largely represent forms of tuberculosis. They are very much swollen as all cases shown by chest X-ray to have old lesions are included in this category. This was done purposely to enable a follow up to be done if necessary. There were also a number of cases of infective hepatitis and infectious mononucleosis.

Tuberculosis

Patients				*Age groups*								
Male	*Female*	*Working*	*Not working*	*0/4*	*5/15*	*16/19*	*20/29*	*30/39*	*40/49*	*50/59*	*60/69*	*70+*
40	43	54	29	—	4	4	6	20	11	20	14	4

Of these, it is estimated that new cases discovered totalled 11 and 72 patients who came for other investigations revealed evidence of old disease.

Delivery and complications of pregnancy, childbirth and the puerperium—The large proportion of these were patients (130) in the ante-natal stage who came for various prophylactic procedures. A few were anaemias following severe haemorrhage in labour.

Diseases of skin and cellular diseases—A high proportion of cases which came for dressings and minor operative procedures came into this category, e.g., boils, carbuncles, various forms of cellulitis and infectious warts.

Prophylactic procedures—Use was made of the Centre for carrying out examinations for administrative purposes (17) and for prophylaxis (68).

Diseases of the digestive system—There were comparatively very few of these as no barium investigations are done. Fifteen of the cases were conditions of the mouth.

Neoplasms—The majority (28) were benign, but several cases of malignant neoplasms were detected; others were old cases sent for check up.

Congenital malformations—An appreciable number (28) of congenital malformations were found during X-ray investigations of other conditions. The majority were not of any significant importance.

Diseases of nervous system and sense organs—These were mainly associated with diseases of the ears: acute and chronic otitis, and cerumen.

APPENDIX E

Statistics of the administrative work carried out by the Metropolitan Borough Councils in 1961.

DWELLINGS, CLEARANCE AREAS and DWELLING HOUSES (Inspections)

Borough	Dwellings: Erected by Borough Council	Dwellings: Erected by other persons	Dwellings: Total number in the Borough	Clearance Areas: Unfit houses: Demolished	Clearance Areas: Unfit houses: Persons displaced	Clearance Areas: Other houses: Demolished	Clearance Areas: Other houses: Persons displaced	Inspections: Initial visits on complaint	Inspections: With a view to action under Part II of the Housing Act, 1957	Inspections: Other reasons	Inspections: Re-inspections
Division 1											
Chelsea	68	36	16,517	—	—	—	—	807	—	14,179	7,524
Fulham	30	40	30,259	29	67	—	—	1,275	37	2,217	4,747
Hammersmith	10	—	28,191	30	109	9	†	2,324	185	2,621	7,898
Kensington	178	424	40,437	—	401	—	—	2,679	1,173	6,654	23,412
Division 2											
Hampstead	8	171	24,078	—	—	—	—	742	81	12,664	12,560
Paddington	10	238	38,225	17	100	—	64	3,325	229	4,079	21,312
St. Marylebone	92	204	24,721	12	24	—	—	629	270	167	3,067
St. Pancras	297	161	29,533	103	584	—	—	2,645	132	2,287	9,175
Westminster, City of	271	224	27,486	6	51	1	6	853	189	3,272	6,912
Division 3											
Finsbury	—	80	9,864	184	651	—	—	832	7	4,220	9,124
Holborn	—	5	6,105	—	—	—	—	79	146	2,431	691
Islington	88	316	46,853	4	129	—	—	4,282	215	2,467	16,628
Division 4											
Hackney	282	37	42,326	—	17	—	—	4,374	405	18,088	28,636
Shoreditch	142	14	11,843	—	—	—	—	1,407	170	1,695	6,762
Stoke Newington	18	191	12,215	—	—	—	—	1,316	—	5,136	3,322
Division 5											
Bethnal Green	31	6	15,057	36	110	34	51	2,008	652	6,222	6,076
City of London	—	—	1,044	—	—	—	—	4	—	20	24
Poplar	18	726	17,064	—	—	—	—	1,446	338	921	7,803
Stepney	93	403	27,257	—	111	—	—	3,221	—	8,105	4,166
Division 6											
Deptford	130	225	17,920	—	—	—	—	1,178	21	5,889	9,844
Greenwich	—	89	24,736	74	243	—	—	1,910	25	6,660	9,546
Woolwich	503	1,005	44,439	116	350	62	47	1,184	213	7,615	6,305
Division 7											
Camberwell	30	248	45,239	68	195	—	—	4,830	978	25,503	13,695
Lewisham	207	493	65,330	28	31	6	†	1,284	54	14,943	14,737
Division 8											
Bermondsey	94	175	15,454	76	181	18	49	1,866	10	2,283	13,213
Lambeth	264	157	56,854	—	61	—	—	2,955	76	2,386	9,260
Southwark	—	326	25,004	67	228	—	—	2,582	80	12,956	4,878
Division 9											
Battersea	293	77	29,387	100	364	49	402	2,438	24	5,012	9,801
Wandsworth	408	725	120,120	70	57	—	22	5,422	15	13,691	16,725
LONDON	3,565	6,796	893,558	1,020	4,064	179	641	59,897	5,725	221,383	287,843

DWELLING HOUSES (continued)

Borough	Repaired as a result of informal action	Defects remedied after service of formal notice: Public Health (London) Act, 1936: By owners	Public Health (London) Act, 1936: By local authority	Housing Act, 1957: By owners	Housing Act, 1957: By local authority	Housing Act, 1957: Made fit for occupation by number of families accommodated	Housing Act, 1957: Overcrowding abated	Houses closed in pursuance of owners' undertaking	Demolition Orders made	Persons displaced	Closing Orders made in lieu of Demolition Orders	Persons displaced	Closing Orders determined	Closing Orders revoked and Demolition Orders made	Houses demolished as a result of formal or informal procedure	Persons displaced
Division 1																
Chelsea	126	51	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Fulham	867	867	11	—	2	2	2	—	1	3	—	—	3	—	1	—
Hammersmith	310	323	—	—	—	—	—	—	—	—	3	7	4	—	—	—
Kensington	610	263	7	2	—	—	—	—	1	5	3	23	6	—	9	35
Division 2																
Hampstead	586	99	—	13	2	—	—	—	24	78	—	—	3	—	24	78
Paddington	702	364	3	—	—	—	—	—	—	—	1	2	100	—	—	—
St. Marylebone	210	70	—	—	—	—	—	—	—	—	—	—	16	—	—	—
St. Pancras	977	857	17	—	—	—	—	—	—	—	17	—	31	—	—	—
Westminster, City of	270	6	—	—	—	—	—	—	1	4	—	—	11	—	2	—
Division 3																
Finsbury	502	64	3	—	—	—	—	—	—	—	4	5	1	—	1	—
Holborn	64	3	—	—	—	—	—	—	—	—	—	—	—	—	—	—
Islington	1,429	842	24	—	—	—	—	—	1	—	21	538	76	—	29	—
Division 4																
Hackney	94	1,452	30	1	—	—	—	—	—	—	3	9	23	—	5	—
Shoreditch	702	76	—	—	—	—	2	3	5	14	2	5	—	—	18	—
Stoke Newington	207	174	8	—	—	—	—	—	—	—	1	6	4	—	—	—
Division 5																
Bethnal Green	858	366	9	—	—	—	—	—	1	—	—	—	—	—	—	—
City of London	5	—	—	—	—	—	—	—	—	—	1	7	—	—	—	—
Poplar	990	327	—	—	—	1	7	—	2	7	—	—	—	3	4	15
Stepney	335	1,325	40	—	—	—	—	—	5	13	2	†	1	—	1	13
Division 6																
Deptford	426	215	1	2	—	—	2	—	—	—	—	—	1	—	—	—
Greenwich	380	183	4	—	—	—	—	—	—	—	1	9	1	—	—	—
Woolwich	517	259	—	—	—	—	7	—	3	13	7	35	4	—	2	—
Division 7																
Camberwell	447	1,583	5	9	—	1	1	—	—	—	2	5	5	1	3	—
Lewisham	134	379	—	8	—	—	—	—	7	21	4	16	10	—	14	21
Division 8																
Bermondsey	710	238	1	—	—	2	—	—	—	—	9	35	—	—	—	—
Lambeth	643	568	108	—	—	—	—	—	—	—	—	—	—	—	3	—
Southwark	707	523	33	—	—	—	—	2	1	4	—	—	9	2	50	163
Division 9																
Battersea	403	519	13	11	—	—	—	—	—	—	4	33	2	—	1	6
Wandsworth	854	425	6	—	—	2	2	1	—	1	—	11	8	—	1	—
LONDON	15,065	12,421	323	46	4	8	23	6	52	163	85	746	319	6	168	331

DWELLING HOUSES (concluded), AIR POLLUTION and CLEANSING AND DISINFECTION

Borough	Rooms closed: Underground rooms: Number	Rooms closed: Underground rooms: Persons displaced	Rooms closed: Other rooms: Number	Rooms closed: Other rooms: Persons displaced	Undertakings accepted: Underground rooms: Number	Undertakings accepted: Underground rooms: Persons displaced	Undertakings accepted: Other rooms: Number	Water supply provided to tenement houses	Air Pollution: Complaints	Observations	Intimation notices served	Nuisance notices served	Prosecutions	Smoke Control Orders confirmed	Cleansing: Adults cleansed: At home	Adults cleansed: At cleansing station	Children cleansed
Division 1																	
Chelsea	—	—	—	—	—	—	—	1	28	20	—	—	—	1	—	77	35
Fulham	3	6	5	8	—	—	—	—	37	94	—	—	—	1	—	45	2
Hammersmith	—	—	—	—	—	—	—	1	—	—	4	—	—	1	—	413	204
Kensington	75	41	11	8	3	—	2	—	17	19	—	—	—	1	3	214	550
Division 2																	
Hampstead	8	14	—	—	—	—	—	10	46	233	—	—	—	1	—	14	8
Paddington	113	6	3	2	1	—	—	19	20	117	3	—	—	1	68	109	23
St. Marylebone	3	6	—	—	1	3	—	—	108	52	29	1	—	2	—	1,120	160
St. Pancras	76	—	8	—	—	—	—	19	60	61	27	—	—	1	—	715	218
Westminster, City of	12	21	3	9	—	—	—	—	41	572	—	—	—	1	—	557	—
Division 3																	
Finsbury	14	—	—	—	—	—	—	3	32	310	5	—	—	2	—	67	40
Holborn	2	—	—	—	1	—	—	1	58	210	1	—	—	1	—	80	—
Islington	28	122	3	17	1	—	—	11	46	388	20	39	—	4	146	148	250
Division 4																	
Hackney	103	62	19	†	—	—	—	—	150	378	—	2	7	1	—	75	26
Shoreditch	5	5	—	—	11	6	—	2	12	457	6	—	—	2	—	7	—
Stoke Newington	2	—	—	—	6	—	—	—	39	42	—	—	—	3	—	15	1
Division 5																	
Bethnal Green	5	—	3	—	—	—	—	—	16	23	—	—	—	1	201	99	5
City of London	—	—	—	—	—	—	—	—	9	—	—	*	—	—	—	945	—
Poplar	—	—	—	—	—	—	—	2	92	147	—	—	—	5	—	44	2
Stepney	2	—	—	—	—	—	—	2	100	125	—	2	—	1	87	241	25
Division 6																	
Deptford	18	—	—	—	—	—	—	—	120	866	1	—	—	1	613	502	204
Greenwich	—	—	—	—	1	—	—	—	15	68	4	4	1	1	1,502	580	100
Woolwich	—	—	—	—	—	—	—	—	20	23	—	—	—	5	103	23	124
Division 7																	
Camberwell	—	1	1	22	—	—	1	—	18	279	1	—	1	1	—	92	184
Lewisham	—	—	48	10	—	—	3	—	7	—	—	—	—	2	—	28	73
Division 8																	
Bermondsey	—	—	4	2	—	—	—	—	8	69	—	—	1	1	—	28	3
Lambeth	3	3	1	—	—	—	—	—	20	167	—	—	—	—	—	75	69
Southwark	2	1	1	2	18	38	—	—	15	210	12	—	—	1	—	948	514
Division 9																	
Battersea	6	9	2	4	—	—	—	—	11	333	1	—	—	1	—	86	305
Wandsworth	6	10	3	†	1	—	2	—	121	282	4	—	—	1	—	33	13
LONDON	486	307	115	84	44	47	8	71	1,266	5,545	118	48	10	44	2,723	7,380	3,140

CLEANSING AND DISINFECTION (concluded), LICENSED OR REGISTERED PREMISES and PUBLIC HEALTH INSPECTORS

Borough	Premises disinfected	Premises disinfested	Licensed slaughterhouses	Other offensive trades	Common and Seamen's Lodging Houses	Dairies and milk shops	Ice cream premises	Establishment	Employed at end of year: Male	Employed at end of year: Female	Employed at end of year: Total	Assistants employed at end of year: Male	Assistants: Female	Assistants: Total
Division 1														
Chelsea	226	337	—	—	—	59	116	9	6	2	8	—	—	—
Fulham	55	514	—	—	—	123	228	16	10	1	11	4	—	4
Hammersmith	55	537	—	—	—	276	418	12	9	—	9	1	—	1
Kensington	291	1,544	—	—	—	201	377§	14	13	—	13	1	—	1
Division 2														
Hampstead	135	327	—	—	—	69§	266	13	12	1	13	2	1	3
Paddington	81	639	—	—	—	141	211	17	11	1	12	3	—	3
St. Marylebone	59	248	—	1	2	92	187	15	10	3	13	1	—	1
St. Pancras	279	393	—	—	—	246	239	19	18	1	19	—	—	—
Westminster, City of	142	530	—	—	2	129	246	20	18	—	18	2	—	2
Division 3														
Finsbury	179	402	—	—	1	131	162	10	10	—	10	2	—	2
Holborn	65	160	—	5	2	74	141	5	4	—	4	—	—	—
Islington	628	1,260	1	11	—	351	557	34	23	2	25	2	—	2
Division 4														
Hackney	450	553	—	5	1	209	445	20	18	—	18	5	—	5
Shoreditch	60	552	—	1	—	84	111	9	5	—	5	2	—	2
Stoke Newington	54	79	—	—	—	55	116	7	7	—	7	—	—	—
Division 5														
Bethnal Green	8	418	—	2	—	93	142	9	8	—	8	2	—	2
City of London	2	18	—	—	1	23	72	19	19	—	19	—	—	—
Poplar	119	2,080	—	1	3	100	197	9	8	—	8	4	—	4
Stepney	37	1,774	—	18§	5	230	324	18	15	—	15	2	—	2
Division 6														
Deptford	106	324	—	—	1	93	198	8	7	—	7	3	—	3
Greenwich	74	1,872	—	—	—	194	232	10	9	1	10	—	—	—
Woolwich	148	362	1	1	—	134	329	19	17	1	18	1	—	1
Division 7														
Camberwell	164	1,093	—	3	1	226	524	20	16	—	16	3	1	4
Lewisham	351	258	—	—	—	120	351	20	20	—	20	4	—	4
Division 8														
Bermondsey	3	297	—	8	1	138	211	11	10	—	10	1	—	1
Lambeth	169	1,077	—	1	—	277	598	21	15	1	16	—	—	—
Southwark	52	1,211	—	3	6	147	306	20	16	1	17	4	—	4
Division 9														
Battersea	1,064	269	—	2	—	135	273	16	11	1	12	1	—	1
Wandsworth	214	291	—	—	—	304	754	22	15	—	15	3	—	3
LONDON	5,270	19,419	2	62	26	4,454	8,331	442	360	16	376	53	2	55

* The whole of the City of London is a Smokeless Zone under the City of London (Various Powers) Act, 1954.

† Included in the previous column.

§ One prosecution.

APPENDIX F

STAFF OF THE PUBLIC HEALTH DEPARTMENT AT 31 DECEMBER, 1961

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	D. J. B. Cooper

Principal Medical Officers

Maternity and child welfare	Dorothy F. Egan
School health	G. D. Pirrie
Epidemiology	Ian Taylor
Tuberculosis	W. Hartston
Mental health	C. W. J. Ingham
Staff medical examinations	R. Cove-Smith

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 G. M. Howes W. H. Joyce
Officer-in-Charge, London Ambulance Service	F. A. Richardson
Statistician	C. W. Shaddick
Chief Inspector	J. C. Clancey
Principal Organiser of Children's Care Work	Frances C. K. Gregson
Principal Mental Welfare Officer	Olive K. Bowtell

Senior Officers of the Divisions

Division	*Divisional Medical Officer*	*Divisional Administrative Officer*	*Divisional Nursing Officer*
1.	Bertha E. A. Sharpe	T. A. Stone	Joan A. Surr
2.	H. L. Oldershaw	N. A. Woodruff	Eveline Beattie
3.	W. G. Harding	N. B. Chapman	Margery D. Butler
4.	S. King	J. C. Minter	Lilian E. Arrow
5.	G. O. Mitchell	E. L. Hannant	Elizabeth J. Early
6.	F. R. Waldron	L. M. Longhurst	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

INDEX

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 96-110.

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