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LONDON COUNTY COUNCIL

Report of the County Medical Officer of Health and Principal School Medical Officer for the Year 1964

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By A. B. STEWART, M.D., D.P.H.

THE COUNTY MEDICAL OFFICER OF HEALTH AND PRINCIPAL SCHOOL MEDICAL OFFICER

THE COUNTY HALL
LONDON, S.E.1

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CONTENTS

INTRODUCTION

In 1892 Sir Shirley Murphy prefaced the first annual report of the Medical Officer of Health of the Administrative County of London with the following statement:

> "The passing of the Public Health (London) Act, 1891, having placed the London County Council in direct relation with sanitary administration in the administrative county of London, I propose to present to the Council each year a report on the health of London."

Both he and his successor, Sir William Hamer, were much concerned with the control of infectious disease and with matters relating to housing. It was evident from the space devoted to certain of the infectious diseases that they were the cause of very grave concern, as the following short table will show:

	Deaths	
	1892	*1964*
Smallpox	29	—
Measles	2,388	2
Scarlet fever	1,169	—
Diphtheria	1,859	—
Whooping cough	2,491	—
Enteric fever	424	—
Erysipelas	292	—
Influenza	2,264	28
Pneumonia	6,164	2,256
Pulmonary tuberculosis	8,053	178

The population in 1892 was 4,284,678, in 1964 3,179,000.

The infant mortality rate for children under one year of age per thousand births was 154 in London in 1892 compared with the present day rate of 21·3. Sir William Hamer's successor in 1926, Sir Frederick Menzies, included in the report for 1925, in collaboration with his predecessor, a report presenting a review of London's health record during the existence of the Council up to that date. He made comment on progress made in housing by the aid of the Housing of the Working Classes Act and the new Building Act of 1894. During this period the school medical work came under the direction of the County Council and had the benefit of the services of Dr. James Kerr who from 1902 played a leading part in the school health service. Sir Frederick Menzies' great contribution to public health was mainly in the field of the re-organisation of London's hospital services. This work was, of course, interrupted by the war in 1939 when Sir Frederick retired. His successors, Sir Allen Daley and Dr. J. A. Scott, devoted their energies to the re-organisation of the personal health services which were transferred to the Council as a result of the National Health Service Act of 1946. Their successor has recently had to devote a great deal of effort to the transfer of services to the new London Boroughs.

In the course of this transfer papers on nearly every aspect of the subject were transmitted to a working party set up to facilitate the working of the London Government Act of 1963, whose reports were furnished to the new Inner London Boroughs together with memoranda on the procedure in use by the London County Council. These documents have been preserved in three volumes which constitute a veritable Doomsday Book of the personal health services as they were in 1964. Inevitably, with progress, they will become out of date but they probably represent the best documented evidence for future historians of how the personal health services had developed.

The County Council's successor, the Greater London Council, is still responsible for the Ambulance Service and has certain duties in slum clearance. The Inner London Education Authority, the other heir to the London County Council, will continue to be responsible for the School Health Service. Although this is the last report as at present constituted it is hoped that the Greater London Council will in "London Statistics" publish a chapter of health statistics annually which will cover not only the old London County Council area but also that of the new Greater London Council.

LONDON ADMINISTRATIVE COUNTY

VITAL STATISTICS, 1964

Figures in brackets are for 1963

Population:

Males	1,504,000	3,185,000 (3,179,000)
Females	1,681,000	

Area comparability factors:

Births	0·86 (0·86)
Deaths	1·06 (1·05)

Number of marriages registered: 32,953 (34,107)

Live births:

Legitimate ..	54,420 (54,465)	63,500 (63,500)
Illegitimate ..	9,080 (9,035)	

Illegitimate live births per cent. of total live births: 14·3 (14·2)

Live birth rate per 1,000 population: 19·9 (20·0) (adjusted rate 17·1 (17·2))

Stillbirths:

Legitimate ..	787 (837)	964 (1,018)
Illegitimate ..	177 (181)	

Stillbirth rate per 1,000 live and stillbirths: 15·0 (15·8)

Total live and stillbirths: 64,464 (64,518)

Deaths:

Males	17,827 (19,866)	35,056 (39,590)
Females	17,229 (19,724)	

Death rate per 1,000 population: 11·0 (12.5) (adjusted rate 11·7 (13·1))

Deaths of infants:

	Legitimate	*Illegitimate*	*Total*
Under 1 month	758 (756)	187 (167)	945 (923)
1 month to 1 year	357 (404)	52 (58)	409 (462)
Total under 1 year	1,115 (1,160)	239 (225)	1,354 (1,385)
Infant mortality rate: .. .. (per 1,000 live births)	20·5 (21·3)	26·3 (24·9)	21·3 (21·8)
Neo-natal mortality rate: .. „ „ „ „	13·9 (13·9)	20·6 (18·5)	14·9 (14·5)
Early neo-natal mortality rate: „ „ „ „	12·5 (12·0)	18·6 (16·7)	13·4 (12·6)
Perinatal mortality rate: .. (per 1,000 total births)	26·6 (26·9)	37·4 (36·0)	28·1 (28·7)

Maternal mortality:

	Post-abortion	*Other pregnancy and childbirth*	*Total*	*Rate per 1,000 live and stillbirths*
Deaths from sepsis	8 (9)	— (—)	8 (9)	
Deaths from other causes ..	1 (1)	14 (18)	15 (19)	
Total ..	9 (10)	14 (18)	23 (28)	0·36 (0·43)

VITAL STATISTICS*

Population

TABLE (i)—*Home population* †, 1955–64

(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+	
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		3,180	247	396	404	893	839	401	37·5
1962		3,186	248	378	422	894	838	406	37·7
1963		3,179	269	368	434	893	826	389	37·2
1964 ..	M	1,504	129	184	212	455	386	138	35·7
	F	*1,681*	*122*	*177*	*235*	*447*	*444*	*256*	*39·2*
		3,185	**251**	**361**	**447**	**902**	**830**	**394**	**37·5**

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

The population figure for 1964 is the estimate based on the final adjustments to the 1961 census enumerated population and therefore the apparent increase of 6,000 on the 1963 estimate may not be a real one. These adjustments make it very difficult to ascertain the trend of population over the past two-three years; all that can be said with any reliability is that there has not been very much change in the total figure. Differences in the age group estimates are also attributable more to adjustments of the figures than to real changes in the age composition of the population. For example, the apparent fall of 18,000 in the 0–4 years age group between 1963 and 1964 is unlikely to be a real change in view of the rise in the annual number of births in the last few years.

Fertility

TABLE (ii)—*Live births and stillbirths*, 1955–64

Year		Live births		Stillbirths	
		No.	Rate per 1,000 population	No.	Rate per 1,000 total births (live and still)
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
1962	..	62,524	19·6	1,054	16·6
1963	..	63,500	20·0	1,018	15·8
1964	..	63,500	19·9	964	15·0

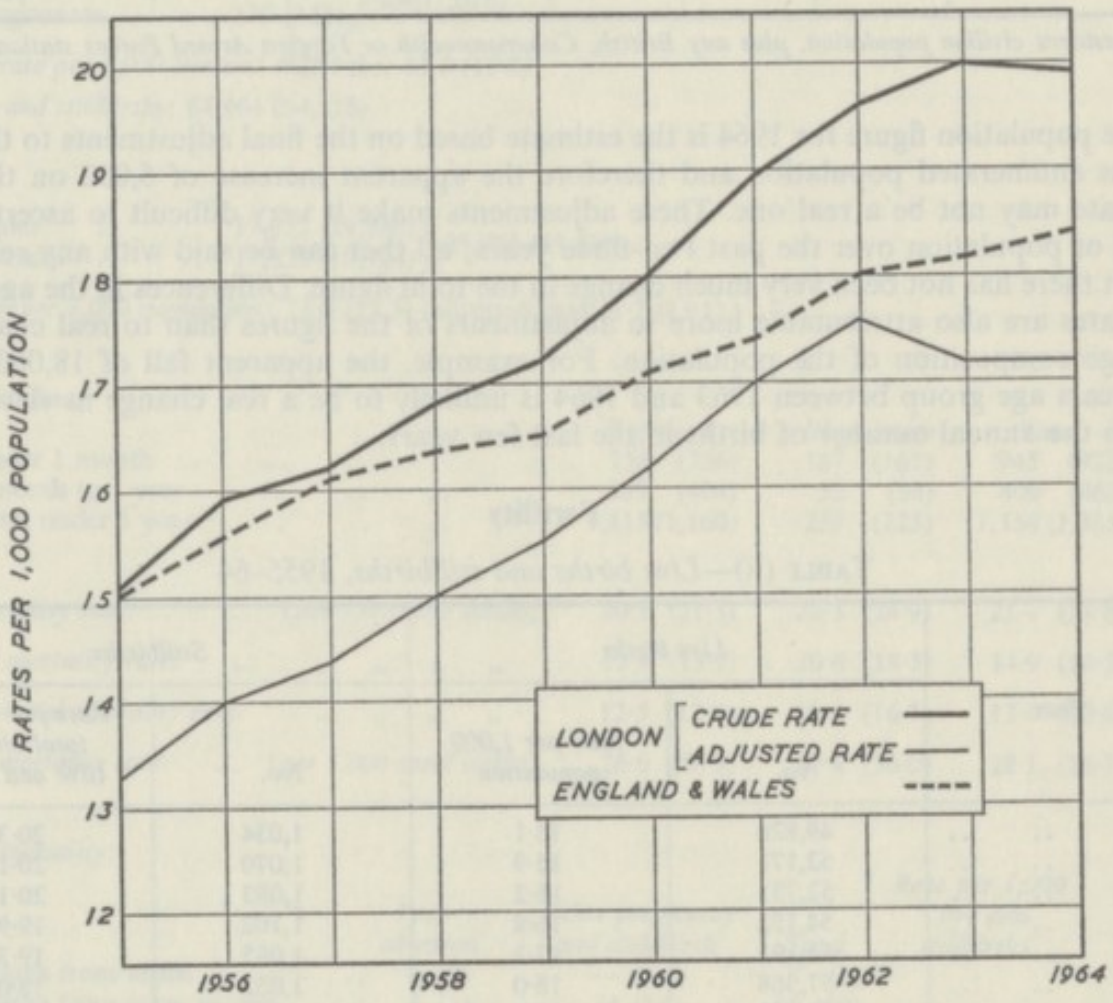
* *The statistics given are based on the latest information available from the Registrar General: instances have occurred in the past in which figures have been subsequently corrected so that data for a previous year may differ from that published in the Annual Report for that year.*

Live births—There were 73,962 live births registered in London in the year; after correction for residence the final figure of births allocated to London was 63,500 (32,529 boys–30,971 girls), the same total as in 1963, which on the increased population of 1964 gives a birth rate of 19·9 per 1,000 population compared with 20·0 in 1963 and 19·6 in 1962. 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; since then the crude London rate has continued to exceed the national rate but whereas in 1964 the London birth rate remained at virtually the same level as that of the previous year that for England and Wales has continued to rise. 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 (0·86 for 1964) the rate becomes 17·1. 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, 1955–64



Illegitimacy—

TABLE (iii)—*Illegitimate live births in London (A.C.) and percentages for London and England and Wales*, 1955–64

Year	Illegitimate live births	Illegitimate live births as a percentage of total live births		Ratio London/ England and Wales
		London (A.C.)	England and Wales	
1955..	3,827	7·7	4·7	1·64
1956..	4,434	8·5	4·8	1·77
1957..	4,686	8·9	4·8	1·85
1958..	5,343	9·9	4·9	2·02
1959..	5,765	10·4	5·1	2·03
1960..	6,530	11·4	5·4	2·11
1961..	7,632	12·7	6·0	2·12
1962..	8,835	14·1	6·6	2·13
1963..	9,035	14·2	6·9	2·06
1964..	9,080	14.3	7·2	1·99

The increase in the percentage of illegitimate live births in London noted in previous years shows signs of slowing down, but the London figure is currently twice the national percentage compared with about one and a half times as great ten years earlier. As in the previous year, one in every seven babies born of London 'residents' in 1964 was illegitimate; in Paddington it was as high as one in four born illegitimate. The age of the mothers of these illegitimate children is shown in table (iv) below.

TABLE (iv)—*Illegitimate live births by age of mother*

Age of mother (a) (years)	London (A.C.)								England and Wales 1963
	1961		1962		1963		1964		
	No.	%	No.	%	No.	%	No.	%	%
12	—	—	—	—	2	0·02	1	0·01	0·0
13	4	0·1	1	0·01	4	0·04	1	0·01	0·0
14	11	0·1	19	0·2	19	0·2	9	0·1	0·3
15	61	0·8	104	1·2	93	1·0	70	0·8	1·6
16	147	1·9	168	1·9	196	2·2	202	2·2	3·8
17	239	3·1	297	3·4	329	3·6	361	4·0	5·6
18	388	5·1	440	5·0	436	4·8	477	5·2	7·0
19	508	6·7	603	6·8	690	7·6	606	6·7	8·0
20–24	2,780	36·4	3,254	36·8	3,265	36·2	3,301	36·4	32·2
25–29	1,714	22·5	2,017	22·8	2,018	22·4	2,091	23·0	19·4
30–34	998	13·1	1,112	12·6	1,141	12·6	1,127	12·4	11·9
35–39	581	7·6	610	6·9	622	6·9	601	6·6	7·1
40–44	186	2·4	196	2·2	206	2·3	219	2·4	2·9
45 and over ..	15	0·2	14	0·2	14	0·2	14	0·2	0·2
Total	7,632	100·0	8,835	100·0	9,035	100·0	9,080	100·0	100·0

(a) Cases in which the mother's age was not stated (40 in 1961, 42 in 1962, 39 in 1963, 33 in 1964) have been proportionally distributed.

It will be noted that the national figures show proportionately more illegitimacies among mothers below the age of 20 years.

It has been remarked in previous years that a complex of factors probably accounts for the higher rate in London—proportionately more single women (37·0 per cent. of those aged 16–44 years in London, compared with 26·9 per cent. in England and Wales (Census 1961)), a high immigrant element in the population, 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.

The following table gives details of women seen by the moral welfare organisations in 1964, from which it will be seen that 1,001 (28·5 per cent.) were pregnant on arrival in London and that, in all, 1,216 (34·6 per cent.) were not born in the United Kingdom. It should be remembered that these components of the illegitimate births are minima; the moral welfare organisations only dealt with 39 per cent. of unmarried mothers, though doubtless they will tend to deal with proportionately more of the non-Londoners.

TABLE (V)—*Unmarried mothers seen by moral welfare associations in London*, 1964

(*Figures in brackets are for 1963*)

	British (U.K.)		*Eire*		*European*		*West Indian*		*Other*		*Total*	
Non-Londoners pregnant on arrival in London	593	(509)	283	(141)	37	(43)	32	(28)	56	(35)	1,001	(756)
*Non-Londoners not pregnant on arrival in London ..	53	(89)	29	(118)	12	(24)	4	(7)	5	(15)	103	(253)
Resident in London one year or more ..	1,654	(1,506)	384	(425)	80	(92)	206	(306)	88	(97)	2,412	(2,426)
	2,300	(2,104)	696	(684)	129	(159)	242	(341)	149	(147)	3,516	(3,435)

* *Had lived in London less than 12 months before making contact with moral welfare association.*

Mortality

The total death rate at 11·0 per 1,000 population was the lowest figure since 1954 (the number of deaths was the lowest ever recorded in London A.C.).

Leading causes of death—The leading causes of death in London in 1964 were as follows:

	Deaths	*Rate per 1,000 population*
Diseases of the heart	10,419	3·27
Cancer	7,946	2·50
Bronchitis, pneumonia*	4,360	1·37
Vascular lesions of the central nervous system	3,672	1·15
Other circulatory	1,978	0·62
Violent causes	1,669	0·52
Digestive diseases	1,078	0·34
Diseases of early infancy (international classification nos. 760–776)	713	0·28
Congenital malformations (0–4 weeks)	184	
Diseases of genito-urinary system	682	0·21
Other respiratory including influenza	347	0·11
Tuberculosis (all forms)	198	0·06
All other causes	1,810	0·57
Total	35,056	11·01

* *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 has remained unchanged since 1954.

Cancer—The cancer death-rate for all ages was 2·50 per 1,000 in 1964—the highest figure since 1960. 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 (vi)—*Cancer mortality rates per* 1,000 *living*, 1955–64

Age and sex	*1955*	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*	*1962*	*1963*	*1964*
Males:										
0–24	0·11	0·14	0·11	0·09	0·10	0·12	0·11	0·11	0·09	0·10
25–44	0·40	0·43	0·37	0·42	0·40	0·38	0·37	0·38	0·37	0·41
45–64	4·50	4·51	4·55	4·52	4·46	4·75	4·52	4·53	4·57	4·67
65+	15·73	15·77	15·29	16·01	15·20	15·74	15·72	15·40	16·06	16·90
All Males ..	2·73	2·76	2·77	2·85	2·76	2·90	2·83	2·81	2·78	2·91
Females:										
0–24	0·07	0·09	0·07	0·10	0·07	0·07	0·07	0·08	0·08	0·05
25–44	0·45	0·50	0·47	0·52	0·51	0·52	0·50	0·43	0·46	0·47
45–64	2·93	2·77	2·97	2·71	2·63	2·82	2·72	2·81	2·79	2·77
65+	8·43	8·75	8·34	8·50	8·18	8·44	8·02	7·93	8·37	8·24
All Females ..	2·08	2·12	2·16	2·15	2·09	2·20	2·11	2·12	2·14	2·13
All Persons ..	2·39	2·42	2·44	2·47	2·40	2·53	2·45	2·44	2·44	2·50

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 (vii)—*Deaths and death rates from cancer of the lung by age and sex*, 1955–64

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

Year	*Age*					
	25–44		*45–64*		*65+*	
	No.	*Rate*	*No.*	*Rate*	*No.*	*Rate*
Males:						
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
1962 ..	37	0·08	903	2·33	860	5·93
1963 ..	44	0·10	907	2·37	865	6·31
1964 ..	49	0·11	924	2·39	935	6·78
Females:						
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
1962 ..	13	0·03	153	0·34	189	0·72
1963 ..	14	0·03	160	0·36	218	0·87
1964 ..	21	0·05	173	0·39	243	0·95

Infant mortality

TABLE (viii)—*Infant mortality*, 1964

	Age at death					*Rates per 1,000 live births*		
	Under 1 day	*1 to 6 days*	*1 to 3 wks.*	*1 to 11 mnths*	*Total under 1 yr.*	*Early neo-natal*	*Neo-natal*	*Total infant mortal-ity*
Legitimate								
Males	235	162	44	226	667	14·2	15·8	23·9
Females	175	108	34	131	448	10·7	11·9	16·9
	410	**270**	**78**	**357**	**1,115**	**12·5**	**13·9**	**20·5**
1963	*414*	*237*	*105*	*404*	*1,160*	*12·0*	*13·9*	*21·3*
Illegitimate								
Males	55	32	7	24	118	18·7	20·2	25·4
Females	56	26	11	28	121	18·5	21·0	27·3
	111	**58**	**18**	**52**	**239**	**18·6**	**20·6**	**26·3**
1963	*103*	*48*	*16*	*58*	*225*	*16·7*	*18·5*	*24·9*
Total legitimate and illegitimate								
Males	290	194	51	250	785	14·9	16·4	24·1
Females	231	134	45	159	569	11·8	13·2	18·4
Both sexes	**521**	**328**	**96**	**409**	**1,354**	**13·4**	**14·9**	**21·3**
1963	*517*	*285*	*121*	*462*	*1,385*	*12·6*	*14·5*	*21·8*

The pattern of infant mortality over the past decade is given in table (ix) below:

TABLE (ix)—*Infant mortality by cause*, 1955–64

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

Cause of death	*1955*	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*	*1962*	*1963*	*1964*
Whooping cough	0·06	0·04	0·02	—	0·05	0·05	—	0·03	0·03	—
Tuberculosis	—	—	—	—	0·02	0·03	0·03	—	—	—
Measles	0·10	—	—	—	—	—	0·03	0·02	0·02	—
Bronchitis and pneumonia	3·57	3·32	2·88	3·45	3·50	3·63	3·18	3·63	4·35	3·81
Gastro-enteritis	0·48	0·35	0·42	0·31	0·27	0·16	0·30	0·37	0·44	0·41
Congenital malformations ..	3·43	3·70	3·96	4·51	4·75	4·32	3·94	3·68	4·11	4·22
Injury at birth	2·59	2·64	2·98	2·27	2·46	2·55	2·81	2·45	2·44	2·71
Post-natal asphyxia and atelectasis	4·32	3·66	4·17	4·08	3·59	3·63	3·61	3·63	3·17	3·26
Haemolytic disease	0·58	0·61	0·51	0·44	0·51	0·54	0·37	0·34	0·47	0·39
Immaturity	4·67	4·10	4·27	4·69	3·86	3·71	3·85	3·47	2·94	2·79
Convulsions	—	0·02	—	—	—	—	—	—	—	—
Accidental mechanical suffocation	0·06	0·21	0·23	0·13	0·16	0·09	0·13	0·16	0·06	0·13
Other causes	3·35	2·55	2·56	2·60	3·26	2·77	3·10	3·28	3·78	3·60
All causes	23	21	22	22	22	21	21	21	22	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*)

Year	Neo-natal mortality		Infant mortality	
	London	England and Wales	London	England and Wales
1955	16·7	17·3	23·2	24·9
1956	15·9	16·8	21·2	23·7
1957	16·3	16·5	22·0	23·1
1958	16·6	16·2	22·5	22·6
1959	15·7	15·8	22·4	22·2
1960	15·4	15·6	21·5	21·9
1961	15·9	15·5	21·4	21·6
1962	15·2	15·1	21·0	21·6
1963	14·5	14·2	21·8	21·1
1964	14·9	13·8	21·3	20·0

As regards neo-natal mortality there were 945 deaths in London; of this number 562 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 62.

TABLE (x)—*Prematurity and mortality by birth weight*, 1964.

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	652	13·9	239	36·7	318	48·8
3 lb. 5 oz. to 4 lb. 6 oz.	744	15·8	56	7·5	650	87·4
4 lb. 7 oz. to 4 lb. 15 oz.	939	20·0	35	3·7	877	93·4
5 lb. 0 oz. to 5 lb. 8 oz. ..	2,366	50·3	38	1·6	2,294	97·0
All premature babies ..	4,701	100·0	368	7·8	4,139	88·0

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
1955	34·8	37·6	1960	31·2	32·9
1956	33·3	36·8	1961	32·0	32·2
1957	34·2	36·2	1962	29·8	30·8
1958	34·3	35·1	1963	28·7	29·3
1959	32·7	34·2	1964	28·1	28·2

The deaths in the first day of life are shown in table (viii) 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) Act, 1960 and the following table gives the causes for 1964.

TABLE (xi)—*Causes of stillbirth*, 1964

*Code No.**	*Cause*	*Male*		*Female*	
		Number	*Per cent.*	*Number*	*Per cent.*
Y.30	Chronic disease in mother	24	4·6	18	4·1
Y.31	Acute disease in mother	2	0·4	2	0·5
Y.32	Diseases and conditions of pregnancy and childbirth:				
	(1) Ectopic gestation	—	—	—	—
	(2) Haemorrhage	26	5·0	19	4·3
	(3 and 4) Toxaemia	69	13·1	39	8·9
	(5) Infection	—	—	3	0·7
Y.34	Difficulties in labour..	28	5·3	30	6·8
Y.35	Other causes in mother	3	0·6	1	0·2
Y.36	Placental and cord conditions	161	30·7	119	27·2
Y.37	Birth injury	17	3·2	14	3·2
Y.38	Congenital malformation of foetus ..	62	11·8	88	20·0
Y.39	Diseases of foetus and ill-defined causes:				
	(0–3) Diseases of foetus	29	5·5	19	4·3
	(4–6) Other ill-defined or unspecified cause	104	19·8	87	19·8
	Total	525	100·0	439	100·0

* *International classification of causes of stillbirth.*

Maternal mortality—

TABLE (xii)—*Maternal mortality*, 1955–64

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*
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
1962	63,578	21	12	33	0·52
1963	64,518	18	10	28	0·43
1964*	64,464	14	9	23	0·36

**For the ninth year running none of the deaths in pregnancy or childbirth was due to sepsis; 8 of the 9 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

The table belows shows for the past seven winters the average levels of pollution based on the recording stations described in appendix B to my report for 1956.

Winter averages of air pollution

Average daily readings of volumetric recording stations

Micrograms per cubic metre

Winter	*'Smoke'*	*'Sulphur dioxide'*	*Ratio smoke/SO_2*
1958–1959	309	340	0·9
1959–1960	206	275	0·7
1960–1961	200	277	0·7
1961–1962	182	302	0·6
1962–1963	173	365	0·5
1963–1964	153	284	0·5
1964–1965	133	276	0·5

There has been a consistent downward trend in the smoke index (a trend which began in 1956–57); although exact comparison is not possible because of a change in the method of measurement in 1961, pollution by smoke is now about one-third of what it was nine years ago. Pollution from sulphur dioxide does not show any consistent trend.

The weather

The monthly averages of temperature, rainfall and sunshine are given in table V.4, page 20. This year was characterised by a warmer than average summer; sunshine was noticeably high in the months July to October but 'sunny June' did not justify its reputation. Rainfall over the year was below average—the fourth successive year in which this has occurred.

INFECTIOUS DISEASES

Notifications of infectious diseases for the years 1955–64 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 1964 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 27 deaths under the age of two years from diarrhoea and enteritis, this being a lower figure than that reported in 1963. A high proportion of the deaths from this condition were associated with concurrent infections of the respiratory tract and took place in the first quarter of the year.

Diphtheria—During the year there were four notifications of diphtheria, all in Southwark. Diphtheria has in recent years ceased to be an endemic infection in London. Whenever the disease is found an energetic search is made for other infected persons in the neighbourhood and this is continued until the infection has been eliminated from the district. Vigilance and general immunisation continue to be necessary. The circumstances of recent outbreaks suggest that they may have resulted from infection imported from abroad.

Dysentery—There were 2,262 notifications of dysentery compared with 4,917 in 1963. The highest incidence of the disease was in the months of February and March and the lowest in the autumn, this being the usual seasonal pattern. Once again the highest attack rate was in pre-school children. The overwhelming majority of notified cases are of mild Sonné dysentery, which has a low fatality rate. One death from dysentery was registered.

Enteric fever—No local outbreaks of typhoid or para-typhoid fever were reported, although a number of single sporadic cases occurred. A high proportion of cases reported had been infected on holiday abroad.

Influenza—The number of deaths from influenza (28) was the lowest for many years.

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

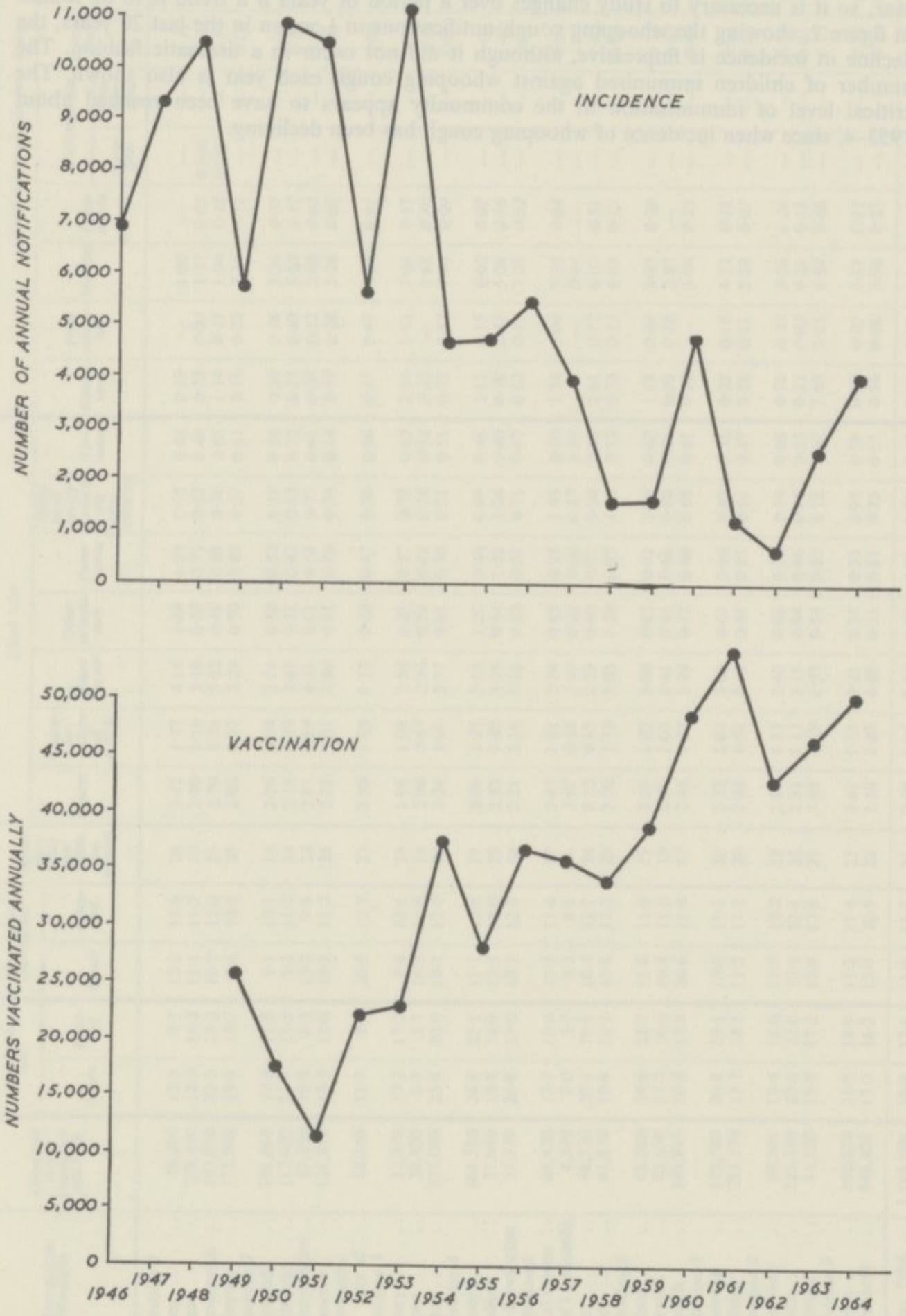
Measles—1964 was an inter-epidemic year, the low incidence encountered in the early months building up in the latter part of the year towards the epidemic peak experienced early in 1965. The disease continues to be mild in the majority of cases. During the autumn injections of measles vaccine were given to over 5,000 children in London as part of a controlled trial organised by the Medical Research Council. The results of this trial are awaited.

Ophthalmia neonatorum—The number of notifications rose from 96 in 1963 to 112 in 1964 and the rate per 1,000 registered live births increased accordingly from 1·31 to 1·51. The number of cases among children born to London residents was 80; in 70 cases vision was unimpaired and there was no information about the remaining ten who had moved from the area.

Poliomyelitis—Only two cases of poliomyelitis were notified during 1964. That only two cases occurred in London in spite of the fact that many thousands of children remain unvaccinated indicates the virtual absence of disease-producing virus from the community. This must be attributed largely to the widespread use since 1962 of the Sabin vaccine which, unlike the Salk-type vaccine, has the effect of reducing the number of symptomless carriers in the population. Thus poliomyelitis, like diphtheria, has now reached the stage when the low level of incidence depends as much on the absence of infection from the community as it does on the high level of immunisation. The continuance of this favourable condition will require vigorous preventive action in the contacts of any case that does occur.

Figure 2

WHOOPING COUGH, LONDON (A.C.)
INCIDENCE AND VACCINATION, 1946–1964



Smallpox—No cases of smallpox were notified during the year.

Whooping cough—There was a fall in the number of notifications in 1964 to 1,401 from the figure of 2,601 in 1963. The incidence of this disease fluctuates widely from year to year, so it is necessary to study changes over a period of years if a trend is to be found. In figure 2, showing the whooping cough notifications in London in the last 20 years, the decline in incidence is impressive, although it did not occur in a dramatic fashion. The number of children immunised against whooping cough each year is also shown. The critical level of immunisation in the community appears to have been reached about 1953–4, since when incidence of whooping cough has been declining.

TABLE V.1—*Vital statistics—Metropolitan Boroughs and the Administrative County of London*, 1964 (*a*)

Metropolitan Boroughs	*Estimated home population mid 1964*	*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	46,200	13·3	9·7	15·2	13·6	26	3·42	1·77	4·16	1·04	1·19	0·95	0·84	*0·19*	—	1·08	—	—	—	*0·11*	*0·17*	*0·24*	*0·02*
Fulham	109,410	18·9	16·8	11·1	11·3	19	2·80	1·16	3·19	0·53	0·71	0·82	0·40	0·23	*0·03*	1·77	*0·05*	*0·009*	—	*0·16*	0·37	0·41	*0·05*
Hammersmith ..	107,530	22·3	19·2	10·7	12·0	26	2·70	0·96	3·02	0·48	0·69	0·76	0·61	1·14	*0·11*	1·94	*0·18*	*0·009*	—	0·19	0·55	0·70	*0·07*
Kensington ..	172,990	18·5	10·7	8·6	10·1	25	2·02	0·97	2·29	0·50	0·40	0·57	0·61	0·18	0·23	2·19	*0·11*	—	—	*0·08*	0·20	0·56	*0·12*
Division 2																							
Hampstead ..	101,060	17·9	11·5	9·1	10·1	16	2·26	0·94	2·74	0·50	0·52	0·37	0·50	0·24	*0·16*	3·24	*0·07*	—	—	0·21	0·34	0·44	*0·07*
Paddington ..	117,050	21·3	15·5	9·3	11·2	14	2·14	0·79	2·87	0·51	0·42	0·62	0·72	*0·15*	0·49	5·27	*0·11*	—	—	0·21	0·37	0·79	*0·13*
St. Marylebone ..	67,250	10·9	8·3	13·2	9·8	23	2·87	1·89	4·51	0·61	0·59	0·77	0·61	*0·06*	*0·22*	2·08	*0·01*	—	—	*0·13*	*0·06*	0·52	*0·10*
St. Pancras ..	121,870	18·5	15·0	10·2	11·2	26	2·53	1·01	2·80	0·61	0·76	0·74	0·44	0·59	0·24	5·28	*0·08*	—	—	0·31	0·35	0·83	*0·07*
Westminster, City of ..	85,840	11·7	9·7	10·5	10·5	23	2·50	1·05	3·13	0·48	0·47	0·56	0·86	*0·15*	0·43	4·53	*0·01*	—	—	*0·06*	*0·16*	0·51	*0·05*
Division 3																							
Finsbury	32,070	17·3	15·2	9·4	10·8	24	1·96	1·06	2·56	*0·25*	0·97	0·72	0·65	2·34	1·31	7·64	1·37	—	—	0·62	*0·47*	0·72	*0·03*
Holborn	20,430	8·1	5·3	10·5	11·6	54	2·94	*0·69*	2·94	*0·34*	*0·44*	*0·78*	*0·54*	*0·20*	—	1·62	*0·10*	—	—	*0·15*	*0·05*	*0·64*	*0·05*
Islington	227,090	25·4	20·8	10·7	12·0	20	2·24	1·06	3·37	0·81	0·70	0·71	0·51	0·73	0·37	7·49	0·09	—	—	0·66	0·60	0·79	0·12
Division 4																							
Hackney	164,350	24·5	22·1	11·1	12·5	17	2·80	1·07	3·18	1·20	0·46	0·69	0·46	2·11	0·15	6·02	*0·07*	—	—	1·00	0·57	0·56	*0·10*
Shoreditch ..	37,040	15·2	14·9	12·5	13·0	23	2·83	1·40	3·19	0·54	1·21	1·24	*0·40*	0·70	*0·35*	5·08	*0·16*	—	—	1·40	0·97	*0·38*	*0·13*
Stoke Newington	53,330	26·8	23·0	10·3	12·8	24	2·21	1·16	3·21	0·62	0·51	0·71	0·47	0·62	*0·17*	7·05	*0·02*	—	—	0·41	0·41	0·71	*0·13*
Division 5																							
Bethnal Green ..	46,420	17·7	16·6	10·5	11·4	17	2·43	1·01	2·84	0·45	0·95	1·03	0·50	1·34	*0·06*	7·56	*0·04*	—	—	0·99	0·73	0·47	*0·04*
City of London(*b*)	4,580	7·0	5·7	8·3	8·3	—	*1·97*	*0·66*	*1·97*	*0·22*	*0·66*	*0·87*	*1·09*	—	—	*0·44*	—	—	—	—	—	*0·44*	—
Poplar	68,530	20·1	19·1	10·4	12·7	24	2·55	0·83	2·79	0·60	0·77	0·98	0·53	2·61	*0·12*	6·07	0·51	—	—	1·62	0·38	0·47	*0·07*
Stepney	91,130	19·9	18·1	11·6	13·2	25	2·70	1·10	3·03	0·59	0·87	1·00	0·52	0·33	*0·11*	6·69	0·57	—	—	0·65	0·55	0·88	*0·11*
Division 6																							
Deptford	68,500	24·4	22·7	11·0	11·9	29	2·29	1·05	3·04	0·42	0·92	1·09	0·42	1·68	*0·04*	5·45	0·29	—	—	0·74	0·54	0·91	—
Greenwich ..	83,630	17·3	16·6	10·8	11·6	19	2·80	1·05	3·41	0·41	0·60	0·80	0·39	0·98	*0·18*	2·87	—	—	—	0·62	0·39	0·36	*0·13*
Woolwich ..	149,810	16·5	17·8	10·6	11·4	17	2·44	1·03	3·39	0·52	0·88	0·65	0·41	*0·12*	—	3·04	0·23	—	—	0·48	0·53	0·31	*0·04*
Division 7																							
Camberwell ..	175,740	20·8	19·1	10·3	11·1	20	2·22	1·03	2·86	0·61	0·94	0·82	0·38	0·22	0·16	4·52	0·18	—	—	0·61	0·25	0·60	*0·02*
Lewisham ..	223,170	18·7	18·1	11·5	11·2	20	2·55	1·51	3·35	0·51	0·81	0·81	0·47	0·56	0·11	5·29	*0·07*	—	—	0·65	0·69	0·56	*0·07*
Division 8																							
Bermondsey ..	50,340	18·4	18·0	11·0	12·2	23	2·94	1·11	2·62	0·66	0·70	0·74	0·44	0·70	*0·30*	3·56	*0·24*	—	—	0·74	*0·30*	0·87	*0·04*
Lambeth	223,140	25·0	22·0	10·8	12·1	22	2·33	1·13	3·16	0·54	0·66	0·96	0·55	0·31	*0·02*	4·21	0·18	—	—	0·41	0·27	0·35	*0·05*
Southwark ..	84,830	18·5	17·2	12·9	12·5	21	3·05	1·19	3·97	0·53	0·83	1·12	0·59	3·69	0·25	4·89	0·46	—	—	1·10	0·38	0·71	*0·05*
Division 9																							
Battersea	102,820	21·9	19·9	11·2	11·4	23	2·41	1·33	3·21	0·74	0·52	0·95	0·59	0·40	*0·03*	5·37	*0·11*	—	—	0·28	0·34	0·57	*0·08*
Wandsworth ..	348,450	19·0	18·2	13·0	10·3	23	2·58	1·43	4·45	0·75	0·81	0·75	0·53	0·54	0·08	2·96	0·23	—	—	0·39	0·63	0·41	0·06
London, 1964 ..	3,184,600	19·9	17·1	11·0	11·7	21	2·50	1·15	3·27	0·62	0·71	0·78	0·52	0·71	0·17	4·40	0·17	*0·0006*	—	0·50	0·44	0·56	0·07
London, 1963 ..	3,178,870	20·0	17·2	12·5	13·1	22	2·44	1·27	3·80	0·69	0·97	1·16	0·57	1·55	0·17	9·19	0·30	0·0003	0·0006	0·32	0·82	0·63	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—Administration County of London*, 1955–64

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)		
	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	Other violence	Infants 0—1	Diarrhoea and enteritis 0—2	Maternal (per 1,000 total births)
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
1962.. ..	19·6	17·6	12·0	11·7	0·08	0·01	2·44	1·22	3·75	0·60	0·05	0·83	0·92	0·11	0·18	0·13	0·25	21	0·4	0·52
1963.. ..	20·0	17·2	12·5	13·1	0·07	0·01	2·44	1·27	3·80	0·69	0·05	0·97	1·00	0·11	0·20	0·12	0·26	22	0·5	0·43
1964.. ..	19·9	17·1	11·0	11·7	0·06	0·01	2·50	1·15	3·27	0·62	0·01	0·71	0·67	0·10	0·17	0·13	0·22	21	0·4	0·36

TABLE V.3—*Deaths by cause—Administrative County of London*, 1964

Cause	*Sex*	*0–*	*1–*	*5–*	*15–*	*25–*	*45–*	*65–*	*75+*	*Total*	
										1964	*1963*
1. Tuberculosis—respiratory ..	M	–	–	–	2	10	54	42	27	**135**	174
	F	–	–	–	–	*12*	*12*	*8*	*11*	***43***	*59*
2. Tuberculosis—other	M	–	–	–	–	1	7	1	1	**10**	13
	F	–	*1*	–	–	–	*4*	*1*	*4*	***10***	*19*
3. Syphilitic disease	M	–	–	–	–	3	13	17	11	***44***	54
	F	–	–	*1*	–	*1*	*4*	*9*	*11*	***26***	*44*
4. Diphtheria	M	–	–	–	–	–	–	–	–	–	–
	F	–	–	–	–	–	–	–	–	–	–
5. Whooping cough	M	–	–	–	–	–	–	–	–	–	–
	F	–	–	–	–	–	–	–	–	–	*2*
6. Meningococcal infection ..	M	1	1	1	–	1	1	–	–	**5**	9
	F	*2*	*1*	–	*1*	–	–	–	–	***4***	*7*
7. Acute poliomyelitis	M	–	–	1	–	–	–	–	–	**1**	–
	F	–	–	–	–	–	–	–	–	–	–
8. Measles	M	–	–	–	–	–	–	–	–	–	2
	F	–	*2*	–	–	–	–	–	–	***2***	–
9. Other infective, &c., diseases	M	3	4	–	4	2	11	2	3	**29**	37
	F	*1*	*3*	–	–	*4*	*8*	*4*	*5*	***25***	*33*
10. Malignant neoplasm: Stomach	M	–	–	–	1	27	210	156	107	**501**	506
	F	–	–	–	–	*8*	*73*	*114*	*160*	***355***	*429*
11. Malignant neoplasm: Lung, bronchus	M	–	–	–	–	49	924	608	327	**1,908**	1,817
	F	–	–	–	*1*	*21*	*173*	*137*	*106*	***438***	*393*
12. Malignant neoplasm: Breast	M	–	–	–	–	–	3	1	–	**4**	4
	F	–	–	–	*1*	*56*	*315*	*184*	*164*	***720***	*697*
13. Malignant neoplasm: Uterus	*F*	–	–	–	–	*27*	*121*	*72*	*54*	***274***	*279*
14. Other malignant and lymphatic neoplasms	M	1	7	12	19	92	634	552	527	**1,844**	1,728
	F	*1*	*2*	*7*	*8*	*90*	*516*	*452*	*619*	***1,695***	*1,688*
15. Leukemia, aleukemia ..	M	1	4	4	3	17	30	34	20	**113**	110
	F	*1*	*3*	*2*	*2*	*8*	*30*	*19*	*29*	***94***	*105*
16. Diabetes	M	–	–	–	–	8	27	24	34	**93**	88
	F	–	–	–	–	*3*	*32*	*40*	*87*	***162***	*182*
17. Vascular lesions of nervous system	M	–	–	1	5	37	303	403	585	**1,334**	1,483
	F	*1*	*1*	*2*	*5*	*35*	*297*	*558*	*1,439*	***2,338***	*2,566*
18. Coronary disease, angina ..	M	–	–	–	–	141	1,608	1,244	1,058	**4,051**	4,404
	F	–	–	–	–	*24*	*390*	*799*	*1,535*	***2,748***	*3,108*
19. Hypertension with heart disease	M	–	–	–	–	1	42	40	67	**150**	258
	F	–	–	–	–	*2*	*20*	*51*	*179*	***252***	*388*
20. Other heart disease	M	–	–	1	9	61	213	241	599	**1,124**	1,412
	F	*2*	*1*	–	*3*	*39*	*191*	*303*	*1,555*	***2,094***	*2,503*
21. Other circulatory disease ..	M	–	–	–	4	21	193	194	346	**758**	843
	F	–	–	–	*4*	*18*	*124*	*236*	*838*	***1,220***	*1,358*
22. Influenza	M	–	–	–	1	2	4	1	7	**15**	63
	F	*2*	–	–	–	*1*	*2*	*1*	*7*	***13***	*98*
23. Pneumonia	M	127	10	–	2	10	142	233	535	**1,059**	1,405
	F	*70*	*9*	*5*	*1*	*5*	*58*	*200*	*849*	***1,197***	*1,682*
24. Bronchitis	M	33	2	1	–	11	388	527	545	**1,507**	2,141
	F	*12*	*6*	*1*	*1*	*5*	*93*	*125*	*394*	***637***	*1,046*
25. Other diseases of respiratory system	M	3	1	1	2	10	67	50	67	**201**	214
	F	*3*	–	–	*1*	*3*	*36*	*16*	*59*	***118***	*138*
26. Ulcer of stomach and duodenum	M	–	–	–	–	12	56	63	73	**204**	203
	F	–	–	–	–	*5*	*15*	*46*	*60*	***126***	*105*
27, Gastritis, enteritis and diarrhoea	M	16	2	–	1	3	20	19	15	**76**	78
	F	*10*	–	–	–	*2*	*15*	*25*	*54*	***106***	*121*
28. Nephritis and nephrosis ..	M	1	1	1	4	16	34	26	24	**107**	114
	F	–	–	*1*	*2*	*8*	*15*	*20*	*39*	***85***	*95*
29. Hyperplasia, prostate ..	M	–	–	–	–	–	10	27	93	**130**	156
30. Pregnancy, childbirth, abortn.	*F*	–	–	–	*7*	*16*	–	–	–	***23***	*28*
31. Congenital malformations ..	M	150	14	4	4	11	12	10	4	**209**	226
	F	*118*	*15*	*7*	*4*	*5*	*18*	*5*	*8*	***180***	*171*
32. Other defined and ill-defined diseases	M	433	15	13	14	73	242	194	256	**1,240**	1,283
	F	*324*	*18*	*12*	*12*	*90*	*248*	*266*	*582*	***1,552***	*1,598*

TABLE V.3 (*contd.*)—*Deaths by cause—Administrative County of London*, 1964

Cause	*Sex*	*0–*	*1–*	*5–*	*15–*	*25–*	*45–*	*65–*	*75+*	*Total*	
										1964	*1963*
33. Motor vehicle accidents ..	M	1	7	22	72	40	53	29	39	**263**	234
	F	*3*	*1*	*11*	*17*	*15*	*23*	*28*	*39*	***137***	*132*
34. All other accidents	M	13	28	21	25	89	104	33	58	**371**	422
	F	*15*	*10*	*4*	*18*	*26*	*56*	*44*	*129*	***302***	*377*
35. Suicide	M	–	–	–	33	116	119	23	24	**315**	368
	F	–	–	*1*	*15*	*57*	*95*	*49*	*22*	***239***	*259*
36. Homicide, operations of war	M	2	–	–	6	12	5	–	1	**26**	17
	F	*4*	–	*1*	*2*	*5*	–	*2*	–	***14***	*14*
ALL CAUSES	M	785	96	83	211	876	5,529	4,794	5,453	**17,827**	19,866
	F	*569*	*73*	*55*	*105*	*591*	*2,984*	*3,814*	*9,038*	***17,229***	*19,724*

TABLE V.4—*Weather during* 1964

(*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	39·2	−0·5	0·53	−1·44	37·1	−6·6
February	41·5	+1·3	0·70	−0·89	64·5	+4·6
March	41·0	−1·9	3·27	+1·74	70·5	−36·6
April	48·4	+0·9	3·18	+1·54	129·4	−23·4
May..	58·1	+4·4	1·67	−0·07	207·9	+7·5
June..	59·7	+0·3	3·89	+1·91	172·0	−31·7
July	64·6	+1·9	1·95	−0·44	224·5	+26·1
August	62·2	+0·3	1·83	−0·45	220·0	+34·0
September	59·4	+2·0	0·41	−1·61	219·4	+76·2
October	48·9	−1·6	1·21	−1·27	132·1	+36·8
November ..	47·7	+3·3	1·34	−1·03	55·0	+2·6
December	40·6	−0·4	1·34	−0·81	50·0	+11·8
Year	50·9	+0·8	21·32	−2·82	1,582·4	+101·3

(*a*) *Average of the daily means of 24 hourly readings.*
(*b*) *Average over the 90 years ended 1960.*
(*c*) *Average over the 80 years ended 1960.*

TABLE V.5—*Notifiable infectious diseases—Annual number of notifications and numbers per 1,000 of population—Administrative County of London, 1955–1964*

Year	Anthrax		Diphtheria		Dysentery		Acute encephalitis		Enteric fever		Erysipelas		Malaria		Measles		Meningo-coccal infection		Ophthalmia neonatorum		Pneumonia		Poliomyelitis				Puerperal pyrexia		Scabies		Scarlet fever		Smallpox		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
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	(a) 1·85	1,903	0·578	512	0·155	448	0·136	1,984	(b) 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
1962 ..	1	0·0003	—	—	2,814	0·883	23	0·007	48	0·015	141	0·044	56	0·018	9,538	2·99	67	0·021	188	2·62	823	0·258	17	0·005	6	0·002	1,374	18·81	369	0·12	863	0·27	1	0·0003	619	0·19	676	0·21
1963 ..	1	0·0003	14	0·004	4,917	1·547	17	0·005	54	0·017	130	0·041	36	0·011	29,209	9·19	64	0·020	96	1·31	955	0·800	1	0·0003	2	0·0006	1,093	14·70	518	0·16	1,025	0·32	—	—	2,601	0·82	528	0·17
1964 ..	—	—	4	0·001	2,262	0·710	14	0·004	42	0·013	147	0·046	13	0·004	14,021	4·40	34	0·011	112	1·53	533	0·167	2	0·0006	—	—	1,149	15·45	528	0·17	1,598	0·50	—	—	1,401	0·44	544	0·17

(*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 30 December, 1963*

Four-weekly periods 1964		Dysentery				Measles				Meningococcal infection				Pneumonia				Scarlet fever				Whooping cough			
		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
1— 4	M	36	19	42	**98**	47	17	4	**69**	2	—	—	**2**	3	3	31	**37**	18	38	1	**57**	44	29	2	**75**
	F	*28*	*12*	*36*	***76***	*43*	*35*	*6*	***84***	—	—	—	—	*4*	*2*	*31*	***37***	*9*	*39*	—	***48***	*59*	*25*	*3*	***87***
5— 8	M	52	49	32	**133**	99	48	3	**150**	4	—	1	**5**	2	3	31	**36**	18	60	1	**79**	52	15	—	**68**
	F	*50*	*58*	*53*	***161***	*79*	*38*	*3*	***120***	*1*	—	—	***1***	*4*	*3*	*19*	***26***	*27*	*52*	*4*	***84***	*59*	*33*	—	***92***
9—12	M	41	28	40	**109**	102	91	4	**197**	—	—	—	—	3	1	27	**31**	26	42	2	**72**	48	29	1	**78**
	F	*52*	*28*	*56*	***136***	*102*	*96*	*12*	***211***	—	—	*1*	***1***	*1*	*3*	*16*	***20***	*12*	*50*	*1*	***64***	*41*	*32*	*4*	***77***
13—16	M	38	41	25	**104**	143	90	10	**244**	2	—	1	**3**	2	5	32	**39**	14	42	4	**60**	38	17	—	**55**
	F	*53*	*23*	*49*	***125***	*163*	*113*	*17*	***293***	*1*	—	—	***1***	*1*	*3*	*25*	***29***	*19*	*35*	*1*	***55***	*32*	*21*	*2*	***55***
17—20	M	35	17	21	**73**	162	99	6	**268**	—	—	—	—	2	2	13	**17**	14	54	7	**75**	25	16	1	**42**
	F	*31*	*11*	*25*	***68***	*162*	*92*	*13*	***268***	*1*	—	—	***1***	*2*	*3*	*13*	***18***	*15*	*41*	*3*	***59***	*34*	*25*	*2*	***61***
21—24	M	24	26	18	**69**	286	164	6	**456**	—	—	—	—	1	—	8	**9**	13	42	1	**56**	24	11	1	**36**
	F	*29*	*22*	*19*	***70***	*256*	*169*	*13*	***438***	—	—	—	—	*2*	—	*6*	***8***	*17*	*29*	*2*	***49***	*22*	*13*	*3*	***38***
25—28	M	45	40	24	**109**	343	272	4	**620**	—	2	—	**2**	—	1	9	**10**	14	51	5	**70**	35	11	1	**47**
	F	*40*	*56*	*24*	***121***	*348*	*294*	*6*	***649***	—	—	—	—	—	*2*	*6*	***8***	*15*	*51*	*5*	***71***	*32*	*15*	*3*	***51***
29—32	M	29	19	17	**65**	546	303	9	**863**	—	—	—	—	2	2	8	**12**	9	25	5	**39**	23	10	1	**34**
	F	*25*	*17*	*19*	***62***	*507*	*283*	*8*	***799***	*1*	—	—	***1***	*1*	*2*	*2*	***5***	*12*	*28*	*1*	***41***	*29*	*25*	*2*	***56***
33—36	M	38	8	18	**65**	363	118	3	**486**	—	1	—	**1**	—	—	13	**13**	4	8	—	**12**	26	19	—	**45**
	F	*34*	*11*	*27*	***73***	*352*	*129*	*4*	***489***	*1*	*1*	*1*	***3***	—	*1*	*7*	***8***	*10*	*13*	—	***23***	*31*	*25*	*4*	***60***
37—40	M	30	9	18	**57**	228	75	3	**307**	1	—	3	**4**	—	1	10	**12**	11	15	1	**28**	40	20	—	**60**
	F	*19*	*5*	*29*	***54***	*199*	*67*	*3*	***271***	—	—	—	—	*1*	*1*	*4*	***7***	*10*	*16*	*1*	***27***	*46*	*14*	*3*	***63***
41—44	M	33	19	18	**70**	295	188	4	**489**	—	—	1	**1**	—	1	14	**16**	23	54	—	**77**	20	15	—	**35**
	F	*37*	*23*	*28*	***88***	*273*	*211*	*5*	***489***	—	—	—	—	*1*	*1*	*11*	***13***	*28*	*49*	—	***77***	*28*	*8*	*1*	***37***
45—48	M	57	24	18	**99**	608	358	2	**972**	—	—	—	—	1	4	21	**26**	37	51	2	**90**	36	10	—	**47**
	F	*45*	*27*	*34*	***106***	*552*	*348*	*10*	***914***	*1*	*1*	*1*	***3***	*1*	*1*	*22*	***24***	*22*	*66*	*2*	***90***	*26*	*9*	*1*	***36***
49—52	M	33	21	15	**69**	947	509	13	**1,471**	1	—	2	**3**	6	3	13	**22**	29	60	2	**91**	27	8	—	**35**
	F	*19*	*13*	*22*	***54***	*835*	*533*	*20*	***1,390***	—	*1*	*1*	***2***	*5*	*2*	*26*	***33***	*29*	*44*	*3*	***76***	*20*	*11*	—	***31***
Total	M	491	320	306	**1,120**	4,169	2,332	71	**6,592**	10	3	8	**21**	22	26	230	**280**	230	542	31	**806**	438	210	7	**657**
	F	*462*	*306*	*421*	***1,194***	*3,871*	*2,408*	*120*	***6,415***	*6*	*3*	*4*	***13***	*23*	*24*	*188*	***236***	*225*	*513*	*23*	***764***	*459*	*256*	*28*	***744***

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 relate to the calendar year 1964.

TUBERCULOSIS

In 1948 the diagnostic and treatment services in respect of tuberculosis became the responsibility of the newly-constituted regional hospital boards. In consequence, the tuberculosis dispensaries in London, most of which had been provided by the metropolitan borough councils, were transferred to the metropolitan regional hospital boards. The provision of preventive and 'care and after-care' services at these dispensaries (later renamed 'chest clinics'), previously included in the Council's comprehensive scheme for the diagnosis and treatment of tuberculosis, became the direct responsibility of the Council. An account of the principal developments in these services follows.

Preventive services

Tuberculosis contacts—The Council continued to operate a scheme, already in existence for over 20 years, whereby children are boarded-out to protect them from infection by tuberculosis in their own homes or to enable their parents to undergo treatment in hospital. In 1950 the scheme was widened to meet the occasional need to segregate children from infectious homes during B.C.G. vaccination.

Placing the children with suitable foster parents or in private nurseries was undertaken by the Invalid Children's Aid Association, acting as the Council's agent, until 1961 when this work was undertaken directly by the Council.

Before boarding away from home is resorted to, the possibility of some alternative form of care, e.g. day nursery, child minder or home help service, is considered. A number of children were thought to have suffered adversely by prolonged removal from home and it became a point of policy only to board a child away from home when no other course was practicable.

The number of children placed under the scheme rose from 362 in 1948 to a peak of 600 in 1953, since when it has been steadily reduced to 77 in 1964.

B.C.G. vaccination—An important development in the preventive field since 1950 has been the initiation of B.C.G. vaccination schemes:

(*a*) in 1950, for susceptible (tuberculin negative) contacts of *known* tuberculosis patients;

(*b*) in 1953, for diabetic children in the Council's special residential school for such children;

(*c*) in 1954, for tuberculin negative 13-year-old children attending London schools;

(*d*) in 1959, for students at establishments for further education within the county—private, Council and university.

The tuberculin testing surveys, which are a first step in the vaccination programme each year, in addition to showing who will benefit by B.C.G. vaccination also provide an accurate reflection of the amount of infective tuberculosis in the adult groups in the school, district and community from which the tested children come. This gives an epidemiological pointer to where mass radiography should be particularly directed by indicating foci of infection.

Children who show 'severe' (more than 20 mm.) local reactions to the moderate dose (10 tuberculin units = 0·0002 mgm.) tuberculin test have been found to manifest twice as many (1·6 per cent.) active lesions on chest radiography as was found among moderate (5–20 mm.) reactors. It was therefore made a routine practice to X-ray annually, while they remained at school, those severe reactors whose first chest X-ray was normal. The many cases of active disease discovered in this way over the years and put on to treatment early has formed a valuable by-product of the protective B.C.G. vaccination scheme. These cases discovered by routine X-ray after a positive tuberculin test form a substantial proportion of the notified cases in their age group and many might have pursued a benign course undiscovered.

The tuberculin survey results and the vaccinations given during the 10 years 1955–1964 are set out below:

Number of tuberculin tests and positivity rate in 13-year-old scholars, 1955–1964

Year	Tuberculin tested	% reactors	Vaccinated
1954–55	22,569	14·4	19,301
1955–56	25,360	14·5	21,655
1956–57	26,517	13·0	23,023
1957–58	27,742	10·9	24,651
1958–59	23,847	8·5	21,798
1959–60	33,172	8·2	30,425
1960–61 to 31.12.61 ..	38,521	8·8	35,050
1962	26,927	8·8	24,498
1963	23,457	7·5	21,629
1964	25,471	8·6	23,117

Active or suspect tuberculous cases ascertained by X-ray of reactors

Year	No. X-rayed	Active or suspected T.B. cases ascertained
1954–55	2,387	14
1955–56	2,768	8
1956–57	2,998	20
1957–58	2,782	10
1958–59	1,966	21
1959–60	2,434	10
1960–61 to 31.12.61 ..	3,229	23
1962	2,198	3
1963	1,673	27
1964	1,745	5

Notified new cases in age groups and two-year periods with percentage rise and fall 1952–1963

	10–11 *years*		12–13 *years*		14–15 *years*		16–17 *years*		18–19 *years*	
	No.	*Rise fall*	*No.*	*Rise fall*	*No.*	*Rise fall*	*No.*	*Rise fall*	*No.*	*Rise fall*
1952 .. 1953 ..	65	—	91	—	115	—	271	—	473	—
1954 .. 1955 ..	60	*− 7*	80	*−12*	96	*−16*	234	*−13*	377	*−20*
1956 .. 1957 ..	40	*−33*	58	*−27*	28	*−70*	163	*−30*	275	*−27*
1958 .. 1959 ..	32	*−20*	53	*− 8*	14	*−50*	97	*−40*	197	*−28*
1960 .. 1961 ..	23	*−28*	51	*− 4*	26	*+86*	66	*−32*	123	*−37*
1962 .. 1963 ..	26	*+13*	41	*−19*	12	*−54*	74	*+12*	107	*−13*

Preventive measures—In addition to the B.C.G. vaccination schemes, other preventive measures initiated since 1948 include the chest X-ray examination of all newly-appointed staff likely to come into close and frequent contact with children, staff at the Council's training centres for mentally handicapped persons, and of tuberculin reactors discovered among the children and students tested with a view to B.C.G. vaccination. The X-ray examinations involved have been carried out mainly at mass radiography units of the regional hospital boards.

Epidemiological investigations have been made among the contacts of cases of tuberculosis notified in children, staff or residents in the Council's establishments when no other source of infection has been established. Similar investigations have been carried out among adults at those secondary schools where the reactor rates disclosed by tuberculin surveys were significantly higher than the average for secondary schools in the area or at that school in previous years.

Care and after-care

Voluntary care committees—Voluntary care committees have continued to operate in association with most of the chest clinics. These committees, which obtain their funds from voluntary contributions, sales of work, Christmas seals, etc., have given valuable assistance to patients by means of money grants, clothes, holidays and other benefits and care not available from official sources.

Hostels—An important development has been the establishment of hostels for homeless infective tuberculous men who, if a hostel were not available, would live in common lodging houses, where they might constitute an infective risk and be less mindful of their nutritional and other needs than men living a normal family life.

The first hostel was opened in 1951 and there are now three hostels with a total of 91 beds. At the end of the year 88 men were in residence, including nine in similar accommodation specially provided for the Council's use at a hostel in British Legion Village, Maidstone, Kent.

These hostels have provided social care and close medical supervision for a group of men known to take inadequate care of themselves and to have scant regard for the treatment needs of their tuberculosis. Although primarily intended for homeless infective cases, they have also provided useful temporary havens for not so infectious cases leaving hospital but with no arranged home or other living accommodation to which to return.

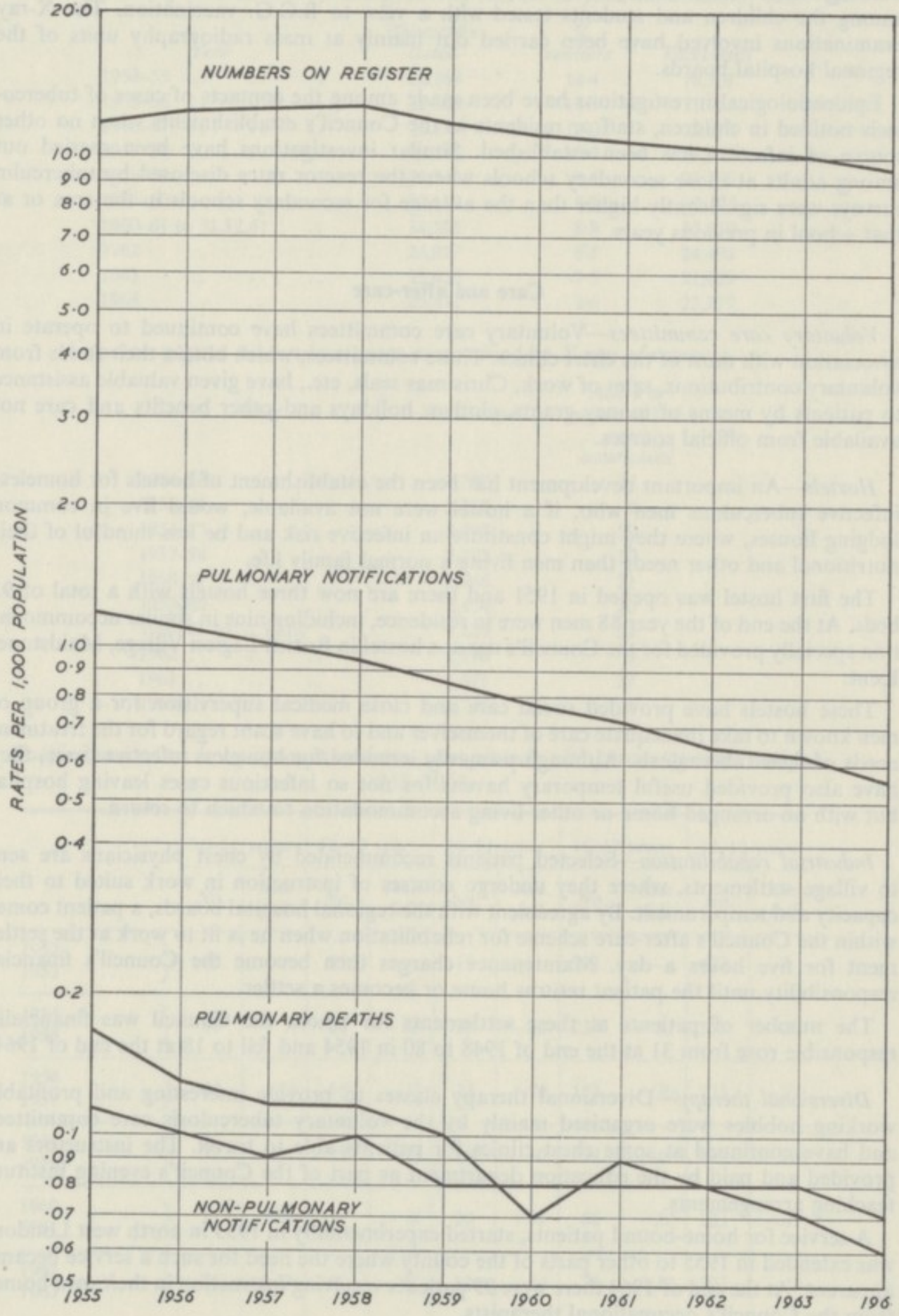
Industrial rehabilitation—Selected patients recommended by chest physicians are sent to village settlements, where they undergo courses of instruction in work suited to their capacity and temperament. By agreement with the regional hospital boards, a patient comes within the Council's after-care scheme for rehabilitation when he is fit to work at the settlement for five hours a day. Maintenance charges then become the Council's financial responsibility until the patient returns home or becomes a settler.

The number of patients at these settlements for whom the Council was financially responsible rose from 31 at the end of 1948 to 80 in 1954 and fell to 18 at the end of 1964.

Diversional therapy—Diversional therapy classes to provide interesting and profitable working hobbies were organised mainly by the voluntary tuberculosis care committees and have continued at some chest clinics for patients able to travel. The instructors are provided and paid by the education department as part of the Council's evening institute teaching arrangements.

A service for home-bound patients, started experimentally in 1953 in north west London, was extended in 1955 to other parts of the county where the need for such a service became apparent. At the end of 1964 there were 99 patients receiving instruction in their own homes from the Council's occupational therapists.

TREND OF TUBERCULOSIS
LONDON (A.C.) 1955–1964



The crafts in which patients have been instructed include basketry, book-binding, leather work and dressmaking. The finished articles are purchased by the patients or their relatives or friends, or sold, after disinfection, at market stalls or sales of work.

Home care—The Council's tuberculosis visitors, in addition to assisting the chest physician with clinic work, see patients in their own homes to advise on diet, hygiene, etc., to ascertain home conditions and needs and to persuade contacts to attend the clinic for investigation.

Extra nourishment (milk, butter, eggs) is provided for necessitous patients on the recommendation of chest physicians. Some patients are helped to obtain extra nourishment by the voluntary care committees.

Nursing attention is arranged under the direction of the family doctor or the chest physician; nursing equipment, e.g., back rests, bedpans, etc., is made available on loan; and home helps are provided in the homes of bed-fast patients and to care for children of mothers undergoing treatment in hospital.

Housing—The Council has set aside a limited number of dwellings for the rehousing of families on purely medical grounds. Among the nominations for such rehousing are those where special preference has been recommended because of urgent need to reduce the danger of infection arising from inadequate accommodation for persons suffering from active tuberculosis. The number of recommendations received and the nominations made in the past five years are shown in the General Public Health section of this report.

Open-air schools—For convalescent tuberculous children of school age not yet fit to return to normal school life, the Council provides day and residential open-air schools where educational activities are continued at a gentle pace in good surroundings with special emphasis on rest periods, medical supervision and nutritious dietary.

Recuperative holidays—Holidays for London tuberculous patients who have recently been ill or in whom breakdown threatens have been arranged through the Spero Holiday Scheme of the Chest and Heart Association (formerly National Association for the Prevention of Tuberculosis) or direct by the Council.

Statistics

TABLE T.1—*Tuberculosis—Statutory notifications (a) and deaths, Administrative County of London*, 1955–1964

Year	*Pulmonary tuberculosis*				*Non-pulmonary tuberculosis*			
	Notifications		*Deaths*		*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*
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
1962 ..	2,092	0·66	252	0·08	245	0·08	27	0·01
1963 ..	1,993	0·63	233	0·07	266	0·08	32	0·01
1964 ..	1,793	0·56	178	0·06	232	0·07	20	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,* 1955–1964

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									
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
1962 ..	0·34	0·38	0·16	0·27	1·04	0·60	1·26	0·24	0·95	0·40
1963 ..	0·38	0·29	0·26	0·32	0·96	0·58	1·16	0·25	0·89	0·40
1964 ..	0·29	0·30	0·27	0·24	0·85	0·50	1·07	0·23	0·81	0·34
	Death rates									
1955 ..	0·02	—	0·005	—	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
1962 ..	—	—	—	—	0·02	0·01	0·32	0·08	0·13	0·04
1963 ..	—	0·008	—	—	0·03	0·01	0·30	0·07	0·12	0·04
1964 ..	—	—	—	—	0·02	0·02	0·23	0·04	0·09	0·03

TABLE T.3—*Non-pulmonary tuberculosis—Notification and death rates per* 1,000 *living by age and sex, Administrative County of London,* 1955–1964

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									
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
1962 ...	0·008	0·041	0·057	0·032	0·111	0·151	0·034	0·044	0·068	0·085
1963 ...	0·029	0·053	0·048	0·039	0·141	0·149	0·052	0·029	0·088	0·080
1964 ...	0·008	0·041	0·054	0·040	0·106	0·114	0·048	0·050	0·071	0·074
	Death rates									
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
1962 ...	0·008	0·017	—	—	0·005	0·007	0·015	0·011	0·008	0·009
1963 ...	—	—	—	0·006	0·006	0·004	0·017	0·022	0·009	0·011
1964 ...	—	0·008	—	—	0·001	—	0·017	0·013	0·007	0·006

TABLE T.4—*Tuberculosis—Statutory notifications by age groups, Administrative County of London*, 1964

Form of tuberculosis notified	*Sex*	*Number of notifications of new cases of tuberculosis*												*Total (all ages)*
		0–	*1–*	*5–*	*10–*	*15–*	*20–*	*25–*	*35–*	*45–*	*55–*	*65–*	*75+*	
Pulmonary tuberculosis ..	M.	3	34	24	26	50	103	202	211	200	223	107	31	1,214
	F.	4	33	22	20	41	85	128	86	74	41	36	9	579
Other forms of tuberculosis ..	M.	—	1	7	3	10	17	23	21	10	7	4	4	107
	F.	—	5	5	2	5	20	33	20	12	8	7	8	125
All forms of tuberculosis ..	M.	3	35	31	29	60	120	225	232	210	230	111	35	1,321
	F.	4	38	27	22	46	105	161	106	86	49	43	17	704

TABLE T.5—*Tuberculosis—Deaths in Administrative County of London*, 1964

Form of tuberculosis	*Sex*	*Age at death*								*Total (all ages)*
		0—	*1—*	*5—*	*15—*	*25—*	*45—*	*65—*	*75+*	
Pulmonary tuberculosis ..	M.	—	—	—	2	10	54	42	27	135
	F.	—	—	—	—	12	12	8	11	43
Other forms of tuberculosis ..	M.	—	—	—	—	1	7	1	1	10
	F.	—	1	—	—	—	4	1	4	10
All forms of tuberculosis ..	M.	—	—	—	2	11	61	43	28	145
	F.	—	1	—	—	12	16	9	15	53

TABLE T.6—*Statutory notification of non-pulmonary tuberculosis—Distribution according to site and age, Administrative County of London*, 1964

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+*	
Meninges and C.N.S.	2	5	2	4	13
Abdomen	—	—	7	7	14
Bones and joints	—	4	10	32	46
Skin and erythema nodosum	—	—	2	3	5
Peripheral glands	3	8	19	67	97
Genito-urinary	—	—	6	43	49
Other sites	1	—	3	4	8
All sites	6	17	49	160	232

TABLE T.7—*Patients on the registers*—1955–1964

At 31 Dec.	*1955*	*1956*	*1957*	*1958*	*1959*	*1960*	*1961*	*1962*	*1963*	*1964*
Pulmonary:										
Males ..	19,300	19,715	19,946	20,308	19,553	19,380	18,759	18,153	17,379	16,553
Females ..	15,846	15,928	15,836	15,597	14,858	14,497	13,833	13,171	12,456	11,586
Other forms:										
Males ..	1,371	1,339	1,274	1,293	1,158	1,163	1,143	1,123	1,098	1,111
Females ..	1,704	1,710	1,709	1,674	1,555	1,527	1,473	1,402	1,368	1,353
Total ..	38,221	38,692	38,765	38,872	37,124	36,567	35,208	33,849	32,301	30,603
No. per 1,000 of population ..	11·6	11·8	11·9	12·1	11·6	11·4	11·1	10·6	10·1	9·6

TABLE T.8—*Principal tuberculosis statistics—Metropolitan Boroughs and the Administrative County of London*, 1964

Metropolitan Boroughs	*Estimated home population mid 1964*	*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 31.12.64*		*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 1964*	
Division 1														
Chelsea	46,200	11	—	1	12	0·26	2	—	2	0·04	0·05	273	3·1	5·9
Fulham	109,410	45	1	5	51	0·47	6	—	6	0·05	0·07	1,197	3·8	10·9
Hammersmith ..	107,530	75	—	7	82	0·76	4	1	5	0·05	0·05	1,373	5·6	12·8
Kensington	172,990	97	1	20	118	0·68	6	1	7	0·04	0·04	975	3·1	5·6
Division 2														
Hampstead ..	101,060	44	—	7	51	0·50	1	—	1	0·01	0·01	602	5·8	6·0
Paddington	117,050	92	1	14	107	0·91	8	1	9	0·08	0·08	1,018	3·6	8·7
St. Marylebone ..	67,250	35	1	6	42	0·62	4	—	4	0·06	0·07	483	2·8	7·2
St. Pancras ..	121,870	101	—	8	109	0·89	8	1	9	0·07	0·08	1,022	1·4	8·4
Westminster, City of	85,840	44	—	4	48	0·56	11	—	11	0·13	0·14	764	0·3	8·9
Division 3														
Finsbury	32,070	23	—	1	24	0·75	6	—	6	0·19	0·23	258	4·1	8·0
Holborn	20,430	13	—	1	14	0·69	1	—	1	0·05	0·06	176	7·1	8·6
Islington	227,090	179	3	24	206	0·91	8	2	10	0·04	0·04	2,207	2·1	9·7
Division 4														
Hackney	164,350	92	1	16	109	0·66	6	1	7	0·04	0·05	1,550	3·4	9·4
Shoreditch	37,040	14	—	5	19	0·51	5	—	5	0·13	0·18	266	5·2	7·2
Stoke Newington ..	53,330	38	—	7	45	0·84	2	—	2	0·04	0·05	658	4·8	12·3
Division 5														
Bethnal Green ..	46,420	22	—	2	24	0·52	2	—	2	0·04	0·05	674	2·8	14·5
City of London ..	4,580	2	—	—	2	0·44	—	—	—	—	—	49	10·6	10·7
Poplar	68,530	32	—	5	37	0·54	1	1	2	0·03	0·02	564	4·1	8·2
Stepney	91,130	80	—	10	90	0·99	7	1	8	0·09	0·10	1,260	2·1	13·8
Division 6														
Deptford	68,500	62	—	—	62	0·91	2	—	2	0·03	0·04	1,104	2·4	16·1
Greenwich	83,630	30	—	11	41	0·49	3	1	4	0·05	0·04	821	3·5	9·8
Woolwich	149,810	47	—	6	53	0·35	3	—	3	0·02	0·03	1,390	3·5	9·3
Division 7														
Camberwell ..	175,740	105	1	2	108	0·61	19	2	21	0·12	0·14	766	8·3	4·4
Lewisham	223,170	126	1	14	141	0·63	5	2	7	0·03	0·03	2,070	1·4	9·3
Division 8														
Bermondsey ..	50,340	44	—	2	46	0·91	7	—	7	0·14	0·18	671	1·6	13·3
Lambeth	223,140	77	—	12	89	0·40	15	3	18	0·08	0·09	3,478	2·6	15·6
Southwark	84,830	60	1	3	64	0·75	6	2	8	0·09	0·09	1,379	3·4	16·3
Division 9														
Battersea	102,820	59	—	8	67	0·65	6	—	6	0·06	0·07	806	4·7	7·8
Wandsworth ..	348,450	144	2	18	164	0·47	24	1	25	0·07	0·08	2,749	1·2	7·9
LONDON	3,184,600	1,793	13	219	2,025	0·64	178	20	198	0·06	0·07	30,603	3·0	9·6

**Cases whose broncho-pulmonary secretion was positive during the year.*

Rehousing on medical grounds

Since the war housing has never been far from the headlines. The demand for municipal housing has been very great and consequently the London County Council and the metropolitan borough councils have devoted a large part of their resources firstly to the repair of war damage and then to slum clearance and increasing the total housing resources. In the immediate post-war years the Council had a points scheme, whereby points were awarded to the applicants for housing accommodation for various factors such as bedroom deficiency, time on the waiting list, etc., and one of these factors was ill health. As a consequence, medical officers of this department had to assess a vast number of medical certificates submitted by housing applicants (between 30,000 and 45,000 each year for the years 1949/1955). As the majority of these cases required further enquiry, for instance of the borough medical officer of health concerning alleged sanitary defects, this was no light task. A review by the Housing Committee of the housing position in 1955 showed that most of the larger areas for building in London had been used and that there was bound to be a slowing up in building additional accommodation owing to lack of sites within the county. Moreover, slum clearance and other redevelopment required about 7,000 houses a year. Slum clearance was given first priority but nevertheless the Council decided to put aside a quota of dwellings annually for rehousing persons on purely medical grounds.

In November 1956 all applicants on the housing list were informed that, as the Council had rehoused 75,000 families between 1945 and 1955, priority in the future had to be given to slum clearance. A letter was sent to hospital staffs and general practitioners explaining the limited amount of housing which could be allocated on medical grounds and requesting them not to submit medical certificates but to send a personal letter to the Medical Officer of Health for his consideration in each case where they considered that an applicant or a member of his family was suffering from a very serious medical condition which would benefit from rehousing. Such letters have since continued to be received at a rate of 2,500 to 3,000 a year, together with some 1,500 requests annually for reassessment of or giving further details of a case previously turned down.

On receipt of a doctor's recommendation a health visitor filled in the family background and where necessary a public health inspector's report on the premises was obtained. A medical officer in each division assessed each case and indicated whether further consideration was justified. This decision has to be a realistic one, having regard to the number of recommendations received from doctors far exceeding the number of dwellings allocated. From those cases marked for further consideration, the most needy cases were selected for nomination by the Medical Officer of Health or his deputy to the Housing Committee for rehousing when dwellings became available. From 1956 there was a separate allocation of dwellings for tuberculous cases but as the number of recommendations received from chest physicians fell from 421 in 1957 to 126 in 1963, this quota was combined with the general health allocation in 1964 when the Housing Committee set aside 500 dwellings (including 50 mobile homes) for rehousing on medical grounds.

During the years 1956–1964 the Council rehoused 2,847 families solely for medical reasons, 838 being on grounds of infectious tuberculosis. The following table shows the cases dealt with in the past five years:

	1960	*1961*	*1962*	*1963*	*1964*
Tuberculous persons					
Recommendations received	232	224	180	126	108
Nominated for rehousing	209	139	110	110	88
Recommendations not qualifying for rehousing	93	20	70	61	19
Under consideration at end of year	45	110	110	65	66
Persons with severe medical conditions					
Recommendations received	3,357	2,570	2,263	2,586	2,570
Nominated for rehousing	607	164	363	449	978
Recommendations not qualifying for rehousing	2,503	1,791	2,082	2,653	1,682
Under consideration at end of year	1,300	1,915	1,733	1.217	1,127

Slum clearance

Extensive surveys of housing conditions had been completed in the period prior to the outbreak of war in 1939, but as a result of the war further proceedings in a number of clearance areas which had been represented to the Council were abandoned and the staff engaged on this work dispersed.

In 1945 housing conditions had vastly changed—many houses had been removed by bombing, while most of those that remained suffered from its effects or were in serious disrepair through neglect. Demobilised servicemen came home to an acute housing shortage and it was not unusual to find them, with wives and children, living in restricted and bad housing conditions with their parents' families.

Slum clearance work was resumed in 1947 leading to the representation of four small areas in 1948, but it was clear that a major effort was required if the worst housing conditions were to be tackled as urgently as the situation demanded. The Council decided, first, that six known large areas in Bethnal Green, Camberwell, Fulham, Southwark and Stepney should be re-surveyed and reported upon, and, secondly, that the metropolitan borough councils should be asked to carry out surveys of their boroughs to determine the extent of the problem. As a result of this and the detailed discussions which followed with the borough councils a joint programme of slum clearance for the period 1951–1955 was agreed, with the Council undertaking to clear 6,842 houses and the borough councils 3,290 houses. The six priority areas (totalling 31 acres and 1,291 houses) were dealt with by 1952 and the joint programme proceeded without undue delay.

The Housing Repairs and Rent Act, 1954, required all local authorities in England and Wales, including the Council and the metropolitan borough councils, to submit joint proposals for dealing with unfit houses. A further five-year programme (1956–1960) for the administrative county was drawn up in respect of 7,218 houses, of which the Council undertook to deal with 4,094. In 1960 sufficient progress had been made to enable a further programme for the years 1961–1965 to be drawn up and this year the first steps have been taken to draw up a programme for the years 1966–1970.

During the fifteen years from 1948 to 1963 the Council has declared some 713 areas, containing 25,404 unfit houses, to be clearance areas.

In two Areas of Comprehensive Development designated by the Council under the Town and Country Planning Act, 1947, one in Bermondsey of 121 acres, and one in Poplar/Stepney of 1,312 acres, clearance of individual unfit houses by Declaration of Unfitness Orders under Town Planning powers was commenced in 1949 and continued up to the end of 1964; 738 unfit houses were dealt with in this way. While unfitness for habitation is determined by the standards of the Housing Acts for this purpose, the provisions require it to be shown that the unfit houses cannot be made fit for habitation at reasonable cost.

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

	1960	*1961*	*1962*	*1963*	*1964*
Areas represented as unfit for human habitation	48	34	87	109	30
Houses in such areas	1,356	932	2,808	2,990	1,247
Areas surveyed but not represented by the end of the year	39	90	74	13	3
Houses in such areas	1,291	2,869	2,183	421	70
Public local inquiries	42	12	10	26	37
Informal hearings	1	4	—	—	4
Orders confirmed					
(i) after inquiry or hearing	41	27	9	17	37
(ii) without inquiry or hearing (no objection received)	15	2	2	7	19
Orders not confirmed by Minister	1	—	—	—	1
Confirmed order quashed on appeal to High Court	—	1	—	—	—

Improvement of houses by grant aid

In an attempt to encourage owners to provide bathrooms, hot water services and other amenities in sub-standard houses not likely to be included in development schemes, the Government in 1949 introduced the improvement grant provisions. These gave the Council powers, concurrent with the borough councils, to make grants, which it has exercised only where borough councils have been unwilling to do so or the Council is offering mortgage facilities. In the whole period up to the end of this year, 3,211 properties have been surveyed and 277 discretionary grants and 90 standard grants to the value of £596,102 have been made by the Council.

	1960	*1961*	*1962*	*1963*	*1964*
Improvement grants					
Surveys following applications to the Council ..	1,178	309	342	447	367
Searches following applications to metropolitan borough councils..	572	595	576	930	1,091
Hostels					
Surveys following application to the Council for loan					
Premises	—	—	—	5	5
Units of accommodation	—	—	—	311	278
*Housing loans**					
Searches following application to the Council for loan	—	—	—	2,459	2,790
Surveys following application to the Council for loan	—	—	—	229	155

**This additional work commenced during 1963 when the Council introduced a more extensive scheme for making loans to intending house purchasers.*

Sanitary inspection

The inspectors dealt with the following matters in Council establishments:

	1960	*1961*	*1962*	*1963*	*1964*
Reports of infestation by a variety of pests ..	274	221	269	250	259
Visits and re-inspections involved	506	409	526	404	372
Inspections of school meals centres	341	208	242	156	195
Investigations of illness following consumption of school meals	8	11	7	3	11
Occasions when the meal was found to be the cause	2	—	—	—	3

Milk sampling

Since 1908 the Council has arranged for samples of milk arriving in London by road and rail to be tested for the presence of tubercle bacilli. In 1959 it was decided that, as milk was received principally from tuberculosis eradication areas, sampling should be concentrated mainly in unpasteurised tuberculin tested milk bottled on the farm. Some 50 to 70 samples a year were taken. Any positive samples were reported to the medical officer of health of the district in which the milk was produced for him to take follow-up action. The following table shows the results of tests during the year, with last year's figures in brackets:

Designation	*Samples examined*	*T.B. bacillus isolated*	*T.B. bacillus NOT isolated*	*Passed phosphatase test*
Tuberculin tested (Farm bottled)	31 (33)	— (—)	31 (31†)	N/A
Tuberculin tested†	4 (4)	— (—)	4 (4)	N/A
Pasteurised	17 (17)	N/A	N/A	17 (17)
Total	52 (54)	— (—)	35 (35†)	17 (17)

* *Samples from a residential school which has its own farm.*
† *In addition the test was not completed on two samples.*

Blind and partially-sighted persons

During the year 1,561 examinations were made in connection with certification under the National Assistance Act, 1948 of blind or partially-sighted persons and 46 persons were found to be neither blind nor partially-sighted. In addition, 550 certificates were accepted from other local authorities, hospitals and private ophthalmologists—47 more than in the previous year. The percentage of new registrations recommended to obtain treatment was 58·7 per cent. compared with 58·3 per cent. in 1963. The number of examinations of persons newly referred during the year was appreciably higher than for 1963, with a corresponding fall in the number of re-examinations of persons previously examined.

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

TABLE (i)

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

Age	*Principal cause of defective vision*				*Total*
	Cataract	*Glaucoma*	*Retrolental fibroplasia*	*Other conditions*	
0–4 years	4	—	2	4	10
5–15 years	1	1	—	1	3
16–64 years	57	14	—	201	272
65–74 years	111	39	—	152	302
75 years and over	334	68	—	397	799
Age not known	7	6	—	18	31
(*a*) Total No. of persons	514	128	2	773	1,417
(*b*) No. recommended to obtain treatment	348	106	—	378	832
(*b*) as percentage of (*a*)	67·7	82·8	—	48·9	58·7

TABLE (ii)

*Treatment recommendations in respect of newly registered persons**

	No. of patients examined	*Treatment recommended*						
		None	*Medical*	*Surgical*			*Optical*	*Hospital supervision*
				Early	*Later*	*If general condition permits*		
Cataract	514	166	39	67	55	43	42	157
Glaucoma	128	22	30	—	5	1	8	81
Retrolental fibroplasia	2	2	—	—	—	—	—	—
Other conditions	773	395	96	7	20	6	46	249
Total	1,417	585	165	74	80	50	96	487

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

TABLE (iii)

Re-examination of persons recommended to obtain treatment

	Principal cause of defective vision			*Total*
	Cataract	*Glaucoma*	*Other conditions*	
No. of persons re-examined	177	64	246	487
No. found to have had treatment	125	59	170	354
Percentage treated..	70·6	92·2	69·1	72·7

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

Notifications of ophthalmia neonatorum are given on page 21.

Registration of nursing homes

During the years since 1948 the number of private nursing homes in the county has shown a steady decline. In 1949 there were 58 registered nursing homes containing 1,023 beds and in addition there were 40 homes exempted from registration on the grounds that they were not run for profit. In 1963 there were 34 registered nursing homes containing 945 beds and 35 homes exempted from registration. The demand for maternity and surgical beds greatly decreased since the inception of the National Health Service but there has been an increase in the need for beds for medical patients, particularly the elderly, infirm and chronic sick. This change of user has led to a review of the staffing standards and state enrolled nurses may now be employed in suitable ratio to fully trained nurses on the staff of nursing homes.

The Mental Health Act, 1959 came into operation in November 1960, and Part III of that Act and the powers for registration set out in the Public Health (London) Act, 1936 have now been applied to mental nursing homes. Four nursing homes have accordingly been registered for the reception of mentally ill patients. The Nursing Homes Act, 1963 repealed the power to grant exemption from the provisions of the Public Health (London) Act, 1936 to non profit-making homes and consequently all the homes previously exempted had to apply for registration. Regulations under this Act governing the conduct of nursing homes came into operation on 27 August 1963 and have strengthened the Council's powers to require and maintain good standards in nursing homes.

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

	1960	*1961*	*1962*	*1963*	*1964*
Registered at beginning of year	34	33	36	36	36
New homes registered	—	5	1	—	1
Homes registered on change of keeper	3	1	—	1	1
Registrations cancelled—voluntary closure or change of keeper	4	3	1	3	2
Applications for registration from homes previously exempted	—	—	—	—	12
Homes previously exempt registered during the year	—	—	—	—	12
Registered at end of year	33	36	36	34	47
Inspections:					
Medical officers	35	46	45	39	70
Public health inspectors	84	122	116	125	199
Homes exempted from registration	40	37	35	35	—

TABLE (ii)—*Accommodation in registered nursing homes at 31 December, 1964*

No. of homes—47	Maternity beds	205*
	Others	917†‡
	Mental	305
	Total	1,427

** Alternative registration for maternity, medical or surgical case.*
† Numbers include beds for medical and surgical patients which cannot be used if maternity patients are accommodated in the same room.
‡ Number includes 45 beds registered for medical or mentally disordered cases.

Invalid meals for London

Under the National Health Services Act, 1946 the Council had power to arrange for the provision of meals at home for the sick, including the aged sick. Many parts of London were served by the Invalid Kitchens of London, a voluntary organisation which provided meals for invalids at several centres or delivered meals by car to the patient's home. The Council paid a grant to this organisation towards the cost of meals provided by them for persons in their own homes. Towards the end of 1959 the voluntary organisation asked the Council to take over this service as soon as possible but the legal formalities were not completed until December 1961. In the meantime, the metropolitan borough councils asked for powers to be obtained in a General Powers Act to enable them to provide this service and provision was included in the London County Council (General Powers) Act, 1961. Discussions then took place through the Metropolitan Boroughs' Standing Joint Committee concerning the transfer of this service to the boroughs but no decision was reached. Under the London Government Act, 1963 this service will be transferred to the new London boroughs. Since 1961 the service has been maintained and operated by the School Meals and Catering department who have replaced and made improvements in vans and equipment. The number of meals served during recent years was as follows:

	1960/1	*1961/2*	*1962/3*	*1963/4*	*1964/5*
Meals served	180,291	196,695	202,430	239,814	*251,525*

Welfare Committee establishments

Medical supervision of all types of establishments under the control of the Welfare Committee continued. These include large and small homes for the aged and infirm, accommodation for mothers and babies, homeless families units, homes for the blind and lodging houses.

The Public Health department has continued to advise on steps to be taken to limit the spread of infectious diseases in homeless families units. The features which are of special importance in the spread of these infections include the close and intimate nature of contact, both of the adults and children, for a large part of the time they are in the units, the common feeding accommodation and the shared sanitary accommodation. Much has been done to stimulate the women inhabitants to a sense of responsibility in the maintenance of sanitary accommodation in good order. Where the inhabitants have failed to respond to training extra domestic staff have been allocated to maintaining clean sanitary accommodation.

In the welfare homes the health of the chronic sick and other illnesses of an ageing population receive the constant attention of the medical and other staff. The treatment of minor conditions within the homes increases the elderly persons' sense of security but when a doctor has a large number of the elderly on his list it can be very time-consuming. Special investigations have been arranged and preventive measures carried out in order to maintain as high a standard of health as possible within the homes.

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.

The maternity and child welfare centres transferred to the Council under the National Health Service Act, 1946 varied considerably both in standard and type, and were mainly accommodated in church halls, shops and converted dwelling-houses. They were generally sub-standard and in need of replacement. Only about 10 per cent. of the transferred premises had been purpose built and while a number of these provided excellent facilities others, built earlier, were too small to be regarded as adequate by modern standards. Furthermore, certain areas were not adequately served either by maternity and child welfare centres or day nurseries, partly as a result of alterations in the density of the population within the county which occurred during and since the war.

It was recognised that shortages of materials and labour would preclude the erection of many centres and other health service buildings and that the rate at which progress could be made would be very largely dependent upon the economic position. Restrictions on capital expenditure prevented the Council from carrying out much of its health service building programme but a substantial number of high priority projects were completed or were nearing completion by the end of 1964. Particulars of these schemes and of other major building works completed since 1948 are set out in tables (i) and (ii) and summarised in table (iii).

Comprehensive health centres

Original proposals—The Council, recognising the importance of the role which the comprehensive health centre could play in securing the fullest co-operation between the personal health services and those provided by the hospital and specialist services and by general medical and dental practitioners, included in proposals for carrying out its duties under section 21 of the National Health Service Act, 1946 the following:

(i) The building of the Woodberry Down comprehensive health centre, Stoke Newington;

(ii) the establishment of a similar centre in each of the nine health divisions, if suitable buildings could be found for adaptation; and

(iii) the acquisition and adaptation of suitable premises for use as group practices only in any area where the demand for such facilities existed.

This constituted the initial stage of the ultimate provision of a comprehensive health centre service, which it was realised would take many years to achieve. The long-term plan was to provide a centre in each of 162 health service areas into which London was to be divided.

Action to implement the proposals—

(i) *Woodberry Down health centre*—Local authority and specialist services began when the centre opened in October 1952. All doctors practising within a mile of the centre were invited to apply for facilities. Although six were eventually selected, they were unwilling to work in partnership. In fact, they practised independently from their surgeries in the centre, although the Council recently agreed to arrangements whereby two of the practices include additional partners in the interests of making greater use of the facilities available.

(ii) *Other comprehensive centres*—No suitable buildings were found for adaptation but some 40 sites were provisionally earmarked for the provision of health centres when circumstances became propitious.

(iii) *Group practices*—All doctors practising in London were invited to say whether they would like to work in group practice buildings provided by the Council, if these could be found in suitable localities, and 29 groups expressed their willingness to do so. Of these, seven groups consisted of less than four doctors, the minimum number felt by the Council to be desirable to form a group. For some years a search was made to find premises for the other groups but without success.

South East London general practitioner centre—The South East London general practitioner centre established by the Council at Queen's Road, Camberwell, which was officially opened in 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 commonroom. The Council provides and maintains the premises, supplies the furniture and non-specialist equipment, nursing, health visiting and secretarial staff. 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. The South East Metropolitan Regional Board and the Camberwell Hospital Management Committee provide the specialist equipment, staff and consultants for the radiological and pathological departments. The College of General Practitioners supported the project and gave invaluable advice and assistance during the planning stages.

Revision of the Council's policy—Long standing restrictions on capital expenditure and the unwillingness of general practitioners to engage in group practice from a health centre precluded the provision of further health centres. These problems were discussed on many occasions with the London Executive Council and with the Ministry of Health; the Minister finally advised the Council in 1955 that he would be unable to approve of the erection of health centres except in areas of new development where existing health services, including general medical services, were inadequate and provided that local doctors agreed to practise from them. In view of this and the practical difficulties in securing the vital co-operation of general practitioners in the provision of general medical services from health centres, the Council decided that it would be unrealistic and, because of the shortage of land in London, undesirable to continue the policy of long term reservation of health centre sites. The London Executive Council's suggestion was accepted that any housing development on these sites should be constructed so that ground floors could readily be converted to accommodation for general practitioners if required later.

The Council has subsequently been willing to assist general practitioners wherever practicable to establish group practices in one of two ways:

(i) to provide a building as the first instalment of the health centre and if a group were anxious to adopt this method in an area of new development the Council would give the proposal sympathetic consideration; and

(ii) to provide accommodation in a housing block at an economic rent on the same basis as a practitioner who might be provided with a surgery by the Council if he were displaced by housing development.

It has been open to any doctors to approach the Council on these matters through the London Executive Council and the London Local Medical Committee, with whom the Council has worked in the closest co-operation.

Maternity and child welfare and school treatment centres

It was apparent at the outset that many years would elapse before designed buildings could be erected in sufficient numbers to replace the improvised clinic accommodation to which reference has been made. To safeguard the future of the service, whenever opportunity arose the freehold or leasehold interest has been secured in the more satisfactory buildings and table (v) shows that the service relies much less now than in 1948 on rented premises. Improved alternative accommodation has been obtained to enable centres functioning in very unsuitable premises to be closed.

Progress has also been made in providing new or improved accommodation for school health service purposes. In suitable cases the opportunity has been taken of incorporating some school health services in maternity and child welfare centres, so as to achieve fuller integration of the two services.

Financial restrictions obliged the Council to defer plans for the erection of replacement buildings and the building of new purpose-designed centres has been largely confined to those areas where expanding population or the development of new housing estates has created a new and urgent demand for services. The Council approved a number of schemes for the incorporation of purpose-designed clinics and day nurseries in ground floor accommodation in blocks of flats. Details of schemes in new housing developments are given in table (iii).

Day nurseries

Most day nurseries transferred in 1948 were established in haste during the war in requisitioned premises or in prefabricated buildings. Although the extent of day nursery provision in London has been appreciably reduced during the past decade, it will be noted from table (v) that effective steps have been taken during this period to place the service on a more secure basis. In addition to providing the new day nursery buildings named in tables (i) and (iii), the Council carried out much needed improvements to the standards of improvised day nursery accommodation in the interests of the care and well being of the children and to promote economy and efficiency in administration.

Mental health services

The 12 training centres for mentally subnormal persons administered by the Council since 1931 were closed during the war. Although war damage and other difficulties prevented the reopening of centres until 1948, by 1958 there were 21 centres established throughout the county. Six were accommodated in adapted buildings owned by the Council and the remainder in hired premises which in many cases were not entirely suitable. With the passing of the Mental Health Act, 1959, the provision of mental health service premises was given high priority in the formulation of building programmes incorporated in the ten-year plans (1962–1972 and 1964–1974) for the development of the health and welfare services. The programmes included provision for the replacement of all junior training centres in unsatisfactory premises by purpose-built centres, with sufficient additional places to permit a lowering of the age for admission and with special care units for subnormal children suffering from additional handicaps, physical or otherwise. All adult centres were to be housed in premises owned or leased exclusively by the Council with extra places to meet rising demand. The revised building programme for the ten years to 1974 included projects for 18 training centres for the mentally subnormal.

The Council recognised that it was too early to determine the ultimate numbers of buildings required for the mental health service but included in the revised building programme initial provision for a further 22 hostels (envisaging a total of 26 by 1974), 15 day centres and six day rehabilitation centres.

Table (i) gives details of the building projects for the mental health services during the years 1948–1964 and the projects at earlier stages of progress at the end of 1964.

As the mental health services have been built up it has been found necessary to rent premises on short leases to meet the demand for new and additional services until such time as these can be accommodated in purpose-built or adapted premises. In addition to those listed in table (i) the following have been opened:

Newlands adult training centre (women), Wandsworth, opened in 1962.

Hindle House, Hackney; St. Giles, Camberwell and Rushey Green, Lewisham day centres were opened in 1964.

Bishop Creighton House Psychiatric Social Club, Fulham opened in 1963 and a part-time social club at The Saville, Lewisham in 1964.

Ambulance service

Despite the limitations placed on capital works, substantial progress was made in restoring war damaged buildings and in providing the new ambulance stations (see table (i))

needed to meet the gradually increasing demand for ambulance transport in London since the inauguration of the National Health Service. The ten-year building programme included a project for the replacement of the London Ambulance Service headquarters by a purpose-designed building and during 1964 the preliminary schedules of accommodation were approved by the Health Committee. The programme included also projects for eight new ambulance stations and 15 improvement schemes.

Other Health Service premises

The Council's first hostel for infective tuberculous men was provided in 1951 in an adapted house in Islington. A second opened in Fulham in 1953 and came into full use a year later, after adaptation and redecoration. The Islington hostel was replaced in 1954 by improved premises in Hornsey and a further hostel was opened in Lambeth during 1958.

The Mayfield Recuperative Holiday Home, Mayfield, Sussex, transferred to the Council in 1948, proved to be uneconomical in maintenance and was replaced in 1950 by Roland House Holiday Home, Littlehampton, Sussex, which has been acquired and adapted to provide accommodation for 36 children. The Council made an agreement with the trustees of the Surrey Convalescent Home for Children, Cambridge House, Bognor Regis, Sussex, to take over and manage the premises as a holiday home for 44 older children. The building was brought into use in 1958 after works of improvement and redecoration.

TABLE (i)—*Health Service building works completed 1949–1964*

Year of completion	*Health Division*	*Scheme*	*Works completed*
		COMPREHENSIVE HEALTH CENTRE	
1952	4	Woodberry Down, Stoke Newington.	New building.
		MATERNITY AND CHILD WELFARE	
1949	2	Sumatra Road, Hampstead ..	New building*.
	7	Consort Road, Camberwell ..	Conversion of existing building.
1950	4	Upper Clapton, Hackney.. ..	Conversion of existing building.
	6	Rustall Lodge, Woolwich ..	Conversion of existing building.
	7	Downham, Kent†	Rebuilding of premises demolished by enemy action.
1951	9	Earlsfield, Wandsworth	Conversion of existing building.
1952	7	Amott, Camberwell	Extension of existing building.
	8	West Norwood, Lambeth ..	Reinstatement of war damage and repairs.
1953	6–7	Blackheath Hill, Greenwich ..	New building.
	7	Queen's Road, Camberwell ..	Conversion of existing building.
	7	Lordship Lane, Camberwell† ..	Adaptations on acquisition.
1954	1	St. Quintin, Kensington	New building.
	5	Mary Hughes, Stepney	Extension of existing building.
1955	5	Greenwood, Bethnal Green ..	New building.
1956	3	West Islington	Major improvements.
	5	Rochelle Street, Bethnal Green ..	Conversion of existing building.
	5	Wellington Way, Stepney ..	Reinstatement of war damage to provide offices and residential accommodation for nursing staff.
	7	Queen's Road, Camberwell ..	Installation of new hot water and heating systems.
1957	2	Daleham Gardens, Hampstead ..	New building.
	2	Queen's Park, Paddington ..	Conversion of existing building.
	6	Lionel Road, Woolwich	Adaptations and improvements.
	9	Victoria Drive, Wandsworth ..	Completion and adaptation of existing building.

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

† *Accommodation also provided for school treatment centre.*

TABLE (i)—*continued.*

Year of completion	*Health Division*	*Scheme*	*Works completed*
		MATERNITY AND CHILD WELFARE—*continued.*	
1958	2	Parkhill, Hampstead	Conversion of existing building.
1959	6	Abbey Wood Estate, Woolwich	Adaptation of flat to provide temporary clinic accommodation.
1960	4	West Hackney	New church hall with special provision for maternity and child welfare sessions.
	7	Bellingham, Lewisham	Tenants' clubroom adapted for infant welfare sessions.
	9	Welcome Hall, Battersea ..	New hall built by Shaftesbury Society incorporating accommodation for health service purposes.
1963	8	Benson Home, Lambeth	Adapted replacement for unsatisfactory centre.
1964	2	Sumatra Road, Hampstead ..	Extension to existing building providing additional facilities.
	5	The Island, Poplar†	New free standing centre in borough council housing development, replacing unsatisfactory premises.
	6	Avery Hill Estate, Woolwich ..	Purpose-designed annexe to new tenants' clubroom to provide improved facilities.
	6	Rusthall Lodge, Woolwich ..	Adaptation to give improved facilities.
		SCHOOL HEALTH	
1949	1	St. Dunstan's Road, Fulham ..	Conversion of existing building.
	7	Gordon Road, Camberwell ..	Conversion of existing building.
	9	Gatton, Wandsworth	New building.
1950	5	Whitechapel, Stepney	Conversion of existing building.
1951	5	East India Dock Road, Poplar ..	Conversion of existing building.
	5	Bethnal Green	Conversion of existing building.
	8	Brixton child guidance unit, Lambeth.	Adaptations on acquisition.
1953	2	Westminster	Conversion of existing building.
1955	9	Tooting, Wandsworth	Conversion of existing building.
1956	8	West Norwood, Lambeth ..	Adaptations to provide school treatment centre.
1959	7	Lewisham	Extension to provide recovery room to dental suite.
1960	3	South Islington	Conversion of basement to form school health suite.
1962	4	Additional child guidance unit in Shoreditch.	Conversion of standing property.
		DAY NURSERY	
1949	4	Wetherell Road, Hackney ..	New building*.
	5	Christian Street, Stepney	New building*.
1950	1	Mulgrave, Fulham	Conversion of existing building.
	2	Ampthill Square, St. Pancras ..	Conversion of existing building.
1951	2	Katherine Bruce, Paddington ..	New building.
1952	3	Springdale, Stoke Newington ..	New building.
	4	St. John's, Hackney	New building.
	4	Woodberry Down, Stoke Newington.	New building.
1953	2	St. Stephen's, Paddington ..	Completion of building.
	5	University House, Bethnal Green	Extension of existing building.
1954	6	Amersham Road, Deptford ..	Conversion of existing building.

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

† *Accommodation also provided for school treatment centre.*

TABLE (i)—*continued.*

Year of completion	*Health Division*	*Scheme*	*Works completed*
		DAY NURSERY—*continued*	
1956	2	Carlton Hill, St. Marylebone ..	Adaptations on acquisition.
	4	Clifton Lodge, Hackney	Major improvements.
1957	2	Camden Road, St. Pancras ..	Major improvements.
	9	Sisters Avenue, Battersea.. ..	Major improvements.
1959	1	Uxbridge Road, Hammersmith ..	Installation of sluices.
	2	Portman, St. Marylebone ..	New fencing and tarpaving of enlarged play space.
	3	Canonbury, Islington	Improvements to water services; additional toilet facilities.
	8	Bishop House, Lambeth	Improvements to grounds.
	8	Coldharbour Lane, Lambeth ..	Major repairs.
	9	Putney, Wandsworth	Resiting of boiler; improved toilet facilities.
1961	1	Ladbroke, Kensington	Additional toilets; new heating and hot water schemes.
	1	Eridge, Fulham	Resurfacing of play space.
	3	Scholefield Road, Islington ..	Conversion to oil-fired boilers.
1964	1	St. Quintin, Kensington	Extension to provide additional places.
		LONDON AMBULANCE SERVICE	
1953	–	Eastern ambulance station, Hackney.	Adaptations and improvements.
	–	Fulham ambulance station ..	Major improvements.
	–	South Western ambulance station, Lambeth.	Extension of existing building.
	–	West Smithfield ambulance station, City of London.	New building.
1954	–	Hampstead ambulance station ..	New building.
1955	–	Headquarters, Lambeth	Conversion of existing building.
	–	Pear Place ambulance station, Lambeth.	Major improvements.
	–	Brook ambulance station, Woolwich.	Reinstatement of war damage.
	–	Mottingham ambulance station, Woolwich.	New building.
1956	–	South Western ambulance station, Lambeth.	Reinstatement of war damage and repairs.
	–	Upper Richmond Road ambulance station, Wandsworth.	New building.
1959	–	Eastern ambulance station, Hackney.	Roofing at station yard.
	–	Headquarters ambulance station, Lambeth.	Additional storage space and office accommodation; installation of stores hoist.
	–	North Western ambulance station, Hampstead.	Reinstatement of war damage; alteration to office accommodation.
	–	South Eastern ambulance station, Deptford.	Extension of garage accommodation; improvements to entrance and offices.
	–	Western ambulance station, Chelsea.	Additional vehicle washing plant.
1960	–	Brook general ambulance station, Woolwich.	Improvement and re-arrangement of staff quarters.
	–	Fulham accident ambulance station, Fulham.	Adaptations for additional staff accommodation.
	–	Western general ambulance station, Chelsea.	Enlargement of office accommodation.
1961	–	Eastern general ambulance station, Hackney.	Improvement and re-allocation of accommodation; improvements to entrance.

TABLE (i)—*continued.*

Year of completion	*Health Division*	*Scheme*	*Works completed*
		LONDON AMBULANCE SERVICE—*contd.*	
1962	–	Battersea accident ambulance station, Battersea.	Replacement of building destroyed by enemy action.
1963	–	South Eastern general ambulance station, Deptford.	Improvements to access, service bay and lighting.
1964	–	North Western general ambulance station, Hampstead.	Adaptations to provide smallpox decontamination suite.
		MENTAL HEALTH	
		(*a*) TRAINING CENTRES	
1954	1	Fulham	Conversion of existing building.
	9	Wandsworth	Conversion of existing building.
1955	5	Stepney industrial centre ..	Conversion of existing building.
1956	5	Bethnal Green	Conversion of existing building.
1957	9	Balham, Wandsworth	Conversion of existing building.
1958	4	Shoreditch	Conversion of existing building.
1959	1	Kensington (junior)	Erection of new building.
	7	Lewisham (junior)..	Erection of new building.
1960	3	Camden Road, Islington ..	Church hall built to incorporate Council's requirements for use as a training centre for elder girls.
1961	1	College Park (elder girls), Hammersmith.	Adaptation of former maternity and child welfare centre.
	4	Hackney (junior)	New junior training centre.
	9	Clapham (industrial), Wandsworth	Adaptation of premises to form an industrial training centre.
1962	6	Blackwall Lane (industrial), Greenwich.	Adaptation of existing building as an additional industrial training centre.
1964	5	Mary Hughes (women), Stepney..	Adapted replacement for unsatisfactory centre.
	5	Unity Hall (men), Poplar ..	Adapted replacement for centre displaced by hospital redevelopment.
	6	Park Vista (women), Greenwich..	Adapted replacement for unsatisfactory premises.
		(*b*) HOSTELS	
1955	7	Dover Lodge, Lewisham	Adaptation of premises to form hostel for subnormal girls in work.
1962	9	Chellow Dene, Wandsworth ..	Adaptation of premises to form hostel for the mentally ill.
	7	Honor Lea, Lewisham	Purpose-built hostel for the mentally ill.
		(*c*) DAY CENTRES	
1960	4	Clifton Lodge, Hackney	Conversion of former day nursery into a centre for the mentally ill.
1964	5	Pritchards Road, Bethnal Green..	Conversion of former day nursery into a day centre for the mentally ill.
		TUBERCULOSIS—HOSTELS FOR MEN	
1951	3	Highbury Quadrant Hostel, Islington†.	Conversion of existing building.
1954	1	Hurlingham Lodge, Fulham ..	Conversion of existing building.
	3	Cromwell Lodge, Hornsey ..	Adaptations on acquisition.
1958	8	Knight's Hill House, Lambeth ..	Conversion of existing building.
1961	3	Cromwell Lodge, Hornsey ..	Provision of new boilers.
1962	1	Hurlingham Lodge, Fulham ..	Improvements to kitchen; alterations to building due to road widening.
1963	3	Cromwell Lodge, Hornsey ..	Annexe for occupational therapy.

† *Closed in 1954.*

TABLE (i)—*continued.*

Year of completion	*Health Division*	*Scheme*	*Works completed*
		RECUPERATIVE HOLIDAY HOMES	
1952	—	Roland House, Littlehampton, Sussex.	Conversion of existing building.
1958	—	Cambridge House, Bognor Regis, Sussex.	Adaptations on acquisition of lease.
		GENERAL PRACTITIONERS' CENTRE AND CHILD GUIDANCE UNIT	
1961	7	South East London general practitioners' centre and Peckham child guidance unit, Camberwell.	Major adaptations to third floor to provide general practitioners' centre and improved accommodation for existing child guidance unit.

TABLE (ii)—*Health Service building works in hand or planned at* 31.12.64

Division	*Premises*	*Work involved*
	Works in hand	
	MENTAL HEALTH	
3	Junior training centre, Basire Street, Islington.	New building.
6	Junior training centre, Maze Hill, Greenwich.	New building.
	LONDON AMBULANCE SERVICE	
–	Russell Square accident ambulance station, Holborn.	Adaptation and reconstruction of out-of-date station to make best use of restricted site.
–	Oval accident ambulance station, Lambeth.	Re-building to accommodate additional ambulances.
–	South Western general ambulance station, Lambeth.	Provision of additional garage space and workshop.
	Works approved but not commenced	
	HEALTH CENTRE	
4	Shoreditch	Additional dental surgery accommodation.
	MATERNITY AND CHILD WELFARE	
6	Garland Road, Woolwich	New building.
	SCHOOL HEALTH	
6	Garland Road child guidance unit, Woolwich.	New building.
9	York Road child guidance unit, Wandsworth.	New building.
	DAY NURSERY	
4	Sun Babies, Shoreditch	Reorganisation of accommodation; improvements to heating and sanitary facilities.
	LONDON AMBULANCE SERVICE	
–	L.A.S. headquarters annexe	Adaptation of premises to provide additional accommodation.

TABLE (ii)—*continued.*

Division	*Premises*	*Work involved*
	MENTAL HEALTH	
1	Junior training centre, Kensington ..	Extension to existing building to provide special care unit and additional facilities.
4	Adult training centre (men), Morning Lane, Hackney.	New centre to replace unsatisfactory centres with extra accommodation to meet demand.
7	Lewisham junior training centre ..	Extension to provide special care unit.
2	Hostel for subnormal men in work, Lancefield Street, Paddington.	New building.
6	Hostel for subnormal children, Ashburnham Grove, Greenwich.	New building.
9	Chellow Dene, hostel for the mentally ill, Wandsworth.	Extension to provide additional accommodation.
6	Day rehabilitation centre, Federation Hall, Woolwich.	Adapted premises to meet new demand.
	Works approved in principle but still in planning stage	
	HEALTH CENTRE	
4	Woodberry Down, Stoke Newington..	Improvements to car park.
	MATERNITY AND CHILD WELFARE	
6	Shooters Hill, Greenwich	Adapted replacement for centre displaced by road scheme.
8	Lancaster Street, Southwark	New building.
	LONDON AMBULANCE SERVICE	
–	London Ambulance Service Headquarters.	New building.
	MENTAL HEALTH	
4	Hackney junior training centre, Hackney.	Extension to provide special care unit.
7	Adult training centre (women), Harders Road, Camberwell.	New building.
8	Three training centres for men, women and children, Grange Tannery site, Bermondsey.	Adapted replacement for adult centres and purpose-built junior training centre.
9	Adult training centre (women), Roehampton Lane, Wandsworth.	New building.
6	Two hostels for subnormal men and youths, Brockley Congregational Church site, Deptford.	New building.
8	Hostel for subnormal children, Grange Tannery site, Bermondsey.	New building.
9	Hostel for subnormal women, Roehampton Lane, Wandsworth.	New building.

TABLE (iii)—*Purpose-designed health service accommodation incorporated in housing schemes*

Year	*Health Division*	*Scheme*	*Authority responsible for housing development*
		Works completed	
		MATERNITY AND CHILD WELFARE	
1955	8	Rose McAndrew, Lambeth ..	London County Council.
1956	5	Will Crooks, Poplar	London County Council.
1959	9	William Harvey, Wandsworth.*	London County Council.
1960	2	St. Albans, St. Pancras ..	St. Pancras Metropolitan Borough Council.
1961	2	Hallfield Estate, Paddington.* ..	Paddington Metropolitan Borough Council.
1962	6	Burney Street, Greenwich ..	Greenwich Metropolitan Borough Council.
	8	John Dixon, Keaton's Road, Bermondsey.*	London County Council.
	9	St. Christopher's, Plough Road, Battersea.*	Battersea Metropolitan Borough Council.
1963	8	Loughborough Estate, Lambeth.*	London County Council.
1964	3	Barnsbury Estate, Islington* ..	London County Council.
		DAY NURSERY	
1956	8	China Walk, Lambeth	London County Council.
1959	8	Coral, Lambeth	London County Council.
		DAY CENTRE FOR THE MENTALLY ILL	
1963	8	Draper Street, Southwark ..	London County Council.
		Works in hand on 31.12.64	
		MATERNITY AND CHILD WELFARE	
—	1	Walmer Road, Kensington.* ..	London County Council.
—	6	Abbey Estate, Woolwich* ..	London County Council.
—	9	Stormont Road, Battersea* ..	London County Council.
		DAY NURSERY	
—	9	Upper Tulse Hill, Wandsworth ..	London County Council.
		Works approved but not commenced by 31.12.64	
		MATERNITY AND CHILD WELFARE	
—	5	Leopold Street, Stepney* ..	London County Council.
—	6	Royal Victoria Yard, Deptford ..	London County Council.
—	7	Dartmouth Road, Lewisham ..	London County Council.
		SCHOOL HEALTH	
—	7	Peckham Park Road	London County Council.
		DAY NURSERY	
—	1	Latymer, Hammersmith	London County Council.
—	7	Peckham Park Road, Camberwell	London County Council.
—	7	Wyndham, Camberwell	London County Council.

* *Includes school treatment centre.*

TABLE (iv)—*Summary of Health Service building works completed* 1949–1964

Service	*New building*	*Completion of existing building*	*Conversion of existing building*	*Extension of existing building*	*Adaptation on acquisition*	*Reinstatement of major war damage*	*Major improvements*
Comprehensive health centre	1	—	—	—	—	—	—
Maternity and child welfare	22	1	8	3	4	3	4
School health ..	1	—	9	1	2	—	—
Day nursery ..	8	1	3	2	1	—	12
London Ambulance Service	4	—	3	2	—	4	10
Mental health—							
(*a*) Training centres	4	—	7	—	5	—	—
(*b*) Hostels ..	1	—	—	—	2	—	—
(*c*) Day centres ..	1	—	2	—	—	—	—
Tuberculosis.. ..	—	—	3	1	1	—	2
Recuperative holidays	—	—	1	—	1	—	—
General practitioners' centre	—	—	1	—	—	—	—
	42	2	37	9	16	7	28

TABLE (v)—*Analysis of the tenure of maternity and child welfare centre and day nursery premises, 1948–1964*

Tenure	*Welfare centres*		*Day nurseries*	
	5.7.48	*31.12.64*	*5.7.48*	*31.12.64*
Freehold	34	65*	8	43
Leasehold	15	33	13	23
Rented	103	59	36	5
Requisitioned..	5	—	54	3
In joint use with other authorities	46	12	9	—

* *Includes 23 centres provided in housing accommodation owned by the Council.*

Since the beginning of the National Health Service the general policy of the Council has been to provide a uniform and properly co-ordinated service; although this still varies to meet local demands, the aim to provide the best possible service in all parts of the county has been continued.

Maternity and child welfare

The Council has made comprehensive provision for the care of mothers and young children. Maternity and child welfare centres provide ante- and post-natal clinics, child welfare clinics, mother-craft classes; the centres make available to mothers certain nutrients and simple medicaments and the full range of national welfare foods. By far the greater part of the maternity and child welfare work is carried out from the Council's own centres but the Council has agreements with and makes very substantial financial contributions (up to 100 per cent. of approved net expenditure) to 13 voluntary organisations and the medical schools of four teaching hospitals for the provision by them of certain maternity and child welfare services and with four voluntary organisations providing day nursery services.

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

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

	1960	*1961*	*1962*	*1963*	*1964*
Ante-natal, post-natal and combined clinics:					
Number at end of year	109	109	108	110	105
Sessions per month	793	787	803	732	703
Total attendances	136,864	143,945	141,862	118,791	103,959
Ante-natal:					
Number of women attending during the year	29,387	32,440	32,809	31,874	27,272
Post-natal:					
Number of women attending during the year	3,369	2,859	2,335	3,822	3,283
Child welfare clinics:					
Number at end of year	179	178	174	173	176
Sessions per month	2,034	2,057	2,081	2,085	2,060
Number of children born in same year who attended	44,718	47,535	50,516	48,916	52,320
Total attendances (all ages)	742,095	768,953	766,837	713,845	814,608
Attendances at special toddlers clinics (not included in above)	37,533	38,203	37,790	40,196	43,965

There has been a gradual reorientation in the function and purpose of the child welfare service in recent years, which is of great significance for the future. Increasingly it has attempted to provide a comprehensive and purposeful diagnostic service for the early detection of mental or physical handicaps.

Preventive mental health—The first steps in preventive mental health were taken when psychiatrists in the child guidance clinics set up to deal with maladjusted school children pointed out that some emotional disturbances might have been prevented or minimised had the child been seen earlier. In 1954 the Council set up case conference groups in maternity and child welfare centres, the groups consisting of medical officers and health visitors with a child psychiatrist and a psychiatric social worker. The groups provide a training for maternity and child welfare staff and at the same time give an indirect service to mothers and young children.

Children 'at risk' of or with handicapping conditions—The aim has been to detect handicaps as early as possible, so that training which will help the child to make the best use of his residual assets can be given at the most favourable time of development when skills would normally be acquired and to see that the child is not lost sight of for any reason; to assist parents to keep the child in the community as long as possible and also to advise in advance on the child's needs for special care for education. In order to do this, a register of handicapped or potentially handicapped children has been set up in each division. Babies are considered to be at risk of developing a handicap by reason of adverse factors occurring during pregnancy, labour or the puerperium. The register is compiled from information provided on the form of discharge report made available by the Council to domiciliary midwives and hospital maternity units and from information about children born with congenital handicaps provided since 1964 on the form of notification of birth. In each division the register is scrutinised at regular intervals by a senior medical officer so that the children's progress and development may be kept under continuous review and the offer of help made at the earliest possible time.

Some 90 per cent. of infants born in the county are seen in child welfare clinics in their first year of life and clinic medical officers thus have the opportunity to screen babies for congenital handicaps. In 1957 training of medical officers in screening tests of the hearing of babies and young children began and all medical officers soon had the opportunity of studying these techniques. Every centre was equipped with the 'Stycar' hearing testing set devised by Dr. Mary Sheridan, Ministry of Health. Medical officers train health visitors not only to refer babies known to be at risk but also to carry out screening tests at the centre. All children suspected of deafness are referred to the divisional otologist. The youngest child for whom a hearing aid and auditory training have so far been prescribed was four months of age.

Detection of children suffering from phenylketonuria—Since 1960 babies' urine has been tested as a routine to detect those with phenylketonuria—a rare inborn error of metabolism which can lead to mental defect—and from this screening test four cases have been found. One of these was a boy who, although tested with phenistix at the age of 32 days with an apparently negative result, was found over a year later to be suffering from phenylketonuria. The boy was admitted to hospital where several further phenistix tests were carried out in the ward with only faint results or none at all, but a more 'pronounced result was obtained after meals. Following this experience, wherever possible the test for urine is done an hour or so after a feed.

Day accommodation for children

Day nurseries are provided for children under five whose home circumstances are detrimental to health or whose mothers have to go out to work, priority being given on health and economic grounds. In recent years places have been set aside for children whose physical or mental development might be advanced in the care of the nursery and through mixing with children not suffering from a handicap.

Since 1961 a number of special units for the admission of severely subnormal children have been provided in nine day nurseries. In addition, young deaf children may be admitted up to a maximum of 15 hours a week. In each case no charge is made except for meals or refreshment taken. Otherwise charges for admission have continued to be made but have remained abatable according to means. To an increasing extent nursery staff have become involved in co-operating with other workers on the social problems of some of the families using the nurseries.

The number of children minded by voluntarily registered child-minders has doubled since the end of 1949. Comparable increases have occurred in the number of private day nurseries and in the number of children that can be minded by child-minders registered under the Nurseries and Child-Minders Regulation Act, 1948.

There are occasional crèches in all divisions where children under five years are looked after without charge whilst their mothers are attending sessions at the centre or where they can be looked after for a small charge, abatable in case of necessity, whilst the mothers visit hospital, attend to domestic duties or shopping etc. Children who need relief from poor home conditions and the only child needing to mix with other children are also accepted at the crèches. These sessions have increased over recent years; in 1964 there was an average of 128 sessions a week with average weekly attendance of 1,759.

From the beginning of November 1964 mothers were allowed to leave their children in occasional crèches free of charge upon production of documentary evidence that they had a hospital appointment on the occasion in question. This was an experiment with the object of assessing the financial burden that it would impose, so that consideration could be given to its introduction as a regular feature of the service.

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

	At 31 December			
	1949	*1954*	*1959*	*1964*
DAY NURSERIES:				
Maintained	114	100	75	72
Grant aided	6	5	4	4
Places	6,615	5,850	4,192	4,003
COUNCIL'S CHILD-MINDER SCHEME (Voluntary registration)				
Child-minders registered	584	925	875	720
Children minded	579	1,000	1,039	971
NURSERIES AND CHILD-MINDERS REGULATION ACT, 1948 (Statutory registration)				
Private day nurseries registered	28	61	60	109
Places	972	1,795	1,620	2,749
Child-minders registered	73	110	167	238
No. of children authorised to be minded ..	501	590	939	1,306

Family planning

In July 1930 the Ministry of Health (Memorandum 153 MCW) authorised local health authorities to give advice on birth control to married women in attendance at maternity and child welfare centres where there were medical grounds for considering that further pregnancy would be detrimental to health. The medical grounds were widened in 1932 to include women suffering from organic diseases such as tuberculosis, heart disease, diabetes, chronic nephritis, etc., in which child bearing was likely seriously to endanger life and other forms of sickness, physical or mental, which were detrimental to them as mothers. What was or was not medically detrimental to health was to be decided by the professional judgment of the registered medical practitioner in charge of the clinic. (Circular 1408, 31 May 1934.) These limitations remain operative and the giving of contraceptive advice in circumstances other than those referred to above is at present outside the Council's powers as a local health authority and also appears to be beyond the scope of the National Health Service in general.

To discharge its responsibilities the Council itself provides a few family planning clinics but over the county as a whole uses the services of the Family Planning Association. A payment of 17s. 6d. (two guineas for women receiving oral contraceptives, plus the cost of

a year's supply of the pills) is paid by the Council to the Association for each patient advised at the Association's clinics on referral on medical grounds by the Council's medical officers. Recommendations by general practitioners and hospitals made through the Council's divisional medical officer are included in this arrangement. The only charge made by the Association to patients referred in this way is for articles provided.

In 1949 the Health Committee decided that the Family Planning Association should be allowed to hold clinics rent free in health service premises. The Association is not permitted to make any charge to the patients except for articles supplied. Women who are not recommended under the Council's scheme may attend the Association's clinics held on Council premises, where they may be advised and/or treated under conditions (including payment) determined by the Association.

At the Council's own family planning clinics, appliances and medicaments on approved lists are stocked and sold or issued free of charge as appropriate. Since 1963 oral contraceptives have been issued free of charge to selected women for whom this is the only practicable means of birth control. A letter is sent to the patient's general practitioner asking for his approval or for information about contra-indication to oral contraception. Oral contraceptives are free of charge because they are regarded as a medicament rather than an appliance.

In May 1963 the Marie Stopes Memorial Foundation, Ltd. started a limited experimental scheme with the Council's agreement, in the first instance in division 2 to which it is still limited, in which the mothers of problem families are visited in their own homes and given advice on family planning and the necessary appliances, etc., free of charge and without cost to the Council. Only families approved and notified by the Council's divisional medical officer may be included and the Foundation has undertaken to communicate with the family doctor before visiting. (Similar experiments by the Foundation are being conducted in Newcastle-upon-Tyne, Southampton and Birmingham.) The indications are that the experiment is proving most satisfactory.

On 1 December 1964 the Council decided that it wished to extend its support to organisations giving family planning advice so as to include all their undertakings, including the giving of family planning advice on other than medical grounds, of advice on marital relationships and of advice to unmarried people. The Minister of Health was asked to receive representatives of the Council to discuss any necessary ministerial authority to enable this decision to be implemented. The meeting took place early in 1965 and the Minister assured the deputation that the Council's views and suggestions were under active consideration.

Attendances at family planning sessions

	1960	*1961*	*1962*	*1963*	*1964*
Attendances at sessions provided by the Council:					
First	945	899	1,034	1,849*	1,982*
Total	4,337	4,226	4,423	4,434	5,288
Women referred by the Council to Family Planning Association ..	741	641	595	641	685

* *First attendances do not exclude women who attended also in earlier years.*

Cervical cancer screening

The value of exfoliative cytology in the early diagnosis of cancer of the cervix is now fully accepted. The Minister of Health has accepted that routine screening should be available to all women at risk as laboratory facilities become available and has said the intention is to rely on general practitioners to carry out the routine screening of their patients but local authorities might wish to assist in some areas. The Health Committee agreed (8.12.64)

that when the time came it should be possible for the Council to offer facilities for screening women attending the Council's ante and post-natal clinics and family planning clinics. In addition, the Council could start *ad hoc* screening clinics if the numbers justified it. The screening could be carried out by the Council's full-time and sessional medical officers but this would be done only at the request or with the agreement of the patient's general practitioner. General practitioners could also be offered facilities for holding *ad hoc* clinics in the Council's premises. At certain centres patients attending the ante-natal clinic are seen by their booked general practitioner obstetrician and he, too, with the agreement of the patient's own doctor, could carry out screening tests at the centre.

Whatever arrangements were made for the taking of smears in the Council's centres, the Council would need to provide supporting nursing and clerical staff to assist the doctor, keep the appropriate records, send specimens to the laboratory and distribute reports from the laboratory on the test results. The Council's staff (health visitors and others) would have an important part to play in educating women to accept screening (particularly women in Social Classes IV and V). The actual arrangements would be agreed locally in the light of local needs and circumstances, but subject always to observance of the principle that smears should be taken only with the agreement of the patient's general practitioner, who would be given every opportunity, if he so wished, to convey the results of the test to the patient and who would always do this if the result were positive or showed the need for further investigation. The Local Medical Committee approved of these proposals, suggesting that when facilities for cytological examinations became available there should be local discussion between the local health authority, the hospital laboratory and the general practitioners in the area.

So far in London four small pilot schemes are in operation (one started early in 1963 and three during 1964). In division 1 smears are taken from women attending a family planning clinic aged 35 and over, selected women aged 30 and over and some women who are taking oral contraceptives. In division 4 smears are taken from women attending a family planning clinic and who have been recommended to use oral contraceptives; in division 6 from all post-natal cases attending three clinics regardless of age and in division 9 from women referred to one clinic by general practitioners who have been advised that this facility is available.

Maternity beds

Although in London over 80 per cent. of births take place in hospital, the maternity bed situation has been a source of continual anxiety for many years. Maternity liaison committees have tried to improve local arrangements to ensure a planned selection of mothers for hospital confinement, but in the north-west parts of the county in particular for some years it has not been possible to book a hospital maternity bed for all the women who need hospital delivery on grounds of age, parity or social conditions, if such women attend for ante-natal care for the first time during the second half of pregnancy. Many such women are older multipare or immigrants, temporary residents or unmarried mothers with accommodation more often than not in lodgings or boarding houses. To help them, a general practitioner is asked to undertake the ante-natal care and, if no bed can be found during the pregnancy, to visit, when labour starts, to arrange for hospital admission through the Emergency Bed Service.

In June 1963, a deputation from the Council informed the Minister of Health that three per cent. of women in London who need maternity beds had to be admitted in labour through the Emergency Bed Service. Most of these women were not emergency cases, for it was known during pregnancy that a hospital bed would be needed but one could not be booked. Nor was it a case of shortage of beds, because when the women went into labour a bed was found for them. The Minister said the problem in London appeared to be one of maldistribution of beds and he undertook to try to improve the situation. The result was the issue of a circular (780) by the Chief Medical Officer proposing:

(*a*) that groups of beds should be assigned to the service of areas defined by the Metropolitan Regional Hospital Boards in consultation with Boards of Governors of Teaching Hospitals, Local Health Authorities, Executive Councils and Local Medical Committees concerned;

(*b*) that in each area so defined the Hospital Board should take the initiative in setting up a body representative of those authorities to agree and keep under review the procedures needed to secure that maternity beds serving the area meet its needs;

(*c*) that it should be the responsibility of the hospital to which any expectant mother from the area served by its group applies, or is referred, to make a firm booking (if a hospital delivery is indicated on medical or social grounds) either in its own hospital or another hospital in the group or in another group.

In response to the Ministry's circular, the four metropolitan regional hospital boards set up area committees (on which serve the Council's divisional medical officers and non-medical supervisors of midwives) to agree and keep under review the prodecures and to secure that maternity beds serving the area meet its needs. These committees made recommendations to the Boards on proposed schemes for maternity catchment areas and the Council's officers were active in seeking improvements to the draft schemes where necessary. The four Boards subsequently provided details of the catchment area schemes which the individual hospitals had been asked to introduce from 1 May 1964, with the object that as bookings proceeded in the natural course of events the schemes would become fully operative by 1 October 1964.

For its part and as a means of making greater use of hospital maternity beds, the Council has taken the initiative and offered to every hospital early discharge schemes for maternity patients discharged 48 hours after confinement. At present (December 1964) there are 22 schemes in operation. The number in each metropolitan regional hospital board area and the maximum number of patients agreed for maternity nursing at home per month are:

M.R.H.B.	*No. of schemes*	*Maximum discharges per month*
North West	6	68
North East	1	12
South West	5	52
South East	10	119

The early-discharged patients are nursed at home either by a part-time midwife specially employed for the purpose, or by the whole-time midwife for the area, as may be arranged. In addition to the schemes arranged by the Council, some hospitals having their own district practice discharge patients delivered in their hospital to the care of their district midwives.

A considerable number of mothers return home early, other than under the agreed early discharge schemes. Some are mothers whose babies were stillborn or died shortly after birth; some, mothers who take their own discharge (often for domestic reasons) and other mothers who return home under an arrangement made by their general practitioner with the hospital. Until 1964 all these were nursed at home by a general nurse from the local district nursing association. However, the view is now taken that every mother requiring post-natal nursing should in her interests, and particularly in the interests of the neo-nate, be attended by a practising midwife within the definition of Rule E.3 of the Central Midwives Board. Accordingly, arrangements were made during the year to encourage sufficient general nurses who were state certified midwives to notify their intention to practise as midwives under Rule E.4 of the Board and to arrange for them to nurse any woman returning home early other than under an agreed early discharge scheme. These nurses receive an allowance of £10 a year.

The Council has introduced a change in procedure to meet the requests from hospital obstetricians and general practitioners for social reports on women who seek a hospital bed but have no medical priority for admission. The visit to assess the suitability or otherwise of the home for domiciliary confinement is now carried out by domiciliary midwives and not health visiting staff, where this was not already the practice, although of course there is close consultation between the midwife and the health visitor who knows the home. The midwives thus have the opportunity to encourage suitable women to accept home confinement and this makes a further contribution to relieving the pressure on hospital maternity units. A very much simplified form of request has been introduced for a home assessment visit for early discharge schemes and where a maternity bed is sought on social grounds, incorporating the domiciliary midwife's report. This new form, by the use of carbon copies, reduces to a minimum the clerical work involved in requesting and providing these reports.

It is as yet too early to make any assessment of the likely success of the steps that are being taken to implement the Ministry's proposals. They are being watched very closely and adjustments made as necessary in the light of experience. However the number of maternity cases referred to the Emergency Bed Service has been very considerably reduced:

Emergency Bed Service monthly totals

Month	*1963*	*1964*
January	156	189
February	186	137
March	318	186
April	230	156
May	234	189
June	294	164
July	200	190
August	225	116
September	179	130
October	138	98
November	153	63
December	133	74
Total	2,446	1,662

Co-operation with hospital and general practitioner services

The Council has placed particular emphasis on co-operation with the other branches of the health service; a strong link has been forged between the maternity and child welfare service and the hospital maternity and paediatric departments, with interchange of staff in some areas, and with the general practitioner service. One unique partnership is with the Institute of Child Health of the University of London at the Province of Natal centre. This centre, opened in 1955, provides a wide range of maternity and child welfare and school health services for the neighbourhood and also provides facilities under the direction of the Institute for post-graduate medical teaching and research. The cost of the centre site, the building and its initial equipment was met out of moneys given during the war by the people of Natal, South Africa to the Gift to Britain scheme, supplemented (for the purposes of the Institute's reference library and laboratory) by the University Grants Committee.

Co-operation with general practitioners—Representatives of the Local Medical Committee and of the London Executive Council serve on the Council's central Health Committee and the Local Medical Committee is represented also on each of the nine divisional Health Committees. The Council nominates eight members of the London Executive Council and the County Medical Officer of Health is a member of the London Medical Committee. At field level, co-operation is seen as a matter of mutual understanding and

the development of close working relationships. The Local Medical Committee is always consulted before new arrangements are made with general practitioners and, in particular, all proposals for use of Council premises by general practitioners (and general practitioners' surgeries by the Council) or of allocation of local authority staff (health visitors, midwives, district nurses, social workers) to general practitioners.

General practitioners are employed in the Council's health services on a sessional basis for many types of work, e.g., ante and post-natal, child welfare, vaccination, immunisation and in the school health service. At the request of the Local Medical Committee, they are not employed within their area of practice.

Free facilities are provided in the Council's ante-natal clinics for general practitioner obstetricians to see their own booked maternity patients and others with the consent of the booked doctor concerned. The Local Medical Committee preferred this arrangement to the allocation of domiciliary midwives to surgeries of general practitioner obstetricians.

The health visitor and general practitioners—Meetings with general practitioners have been arranged locally at which the part of the health visitor was given prominence and the wide range of her duties stressed. The fact that there are only some 400 health visitors in London and over 2,200 general practitioners on the Local Medical Committee's list limits the amount of effective help which the health visitor can give. Co-operation is very fruitful in dealing with the medico-social problems of families where difficulties do not come singly: the family doctor plays his part by giving treatment and influencing the family to accept specialised local authority services and to follow the skilled guidance of the health visitor. In some instances, especially where a group practice is concerned, it has been possible to set aside a regular time each week when a health visitor would call at the surgery to talk over such cases with the practitioner.

Where attendances justify it, a health visitor is allotted to attend child welfare sessions provided by practitioners in their own surgeries. A condition is that the practitioners are willing to complete all appropriate maternity and child-welfare records and make them available as required. In addition, general practitioners doing child-welfare work should be willing to co-operate in the application of new trends in child-welfare introduced into the Council's own clinics, e.g., developmental diagnosis and routine screening tests of children ' at risk ' of congenital handicaps; preventive mental health in the child welfare service. It is thought possible in these circumstances that the health visitor may gradually come to be based on the list of families registered with the practice, such families being withdrawn from the care of the district health visitors. The attendance of a minimum of ten children per session is thought to justify the allocation of a health visitor to an infant welfare session at a general practitioner's surgery.

Social work with families

Special mention must be made of the tremendous changes that have taken place in social work with families. Up to the end of the War the social services had been deployed mainly to serve the needs of the individual, with an emphasis on physical needs and the improvement of environmental conditions. The measures of social legislation passed after the War—the Family Allowances Act, 1945, the National Health Service Act, 1946, the National Insurance and the National Insurance (Industrial Injuries) Acts, 1946, the Children Act, 1948 and the National Assistance Act, 1948—changed the pattern of social and welfare services and made available to all without distinction the benefits of these new services. The new services, coupled with general advances in living standards and education, brought into sharp relief the problems of a minority of families who appeared not to be benefiting from the new legislation and showed that now the need was for family casework and not casework with the individual in isolation from his family. Increasingly it became clear that such families' problems needed to be considered as a whole and services deployed in an integrated way if proper use was to be made of them.

Divisional co-ordinating committees were set up, under the chairmanship of divisional medical officers, with the object of bringing together all interests and activities available to help in the prevention of ill-treatment or neglect of children, the prevention of juvenile delinquency and the prevention of family break up. The committees have gained most valuable experience in the years since their formation in 1952. They have had to give particular attention to the problems of families facing eviction as unsatisfactory tenants. In each division the divisional social worker, the successor to the divisional treatment organiser of the school health service, acts as secretary, strengthening the links between the social agencies in the area, both voluntary and statutory. Increasingly the Children's, Education, Housing and Welfare departments, as well as other statutory and voluntary agencies and individuals, have referred families for the consideration of these committees. Family and hospital doctors seek help with their cases and often give active support to the co-ordinating committee.

As much as possible is done to ensure that all those who come into contact with families and children know and understand the Council's policies and procedures and the interest of and the part played by each department. To help in this, a directory of social services has been issued to field workers and others, describing the arrangements made by the several departments of the Council and by other agencies (both national and local, and statutory and voluntary) for carrying out their aims and duties.

In 1955 an approximate estimate of the number and distribution of problem families was made. The survey also revealed that there was good co-operation between the health visiting service and other statutory and voluntary bodies, but that the distribution of problem families, who tended to be found in or drift to areas of poorer housing, had resulted in some health visitors bearing a disproportionate case-load.

The health visitor is well placed to recognise the early stages of family breakdown and her continued support of the family is essential when her special skills are needed to cope with health problems. On the other hand, she has not the time to spend from her normal duties to carry out intensive time-consuming casework with these families. In 1957 four full-time and two part-time social workers were appointed experimentally to do family casework in some of the divisions, the divisional social workers acting as their consultants and supervisors.

Families are selected for this intensive casework by the divisional co-ordinating committees. Broadly the families fall into two main groups:

(*a*) those in which there is some inherent or permanent disability such as severe subnormality, mental illness or low mentality which limits the extent to which the family is able to carry on without support;

(*b*) those where it can be assumed that, given intensive support, the family will in time be enabled to become independent of the social caseworker, although still needing support from the ordinary social services.

Early in 1959 an attempt was made to assess the work of the social caseworkers using the points system introduced for the 1955 survey. It appeared that more than half the families referred to social caseworkers had shown some definite improvement and there was no doubt that intensive casework could be successfully carried out within the framework of a statutory authority. It was decided, therefore, to appoint further caseworkers to bring the total staff up to fifteen. In addition, a number of health service social workers was selected, each to do similar work with two or three families and continuing their former duties in the school health service for the rest of the time. A casework consultant was appointed in 1962—the first appointment of its kind by a local health authority.

Family Service Units, voluntary organisations employing trained caseworkers, carry out with substantial grants from the Council similar intensive work in several parts of the

county, namely, Kensington and Paddington; Islington, Finsbury and Holborn; Stepney, Poplar and Bethnal Green; Southwark and the northern parts of Lambeth and Bermondsey. From 1961 a grant has been made to the Family Welfare Association towards their work with families with problems. In 1964 a small grant was made to the Elfrida Rathbone Committee (Islington Branch) to enable that Committee to continue its work with problem families having educationally sub-normal children.

The Council also provided training courses for selected home helps who were willing to work with problem families, helping them under the direction of the health visitor or social worker to be self-supporting.

Since 1954 the Council has been associated with special home-making courses for selected mothers. Some of these have been organised by voluntary committees under the auspices of the London Council of Social Service, with financial support from the Council; others are run by the Council's own staff. The courses provide for regular weekly meetings of small groups of mothers known to have problems, including some mothers from ' problem families '.

Residential establishments for young children in care

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, child health and problems of any children whose development is causing concern. Also the progress of handicapped children is discussed with the nursery staff and, if necessary, the question of additional investigation, treatment and training discussed with the visiting medical officer.

A register is maintained of physically and mentally handicapped children and individual case histories are regularly reviewed by a senior medical officer, so that constructive plans can be made for special education or long-term care.

Adoption and boarding out

The number of children in care referred for advice by the Children's Officer and the decisions reached are shown below:

	1960	*1961*	*1962*	*1963*	*1964*
1. *Adoption cases:*					
Suitable for adoption	270	259	291	270	283
Suitable for adoption subject to certain conditions ..	2	34	45	48	73
Unsuitable for adoption but suitable for boarding out	23	13	6	9	—
Withdrawn by Children's Officer	1	9	4	—	3
	296	315	346	327	359
2. *Boarding out cases:*					
Suitable for boarding out	454	445	486	465	440
Suitable for boarding out subject to certain conditions	—	—	—	—	5
Withdrawn by Children's Officer	6	5	1	1	1
	460	450	487	466	446
3. *Unsuitable for either adoption or boarding out* ..	—	1	1	5	—
TOTAL	756	766	834	798	805

Care of the unmarried mother and her child

Moral welfare associations—Financial assistance totalling £18,760 was given during the year 1964/65 to the five large moral welfare associations of the major religious denominations:

	£
London Diocesan Council for Moral Welfare	10,450
Southwark Diocesan Association for Moral Welfare	7,000
Westminster Catholic Social Welfare Committee	660
Southwark Catholic Rescue Society	500
Jewish Board of Guardians	150

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. A total of £13,214 was paid during the year to the 17 homes receiving grant and the number of expectant and nursing mothers admitted to these homes was 1,558. One mother and baby home is maintained by the Welfare department together with two other units within their larger homes.The following table shows grants and number of girls admitted to the voluntary homes during the last five years.

	1960	*1961*	*1962*	*1963*	*1964*
Total grants	£8,865	£9,998	£11,743	£15,647	£13,214
Number of expectant and nursing mothers admitted	1,136	1,171	1,599	1,545	1,558

Child protection

Child protection work under Part 1 of the Children Act, 1958 and Part IV of the Adoption Act, 1958 continued to be undertaken on behalf of the Children's Officer in six of the health divisions, visits being made mainly by health visitors. During 1964, however, the Children's Officer took over direct control in three areas and made arrangements to take over the direct control of the three remaining areas early in 1965.

Marriage guidance

The Council has made financial grants to the London Marriage Guidance Council, the Catholic Marriage Advisory Council and the Family Discussion Bureau. The latter was formerly a branch of the Family Welfare Association; since 1950 the Bureau has been associated with the Tavistock Institute of Human Relations and through it functions as an independent body. The London Marriage Guidance Council holds many of its weekly counselling sessions free of charge in the Council's maternity and child welfare centres. Monthly talks are given to groups of engaged or newly married couples and a rapidly expanding side of the work is visits to secondary schools, colleges and youth centres for talks and informal discussions with young people. The Catholic Marriage Advisory Council holds weekly sessions in its own headquarters but in some cases sessions are held free of charge in the Council's maternity and child welfare centres. Grants totalling £10,500 were made to the three marriage guidance bodies in 1964.

DOMICILIARY MIDWIFERY

The coming into force of the National Health Service Act, 1946 meant that this service became free to the patient. The Council's domiciliary scheme has been basically unchanged since its inception in 1938. Over the years the number of midwives employed by hospital districts has fallen, their work being taken over almost entirely by midwives employed directly. The main result of the Act was to allow closer integration of the domiciliary midwifery service with the maternity and child welfare services and other services for which the Council became responsible under the Act and also with the maternity medical services provided under Part IV of the Act.

It thus became Council's policy for all domiciliary midwives to use its ante-natal clinics for the booking and examination of their patients. (The clinics are also used by an even greater number of women booked for hospital confinement to obtain their intermediate ante-natal care.) A doctor, who is either a full-time assistant medical officer, a general practitioner with special experience or, to an increasing extent, a general practitioner obstetrician, attends all or alternate sessions with the domiciliary midwife, depending on the numbers in attendance at each session. Blood specimens are taken from all mothers attending the Council's ante-natal clinics for haemoglobin estimations, Wasserman and Kahn tests, determination of Rhesus factor and tests for Rhesus antibodies in appropriate cases. General practitioners are invited to use these facilities for their own patients. Midwives also take cord blood in those Rhesus negative cases which are fit for home confinement.

Special emphasis is laid on the early recognition of toxaemia and weight records are kept as a routine. During 1960 the preventive measures against toxaemia were further reinforced by making home helps available free of charge where hospital consultants or general practitioners certify that rest at home is essential for this reason and that admission to hospital is thought unnecessary or impracticable.

The administration of analgesia by midwives has shown a marked and rapid rise—expressed as a percentage of domiciliary confinement, from about three per cent. in 1946 to 34 per cent. in 1948, to over 70 per cent. in 1951 and to over 80 per cent. from 1955 onwards.

There has also been a marked change in the number of domiciliary confinements booked by general practitioners for maternity medical services. In the early years of the National Health Service the number of domiciliary confinement in London booked by general practitioners for maternity medical services was low and by 1956 it was only 26·6 per cent. of all home deliveries. However, the Council's policy was that a general practitioner obstetrician and a domiciliary midwife should be booked for every domiciliary confinement and since 1961 the percentage has been well over 80 per cent. Plans to promote the fullest co-operation with general practitioner obstetricians were agreed with the London Local Medical Committee and in 1960 they were offered free facilities at the Council's ante-natal clinics.

Further consideration was given during 1964 to the introduction of revised off-duty and night-duty schemes for the Council's directly-employed midwives and experimental schemes were tried out in several areas. By the end of the year a new off-duty and night-duty scheme had been adopted for the county, the principal feature of which was that in normal circumstances, with a full complement of staff, it is only necessary to require a midwife to be on duty at night on two nights a week. Naturally the midwife is on call for a much larger area than was previously the case and if she has not her own transport she may now call on Radio Taxis to take her to and from the patient's home. The midwives much appreciate the new arrangements and undisturbed nights.

TABLE (i)—*Staff*

District midwives employed at 31 December by

	1960	*1961*	*1962*	*1963*	*1964*
The Council	94	94	100 (+ 7 pt.)	107 (+ 12 pt.)	112 (+ 17 pt.)
District Nursing Associations* ..	46	43	46	30 (+ 18 pt.)	22 (+ 8 pt.)
Hospitals*	43	40	37	30 (+ 1 pt.)	32 (−)
	183	177	190 (+ 7 pt.)	167 (+ 31 pt.)	166 (+ 25 pt.)

**Including supervisory staff.*

In addition there were midwives employed in nursing homes or voluntary hospitals, or working through nursing co-operations or independently.

TABLE (ii)—*Domiciliary confinements attended and institutional deliveries nursed at home.*

	1960		*1961*		*1962*		*1963*		*1964*	
	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. ..	178	2,197	83	1,069	61	708	44	209	15	101
D.N.A. ..	47	1,193	39	716	9	359	11	111	5	47
Hospital district	—	—	—	—	—	—	—	—	—	—
	225	3,390	122	1,785	70	1,067	55	320	20	148
	3,615		1,907		1,137		375		168	
(*b*) Doctor booked										
L.C.C. ..	1,563	2,848	2,237	3,759	2,608	4,238	2,696	4,501	2,421	4,447
D.N.A. ..	280	692	339	1,010	501	1,561	408	1,590	363	1,506
Hospital district	202	1,745	302	1,666	344	1,607	427	1,372	419	1,250
	2,045	5,285	2,878	6,435	3,453	7,406	3,531	7,463	3,203	7,203
	7,330		9,313		10,859		10,994		10,406	
Total	10,945		11,220		11,996		11,369		10,574	
(*c*) No. of institutional deliveries attended by midwives on discharge before the tenth day ..	1,463		1,954		2,187		2,810		4,051	

Domiciliary confinements decreased by 795 from 1963 but institutional deliveries discharged home before the tenth day showed an increase of 1,241. The figures of early discharges include (i) cases sent into hospital during labour from the domiciliary midwifery service on account of some abnormality and returned for nursing by a domiciliary midwife (this has long been a normal practice); (ii) cases accepted after 48 hours in accordance with pre-arranged schemes with certain maternity hospitals (see page 53). The number of home confinements booked by general practitioners for the provision of maternity medical services continues to increase steadily; in only 168 cases, which included emergencies delivered by domiciliary midwives, had a doctor not been booked.

TABLE (iii)—*Confinements by age and parity*

Age		*Total confinements*	*Parity*						
			0	*1*	*2*	*3*	*4*	*5 and over*	*Not known*
Under 20 ..	No. ..	519	171	271	69	8	—	—	—
	% ..		1·6	2·6	0·7	0·1	—	—	—
20–29 ..	No. ..	7,180	495	3,149	2,214	962	251	107	2
	% ..		4·7	29·7	20·9	9·1	2·4	1·0	0·0
30–39 ..	No. ..	2,754	29	567	910	704	293	250	1
	% ..		0·3	5·4	8·6	6·7	2·8	2·4	0·0
40 and over..	No. ..	109	—	4	27	23	22	33	—
	% ..		—	0·0	0·3	0·2	0·2	0·3	—
Not known..	No. ..	12	1	1	4	5	—	—	1
	% ..		0·0	0·0	0·0	0·0	—	—	0·0
Total ..	No. ..	10,574	696	3,992	3,224	1,702	566	390	4
	% ..		6·6	37·7	30·5	16·1	5·4	3·7	0·0

Percentages are of the total confinements.

On grounds of parity, 1,652 (15·6 per cent.) of mothers delivered by domiciliary midwifery services should have been delivered in hospital, but this was not possible either because beds were not available at the time the mother came for her ante-natal care or because the patient herself refused hospital booking.

The peri-natal mortality rate for the domiciliary midwifery service was 8·3 per thousand total births and the stillbirth rate was 4·4 per thousand total births.

TABLE (iv)—*Premature domiciliary live births*

	1960	*1961*	*1962*	*1963*	*1964*
Number	517	525	474	438	385
Per cent. of live births ..	4·7	4·7	4·0	3·9	3·7

Particulars of domiciliary live births follow. The difference between the total (513) shown in this table and the number (385) quoted above represents the number of deliveries attended by doctors and midwives independently of the Council's domiciliary midwifery service and those which took place in nursing homes.

TABLE (v)—*Domiciliary or nursing home births—prematurity and mortality by birth weight*
1964

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*
2 lb. 3 oz. or less	28	5·5	12	42·9	15	53·6
3 lb. 4 oz. or less	36	7·0	10	27·8	20	55·6
3 lb. 5 oz. to 4 lb. 6 oz. ..	58	11·3	5	8·6	48	82·8
4 lb. 7 oz. to 4 lb. 15 oz. ..	93	18·1	4	4·3	87	93·5
5 lb. to 5 lb. 8 oz. ..	298	58·1	6	2·0	291	97·7
All cases	513	100·0	37*	7·2	461	89·9

* *Fifteen babies died after the first day.*

Midwives Act, 1951

Notifications received of intention to practise as a midwife:

1960	*1961*	*1962*	*1963*	*1964*
1,404	1,447	1,502	1,560	1,697

In accordance with section G of Rules of the Central Midwives Board, 176 midwives in the county attended a refresher course during the year.

Fees to medical practitioners called in by midwives in emergency:

	1960	*1961*	*1962*	*1963*	*1964*
Number of claims	2,350	1,291	711	357	200

The decline in medical aid claims by general practitioners is a direct result of the encouragement given to every woman having home confinement to book a doctor as well as a midwife. When a doctor is booked he claims a fee from the local Executive Council under Maternity Medical Services Regulations.

HEALTH VISITING

Even before 1948 there was a shortage of health visitors and the National Health Service Act, 1946, which laid new responsibilities on local health authorities, considerably broadened the scope of the health visitor's work. Her functions now covered the care and welfare of the family as a whole, not solely the expectant and nursing mother and the child under five, as had been the case in London before 5 July, 1948. The new spirit of social service added depth to her work and gave her the opportunity to enlarge her outlook and widen her experience and her value to the community.

Even without a shortage of health visitors, redeployment would have been necessary in the new situation, so that the health visitor could use her special skills to the greatest advantage. Selective visiting has also enabled her to allocate more time to the families most in need of the help and support which she can give. Group working has enabled problems to be shared, language and religious difficulties to be met more easily and has provided continuity of staff during sickness and leave.

For over fifty years most of the home visiting and medical follow-up of children attending the Council's schools has been undertaken by voluntary children's care committee workers, trained and organised by social workers employed in the education and public health departments. A continuing aim is the association of the health visitor with the voluntary worker in the care of the schoolchild.

Home visits	*1960*	*1961*	*1962*	*1963*	*1964*
First visits this year to:					
Children under 1	55,226	60,995	67,829	68,661 (*a*)	68,065
Children 1–5	369,122	379,793	375,543	222,643 (*b*)	196,914
Persons aged 65 or over	14,350	14,772	15,526	7,945 (*b*)	6,571
Mentally disordered persons	—	—	—	1,893 (*c*)	1,385
Persons discharged from hospital (other than mental hospital)	—	—	—	2,894 (*c*)	2,049
Infectious households (other than T.B.) ..	—	—	—	2,804 (*c*)	1,007
Unsuccessful visits	104,014	111,958	117,113	139,871	146,201
Total visits	838,990	878,767	891,079	822,517	851,646

(*a*) *Since 1963 figures relate to children born in the same year.*

(*b*) *Since 1963 first visits are shown, i.e. number of persons visited; for earlier years the figures relate to total visits.*

(*c*) *Not available for previous years.*

HOME NURSING

Throughout the county the home nursing service has been provided on the Council's behalf entirely by the voluntary district nursing associations, with the Central Council for District Nursing in London acting as the liaison and advisory body. Although from time to time individual associations have ceased work, others have always taken over their areas. Since 1948 the Council has paid an increasing proportion of the approved expenditure of the associations; from 1954 this has amounted to 93 per cent. and for some associations there has been an additional deficiency grant.

With the coming of the National Health Service Act, 1946 the home nurse, who previously had provided nursing only for those who could not afford the services of a private nurse, began to serve all sections of the community. More and more, however, her concern was with older people. Ever since 1938 the proportion of elderly patients dealt with by the home nursing service has increased steadily; 52 per cent. of the patients were over 60 by 1949 and 58 per cent. over 65 by 1962. At the other end of the scale the improvement in child health has led to a decline in paediatric cases.

New medical knowledge has meant an increase in injection therapy for complaints which used to need prolonged treatment, but many new patients, including children, now learn to give their own injections. In addition, there has been an increasing use of oral therapy, especially for diabetic and cardiac cases. The result has seen a steady fall, year by year, in the number of visits paid ' for injection only '.

The shift of emphasis from hospital to the community care of the mentally disordered, with the operation of the Mental Health Act, 1959, had some repercussions on the home nursing service. Senility is commonly a reason for repeated visits by the nurse. Home nurses, too, have been called in to supervise the administration of drugs to the mentally ill discharged to their own homes.

Other changes since the passing of the National Health Service Act, 1946 have been the integration of the home nurse with other members of the local authority team (the health visitor, the midwife and the home help); also the entry into the domiciliary nursing field, although only on a small scale so far, of the male nurse and the enrolled nurse.

In the past few years there has been a steady decline in the number of patients nursed and in the total number of visits paid. From 1957–1962 the number of patients fell by 37 per cent. and visits by 21 per cent. The main reason these figures have kept in step is that the higher number of old people nursed has necessitated frequent visits in a growing proportion of cases.

Details of the work done by the 24 voluntary grant-aided district nursing associations who act as agents for the Council are given below:

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

	1960	*1961*	*1962*	*1963*	*1964*
State registered nurses	517	495	510	490	494
State enrolled nurses	34	35	36	43	44
Total number of nurses employed	551	530	546	533	538
Male nurses (included above)	39	38	40	39	38
Full-time equivalent of nurses employed	508	492	509	481	449
Students	27	64	32	20	33

**Exclusive of supervisory staff.*

TABLE (ii)—*Numbers of patients and visits*

	1960	*1961*	*1962*	*1963*	*1964*
Total no. of patients	51,325	49,137	46,263	47,226	45,709
Total no. of visits	1,690,084	1,601,860	1,569,004	1,559,246	1,576,008
Average no. of visits to each patient	33	33	34	33	35

TABLE (iii)—*Types of case nursed*

Type of case	*Number of new cases undertaken*	%
Medical	28,665	79·2
Surgical	4,914	13·5
Tuberculous	540	1·5
Early maternal discharge ..	1,342	3·7
Maternal complications	722	2·0
Mental ill-health	52	0·1
	36,535	100·0

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

Visits for	*At patients' home*	*Elsewhere (e.g., Nurses' Homes)*	*Total visits*	%
Injections only	482,144	18,248	500,392	32
Injections plus other treatment ..	93,218	1,132	94,350	6
Other treatment only	979,291	1,975	981,266	62
	1,554,653	21,355	1,576,008	100

TABLE (v)—*Long-term cases (i.e., those nursed for three months or more)*

Number	*Percentage of total patients nursed*
8,569	23·5

Long-term cases were formerly defined as those visited more than 24 times during the year.

TABLE (vi)—*Age distribution of patients*

Age	*No. of patients*	%
0–4 years	1,983	4·4
5–64 years	17,283	38·3
65 years and over	25,813	57·3
	45,079	100·0

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

	1960	*1961*	*1962*	*1963*	*1964*
Number of completed treatments	43,118	41,010	37,489	38,647	36,464
Number of patients being nursed at end of year ..	11,118	10,898	11,233	11,341	11,414
Average case load per equivalent whole-time effective* nurse at end of year	24	22	24	26	25

**Allowing for holidays and sickness.*

HOME HELP

Immediately before 5 July 1948 all the metropolitan boroughs (but not the City of London) operated home help schemes for maternity cases and all but one of the boroughs and the City had schemes for assisting sick and infirm persons. The extent of the provision varied widely from borough to borough—in all 7,389 cases were attended in 1947 and at the end of that year 826 home helps were employed. Section 29 of the National Health Service Act 1948 brought together these two kinds of help (previously provided under separate powers) and widened the circumstances in which help could be given, making it turn on the presence in the household ' of any person who is ill, lying-in, an expectant mother, mentally defective, aged, or a child not over compulsory school age . . . ' After 5 July 1948, under the Council's arrangements, there was a rapid increase in the number of home helps and cases assisted and the demand for the service continued to increase thereafter:

	1947	*1949*	*1959*	*1962*	*1964*
No. of home helps (equivalent full-time units)	826	1,265	2,150	2,192	2,469
Households assisted	7,389	25,933	36,056	38,461	40,217

The growth in the service, since the first expansion in the late 1940s, is accounted for almost entirely by the increasing demand from old people and the chronic sick. The number of maternity cases has remained fairly steady; the number of tuberculous and miscellaneous cases has declined.

The Council has introduced five extensions of the service:

Night helps—introduced in 1953 (after an amendment to the scheme)—provided for the chronic sick in their own homes to enable relatives to get one or two nights' undisturbed sleep a week. Demand was always small and, perhaps because of known difficulty in finding staff, has latterly declined even further.

Child helps—also introduced in 1953—for children in their own homes who are temporarily deprived of both parents and with no other adult to care for them. Again demand has been small, partly because home conditions are often unsuitable for sleeping an additional adult. Alternative arrangements under section 1 of the Children and Young Persons Act 1963, are now possible.

Morning and evening helps—introduced in 1954—provided for children who owing to their parents' hours of work cannot be cared for in the day time at a day nursery or school. This service has continued to play a part in avoiding the reception into care of the children of between 150 and 250 families every year.

Specially trained home helps—introduced in 1956—for families in danger of breaking up. They teach the rudiments of housekeeping to the mothers of such families in an attempt to keep the home together and prevent the children coming into care. These home helps, there are now 118 trained, do not spend their whole time on these more demanding calls but have helped about a hundred or more every year.

Provision—introduced in 1960—of free home help for expectant mothers suffering from toxaemia of pregnancy to ensure complete rest for the patient.

In addition, experiments have been in hand in limited areas to provide a more flexible allocation of help to old people. Something on these lines, possibly leading to an arrangement where one help is made responsible for a group of old people, is the most likely next development in the service.

Statistics of the service provided during the past five years are shown in the following tables.

	1960	1961	1962	1963	1964
Number of households assisted	38,031	38,546	38,461	39,389	40,217
Number of new applications received ..	18,168	18,096	17,085	17,976	18,295
Applications deferred or refused because home helps were not available	23	18	17	7	9

Details of households assisted

	1960	1961	1962	1963	1964
Maternity	1,913	1,785	1,642	1,670	1,625
Tuberculosis	692	647	547	509	473
Old people	31,602	32,215	32,744	31,190	31,834
Chronic sick				3,253	3,448
Early morning and evening help	244	257	238	244	254
Child help (resident)	8	24	12	2	20
Night help for chronic sick	28	17	17	15	12
Special help (problem families)	116	112	109	101	99
Miscellaneous	3,428	3,489	3,152	2,405	2,452
	38,031	38,546	38,461	39,389	40,217

In the scheme for free home help service to women suffering from toxaemia of pregnancy whose applications were supported by request from a hospital consultant or general practitioner obstetrician, assistance was given to 79 cases (included above), amounting to 6,552 hours of service.

Staff details

	1960	1961	1962	1963	1964
Home helps employed at end of year ..	3,830	3,896	4,040	4,210	4,200
Equivalent of whole-time staff*	2,242	2,164	2,192	2,595	2,469
Hours worked during the year	5,129,000	5,059,064	5,064,696	5,372,640	5,473,104

**Excluding staff on annual and sick leave.*

IMMUNISATION AND VACCINATION

Vaccination against smallpox had been a function of the metropolitan borough councils before 5 July 1948 but on that day the Public Vaccinator and the Vaccination Officer, who had for many years been responsible for carrying out the provisions of the Vaccination Acts, disappeared from the scene. Thereafter compulsion was replaced by persuasion and in London this resulted in a steady increase in the acceptance rate of infant vaccination. In twelve years the acceptance rate rose to about double its previous level. From 1963 onwards, largely as a result of altering the age for vaccination to 18 months of age, the acceptance rate fell considerably and it is still uncertain whether it will be possible to restore it to its previous level.

The rate of diphtheria immunisation fell for a few years from 1949 onwards, following reports of provocation poliomyelitis following inoculations and the uncertainty resulting therefrom. This fall was not as great as that occurring in some areas because, although alum-containing prophylactics were discontinued at that time, it was decided to continue using combined and triple prophylactics not containing alum. A considerable improvement in the rate of primary immunisation against diphtheria occurred following the introduction of a standard schedule of immunisation in 1959. The virtual abolition of diphtheria since the beginning of the immunisation campaign is now a matter of history.

The result of many years of infant vaccination against whooping cough is now becoming apparent in the very marked reduction in incidence of this disease in recent years.

Since 1959 the routine infant course of vaccinations has included three injections of tetanus toxoid. The object of this course is to try to reduce the necessity to give an injection of horse serum to injured persons. The fact that by now most of the children in London under the age of five years have had a course of active immunisation against tetanus must in time affect the routine of treatment in the hospital accident departments.

Inoculation against poliomyelitis began on a small scale in 1956, being restricted at first to children born from 1947 to 1954. It was extended in 1957 to young people aged under 16 years, expectant mothers and other priority groups and was further extended in 1958 to everyone under the age of 40 years. British Salk-type vaccine was used from the early years but Sabin (oral) vaccine was available from early in 1962. Salk vaccine reduced the incidence of the disease but had no effect on the carrier rate in the population. The introduction of Sabin vaccine, by inducing intestinal immunity, produced the virtual elimination of carriers of pathogenic poliomyelitis virus from the community, with consequent benefit to immunised and unimmunised alike. In 1964 there was only one notification of poliomyelitis in London.

At the invitation of the Ministry of Health, a yellow fever vaccination service has been provided by the Council since 1960. This is operated by arrangement with the authorities of the centres shown in table (v) who give vaccination and issue the appropriate international certificates. No charge is made to the public for this service.

Diphtheria, tetanus, whooping cough—

TABLE (i)

	1960	*1961*	*1962*	*1963*	*1964*
Diphtheria immunisation:					
Primary course—					
Born in same year	20,203	20,990	20,852	22,710	23,826
Born in previous four years	28,980	32,276	22,054	24,068	27,375
Total under 5	49,183	53,266	42,906	46,778	51,201
Age 5–14	7,648	14,490	12,902	3,972	5,361
Reinforcing doses	40,511	87,758	42,472	57,625	66,495
Immunity index 1–4 years	74·1	82·2	87·3	82·7	94·7
Tetanus immunisation	48,605	60,298	46,963	51,168	57,194
Whooping cough vaccination	48,539	54,064	42,637	46,122	50,374

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

TABLE (ii)

	1960	*1961*	*1962*	*1963*	*1964*
Diphtheria/whooping cough	1,536	722	215	106	148
Diphtheria/whooping cough/tetanus ..	46,650	52,927	42,108	45,548	49,667
Diphtheria/tetanus	1,734	5,860	2,435	3,415	5,290

Smallpox—

TABLE (iii)

	1960	*1961*	*1962*	*1963*	*1964*
Primary vaccinations:					
Under 1 year	23,057	30,482	36,406	2,974	1,844
One year	2,135	3,568	12,036	3,177	15,913
2–4 years	1,259	1,937	20,876	1,032	4,249
5–14 years	808	1,186	74,080	831	402
15 years or over	1,072	1,372	115,662	1,453	836
Total	28,331	38,545	259,060	9,467	23,244
Given by—					
L.C.C.	20,583	29,913	150,157	4,740	18,043
General practitioners ..	7,748	8,632	108,903	4,727	5,201
Re-vaccinations:					
Under 1 year	44	63	8	2	—
One year	22	31	200	50	63
2–4 years	113	185	11,405	319	324
5–14 years	455	556	73,000	1,019	532
15 years or over	2,940	3,024	267,464	5,902	4,041
Total	3,574	3,859	352,077	7,292	4,960
Given by—					
L.C.C.	1,598	1,715	171,538	1,854	1,998
General practitioners ..	1,976	2,144	180,539	5,438	2,962
Population	3,194,000	3,180,000	3,186,000	3,179,000	3,184,600
Percentage vaccinated during the year	0·9	1·2	8·1	0·3	0·7
Percentage re-vaccinated during the year..	0·1	0·1	11·1	0·2	0·1

During the year one vaccinated child aged 23 months developed post vaccinial encephalitis, and one other child aged 13 months developed eczema vaccinatum; both children recovered. Four other cases of eczema vaccinatum were reported in unvaccinated children, one of whom died.

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

TABLE (iv)

	Salk		*Sabin*	
	1964	*Since commencement of scheme*	*1964*	*Since commencement of scheme*
Primary vaccination:*				
Born in 1960–64	11,872	495,158	48,630	165,765
1943–59	387		15,312	
1933–42				
Londoners	238	184,311	2,939	15,043
Others	—	48,541	96	495
1932 or earlier (under 40)				
Londoners	130	85,337	1,562	15,004
Others	—	17,711	215	975
Other (over 40)	5	15,427	145	1,184
Total	1,947	846,485	68,899	198,466
Given by—				
L.C.C.	420	601,769	57,444	165,103
General practitioners and hospital doctors	1,527	244,716	11,455	33,363
Booster doses†	570	103,729	32,632	65,504
Given by—				
L.C.C.	117	84,387	29,327	58,600
General practitioners and hospital doctors	453	19,342	3,305	6,904

** Those who have received a third injection of Salk or three doses of Sabin.*

† Those who have received a fourth injection or a fourth dose of vaccine orally.

Yellow fever vaccination—The numbers of persons vaccinated were:

TABLE (v)

	1960	*1961*	*1962*	*1963*	*1964*
Hospital for Tropical Diseases	10,571	9,297	9,550	8,978	9,181
Shipping Federation Clinic, King George V Dock	809	2,762	2,937	2,529	2,478
Unilever House	1,249	1,173	1,263	1,277	1,311
West London Centre	4,031	3,682	4,055	4,254	4,392
	16,660	16,914	17,805	17,038	17,362

LONDON AMBULANCE SERVICE

London had a comprehensive ambulance service even before the coming into effect of the National Health Service Act on 5 July 1948. The London County Council had itself instituted an accident ambulance service in 1915 under powers secured by a private Act of Parliament introduced by Sir William Collins. At first this Service operated from one station only but by the end of 1915 five additional stations had been opened and by 1930 there were 14 stations with 20 vehicles and a staff of 165. In 1930, under the Local Government Act of 1929, the Council took over the ambulance services previously provided by the Metropolitan Asylums Board and Boards of Guardians. The former operated from six large stations attached to infectious diseases hospitals and the Boards of Guardians operated ambulances from certain general hospitals and infirmaries. These services for general sick removals and the accident section were placed under the direction of the Medical Officer of Health. For reasons of operational and administrative convenience, the London Ambulance Service has continued to operate an emergency section and a general service section although vehicles and men are interchangeable. At the outbreak of war in 1939, the Council had a fleet of some 200 vehicles and a staff of 422 operating from 22 stations.

When the National Health Service Act became effective in 1948 the ambulance service had still not fully recovered from the effects of the war; enemy air attack had destroyed the Western ambulance station and the Battersea accident station and much damage had been sustained to other ambulance buildings; in addition the vehicle fleet was obsolescent. Plans had been prepared during 1947 for the expansion of the service to meet the expected needs arising from the new Act as well as to repair the war damage. Provision for an additional 25 ambulances was planned by extending the South Eastern and South Western ambulance stations and building a new accident station in Hampstead. A second stage provided for the extension of the Brook and the Eastern ambulance stations, the provision of accident services from a station in the City of London (where the service had previously been provided by the City itself) and the building of accident ambulance stations in Mottingham and Putney—providing in all for a further 36 ambulances.

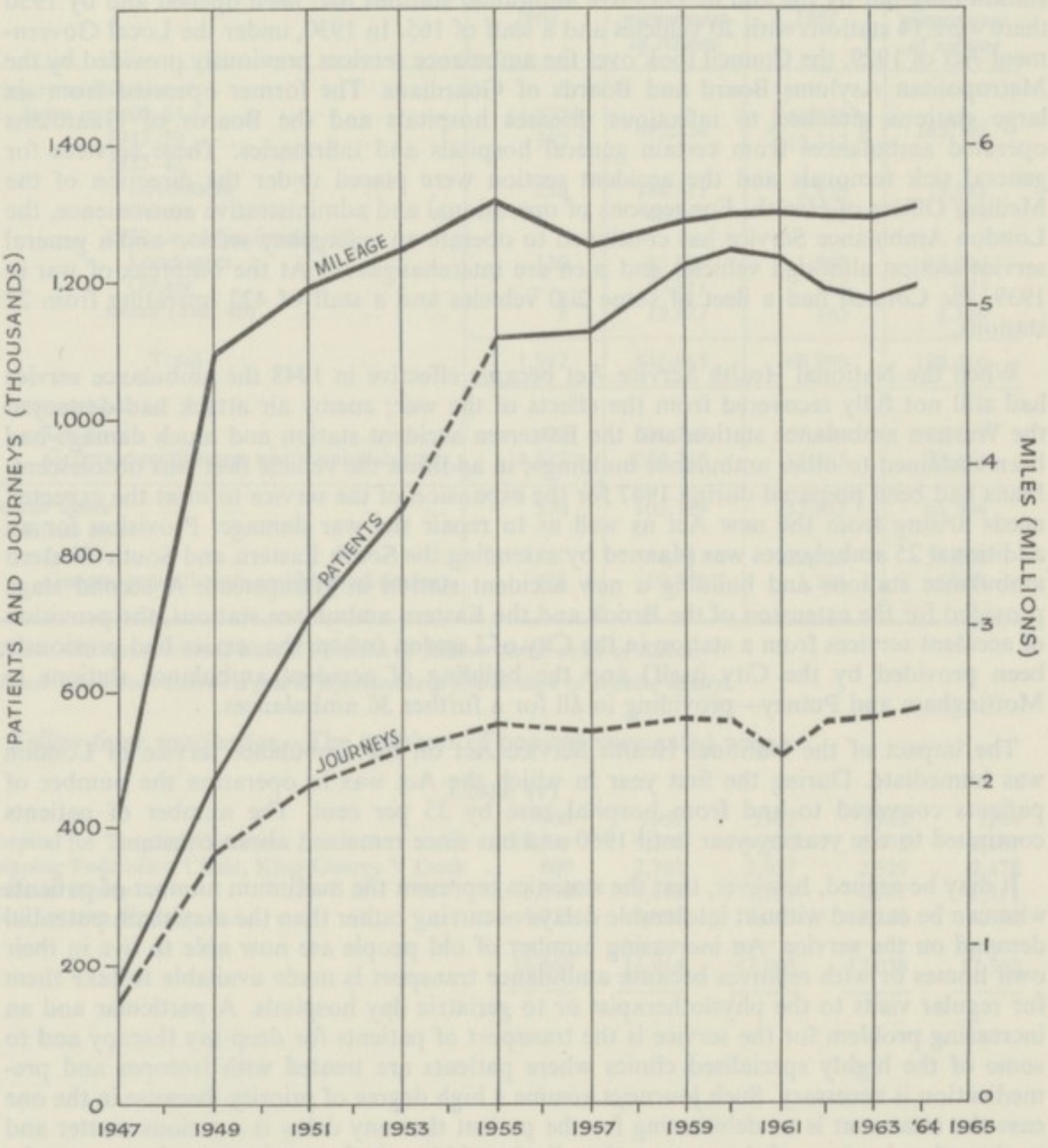
The impact of the National Health Service Act on the ambulance service of London was immediate. During the first year in which the Act was in operation the number of patients conveyed to and from hospital rose by 35 per cent. The number of patients continued to rise year by year until 1960 and has since remained about constant.

It may be argued, however, that the statistics represent the maximum number of patients who can be carried without intolerable delays occurring rather than the maximum potential demand on the service. An increasing number of old people are now able to live in their own homes or with relatives because ambulance transport is made available to take them for regular visits to the physiotherapist or to geriatric day hospitals. A particular and an increasing problem for the service is the transport of patients for deep-ray therapy and to some of the highly specialised clinics where patients are treated with isotopes and pre-medication is necessary. Such journeys assume a high degree of priority, because in the one case the treatment is so debilitating for the patient that any delay is a serious matter and in the other because of the narrow time limits within which certain procedures must be carried out. Reference must also be made to the intention of the Minister of Health* to provide for out-patient surgery and day wards on an increasing scale, which will undoubtedly lead to increased demands on the ambulance service.

* *A Hospital Plan for England and Wales* (*Cmd. 1604*).

LONDON AMBULANCE SERVICE, 1947-64

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.

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

	1960	*1961*	*1962*	*1963*	*1964*
Patients:					
Accident Section	103,497	108,235	110,225	117,567	121,553
General Section	1,033,909	1,008,539	969,215	956,546	980,125
Total—directly provided service	1,137,406	1,116,774	1,079,440	1,074,113	1,101,678
Joint Committee	32,593	31,701	31,349	33,515	40,523
Hospital Car Service ..	189,337	183,231	188,365	189,559	187,666
West Ham C.B.C. ..	338	331	326	330	402
Total—agency and supplementary services ..	222,268	215,263	220,040	223,404	228,591
Total patients	1,359,674	1,332,037	1,299,480	1,297,517	1,330,269
Journeys:					
Accident Section	109,551	114,953	117,020	125,183	129,452
General Section	488,422	480,978	476,081	479,751	491,571
Total—directly provided service	597,973	595,931	593,101	604,934	621,023
Joint Committee ..	10,877	10,858	10,456	10,829	11,165
Hospital Car Service ..	58,441	61,294	66,704	66,111	74,938
West Ham C.B.C. ..	335	329	324	328	393
Total—agency and supplementary services ..	69,653	72,481	77,484	77,268	86,496
Total journeys	667,626	668,412	670,585	682,202	707,519
Mileage:					
Accident Section ..	556,390	605,904	618,075	661,082	674,830
General Section	3,960,964	3,928,746	3,908,580	3,898,270	3,995,283
Total—directly provided service	4,517,354	4,534,650	4,526,655	4,559,352	4,670,113
Joint Committee	441,468	435,851	427,119	436,759	430,497
Hospital Car Service ..	1,207,439	1,191,201	1,271,863	1,265,272	1,276,856
West Ham C.B.C. ..	4,061	3,850	3,543	3,622	4,017
Total—agency and supplementary services ..	1,652,968	1,630,902	1,702,525	1,705,653	1,711,370
Total mileage	6,170,322	6,165,552	6,229,180	6,265,005	6,381,483

Another problem in London arises from the concentration within the county of so many teaching and specialist hospitals. Patients come to the capital from all parts of the country for specialised treatment; many others, travelling for convalescence from their homes and from hospitals outside the county, frequently have to cross London in the course of their journeys. For these reasons a technique of sending patients who have long distances to travel by ambulance/train/ambulance arrangements was rapidly developed; the Service now meets over 100 trains a day to pick up patients arriving in London or to send them to their homes after treatment.

TABLE (ii)—*General section*

	1960	*1961*	*1962*	*1963*	*1964*
Average mileage per patient	3·83	3·89	4·0	4·1	4·07
Average mileage per journey.. ..	8·11	8·17	8·2	8·1	8·12
Patients carried per 100 journeys ..	212	210	208	199	199

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)*
1960	109,551	9,644	6·8	6·4
1961	114,935	10,350	7·0	6·2
1962	117,020	10,420	7·0	6·5
1963	125,183	11,584	7·0	6·5
1964	129,452	12,718	7·0	6·3

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*

	1960	*1961*	*1962*	*1963*	*1964*
Public and L.C.C. staff ..	76,705	81,755	84,261	88,947	93,506
Police	16,505	16,753	16,396	16,937	17,599
Midwives*	326	339	307	234	162
Doctors	7,522	7,964	8,549	11,225	10,243
Hospitals	2,186	2,045	1,933	2,000	1,798
Railway officials	2,896	2,868	2,654	2,690	2,808
Local calls†	893	788	827	779	162
London Fire Brigade ..	1,055	789	596	687	761
Out county	1,463	1,634	1,497	1,684	1,813
Total calls	109,551	114,935	117,020	125,183	129,452

** 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.

Operational control and communication—The volume of work undertaken by the Service increased much more rapidly than it was possible to increase the staff and vehicles and while the volume of work undertaken in 1964 was two and a half times greater than in 1947 the staff had increased by less than 50 per cent.

To enable the Service to cope with these dramatic increases every effort had to be made to improve the efficiency of the Service, much of which depends on efficient communication. To this end radio control was introduced in 1956, at first on an experimental basis. It was soon clear that it had a valuable part to play in ambulance control; it was extended to the whole accident section and subsequently by progressive stages to the general service, the last stage in the development being made in 1964/65. Telex was introduced in 1963,

primarily as a time-saving method of passing information between general ambulance stations and headquarters control, but it was hoped that with the general spread of this system it would provide a valuable means of communication with major hospitals and with other ambulance services.

Major incidents are fortunately very few in number—the outstanding one of the past decade being the Lewisham disaster in 1957, when two trains collided in dense fog and 85 people died as a result. In all 223 casualties were removed by ambulance, the last vehicle leaving the scene of the disaster 60 hours after its occurrence. Arising from this disaster existing plans of the hospitals and other authorities for dealing with these emergencies were reviewed and these have been amended from time to time to suit changing circumstances. The plans provide for close co-operation between the Ambulance Service and hospital authorities, the London Fire Brigade and the Police. Since 1951 a mobile control vehicle has been maintained at headquarters. This is designed to serve as a mobile control room with radio communications with Headquarters Control, as well as ' walkie/talkies ' enabling officers to maintain control while moving about the scene of an incident. It carries, in addition, a considerable supply of reserve equipment (see Annex).

Agency services—In addition to the services directly provided by the Council, services under agency arrangements have continued to be given by the Hospital Car Service and the Joint Committee of St. John and the British Red Cross. The latter having indicated their wish to hand over to the Council, negotiations to this end were opened during the year.

Vehicles

As previously stated, the ambulance fleet at the end of the war was in a run down condition and the Council's officers gave much thought to the design of a suitable replacement vehicle. A prototype vehicle was built under the direction of the Council's transport officer in the Mechanical Works division of the Supplies department. Trade enquiries drew from the Daimler Motor Company an offer to produce an ambulance which would embody practically every feature of the Council's prototype, including the requirements regarded as essential by a Working Party appointed to advise the Minister of Health on the subject. The Daimler, which became the standard vehicle in the London Ambulance Service and for years was used also by many other services, set a new trend in ambulance design. Its salient features were low loading; a spacious, well equipped and easily cleaned interior; a high powered engine; fluid transmission; pre-selective gear box, off-set transmission shaft; excellent suspension and independently sprung front wheels.

These vehicles gave excellent service, their only defects being lack of manoeuvrability and heavy petrol consumption. It became apparent, however, that the Daimler Motor Company would discontinue the manufacture of these vehicles and the need to provide an alternative became a matter of urgency. During 1956 a fresh prototype ambulance was designed in the Mechanical Works division of the Supplies department, which took advantage of developing techniques in the use of resin bonded fibre glass for the manufacture of vehicle bodies. While preserving the same low-loading level and providing accommodation for patients comparable with that of the Daimler ambulances, the new vehicle was smaller in over-all dimensions, lighter in weight and more economical in operation. The Council authorised the production of these vehicles by direct labour in the Supplies department and nine were in operation by the end of 1958. In due course they replaced the Daimler ambulances entirely, the last Daimler being taken out of commission in 1964. The vehicle strength at 31 December, 1964, was:

Large ambulances	264
Single stretcher, sitting case ambulances	104
Sitting case cars	18*
Ambulance coaches	6
Mobile control unit for major accidents	1
Tenders	2
	395

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

The new ambulances have been modified from time to time and of special note is the sprung stretcher bed developed jointly by the Council's staff and Messrs. Delaney-Gallay during the course of 1963. This bed is independently sprung on vibrashock pads which were originally developed for the insulation of delicate instruments in rockets. It was decided to instal oil burning heaters independent of the engine in all the stretcher-carrying vehicles; this was found to be the only effective means of maintaining a high temperature in the patients' compartment during winter in vehicles operating in circumstances in which the large rear doors are opened at frequent intervals.

The changing needs of the Service, which now carries many more patients able to sit while in transit, led to the purchase of vehicles designed to the Council's specifications for the carriage of such patients.

All ambulances in the emergency section carry a most comprehensive range of equipment, including portable apparatus for the administration of pure oxygen or a mixture of oxygen and carbon dioxide either on demand or under manual control. In 1964 plastic inflatable splints were taken into service. These provide an entirely new system of splinting fractured limbs and eliminate the need for wooden splints and padding. The double skin of plastic is placed round the injured limb, the ends are joined together by a rapid fastener and the splint is inflated by mouth.

A list of the equipment carried on emergency and on general service vehicles is given at the end of the article.

An exhibition of ambulance vehicles and of ambulance equipment was held at the Mechanical Works division depot at Wandsworth in March 1964 at which recent developments, many pioneered by the Council, were displayed. A large number of the public and of representatives of other ambulance services visited the exhibition.

Premises

During the period 1948–1964 major improvements and adaptations were carried out at the following stations:

Year	*Station*	*Details*
1948	Western	Moved from temporary accommodation in Allen Street to present location.
1950	Oval	Moved from South Western Ambulance Station to former fire station, Foxley Road, S.W.9.
1953	West Smithfield ..	Station rebuilt.
1954	Hampstead	New station opened.
	Brook	Reinstatement after war damage.
1955	Mottingham	New station opened.
1956	Upper Richmond Road	New station opened.
1958	Streatham	Yard roofed to provide accommodation for a third ambulance.
	Fulham	Former superintendent's house reinstated after war damage for use by staff engaged on day work ambulances.
1959	North Western ..	Extra accommodation for vehicles provided.
1962	Battersea	New station opened—rebuilt on old site.
1963	Oval	Moved to temporary premises at South Western Hospital during rebuilding of station.
1964	Russell Square ..	Improvements to station officer's office and staff accommodation.
	South Eastern ..	Extra accommodation provided for fitters and vehicles.

At the end of 1964 work was in progress on the provision of extra accommodation for vehicles and the provision of a workshop at the South Western station.

Staff

At 5 July 1948 the total fixed establishment of staff was 642 made up as follows:

Administrative staff		*Uniformed staff*	
Officer-in-Charge	1	Chief Superintendent	1
Assistant Officer-in-Charge	1	Superintendents	6
Administrative and clerical	21	Assistant Superintendents	6
Supervisor, Control Room	1	Station Officers	21
Assistant Supervisor, Control Room	1	Driver/attendants	514
Senior Ambulance Clerks	16		
Ambulance Clerks	53		

The subsequent great increase in the volume of work undertaken and various developments of the Service have led to the enhancement of staff numbers in most grades and by the end of 1964 the establishment was as follows:

Administrative staff		*Uniformed staff*	
Officer-in-Charge	1	Chief Superintendent	1
Assistant Officer-in-Charge	1	Assistant Chief Superintendent	2
Administrative and clerical	31	Superintendents	8
Supervisor, Control Room	1	Senior Assistant Superintendents	20
Assistant Supervisor, Control Room	1	Assistant Superintendents	5
Ambulance Control Officers	78	Station Officers	25
		Station Sub-Officers	28
		Driver/attendants	749

In addition the establishment provides for 11 staff in domestic grades at Headquarters and general stations.

In practice, owing to sickness and holiday reliefs it has been necessary to employ a larger number of driver/attendants than indicated in the establishment.

In addition to an increase of about 45 per cent in the establishment of driver/attendants, the greater number of supervisory staff now provided for has come about in consequence of the introduction of a full training scheme (see below) and because of closer supervision which it is now possible to undertake to the benefit of the Service as a whole. Certain redesignations have taken place since 1948 and in some instances new positions introduced. Thus in 1954 the grade of ' leading driver ' was first created to help superintendents, particularly on yard supervision; this grade was re-titled ' station sub-officer ' in 1963. There are now 28 such officers, three at each general station and Fulham, the remainder at Headquarters. Other additions in supervisory grades have been in respect of instructional staff at the training school and training stations and in consequence of a system of visiting officers. Four of these, in the rank of senior assistant superintendent, are known as hospital visiting officers and undertake much useful liaison work with the many hospitals in the county. This system is regarded as having been notably successful. Seven positions of senior assistant superintendent are filled by duty officers who provide a 24-hour rota at Headquarters, as well as a rota of visiting officers throughout the day and night whose duties include visiting stations and hospital casualty departments.

Training—One of the great changes over the years has concerned the arrangements for new entrants to the London Ambulance Service. In 1948, in common with other ambulance services, new entrants acted as a ' third man ' with an experienced crew and picked up what knowledge they could until their station officer felt they were proficient. They had to obtain a first aid certificate in their own time within six months of entry. In February, 1951 basic civil defence training for men already in the Service commenced and the 42 one-week courses held in that year were attended by 386 men. This training continued throughout

1952 and was concluded in 1953. From then on, all members of the regular service began to receive advanced civil defence training and new entrants were given basic training on entry. In 1956 the Civil Defence Training School was expanded to take in peace-time training and a three-week course was given—one week being devoted to Civil Defence and the other two to first aid and ambulance duties. From April to December 1956 there were seven such courses, attended by 79 men.

In October 1962 the procedure was again revised to provide a more comprehensive scheme. The syllabus in the Training School was expanded to four weeks and in addition new entrants are now sent to a Training Station for a minimum of four weeks, where they are paired up and allocated to an Instructor who accompanies them on all calls. Initially the instructor does most of the work at a call but gradually, as trainees become more competent, he remains in the background ready to advise if necessary. The Training Station has three accident ambulances manned by 16 driver/attendants. The most recent development in the training field was the agreement by the Health Committee that the Oval station, when rebuilt, would become the new Training Station and with 10 general ambulances in addition to three accident ambulances. The number of trainees at any one time will thus be greater and wider training and experience will be possible. At the time of writing the new station has not become operational.

Staff awards—It is gratifying to record various awards which have been made to members of the Service. Details of the more important ones are given below:

1952	B.E.M.—Driver F. W. Summerfield.
	Council's Silver Medal Driver H. Legon (first time ever awarded).
1956	M.B.E.—Superintendent Ridgwell.
1958	Council's Silver Medal—Driver P. Poole.
1961	Council's Silver Medal—Driver E. Shoults.
1962	Council's Silver Medal—Driver A. W. Drury.
1964	Queens Commendation for Bravery—Drivers A. C. Jewby and B. T. Eagle.

In addition, the Resuscitation Certificate of the Royal Humane Society has been awarded to one station officer and thirty-three drivers.

Competitions—The National Association of Ambulance Officers has for many years organised Regional Ambulance Efficiency Competitions. London is situated in No. 5 Region covering the Home Counties. In this competition the London Ambulance Service won the Wadham Trophy in 1954 and the Lomas Shield (for the runners up) in 1963.

Until 1964, staff were invited to form teams to compete in an eliminating round to decide on the representative team for the Service; in 1964 a fully fledged inter-station competition was introduced for this purpose—the Brook Ambulance Station being awarded the Richardson Cup (presented by the then Officer-in-Charge, Mr. F. A. Richardson).

An international competition organised by the Casualties Union was started in 1961 and teams from various N.A.T.O. countries were invited to take part. The competition was in two parts, a first aid test and a diagnosis test and two cups were awarded, the Buxton International Trophy and the Dawson Cup. The Council received a request to enter a team to represent the United Kingdom and despite short notice the team was successful in winning both cups. The team retained the Buxton Trophy in 1962 but was placed third in 1963. The Casualties Union also stages a National Competition for first aid and diagnosis and in 1964 it was decided that only the winning team in the National Competition should be eligible to enter the International one.

Evening Standard Photograph

Incident in Leadenhall Street, 4th April 1964

North London Press photogr

London Ambulance Service Training School

National Safe Driving Competition—In common with drivers in other departments of the Council, most ambulance driver/attendants enter for the annual National Safe Driving Competition held by the Royal Society for the Prevention of Accidents. The following table shows the number of drivers entered annually and the success achieved:

Year	*Entrants*	*Total*	*Awards*			
			1–9 years	*10–14 years*	*15–19 years*	*20 years or more*
1948 ..	N/A	347	263	35	25	24
1949 ..	N/A	397	321	32	22	22
1950 ..	N/A	432	339	51	20	22
1951 ..	N/A	462	357	60	21	24
1952 ..	N/A	474	369	60	23	22
1953 ..	628	500	395	62	23	20
1954 ..	676	546	434	63	24	25
1955 ..	671	570	441	70	33	26
1956 ..	716	615	473	77	37	28
1957 ..	750	610	464	77	39	30
1958 ..	763	531	394	82	31	24
1959 ..	765	519	371	88	40	20
1960 ..	779	520	362	101	41	16
1961 ..	692	481	324	104	38	15
1962 ..	769	539	384	99	39	17
1963 ..	753	536	383	92	37	24
1964 ..	769	547	403	82	42	20

To this statistical data about the staff of the London Ambulance Service there should be added a word of recognition of the spirit which imbues the Service. Throughout the years reviewed in this report a remarkably high level of morale has been maintained. The men and women of the London Ambulance Service, with very few exceptions, have shown a notable devotion to their calling. For them 'Service' is no casual expression lightly thrown off: it has real significance.

Civil Defence

A review of Civil Defence training over the period 1948–1964 falls naturally into two parts: training given to members of the regular peacetime service and training given to volunteers in the Civil Defence Corps.

Training given to members of the peacetime service—Local authorities are required by Regulation 2(*b*) of the Civil Defence (Ambulance) Regulations 1949 (S.I.2146) to train in Civil Defence members of the staff of their ambulance services. As mentioned above such training in London commenced in February 1951 when 10 men at a time were given a week's course; lectures were given by two station officers and 42 courses were held that year. This basic Civil Defence training was completed in 1953 and from then on it was given to all new entrants to the Service, whilst drivers already in the Service were given more advanced training. In 1956 the one week's Civil Defence course was incorporated in a three-weeks course for new entrants, the other two weeks being related to peacetime duties and to first aid.

As more and more Civil Defence exercises have been held, designed particularly for participation of volunteers, so members of the peacetime service have increasingly taken part. Plans made to introduce refresher training for the peacetime service early in 1965 include a strong element of Civil Defence revision to bring drivers' knowledge up-to-date in the light of many changes in Civil Defence organisation which have taken place since reorganisation in 1962.

The training of Civil Defence volunteers must be given by persons who hold a Civil Defence instructor's certificate either obtained centrally (i.e. at one of the Home Office Civil Defence Schools at Falfield, Gloucestershire, or at Easingwold, Yorkshire) or obtained locally and it has been the aim of the London Ambulance Service to allow as many as possible uniformed supervisory staff to attend instructors' courses at the Home Office Schools. Over the years 25 officers have attended; because the instructors' certificates are only valid for a period of six years, eight have attended instructors' requalifying courses. In addition, 42 senior officers, both uniformed and administrative staff (including three volunteer officers) have attended ambulance officer courses at the Home Office Schools and 11 have attended a senior officers' course at the Civil Defence Staff College, Sunningdale, where the aim has been to provide a wide background knowledge to Civil Defence in a way which is not possible within the framework of the usual training syllabuses.

Training for volunteers in the Civil Defence Corps—The Civil Defence Act, 1948 brought various sections of the Civil Defence Corps into being, among them the Ambulance Section. When a volunteer enrolled in the Corps he did so through a metropolitan borough council and his general basic training was arranged by that borough. It was only after he elected to join a particular section, where specialist training was required, that he was passed on to the appropriate authority. This meant that ambulance service instructors confined their attentions to first aid and ambulance duties. Home Office Circular 32/1953 discontinued this arrangement; from 1954 onwards a volunteer enrolled directly into the section of his choice and all his training was arranged by that section. The Ambulance Section was renamed the Ambulance and Casualty Collecting Section. Also in 1954, plans were completed for volunteers to receive driving instruction and practice accompanied by members of the regular service. For volunteers who were non-drivers, instruction at the Council's expense was arranged through a driving school, whilst volunteers holding a full driving licence proceeded to driving practice on various types of ambulance under the eye of a peacetime driver. In addition, courses began in elementary vehicle maintenance. In 1956 courses in casualty simulation (a valuable adjunct to first aid training) and for the selection of officers were added to the curriculum.

In 1960, following an extensive review of the organisation and functions of the Section by the Home Office, it was renamed the Ambulance and First Aid Section, with functions altered to match new concepts in Civil Defence. There followed in 1962 a full-scale reorganisation of the whole Corps, aimed at bringing into being a more efficient nucleus of volunteers around which to expand in case of emergency. The Home Office introduced tests of standard and advanced training; classes in which volunteers could elect to serve following the recruit stage and after passing the standard test; and the payment of an annual bounty, varying with the rank held and depending upon fulfilling certain conditions of training. Furthermore, recruits were given a limited period in which to complete their standard training. The full effects of the reorganisation are only now being experienced and have been entirely beneficial. Although the new scheme resulted in a substantial fall in 1962 and 1963 in the number of volunteers on roll, it could be felt that the lower numbers were at least realistic.

The following table shows the strength of the Section over the years:

Year	*No. of volunteers at 31 December*	*Year*	*No. of volunteers at 31 December*
1950 ..	940	1958 ..	1,623
1951 ..	1,244	1959 ..	1,600
1952 ..	1,452	1960 ..	1,678
1953 ..	1,662	1961 ..	1,895
1954 ..	2,060	1962 ..	1,310
1955 ..	2,215	1963 ..	1,129
1956 ..	2,052	1964 ..	1,031
1957 ..	1,747		

An indication of the various training courses held since 1954 is given below:

Year	Type of courses: Ambulance duties	First aid	Vehicle maintenance	Officer selection	Other	Total
1954 ..	15	14	—	—	31	60
1955 ..	37	16	12	—	—	65
1956 ..	29	14	9	1	2	55
1957 ..	20	21	12	6	3	62
1958 ..	26	15	5	3	16	65
1959 ..	19	12	11	4	2	48
1960 ..	24	13	9	6	7	59
1961 ..	17	7	12	6	6	48
1962 ..	28	8	11	4	3	54
1963 ..	24	12	7	2	30	75
1964 ..	16	9	6	—	23	54

The 1,129 volunteers registered at the end of 1963 comprised 596 recruits (i.e. had not completed their standard training, or having completed it had not taken a standard test revision course and passed the test), 353 in Class A (the most active class and taking advanced training), 32 in Class B and 148 in the Reserve. At 31 December 1964 the corresponding figures were: 337 recruits; 440 in Class A; 36 in Class B; and 218 in the Reserve, a total of 1,031.

Civil Defence exercises—To supplement the theoretical and practical training given in the lecture room, numerous Civil Defence exercises have been organised either by the Council or by the metropolitan borough councils. Some have been confined to activities of a particular section of the Corps but a number of large scale exercises have been held in which all sections have taken part. It is gratifying that the Ambulance and First Aid Section has figured largely in nearly all these exercises and has indeed promoted many of them. Week-end schools and camps for the more highly trained volunteers have been held and ceremonial occasions have also been well attended. The following notes on a few of the many exercises held over the years give some impression of their scope and of the planning and administration involved.

In October 1962 exercise ' Leader 4 ' involved, for the first time in London, the deployment of a full ambulance column—some 100 vehicles and 330 personnel.

Exercise ' Leader 7 ' in March 1963 involved some 700 personnel from all sections of the Corps, all of whom were fed by the Welfare (Emergency Feeding) Section. Some 250 ' casualties ' (all ambulance section volunteers) were made up and taken to the Training Ground at Bully Fen where they were rescued, treated and taken to ambulance loading points; from there they were taken by ambulance to a Forward Medical Aid Unit and were finally evacuated by launch across the Thames, loaded into ambulances again and returned to a simulated hospital area.

Exercise ' Leader 10 ' in September 1963 involved over 1,000 personnel and over 100 vehicles—once again a full ambulance column worked to a Forward Medical Aid Unit in dealing with large numbers of casualties.

Exercise ' Cabot/Whittington ' in November 1963 involved Ambulance and Rescue Section volunteers from both London and Bristol. A convoy and map reading drive to Bristol on Saturday afternoon was followed by a social evening organised by the Bristol authorities and by an exercise in the grounds of the Home Office Civil Defence School, Falfield, Gloucestershire, on Sunday morning. Units returned to London on the Sunday afternoon.

In May 1964 exercise ' Olympic 1 ' broke new ground in that the preliminary planning for the exercise and the direction of the exercise (movement at night in the early hours of Sunday morning) was all carried out by volunteer officers as opposed to regular service training and administrative staff.

Exercise ' Scottish Border ' in September 1964 was one of the most ambitious exercises ever attempted and involved some 120 personnel and 60 vehicles from all sections of the Corps, who were away from London for four days on a convoy publicity and recruiting drive which took them the length of the country. Various small exercises were carried out en route in collaboration with other County Divisions of the Corps. The exercise obtained considerable publicity, both locally and nationally, and had an undoubted effect on recruitment as well as a stimulating effect on those taking part.

The Section has also provided detachments or representatives at a number of national and civic occasions.

ANNEX A

LONDON AMBULANCE SERVICE

EQUIPMENT CARRIED BY ACCIDENT AMBULANCES

Beds, rubber (2)
Bed-pan, plastic (1)
Bed-pan cover (1)
Blanket, cot, in canvas envelope (1)
Blankets, red (6)
Bowls, kidney, small (2)
Bowl, kidney, large (1)
Bowl, round (1)
Bowl, vomit (1)
Burns sheet (1)
Carrying chair (1)
Carrying sheet (1)
Deodorant spray (1)
Dressings case (1)
Drinking-water bottle (1)
Drugs case (1)
Feeding cup (1)
Fracture board (1)
Gloves, rubber, electrician's, pair (1)
Guide lines, 12 yd. lengths (2)
Hacksaw (1)
Hacksaw blades (6)
Hot-water bottle, rubber (1)
Hot-water bottle cover (1)
Manifold harness (1)
Mask, Schimmelbusch (1)
Oxygen apparatus (1)
Pillows, rubber (2)
Resuscitator, bellows (1)
Rope, 40 foot length (1)
Rubber sheet, 8 ft. (1)
Satchel, first aid (1)
Splints, inflatable (2)
Splints, set of 16 (1)
Splint, back leg, 18 in. (1)
Stretcher canvases (6)
Stretcher poles, duralumin, pairs (2)
Stretchers, rigid (2)
Stretcher, Neil Robertson (1)
Surgical instruments, set (1)
Tissues, paper, in box (1)
Towelling square for use with cot blanket (1)
Traverse irons, pairs (2)

Additional equipment

Clip-board, phonetic alphabet (1)
Coats, crew's protective (2)
Jemmy (1)
Key, housing-estate barrier (1)
Key, station (1)
Key-ring and plastic ball (1)
Lamp, electric, Hunter pattern (1)
Lamp, electric, Pifco, red (1)
Pliers, pair (1)
Screwdriver (1)
Spanner, adjustable (1)
Wheel chock (1)

Contents of Drugs case

Cetrimide, 4 oz. bottle (1)
Epsom salts, saturated solution, 4 oz. bottle (1)
Labels, casualty (6)
Magnesium oxide, 2 oz. bottle (1)
Measure, 4 oz. (1)
Measure, 2 oz. (1)
Mustard, 2 oz. bottle (1)
Olive oil, 4 oz. bottle (1)
Sal volatile, 4 oz. bottle (1)
Skin pencils (2)
Teaspoon (1)
Vaseline, tube (1)
Vinegar, 4 oz. bottle (1)

and the following items TO BE USED ONLY BY A MEDICAL PRACTITIONER

*Adrenalin tartrate ampoules (6)
Amyl nitrite ampoules (12)
Chloroform, 2 oz. bottle (1)
†Morphine (Omnopon) in ampoule-syringes (6)
*Nikethamide (coromine) ampoules (6)
Surgical needles and sutures, sterile, in tubes (3)
Syphon, stomach (1)
Syringe, hypodermic, sterile, with three needles, including one 3½ in. (1)

* *For hypodermic injection.*

† *Carried in special locked cupboard containing also six casualty labels and one skin pencil.*

Contents of Dressings case

Dressings, No. 0 (6)
Dressings, No. 1 (6)
Dressings, No. 2 (6)
Dressings, No. 3 (6)
Dressings, No. 4 (6)
Bandages, roller, 1 inch (6)
Bandages, roller, 2 inch (6)
Bandages, roller, 3 inch (6)
Bandages, triangular (12)
Cotton wool, 4 oz. packet (1)
Gauze, white, roll (1)
Gloves, surgical, pair (1)
Lint, white, 4 oz. packets (2)
Lint, boric, 4 oz. packet (1)
Mouth cloths (3)
Pins, safety (12)
Plaster, adhesive, 1 inch roll (1)
Plaster, adhesive, 2 inch roll (1)
Scissors, dressing, pair (1)
Splinter forceps, pair (1)

Surgical instruments contained in sterile cellophane wrappings

Forceps, artery (4)
Forceps, dissecting (1)
Forceps, Treves (1)
Knife, amputation (1)
Probe (1)
Saw (1)
Scalpels (2)
Scissors, surgical, pair (1)
Tracheotomy tube, adult (1)
Tracheotomy tube, child (1)

Contents of First Aid satchel

Dressings, No. 0 (1)
Dressings, No. 1 (6)
Dressings, No. 2 (6)
Dressings, No. 3 (4)
Dressings, No. 4 (2)
Bandages, roller, 1 inch (6)
Bandages, roller 2 inch (6)
Bandages, triangular (6)
Cotton wool, 1 oz. packet (1)
Gag (1)
Glucose, in 2 oz. polythene bottle (1)
Lint, white, 1 oz. packet (1)
Mouth cloth (1)
Rubber bandage (1)
Sal volatile, 4 oz. bottle (1)
Tongue depressors, wooden (6)

EQUIPMENT CARRIED BY GENERAL SECTION AMBULANCES

Beds, Dunlopillo (2)
Bed-pan (1)
Blankets (as required)
Carrying chair (1)
Deodorant spray (1)
Drinking water bottle (1)
Feeding cup (1)
Hot water bottle } available from station
Hot water bottle cover } when necessary
Pillows (2)
Satchel, first aid (1)
Stretcher canvases (2)
Stretcher poles, duralumin, pairs (2)
Tissues, paper (as required)
Traverse irons (2)
Urine bottle (1)
Vomit bowl (1)

EMERGENCY VEHICLE EQUIPMENT

First Aid equipment

Dressings, No. 1 (48 doz.)
Dressings, No. 2 (64 doz.)
Dressings, No. 3 (80 doz.)
Dressings, No. 4 (84 doz.)
Roller bandages, 1 inch (24 doz.)
Roller bandages, 2 inch (24 doz.)
Roller bandages, 3 inch (24 doz.)
Triangular bandages (40 doz.)
Lint, 4 oz. packets (66)
Cotton wool, 4 oz. packets (66)
Mouth cloths (24)
Splints, wooden (3 sets)
Splints, plastic (3 sets)
Burns sheets (6)
First Aid satchels (6)
Skin pencils (12)
Casualty labels (200)

Ambulance equipment

Stretchers, rigid (20)
Stretcher canvases (6)
Stretcher poles (24)
Traverse irons (6 pairs)
Neil Robertson stretcher (1)
Carrying chair (1)
Blankets (52)
Rubber beds (4)
Rubber pillows (4)
Bed pan (1)
Stretcher carrying slings (24)

Resuscitation equipment

Oxygen set (Oxyvator) (1)
Spare cylinders, oxygen (4)
Spare cylinders, mixture (O_2 and CO_2) (4)
Bellows resuscitator (1)

Medical equipment

Omnopon (6 ampoules)
Surgical instruments (2 sets)
Hypodermic syringe (1)
Chloroform (2 bottles)
Schimmelbusch masks (2)
White coats (medical officer) (3)
Armbands (doctors) (12)

Radio equipment

Pye radio set, complete (1)
Walkie-talkie master set (1)
Walkie-talkie sets, with aerials (4)

Miscellaneous equipment

Rubber boots (6 pairs)
Boiler suits (1)
Fog flares (48)
Lamp (Hunter) (1)
Batteries, Ever Ready 45 v. (8)
Batteries, Ever Ready 1½ v. (12)
Batteries, 6 v. (6)
Batteries, 12 v. (1)
40 ft. rope (1)
Guide ropes (2)
Saws (set of three) (1 set)

Stand-by equipment

Calor gas cylinders (2)
Calor gas fire (1)
Emergency rations (2 tins)

Administrative equipment

Map of London (1)
Sectional maps (24)
Atlas of Greater London (Geographia) (1)
Occurrence book (1)
Armbands (L.C.C. Ambulance) (70)

Chiropody

In 1948 the London County Council took over 26 foot clinics established by the metropolitan borough councils; the service was, however, unevenly distributed over the county area. The Minister of Health agreed to the service being continued by the Council at that level pending a decision as to whether chiropody was an appropriate form of treatment for provision by local health authorities. Despite repeated representations from the Council, the Minister was unable to agree to any extension of the service. The Cope Committee recommended in 1951 that local health authorities should be empowered to provide chiropody under the National Health Service Act, but the Minister stated that an extension of this service was not possible in the then existing financial circumstances. In 1956, however, the Minister agreed to a more even geographical allocation of existing sessions and this was carried out. In 1959 the Minister sanctioned the extension of chiropody services and the Council immediately approved an increase of 100 sessions a week, pending a full review of the needs in the county. Unfortunately it was not possible fully to implement the increase owing to lack of chiropodists. Only recently, following the setting up of the Register of Chiropodists, has it appeared that sufficient staff might be available.

Services provided by the Council have been augmented since 1959 by services provided by various voluntary organisations, usually Old People's Welfare Associations, who provide chiropody services for the elderly. The Council pays these organisations 100 per cent. deficiency grants for the services provided. In 1964 grants were made to 32 such organisations.

The following tables show the attendances at the Council's clinics in recent years:

New cases and attendances

Year	*New cases*	*Attendances*	*Staff at the end of the year (in terms of whole units)*
1960	9,405	186,735	57·7
1961	10,379	196,788	55·6
1962	8,575	192,500	57·7
1963	7,510	193,498	60·7
1964	8,305	218,076	66·7

Analysis in age groups of treatment given at clinics

Group		*1960*	*1961*	*1962*	*1963*	*1964*
Children under 5 years		129	117	78	91	110
	5–14 years	7,062	6,599	6,549	5,940	5,502
Males	15–64 years	14,766	14,076	12,237	11,181	11,829
	65 years and over	17,613	19,675	20,106	21,188	25,478
Females	15–59 years	57,980	55,237	49,957	45,546	47,376
	60 years and over	89,185	101,084	103,573	109,552	127,781
Total		186,735	196,788	192,500	193,498	218,076

Recuperative holidays

Recuperative holidays, where the emphasis is on rest, fresh air and good food but regular medical and nursing attention are not required, totalled 8,467 in 1949, the first full year in which the service was provided. There was a considerable increase in the following year but since then, apart from 1959, there has been a steady reduction in the demand for the service. One reason is that doctors in child welfare centres and general practitioners no longer refer very young children, especially those under two years, for recuperative holidays unless the circumstances are quite exceptional.

The risk of infection among babies has always been a problem in placing mothers with very young children. This has been minimised by the use of private accommodation, where only one or two mothers with such children are received for recuperative holidays at any one time. This accommodation is kept under close surveillance by a medical officer. Private accommodation is also largely used for holidays for adults.

It has been the Council's policy for social as well as medical reasons not to send patients with a history of tuberculosis to the same homes as non-tuberculous patients. Although these patients may be non-infective and the tuberculosis quiescent, experience has shown that their presence in ordinary homes may upset other patients. The homes approved to take tuberculous patients are grouped as follows:

Group I—Approved to take adult patients with active or quiescent tuberculosis

Group II—Approved to take a tuberculous person accompanied by his/her family.

A few homes are placed in both groups, on the clear understanding that at any one time the patients in residence must be in only one of these groups.

For the purposes of the Council's recuperative holiday scheme for tuberculous patients, it is not thought safe to differentiate between a case of known active pulmonary tuberculosis and what may be thought to be a quiescent case in a patient who has recently been ill enough to need a recuperative holiday on medical grounds. The proprietors of some homes will not accept patients with known active pulmonary tuberculosis and their wishes are observed.

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 cannot be accommodated in these homes and all adults are placed at the Council's expense in homes under private ownership or maintained by voluntary organisations. For the first fourteen weeks of 1962 Roland House, Littlehampton, was used exclusively for children from homeless families in Welfare department establishments. This proved beneficial both to the children and to their families, who were relieved from the need of caring for them in difficult circumstances for a short period during which they would find it easier to search for a new home for the family. Similar arrangements were made in subsequent years and some 200 children benefited each year.

Admissions to recuperative holiday homes

	1949	*1954*	*1959*	*1964*
Expectant and nursing mothers ..	379	197	123	81
Other adults	2,779	2,954	2,457	2,040
Children under 5 not at school (*a*) ..	1,517	486	571	410
School and nursery school children (*b*)	3,121	3,404	2,597	2,032
Children in age groups (*a*) and (*b*) above accompanying parents but not included in these totals	671	424	*	*
	8,467	7,465	5,748	4,563

* *Included in* (*a*) *and* (*b*).

Health education

The department's health education activities in 1964 were directed mainly in four fields, three regarded as of growing importance with dental health of continuing importance.

Smoking and health—The health education mobile unit continued its work of visiting schools, youth clubs and other groups.

Visits by health education unit—1964

	No. of establishments visited
Primary schools	13
Secondary schools	88
Youth clubs	19
Further education establishments	9
Teacher training colleges	4
Welfare centres	7
Other groups	8

Many of the establishments were visited a number of times and a total of 262 lectures was given by the health educator, aided by films, film strips and other material to some 32,300 persons. Because of the demand for the services of the unit and the need for follow-up visits, the provision of a second unit was authorised.

At various times during the school holidays film shows on health education topics have been held for staff at County Hall. In all, there were 91 showings to a total audience of 2,874. In the summer school holidays a van was adapted for the rear projection of films on the smoking theme and appeared in 18 of the Council's parks. This was very successful and attracted a total of 9,450 children and young adults. No doubt the exceptionally sunny weather contributed to the success. Two leaflets were produced within the department with the assistance of the Chief Officer of Supplies. One stresses the need for adults who have constant contact with children to set a good example by not smoking; this has been made available to head teachers of all the Council's schools and to youth club leaders in London. The other emphasises the statistical evidence for an association between smoking and chest disease and this has been distributed to older school children, to members of youth clubs and other young persons.

While the smoking advisory sessions held in three of the divisions continued to operate, attendances were not maintained at the initial levels.

Venereal disease—Leaflets and posters were produced by the department with the aim of persuading young people who had taken risks to seek proper advice and, as necessary, treatment. This material was offered to every London youth club leader, to London general practitioners, to principals of colleges of further education and to medical officers of health of the metropolitan borough councils for distribution by them; the response has been encouraging. A special direct telephone line was made available at County Hall to permit those worried about their possible condition to seek advice as to where to obtain treatment this facility was publicised in the leaflet. In addition, descriptive leaflets of the venereal diseases issued by the Central Council for Health Education were distributed to head teachers and to youth club leaders to assist them and their staffs in answering questions on the subject.

Dangers from oil heaters—An intensive campaign was launched in the autumn to encourage awareness of the dangers from:

(i) Unguarded oil and other heaters, particularly when young children or the elderly are present;

(ii) Improperly maintained oil heaters, and

(iii) Oil heaters which do not conform to British Standard 3300.

A leaflet was specially designed and distributed to 650,000 homes, including all of the Council's houses and flats (both in and out-county), many of the metropolitan borough councils' housing estates and to houses in areas regarded as risk areas by reason of gross multiple occupation or large immigrant populations. For the latter purpose the leaflets were translated into Turkish and Greek Cypriot, Urdu, Bengali and Hindi. In addition, a poster was produced illustrating the desirability of providing a separate guard for all types of heater when children are present; this was displayed on most London railway and underground stations. Monthly advertisements based on this poster were inserted in local newspapers during the autumn and early winter.

Dental health—In response to a suggestion to local authorities by the Ministry of Health, dental health weeks have been held in each division with the co-operation of the divisional education offices. These ' weeks ' were preceded by periods of build-up and followed by periods of lower level dental health activity in an endeavour to consolidate the message. The degree of activity has varied between the divisions but many schools have participated and much publicity material produced by the Council and by outside agencies has been used. The campaigns have been supplemented by film showings, exhibitions and competitions.

Other material—While care has been taken not to produce any publicity material which is exactly covered by that produced by outside agencies, the year has seen the production of a wide variety of health education material produced by the department in co-operation with the Chief Officer of Supplies. In addition to that referred to above, a leaflet was produced on mouth-to-mouth resuscitation; this has been made available to professional staff in the department who may be called upon to meet an emergency situation and it has also been supplied to schools. A poster with an associated leaflet was prepared for display in child welfare centres, warning mothers of the desirability of first ascertaining that any child minder to whom they wish to give the charge of their child is either not in a registerable category or if so, is properly registered. The leaflet was so designed that it could be distributed by health visitors on its own. A separate leaflet was prepared for distribution by health visitors and other field workers warning likely child minders, or potential child minders, of the legal requirements of registering. A leaflet was also produced for distribution to parents on the need for care in choosing children's shoes.

General—The nine health divisions have continued to provide health education on a personal level through the day-to-day contact of the field staff with the public and make their own arrangements for the ordering of material direct from those supplying it. The departmental advisory panel on health education has met at approximately quarterly intervals, as has the health education working party of senior nursing officers in the divisions. The department has continued to be represented on the Education Officers' standing advisory committee on health education in schools which has met quarterly.

Health education talks—The following tables show the variety and volume of talks and discussions arranged and given by the field staff. Films and film strips supplied from the central office continued to be widely used in these activities. Talks given by health visitors in schools at the invitation of head teachers ranged over a variety of subjects and numbered over 4,000.

TABLE (i)—*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	978	6,968	772	6,119	279	3,071	325	3,417	366	4,532	637	6,218	634	6,286	35	356	203	1,785	4,229	38,752
Care of older children	3	16	25	253	—	—	7	75	13	230	—	—	9	113	—	—	9	46	66	733
General family health topics ..	11	104	5	53	12	142	27	200	15	232	—	—	23	318	6	156	4	20	103	1,225
Environmental hygiene	6	49	2	20	—	—	—	—	2	26	—	—	—	—	—	—	—	—	10	95
Infectious diseases and prophylaxis	26	171	5	39	12	126	—	—	5	78	16	260	32	279	3	10	5	24	104	987
Prevention of accidents	29	243	12	141	4	31	4	59	13	144	6	65	17	186	3	57	5	34	93	960
Smoking and lung cancer	1	2	—	—	1	11	1	40	5	64	—	—	3	40	1	16	—	—	12	173
Cancer education (other than above)	—	—	—	—	—	—	1	50	—	—	—	—	—	—	—	—	—	—	1	50
Mental health	—	—	—	—	4	41	—	—	3	26	—	—	6	66	3	49	—	—	16	182
First aid	3	25	1	15	—	—	—	—	9	88	3	41	2	27	1	40	1	16	20	252
Other	35	319	155	1,063	7	83	55	723	58	622	9	129	147	2,148	9	114	30	194	505	5,395
Total	1,092	7,897	977	7,703	319	3,505	420	4,564	489	6,042	671	6,713	873	9,463	61	798	257	2,119	5,159	48,804

TABLE (ii)—*Speakers*

	Divisions									
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*Total*
Medical officers	—	52	5	1	—	—	1	2	—	61
Nursing officers	—	—	—	—	—	—	—	—	—	—
Health visitors and school nursing sisters	1,044	691	294	304	348	661	694	41	252	4,329
Domiciliary midwives.. ..	9	17	4	—	1	1	28	—	—	60
Teachers/instructors	19	192	9	109	77	—	14	—	—	420
Other Council officers ..	1	2	2	—	3	—	23	2	—	33
Lecturers from outside the Council's service—Nursing	1	4	2	3	—	—	2	2	1	15
Other.. ..	18	19	3	3	60	9	111	14	4	241
Total	1,092	977	319	420	489	671	873	61	257	5,159

TABLE (iii)—*Audience groups*

	Divisions									
	1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*Total*
Expectant mothers	890	593	245	250	247	628	441	30	191	3,515
Mothers, mothers' clubs, etc.	174	384	74	102	232	43	429	28	66	1,532
Parent/teacher associations ..	1	—	—	—	—	—	3	1	—	5
Day continuation classes ..	3	—	—	68	—	—	—	—	—	71
Voluntary organisations ..	24	—	—	—	10	—	—	2	—	36
Total ..	1,092	977	319	420	489	671	873	61	257	5,159

Venereal diseases

The responsibility for the diagnosis and treatment of venereal diseases passed to the hospital authorities with the coming into operation of the National Health Services Act, 1946. The Council's interest was, therefore, restricted to prevention. Under Defence Regulation 33B the Council had power to bring to treatment certain persons believed to be suffering from venereal disease and employed staff for this purpose. This power expired on 31 December 1947, but the Council continued to employ staff under section 28 of the National Health Service Act to persuade contacts and defaulters from treatment to attend clinics.

In 1950, at the request of the Prison Commissioners, the part-time services of a welfare officer were made available for attendance at clinics at Holloway Prison and for following up contacts and persons on discharge who needed to continue under treatment. The initial trial period showed great scope for this work and a whole-time welfare officer has been allocated to these duties since 1951. Another welfare officer employed on tracing the contacts notified to the department at County Hall continued this work, in addition to attending the Endell Street clinic of St. Peter's, St. Paul's and St. Philip's hospital. The services of a male inspector have always been available where necessary.

The incidence of venereal disease, as indicated by the number of new cases attending clinics in London, fell gradually until the mid-1950's; then there was a rise until 1961, thereafter the figures appeared to have levelled off at about double the 1955 level. This increase led to a request for the services of a welfare officer at St. Mary's hospital, Paddington, which is one of the busiest clinics in London and later a welfare officer was employed at St. Thomas's and the London hospitals.

In 1964, after discussions with the consultant venereologist concerned and with officers of the Ministry of Health, it was decided to try out a scheme of concentrated contact tracing at two clinics. In this scheme the welfare officer would see each patient, as far as possible, on his first attendance. The old method of issuing ' contact slips ' will continue in suitable cases with closer follow-up of results. The Council agreed to the employment of two additional welfare officer's for a period of six months at the London and St. Thomas's hospitals, so that the needs and effectiveness of such a scheme could be assessed. This scheme started at the end of November 1964 and results are awaited with interest.

The tracing of contacts and the help that the local health authority can give is now appreciated by the staffs of most clinics and at the end of the year requests from four more hospitals for help from welfare officers were under consideration by the Council. These requests were subsequently approved and the number of staff employed full-time on this work was increased to nine.

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.
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
1962 ..	1,060	533	52	2	12,225	2,533	13,337	3,068	27,360	11,939	243,078	87,860
1963 ..	909	426	49	2	11,895	2,906	12,853	3,334	29,005	13,189	229,506	89,050
1964 ..	1,073	389	47	2	12,000	3,131	13,120	3,522	29,512	13,855	206,666	85,174

Number of patients completing treatment and of defaulters

	1960	1961	1962	1963	1964
Syphilis—patients completing treatment—					
Males	526	572	507	430	420
Females	434	362	359	229	218
patients not completing treatment—					
Males	677	776	682	528	737
Females	431	390	389	199	210
Gonorrhoea—patients completing treatment—					
Males	5,700	7,800	5,398	4,429	6,157
Females	1,334	1,269	1,129	1,163	1,461
patients not completing treatment—					
Males	6,536	8,085	4,929	7,466	6,078
Females	1,485	1,550	1,237	1,743	1,705

MENTAL HEALTH

Historical developments

Social workers have been employed on mental deficiency work ever since the Mental Deficiency Act, 1913 came into operation. From the beginning the social enquiries necessary for the ascertainment of new cases were carried out by social workers, designated Mental Deficiency Act inspectors, employed by the Council and based at County Hall, but the supervision of mentally subnormal persons (then known as mental defectives) living in the community was originally undertaken on the Council's behalf by social workers employed by the London Association for Mental Welfare. The work of that body 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 early that the provision of centres for the training and occupation of mentally subnormal 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, the best available but many of them 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 1,270 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.

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 being carried out by the National Association for Mental Health and the Mental After Care Association 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 consultant in mental health.

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 hospital care and treatment for persons suffering from mental illness.

The Council welcomed the findings published in May, 1957 of the Royal Commission on the Law Relating to Mental Illness and Mental Deficiency 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 underlined the concepts now accepted by many of the general public, as well as by those 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.

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 1964, to put them into effect.

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 all the services were administered centrally from the County Hall.

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 under a divisional mental welfare officer (now divisional mental health social worker) responsible to the divisional medical officer. A principal mental welfare officer (now principal mental health social worker) was appointed 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 background, training and experience of the members of the divisional teams varied widely and the bringing together 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 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 together 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 divisional basis 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 mentally disordered persons, 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.

The devolution of responsibilities for the mental health services to Divisional Health Committees included 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. Planning and the formulation of policy, the supervision of training and general control over admissions, the engagement and allocation of supervisory staff and the arranging of transport were retained as central responsibilities under the guidance of a principal medical officer assisted by an organiser of training centres.

In 1961 the divisional staffing structure was reviewed. It was evident that staff had been working under extreme pressure and the Health Committee agreed to an increase of 18 additional social worker positions to a total of 95 and to a further review in the light of 18 months' experience. It was soon evident that the increased establishment was inadequate to deal with the very considerable increase in the volume of work falling to the social worker staff and this was confimed by an O. and M. review of the service carried out in 1963. An increase of 25 per cent. in the volume of work since the Act came into operation (85 per cent. of which related to mentally ill persons) was revealed and to enable the staff to continue adequately to perform the Council's statutory functions and to allow for a further anticipated expansion of service a 35 per cent. increase in social worker positions was approved. A case load of 40 mentally ill persons or 160 mentally subnormal persons receiving community care for each social worker was suggested as a general yardstick. To improve recruitment and give greater stability to the service a revised grading structure was also agreed. At the end of 1964 a total of 136 mental health social workers were employed.

The staffing of training centres has followed a formula fixed some years ago, namely, a supervisor with one assistant supervisor for each group of 15 or part of a group, with attendants as necessary, subject to the overall ratio of staff (supervisory and attendants) not exceeding 1 : 10. A slight strengthening of the supervisory staffing at the larger centres was subsequently found to be desirable. The number of staff employed in the training centre service at the end of 1964 was 147, comprising one organiser of training centres, one industrial manager, 24 supervisors, 84 assistant supervisors, 34 attendants and three home teachers.

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. 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.

During 1964, the Council paid the fees of selected officers attending evening courses on such subjects as abnormal psychology, human relations, marriage guidance, case work principles and problems of old age. The policy of seconding suitable officers to full-time courses continued; four officers so seconded completed the Mental Health course during the year and five commenced the course. Two officers were also seconded to take the two-year 'Younghusband' course and two the National Institute of Social Work one-year course ; another six returned from these courses. Arrangements also continued for officers to attend conferences and residential weekend schools.

While 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, it has been possible during the year to start in-service training on these lines. A case discussion group has met weekly, made up of a mental health social worker from each division and led by the assistant principal mental health social worker. The response in growing understanding and awareness has been most encouraging. Springfield hospital arranged for the second time a useful intensive course lasting a week and two social workers attended it. Staff have also started to attend seminars in mental subnormality at Queen Mary's hospital, Carshalton.

Five training centre staff were seconded on one-year full-time courses arranged by the National Association for Mental Health and six returned to duty. Five assistant supervisers successfully completed the diploma course for teachers of the mentally handicapped, one of whom gained the highest examination marks and was named the student of the year. One assistant supervisor completed the diploma course held in Birmingham for staff of adult centres.

Medical and diagnostic services

Since the passing of the Mental Health Act, 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 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 specialising in mental subnormality. These officers, based centrally at the County Hall, are responsible for the more difficult and complicated clinical work arising from the local health authority's duties under the Act and are also available for carrying out diagnostic examinations in the divisions at the request of the divisional medical officers. They 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.

Special advisory clinics

The Royal Commission on the Law relating to Mental Illness and Mental Deficiency had 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.

Special clinics have been set up in all the Council's health divisions, 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 an 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 care and training indicated and necessary arrangements made. These clinics are staffed by medical officers with considerable experience in mental subnormality, most 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.

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

During 1964, 4,689 persons who were alleged to be mentally ill and in urgent need of care and control were referred to the Council's mental health social workers for investigation, of whom 3,706 were removed to hospital.

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 and Tooting Bec hospitals. The remaining seven hospitals are Bexley; Banstead; Cane Hill, Coulsdon; Horton, Epsom; Long Grove, Epsom; West Park, Epsom and Friern, 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. Rather more than 200 beds are provided at the general hospitals for these cases.

There are 21 hospitals which admit subnormal and severely subnormal persons from the county area; two in London and 19 out-county. The Council acts as the normal channel for admissions of London patients to these hospitals, assists with the assessment of priorities and in the provision of medical and social reports. These patients are normally received in hospital on an informal basis. Difficulties persist in obtaining beds, particularly for children; at the end of the year 148 children under 16 and 27 patients over this age were awaiting admission, of whom 61 were regarded as being in urgent need.

Informal admission to hospital—Hospital care under the Mental Health Act, 1959 is 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 health social workers are not, of course, concerned with the large majority of informal admissions of mentally ill persons to psychiatric hospitals but in 1964, of all removals of such patients dealt with by mental health social workers, 26.6 per cent. were arranged informally.

Compulsory admissions to hospital—The Mental Health Act embodied a new code for compulsory admission to hospital of mentally disordered patients, whereby compulsion is applied only in the case of 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 health social worker or the nearest relative supported by two medical recommendations. In the case of an emergency admission under section 29, a mental health social worker 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 1964, 977 persons were admitted to hospital for observation under section 25, 367 for treatment under section 26 and 1,583 were the subject of emergency admissions for observation under section 29.

The police have 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 health social worker and for making any necessary arrangements for treatment or care. During 1964 mental health social workers were concerned in the compulsory removal to hospital of nine 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 the nature or degree of 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 staff. During 1964 the Council's staff were concerned in the compulsory removal to hospital of 199 persons as the result of Court Orders.

Guardianship—Under the Mental Health Act, 1959 a local health authority can itself act as guardian and guardianship may 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 1964, however, this form of control had not been used by the Council for mentally ill or psychopathic persons. 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 in 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 of 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, which must be accompanied by a medical recommendation, are made by the nearest relative or by a mental health social worker and in these applications reasons must be given why the person cannot properly 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 mentally disordered person's father and the person 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 on severe subnormality or mental illness or in relation to patients who are the subject of Court Orders.

Under the new Act a ' responsible medical officer ' had 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. Of 92 London cases then under guardianship 51 were discharged and continued in community care on an informal basis, three were admitted to hospital and 38 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. These 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 are appointed to exercise the power to order the discharge of a patient from guardianship, a power which

is also given to the nearest relative. At the end of 1964 there were 26 persons under statutory guardianship, of whom 13 were placed at addresses in the care of the Guardianship Society, Brighton.

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 the 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 21 members who, up to the end of 1964, had considered 345 applications and approved 317.

Residential accommodation

The Council has long been alive to the need to provide residential accommodation for mentally disordered persons. The scheme submitted to the Minister of Health in 1948 under section 28 of the National Health Service Act, 1946 stated that the Council would:

(i) Make use of homes founded by voluntary organisations for persons not needing treatment in a hospital and would itself consider making direct provision in suitable cases ; and

(ii) would consider the provision of hostels for mental defectives under guardianship.

In 1955 the Council established Dover Lodge hostel, Camberwell, the first of its kind in the country, where accommodation is provided for up to 13 mentally sub-normal 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 very useful purpose in training them to become self-supporting members of the community. Fifteen girls were accommodated in the hostel during 1964 and nine were resident at the end of the year.

Since the passing of the Mental Health Act, the problem of providing residential accommodation for various classes of mentally disordered persons has been one of the most onerous that the Council has had to face in developing its mental health service. Whilst recognising its ultimate obligations under the Act to provide such accommodation for a very large number of persons, the Council decided to proceed with the provision of hostels on a broad basis of priority for certain classes. Initially, the categories of persons for whom hostel provision was proposed, were :

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

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

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

(iv) Subnormal persons discharged from hospital and urgently requiring temporary accommodation or living accommodation on a somewhat longer term basis where necessary in the person's interests.

(v) Persons needing long-term care who are (*a*) in outside employment ; (*b*) not working (including the aged mentally infirm).

' Chellow Dene ', the Council's first hostel for mentally ill persons, opened in specially converted premises in Putney in 1962 with accommodation for 23 men and women between the ages of approximately 18 and 60 years, who require a period of sheltered accommodation to help establish themselves in employment and in the community when recovering from mental illness. Admissions are on a trial basis, normally of one month. During this period, and indeed during the whole period of stay, very active rehabilitation is often necessary by the warden and psychiatric social worker to help the residence in the process of re-adjustment. During 1964 a total of 75 persons were resident in the hostel, the average stay being ten weeks ; the length of stay varied between one day and twelve months. At the end of the year 18 persons were resident.

When the Council was required by the Minister of Health in Circular 2/62 to submit its ten-year plan for the Development of Health and Welfare Services, further consideration was given to the hostel development programme and the categories of mentally disordered persons for whom such accommodation should be provided. A total of 19 hostels was proposed for the ten years up to 1972 ; of these, 11 hostels were programmed for the first five-year period to 1967.

The general principle was adopted that in the first instance there should be one hostel for each of the approved categories, so that the need for further hostels of each type could be re-examined in the light of experience. It was found in practice, however, that consideration of possible sites in relation, for example, to existing and projected health service premises and to the location of nearby light industry and neighbouring properties, determined to a large extent the categories of persons for which hostel accommodation could be suggested, with the result that a second or even third hostel of a particular type might be possible before the provision of an initial hostel in another category. This was recognised when the first revision of the ten-year plan was carried out in 1963 ; at the same time the development programme was expanded to provide for a total of 26 hostels in the period up to 1973. The following additional priority categories were approved:

(i) Chronic unemployable mentally ill persons needing long-term care.

(ii) Employable mentally ill persons requiring long-term care.

(iii) Employable subnormal women requiring short or long-term care.

(iv) Subnormal or severely subnormal persons of both sexes not able to be employed in the community and needing long-term care.

' Honor Lea ', the Council's first purpose-built hostel for mentally ill persons, opened at Brockley Rise, Lewisham in September 1964 with accommodation for a maximum of 59 persons requiring a sheltered hostel environment after hospital care or a period of support away from home surroundings to prevent a more serious breakdown. Admission is normally restricted to persons who are sufficiently recovered as to be capable of undertaking outside employment within a reasonable period following admission or are suitable to attend a day centre for the mentally ill in South London. By the end of the year 44 persons had been accommodated in the hostel and 33 persons were resident at 31 December.

Further progress made towards the implementation of the hostel development programme is shown in the section of the report dealing with health services premises.

Voluntary organisations—In addition to direct provision of hostels, the Council places and maintains a number of mentally disordered persons in hostels and homes under the control of voluntary organisations and with private persons. In particular, use has been made of homes provided by the Mental After-Care Association for the long-term care of persons suffering from mental illness. Persons are maintained at homes owned or sponsored

Honor Lea Hostel
Brockley Rise
Lewisham

Top—Library or
Quiet Room

Centre—The Lounge

Bottom—A Bedroom

by the Association; at Parnham House (National Association for Mental Health); at Winston House, Cambridge, and Hill House, Elstree (S.O.S. Society); at Cheshire Foundation, Richmond Fellowship and Jewish Welfare Board hostels. Persons who are maintained by the Council contribute towards the cost according to their means.

As regards mentally subnormal persons, private homes and hostels run by voluntary organisations are used when this form of care is considered appropriate. Placings are made in convents and other training establishments run by religious communities and through the Guardianship Society, Brighton. At the end of 1964 the Council was maintaining 186 subnormal persons under these arrangements.

Grant-aided hostels—The Council contributes 90 per cent of the net cost of maintenance of a hostel for the after-care of alcoholics run by the West London Mission, at the Alcoholic Rehabilitation Centre in Lambeth. This hostel opened in 1961 to provide after-care for up to 40 persons who have received psychiatric treatment and who are under the continuous supervision of psychiatrists. Subsequently, in 1963, a female wing for up to 12 patients was opened. During 1964 a total of 174 men and 27 women were resident in the hostel.

A similar maintenance grant is paid by the Council to the Easton House Trust in respect of a hostel opened in 1963 in Stoke Newington for leavers from the Council's boarding special schools for maladjusted boys. The hostel provides accommodation for 12 boys and was fully occupied throughout 1964.

Short-term care and holidays for mentally disordered persons—The provision of short term residential 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 1964, 529 persons were placed under these arrangements for periods normally not exceeding eight weeks. 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.

Recuperative holidays are provided for persons recovering from mental illness in the same way as for those who have suffered from physical illness. During the year 159 persons were given holidays for two or three weeks in approved recuperative holiday homes.

Each year since 1951, the Council has organised a two-week seaside holiday for about 200 mentally subnormal children and adults who attend training centres, at a holiday camp at St. Mary's Bay, Dymchurch, Kent.

A grant to a local branch of the National Society for Mentally Handicapped Children, towards the cost of purchasing two caravans to be used to provide seaside holidays for families with mentally subnormal children, was approved by the Council in 1964.

Training for mentally subnormal and severely subnormal persons

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 :

(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 attention because of physical handicap or other difficulty ;

(iii) reduction in the general age of admission 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 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 and Greenwich of two additional industrial centres with places for 126 youths and men, the opening of additional centres for older girls and women in Islington and Wandsworth with a total of 80 extra places, and the opening of centres for older girls and women in Bethnal Green, Stepney and Hammersmith in specially adapted premises to replace centres in unsatisfactory church hall premises. By the end of 1964 the number of centres had increased to 24 and the total number of available places to 767 for juniors, 365 for older girls and women and 381 for youths and men, a total of 1,513 places.

The provision of new centres has been hampered by difficulties in acquiring suitable sites but at the end of 1964 the following projects were in hand :

(i) Erection of two new junior centres each with 112 places in Greenwich and Islington, which had reached an advanced stage of construction.

(ii) Replacement of older girls' centre in unsatisfactory premises in Greenwich by a centre in specially adapted premises ready for occupation in January 1965.

(iii) Provision of a new industrial centre in Hackney to provide training for 120 youths and men—detailed plans approved and building work about to commence.

(iv) Provision, on a site in Bermondsey, of a new junior centre with 112 places, a female adult centre and one for youths and men, including an industrial workshop—scheme approved and detailed plans under consideration.

Special care units—The Council's first special care unit was brought into use in a specially adapted part of the Bethnal Green centre in 1962. The unit provides accommodation for 12 severely subnormal children aged 5 to 16 who are also severely physically handicapped or of such a restless or aggressive behaviour that they could not be accepted for admission to an ordinary junior training centre. A more generous staffing ratio is provided, which enables the children to be given a greater amount of individual attention than is possible in a training centre. Attendances are very good and the results achieved are most encouraging. A few children improve sufficiently to enable them to be transferred to junior training centres.

It is the intention that special care units should form part of all new purpose built junior centres and plans have been approved for the addition of these units to the three existing purpose-built centres.

The Council makes a grant to the Friends of the Centre for Spastic Children of 90 per cent of the net annual cost of maintaining a special care unit for subnormal, multi-handicapped spastic children at the centre in Cheyne Walk, Chelsea. The unit, which was opened at the end of 1962 and considerably enlarged in 1963, provides accommodation for up to 30 of these severely handicapped children between the ages of two and seven years.

Training of children—Training for mentally subnormal children between the ages of five and sixteen is provided in the nine junior training centres. These are open during ordinary school hours and are run as closely as possible on the lines of schools, the aim being to make the children socially acceptable and to enable them to make the fullest use of their limited potentialities.

Pending the opening of new and larger centres, lack of places has precluded any general lowering of the age of admission to junior centres below five years, although it has been possible to accommodate a number of four-year-olds in the centres serving west and south west London and children of this age are admitted to other centres in special circumstances.

Following the publication of the report of the Ministry of Health Sub-Committee on the training of staff of training centres for the mentally subnormal (of which Dr. J. A. Scott, the Council's former Medical Officer of Health, was Chairman), which drew attention to the need for further educational psychological research into mental subnormality, arrangements were made for educational psychologists employed in the Council's Education department to visit all the junior training centres to investigate the training potentialities of the children and to advise on training methods generally and, at the request of supervisors, on individual children.

As an experiment, Montessori training has been introduced with most encouraging results at two junior centres, whose supervisors have taken a special course of training in this method of teaching. It is planned to extend the experiment to other centres as soon as the supervisory staff have completed the appropriate training.

Speech therapy is provided for those children who need it and the whole range of school medical services is available to them. Midday meals are provided by the school meals service at a charge of sixpence and coach transport is provided for all juniors as well as trainees attending centres for older girls and women.

Special units in day nurseries—In furtherance of the Council's intention to provide training for subnormal children from an early age, it has been possible to open special units for these children in nine of the Council's day nurseries. A total of 63 places is provided, the children being admitted on the recommendation of the medical officers conducting the special advisory clinics.

In addition, the Council approved grants representing 90 per cent of approved maintenance costs of nursery units run by three local branches of the National Society for Mentally Handicapped Children. A grant to a fourth local society for a similar purpose is under consideration. The Council is represented on the management committee of these units.

Play centres—Following the Council's proposal to afford additional relief to the parents of children attending junior training centres, a small number of centres have been kept open as play centres each year for four weeks of the centres' summer holiday period. Attendances at the play centres have been rather disappointing, but this additional service has been appreciated by the parents of those children who attended the centres.

Training of adults—Adult centres provide accommodation for persons normally from the age of 16, the social training given in the junior centres being continued with more

emphasis placed on craft work and the production of useful articles. Carpentry and other crafts are taught to the boys and the older girls receive instruction in domestic crafts, such as cookery, laundry work and needlework. Industrial outwork has been introduced at most of the adult centres ; to stimulate this form of activity, an industrial manager was appointed in 1961 to negotiate orders for and generally supervise the work. There is no doubt that this new activity has been welcomed by the trainees, who have shown keenness capable of quite a wide range of work. Income received by the Council for the work done is shared between the trainees who take part in it.

At the three industrial training centres, to which the most promising boys are transferred on the recommendation of the industrial manager, the trainees concentrate on industrial work. Two of the centres carry out work for the Council's Supplies department, orders to the value of about £4,000 having been completed in 1964 and the third undertakes work for outside firms. Each trainee at an industrial centre receives a daily payment of 3s., a figure calculated on the annual profits of the three centres. Some trainees from industrial centres have been able to secure and keep outside employment, but for the majority the centres must serve as a form of sheltered workshop.

Part-time centres for older mentally subnormal persons—The need for centres of this kind was not regarded as a first priority when the Council's development plans were formulated, but it is now evident. A plan for an experimental centre in Camberwell in 1964 unfortunately had to be abandoned, as the premises it was hoped to use were no longer available.

Training and occupation at home—When the Council made proposals under the Mental Health Act two 'home teachers' were employed to give instruction and occupation to mentally handicapped persons who were prevented by an additional handicap from attending training centres; about 40 persons were visited in 1959. A third home teacher was appointed in 1960 and since the number of persons receiving teaching remains roughly the same, it has been possible to increase the amount of attention devoted to each one. The opening of the special care unit at the Bethnal Green training centre resulted in less demand for 'home teachers' for children living in north east London and the opening of further special care units should have a similar effect.

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 necessary and practicable, both directly and through 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. It also intended to participate in the provision of such psychiatric day hospitals as were considered appropriate within the limits of its statutory functions, generally by making available the services of occupational therapists and social workers.

Day rehabilitation centres—The Council's first day rehabilitation centre, Clifton Lodge, Hackney, opened in 1960 to provide for the rehabilitation of 40 persons who had been suffering from some form of mental illness with a view to their ultimate return to full community life. At first only traditional occupational therapy was available, but in 1961 a start was made on industrial work obtained through local firms and this work now forms a major part of the activity of the centre. Originally, all the persons attending were referred from the main psychiatric hospital serving the area but increasing numbers of referrals are now received from other sources. During 1964 there were 26 persons admitted to the centre and at the end of the year 34 persons were on the register.

The Castle day rehabilitation centre, the first specially built centre, opened in Southwark early in 1964 with accommodation for 30 persons. Activities are similar to those at Clifton Lodge and 81 persons have been admitted to the centre during the year. There were 27 on the register at 31 December.

Admission to the centres are made on the recommendation of the Council's consultants in mental health and after interview by the supervisor and a mental health social worker. Persons attending the centres who carry out productive work receive, after an initial probationary period, a daily payment of three shillings. Travelling expenses are refunded and meals provided at a charge of two shillings, which is abated in cases of need.

When the Council's ten-year development plan was formulated in 1962, it was proposed to open two additional day rehabilitation centres during the period 1967 to 1972. Five further such centres by 1973 were proposed when the first annual revision of the plan was carried out, so that there would be a centre of this kind within easy reach of persons living in all parts of London.

Day centres for chronic mentally ill persons—A day centre for 20 chronic mentally ill persons opened in Shoreditch in 1962, its purpose being to prevent further deterioration by providing a meeting place for patients for a few hours daily and some occupational and educational interests to relieve relatives from the care of patients and to provide an opportunity for them to discuss and receive advice on personal problems and difficulties from the Council's mental health workers. Some industrial work was carried out and after an initial probationary period persons taking part received a daily payment of two shillings.

Further centres of this type have since been opened in Camberwell (40 places), Hackney (30 places), Bethnal Green (40 places), Lewisham (14 places part-time) and Deptford (12 places part-time) ; a number of additional centres in other parts of London are in the planning stage.

Voluntary centres—Since 1949 the Institute of Social Psychiatry has provided a centre, the Blackfriars rehabilitation centre, for the rehabilitation of mentally ill persons and the Council has contributed 90 per cent of the approved cost of attendance of London residents. As there was only one centre, it was necessary for persons needing to attend on a long term basis to be treated in association with those who were recoverable, but in 1961 the Institute opened a second centre, Crossway rehabilitation centre, which was also grant aided on the same basis by the Council. This centre was adapted to cater for recoverable mentally ill persons capable of some industrial work and there is special emphasis on work routine and work tolerance with a view to their eventual rehabilitation in the community. At the Blackfriars centre, which caters for those who are more withdrawn and require long term attendance, the emphasis is on group activities and resocialisation in the group, thus encouraging them to live a fuller life outside the centre. During 1964, 70 persons resident in London were admitted to the two centres and at the end of the year there were 76 London persons on the registers.

In 1962 the Psychiatric Rehabilitation Association opened a day centre for 40 mentally ill persons in Hackney and a similar centre for 40 persons in Stepney in 1963. The Council makes a grant of 90 per cent of the approved maintenance costs of the centres.

Grants are also made to the Blackfriars Settlement in respect of the attendance of mentally ill persons at the Settlement's occupational work centre and to Trinity Church, Poplar, in respect of a centre in East India Dock Road for older persons who have been discharged from the day hospital at St. Clements hospital.

Occupation and instruction in the home—In 1961 an experiment was carried out in two health divisions, where the part-time services of occupational therapists previously employed on work with tuberculous patients were given to the home teaching and occupation of mentally ill persons. The experiment was welcomed by hospital doctors and general practitioners and has since been extended to other health divisions. By the end of 1964 the employment of occupational therapists for a total of 78 sessions a week had been authorised for this work. Simple industrial work is carried out by some home-bound persons and payments on the same basis as at day centres for chronic mentally ill persons are made to them.

Social clubs—Since 1948 the Council has contributed 90 per cent of the approved cost of attendance of London residents at the psycho-therapeutic social clubs run by the Institute of Social Psychiatry, which include a drama group and a youth club. The clubs meet on 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 clubs run by psychiatric hospitals for persons living in their catchment areas and psychiatric departments of general hospitals, to a club run by the psychiatric department of one of the London teaching hospitals (which has an average attendance of 50) and to other voluntary organisations. St. Olave's psychiatric day hospital, which is run in association with the Council's mental health staff, has its own associated social club.

The Council runs its own social clubs in Hackney (Clifton Lodge and Hindle House day centres), Shoreditch (Shoreditch day centre), Putney (Putney health centre), Stoke Newington (Woodberry Down health centre), Islington, Fulham, Lewisham, Poplar and Wandsworth. These clubs are well attended and consideration was being given at the end of the year to the establishment of further clubs of this kind in other parts of London. The present clubs cater for a maximum of 400 persons weekly.

In 1964 the Council agreed to make a grant to the Central After-Care Association towards the cost of establishing the Circle Trust Club, a club for discharged prisoners who suffer from some form of mental disorder and to the Blackfriars Settlement in respect of a social club for mentally disordered persons.

Psychiatric day hospitals—The Council co-operated with the South East Metropolitan Regional Hospital Board and the Bermondsey and Southwark and Cane Hill Hospital Management Committees in the establishment in 1960 of a psychiatric day hospital at St. Olave's hospital, Bermondsey. The Council assumed responsibility for the provision of occupational therapy for those patients attending the day hospital who would benefit from it ; this entailed the appointment of an occupational therapist and the provision of equipment and materials. In addition, the Council meets the cost of providing recreational activities for the patients, such as tennis and ballroom dancing, which are considered to be of a therapeutic nature. In view of a marked increase in the number of persons attending the day hospital a second occupational therapist was authorised in 1964. A social worker who attends the day hospital is also a member of the Council's staff.

Experience of the working of the day hospital has been very encouraging ; it has been possible to treat a wide range of physical illness and patients who have been able to travel daily from home and a number of persons who would otherwise have needed in-patient treatment have been catered for satisfactorily as day patients.

Since 1962 the Council has co-operated with the hospital services in the provision of occupational therapy and social worker services at further day hospitals set up by Bexley Hospital Management Committee, at Castlewood hospital, Woolwich ; by the Paddington Group Hospital Management Committee in Torquay House, Harrow Road, W.9, and by Westminster hospital, Vincent Square, S.W.1. Co-operation on a similar basis in respect of a fifth day hospital at the West Park and St. George's day hospital

centre, Tooting, began in 1963 and the provision of a second occupational therapist was authorised in 1964. The Council also agreed to cooperate with Tooting Bec hospital by allocating a psychiatric social worker for half time at Tooting Bec day hospital.

Social work with alcoholics—Since 1963 the Council has made a grant to the Royal London Discharged Prisoners' Aid Society, representing 90 per cent of the salary of a social worker employed on work with alcoholics, both prior to and after discharge from Wandsworth Prison.

Samaritan service—Since 1964 the Council made a grant to the St. Giles Centre (formerly Camberwell Samaritans), towards the cost of employing a psychiatric social worker to organise the social work of the centre and the training of a corps of 'Befrienders' for persons faced with social problems. A grant to the Samaritans towards the cost of services provided for persons on the verge of suicide was authorised in 1964.

Crude spirit drinking—Following a noticeable increase in crude spirit drinking in certain parts of London, particularly Stepney, Southwark and the City of London, the Council in 1963 set up a special sub-committee to consider this problem. During 1964 a large number of interested statutory and voluntary bodies were contacted and invited to give their views as to the best way of dealing with the problem and a comprehensive report by the sub-committee was submitted to the Council early in 1965.

Social work in the mental health service

The Principal Mental Health Social Worker 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. 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 come from many quarters and the number known to the service increases steadily. The community has, of course, always carried a heavy burden of mental illness but until comparatively recently the load was lightened by long term hospital care, 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 still 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.

The needs of parents of patients and relatives are various. For some a friendly visit and re-assurance that help is available is enough, others may require constant care over a long period. Visits may need to be frequent and of a length that enables social worker and patient or relative to develop a knowledgeable and friendly relationship that will be supportive whilst also, where possible, enabling a progressive independence to be established.

For cases requiring special skills, psychiatric social workers in the mental health teams are available. They are also able to offer advice and consultation to mental health social workers who seek help with their more difficult problems. Steps taken to prevent further breakdown or assist rehabilitation 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 health social worker. 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 health social workers remain in close touch with all severely subnormal children and also with 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 afford a valuable opportunity for fostering good relationships with the family and liaison with centre staff.

Closeness of contact is usually maintained by mental health social workers 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.

Hostels for the mentally disordered—Social work for the residents of the three hostels so far established by the Council is undertaken by a mental health social worker or psychiatric social worker from the division in which the hostel is situated, although contact may be maintained by a social worker from another division with certain residents needing this kind of continuing relationship.

The role of the social worker includes close co-operation with the youth employment service and child care officers in the case of subnormal girls and with employment officers, employers, psychiatric out-patient clinics and the hospitals in that of the mentally ill. The social worker must also work closely with the staff of the hostel on all that concerns the well-being of the residents, such as employment conditions, recreational activities, relationships within the group and personality difficulties. They must also play their part in helping to establish in the community those subnormal girls and mentally ill adults who are ready to go into lodgings, residential work or their own homes and arrange where necessary for their follow-up and care by the local mental health social worker or other social worker.

Day centres and social clubs—The essential, individual help that is given by social workers will release potentials that can find healthy and constructive outlets in the activities of a centre. The social worker may need to persuade the over-protective parent of the adult subnormal that there is reward for both if the subnormal is allowed to attend a centre. The parent will gain regular daily relief from the arduous task of care ; the subnormal gains from social exchange and learns to develop self-reliance and new skills. But in the case of the mentally ill, the relatives are often glad for the patient to attend a day centre, though the patient may need encouragement and persuasion to try it. Once the initial difficulties are overcome these centres are found to benefit the whole family situation.

Social clubs are also necessary and important functions in the rehabilitation of the mentally ill as they enable social workers to introduce patients into groups which help to reduce the sense of social isolation and increase the channels of communication with others.

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, outpatient 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 health social workers have actively participated in the meetings held at divisional level to which general practitioners and others were invited. During the year they 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 students attending various social work training courses, welfare officers in other fields, nurses in hospital and there has been a growing demand from training colleges and universities for student placements in the divisional teams. It can be said that the educational role of the mental health social 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

Details of the work of the mental health service during 1964 are given in the following tables, with comparative figures for 1963 in italics.

TABLE (i)—*Source of referral of all cases*

	Mentally ill				*Subnormal and severely subnormal*		*Total 1964*		*Total 1963*	
	With a view to hospital admission		*Community care*							
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Psychiatric hospital or ward ..	608	13·0	999	35·9						
Psychiatrist at general ward ..	303	6·5	80	2·9	111	9·4	2,471	28·5	*2,568*	*28·8*
Non-psychiatric referrals from hospitals	340	7·3	30	1·1						
Psychiatric out-patient clinic or day hospital	182	3·9	257	9·2	41	3·5	538	6·2	*387*	*4·4*
Non-psychiatric hospital out-patient	—	—	58	2·1						
General practitioner	1,832	39·1	295	10·6	19	1·6	2,146	24·8	*2,496*	*28·1*
Police or court	452	9·6	25	0·9	28	2·4	505	5·8	*622*	*7·0*
Patient or relative	270	5·7	253	9·1	71	6·0	594	6·9	*618*	*6·9*
Landlord or neighbour ..	156	3·3	—	—	—	—	156	1·8	*173*	*1·9*
Education officer			101	3·6	601	50·7				
Health visitor	546	11·6	49	1·8	75	6·3	2,246	26·0	*2,028*	*22·9*
National Assistance Board ..			—	—	—	—				
Miscellaneous*			636	22·8	238	20·1				
Total 1964	4,689	100·0	2,783	100·0	1,184	100·0	8,656	100·0		
Total 1963	5,543		2,155		1,194		8,892		*8,892*	*100·0*

* *Includes other departments of L.C.C., other local authorities, government departments and welfare associations.*

TABLE (ii)—*Initial action and final disposal of mentally ill persons referred to mental health social workers with a view to removal to hospital*

	Initial action				*Final disposal*			
	No.		*%*		*No.*		*%*	
Informal admission	838	(*1,017*)	17·9	(*18·3*)	2,263	(*2,596*)	48·3	(*46·8*)
Compulsory admission:								
For observation (sec. 25)	977	(*973*)	20·8	(*17·5*)	—	—	—	—
Emergency admission for observation (sec. 29)	1,583	(*1,874*)	33·8	(*33·8*)	—	—	—	—
For treatment (sec. 26)	100	(*79*)	2·1	(*1·4*)	367	(*402*)	7·8	(*7·3*)
Court order	199	(*300*)	4·2	(*5·4*)	199	(*202*)	4·2	(*3·6*)
Absent from hospital without leave (sec. 40)	9	(*2*)	0·2	(*0·0*)	9	(*9*)	0·2	(*0·2*)
Psychiatric out-patient clinic or day hospital	111	(*148*)	2·4	(*2·8*)	111	(*149*)	2·4	(*2·7*)
General ward for physical care ..	42	(*59*)	0·9	(*1·1*)	42	(*80*)	0·9	(*1·4*)
Community care from general practitioner, Welfare dept., etc.	133	(*194*)	2·8	(*3·5*)	133	(*194*)	2·8	(*3·5*)
Other cases, including no further action	694	(*897*)	14·8	(*16·2*)	1,562	(*1,191*)	33·3	(*34·5*)
Not known	3	—	0·1	—	3	—	0·1	—
	4,689	(*5,543*)	100·0	(*100·0*)	4,689	(*5,543*)	100·0	(*100·0*)

TABLE (iii)—*Hospital admissions dealt with by mental health social workers 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		*65 years and over*		*Total*		*Under 65 years*		*65 years and over*		*Total*	
	No.	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*	*No.*	*%*
Informal admission	632 (770)	21·8 (23·8)	206 (247)	34·1 (35·0)	838 (1,017)	24·0 (25·8)	1,764 (2,033)	83·6 (84·6)	499 (563)	95·8 (94·8)	2,263 (2,596)	86·0 (86·6)
Compulsory admission:												
For observation (sec. 25)	770 (743)	26·6 (23·0)	207 (230)	34·3 (32·6)	977 (973)	27·9 (24·7)	— —	— —	— —	— —	— —	— —
Emergency admission (sec. 29) ..	1,399 (1,649)	48·4 (50·9)	184 (225)	30·4 (32·0)	1,583 (1,874)	45·2 (47·5)	— —	— —	— —	— —	— —	— —
For treatment (sec. 26) ..	93 (76)	3·2 (2·3)	7 (3)	1·2 (0·4)	100 (79)	2·9 (2·0)	345 (371)	16·4 (15·4)	22 (31)	4·2 (5·2)	367 (402)	14·0 (13·4)
Total ..	2,894 (3,238)	100·0 (100·0)	604 (705)	100·0 (100·0)	3,498 (3,943)	100·0 (100·0)	2,109 (2,404)	100·0 (100·0)	521 (594)	100·0 (100·0)	2,630 (2,998)	100·0 (100·0)

TABLE (iv)—*Disposal of cases referred specifically for community care*

(*a*) *Suffering or suspected to be suffering from mental illness*

	1964		*1963*	
	No.	*%*	*No.*	*%*
Hospital care:				
Informal admission	84	3·0	*73*	*3·4*
Compulsory admission	40	1·4	*33*	*1·5*
Psychiatric out-patient clinic or day hospital ..	23	0·8	*55*	*2·6*
Community care of mental health service	2,025	72·9	*1,634*	*75·8*
Other community care, e.g., Welfare or Children's depts., general practitioner, probation officer, etc.	57	2·0	*70*	*3·2*
No further action	554	19·9	*290*	*13·5*
No. of persons involved	2,783	100·0	*2,155*	*100·0*

(*b*) *Mentally subnormal and severely subnormal*

		1964			*1963*	
		No.	*%*		*No.*	*%*
Hospital care		55	4·6		*67*	*5·7*
Community care of mental health service:						
Residential home, hostel, convent, etc. ..	42			*49*		
Attendance at training centre	61			*78*		
Receiving visits from m.h.s.w.	885	902*	76·3	*895*	*924**	*77·3*
Other types of community care	24			*24*		
Other community care, e.g., Welfare or Children's depts., general practitioner, probation officer, etc.		68	5·7		*45*	*3·8*
No further action		159	13·4		*158*	*13·2*
Miscellaneous		—	—		—	—
No. of persons involved		1,184	100·0		*1,194*	*100·0*

**Number of persons; some cases are being visited as well as receiving some other form of care.*

TABLE (v)—*Persons receiving community care at* 31.12.64

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.	279 (*230*)	52 (*42*)	4·1 (*3·3*)	102 (*92*)	2·8 (*2·4*)	154 (*134*)	3·1 (*2·6*)	433 (*364*)
Boarded out	2	4 (*5*)	0·3 (*0·4*)	56 (*60*)	1·5 (*1·6*)	60 (*65*)	1·2 (*1·3*)	62 (*68*)
Home training	27	17 (*17*)	1·3 (*1·3*)	36 (*28*)	1·0 (*0·7*)	53 (*45*)	1·0 (*0·9*)	80 (*45*)
Attendance at day centres..	350 (*218*)	—	—	—	—	—	—	350 (*218*)
Attendance at social clubs for mentally ill* ..	475 (*526*)	—	—	—	—	—	—	475 (*526*)
Training centres for subnormal and severely subnormal	—	623 (*668*)	48·9 (*52·1*)	784 (*740*)	21·2 (*19·5*)	1,407 (*1,408*)	28·4 (*27·7*)	1,407 (*1,408*)
Receiving visits from m.h.s.w. or p.s.w. ..	3,055 (*2,427*)	1,214 (*1,226*)	95·2 (*95·7*)	3,579 (*3,671*)	96·6 (*96·5*)	4,793 (*4,897*)	96·0 (*96·5*)	7,848 (*7,324*)
Other types of community care	165 (*146*)	61 (*37*)	4·8 (*2·9*)	101 (*117*)	2·7 (*3·1*)	162 (*154*)	3·2 (*3·0*)	327 (*300*)
†No. of persons involved..	3,322 (*2,664*)	1,275 (*1,281*)	—	3,706 (*3,795*)	—	4,981 (*5,076*)	—	8,303 (*7,740*)

**Some patients who are not included were attending clubs which receive financial or other help from the Council.*

†*Some persons were receiving more than one type of service.*

Pupils on day school rolls—

Type of School	*January 1965*	*January 1964*
Primary	234,982	232,242
Secondary	169,648	171,463
Nursery	2,422	2,188
Special	8,422	8,319
Hospital	271	386
Total	415,745	414,598

Medical inspection

Details of medical inspections during 1964 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 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.

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 1964 was 37·3 per cent of the school roll, compared with 37·0 per cent. in 1963 and 39·3 per cent. in 1962. It is of interest that of the 11,285 special inspections, over half were requested by head teachers, a quarter by school health visitors and one-tenth by parents.

In an experiment started during 1962, the routine examination of the seven to eight years age group was suspended in selected schools to allow more time for the examination of children considered to be in need of particular attention. This experiment has been extended to further schools throughout the county but the number of inspections is not yet sufficient to allow a full assessment of its value. Preliminary findings indicate a much greater yield of defects noted, proportionally about a third more eye defects, twice as many defects for tonsils and adenoids, speech, lungs, nervous, psychological, rheumatism and enuresis and about three times as many cervical gland defects.

During the year 3,791 pupils were interviewed or discussed at case conferences and found not to warrant a medical examination.

The total number of medical inspections (periodic and other) carried out in 1964 was 277,464.

Periodic general medical inspections

Age groups	*1962*		*1963*		*1964*	
	No.	*%*	*No.*	*%*	*No.*	*%*
4 and less	7,995	4·9	7,874	5·1	8,166	5·3
5	28,647	17·4	27,811	17·9	28,667	18·5
6	8,972	5·5	9,670	6·2	10,778	6·9
7	9,039	5·5	9,345	6·0	9,300	6·0
8	20,783	12·7	19,585	12·6	20,501	13·2
9	5,843	3·6	5,199	3·3	5,655	3·6
10	2,109	1·3	2,051	1·3	2,525	1·6
11	10,416	6·3	11,636	7·5	11,502	7·4
12	18,992	11·6	18,578	11·9	16,954	10·9
13	6,280	3·8	6,366	4·1	5,496	3·5
14	8,152	5·0	5,316	3·4	4,508	2·9
15 and over	36,828	22·4	32,072	20·7	31,221	20·2
Total	164,056	100·0	155,503	100·0	155,273	100·0

Non-routine medical inspections

	1962	1963	1964
Reinspections	73,794	71,675	72,911
Secondary school reviewals	1,994	1,637	1,497
Other non-routine inspections (see next table)	46,682	47,685	47,783
Total	122,470	120,997	122,191

Analysis of non-routine medical inspections

Nature of inspection	*Number inspected*		
	1962	1963	1964
Bathing centre inspections—scabies	23	25	24
Bathing centre inspections—other	31	31	93
Employment certificates	4,226	3,910	4,421
Licences for theatrical employment	399	419	381
School journeys	20,556	20,847	20,520
Recuperative holidays—before holiday	952	1,216	1,200
—on return	69	31	80
Candidates for higher awards	50	41	79
Nautical School entrants	159	107	104
Outward Bound and Adventure courses	183	229	167
T.B. contacts	7	25	9
Boarding schools for the delicate—			
Before departure	133	171	182
On return	38	28	35
Other handicapped pupils—			
Statutory examination	1,175	1,631	1,675
Periodic special defect examination	5,795	5,897	5,924
Research investigations and enquiries	339	384	199
	34,135	34,992	35,093
Specials, at request of:			
Head teacher—special book	1,572	1,321	1,554
—other	4,496	4,209	4,605
School nurse—after health survey	1,076	932	1,005
—other	1,819	1,899	1,867
Divisional officer (Education)	716	805	722
Divisional school care organiser or care committee	485	582	441
Parent	1,175	1,158	1,091
	11,339	10,906	11,285
All other non-routine inspections	1,208	1,787	1,405
Total	46,682	47,685	47,783

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

Age groups inspected	*For defective vision (excluding squint)*	*For other conditions*	*Total individual pupils*
4 or less	26	686	709
5	294	2,433	2,679
6	223	1,048	1,228
7	690	819	1,442
8	1,617	1,606	3,075
9	526	555	1,023
10	221	239	438
11	1,376	670	1,963
12	1,932	985	2,794
13	656	304	919
14	583	200	757
15 or over	4,219	986	5,054
	12,363	10,531	22,081

Defects noted at routine medical inspections—The percentage of children referred for treatment of a defect was 14·2 in 1964 compared with 13·4 in 1963. The comparative percentages for sex and age are shown in the following table. The percentage referred for vision defects has increased from 7·1 in 1962 to 8·0 in 1964; for other defects it has increased from 6·4 in 1963 to 6·8 in 1964. In nearly all age groups the percentages of boys and girls referred for treatment of vision defects have increased over those of last year. Vision defects are dealt with in more detail in a later paragraph.

If the figures for the percentage of children found to have defects in those age groups where the largest numbers of children were examined are compared with those for 1963, marked increases are apparent in respect of boys and girls aged 15 or over, and less marked ones in respect of boys aged 5 and 12; for 8-year-old boys there is a decrease and no appreciable change in respect of the girls aged 5, 8 and 12. For boys and girls aged 15 and over and for boys aged 12 the increases are attributable to increases in vision defects but for boys aged 5 the increase was greater in other defects. In the case of boys aged 8 the decrease was attributable solely to a decrease in vision defects.

Percentage of children noted for treatment

Age and sex		*All defects*			*Vision defects*			*Defects other than vision*		
		1962	*1963*	*1964*	*1962*	*1963*	*1964*	*1962*	*1963*	*1964*
4	Boys	8·6	9·8	9·3	0·3	0·2	0·2	8·3	9·6	9·1
	Girls	7·9	7·6	8·0	0·3	0·3	0·4	7·6	7·3	7·7
5	Boys	8·6	9·8	10·4	0·8	1·0	1·2	8·0	8·9	9·3
	Girls	7·9	8·0	8·2	0·9	1·0	0·8	7·1	7·2	7·6
6	Boys	11·3	12·4	12·6	1·6	2·2	2·3	9·8	10·6	10·8
	Girls	9·5	10·1	10·1	1·5	2·0	1·9	8·3	8·3	8·6
7	Boys	15·0	15·6	16·6	6·4	7·1	7·4	9·4	9·3	10·1
	Girls	14·1	13·4	14·4	7·4	6·7	7·4	7·5	7·4	7·5
8	Boys	13·7	16·1	15·5	7·0	8·3	7·7	7·3	8·6	8·6
	Girls	12·4	14·4	14·5	7·0	8·3	8·1	6·0	6·8	7·0
9	Boys	14·3	16·2	18·6	6·4	7·8	9·3	8·4	9·2	10·3
	Girls	14·1	15·5	17·5	7·9	8·8	9·3	7·0	7·5	9·3
10	Boys	15·4	17·4	19·0	7·0	8·6	9·0	9·3	9·4	11·2
	Girls	14·9	15·4	15·6	8·7	8·4	8·5	6·7	8·0	7·7
11	Boys	12·4	13·3	15·6	8·1	8·9	10·5	4·9	4·9	5·7
	Girls	17·2	17·9	18·5	12·1	13·0	13·4	6·0	5·5	6·0
12	Boys	14·3	14·4	15·1	9·8	9·6	10·1	5·1	5·5	5·6
	Girls	17·2	17·8	18·0	11·4	12·5	12·9	6·6	6·2	6·0
13	Boys	13·0	14·9	15·8	8·8	10·7	10·7	4·7	4·8	5·8
	Girls	17·5	18·6	17·7	11·9	13·2	13·3	6·6	6·2	5·2
14	Boys	11·7	13·7	15·9	9·0	10·8	11·7	2·9	3·5	4·6
	Girls	15·5	16·4	17·8	12·2	12·6	14·3	4·0	4·5	4·2
15 and over	Boys	11·8	12·5	13·8	9·5	10·2	11·5	2·6	2·7	2·7
	Girls	14·9	16·9	18·6	12·1	13·5	15·5	3·3	4·1	3·6
Total	Boys	12·0	13·1	13·9	6·4	6·9	7·2	6·0	6·7	7·2
	Girls	13·2	14·1	14·6	7·8	8·4	8·7	5·9	6·2	6·4
Total	Both sexes	12·6	13·6	14·2	7·1	7·6	8·0	6·0	6·5	6·8

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 total percentage referred for treatment.*

The following table shows the percentage of children of all ages noted for treatment or observation of the defects listed for the years 1961 to 1964. These percentages remain fairly stable over the period but some variations of detail will be noted.

	1961	1962	1963*	1964
Numbers examined	163,598	164,056	155,503	155,273
		Percentages		
Skin diseases	1·19	1·14	1·17	1·18
External eye diseases	0·54	0·48	0·51	0·41
Defective hearing	0·90	0·99	1·05	1·15
Otitis media	0·51	0·49	0·49	0·54
Enlarged tonsils and adenoids ..	3·59	3·72	3·65	3·57
Defective speech	0·87	0·89	0·95	1·00
Enlarged cervical glands	0·63	0·66	0·65	0·60
Heart and circulation	0·87	0·86	0·94	1·00
Lung disease (not T.B.)	1·21	1·25	1·40	1·46
Orthopaedic defects	3·52	3·31	3·39	3·00
Defects of nervous system	0·43	0·43	0·46	0·56
Psychological defects	1·08	1·06	1·44	1·42
Anaemia	0·12	0·11	0·12	0·13
Enuresis	1·77	1·96	2·28	2·41

** Details of children examined at age seven under the experimental selective arrangements have now been included in this column although omitted from the corresponding table in the Report for 1963.*

Attendance of parents and care committee representatives at periodic inspections—The percentage of medical inspections at which a parent is present decreases as children get older. The overall percentage was 50·9, slightly higher than in 1963 when it was 49·6 per cent. Care committee representatives attended 85·0 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 76 per cent. in the secondary school age groups. This was probably the result of a shortage of care committee workers in some large secondary schools.

Attendance of parents and care committee representatives

Age group	*Number of pupils inspected*	*Parent present*	*Care committee representative present at inspection*
		%	%
4 or less	8,166	93·3	80·5
5	28,667	86·7	92·7
6	10,778	78·4	94·4
7	9,300	70·9	91·8
8	20,501	69·4	94·6
9	5,655	61·7	94·0
10	2,525	52·0	92·4
11	11,502	36·2	74·9
12	16,954	29·6	79·6
13	5,496	24·0	82·7
14	4,508	9·8	81·6
15	31,221	5·0	73·1

Physical condition of pupils

The classification of pupils' physical condition at medical inspections during 1964 and the four preceding years is set out below.

	Physical condition		*Nutrition defect noted for*	
	Satisfactory	*Unsatisfactory*	*Treatment*	*Observation*
	%	%	%	%
1960	99·0	1·0	0·2	0·5
1961	99·2	0·8	0·2	0·4
1962	99·4	0·6	0·2	0·4
1963	99·4	0·6	0·2	0·4
1964	99·4	0·6	0·2	0·5

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 five years' figures are:

Percentage unsatisfactory physical condition

Year of birth	*Year of examination*				
	1960	*1961*	*1962*	*1963*	*1964*
1945	0·4	—	—	—	—
1946	0·6	0·4	—	—	—
1947	0·8	0·4	0·3	—	—
1948	0·9	0·6	0·3	0·4	—
1949	0·9	0·6	0·5	0·5	0·3
1950	2·2	0.6	0·5	0·6	0·6
1951	1·6	1·7	0·4	0·5	0·7
1952	1·1	1·5	0·9	0·5	0·6
1953	1·8	1·0	0·9	1·2	0·7
1954	1·8	1·2	0·8	0·8	1·1
1955	1·2	1·8	0·9	0·8	1·0
1956	1·0	0·7	0·8	0·8	0·5
1957	—	0·8	0·6	1·1	0·9
1958	—	—	0·8	0·7	1·0
1959	—	—	—	0·6	0·5
1960 and later ..	—	—	—	—	0·3

School meals and milk

The Department of Education and Science 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 22 September or the nearest normal school day thereto. The figures are set out below with those for 1963 in brackets.

Type of school	*Number of children present*	*Number who took school dinners*			
		On payment	*Free*	*Total*	%
Secondary	152,895	91,877	8,076	99,953	65·37
	(158,824)	*(95,347)*	*(8,010)*	*(103,357)*	*(65·08)*
Primary	207,319	121,281	15,014	136,295	67·19*
	(205,055)	*(115,640)*	*(14,098)*	*(129,738)*	*(64·22)*
Special	5,553	4,235	1,239	5,474	98·58
	(5,652)	*(4,275)*	*(1,233)*	*(5,508)*	*(97·45)*
Nursery	1,961	755	69	824	98·21†
	(1,870)	*(885)*	*(95)*	*(980)*	*(96·55)*
	367,728	218,148	24,398	242,546	66·98‡
	(371,401)	*(216,147)*	*(23,436)*	*(239,583)*	*(65·19)*

**Percentage of 202,846 children, as 4,473 children attended half time and did not have dinners.*
†Percentage of 839 children, as 1,122 children attended half time and did not have dinners.
‡Percentage of 367,505 children.

On the selected day 303,527 children in Council-maintained schools took milk compared with 300,383 in September, 1963. Of 28,974 children present in independent schools, 21,278 had milk under the scheme. The percentages for the several types of school for the corresponding days were:

	1960	*1961*	*1962*	*1963*	*1964*
Secondary.. ..	66·05	63·12	61·08	59·64	61·72
Primary	96·32	96·51	96·01	95·42	96·05
Day special ..	98·47	99·18	97·32	97·26	97·59
Nursery	98·51	98·67	97·86	96·84	97·04
Boarding	98·51	97·52	98·41	97·42	98·64
Independent ..	74·60	77·66	74·62	71·90	73·44

Vision

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

The proportion of children not already wearing spectacles who are referred for treatment does not vary much from one age group to another, 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, 0·7 per cent. were noted for treatment of squint, compared with 0·6 per cent. in 1961, 1962 and 1963. The percentage ranged from 1·4 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	87·5	6·6	4·4	4·9	0·7	0·3	0·5	0·5
7	80·1	9·7	6·5	6·5	1·3	1·0	1·4	1·6
8	81·4	8·6	5·3	5·6	1·5	1·2	2·0	2·2
9	80·0	7·9	6·7	7·0	1·8	1·6	2·0	2·5
10	82·5	5·9	6·8	7·0	1·7	1·4	1·7	2·2
11	79·3	5·7	6·5	6·7	3·7	2·4	2·4	3·8
12	79·7	5·7	6·0	6·0	3·6	2·3	2·7	4·1
13	80·3	4·7	6·4	6·1	4·0	2·5	2·1	4·6
14	78·5	4·6	6·9	6·5	4·3	2·7	3·0	5·3
15 and over	76·7	4·1	6·0	5·7	7·0	2·9	3·3	5·9
Total	80·0	6·2	5·9	5·9	3·6	2·0	2·3	3·6

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	88·8	6·3	3·4	3·8	0·7	0·3	0·5	0·4
7	79·2	10·6	6·3	6·7	1·6	1·0	1·3	1·4
8	79·8	9·5	5·6	5·8	1·9	1·4	1·8	2·4
9	78·8	8·9	2·1	7·0	1·7	1·6	1·9	2·4
10	80·6	8·1	5·4	6·3	2·1	1·4	2·4	2·4
11	75·2	7·0	6·9	7·8	4·4	3·3	3·2	5·7
12	76·2	6·0	6·8	7·5	4·6	3·1	3·3	5·4
13	76·6	6·2	7·0	8·1	4·8	2·4	3·0	5·4
14	76·4	5·5	6·0	7·6	5·4	2·6	4·1	6·7
15 and over	72·3	4·8	6·3	6·6	9·0	3·9	3·7	8·9
Total	77·3	6·9	6·0	6·6	4·6	2·5	2·7	4·9

NOTE: *The percentages of children referred for treatment differ slightly from those quoted in the defects for treatment table on page 116 in which the percentages were based on the number of children medically inspected.*

Personal hygiene

Health surveys—The number of comprehensive health surveys conducted in 1964 was six per cent. less than that conducted in 1963. There was an increase of 11 per cent. in the number of selective health surveys.

	No. examined	*No. found verminous*	*Pupils found to be verminous % of No. examined*
Comprehensive health surveys*	274,128	2,659	0·97
	(*293,770*)	(*2,401*)	(*0·82*)
Selective health surveys*	157,390	3,150	2·00
	(*141,130*)	(*2,557*)	(*1·81*)

* *1963 figures in brackets.*

The number of individual children found to be verminous at both types of survey in 1964 was 3,135, an increase of 279 over the number in 1963 and a reversal of the downward trend of recent years.

Percentage found to be verminous at health surveys

	1960	*1961*	*1962*	*1963*	*1964*
Comprehensive surveys ..	0·93	0·90	0·83	0·82	0·97
Selective surveys	1·24	1·77	1·83	1·81	2·00

The introduction in 1960 of Lorexane No. 3 shampoo throughout the county swiftly brought about a decline in the percentage of children found at comprehensive surveys to be verminous, but 1964's figure shows a sharp increase and a return to just above the 1960 level. Most of this increase was accounted for by abnormal figures in division 3; but even excluding this division the percentage for the rest of the county was 0·86, again a reversal of the trend of recent years.

Selective surveys have also indicated an increase in the percentage of infestation. These of course are concentrated on schools whose ' infestation ' record indicates a need. If the frequency and number of the selective surveys is increased (16,260 more were carried out in 1964 than in 1963) and the examinations restricted to known likely cases, it is to be expected that this percentage would increase without necessarily indicating that the incidence of infestation is greater. Excluding division 3, the percentage for the rest of the county was 1·94 for selective surveys. It should be noted that the overall trend has been for the proportion found verminous to increase at selective surveys since their introduction in 1959/60.

Nevertheless, the rise in the percentage figure for infestation found at comprehensive surveys and the increase in the number of individual children found verminous at comprehensive surveys, coupled with an increase in the number of cases treated at bathing centres, reinforce the suggestion of an increase in the number of verminous cases.

The problem is how much of the increase is due to improved case finding and how much of it is a real increase, which poses the question of the cause of any such increase. This is a matter worthy of further investigation, which it will receive.

Details of the work done under the cleansing scheme are shown below. The emphasis of the cleansing scheme as now carried out is on the children being cleansed by the parents at home, where any other verminous members of the family may, in the privacy that the home affords, also use the Lorexane No. 3 shampoo, eradicating a possible source of recurring infestation.

In about nine per cent. of the instances where children were found verminous at comprehensive and selective surveys the issue of advice alone was necessary; in about 74 per cent. a tube of Lorexane No. 3 shampoo was given. For the remaining 17 per cent. voluntary attendance at bathing centres was sought and on six occasions statutory notices were issued to enforce attendance. (93 such notices were issued in 1962.)

Cleansing scheme

	1960	*1961*	*1962*	*1963*	*1964*
Advice notice only issued	2,381	575	405	483	530
Advice notice with Lorexane No. 3	6,552	4,488	4,087	3,709	4,305
Number of pupils referred for further action	N/A	1,204	996	766	993
Pupils attending bathing centre voluntarily	1,628	735	758	617	804
Statutory cleansing notices issued	320	62	93	8	6
Pupils cleansed after service of statutory notice:					
Voluntarily	84	18	12	3	2
Compulsorily	197	37	81	5	4
Total	281	55	93	8	6

Bathing centres—The number of cases of infestation with vermin treated at bathing centres showed an increase of 29 per cent. compared with 1963 and the number of attendances for treatment a similar increase.

	1960	*1961*	*1962*	*1963*	*1964*
Scabies					
Pupils treated	637	514	458	451	534
Vermin					
Pupils treated	3,441	2,265	1,983	1,813	2,349
Treatments needed	4,345	2,764	2,422	2,242	2,905
Impetigo					
Pupils treated	1,020	1,033	903	699	675
Ringworm					
New cases	10	7	6	5	6

Employment of schoolchildren

Medical examinations were carried out divisionally of 4,421 children with a view to the issue of employment certificates and 381 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 13·0 per cent. of those inspected, only 0·2 per cent. less than that for 1963. For boys the figure fell slightly from 15·2 per cent. in 1963 to 15·1 per cent. and for girls it fell from 11·3 per cent. to 10·7 per cent. As in recent years, work involving 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	248	128
Sedentary work	12	6
Indoor work	3	—
Exposure to bad weather	108	102
Wide changes of temperature	61	144
Work in damp atmosphere	77	73
Work in dusty atmosphere	151	103
Much stooping	46	36
Work near moving machinery or moving vehicles	116	80
Prolonged standing, much walking or quick movement from place to place, work at heights	248	175
Normally acute vision	1,246	960
Normal colour vision	334	2
Normal use of hands	32	12
Work requiring freedom from damp hands and skin defects	22	27
Handling or preparation of food	51	24
Normal hearing	71	39
Any other work which would be unsuitable	28	10
Unfit for any employment	—	1

NOTE: *An individual may be noted for two or more contra-indications.*

Infectious diseases in schools

When a pupil was absent from school and the cause either known or suspected to be due to infectious disease, the head of the school notified 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 nurse/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 1964 and the preceding years are given below:

	1960	*1961*	*1962*	*1963*	*1964*
Chicken-pox	8,357	5,895	8,332	7,176	6,868
Dysentery, diarrhoea or enteritis	1,557	669	988	3,180	1,355
German measles	631	3,891	12,332	1,314	2,006
Impetigo	194	187	193	167	191
Influenza	229	127	183	140	97
Jaundice	253	493	274	106	217
Measles	2,544	14,343	2,875	6,141	4,091
Mumps	8,783	2,338	1,677	8,250	5,821
Ophthalmia and conjunctivitis	299	536	645	277	289
Ringworm (scalp)	8	10	10	18	12
Ringworm (body)	51	26	19	18	22
Scabies	76	78	59	65	66
Scarlet fever	721	634	526	548	940
Sore throat and tonsillitis	905	1,416	911	1,302	1,643
Whooping cough	1,454	395	245	879	514

Prophylaxis—The 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 68, 69 and 70.

Age group	*Number of pupils inspected*	% *vaccinated against smallpox*	% *immunised against diphtheria*	% *immunised against whooping cough*	% *vaccinated against poliomyelitis*
4 or less	8,166	80·0	90·8	89·2	84·7
5	28,667	77·6	86·7	83·8	82·2
6	10,778	74·1	81·0	76·7	77·1
7	9,300	77·0	86·0	78·6	83·5
8	20,501	75·8	89·2	80·1	85·2
9	5,655	71·5	83·0	73·2	78·3
10	2,525	69·3	71·2	59·8	69·2
11	11,502	72·6	88·7	71·9	85·0
12	16,954	69·9	88·2	64·8	82·3
13	5,496	69·0	83·6	60·2	77·9
14	4,508	69·9	81·9	53·9	75·9
15 and over	31,221	70·1	84·9	57·9	81·5

Medical treatment of schoolchildren

Treatment statistics—The number of sessions, new cases and total attendances at schoolchildren's clinics during 1964 (including sessions held in hospital premises) were as follows:

Type of clinic	*Sessions*	*New cases*	*Attendances*
Minor ailments (nurse)	13,784	39,689	275,902
Minor ailments (doctor)	1,688	15,256	
Special investigation	2,015	2,274	14,643
Dental	26,389	75,545	217,923
Vision	4,452	22,458	63,738
Orthoptic	1,660	859	5,237
Ear, nose and throat	473	1,832	4,347
Audiology	520	1,873	4,442
Rheumatism (supervisory)	79	34	567
Enuresis	125	109	695

Handicapped pupils

New assessments—During 1964 the numbers of new assessments of pupils for special educational treatment were as follows:

	Day	*Boarding*
Blind	1	3
Partially sighted	40	—
Deaf	28	1
Partially hearing	51	1
Delicate	456	237 (*a*)
E.S.N.	912	86 (*b*)
Epileptic	—	5
Maladjusted	414	225
Physically handicapped	146	10
Speech defect	1,280 (*c*)	28 (*d*)
Dual/multiple defect	—	108

(*a*) *Including seven diabetic/delicate, 22 already E.S.N., one already partially sighted and one already maladjusted.*

(*b*) *Including seven already delicate.*

(*c*) *All these children received speech therapy at clinics or in schools they already attended.*

(*d*) *Includes only one child recommended specifically for admission to boarding school for children suffering from speech defects. The other 27 children received speech therapy at clinics or in the boarding schools they already attended.*

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Special educational provision—At the end of 1964 special educational treatment was being provided for almost 13,000 pupils (London and out-county). The following table shows the main categories of handicap and numbers of pupils receiving full-time special education:

	Day special schools			*Council boarding special schools*			*L.C.C. pupils in non-Council boarding schools, hostels and foster homes*	*Council's hospital schools and groups*			*Special classes, etc.*
	London County Council pupils	*Out-county pupils*	*Total*	*London County Council pupils*	*Out-county pupils*	*Total*		*London County Council pupils*	*Out-county pupils*	*Total*	
Blind	—	—	—	60	48	108	30	—	—	—	—
Partially sighted	235	158	393	—	—	—	9	—	—	—	—
Deaf	172	35	207	—	—	—	68	—	—	—	—
Partially hearing	146	16	162	31(*a*)	41(*a*)	72(*a*)	28	—	—	—	—
Physically handicapped..	806	67	873	80	34	114	77	207	163	370	—
Delicate ..	1,343	55	1,398	154	12	166	108	—	—	—	—
Educationally Subnormal ..	3,640	60	3,700	616	13	629	152	—	—	—	—
Epileptic (*b*) ..	—	—	—	—	—	—	26	—	—	—	—
Diabetic ..	—	—	—	12	29	41	5	—	—	—	—
Maladjusted ..	269	8	277	379	10	389	373	46	44	90	467(*c*)
Speech defect ..	—	—	—	—	—	—	4	—	—	—	2,623(*d*)
Dual/multiple defect.. ..	—	—	—	19	10	29	—	—	—	—	—
	6,611	399	7,010	1,351	197	1,548	880	253	207	460	3,090

(*a*)*Partially hearing with additional handicap.*

(*b*)*A number of epileptic children (apart from those in ordinary schools) are placed in schools for the delicate, physically handicapped or educationally subnormal.*

(*c*)*These day school children (nearly all L.C.C. pupils) attend only part-time at the special classes.*

(*d*)*Includes 914 pupils in day and boarding special schools.*

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 considered unsuitable for education at school, the review of cases previously so reported 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:

	1960	*1961*	*1962*	*1963*	*1964*
Children not in any school	84	100	133	97	141
Children in ordinary schools	—	3	3	5	4
Children in special schools	57	68	72	60	49
Children receiving home tuition under section 56 of the Education Act, 1944	—	1	—	—	—
	141	172	208	162	194

Section 57A—Review of cases:

	1961	*1962*	*1963*	*1964*
Number reviewed	20	27	20	28
Still considered unsuitable for education at school	16	19	13	21
Cancellation of report	4	8	7	7

Routine audiometer testing—The numbers of children given ' rapid-sweep ' audiometer tests during 1964 are as follows:

Pupils given screening tests	59,052
Pupils failing screening tests and given pure tone tests	4,481
Pupils failing pure tone tests and referred to otologists	1,720

Speech therapy—By the end of the year 310 sessions a week were being held, 148 in 54 clinics and 162 in special schools. During the year 1,314 pupils were assessed as requiring speech therapy (including two recommendations for boarding schools), 618 were discharged from treatment and 289 ceased to attend. The number of pupils under treatment at the end of the year was 2,592 and 327 were on the waiting list.

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

	No. of patients	
	1963	*1964*
At 31 December		
On waiting list:		
(*a*) awaiting first interview	207	222
(*b*) interviewed and awaiting treatment	85	94
In attendance:		
(*a*) active..	415	422
(*b*) under review*	376	429
During year		
Applications received	988	1,156
Applications withdrawn	266	335
Cases closed	819	737

** 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 '.*

Student health service

The student health service continued to function during 1964 at the London College of Fashion (formerly Barrett Street Technical College), Westminster Technical College and Brixton Day College where the service was extended to include students from the Brixton School of Building.

At the City of Westminster College the demand for the service was not sufficient to justify its continuance and a medical advisory service was introduced instead.

It was decided to bring the London College of Printing into the scheme as soon as practicable.

DENTAL SERVICES

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

To give dental treatment to young patients, to overcome their dislike and fear and to gain the respect and confidence of parents, requires professional skill of a high order as well as great personal patience and integrity.

In this, my final annual report, I would like to place on record my personal thanks to and appreciation of those members of my profession who have helped to sustain—particularly through the past few difficult years and health service changes—the Council's dental services at a high standard of personal service.

School dental service

During 1964 increasing numbers of parents declared their intention to make private arrangements for the care of their children's health; intending in most cases, no doubt, to make demands on National Health Service dentists as well as on National Health Service doctors. A slight increase in dental sessions was necessitated by an expansion and intensification throughout the year of the revisional treatment introduced in 1962 for patients who had completed a course of treatment. This of itself is an improvement in the quality of dental care now given to children who attend the Council's dental surgeries with regularity, but must, of course, result in smaller numbers of children being treated per dentist.

TABLE (i)—*Staff and sessions*

	1960	*1961*	*1962*	*1963*	*1964*
Dental officers					
Number employed (i) full-time	36½*	36½*	33½*	32½*	33½*
(ii) part-time	84	72	68	65	64
Total	120½	108½	101½	97½	97½
Full-time equivalent					
(i) School service	64·6	60·9	58·9	56·4	57·5
(ii) M & CW service	4·9	4·8	4·8	4·6	4·6
Total	69·5	65·7	63·7	61	62
Establishment (temporary)	95	95	95	95	95
Weekly sessions					
School service					
(i) by full-time dental officers	373	361	338	326	342
(ii) by part-time dental officers	337½	308½	300½	292½	289½
Total	710½	669½	638½	618½	631½
M & CW service					
(i) by full-time dental officers	31	32	34	30	32
(ii) by part-time dental officers	22½	20½	18½	19½	19½
Total	53½	52½	52½	49½	51½
Grand Total	764	722	691	668	683

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

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

	1960	*1961*	*1962*	*1963*	*1964*
Number of inspection sessions held at schools ..	2,473	2,514	2,092	1,773	1,758
Number of children inspected at schools by dental officers	244,630	246,803	212,597	194,886	202,814
Number found to require treatment	165,439	161,277	137,853	127,308	129,599
Percentage requiring treatment	67·6%	65·3%	64·8%	65·3%	63·9%
Additional number inspected at centres	23,229	19,778	17,580	16,063	14,987
Total number found to require treatment ..	188,668	181,055	155,433	143,371	144,586
Total cases treated	77,781	69,470	66,558	75,027	75,834
Attendances	256,983	237,411	220,639	226,651	224,826
Ordinary treatment sessions	29,006	28,060	26,638	25,747	*25,838
General anaesthetic sessions	1,049	922	699	628	551
Temporary teeth extracted	42,343	35,286	29,147	27,866	26,432
Permanent teeth extracted	14,467	11,072	8,947	7,525	6,757
Temporary teeth restored by fillings	38,164	37,533	40,091	42,705	47,125
Permanent teeth restored by fillings	109,586	100,755	89,130	85,718	84,999
Fillings in temporary teeth	40,996	40,350	43,935	46,143	51,453
Fillings in permanent teeth	124,821	115,294	101,534	96,676	96,271
Other operations:					
temporary teeth	43,889	38,682	40,493	42,325	43,889
permanent teeth	63,835	57,641	51,009	53,513	53,977
General anaesthetics	21,753	18,101	14,125	12,293	10,814
Cases for whom immediate treatment was completed	8,407	5,317	4,364	4,099	4,336
Cases discharged as dentally fit	50,584	45,003	40,011	45,758	48,478

**For 1,274 of these sessions certain dental officers were also supervising the work of dental auxiliaries.*

From inspections in the schools and observations in the surgeries, there is no doubt that a very considerable amount of treatment is now being obtained for schoolchildren from sources other than the school dental service. A study of ' acceptance ' and ' dentally fit ' figures would indicate that approximately 50 per cent. of schoolchildren obtain dental treatment within any 12 months. Only half the school population attending for such treatment in a year does not necessarily imply neglect of/by the absentee half; many of them will have attended in preceding months or will attend later, while of those co-operating in a current year not all will continue to do so in a succeeding year. The one-time familiar figure of total dental neglect is now very seldom seen. Parents are no longer ignorant of the advisability of ensuring that their children have a regular dental ' check-up '; nevertheless procrastination and deliberate avoidance are still too commonplace.

Tables (i) and (ii) show fluctuations and afford comparison with previous years and also show that there is little difference in results from the preceding year. Reflections of the better standard of dentistry in the Council's treatment centres can be seen in table (iii) where the ratio of fillings in permanent teeth to extractions has reached the highest point recorded (12·5:1) and table (ii) shows a continuing decline in the number of sessions devoted to ' gas extractions '—from approximately 1,000 in 1960 to half that number in 1964. Attendances on average at the sessions held were also reduced, indicating that need for destructive treatment is declining.

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

1955	7·39
1956	6·50
1957	6·41
1958	6·34
1959	7·41
1960	7·57
1961	9·10
1962	9·96
1963	11·39
1964	12·58

EXPERIMENTAL PROCEDURES IN DIVISIONS 1 & 9

These experiments, aimed at estimating, *inter alia*, parental co-operation and commented upon in my reports of the past two years, were finalised and results analysed towards the end of 1964. As these experiments aimed at a revolution in methods of screening the school population to meet dental facilities which have changed through out the land, I feel justified in reporting procedures and results rather extensively.

In May, 1961, approval was given to institute, in divisions 1 and 9, a trial scheme whereby routine dental inspections in schools would be suspended; parents of schoolchildren were to be advised by letter to obtain a dental ' check-up ' for their children at least annually and invited to make use of the school dental service *OR* to make their own arrangements (in most cases possibly through the National Health Service). Reports were to be furnished after an experimental period indicating, *inter alia*, the degree of apathy among parents. The scheme was introduced at the beginning of the summer term 1962, following discussion with the London Executive Council and the London Local Dental Committee. The main object of the experiment was to make a positive contribution to the preservation of healthy mouths by encouraging regular visits to dentists and, where necessary, early conservative treatment, bearing in mind the shortage of dental manpower. It was hoped that the Council's dental resources could, under these arrangements, be utilised to the best advantage, since the dental time saved from school inspections would be available for treatment. Abortive work in making dental appointments for children whose parents did not desire the Council's facilities would be avoided and there would be less interruption of school activities. At dental inspections in schools a large number of children are repeatedly inspected who are patients of National Health Service, or other practitioners, and normally attend those dentists—they do not intend, generally speaking, to make use of the school dental service.

Routine dental inspections in the schools in the two divisions were suspended and a letter was distributed, through the school organisation, at annual intervals to the parents of every pupil. The letter reminded parents, in the interests of their child's well-being, that at least an annual check of a developing mouth by a dentist was highly desirable; that regular and systematic checks could detect at an early stage defects that might arise and that any treatment subsequently found necessary would have a better chance of proving successful. Parents were asked to return a slip to the school stating whether they (a) wished the child to have a dental check at a Council surgery or (b) intended to make private arrangements; school teachers were asked to see that forms were returned by the parents.

A basic feature of the new scheme was the fact that it brought many children within the orbit of dental care *before* dental defects developed and some children before the defects had become extensive or severe; whereas under the old scheme of routine inspections in schools children were not classified and called for treatment unless and until they *had* defects. We have long had preventive medicine but still need to advance in preventive dentistry. This scheme is a real step in that direction.

When a dental check at one of the Council's centres was requested an appointment was made at which full inspection could be carried out and any necessary treatment commenced. Where the name and address of a general dental practitioner was given, the dentist—with the agreement of the London Executive Council and the London Local Dental Committee—was informed. It was hoped that the general dental practitioner selected by the parent would take any initiative necessary to ensure that the child was offered dental care if not presented at an early date by the parent. In many cases the child was already a patient in the care of the practitioner.

The statistical results from both divisions 1 and 9 show no significant variation and I consider that the lessons learned should be applied to the whole of London and give a reasonable basis on which the need for dental provision for London schoolchildren can be assessed. Of the parents asked to express a choice 95 per cent. did so. Of these, 35 per cent. indicated that they wished to use the school dental service, but in actual fact only

about one half of these parents actually responded to appointments to attend. It appears therefore, that some 20 per cent. of London schoolchildren will, at the present stage of developments, avail themselves of the school dental service; this would seem to indicate that on the basis of the present school population of 414,598 the school dental service may expect to be asked to provide attention for some 83,000 children.

With regard to the remaining 65 per cent. of the parents—i.e. those who replied stating that they would be making their own arrangements for their children's dental care—it was not, of course, so easy to obtain so exact a picture of the proportion of these children who actually attended for treatment, as not all general dental service practitioners were prepared to co-operate and not all parents actually named a dentist. The picture does emerge however, from the cross-section samples obtained from the London Executive Council, of some 50 per cent. of attendances. It is interesting to note that the failure rate was similar to that for the school dental service.

This common failure rate of around 50 per cent. both of those who nominated a National Health Service dentist and of those who chose the school dental service—is disturbing but can hardly be unexpected as dental treatment is seldom regarded with enthusiasm. It must be stressed that these figures reflect the position at one given time, that a follow-up service operates for non-attenders and that parents who do not send their children for treatment one year may do so the next. It must also be remembered that pain acts as a spur to attendance for treatment and that children so attending will receive not only treatment for the immediate emergency but also be offered such other treatment as may be found necessary. It can be accepted in fact that, one way or another, the great majority of schoolchildren in London do receive relatively frequent dental treatment during their school life, though not necessarily as often as is desirable.

During 1964 officers of the Department of Education and Science and of the Ministry of Health were consulted informally about the scheme and expressed great interest (as did the Estimates Committee of the House of Commons on the Dental Services in 1962). They pointed out, however, that there remains a statutory duty to inspect the mouths of children at schools and suggested that this might be met in a manner acceptable to all by continuing at least one school dental inspection during school life. They thought that this could be carried out with greatest benefit on school entrants and this is particularly valid because this is the one dental inspection which parents are most likely to attend. This would therefore afford the best opportunity to impress on parents the importance of regular attendance for care by a dental practitioner and the various ways in which professional dental services can be obtained.

In September 1964 a report on the above lines was submitted to the relevant Committees carrying the following recommendations:

(a) All children should have a dental inspection at five years of age or as soon as possible thereafter, and all parents should then be informed of the Council's arrangements for dental care and their responsibilities for their children's dental health.

(b) Each year parents to be reminded of the need for an annual dental check and asked whether they wish their children to have this at one of the Council's surgeries or by a National Health Service dentist.

(c) A follow-up of any children found at routine medical or hygiene inspections to be in need of dental treatment.

The recommendations were approved.

Further support for the scheme was forthcoming when the developments were reported to the Central Consultative Committee of Headmasters and Headmistresses and to the Standing Joint Advisory Committee of Teachers and Officers. The London Executive Council and the London Local Dental Committee were also furnished with a copy of the official report on the scheme and were officially thanked for their co-operation in the experiment.

Under the London Government Act, 1963 responsibility for the school dental service will pass to the Inner London Education Authority on 1 April 1965. Full information on this new method of screening the school population for dental treatment purposes was passed to this new authority, in anticipation that the method will come into use generally throughout the Inner London area. The I.L.E.A. expressed the intention to implement the method as from 1 April 1965.

Orthodontics

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

	1960	*1961*	*1962*	*1963*	*1964*
Number of special orthodontic sessions ..	237	254	422	422	411
Number accepted at special orthodontic sessions	152	171	275	257	282
Number accepted at routine sessions ..	401	470	227	251	232
Number referred to hospitals	154	154	237	186	202
Total number of patients accepted or referred	707	795	739	694	716

In the special field of orthodontics there was little change in results. The gross malocclusions which were relatively common in the earlier years of the school dental service are now seldom seen and, with a slower flow of patients through the surgeries, dental officers have now an opportunity to treat at least some of the more simple cases that still appear. I would like once again to acknowledge the excellent assistance given in the production of appliances by the staff of the Central Dental Laboratory.

Maternity and child welfare dental service

As in the case of schoolchildren, the drift towards the use of facilities available in the national dental services continued. Expectant and nursing mothers (like their children) are not charged for their treatment by general dental practitioners and, in the main, seem to prefer private arrangements for their treatment. Table (v) shows numerical fluctuations in the Council's dental service in 1964, when the principle agreed with the Ministry of Health some years ago continued to be applied, viz.: that approximately 10 per cent. of the Council's dental efforts should be specifically directed to the dental service for maternity and child welfare patients.

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

	1960	*1961*	*1962*	*1963*	*1964*
Number of sessions	2,592	2,300	1,908	1,838	1,739
Number of appointments offered	27,368	23,864	19,158	17,728	15,411
Attendances—by appointment	19,651	16,500	12,958	11,893	10,437
—other	1,060	894	553	422	322
Silver nitrate treatment	5,858	5,718	4,141	4,206	2,588
Fillings	8,716	7,399	5,976	5,411	5,449
Extractions	4,513	3,624	2,619	1,588	1,301
Dentures supplied—new full	351	327	151	91	89
—new partial	468	485	240	231	134
Number made dentally fit	4,165	3,255	2,507	2,234	2,185

TABLE (vi)—*Breakdown of table* (v) *separating nursing or expectant mothers from children under five*—1964

	Total	*Nursing or expectant mothers*	*Children (under 5)*
Number of sessions	1,739	—	—
Number of appointments	15,411	7,814	7,597
Attendances—by appointment	10,437	5,069	5,368
—other	322	103	219
Silver nitrate treatment	2,588	337	2,251
Fillings	5,449	2,682	2,767
Extractions	1,301	863	438
Dentures supplied—new full	89	89	—
—new partial ..	134	134	—
Number made dentally fit	2,185	665	1,520

Residential homes and schools

Treatment for children at residential establishments continued to be erratic and not altogether satisfactory at all establishments. Visiting dental officers were not easily recruited and the contracted services of local practitioners produced transport and other difficulties not always capable of satisfactory solution. At most schools local general dental practitioners undertook treatments and were paid N.H.S. standard fees by the Council.

Dental auxiliary experiment

Participation in the national experiment in the use of dental auxiliaries continued, but resignations and replacements of staff clouded results. Towards the end of the year two of the five girls employed in the Council's services were re-deployed to work in the two Council surgeries at New Cross School for Dental Auxiliaries, as their full employment in normal Council surgeries could not be maintained, and one girl resigned.

STAFF

Some account is given below of the problems and development of staff and establishment matters since 1948.

During 1948 there were many staffing problems arising from the large changes in the health services. During the first six months, in addition to carrying on the normal administration of the hospital service, detailed arrangements were made for handing over nearly 100 hospitals to the new Hospital Boards and a considerable number of staff experienced in hospital administration were sent to the Boards to assist in the heavy task of preparation. Concurrently, arrangements were made for taking over the personal health services transferred from the metropolitan borough councils and for the general assumption by the Council on 5 July 1948 of powers and duties under the National Health Service Act, 1946. This creation of the nucleus of a new department within the framework of one that was to end was achieved without the employment of additional staff.

It was realised at the outset that efforts should be directed towards co-ordination of the services which the Council had taken over and those for which the metropolitan borough councils continued to be responsible, viz. environmental health. A scheme was adopted in October 1948 for the use of the services of borough medical officers of health as administrative medical officers in the personal health services and as a corollary certain of the Council's medical staff were seconded for part of their time to act as borough medical officers of health and deputy medical officers of health. These arrangements were maintained and extended during the ensuing years as opportunity offered; in addition some borough medical officers undertook clinic duties in the Council's establishments.

Nearly 5,000 staff in many different grades were taken over from the boroughs and the major task of assimilating most of these staff on to appropriate scales of pay and conditions of service was progressively achieved in the ensuing three years. In some services, notably health visiting and dental, there was significant under-manning and central recruitment for a number of grades was introduced to ensure allocation of new entrants to areas experiencing severe staff shortages. Reference is made later to the development of staff training.

By the end of 1950 the general shortage of qualified nursing staff was acutely felt in welfare homes and residential nurseries and schools; despite earnest efforts to improve recruitment complete stability was unfortunately never achieved. Also by this time the appreciable yearly wastage of health visitors largely made good by the induction of newly-trained staff, under arrangements sponsored by the Council, emerged as the pattern for the years ahead. The introduction in 1951 of the new grade of clinic nurse relieved health visitors of certain clinic duties, enabling them to devote more time to district work. In the dental service the first pay recommendations of the Dental Whitley Council were not made until 1950. Although further pay awards were made subsequently, the shortage of dental officers persisted for some years; unlike the position in most nursing grades, however, and due in part to the decrease in demand for the service, the shortage became much less acute.

Assimilation of the transferred services and staff was completed by 1952 and the steady development of services in the next three years produced no staff changes of any magnitude. The general upward trend of salary and wage levels was followed in varying degrees amongst the department's staff. Some new grades appeared, notably those of night help and child help, which were introduced as an extension of the home help service, in connection with schemes for the care in the home at night of the aged and chronic sick and the care of children temporarily deprived of their parents.

A comprehensive review of the work, organisation and staffing of the department was completed in 1955. This review, started in 1953, of the third largest department of the Council with 7,500 staff and a salary and wages bill at that time of £3,500,000 a year was

a formidable undertaking. The Reviewing Committee found no need for radical changes in the staffing structure, although some changes in numbers and gradings as well as detailed improvements in methods and procedures were recommended. The original decision to permit the largest practical measures of decentralisation of services by dividing London into nine divisions—about 80 per cent. of the staff worked in services locally controlled—was found to be sound.

During the next five years, Ministerial Working Parties published reports which, although full achievement of their aims has not as yet been realised, have profoundly affected the approach to staff training and deployment in several vital sections of the Council's Public Health department. In 1956 the report of the Jameson Committee on the existing and future functions of the health visiting service was published. The Committee's recommendations envisaged that the field work of the health visitor would include health teaching and social advice for the whole family and have an important place in mental hygiene and the care of the elderly. To fit the health visitor for her enlarged role, revised training arrangements were proposed which were eventually instituted by the Health Visiting and Social Work (Training) Act, 1962. In the light of the Committee's advice on remuneration, a national pay award in 1957 secured a significant salary increase for health visitors. The Jameson Report was followed by the publication in 1959 of the report of the Younghusband Committee on the field of work, recruitment and training of social workers. This Committee recognised the serious deficiency of social workers of all kinds and among their proposals for stimulating recruitment were measures for improved training facilities and better career prospects. Although no specific proposals were made, negotiation of new salaries was recommended. The Council already had a coherent staffing structure for its social workers based on grades reflecting various levels of responsibility and no fundamental change in its own structure was considered necessary. Even so, the Committee's general recommendations, notably those on training, had a marked effect on the work of the department's staff division.

In 1960 new staffing arrangements were introduced to meet proposals for the reorganisation and development of the department's mental health work in the light of the Mental Health Act, 1959. This reorganisation involved the decentralisation of existing services to the nine health divisions, in each of which a mental health social worker team was set up under the leadership of a divisional mental welfare officer. Central co-ordination and supervision of mental health social work were provided for in the appointment of a principal mental welfare officer. Three years later a comprehensive review of the mental health services by the O. & M. branch of the Clerk of the Council's department resulted in revised salaries and a substantial increase in staffing for statutory and community care work. There was considerable difficulty, however, in recruiting experienced staff to fill the additional positions and in spite of intensive advertising there were still vacancies in 1965.

The last and by far the most important event affecting the work of the central staff division and the divisional staff sections was the passing of the London Government Act, 1963 under which the department's services fell to be transferred to 15 new authorities, 12 Inner London boroughs and the City of London, the Inner London Education Authority and the Greater London Council. By 1965 the total staff had increased by more than 1,000 to well over 8,000 and the exacting task of arranging for their transfer to the new authorities in accordance with the Act and the regulations issued under it and bearing at the same time the normal load of staff work was accomplished without additional staff. It is not possible in this brief summary of the department's staff work to detail the processes of the staff transfer arrangements which were, of course, intimately related to the transfer of the various services. Over a period of 18 months, the transfer arrangements were planned, developed and kept under constant review by senior officers. In the final phase, as the momentum of transfer work gathered, staff at different levels were increasingly occupied with the work and despite their feelings of uncertainty about their own future this massive task was well done.

Finally, reference should be made to the department's relations with trade unions and staff organisations. It was the Council's policy to encourage all members of its staff to belong to their appropriate trade union or staff organisation; necessarily there were frequent consultations and negotiations with the various associations concerned on pay and conditions for the department's many grades of staff and on matters affecting the interests of individuals. Relations remained cordial throughout and in all the considerable activity in this field in the 16 years from 1948 official disputes were rare. Local problems affecting day nursery staff and dental surgery assistants were discussed by joint consultative committees and senior officers of the department represented the Council on the management sides of Medical and Dental Whitley Councils, the Nurses and Midwives Whitley Council and the Professional and Technical Councils 'A' and 'B' of the Health Service.

The following statement shows the number of staff employed in the department at the end of 1964 (part-time staff are expressed as whole-time equivalents). The principal officers of the department at that date are shown in Appendix A.

Types of staff	*Location*			*Total*
	Central office	*Divisional offices and establishments (a)*	*Other establishments (b)*	
Administrative and clerical (including ambulance control clerks)	262	671	78	1,011
Medical officers (*c*)	27	163	—	190
Dental officers	3	62	—	65
Scientific branch staff	59	—	23	82
Inspectors	16	—	—	16
Medical auxiliaries (*d*)	36	186	15	237
Social worker grades (*e*)	33	413	26	472
Nursing and midwifery staff	11	1,783	265	2,059
Ambulance service operational staff ..	—	—	856	856
Manual workers, home helps, domestic grades, telephonists, etc.	17	3,295	17	3,329
Totals	464	6,573	1,280	8,317

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

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

(*c*) *There are 125 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 health social workers, welfare officers (chest clinics), social workers (health services), etc., and workers in allied fields (e.g. home help organisers).*

Appointments and retirements—Dr. J. A. Scott, Medical Officer of Health and Principal School Medical Officer retired on 8 August. He was succeeded by his deputy, Dr. A. B. Stewart, who was appointed Medical Officer of Health and Principal School Medical Officer on 11 November.

Dr. B. E. A. Sharpe, Divisional Medical Officer, Division 1, retired on 17 August and Dr. E. M. Cran was appointed acting Divisional Medical Officer.

Mr. F. A. Richardson, Officer-in-Charge, London Ambulance Service, retired on 31 July and was succeeded by Mr. N. A. Woodruff (formerly assistant Officer-in-Charge) in an acting capacity. Mr. L. J. J. Clark, Divisional Administrative Officer, Division 2, replaced Mr. Woodruff and was succeeded in Division 2 by Mr. D. A. Collins.

Staff training

There was full recognition by the department of the importance of a comprehensive and adaptable programme of staff training which resulted in a steady expansion in the volume and variety of the facilities provided.

With, as its main objective, improved recruitment in the grade of health visitor, the department from 1948 appointed each year a number of student health visitors and arranged for their attendance at courses of instruction leading to the health visitors' certificate. By 1964 the annual number of such students had risen to 75, the majority being trained on a special course provided by the London University Institute of Education, in association with the Council. Over 600 students have qualified in this way, of whom nearly one half were still serving with the Council as health visitors or in higher positions. Without this scheme the department would have been unable to maintain an adequate health visiting service in London.

The training of nursery students in day nurseries, started by the metropolitan borough councils before 1948, was fostered; by the end of 1964 over 1,500 students had successfully completed the two-year course and obtained the certificate of the National Nursery Examination Board. There were then 46 day nurseries providing practical training for nursery students with the approval of the Ministry of Health.

The department welcomed the lead given in 1959 by the Younghusband Committee towards improved facilities for the training of social workers. The annual number sent to full-time courses arranged by universities and professional bodies increased until in the autumn of 1964 ten social workers in the department, nine of them employed in the mental health service, were embarked on one- and two-year full-time courses besides those attending a part-time course. In addition, by that time the annual number of supervisory staff of training centres for the mentally subnormal who were taking one-year full-time diploma courses had risen to six.

Regular refresher training, on the basis of courses of one to two weeks' duration every five years for medical, health visiting, school nursing and midwifery staff was provided through professional bodies to keep the staff abreast of current professional thought and practice. In other instances, specific training needs were effectively and economically met by ' in-service ' courses arranged by the department. In this way specialised training was provided for many categories of staff, notably medical and nursing.

Food handlers

Since 1953 it has been the practice to arrange for employees of the School Meals and Catering, Education, Children's and Welfare departments who handle food to have appropriate bacteriological examination before returning to work after suffering from illnesses which might give rise to food-borne infection. Staff who have been in contact with such illnesses in their own homes are similarly scrutinised. The numbers of staff referred for investigation during recent years are set out below.

	1960	*1961*	*1962*	*1963*	*1964*
Contacts	205	118	114	212	147
Ill	419	307	375	553	395
Allowed to resume work after examination or fixed period of exclusion	578	406	444	728	508
Resigned, retired or died	23	16	28	28	25
Excluded from work and referred to own doctor for treatment	23	3	17	9	9

The nine cases referred to their doctor in 1964 had been found to have the following micro-organisms:

Condition	*Organism isolated*
Discharging ears	*Staphylococcus aureus*
Enteritis	*Shigella sonnei*
Enteritis	*Salmonella typhi*
Vomiting	*Salmonella tenessee*
Scarlet fever contact (4)	*Haemolytic streptococcus*
Dysentery contact	*Shigella sonnei*

Staff medical examinations

The number of staff medically examined on entry to the service or following prolonged sickness has increased considerably in the past 15 years, the greatest change being, of course, in the larger number of recruits to the service. Medical examinations reached a total of 13,832 in 1964 compared with 5,768 in 1953. Another significant change has been the casualties (i.e., staff requiring treatment whilst on duty), which have risen to over three times the 318 treated in 1953. Details for the past four years are set out below.

Medical examination of staff—

	1961	*1962*	*1963*	*1964*
Number of medical examinations	14,410	14,265	14,186	16,284
Number of recommendations without medical examination	1,384	1,111	1,138	1,200
Number of follow-ups (i.e. usually hospital or specialist reports)	5,292	5,541	5,120	4,749
Number of medical examinations carried out for other authorities	135	125	148	185
Total	21,221	21,042	20,592	22,418
Reason for medical examination (persons)				
Candidates for employment	11,388	11,536	11,853	13,832
Following prolonged sick leave	2,993	3,010	3,356	3,035
Following accident on duty	541	470	375	439
Fitness for duty (e.g. approaching confinement leave, special duties)	570	659	422	511
Eligibility for spouse pension	86	80	89	120
Total	15,578	15,755	16,095	17,937
Candidates examined for the Council by other authorities	72	104	157	94
Staff casualties dealt with in the medical inspection rooms at County Hall	863	1,058	1,017	967

Making of charges and assessments—Some of the services provided by the local health authority under the National Health Service Act, 1946 must be free of charge (as are general medical services and hospital treatment) but the health authority may, with the approval of the Minister, make and recover reasonable charges for services and articles provided under sections 22, 28 and 29 having regard to the means of the persons availing themselves of the services. The Minister, in approving the making of charges under these sections, prescribed in Circular 100/48 that the charge should not exceed the actual cost to the authority of providing the service and that the charge should be reasonable having regard to the means of the persons concerned.

Section 6 of the Mental Health Act, 1959 permits local health authorities to provide, *inter alia*, residential accommodation for persons suffering from a mental disorder and, with respect to charges, applies section 28 of the National Health Service Act, 1946.

When the principal Act came into force in July 1948, the Council fixed charges for services and scales of assessment for abating the charge where the person responsible for payment was unable to meet it in full. These charges and scales followed closely the national recommendations of the County Council's Association and associated bodies. The scales have been reviewed from time to time to conform with changes in National Assistance scales of grants and amendments have also been made when experience has shown them to be appropriate, e.g. having regard to increased costs of the services and in incomes.

At present, voluntary organisations providing similar services (such as day nurseries) for which they are grant-aided by the London County Council are required, as one of the conditions of assistance, to conform to the Council's scales and assessment procedures.

Charges are made in accordance with the scales approved by the Council. There are in effect five assessment scales:

Scale A—for services which are small in cost or needed at irregular intervals.

Scale B—which is applied for services of a more continuous nature.

Scale C—for ascertaining charges payable in respect of residential care provided for the mentally disordered (other than short-term care for the mentally subnormal).

Day nursery service—special scale.

Home help service—special scale.

Expenditure:

Capital—The total capital expenditure on the health services for the period from 5 July 1948 to 31 March 1964 was £1,917,761. That for the year ended 31 March 1964 was as follows:

	£
Ambulance stations—acquisitions, erection and adaptation ..	13,825
Day nurseries—extension of premises	4,949
Maternity and child welfare centres—acquisition and erection ..	53,369
Mental health hostels and training centres—acquisition, erection and equipment	145,019
	£217,162

Maintenance—The gross cost of the various health services in 1949/50 was £4,167,204 and the contributions recovered from recipients of the services amounted to £206,136. Comparative figures for the year 1963/64 are given below:

Service	*Cost* £	*Amount recovered in contributions* £
Ambulance	1,549,199	—
Day nurseries	1,219,099	146,274
Domiciliary midwifery	328,192	—
Foot clinics	136,172	12,316
General health (including health education)	65,121	—
Health centres	46,510	—
Health visiting	498,093	—
Home nursing	694,378	—
Home help	1,596,587	76,099
Maternity and child welfare	1,085,350	118,004
Mental health	700,451	36,696
Prevention of illness, including care and after-care of tuberculosis	454,608	27,510
School health	1,195,320	—
Vaccination and immunisation	180,429	—
	9,749,509	416,899

Whilst to some extent the increase in expenditure over the years can be attributed to the general rise in the cost of staff and services there were many expansions of services, of which three prime examples are shown:

Service	*Cost 1949/50* £	*Cost 1963/64* £
Ambulance	506,946	1,549,199
Mental health	122,926	700,451
Home help	340,008	1,596,587

VISITORS TO THE DEPARTMENT

During the year 419 visitors were received through the central office—of whom 182 came from overseas. As in past years many visits were arranged at the request of authoritative bodies, amongst which were the Ministry of Health, the British Council, the Central Office of Information, the Women's Council and several foreign embassies.

Individual overseas visitors included H.R.H. Princess Himalaya Bir Bikram Shah Deva, sister of the King of Nepal; the Chairman of the Municipal Corporation of Karachi; the Director of the Maternity and Child Welfare Service and the Director of Commission of Public Health, Cairo; the Head of Pathological Services, California and the Head of Bureau of Sanitary Health, Kobe City.

Parties included members of Bombay Municipal Corporation and members of the National Assembly of Malawi. Another party comprised some 40 participants in a World Health Organisation Mental Health Seminar.

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 635 people, 72 from overseas and 563 (506 students) from the United Kingdom; the Ambulance Service headquarters received 350 visitors and training centres 471 visitors, including 357 students.

Facilities were again provided for medical, nursing and social science students to study the health services. Courses of visits of observation and talks were arranged for post-graduate students preparing for the Diploma in Child Health and the Diploma in Public Health. Members of the department's nursing staff gave talks to student nurses at hospitals and programmes were arranged to enable 3,900 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
University of London (Institute of Education)

Speech therapy students

Speech Therapy Training School of the West End Hospital for Neurology

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

Bedford College
Cheshire County Training College
London School of Economics and Political Science
National Association for Mental Health
National Children's Home Staff Training College
North Western Polytechnic
Nottingham Training College
Queen's Institute of District Nursing
University College of Swansea
University of Edinburgh
University of Exeter
University of London—Institute of Education
University of London—Department of Social Studies
University of Manchester

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. Eva M. Cran reports:

During the year normal activities have been fully maintained, notwithstanding the additional responsibilities and duties arising in connection with the transfer of functions to the new London Boroughs on 1 April 1965. As part of the preparation for this transfer, responsibility for a number of services was decentralised to divisions, e.g. B.C.G. vaccination, inspection of nursing homes, registration of the blind and a variety of additional duties under the Mental Health Act 1959.

These additional functions, together with the onerous task of dividing the work of the division in anticipation of the transfer to the London Borough of Hammersmith and the Royal Borough of Kensington and Chelsea have been loyally and conscientiously undertaken by the staff and I am deeply grateful to them for their devoted service.

As regards the normal work of the division, it has again been a year of satisfactory progress consistent with the record of development and expansion which has been maintained since 1948.

Day nurseries—Attendances were consistently high throughout the year and in many weeks reached 96 per cent. The extension to provide 37 additional places at St. Quintin day nursery was completed by the end of the year and is expected to be fully staffed and occupied early in 1965.

Occasional crèches—At these also there have been near capacity attendances at all sessions. An interesting experiment, authorised by the Health Committee, started in November to allow children to attend crèches free of charge while their mothers are attending hospital. There has not, of course, been sufficient time as yet to assess the effect of this.

Chiropody—The demand for this service continues to increase and an additional clinic was opened in April at Westbourne Grove welfare centre to provide two additional sessions weekly. These proved so popular that a third session was added in August.

Maternity and child welfare—The divisional maternity bed bureau established in 1962 produced quite remarkable results. Of a net total of 1,513 cases referred to the bureau during the year (another 50 were withdrawn), a hospital booking was arranged for 1,508 and in only five cases had the mother to be referred for admission through the Emergency Bed Service. This probably represents the optimum achievement of the Bed Bureau, bearing in mind that the ' failures ' were all social cases who attended a clinic for the first time very late in pregnancy. For the third year running a bed was found for every case referred on medical grounds.

Co-operation with general practitioners and general practitioner obstetricians was further strengthened and improved. The weekly evening paediatric session at Lancaster Road welfare centre was continued throughout the year and a high average attendance of working mothers was maintained.

Health education—The Smokers' Advisory clinic at the Fulham Chest clinic, which started in October 1963 with one session a week conducted by Dr. H. C. Price, Chest Physician, was extended in February by the addition of a second weekly session conducted by Dr. J. Vahrman. I reported in November that the Chest Physicians, although they were unable to make any firm assessment of results, were satisfied that the progress made by individual patients amply justified the extension of the experiment and the Health Committee authorised the continuance of the clinic until further order.

A campaign was launched at the beginning of the Autumn school term and is to be continued until the end of the Spring term 1965, directed at the education of school children in the importance of dental hygiene. During November a ' Dental Health week ' was held in the division, when talks were given and films shown to children at schools and clinics, highlighting this important aspect of school health.

Further efforts were made to increase public awareness of the fire risk from the use of oil heaters. Specially printed leaflets were distributed in the Autumn by bulk postage delivery and, in the case of houses in multiple occupation, personally by health visitors.

Prophylaxis—The immunisation state of children in the division was further improved and in November a trial was started with an additional protection, namely, vaccination against measles. With the approval of the Health Committee arrangements were made, in co-operation with the Medical Research Council, to offer this vaccination to children in the age group ten months to two years and to follow-up all children vaccinated and also a suitable control group. Six thousand invitations were issued to parents and two thousand consents received. Forty-eight additional vaccination sessions were held between the end of September and the end of November and all children will be seen again after three, six and nine months.

Prevention of break-up of families—Divisional co-ordinating committee meetings and an increased number of intermediate case conferences have been held throughout the year. Nearly 40 per cent of the cases referred have come from Housing departments (both L.C.C. and Borough Council) and rent arrears has been the biggest single problem. Referrals have also been made by the N.S.P.C.C., the Family Welfare Association, the Family Service Unit, probation officers, general practitioners, and the Council's own officers in Children's, Health, Education and Welfare departments, the Mayor of Hammersmith and a Building Development Corporation. During the year a second full-time family caseworker was appointed, making two full-time and three part-time caseworkers.

School health service—The seven special investigation clinics continue to be well attended, the main problems presented being enuresis and obesity. An increasing number of fathers accompany children to these clinics, especially among the immigrant population. The number of children attending vision, ear, nose and throat, and minor ailment clinics continues to decline slightly.

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

Dr. H. L. Oldershaw reports:

Population—Despite a large increase in immigrants to parts of the division, the total population has fallen by 76,000 (13·5 per cent) since 1948, due largely to the clearance of slum dwellings and redevelopment schemes providing less housing accommodation than hitherto. This, together with an expansion of service in some fields to older people, has produced interesting changes in the use of the health services and consequential effect upon the role of the health visitor, who traditionally had been associated almost solely with maternity and child welfare.

Maternity and child welfare—Nine new centres have been opened since 1948, some replacing obsolete buildings and others to provide amenities in areas previously inadequately served.

Evening sessions for ante-natal, infant welfare, immunisation and family planning have been opened in various parts of the division for the convenience of mothers employed during the day and these are well attended. Many immigrants with no knowledge of English present a serious language difficulty. Apart from the occasional use of interpreters, printed instructions for the guidance of mothers on all aspects of maternity and child welfare have been made available in nine different languages.

Owing to the high birth rate and the poor housing conditions in many parts of the area the demand for hospital confinement greatly exceeds the supply of maternity beds. In order to obtain as many beds as possible for priority cases, a divisional Bed Booking Bureau was set up in 1956. This has been successful in obtaining beds for about 50 per cent of the unbooked ' emergencies '.

Day nurseries—Five day nurseries have been closed, reducing the number of places from 1,404 to 971, provided in 18 day nurseries. In recent years the daily attendance has been 90 per cent of the approved accommodation and the demand continues to be high.

Private day nurseries and child-minders—In 1948 there were 28 voluntary child-minders in the division, minding 22 children; these figures have increased to 165 and 134 respectively in 1964. There are also 21 child-minders registered under the Nurseries and Child-Minders Regulation Act, 1948, minding 129 children for reward; while 37 registered day nurseries provide places for 940 children.

One of the major problems today is to counteract the indiscriminate use of unguarded and inefficient oil heaters used by child-minders. The advice and help given by the Council's public health inspectorate, who have visited homes upon request, have been invaluable. Arrangements are being made for Fire Prevention Officers to inspect unsatisfactory conditions as they come to notice.

Home help service—One of the most outstanding changes in the use of the personal health services is demonstrated by the work now undertaken by the home helps. Since 1948 the number of home helps employed has trebled and the households served increased five-fold. This massive extension of the service is mainly devoted to the care and attention of the elderly and infirm and the visit of the ' help ' becomes a highlight in the recipient's life, not only for the assistance given but also for the social contact.

Chiropody—In 1948 four sessions a week were provided by the Council, the bulk of the chiropody work for the elderly being undertaken by the Old People's Welfare Associations. Because of increasing demand, a large expansion of this service was authorised in 1960. Recruitment presented a problem but 29 sessions a week, with an average attendance of seven per session, are now being held at five different centres.

Cleansing scheme—Following a report by the Council's Scientific Adviser on the efficiency of a shampoo, Lorexane No. 3 containing gannaxene, as a parasiticide, a six-months experimental use of the preparation was undertaken in the division in January 1959, with the object of ascertaining whether parents would use the shampoo on themselves and their children without the need for special home visits to urge them to do so.

The experiment proved that the home use of Lorexane was successful and the reinfestation of school children was frequently avoided because other members of the family were willing to use the shampoo. This had the direct effect of markedly reducing the number of attendances of verminous children to cleansing stations, resulting later in the closure of unwanted sessions. The trial led in 1960 to the use of this shampoo throughout the county.

Disposable syringes—In 1959 attention was given to possible alternative methods for providing sterile syringes and needles for immunisation work in the division other than by boiling, which was the then accepted practice. The Health Committee approved the provision through the Paddington Group Hospital Management Committee's central syringe service of sterile syringes and needles to be distributed to the various clinics in sealed containers for a twelve-month trial period; this arrangement proved to be a distinct advance on the boiling method. Plastic disposable syringes were made available in March 1961. They were found to be more satisfactory and the cost less than that of the syringe service and their use was extended to all the centres in the division and subsequently to other divisions.

Prevention of break-up of families—It is of particular interest to note that the experiment carried out in March 1956 in three divisions, of which this division was one, of appointing the divisional treatment organiser (later styled the divisional social worker) as secretary of the local co-ordinating committee was so successful that it was extended to the remaining divisions. As a result of the work undertaken by the committee, there has been a marked increase in the amount of consultation and co-operation with other statutory and voluntary organisations, whose representatives are constantly in touch with the divisional social worker about problem families. This is invaluable in the casework and is probably one of the most encouraging developments of social work.

This division was also one of the first to introduce home advice groups for selected mothers, as part of the general arrangements for dealing with mothers of problem and potential problem families. There are two in the division and although the numbers attending are small they serve a most useful purpose.

Mental health—Over the four years of decentralisation since 1960 the mental health work in the division has steadily increased and with the provision of additional staff, advances have been possible in the community care field. Mental health social workers attend weekly after-care conferences at two of the division's catchment area hospitals and also at the Westminster day hospital. Another valuable link has been forged by the arrangement whereby two medical students studying psychiatry spend a whole day once a month in training with the mental health social workers.

The special unit for severely sub-normal children at Coram's Garden day nursery was opened in 1963; this year six children attended regularly.

Health education—Health education plays a prominent part in the activities of this division and has developed considerably during the past sixteen years. In addition to individual teaching, health visitors have organised health education in the welfare centres through mother's clubs, courses in mothercraft and ante-natal exercises, cookery and sewing classes. A programme covering the year and projecting a different health education theme each month is compiled; literature, posters, leaflets and films are discussed and selected for distribution at each monthly meeting. The meetings also act as a forum for the exchange of information and ideas between health visitors.

In addition, large-scale campaigns are held from time to time with the co-operation of the Education Officer and other organisations. The local press help with publicity and exhibitions, displays, films and talks are given at schools and welfare centres. An indication of the interest aroused is shown by the fact that at the campaign at the end of 1964, which was on dental health, over 1,200 school children from 26 schools attended an exhibition during one week in October and 142 film shows and talks were given at schools and welfare centres.

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

Dr. W. G. Harding reports:

Maternity services—During 1964 a series of meetings of liaison committees were held under the auspices of the North East and North West Metropolitan Regional Hospital Boards. Senior officers represented the Council and agreement was reached on comprehensive maternity catchment areas served by a number of hospitals. This resulted in part of South East Islington being transferred, for this purpose, from the North West to the North East Board's area, with a consequent re-arrangement of the system for referring maternity patients to hospital.

Arrangements for planned early discharge from hospital for suitable maternity cases operated throughout the division by the end of the year.

Handicapped and Risk Registers—The total number of children under five years old on the handicapped register at the end of 1964 was 274 and on the ' at risk ' register 2,033. This scheme is now being extended to include school children over five years of age.

Day nurseries—The increasing demands for day nursery places made it necessary to continue the exclusion of all the less urgent priority cases and to accommodate, where possible, children living near the boundaries in day nurseries in the two adjoining divisions. During the year approval was given to the provision of a second new 50-place day nursery.

Health education—Approval was given to the continuation of the smoking advisory evening clinic sessions at East Islington welfare centre.

A dental health campaign was carried out in the Autumn school term in co-operation with heads of local schools and officers of the Education department and the local Dental Committee. Two ' Dental Health Weeks ' in October and November served as foci of the campaign, when the preliminary build up was intensified by film shows and talks on dental health subjects in schools and a special exhibition at Barnsbury welfare centre. The assistance of local authorities and organisations, doctors and dentists was obtained in distributing publicity material during this phase of the campaign.

Infectious disease—It was noted that a very low number of infectious disease notifications was being received from many schools; head teachers throughout the division were therefore reminded of the importance of notifying every case of infectious disease occurring in their pupils. This resulted in about double the number of notifications being received and enabled the divisional health services to take prompt action where necessary.

Prophylaxis—Approval was given in January to participation, in association with the Institute of Child Health, in a field trial of a new measles vaccine to be given intra-muscularly in one dose, without gamma-globulin. The trial continued throughout the year.

In September another measles vaccine trial was begun in association with the Medical Research Council with the two-fold purpose of:

(a) confirming the findings of small scale trials about the absence of significant vaccination reactions; and

(*b*) assessing the degree and duration of protection against measles after vaccination.

Under this scheme parents of all children born in 1963 living in Islington and Finsbury were invited to register their children for vaccination; 1,700 out of some 6,000 children at risk were registered and allocated at random to vaccine or control groups. Vaccinations were carried out during October and November; follow-up investigations will take place at intervals of three weeks, three, six and nine months.

The routine vaccination with B.C.G. of all tuberculin negative children between the ages of 13 and 14 years whose parents give their consent is now to be spread more evenly through the year. A divisonal team (doctor, nurse and clerk) instead of a team from central office will undertake the work.

Tuberculosis incidents in schools are being particularly closely followed up.

Family planning—A six-month survey of the family planning clinics in the division showed that only about one third of the women referred to the clinics on medical grounds actually attended. Accordingly, arrangements have been made for clinic doctors who have referred women to these clinics to be informed at monthly intervals of patients who have not followed their advice.

Premises—The Islington training centre closed in April; the staff and 12 of the girls transferred to the Mary Hughes centre, Whitechapel, and the remaining nine girls went to the Camden training centre.

West Islington welfare centre and South Area home help office vacated premises at Richmond Avenue, N.1, at the end of September. The services were transferred to the new purpose-build Barnsbury maternity and child welfare centre, Carnegie Street, N.1, which was opened ceremonially by the Chairman of the Health Committee, on 5 November, in the presence of the Mayor of Islington. Services previously conducted at Pentonville school treatment centre, Vittoria Street, N.1 were also transferred to the new centre, where six weekly chiropody services are also held.

Mental health—Casework has continued to develop steadily during the year, one notable feature being the increasing number of referrals for community care coming from general practitioners. At the request of the psychiatrist concerned, the mental health social workers now attend one of the weekly out-patient clinics connected with Friern hospital. It has still not been possible to open a much-needed day centre in the division, but it is hoped that the vacated premises referred to above may become available for this purpose. An interesting recent development has been a very successful occupational therapy class for former housebound patients, held twice a week at the divisional office; also the psychiatric social worker now runs a therapeutic group at the office once a week which is proving very useful. The psychiatric social club, which was at first slow to grow in numbers, is now a happy well-established group.

School health service—The scheme for selective medical inspections, which in 1963 showed a proportionately greater incidence of defects in children examined than did the routine seven-year-old medical inspections, has continued successfully in the past year with encouraging results.

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

Dr. S. King reports:

On the eve of a major re-organisation of London's government it seems that I should comment on changed aspects of the personal health service since 1948.

Maternity and child welfare—This service, basically the same, but re-shaped to fit changing circumstances, now includes close liaison with general practitioners and the provision of facilities at welfare centres for general practitioner obstetricians and domiciliary midwives.

The integration of the child welfare and school health services now provides continuous supervision and it is hoped that this will continue.

Prophylaxis—The very much greater prominence of prophylaxis with the resultant decrease in the incidence of infectious disease and the introduction of B.C.G. vaccination of school children are worthy of mention. It is pleasing to record that in 1964 not one case of diphtheria or of poliomyelitis was notified.

Health centre—In 1952 the first (and only) comprehensive health centre in the administrative county was opened in the division. This centre caters not only for the local health services but for general medical and dental services also and is attended by more than 2,000 persons each week, including the patients attending the general practitioner and dental surgeries. Each year since it opened there has been a constant flow of students and visitors from overseas to view the centre and the services provided. This year there were 89 parties comprising 635 visitors.

Mental health—With the implementation of the Mental Health Act, 1959, with its emphasis on community care, considerable local development took place. One of the most important developments has been the provision of day centres where persons suffering from mental illness can perform simple tasks. Formerly this type of patient when not kept in hospital was left to his own devices in his own home: by encouraging him to attend a day centre where output is not the main feature he is able to gain sufficient confidence to take a more normal and active part in community life.

In the last four years three day centres have been opened, providing places for 90 patients. As our knowledge increases it has been possible to develop the potentials of this service. A variety of simple industrial processes are carried out at these centres and I am pleased to report a satisfactory standard of success. Each of these day centres has a social club and there have been very successful evening ventures.

Because of lack of accommodation and staff, admissions to training centres for the mentally sub-normal have had to be restricted to children over five years of age. Their handicap usually becomes apparent at a much earlier age and many parents suffer severe mental strain in looking after the mat home. To ease some of the burden, two special-care units for severely mentally sub-normal children have this year been opened at St. John's and Victorian Grove day nurseries. Up to four such children may now be admitted to each of these nurseries.

Dental health—The Ministers of Health and Education drew attention to the poor condition of school children's teeth and to help imprint on the school children's minds the importance of looking after their teeth a Dental Health exhibition was held in October. The exhibition which lasted four days was held at Shoreditch Health Centre and was attended by over 2,000 children. Subsequently, the children were asked to produce projects illustrating some aspects of dental health and a further exhibition of their work was held at Hackney Town Hall in November.

Prevention of break-up of families—The divisional co-ordinating committee met regularly during the year and 73 individual families were discussed at intermediate case conferences. As in previous years many cases were referred from the Housing department, not less than 27 being in arrears of rent sufficiently high to put them in danger of eviction. The difficulties involved in unravelling and straightening tangled financial situations gave the most trouble.

Staff—During my 16 years in office I have been highly impressed by the consistently high standard of work of the entire divisional staff and I take this opportunity of expressing my appreciation.

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

Dr. A. L. Thrower reports:

In any review of the development of the Council's health services in this division since 1948, tribute must be paid to my predecessor, Dr. G. O. Mitchell and his deputy, Dr. Lily Butler who, because of their links with and knowledge of the East End for many years prior to 1948 and thereafter until the end of 1963, were responsible not only for the smooth re-organisation following the transfer of services from the boroughs to the Council in 1948, but also for the continuity in administration thereafter. These officers played no small part in the co-operation always forthcoming in this locality between the varied voluntary and statutory organisations and committees working for the health and welfare of all concerned.

Drastic changes have occurred in the area and re-building in this part of London may well be greater than in any other area of the Metropolis. This is not surprising when one recalls the widespread destruction of property in the City and in the East End during the war-years 1939-1945 and the enormous programme of slum clearance initiated since the war. This has led to great population movements.

Vital statistics—A comparison between the census of 1951 and that of 1961 reveals that the population of the division dropped by over 25,000 (i.e. from 236,114 to 210,449). The live births occurring to residents, however, in the years under review (1948-1964) have remained fairly constant. In 1949, for instance, the total number of live births was 4,272; the number each year thereafter fluctuated between the lowest recorded, 3,742 in 1960, and this year's figure of 4,172. The number of still-births during this same period has decreased encouragingly from the highest of 99 (in 1952) to 78 this year.

Quads—Whilst reviewing the number of births it is appropriate to recall that one of the few surviving sets of quads are two boys and two girls born to a Stepney mother in December 1957 in the East End maternity hospital. Nursing and home help services were provided to assist the parents in caring for the children at home and the family were moved to larger accommodation by the Stepney Borough Council. The children made excellent progress and are now at school.

Maternity and child welfare premises—It was recognised in 1948 that much needed to be done to provide more suitable accommodation for this purpose. The movement of population due to rehousing schemes also necessitated the resiting of some welfare centres. Steady progress has been made and the use of most of the unsatisfactory premises discontinued. In all, eight new centres have been opened in the division.

Day nurseries—In 1948 there were seven Council day nurseries in the division; in addition, 65 places were available at two voluntary nurseries. The total number of places available was 485. Four nurseries have been closed and the total number of places available at the end of 1964 in five day nurseries (four Council and one voluntary) was 235. In spite of the closures there was no undue pressure on places. One reason for this may be the relatively generous provision of nursery school places in the division and the provision of full-time nursery classes in many primary schools.

In September 1963, a special unit was opened in Queen Mary day nursery for the admission of up to six severely sub-normal infants. This provides special care for these mentally handicapped children and some relief to the parents from the often overwhelming task of caring for them at home.

Occasional crèches—These are provided at selected welfare centres for minding children aged 2-5 years for short periods to enable the mothers to visit hospitals, attend to shopping and other domestic duties, or to take part in activities at the centres in which the crèche is held. A growing demand for the service has led to the opening of these crèches at seven welfare centres in recent years.

Child minders—The Nurseries and Child Minders Regulation Act, 1948 requires those women who wish to daily mind for reward more than two children to whom they are not related to apply to the local health authority for registration. By the end of 1964 there were only eight statutory minders.

The Council also encourages the voluntary registration of women who wish to mind one or two children daily. In 1949 only eleven such minders were registered. This number increased steadily until in 1957 it reached a peak of 133 minders on the voluntary register; since then fewer women have come forward and at the end of 1964 only 60 names were on the register.

Recuperative holiday scheme—The demand for recuperative holidays for all age groups has shown a continual decrease year by year from the peak in 1950 when a total of 2,381 applications for this service was received. During 1964, this number had dropped to just over 1,000.

Loan of home nursing equipment—An increasing number of handicapped and aged persons are now able to remain in their own homes with the supporting health and welfare services now available. One of these facilities is the loan by the Council of home nursing equipment. This loan scheme has developed rapidly from very small beginnings in 1949 and items now loaned, without charge, include special beds, Dunlopillo mattresses, hoists of various kinds, wheel chairs, walking aids, commodes, etc. At the end of 1964 some 280 of these articles were on loan.

Home help service—The picture of the rapid development of this service in the division over the sixteen years is akin to that which took place throughout the county. The service inherited in the division in July 1948 was very limited and in some parts of the area almost non-existent. The extent of the expansion over the years, despite the difficulties experienced in recruiting suitable home helps is illustrated by the following statistics:

Year ending	*Number of home helps employed*	
	Whole-time	*Part-time*
31.12.48	3	78
31.12.64	21	274

While in the last six months of 1948 only 432 persons in all received home help, the number of households actually being attended on 31 December 1964 was 2,355. Much credit is due to the organising staff for the service now available.

Foot clinics—No municipal foot clinics were in existence in the division in 1948. For a number of years thereafter Ministry of Health restrictions made it impossible to initiate such a service. In 1954, however, two foot sessions a week were authorised. Development since then has been very slow, mainly because of the difficulty in this part of London of recruiting chiropodists. Nevertheless, gradual improvements were made and further foot clinics opened. By the end of 1964 there were such clinics at six centres, with a total of 28 sessions weekly. In addition, some foot treatment service was provided by old peoples' welfare organisations, grant-aided by the Council.

Mental health—The Mental Health Act, 1959 emphasised the urgent need for developing community care services for the mentally ill and considerable progress to this end is being made in this division though much remains to be done. An increasing number of mentally disturbed persons are being referred to the mental health team by doctors, hospitals, courts,

relatives, neighbours, etc., and more and more home visits are being made to patients by mental health social workers. Close co-operation has been built up with hopital and other social workers and voluntary bodies. Invaluable help is received from the consultants at Long Grove hospital, who are always willing to see patients at short notice. Also of immense value is the day hospital at St. Clements, Poplar, which caters mainly for the elderly mentally ill. Nurses from this hospital visit the homes of the patients with mental health social workers to the benefit of all concerned.

The Pritchards Road day centre, Bethnal Green, for 40 mentally ill persons was opened by the Council in August 1964. This is not yet running to full capacity but is proving worthwhile. Already four patients have benefited sufficiently to return to open employment. There are three evening social clubs for the mentally ill, two of which are run in conjunction with the Psychiatric Rehabilitation Association.

A special advisory clinic for mentally backward children under five—the first of its kind in London—started in this division in 1953. It is conducted by a doctor with special experience in this field and sessions continue to be held once monthly.

The first experimental industrial training centre in London for mentally handicapped older boys and men opened in the division in Whitechapel in 1955. The unit was transferred in February 1964 to better accommodation at Unity Hall, Poplar and the number of places increased from 20 to 30. This is a most successful project. Two training centres in the division for older girls and women—one at Bethnal Green and one at Whitechapel—provide a total of 85 places. These opened in 1962 and 1963 respectively. The centre at Bethnal Green also has a special care unit for 12 children who are physically as well as severely mentally handicapped.

The staffs of all these centres give devoted service and there is no doubt that more projects of this kind would be of immense benefit.

There is a flourishing Peter Pan Society (a local branch of the National Society for Mentally Handicapped Children) and a club run by parents for all of the severely subnormal who are over 12 years of age.

Health education—This has steadily expanded in the division and now includes thriving mothers' clubs at seven centres, and a schoolgirls' club for 15-17 year olds at Wapping, which is doing very well. Talks and demonstrations by representatives from various outside organisations are given regularly and are very much appreciated. The mothers choose the type of lecture to be given and the programmes cover a wide range of health education subjects. Crèches are provided for the afternoon clubs. Evening film shows are given at Wellington Way centre, which parents attend regularly.

Health visitors teaching in schools arrange for the girls to see at the welfare centres the practical part of mothercraft lectures, e.g. ' Bathing the baby ', ' Making up feeds ' etc. which is more interesting for them than ' just another lecture at school '.

Posters and projects are planned for each month in all child welfare and school treatment centres, in day nurseries and in home help offices.

Social work for schoolchildren—The great improvement since the war in the health of schoolchildren and also the facilities available under the National Health Service are reflected in the reduced social worker effort needed to ensure that individual pupils receive the medical and dental treatment which they have been found to require. Special observation clinics for rheumatism cases and sessions for treating ear conditions are not required, while social workers no longer have to play a regular part at minor ailment sessions, which have greatly declined, or in the dental service. The social work associated with special investigation clinics which absorbed the nutrition and enuresis clinics has, however, increased and liaison work with hospitals on behalf of schoolchildren continues unabated.

Mention must be made of the social work arising from the Council's development over the years of schemes for improving the standard of its service for children with defective hearing. A divisional audiology clinic has functioned for 12 years and for four years there has been there a teacher of such children. In addition, the divisional social worker has been given special responsibility for the maintenance of a divisional register of the deaf.

Perhaps the most important change has been the appointment of the divisional social worker as secretary of the divisional co-ordination committee, which deals with the problems of families whose activities or social weaknesses, for one reason or another, often need the assistance of social workers in a number of departments of the Council or in the employ of other statutory bodies or voluntary organisations. From 1957, when the divisional social worker assumed this function, the extent of the work involved has mounted year by year and latterly much time has been devoted to trying to prevent families from breaking up because of eviction. Case conferences, at each of which a number of families are discussed, now have to be held at least weekly and, because the discussions have to be thorough, are very time-consuming.

One aspect of this work in this part of London which calls for special mention is the amount of effort arising from the rehousing into the area of difficult families from Welfare department accommodation in other parts of London. In addition to their other troubles, many of these families are not familiar with the East End and settlement here is not always easy for them. The division now has two full-time family case workers for intensive effort with ' problem ' families and the divisional social worker and some of her staff also undertake a small amount of this work. The divisional social worker herself now supervises case work students.

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

Dr. F. R. Waldron reports:

Premises—New purpose designed clinic accommodation was opened at the Tenants' Clubroom, Anstridge Road, Avery Hill, Eltham, in July and named the Anstridge Welfare Centre. These new premises replaced a temporary centre conducted in a church hall in the area served.

Maternity services—Since catchment areas were delineated by the South East Regional Hospital Board, pressure on local units decreased as far as Greenwich and part of Deptford were concerned. The district of Deptford, which was transferred to the Lewisham hospital catchment area, continued to pose problems in connection with booking of ' social need ' cases. Early discharge schemes from the St. Alfege's hospital and Lewisham hospital units worked well and contributed a large measure of easement to the general problem.

Ante-natal care—The general practitioner obstetrician scheme, which started in 1957 at one centre and with one general practitioner and covered the whole area of the division by 1961, has since worked very smoothly to the general benefit of the ante-natal case.

Prophylaxis—An assessment of the results of the quadruple vaccine trial is still awaited. During the Autumn months the division took part in a measles vaccine trial which was still proceeding at the end of the year.

Chiropody—Due to staffing difficulties the maintenance of a full service continued to present difficulties. Credit is due to the staff who made every effort to meet the demand of the priority classes, but at times the waiting period was inevitably longer than desirable.

Prevention of break-up of families—The co-ordinating committee met regularly to consider policy and matters of common concern, as well as measures to help particular families who presented especially difficult problems, the allocation of social workers and of specially trained home helps. A number of departments of the Council and the majority of other local statutory and voluntary agencies continued to be associated with the work of intermediate case conferences.

Staff—I would like to take this opportunity of acknowledging gratefully the support of all grades of staff during the years since the division was established. There were many testing occasions including polio and diphtheria outbreaks in the early years and more recently the small-pox scare of 1962 when, through the untiring efforts of the professional and administrative staff, 150,000 members of the public were vaccinated in two weeks.

DIVISION 7, comprising the boroughs of Camberwell and Lewisham

Dr. Ann Mower White reports:

During the year the full range of activities has been maintained, with some additions in anticipation of the re-organisation under the London Government Act, 1963. I should like to pay tribute to the way in which the staff of all grades and at all levels have carried on existing work, often under trying conditions, and have also looked ahead to the need for planning the new local health services. In this report I have summarised the principal changes that have occurred in the services provided by the division since its inception in 1948.

Maternity and child welfare—During the period 14 new welfare centres have been opened, in rented or adapted premises, to serve new areas or to replace unsatisfactory accommodation often in church halls and seven new school treatment centres have been started. Of the ten voluntary committees who ran centres in 1948, six still continue.

Day nurseries—The number of day nurseries has fallen from eight (with 439 places) to six (with 279 places) and the average daily attendance from over 350 to under 250. More and more use has been made of them for children with the most urgent priority need, i.e. families in an adverse environment or with a lone or sick mother. Crèches for the occasional care of young children have been introduced successfully.

At two day nurseries special units have been established, each for nine severely sub-normal children under the age of five years, where they receive special care and training. The work is closely associated with the day nursery and is staffed by day nursery staff who work in close association with health visitors and mental health social workers and, wherever possible, in touch with the parents.

Associated with the decline in the day nurseries is an increase in child-minding. Pre-school play groups have been developed privately of recent years and receive advice on standards of child care and hygiene from the Council's officers, voluntarily if they are not statutorily registered under the Nurseries and Child-Minders' Regulation Act, 1948.

General Practitioners' Centre—In 1961 the South East London General Practitioners' Centre was set up in the division for use by local doctors, where they can see their patients for minor operative treatment and refer them for bacteriological and X-ray examination. Post graduate discussions and meetings are also held.

Home help—This service has responded to the national policy of using it as an ancillary to the other medical and hospital services for confinement cases and for chronic sick persons. The needs of old people and problem families have received special attention both in the training and allocation of home helps. The full-time equivalent number of helps employed has grown from 185 to 431 and the number of households served from 1,160 to 5,868.

Chiropody—From 1959, in accordance with a Ministry of Health decision, the number of chiropody sessions at foot clinics for old people, expectant mothers and handicapped persons was increased; 86 weekly sessions are now held, including a few at welfare centres.

Handicapped children—Intensive attention has been given to the care and treatment of handicapped children of all ages, beginning with congenital malformations notified at birth, incorporating the observations of clinic doctors and linking with the statutory examinations under the Education Act and the Mental Health Act. Divisional registers have been built up of children who are deaf, at risk for deafness and handicapped; the registers serve not only as an index but as a basis for the regular review of the progress of each child.

Prophylaxis—Vaccination and immunisation have been maintained on a voluntary basis by invitations to parents and general emphasis as part of health education. From time to time public demand has been stimulated by incidents of infectious disease and resultant press publicity. The divisional staff have taken a leading part in investigating local outbreaks and in providing mass vaccination sessions in co-operation with general practitioners and borough officers. Recent incidents of tuberculosis in schools have called for investigations on a large scale and B.C.G. vaccinations in co-operation with the local chest physician and mass X-ray unit.

School health service—The special investigation of pupils referred from school medical inspections has grown considerably, due perhaps in part to the withdrawal of the issue of cod liver oil and malt and halibut oil capsules in schools. The most noticeable fall has been in cases and attendances at rheumatism supervisory clinics; although this may be partly offset by a diversion of cases to special investigation clinics or to hospital departments, it undoubtedly reflects a decrease in the overall number of cases. There has been a greatly increased use of ear, nose and throat sessions over the same period.

The co-ordination of the activities for the prevention of break-up of families and the rehabilitation of problem families has continued under the chairmanship of the divisional medical officer and family caseworkers have been employed on the ' hard-core ' cases.

Co-operation—A well-defined pattern of co-operation has evolved with other branches of the National Health Services, with other local authority services and public bodies. These efforts have been directed towards special classes in the community, the care of expectant mothers, problem families, maladjusted children and old persons, the prevention and control of infectious disease, in health education and the avoidance of accidents. They have included surveys, investigations and experimental schemes.

Following the recommendations of the Maternity Services (' Cranbrook ') Committee, free use of ante-natal clinics has been given to general practitioner obstetricians to see their own booked maternity patients and, by agreement, those of other doctors. At the end of 1964, ten ante-natal clinics were attended in this way for 15 sessions a week by 29 doctors.

Mental health—Following the passing of the Mental Health Act, 1959, with its emphasis on community care, a team of mental health social workers was set up in the division in October 1960. Since that date the establishment has risen to 16, including two psychiatric social workers (one of whom is the divisional mental health social worker), two senior occupational therapists and a craft instructor.

A full-time day centre for 40 mentally ill pateints has been opened in Camberwell and a part-time centre in Lewisham for 12 patients. The centres provide sheltered occupation for those either unable or not yet ready to work in open industry; day to day activities are organised by a senior occupational therapist. A full time centre has been planned for Lewisham. Similar centres have been planned for subnormal persons who are too old or unsuitable for the existing training centres. Evening clubs have been commenced for the mentally ill meeting weekly.

' Honor Lea ', a purpose built hostel for chronic mentally ill patients, able to work or attend a day centre, opened in Lewisham in September 1964. It is run by an experienced warden, an ex-mental nurse, and caters for 59 residents of both sexes. A full time trained social worker is attached to the hostel and it is hoped to develop various social activities for the residents, with the aid of a local church group who have shown great interest in the hostel.

An important part of the community care service is that dealing with the educationally subnormal and maladjusted school-leavers. In addition to the normal social work, plans have been made with one of the local (Camberwell) University Settlements for two clubs to be opened, one for E.S.N. school children, the other for E.S.N. school-leavers. A number of maladjusted teenagers will be absorbed by the latter, which will be run by one of the trained workers at the Settlement together with voluntary helpers. Two clubs for lower grade teenage subnormal boys and girls in Lewisham have been organised by the Lewisham Branch of the National Association for Parents of Mentally Handicapped Children and by a local church minister.

A recent venture has been the work in liaison with the Camberwell Centre in an experimental scheme on the lines of the Samaritans, whereby six voluntary workers who have had a certain amount of training in mental illness are asked to visit selected clients regularly in order to support and befriend them.

During the four years liaison has been built up with the local catchment area mental hospitals. Weekly case conferences have been held at the Maudsley hospital and monthly conferences with Bexley and Cane Hill hospitals. Recently the divisional mental health social worker has been invited to attend the two-monthly conferences held at Goldie Leigh, the children's unit of Darenth Park hospital for the severely subnormal.

Dover Lodge, the hostel for subnormal working girls, has built up a good average number of girls and the deputy divisional mental health social worker attends regularly as the social worker and helps them to find work in the district.

An interesting development has been the practical work placing of students with the community care service. Students from the University of Manchester mental health course have spent two months in the division, a Nottingham University Social Science student six weeks and students from the National Institute for Social Work Training and the North-Western Polytechnic ' Younghusband ' courses have been placed for five months.

Overall the picture has been one of a community care service gradually expanding and taking a definite shape.

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 centres taken over from the boroughs in 1948 were of different types and quality. Most of the centres in Lambeth had been under voluntary control, many centres were in unsatisfactory premises and new

accommodation was difficult to find. The task of rationalising the services, with adequate premises conveniently placed for the mother and with the health visitors' case loads evenly spread, has been carried on over the 16 years. The policy of providing fairly large centres, where there can be a staff of several health visitors working together and complete maternity and child welfare and health education services provided, has proved successful. New first-class centres have been provided—Tulse Hill, Rose McAndrew, Loughborough, Moffat and John Dixon. These centres have attracted large attendances of mothers and children and given opportunities for teaching and guidance to mothers that have played a great part in the improvement of health and welfare of the community.

The development of the ante-natal services in co-operation with the hospitals and general practitioners has been carried on over the years. The continued shortage of maternity beds, coupled with a rising birth rate and immigrant population, has led to constant pressure on hospital admissions. Agreement has finally been reached with the hospitals for them to have definite catchment areas for which they are responsible for all maternity cases requiring a hospital bed. Co-operation has also been effected with the general practitioners, many of whom are using the Council's premises, where, together with the midwives, they see their own patients booked for home confinement at the ante-natal clinics.

Day nurseries and crèches—There has been a gradual decline in the use of day nurseries. This has followed the policy of providing nursery places only for children of mothers who are in the priority groups and not for mothers only working to supplement the family income. The number of day nurseries in 1948 was 16, of which 11 still remain. One new day nursery (Coral day nursery) has been built to replace one in hutted accommodation. This excellent building has attracted many visitors, who have appreciated its design and lay-out. The number of children in the day nurseries would have fallen much further if it had not been for the large immigrant population in parts of the division, among whom there is a large proportion of priority cases requiring admission to a day nursery. The nurseries also provide assistance for the children of problem families and children whose parents are in temporary or permanent difficulties. The nurseries have played a most valuable part in the prevention of children being taken into care.

The development of the crèche, where children can be left for a short time to allow the mother to be free at times for shopping, attendance at hospital or other urgent business, has proved a most popular and valuable service. These crèches have been provided at four welfare centres in the division.

Immunisation—Facilities have been provided at all welfare centres for the complete immunisation programme to be carried out on all children. A follow-up system has been arranged for the health visitors to persuade all mothers to have their children immunised. At most infant welfare clinic sessions material and facilities for immunisation are kept at hand during the sessions, so that mothers can have their children immunised without having to attend at a special session. A special evening session for immunisation has been opened at the Loughborough centre. This has proved a most successful and busy session, which is attended by many mothers who may be at work or who cannot attend during the day. During this last year measles vaccine has been introduced and given under controlled conditions under the direction of the Medical Research Council.

Health education—The work of the doctors and health visitors advising the mothers individually at clinic sessions, in school and in the homes, is, of course, a major part of health education in its widest sense. Many other branches of health education, aimed at teaching all members of the community the rules of healthy living, have also been developed. Mother clubs have been organised at many clinics, where films, lectures and discussion on health topics have been held. Health visitors have attended schools to give talks to the children. Displays on health topics were exhibited in the Brixton shop window for several

years. The subjects have included immunisation, dental health, feeding and diet, care of the feet and footwear, sleep and exercise, prevention of accidents, and anti-smoking.

Recently the most important subject of the danger of smoking has been brought before the public. Attention has been drawn to the relationship between lung cancer and heavy cigarette smoking and every effort has been made to draw the attention of the public to the grave danger of cigarette smoking. In particular, efforts have been concentrated on the school children. It is particularly tragic to see the practice of smoking among so many children at such an early age. A health education officer from County Hall has visited the schools, clinics and offices with a cinematograph projector, giving lectures and anti-smoking propaganda. This has been a most valuable asset to the campaign.

School health service—The great achievement of the school health service, particularly since 1948, has been the outstanding improvement in the health of the school children. This has resulted in the main in a reduction of the services which have been provided and it has been possible to terminate several treatment facilities which were no longer needed. These included a tonsil and adenoid operative service, rheumatism supervisory sessions and some minor ailment sessions. All minor ailment times throughout the division have in fact now been drastically reduced, without ill effect, as is clearly shown from the satisfactory results of school medical inspections.

Three sections of the school health service are still expanding, however—hospital work, audiology and special investigation clinics.

During the period the teaching hospitals in the division have greatly developed both their social medicine services and their arrangements for the assessment and treatment of handicapped children, giving consideration not only to the child's medical condition, but also to the personal and family problems arising from the condition, and to the close integration of hospital and community services in meeting these problems. The public health social workers attached to the hospitals have been asked to play an active part in both these fields.

There has also been a great extension of awareness at all levels of the problems of the children with impaired hearing and of the services for the early diagnosis, treatment and education of such children. Audiology sessions have increased in the division from one a month to two a week. Specially trained teachers from the deaf schools have been seconded as peripatetic teachers of the deaf and, in fact, play a considerable part in the assessment and treatment of infants, as well as of children over two. Partially hearing units have been opened in both primary and secondary schools, divisional deaf and ' at risk ' registers have been established and a medical officer designated for the general supervision of the registers, in addition to the specialised diagnostic work of the divisional otologists. These services are now linked through a public health social worker.

The third expanding service, the special investigation centres, is popular with the parents largely because of the time available at the school treatment centres. Appointments can be spaced to give mothers plenty of time to talk to the doctor about minor difficulties of diet and behaviour and particularly about the social difficulties of enuresis, which some feel nervous of raising in the more formal setting of a hospital out-patient clinic. Moreover, many girls who have menstrual difficulties refuse to go to hospital and do not wish to consult a male general practitioner but are set at ease by women medical officers who deal with this matter at the school centres.

Mental health services—The mental health services have been steadily developed and consolidated since the passing of the Mental Health Act, 1959. Referrals for mental health action now amount to over 1,000 each year and the department carries an active case-load of approximately 900 mentally disordered persons. At the same time, the mental health social workers have been taking in their stride the admission of over 600 patients each year to psychiatric hospitals.

Castle day rehabilitation centre, which opened officially in July 1964, had already begun admitting mentally ill patients early in the year. An encouraging number of these have been rehabilitated and have returned to work, including some who had spent many years in hospital.

St. Olave's hospital has been a focal point for much mental health community care in Bermondsey and part of Southwark. Social workers and occupational therapists are provided by the Council for the day hospital. Patients admitted to the psychiatric in-patient unit for short-term treatment may pass from there through the day hospital and into the community with the Council's social workers keeping in touch at every stage. A further link between this hospital and the community has been the appointment of an additional occupational therapist to share her time equally between working in the day hospital and visiting house-bound psychiatric patients in the community.

Co-ordinating committee—The committee began as a result of the need that was felt for the prevention of child neglect and ill treatment and juvenile delinquency, and in the hope of reducing the necessity for reception of children into care. It has brought together members of the staffs of Council departments, statutory and voluntary organisations concerned and led to a great improvement in mutual understanding.

The divisional co-ordinating committee has met at regular intervals for policy and reviewing, under the chairmanship of the divisional medical officer and with the divisional treatment organiser (later divisional social worker) as secretary. Intermediate case conferences on individual families, to which field workers from every agency concerned and the family doctor are invited, are held as frequently as required and there has been an increased number of field-level conferences, at school medical inspections, in M. and C.W. centres and care committee offices, etc. to avoid both duplication and confusion in immediate action. This remains the structure of the work in the division today but the outlook has changed from the original plan of collaboration in known cases of neglect or suspected neglect to close collaboration at much earlier stages, aiming at long-term educative work to remove or modify possible causes rather than to deal with effects. A number of services and routines have been evolved to further this end.

A rent guarantee scheme, worked out by the divisional co-ordinating committee, was later accepted for the county. Specially selected home helps were given brief appropriate training to prevent breakdown in the home and used, with considerable success, in rehabilitating some inadequate and discouraged mothers or in helping fathers who have undertaken to look after their children without a mother. Residential rehabilitation has also been tried in a few cases, but with less success, local experience being that very disorganised families may manage in sheltered conditions but they tend to break down again on return to the normal community.

There was, however, an obvious need for additional case work service in the community and the co-ordinating committee gave every support from the earliest discussions to the establishment of the South London Family Service Unit; indeed the first organiser of the unit was housed in a school treatment centre until the unit found its own premises. Collaboration with the Family Service Unit has remained very close, a high proportion of the families with whom the unit has worked throughout having been referred through intermediate case conferences called for the purpose, at which Family Service Unit workers are, of course, present. Following the appointment of public health caseworkers to the division in September 1963 the same procedure has been used in allocating their families.

Rent arrears were recognised very quickly to be a symptom of social circumstances which might well lead to neglect or breakdown and a routine for their early notification to the co-ordinating committee, by both Council and borough housing departments, was established

and is now working well. Another matter of serious concern was the question of rehousing of problem families and of the rehabilitation of families rehoused. In 1963 a special drive was made to collaborate with the housing and welfare departments in clearing the bottleneck in short-stay accommodation.

It is difficult to assess the ultimate effect of the great amount of social work being done for problem families and all families suffering as a result of neglect, ignorance and incompetence. These social problems are the problems of our times and we may consider ourselves fortunate that now that the effect of physical disease have been largely overcome we can turn our attention to the social problems that so often lead to more serious consequences. We can pay tribute to the patience and understanding given by the health visitors and social workers and all the staff concerned who are constantly dealing with these difficult problems.

DIVISION 9, comprising the boroughs of Wandsworth and Battersea

Dr. J. T. R. Lewis reports:

Development since 1948—Apart from the normal developments to be expected in an expanding health service, the main special feature has been the attempt to integrate the environmental and personal health services by the 'tripartite' agreement between the Council and the two Metropolitan Boroughs of Battersea and Wandsworth. This is now old history but it is worthwhile recording that this scheme was not only the largest of its kind in the country but over a period of more than 13 years secured the closest co-ordination of the environmental and personal health services that is possible outside a county borough organisation. It has been to me, and I also speak for my medical colleagues, a great privilege and pleasure to participate in this form of administration. Although very demanding from the personal point of view and time consuming, it has been an interesting and worthwhile experience.

A noteworthy development has been the growth of the mental health service in the last four years. This has been put on a basis from which there is every hope of expansion and growth.

I should like to place on record the help I have received from all grades of staff in this area since 1952. The co-ordination of the services to which I refer above would not have been possible without the wholehearted support of all my colleagues.

Putney health centre—The history of this centre testifies to successful pioneer voluntary endeavour and partnership between local authority and voluntary bodies. The forerunner of the present centre was opened in a converted shop in 1914 by Miss Eileen Lecky, M.B.E., with voluntary support. The existing purpose-built establishment in Clarendon Road was opened in 1931 as the Children's Health Centre for South-West London; from 1948 to 1958 the Council co-operated with the Trustees in the provision of a full range of health clinics. Full responsibility for the operation of Putney health centre was taken by the Council in July 1958.

Mental health—One of the early fruits of the Mental Health Act, 1959 was the opening in July 1962 of the mental health hostel 'Chellow Dene'. The hostel meets the needs of persons who require a period of sheltered accommodation to help them to establish themselves in employment and in the community as a whole after recovery from mental illness and includes the temporary care of patients from the community in circumstances where a period of support away from home surroundings might prevent a more serious breakdown.

The Clapham training centre for 100 mentally subnormal men and boys aged 16 and over is the largest of the Council's industrial centres for the subnormal and the first to be opened (1961) in South London. The centre includes power driven machinery. Training aims to help those attending to make the most of their capabilities and to enjoy lives as full and independent as possible. The emphasis is on the production of useful articles for which contracts are negotiated with local firms and the Council's own supplies organisation.

Premises—The very extensive housing developments in the Roehampton area led first to the establishment of welfare centres in hired premises and next to their replacement by Victoria Drive centre (within the ' shell ' of a house partially erected before the war) and by the William Harvey centre. This purpose built centre was opened in July 1959 on the Council's Ashburton Estate at Roehampton. The two-storey centre is incorporated into a three-storey block of flats and has been planned to provide a full range of clinical services. There are clinics for expectant mothers, and young children; a child guidance clinic staffed by part-time psychiatrist, psychotherapist, psychologist and social worker; and for school children, minor ailment clinics, consultative ophthalmic and orthoptic clinics staffed by the hospital service.

It is a curious fact that hitherto no hospital or clinic has borne the name of the eminent physician renowned as the discoverer of the circulation of the blood. William Harvey spent the declining years of his life in a house at Roehampton not far from where the centre now stands.

Older areas of the division were not neglected although here the problem of development is clearly much more difficult. It was possible, however, with the co-operation of the Battersea Borough Council, to provide the St. Christopher's combined welfare and school treatment centre on the ground floor of a block of flats in 1961.

Statistical summary 1964—health divisions

Health division	1	2	3	4	5	6	7	8	9	Total
Estimated population—mid 1964	436,130	493,070	279,590	254,720	210,660	301,940	398,910	358,310	451,270	3,184,600
Births and associated mortality										
Live births	8,283	8,296	6,495	6,011	4,043	5,595	7,819	8,074	8,884	63,500
Rate per 1,000 population	19·0	16·8	23·2	23·6	19·2	18·5	19·6	22·5	19·7	19·9
Deaths under 1 month	139	117	97	81	57	82	112	109	151	945
Rate per 1,000 live births	16·8	14·1	14·9	13·5	14·1	14·7	14·3	13·5	17·0	14·9
Deaths										
All ages	4,563	5,052	2,954	2,833	2,294	3,239	4,381	4,063	5,677	35,056
Rate per 1,000 population	10·5	10·2	10·6	11·1	10·9	10·7	11·0	11·3	12·6	11·0
Health visiting										
Total visits	131,232	139,446	69,517	64,691	60,511	73,572	102,368	116,896	93,413	851,646
Staff at 31 Dec. W/T equivalents	60	60	40	32	28	39	52	51	55	417
Welfare centres										
Children—										
Sessions	2,403	3,413	2,488	1,522	1,923	2,253	2,525	2,902	2,456	21,885
Total attendances	81,135	110,681	82,248	63,132	62,865	91,427	106,288	99,424	111,408	808,608
Expectant mothers—ante and post natal clinics—										
Sessions	1,713	1,755	881	601	205	1,178	1,110	251	740	8,434
First attendances this year—										
Ante-natal	3,394	5,869	5,351	2,230	320	2,596	3,123	1,203	3,186	27,272
Post-natal	70	259	539	852	140	668	352	108	295	3,283
Total attendances	12,358	21,084	19,880	8,475	2,064	11,196	13,260	4,378	11,264	103,959
Prophylaxis										
Poliomyelitis (L.C.C. and general practitioners)—										
Salk vaccine										
Primary course (3 injections)—										
born 1960–64	155	147	81	10	40	83	410	116	145	1,187
born 1943–59	25	52	50	5	34	18	94	49	60	387
born 1933–42	30	24	33	15	26	38	22	23	27	238
born 1932 or earlier and under 40 years	14	23	34	4	7	6	18	12	12	130
over 40 years	1	—	—	—	—	—	4	—	—	5
Total	225	246	198	34	107	145	548	200	244	1,947
Reinforcing injections	66	72	5	1	16	34	157	108	111	570
Sabin vaccine										
Primary course (3 doses)—										
born 1960–64	5,986	6,008	4,969	4,790	3,177	4,581	5,945	6,595	6,579	48,630
born 1943–59	3,232	2,293	1,457	1,348	971	1,914	985	2,201	911	15,312
born 1933–42	545	220	431	528	223	215	171	498	204	3,035
born 1932 or earlier and under 40 years	140	155	169	133	94	118	121	674	173	1,777
over 40 years	6	42	9	2	5	7	18	40	16	145
Total	9,909	8,718	7,035	6,801	4,470	6,835	7,240	10,008	7,883	68,899
Reinforcing dose	6,238	4,430	4,228	3,059	1,820	3,781	2,380	4,816	1,880	32,632
Smallpox—Vaccinations	2,844	2,787	2,780	2,535	1,082	2,025	3,293	2,686	3,212	23,244
Re-vaccinations	661	948	390	902	330	310	513	288	618	4,960
Diphtheria—Primary course	7,050	7,417	6,341	5,420	3,595	5,247	7,062	7,206	7,252	56,590
Reinforcing injections	7,627	9,420	8,060	5,526	4,310	9,911	6,800	9,035	6,090	66,779
Whooping cough—Primary course	5,589	6,490	5,248	4,926	3,144	4,632	6,497	6,732	7,116	50,374
Reinforcing injections	3,456	3,395	3,918	3,060	2,078	3,528	4,433	4,557	4,244	32,669
Tetanus—Primary course	7,502	7,391	6,015	5,616	3,617	5,168	7,054	7,242	7,589	57,194
Reinforcing injections	6,002	6,515	6,090	5,177	3,386	7,191	5,977	7,729	5,802	53,869

Health division	1	2	3	4	5	6	7	8	9	Total
Foot clinics										
Sessions	4,974	1,305	4,285	3,961	1,129	6,219	3,685	3,515	2,612	31,685
Total attendances	34,822	9,115	28,416	30,162	6,650	47,158	20,656	23,975	17,122	218,076
Day nurseries										
Number of places at 31 Dec.	629	971	361	379	235	58	279	654	437	4,003
Total attendances	148,451	225,581	85,511	89,853	49,782	13,723	63,391	149,637	94,978	920,907
Child minders										
Statutorily registered 31 Dec.	34	20	21	20	8	53	49	3	30	238
Children minded (authorised no.)	166	129	120	84	33	287	258	26	203	1,306
Voluntarily registered 31 Dec.	111	119	72	49	38	103	106	109	13	720
Children minded	190	136	120	58	61	121	130	132	23	971
Home help										
Households attended	4,517	4,950	3,043	4,448	3,299	4,312	5,868	4,867	4,913	40,217
Households attended per 1,000 population	10·4	10·0	10·9	17·5	15·7	14·3	14·7	13·6	10·9	12·6
Home nursing										
Total visits	222,738	226,390	115,727	124,873	102,496	211,865	198,867	185,876	187,176	1,576,008
Visits per 1,000 population	511	459	414	490	487	702	499	519	415	495
School health service										
Medical inspection, routine, special, reinspection	35,236	30,178	26,817	20,529	23,949	32,906	36,743	28,996	40,667	276,021
Health surveys	78,741	104,883	64,134	33,753	28,466	89,777	51,531	43,234	67,261	561,780
Hospital/specialist clinics—										
New cases	3,854	3,276	3,525	2,222	1,898	3,141	2,039	1,967	3,227	25,149
Total attendances	7,176	9,150	12,642	5,637	5,563	7,413	6,683	*7,869	11,189	73,322
Dental services										
Schools—										
New cases	10,509	9,377	6,471	11,257	6,107	5,336	4,963	8,229	13,296	75,545
New cases per 1,000 population age 5–14	259	231	207	352	212	136	97	180	258	209
Total attendances	28,046	27,896	20,400	33,226	16,677	16,409	15,644	26,099	33,526	217,923
Maternity and child welfare—										
First treatment	340	566	288	841	154	191	20	210	149	2,759
Total attendances	1,483	2,081	1,309	3,412	607	591	65	596	537	10,681

*Excluding attendances at Royal Eye Hospital.

APPENDIX A

STAFF OF THE PUBLIC HEALTH DEPARTMENT AT 31 DECEMBER, 1964

Medical Officer of Health and Principal School Medical Officer	A. B. STEWART
Senior Principal Medical Officer	M. MACGREGOR
Administrative Officer	T. A. WRIGHT
Principal Medical Officers	
Maternity and child welfare	DOROTHY F. EGAN
School health	R. E. C. COPITHORNE
Epidemiology	IAN TAYLOR
Tuberculosis	W. HARTSTON
Mental health	C. W. J. INGHAM
Staff medical examinations	R. COVE-SMITH
Child psychiatry	JESSIE PARFIT
Chief Dental Officer and Principal School Dental Officer	W. RITCHIE YOUNG
Chief Nursing Officer	EVELYN ROBINSON
Scientific Adviser	S. G. BURGESS
Principal Clerks	G. BERRIDGE N. B. CHAPMAN
Principal Clerk and Statistician	C. W. SHADDICK
Acting Officer-in-Charge, London Ambulance Service	N. A. WOODRUFF
Deputy Establishment Officer	R. C. COULTER
Chief Inspector	J. C. CLANCEY
Principal Social Worker (Health Services)	FRANCES C. K. GREGSON
Principal Mental Health Social Worker	PHYLLIS M. PERROTT

Senior Officers of the Divisions

Division	*Divisional Medical Officer*	*Divisional Administrative Officer*	*Divisional Nursing Officer*
1.	EVA M. CRAN (Acting)	T. A. STONE	JOAN A. SURR
2.	H. L. OLDERSHAW	D. A. COLLINS (Acting)	ESTHER A. EVANS
3.	W. G. HARDING	N. A. C. BIGNELL	MARGERY D. BUTLER
4.	S. KING	T. A. MAXWELL	LILIAN E. ARROW
5.	A. L. THROWER	E. L. HANNANT	ELIZABETH J. EARLY
6.	F. R. WALDRON	L. M. LONGHURST	MARGARET V. NAUNTON
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

APPENDIX B

STAFF—SURVEY OF LONG-TERM SICKNESS 1961/63

Introduction

1. The Medical Officer of Health is responsible for the medical examination of the Council's staff:

(i) as to fitness for appointment to the Council's service;

(ii) after a prolonged period of sickness;

(iii) after an accident on duty, and

(iv) when physical fitness to remain in the Council's service is in question.

There are also other minor aspects—eligibility for spouse pension, confinement leave, etc. In practice, staff on sick leave are normally referred for examination after two months' absence and after one month's absence arising from an accident on duty. Earlier arrangements apply in the case of staff reported to be suffering from tuberculosis and cases are occasionally referred earlier when physical fitness to remain in the service is under consideration.

Method

2. In 1960 a pilot scheme for the indexing on punched cards of cases referred for medical examination was introduced and this was extended and made permanent in 1961. The prime purpose of the system is to provide an alphabetical index of all the cases, containing particulars of age, sex, grade, reason for examination, diagnosis and outcome: the system also provides statistics required for administrative purposes. It was decided to explore the potentialities of this scheme by carrying out a limited analysis of long-term absence from work owing to sickness (item (ii) above), for the years 1961/63 inclusive—limited because of inability to obtain all the requisite supplemental data as instanced below.

3. A major difficulty encountered was in the ascertainment of the 'exposed to risk' population for the various grades of staff employed by age and sex. In the case of some grades, information was obtained of the numbers of staff employed in mid-1964 from a computer tabulation of salaried staff by age group and sex, supplemented by manual methods in the case of weekly paid staff. This information was readily available from computer sources because the first two digits of the L.C.C. Superannuation and Provident Fund number allocated to each member of the staff are the year of birth of the staff concerned. In a few instances where individuals were not on the Council's Superannuation Fund the information was obtained by reference to departmental sources. In the case of firemen and teachers, both of which grades have special superannuation schemes, the information was not obtainable from this source as the national superannuation schemes for these two grades of staff do not employ a numbering system incorporating year of birth. For Fire Brigade personnel a manual count was made of all records of the uniformed staff. With teachers, owing to the large numbers concerned (over 20,000), a manual count was made on a sample basis from records maintained in the Education Officer's department: one card in every five was sampled. Hence the numbers of teachers shown as employed always ends in the figure 5 or 0, because the sample results had to be multiplied by five to equate them to the actual numbers in the Council's service. As it was not possible to obtain easily the numbers of other grades of staff by age and sex, the analysis was limited to A.P.T. and C. grades (administrative, professional, technical and clerical grades within the purview of the L.C.C. Interim Panel), teachers, nursing staff (including health visitors and midwives), Fire Brigade and Ambulance Service uniformed staff.

Results*

(*a*) *Sickness*

4. Table 1, sections A to E, shows the results of this survey of sickness for these five groups of staff. The section for nursing staff is limited to females because the number of male nurses employed was too small for a meaningful analysis; for similar reasons figures for Fire Brigade and Ambulance staff have been limited to males. The table shows the number of staff employed by age and sex at mid-year 1964 related to the occurrence of long-term sickness in the years 1961 to 1963. The sickness figures should strictly have been related to a mid-1962 employed population but by the time it was decided to make this survey the opportunity had passed. The extraction of the employed population figures for two years earlier would have been both time consuming and liable to inaccuracy. Hence the 1964 figures have been used and to this extent this survey is not a strict comparsion of ' like with like '. However, in a service the size of the London County Council, provided there has been no major change in staffing policy, this deficiency is not likely to invalidate any broad conclusions drawn from the figures. The table goes on to show the number of spells of sickness in these three years, the number of persons concerned with these (a person can be referred more than once during these three years—the maximum encountered was five spells although the most frequent number of multiple referrals in the three years was two); the percentage of persons sick in these *three* years, the total duration of sickness with the average per spell, the disposal of these sickness cases and finally the percentage dying or invalided from the Council's service.

It must be remembered that throughout this analysis it is long-term sickness that is under discussion—something involving, with minor exceptions, at least two or more months absence from duty. It is not a quantitative measure of *total* sickness in the Council's service.

5. Dealing with each section of table 1 in turn, section A for the A.P.T. and C. grades shows that as between males and females there was a higher incidence of long-term sickness (column 5) in females up to age 55 years, thereafter the male figure was much higher, which is in line with national mortality experience—mortality at these ages in males is twice that of females. The number dying or invalided (P.U. = permanently unfit) in the three years reaches a figure of 14·6 per cent. for males and 17·8 per cent. for females (column 14) at ages 55—64 years, a wastage rate of some five per cent. a year. Figures for age 65 years and over may be the least reliable, because the staff employed at this age may have been subjected to the greatest change between the census of 1964 and the middle year of the survey—1962.

6. Section B for teaching staff employed shows about three and a half times as many female as male teachers under 25 years of age, nearly twice as many females at ages 25—34 years, near equality between the sexes at ages 35—54 years with a ratio of 3:2 in female/male teachers beyond that age. Doubtless this is a consequence of current events in the recruitment of teachers. Column 5 shows a higher percentage of long-term sickness in females than males at all ages. (A separate analysis of *all* sickness in teachers showed a similar pattern up to age 45 years.) Compared with A.P.T. & C. staff (their nearest equivalent in this survey) teachers had a lower incidence of long-term sickness and a much lower wastage rate owing to death or retirement, permanently unfit; under one per cent. a year compared with the five per cent. for A.P.T. & C. grades at ages 55–64 years.

7. Section C for nurses shows percentage sick figures nearer to female A.P.T. & C. grades than to female teachers: similarly for the percentage died and permanently unfit.

8. Firemen (including fire officers), section D, show high rates of sickness, especially under 55 years, but a lower average duration of sickness compared with other male employees—all under two months. In practice, firemen are referred to the examining medical officer before the expiration of two months sick leave and this accounts for some of

* *See tables on pages* 167 to 169.

the high percentage sick figures. The percentage dying and permanently unfit was higher up to age 55 years than for any other grade of staff in this survey. The number of deaths, six in total among 2,503 firemen, was proportionately lower than in the A.P.T. & C. grades, so that the high percentages in this category were due to a higher rate of men retired permanently unfit. It must be remembered that fire-fighting requires a high physical standard and what might incapacitate a man for this activity might not impair his ability to carry on a less strenuous activity as, say, a clerical or administrative officer.

9. Ambulance staff, section E, show high rates of sickness up to 55 years of age and especially at younger ages—9·1 per cent. under 25 years of age or three per cent. a year. Again, as with firemen, the average duration of each spell of sickness under two months up to 55 years suggests earlier referral. (A survey of staff sickness for all departments 1951-53 suggested a relatively high incidence of sickness in London Ambulance Service operative staff, especially in uncertificated sickness.) This led to more frequent referral to the examining medical officer which may, in part, account for the higher figures. The percentage retired unfit (there was only one death reported) was relatively high but not as high as for firemen.

10. There is, however, a deficiency in the figure of deaths reported in these tables. These deaths are of those in staff already referred to the examining medical officer because of continued sickness absence and they take no account of sudden death in staff not so referred. A separate investigation based on the year 1964 was made to ascertain the extent of this. The results indicated that about 40 per cent. of deaths occurred in persons referred to the examining medical officer but that this proportion varied with grade of staff and was lowest for manual workers. Most of these sudden deaths were from heart conditions.

(b) The causes of sickness, invaliding from and death in the service

11. Table 2, sections A to E (where applicable sub-divided into males and females) shows for the different grades of staff, by age, the causes of long-term absence on sick leave with total figures for cases permanently unfit and dying. The causes shown are the 50 causes for tabulation of morbidity of the International Statistical Classification of Diseases, Injuries and Causes of Death (seventh revision 1955). The ' Not stated ' category refers to cases in which the diagnosis was not coded; these were relatively few and arose from ' teething ' troubles in the early days of the scheme, the percentage figure shown in this table excludes these 'Not stated' cases. The table is related to spells of sickness, not persons; it would be difficult to do otherwise, because each spell of sickness can relate to a different cause and many of such multiple referrals in the course of the three years were of this nature.

12. For the A.P.T. & C. staff, section A, in males the principal causes were respiratory diseases (code Nos. 28–34), psychoneurotic (No. 19), heart and circulatory diseases (Nos. 23–27), tuberculosis (Nos. 01 and 02), accidents (No. 50) and cancer (No. 12) in that order; for females they were psychoneurotic, diseases of the genital organs (No. 42), heart and circulatory diseases, cancer, accidents and rheumatic diseases (No. 46). There is, of course, an age pattern in these causes which is in line with general morbidity experience. Cancer is very much a disease of age and assumes its greatest impact from age 55 years onwards; of the specific sites for cancer (not listed in the table), cancer of the lung was the principal site for males and cancer of the breast for females. It is surprising that psychoneuroses and psychoses should figure so prominently for both men and women in the A.P.T. & C. grades, spread throughout the age range. Heart and circulatory diseases rank third in order of importance for both men and women, again very much related to age. Respiratory diseases were proportionately more than twice as frequent in males as females, this difference being mainly due to bronchitis (Code No. 32), especially from age 55 years onwards. This again is a reflection of national experience. Diseases of the genital

organs were especially important in women, ranking second in order of importance, between the ages of 35–54 years. Arthritis and rheumatism (very much related to age), were not as important as may be generally supposed, ranking in order of importance sixth in women and seventh in males. Of the causes of death, cancer and heart disease were the most important in males whilst in females 13 of the 16 deaths recorded were due to cancer. The diseases mainly causing retirement from the service on medical grounds were in males psychoneuroses, diseases of the nervous system (strokes) and bronchitis, whilst in females psychoneuroses was the outstanding cause.

13. With teaching staff, section B, much the same sort of pattern of the cause of long-term sickness as was found in the A.P.T. & C. grades applies, except that there is *proportionately* more psychoneurotic disorder—in men teachers nearly twice and in women teachers one and a half times that of male and female staff in A.P.T. & C. grades. The difference between the two groups of staff in this respect is demonstrated by the following figures:

	No. of spells of sickness	*Percentages with psychoneuroses and psychoses (all ages)*	
		Spells of sickness	*Permanently unfit*
A.P.T. & C. staff			
Male	719	10·6	1·8
Female	671	17·7	3·3
Teachers			
Male	308	19·2	0·3
Female	706	22·8	1·3

14. Among nurses, section C, the biggest causes of sickness were psychoneuroses, cancer, heart and circulatory diseases, and diseases of genital organs in that order—the same sort of pattern, with minor variations in order of preference, as was found with female A.P.T. & C. grades and women teachers. Heart and circulatory diseases were the principal causes of invaliding from the service, followed by psychoneuroses; cancer was the only cause of death in the service recorded.

15. For firemen, section D, the principal causes in order of importance were accidents (not on duty), heart and circulatory diseases, psychoneuroses, diseases of the stomach and duodenum (code No. 35), arthritis and rheumatism and hernia (code No. 37). Compared with male A.P.T. & C. staff and teachers, firemen experienced proportionately less cancer, less psychoneurotic illness and far less respiratory disease; they experienced proportionately many more accidents (three times as many), more diseases of the stomach and duodenum and for the first time in these tables hernia becomes of some importance. The lower incidence of cancer and respiratory diseases can be partly explained by fire staff having a younger age composition than A.P.T. & C. staff and teachers (see table 1, sections A, B and D). The higher rate from hernia is understandable because of the standards of fitness required in their occupation: a small hernia in, say, a clerical officer might not give rise to invaliding from the service, whereas the same sized hernia in a fireman might mean permanent unfitness for duty. This in itself may also contribute to the high proportion of sickness noted earlier in this grade of staff. Heart and circulatory diseases, diseases of bones and organs of movement, arthritis and rheumatism, and accidents were the principal cause of permanent unfitness for further service.

16. Ambulance staff, section E, showed a similar pattern of sickness to firemen (including a proneness to accidents *not* on duty), except that they had fewer psychoneuroses (the lowest of any grade of staff in this survey) and an incidence of respiratory disease more in line with that for men A.P.T. & C. grades and men teachers—the latter can probably be accounted for by a somewhat older staff (fewer young men). Hernia again is of some importance in this grade, ranking fifth in order of importance—lifting is also very much a part of an ambulance driver's duties and hernia is therefore an invaliding condition.

Discussion

17. This survey was carried out more as a feasibility study of the potentialities of the punched card system for recording sickness data than as an exact analysis. Nevertheless, in spite of the difficulties encountered and the imperfections inherent in the figures, it is felt that the main findings demonstrated by this analysis justified the work involved and pointed the way to a more precise and more comprehensive survey in the future. It is clear that as well as sex, age is an important factor and that type of employment has a bearing on sickness.

18. The striking feature of this analysis is the extent of long-term sickness in the Council's service and the wastage by premature retirement or death. For convenience the essential particulars from table 1 are summarised below:

Percentage of persons sick, dying and permanently unfit 1961–63

Age	*A.P.T. & C. grades*		*Teachers*		*Nurses*	*Firemen*	*Ambulance Staff*
	Male	*Female*	*Male*	*Female*	*Female*	*Male*	*Male*
			Percentage sick				
Under 25	0·9	1·5	0·9	2·3	2·6	5·4	9·1
25–34	3·0	6·8	1·5	3·1	6·8	8·1	8·8
25–44	4·8	9·4	2·9	5·5	6·9	13·6	10·2
45–54	8·2	13·5	3·6	6·9	11·5	26·7	17·2
55–64	51·0	39·2	7·1	9·5	40·5	32·5	27·3
65 and over ..	57·0	32·8	10·9	14·3	42·9	—	25·0
All ages	8·3	9·5	3·3	5·2	8·2	13·8	14·0
			Percentage died and permanently unfit				
Under 25	—	0·11	—	0·05	0·12	—	1·8
25–34	0·06	0·35	—	0·14	0·97	1·5	0·4
35–44	0·36	0·99	0·05	0·40	0·40	2·4	0·8
45–54	1·53	1·56	0·46	0·45	1·58	7·2	3·3
55–64	14·62	17·85	1·65	2·06	14·88	11·1	5·8
65 and over ..	17·77	9·83	—	2·86	14·29	—	—
All ages	1·73	1·83	0·38	0·57	1·44	3·0	2·1

19. Over a period of *three years*, at ages 55–64 years about one-half (rather less for females) of A.P.T. & C. staff were absent on sick leave for a period of two months or more; for teachers the proportion was much lower, rather less than one-tenth, whilst for female nurses it was two-fifths. For firemen and ambulance staff, where the circumstances of referral were slightly different, it was about one-third.

The figures for premature retirement or death in the same age group are also very high. Equated to an annual basis they approximate to five per cent. a year for A.P.T. & C. grades (men and women) and for female nurses. It is true that permanent ' unfitness for duty ' may be an exaggeration for staff at these ages; it might be more appropriately termed ' premature retirement ', but there can be no such explanation for death—approximately one-third of the figures in the category ' died and permanently unfit ' in persons aged 55–64 years were deaths whilst in the Council's service in the case of male A.P.T. & C. grades, teachers (both sexes) and nurses.

Even so, some of the death rates recorded in this survey are not as high as those in the general population, comparative figures are:

Annual death rates per 1,000 *population, aged* 55–64 *years*

	Men	*Women*
This survey		
A.P.T. & C. grades	15·0	17·9
Teachers	2·4	2·5
National figures		
England & Wales (1961–62) ..	22·1	10·8

The survey figures may be minimal for the reasons given in paragraph 10 and by the fact that some of the staff retired permanently unfit may have had a comparatively short expectation of life. The low mortality rate for teachers is not altogether unexpected—they have a low occupational mortality, a standardised mortality ratio of 66 compared with the national figure of 100 for the whole population (Registrar General, Occupational Mortality, 1951).

20. Less striking, but also of some importance, are the high figures for the incidence of psychoneuroses and psychoses in A.P.T. & C. grades and teachers referred to in paragraph 13. This cause of sickness is more understandable with teachers than office staff but the figures (paragraph 13) show that as a cause of premature retirement it is higher in A.P.T. & C. grades than in teachers. Also of some concern should be the high incidence of accidents *not* on duty sustained by firemen and ambulance staff.

21. The high incidence of psychoses and psychoneuroses and of accidents off duty in certain categories of staff obviously calls for further study, both to confirm the validity of the problems disclosed and to elucidate their causes. Two methods of study are available. First, the study of the individual case histories of those cases brought to light in the present study (or a random sample of them); second, a prospective study beginning now and continuing into the future in which the records of certain categories of staff with certain types of illness are made in such a way that additional information will be available which may serve to confirm or refute certain hypotheses.

It may be mentioned that neither the original survey that brought to light the suggestive findings nor either of the suggested methods of following-up these findings would have been possible without the special recording procedure in use during the last three years.

Summary

22. This survey has shown that comprehensive recording of long-term sickness in the Council's staff is possible; in addition certain significant findings have been disclosed.

In the grades of staff where the numbers were adequate for a comparison between the sexes—A.P.T. & C. group and teaching staff—the incidence of long-term sickness was generally higher in females than in males. The incidence of sickness in A.P.T. & C. grades was about twice that in teachers; in nursing staff it approximated to that in female A.P.T. & C. grades; and fire and ambulance staff had the highest incidence of all, but this may have been due to the practice within these two grades of earlier referral to the examining medical officer.

The wastage rate by permanent unfitness for further duty or by death in the service amounted to as much as five per cent. a year for both men and women aged 55–64 years in the administrative, professional, technical and clerical staff.

Psychoneuroses and psychoses were the principal causes of long-term sickness in female A.P.T. & C. grades, in both men and women teachers and was the second principal cause in male A.P.T. & C. grades. Fire and ambulance staffs had proportionately fewer psychoneurotic difficulties but experienced more hernias, diseases of the bone and organs of movement and accidents not on duty.

Diseases of the genital organs were relatively common (8–11 per cent. of all causes) in all grades of female staff, more noticeable around the age of the menopause.

TABLE 1—*Staff long-term sickness* 1961–63

Numbers employed, number sick, duration of sickness and disposal by age, sex and grade

Age (years)	*No. employed mid 1964*	*No. sick 1961–63*		*Persons sick per cent of total employed*	*Duration of sickness—months*		*Disposal—each spell of sickness*						
		Spells	*Persons*		*Total*	*Average per spell of sickness*	*Fit to resume duty*	*Resigned*	*Permanently unfit*	*Died*	*Other*	*Total*	*No. died and P.U. as per cent of No. employed*
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)
						A.—A.P.T. & C. staff—MALES							
Under 25 ..	1,630	16	14	0·9	51	3·2	12	4	—	—	—	16	—
25–34	1,692	55	50	3·0	162	2·9	42	8	1	—	4	55	0·06
35–44	1,939	105	92	4·8	358	3·4	88	8	4	3	2	105	0·36
45–54	1,764	174	144	8·2	472	2·7	139	2	12	15	6	174	1·53
55–64	534	321	272	51·0	1,060	3·3	218	14	54	24	11	321	14·62
65 and over ..	107	65	61	57·0	279	4·3	28	17	15	4	1	65	17·77
Total ..	7,666	736	633	8·3	2,382	3·2	527	53	86	46	24	736	1·73
						A.—A.P.T. & C. staff—FEMALES							
Under 25 ..	1,855	28	27	1·5	63	2·3	18	6	2	—	2	28	0·11
25–34	1,130	85	77	6·8	256	3·0	65	15	4	—	1	85	0·35
35–44	1,623	180	153	9·4	548	3·0	142	15	14	2	7	180	0·99
45–54	1,348	206	182	13·5	615	3·0	170	8	17	4	7	206	1·56
55–64	381	174	149	39·2	566	3·3	88	8	59	9	10	174	17·85
65 and over ..	61	20	20	32·8	51	2·6	10	4	5	1	—	20	9·83
Total ..	6,398	693	608	9·5	2,099	3·0	493	56	101	16	27	693	1·83
						B.—Teaching staff—MALES							
Under 25 ..	550	6	5	0·9	10	1·7	6	—	—	—	—	6	—
25–34	2,170	38	32	1·5	86	2·3	34	2	—	—	2	38	—
35–44	2,175	72	64	2·9	175	2·4	60	9	1	—	2	72	—
45–54	2,180	86	79	3·6	218	2·5	71	—	3	7	5	86	0·46
55–64	1,275	106	91	7·1	316	3·0	68	11	12	9	6	106	1·65
65 and over ..	110	13	12	10·9	49	3·8	9	2	—	—	2	13	—
Total ..	8,460	321	283	3·3	854	2·7	248	24	16	16	17	321	0·38
						B.—Teaching staff—FEMALES							
Under 25 ..	2,030	52	46	2·3	91	1·8	37	11	1	—	3	52	0·05
25–34	3,505	123	107	3·1	442	3·6	97	13	1	4	8	123	0·14
35–44	2,255	146	125	5·5	410	2·8	118	12	4	5	7	146	0·40
45–54	2,230	164	153	6·9	465	2·8	143	8	5	5	3	164	0·45
55–64	1,845	216	176	9·5	681	3·2	149	20	24	14	9	216	2·06
65 and over ..	175	28	25	14·3	92	3·3	16	6	3	2	1	28	2·86
Total ..	12,040	729	632	5·2	2,182	3·0	560	70	38	30	31	729	0·57

TABLE 1—*Staff long-term sickness* 1961–63—*continued*

Numbers employed, number sick, duration of sickness and disposal by age, sex and grade—continued

Age (years)	*No. employed mid 1964*	*No. sick 1961–63*		*Persons sick per cent of total employed*	*Duration of sickness—months*		*Disposal—each spell of sickness*						
		Spells	*Persons*		*Total*	*Average per spell of sickness*	*Fit to resume duty*	*Resigned*	*Permanently unfit*	*Died*	*Other*	*Total*	*No. died and P.U. as per cent of No. employed*
(1)	*(2)*	*(3)*	*(4)*	*(5)*	*(6)*	*(7)*	*(8)*	*(9)*	*(10)*	*(11)*	*(12)*	*(13)*	*(14)*
						C.—Nursing staff—FEMALES							
Under 25 ..	801	22	21	2·6	40	1·8	17	2	1	—	2	22	0·12
25–34	412	28	28	6·8	101	3·6	16	5	4	—	3	28	0·97
35–44	506	39	35	6·9	85	2·2	33	2	2	—	2	39	0·40
45–54	444	56	51	11·5	228	4·1	43	4	5	2	2	56	1·58
55–64	121	52	49	40·5	181	3·5	28	3	13	5	3	52	14·88
65 and over ..	7	3	3	42·9	11	3·7	—	2	—	1	—	3	14·29
Total ..	2,291	200	187	8·2	646	3·2	137	18	25	8	12	200	1·44
						D.—Fire officers and firemen—MALES							
Under 25 ..	483	27	26	5·4	41	1·5	22	5	—	—	—	27	—
25–34	807	76	65	8·1	138	1·8	56	6	12	—	2	76	1·49
35–44	579	94	79	13·6	182	1·9	77	2	14	—	1	94	2·42
45–54	517	169	138	26·7	294	1·7	128	1	32	5	3	169	7·16
55–64	117	46	38	32·5	83	1·8	28	2	12	1	3	46	11·11
Total ..	2,503	412	346	13·8	738	1·8	311	16	70	6	9	412	3·04
						E.—Ambulance officers and ambulance drivers/attendants—MALES							
Under 25 ..	55	5	5	9·1	2	0·4	3	—	1	—	1	5	1·82
25–34	227	22	20	8·8	28	1·3	20	1	1	—	—	22	0·44
35–44	245	26	25	10·2	40	1·5	23	1	2	—	—	26	0·82
45–54	209	43	36	17·2	57	1·3	31	4	6	1	1	43	3·35
55–64	121	38	33	27·3	75	2·0	28	2	7	—	1	38	5·79
65 and over ..	8	2	2	25·0	9	4·5	1	1	—	—	—	2	—
Total ..	865	136	121	14·0	211	1·6	106	9	17	1	3	136	2·08

TABLE 1—*Staff long-term sickness 1961–63—Cause of sickness by age, sex and grade.*

Code No.	Cause of sickness	A—A.P.T. & C. staff															
		Males								Females							
	Age	Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %	Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %
01	Tuberculosis respiratory	2	7	17	13	15	3	57	7·7	6	6	14	7	1	1	35	5·1
02	Tuberculosis, other forms	1	3	2	2	1	—	9	1·2	—	2	—	—	1	—	3	0·4
03	Syphilis and its sequelae	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
04	Gonococcal infection	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
05	Dysentery	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	0·1
06	Other infective diseases (intestinal)	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	0·1
07	Diseases common in children	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
08	Typhus and rickettsial diseases	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
09	Malaria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10	Diseases due to helminths	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
11	Other infective and parasitic diseases	—	1	2	1	2	—	6	0·8	—	2	2	—	2	—	6	0·9
12	Cancer	—	—	3	9	21	4	37	5·0	—	—	11	17	23	2	53	7·6
13	Non-malignant neoplasms	—	1	—	3	3	—	7	1·0	—	—	1	6	—	—	7	1·0
14	Allergic disorders	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
15	Diseases of thyroid gland	—	—	—	—	2	—	2	0·3	—	2	3	5	1	—	11	1·6
16	Diabetes mellitus	—	1	—	2	3	—	6	0·8	—	1	—	1	—	1	3	0·4
17	Avitaminosis and deficiency state	—	—	—	—	1	—	1	0·1	—	—	1	—	—	—	1	0·1
18	Anaemias	—	—	—	4	4	1	9	1·2	—	1	3	5	5	—	14	2·0
19	Psychoneuroses and psychoses	4	9	16	21	23	4	77	10·5	7	26	44	25	15	1	118	17·0
20	Diseases of nervous system	—	3	1	8	16	3	31	4·2	—	—	4	6	4	1	15	2·2
21	Diseases of eye	—	—	4	4	5	4	17	2·3	—	2	3	3	3	—	11	1·6
22	Diseases of ear	—	—	—	4	6	—	10	1·4	2	—	1	1	2	1	7	1·0
23	Rheumatic fever	—	—	1	1	1	—	3	0·4	—	—	—	—	—	—	—	—
24	Chronic rheumatic heart disease	—	1	1	2	6	2	12	1·6	—	—	1	6	3	—	10	1·4
25	Arteriosclerotic and degenerative heart disease	—	1	5	21	34	8	69	9·4	—	—	1	5	11	—	17	2·5
26	Hypertensive disease	—	—	3	5	28	9	45	6·1	—	—	—	6	12	1	19	2·7
27	Diseases of veins	—	—	—	5	5	1	11	1·5	—	1	7	7	6	—	21	3·0
28	Common cold	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
29	Pharyngitis and diseases of tonsils and adenoids	—	—	—	1	—	—	1	0·1	—	—	1	1	2	—	4	0·6
30	Influenza	—	1	—	1	—	—	2	0·3	—	1	—	1	2	—	4	0·6
31	Pneumonia	—	—	2	1	2	1	6	0·8	—	—	—	2	—	—	2	0·3
32	Bronchitis	—	—	3	9	37	6	55	7·5	—	2	3	5	7	—	17	2·5
33	Silicosis and occupational pulmonary fibrosis	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
34	All other respiratory	2	—	4	6	10	—	22	3·0	—	—	3	2	—	1	6	0·9
35	Diseases of stomach and duodenum	—	2	1	8	13	1	25	3·4	—	2	—	2	5	—	9	1·3
36	Appendicitis	—	1	1	2	—	—	4	0·5	3	1	—	1	1	—	6	0·9
37	Hernia	—	1	2	1	8	—	12	1·6	—	—	1	3	—	—	4	0·6
38	Diarrhoea and enteritis	—	—	—	3	—	1	4	0·5	—	1	1	1	1	—	4	0·6
39	Diseases of gallbladder and bile ducts	—	2	3	3	3	—	11	1·5	—	—	—	4	1	1	6	0·9
40	Other digestive	—	—	1	3	4	1	9	1·2	1	1	2	—	3	—	7	1·0
41	Nephritis	—	—	1	—	—	—	1	0·1	1	5	2	2	1	—	11	1·6
42	Diseases of genital organs	—	—	1	4	7	5	17	2·3	1	7	23	36	8	2	77	11·1
43	Complications of pregnancy and childbirth	—	—	—	—	—	—	—	—	1	3	1	—	—	—	5	0·7
44	Boils, abscess and skin infections	—	—	1	1	1	—	3	0·4	—	—	3	2	—	—	5	0·7
45	Other diseases of skin	—	2	1	3	3	1	10	1·4	2	1	—	1	—	—	4	0·6
46	Arthritis and rheumatism	1	1	3	3	20	2	30	4·1	1	2	7	9	17	4	40	5·8
47	Diseases of bones and organs of movement	—	2	9	14	5	—	30	4·1	—	3	19	10	11	1	44	6·3
48	Congenital malformations	1	—	1	—	—	—	2	0·3	—	1	1	1	3	—	6	0·9
49	Other diseases	—	—	2	1	1	—	4	0·5	1	2	1	1	7	—	12	1·7
50	Accidents (Not on duty)	5	13	9	5	21	7	60	8·2	1	7	9	16	9	3	45	6·5
—	Not stated	—	3	1	2	10	1	17	—	1	3	6	5	7	—	22	—
	TOTAL	16	55	103	174	323	65	736	100·0	21	85	180	206	174	27	693	100·0

Code No.	Cause of sickness	B—Teaching staff															
		Males								Females							
	Age	Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %	Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %
01	Tuberculosis respiratory	1	9	16	2	3	—	31	10·1	4	9	4	4	—	—	21	3·0
02	Tuberculosis, other forms	1	—	—	1	—	—	2	0·6	—	1	—	—	—	1	2	0·3
03	Syphilis and its sequelae	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
04	Gonococcal infection	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
05	Dysentery	—	1	—	—	—	—	1	0·3	—	—	—	—	—	—	—	—
06	Other infective diseases (intestinal)	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
07	Diseases common in children	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	0·1
08	Typhus and rickettsial diseases	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
09	Malaria	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
10	Diseases due to helminths	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
11	Other infective and parasitic diseases	—	—	—	1	1	—	2	0·6	5	3	1	—	2	—	11	1·5
12	Cancer	—	—	3	3	6	1	13	4·0	—	1	3	18	36	4	64	8·8
13	Non-malignant neoplasms	—	—	—	—	1	1	2	0·6	—	—	2	3	6	2	13	1·8
14	Allergic disorders	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	0·1
15	Diseases of thyroid gland	—	—	3	2	3	—	8	2·5	—	2	5	6	4	—	17	2·3
16	Diabetes mellitus	—	—	—	—	—	—	—	—	—	—	1	1	1	—	3	0·4
17	Avitaminosis and deficiency state	—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	0·1
18	Anaemias	—	1	—	1	1	—	3	0·9	—	1	2	1	3	2	9	1·2
19	Psychoneuroses and psychoses	1	8	15	19	15	1	59	18·4	18	46	48	20	27	1	160	21·9
20	Diseases of nervous system	—	2	2	4	3	—	11	3·4	1	10	2	7	3	—	23	3·2
21	Diseases of eye	—	—	—	2	4	—	6	1·9	1	1	—	5	10	2	19	2·6
22	Diseases of ear	—	—	—	—	2	—	2	0·6	1	—	3	5	1	—	10	1·4
23	Rheumatic fever	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—
24	Chronic rheumatic heart disease	—	—	—	3	2	—	5	1·6	—	1	3	3	2	—	9	1·2
25	Arteriosclerotic and degenerative heart disease	—	—	5	13	20	3	41	12·8	—	1	—	3	9	4	17	2·3
26	Hypertensive disease	—	—	1	3	11	—	15	4·7	—	—	2	1	17	1	21	2·9
27	Diseases of veins	—	—	—	—	2	—	2	0·6	—	—	1	3	2	—	6	0·8
28	Common cold	—	—	1	—	—	—	1	0·3	—	—	—	—	—	—	—	—
29	Pharyngitis and diseases of tonsils and adenoids	—	—	—	1	—	—	1	0·3	—	1	1	—	—	—	2	0·3
30	Influenza	—	—	—	—	—	—	—	—	—	2	2	—	—	2	6	0·8
31	Pneumonia	—	—	3	4	4	—	11	3·4	1	—	2	—	4	—	7	1·0
32	Bronchitis	—	3	1	3	3	1	11	4·0	1	1	—	—	7	—	9	1·2
33	Silicosis and occupational pulmonary fibrosis	—	—	—	—	1	—	1	0·3	—	—	—	—	—	—	—	—
34	All other respiratory	—	—	2	—	—	—	2	0·6	2	4	4	1	2	—	13	1·8
35	Diseases of stomach and duodenum	—	—	—	2	1	—	3	0·9	—	3	—	2	6	—	11	1·6
36	Appendicitis	—	—	—	2	—	—	2	0·6	1	—	3	1	3	—	8	1·1
37	Hernia	—	3	3	—	1	2	9	2·8	—	—	1	4	1	—	6	0·8
38	Diarrhoea and enteritis	—	1	2	—	1	1	5	1·6	—	3	1	—	1	—	6	0·8
39	Diseases of gallbladder and bile ducts	—	—	—	1	1	—	2	0·6	—	—	1	4	2	—	7	1·0
40	Other digestive	—	1	—	—	1	—	2	0·6	—	1	3	1	4	—	8	1·1
41	Nephritis	—	—	2	—	—	—	2	0·6	—	1	—	—	3	1	6	0·8
42	Diseases of genital organs	—	—	1	1	1	—	3	0·9	2	3	18	26	9	—	57	8·1
43	Complications of pregnancy and childbirth	—	—	—	—	—	—	—	—	3	1	1	1	—	—	6	0·8
44	Boils, abscess and skin infections	—	—	—	2	—	—	2	0·6	—	—	—	3	1	—	4	0·5
45	Other diseases of skin	—	—	1	—	1	—	2	0·6	3	2	—	1	1	—	7	1·0
46	Arthritis and rheumatism	—	—	1	4	2	—	7	2·2	2	3	6	9	13	3	36	4·9
47	Diseases of bones and organs of movement	—	1	1	4	—	—	6	1·9	—	4	8	12	8	—	30	4·2
48	Congenital malformations	—	1	1	—	—	—	2	0·6	—	3	—	—	—	—	3	0·4
49	Other diseases	3	—	1	—	4	—	8	2·9	—	2	3	2	3	—	10	1·4
50	Accidents (Not on duty)	—	2	5	4	7	1	19	6·0	5	7	13	8	18	4	56	7·6
—	Not stated	—	3	3	3	1	1	11	—	2	5	7	6	4	1	23	—
	TOTAL	6	38	72	86	106	13	321	100·0	32	123	146	166	234	28	729	100·0

C—Nursing staff								D—Fire officers and firemen								E—Ambulance officers and ambulance drivers/attendants								Code No.	Cause of sickness
Females								Males								Males									
Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %	Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %	Under 25	25–34	35–44	45–54	55–64	65+	Total No.	Total %		
1	1	2	2	—	—	6	3·0	2	—	1	2	1	—	6	1·5	—	1	1	2	1	—	5	3·7	01	Tuberculosis respiratory
—	1	1	—	—	—	2	1·0	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	02	Tuberculosis, other forms
—	—	—	—	1	—	1	0·5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	03	Syphilis and its sequelae
—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	0·2	—	—	—	—	—	—	—	—	04	Gonococcal infection
—	—	—	1	—	—	1	0·5	—	—	2	—	—	—	2	0·5	—	—	—	—	—	—	—	—	05	Dysentery
1	—	—	1	—	—	2	1·0	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	06	Other infective diseases (intestinal)
—	1	—	—	—	—	1	0·5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	07	Diseases common in children
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	08	Typhus and rickettsial diseases
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	09	Malaria
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	10	Diseases due to helminths
—	2	—	—	1	—	3	1·5	—	—	—	—	—	—	—	—	—	2	—	—	—	—	2	1·5	11	Other infective and parasitic diseases
—	2	6	7	6	1	22	11·0	—	—	4	2	2	—	8	1·9	—	—	—	1	—	—	1	0·7	12	Cancer
—	—	2	—	—	—	2	1·0	—	1	1	3	2	—	7	1·7	—	—	—	1	2	—	3	2·2	13	Non-malignant neoplasms
—	—	—	—	1	—	1	0·5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	14	Allergic disorders
—	—	—	1	2	—	3	1·5	—	—	—	—	—	—	—	—	—	—	1	—	—	—	1	0·7	15	Diseases of thyroid gland
—	2	—	1	1	—	4	2·0	—	—	2	1	—	—	3	0·7	—	—	—	1	—	—	1	0·7	16	Diabetes mellitus
—	—	—	—	—	—	—	—	—	—	1	1	—	—	2	0·5	—	—	—	—	—	—	—	—	17	Avitaminosis and deficiency state
—	1	1	1	—	—	3	1·5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	18	Anaemias
6	6	6	9	—	—	27	13·5	2	4	10	9	1	—	28	6·8	—	—	—	2	—	—	2	1·5	19	Psychoneuroses and psychoses
—	—	1	—	2	—	3	1·5	1	7	4	5	1	—	18	4·4	—	1	2	1	1	—	5	3·7	20	Diseases of nervous system
—	—	—	—	—	—	—	—	—	4	1	5	1	—	11	2·7	—	—	—	2	—	—	2	1·5	21	Diseases of eye
—	—	—	1	1	—	2	1·0	—	—	2	5	—	—	7	1·7	—	1	—	1	—	—	2	1·5	22	Diseases of ear
—	1	—	—	1	—	2	1·0	—	—	—	—	—	—	—	—	1	—	—	—	—	—	1	0·7	23	Rheumatic fever
—	—	—	1	1	—	2	1·0	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	0·7	24	Chronic rheumatic heart disease
—	—	—	1	2	—	6	3·0	—	—	3	15	7	—	25	6·1	—	—	3	3	2	—	8	5·9	25	Arteriosclerotic and degenerative heart disease
—	—	—	2	3	2	7	3·5	—	—	1	9	1	—	11	2·7	—	—	—	2	3	—	5	3·7	26	Hypertensive disease
—	1	1	2	—	—	4	2·0	—	—	1	3	2	—	6	1·5	—	—	3	—	1	—	4	3·0	27	Diseases of veins
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	28	Common cold
—	—	—	—	—	—	—	—	—	—	—	1	—	—	1	0·2	1	—	—	—	—	—	1	0·7	29	Pharyngitis and diseases of tonsils and adenoids
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	1	0·7	30	Influenza
—	—	—	2	1	—	3	1·5	—	—	2	—	—	—	2	0·5	—	2	—	1	—	—	3	2·2	31	Pneumonia
—	—	—	4	1	—	5	2·5	—	1	—	5	1	—	7	1·7	—	—	—	2	3	—	5	3·7	32	Bronchitis
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	33	Silicosis and occupational pulmonary fibrosis
1	—	1	1	—	—	3	1·5	—	—	—	1	1	—	2	0·5	—	2	—	2	—	—	4	3·0	34	All other respiratory
1	1	—	—	1	—	3	1·5	—	3	4	17	3	—	27	6·6	—	1	1	3	2	1	8	5·9	35	Diseases of stomach and duodenum
2	—	—	—	—	—	2	1·0	—	2	—	1	2	—	5	1·2	—	—	2	—	2	—	4	3·0	36	Appendicitis
—	—	—	2	—	—	2	1·0	1	4	2	11	5	—	23	5·6	—	—	1	3	2	1	7	5·2	37	Hernia
—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	38	Diarrhoea and enteritis
1	—	—	—	2	—	3	1·5	—	1	—	—	1	—	2	0·5	—	—	—	—	—	—	—	—	39	Diseases of gallbladder and bile ducts
—	1	—	1	2	—	4	2·0	—	—	1	—	—	—	1	0·2	—	—	1	—	—	—	1	0·7	40	Other digestive
1	—	—	—	1	—	2	1·0	—	1	1	1	1	—	4	1·0	—	1	1	1	—	—	3	2·2	41	Nephritis
4	1	10	4	1	—	20	10·0	—	1	—	1	—	—	2	0·5	—	—	—	—	3	—	3	2·2	42	Diseases of genital organs
—	1	—	—	—	—	1	0·5	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	—	43	Complications of pregnancy and childbirth
—	—	—	1	—	—	1	0·5	—	1	—	2	1	—	4	1·0	—	—	1	—	—	—	1	0·7	44	Boils, abscess and skin infections
—	—	1	—	—	—	1	0·5	—	5	2	6	—	—	13	3·2	—	2	4	1	6	—	13	9·6	45	Other diseases of skin
3	1	1	1	5	—	11	5·5	1	3	3	14	4	—	25	6·1	—	—	2	2	—	—	4	3·0	46	Arthritis and rheumatism
—	1	6	1	2	—	10	5·0	4	9	15	18	4	—	50	12·1	—	3	2	3	3	—	11	8·1	47	Diseases of bones and organs of movement
1	—	—	—	—	—	1	0·5	—	—	—	1	—	—	1	0·2	—	—	—	—	1	—	1	0·7	48	Congenital malformations
—	—	—	3	3	—	6	3·0	1	2	1	—	—	—	4	1·0	—	—	—	1	—	—	1	0·7	49	Other diseases
2	1	—	4	4	—	11	5·5	14	22	29	28	4	—	97	23·5	3	4	2	7	5	—	21	15·4	50	Accidents (Not on duty)
—	1	2	2	2	—	7	—	1	1	1	4	1	—	8	—	—	—	—	1	—	—	1	—	—	Not stated
22	28	39	56	52	3	200	100·0	27	76	94	169	46	—	412	100·0	3	22	26	43	38	2	136	100·0		TOTAL

APPENDIX C

Statistics of the administrative work carried out by the Metropolitan Borough Councils in 1964.

BOROUGH	DWELLINGS: Erected by Borough Council	DWELLINGS: Erected by other persons	DWELLINGS: Total number in the Borough
Division 1			
Chelsea	48	95	17,129
Fulham	93	7	50,184
Hammersmith	78	—	35,200
Kensington	58	113	42,787
Division 2			
Hampstead	176	213	25,192
Paddington	—	239	37,765
St. Marylebone	88	489	23,117
St. Pancras	414	149	39,797
Westminster, City of	—	285	27,862
Division 3			
Finsbury	119	8	9,340
Holborn	33	3	3,096
Islington	1172	1127	41,537
Division 4			
Hackney	131	187	50,393
Shoreditch	*	*	*
Stoke Newington	44	77	12,486
Division 5			
Bethnal Green	285	308	14,205
City of London	—	—	1,051
Poplar	50	421	18,921
Stepney	34	312	26,130
Division 6			
Deptford	*	*	*
Greenwich	231	264	25,012
Woolwich	345	581	46,172
Division 7			
Camberwell	266	551	46,467
Lewisham	409	*	66,307
Division 8			
Bermondsey	140	114	15,665
Lambeth	*	*	57,258
Southwark	92	49	28,251
Division 9			
Battersea	14	157	28,124
Wandsworth	640	744	122,800
LONDON	5,905	5,355	879,765

* Information not available. † 20 repair conversions. ‡ 49 L.C.C. repair conversions. § 327 (Total No. of persons displaced from both unfit and other houses).

INDEX

References to local activities in the sphere of chiropody, health education, mental health education, home making courses, problem families, prophylaxis, etc., will be found in the divisional medical officers' reports, pages 140-158.

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INDEX—*continued*

References to local activities in the sphere of orthopædic, health education, mental health, home nursing, nursing, problem families, prophylaxis, etc., will be found in the divisional medical officers' reports, pages 146–151.

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